

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

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.

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

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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(caption continued from cover page):

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

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 Trident's got a market share for the entire
2 county at 53 percent or 54 percent, it's market
3 share in the zip codes within this seven mile
4 radius, which is what Roper's drawn, in fact,
5 in their first draft of the application they
6 said that's the service area. They expect 80
7 percent of the patients to come from within
8 that seven miles. Now, they don't tell you
9 where their patients are coming from but they
10 still draw the circle. So it's obviously
11 important to them. They make an argument that
12 Goose Creek's got more people than Moncks
13 Corner and it's growing faster and so that must
14 be the community they're serving. And if
15 that's the community they're serving, they're
16 targeting an area that's well-served by two
17 existing providers that are in the Trident
18 system who have a higher market share in those
19 zip codes than they do countywide. So if you
20 think about it, it's quite possible that if the
21 Roper system actually gets most of its patients
22 from within this seven mile circle, the adverse
23 impact could be higher than I'd estimated
24 because instead of 54 percent being the
25 appropriate number for Trident, it might be 60

1 percent or slightly higher than 60 percent,
2 which means that they would get more adverse
3 impact assigned to them.

4 Q: Okay. And would you go to, we're almost done
5 with Petitioner's 46, if you'd go to Baehr 1627
6 and 1628.

7 A: Okay. I got it.

8 Q: Could you explain to the Court please --

9 A: Yeah, this is the backup for two of the numbers
10 in the adverse impact calculations, 1627 shows
11 the relationship between inpatient gross
12 revenues and total gross revenues that Roper is
13 projecting for their new hospital. So if you
14 look on 1627, look at year three over on the
15 right, \$61 million in inpatient gross revenue,
16 \$120 million in total. That's where we come up
17 with our multiplier of two. In other words,
18 the total hospital activity is about twice the
19 inpatient activity and that's why you make that
20 adjustment to inpatient admissions lost to a
21 adjusted admissions lost. And then on 1628 is
22 the historic data for both Roper and Trident of
23 the Berkeley County residents that they have
24 served, how many of them were tertiary and
25 specialty versus non-tertiary, non-specialty.

1 And again, you can see the ratios are about 12
2 percent or 1 to 7, 1 to 8 for the two
3 hospitals.

4 Q: Okay. And then on 1629, that's your, it's
5 labeled 1629 through, let's see here, 1649; is
6 that the technical appendix?

7 A: Yeah. This is backup data with calculations
8 that support some of these tables we've gone
9 through this morning.

10 Q: Okay.

11 A: In addition to the other Petitioner Exhibits
12 you've mentioned.

13 Q: All right. We've talked a lot about
14 redirection and -- actually, before we jump
15 out of 46, go back to 1625 for me. I think I
16 did say we were going to go back to that slide.

17 A: Okay.

18 Q: I skipped that.

19 A: Yeah, I got it.

20 Q: Do you have an opinion as to Roper's assumption
21 of the 50 percent patient redirection?

22 A: Yeah. I think given where they're locating and
23 how the patient population from the area
24 they're proposing to serve is now, where that
25 patient population is now going, I think it's

1 much more likely that they will take more from
2 existing providers and rely less on
3 redirection, again, given the historic market
4 shares and the market shares in this particular
5 collection of zip codes within that seven mile
6 radius. And evidence of that is that we have
7 initial data now on what's happening in Mount
8 Pleasant. And in Mount Pleasant there was an
9 assumption that two-thirds of the existing
10 volume at Roper and Bon Secours would be
11 transferred to the new Mount Pleasant Hospital.

12 Q: So not --

13 A: Two-thirds. That's higher.

14 Q: Right. Okay.

15 A: Yeah. In Berkeley County they're assuming 50
16 percent of the Roper business will move over to
17 the new hospital. In Mount Pleasant they
18 assumed two-thirds. So far, based on the data
19 that we're able to get, that we've looked at in
20 discovery for the first eight months of 2011,
21 there doesn't appear to be any redirection. In
22 fact, all of the Mount Pleasant volume appears
23 to be pick up from other providers.

24 Q: Okay. Explain what you did to make that
25 determination.

1 A: Yeah. There are zip codes that are identified
2 as the service in the Mount Pleasant
3 application as you know. In Mount Pleasant
4 they provided a service area, they provided zip
5 codes. In this application in Berkeley County
6 they didn't, which to me is a major deficiency.
7 The State, at a minimum, should have asked them
8 for that so they would know where their
9 reported access improvement was coming from and
10 where their adverse impact might be. They
11 didn't do that so I don't think the State could
12 have made a judgement on weighing and balancing
13 their application. But in the Mount Pleasant
14 they did say we expect to get a certain number
15 of our patients from these seven zip codes.
16 They expected actually a larger amount to come
17 from out of the service than was the case in
18 Berkeley County. So we have the data. If you
19 look at the 2010 column here, it shows you for
20 the seven zip codes how many patients in 2010
21 went to Roper and how many went to Bon Secours.
22 And in total in 2010 from the seven zip codes
23 in the service area, Roper's two hospitals
24 obtained 1,826 admissions.
25 Q: Let me ask you, Bon Secours, that is a Roper-

1 affiliated hospital?

2 A: Yeah, that's the St. Francis hospital in the
3 West Ashley area.

4 Q: All right.

5 A: Okay.

6 Q: I just wanted to make that clear for the
7 record.

8 A: Now look at the middle column. We know now for
9 January to August 2011 we have data on how many
10 admissions roper and Bon Secours got from the
11 same seven zip codes. And in those eight
12 months they got 1,000 from Roper and 250 from
13 Bon Secours. But this is only eight months of
14 the year. So if we wanted to compare apples
15 versus apples, you need to take these eight
16 month figures an annualize them, which you can
17 do by multiplying by 1.5 or three over two.
18 Because 12 months of the year divided by eight
19 months of the year is basically 150 percent of
20 what you have in the eight month total. So if
21 you try to come up with a comparable number for
22 2011 to compare to 2010, look at the yellow
23 box, the bottom right-hand number, 1,825.
24 Essentially based on the activity through eight
25 months, Roper St. Francis downtown and the Bon

1 Secours downtown look like they will have
2 exactly the same volume from these seven zip
3 codes in 2011 when Mount Pleasant is open as
4 they had in 2010 when it was only open for two
5 months or slightly less than two months. That
6 would indicate to me so far there is no
7 redirection. Roper and Bon Secours are
8 maintaining their patient activity levels from
9 these historic zip codes and these zip codes
10 that are now the service area of the new
11 hospital. And if there's volume at the new
12 hospital, it's not coming at the expense of
13 Roper St. Francis, it's coming from either
14 growth in the market or volume coming from
15 market share shifts from East Cooper. Now,
16 remember we've seen that the East Cooper volume
17 numbers have dropped. They dropped in the
18 emergency room either by a little or a lot,
19 depending on which number you use, and they
20 dropped substantially on the inpatient side.
21 It looks like East Cooper has been hurt by the
22 Mount Pleasant facility opening. And that
23 shouldn't come as a great surprise when you
24 have 100 beds in an area and you approve two
25 facilities and suddenly you have 225 beds in

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1 the area. That doesn't strike me as good
2 healthcare planning, just as it doesn't strike
3 me as good healthcare planning to put 100 new
4 beds and two new hospitals in Berkeley County
5 when there's a need for only one.

6 Q: Okay. Would you go to Petitioner's 221 for me?

7 A: Okay.

8 Q: What's significant -- did you create this file,
9 Mr. Baehr?

10 A: Yes.

11 Q: Okay. What's the significance of this?

12 A: One of the things we wanted to do is, again,
13 each hospital is projecting that most of their
14 patient days at the new hospital will be in the
15 county in which they're located. Roper system
16 estimates about ten percent, in the case of the
17 Trident system there's a higher, slightly
18 higher percentage that comes from out of county
19 because of, primarily because of that split zip
20 code, 29483. But what we wanted to do was
21 compare the projected number of days in the
22 county that are needed for the hospitals to
23 meet their targets with the number of total
24 projected days expected for that system in the
25 county in 2017. If you follow the model, the

1 essentially population, age-specific population
2 driven model, same one the state uses to
3 forecast each systems patient days in 2017,
4 what it shows is Trident needs fewer than 30
5 percent of the projected days for the Trident
6 system in 2017 in Berkeley County, Roper needs
7 over two-thirds of the days, of its systems
8 days. Which again is why I think it's more
9 likely, more likely, that they will rely to a
10 larger extent on market share pick up and gains
11 from other providers than the amount of
12 redirection that they're projecting.

13 Q: Okay. And would you turn to Petitioner 227 for
14 me?

15 A: Okay.

16 Q: All right. Can you explain to the Court the
17 significance of this particular Exhibit?

18 A: Yeah. Mr. Richardson prepared some Exhibits in
19 which he basically operated under the
20 assumption there's nothing in Berkeley County,
21 there are no hospitals in Berkeley County, and
22 because there's no hospital within the contours
23 of the county, there's no hospital effectively
24 serving the county, which again I think is
25 false when you have a hospital that's one mile

1 away which is large tertiary institution. So
2 we took this approach, what if Trident Medical
3 Center was picked up and moved one mile or 1.2
4 miles and put inside of Berkeley County. All
5 right? And what that shows is if that was put
6 inside of Berkeley County, in terms of non-
7 tertiary beds, if you really had 296 beds
8 within the County, you wouldn't need any new
9 hospital beds. Now, I'm not saying all 296 of
10 those beds are serving Berkeley County patients
11 now, they're not and I wouldn't make that
12 claim. But it is equally absurd to claim that
13 the 296 beds at the Trident Medical Center
14 don't matter to Berkeley County and because
15 they're one mile south they can be ignored and
16 as a result Berkeley County can be compared to
17 a county with 15,000 people which doesn't have
18 any 296 bed tertiary facility located on its
19 doorstep. In essence, think about it this way.
20 Is Berkeley County better served right now,
21 particularly the southern half of the county
22 where most of the population is, two-thirds or
23 so of the population, by Trident Medical Center
24 being where it is than if you had a hospital
25 located in the county in one of those northern

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1 areas right by the border and you can say we've
2 got a bed in Berkeley County, 100 bed hospital,
3 200 bed hospital, it's in the county. Would
4 that serve residents of the County better where
5 it is than Trident Medical Center does where
6 it is, and the obvious answer is no. And to
7 ignore Trident Medical Center as if it's not a
8 facility so the State in its opinion can say
9 the first local provider is being approved with
10 a Roper facility, is simply false.

11 Q: Based on bed need, Mr. Baehr, is there, are you
12 aware of anything in the 2008-2009 State Health
13 Plan that indicates there's a need for a new
14 hospital in Goose Creek, South Carolina?

15 A: No.

16 MR. THOMAS: Can we take a quick break? I'm about
17 to wrap up and I just want to ask Mr. Summer a
18 couple of questions.

19 THE COURT: Five minutes.

20 MR. SUMMER: That would be perfect, Your Honor.
21 Thank you very much.

22 (Off the Record)

23 Q: Mr. Baehr, just a couple of summary questions
24 for you. If you, do you have a copy of the, in
25 front of you, regulation 61-15 that you can

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1 refer to?

2 A: Yes.

3 Q: And if you would turn to that section 802 for
4 me.

5 MR. THOMAS: Judge, do you need one?

6 THE COURT: It's under this mass of books here.

7 MR. THOMAS: Could be.

8 THE COURT: If you have another one handy, that
9 might be better.

10 MR. THOMAS: Yes, sir.

11 THE COURT: I believe I have it. Just a second.
12 Yes, I have it. Section what?

13 MR. THOMAS: 802.9, in your version it may be page
14 25.

15 A: Section 9?

16 Q: Yes, net income.

17 A: Okay.

18 Q: Okay. Now, I think you testified that Roper
19 St. Francis may have understated the
20 redirection, or excuse me, understated the
21 census at the new facility?

22 A: I think what they did is they may have
23 overstated the percentage of their total
24 patient population which was incremental based
25 on the numbers in Mr. Richardson's forecast.

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RECORD 001982

1 Q: Okay. And you believe that it resulted in over
2 projection of net revenue?

3 A: Yes. On the incremental basis it does.

4 Q: Okay. And why is that important with respect
5 to this particular project review criteria net
6 income?

7 A: Well, because Roper has chosen to provide the
8 Department its projection only on an
9 incremental basis, that's all the Department
10 can go on. And if instead of half of their
11 patients being incremental or new patients, the
12 actual number is 46 percent or 40 percent.
13 That's a loss of patient revenue, that's a loss
14 of volume of patient revenue and it's going to
15 shift the hospital income statement from a
16 small gain in year three to a much more
17 substantial loss because of that slope we were
18 talking about, which is almost \$4,000 per day.

19 Q: So it wouldn't satisfy project review criteria
20 nine?

21 A: They would not based on the older statement of
22 the number of incremental days. If they had
23 done it correctly, they would have been in a
24 loss position.

25 Q: Sarah, could you get up Joint 4 for me, 2008-

1 2009 State Health Plan?

2 A: That's Joint Exhibit 3.

3 Q: Four.

4 A: Four?

5 Q: Yeah. Go to page 219.

6 A: I have it.

7 Q: All right. In terms of the bed need at their
8 two facilities according to the 2008-2009 State
9 Health Plan in the tri-county service they had
10 bed need, correct?

11 A: Yes. Trident Medical Center and Summerville
12 Medical Center.

13 Q: Now is that bed need, that bed need based on
14 people using those facilities, correct?

15 A: It's based on the current occupancy levels of
16 those facilities, projected population growth,
17 and then a standard for target occupancy for a
18 particular size facility. But the fundamental
19 grounds on which all the forecasts are based is
20 current utilization. If your utilization is
21 high enough, you will show a bed need.

22 Q: And as a health planner and your knowledge of
23 health planning and State health planning in
24 South Carolina, do you believe that Trident and
25 Summerville have a stake in that future growth?

1 A: Of course.

2 Q: Okay. Why?

3 A: Well, A, they're committing capital and they
4 have made investments in the past which have
5 gotten them to the position there in the
6 future, they achieved sufficient volume so that
7 their projected growth enables them to show a
8 positive bed need. That bed need is either
9 going to be filled, it's going to be addressed,
10 or essentially those patients will wind up
11 coming to facilities and if they come to their
12 facilities, you result in occupancy levels
13 which are generally considered too busy, too
14 high.

15 Q: And the State says, right here, that they need
16 these beds, correct?

17 A: Correct. I think the Trident, if they didn't,
18 based on these forecasts, would have had
19 occupancy levels, Trident Medical Center, in
20 the mid-80 percent range by seven years into
21 the future if they didn't add any beds.

22 Q: But overall the other facilities do not have
23 bed need, correct?

24 A: That's correct.

25 Q: If you go back to regulation 61-15 for me real

1 quick.

2 A: Okay.

3 Q: And go to section 103 this time.

4 A: 103?

5 Q: Yes, sir. It's a definition section.

6 A: Okay. Give me a second. Okay.

7 Q: All right. Go to the competing applicants
8 definition for me.

9 A: Sure.

10 Q: Okay.

11 A: That's section six?

12 Q: Yes.

13 A: Competing applicants means, do you want me to
14 read it?

15 Q: Yes.

16 A: Competing applicants means two or more persons
17 and/or healthcare facilities as defined in this
18 regulation who have applied for certificates of
19 need to provide similar services and/or
20 facilities in the same service area and whose
21 applications if approved would exceed the need
22 for this facility or service.

23 Q: Okay.

24 A: And application shall be considered competing
25 if it is received by the Department no later

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1 than 15 days after a notice of affected persons
2 is published in the State Register for one or
3 more applications for similar services and/or
4 facilities in the same service area. All
5 applications received by the Department within
6 15 days of publication of the notice of
7 affected persons in the State Register for the
8 first application will be considered to be
9 competing. Any applications received by the
10 Department later than the 15th day following
11 publication of the notice of affected persons
12 in the State Register from the first
13 application will not be considered to be
14 competing to these applications.

15 Q: With respect to the first part up there, if
16 both approved would exceed the need, as a
17 planner who was asked by Trident to review
18 these two applications and who did present an
19 analysis to the State, do you think these
20 applications are competing per this definition
21 in the --

22 A: Yes.

23 Q: -- regulations?

24 A: Yes, I feel very strongly about that.

25 Q: And can you summarize why?

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1 A: Yeah. The two applicants are proposing the
2 same thing, new 50 bed hospitals, basically the
3 same mix of services, same cost, so in terms of
4 what they're proposing to provide, they
5 certainly satisfy the similar services and/or
6 facilities. The second test is the same
7 service area. Well, almost all the zip codes
8 in the counties overlap between the service
9 areas of one and the historic service area of
10 the other, since we don't know exactly what
11 service area Roper St. Francis is proposing.
12 But we do know where they're proposing to be
13 located and that's right on the border of two
14 zip codes which are crucial to the success of
15 Berkeley Regional Medical Center. So certainly
16 Roper at its proposed site is competitive with
17 Berkeley Regional Medical Center and its need
18 for patients to fill its facility from those
19 zip codes. The hospitals are a little less
20 than 12 miles apart, same zip code, same
21 county, same road, and if you go up and down
22 that road between the two of them, there are
23 obviously patients along that road who would be
24 competitive between the two institutions.
25 Obviously the ability of the hospital in Moncks

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1 Corner to get patients from the 29483 zip code
2 is impacted by having a hospital located on
3 that border closer to it. It certainly seems
4 to me that they're in the same service area.
5 The third issue is the hospitals are providing
6 the same stuff, they're doing it in the same
7 area, the only other test is whether there's a
8 need for both of them. And I have seen zero
9 evidence presented that suggests that there's
10 enough growth in the market to support two 50
11 bed hospitals. The only argument that's
12 offered is that Berkeley County has no beds so
13 really it could support a 250 bed hospital, as
14 if the hospitals that providing service to
15 Berkeley County patients now don't count, even
16 though one of them is only a mile away and is
17 located in a place that got the approval of the
18 county fathers from the two other counties that
19 agreed to close their hospital if Trident
20 Medical Center agreed to build where it chose
21 to build. It is as Mr. West, I believe was his
22 name, stated Trident Medical Center serves that
23 part of the County. It serves the southern
24 part of what he called New Berkeley County. So
25 if there's a need for a one 50 bed hospital and

1 you've got two 50 bed hospitals applying and
2 they're basically in the same zip code, that's
3 what some people would say are on top of each
4 other, it's a big county. It's 1,100 square
5 miles; 11 miles apart is not a big deal in a
6 county like Berkeley County, especially when
7 they're in the same zip code and the same road.
8 So I just don't see how you can not conclude
9 that they're competing applications.

10 Q: In the event that both are approved and HCA
11 made the business decision not to build, in
12 your opinion as an expert based on the adverse
13 impact analysis that you've done, communicated
14 to Trident Medical Center management and the
15 division office management of HCA, would you
16 believe that that, in your opinion, is that a
17 prudent decision?

18 A: Again, I'm a consultant, they're the managers.
19 This decision is theirs, it's not mine. What
20 I've provided to them is the information to
21 help make that decision and the information
22 shows that if two hospitals are built, the
23 impact on the ability of the Moncks Corner
24 facility to be successful I think is
25 catastrophic. I think it simply becomes

1 impossible in a short term for any number of
2 years for that hospital to consequently have a
3 chance to succeed. It's a small margin
4 hospital as a standalone. Take away
5 essentially the two zip codes, pretty much all
6 of one and a significant portion of another,
7 that the hospital depends on for its success,
8 I just don't see how you've got the volume
9 sufficient to make that hospital have it as a
10 going concern.

11 Q: Did you --

12 A: It's not going to make money. I mean, the
13 decision about going concern, I mean, obviously
14 if someone builds it they're going to decide to
15 keep it open, but it's not going to be
16 profitable any time soon.

17 Q: Well, not only is not going to be profitable
18 according to your analysis, but then Trident
19 also has to deal with an adverse impact --

20 A: Sure.

21 Q: -- as well, correct?

22 A: Yeah, it's going to have an adverse impact from
23 the second hospital that's built. It will kill
24 the chances of the first hospital being
25 successful. Yeah, I think that's pretty

1 dramatic stuff.

2 Q: Mr. Baehr, did you have an opportunity to
3 review some resolutions that supported
4 endorsing a citizens petition that only one
5 hospital is needed in Berkeley County and it
6 should be located in Moncks Corner, South
7 Carolina? Did you see those?

8 MR. LONG: Your Honor, I'm going to object to this
9 line of questioning. I mean, he -- we were
10 given those resolutions a couple of days ago.
11 I've looked at them, but these are resolutions
12 made by the political entities and I don't see
13 how that would be relevant to an opinion that
14 he could give as a health planner in regards to
15 this matter.

16 MR. THOMAS: Actually, Your Honor, what the
17 resolutions are is attached petitions by the
18 citizens of Berkeley County, by the citizens of
19 four townships in Berkeley County. And, you
20 know, the petition is from the citizens of
21 Bonneau, Jamestown, Moncks Corner and St.
22 Stephen, which are in upper Berkeley County.
23 And it basically indicates their support for
24 only one hospital in Berkeley County which is
25 to be located in Moncks Corner. These

1 petitions are affixed to resolutions which were
2 taken up by the city councils in the, you know,
3 the various town councils in the Berkeley
4 County and they're certified as true and
5 correct. So they attached a public petition,
6 they're documents that this expert can rely
7 upon to give a further opinion about community
8 support and in some respects opposition to
9 Roper's project but community support for the
10 Moncks Corner project. I think he's allowed to
11 testify to them and that they should come into
12 evidence.

13 **MR. LONG:** Your Honor, he hasn't laid any
14 foundation. And a couple of things that I
15 would point out about it. First is in regards
16 to the community support issue, these documents
17 would be irrelevant to the determination of
18 the, that determination before the Court
19 because there's no doubt that both projects
20 have substantial community support. Mr. Baehr
21 has testified now for over six and a half
22 hours. He's never mentioned anything about
23 what other people in the community think in
24 regards to his opinions. He testifies in
25 regards to health planning, he spent all day

1 talking about calculations, numbers, and other
2 aspects to what he does, and he's not going to
3 -- to say that his opinion would be affected by
4 what people in the community signed on a
5 petition is kind of absurd, Your Honor.

6 **THE COURT:** What do you say about the admissibility,
7 generally, they come in under the public
8 records exception, is that the basis for it?

9 **MR. THOMAS:** Yes, Your Honor. That's exactly why
10 they're all certified.

11 **MR. LONG:** Your Honor, we really haven't, we've
12 looked at this briefly in regards to it because
13 we were just handed it,-- it comes very late in
14 the process. These documents were done
15 earlier, they handed them to us during the
16 trial. I don't think that --

17 **MR. THOMAS:** There's nothing to look at.

18 **MR. LONG:** Well --

19 **MR. THOMAS:** It's a petition.

20 **MR. LONG:** They were handed to us -- yeah, but the
21 documents and the information itself were
22 handed to us then. I haven't studied the
23 hearsay exception about the public record, Your
24 Honor, I mean, they claim that they are stamped
25 and certified. But if a -- I still think a

1 resolution of what a community says in January
2 is irrelevant to the ultimate decisions that
3 need to be made in this case.

4 **THE COURT:** Well, are you willing to stipulate, I
5 believe is what you said a moment ago, that
6 it's community support from both sides of the
7 aisle; isn't that correct?

8 **MR. LONG:** Yeah, I mean Your Honor, there's no doubt
9 about that. I mean both projects have
10 community support. I don't think that there's
11 any question that communities -- hundreds --
12 it's all in the application, hundreds of people
13 wrote letters supporting the hospital in Moncks
14 Corner, hundreds wrote letters supporting the
15 hospital in Goose Creek.

16 **THE COURT:** That being said I'm going to sustain
17 your objection and not allow those.

18 **MR. THOMAS:** You're not going to allow these in?
19 Can I at least put my argument on the record,
20 Your Honor.

21 **THE COURT:** You --

22 **MR. LONG:** I think he already has, Your Honor.

23 **MR. THOMAS:** I really haven't had, I mean, I've
24 barely got a chance to speak. First of all,
25 they are public records, they're not hearsay.

1 Secondly, they go to acceptability under the
2 project review criteria. Mr. Long just said
3 Mr. Baehr hasn't spoken to this issue at all.
4 He's mentioned the MUSC Hospital letters, he's
5 mentioned the letter of support from East
6 Cooper Regional Medical Center, okay, those are
7 two letters that he specifically referenced and
8 spoke to. And these are community letters that
9 not only speak to the support of Moncks Corner,
10 Your Honor, but they speak to the opposition of
11 two being there in Berkeley County. And I'll
12 read to you from Number 4, acceptability
13 project review criteria that says, where
14 documented opposition exists to a proposal such
15 opposition will be considered along with the
16 application. Now, these petitions and
17 resolutions did come late in the game, but it's
18 something that the citizens of the towns did
19 late in the game. I mean they've, you know,
20 this thing has been in the media, this case has
21 been in the media down in Berkeley County for
22 the last, you know, year or so. And so, they
23 got together and they got these petitions and
24 they're affixed with the resolutions. And, you
25 know, we're talking about, I think it's over

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1 4,000 signatures, 4,000 people that want to be
2 heard. And they want their support
3 acknowledged and their opposition acknowledged
4 as well. And I'd like to put it in through
5 this expert witness to show the support. And
6 to also go to this fourth project review
7 criteria, which, Your Honor, is considered one
8 of the most important project review criteria
9 that the Department considered when evaluating
10 these applications. And if you still decide to
11 sustain, I would like to just make a proffer if
12 I could.

13 **THE COURT:** Yes, I will sustain the objection.

14 **MR. THOMAS:** Okay. Well, can I --

15 **THE COURT:** Yes.

16 **MR. THOMAS:** -- proffer the Exhibits, Your Honor, and
17 the testimony?

18 Q: Mr. Baehr, show your copy of these original
19 resolutions. And the signatures, Your Honor,
20 this would be Exhibit Number 238, I believe,
21 wouldn't it? And actually the signatures
22 themselves, there are thousands of them --

23 **MR. LONG:** which I might add, Your Honor, we were
24 never provided with. And I really don't want
25 them at this moment, okay..

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1 MR. THOMAS: There are thousands of them.

2 MR. LONG: I've never been provided with that or
3 even knew they existed until just a minute ago.

4 MR. THOMAS: Anyway, Mr. Baehr can just proffer
5 testimony here.

6 Q: Did you have an opportunity to review the
7 resolutions and petitions?

8 A: Yes, sir.

9 Q: And what, if any opinion, do you have with
10 respect to those resolutions and petitions,
11 with respect to the acceptability of the
12 project review criteria as a health planner?

13 A: Yes. Obviously, it's strong support in these
14 communities toward the project in Moncks
15 Corner. And it appears an awareness that the
16 fate of that facility is dependent on whether
17 two hospitals are approved rather than one.

18 Q: Okay. And why do you think it's important to
19 those citizens?

20 A: Because of the fact that I think all of the
21 documentation I provided earlier in my
22 testimony about the significant population that
23 now does not have convenient access, does not
24 have 30 minute drive time access. The 30
25 minute drive time, I think, is a reasonable

1 basis for evaluating whether there's access
2 improvement. And obviously, having a hospital
3 in Moncks Corner is significant for this
4 population for improved access reasons.

5 Q: Thank you. That would be the end of the
6 proffer testimony, Your Honor.

7 **THE COURT:** Thank you.

8 Q: Two more questions for you, Mr. Baehr. And I
9 know you testified already that you believe the
10 applications should have been considered
11 competing. But I've got another question for
12 you, in your opinion, and based on your
13 understanding of the CON regulations, the
14 project review criteria, the purposes on the
15 CON Act, and the State Health Plan, was DHEC
16 correct in approving Trident's CON application,
17 regardless of whether the CON applications are
18 competing?

19 A: Yes.

20 Q: Okay. In your opinion, and based on your
21 understanding of the CON regulations, the
22 project review criteria, the purposes of the
23 CON Act and the State Health Plan, the
24 standards in the State Health Plan, was DHEC
25 correct in approving Roper's CON application,

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1 regardless of whether the CON application were
2 competing?

3 A: No.

4 Q: And could quickly summarize why?

5 A: Yeah. I think that the access improvement in
6 that application is outweighed by adverse
7 impact. I think the application was deficient,
8 in terms of identification of the communities
9 it's going to serve. There are mistakes in the
10 financial projections, based on what appears
11 misinterpretation of the correct percentage of
12 patients who are incremental, such that the
13 financial numbers are overstated. And, in
14 fact, the hospital doesn't satisfy the
15 feasibility test, doesn't have positive net
16 income within three years.

17 Q: Okay. And in terms of acceptability?

18 A: I think the fact that they didn't get letters
19 of support from other hospitals is a
20 deficiency, including one of the two hospitals
21 actually not just being sort of on the
22 sideline, but saying they wouldn't support,
23 it's unusual.

24 Q: Is there a need in Goose Creek for a hospital?

25 A: I don't believe so.

1 Q: Thank you, Mr. Baehr, no further questions.

2 THE COURT: Mr. Long?

3 MR. LONG: Your Honor, I ask that we take a lunch
4 break now. It's 12:30 and he's been on the
5 stand for over six and a half hours. I could
6 probably use a few moments to organize.

7 THE COURT: Come back at 2:00; will that suit
8 everybody? Be in recess until 2:00 p.m..

9 (Off the Record)

10 THE COURT: Be seated please. Back on the record.
11 Okay. Mr. Summer, Mr. Thomas, although there's
12 no rule that allows me to do this, I'm going to
13 ask you to assiduously take notes on this cross
14 examination so that I can properly limit the
15 scope of redirect.

16 MR. LONG: May it please the Court?

17 THE COURT: Yes, sir. Proceed.

18 MR. BAEHR - CROSS EXAMINATION BY MR. LONG:

19 Q: Mr. Baehr, it's good to see you. Let's talk a
20 little bit about what services are in Berkeley
21 County at the moment, okay? Right now, there
22 are two emergency departments in Berkeley
23 County, right?

24 A: Correct.

25 Q: And one of them is operated by Roper St.

1 Francis and one of them is operated by Trident
2 Health System, correct?

3 A: That's correct.

4 Q: And they're about two miles from each other?

5 A: Correct.

6 Q: And they're free standing EDs?

7 A: Yes.

8 Q: And that means they're not connected to like a
9 hospital or any sort of acute care?

10 A: The only thing is, it's my understanding is
11 that the Moncks Corner ED or Trident is part of
12 the hospital license.

13 Q: Well, they are all licensed and they do their
14 financials all together, but it's not anywhere
15 near the hospital?

16 A: No, no, no.

17 Q: It's like over 20 miles away, right?

18 A: Correct.

19 Q: And so these were separate facilities. Now,
20 you would agree with me that the two
21 overwhelming sources of patients for an acute
22 care hospital are the emergency department and
23 physician referral, right?

24 A: Yes.

25 Q: I think you looked at something yesterday in

1 the application that showed over 90 percent, it
2 may be 95 percent, of the referrals are from
3 those two sources?

4 A: Yeah, I believe it was closer to 95.

5 Q: Well, have you done any, other than hearing the
6 testimony in the courtroom, have you done any
7 work to determine how the medical staffs for
8 Trident Health System and Roper St. Francis
9 overlap?

10 A: I have not done anything specific other than
11 become familiar with what's in the
12 applications.

13 Q: And you heard Mr. Gallati's testimony?

14 A: Yes.

15 Q: And Trident Health System I believe, has a
16 medical staff of 500 physicians?

17 A: I'll take your word for it, I don't know the
18 exact number.

19 Q: Roper, I think is over 600, you can expect that
20 from a tertiary hospital like Roper Healthcare,
21 right?

22 A: Correct. Sure.

23 Q: And Mr. Gallati testified that those medical
24 staffs were distinct, in other words, they
25 don't really overlap. The Trident physicians

1 to use the Trident facilities. The Roper
2 physicians use the Roper facilities, right?

3 A: Correct. The only thing I would note is that
4 physician affiliation with a particular system
5 can change over time, based on actions taken by
6 health systems.

7 Q: Well, really it's actions taken by physicians.
8 I mean, physicians get to choose what facility
9 they want to use as long as they have
10 privileges at that facility.

11 A: Well, no, the comment I was making is if there
12 are purchases or practices that can shift the
13 market from general affiliation with one to
14 general affiliation of another.

15 Q: Well, every time that a physician becomes
16 employed is what you're talking about on the
17 purchase of a physician practice. The
18 physician chooses to become employed by the
19 healthcare facility, right?

20 A: Yes.

21 Q: No one forces him.

22 A: That's correct.

23 Q: Nobody shows up and says I'm buying your stuff
24 today, the government says I get it, right?

25 A: I agree.

1 Q: Okay. So it would certainly appear that, since
2 95 percent of the sources of patients come from
3 physicians and ED, that Berkeley County at the
4 moment is two distinct markets, Trident Health
5 System or Roper St. Francis, right?

6 A: It's actually probably at least three, because
7 I think the Medical University of South
8 Carolina also has a significant practice in the
9 county and has about 20 percent of the patient
10 draw.

11 Q: True. Now, you would agree with me that when
12 patients, particularly in northern Berkeley
13 County, make a decision as to whether they're
14 going to go to the ED or not they have two
15 choices that are pretty much the same choice,
16 right?

17 A: Yeah, they're fairly equidistant to whichever
18 community you pick.

19 Q: And once a hospital is located in Moncks Corner
20 that choice will not be the same anymore,
21 right? You'll have one ED with a hospital and
22 one free-standing ED, right?

23 A: That's correct.

24 Q: Now, wouldn't you think that adding an
25 emergency department in northern Berkeley

1 County that was affiliated with a hospital
2 might change the market share percentages in
3 northern Berkeley County?

4 A: Well, it could, if the share is already fairly
5 high it's less likely to. To the extent that
6 the other system remains in place and has some
7 connection to the community and some history of
8 getting patients and also physicians. I don't
9 think the shift would be overwhelming. If, in
10 fact, all the services that Roper had in Moncks
11 Corner were moved down to Goose Creek, I think
12 you would potentially have more of a share.

13 Q: Well, in your application that Trident filed
14 for the hospital at Moncks Corner, they assumed
15 no change in market share at all from the
16 hospital, right?

17 A: Correct.

18 Q: You think that's reasonable?

19 A: Again, you've got to read through the
20 application. And it actually begins with
21 saying that we wanted to test whether there was
22 enough growth in the Trident System, given that
23 the State Health Plan was indicating a need for
24 56 beds in 2008-2009 to support a 50 bed
25 hospital. Was there enough average daily census

1 growth for Trident overall, to support whatever
2 the volume would be at the new hospital? And
3 that test suggested that it was and there would
4 be some volume left over. That doesn't mean
5 that it's inconceivable that there would be
6 market share shifts occurring. But the major
7 thing was to test whether Trident's system
8 growth, because they did have a bed need, was
9 strong enough to support that. And remember,
10 I think I said this morning that over 60
11 percent of the volume in Berkeley County for
12 Trident can be accounted for just for the
13 growth from the growth in the Trident System in
14 the county. So you don't need that much more
15 on top of growth, just within Berkeley County,
16 to support the volume at the new hospital in
17 Berkeley County. So I didn't think it was that
18 much of a stretch to make the assumption that
19 we did.

20 Q: Well, that's right. So basically, the whole
21 premise of the application is based on this
22 question, which you just said, which is, was
23 Trident's Health System growth enough to shift
24 patients to a facility in Moncks Corner, right?

25 A: Correct.

1 Q: And so my next question for you, you think it's
2 likely that there would be no market share
3 shift if there was a hospital in Moncks Corner?

4 A: I think there would probably be some.

5 Q: All right. Trident Health System has filed
6 this application in Summerville to add 30 beds
7 to its facility, right?

8 A: Correct.

9 Q: And you're aware, Mr. Sullivan's actually the
10 consultant on that, but you work with him all
11 the time, right?

12 A: Yes.

13 Q: And you're aware that they projected in that
14 application a three percent increase in market
15 share just by adding beds to the current
16 facility, right?

17 A: Well, I believe it was in Dorchester County zip
18 codes is where the three percent market sharing
19 piece was. And in part, that's why when we did
20 our updated projections, we provided two
21 different sets of projections. One with a
22 constant market share and one with three
23 percent growth in Berkeley County.

24 Q: Right. We'll get to that in a little bit. But
25 in the Summerville facility they're adding beds

1 at the current location?

2 A: That's correct.

3 Q: The Moncks Corner hospital is building a new
4 hospital over 20 miles away from the existing
5 Trident Health System providers, right?

6 A: That's correct.

7 Q: And so because of that distance of 20 miles you
8 actually would expect the market share would be
9 greater for building a hospital 20 miles away
10 than you would from adding on in a current
11 location, right?

12 A: The only thing I would say is in the zip codes
13 where you might expect to see some market share
14 growth, those are the zip codes basically
15 around the lake. And the market share is not
16 insubstantial in those zip codes right now, but
17 the population in some of those individual zip
18 codes is not great. So you might get some
19 share, but the impact of increasing share, in
20 terms of, say, adverse impact on other
21 providers would be less significant than a
22 significant increase in volume, say, at one of
23 the zip codes that was closer to Trident in
24 Summerville, which have much more population.

25 Q: All right. Did you ever, at any time during

1 this case, in the application or since now,
2 calculate or forecast the number of patients
3 that would be seen at a Trident Moncks Corner
4 hospital through the ED?

5 A: I didn't do that specific calculation, but you
6 could apply the same percentage that's in
7 existence now for all of the patients coming
8 out of Berkeley County that are winding up at
9 Trident facilities. And I think that's the
10 slide you were referring to earlier when you
11 mentioned the 95 percent of the source of
12 patients. And I believe that the ED component
13 was a little smaller than the physician
14 component so it's less than half. It might
15 have been 40 or some-odd percent of the total.
16 I wouldn't be surprised if you had a number
17 somewhat similar to that, maybe a bit less, I
18 don't know.

19 Q: Until you can calculate the number of ED visits
20 that you have in a proposed hospital and then
21 use a percentage based on historical use at
22 other facilities and say we'll get this many
23 inpatients from this many ED visits, right?

24 A: Yeah. It's certainly possible, but we didn't
25 get to that level of detail when we did the

1 application, so I don't know what the numbers
2 would look like, but we didn't do it.

3 Q: And you would agree with me that if you've got
4 two emergency departments in Moncks Corner and
5 that are two miles from each other, the
6 patients are going to choose the one they want
7 to go to. There's no distance reason for them
8 to choose one or the other, right?

9 A: I think that's probably true.

10 Q: And EMS drivers are going to, certainly, take
11 the more serious patients to the hospital as to
12 opposed to the free standing ED, right?

13 A: I think that's likely.

14 Q: Okay. Now, you know how many physicians Roper
15 St. Francis employs in Berkeley County today?

16 A: I do not have the number off-hand.

17 Q: Okay. Now, let's look at Petitioner's 202, if
18 you can?.

19 A: That's, you mean, this one.

20 Q: We're going to put it on the screen for you
21 too. And I've got an extra copy.

22 A: Give me a second. Okay. All right, I can see
23 it on here.

24 Q: Actually, this is a little bit smaller, but
25 we're just going to do the first six or seven

1 lines --

2 A: Okay.

3 Q: --- for you to read. But I've got a copy if
4 anybody wants it. Now, you've spent a good bit
5 of time talking about two in your direct, two
6 zip codes, right?

7 A: Uh-huh (affirmative response).

8 Q: 29461 and 29483, right?

9 A: Correct.

10 Q: Okay. Now, let's take our map here, just sort
11 of refresh ourselves, where these zip codes are
12 located, all right?

13 A: Sure.

14 Q: 29461 is what we call the Moncks Corner zip
15 code, and it is the zip code where the Moncks
16 Corner facility is in, pretty much, the
17 geographic center of that zip code, just
18 slightly to the north, right?

19 A: Correct.

20 Q: And then the Roper St. Francis hospital in
21 Carnes Crossroads is in the southern part of
22 the zip code.

23 A: Southwest.

24 Q: Southwest, exactly, and right on the border
25 between 29461 and 29483?

1 A: Correct.

2 Q: Okay. Now, 29483 is the zip code, I don't have
3 the number on here, but you can see the shade.
4 You can see the county line cuts right through
5 29483, right?

6 A: Correct.

7 Q: So actually 70 percent of the people in 29483
8 live in Dorchester County, right?

9 A: That's correct.

10 Q: And 30 percent live in Berkeley County?

11 A: That's correct.

12 Q: And, of course, the zip code has a funny shape
13 to it. It's got this little, looks almost like
14 a head or something. It kind of pokes up here,
15 right, in the northern part? So people in the
16 most northern part of 29483 are probably closer
17 to Moncks Corner than they are to Summerville,
18 aren't they?

19 A: I would agree with you.

20 Q: Okay. And this zip code, you projected 20
21 percent of the Trident patients would come to
22 the Moncks Corner facility, right?

23 A: That's correct.

24 Q: Not 20 percent of the total, 20 percent of the
25 Trident patients?

1 A: That's correct.

2 Q: And the Trident Health System market share for
3 this zip code is 60 percent?

4 A: Roughly, yes.

5 Q: So you're projecting one-fifth of 60 percent?

6 A: Twelve percent.

7 Q: Twelve percent would go to the new hospital in
8 this zip code right here?

9 A: Correct.

10 Q: Okay. 29461 is probably the largest population
11 zip code, in what we call the northern part of
12 the county, right?

13 A: That's correct.

14 Q: Certainly, the zip codes that touch the lake?

15 A: Correct.

16 Q: All right. Let's look and see what, would you
17 agree with me that the current volume at the
18 emergency department for the Moncks Corner
19 facility would be a good indicator of where the
20 patients are going to come from in the
21 hospital?

22 A: It's an indicator. It doesn't necessarily mean
23 that the rank order or the relative size would
24 be exactly the same way if there were a
25 hospital there instead of an emergency

1 department, but it is an indicator.

2 Q: And let's look and see, this is the Moncks
3 Corner Medical Center, this is the free
4 standing ED in Moncks Corner for Trident?

5 A: Uh-huh (affirmative response).

6 Q: The overwhelming number of patients come from
7 the 29463 zip code, right?

8 A: 461, correct.

9 Q: I'm sorry. 29461, I think I said incorrectly.

10 A: Correct.

11 Q: And the next two zip codes are 29479 and 29431,
12 right?

13 A: One of those is St. Stephen and the other may
14 be Bonneau, let's see.

15 Q: They're actually north of the lake, aren't
16 they?

17 A: Correct.

18 Q: And then the next one is 29436, north of the
19 lake, right?

20 A: West of the lake.

21 Q: West of the lake. And then we get to 29483,
22 right?

23 A: Correct.

24 Q: And it only has 492 visits to the ED, right?

25 A: Correct.

1 Q: So you still think that zip code is critical to
2 the success of the Moncks Corner hospital?

3 A: I do. In part, again, it's a large population
4 zip code. And right now, if the choice is for
5 patients to go to an emergency department that
6 is a standalone emergency department versus
7 going to an emergency department that's part of
8 a hospital, I think the choice is pretty easy.
9 For those patients surrounding the lake, who
10 are on the north side, they're the closest
11 facility, if you're going to an emergency
12 department, is going to be the Moncks Corner
13 facility. And if they're going to go to a
14 hospital, as you said, it's 20 miles further.
15 And this is when someone needs an emergency.
16 But if you're in 29483 right now, I think that
17 the logical choice is not an equivalent one
18 between the standalone ED versus a hospital.
19 So I think it's to be expected that the
20 hospitals would get more from that zip code.
21 And that the share that 29483 would represent,
22 if there were a hospital in Moncks Corner,
23 would be higher.

24 Q: That's why you gave it the 12 percent?

25 A: Yeah. And we thought again. And we went

1 through this in my deposition and I think what
2 I told you is, this is not exact science.

3 Q: Right.

4 A: If the 20 percent was a bit too high and it
5 could be 16 percent or 17 percent of Trident
6 volume, maybe some of the 50 percent zip codes
7 could be 53 percent or 55 percent. All of
8 these things have certain room, I think. The
9 major thing is whether the assumptions added up
10 and whether they were a reasonable possibility
11 for the hospital to achieve what we thought
12 they were.

13 Q: Well, let's take a look at Respondent's Exhibit
14 50, which is the Roper St. Francis ED cases.

15 A: Okay. You going to bring that up on the
16 screen?

17 Q: She is.

18 A: Okay.

19 Q: If you can blow up the first five or six.
20 Okay. Its track is almost identical to the
21 Moncks Corner one, doesn't it?

22 A: Yeah, I mean the northern zip codes reflect
23 relative population in those zip codes.

24 Q: I just want to correct -- this is a different
25 year. This is 2009 and we were looking at 2010

1 before, but you would agree with me that's not
2 a material difference?

3 A: I don't believe so.

4 Q: And so again, the great majority of those
5 visits come from these three counties at the
6 top, right?

7 A: Three zip codes.

8 Q: Three zip codes. I'm sorry.

9 A: Correct.

10 Q: Three zip codes listed here, Moncks Corner, St.
11 Stephen and Bonneau, right?

12 A: Correct.

13 Q: Now, you heard the testimony of Mr. West?

14 A: Uh-huh (affirmative response).

15 Q: You've talked a lot about drive times and
16 access. Wouldn't you agree that the most likely
17 place where there would be a market share shift
18 would 29461 and all of the zip codes above
19 north of the lake, east, west, east, north, and
20 west of the lake?

21 A: Well, I want to make sure I understand your
22 question. Where there would be shifts in the
23 market share for the entire Trident system or
24 shifts from the market share we assumed for the
25 Berkeley Regional Medical Center?

1 Q: Shifts for the Berkeley Regional, well, both.
2 First, let's talk about both of those. The
3 greatest shift of patients from the Trident
4 system to the new hospital would occur in these
5 zip codes around the lake, right?

6 A: Yeah. And let me just note one thing about
7 that. Because the population is smaller
8 relative to the entire size of Berkeley County
9 and those zip codes north of Moncks Corner, and
10 the St. Stephen and Bonneau and crossing
11 Pineville. For instance, the three percent
12 market share increase that we simulated for the
13 county as a whole, if all of that three percent
14 were realized in those zip codes to the north,
15 it would mean there would be more of it than a
16 three percent there, because I don't think you
17 would see an increase in Goose Creek or
18 southern zip codes because you had a new
19 hospital in Moncks Corner.

20 Q: I thought the three percent was in Summerville.

21 A: No, remember I said that we did two different
22 tests in the updated projections. One was
23 where we kept market share the same.

24 Q: Right.

25 A: And the second one where we increased the

1 Trident system market share by three percent in
2 Berkeley County. And all I'm saying is a three
3 percent overall increase in the county could
4 mean an eight or ten percent increase in some
5 of the zip codes up north and zero in a zip
6 code like Goose Creek or something else to the
7 south, which shouldn't really be affected by
8 having a new hospital in Moncks Corner.

9 Q: But in the application that you presented to
10 the Department and presented a project review
11 and didn't change in any subsequent letter or
12 whatever, contemplated that all the patients at
13 the Trident Moncks Corner hospital were Trident
14 Health System-aligned patients, right?

15 A: Correct. They were a share of the Trident
16 volume we expected in the future.

17 Q: And you estimated that 50 percent of the people
18 in the zip codes around the lake would still
19 continue to drive 25 miles to the south to go
20 to Trident Medical Center as opposed to going
21 to Berkeley Regional Medical Center, the
22 Trident facility in Moncks Corner?

23 A: There are people now who are going 25 miles to
24 a Roper facility and bypassing hospitals that
25 are seven or eight miles away from Trident in

1 Summerville. There are reasons why people do
2 what they do. And there are historical
3 relationships sometimes that exist with
4 physicians, there are comfort levels. Remember
5 that the two hospitals that are in existence
6 have been in existence for a long time.
7 Dorchester Hospital in Dorchester County has
8 been there since the mid-nineties, I believe,
9 and Trident Medical Center since 1975.
10 Patients who have gone to a particular hospital
11 for a long period of time may continue to want
12 to be at a hospital which they're comfortable
13 rather than a new one.

14 Q: Well, let's talk about shifting market share
15 from the other providers to the Trident
16 facility in Moncks Corner.

17 A: Sure.

18 Q: And you just testified a little while ago you
19 thought it was very possible, right?

20 A: It's possible.

21 Q: Or very likely there would be a shift in market
22 share, right?

23 A: Sure. I'm not averse to the possibility or
24 even the likelihood that there might be some
25 shift in those that goes around the lake.

1 Q: No doubt, though, that a shift in market share
2 in the 29461 zip code is going to give you more
3 patients in the Moncks Corner hospital than a
4 shift in zip code in the 29483 zip code?

5 A: It's a bigger population, correct.

6 Q: And not only a bigger population, but a much
7 bigger population going to the facilities in
8 Moncks Corner?

9 A: Yeah, but what I'm saying is if you're
10 comparing it to like 29479 or 29431, it's a
11 bigger population in the 29461 zip code and
12 there are more patients. The two of them are
13 related. They go together.

14 Q: But what I'm just pointing out, not only is
15 there more patients overall, there are also
16 more patients inclined to go to Moncks Corner.
17 A ten percent change in market share in the
18 29483 means that Trident in Moncks Corner gets
19 five patients, right, or 50 patients?

20 A: Fifty, it would be 50 visits.

21 Q: Fifty visits?

22 A: Yeah.

23 Q: Okay. Ten percent difference on 6,116, a lot
24 higher number, right?

25 A: Yeah. But the only thing, it's not exactly

1 accurate. Because the total volumes that are
2 expected to be seen in a hospital setting are
3 substantially greater than are going to be seen
4 in a standalone emergency department with some
5 outpatient facilities. So all the volumes are
6 higher, you know, the shifts in market size or
7 shifts in the percentage of Trident volume are
8 a bigger number when you're going off of a
9 bigger base.

10 Q: But the comparisons were certainly different?

11 A: Yes.

12 Q: It's significant, right?

13 A: That's right.

14 Q: All right. Now, what if the physicians don't
15 change their alignment? In other words, the
16 physicians continue to use Roper that
17 traditionally used Roper and the physicians
18 that traditionally used Trident continue to use
19 Trident. Will the market shares be likely to
20 be stable?

21 A: Under what circumstances, one hospital built,
22 two hospitals are built?

23 Q: No, the hospital in Moncks Corner?

24 A: Okay. And that's the only hospital.

25 Q: Well, we're talking about the northern Berkeley

1 County right now and there's a hospital in
2 Moncks Corner, but the physicians continue to
3 do their traditional practice.

4 A: Okay.

5 Q: That will chill any change in market share,
6 right?

7 A: I'm still not getting the complete question
8 you're asking, because it matters whether I'm
9 assuming one hospital or two to be able to
10 answer your question.

11 Q: Why?

12 A: Because if there are two hospitals, I think the
13 potential shifts would be smaller than if
14 there's just one hospital.

15 Q: So you think if there's one hospital in Moncks
16 Corner the physicians will change their
17 practices and start using the Trident facility
18 in Moncks Corner where they would not have done
19 so if there are two hospitals?

20 A: No, what I'm arguing is, that the percentage
21 market share pickup in one case would be less
22 than it would be in the other case.

23 Q: But you're doing that, I'm just talking about
24 physician referrals.

25 A: Okay.

1 Q: We know the physicians are either the number
2 one or number two referral sources.

3 A: That's correct.

4 Q: For an acute care hospital.

5 A: Correct.

6 Q: And those physicians are aligned with a certain
7 system?

8 A: Uh-huh (affirmative response).

9 Q: It really doesn't matter whether they build a
10 hospital or not, does it?

11 A: Well, it does matter to the extent that if
12 there's another hospital in the area, there's
13 another option, physicians could choose to
14 supplement their income. And physicians may be
15 susceptible, given the current market
16 conditions and the way Medicare works and
17 Medicaid works and the payment mechanism for
18 physician payment. Some of them may seek the
19 security of having a physician purchase, a
20 physician practice purchased and having salary.

21 Q: Why did you never at any time go back and redo
22 your analysis to take into consideration that
23 two hospitals were being considered by the
24 Department?

25 A: At what time?

1 Q: During the review cycle, from the beginning?

2 A: Because my assumption all along was that only
3 one would be built. And we did address it at
4 project review and then in the follow-up
5 letters where we made an attempt at looking at
6 the impact on the financial performance and the
7 volume of two hospitals, based on what they had
8 put in their applications, and what I thought
9 might happen to those volumes and the financial
10 effect of that if two were approved. So I
11 don't think that's less accurate.

12 Q: Well, your application is built on 100 percent
13 redirection of Trident patients to Moncks
14 Corner, correct?

15 A: It's really built, the way I would refer to it
16 is, we tested whether there was enough system
17 growth to support the volume at Berkeley
18 Regional Medical Center and there was. That's
19 how it's described actually in the introduction
20 to that section.

21 Q: Basically, you put a test out there, will
22 Trident Health System grow enough to support a
23 50 bed hospital, you look at the data, you
24 concluded it would and you stopped, right?

25 A: Yeah. Because remember Trident had a 56 bed

1 need. That was certainly the case at the point
2 when Roper applied. And it was even known at
3 the time when Trident applied, which meant that
4 the total system growth was likely to be able
5 to support a 50 bed hospital. Because for a 50
6 bed hospital you don't even need a census that
7 would be required for a 56 so that was the
8 test. But as to why we didn't redo the
9 numbers, if we redo the numbers and the project
10 becomes infeasible, you might as well withdraw
11 the application. The argument that Trident was
12 making is that there's only need for one, one
13 should be approved and it should be Berkeley
14 Regional Medical Center. So to redo the
15 application says we're submitting to you an
16 application, which we think will not get to the
17 volumes that we need to be successful, because
18 another hospital is in the market cutting off
19 our opportunities for growth. That would seem
20 to be an odd submission to the Department.

21 Q: Well, Mr. Baehr, it's more than just
22 determining whether there's sufficient growth
23 to add the hospital. Trident could propose,
24 for example, they're going to put a hospital in
25 Anderson. That wouldn't be the growth of a

1 Trident Health System in the tri-county service
2 area. It wouldn't have any impact on that
3 hospital they want to go to in Anderson, would
4 it?

5 A: I'm not sure I understand.

6 Q: Let me ask you a follow-up question. You have
7 to do the next step, which is what you did in
8 the application, which is look at the area and
9 determine what percentage -- where will the
10 patients come from, right?

11 A: Correct.

12 Q: It's both steps. Look at the growth and look
13 at where the patients will come from?

14 A: That's correct.

15 Q: And at no time before the Department did you
16 ever say, whoa, you put a hospital at Roper, at
17 Carnes Crossroads, and approve both of these
18 applications there'll be a change in the
19 patients that go to Moncks Corner?

20 A: What we did say is that there would not be
21 enough growth in the market to support the two
22 hospitals. And both of them are dependent on
23 the growth that's in the market. In other
24 words, the number that I was throwing out
25 several times today, the 12,269, I think was

1 the number, that's the latest number to come
2 out of updates from 2010 was a slightly
3 different number if you projected back in 2008,
4 which was when Mr. Richardson did it and I did
5 it. But in any case, you never come up with
6 enough volume, in terms of growth, based on
7 population projected forward to support the
8 volume needed to keep two 50 bed hospitals
9 going. Now, you can, you know, make an
10 argument that, well, that's why we're
11 redirecting and so on. But redirection, a
12 large part of redirection is growth. In the
13 Trident case, it's over 60 percent of the
14 redirection is growth, all right. It's a much
15 smaller percentage in the case of Roper, you
16 know, which is why they need more what I'll
17 call non-growth redirection or market share
18 pickup from other providers. That's a
19 significant difference. But I don't, you know,
20 we went through the service area when we talked
21 about the application and I think Roper talked
22 about their service area when they had their
23 presentation in the project review. I don't
24 think the maps were that dissimilar. I mean,
25 if you look, they weren't claiming at that time

1 they were only going to do this in these
2 models, they said they would serve all of
3 Berkeley County.

4 Q: Well, first, the reason your application, the
5 Trident application assumes 100 percent
6 redirection. So when you talk about growth in
7 the Trident application, you're talking about
8 Trident Health System and growth?

9 A: Correct.

10 Q: You're not considering growth of any other
11 provider, MUSC, Roper St. Francis, anybody,
12 because the market shares are completely static
13 even though they're dropping a new hospital in
14 northern Berkeley County 25 miles from the
15 closest hospital?

16 A: Correct. What we're showing is that a hospital
17 has a need for 50 beds. Trident Medical Center
18 now serves Berkeley County and Dorchester and
19 North Charleston. You could put the 50 beds
20 there and that essentially would serve the
21 growth of all three regions, all three areas or
22 you could put a 50 bed hospital in Moncks
23 Corner and try to improve access to residents
24 of a particular county. You're not going to
25 have enough growth in the Trident System, just

1 in Berkeley County to support the volume at the
2 Berkeley Regional Medical Center. But there's
3 enough growth over all. So the question is, is
4 Trident willing to make the investment of
5 taking some of its growth in other areas to
6 support a new hospital in Moncks Corner and it
7 wasn't.

8 Q: Okay. Now, Trident's also using its capital to
9 try to add 30 beds in Summerville, right?

10 A: Correct, a lesser amount. I think it's 25 to
11 30 million.

12 Q: Yeah, 25 to \$30 million, but still for 30 beds
13 in Summerville, right?

14 A: Correct.

15 Q: And it's relying on Trident Health System
16 growth to support that application, right?

17 A: Correct, but primarily in Dorchester County,
18 not Berkeley County.

19 Q: And it's relying on market share shifts, right?

20 A: Small market share shift in Dorchester County,
21 correct.

22 Q: And that market share shift will come from
23 Roper St. Francis and MUSC, because they're the
24 main providers, right?

25 A: Correct. They could lose a one half percent

1 share if it's split evenly among the three
2 percent.

3 Q: And so as we sit here today Trident Health
4 System is telling this Court that 30 beds in
5 Summerville and 50 beds in Moncks Corner is
6 feasible and appropriate, right?

7 A: It exactly matches the bed need in the 2008-
8 2009 Plan, which was 56 plus 24 was 80 and
9 they've applied for two separate projects
10 totaling 80. So it's completely in sync with
11 what the department thought was the bed need
12 for the Trident System at those two facilities.

13 Q: But 50 beds in Moncks Corner and moving 50 beds
14 from the peninsula is not feasible or
15 reasonable, that's Trident's position, right?

16 A: Correct. It's also, I think, poor planning.

17 Q: You think it's better planning to add 80 beds
18 in the two facilities, build a hospital at
19 Moncks Corner, add 30 beds to Summerville than
20 it is to move beds from the peninsula to
21 Berkeley County?

22 A: Yes.

23 Q: Even though the population is moving to
24 Berkeley County, right?

25 A: The population is growing in Dorchester County

1 at a faster rate than it is in Berkeley County.

2 Q: You think there's enough growth there to
3 support all three projects?

4 A: I think it's enough growth in Dorchester County
5 to support the 30 beds at Summerville Medical
6 Center.

7 Q: Okay.

8 A: As does the State.

9 Q: And you don't think the market shift will have
10 a material adverse impact on existing providers
11 I assume, right?

12 A: A one half percent shift from a three percent
13 increase in share at the hospital, I don't
14 think it's significant.

15 Q: Okay. You would agree with me that we've
16 already said the three primary providers are in
17 Berkeley County, right?

18 A: Yes.

19 Q: Trident has 53 percent of the market share,
20 Berkeley St. Francis, 23 percent, MUSC, like 18
21 percent.

22 A: I mean, the numbers vary by one or two percent,
23 depending on the year, correct.

24 Q: Pretty stable though, they're usually just one
25 or two points off, right?

- 1 A: That's correct.
- 2 Q: That's like 94 percent of the patients going to
- 3 those three systems, right?
- 4 A: That's correct.
- 5 Q: East Cooper has less than five, nobody else is
- 6 really a player, right?
- 7 A: Correct. Now, Mount Pleasant may start getting
- 8 some more patients from the eastern portions of
- 9 Berkeley County, that's possible.
- 10 Q: We haven't seen that yet though, that right?
- 11 A: No.
- 12 Q: Let's look at Respondent's 52.
- 13 A: Okay. Oh, Respondent's 52, I'm not sure I have
- 14 that.
- 15 Q: She'll put it up on the board. I'll give you
- 16 a copy if I need to.
- 17 A: I can read this, it's okay.
- 18 Q: If you need the books, let me know.
- 19 A: I can read this.
- 20 Q: All right. It mentions Roper St. Francis
- 21 Healthcare for 2010, partial 2011 from Berkeley
- 22 County, right?
- 23 A: Correct.
- 24 Q: Non-tertiary?
- 25 A: Correct.

1 Q: So these would be apples to apples if you're
2 looking at a potential acute care hospital in
3 Berkeley County, right, because it's a non-
4 tertiary hospital?

5 A: Correct.

6 Q: Correct. And the total number of admissions,
7 just from Berkeley County, in 2010 was 3,463,
8 right?

9 A: Correct.

10 Q: Now, we've been using in the case an average
11 daily census of 4.25. I mean, I'm sorry, we've
12 been using in the case an average length of
13 stay of 4.25, you agree with that, right?

14 A: That's right.

15 Q: Okay. And we've thrown around a couple of
16 different terms, but the average daily census
17 is the number of patients, on average, in the
18 hospital each day, right?

19 A: Correct.

20 Q: And it's an average, because there are more
21 during the week. Weekends, surgeons don't like
22 to do surgery on Saturdays or Friday afternoon,
23 right?

24 A: Correct.

25 Q: And so there are more people during the week

1 than there are the weekends, there are more
2 people in the winter than there are in the
3 summer, right?

4 A: Yes.

5 Q: And there are more people during non-holiday
6 time as opposed to holiday time, right?

7 A: That's correct.

8 Q: So it's an average?

9 A: That's correct.

10 Q: And the way you calculate the average daily
11 census is you can take your patients, your
12 total admissions or discharges and use your
13 average length of stay, how long do you think
14 they'll stay there on the average and then back
15 it out and give you an ADC, right?

16 A: You divide by 365, patient days divided by 365.

17 Q: You got a calculator over there?

18 A: I do.

19 Q: Can you give me the average daily census for
20 3,463 patients, with a 4.25 average length of
21 stay?

22 A: Sure.

23 Q: What we've been using throughout the case.

24 A: And then divide by 365?

25 Q: Right.

1 A: It's 40.

2 Q: A little over 40, right?

3 A: 40.4.

4 Q: Okay. So that means that, just in a
5 hypothetical world, no change in market share,
6 everything stays the same. But these 3,463
7 patients, instead of driving all the way
8 downtown to the peninsula, they go to the
9 hospital at Carnes Crossroads, that hospital
10 has an average daily census of 40, right?

11 A: If all of the patients were transferred, right.

12 Q: And that is an occupancy percentage of 80
13 percent, isn't it?

14 A: That's correct.

15 Q: All right. Now, that's a very high utilization
16 for a 50 bed hospital, right?

17 A: It is.

18 Q: Because if, not only did we just talk about the
19 variances between weekdays and weekends and
20 other times, you also could have spikes in
21 utilization, right?

22 A: Correct.

23 Q: For a bad time of the flu or pneumonia or
24 something, suddenly a bunch of people show up
25 in your emergency department, you've got a lot

1 more people coming in the hospital, right?

2 A: That's right.

3 Q: And for a 50 bed hospital, if five people show
4 up, more than you expected, you just got a ten
5 percent increase in utilization, right?

6 A: That's right.

7 Q: And so because of that, the State Health Plan
8 uses these different occupancy percentages?

9 A: Correct.

10 Q: And for smaller hospitals, the Health Plan
11 considers the hospital to be full, you use that
12 word some in your direct, at 65 percent, right?

13 A: They consider that adequate occupancy.

14 Q: Right. And once you start getting above 65,
15 the formula will start showing you a bed need,
16 right?

17 A: That's correct.

18 Q: You probably need some more beds, because your
19 occupancy percentage is over 65 percent on a
20 small hospital, right?

21 A: That's correct.

22 Q: And if you did a 100 percent redirection on
23 this, you're looking at 80 percent occupancy,
24 right?

25 A: That's correct.

1 Q: All right. So that's a very full hospital,
2 right off the bat, right?

3 A: Correct.

4 Q: This doesn't take into account any potential
5 growth that would occur in the next seven
6 years, right? Well, until at least 2017 or
7 later, right?

8 A: Correct.

9 Q: But you would agree with me that even if
10 something magical happened and both hospitals
11 started construction, it's going to take about
12 two and a half to three years before they're
13 built, right?

14 A: Yeah. I know the Trident project estimated a
15 30 month construction period. Roper may have
16 been about the same, longer or shorter. I'm
17 not sure.

18 Q: So really, 2016, 2015 is the earliest these
19 hospitals could possibly be open, right?

20 A: That's fair.

21 **THE COURT:** Excuse me, Mr. Long.

22 **MR. LONG:** Yes.

23 **THE COURT:** I've lost the definition of redirection
24 in the jumble of testimony. Could we have the
25 witness restate that? Would you ask that

1 question, please?

2 MR. LONG: Sure.

3 Q: Well, how would you explain what redirection of
4 patients is?

5 A: Yeah. As I understand it here, it's patients
6 who would have gone to another hospital and
7 system that instead will go to the new hospital
8 and system as a result of it being built.

9 Q: Let me follow it up with a couple of other. We
10 also have talked a little bit about aligned
11 patients, right?

12 A: Correct.

13 Q: And patients who are predisposed to go to
14 either one of the two systems or one of the
15 three systems, including MUSC, right?

16 A: That's correct.

17 Q: And so the expectation is with redirection that
18 patients who would have otherwise gone to, say,
19 Trident Medical Center, will now be redirected
20 and go to Moncks Corner?

21 A: Correct.

22 Q: If the hospital is built, right?

23 A: That's right.

24 Q: And that's what the application for Trident is
25 built upon, the premise that patients would

1 otherwise have gone to either Trident Medical
2 Center or Summerville Medical Center, will now
3 go to Moncks Corner?

4 A: Correct.

5 Q: And likewise, the Roper St. Francis application
6 is built upon the premise that patients who are
7 now currently driving to the peninsula or West
8 Ashley, the St. Francis west of the Ashley,
9 right?

10 A: Correct.

11 Q: Roper Downtown is right there in the peninsula
12 of Charleston, those patients will now be
13 redirected to Carnes Crossroads?

14 A: Correct. Some of them, yes.

15 Q: And one of the differences in the two
16 applications is that the Trident application
17 assumed 100 percent of the patients in the
18 Moncks Corner hospital would be redirected
19 patients?

20 A: Yeah. It's a lot easier to make that
21 assumption, given Trident's historical volume.
22 Remember that Trident has, I believe 29,000 was
23 their patient day as of 2010, in the county.
24 And it's projected to something on the order of
25 35, 36,000 in the future to get 10,000 days at.

1 a hospital. That's a different share of 36 to
2 37,000 than Roper trying to fill 32 beds in
3 Berkeley County. Because that's the 35, about
4 32 are from Berkeley County out of 40 plus some
5 growth. It's a much higher share of the total
6 existing volume for Roper that's represented by
7 what they expect to see at their new hospital
8 than is the case for Trident. Because Trident
9 has such volume is the reason why we did the
10 test we did. If Trident had been the size of
11 Roper, it wouldn't have made any sense to do a
12 100 percent redirection test. I think that
13 would have been just unlikely.

14 Q: Well, you looked at that factor, which is the
15 size of the systems in Berkeley County. But
16 another factor that would certainly affect
17 redirection is distance to the facility, right?

18 A: It can, sure.

19 Q: But these hospitals are about 25 miles from
20 their kind of mother-ship hospital, the large
21 tertiary hospital in the system?

22 A: The only thing I'd note is, right now we have
23 evidence and, in fact, you know, the argument
24 I've heard from Roper is that patients have
25 been choosing to bypass closer facilities to go

1 to the Roper downtown facilities.

2 Q: They do.

3 A: What's that?

4 Q: They do.

5 A: Well, they do in conjunction with the referral
6 or recommendation by a physician. Not being
7 privy to any conversation between any patient
8 and any physician, I can't tell you whether it
9 was a 80/20 call or 90/10 or which way, but I
10 suspect that the physician component had a lot
11 to do with it. Physicians still may, to some
12 extent, be more comfortable with some
13 facilities than other facilities, especially
14 given their size the comprehensive nature of
15 what they provide. I think it's unrealistic to
16 assume, for instance, that a hospital like
17 Roper Downtown will be viewed by physicians and
18 patients as comparable to a 50 bed hospital in
19 Berkeley County. Just as I don't think Trident
20 Medical Center will be viewed identically to a
21 50 bed hospital in Moncks Corner, even though
22 there are services that are identical. In
23 other words, the services that will be at the
24 new facilities are all at the other facilities.
25 The nature of a comprehensive tertiary hospital

1 is attractive to some physicians and also
2 attractive to some patients. So that's why,
3 for instance, if you assume that all of the
4 patients that are now being seen at the Roper
5 facilities would all be redirected to a new
6 hospital. I think that would be unrealistic.

7 Q: But, I don't disagree with you that there's
8 going to be redirection in Moncks Corner, okay,
9 you proposed a 100 percent redirection. What
10 I'm saying in the Roper St. Francis
11 application, we just said 50 percent, right?

12 A: Correct. But that 50 percent accounts for 60
13 percent of the volume in Berkeley County, okay.
14 It's not a 50/50 overall. And there may be
15 some additional redirection coming from the ten
16 percent that's out of the county so. I mean,
17 if there's a share of the patient population,
18 the redirection is, at least, according to the
19 application 54 percent, could be as high as 64
20 percent given the patients outside the county.

21 Q: But you would have to agree with me that
22 Trident Medical Center is a tertiary hospital
23 20 to 25 miles from the proposed new hospital
24 in Moncks Corner. Roper Downtown is a tertiary
25 hospital 20 to 25 miles from the proposed

1 hospital in Carnes Crossroads, right?

2 A: Correct.

3 Q: And both of these providers have served
4 significant patient bases in Berkeley County,
5 right?

6 A: Yes.

7 Q: They've been serving as providers?

8 A: Yes.

9 Q: Now, let's go back to this slide right here
10 where we talk about redirection?

11 A: Sure.

12 Q: If you say that half, and you just calculated
13 for me that the ADC would be over 40 from 3,463
14 admissions. And we're just talking about
15 patients, Roper St. Francis patients from
16 Berkeley County.

17 A: Correct.

18 Q: Trident, the peninsula or West Ashley, because
19 2010, Mount Pleasant didn't open until
20 November, right?

21 A: That's correct.

22 Q: So that's going to be negligible where that
23 number rank?

24 A: I agree.

25 Q: Okay. Going to those two hospitals, half of

1 them redirected to Carnes Crossroads, that's 20
2 patients, right?

3 A: Yes. A little over 60 percent of the patient
4 population from within the county, which is
5 similar to what I talked about before, that
6 54/36 split is 60 percent.

7 Q: I don't want to talk about that, that's not
8 what I'm asking you. What I'm asking you is
9 this, 3,463 patients is in ADC, an average
10 daily census of 40?

11 A: Correct.

12 Q: And if one half of those goes to Carnes
13 Crossroads, that means the Carnes Crossroads
14 hospital has an average daily census of 20,
15 just from these patients right here, right?

16 A: That's correct.

17 MR. THOMAS: Your Honor, objection.

18 MR. LONG: He --

19 MR. THOMAS: No, I've got an objection. Because I
20 think Mr. Long has basically provided an
21 improper foundation about the average length of
22 stay. Roper knows exactly what the average
23 length of stay is on that number 3,463. It's
24 not 4.25. And so I think that a different, a
25 proper foundation needs to be laid on the exact

1 number. If he's going to be talking about the
2 number of patients in a hospital in Berkeley
3 County, then we need to know exactly what that
4 number would be based on actual numbers, and
5 not what was used in a CON application drafted
6 back in 2008.

7 **MR. LONG:** Your Honor, I asked, I said aren't the
8 applicants using 4.25 as an average length of
9 stay in the case and he said, yes. Because
10 they are. In all their projections, they're
11 using that. So my basis and my question is to
12 an expert, I'm saying what if half of 3,463
13 went to Carnes Crossroads with an average
14 length of stay of 4.25, that's a 20 census. He
15 agreed to that. That's what I just asked him.

16 **MR. THOMAS:** Your Honor, I can take the time to mop
17 it up on cross, I mean on redirect.

18 **THE COURT:** Re-direct. Overruled.

19 **MR. THOMAS:** Okay.

20 **MR. LONG:** But, I'll point out. Judge, and I
21 appreciate the ruling, Your Honor. But, I'll
22 point out --

23 **THE COURT:** Excuse me a second. Did you get my
24 ruling?

25 **COURT REPORTER:** Yes, sir.

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1 THE COURT: The objection is overruled. Now,
2 continue Mr. Long.

3 Q: So you have 20 average daily census from the
4 half of that 3,463 patients, okay?

5 A: Uh-huh (affirmative response).

6 Q: Now, going back to our occupancy percentage, 65
7 percent is the number the State uses for small
8 hospitals, right?

9 A: Right.. I think the projection by the applicant
10 was 70 percent.

11 Q: They did. Both applicants projected that they
12 would have by the third year 70 percent
13 occupancy or just a shade under, right?

14 A: Correct.

15 Q: Or 69 point something, right?

16 A: Yes.

17 Q: All right. But the Health Plan uses 65 percent
18 occupancy.

19 A: And I might note, also, that actually the
20 calculations Mr. Richardson had produced a
21 volume greater than 70 percent and then he
22 backed the number down to the average daily
23 census of 35. His actual model produced a
24 number greater than 35.

25 Q: All right. Because he was relying heavily on

1 this redirection number and so basically it
2 projected a higher number than 70 percent. But
3 he said, well, anything over 70 percent would
4 be pretty high for a 50 bed hospital so they
5 probably won't get that, right?

6 A: And I don't know what's the inner workings of
7 Mr. Richardson's mind, but the --

8 Q: Well, that's what the application does, he caps
9 it at 70.

10 A: Correct.

11 Q: Because of the high occupancy percentage?

12 A: Yes.

13 Q: But let's just go back to our issue here.
14 Let's talk about occupancy percentages.
15 Occupancy in a large hospital, the occupancy
16 percentage can be higher, right?

17 A: It's easier to be higher. I mean, there are
18 hospitals in New York City that run 90 to 95
19 percent year round. I wouldn't necessarily
20 recommend anyone in my family go there.

21 Q: Okay.

22 A: But hospitals can run at a higher occupancy
23 levels. These are what I think, and I
24 mentioned this the other day, what the
25 Department is establishing are reasonable

1 targets based on bed size. I don't have a
2 problem with them as guidelines.

3 Q: That's what I was trying to get you to say and
4 I heard you say that yesterday. All right. At
5 a 65 occupancy on a 50 bed hospital, what would
6 the average daily census be?

7 A: 32.5.

8 Q: 32.5. So if we are getting 20 with a 50
9 percent redirection, we only need 12 more
10 patients a day to be full, right?

11 A: Except that you're sort of mixing apples and
12 oranges, since the application didn't rely on
13 just getting to 65 percent, but getting the 70
14 percent.

15 Q: I know, but I'm just asking the question,
16 you're full at 12 more patients, right?

17 A: Again, I don't think 65 percent means full. It
18 just means it's hit what is considered by the
19 State an adequate year-round occupancy level
20 for a hospital of that size. Most people would
21 say full is 100 percent. Full is not a
22 realistic number for a hospital; which is why
23 it's going to be something lower than that for
24 it to be effectively full. But 65 percent is
25 not a number that can't be beaten by a hospital

1 that's 50 beds. Certainly, hospitals at 50
2 beds can be higher than 65 percent.

3 Q: Mr. Baehr, you're a health planner. And you
4 know that hospitals don't operate at a 100
5 percent full for any extended period of time at
6 all, do they?

7 A: Except in a few locations.

8 Q: Outliers?

9 A: Yes.

10 Q: Okay. So there are always going to be beds in
11 a hospital that are not being used every day,
12 right?

13 A: That's correct. Again, you know a hospital
14 that has 70 percent or 75 percent occupancy
15 could have periods during the year when its
16 occupancy in excess of 90 percent or 95
17 percent. There could be days, even weeks, when
18 they have very high occupancy. That's why you
19 have an average.

20 Q: Now, let's take a look at the pro forma.

21 A: Sure.

22 Q: That Trident did in the application.

23 A: Okay.

24 Q: And it's found in Joint Exhibit 1, page 642.

25 A: Okay. I have that in front of me.

1 Q: You can get that one from it?

2 A: Yeah. Now, I've got it.

3 Q: You got it?

4 A: Yeah.

5 Q: First, let's just kind of, you have an
6 extensive background in finance, right?

7 A: Correct.

8 Q: And you are certainly capable of doing a pro
9 forma for a new hospital, right?

10 A: Yes.

11 Q: And you've done it many times in the past?

12 A: Yes.

13 Q: But in this application you were not hired to
14 that, were you?

15 A: I was not.

16 Q: And you and Mr. Davidson, who works with you,
17 right?

18 A: Right.

19 Q: Y'all did the forecasting in the volumes,
20 right?

21 A: Correct.

22 Q: And so your only role, in regards to the
23 financials in the application was to present to
24 Trident, and Trident's your client, right, the
25 volume forecast, right?

1 A: That's correct.

2 Q: And then they did all of the numbers for the
3 pro forma, right?

4 A: They put the pro forma together, that's
5 correct.

6 Q: And at no time since then have you redone the
7 pro forma yourself, right?

8 A: Well, what I have done is become familiar with
9 the assumptions beyond what I have seen in the
10 application, and had conversations with the
11 people who did prepare these. So I understood
12 what they were trying to do, what they relied
13 on, and how the numbers came out the way they
14 did. So that's similar to what I would do when
15 evaluating Mr. Knapp's numbers submitted as
16 part of the Roper application, which I also
17 didn't prepare, and similar to what I've done
18 in many other cases. In other cases where HCA
19 hired me just to do the planning and not the
20 finance. And I've had some cases that had a
21 different expert do the projections, which is
22 fine. I'll do what I'm hired to do so.

23 Q: Now, a gentleman named Mr. Woodford was hired
24 to do these financials, right?

25 A: Correct. In conjunction with the hospital

1 personnel.

2 Q: And have you ever spoken to him?

3 A: Yes.

4 Q: When?

5 A: I've spoken to him I believe once in -- first
6 of all, it's possible I was on a conference
7 call with him back in May of 2008, though I'm
8 not sure.

9 Q: You don't recall and I don't think he does
10 either, right?

11 A: Yeah, I don't know. I don't know if I was on
12 the call.

13 Q: Okay.

14 A: I did speak to him twice in the period leading
15 up to the litigation dates, had the case gone
16 to trial as we expected it to back in, I guess
17 the end of last year, back at the end of 2010.
18 I think the trial date was originally set in
19 2011, that I was on schedule to do. And then
20 I was told, case is stopped, there's
21 arbitration or whatever's going on and some
22 attempt at settlement, stop work, don't do
23 anything. When I got the word the case was
24 back on, that's one of the things we did,
25 because we knew we needed to be able to talk

1 about this and make sure they were comfortable
2 with what had been done so --

3 Q: That would have been 2012?

4 A: 2011.

5 Q: 2011?

6 A: Yeah. I think the first time I spoke to him
7 was in October. We had another call sometime
8 in January.

9 Q: In 2012?

10 A: Yeah. And met with Mr. Midgett in October.
11 Mr. Gorrell, I think may have been on a
12 conference call as well at one point. And Mr.
13 Midgett was on a conference call also, with Mr.
14 Woodford so we've had three or four shots at
15 talking to people. Mr. Midgett, I've had
16 several conversations with since the first time
17 I met him at Trident.

18 Q: Okay. And so let's look at these financials.

19 A: Sure.

20 Q: You have studied them, right?

21 A: Yes.

22 Q: All right. First thing, in regards to --
23 actually I've got to do a switch over here.

24 Let's go to Joint Exhibit 1, page number 35.

25 A: Thirty-five? Okay.

1 Q: And then let's look at some -- I'm going to put
2 page 644 on the -- okay, let's look at this for
3 a second. In your projections, you projected
4 that the average daily census at the Moncks
5 Corner hospital in year one would be 19.3?

6 A: No, you're reading this table wrong. The table
7 on page 35 is the incremental non-tertiary
8 volume for the Trident System by year. It's
9 not the forecast for Moncks Corner.

10 Q: I'm sorry. Next page, 36.

11 A: Okay.

12 Q: This is the one that shows the ADC for the
13 hospital, right?

14 A: It is.

15 Q: So you've projected in the first year the
16 average daily census would be 19.8, right?

17 A: Correct.

18 Q: Correct?

19 A: Correct.

20 Q: So that means in year one of the hospital
21 you're projecting there'll be 20 patients in
22 the hospital on an average?

23 A: Yes.

24 Q: Year two, 26 patients, correct?

25 A: Correct.

1 Q: Year three, 33.7?

2 A: Now, again, this is a little bit of an issue on
3 year three. Remember that we were looking --
4 an incremental model was built. And year
5 three, there's actually less system growth, as
6 of that year, than the volume that was
7 projected. For the Berkeley facility is a
8 difference of about 1.5 so actually the full
9 volume projected was 12,317. That's what it's
10 in here, but it's not the number that's in the
11 financials. Mr. Woodford backed out the days
12 that were in excess of the total system growth
13 for that year so.

14 Q: Did you know that, at the time he was doing
15 that?

16 A: What's that?

17 Q: Is that something you just learned?

18 A: I learned it when I looked at the numbers.
19 You're able to see that there was a different
20 number that was used in the assumptions. It's
21 a very modest change. It's not a big deal, but
22 you will see it at one point. And his number
23 is 11,717 for that year. And in some of my
24 tables I used the same numbers, because the
25 financial projections in year three are based

1 on 11,717. So if you remember those tables I
2 showed today with the slope for the Berkeley
3 Regional Medical Center, the third year is
4 11,717, not 12,317. That's because of the way
5 the model was built, as incremental, in terms
6 of number of days.

7 Q: All right. And 2016, you projected ADC of
8 34.6?

9 A: That's correct.

10 Q: All right. All of that from growth in the
11 Trident Health System all over?

12 A: That's correct. With the exception again, of
13 2014.

14 Q: All right. Now, let's go to page 644, the
15 Trident applications. Now, what was proposed,
16 what was sent to the Department in regards to
17 the financials, was a pro forma that showed
18 Trident Health System, which would be both
19 hospitals, right, Trident Medical Center and
20 Summerville, correct?

21 A: Correct.

22 Q: Without Berkeley Medical Center being
23 constructed --

24 A: No. My understanding of what these three
25 tables show is, the third table on 644

1 represents the entire system, including
2 Berkeley Regional Medical Center.

3 Q: That's 645.

4 A: 645, I'm sorry; 644 represents the incremental
5 numbers for Berkeley Regional Medical Center
6 and 643 is the difference between the two,
7 which is the remainder of the Trident system,
8 other than Berkeley Medical Center. So it's
9 not a Trident without Berkeley, a Berkeley
10 number Trident with Berkeley. It's all of them
11 or at the same point in time assuming Berkeley
12 is built. So it's really page 3, minus page 2,
13 is page 1.

14 Q: As opposed to page 1 plus page 2 is page 3?
15 It's page 3 minus 2 --

16 A: Page 1 plus page 2 will equal page 3.

17 Q: But page 644, which will be page 2 in your
18 answer --

19 A: Correct.

20 Q: -- there is Berkeley Regional Medical Center as
21 a standalone facility in Moncks Corner, right?

22 A: It's a standalone. But it's an incremental
23 model of new activity at the site, on the
24 outpatient side, because there is already
25 outpatient activity there. So what Mr.

1 Woodford did is, he only forecast -- we came up
2 with the volume projection for our piece. He
3 then looked at what the existing volume was.
4 He grew that a little bit out to the start date
5 for the new hospital and the difference between
6 the existing volume, the growth inflated out by
7 population for a few years. And for our
8 overall volume for the site, he included as the
9 outpatient volume to build the forecast here
10 and our new patients as we described earlier.

11 Q: All right. Bear with me so I can make sure
12 that we're on the same page in what you're
13 saying here. This pro forma on page 644
14 includes a 100 percent of the inpatient revenue
15 and expenses for the Berkeley Regional Medical
16 Center in Moncks Corner, right?

17 A: With the exception of 2014 when it doesn't
18 include 600 days.

19 Q: Okay. And every other year it's 100 percent of
20 the inpatient revenue, 100 percent of the
21 inpatient expenses?

22 A: That's correct.

23 Q: It is part of the outpatient revenue and part
24 of the outpatient expenses?

25 A: Correct.

1 Q: Because he's backing out the ED and some of the
2 other outpatient services that would be there?

3 A: Exactly.

4 Q: Okay. It's not a standalone pro forma?

5 A: Correct. I think there was a request, actually
6 by the Department, some months later to see a
7 standalone Summerville and a standalone
8 Trident. And the standalone Berkeley was
9 produced or was prepared at that time, because
10 if you're doing a standalone Trident you
11 wouldn't include a piece of the Moncks Corner
12 facility, Moncks Corner outpatient, so that had
13 to be done.

14 Q: Okay. Going back to, let's look at year one on
15 this pro forma.

16 A: On 644?

17 Q: Right.

18 A: Sure.

19 Q: And the year one has projected 2012, right?

20 A: Correct.

21 Q: Okay. Now, with an ADC, an average daily
22 census of less than 20, 19 point something,
23 this facility has a positive cash flow, a
24 positive in year one, doesn't it?

25 A: Correct. The depreciation charges five

1 million, which is larger than the net income
2 lost.

3 Q: Right. And so that means that even in year
4 one, with just less than 20 patients in the
5 facility and not counting 100 percent in the
6 outpatient revenue this facility will earn more
7 revenue than its expenses?

8 A: Right. Well, your question is not precise. It
9 won't earn more revenue. It will have a
10 positive cash flow, which is not the same as
11 earning more revenue. Any hospital you would
12 expect, would earn more revenue than would be
13 its depreciation numbers.

14 Q: And any financial person or any hospital
15 administrator looking at financials is going to
16 zero in on that EBITDA line, because that's the
17 cash flow line, right?

18 A: Well, I think net income line is the number you
19 have to look at, because depreciation matters
20 as do other expenses that may not be included
21 above the line. And the State, in particular,
22 is looking for a net income number. They don't
23 defer to cash flow. They're interested in
24 whether --

25 Q: Did you hear Mr. Gallati talk about cash flow

1 when he testified on Tuesday of last week?

2 A: Yeah. I mean he talked about what he can
3 control and that's the whole thing. An
4 administrator on site has control over certain
5 elements of the income statement and some of
6 them he doesn't. Depreciation is a charge that
7 is based on capital expenditure decisions
8 already made, approved, and where investments
9 have been made. Same thing for financing costs
10 and interest, depending on how a multi-hospital
11 system allocates individual hospitals. It's
12 net interest cost for the system, management
13 fees, the same way. But above the line, things
14 like salaries, wages, revenues, those are the
15 things for which an administrator on site is
16 held accountable. So when he says he's
17 interested in cash flow because that's what he
18 controls, so --

19 Q: Depreciation is often times referred to as soft
20 expense, right, as opposed to a hard expense?

21 A: I don't use that terminology. But I --

22 Q: A lot of people do.

23 A: I've always recommended to hospitals that they
24 need to basically either reinvest depreciation
25 or have it in a cash account reserved for

1 future capital expenditures or at some point
2 down the road, when their facility is worn out,
3 they won't have the capital and they'll have to
4 rely on a higher percentage of debt than they
5 did in the past to finance their continued
6 operations and growth.

7 Q: Okay. Well, my point is, even in year one with
8 an ADC of 20, this facility generates enough
9 cash flow to begin some reinvestment towards
10 the facility, doesn't it?

11 A: Correct.

12 Q: Now, let's look at number three, which is page
13 645.

14 A: Okay.

15 Q: Let's talk about operating margin in regards to
16 a facility. Operating margin is EBITDA divided
17 by net revenue, right?

18 A: Operating margin?

19 Q: Yes.

20 A: Okay. Sure.

21 Q: Okay. In other words, the percentage of
22 earnings before depreciation, interest and
23 taxes compared to the net revenue, the actual
24 cash in the door, right?

25 A: The only thing I can say is, as came out during

1 some of these discussions over the last couple
2 of days, EBITDA is not exactly comparable,
3 necessarily, for all systems. For instance, a
4 hospital that has management fees below the
5 line, and otherwise would have had expenses
6 above the line is going to have a different
7 EBITDA percentage of revenue than would be the
8 case for a hospital that had the opposite.

9 Q: Well, let's just talk about Trident.

10 A: Okay.

11 Q: Okay. Can you calculate the operating margin
12 for 2009, well, let's do 2008, the projected
13 year, first year on that? You got a calculator
14 with you?

15 A: Yeah, I do. I'm not going to go beyond the
16 millions level here. I'll just give you a
17 round number if that's okay, 19 percent,
18 basically.

19 Q: Nineteen percent?

20 A: Correct.

21 Q: And that's a pretty good operating margin,
22 right?

23 A: Yes.

24 Q: For a hospital, nothing dramatic, but it's
25 good, right?

1 A: Correct. Again though, remember you have a
2 management fee number. And that management
3 fee, which in these calculations is, by the
4 way, the difference between pure management fee
5 and a negative interest number, which is
6 assigned to the hospital, which is a reflection
7 again of due from and due to, which is why the
8 management fee number here doesn't exactly
9 reflect the management fee numbers on some of
10 those sheets you were showing because there was
11 a negative interest number.

12 Q: Okay.

13 A: Okay.

14 Q: Calculate 2016 for me.

15 A: Sure. It's a little bit shy of 14 percent.

16 Q: It's 13 something, right?

17 A: 13.7 is what I get.

18 Q: You know, that's not very good, is it? The
19 operating margin dropped, some of the pro forma
20 from 2008 to 2016, from 19 percent, to over 19
21 percent, to over 13 percent, right?

22 A: Yes. What they've done is, this is a conscious
23 decision by a hospital to make an investment in
24 a new facility in an area where they're
25 basically presuming in this model, transferring

1 volume from A to B. What that means is, in the
 2 absence of a new project, if all of that
 3 revenue had been essentially at a particular
 4 site without the cost associated with it being
 5 a new facility, their margins would have been
 6 higher. This was in a sense, an investment
 7 that lowers their margins over a period of
 8 years, reflecting the fact that the patient
 9 population of the new hospital is a transfer.
 10 If you backed off that 100 percent assumption,
 11 if you had a lower number and you had some
 12 market shared growth, these numbers would be
 13 better.

14 Q: Okay. Why don't you flip over --

15 A: Let me say one more thing. There is a second
 16 thing, which is that this also reflects the
 17 forecast going forward of revenue growth on the
 18 gross revenue side and net revenue growth. And
 19 an assumption that the payer situation is not
 20 going to get any better, but actually will be
 21 getting worse. So even though there are two
 22 issues that can result in these reduced
 23 margins. One is, the investment for the Moncks
 24 Corner facility. The second is, these are
 25 conservative assumptions about the

1 reimbursement rates going forward for some of
2 the third-party payers, which already don't pay
3 very much.

4 Q: Well, there is another possibility that they're
5 just wrong, right, it's not well done?

6 A: I don't understand what you're saying.

7 Q: I said there's another possibility as to why
8 that operating margins declining and that's
9 because they're not doing a very good job of
10 forecasting. They're underestimating their
11 revenue?

12 A: Forecasting --

13 Q: It's a possibility, isn't it?

14 A: Let me just say this. There's no such thing as
15 wrong if you haven't yet gotten to the years
16 where you've made the forecast.

17 Q: Okay.

18 A: You can certainly criticize a forecast and say,
19 I would have done it differently. I think they
20 should have been more aggressive here. I think
21 the numbers should have been higher there,
22 that's perfectly reasonable. They've done a
23 little bit of that with Mr. Knapp today, that's
24 fine. All I'm saying is to say it's wrong,
25 there's mathematically wrong and there's you

1 disagree with the assumptions and those are two
2 different things.

3 Q: Okay. Well, you did 643, which is the first
4 page of the first pro forma?

5 A: Correct.

6 Q: And that is the pro forma without the Berkeley
7 Regional Medical Center in it, right?

8 A: Correct. And you see here declines in the
9 bottom line of net income.

10 Q: Calculate the operating margins for me, if you
11 would, in 2008 and 2016?

12 A: Correct. So a modest improvement of about five
13 million.

14 Q: In its percentages?

15 A: Oh, I'm sorry. Well, the first year would be
16 the same as we calculated before, nothing's
17 changed.

18 Q: All right. Nothing's changed so that's going
19 to be 19 something?

20 A: Correct. This is again, almost 14 percent. A
21 drop higher than in the prior table.

22 Q: So since the operating margins are the same
23 with the hospital as without, then you can
24 safely assume that the hospital is not causing
25 the decline in operating margin, right?

1 A: No, because these tables on this first page
2 reflect the loss of patient volume, primarily
3 at Trident Medical Center and to a lesser
4 extent to Summerville Medical Center that are
5 being moved to the Berkeley Regional Medical
6 Center. In other words, in the absence of the
7 Berkeley Regional Center, you would have under
8 the 100 percent transfer arrangement, all of
9 that revenue without all of the expense. Not
10 only would you not have the depreciation
11 expense, you wouldn't have a lot of the salary
12 expense and so on that simply occurs from
13 running a third facility.

14 Q: And you would assume that the operating margin
15 would be better without the hospital under
16 that. If you're going to assume that the
17 hospital is a drag on the profits of the
18 system, then not having the hospital would
19 increase the operating margin, right?

20 A: I started it by saying this is an investment
21 that Trident made. They did not expect, from
22 my conversations with them, that the Berkeley
23 Regional Medical Center would be a particularly
24 profitable hospital. And this 100 percent
25 assumption, which we developed, and they

1 accepted, and that's what was submitted in the
2 application, guarantees, guarantees that the
3 margins will drop. Because all the revenue's
4 being shifted, which means, you don't have
5 additional revenue. The revenue is the same,
6 it just moved from one pot to another. But you
7 had additional expenses for the system
8 associated with the capital cost, as well as,
9 some of the operating costs.

10 Q: Let's just go back to 645, which is the
11 forecast, including the hospital.

12 A: Sure.

13 Q: Okay. And look at the total --

14 A: Let me just say, I disagree with you. That 14
15 percent is lousy performance, in terms of
16 EBITDA. I mean, I work with hospitals all over
17 the country and not all systems are like
18 Trident and Roper. There are lots of hospitals
19 that would die to have numbers like these.

20 Q: Yeah. But 13 compared to 19 is lousy.

21 A: Well, 14 compared to 19 is a drop. But the
22 question is, is it an absorption period? And
23 then in the future going forward, you're no
24 longer having any transfer to the Berkeley
25 Regional Medical Center. So the system begins

1 to grow, as it did in the past with population,
2 at its existing facilities and the numbers
3 start coming back.

4 Q: It's the same percentage without the hospital.

5 MR. THOMAS: Your Honor, could you let my, well, let
6 him finish.

7 MR. LONG: I'm trying to do it, I'm trying --

8 THE COURT: Go ahead and finish your question.

9 Q: It's the same percentage without the hospital
10 being considered.

11 A: I --

12 Q: It can't be because of the hospital.

13 THE COURT: Let him finish answering.

14 A: No, no, that's not true. You're missing what
15 I want to say.

16 THE COURT: Mr. Baehr, hold on a second. I can't
17 hear. The court reporter can't hear when y'all
18 talk over each other.

19 MR. BAEHR: I apologize.

20 THE COURT: Mr. Long, when you ask your question
21 again and then stop for Mr. Baehr to respond.

22 Q: But the operating margin percentages are the
23 same, whether the hospital in Berkeley County
24 is included or not; isn't that correct?

25 A: They're similar, but both of them are

1 depressed. In other words, both the numbers on
2 643 and the numbers on 645 are depressed
3 because of a transfer of patient population
4 from two existing facilities to a new facility.
5 And in that case, money that would have been in
6 A is now money that's in B, but the net to the
7 system hasn't changed. But, you do have some
8 incremental expenses associated with the fact
9 that you're seeing those patients at a
10 different site. That's being done to improve
11 access. It has a short-term cost to the
12 system, in terms of reduced margin. But in
13 terms of the overall EBITDA, even with the
14 change, the EBITDA number is 11 million higher
15 in 2016 than 2008. And it's six million higher
16 than it is in 2011 before the new hospital
17 opens. So I think the system has absorbed the
18 change fairly well. And the other point I
19 mentioned, which was about the shift in other
20 payers, you can see that there is a decline
21 from 2008 to 2011 before Berkeley even opens,
22 in terms of the EBITDA margin, which would be
23 consistent with the shift in the payer
24 percentages and the shift in the payment rates
25 by third-party payers.

1 Q: Do you know, sitting here today, whether the
2 revenues and expenses for Berkeley Regional
3 Medical Center are included in the pro forma on
4 page 643 in the application? Do you know
5 whether they are or not?

6 A: The Berkeley numbers are in 645, not in 643.

7 Q: So in 643 --

8 A: You can look --

9 Q: Okay.

10 A: If you look, I'm sorry. Look at 2016, the
11 revenue is two million, 422. On page 643,
12 gross revenue. And then on the next page it's
13 196 million for Berkeley Regional Medical
14 Center. If you add 2,422,000 to 196 million
15 you get 2619, which is the number on page 645.
16 And that's true of every single cell in these
17 three pages.

18 Q: Okay. Let's go back to 643. I'm sorry, let's
19 go to 643. This is the pro forma that does not
20 include the Berkeley Regional Medical Center.

21 A: What it includes is the piece of Berkeley
22 Regional Medical Center that wasn't included in
23 the Berkeley numbers.

24 Q: The ED?

25 A: ED and some outpatient, correct, right.

1 Q: All right. The projection for 2008 is that the
2 total net revenue for Trident Health System is
3 371,610,548 right?

4 A: That's correct.

5 Q: And it's projected to grow in 2016 to
6 558,572,000?

7 A: Correct.

8 Q: And that's net revenue, that's cash in the
9 door. Okay.

10 A: That's correct.

11 Q: But the EBITDA number only grows from 72
12 million,562 to 77 million, 796, right?

13 A: That's correct.

14 Q: So they're going to make \$5 million more in
15 EBITDA, just five million and they're going to
16 have \$180 million more in cash.

17 A: \$180 million more net revenue.

18 Q: Yeah, more. \$180 million coming into the
19 system, but their EBITDA number or their
20 earnings will only go up about 5 million,
21 right?

22 A: Correct.

23 Q: Somebody's getting fired over that, aren't
24 they? If that happens in the real world?

25 A: I don't know. I think the Trident people are

1 aware of what these numbers look like. They
2 approved them. They understand there's an
3 investment being made over a short-term period
4 of time to get this facility up and going. And
5 that's my understanding.

6 Q: Okay.

7 A: Now, I'll say one thing, the fastest growing
8 number on the expense side, which has a
9 significant impact on the EBITDA number is bad
10 debts. All right, if you look at the net
11 revenue number on page 643, total net revenue
12 grows from 371 million to 557 million. That's
13 a growth of about 50 percent. All right, look
14 now at bad debts, that grows from 67 million to
15 140 million, that's 73 million growth. That's
16 growth of over 100 percent. Bad debts, in many
17 ways, should be above the line under
18 deductions. That would be, in my judgement, a
19 more appropriate way to look at it. It's no
20 different than contractual allowances. Move
21 that bad debt number up, all right, above the
22 line and you wind up with net revenue of 304
23 million in 2008 and in 2016, 418 million. All
24 right, then the growth is more on the order of
25 a third, not 50 percent. That's a significant

1 difference. The biggest change in the expense
 2 items, in terms of percentage growth, is bad
 3 debts. Bad debts are a reflection of what's
 4 been happening in the hospital industry. One
 5 of the reasons why healthcare reform, the
 6 president and Congress try to address the
 7 number of uninsured, who are the result, this
 8 is where bad debts come from. Okay. You can
 9 like the new bill or not like the new bill,
 10 that's irrelevant. The point is, bad debts are
 11 a real problem in the hospital industry,
 12 they're growing. And I think this estimate of
 13 the growth and bad debts is a realistic one.
 14 And if you place that above where the net
 15 revenues are, then that revenue growth is much
 16 more modest than you've indicated over this
 17 eight year period.

18 Q: Well, let's just look at the EBITDA number for
 19 earnings reporting, interest, taxes and
 20 depreciation and let's take a look at
 21 Petitioner's 160. Before we leave that, let's
 22 write down what the projected EBITDA numbers
 23 were in the pro formas submitted to the
 24 Department for 2009 and 2010.

25 A: Slow down, Jimmy.

1 Q: Can you write down the EBITDA numbers, the
2 forecasted earnings numbers for 2009 and 2010
3 in the pro forma that was provided to the
4 Department?

5 A: Okay. Sure. Okay.

6 Q: 2009 is 73 million, 390 and some change, 885.

7 A: Correct.

8 Q: 2010, they projected an EBITDA number of
9 75,757,224, okay?

10 A: Sure.

11 Q: Let's go to Respondent's 160 and see how they
12 actually did it.

13 A: You'll put that up on the screen?

14 Q: Yes. This is the summary, but it lists the
15 EBITDA numbers off the actual financials. In
16 2009, they projected 73,390,000, how did they
17 do?

18 A: 2009?

19 Q: Uh-huh (affirmative response).

20 A: 78 million, 077.

21 Q: So they exceeded it, right?

22 A: Yeah. It's about a five or six percent.
23 That's six percent higher.

24 Q: You think that's significant?

25 A: It's positive. I'm sure they would rather be

1 higher than lower.

2 Q: You think it's a significant number?

3 A: Yeah, four or \$5 million is a decent size
4 number, sure.

5 Q: Look at 2010, they projected 75 million, 757
6 and how did they do?

7 A: 92,862.

8 Q: Missed that one, didn't they? They did a lot
9 better in 2010 than they projected on the
10 forecast, right?

11 A: Correct. From 2010, my understanding was a
12 very good year. I don't believe 2011 has been
13 quite as good.

14 Q: But you had nothing to do with these
15 financials, right? You didn't review these pro
16 formas. You didn't test them. You didn't --

17 A: I did all those things in preparation for this
18 hearing. I did not do them at the time they
19 were submitted.

20 Q: You stand by these forecasts today?

21 A: I think they're reasonable, yes. And again, I
22 think forecasts should be prepared in a
23 conservative fashion. So it's worse to be over
24 optimistic and project numbers that are
25 unattainable or unlikely to be attainable than

1 to project numbers that there is a reasonable
2 chance that you might exceed, but represent a
3 fair estimate of how you're likely to do. I
4 think, for instance, Mr. Knapp's numbers for
5 the St. Francis-Berkeley facility are
6 extravagant in terms of the net incomes. So
7 that -- these were a little conservative, they
8 didn't project as much EBITDA as they might
9 have. I think the other one is guilty of the
10 other case, which is being way too high.

11 Q: Well, you told the Court earlier today that you
12 thought the hospital at Carnes Crossroads would
13 make \$25 million?

14 A: If you just follow Mr. Knapp's model and you
15 treat all patient days, treat it as a venue, as
16 a site, all the volume at the hospital is at
17 the site. It's just a complete hospital
18 standalone model, not just the incremental
19 days, what you get from, essentially, the
20 change in his numbers from the first year to
21 the third year suggest that the standalone
22 hospital with all the days would make 24
23 million. And that struck me as not realistic.

24 Q: Okay. I didn't get to finish my question. You
25 testified earlier today that the pro forma

1 showed for the Roper St. Francis Hospital at
2 Carnes Crossroads that it would make \$25
3 million in the third year. And you also
4 testified that it was not financially feasible,
5 because it would not have a positive net
6 income, which one is it?

7 A: I'll say it again. The applicant made a
8 decision about what to show the Department.
9 And what's at issue here is whether the
10 Department made the right decision or not. The
11 Department got financials that showed patient
12 activity for half the days, okay. If they
13 thought that was odd, they could have asked
14 about it. They could have asked to see a full
15 hospital model. They asked a lot of questions
16 of Trident Medical Center. They wanted to know
17 what the impact would be in zip code 29483 of
18 Berkeley Regional Medical Center in
19 Summerville. They wanted the impact on all
20 the zip codes as a result of these two new
21 hospitals. They were asking tons of questions
22 of Trident Medical Center. And they didn't
23 really ask anything of Roper, including where
24 they were going to get their patients from, why
25 their patient activity and the financials only

1 reflected half the days. I mean, these are
 2 important questions, which they simply passed
 3 on. Since the Department only gets what's
 4 submitted, you have a volume that shows break-
 5 even. And what I'm saying is, that volume is
 6 based on the wrong numbers given what Mr.
 7 Richardson developed about the number of
 8 incremental days. Mr. Knapp used too high a
 9 number of incremental days. And if he had used
 10 the right number that Mr. Richardson projected,
 11 he would have shown a negative net income on
 12 the 6,000 days. It would have been less than
 13 6,000 days. It might have been 5,000
 14 something, 5,500. As a full venue they would
 15 show profitability, but they didn't. That's
 16 not what they showed the Department.

17 Q: What do you believe, which one is it?

18 A: I believe the hospital will make money, okay.
 19 I think they will make money. I don't know if
 20 they'll make as much as 25 million, okay. I
 21 mean, they're in a better area than Moncks
 22 Corner, in terms of payer mix. In terms of
 23 patient population as far as affluence, and
 24 given the forecast for Moncks Corner, one would
 25 expect that numbers coming from a community

1 where a lot of the patients are going to be
2 within a 7 mile area around the hospital that
3 they would do better, that if they get their
4 hospital filled with the same 35 beds that they
5 should do better. My problem was, I saw two
6 projections. If I'm at the Department and I
7 get an application from Berkeley Regional
8 Medical Center that shows break-even on 35
9 patients in year three. And then I get an
10 application from Roper St. Francis Berkeley
11 that shows break-even at 17 and a half patients
12 in year three, that would strike me as odd.
13 How can one hospital with half the volume make
14 as much money as another hospital with twice
15 the volume?

16 Q: Well, Mr. Baehr, that's because there are two
17 different approaches to the financials and you
18 know that it's incremental and --

19 A: No, no, no.

20 **THE COURT:** Wait a second and what?

21 **MR. LONG:** -- incremental versus venue?

22 A: No. Not true.

23 Q: Can I ask you a couple of questions to set it
24 up for the Judge here?

25 A: Sure.

1 Q: Did Trident's pro formas include a 100 percent
2 of the inpatient revenue and a 100 percent of
3 the inpatient expenses in almost all of the
4 outpatient revenue and almost all of the
5 outpatient expenses?

6 A: It's not almost all. It's a fairly significant
7 number in the first year that relates to
8 existing volume at the Moncks Corner facility.

9 Q: Is it even 20 percent? Do you know what the
10 percentage is?

11 A: Well, in the ER it's more than half the visits
12 in the early years.

13 Q: Is it 20 percent of the total, do you know?

14 A: That's about right. That might be about right.

15 Q: Okay. Now, in contrast, the Roper St. Francis
16 application doesn't consider the redirect of
17 patients. So it's just like a portion of the
18 inpatient revenue, a portion of the inpatient
19 expenses, a portion of the outpatient revenue
20 and a portion of the outpatient expenses,
21 right?

22 A: I completely agree. But, think again of what's
23 arriving at the Department. Each hospital has
24 projected overall volume of roughly the same
25 number, something around 12,000 plus days by

1 year three. They've each done that. Each
 2 hospital submits financials. The financials
 3 for the Moncks Corner facility are based on
 4 those 12,000 days. And it shows they make a
 5 small amount of money in year three. The Roper
 6 St. Francis financials arrive and even though
 7 the demand forecast, the need analysis shows
 8 12,000 days, there's a model built where in
 9 year three, the volume is only 17.5 patients
 10 and they have a slightly higher net income than
 11 the Moncks Corner facility does with 35. I'm
 12 not saying that it's not an apples versus
 13 oranges. If you had the full 35 beds, I
 14 guarantee you that the Goose Creek numbers
 15 would dwarf the Moncks Corner numbers, in terms
 16 of profitability. All I'm saying is, what the
 17 Department sees is what they're sent. And
 18 they're seeing two hospitals, one that says
 19 they can break-even with 17, the other says
 20 they can break-even with 35. I have my doubts
 21 that they can break-even at 17. In other
 22 words, I think the financial projections as
 23 prepared by Mr. Knapp is too optimistic. As
 24 a result, I don't really think they'll make 25
 25 million. I don't think their net revenue for

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1 adjusted patient day will be 30 percent and
 2 higher than the rest of the Roper System. So
 3 I think their numbers are going to be a lot
 4 short of that. What that would mean is, if
 5 they really showed a realistic half hospital
 6 with more realistic numbers, they would have
 7 shown significant losses. And that should have
 8 attracted the attention of the Department. I
 9 think just what they submitted should have
 10 attracted the attention. If I'm a reviewer,
 11 and I see one hospital says 35 is what I need
 12 to break-even and the other hospital says 17
 13 and a half, a light should go on. How can that
 14 be? How can two hospitals in the same county
 15 have so different a situation that one could
 16 break-even with so many fewer patients.

17 Q: Did you bring it to the Department's attention
 18 during the review process, that fact alone that
 19 you've just been talking about? Did you bring
 20 that to the Department's attention during the
 21 review process?

22 A: That was not the issue that I raised, no. But,
 23 if I don't raise an issue that doesn't mean
 24 that the Department can't ask questions of one
 25 of the applicants, since they asked many of the

1 other. I mean, there is the appearance that
2 there were rounds of questions for Trident to
3 keep a cycle open, to make sure they both sort
4 of got in the same cycle. And once the Roper
5 application was in, it didn't take long for the
6 Roper application to be complete. I mean, I
7 don't see the same kind of scrutiny, the same
8 kind of evidence of careful examination of
9 questioning, of asking for more information of
10 one application than I had of the other. That
11 would have been -- if I'm a reviewer, yeah, I
12 would have noticed that. That would have been
13 one of my first questions.

14 Q: Mr. Baehr, we filed our application before the
15 Department even deemed the Trident application
16 complete.

17 A: Correct, because they continually asked them
18 more questions.

19 Q: We could have waited two more months and still
20 been within the same cycle, right?

21 A: But they were asking lots of questions of
22 Trident, which in a sense, kept them from being
23 up to date where they were complete.

24 Q: Well, they did two rounds of questions, right?

25 A: Correct.

1 Q: Now, we've raised another issue. The
2 contribution margin, which we talked a little
3 bit about that you used on the adverse impact
4 analysis, which you got from the Trident Health
5 System?

6 A: For the second.

7 Q: For the second adverse impact analysis was
8 higher than the contribution margin in the pro
9 forma, wasn't it?

10 A: Correct. It's higher than the number that
11 comes out of the earlier numbers, correct.

12 Q: And Mr. Knapp caught that, presented that in
13 the litigation. And he's right about the pro
14 forma underestimate the actual contribution
15 margin, which would also explain why the EBITDA
16 number doesn't increase enough in the pro
17 formas submitted with the application.

18 A: Actually, what Mr. Knapp did --

19 Q: Isn't that right? That was my question.

20 A: Yeah. Unless we're referring to a different
21 document, what I recall that Mr. Knapp did, is
22 he tried to make an argument that the
23 contribution margin for the Berkeley Regional
24 Medical Center was not high enough as compared
25 to the contribution margin for the entire

1 Trident system for their non-tertiary activity.
 2 And as result, he was making an argument that
 3 if you project out to 2016, if they had the
 4 same kind of contribution margin as the whole
 5 Trident system, then they would make more
 6 money. So heck, they could lose a few thousand
 7 days, because Roper's being built and it's no
 8 skin off their back. The problem is Mr. Knapp
 9 in that analysis is comparing apples and
 10 oranges. Because he's comparing the
 11 contribution margin for the Berkeley Regional
 12 Medical Center, which doesn't include all the
 13 outpatient activity, with the contribution
 14 margin for the entire Trident system. And all
 15 of the Trident system for non-tertiary is on
 16 average going to be slightly more intense and
 17 slightly better payer mix than what you're
 18 going to get at Berkeley Regional Medical
 19 Center, because of the nine zip codes that were
 20 selected to be used for the financial
 21 calculations for Berkeley Regional Medical
 22 Center. If you're looking at all of the
 23 Trident Medical Center activity or all the
 24 Trident system activity coming out of Berkeley
 25 County, just the non-tertiary, you're going to

1 get patients from Goose Creek. You're going to
2 get patients from Ladson. You're going to get
3 patients from the southern end of the county,
4 better payer mix, higher net revenues, and as
5 a result, higher contribution margin. One
6 should not expect that the Berkeley Regional
7 Medical Center numbers, given their payer mix
8 and their distribution of patients would be the
9 same as those for the Trident system as a
10 whole.

11 Q: Well, the pro forma they had did not include
12 the Berkeley Regional Medical Center. It still
13 had a lower contribution margin than what you
14 provided as the actual contribution margin in
15 the adverse impact analysis. Is that correct?

16 A: Okay. You're referring to a different
17 document.

18 Q: Is that statement correct or not?

19 A: I'm not sure. You would have to show me the
20 document. Because what I'm talking about was
21 the most recent document that Mr. Knapp
22 submitted, arguing that Berkeley would be more
23 profitable because it should have exactly the
24 same contribution for non-tertiary activity
25 coming out of the county as all patients that

1 Trident has seen. And that's not the case, it
2 shouldn't. You would expect it to be lower,
3 for a couple of reasons. One of which includes
4 that the Berkeley numbers are not a full
5 hospital.

6 Q: All right. Let's talk about adverse impact.
7 When a hospital or a hospital system decides to
8 construct a satellite hospital, it will have an
9 impact on the existing providers, won't it?

10 A: Yes. And add new beds, yes.

11 Q: If they just construct the hospital, it'll have
12 some impact?

13 A: Yes. But the new player in a market that
14 hasn't been there before, it's a new geographic
15 area that has a facility that didn't have one
16 before, yes, it changes things.

17 Q: Now, the impact, it will be based on a number
18 of different factors, right? Distance from the
19 existing provider is certainly a factor, right?

20 A: Yes. Also, whether a player is new to the
21 market. For instance, I would make an argument
22 that Trident, which already has two hospitals
23 in Berkeley County and is establishing a third
24 would have a different impact than a new
25 provider coming into the county for the first

1 time.

2 Q: Well, a new provider coming in for the first
3 time will have a greater impact, right?

4 A: It would shake the market up more, correct.

5 Q: All right. So if the Lexington Medical Center
6 decided to open a hospital in Berkeley County
7 that would shake up the market more than one of
8 the existing providers opened a hospital in
9 Berkeley County?

10 A: If who did that, I didn't catch the question.

11 Q: Lexington Medical Center.

12 A: If who?

13 Q: Lexington Medical Center.

14 A: Came into Berkeley County.

15 Q: Came into Berkeley County and opened up a
16 hospital?

17 A: I would have two different clients, wouldn't
18 it. I don't know which side I would have to
19 work on in that case. Yeah, if somebody came
20 from afar and has no relation whatsoever to a
21 market, that's problematic. I've seen
22 instances of the two big Carolina Systems sort
23 of moving into markets far afield. And those
24 I think, do have some ability to shake up a
25 market significantly.

1 Q: So if the standard was simply, will you or will
2 you not be adverse, no one can ever build a new
3 facility or add a service, right, it has to be
4 materially adverse?

5 A: And it has to be weighted against access
6 improvement. That's what the State, at least
7 that's how it's written here in South Carolina.
8 You have to look at two things. You have to
9 look at how much access improvement. And you
10 have to look, on the other hand, at how much
11 damage you do to existing providers. And one
12 will usually outweigh the other.

13 Q: And usually, well, when you talk about the
14 State Health Plan, the statement, didn't you
15 say that?

16 A: Yeah. Right below the section where they
17 mention that a majority of residents of South
18 Carolina within 30 minutes drive time. They
19 talk about that there would be equal
20 consideration given to the access improvement
21 and adverse impact.

22 Q: Well, you testified in numerous cases and CON
23 cases in South Carolina and Florida that the
24 adverse impact has to be material, right?

25 A: Yeah. If it's a \$100,000 and the system makes

1 a \$100 million, I don't think that's material.

2 Q: Okay. Now, in 2006, you testified in an open
3 heart case here in this courtroom, before it
4 was redone, right?

5 A: Correct. This is a huge improvement.

6 Q: It's a lot nicer courtroom, isn't it?

7 A: Tremendous.

8 Q: Okay. You were asked in that case, how do you
9 measure if there's too much adverse impact? Do
10 you remember what your answer was?

11 A: I do not recall the exact words that I said six
12 years ago. I'm sorry.

13 Q: Let me show you the transcript and maybe it can
14 refresh your memory a little bit, okay?

15 A: Sure. Thank you.

16 MR. THOMAS: Your Honor, I believe, in your order,
17 you specifically said that these impeachment
18 documents would need to be submitted along with
19 the Exhibit list. And this is the first time
20 I've gotten this, the day of the cross
21 examination of the witness. I understood your
22 order to say that these need to be marked as
23 Exhibits well in advance.

24 MR. LONG: Your Honor --

25 THE COURT: Yeah. Read my order into the record,

1 please.

2 **MR. THOMAS:** I'll need to get it. I actually
3 provided the trial testimony for Mr. Knapp and
4 Mr. Richardson to Mr. Long back in December
5 when we were supposed to -- I'll get your
6 order.

7 **THE COURT:** If it's too difficult I can get Mr.
8 Goldman to get it when he comes back.

9 **MR. THOMAS:** Here we go. All right, Your Honor, I
10 think we found it. This is your order filed
11 like January 26, 2010, signed by you. Notice
12 shall be given to the opposing counsel of any
13 documents to be used in cross examination,
14 whether or not it's to be introduced into
15 evidence. Notice shall be given to opposing
16 counsel of any hearsay statement intended to be
17 introduced as a declaration against interest or
18 for any other reason or to give opposing
19 counsel opportunity to rebut such testimony.
20 So then you said this provision envisions, but
21 is not limited to a situation which witness
22 testifies without statements made by an
23 employee of the State agency or the officer or
24 agent of the business institute. Disclosure
25 will prevent surprise to the adverse party and

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1 ensure availability for rebuttal witnesses.
2 And so, Your Honor, the first sentence there,
3 I think is the one that's applicable here.
4 Notice shall be given to opposing counsel if
5 any documents to be used in cross examination
6 whether or not to be introduced into evidence.
7 Mr. Long has probably known for two years that
8 he would probably use this document at this
9 trial.

10 **THE COURT:** Thank you. Mr. Long?

11 **MR. LONG:** I have not known for two years that I
12 would use this at the trial. Your Honor, I
13 came upon it and I decided -- well, first, Your
14 Honor, here's the thing. I'm not seeking to
15 introduce as an Exhibit, okay. And I merely
16 asked him if he remembered and I gave him the
17 document to refresh his memory. And so, once
18 his memory is refreshed, I'm going to ask him
19 about the testimony in the other case, which I
20 think is perfectly legitimate cross
21 examination. I'm not seeking to introduce. I
22 asked to refresh his memory, which the rules
23 have a special provision in the rules of
24 evidence that you can allow a witness to
25 refresh his memory in regards to his testimony.

1 And that's the reason I presented it. I gave
2 him a copy of it. I'm not seeking to put it
3 in. I'm not handing it up to the Court. I'm
4 not putting it on a screen. I'm not doing
5 anything with it. I just asked him. I handed
6 him the document and asked him if he wanted to
7 refresh his memory and the --

8 **THE COURT:** Are you not seeking to impeach him by it
9 though?

10 **MR. LONG:** No. Because I fully expect him to
11 testify to what he testified to when he, once
12 he refreshes his memory. I'm not trying to
13 impeach him.

14 **THE COURT:** Mr. Thomas?

15 **MR. THOMAS:** You say specifically whether or not
16 it's to be introduced into evidence. You say
17 that.

18 **THE COURT:** All right.

19 **MR. LONG:** I'm not trying to impeach him, Your
20 Honor. I'm not pitting his statement against
21 him. I'm going into an area I fully expect him
22 to agree with me, in regards to the discussion
23 of it. I'm just trying to set it up and so I'm
24 using it to refresh his memory.

25 **MR. THOMAS:** There's a problem, Your Honor, I've

1 never read this before, you know, I have not
2 had the opportunity to review it.

3 **MR. LONG:** You wouldn't have needed it if he
4 remembered. I specifically said, do you recall
5 what you testified about in regards to adverse
6 impact in that case.. He said I can't recall
7 exactly. I said here's a document to help
8 refresh your memory. He can look at the
9 document to refresh his memory. I'll take it
10 back from him. I'm not putting it on the
11 screen. I'm not introducing it. I don't
12 expect to have to read from it.

13 **THE COURT:** Objection sustained.

14 **MR. THOMAS:** Thank you, Your Honor.

15 **MR. LONG:** Your Honor, can I ask him about the
16 testimony?

17 **MR. THOMAS:** He said he didn't remember it.

18 **MR. LONG:** Well, let's go. Let's see if we can jog
19 his memory a little bit.

20 **Q:** You represented Lexington Medical Center in the
21 open heart case in 2006. You remember it,
22 right?

23 **A:** I remember the trial.

24 **Q:** Right. Sixteen days.

25 **A:** Even longer than this one.

1 Q: Longer than this one, 16 days here in the
2 Administrative Law Court of South Carolina,
3 right?

4 A: I remember 19.

5 Q: I think it's 16, the trial days. You
6 represented Lexington Medical Center, right?

7 A: Correct. And Lexington Medical Center was
8 proposing to have an open heart program at its
9 hospital here in the Midlands, right?

10 Q: And there were two providers that opposed that
11 program and they alleged adverse impact, right?

12 A: Correct.

13 Q: And you testified and gave opinions in the
14 Court that the Lexington Medical Center open
15 heart program would not have a materially
16 adverse impact on the existing providers,
17 right?

18 A: What I testified was that there would a
19 financial calculation that we could make that
20 would show adverse impact. And I made one that
21 was different than those that were provided by
22 the expert witnesses on behalf of Providence
23 and Palmetto, numbers that I thought were too
24 high. They estimated too many cases lost.
25 They estimated too many dollars adverse impact.

1 So based on the numbers that I had calculated,
2 and also, I think there was an individual
3 named Mr. Ellis, I think that made some
4 calculations for Palmetto. I think it was
5 Palmetto, whose numbers I thought were more
6 reasonable. The numbers were modest. They
7 were a lot short of the kind of 16 million
8 you're dealing with here. They were two
9 million, three million, whatever. They're much
10 smaller numbers. And again, you're weighing
11 and balancing adverse impact versus access
12 expansion. In that case, the big issue was
13 that Lexington Medical Center was transferring
14 800 patients a year to the two hospitals across
15 the river, some of them on an emergency basis
16 in sort of a life-threatening situations. And
17 that having -- the patients were first arriving
18 there. Lexington Medical Center has been a
19 very successful hospital. It's got a network
20 that draws patients into its system and that
21 the patients were there. And they had pretty
22 much every other service, but this one they had
23 to transfer patients across the river, which is
24 difficult to the patient, potentially to have
25 a real quality outcome issue, doctors

1 testified to that. And looking at the access
2 improvement issue versus what I thought to be
3 fairly modest adverse impact, my conclusion was
4 that the project did not create the kind of
5 adverse impact which would derail the project.

6 Q: And really when you were talking about access
7 in the open heart case, the access was focused
8 on the patients who were choosing to go to
9 Lexington Medical Center?

10 A: They were arriving at Lexington Medical Center
11 with a heart condition, correct.

12 Q: Primarily, through the ER?

13 A: Primarily, through the ER, sometimes from some
14 of their outpatient clinics.

15 Q: They have a lot of Urgent Care Centers.

16 A: Urgent Care Centers, yes.

17 Q: Which were also owned by the hospital and
18 they're known as being part of the hospital,
19 right?

20 A: That's correct.

21 Q: And so you were increasing access for those
22 particular Lexington Medical Center patients as
23 part of your analysis?

24 A: Correct.

25 Q: And you recognized that as a valid

1 accessibility issue, right?

2 A: Yeah. You know there are some things that
3 drive time is an improvement, here you're
4 dealing with patients who some of them needed
5 an emergency angioplasty, some of them needed
6 open heart surgery. And they were arriving in
7 fairly substantial numbers into the Lexington
8 System. And the question is, why should a
9 hospital that size, which is attracting the
10 patients to begin with, who are from the county
11 by and large, have to send them for that kind
12 of critical care across the river to other
13 hospitals. Obviously, there was some adverse
14 impact as the market on open heart was flat,
15 maybe slightly declining, slightly up. I mean,
16 it was not a growth market. The angioplasty
17 market was, on the other hand, growing. But
18 overall, I calculated in my own analysis, cases
19 lost. There would be cases lost by the
20 existing providers. I didn't disagree with
21 that. The question is, did that outweigh a
22 fairly significant qualitative access
23 improvement for the patients who were being
24 transferred.

25 Q: And the need analysis that was done in the CON

1 application that you worked on as the
2 consultant was based on county, right?

3 A: Actually, I didn't prepare the certificate of
4 need application. I was brought in after the
5 application had been submitted. My first sort
6 of premier in the case was at project review.

7 Q: But you did change it, you improved the need
8 analysis, right, you made some changes to it?

9 A: I think I improved it, yes. I would not have
10 had the application looking the way it looked.

11 Q: Right. But the need analysis was based on
12 county, not zip code?

13 A: Correct.

14 Q: And you recognize today, doing a need analysis
15 based on county is appropriate?

16 A: For tertiary service, I think so.

17 Q: Okay. You've done it for other services and
18 other hospitals too, right?

19 A: It depends on again the community, the state.
20 I mean, you're dealing in West Virginia with a
21 whole state, area wise, that is about the same
22 size as South Carolina, but only has 1.7
23 million people. For today, it's probably
24 1,695,000. The counties may be more
25 appropriate even for some other services as

1 well.

2 Q: Well, one reason to do county in this case,
3 this particular case, as opposed to zip codes
4 is because of the zip code 29483, right?
5 Because if you do county 29483, you actually
6 capture the Berkeley County residents. But if
7 you use zip codes, you've got to make an
8 assumption as to where the people are living,
9 right?

10 A: Yeah. But I think that's an appropriate thing
11 to do. The other thing is, a lot of the, you
12 know, zip code analysis they classify a
13 particular zip code as being with one county or
14 another based on where a majority of the
15 population is. I think zip code analysis is
16 far better for a situation like this where you
17 have, essentially a new hospital in a
18 community. And you're making a case that the
19 access improvement is going to be particularly
20 strong in certain sections of the county. If
21 you just do a countywide analysis, you're going
22 to miss what Moncks Corner facility does for
23 the communities around the lake. And from
24 Moncks Corner is, as opposed to what the Roper
25 facility might do in Goose Creek. I think it's

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1 a deficiency not to address the zip codes-
2 specific issues here, because it's harder to
3 calculate adverse impact. It's harder to know
4 where the access improvement is. And those are
5 the two things that have to be weighed and
6 balanced.

7 Q: All right. Let's go back to the adverse impact
8 in the open heart case, okay? In the open
9 heart case one of the providers that was
10 contending would be adversely impacted was
11 Palmetto Richland, right?

12 A: Correct.

13 Q: Palmetto Richland is a large system with a
14 substantial net revenue, a multiple hospitals,
15 isn't it?

16 A: Yes. They had two in the Columbia area and
17 they had one in another location.

18 Q: The Baptist facility up there, right? And you
19 opined in that case that is was appropriate to
20 look at the size of the system for Palmetto to
21 weigh whether the adverse impact of the lost
22 cases to Lexington would have a material
23 adverse impact of them, right?

24 A: Yeah. I thought that was a reasonable test.
25 I mean, Palmetto also is a large provider and

1 the largest provider of services, for instance,
2 within Richland County. This was an open heart
3 project proposed for Lexington County. So one
4 of the arguments I made in that case, and I
5 believed it then and I believe it now, was more
6 than half of the volume, there were more open
7 heart cases being treated at Richland and
8 Providence coming from Lexington County than
9 from Richland. Now, Lexington had a better
10 payer mix. Lexington also had a system that
11 drew patients into its system because of all of
12 these Urgent Care Centers. I made the specific
13 comment, Richland would have the ability to
14 make some of the same kinds of investments in
15 the same kind of Urgency Care Centers, the same
16 kind of patient network to better handle the
17 Richland facility, because I thought the
18 numbers for open heart cases coming out of
19 Richland were too low relative to the number
20 that were coming out of Lexington. And if they
21 lost some cases in Lexington County to
22 Lexington Medical Center, they could gain them
23 in Richland, given the strength of their system
24 if they made some initiatives.

25 Q: But you also testified, didn't you, that the

1 reason there was no material adverse impact at
2 Palmetto Richland is they could take it? In
3 other words, they were successful enough as a
4 hospital and large enough as a system to
5 withstand the hit of the adverse impact, right?

6 A: They could withstand the size of the hit
7 associated with the adverse impact here, which
8 was of a different scale entirely than what
9 we're talking about in this case.

10 Q: And you also testified that you need to look at
11 the sheer magnitude of the dollars, right?

12 A: That's an issue.

13 Q: And in that case, Providence Hospital's
14 operating income was less than \$7 million, not
15 70 like Trident Medical is, but seven.

16 A: I understand. But they were part of this --

17 **MR. THOMAS:** Objection, Your Honor.

18 **THE COURT:** All right.

19 **MR. THOMAS:** I think we're getting into some facts
20 being in the case of six years ago. And Mr.
21 Summer was actually in that case --

22 **MR. SUMMER:** I tried the case, Your Honor.

23 **MR. LONG:** Your Honor, I do object to Mr. Summer
24 making objections in testimony. I don't deal
25 with her case witnesses and she doesn't deal

1 with mine. And I think it's inappropriate for
2 him to do that.

3 **MR. THOMAS:** What I'm being told by my co-counsel,
4 who actually tried that case with Mr. Long some
5 six or seven years ago, was that the number
6 that he just threw out was incorrect.

7 **MR. LONG:** Your Honor, here's the thing. That's so
8 inappropriate for them to do that, because I'm
9 questioning the witness who was there on the
10 stand. He can testify as to what he remembers
11 and what happened in the case. They don't need
12 to be coaching him from the table, which is
13 exactly what they just did. They stood up and
14 said, oh, no, that question is wrong. That is
15 clear coaching of the witness. It's
16 inappropriate and I would ask that stop. It's
17 happened earlier in the case too.

18 **THE COURT:** I agree with that and overrule the
19 objection.

20 **MR. SUMMER:** May I make one statement, Your Honor?

21 **MR. LONG:** Your Honor, I ask that he not.

22 **THE COURT:** What you're going to stop is talking
23 over each other, one at a time.

24 **MR. THOMAS:** You know, it kind of goes back, had I
25 been provided with the document that Mr. Long

1 wanted to question Mr. Baehr about, then
2 perhaps we would have been more prepared.
3 However, you recall from maybe last week, I
4 actually tried to approach the bench. Mr. Long
5 wouldn't let me do that with you. And so, I
6 guess I'm a little confused now and I'm trying
7 to make an objection --

8 **THE COURT:** Wait a minute. You're two seasoned
9 lawyers standing here pointing the finger at
10 each other about something that's passed.
11 Let's move on. I would agree that we're
12 getting pretty far afield talking about heart
13 surgery at Lexington Medical Center so let's
14 get back on track.

15 **MR. LONG:** I will, Your Honor. I just have a couple
16 more questions for him. I promise it's just
17 one or two more then I'll move into something
18 else to show the contrast.

19 **Q:** In the open heart case, Providence financials
20 were not very strong, were they?

21 **A:** I don't recall the exact number, what I do
22 recall is that their system had hundreds of
23 millions of dollars in cash. I think something
24 like 300 or 350 million. And that was, I
25 thought, an important backstop in case this

1 particular hospital, which had by far the
2 largest volume of cases in the market,
3 somewhere in the order of 800 to 900. If they
4 lost a 100 cases, they could absorb that. They
5 would still have a very high quality program,
6 still have the largest volume. There would be
7 some adverse impact in terms of dollars. But
8 I did not think, given the strength of the
9 system, which was a backstop for this hospital,
10 and even with the individual net income, I
11 didn't agree, obviously with Mr. Levitt, who
12 was the witness, his estimates of adverse
13 impact numbers. I had much smaller ones.

14 Q: When you talk about the system for Providence,
15 you're not talking about Providence and
16 Providence Northeast, you're talking about
17 Sisters of Charity, right?

18 A: Right. But they only have, I think a few
19 hospitals. It's not like HCA, which has a 100
20 hospitals around the country. The Sisters of
21 Providence had, I think a hospital left in
22 Cleveland. They may have had one in Canton.
23 And they had the two here, that's it. Those
24 resources were really for the benefit of those
25 three or four hospitals.

1 Q: But those were sources held by the owner, the
2 parent, not the Providence Hospital?

3 A: That's correct. They weren't held at that
4 level, that's correct.

5 Q: They were held, all right. Now, let's go to
6 the application Joint Exhibit 1, page 38.

7 A: Sure.

8 THE COURT: We've been running two hours, let's take
9 about a 10-minute break.

10 (Off the Record)

11 THE COURT: Mr. Long.

12 Q: Thank you, Your Honor. We're now in Joint
13 Exhibit 1, which is the Trident CON application
14 for Moncks Corner, page 38.

15 A: Okay.

16 Q: Do you have it in front of you?

17 A: I do.

18 Q: Okay. At the bottom paragraph, if you would
19 look at kind of the bottom of the paragraph
20 there, this is the section of the application
21 where you discuss or begin to discuss adverse
22 impact, right?

23 A: Correct. It's addressed here and in other
24 sections later, yes.

25 Q: And let's look at what you said here on page 38

1 about adverse impact. You said this point
2 merits additional discussion. In some
3 certificate of need applications, applicants,
4 which would be Trident Medical Center in this
5 case, contend that a total service area of
6 growth is sufficient to maintain existing
7 providers at their existing levels of service
8 while at the same time permitting their
9 proposed facility to achieve needed volume then
10 the issue of adverse impact can be dismissed.
11 The existing providers will not, under this
12 scenario, experience a material adverse impact.
13 Now, that's your words in the application
14 submitted to the Department, correct?

15 A: That actually turns out to be exactly the
16 contention that Mr. Richardson made about what
17 adverse impact is, that particular paragraph.

18 Q: Yeah, but these are your words, not Mr.
19 Richardson's.

20 A: No, I understand. But I'm saying I talked
21 about some applicants contend, okay, so I
22 wasn't talking about me making that statement.

23 Q: Well, yeah. But the reality is that it being
24 -- your a health planner, you testified in more
25 cases than we can count other than this trial,

1 right?

2 A: Certainly, more than I have fingers and toes.

3 Q: Way more than that. Now, and you've testified
4 in some cases that you should look, in regards
5 to determining adverse impact as we just talked
6 about, look at the actual providers themselves
7 and can they withstand the hit, right?

8 A: Yeah. I will say this though, I always make
9 both calculations. And where I have made the
10 kind of argument that's made at the bottom of
11 page 38, it has been much more in circumstances
12 where there is an adverse impact standard in
13 the State Health Plan. For instance, in South
14 Carolina there was a number that was regarded
15 as meaningful in terms of quality, that you
16 didn't want to drive a provider below a certain
17 volume level. You don't have that for the
18 acute care section. There is no guide that
19 says the key is to maintain volume at such and
20 such, an occupancy, for instance. Okay. So in
21 a situation where you have the State telling
22 you, the key is not to drive someone below a
23 certain level. That leads one to look at what
24 level you were at before and whether you're
25 going to be driven below that level in the

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1 future. Even in those cases and the open
2 heart, I made calculation of what I called the
3 full adverse impact, as well as the more
4 limited version, which essentially figures as
5 long as there is no impact to base volume, it's
6 okay; so, I always make both. Okay. The
7 numbers are there. I don't hide them.

8 Q: I didn't -- I wasn't saying otherwise. But I
9 want to take a minute and try to explain this
10 concept to the Court.

11 A: That's fine.

12 Q: All right. I thought maybe the easiest way to
13 explain this to the Court was to give an
14 example if you'd go along with it, okay?

15 A: Sure.

16 Q: Let's just assume for a moment, we're going to
17 use ridiculously low numbers, because I think
18 that's easier sometimes in talking about
19 millions and thousands. That Trident Medical
20 Center has 100 patients in the year 2008.

21 A: Okay.

22 Q: And that the market was going to grow to such
23 an extent that there would be a 150 patients in
24 2015.

25 A: Okay.

1 Q: To where Trident has a 100 now and the market's
2 going to grow to a 150 patients in 2015. A new
3 provider is coming into the market in 2015,
4 they're going to take 40 patients and Trident
5 Medical Center will have 110.

6 A: Okay.

7 Q: All right. What this paragraph says, in that
8 scenario, adverse impact can be dismissed.

9 A: Right.

10 Q: The adverse impact for existing providers will
11 not, under this scenario, experience a material
12 adverse impact. That is what this paragraph is
13 saying, right?

14 A: Right. And I think that's absolutely wrong, as
15 far as acute care bed standard and need, based
16 on the way the State calculates future bed
17 need. And the way adverse impact is defined,
18 as far as projected and future growth, in the
19 certificate of need and the regulations. And
20 I think losing 40 of 150 cases would be losing
21 about 26 percent of your volume that would have
22 occurred in that year. That's pretty sizeable.
23 So, I mean, to say that's not damaging to you
24 -- I mean, you had built a new facility at the
25 time you were 100 to anticipate the growth to

1 a 150. If you then lose the growth or 80
2 percent of it to a new provider and you say,
3 well, that doesn't mean anything, that's not a
4 problem, because I've still got 10 more. Well,
5 you didn't fill the beds in which you made the
6 investment to build for that future growth.

7 Q: Mr. Baehr, the question is whether it is a
8 material adverse impact, okay?

9 A: Yeah, I think all things done equal. If you
10 had a hospital and there are 100 patients and
11 would have gone to 150 and they lose 40 of
12 them, that's a big share of their total volume.

13 Q: Nowhere in the B-11 analysis or anytime did you
14 ever tell the Department that this paragraph
15 that you wrote and the application that you
16 disagreed with, did you?

17 A: What I said was, there's a different test
18 that's used here.

19 Q: Let's go to the next page?

20 A: Sure.

21 Q: And this is the bottom of that page. We'll go
22 to the next page.

23 A: Correct.

24 Q: Top paragraph up there. So what you said, you
25 said -- you laid out the adverse impact test

1 but it's dismissed if the existing providers
2 are at a level higher than they were in the
3 first year.

4 A: That's one approach. That's correct.

5 Q: And you said this project passes an even more
6 rigorous adverse impact test, as shown above,
7 the existing providers will maintain their
8 current market shares and they will be able to
9 enjoy the same benefits of service area
10 population growth that they historically had,
11 right?

12 A: Correct. This test is that if everybody
13 maintains their same market share, they haven't
14 been damaged, okay? And since the assumption
15 in the application or the test in the
16 application was whether there was enough volume
17 and growth in the Trident System to support the
18 movement of 50 beds into Berkeley County, which
19 would have a census of about 34 or 35 by year
20 three and that test worked. You don't need to
21 take other volume because there is enough in
22 the Trident System. That was our test.

23 Q: Okay. But in the language you use, this test
24 is the more rigorous adverse impact test,
25 right?

1 A: That's correct.

2 Q: All right. Now, let's go to Joint Exhibit 2,
3 page 32.

4 A: Say that again, Jimmy.

5 Q: I'm sorry. Joint Exhibit 2, page 32. This is
6 what Roper St. Francis, this is what Mr.
7 Richardson proposed in the application.

8 A: Give me the page again, Mr. Long.

9 Q: Thirty-two. You there?

10 A: I'm here. I'm there.

11 Q: Okay. What Mr. Richardson proposed was that
12 roughly 3,000 admissions that the Carnes
13 Crossroads facility would have in the third
14 year that 1,775 of those would be a
15 redirection.

16 A: Yes.

17 Q: Already aligned with Roper St. Francis Hospital
18 that would choose to come to a closer facility
19 --

20 A: And I mean, it could include, obviously my
21 assumption, that it includes growth in the
22 market too, that close to Roper.

23 Q: And then there would be 1,188 patients that
24 would come from the growth in the market?

25 A: Correct.

1 Q: Okay. And so, because there's going to be, at
2 least, a growth of 2,000 patients that the
3 existing providers would be above what they
4 would be in the initial year, right?

5 A: To be fair to Mr. Richardson, he acknowledges
6 that some of that growth is for Roper. All
7 right. And that's a build up of Roper volume
8 that's assumed in the redirection analysis. So
9 he only comes up with a number of 1,516
10 increase in discharges for the non-Roper
11 market. In other words, it may be 2,000
12 overall, but it's only 1,516 for all other
13 providers and 1,188 of the 1,516, Roper takes.
14 In other words, Roper is taking almost 80
15 percent of the growth available to other
16 providers. And this is an application that
17 follows submission by Trident on behalf of
18 Berkeley Regional Medical Center in which it's
19 apparent that the Trident system is relying on
20 its growth in Berkeley County to build its
21 hospital. So you have, right off the bat, a
22 conflict between -- it doesn't hurt other
23 providers because we're only taking their
24 growth. If you're only taking their growth,
25 but they're also relying on that growth for an

1 application they submitted a few months before
2 you did.

3 Q: If Mr. Richardson's analysis is correct and the
4 existing providers will be at a higher level of
5 utilization than they would be without the
6 service and so, therefore, under your statement
7 and your application and many applicants, the
8 adverse impact would be dismissed, right?

9 A: Yes.

10 Q: What he's describing in the Roper St. Francis
11 application is what you were talking about, and
12 we just looked at in your Trident application

13 --
14 A: Let's be clear about this. That word dismissed
15 refers to an applicant trying, essentially, to
16 put the best positive spin on their application
17 and minimize adverse impact. Because if you
18 make that argument, then what you're saying is,
19 it doesn't really matter. I haven't done
20 damage, because even though I'm taking patients
21 away I'm increasing my market share at their
22 expense. In the long run, they still wind up
23 with a few more patients than they had before,
24 even though their market share has dropped. In
25 South Carolina, you have bed needs defined by

1 projected growth for individual systems with
2 constant market shares. So Mr. Richardson's
3 approach, in terms of what adverse impact is,
4 is clearly not dismissed by the State in its
5 definition of adverse impact, that's the first
6 thing. The second is, this is an application,
7 again, that I just mentioned, that followed the
8 application by Berkeley Regional Medical Center
9 for Berkeley Regional Medical Center, clearly
10 contemplating heavy reliance on that growth in
11 the same market in Berkeley County to enable
12 that Berkeley Regional Medical Center to be
13 successful. So to do this and not even
14 acknowledge that there's another application
15 already submitted, which is relying on that
16 growth, I think is inappropriate. You either
17 have to say, there is another application
18 relying on that growth or we think this
19 application is superior. Make a case as to why
20 your application is the better one or it's like
21 just ignoring it, like it never happened, but
22 it did happen.

23 Q: Let's go back and look at Joint 1, page 38.

24 A: Joint 1?

25 Q: Page 38, we just looked at it.

1 A: Sure. Got it.

2 Q: And I just want to be clear for the record,
3 okay? Listen carefully to my question.

4 A: Sure.

5 Q: What Mr. Richardson proposed in the Roper St.
6 Francis application is the factual circumstance
7 that is being described in this paragraph in
8 the Trident application?

9 A: That's correct.

10 Q: And in the Trident application you state that
11 some certificate of need applicants state that
12 if the providers stay in their existing levels
13 of service then the issue of adverse impact can
14 be dismissed, right?

15 A: I never, however, support that statement in
16 this application. I didn't calculate adverse
17 impact that way. I never did, at any point, in
18 the four years since these applications were
19 submitted until the date of this trial. All
20 this statement means is, that's one way that
21 someone could try to get off easy with an
22 application. That's not what was done here.
23 I'm saying that you have to look at whether
24 there's a shift, a change in the market shares.
25 Now, if you want to argue with me what I did

1 was unrealistic that there actually will be a
2 shift in the market shares, I think I already
3 conceded, yeah, it could possibly happen that
4 their market share would be a couple of points
5 higher. But remember what we did, we were
6 doing a test to see whether the total system
7 could support it. So if someone wants to take
8 and make an estimate of how much market share
9 would change as a result of the Trident
10 application, they can do it. And they can
11 calculate what their adverse impact was. No
12 one in the three and a half years on the Roper
13 side has done that, so --

14 Q: Let's look at Petitioner's 46, which we
15 discussed this morning, pages 33 and 34. And
16 we didn't talk about these pages this morning,
17 but they were in your --

18 A: What Exhibit are you on?

19 Q: It's Petitioner's 46.

20 A: Forty-six.

21 Q: Pages 33 and 34. I've got copies if you need,
22 that would be helpful to the Court.

23 A: Pages 33 and 34?

24 Q: Right.

25 A: Actually, we did go through these pages.

1 Q: These are the sheets that you prepared, because
2 they're part of your Exhibit, is to calculate
3 the growth in the Trident Health System alone
4 between 2010 and 2017, right?

5 A: Right. And this is essentially updated
6 numbers, what was in the application using the
7 methodology, in terms of shares, in Trident
8 volume. The only difference is the way we
9 projected Trident's volume this time was to do
10 it the same way the State does, essentially
11 with age-specific use rates, which does get you
12 slightly more growth going forward than the way
13 Mr. Richardson and I did it in the
14 applications.

15 Q: Okay. Let's just back up one question. The
16 one thing I forgot to ask you, you have in the
17 past calculated and testified about adverse
18 impact, doing the calculations both ways.

19 A: Yes.

20 Q: The way you described it in the application
21 that we just talked about, you've done that in
22 the past, correct?

23 A: Correct.

24 Q: And you've also done it the way you're doing it
25 here, right?

1 A: In fact, in virtually every case, as far as I
2 remember, I've made both calculations in that
3 case.

4 Q: Okay. All right. Now, let's look at this
5 sheet. This is your updated methodology,
6 right?

7 A: Right.

8 Q: Now, let me just confirm what this is. This is
9 supposed to be the sheet with no increase in
10 market share, right?

11 A: Yeah. That's 1621.

12 Q: And the next page is the three percent
13 increase, okay?

14 A: Correct.

15 Q: And you project, you're doing average daily
16 census in here. Okay. This is your forecasted
17 growth in Trident system utilization. This is
18 just Trident Health System alone, not
19 considering growth to Roper St. Francis, MUSC
20 or any other provider, right?

21 A: Right. And this is with constant market share
22 for Trident's system.

23 Q: Constant market share. And you project in 2017
24 that Trident Health System will have an
25 additional 50.9 patients, average daily census,

1 50 patients a day?

2 A: If the population-driven model proves to be
3 realistic, which given the results of the last
4 couple of years, I'm a little more skeptical on
5 that than I may not have been a while back.

6 Q: Okay. And you would agree with me that if
7 Roper St. Francis was to take all of the
8 patients that are not redirected from Trident
9 Health System alone that would be the worst
10 case scenario for Trident Health System, right?

11 A: No, because a worse case is in my section four
12 of the new Exhibits, where I give credit to
13 Roper for their new hospital for a smaller
14 amount of redirection equivalent to the growth
15 in the market. In other words, if Roper's
16 historic share is, let's use for convenience,
17 25 percent then I'm assuming that if Roper
18 builds a new facility 25 percent of the impact
19 is on Roper, because that's been their historic
20 share. So the other 75 percent would be on
21 other providers. And between the two
22 hospitals, because Trident has the bigger
23 share, they get a little over 50 and MUSC gets
24 about 20.

25 Q: I'm not sure you understood the question,

1 because that's not what I was really asking
2 you. So let me do it a better way.

3 A: Okay.

4 Q: Okay. You projected an ADC of 50.9 growth in
5 the Trident Health System between 2010 and
6 2017. There'll be 50 new patients per day for
7 Trident Health System alone, correct?

8 A: Correct.

9 Q: Just growth. That obviously isn't the total
10 number of Trident's patients that number would
11 be dramatically higher for the whole system,
12 right? This is just the growth.

13 A: And that's based on the growth model,
14 population growth model, correct.

15 Q: Okay. And if the Berkeley Moncks Corner
16 facility had an ADC of 32 that would still
17 leave 18 patients available for other
18 providers, wouldn't it? And Trident Medical
19 Center would be at the same level of
20 utilization in 2017 as it was in 2010?

21 A: I'm not sure I'm understanding your question.
22 If Berkeley Medical Center got 32 of the 50
23 growth for the system, okay. And you're saying
24 the other 18 of Trident growth is available to
25 other providers?

1 Q: It's available to anybody. It's available to
2 Trident Health System. It's available to the
3 other providers or anybody. There is enough
4 growth in the system to fill the hospital in
5 Moncks Corner.

6 A: Right.

7 Q: You still have 18 more patients available for
8 other people, for other providers, right?

9 A: But remember also, Dorchester has a project for
10 30 beds, based on the 24 bed need in the same
11 plan that showed Trident Medical Center with a
12 56 bed need. And you can see in these numbers
13 in the second box, Summerville Medical Center
14 is projecting significant growth, particularly
15 in Dorchester, and to a lesser extent in
16 Berkeley County, which is needed to support
17 their 30 bed addition.

18 Q: Right. So it becomes difficult, more difficult
19 for Trident Health System growth alone to
20 support both those projects, doesn't it?

21 A: Remember again, both hospitals were applied
22 for. And in the 2008-2009 Plan shows a need
23 for 80 beds between the two facilities, that's
24 exactly what was applied for. If you believe
25 the State numbers are accurate that, in fact,

1 the Trident System had a need for a net 80 new
2 beds then what they applied for is appropriate.
3 Now, if the growth has slowed down in Berkeley
4 County and maybe it has in Dorchester County
5 too, that may make those projects, and
6 certainly having a second hospital in Berkeley
7 County a lot more difficult. But these 80
8 beds that were applied for are consistent with
9 the State's bed need methodology and the
10 calculation of the State of bed need.

11 Q: Let's just do a couple of quick math problems
12 and then we can move onto the next sheet.

13 A: Sure.

14 Q: 50.9 is the ADC, 32 to Moncks Corner, and
15 remember you've already calculated that the
16 redirection we did earlier --

17 A: Why do you have 32, 35 to Moncks Corner,
18 because that's not the projection.

19 Q: Well, it's 65 percent occupancy.

20 A: Yeah, but it's not what they project.

21 Q: It's 65 percent occupancy, right?

22 A: Yeah, but it's not what either of the
23 applicants is projecting. If you're trying to
24 test whether there's enough volume to support
25 what they're trying to do and what they

1 projected -- remember, they've been approved
2 with a submission that didn't have 32.5, but
3 had about 35.

4 Q: Mr. Baehr, a growth of 50 patients in the
5 Trident system alone and redirection from Roper
6 St. Francis fills both those hospitals, doesn't
7 it?

8 A: Start again.

9 Q: A growth of 50 patients in the Trident Health
10 System alone and the redirection projected by
11 Roper St. Francis in its application fills both
12 of those hospitals. There are enough patients
13 with that scenario to bring both those
14 hospitals to 65 percent occupancy; isn't that
15 correct?

16 A: No.

17 Q: Why not?

18 A: Because the Roper projection also relies on
19 taking its share of the growth of other
20 providers and that growth number includes the
21 growth number that we've already assigned to
22 Berkeley Regional Medical Center coming out of
23 Berkeley County.

24 Q: I just said, don't worry about the Roper
25 growth. I'm just saying the growth of Trident

1 Health System, 50 patients. The redirection
2 proposed by Roper St. Francis was just 15, 17
3 patients, right?

4 A: Uh-huh (affirmative response).

5 Q: That's enough to fill the hospital.

6 A: It's actually 20. This morning you were saying
7 the redirection was 20.

8 Q: That's right I did. It's 20.

9 A: That's correct.

10 Q: You do that, it's enough to fill both the
11 hospitals. Seventy patients divided by two
12 hospitals is 35 each, if both hospitals are
13 full.

14 A: Not quite, again, because of a couple of
15 things. One is the numbers don't quite make
16 it, because if you use 35 and 35 rather than
17 32.5, the volume number here for Berkeley
18 Regional Medical Center at 35, and if you add
19 the 20 of the redirection and then you also
20 have growth that's coming in the Roper
21 application from out of service area. If
22 that's taken from Trident Medical Center,
23 that's got to be included. And the areas where
24 they're likely to get it from are, in fact,
25 areas where Trident has a high market share.

1 And your scenario would mean that Summerville
2 would not grow at all. So that to enable Roper
3 St. Francis to move beds into an area, with
4 virtually no improvement in access, that would
5 be okay if it means that a hospital that had a
6 24 bed need would, therefore, be wiped out of
7 their ability to grow successfully to meet
8 their goals for their 30 bed need for the 30
9 beds that they've applied for. So your
10 mathematics may be closer, about right, but why
11 would that be viewed as a positive development.
12 Why would it be positive to not grow in an area
13 where the Trident system is showing significant
14 growth in Dorchester County, to rob Dorchester
15 County's growth, to provide potential patients
16 from the Trident overall system growth to
17 support Roper St. Francis. That sounds like a
18 very sort of odd defense of the Roper
19 application.

20 Q: Let's look at the next page. The next page is
21 the same chart, but on this page you estimated
22 that the market share for the Trident Health
23 System would grow by three percent?

24 A: Correct.

25 Q: Which is a modest level of growth, especially

1 if you're adding a hospital 25 miles away from
2 your existing providers, right?

3 A: What I would say is, again, they're adding a
4 facility, they're already serving a community,
5 they've already been in those communities.
6 They have already been, essentially the system
7 of choice for residents of Berkeley County. So
8 it is less disruptive to the patient dynamics
9 and the market shares than would be a totally
10 new provider coming in with beds transferred
11 from downtown. But in answer to your question,
12 this would make a change of about five
13 additional patient day growth in Berkeley
14 County.

15 Q: So it would be five more patients?

16 A: Correct.

17 Q: Of growth available?

18 A: That's correct.

19 Q: For the two hospitals?

20 A: Correct. Which comes closer, but still doesn't
21 quite equal the need for the projection
22 currently for the Berkeley Regional Medical
23 Center plus Summerville. There's still a tiny
24 deficit.

25 Q: Now, You spent a lot of time in your testimony

1 talking about access, right?

2 A: Okay.

3 Q: This is a yes or no question, okay? And in
4 that, you opined about you compared the access
5 issues between the two hospitals, right?

6 A: Correct.

7 Q: Moncks Corner and Carnes Crossroads?

8 A: Correct.

9 Q: Now, you testified in your deposition that a
10 lack of access was not a reason to deny the
11 Carnes Crossroads application.

12 A: Lack of access?

13 Q: Yeah.

14 A: I'm not sure I said anything in exactly that
15 way.

16 Q: Well, you may not have said exactly those
17 words, but you said, I'll ask you the question.

18 A: In my testimony I said it?

19 Q: In your deposition testimony, I asked you, you
20 were going through your slides, the first
21 group. Let's go to Petitioner's 46 and look at
22 the first page. Improving patient access, that
23 was your first opinion in Petitioner's Exhibit
24 46, right?

25 A: Correct.

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1 Q: And I asked you whether the failure to improve
2 patient access was a reason to deny the Carnes
3 Crossroads application.

4 A: Can you show me?

5 Q: My question to you on line 18 and page 190 was,
6 so your opinion, as I read these bullets and
7 looking in this section, you do not have an
8 opinion, do you, that Roper St. Francis
9 Berkeley should be denied, because it doesn't
10 -- for not improving patient access. Only your
11 opinion is that Berkeley Medical Center in
12 Moncks Corner does that better. Your answer,
13 read your answer.

14 A: Yes. My answer is, correct. The co-linear to
15 that would be whether the improvement and
16 access by the Roper facility is sufficient to
17 outweigh the adverse impact that's created by
18 locating a facility there as close to two
19 existing providers. Now, remember the tables
20 we looked over included the table that showed
21 that there is some access improvement for 940
22 people, if both hospitals are built. And for
23 half as many as Berkeley Regional Medical
24 Center, if it's one or the other. So I wasn't
25 making a comment that if one hospital is only

1 going to be built and it was Roper St. Francis
 2 Berkeley that there's zero improvement in
 3 access. That's incorrect. All right. What I
 4 said this morning and what I said during my
 5 deposition is that A, clearly, one is superior
 6 to the other. And the second is, since
 7 everyone sort of agreed that the Trident
 8 Medical Center project in Berkeley County was
 9 a good idea, improved access. If you put that
 10 one on the ground, how much additional access
 11 do you get from Roper, 940 people. That to me
 12 is a negligible number, even though it's a
 13 positive number and would clearly be outweighed
 14 by adverse impact.

15 Q: But my point is that your testimony, in regards
 16 to section number one of your opinions on page
 17 46, is essentially a comparison between the two
 18 projects?

19 A: Correct. But the Department has to receive an
 20 application and make a determination about
 21 whether there's access improvement. We
 22 attempted to do that. Roper really didn't.
 23 They simply identified Roper-aligned patients
 24 who could go to facilities that are in the area
 25 that are already close by. And it relies on

1 picking up market share from other hospitals
2 that are already serving patients conveniently
3 in that community. So the access improvement
4 side, I thought was a pretty weak case made in
5 the application. The Department, I think, at
6 a minimum, could have tried to push the
7 applicant, which would have required them to
8 identify where they expected that patient
9 population to come from to find out how much
10 access improvement there was. In the absence
11 of that, we drew those 15 mile circles and made
12 the calculations. But I would grant you this,
13 if it's one hospital and Roper St. Francis
14 alone, they create a little more access than if
15 both hospitals are built. In which case,
16 there's almost nothing that they contribute to
17 the equation.

18 Q: Let's go back into the application, showing
19 Exhibit Number 1, page 832.

20 A: Okay.

21 Q: This is your letter to Ms. Brandt after project
22 review, right?

23 A: That's correct.

24 Q: Now, between the time of the submission of the
25 application, the application being deemed

1 complete, and the project review, you did not
2 submit any additional materials to the
3 Department, did you?

4 A: That's actually not technically correct because
5 there was a lengthy response that I think Ms.
6 Brisbin may have been the signator on that
7 included a lot of calculations about the impact
8 of the Berkeley Regional Medical Center on the
9 Summerville Hospital and on the Trident
10 Hospital and what happens in zip code 29483.
11 It was a fairly lengthy collection of pages and
12 exhibits and we did prepare that and provide it
13 to Ms. Brisbin. Ms. Brisbin, herself, did not
14 prepare any of that analysis so that was
15 provided.

16 Q: You're talking about the second round of
17 questions, right, that were asked by the
18 department?

19 A: I don't know if it were first or second, but
20 there was a lot of questions related to the
21 individual facilities.

22 Q: And the Department asked two rounds of
23 questions. And in the second round -- let's go
24 look at that real quickly. Page 663, this what
25 you're talking about?

- 1 A: I believe so. Yes.
- 2 Q: And you and Mr. Davidson, Mr. Davidson said you
3 reviewed it, submitted these tables, right?
- 4 A: Correct. As well as some of the text in the
5 letter.
- 6 Q: Okay. Now, this was before the application was
7 deemed complete. This was part of the review
8 process?
- 9 A: That's correct.
- 10 Q: All right. And actually, this letter was
11 actually sent before the application for Roper
12 St. Francis was filed, right, October of '08?
- 13 A: Correct. Which is why we would not have been
14 able to incorporate any assumptions about
15 Roper.
- 16 Q: Right. So you didn't mention the proposed
17 hospital at Carnes Crossroads in this letter,
18 did you?
- 19 A: No.
- 20 Q: Because the application had not been filed yet,
21 right?
- 22 A: That's correct.
- 23 Q: All right. I understand you participated in
24 this letter, so from this letter in October of
25 2008 until project review in May of '09, you

1 did not, or Mr. Davidson, did not submit any
2 additional materials to the Department,
3 correct?

4 A: That's correct.

5 Q: All right. And then you went to project
6 review, take a look at it, take a minute. And
7 after project review Mr. Brandt asked you to
8 submit your final comments, which just happens
9 in every CON case that has project review,
10 right?

11 A: Correct.

12 Q: Everybody knows walking out of there, knows
13 they got a lot of work left, right?

14 A: That's correct.

15 Q: And she asked that that be submitted by May 28
16 and you knew the decision was going to be made
17 at the end of June, right?

18 A: I don't recall the May 28 date as a deadline.
19 I just remember that I had to prepare a letter
20 fairly quickly.

21 Q: Okay. And this is the letter you prepared on
22 page 832 of the CON application, right?

23 A: Correct.

24 Q: Let's go to that. And you wrote a paragraph in
25 that letter on page 836, where you identified

1 the adverse impact that would result from the
2 hospital at Carnes Crossroads, right?

3 A: Correct.

4 Q: It's two paragraphs, right?

5 A: You'll have to point me to the --

6 Q: It's number 4. Take a minute if you need to
7 review the whole letter because I think this is
8 important.

9 A: It's actually two different adverse impact
10 sections of this letter. The first is in part
11 one, where I make the case for one hospital and
12 not two. Because my argument is that having a
13 second hospital will lead to very poor
14 financial performance for each of the two
15 hospitals.

16 Q: Do you believe that a hospital can adversely
17 impact a hospital that has not been
18 constructed?

19 A: It can guarantee or close to guarantee that it
20 is a lot less likely to succeed. If both are
21 built, cause severe damage to its financial
22 projections. I mean, you're obviously talking
23 about futures. But if you believe that the
24 growth level is X and two hospitals, one to be
25 built, and if each of them is built then you

1 need 2X, two times that, to fill each hospital.
2 Then it's not a difficult conclusion to reach
3 that each hospital is not going to attract
4 enough patients and they're going to lose
5 money. That's really the argument in number
6 one.

7 Q: Well, number one is focused on -- let me ask it
8 this way. Number one is not focused on the
9 impact of Trident Medical Center or Summerville
10 Medical Center, is it?

11 A: Correct. It's the joint impact, essentially of
12 two hospitals being built on each of them.

13 Q: On each other?

14 A: On each other, correct.

15 Q: Number four, the two paragraphs on page 836,
16 number four is the place in the letter where
17 you address the potential adverse impact on the
18 existing providers, right?

19 A: Correct.

20 Q: Okay. Now, you just testified a little while
21 ago that you always provide all the numbers of
22 the lost cases to the Department, right? And
23 you like to run the adverse impact both ways?

24 A: Yeah.

25 Q: I believe that was what you testified to,

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1 right?

2 A: Yeah. I don't think I testified that I always
3 provide all of the numbers to the Department.
4 I said when I make calculations, particularly
5 in litigation cases, as was the case in the
6 open heart case, I had extremely detailed
7 calculations with different scenarios with
8 adverse impacts for each of the two existing
9 providers. That's where I meant by making --
10 I don't provide 50 pages of backup
11 documentation with incredible detail, generally
12 to a Department, in this kind of five or six-
13 page letter you write after project review. My
14 experience has been, if the Department reads
15 something and they want to get a better
16 understanding of it, they will contact me.
17 And, generally, sometimes ask me to come in and
18 explore it with them, which has happened in the
19 past.

20 Q: Well, it doesn't have to be 50 pages for you to
21 calculate lost cases to existing providers from
22 the new project, right?

23 A: Correct.

24 Q: You could just do a table and present it to the
25 Department as this is what the lost cases will

1 be at Trident Medical Center and Summerville
2 Medical Center, right?

3 A: Correct.

4 Q: And you didn't do that?

5 A: Well, let me see what I did do here. Well, it
6 looks like the supplemental stuff is from
7 project review. No, it's just the text that's
8 in here. That's correct.

9 Q: Okay. And you would agree with me that there
10 were no calculations of lost cases at Trident
11 Medical Center or Summerville Medical Center
12 presented to the Department in the project
13 review?

14 A: Correct.

15 Q: Okay.

16 A: Well, again, at project review the focus was,
17 one hospital or two. We made an argument that
18 there was a need for one. The Roper people
19 made an argument that two was no sweat, that
20 could be done. You know, A's going to get
21 patients here, B's going to get patients there
22 and the trains will never meet. I followed
23 that up with this letter. And I emphasized,
24 because it's in point one, that scenario was a
25 mistake. In fact, the points in this letter

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1 are focused much more, one, two, and three on
2 comparatives between the two. Because I
3 thought that was the issue that was coming out
4 of project review. Would there be two approved
5 or would there be one? Two, I was arguing was
6 a bad idea. If there was one, I would make the
7 argument that one application, I felt was
8 superior than the other. The fourth point,
9 which is on the adverse impact, simply is
10 adding this issue. If the Department decides
11 to choose one and that one is Roper St. Francis
12 Berkeley, there is a second issue to consider,
13 which is that their market, the market they're
14 going to be in, is a market in which they're
15 proposing to grow market share in which the
16 hospital only has an existing market share of
17 23 percent. So we were making an argument that
18 to reach the kind of volume levels they needed
19 to, they would have to take some patients from
20 existing facilities, again, if they were the
21 only one approved. I followed that up with a
22 letter a few weeks later, which has a lot more
23 detail on this particular point.

24 Q: Let's go to that, page 900.

25 A: What was the page number?

1 Q: Nine hundred. And this is the letter that you
2 sent on June 23, three days before Ms. Brandt
3 was scheduled to make the decision and did make
4 the decision, right?

5 A: Correct.

6 Q: And you're not really going to complain that
7 Mr. Brandt didn't call you and have you fly
8 down from Chicago between June 23 and June 26
9 to discuss this letter, are you?

10 A: No. But I think, certainly, the first point in
11 my prior letter, which was a point that got
12 some attention at project review, which is what
13 happens if there are two hospitals built.
14 Because, eventually she wound up approving two
15 hospitals. She certainly had time to go
16 through that one, which I thought was the most
17 critical issue at that point in the case,
18 whether these facilities are competing and
19 whether it was a wise decision to approve two
20 of them.

21 Q: In the letter on June 23, on page 900, you did
22 set forth some lost cases, correct?

23 A: Correct.

24 Q: All right. You don't have a table comparing
25 growth and not growth?

1 A: No.

2 Q: This is not anything like you certainly have

3 done in this case, or in other cases, right?

4 A: No. This is a model that's consistent with

5 actually the second adverse impact model that

6 I described in the application, which is namely

7 there are market share changes. And the market

8 share changes mean that if Roper succeeds,

9 other hospitals will suffer market share

10 declines. And the best way to evaluate what

11 that market share shift would be is not to

12 essentially take a self-serving document, which

13 is in the application, which minimizes adverse

14 impact by relying more on redirect or

15 potentially relying on redirect, maybe it'll

16 turn out to be the right number. But

17 certainly, the higher the redirection number

18 the less adverse impact. I've always thought

19 that the fairest way to evaluate adverse

20 impact, when you have comparative cases like

21 this, which is what I did in my additional

22 Exhibits, is to look at Roper's impact on

23 Trident. The Berkeley facility in Moncks

24 Corner's impact on Roper, calculate the cases

25 in the identical fashion, in terms of the

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1 impact. And what is that methodology, what was
2 the historical market share. If Roper puts up
3 a new hospital, they'll take 25 percent from
4 Roper, 53 or 54 percent from Trident and the
5 rest are other providers. If Trident opens a
6 new hospital, they'll take 25 percent from
7 Roper, 53 or 54 percent from Trident and the
8 rest from others. Identical methodology we
9 applied to both and that methodology is
10 consistent with what's described in this
11 letter.

12 Q: Well, Mr. Baehr, you've used three
13 methodologies in your career. One, where you
14 don't really calculate, you just look at the
15 providers themselves. And then there are two
16 other methodologies --

17 A: I don't catch the first one. I don't know what
18 you mean.

19 Q: Where the focus is looking on the actual
20 existing providers themselves and their ability
21 to withstand the hit, okay. But also, you have
22 two other methodologies that are set out that
23 we just talked about an hour ago, which is,
24 one, you look at whether the existing providers
25 have the same level of utilization in the first

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1 year or do you expect them to participate in
2 both. And you said you do it both ways.

3 Q: First of all, it's only two, there's not three.
4 The first methodology or approach you've
5 suggested is really a materiality test. It's
6 not a methodology to determine the number of
7 lost cases. The determination of lost cases is
8 either one of the two methods you suggested,
9 both of which I reference in the application,
10 indicate that one can do it one way and I chose
11 not to do it that way, which would make Trident
12 look better. The other's to do it a second
13 way, which assumes market shares should stay
14 the same. And if they don't stay the same then
15 there is adverse impact. What you're talking
16 about is a third methodology. It's simply
17 taking the calculation of lost cases,
18 translating it to lost dollars and then making
19 a determination as to whether it's material or
20 not compared to the total income or resources
21 of a system and that's a total different
22 consideration. That's how you weigh adverse
23 impact, not how you calculate it.

24 Q: In this letter on June 23, 2009, you do not
25 calculate any redirection from Roper Downtown

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1 or St. Francis to the new facility. You assume
2 zero redirection.

3 A: That's not true.

4 Q: In this letter on June 23, 2009.

5 A: No. The assumption is that it's the historical
6 market share, at that time was 23 percent. In
7 other words, the way the calculation works is
8 you assume the hospital essentially takes from
9 its existing providers according to the
10 historic market shares. Roper has a historic
11 market share. If it takes 23 percent from
12 itself, that's redirection.

13 Q: Well, you worked with Mr. Davidson, right?

14 A: Yes.

15 Q: And he actually wrote this and you reviewed it?

16 A: Not true at all. I wrote this entirely. Mr.
17 Davidson had no input into the writing of any
18 of these letters.

19 Q: No, I'm talking about the application.

20 A: Mr. Davidson wrote sections of the application
21 under my direction, which I reviewed, correct.

22 Q: Like B-11, the need analysis?

23 A: Yes. He drew the first draft.

24 Q: Okay. Let's go look at Petitioner's 3.

25 A: Petitioner's 3?

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1 Q: Yes. Page 4. Okay.

2 A: I don't have Petitioner's 3 in this book. Mine
3 goes from one to four.

4 Q: Well, I think I have a copy. This Exhibit is
5 Mr. Davidson's backup review. And on this
6 fourth page here, he calculates how the impact
7 projections are affected by the two approaches
8 on adverse impacts. This page is intended to
9 show how the impact projections are influenced
10 by the two different approaches as follows.

11 A: Correct.

12 Q: You do a market impact analysis. There's quite
13 a difference. So in other words, he's talking
14 about the two different approaches to measure
15 adverse impact, right?

16 A: No. The difference here is in one case we take
17 the assumptions that are in the application.
18 And the other case, we applied the methodology,
19 which I've described. In other words --

20 Q: Exactly.

21 A: Okay.

22 Q: So what Mr. Davidson did was he calculated out
23 how many lost cases there was in the Trident
24 system if Roper redirected the patients that
25 they proposed and this is what the lost cases

1 would be if there was no redirection?

2 A: Right. The difference is --

3 Q: The Baehr column has no redirection from the
4 column as Berkeley?

5 A: No, it's not no redirection. If it was no
6 redirection, then essentially you wouldn't give
7 credit to Roper for the 23 or 24 percent market
8 share they had. In other words, 100 percent of
9 the impact would be divided among Medical
10 University of South Carolina and Trident.
11 That's what you don't seem to be catching, is
12 that Roper has historic market shares. It's a
13 significant market share. That impact of Roper
14 on Roper is the same thing as redirection.

15 Q: Well, Mr. Davidson caught it and he said to you
16 at the top of the page, there's quite a
17 difference between the numbers and there is.
18 It's 817 cases, I think, I'm not sure what that
19 last number is, versus 1590, right?

20 A: Correct.

21 Q: And nowhere in your letter to the Department
22 did you explain any of this, did you?

23 A: Correct. The reason is --

24 Q: You took the highest number and gave that to
25 the Department and said that's the adverse

1 impact?

2 A: Because if you're going to look at adverse
3 impact of A on B or B on A, which inevitably is
4 going to become an issue in a case like this,
5 which is sure to be litigated, because
6 someone's probably going to be unhappy one way
7 or the other. You want to have a consistent
8 approach all the way through. That approach I
9 took is Roper's calculation of impact on
10 Trident is calculated exactly the same way I
11 calculated Trident impact on Roper. And that's
12 consistent with what's in these columns on the
13 right. The columns on the left, in a sense,
14 show the benefit to Roper in minimizing adverse
15 impact by assuming more cases are coming from
16 the Roper System than has historically or the
17 expectation would be supplied by Roper given
18 its historic market share. In other words,
19 they're moving into a new market. And in that
20 market Trident's got a 65 percent share,
21 somewhere between 60 and 65 percent. Roper's
22 going to spend a \$115 million to move into a
23 market that Trident is by far the largest
24 provider, so they can only take a few cases
25 from Trident, and basically, just take cases

1 from themselves. I mean, is that consistent
 2 with what they've been doing in Mount Pleasant,
 3 what they're doing here? I think there's a
 4 different pattern, which is move into the areas
 5 where there's a wealthy payer mix and try to
 6 grab it from existing providers. That's what's
 7 going on so an assumption that looks like it
 8 makes Roper look more favorable is not one I'm
 9 going to use when there's a history. History
 10 as opposed to projection. And the history is
 11 Roper's historic share of 23, 24 percent.
 12 That's the level of redirection assuming in the
 13 adverse impact letter I sent to Ms. Brandt.

14 Q: I just want to be clear. You picked the
 15 highest number and you applied it to both
 16 applicants?

17 A: No.

18 Q: That's what you're testifying to. I picked the
 19 highest number and applied it to both
 20 applicants, right?

21 A: I picked the historic market shares to use as
 22 the basis for calculating adverse impact of
 23 each of the two projects on the other.

24 Q: As we sit here today in your testimony have you
 25 made a determination or do you have an opinion

1 as to what the actual volume will be at the
2 Berkeley Regional Medical Center in three years
3 if both hospitals are constructed? Can you
4 tell that to me? The actual number of patients
5 and discharges, patient days or the ADC?

6 A: Yes. I can come up with an estimate, which
7 would be, I think, would be the number of lost
8 patient days, if 12,000 is the projection.
9 Something in the range of 12,000 in the third
10 year that the loss would be in the range of
11 four to 6,000 days. That would be my best
12 estimate.

13 Q: All right. But that's not really what I asked
14 you. What I asked you is how many patients
15 will be in the Berkeley Regional Medical Center
16 in year three, if both applicants are approved
17 and constructed?

18 A: Well, all you got to do is take that number I
19 just gave you and subtract it from 12,000. The
20 reverse is the number would probably be 6,000
21 to 8,000.

22 Q: Six thousand to 8,000. Do you have an opinion
23 as to how many patients would be in the
24 Berkeley, I mean, Roper St. Francis facility at
25 Carnes Crossroads?

1 A: I think their losses would probably be a little
2 less severe, maybe in the range of three to
3 4,000.

4 Q: Okay. What would you project their volume to
5 be?

6 A: Eight to 9,000 if you take it off of the 12,000
7 number.

8 Q: So you say Berkeley Regional Medical Center is
9 6,000 to 8,000 patient days?

10 A: Correct.

11 Q: And Roper St. Francis is, say it again?

12 A: It'd be probably in the range of three to
13 4,000. I mean, you could have some --

14 Q: So 8,000 to 9,000?

15 A: Yeah, you've got some variability on either
16 side of that. And you can look at what the
17 financial impact was at in the table I
18 prepared.

19 Q: And you had no role whatsoever in the decision
20 to apply to build the hospital in Moncks
21 Corner, right?

22 A: No.

23 Q: And so you were not a party to the strategic
24 decision to go to Moncks Corner, were you?

25 A: No, but I certainly believed during the process

1 in which we prepared the application that the
2 people at the Trident system were interested in
3 seeing what the numbers looked like and whether
4 you could get the volume you wanted and what
5 our approach was going to be. I mean, we had
6 come up with something that said we don't see
7 how you can get there. In other words, the
8 market shares required were simply too high and
9 they're not attainable they might have
10 reconsidered.

11 Q: Let's look about the East Cooper situation for
12 a few minutes, okay?

13 A: Sure.

14 Q: Okay. And you would agree with me, if you
15 know, that the CON applications at East Cooper
16 were for the Mount Pleasant Hospital and for
17 the East Cooper replacement hospital were
18 approved in 2005, right?

19 A: I don't remember the exact year, but I'll take
20 your word for it, that's sounds about right.

21 Q: The CONs were actually issued in '05, right?

22 A: I think that's right.

23 Q: The Roper St. Francis Hospital in Mr. Pleasant
24 didn't open until November of 2010, right?

25 A: Correct. And I believe the East Cooper, the

1 new East Cooper facility opened sometime before
2 that, but not very long.

3 Q: All right. Let's look at some of East Cooper's
4 historical utilization. Can you look at Joint
5 Exhibit 4, I think is the '04 or '05 Health
6 Plan? I misspoke, Your Honor. Joint Exhibit
7 3, let's look at page II-17. At the bottom of
8 the page shows East Cooper's 2003 --

9 A: Which page?

10 Q: II-17.

11 A: Okay.

12 Q: And that shows in the State Health Plan that
13 East Cooper's 2003 patient days were 20,800,
14 right?

15 A: Correct.

16 Q: All right. We're going to have to go back into
17 those JARs again. I'm going to need you to
18 pull out a few numbers for me. And, actually,
19 if you would, you have a piece of paper up
20 there you can jot some of these numbers down?

21 A: Sure.

22 Q: So 2003, 20,800 patient days.

23 A: Okay.

24 Q: Okay. Let's look at Joint Exhibit 15.

25 A: Okay.

- 1 Q: Which is the East Cooper JARs, right?
- 2 A: Correct. What page do you want me to look at?
- 3 Q: If you turn to page 519 that would give you the
- 4 2006 patient days?
- 5 A: Okay. Yes. It looks like 17,000.
- 6 Q: You sure it's not 19,000?
- 7 A: Yes, 2006, yes, 19,404.
- 8 Q: Okay. And the discharges?
- 9 A: Five thousand, two twenty-seven.
- 10 Q: Now, let's go look at 2007. So we've gone from
- 11 20,800 to 19,404 from '03 to '06, right?
- 12 A: Correct.
- 13 Q: And in the interim the CON applications have
- 14 been approved by the Department and issued to
- 15 the applicants?
- 16 A: Correct.
- 17 Q: Let's look at 2007 patient days and that's on
- 18 page 570, I think?
- 19 A: Actually, patient days for both 2006 and 2007
- 20 --
- 21 Q: Okay, great. I'm sorry. I guess that's 520.
- 22 So what do you have for 2007?
- 23 A: Seventeen thousand, nine one eight. But, what
- 24 I just noticed is that admissions were actually
- 25 up between 2006 and 2007, which means the

1 patient day decline was entirely due to a
2 change in the length of stay.
3 Q: Right. You're sure it's not --
4 A: Excuse me.
5 Q: Any of that. The discharges from '06 to '07
6 were actually up slightly, right?
7 A: They were, as well as admissions.
8 Q: In 2008?
9 A: Well, let me just look a number down. I think
10 you wanted me to --
11 Q: I'm just looking at the trends.
12 A: Okay.
13 Q: So now we're at 18. And then look at 2008, how
14 many patient days do they have in 2008?
15 A: I don't know what page you're on.
16 Q: I'm sorry, 573.
17 A: Okay. All right. First thing, it looks like
18 the 2007 number, 2008 number, okay, 2008 and
19 2009 are on this page. And the 2008, it looks
20 like it's 18,026 and the 2009, if I'm reading
21 this right, is 16,966, I believe.
22 Q: And how about 2010? That's the one we looked
23 at earlier today on the sheet.
24 A: I don't remember what page.
25 Q: Is it on page 601? If I can find that

- 1 document, here it is. 2010 patient day.
- 2 A: Sure. This is 2011.
- 3 Q: I'm sorry. Look at 2010 on page 601 and then
- 4 we need to do 2011.
- 5 A: Okay, 15,922.
- 6 Q: Fifteen nine twenty-two.
- 7 A: Correct.
- 8 Q: And how many discharges? This is for 2010,
- 9 right?
- 10 A: I don't see the number of discharges on this
- 11 table on the screen.
- 12 Q: What are the patient days for 2011?
- 13 A: Fifteen two five one.
- 14 Q: Okay. So from 2010 to 2011, the patient days
- 15 decreased from 15,922 to 15,251 so that's 700
- 16 patient day decrease, right?
- 17 A: That's correct.
- 18 Q: And that's the year that the hospital in Mount
- 19 Pleasant was open in 2011?
- 20 A: Correct.
- 21 Q: Okay. Now, the drop from 2008 to 2010 is like
- 22 3,000 patient days, isn't it?
- 23 A: I expect a little over 2,000 actual from 2008
- 24 to --
- 25 Q: For 2,000 patient days?

1 A: Right. Some of that was length of stay.

2 Q: Okay. But dischargers are dropping too, right?

3 A: Correct. Now, my understanding is and I have
4 not been to the East Cooper facility, but that
5 the rationale for their replacement facility
6 was that the existing facility was not
7 particularly attractive. Not up to competitive
8 modern standards for a market like Charleston
9 so they needed to replace it. Some of this
10 decline, these kinds of declines are not
11 atypical for hospitals that do not have
12 competitive physical plans and are competing
13 with other hospitals that have better, more
14 modern physical plans.

15 Q: Okay. Now, other than the fact that there has
16 been a change in physical plans at East
17 Cooper, you don't know really much more about
18 the market there, do you?

19 A: I didn't study those applications. I didn't
20 prepare them. I wasn't involved in the
21 litigation case, which would have made me study
22 them, so my familiarity is related to the
23 documents I've reviewed for this case.

24 Q: Which is the JARs?

25 A: It's also the JARs. It's also the application.

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1 It's also the opinion of the State's.

2 Q: You don't know, for example, how many employee
3 positions Roper had in Mr. Pleasant in 2008, do
4 you?

5 A: No. I know the number they had that was in
6 that slide that we talked about on my direct
7 testimony with Mr. Thomas.

8 Q: That's a more recent number, isn't it?

9 A: Yes.

10 Q: That's like a 2010, 2011 number, isn't it?

11 A: I don't recall the year, but I think it's
12 probably more recent than this.

13 Q: You also don't know anything about any changes,
14 any new providers that would have come in, in
15 regards to services that could have affected
16 East Cooper, do you?

17 A: I'm not sure what you're referring to, but no.

18 Q: Have you ever driven up there to actually get
19 to the hospital?

20 A: I have not.

21 Q: Okay. Is it your opinion that the East Cooper
22 utilization trends from 2003, when they had
23 20,800 patient days to 2011 when they had
24 15,251 is because of Roper St. Francis?

25 A: No, I don't think I ever claimed that, because

1 Roper St. Francis only opened in 2011. That
2 would have been an absurd statement for me to
3 make. The only year in which you could have
4 looked at any kind of data and had any kind of
5 conclusion was 2010-2011. You know, the Mount
6 Pleasant facility opened, it looks like they've
7 had a census in the first year, starting from
8 that period on November 2010 of maybe something
9 on the order of four or 5,000 patient days.
10 Could some of those have contributed to a
11 decline at East Cooper and the new facility,
12 yes, it's possible.

13 Q: Now, you said you were surprised when the
14 Department found that these applications were
15 not competing, right?

16 A: Yes.

17 Q: But you were aware of the situation in East
18 Cooper when the applications were filed, right?

19 A: Correct.

20 Q: And in East Cooper, the Department found that
21 the transfer of 85 beds to Mr. Pleasant and the
22 building of a replacement hospital had 40 beds
23 in Mount Pleasant were not competing
24 applications?

25 A: Yeah. No, I thought that decision was wrong.

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1 I thought it led to significant duplicative
2 capital expenditures. And contributed 125 net
3 new beds to an area where you cannot come
4 remotely close to justifying the need for that
5 number of beds based on the growth in that
6 market. And they're not even close.

7 Q: But regardless of your personal opinion, you
8 would have to agree with me that the
9 Department's decisions in Mr. Pleasant and in
10 Berkeley are consistent, aren't they?

11 A: Consistently bad. And I sometimes think that
12 people learn from mistakes, especially when in
13 the course of the project review. And later
14 materials submitted to the Department, the
15 question about two hospitals being more than
16 was needed was made. The point was made about
17 the financial implication of awarding two
18 hospitals. The Trident people came in and made
19 a big issue, apparently, with Ms. Brandt about
20 whether this was a competitive cycle or not,
21 because they thought that was a big issue. And
22 they clearly believed, that these were
23 competitive applications. Sometimes you think
24 people learn from prior mistakes and do it
25 right the next time. You know, if the

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1 Departments consistently don't read the letter
2 of what their rules say, they don't read
3 essentially the certificate of need
4 regulations, they don't read their own State
5 Health Plan very carefully and they just sort
6 of make it up as they go along and they do it
7 consistently then I guess, yeah, they're
8 consistent. But that doesn't mean that I, as
9 a planner, am not surprised at seeing a
10 continuation of consistently, what I think, are
11 bad planning decisions. Adding more beds than
12 a market can absorb, is in my judgement, a bad
13 decision. The Mount Pleasant case is more
14 blatant than Berkeley.

15 Q: Because what's the market?

16 A: What's that?

17 Q: What's the market in the Mount Pleasant case,
18 what was the market?

19 A: Zip codes were defined, but the applicants also
20 said that there was a wider area in which they
21 expected to draw a larger share of the patients
22 than was the case in Berkeley. And Berkeley,
23 I believe Roper said ten percent of their
24 patients would come from outside the county.
25 That number is slightly higher than that. In

1 the case of Trident, if I remember correctly,
2 the number in the case of East Cooper was about
3 half or something that was coming from that
4 market area. And the Mount Pleasant number
5 also had a significant percentage coming from
6 outside the seven zip codes.

7 Q: Mr. Baehr, the market is the service area,
8 isn't it, which is the tri-county area?

9 A: That doesn't work for a transfer. It doesn't
10 work, because the whole logic of a transfer --
11 the whole logic of the transfer section, as
12 interpreted by the State, is that you can move
13 hospital beds, bed capacity to create a new
14 hospital from one section of either a county
15 or, in this case a tri-county area, because
16 that's how the State defines this market to
17 another area because there maybe more rapid
18 growth in one sector of the market than
19 another. And the beds may be, as a result,
20 more needed. But that doesn't, on its own,
21 stop the discussion. You also have to document
22 that where the beds are being dropped, where
23 they're being transferred, that you're not
24 creating a new access situation. Of course,
25 it's the tri-county service area, but both

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1 hospitals here are simply picking any place in
2 the tri-county service area to locate. They're
3 both picking Berkeley County. They both define
4 the Berkeley County market. Using the State's
5 methodology in determining bed you can
6 calculate the growth in the market in Berkeley
7 County. You can see that growth doesn't
8 support two hospitals. That alone suggests you
9 can't conclude that a transfer is enough reason
10 to disregard or conclude that the applications
11 can't be competitive, because you're not
12 increasing the overall bed supply with that
13 second hospital. You are increasing the bed
14 supply in the service area that's been defined
15 by the applicants. And good health planning
16 suggests you're trying to move the beds
17 according to this transfer section to where
18 they are needed. But if they're not needed,
19 they're excessive, how have you resolved the
20 situation. You're taking a system like Roper,
21 which you're saying has too many beds, and then
22 you're having them move them to a new location,
23 which as a result of the transfer will have too
24 many beds.

25 Q: Well, there's no net increase in beds in this

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1 service area from the transfer?

2 A: Not in the tri-county service area. I'll
3 concede that.

4 Q: Going back to Mount Pleasant, are you going to
5 tell this court that the Mr. Pleasant Hospital
6 is a failure based on 12 months of utilization
7 data?

8 A: Absolutely, not. No.

9 Q: Because it's way too premature to draw any
10 conclusions about the Mount Pleasant Hospital
11 based on the data that we have; isn't that
12 correct?

13 A: Correct. My judgement has been, and is, that
14 I would be stunned if these two hospitals can
15 get to an adequate occupancy level on 225 beds,
16 when in the past this market was served by a
17 100 beds, I'd be very, very surprised. The
18 market growth is not there to support that
19 level of increase in bed capacity. So the
20 comment I would make about the Mount Pleasant
21 numbers are, Mr. Pleasant made a forecast. And
22 when they made the forecast, presumably they
23 were expecting there would two facilities. It
24 wasn't like East Cooper was going to disappear.
25 So the only issue might have been whether East

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1 Cooper was going to get 40 additional beds, but
2 they knew there would be the 100. I mean, if
3 East Cooper was turned down they would still
4 have the 100 beds. So the question was they
5 put together some forecasts, so far, they're
6 below the forecasts. In other words, they made
7 a projection, so far that projection doesn't
8 look too reliable. It doesn't look too
9 reliable in terms of total volume. It doesn't
10 look reliable at all in terms of the assumption
11 about redirection.

12 Q: Well, let's talk about that. Because all you
13 know, in regards to drawing your opinion on
14 redirection, is the actual volume at the Roper
15 Hospital. You don't know whether there's been
16 an increase in volume at the Roper Downtown or
17 Roper St. Francis Hospital, do you, across the
18 system?

19 A: That's correct, in these seven zip codes.

20 Q: And if there was an increase in utilization
21 across the system and those zip codes were flat
22 that would suggest redirection, wouldn't it?

23 A: Possibly. It could also suggest that maybe
24 this area simply wasn't growing as rapidly and
25 Roper was simply more successful picking up

1 share elsewhere than they were here.

2 Q: And it could suggest redirection?

3 A: It's possible.

4 Q: You don't know whether that's happened or not?

5 A: All right. But even it occurred it would be
6 pretty limited compared to an assumption of
7 two-thirds redirection. If you have two-thirds
8 redirection that 18,000 patient days, you'd
9 expect to see 6,000 patient days and 12 would
10 be moot.

11 Q: You have a ramp-up in the Moncks Corner
12 application?

13 A: Of course.

14 Q: Just like Carnes Crossroads application has a
15 ramp-up and just like the Mount Pleasant
16 application and existence will have a ramp-up?

17 A: Perfectly reasonable.

18 Q: And the reason you have a ramp-up is because it
19 takes a while to change people's patterns to
20 redirect the patients.

21 A: It takes time for a hospital to get to its
22 ultimate volume and success. Doctors, patients
23 don't immediately simply jump, especially here
24 where you have two new hospitals that could be,
25 in part the case, that you have yet two new

1 providers on the market rather than one new one
2 and one old one. But nonetheless, you do have
3 to judge the Roper forecast. You have some
4 ability to judge the Roper forecast in the
5 Berkeley case by sort of what they assumed and
6 what's happen so far in the Mount Pleasant
7 case, because they accept the information as
8 limited, you only got a year. But so far it
9 doesn't provide a lot of backing to what was
10 done in the Roper application and Berkeley.

11 Q: It's more than just limited, isn't it? It's
12 also premature, because it's only one year?

13 A: I know, it's early, sure.

14 Q: In regards to the East Cooper facility, you're
15 not going to contend to this Court, are you,
16 that Roper St. Francis is the cause for East
17 Cooper to have a 25 percent drop in patient
18 days between 2003 and 2010, are you?

19 A: Yeah, you actually asked me that question a few
20 minutes ago and I told you that between 2003
21 and whenever East Cooper opened its new
22 facility and actually even up until the time
23 that Mount Pleasant opened its doors, you
24 clearly can't attribute any of the change in
25 volume at East Cooper to Mount Pleasant. So

1 I've already conceded that twice.

2 Q: Now, you testified earlier about the slight
3 decrease in unitization that occurred at the
4 end of say, between 2008 and 2010 in the
5 Berkeley market; is that accurate?

6 A: Yeah.

7 Q: Now, the only time the -- numbers we know for
8 certain is 2000 and 2010, because that's the
9 census, right?

10 A: Well, if you accept the census is accurate,
11 it's the best estimate we have --

12 Q: Health planners accept that as being an
13 accurate hard number, right?

14 A: Correct.

15 Q: The other years in between are a forecast?

16 A: Correct. Either by South Carolina or by
17 ourselves.

18 Q: Ourselves or somebody else, right?

19 A: Sure.

20 Q: Okay. Now, you don't know the market well
21 enough in regards to insurance products to know
22 what the cause of that utilization blip in 2008
23 and 2010 was, do you?

24 A: No. The only thing I will say, the decline in
25 patient activity is not limited to the Berkeley

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1 County market. I mean, I've seen it in other
2 areas in which I've worked and there simply has
3 been a softening in demand for hospital
4 services as a result, I think, of the economic
5 slow down.

6 Q: Right. And you would agree with me, wouldn't
7 you, that it's driven primarily by two things.
8 One is, in difficult economic times people will
9 put off elective procedures, right?

10 A: Correct.

11 Q: You talked about the veterinarians this
12 morning, but the plastic surgeons probably
13 caught it during the recession too, right?

14 A: Maybe some of the Lasik eye surgery.

15 Q: Lasik eye surgery, Botox, those are the kind of
16 things that basically would have declined in
17 utilization during hard economic times.

18 A: Well, that will affect people in a certain
19 economic bracket. There are people in lower
20 economic brackets who may not show up to see
21 their doctors as often so they don't even get
22 into the system.

23 Q: Right, well that's my next point. In the
24 second impact on the economy may be that if
25 there are more people unemployed, there might

1 be more uninsured people and if people don't
2 have insurance then they might be less likely
3 to go to the doctor or they may put off their
4 kind of routine visits, right?

5 A: And some of them think the place to go then is
6 the emergency room and not everybody wants to
7 go to the emergency room for what might not be
8 an emergency.

9 Q: So there can be other effects. It's not just
10 a pure just dropping demand, it can appear in
11 other ways in the system too?

12 A: Yeah, but all of it's related to economic
13 circumstances, both of the situations we just
14 talked about.

15 Q: But if someone has a serious need for medical
16 services, say somebody breaks their leg, they
17 don't put off the surgery because the times are
18 tough, do they?

19 A: I don't think so.

20 Q: They get their cancer treated, don't they?

21 A: Well, I would make the argument again --

22 Q: If they're diagnosed?

23 A: Yeah. But some people may not get diagnosed.

24 Q: But if they're diagnosed, they seek --

25 A: If people have routinely gone in to see their

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1 physician, this is where it's similar to the
2 veterinarian issue. The people who would
3 routinely go in to see their doctor twice a
4 year, and instead they go in once a year, there
5 could be a six month delay in even being
6 diagnoses, with getting someone into a system
7 with a serious illness.

8 Q: And if everybody in America is required to buy
9 health insurance in the future, then the idea
10 is that they're all going to have access to
11 healthcare?

12 A: That's the logic behind the bill, right.

13 Q: Behind the bill, right. And that would cause
14 more people to use hospital services in the
15 future, wouldn't it?

16 A: Well, there are all kinds of different effects
17 in the bill. There are clearly expansion and
18 access to those who are uninsured, but, there's
19 an out. And the out is that individuals can
20 pay penalty and remain uninsured. And
21 corporations can drop coverage and pay a
22 penalty and that penalty is lower than the
23 current cost to providing insurance for many
24 companies. Which means you could have the
25 alternative impact of many more people being

1 thrown into these exchanges and then having, as
2 individuals, the choice of whether to buy
3 insurance or not. Anyone who can tell you with
4 any degree of certainty how this is going to
5 work, I think, is kidding themselves.

6 Q: But the idea behind it is that it will be
7 expanded?

8 A: All good intentions, but, it's a 2,400 page
9 bill and the section about improved access and
10 how you deal with an individual mandate, for
11 instance, is a few pages, which is one of the
12 issues that's going to come before the Supreme
13 Court, whether the whole bill goes out if those
14 five pages go out.

15 Q: All right. And you would acknowledge, though,
16 that these hospitals are built to last longer
17 than a few years, right?

18 A: Oh, sure.

19 Q: Now, let's talk about the staffing issue. Now,
20 in your deposition, I asked you about staffing
21 and you said you did not have any knowledge
22 about the shortage of nurses in this market?

23 A: Right. I had no knowledge that there was a
24 nursing shortage, correct.

25 Q: And as the scholarly work that you ascribe to

1 and have read on this subject says, that when
2 economic conditions deteriorate in the face of
3 unemployment, a fair number of nurses rejoin
4 the job market because they are secondary wage
5 earners?

6 A: That has happened in past downturns, correct.

7 Q: And nationally, and this has occurred, the
8 nursing shortage is not nearly what it was in
9 2012 as it was, say, when we were doing the
10 case in 2006, right?

11 A: I think that's fair.

12 Q: And one of the things that happened is when
13 there was a nursing shortage, then the
14 providers began to take action to try to
15 increase the number of nurses, right?

16 A: Correct.

17 Q: So you were starting to see more programs and
18 more just of a general focus on that, correct?

19 A: Yeah, there was certainly for a period of time,
20 yes.

21 Q: And in these facilities -- these are general
22 acute care hospitals, so they're not offering
23 the kind of specialized services that you would
24 see in a tertiary facility, right?

25 A: No, you're not getting the kind of staff that

1 would be required for an open heart surgery
2 program.

3 Q: So the pool of people that can work in a
4 general acute care hospital is significantly
5 greater than the pool of nurses that can work,
6 say, on the open heart ward?

7 A: Sure.

8 Q: Or doing technical cancer treatments?

9 A: Sure.

10 Q: Okay. So you're not going to give an opinion,
11 are you, in this case, that the hospital at
12 Carnes Crossroads will have a material adverse
13 impact on Trident or Summerville because of the
14 staffing?

15 A: Yeah. No. The question that was asked, as I
16 recall, and I don't know whether it was this
17 morning or yesterday, was would there be a
18 difference potentially for Berkeley Regional
19 Medical Center and the Trident system, if,
20 rather than one new hospital was built in
21 Berkeley County, that there were two built.
22 And I said, yeah, that could have an impact and
23 create some pressure on price increases and
24 lead to some shifts in staffing patterns
25 between hospitals. In the same way that

1 hospital admissions shift when there are new
2 hospitals brought into the market, physicians
3 shift allegiance, staff shift allegiance too.
4 All of that is possible. I didn't quantify it
5 and I certainly didn't have a conclusion about
6 any materiality as far as dollar impact versus
7 other impacts that we've calculated in this
8 case.

9 Q: Okay. That's what I want to confirm. You have
10 no conclusion in regards to the materiality of
11 any adverse impact by the new providers in
12 regards to the existing providers in regards to
13 staffing.

14 A: That's correct.

15 MR. LONG: Well, I'm trying -- Your Honor, we've
16 been going pretty hard today. I feel like I'm
17 getting fairly close, but I will need to talk
18 to him some about the Exhibits that we talked
19 about this morning. That's probably a little
20 bit bigger topic, so I can -- I mean if could,
21 I mean, what's Your Honor's pleasure in regards
22 to how late you'd like to go?

23 THE COURT: That's up to you folks.

24 MR. LONG: We'd be well past six. I do think I
25 could probably keep it under an hour.

1 THE COURT: I think we ought to take into
2 consideration, too, that the witness has been
3 on the stand.

4 MR. LONG: I agree with that, Your Honor. I would
5 need to take a break now, Your Honor, just to
6 kind of assess where I am and that would end up
7 pushing me to almost ten til six. That's my
8 concern. Then we come back in here and start
9 back up. So maybe this is a good time for me
10 just to break for the day. And I will do, he's
11 got witnesses ready for tomorrow and I'm going
12 to do everything I can to finish within an hour
13 tomorrow morning and hopefully I can be done.

14 THE COURT: We will be in recess until 9:30 in the
15 morning, but remember on Thursday, we will
16 start at 10 instead of 9:30. Thank you.

17 MR. LONG: Thank you, Your Honor.

18 MR. THOMAS: Thank you.

19 THE COURT: Be at ease.

20 (There being nothing further, the hearing recessed at
21 5:36 p.m.)

22 DAY 8 - WEDNESDAY, FEBRUARY 8, 2012

23 THE COURT: Good morning, ladies and gentlemen. Be
24 seated, thank you. We're back on the record,
25 please, ma'am. Mr. Long?

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1 MR. LONG: Thank you, Your Honor.

2 MR. BAEHR - CONTINUATION OF CROSS EXAMINATION BY MR.

3 LONG:

4 Q: Mr. Baehr, I hope you had a good night. I just
5 want to talk to you really this morning about
6 just a few issues that we didn't get to
7 yesterday in regards to your testimony. The
8 first issue I want to talk to you about is you
9 testified about the community benefit that
10 nonprofits, nonprofit hospitals are supposed
11 to, are required to offer; is that right?

12 A: Yeah, there was actually two parts to that. One
13 is requirements to maintain their tax-free
14 status, the other are arguments they make to
15 justify it.

16 Q: And do you know how much community benefit a
17 nonprofit healthcare provider should provide,
18 the amount?

19 A: That's an open question, given that some
20 hospitals in the state Illinois, where I'm
21 from, have actually lost tax-free status
22 because arguments were made in error, and
23 they're appealing it, that they were providing
24 inadequate levels.

25 Q: Are you familiar with the IRS regulations and

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1 whether the IRS is actually established a
2 specific quantity or percentage of community
3 benefit, of a nonprofit --

4 A: I haven't seen that, I haven't seen that test.

5 Q: Are you familiar with what other states have
6 done, passing legislation to designate how
7 much?

8 A: Yes, that's what I was referring to in
9 Illinois, is that the test was apparently not
10 met by a couple providers in the Catholic
11 system.

12 Q: Do you know what the test is?

13 A: I wasn't involved in the case so I don't know
14 the specific numbers.

15 Q: Now, do you believe that community benefit for
16 a nonprofit should include bed debt?

17 A: Well, I think there's two components of
18 patients who have no insurance. One is those
19 who are recognized as charity cases according
20 to essentially qualifications for fitting in
21 that category, and then there are others who
22 don't fall into that category, just sort of not
23 quite poor enough to be Medicaid, but they
24 don't have insurance. That's been a growing
25 segment of the population and bad debts are

1 typically what happens with a large part of the
2 bill for those patients. I think it's a
3 measure of what the hospital does. Now,
4 they're not getting compensated for, so I think
5 that's fair.

6 Q: A couple follow-ups. The hospital doesn't get
7 compensated for bad debt or for services they
8 provide to people that they don't charge them
9 for, right?

10 A: There is a tiny adjustment, there used to be,
11 I think there still is in Medicare, for bad
12 debts, but basically that's true.

13 Q: Okay. And a charity case is somebody who comes
14 into the hospital and typically qualifies; they
15 tell the hospital, I don't have any money, this
16 is my net worth, this is my income and the
17 hospital says based on your financial
18 circumstances we will provide these services to
19 you for free, right?

20 A: That's correct.

21 Q: And generally a charity care patient doesn't
22 receive a bill and there's no discussion of
23 finances with them, right?

24 A: That's correct.

25 Q: Bad debt on the other hand, is somebody who

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1 just doesn't pay they're bill, right?

2 A: Right, I mean, hospitals sometimes will seek
3 payment arrangements to get partial payment
4 over time.

5 Q: So, is it ever appropriate for a for-profit or
6 a not-for-profit to combine charity care and
7 bad debt?

8 A: I think it's okay. I mean, I think there's
9 actually a much bigger number on the bad debt
10 side and it does reflect the fact that they're
11 serving those patients.

12 Q: Was is ever appropriate in a legal proceeding,
13 like this, where it might be an issue to call
14 bad debt charity care? To not differentiate
15 between the two?

16 A: Yeah, I'm sure people slide into it all the
17 time, but they are distinguishable.

18 Q: Okay. Now, yesterday you testified a lot about
19 the access issue, we look at the maps with the
20 circles and we went back and kind of did
21 another map for ourselves. I'd like to show, if
22 I could, Respondent's Exhibit 163. I know you
23 haven't seen this, but I just show it to you
24 to ask you for your comment.

25 A: Sure.

1 Q: Okay. We went back and drew circles yesterday
2 over all the hospitals in the tri-county area.

3 A: Uh-huh (affirmative response).

4 Q: This is the seven mile circle.

5 A: Correct.

6 Q: Okay. So don't you think that, first, that the
7 least amount of overlap occurs in the Berkeley
8 County area, doesn't it?

9 A: The least amount of overlap is the Moncks
10 Corner site with any other circle.

11 Q: Yeah, and in the second least is the Roper St.
12 Francis Berkeley site, right?

13 A: Looks about similar to the Mount Pleasant
14 circle.

15 Q: And, you certainly agree that on the peninsula
16 --

17 A: There's actually a couple of them, the Roper
18 St. Francis also has about a half, so --

19 Q: And what this is, you can see, these are seven
20 mile circles for each hospital in the service
21 area, and you'd agree with me that on the
22 peninsula the circles are all over each other,
23 aren't they?.

24 A: Yeah, for the most part.

25 Q: Okay. And you'd also agree with me that

1 Summerville and Trident Medical Center circles
2 overlap a great deal, don't they?

3 A: Yes.

4 Q: Okay, let's go to the 15 mile map.

5 A: Sure. That? Okay.

6 Q: That's the next one.

7 A: Okay.

8 Q: This is it right here. The circles are even
9 more on top of each other, aren't they?

10 A: Yeah, well one thing is -- I think this
11 actually makes my point, which is, the one area
12 that appears to be distinct in the 15 mile
13 circle, it's the Moncks Corner area,
14 essentially about half of the circle, which is
15 really the area in which I think most of those
16 30,000 people live who are not now within 15
17 miles or 30 minutes drive time of an acute care
18 facility. Nothing's changed as a result of
19 these circles other than there's a little tiny
20 piece of the Moncks Corner circle down in, what
21 I'd call the southeast corner, which is
22 captured by some of the hospitals in Mount
23 Pleasant. But most of the population, the
24 great majority within the 30 minute drive time,
25 is as distinct here as it was in the graphs I

1 showed yesterday.

2 Q: Well, then you also have to agree then with a
3 couple of other points about this graph. First
4 is when you have the circles, the hospitals on
5 the peninsula are all over each other, right?
6 As far as overlapping?

7 A: Sure. Yes, I do.

8 Q: Also, secondly, the Moncks Corner hospital
9 circle encompasses a very large piece of water,
10 doesn't it?

11 A: Yes.

12 Q: Which is Lake Moultrie.

13 A: Correct.

14 Q: And the hospital on the peninsula jut way out
15 into the Atlantic Ocean, don't they?

16 A: That's correct.

17 Q: So there's a significant amount of water that
18 surrounds these hospitals and of course people
19 aren't living there.

20 A: Sure. Yeah, I mean the point I'd make is the
21 calculations we did were based on where the
22 people live. We didn't count anybody who lives
23 on the water, just counted people who live 15
24 miles or more from the healthcare facility now
25 who will be within a 15 mile distance once the

1 Moncks Corner facility is built.

2 Q: And you talked about the difference between the
3 seven and the 15 miles yesterday, let me ask
4 you a couple of questions. First, you'd agree
5 with me a seven mile circle in downtown
6 Chicago, where you're from, is dramatically
7 different from a seven mile circle in
8 Williamsburg County, South Carolina, right?

9 A: I agree with that.

10 Q: And that's one of the reason you choose
11 different mile distances, because of the
12 density of the population, the more people
13 living in a smaller area, you draw a smaller
14 circle, right?

15 A: Correct, I say seven mile radii within the city
16 of Chicago, which is 2.8 million people, which
17 is a lot different southern Berkeley county.

18 Q: Okay. And also you'd agree with me that if you
19 drew a -- that in Columbia, your familiar with
20 the Columbia hospitals having worked on your
21 other cases here, two other cases.

22 A: Sure.

23 Q: If you did a seven mile circle from Palmetto-
24 Richland you would capture, I believe this is
25 correct, Providence Northeast, Providence

1 Downtown, Baptist, and Lexington Medical
2 Center, wouldn't you?

3 A: I couldn't say for sure about Providence
4 Northeast, but it might be.

5 Q: Right.

6 A: The other I believe are within seven.

7 Q: So potentially five hospitals are within the
8 seven mile circle of Palmetto-Richland,
9 correct?

10 A: Correct.

11 Q: Which is one of the largest hospitals in the
12 State of South Carolina.

13 A: Correct.

14 Q: Now, I want to ask you about this chart here.

15 A: Sure.

16 Q: And will you read the number on this one to
17 confirm that for me? I'm sorry, Your Honor.

18 **THE COURT:** What's this Exhibit number?

19 **MR. LONG:** This is Respondent's 75.

20 A: Uh-huh (affirmative response).

21 Q: These are some maps that we prepared, you know,
22 several weeks ago, whatever, and this is one
23 that we blew up on the board, and basically
24 this is the map that separates out the three
25 counties in a service area and it shows where

1 the beds are located, correct?

2 A: Okay.

3 Q: And you've seen this, right?

4 A: Yes.

5 Q: You said yesterday that the decision in Mount
6 Pleasant was bad healthcare planning and the
7 decision in Berkeley County was bad healthcare
8 planning. What I want to ask you is, why is it
9 good healthcare planning to have 95 percent of
10 the beds in Charleston County and only 53
11 percent of the people, why is that good
12 healthcare planning?

13 A: Well, the first thing is you have essentially
14 locked in some of what's occurred in the past
15 before the population began to move out to the
16 north, northwest and northeast. So hospitals, I
17 think Roper you said was built, whatever, 150
18 years ago, something like that. I would
19 disagree with you and I think this chart is
20 unrealistic, because, for instance, it counts
21 the 296 beds in the Trident Medical Center as
22 effectively the same kind of bed in Charleston
23 County as the beds in the peninsula. And given
24 that it was designed and located to serve that
25 northern-most area of Charleston County and two

1 counties to the northwest and northeast,
2 Berkeley and Dorchester, whose county hospitals
3 agreed to close and where happy with the
4 location of the Trident site and they supported
5 it. So, to argue that somehow the Trident
6 facility should count the way all other
7 Charleston beds do down in the peninsula and
8 not be allocated to Berkeley and Dorchester,
9 which they were in the State Health Plans,
10 right through 2001. They actually had a
11 Charleston County and then they had
12 Berkeley/Dorchester, and Berkeley/Dorchester
13 included Trident, which wasn't within the
14 county line.

15 Q: Yeah, but it's located in Charleston County,
16 isn't it?

17 A: Yes.

18 Q: And North Charleston is a significant
19 population center for that area, isn't it?

20 A: Yeah.

21 Q: And you'll see in the historical numbers, which
22 show that at the time the hospital was built
23 they placed it in the population center, which
24 was North Charleston, right?

25 A: Yeah, I still think it's the population center

1 of the areas they're proposing to serve.

2 Q: And, is your opinion that when the State
3 allowed Trident Medical Center to build it's
4 hospital in North Charleston that it gave it
5 Berkeley and Dorchester County forever?

6 A: No. No, I think what they did was that the
7 communities and the county people who were
8 responsible for running the two local hospitals
9 agreed to close them and to have this larger
10 hospital built by an organization that they
11 thought had the financial wherewithal to make
12 capital investments and have a modern facility
13 to serve those communities.

14 Q: Well, apparently you think that's a relevant
15 fact in the case, right?

16 A: I do.

17 Q: Okay. And that was 40 years ago, right?

18 A: Correct.

19 Q: Is it going to be relevant in the year 2040?

20 A: Let me say two things. One is, right through
21 2001 the State was counting, as they just said,
22 Trident Medical Center as a Berkeley/Dorchester
23 facility. The second is, there have been
24 changes to the State Health Plan over time,
25 there were changes between 2004 and 2005, and

1 2008 to 2009, and I'm sure there will be
2 changes going forward. No hospital has a
3 right, they don't own territory. All I'm
4 saying is, this chart misleads, because it
5 suggests that somehow the beds at Trident
6 Medical Center are really there for Charleston
7 County and should be counted among Charleston
8 County rather than being primarily available
9 for Berkeley and Dorchester.

10 Q: All right. If you're correct in your opinion,
11 which is that ultimately one hospital was built
12 in Moncks Corner --

13 A: Uh-huh (affirmative response).

14 Q: -- by HCA --

15 A: Correct.

16 Q: Do you think it's good healthcare planning for
17 one company, HCA, to have a monopoly for two of
18 the fastest growing counties in South Carolina?
19 Do you think that's good healthcare planning?

20 A: My perspective is, and I said this during my
21 direct testimony, had Roper proposed to locate
22 in Moncks Corner I think this would have been
23 an entirely different case. They looked at it,
24 they decided not enough population, not enough
25 money is going to be made, weak payer mix. And

1 as a result they located in the most affluent
2 part of the county, right on top of two
3 existing hospitals that are serving that
4 county, particularly Trident Medical Center.
5 That's not an argument for monopoly, its an
6 argument that in this case you have a choice to
7 make between one hospital that proposed to
8 locate in one site and another hospital that
9 proposed to locate in a different site.

10 Q: Do I understand your testimony to be that if
11 Roper St. Francis proposed to put it hospital
12 in Moncks Corner that they should be picked
13 over HCA.

14 A: I think it would make the equation much more
15 even. You still have to look at, essentially,
16 and I think you have a lot more information
17 required from Mr. Richardson than was in the
18 application. You'd have to look at where
19 they're proposing to get their patients from,
20 but they didn't do that. So, its pure
21 speculation to say what their application would
22 look like if it had been in Moncks Corner. All
23 I can judge is by what they did in Goose Creek
24 and that application suggests to me that
25 they're trying to take patients from other

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1 hospitals, and take some of their own, but
 2 they're not really serving any need of the
 3 community, they're not really serving any
 4 growth need of the community, and they haven't
 5 made any argument that there's enough growth in
 6 the community for two 50 bed hospitals to be
 7 approved. That's not a permanent forever
 8 situation. It's the facts now with two
 9 hospitals impeding, in my judgement, that
 10 should have been viewed as competing
 11 applicants.

12 Q: Well, let me just ask you again, do you think
 13 it is good healthcare planning for one company
 14 to have a monopoly for two of the fastest
 15 growing counties in South Carolina; do you
 16 think that's good healthcare planning?

17 A: All I'd say is they would have 50 beds in
 18 Berkeley County, there are 94 in Dorchester
 19 that might to go 124. The best I can tell,
 20 almost half the population -- of residents of
 21 the county who seek medical care are not going
 22 to the supposed monopolists at this point, so
 23 it doesn't seem to me that it prevents other
 24 systems from obtaining patients. They have
 25 other facilities in place in the county, they

1 can build more of those kind of facilities in
2 place in the county without this kind of
3 combat, you know, takes three weeks and all the
4 money that's involved. And you can build it,
5 you can build up a presence, you can increase
6 your share that way, and at some point if
7 you've made the right decisions about where
8 you're locating your facilities you'll show
9 need and you'll be able to justify it.

10 Q: But Mr. Baehr, you just said they can build
11 other facilities in the county, I mean, you
12 opposed Roper moving beds from downtown to
13 Mount Pleasant as bad healthcare planning, even
14 though the population moved to Mount Pleasant.
15 And, you also opposed Roper moving beds to
16 Berkeley County, even though the population
17 went to Berkeley County, so where would they
18 build a facility?

19 A: You missed my point. I wasn't talking about
20 hospitals. I was talking about making
21 investments on the ground, just as they did,
22 for instance, with ambulatory and the Emergency
23 Department in Moncks Corner. They could do the
24 same on the land they now have in Carnes
25 Crossroads. They could develop facilities

1 there, they could build up their market share.
2 And over time, the Roper system may show a bed
3 need, and if they show a bed need then it's a
4 very different argument about where they should
5 be able to locate a hospital without having to
6 use, what I'll call, this twisted language from
7 the transfer section of the State Health Plan
8 to justify it.

9 Q: Let's take a look at Petitioner's 222, pages
10 1855, six, seven, eight and nine.

11 A: You'll have it on screen, I won't need a book
12 for that?

13 Q: You probably won't need it.

14 A: Okay.

15 Q: I'm sorry, it's 1855, 22-2 is the next page I
16 think

17 A: Okay.

18 Q: You testified about this chart yesterday which
19 shows the number of people in selected zip
20 codes that have an annual income under \$25,000.
21 And, of course Moncks Corner is 29461 zip code
22 is clearly the largest number of people, right?

23 A: Correct.

24 Q: Slightly over 2500, maybe 26, 2700 people,
25 2662.

1 A: I mean, you may remember my testimony was that
2 far more important were the percentages. And
3 that really is the comparison I make, I didn't
4 really rely on the raw numbers to a great
5 extent. In fact, I think I argued that there
6 are more people who fall into categories that
7 are in the southern part of the county because
8 there are more people in the southern part of
9 the county. But as a percentage, Goose Creek
10 was 18 percent and all of the areas in the
11 north that would be severed by the Monk's
12 Corner facility were well over that.

13 Q: Well in your opinion the percentages are more
14 important, but let's look at the raw data
15 actually. So it's 2662 for Monk's corner, now
16 let's move over to 1857.

17 A: There's a second point your missing though, Mr.
18 Long, which is the population that's in the
19 southern part of the county we can come up with
20 bigger numbers of low-income people. They're
21 already within, in many cases, seven miles of
22 two acute care facilities and in other cases
23 clearly within 15 miles. So is there an access
24 issue for the patients who may be big numbers
25 in Goose Creek or other communities when there

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1 are two other hospitals already in existence.
2 The communities I pointed out that are around
3 the lake and Moncks Corner don't have that good
4 access right now.

5 Q: We heard your testimony yesterday. I just want
6 you to confirm some numbers for me.

7 A: Okay, sure.

8 Q: Seven miles of each one of the facilities,
9 population under 15,000, that number right
10 there. Roper St. Francis Berkeley, the Carnes
11 Crossroads facility has four times more people
12 in its seven mile circle, almost four times,
13 three and a half times, I guess, right?

14 A: Uh-huh (affirmative response).

15 Q: I guess your good with math, so -- three and a
16 half times more people in that facility then it
17 was in the Moncks Corner facility. You look at
18 under 25,000 combine those two numbers, same
19 thing, four times more people.

20 A: Sure.

21 Q: Talking almost 10,000 people.

22 A: Sure.

23 Q: Seven, 8,000 people, at the Carnes Crossroads
24 facility versus less than 2,000 at the Berkeley
25 Regional Medical Center, right?

1 A: Right.

2 Q: Well just confirm the numbers for me. The
3 volume of the number of people is --

4 **THE COURT:** Wait a minute.

5 **MR. THOMAS:** Your Honor, objection.

6 **THE COURT:** You're all starting to talk over each
7 other again. The court reporter cannot get it,
8 nor can I.

9
10 **MR. THOMAS:** I just like for him to be able to
11 answer the question here.

12 Q: Well that's what I'm trying to do, I just want
13 to get my question out. Okay? So you would
14 agree with me that the actual number of people
15 within the seven mile circle of the two
16 facilities, there's a significantly larger
17 number of people with incomes over \$25,000 in
18 the seven mile circle of the Carnes Crossroads
19 facilities compared to -- right?

20 A: Correct. Remember there's a top half of this
21 table and a bottom half. If you combine the
22 Roper St. Francis numbers for under 15 and
23 under 25,000, it's about 8,000 people. If you
24 look below the line there are only 2,000 of
25 them that are now within seven miles of

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1 existing hospitals. On the other hand, if you
2 look at Berkeley Regional Medical Center, they
3 have about 2,000 people above, you know, on the
4 top half who are around the 25. All of them
5 show up on the bottom because they're not
6 within seven miles. So in other words, 100
7 percent of the Berkeley Regional Medical Center
8 under 25 are not now within seven miles of any
9 other facilities, 75 percent of those for Roper
10 St. Francis Berkeley's location in Goose Creek
11 or the Moncks Corner zip code do have access
12 within seven miles right now, which is very
13 good access. It's a lot better than typically
14 what you would find as a requirement.

15 Q: Go to the next page. And blow up the top part.

16 **THE COURT:** That's 1858?

17 Q: Yes, this is 1858. Page five of the Exhibit,
18 Petitioner's 222. And again, this is the 15
19 mile number, again just going to ask you to
20 confirm the numbers for me.

21 A: Sure.

22 Q: Okay, within the 15 mile circle of Roper St.
23 Francis Berkeley, the facility at Carnes
24 Crossroads, almost 20,000 people who have
25 incomes under \$25,000, right?

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1 A: Correct.

2 Q: Actually a little over 20, I guess, or right at
3 it. And then Berkeley Regional Medical Center
4 and Carnes Crossroads the number is less than
5 6,000, right?

6 A: Correct. But this is only the top half. It
7 doesn't show you essentially the access
8 improvement based on what other facilities are
9 already in existence.

10 Q: But three times more.

11 A: Correct, sure.

12 Q: In regards to the number of people.

13 A: Sure.

14 Q: And one more page, 1859, which is a real hard
15 one to read, we'll try to blow it up for you.

16 A: Okay, I can't see that other screen.

17 Q: We'll blow it up hopefully we're gonna be able
18 to.

19 A: Can I get the page with the -- could I get
20 actually get a page, a hard copy would be a lot
21 easier for me to read.

22 Q: Yeah, let me see. I'll give you the one here,
23 it's hard to read, too.

24 A: Thanks a lot.

25 Q: And all I want you to do, if you can, on the

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1 screen, is just kind of quickly tell me in the
2 Goose Creek zip code, 29445 zip code, which is
3 right below the Roper St. Francis facility at
4 Carnes Crossroads. Just tell me the number of
5 people in that zip code who have households
6 with number of people with income under
7 \$25,000.

8 A: Is this seven or 15, by the way, I can't tell
9 from this table.

10 Q: Well, unfortunately it's your table, so I don't
11 know that I can give you the --

12 A: It looks like 1,652 plus 1,942 was the numbers.

13 Q: Can you do that kinda quickly for me, don't --

14 A: Yeah, it's about 3,600.

15 Q: So, 3,600 people.

16 A: That's what it looks like.

17 Q: So, more people under 25,000 in income than
18 there are in the 29461 Moncks Corner zip code.

19 A: Yes. But remember where the Goose Creek zip
20 code is, it's right on top of Trident Medical
21 Center and very close to Summerville Medical
22 Center, so --

23 Q: I'm going to show you this map again, which is
24 my favorite map here, the zip codes with the
25 colors on it, okay?

1 A: Sure.

2 Q: I'm sorry, just --

3 THE COURT: Wait a minute. Which Exhibit is this?

4 The Petitioner's 77?

5 Q: This is Respondent 77. I'm sorry, let's
6 correct it for the record. It's Respondent's
7 76 and it's the map that shows the Trident
8 projected inpatient market share with the zip
9 codes on it. Okay, your application that you
10 submitted to the Department, assumes -- I know
11 we covered this but I'm laying the foundation
12 -- your application that you submitted to the
13 Department assumes that the zip codes there'll
14 be no change in market share from the location
15 of the hospital at Moncks Corner, right?

16 A: Correct. Again that was the threshold test, as
17 I described yesterday.

18 Q: And the zip codes that are in pink on this map,
19 you projected in your application that these
20 zip codes, that the hospital in Moncks Corner
21 from these zip codes would attract 50 percent
22 of the Trident Health System market share,
23 right?

24 A: Correct.

25 Q: And so Trident Health System market share in

1 these zip codes is roughly a little over 50
2 percent, right?

3 A: That's correct.

4 Q: So you project that the hospital at Moncks
5 Corner from these zip codes around Lake
6 Moultrie will have a market share for that
7 hospital of 25 percent, right?

8 A: Correct.

9 Q: Okay, now if a hospital -- well first, if the
10 hospital's only going to have market share of
11 25 percent --

12 A: Uh-huh (affirmative response).

13 Q: And the market shares aren't going to change,
14 how does the hospital improve access for the
15 people around the lake?

16 A: It improves access because it reduces driving
17 time, because right now people in those zips
18 codes have to get to Trident Medical Center or
19 they have to get to Summerville Medical Center
20 and instead they'll have a facility which is
21 much closer driving range, bringing 30,000
22 people within a 15 mile radius and 30 minute
23 drive time.

24 Q: But in your application 75 percent of the
25 people in these zip codes will reject the drive

1 time of less than 30 minutes and choose to
2 drive more than 30 minutes to either go to
3 Trident Medical Center or all the way to the
4 peninsula to Roper St. Francis, that's what you
5 submitted to the Department, isn't it?

6 A: That's correct. And I think a new 50 bed
7 hospital, located in a community like Moncks
8 Corner, over time there may be changes in the
9 patterns and dynamics. In a short term, I
10 don't think you'll find that immediate shift as
11 you might be suggesting by challenging
12 assumptions I've made.

13 Q: So, now your suggesting that the market share
14 for the hospital will be higher than 25
15 percent?

16 A: In ten years from now, when the hospital's
17 established, maybe.

18 Q: Wouldn't the greatest way to increase access to
19 these people around the lake is to put both
20 hospitals in Berkeley County, since half the
21 people, or 75 percent of the people, are going
22 to the reject the Moncks Corner hospital and
23 choose to drive?

24 A: Well first thing is, I don't know if the Roper
25 facility is even targeting those patients. If

1 you read the application, pretty much
2 everything they say talks about Goose Creek,
3 southern Berkeley County, a big population of
4 the southern half of the counties, seven mile
5 radius. They seem to be sort of ignoring it.
6 So if they think that's a target area, then I
7 think they could have chosen a better location
8 to serve that if they think that's the
9 community with the most need. I think if you
10 had a facility in Carnes Crossroad, yeah, Roper
11 might get some of the patients that they're now
12 moving downtown, who would shift to that
13 facility. But given the size of the facilities
14 and the nature of those facilities compared to
15 Trident Medical Center 296, you wouldn't move
16 a hospital the size of Trident Medical Center
17 into Moncks Corner. And in essence you start
18 small, this hospital had 17 bed need, at the
19 time of 2008 Plan it was 56, they proposed 50
20 beds which I think is appropriate. Fifty beds
21 can be filled essentially with the market
22 assumptions we made. And as I admitted to you
23 in the deposition, and again yesterday, the
24 market share assumptions I made are not hard
25 and fast so the couldn't be off by a little

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1 bit. I mean, this is not anymore scientific
2 than forecasting the weather six years out.
3 You do the best you can, you make assumptions
4 you think are reasonable, and if those zip
5 codes turned out to be 55 percent share, or 60
6 percent share of Trident, and Trident had a
7 couple percent increase in market share in the
8 county, it doesn't change the numbers very
9 much. They still, to a large extent, will need
10 a large number of patients from 29461 and 29483
11 to be successful. There aren't enough in those
12 northern quadrants, even if you assume
13 essentially that everything goes there, which I
14 think is unrealistic, your not going to shift
15 the 50 or 40, 50 percent, I think, by your
16 numbers, who have chosen, for whatever reason
17 to go somewhere else, because they're tired to
18 a system, physician relationships, whatever,
19 there's all kinds of dynamics at play. Within
20 the Trident system we thought this was a
21 reasonable way to go at it.

22 Q: But that's almost 50 percent will not have
23 greater access unless that hospital is build at
24 Carnes Crossroads, right?

25 A: No. Everybody has greater access because you

1 don't know who's going to what hospital in what
2 year. And that's why I have a problem with the
3 whole concept of Roper-aligned. Different
4 patients in one year can show up at a hospital,
5 different patients in other years can show up
6 at a different hospital. People try it, they
7 see whether they like the outpatient facility,
8 whether they like the physicians. That's the
9 way the market works.

10 Q: I understand you have a problem with the
11 concept of Roper-aligned. I don't understand
12 why you don't have a problem with the concept
13 of Trident Health System-aligned. Because you
14 built your whole application around it.

15 A: What I built was a model. Remember what I said
16 yesterday, over 60 percent of the volume in
17 Berkeley County that's needed to support a new
18 hospital in Moncks Corner comes from the
19 projected growth in the Trident system just in
20 Berkeley County. There's about 6,600, 6,700
21 projected new days for Trident Medical System
22 in Berkeley County by 2017. They're only
23 projecting 10,700 days total for Berkeley
24 County. So you have 4,000 net new days, all
25 right, beyond the growth that are required.

1 Because of the fact that the Trident System
2 itself was growing so substantially and could
3 support, essentially, this transfer of capacity
4 to a new hospital, we made this assumption of
5 essentially the 100 percent transfer. I'm not
6 arguing that that threshold test means that you
7 couldn't have some modest market share increase
8 or that you'd have different percentages in
9 terms of market shares, of course that's
10 possible.

11 Q: Backing up for a second on the charity care, do
12 you know what the charity to gross revenue
13 percentages were from the Berkeley Regional
14 Medical Center pro forma?

15 A: I'm going to have to look at that page and I
16 can give you an estimate.

17 Q: You didn't have anything to do with preparing
18 that, I guess, or reviewing that?

19 A: No, no.

20 Q: Okay. Let's look at Petitioner's -- I just
21 want to confirm something in your materials,
22 and you may already know it, but it's located
23 at Petitioner 45, page 1551.

24 A: Okay.

25 Q: I believe this Exhibit is something that you

1 testified was some of the backup material that
2 you used to do your calculations in your
3 Exhibits?

4 A: Okay.

5 Q: It came in yesterday and I believe it was one
6 of the exhibits that you --

7 A: I, I --

8 Q: Does that look like what that is?

9 A: I can't read it.

10 Q: Well, do you have Petitioner's Exhibits up
11 there?

12 A: Yes, I have -- yes.

13 Q: Okay. If you look at the first page of this.

14 A: Again, it's unreadable. For me at least.

15 Q: And my question really in looking at it is I'm
16 asking you to confirm that this is some of the
17 backup material that you used to do your
18 calculations.

19 A: Okay.

20 Q: Okay. And in these calculations didn't you use
21 an average length of stay of 4.2, or you or Mr.
22 Davidson did in your calculations?

23 A: I've got to see that --

24 Q: If you need to calculate it, if you take the
25 patient days and divide it by the cases,

1 doesn't that give you an average length of stay
2 of about 4.2?

3 A: That may be the number but I can't read this to
4 tell you where the numbers are to make that
5 calculation.

6 Q: Well, didn't you use, do you recall, didn't you
7 and Mr. Davidson use an average length of stay
8 of about 4.2 or somewhere between 4.2 and 4.25
9 in doing your calculations?

10 A: Yeah. I think the first time through with this
11 we had a slightly higher assumption, it might
12 have been 4.4. And I think it's come down in
13 the second model.

14 Q: Right. And so in the later documents that
15 you've presented to the Court in regards to
16 your calculation, you're using a 4.2 and I
17 think we talked about 4.25 also?

18 A: Yeah.

19 Q: That's the average length of stay that you've
20 been using, right?

21 A: Yeah. I believe that's correct. But again, I
22 can't determine that from these numbers because
23 I can't read them.

24 Q: But do you think it might not be that?

25 A: No. I -- there's too many numbers flying

1 around to tell you for sure and I don't want to
2 mislead and say it is. But I'm not doing a
3 calculation now to guarantee that.

4 Q: If we can blow that up, because all you would
5 need is to know the cases in the -- is that not
6 legible?

7 A: No.

8 Q: Okay.

9 A: I'm not saying you're wrong.

10 Q: Okay. All right. Thank you. Let's take a
11 look at Petitioner's 221.

12 A: I don't have that book.

13 Q: It will be up on the screen. You'll recognize
14 this, it doesn't have a whole lot of numbers on
15 it. I'm sorry, page -- Petitioner's 221, page,
16 it is Baehr 1853. Oh, it's a one page Exhibit
17 --

18 A: Yes.

19 Q: -- that's why I didn't write the page number
20 down. Okay. You recall this one, right?

21 A: Yes.

22 Q: Okay. I just want to get you to confirm
23 something for me. In your projections that you
24 have prepared for the Court and submitted here
25 today you have projected the number of patient

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1 days in the Roper system for 2017, right?

2 A: Correct.

3 Q: And that number is, and this is non-tertiary,
4 non-specialty, right?

5 A: That's correct.

6 Q: So you're carving out the specialty cases --

7 A: Correct.

8 Q: -- that could not be done at the hospital --

9 A: That's correct.

10 Q: -- because it doesn't offer tertiary services?

11 And so the number of patient days in 2017 is

12 16,934 to Roper --

13 A: That's correct.

14 Q: -- Roper St. Francis system, correct?

15 A: That's correct.

16 Q: All right. And could you calculate for me from
17 the patient days what the average daily census
18 of that would be with an average length of stay
19 of 4.25?

20 A: Sure. Actually, you know, the length of stay
21 is irrelevant to figuring out the average daily
22 census.

23 Q: That's right, the average stay, you're right.
24 You're right.

25 A: You had me dividing a number which didn't make

1 any sense.

2 Q: You're right. I get confused on that. Thank
3 you.

4 A: You're welcome.

5 Q: You're right. So the average length of stay is
6 irrelevant. All you're doing is dividing the
7 patient days by 365 and that gives you the
8 average daily census?

9 A: It's a little over 46.

10 Q: And it's a little over 46. So if,
11 hypothetically, if everyone of those patient
12 days was redirected to the Berkeley Hospital in
13 Carnes Crossroads, the Roper St. Francis
14 facility in Carnes Crossroads, that would be 46
15 patients per day, right?

16 A: Uh-huh (affirmative response).

17 Q: In 2017?

18 A: Correct.

19 Q: Which is when the hospital would probably open

20 --

21 A: Right.

22 Q: -- based on construction?

23 A: The only thing in that sentence --

24 Q: Well, it may be a little before that. Maybe
25 2015, 2016. Let me just finish my question.

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1 A: Sure.

2 Q: That would be 46 patients in the hospital.
3 What would the occupancy rate be in a 50 bed
4 hospital with 46 --

5 A: Ninety-two percent.

6 Q: That would be extremely high, wouldn't it?

7 A: Right. That's extremely high and the
8 assumption is extremely unrealistic.

9 Q: Okay. But it's extremely high. Now, let's say
10 you only redirected half, that would be ADC of
11 23, wouldn't it?

12 A: Correct.

13 Q: So if you redirect half of the 2017 patient
14 days, that would be an ADC of 23, you'd only
15 need nine more patients each day and you'd be
16 operating at 65 percent capacity?

17 A: Right. But again, they're projection is 70 so
18 it would be 12. But the point is this, that
19 same approach could also be used by the Medical
20 University of South Carolina to justify that
21 they should have a 50 bed hospital because
22 they'll have maybe 35 to 40 patients in the
23 county as of that time. The relevant question
24 is not whether there are patient populations
25 but how much growth there is. The Roper system

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1 grows 3,000, so it's 3,000 days and they're
2 going to fill 11,500 in the county. So that's
3 not a big share. The growth of the Roper
4 system is not a big share of the number of days
5 they need for their system. Trident, it's an
6 entirely different story and that to me is the
7 substance of this. The argument that the
8 hospital located downtown has a certain number
9 of patients coming out of the county and,
10 therefore, they deserve a hospital in the
11 county, suggests that that's a new definition
12 of need. It's a hospital-specific definition
13 of need which suggests that if I have enough
14 patients, regardless of whether the growth in
15 the market supports a second \$115 million
16 hospital, I get my hospital. And under that
17 logic I don't know how you could deny Medical
18 University of South Carolina if they applied
19 for their own hospital with the same logic
20 because they have almost as many days in the
21 county as Roper does.

22 Q: All right. Well, in regards to MUSC, first
23 they have not applied, have they?

24 A: No, in fact they supported the Moncks Corner
25 facility saying they thought there was a need

1 for it.

2 Q: And secondly, their patient days in 2017 are
3 going to be lower than Roper because they have
4 a lower market share?

5 A: Yeah, I assumed that. I said that if Roper was
6 46, theirs might be 35 to 40.

7 Q: Yeah, but you didn't run the calculations, you
8 don't know exactly what the number would be;
9 you're speculating on that?

10 A: No, I'm certain based on the comparative market
11 shares it would be between 35 and 40.

12 Q: Okay. And your testimony is that it's more
13 important to the Court to look at the
14 difference between 2010 and 2017 than it is to
15 look at the actual number of patients in 2017?

16 A: Correct. Because the formula for need in the
17 State Health Plan is based on population-driven
18 growth and patient days. That's how need is
19 determined and if you apply the State
20 methodology to Berkeley County, comparing 2010
21 to 2017, you get enough growth to support one
22 50 bed hospital. That's really what I'm
23 saying.

24 Q: But you would have to agree with me, wouldn't
25 you, that based on the patient days that you

1 projected in 2017, there are enough Roper
2 system patient days to fill the hospital at
3 Carnes Crossroads whether you redirect 50
4 percent, as we projected, or 100 percent as you
5 projected in the Trident application, right?

6 A: Right. But again --

7 Q: Would you agree with me on that?

8 A: Yes. But I need to express, again, an
9 objection because from a planning perspective
10 that would suggest that the transfer language
11 could be used sort of willy nilly to move beds
12 from one location to another, any place where
13 you can show a high enough average daily
14 census, for a collection of zip codes that you
15 happen to draw. And that just flies in the
16 face of good healthcare planning. It's
17 hospital specific planning and that I don't
18 think is the way you should make a
19 determination in this kind of case.

20 Q: That's all I have.

21 A: Thank you.

22 THE COURT: Ms. Biggers?

23 MS. BIGGERS: I don't have any questions.

24 THE COURT: Thank you. Mr. Thomas?

25 MR. THOMAS: I've got a few. I would like just a

1 quick break to allow my paralegal to set up.

2 **THE COURT:** Let's just stay in place unless
3 everybody needs, does anybody need an outside
4 break? Let's just be at ease.

5 **MR. BAEHR - REDIRECT EXAMINATION BY MR. THOMAS:**

6 Q: Mr. Baehr, I'd like to go over a few topics
7 here from my notes, as Judge McLeod directed me
8 to stay on topic. Yesterday Mr. Long asked you
9 about medical staff overlap, correct? He said
10 that medical staffs of Trident and Roper St.
11 Francis didn't overlap; do you recall that
12 testimony?

13 A: Yes.

14 Q: And he also mentioned something about the
15 medical staffs comprised separate markets; do
16 you recall that testimony?

17 A: Yes.

18 Q: Okay. Have you ever heard of medical staff
19 markets before?

20 A: No, I think medical staffs tend to favor,
21 medical staff, individual physicians and
22 groups, tend to work with one hospital, one
23 system more than another. But generally
24 there's some ability to admit patients to other
25 locations and systems.

- 1 Q: Okay. Now, if Roper St. Francis decides to
2 spend millions of dollars acquiring physician
3 practices in Berkeley County or placing
4 employed physicians in Berkeley County, how
5 could that affect Trident's market share?
- 6 A: It would probably knock it down.
- 7 Q: Okay. Now, Mr. Long mentioned adding another
8 ED in northern Berkeley County attached to a
9 hospital and how that would shift market shares
10 in his questions yesterday. First of all, is
11 Moncks Corner in northern Berkeley County?
- 12 A: Central Berkeley.
- 13 Q: Okay. Now, Trident already has an ED in Moncks
14 Corner, correct?
- 15 A: Correct.
- 16 Q: All right. And it's located in its hospital
17 right next to that?
- 18 A: That's my understanding.
- 19 Q: Is that right? Now, assuming an ED does
20 increase market share, how would adding one in
21 Carnes Crossroads, where there is one now,
22 affect Trident's market share?
- 23 A: How would adding an ED?
- 24 Q: Attached to a hospital --
- 25 A: Attached to a hospital.

1 Q: -- in Carnes Crossroads where there is nothing
2 there now, how would that affect Trident's
3 market share?

4 A: I think that would cause a big hit to the
5 Trident system.

6 Q: And your adverse impact analysis takes that
7 into account, correct?

8 A: Yes. Because where they're located, where the
9 market is now distributed in those particular
10 zip codes suggests that Trident would have a
11 disproportionate impact compared to other
12 hospitals.

13 Q: Now, Trident is currently located on the border
14 of Berkeley County and serves Goose Creek,
15 right, we've established that?

16 A: Correct. Very close.

17 Q: But nonetheless, because of Roper St. Francis'
18 ED, Roper St. Francis actually manages a 23
19 percent market share in Berkeley County; is
20 that right?

21 A: Yeah, and I think Medical University comes
22 close to 20.

23 Q: Okay. Now, you were asked if Trident ever did
24 an analysis forecasting the number of patients
25 that would be seen at the Berkeley Medical

1 Center Emergency Department, correct; do you
2 remember that?

3 A: Yes.

4 Q: Okay. Wouldn't the forecast that you did
5 actually take that into account by virtue of
6 the past utilization of Trident?

7 A: Yeah. We did a very specific forecast not only
8 for inpatients but for emergency department,
9 for ambulatory surgery, and for all outpatient
10 services on a zip code by zip code basis with
11 specific market share assumptions.

12 Q: So you actually did the analysis?

13 A: Yeah, I did. Couldn't be a greater contrast
14 than what's in the other application.

15 Q: Okay. You were asked by Mr. Long how many
16 physicians does Roper St. Francis employ in
17 Moncks Corner today, you didn't know the
18 answer, did you?

19 A: I didn't know.

20 Q: Okay.

21 Q: Could you put up Petitioner's 235?

22 MR. LONG: Actually, Your Honor, I do object. The
23 question I asked him was did you know in 2008,
24 not today.

25 MR. THOMAS: Okay. That's fine.

1 MR. LONG: I asked him if he knew how many were in
2 2008.

3 MR. THOMAS: All right.

4 MR. LONG: It was an earlier year, I believe it was
5 '08, but it was earlier.

6 Q: You said you didn't know, right?

7 A: That's correct.

8 Q: Okay. But we haven't --

9 THE COURT: Wait.

10 MR. THOMAS: Sorry, Your Honor.

11 THE COURT: Before you go ahead. No ruling is
12 necessary on that. I mean, he's cleared that
13 up. Are you satisfied?

14 MR. LONG: Yes, Your Honor.

15 THE COURT: Thank you.

16 Q: But the fact is, Mr. Baehr, we do know how many
17 practices are Roper St. Francis Physician
18 Partners in the Goose Creek/Moncks Corner area
19 today, don't we?

20 A: Yeah, this chart appears to tell you where
21 they're located around the tri-county area.

22 Q: Well, and these two here, Number 29 and Number
23 76, right by I-26 where it says North
24 Charleston; do you see those two?

25 A: Yes.

1 Q: Okay. Those are actually on Trident's campus,
2 aren't they?

3 A: It's hard to tell from this, but presumably
4 very close.

5 Q: And then I count another 12 dots, well, 12 dots
6 in North Charleston, four in Goose Creek and I
7 guess, what is that, two, four, six, yeah,
8 another 12 dots in Berkeley County, right?

9 A: Yes, that's what it looks like.

10 Q: Okay. And these practices are owned by Roper,
11 aren't they?

12 A: Yes. I don't know what year this is.

13 Q: I pulled this off the website yesterday.

14 A: Okay.

15 Q: Now, in Mount Pleasant --

16 **MR. LONG:** Your Honor, I've got to object a second.
17 Do we have 235? We don't have that on our
18 list. Did y'all send us that?

19 **MR. THOMAS:** Yeah, we sent you that.

20 **MR. LONG:** Yesterday morning?

21 **MR. THOMAS:** Yeah.

22 **MR. LONG:** Do y'all have some copies? They haven't
23 seen it.

24 **MR. THOMAS:** You can have this one.

25 **MR. LONG:** I'm sorry, Your Honor.

1 Q: Mr. Baehr, in the Mount Pleasant area there's
2 over 30 different Roper St. Francis Physician
3 Partners doctors, correct?

4 MR. LONG: Your Honor.

5 THE COURT: Wait a minute.

6 MR. LONG: I have an objection. Mr. Thomas, he's
7 leading.

8 MR. THOMAS: I'm sorry.

9 MR. LONG: And he's calling it a cross examination.

10 MR. THOMAS: I apologize, Your Honor. I'm trying to
11 move this along on a timely basis.

12 THE COURT: Sustained. Don't lead.

13 MR. THOMAS: Yes, sir.

14 Q: Mr. Baehr, please count the dots that represent
15 the practices in Mount Pleasant.

16 A: Okay.

17 Q: Owned by Roper St. Francis.

18 A: It looks like there are 14 on the southern end,
19 16 on the northern end.

20 Q: How many is that?

21 A: Thirty.

22 Q: Okay. And this conglomeration up in the
23 northern end of Mount Pleasant, what do you
24 understand is located in that location?

25 A: It's right near the hospital, the new hospital.

1 Q: Okay. Now, based on what you know about
2 Roper's past practices, what do you think would
3 occur in the Carnes Crossroads area if there
4 was a hospital there?

5 A: I suspect there would be some of the same kind
6 of activity.

7 Q: All right. You were asked a lot about the
8 29483 zip code yesterday, the portion that's in
9 Berkeley County where Berkeley Medical Center
10 projects to get a lot of its patients, correct?

11 A: Correct.

12 Q: All right. Now, if Berkeley Medical Center
13 locates an ED in Moncks Corner, which is
14 attached to your hospital, in your opinion will
15 that act increase referrals to that facility?

16 A: I'm not sure I understand the question because
17 there is an ED already.

18 Q: But there's not one attached to a hospital --

19 A: That's correct.

20 Q: -- in Moncks Corner, is there?

21 A: Yeah, I do think that changes the market
22 significantly because the answer I gave
23 yesterday was that the reason I think this zip
24 code is likely to provide a higher percentage
25 of patients in the future than might have been

1 their historic share of the number of patients
2 at the Moncks Corner ED was because right now
3 the choices between a standalone ED and EDs
4 that are attached to two hospitals. That's
5 kind of an easy choice for most patients to
6 make when they're deciding where to travel.
7 Once you have a hospital, a third hospital's an
8 alternative I think, you're likely to change
9 that dynamic significantly.

10 Q: Okay. Now, is it your understanding that many
11 folks in the 29483 zip code will actually be
12 closer to the Berkeley Medical Center ED than
13 the Trident Medical Center in Summerville?

14 A: Yeah. Actually, my recollection is when Mr.
15 Long was examining Ms. Brandt he asked her it's
16 reasonable, isn't it, 20 percent, that they get
17 a share because look where the zip code is,
18 there's a significant part that's up, you've
19 got this piece up north, you've got the
20 geographic area and more than half is
21 reasonable, right? And she agreed. So, I
22 mean, I sort of agreed with that line of
23 questioning. I think 29483 will be an
24 important zip code so long as the Roper St.
25 Francis facility is not built.

1 Q: Okay. What happens to the market share capture
2 in 29483 for Trident if Roper St. Francis
3 Berkeley is built?

4 A: In that zip code more than any other, the
5 bottom just falls out because if you look on
6 the map and you see where Roper is proposing to
7 locate, then there's a very small percentage of
8 the people in that zip code who will be closer
9 to the Moncks Corner facility than to Roper St.
10 Francis Berkeley.

11 Q: Okay. Mr. Long asked you about market share
12 shifts that would occur around the lake because
13 of the hospital in Moncks Corner; do you recall
14 that line?

15 A: Yes.

16 Q: And did Roper St. Francis do any market share
17 shifts by zip code in their CON application?

18 A: No.

19 Q: Okay.

20 A: They only did it overall for the county.

21 Q: Okay. Now, Mr. Long implied that Trident
22 should have assumed a larger shift from those
23 zip codes around the lake, correct?

24 A: Correct.

25 Q: Now, are you under any impression that Roper

1 St. Francis has made any plans to abandon their
2 50,000 square foot outpatient center and ED in
3 Moncks Corner?

4 A: No.

5 Q: And if Roper buys more practices or simply
6 locates more physician practices around Moncks
7 Corner, potentially even across the street from
8 Trident, from the Berkeley Medical Center, what
9 effect, if any, would that have on the ability
10 to capture market share from around the lake or
11 to shift market share?

12 A: I think it enhances their ability to do that.
13 I think some of these physician practices you
14 show in the Mount Pleasant area are literally
15 near or on right close to the East Cooper
16 facility.

17 Q: Right. And where's your understanding on the
18 map of Petitioner's 235 of where the East
19 Cooper Medical Center is?

20 A: It's right in sort of the midst of that
21 collection of colored dots on the southern part
22 of Mount Pleasant.

23 Q: Now, Mr. Long asked you why you didn't redo the
24 CON application to assume that two hospitals
25 would be built; do you recall that?

- 1 A: Yes.
- 2 Q: He used the term redo?
- 3 A: Uh-huh (affirmative response).
- 4 Q: Did you assume the CON applications would be
- 5 competing?
- 6 A: Yes.
- 7 Q: Okay.
- 8 A: Certainly after Roper applied, yes.
- 9 Q: Would that be a reason that you'd redo the CON
- 10 application?
- 11 A: Yeah, I think it's going to be, I thought it
- 12 was going to be one or the other. It seemed
- 13 pretty obvious that the two are in competition.
- 14 They met all the tests for competing facilities
- 15 in the State Health Plan. And the idea of
- 16 redoing the financials to reflect two hospitals
- 17 would have meant that the final copy on file
- 18 with the Department would have shown any
- 19 feasible hospital. What's the point of
- 20 submitting now?
- 21 Q: Well, and one of these applicants actually did
- 22 have knowledge that a hospital had been
- 23 applied, is that --
- 24 A: Correct.
- 25 Q: -- your understanding?

1 A: That's Roper.

2 Q: Did Roper make any consideration for the second
3 hospital that you could see in the CON
4 application?

5 A: No. In fact, they proposed to take the growth
6 in the market that Trident would otherwise have
7 and they say it's not really a problem, yet
8 they were aware that the Trident application
9 made very clear that the Berkeley Medical
10 Center relied to a large extent on growth of
11 the Trident system in the county. You can't
12 count the patients twice.

13 Q: In your --

14 A: They can only go one place or the other.

15 Q: In your opinion did Roper St. Francis draft the
16 application as if it would be competing?

17 A: That's the way I interpreted it, yes. I mean,
18 there are a couple places in the application
19 where you can see what appears to be an
20 argument for A over B, the first local
21 provider, things like that. But, you know,
22 project review, sort of two arguments were
23 made, you know, there's enough for two but let
24 me tell you why Roper is better. I mean, both
25 arguments were made by Mr. Bowling.

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1 Q: Okay. Now, Mr. Long asked you about Trident
2 using it's capital to build the Summerville
3 Medical Center 30 bed project, correct?

4 A: Correct.

5 Q: Okay. Did Summerville Medical Center have a
6 State calculated bed need?

7 A: Yes. At the time they applied for the beds
8 they had a need for 24.

9 Q: What was that bed need based on?

10 A: It was based on their relatively high census in
11 the year prior, that was used in the 2008-2009
12 Plan for calculations which was 2006 projecting
13 their volume out to 2013 based on age-adjusted
14 use rates carried forward to that period and
15 then comparing the number of days you get to
16 the occupancy target for a hospital that size,
17 which was 65 percent.

18 Q: Okay. And the way I understood the question
19 was he was trying do a comparison of 30 beds on
20 Summerville's campus as opposed to just
21 transferring 50 beds to Carnes Crossroads?

22 A: Correct.

23 Q: Is that a valid comparison?

24 A: No. I mean, when a hospital has a bed need in
25 the Plan and they then apply to make use of

1 that bed need either at an existing location or
2 at an alternative location, that's -- they're
3 being utterly inconsistent with what's in the
4 State Health Plan. When you simply argue that
5 any other hospital can simply move beds from
6 anywhere to anywhere else and they don't really
7 need to justify anything because after all the
8 total beds are not going up, that seems to be
9 the logic I'm getting from two consecutive
10 State decisions in these kind of similar areas
11 and that's just wrong. There is a bed --
12 clearly there's an overall need in the tri-
13 county service area. But if the transfer
14 language makes any sense, makes any sense
15 whatsoever, then presumably there's a value in
16 the distribution, doing a better job of
17 distributing of beds, taking them from A where
18 there's slower growth and taking them to an
19 area where there's faster growth. But that's
20 not enough. You still have to show that
21 putting those beds in there doesn't create
22 excess capacity and the State has ignored that
23 consideration entirely. They view -- there's
24 no excess capacity so long as the hospital
25 submits a certificate of need application and

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1 shows they're going to fill their beds.

2 Q: Okay. Let me ask you this. The Summerville
3 Medical Center project of 30 beds is about \$26
4 million or \$866,000 a bed; is that your
5 understanding?

6 A: That's my understanding, yes, sir.

7 Q: How much is Roper's project per bed?

8 A: It's about \$2.3 million.

9 Q: So obviously adding beds in an existing
10 facility and adding beds at a non-existent
11 facility, those are two different things,
12 right?

13 A: Yeah, very much so in terms of cost.

14 Q: Okay. Now, Mr. Long spoke at length about
15 patient redirection and the importance of that
16 concept for Roper. Now, even accepting Roper's
17 redirection number as valid, which I know you
18 do not, how many of the patients would not be
19 redirected but would be new according to
20 Roper's projections?

21 A: Roper's projections indicate about 3,000
22 incremental patient days over a seven year
23 period. That's an average daily census of
24 about eight.

25 Q: So they are looking -- they're project is not

1 all redirection, is it?

2 A: No. But I'm saying the growth in their patient
3 population is simply not sufficient to support
4 a new hospital.

5 Q: Okay.

6 A: Not even close.

7 Q: And under their assumptions, I think they
8 projected about 3,300 patients in the first
9 year of operations or maybe it's the third year
10 --

11 A: Again, they'd have this odd forecast because
12 they're only looking at incremental days so
13 it's actually more than that.

14 Q: Okay. And so -- but there's a ten percent
15 market catch, correct?

16 A: That's a ten percent growth in the market share
17 for all those patients who are not now aligned
18 with the Roper system. So they're now 77
19 percent of the patient population of Berkeley
20 County Mr. Richardson assumed was not now going
21 to Roper facilities, he assumed they'd win ten
22 percent of that, which is an additional eight
23 percent market share for the system. So it
24 would grow from 23 percent to 31 percent.

25 Q: Okay. So those aren't patients that could be

1 redirected; is that right?

2 A: No, they're just taken from other providers,
3 they're share, their growth.

4 Q: Now, Mr. Long asked you about redirection and
5 distance, implying that there would be more
6 redirection for a facility that I guess is
7 further away; do you recall that?

8 MR. LONG: Your Honor, I just would ask that he
9 would not characterize my questions. The
10 importance is what he said.

11 THE COURT: No, sir, I want him to lead in with your
12 question because that spikes it down for any
13 ruling that I might have to make.

14 MR. LONG: Thank you, Your Honor. I see your point.
15 I would disagree with it.

16 THE COURT: You what?

17 MR. LONG: I said thank you, Your Honor.

18 THE COURT: You said you don't disagree?

19 MR. LONG: No, I understand now. I withdraw that.

20 Q: But do you have any idea or can you explain why
21 that Roper St. Francis shows a two-thirds
22 redirection for Mount Pleasant and a 50 percent
23 redirection for Roper St. Francis Berkeley when
24 Mount Pleasant Hospital is a lot closer to the
25 Roper St. Francis downtown facility than the

1 Berkeley Medical Center is?

2 A: Yeah. It seemed odd. It's clearly less than
3 20 to 25 miles.

4 Q: So do you have any explanation for that?

5 A: Whatever makes the numbers work, I guess.

6 Q: All right. Now, Mr. Long asked you to do some
7 calculations yesterday wherein he wanted you to
8 determine patient days for the proposed --

9 A: One thing I note --

10 Q: Go ahead.

11 A: Mount Pleasant is an 85 bed hospital, you've
12 got to fill more beds, you may need more
13 redirection.

14 Q: Understood. But yet Mr. Long asked you about
15 calculations where wanted you to actually
16 determine patient days for the proposed Roper
17 St. Francis Berkeley using the average length
18 of stay of 4.25, correct?

19 A: Correct.

20 Q: Okay. Sara, would you put up Petitioner's 168
21 for me?

22 Q: All right. Now, what do you understand Roper
23 St. Francis how did they, what did they rely
24 upon in terms of a hospital within their own
25 system to do the financial projections?

1 A: I'm not sure I understand the question.

2 Q: Okay. Well, did Roper St. Francis use Bon
3 Secours as a model?

4 A: I think, I believe so, yes.

5 Q: Okay. What is the average length of stay at
6 Bon Secours-St. Francis Hospital?

7 A: In the period of time here is 3.88.

8 Q: For year-to-date through August 2011, correct?

9 A: Correct.

10 Q: What is it for Roper St. Francis Mount
11 Pleasant's Hospital?

12 A: 2.73.

13 Q: Okay. So the new hospital has an average
14 length of stay of 2.73. Okay. And it's a non-
15 tertiary, non-specialty facility, correct?

16 A: Correct.

17 Q: Okay. But if we average Bon Secours and Roper
18 St. Francis Mount Pleasant, what would we come
19 up with?

20 A: Well, the right way to do it would be to weight
21 average it because there are many more patient
22 days at St. Francis. If you just did a
23 straight average, you would get about 330. If
24 you did a weight average, you'd get something
25 below 388 but not that low.

1 Q: Okay. So all those calculations that he had
2 you do based on a 4.25 average length of stay,
3 that's not a reflection of the reality, at
4 least at the Roper Hospitals that are more like
5 what's going to be in Carnes Crossroads; is
6 that correct?

7 A: Yeah. The Mount Pleasant number is really
8 quite low. And generally when you see an
9 average length of stay that low it usually
10 means a pretty high percentage of obstetrical
11 patients.

12 Q: Now, Mr. Long, he referenced the pro formas
13 yesterday and asked you some questions about
14 those. And he said and the fact that EBITDA
15 was going down in one of them, and he
16 specifically asked you is someone going to get
17 fired; do you remember that line of
18 questioning?

19 A: I do recall that.

20 Q: Okay. Now, if admission is actually enhancing
21 access, okay, to these citizens, the
22 underserved citizens of Berkeley County, and
23 they can do that and make a little money at the
24 same time, in your opinion does that mean
25 someone should actually be promoted?

1 A: No, I think what they're doing is consistent
2 with admission and they chose to locate a
3 hospital in an area where it would do the most
4 good for the greatest number of people in terms
5 of expanding access to a population that's not
6 now within 15 miles or a 30 minute drive time.

7 Q: Okay. Now, for the record, the pro formas were
8 developed when Trident believed that it was
9 going to be the only hospital in Berkeley
10 County?

11 A: Yes.

12 Q: Okay. And how would those pro formas look if
13 there were two? You actually did that
14 calculation, didn't you?

15 A: Yeah. We tried to do it twice.

16 Q: Okay. And just briefly could you summarize
17 what those pro formas look like?

18 A: Yeah, it shows that financial results are
19 seriously damaged if a second hospital is in,
20 as a significant number of patients,
21 conceivably as many as half, could be lost.

22 Q: Okay. And so in your opinion, and I know Mr.
23 Long likes to focus on EBITDA rather than net
24 income which is what the State focuses on, but
25 would there be any positive cash flow for

1 , Berkeley Medical Center if Roper St. Francis
2 Berkeley is allowed to build in the same
3 county, the same zip code, along the same road?

4 A: Would there be any positive?

5 Q: Yeah.

6 | A: No.

7 Q: Okay. Could you go to Trident DHEC record page
8 643 for me? It's the pro forma. Do you have
9 your calculator up there?

10 A: Yeah, I do. Joint Exhibit 1?

11 Q: Yes, that would be Joint Exhibit 1.

12 A: Can we take a short break? I'm like burning up
13 here, I think I've got a fever.

14 **MR. THOMAS:** Can we take a short break, Your Honor?

15 **THE COURT:** Okay. Ten minutes. Keep your seats.

16 (Off the Record)

17 THE COURT: On the record. Mr. Thomas?

18 Q: All right. Mr. Baehr, if you'd look on -- Mr.
19 Long asked you questions about the EBITDA
20 projections on page 643 of the DHEC record.

21	A: Correct.

22 Q: And what I'd like you to do quickly is take the
23 year 2008, 2009 and 2010, if you would, and
24 just average those for me.

25 | A: The E-B-I-T number?

1 Q: Yes. The EBIT number.

2 A: It's about 73.8.

3 Q: 73.8 million, right?

4 A: Right.

5 Q: Okay. Now, let's look on Respondent's 160 if
6 we could. Would you, for -- and I believe this
7 is for -- let's take the 2008, 2009 and the
8 2010, because we've got the three years
9 projections and then I wanted to do it against
10 those three years of the actual EBITDA. If you
11 would average those numbers for me.

12 A: Sure. It's about 76.

13 Q: 76 million?

14 A: Uh-huh (affirmative response).

15 Q: So over a three year period, pretty close,
16 weren't they?

17 A: They're very close.

18 Q: The projection and the actual?

19 A: Very close.

20 Q: Okay. And of course, again, on Respondent's
21 160, the EBITDA, that's not what Trident really
22 gives the bank at the end of the year, is it?

23 A: No.

24 Q: Okay. Now, Mr. Long, when he was questioning
25 you, he said you didn't review or test the pro

1 formas or their assumptions; do you recall
2 that?

3 A: Yes.

4 Q: Okay. Is that correct?

5 A: I did not review them before they were
6 prepared.

7 Q: Okay.

8 A: I have reviewed them at some detail since.

9 Q: Okay. And could you just briefly state what
10 you did?

11 A: Yeah. We examined them the way I would examine
12 any financial statement that I'm asked to
13 review, whether it would be one put together by
14 Mr. Knapp for Roper St. Francis Berkeley or one
15 that's been put together by financial people
16 plus Mr. Woodford at Trident. I try to
17 understand the assumptions. I try to challenge
18 some of the things, look for things that stand
19 out that don't look right, and then actually
20 talk to the people who actually prepared it, to
21 the extent I can, and get some questions
22 answered.

23 Q: Other than actually doing the pro formas is
24 there anything else that you could have done
25 here?

- 1 A: No. I think I spent a lot of time on this.
- 2 Q: Okay. Mr. Long asked you some questions about
- 3 the \$24 million net income figure that by the
- 4 calculations you did would result from a venue
- 5 or a standalone Roper St. Francis Berkeley; do
- 6 you recall that?
- 7 A: I do.
- 8 Q: Okay. Now, were you present for Mr. Knapp's
- 9 deposition?
- 10 A: Yes.
- 11 Q: Okay. And do you recall when I was deposing
- 12 Mr. Knapp we actually went through the venue
- 13 conversion exercise?
- 14 A: Yes.
- 15 Q: Did Mr. Knapp at that time express some
- 16 disagreement with the \$24 million figure?
- 17 A: He said it seemed high.
- 18 Q: But he didn't say that that wasn't a correct
- 19 figure, did he?
- 20 A: He just said it does look too high.
- 21 Q: Okay. And the \$24 million, that's not what
- 22 you're saying the Roper St. Francis Berkeley is
- 23 going to make, is it?
- 24 A: Well --
- 25 Q: Let me ask you this. All right. Is it your

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1 understanding that that's what the pro formas
2 with the inputs given that it's going to make
3 \$24 million?

4 A: That's, those pro formas that would show the
5 \$24 million net income with all of the
6 revenues, all of the expenses associated just
7 with the Roper facility, to produce that number
8 would mean that you would have the impact of
9 the redirection reflected in the rest of the
10 Roper System. So if there was income of X
11 dollars at Roper St. Francis Berkeley, there
12 would be a loss of a significant amount of
13 money in the Roper St. Francis system other
14 than Berkeley because, again, what Mr. Knapp
15 eventually forecast is the net, the net of
16 essentially ignoring patients that simply come
17 from Roper Downtown to Berkeley. In other
18 words, Roper loses a patient, the Roper St.
19 Francis gains one. That's no gain to the
20 system, that's just moving a patient in terms
21 of revenue and expense. His numbers suggest
22 that on an incremental basis they're about
23 break even once you consider that half the
24 patients they're not really getting any gain
25 from because they're just taking them from

1 themselves, and what's left they basically
2 break even because they have to cover the
3 capital costs of their new facility.

4 Q: Now, Mr. Long asked you about the contribution
5 margin for Berkeley Medical Center, and he
6 implied maybe that it was too low. Could you
7 explain for the record why the Berkeley Medical
8 Center contribution margin would be lower than
9 Trident's overall contribution margin?

10 A: Yeah. Berkeley Medical Center's going to have
11 a weaker payer mix, that's a significant one.
12 The per patient, that's the best way to compare
13 facilities in terms of how they stand and if
14 you have a weaker payer mix in one than
15 another, than per patient you're going to have
16 less net revenue at some facilities than you
17 would at others. You know, the other is that
18 the entire Trident system includes tertiary
19 services, it includes a lot of stuff that's not
20 being provided at Berkeley Regional Medical
21 Center which are profitable services, like open
22 heart surgery.

23 Q: Are there more kind of rigorous outpatient
24 services being provided at --

25 A: Yeah.

1 Q: -- Trident as well?

2 A: In general, and this is one of the reasons why
3 I'm not concerned that we didn't project a
4 higher redirection of Trident business to these
5 other services is that patients are, to some
6 extent, familiar with a broad range of
7 facilities at larger hospitals, which is why I
8 think the shifts are gradual in terms of moving
9 patients over.

10 Q: Now, Mr. Long brought up the comparison to the
11 open heart case and asked you some questions
12 about adverse impact. Weren't the alleged
13 adverse impact losses in that case a fraction
14 of the potential losses in this case?

15 A: Yeah. They were definitely much smaller for
16 the Palmetto system. The consultant Mr. Long
17 used in that case had a larger number for the
18 impact on Providence, which obviously I
19 disputed, I thought it was too high, but even
20 in that case it's still a lot smaller than what
21 we're talking about here.

22 Q: And in that case, in terms of just the patient
23 access issue, we're talking about patients that
24 are in the process of having a heart attack,
25 correct?

- 1 A: Correct. That was certainly at issue.
- 2 Q: And that's a little bit different than what's
- 3 going on here; is that right?
- 4 A: That's simply making it more convenient for
- 5 some of your patients in an area that's already
- 6 well-served.
- 7 Q: Okay. And so in that case there's also the
- 8 weighing the adverse impact versus the increase
- 9 in access as well, correct?
- 10 A: Correct. And I don't want to indicate the
- 11 Lexington case was a slam dunk, it was a
- 12 complex case. There were good arguments,
- 13 issues on both sides, but you know, obviously
- 14 I believe in the position we had which was that
- 15 on balance that the access improvement for
- 16 Lexington Medical Center outweighed the adverse
- 17 impact.
- 18 Q: And they have an open heart suite today, no?
- 19 A: Yes, they have eventually been approved. Yes.
- 20 Q: Approved, correct.
- 21 A: Now, wouldn't a better comparison be to see how
- 22 you would have handled an adverse impact in
- 23 other cases involving the adverse impact of a
- 24 satellite hospital on another hospital, whether
- 25 it be tertiary or non-tertiary?

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1 Q: Yeah, they're clearly more similar than that
2 situation.

3 A: Okay.

4 Q: Let's go to Trident DHEC record 38 if we could.

5 A: That's in this book?

6 Q: Yes. We put it up on the screen but I don't
7 know if you're going to be able to read it.

8 A: Yeah, probably easier for me to look at it in
9 here. Actually, I have 37 and then 39. I
10 don't have a, oh, you mean page 38?

11 Q: Yeah. In the DHEC record. Joint 1, I'm sorry,
12 Joint Exhibit 1.

13 A: Okay.

14 Q: Are you there?

15 A: I am there.

16 Q: Okay. Now, Mr. Long asked you some questions
17 about the adverse impact, correct?

18 A: Uh-huh (affirmative response).

19 Q: And if you look at the paragraph there right
20 underneath the forecast Berkeley Medical Center
21 utilization for outpatient, could you read that
22 into the record because I don't believe that
23 was shown on the screen yesterday.

24 A: Below the table on page 38?

25 Q: Yes. Start with as with.

1 A: As with the inpatient utilization projections,
2 it is assumed that the Trident Health System
3 market share of all outpatient services will
4 remain at 2007 levels. No existing provider
5 outside of the Trident system is projected to
6 lose market share and all are expected to
7 benefit from future population driven increases
8 in demand for services consistent with their
9 current market share.

10 Q: Okay. Now, is it your understanding that that
11 embodies what the State's definition of adverse
12 impact is in the project review criteria?

13 A: Yes.

14 Q: Okay. And then the paragraph underneath that
15 paragraph that you just read, that's a contrast
16 paragraph, correct?

17 A: That's correct.

18 Q: Okay. That's not -- this basically says, it's
19 almost sarcastic, isn't it, in some certificate
20 of need applications, applicants contend,
21 right? Isn't that what it says?

22 A: It's almost as if I was anticipating Mr.
23 Richardson's argument in the Roper application.

24 Q: All right. And then it says then the issue, it
25 says, it says applicants contend that if the

1 total service area growth is sufficient to
2 maintain existing providers and then you
3 italicize existing levels of service while at
4 the same time permitting the proposed facility
5 to achieve needed volume and the issue of
6 adverse impact can be dismissed. And that's
7 what you say, right?

8 A: Correct.

9 Q: All right. And you say even under, basically,
10 that lower test what happens?

11 A: Under that lower test there's no adverse impact
12 here.

13 Q: Right. But that's not the test the State uses,
14 right?

15 A: That's correct.

16 Q: Okay. And go to the next page, if you would,
17 in Joint 1, page 39. And then you go on to
18 actually put what test you use, right?

19 A: The proposed project passes an even more
20 rigorous adverse impact test shown above,
21 existing providers will maintain their current
22 market shares and be able to enjoy the same
23 benefits of service area population growth that
24 they historically have done.

25 Q: And so that's the calculation that you made,

1 correct?

2 A: Yeah. And just to elaborate on one point on
3 this because there's been sort of some
4 confusion on this point. Trident application
5 -- I've heard argument is based on 100 percent
6 transfer of volume. It's based on redirection
7 of 50 percent in some counties and a lower
8 percentage in others. In fact, you only need
9 30 percent overall redirection rate to get you
10 to the 12,000 days. So I make an argument that
11 the redirection rate actually that's been used
12 for Trident fills their hospital entirely
13 relying on about a 30 percent redirection from
14 Berkeley County. Roper relies on 50 percent
15 redirection and they still need to take a lot
16 of patients from others. Why does that happen?
17 Because Trident has a bigger footprint in the
18 market and as a result has more patients that
19 it can take from its existing base in the
20 county and transfer them.

21 Q: And that's what will result in adverse impact,
22 correct

23 A: Correct. If you don't, if you don't have to
24 rely on growth from other systems, then you
25 don't have adverse impact.

1 Q: Let's go to redirection. Go to Petitioner's 46
2 for me.

3 A: In the same material?

4 Q: I'm going to direct you to Petitioner's 46, I'm
5 going to see if we can't get it up on the
6 screen.

7 A: Okay.

8 Q: This is Baehr 1625 for the record.

9 A: Sure.

10 Q: Mr. Long asked you about patient redirection in
11 the Mount Pleasant facility and is it your
12 understanding that the actual zip code Roper
13 Mount Pleasant is located in is 29466?

14 A: That's my understanding, yes.

15 Q: Okay. So in this one, in 2010, 29466 --

16 MR. THOMAS: Your Honor, that's where the hospital
17 is located.

18 Q: In 2010 how many patients from that zip code
19 when to Roper or Bon Secours?

20 A: Three hundred seventy-five.

21 Q: Okay. And so what's the annualized rate from
22 that zip code in 2011?

23 A: Four forty-six.

24 Q: Okay. So those are patients that used a --
25 didn't use the Roper St. Francis Mount Pleasant

1 facility, correct?

2 A: These are patients who have historically used
3 either Roper or Bon Secours and now that
4 there's an option of also using the Mount
5 Pleasant facility, it looks like they're
6 continuing to go, from that zip code anyway, to
7 Roper or Bon Secours in increasing numbers.

8 Q: And these are the non-tertiary, non-specialty
9 patients, right?

10 A: The appropriate patients.

11 Q: And is that what you would expect to see if
12 there was going to be a lot of redirection of
13 the market?

14 A: Two-third redirection, no. And again, to be
15 fair, you wouldn't expect two-third redirection
16 in year one, that's not going to happen. But
17 this is also kind of a surprising result.

18 Q: Okay. Mr. Long asked you about your letter, if
19 we could go back to the DHEC record and go to
20 page 900 in that letter, in that Joint Exhibit
21 1, please.

22 A: What page?

23 Q: Nine hundred.

24 A: Sure. I got it.

25 Q: Okay. This is your letter to DHEC that

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1 explained the adverse impact analysis that you
2 did; is that right?

3 A: Yes, the adverse impact if Roper St. Francis
4 Berkeley was the only hospital that was
5 approved.

6 Q: Okay. What's at the top, the very top of the
7 page there right to the right of Richard A.
8 Baehr and Associates? The very top.

9 A: It has a Joint Exhibit number.

10 Q: Well, how about right beneath that?

11 A: It's got a date and then Ms. Brandt's address.

12 Q: No, no, no. You're missing this. There's a
13 phone number right up there in the corner --

14 A: Oh, sure, sure, sure. Okay. All right.

15 Q: Mr. Long said, asked you about you didn't
16 expect Ms. Brandt to ask you to fly down to
17 Chicago to discuss the letter if she had any
18 questions; do you recall that?

19 A: Yes.

20 Q: She didn't, you didn't have to fly down, right?
21 There's your phone number right up there, she
22 could have called?

23 A: Correct.

24 Q: Okay.

25 A: I certainly would have attempted to explain

1 what it is.

2 Q: right. And you didn't get a phone call, did
3 you?

4 A: I did not.

5 Q: You didn't get any, you didn't get an email and
6 there's your email address right there on the
7 letter saying I'm not going to consider this,
8 the letter is too late?

9 A: I also didn't get, I wasn't contacted after my
10 original letter which also had discussion of
11 the joint, what happens when both facilities
12 are built.

13 Q: And just for the record, Mr. Long asked you
14 some questions about the adverse impact and
15 whether or not there was, any of the
16 redirection was considered on the part of Roper
17 St. Francis Berkeley. Can you explain that
18 point?

19 A: Yeah. The -- what we do in this analysis, and
20 it's the same way I do it, to be consistent is
21 you look at historical market shares so if
22 Roper has a 25 percent market share, let's use
23 that for round numbers, if they build a new
24 hospital we assume that 25 percent of the
25 impact will be on Roper. If Trident has a 50

1 percent market share, 50 percent of the impact
2 is on Trident. In other words, if the hospital
3 wasn't built, you'd expect Trident to have 50
4 percent of the volume that's being projected at
5 this hospital and Roper would have 25 percent.
6 So Mr. Long was asking me a bunch of times
7 you're assuming no redirection, that's
8 absolutely not true. When I assign 25 percent
9 of the adverse impact to Roper, that's 25
10 percent redirection and it reflects their
11 historical percentage of share of the market
12 which is, I think, the fairest way to do an
13 adverse impact calculation.

14 Q: Okay. Petitioner's 46 page 31. Okay. Mr.
15 Long asked you some questions about what the
16 volume would be in year three if both
17 applicants were approved --

18 A: Correct.

19 Q: -- do you recall that? And you supplied him
20 with the numbers?

21 A: Yes.

22 Q: Okay. Isn't that what you do here on Baehr,
23 Petitioner's 46, Baehr 1619?

24 A: Correct.

25 Q: Okay. Which, I mean, you provided several

1 scenarios here, correct?

2 A: Right. As an example I think Mr. Long asked me
3 how many patient days would I expect that
4 Trident's hospital in Moncks Corner would lose
5 as compared to its forecast if the Roper St.
6 Francis Berkeley project were approved and in
7 existence and both were built. And I told him
8 I thought probably in the range of 4,000 to
9 6,000. Now, let's pick the middle of that
10 range, 5,000. You take 5,000 days, start with
11 11,717 on the bottom on the left.

12 Q: Right.

13 A: Take away 5,000 days it gets you to about
14 6,500, that would be for Berkeley Regional
15 Medical Center a loss of over \$5 million as
16 opposed to a small gain of \$69,000 in year
17 three.

18 Q: Okay. Now, Mr. Long took you through an
19 exercise regarding the East Cooper Regional
20 Medical Center numbers because we, in your
21 direct, had gone through some discharge days,
22 right?

23 A: Correct.

24 Q: Okay. And so I guess the patient days, if my
25 notes are right, went from in 2007 to 17,900

1 and 918 patient days, in 2008 I wrote down
2 18,026 patient days. Now, in 2009 it went to
3 16,966 patient days; do you recall that?

4 A: Yes. I actually have it written down here. I
5 still have my pad.

6 Q: Okay. And hopefully I got those right for the
7 record.

8 A: They are.

9 Q: Okay. Now, do you recall reading Mr. Bowling's
10 deposition?

11 A: Yes.

12 Q: Okay. And if you would look at page 282, line
13 3 --

14 MR. LONG: Your Honor, I would object here. I mean,
15 I know I didn't ask him about Mr. Bowling's
16 deposition or his testimony for Mr. Bowling.
17 I also think that's kind of classic pitting the
18 witnesses.

19 MR. THOMAS: I'm not trying to pit the witness, Your
20 Honor.

21 MR. LONG: Well, you're showing him the deposition
22 and asking him to comment on it.

23 MR. THOMAS: No, I'm not. I'm asking him to read it
24 into the record because he said he'd read it.
25 And it explains what the numbers, excuse me,

1 that we just read into the record, why those
2 numbers did what they did.

3 **THE COURT:** Overruled.

4 Q: Okay. If you would read 282-3 through 14 for
5 me. Just read it into the record. This is Mr.
6 Bowling's testimony.

7 A: Sure. Question: Okay, at this point, I mean,
8 but at this point Roper had started embarking
9 on aggressive growth strategy, correct, in
10 terms of -- Answer: practice acquisition.
11 Question: Yes. Answer: You know really in
12 2008, I mean our first practices that we
13 brought on were late 2007, by early 2008 we're
14 still pretty immature in the practice growth
15 process. Question: Okay. Answer: It was
16 really May. It was actually in May 2009 where
17 the majority of our practices were purchased.

18 Q: Okay. Thank you, Mr. Baehr. And from 2008 to
19 2009 there was a decrement there, correct?
20 Patient days from 18,026 to 16,966, correct?

21 A: Right. About a six percent drop.

22 Q: Okay. And then in 2010 there was another drop,
23 correct?

24 A: Right. Also about six percent..

25 Q: Okay. And then in 2011 another drop; is that

1 right?

2 A: Right. More in the four to five percent area.

3 Q: Okay. And just to back up, those patient day
4 numbers that we went through, those were for
5 Roper St. Francis Mount Pleasant facility,
6 correct?

7 A: No, they were for the East Cooper facility.

8 Q: Oh, I'm sorry. Thank you. And then, and what
9 happens -- this chart here shows the medical
10 staff development, correct? Roper St. Francis
11 has seen tremendous growth in the employed
12 physician network over the last year. What
13 happened from October of 2008 to June 2009?

14 MR. LONG: Your Honor, can I -- I have an objection.
15 Mr. Baehr testified he didn't know anything
16 about the physician numbers that Roper St.
17 Francis had in 2008 and then now he's going in
18 and using documents into evidence that are not
19 in the record and also weren't, he wasn't asked
20 about, on redirect to try to basically educate
21 the witness to get opinions from him. I just
22 think it's outside the scope of redirect.

23 MR. THOMAS: I'm refreshing his recollection, Your
24 Honor, because I asked him if he had read Mr.
25 Bowling's deposition and he had. It was late

1 in the day yesterday and that refreshes his
2 recollection and I'm about to get to my point.
3 He also has reviewed this graph here which is
4 very important.

5 MR. LONG: And this document is not in evidence. It
6 has not come in yet. It's Petitioner's 92 is
7 not in evidence, right?

8 MR. THOMAS: Well, it is now.

9 MR. LONG: Well, no, I just objected. So it's not
10 in yet.

11 MR. THOMAS: Okay. Okay. Well, let me lay a
12 foundation if I could, Your Honor.

13 THE COURT: Try that.

14 MR. THOMAS: Okay.

15 Q: Let's go to page one of this document. Mr.
16 Baehr, have you seen this document before?

17 A: Yes.

18 Q: Okay. And what is it?

19 A: It's a report that, the presentation really,
20 that Roper St. Francis made to the rating
21 agency, Standard and Poor's.

22 Q: Okay. And we've already talked about another
23 rating agency presentation that Roper did,
24 correct?

25 A: Correct.

1 Q: And that's, I believe that is in evidence. And
2 did you review this document?

3 A: Yes.

4 Q: Okay. And this is Petitioner's --

5 MR. LONG: Your Honor --

6 Q: -- 92.

7 THE COURT: Wait. Let me hear his objection.

8 MR. LONG: Your Honor, I withdraw the objection on
9 the admission of the document. However, I
10 didn't ask Mr. Baehr about the S&P 500
11 PowerPoints that Roper St. Francis did. I
12 didn't ask him about that.

13 THE COURT: I certainly don't remember that, Mr.
14 Thomas.

15 MR. THOMAS: I can get out the rule, Your Honor, but
16 just because he didn't ask him about a specific
17 Exhibit, he did ask him about the topic. And
18 what I'm doing is I'm going back into the topic
19 to explain exactly what these numbers mean.

20 THE COURT: Well, I know you have some latitude, but
21 get the rule out and read it to me.

22 MR. THOMAS: Okay. Your Honor, I believe it's Rule
23 611(D), mode and order of interrogation of
24 presentation and (D) is a witness may be re-
25 examined as to the same matters to which he

1 testified. It does say only in the discretion
2 of the Court.

3 **MR. LONG:** We're all playing under the same rules.
4 No re-cross, which I support. So when he goes
5 into redirect I'm at a huge disadvantage
6 sitting over here because I can't get up and
7 try to ask any questions about it. I'm fine
8 with it. I think the Court made the right
9 decision. Who knows how long the trial would
10 last if we had re-cross and re-redirect and
11 everything. I just think that basically when
12 the witness says he doesn't know and if he's
13 asked a question, the witness says he doesn't
14 know, I think it's beyond the scope of redirect
15 for Mr. Thomas to in effect educate him on the
16 topic and then try to draw an opinion out of
17 him, because that's what's going on here.

18 **THE COURT:** I sustain the objection.

19 **MR. THOMAS:** Just for the record, Your Honor, in
20 order to refute the conclusion that Mr. Long
21 drew from the witness, I'm just trying to show
22 him documents that he's seen before to refresh
23 his recollection.

24 **THE COURT:** Your argument's in the record. Thank
25 you, sir.

1 MR. THOMAS: Thank you.

2 Q: All right. Mr. Baehr, we just went through
3 those numbers, the 2008, 2009, 2010 and 2011
4 patient day numbers of East Cooper.

5 A: Uh-huh (affirmative response).

6 Q: In your opinion as a health planner, and
7 knowing what did occur over there in Mount
8 Pleasant with the physician employment and the
9 placement of the new hospital in that market,
10 do you have an opinion to what the most logical
11 explanation is for that decrease in patient
12 days?

13 A: Yea. Again, I think you've got to separate
14 time periods. Mr. Long was asking me about
15 what impact the opening of the Mount Pleasant
16 hospital would have had on these numbers and I
17 think it's fair to say that since that hospital
18 only opened in November of 2010, you can't
19 attribute losses prior to that to the opening
20 of the hospital. However, to the extent that
21 Roper, as a competitor in this market, they've
22 been taking patients from this market and
23 sending them downtown to their two other
24 hospitals before the Mount Pleasant facility
25 was built and they were acquiring physician

1 practices during this period, clearly that has
2 the ability to shift market prior to the
3 opening of the hospital which may very well be
4 what's happened here.

5 Q: Okay. Thank you, Mr. Baehr. Now, Mr. Long
6 said that this hospital, Roper St. Francis
7 Mount Pleasant Hospital, is just getting off
8 the ground in its first year and that its
9 average daily census may be a function of that,
10 correct?

11 A: Correct.

12 Q: All right. Now, this was in a booming
13 population epicenter of Mount Pleasant; is that
14 right? Is that your --

15 A: Yes.

16 Q: -- understanding? Okay. Now, I'm showing you
17 what's in evidence as Joint Exhibit 8, this is
18 the Roper Mount Pleasant Hospital CON, it's the
19 forecasted statement of operations for venue
20 and, sir, if you would, view that first couple
21 of --

22 A: Yeah, I'm going to try to find the actual
23 pages. It's easier.

24 MR. LONG: Your Honor, Joint 8 has not been admitted
25 in the case yet.

1 MR. THOMAS: Oh, I'm sorry, I thought --

2 MR. LONG: I did not ask him about Joint 8, which is
3 the Mount Pleasant CON application.

4 MR. THOMAS: Okay. Your Honor --

5 MR. LONG: It goes beyond the scope of redirect.

6 MR. THOMAS: No, it would not. He went into the
7 average daily census there, he talked about,
8 you know, it's just taken a year to get off the
9 ground. What this shows is what Roper St.
10 Francis actually projected that they would do
11 in their first year. Your Honor, that's very
12 relevant.

13 MR. LONG: In 2005. This CON application was filed,
14 in I think '05.

15 MR. THOMAS: Your Honor --

16 MR. LONG: It was filed in '05 and --

17 THE COURT: Are we talking about the East Cooper
18 decline in patient days?

19 MR. LONG: Your Honor, that's exactly right. He
20 asked him on direct about the JARs and we
21 walked through all of East Cooper days, you
22 remember that. I asked him on cross to convert
23 the East Cooper JARs, what I did is to convert
24 East Cooper JARs from discharges, which Mr.
25 Thomas asked about the patient days so I could

1 use the '03 patient day number out of the
2 Health Plan to show the decline in East Cooper
3 prior to the opening of the hospital, and of
4 course Mr. Baehr just testified a second ago
5 like he did on cross that the opening of the
6 hospital had no impact on that decline. That
7 was the testimony. It was at the end of the
8 day yesterday. I didn't, I didn't talk about
9 the Mount Pleasant CON, I didn't talk about
10 the, you know, I didn't come tie into the
11 physician practices, he said he didn't know how
12 many physicians were employed in '08, and then
13 I went on.

14 **MR. THOMAS:** This issue is completely different.
15 And Mr. Long brought up the average daily
16 census at the Roper Mount Pleasant Hospital and
17 tried to attribute that to, well, it had only
18 been opened for a year. Do you remember that?
19 That was a whole line --

20 **THE COURT:** That is correct.

21 **MR. THOMAS:** And so what I'm trying to show is that
22 it's unusually low, Your Honor. And I just
23 want to juxtapose it to Roper St. Francis' own,
24 very own projections.

25 **THE COURT:** Well, you've related it enough to

1 satisfy me. So I'm going to overrule the
2 objection.

3 MR. THOMAS: Thank you, Your Honor.

4 Q: All right. Mr. Baehr, if you would look at the
5 patient days venues that Roper projected for
6 its first year of operations, that's 10,083,
7 right?

8 A: Correct.

9 Q: Okay. And that's for a standalone operation --

10 A: Correct.

11 Q: -- is that right? Do you know what that would
12 be in terms of the average daily census if we
13 were to convert the patient days to the average
14 daily census?

15 A: About 27.

16 Q: Okay. So they projected, what Roper Mount
17 Pleasant projected was an average daily census
18 of 27 in year one, correct?

19 A: Correct.

20 Q: What's your understanding with the latest data
21 we have, what it actually is?

22 A: Through the first ten months it appears to be
23 about 11.

24 Q: Okay. And is it your understanding the
25 prediction --

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1 A: Well actually, it might be -- it's dropped
2 lower than that. It might be a little over
3 nine.

4 Q: I think you're right. And that prediction was
5 based on a population explosion and redirection
6 of two-thirds of its patients in that area; is
7 that right?

8 A: Correct.

9 **MR. THOMAS:** Just a few more questions, Your Honor.

10 Q: You were asked by Mr. Long this morning about
11 community benefit; do you recall that?

12 A: Yes.

13 Q: Okay. Now, in your experiences have you seen
14 that not-for-profits generally seek out the
15 highest payer mix areas to locate their
16 facilities?

17 A: It depends on the not-for-profit and the
18 system; it depends on parts of the country. I
19 don't think there's a fair way to characterize
20 all in one category or another.

21 Q: Okay. What have you seen in this case?

22 A: In this case it looks like, at least in the
23 case of Roper St. Francis with the two
24 facilities where they've attempted to use this
25 transfer provision, they've basically chosen to

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1 drop the beds in areas that are affluent, have
2 high growth rates and are, I'm sure, internal
3 projections would be that they would be
4 profitable in the long run. More profitable on
5 average than the average patient downtown.

6 Q: Okay. Mr. Long asked you a couple questions
7 about this exhibit, correct?

8 A: Correct.

9 Q: Okay. And it's Roper Berkeley 4 of 7. I think
10 it's Respondent's 76. Oh, I'm glad the court
11 reporter got it right. Respondent's 75, do you
12 recall this one?

13 A: Yes, I do.

14 Q: Okay. And it shows zero beds in Berkeley
15 County, doesn't it?

16 A: Correct.

17 Q: Okay. If this line were moved west by a mile,
18 what happens to the number of beds?

19 A: Two ninety-six.

20 Q: Okay. And is there a need for beds in Berkeley
21 County?

22 A: I believe there is a need for beds in Berkeley
23 County, but not 296, nor 100. I think there's
24 a need for 50.

25 Q: Okay. In terms of this map, based on the

1 location, the location is right in this red
2 area between the green and the blue, isn't it,
3 Trident; is that right?

4 A: Correct.

5 Q: Now, there's a river that runs down, what this
6 map doesn't show is the lake, correct?

7 A: Correct.

8 Q: And the river kind of cuts the county in half,
9 doesn't it?

10 A: Correct.

11 Q: Okay. Thank you. Now, what does the Trident
12 Health System done as the population epicenter
13 has grown in southern Berkeley County?

14 A: They've moved facilities out from that
15 population center. They opened outpatient
16 facilities and then a hospital in Dorchester
17 County and they created outpatient facilities
18 in Moncks Corner where the hospital had been in
19 the past. They have now proposed a small
20 hospital to supplement that.

21 Q: And Mr. Long asked you kind of some questions
22 about whether or not the Berkeley Medical
23 Center in Mount Pleasant, Mount Pleasant's
24 hospital of Roper's was bad healthcare
25 planning. But in your opinion is healthcare

1 planning is supposed to be guided by what
2 document in the State of South Carolina?

3 A: State Health Plan.

4 Q: Okay. And that document indicates what
5 facilities have beds?

6 A: Correct.

7 Q: Which facilities?

8 A: Have bed need?

9 Q: Yeah, bed need.

10 A: Trident Medical Center in Summerville in the
11 2008-2009 Plan.

12 Q: And is Trident's CON application for Berkeley
13 Medical Center consistent with that State
14 Health Plan?

15 A: Yes, it is.

16 Q: How about Summerville Medical Center?

17 A: Yes.

18 Q: And why?

19 A: They are taking the bed need they have and
20 trying to address that need and do it in I
21 think an appropriate fashion. In the case of
22 Summerville Medical Center adding 30 beds is
23 not a particularly expensive way to add
24 capacity to deal with future growth. In the
25 case of Trident in Berkeley County, there are

1 still a fairly significant number of people who
2 are in the northern parts of the county who do
3 not have good access right now based on drive
4 times and mileage from existing hospitals and
5 where they've chosen to locate a hospital at
6 this point seems to me to be an appropriate
7 location.

8 Q: Okay. Now, I think you were asked about some
9 monopoly, whether or not the State Health Plan
10 or CON Act is supposed to guarantee a monopoly.
11 First of all, you're not aware of any Sherman
12 Anti-Trust Act claims being filed against
13 Trident Medical Center, are you?

14 A: Yeah, and actually more often when you see
15 those -- I've been involved in several anti-
16 trust cases, they have to do with mergers and
17 acquisitions, not with hospitals expanding with
18 bed need that's indicated in the State Health
19 Plan.

20 THE COURT: Let me interrupt here. To my ear he
21 answered in the affirmative and I don't want
22 you to --

23 A: I didn't hear what you said, Your Honor.

24 THE COURT: I said to my ear you answered the
25 question about the Sherman Anti-Trust Act in

1 the affirmative. I don't think that's what you
2 intended and I want the record to be clear.

3 MR. THOMAS: Yeah, let me clear that up.

4 Q: Are you aware of any Sherman Anti-Trust Act
5 claims being brought against --

6 A: Oh, no, no, no, not in this case.

7 Q: -- Trident for a monopoly?

8 A: Definitely not.

9 Q: Okay. And that's because --

10 A: Thank you, Your Honor.

11 Q: That's because there are other providers in
12 that area that have market share, correct?

13 A: Yeah. It's perfectly acceptable under, again,
14 I'm not an attorney but I've dealt with and
15 written articles about anti-trust cases in
16 healthcare for hospitals to expand, buy
17 physician practices, to using the State Health
18 Plan supplement the number of beds they have in
19 an existing site or even a new site. That's
20 not typically the issues where these cases come
21 up in the anti-trust. And there aren't very
22 many of them but where they do it typically
23 relates to mergers and acquisitions.

24 Q: Well, what provider in the tri-county service
25 area has the largest market share in terms of

1 inpatient and outpatient?

2 A: My understanding is Trident is third and
3 Medical University and Roper are both somewhat
4 larger. I think Roper may be first.

5 Q: Roper is the market leader, aren't they?

6 A: Correct.

7 Q: Now, go to Petitioner 222. I've got a couple
8 more questions here. Mr. Long asked you
9 questions about this one and I just wanted to
10 make sure --

11 A: Give me a second, Your Honor -- give me a
12 second, Mr. Thomas. Okay. I got it.

13 Q: Okay. I think you were trying to explain
14 something and only half of the page was
15 actually visible to you because you kept saying
16 you have to look at the bottom of the page; do
17 you recall that?

18 A: Correct.

19 Q: I just wanted to make sure that you got that
20 testimony in the record.

21 A: Correct. That was, it's page 1858.

22 Q: Okay. Baehr 1858?

23 A: Right. Mr. Long asked me about the top half of
24 the table which showed there were about 20,000
25 households in the Roper St. Francis Berkeley

1 area that had in family incomes, household
2 incomes \$25,000 or lower and the Berkeley
3 Regional Medical Center the number is about
4 6,600. Again, using that service area as a 15
5 mile service area. But at the bottom you can
6 see that for Roper St. Francis Berkeley only
7 six percent of those under \$15,000 are not now
8 within 15 miles of an existing facility. In
9 other words, out of the 10,000 there are only
10 600 that make it to the bottom. 9,400 are
11 within 15 miles of one or more existing
12 providers. Similarly for the 15,000 to 25,000,
13 9,800 households but how many of them are not
14 now within 20, within 15 miles, 439. So it's
15 fewer than five percent. On the other hand for
16 Berkeley Regional Medical Center, approximately
17 half of all of the households who will now be
18 within 15 miles of an identified applicant are
19 not now within 15 miles of another. That's
20 significant. In other words, in the case of
21 Berkeley, because you don't have other
22 competitors, especially in those northern parts
23 of the county, they are alone in serving them,
24 they're bringing new access. That's not the
25 case where you may have a large number of

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1 households who are under a certain income level
2 but they are now being served, 95 percent of
3 them, by existing facilities within 15 miles.
4 So there's very little additional improvement
5 in access.

6 Q: In terms of the raw numbers that Mr. Long was
7 asking you about Goose Creek, I mean, which
8 facilities already serve that?

9 A: Trident --

10 Q: Those indigent patients.

11 A: Primarily Trident Medical Center and to a
12 lesser extent, Summerville. And some of them
13 are served by the other competitors in the
14 market.

15 Q: But Trident didn't get its disproportionate
16 payment cut recently, did it?

17 A: No.

18 Q: Because it serves a large number of indigent
19 patient, doesn't it?

20 A: It does.

21 Q: Respondent's -- Mr. Long brought up, I believe,
22 Respondent's 76 about the projected market
23 share and the market share capture.

24 A: Correct.

25 Q: And he started saying that 75, that per your

1 calculation 75 percent of patients will reject
2 the access; do you recall that?

3 A: Yeah. I remember.

4 Q: Okay. Well, I mean, is it your understanding
5 that patients usually go where their physicians
6 refer them, Mr. Baehr?

7 A: Generally, yes.

8 Q: Okay. So it's not necessarily the patient
9 rejecting the referral, or not choose -- strike
10 that. It's generally not the patient that is
11 deciding to go somewhere but the physician?

12 A: There's some evidence that some residents of
13 the northern zip codes have been bypassing
14 closer facilities to go into the city for
15 hospital care. I mean, just because there's a
16 hospital in Moncks Corner I don't think that
17 the infrastructure that's in place with those
18 competitors, the investment that they've made
19 in physicians and services and facilities will
20 go away.

21 Q: And, in fact, in the slide we saw earlier, the
22 exhibit where Roper Hospital is located right
23 in 29466 zip code, patients living in that zip
24 code are rejecting Roper St. Francis Mount
25 Pleasant, aren't they?

1 A: They're going in increasing numbers to the
2 downtown facility despite having a new hospital
3 in that zip code.

4 Q: Okay. Mr. Baehr, no further questions for you.

5 A: Thank you.

6 MR. THOMAS: Your Honor, at this time I think Mr.
7 Summer would like to address the Court.

8 MOTION - BY MR. SUMMER:

9 MR. SUMMER: Your Honor, that is our last witness
10 and I would like to take this opportunity based
11 upon the Court's prior ruling summary judgment
12 was that the Court needed and sought
13 information on several issues before it would
14 make a decision on the law. And I'd like to
15 revisit those with the Court's permission at
16 this point in our case. We had moved for
17 summary judgment on multiple issues and I think
18 to take these in a logical order, the first
19 issue that we had moved on, when I say first,
20 the first one I'd like to address, is the
21 notion that the bed transfer section cannot be
22 used on its plain written language, the way
23 it's written in the English language, that it
24 cannot be used to create a new hospital. And
25 we've cited in our briefs the rules of

1 statutory construction. And the two that I
2 think are most important, if you'll remember
3 Marlboro Park, the Court of Appeals said we
4 look at the plain ordinary meaning of the
5 words and even the DHEC witnesses had to
6 acknowledge the plain, ordinary meaning of the
7 words. Even Mr. Shelton himself, who wrote the
8 Plan, said that a receiving facility, it
9 contemplates, that that language contemplates
10 that a receiving facility exist to take the
11 bed. And of course Your Honor heard all the
12 testimony that we went through in that section
13 of the Plan that there is a receiving facility,
14 that the receiving facility has historical
15 utilization of having taken care of patient
16 populations and that it can make projections
17 into the future of taking care of those patient
18 populations. And without belaboring the Court
19 on this issue, three witnesses have talked
20 about that; the Department witnesses as well as
21 the expert planner. And what the clear meaning
22 of the language is, is that it must exist.
23 Now, we've heard testimony that we do this all
24 the time, this is what we do, but if you look
25 at it, it's not whether or not a department has

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1 a customary practice, it's whether or not it's
2 legal. And I want to remind the Court about
3 the specific statutory requirement that our
4 legislature has mandated the Department do to
5 create that Plan. It must collaborate with a
6 Health Planning Committee that includes a
7 cross-section of consumers, payers and
8 providers. It takes information, provides it
9 to that Committee, that Committee then blesses
10 off on that Plan. That Plan is then required
11 to be published to the public for 30 days and
12 the Department then conducts hearings where
13 providers have an opportunity to make comment
14 and to see the Plan. It then comes back with
15 comments to the Health Planning Committee. The
16 Health Planning Committee then makes its
17 determination of what should or should not go
18 in the Plan. And then that Plan goes to the
19 DHEC Board and it is either approved, modified
20 but ultimately promulgated. And no change can
21 be made -- the Act is clear, you can't change
22 or amend that Plan without going through that
23 same process of public hearings. Okay? So
24 this becomes a document that is not nearly an
25 expression of policy, it is a pronouncement to

1 the public of how the program is to be
2 administered and what the standards are to be.
3 So our first grounds for a judgment on the law
4 is that we believe that Your Honor's heard the
5 facts of what the English is and nothing that
6 we're going to hear from this point forward is
7 going to change the English language. It is
8 what it is and it is to be accorded its plain
9 and ordinary meaning. And had there been
10 another mechanism perhaps Roper could have
11 availed itself of it, but the Department
12 witnesses were clear, both of them, and I made
13 them both state the only way that they as a
14 Department could approve this was under this ad
15 hoc thing that they allowed people to use that
16 language to accomplish these ends. That's
17 arbitrary, that's capricious. It is contrary
18 to the law. It is inconsistent with the State
19 Health Plan and let's remember, Your Honor, the
20 number one rule in the CON Act is no
21 application can be approved unless it's
22 consistent with the Plan. And so our position
23 on this bed transfer language is it doesn't
24 work, their application is inconsistent with
25 the plain language and as a matter of law that

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1 decision to award it should be reversed.
2 Number two. Number two is, is that it is
3 clearly inconsistent with the Plan. And, Your
4 Honor, there's absolutely no bed need that
5 Roper can bootstrap itself to. I think Your
6 Honor is probably very familiar with the '08-
7 '09 Plan now, perhaps more familiar than you
8 ever wanted to be, but II-18, II-19 contained
9 the projections of need under the State Health
10 Plan for beds for this particular region. The
11 service area is not the county but the three
12 country tri-area. That's what the Department
13 selected, that's what's been published to the
14 world, that is what they are bound by. And
15 both the Department witnesses testified there
16 are two categories of need in this bed
17 projection. Category one is facility specific
18 and we have gone over this over and over again,
19 there are only two facilities in that region
20 that have positive, facility specific bed need
21 and those are the Trident facilities. Fifty-
22 six for Trident, 24 for Summerville. Roper has
23 an excess of beds, no need. So when we look at
24 it can Roper be consistent with the Plan in any
25 other way? Is there any other bed need? The

1 answer to that question has to be no because
2 the only facilities who have it are using it
3 and have been approved to use it by the
4 Department and so what Roper is basically
5 trying to do is to launch itself into another
6 segment of the market and somehow lay claim to
7 or appropriate, or in my position
8 misappropriate, that bed need. All Your Honor
9 has to do is to look at this and say hey, there
10 is limited need. The Department has already
11 expressed what that limited need is and by the
12 very terms of the State Health Plan, Roper is
13 not entitled to any of that need. That need is
14 expressed in two ways. Had Roper created use
15 in its own facilities and created a positive
16 bed need, the story could be different here,
17 but they haven't. And I think Your Honor will
18 remember it was Mr. Shelton's logic, Trident
19 has done well, Trident has had high
20 utilization, Trident is entitled to have these
21 beds. That's how we've done it. And if they
22 tell us that they want to put those beds at
23 their Moncks Corner facility, we accept that.
24 The logical corollary to that that Mr. Shelton
25 had no real answer to, he said, I never thought

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1 of that before. The logical corollary is the
2 other providers in the market place is have not
3 used their talents to their maximum yet. I'm
4 not suggesting that they've buried them in the
5 backyard as a parable would suggest, but they
6 haven't maximized what they have. They have
7 capacity. They've invested in their
8 infrastructure and until they increase that
9 utilization our system won't generate need. So
10 Roper has no need and the only limited need
11 expressed is in the Trident service area and we
12 know what that service area predominantly is,
13 it is predominantly Dorchester and Berkeley
14 Counties. So now they're attempting to leap
15 frog up and use that need. Well, Your Honor,
16 the only way they can do that, they're going to
17 have to be consistent with the Plan. They
18 can't be consistent with the bed transfer
19 section and if we look at II-11 of the State
20 Plan, it talks about relative importance of
21 project review criteria for beds. It also
22 talks that general hospital beds are located
23 approximately 30 minutes travel time. I've
24 heard the convoluted testimony of the
25 Department that that's not a standard. But we

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1 also know that the statute mandated that they
2 have standards in the Plan. And so it had to
3 have a time travel standard and they had to be
4 able to measure, and they say this, the
5 benefits of an improved accessibility will be
6 equally waived with the adverse affects of
7 duplication in evaluating Certificate of Need
8 applications of these beds. So you have to
9 measure, as Mr. Baehr was talking about, what's
10 the benefit of increased accessibility and
11 what's the adverse impact. Now, the
12 Department's taking the position there are no
13 standards, 30 minutes is not a standard, it
14 doesn't exist. Okay. If that is the case, if
15 that's not a standard, then any decision about
16 where to locate the hospital would be arbitrary
17 because you've got to have something to measure
18 by. That's why the statute says under number
19 III that you've got to promulgate standards for
20 hospitals to include travel time. Without that
21 I don't have a yardstick to measure by. So if
22 it is the standard, okay, clearly the benefits
23 of improved accessibility do not out weigh the
24 adverse impact. And if we throw that out and
25 there is no standard, then there's nothing to

1 measure it by. So, Your Honor, first we would
2 say that the bed transfer section can't work
3 and the DHEC witnesses said that's the only way
4 that they could approve this. So if we take
5 that on the plain English language, we're done.
6 If we move to the next step and we start trying
7 to look at the criteria and evaluate this,
8 that's going to take us into our third
9 argument, and that is that these are clearly
10 competing applications. Why are they clearly
11 competing? I think it's very clear based upon
12 the testimony of the witnesses that the only
13 element, the only element left to determine
14 about whether or not these are competing is
15 whether or not these are applications if
16 approved would exceed the need for the
17 facility. Does it exceed the need? Well, that
18 takes us straight back to what we were talking
19 about in II-18. Okay. Yeah, it does exceed
20 the need. The reason it exceeds the need is
21 they're only facility specific needs for that
22 region. I completely agree that what we're
23 looking at is a planning region of three
24 counties. But they keep pushing, Roper keeps
25 pushing saying look at Berkeley County, look at

1 Berkeley County, look at Berkeley County and
2 since the only way to justify whether or not
3 there's need, that's the only way to justify,
4 I would tell you, Your Honor, that the Plan is
5 pretty clear on its face, the only regional
6 provider to that area that has need are Trident
7 facilities. That need is consumed by both the
8 application for the Moncks Corner facility and
9 the application, 30 bed application for
10 Summerville, both approved by the Department.
11 Approving another hospital in that area served
12 by that system exceeds the need in that area,
13 of the service area. Now, if we don't make
14 that micro analysis, if we don't go into
15 Berkeley County and look and say, okay, where's
16 the bed need, well it's Trident's, they have it
17 in two places, if we come back out and say,
18 okay, where is the bed need, there's an excess
19 bed need in the county, in the three county
20 region of 49. So the notion of there being a
21 need for Roper to do anything with its beds is
22 non-existent. So our position is is that, one,
23 the bed transfer section does not work, and
24 under the rules of statutory construction this
25 Court, from our position, has heard from the

1 only DHEC witnesses who are going to testify in
 2 this case. They've heard that that is all it
 3 is and that the plain English language by their
 4 own admission is different from DHEC language.
 5 And so as a matter of law we believe we're
 6 entitled to summary judgment on that issue. It
 7 would moot the case, Your Honor, because Roper
 8 has not challenged whether or not our
 9 application should have been approved. The
 10 only thing Roper challenged was if at some
 11 point in time this Court deems that they're
 12 competing, they believe they're better. That's
 13 what their pleadings say. So they haven't
 14 challenged us on the merits of whether or not
 15 we can do what we're doing with our beds, which
 16 is I would submit, Your Honor, exactly what
 17 Loris did with their beds, they took their beds
 18 to their ED from Loris to Little River at the
 19 Seacoast facility. That has not been
 20 challenged by Roper. It is not an issue before
 21 the Court. It is not an issue that can be
 22 adjudicated. So if Your Honor were to reverse
 23 Roper's decision, the decision for Roper, the
 24 case is moot. If, on the other hand, Your
 25 Honor deems them to be competing and you want

1 DHEC to choose, that issue is squarely before
2 the Court and your preliminary ruling was that
3 if you found them competing, the way I read it,
4 was that you were going to send them back. The
5 only issue before the Court on competing now,
6 based upon the admissions of DHEC record is,
7 does approval of both exceed the need. So if
8 Your Honor, chooses not to make that decision
9 on the bed transfer section and to send it
10 back, we believe we've met any burden of proof
11 in terms of what the testimony is and what's in
12 the record based upon need. There isn't enough
13 need to go around by the plain base of the
14 document and based upon the testimony Your
15 Honor's heard thus far. It is that to approve
16 both basically allows Roper to come in in a
17 predatory manner and poach that need from
18 Trident. And it doesn't take a rocket
19 scientist to figure out why Trident has made a
20 decision and told the community that it can't
21 afford to build in Moncks Corner if Goose Creek
22 remains approved, because there's not enough
23 need to sustain it.

24 **THE COURT:** If Goose Creek remains approved?

25 **MR. SUMMER:** Right. Roper St. Francis. Carnes --

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1 THE COURT: Carnes --

2 MR. SUMMER: -- Crossroads.

3 THE COURT: -- Crossroads.

4 MR. SUMMER: If that remains approved, no wonder
5 they don't to build, it's a prudent decision
6 too. We can look at the documents and see that
7 there's a static bed need expressed in the
8 Plan, it's only expressed in the service area
9 that Trident serves, and Trident's been
10 approved to the total bed number of 80 of what
11 exists in the '08-'09 Plan. And so, Your
12 Honor, I understand you may very well want to
13 take additional testimony on this but based on
14 the Court's prior ruling, I wanted to renew
15 those motions for summary judgment on those
16 grounds because I felt like that is kind of the
17 direction the Court has given us. It is show
18 me. That's what we've been doing for the last
19 several days. Thank you.

20 THE COURT: Thank you. Mr. Biggers or Mr. Long?

21 MR. LONG: I'd like to respond first, if it's okay
22 with Ms. Biggers. Thank you, Your Honor.

23 RESPONSE - BY MR. LONG:

24 MR. LONG: It's important to remember where we are
25 in the context of the trial, Your Honor. And

1 obviously we're at the close of the
2 Petitioner's case. All right. And he has --
3 I'm still not exactly clear having listened to
4 his argument, which was eloquent, but I'm not
5 sure what motion he's filing. It is not
6 appropriate to file a motion for summary
7 judgment in the middle of the trial because a
8 motion for summary judgment requires that there
9 be no disputed material of facts and clearly
10 there are disputed material facts in this case
11 after having seven and a half days of
12 testimony. The Court, the South Carolina Court
13 of Appeals has clearly stated in the case of
14 *Fickling versus The City of Charleston* in
15 footnote one written by Judge Doosley, that we
16 recognize that a motion for directed verdict
17 under Rule 50 is appropriate only in jury
18 trials. So if what he's just done is file a
19 motion for directed verdict, he can't do that.
20 Because in a non-jury trial what the Court of
21 Appeals is apparently saying in *Fickling*, and
22 that's actually a case where the Court went out
23 of its way to kind of instruct the lower court
24 because in that case the parties filed cross
25 motions for directed verdict at the close of

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1 the plaintiff's case and it went up on appeal
2 and everybody acted like that was fine and the
3 court said you can't do what you guys did
4 below, you can't file a motion for directed
5 verdict without allowing the respondents to
6 testify. Now, in regards to what you can do,
7 we as the Respondents, because he bears the
8 burden of proof, he forgot to mention that it
9 showed in his argument I think, he bears the
10 burden of proof, we can file a motion for
11 involuntary dismissal and are going to do that
12 at the moment in regards to Trident's
13 application. But first I want to respond to a
14 couple of the points that he makes in regards
15 to the bed transfer prevision. I do -- we are
16 prepared to put a case up, we've got several
17 witnesses, it's going to take several days, and
18 we've got experts. I think the Court has heard
19 from the fact witnesses in regards to the bed
20 transfer provision. I'm not going to suggest
21 to you that you haven't. Our position is that
22 the experts, Mr. Baehr and Mr. Richardson
23 should not be allowed to further testify on
24 that and the reason is this. It is a statutory
25 construction analysis for the Court. And the

1 analysis for the Court works in these stages.
2 First, the Court looks at the plain meaning of
3 the language, it looks at the document itself
4 and tries to determine what it says, because
5 the whole purpose of the statutory construction
6 is to determine the intent of the document,
7 what does it mean. We look at the words
8 themselves, if it's clear based on the
9 language, then it's game over. That's what we
10 do. Okay? That's what Marlboro Park held,
11 that's not a profound opinion in that regard or
12 anything that's particularly unusual in South
13 Carolina jurisprudence. In that case the
14 statute said issue, it didn't say evidence, the
15 Court said it said issue not evidence. In the
16 -- once we look at it, in regards to the bed
17 transfer provision itself it's not clear on its
18 face that it prohibits the transfer of beds to
19 construct a hospital. It's not. It doesn't do
20 that. It doesn't say that a receiving facility
21 has to be existing and Mr. Summer admitted in
22 his argument that at best for him its ambiguous
23 because he said Mr. Shelton testified it
24 contemplated that. Well, if it doesn't, if the
25 language contemplates, it isn't plain on its

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1 face. It either says it or it doesn't. Now,
2 if the Court were to determine that the
3 language in the bed transfer provision was
4 ambiguous, then you are allowed to go look at
5 other evidence to determine what the intent
6 would be. In regards to the bed transfer
7 division, that's over and done with because the
8 DHEC Board, who is the, who proposes the Plan,
9 it's the Department that issues the Plan, it's
10 their Plan, they said in a written order this
11 is what it means. There is no better evidence
12 than that. And, Your Honor, Mr. Shelton and
13 Ms. Brandt, with all due respect, they can't
14 override the Board. It doesn't matter what
15 they say. They consistently testified that in
16 their, based on their experience of working
17 with the Plan, based on their personal
18 interpretation of the Plan and the way that
19 they deal with the bed transfer provision in
20 the Plan, they believe that the Plan allows the
21 transfer to construct a hospital. That was
22 their testimony. Mr. Summer walked them
23 through when their words were plural or
24 singular and dealt with a lot of different
25 issues in that regards, but their ultimate

1 testimony was consistent, it is allowed. But
2 let's just assume for one moment that Mr.
3 Shelton had taken the stand and said it doesn't
4 allow it, I read the Plan, I work on the State
5 Health Plan, it doesn't allow it, if he had
6 said that, he did not, I don't want to confuse
7 the record, it wouldn't matter because the case
8 law is clear that the Department's staff cannot
9 override the Board. The Board has spoken on
10 this issue and it's over and I would say that
11 it's consistent with the fact that the Board
12 wants this language to be drafted broadly. And
13 so, Your Honor, we could -- based on the
14 evidence they have failed to prove by the plain
15 language of the statute that the bed transfer
16 is not ambiguous and the language in regard to
17 its ambiguity is clear, that it is, that the
18 bed transfer to construct a hospital is
19 allowed. Now, I want to turn my attention to
20 another portion of this which is the transfer
21 of need. Trident proposed to move facility
22 need to a new location, not an existing
23 facility, a piece of land that they don't even
24 own, to build a hospital. And they did that
25 under the '04-'05 Plan. The witnesses were

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1 questioned about that and clearly said that
2 that was not permitted. The DHEC Board has
3 never, the language itself does not say that
4 you can do that. And the DHEC Board has never
5 spoken on that, unlike the bed transfer
6 provision they have never spoken on that. We
7 did raise that issue below. Your Honor, this
8 is an administrative hearing, of course, and
9 it's a contested case. We don't have the
10 formal rules of pleadings in these cases. We
11 don't file complaints and answers. We file
12 pre-hearings statements with the Court and the
13 Court has discretion to ask us to file
14 pleadings, they typically do not. I appreciate
15 that, I don't want to change your mind on that.
16 But it is certainly relaxed as regards to the
17 issues that come and raising issues before.
18 But I would say this, the issues certainly have
19 to be raised with the Department below and we
20 did that, and we raised with the Department
21 below that Trident's application was not
22 consistent with the Health Plan provision and
23 the Department in its decision specifically
24 referenced that provision that they applied on
25 for their application so it clearly was dealt

1 with by the staff below. In our amended pre-
2 hearing statement filed with this Court we
3 stated Trident's application is not consistent
4 with the South Carolina Health Plan. In our
5 request for contested case, I'm sorry, filed
6 with the Court, and then in our pre-hearing
7 statement we said another important issue to be
8 considered by this Court is whether Trident's
9 proposal to transfer it's institutional bed
10 need as opposed to transferring existing beds
11 is appropriate or even possible under the State
12 Health Plan in these circumstances. We clearly
13 raised the issue. Also, there were questions
14 of the witnesses so to the extent that they
15 want to argue that it was not properly raised,
16 which it was, the Court can certainly take
17 consideration of that issue and conform our
18 prayer or our request to the evidence. So our
19 position is this, Your Honor. If you determine
20 that the plain language of Section I think it's
21 G of the '04-'05 Plan, G(1)(A)(4)(d) of the
22 '04-'05 Plan, does not allow -- we contend it
23 does not allow the transfer of bed need to
24 construct a hospital as they have done and so,
25 therefore, their application fails. At a bare

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1 minimum Your Honor could consider sending it
2 back to the DHEC Board in regards to their
3 application alone. Now, because the DHEC Board
4 has never spoken on that. So we make that
5 motion, the interpretation of that Plan. Now,
6 Your Honor, we also, based on if Your Honor
7 concludes that the document is ambiguous based
8 on the evidence that's been presented because
9 the DHEC Board order is before you, Your Honor
10 under Rule 41(B) can conclude that the transfer
11 provision allows the transfer of the beds in
12 this stage of the case. You cannot conclude
13 that it does not because that's just the way
14 the circumstances play themselves out in
15 regards to the situation that we find ourselves
16 in. And we would certainly say to Your Honor
17 that it does allow that. In regards to the
18 other issues in the case, it's inappropriate I
19 think to end the case at this time. I would
20 point out that while we certainly have
21 rigorously cross-examined the witnesses, we
22 have not put up any witnesses in our case for
23 Roper St. Francis. We have -- Mr. Summer
24 continues to ignore the fact that the
25 relocation of these beds in the service area

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1 will not add any beds to the service area. The
2 net is a negative, is zero. It's the same
3 number of beds that Roper St. Francis will have
4 before the hospital is constructed and the same
5 number of beds after. He may not like it that
6 the Health Plan and the circumstances in this
7 area of the state support the relocation of
8 these beds but they do and the facts clearly
9 support it. And we've shown clearly in our
10 testimony many facts to suggest why the
11 approval of both of these applications will not
12 exceed the need. So I would ask Your Honor to
13 wait until the end of the trial to make the
14 determination on the competing application
15 issue unless you determine that their
16 application fails as a matter of law. The --
17 let's see if there's any other -- this issue
18 regarding the standards in the Plan Your Honor,
19 I'm not sure exactly what he's, where they are
20 on this. It's not clear to me exactly what
21 they're asking this Court to do. The State
22 Health Plan has standards for hospitals. It
23 sets out a bed need formula for a facility
24 specific bed need. It sets out a standard for
25 transfer. It sets out provisions in regards to

1 the project review criteria that are most
2 important. It's very consistent with the Plan
3 as a whole. I think Your Honor would have to
4 throw out the entire State Health Plan to buy
5 their argument about the standards because what
6 they're really saying is that the Health Plan
7 doesn't comply with the statute. They never
8 raised that issue below. You can look at Mr.
9 Baehr's letter, Mr. Summer wrote a letter in
10 the CON application. It's in evidence where he
11 laid out the legal case he thought to the
12 Department of why the applications were
13 competing. He never one time said, oh by the
14 way, the State Health Plan doesn't comply with
15 the statute. They never raised this. This is
16 all new in the litigation, so clearly they have
17 not proved that that issue is appropriately --
18 they have not met their burden to show that
19 that issue was raised below and they have to do
20 that, they're the Petitioner. So they failed
21 in that regard. So I just wanted to comment on
22 that. That's all I have at the moment unless
23 Your Honor has any questions.

24 **THE COURT:** Thank you. Ms. Biggers.

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

RESPONSE - BY MS. BIGGERS:

MS. BIGGERS: The bed transfer provision in the State Health Plan clearly does allow for the transfer of hospital beds from one facility to allow for the creation of a new satellite hospital. The Department thinks this is clear. I understand Mr. Summer's argument and I would just point out that Trident has the burden of proof in this if they believe that it is clear the other way. And based on the evidence that they've presented I think at best what you conclude is that there's an ambiguity. I think the Plan, I'd like to direct your attention to, and this is the Joint Exhibit 4, the '08-'09 Health Plan which is in evidence, and I'm looking at page I-4 and this is section I. This is in the general provisions of the Plan that govern all sections that come after. This is interpretation of the Plan, that criteria and standards set forth in the Plan speak for themselves and each section of the Plan must be read as a whole. When Mr. Shelton testified about the bed transfer provision, he testified that you do have to read the Plan as a whole and that it is reading, you have to read the

1 section as a whole. And he did testify that
2 reading the hospital section as a whole; that
3 there are standards for a creation of a
4 satellite hospital through the bed transfer
5 provision. Mr. Summer of course questioned
6 about both witnesses, both DHEC witnesses about
7 whether or not certain words were singular or
8 plural. Well, that does not get you to the
9 question of interpreting the section as a
10 whole. You have to look beyond that, you have
11 to look at the whole section. I think that
12 there is a enough testimony from Ms. Brandt and
13 Mr. Shelton as well as the evidence of the
14 Board order in the Parkridge case to show that
15 from DHEC's perspective it clearly allows for
16 the transfer of beds to create a satellite
17 hospital when none exists. But based on the
18 evidence before you from Mr. Summer's
19 perspective I think the best that he can
20 establish is that there's an ambiguity before
21 you. And so, therefore, applying the rules of
22 statutory construction, you need to look and
23 determine what is the intent of the provision.
24 And I think the best evidence of the intent of
25 the provision is the Board order in the

1 Parkridge case where they were specifically
2 asked just to answer one question which was
3 does the bed transfer provision allow for the
4 creation of a satellite hospital where no
5 hospital currently exists. That was the only
6 question they were asked to answer and they
7 answered clearly that it does and that is based
8 on their interpretation. And that, Mr. Shelton
9 also testified at that Board hearing and Ms.
10 Brandt read aloud the portion of the DHEC order
11 that clearly Mr. Shelton is saying that the
12 language in the Plan is meant to be flexible.
13 Mr. Shelton testified to that as well in his
14 testimony that this Plan language is meant to
15 be flexible as drafted. So looking at the
16 intent behind the Plan provision I think it's
17 clear on the evidence here that the intent is
18 to allow for the construction of a new
19 satellite hospital through the bed transfer
20 provision. As to the other arguments Mr.
21 Summer raised in his motion, I'm not quite
22 clear as well on exactly how to address these
23 because I'm not sure exactly what it is he's
24 moving for on these other, other issues. I
25 agree with Mr. Long that summary judgment would

1 be inappropriate at this time in the middle of
2 a trial. However, I think there is enough
3 evidence before you to deny their motion to the
4 extent that they've made it about Roper being
5 inconsistent with the Plan. They've had Ms.
6 Brandt testify, Ms. Shelton testified, they've
7 both testified that Roper's application is
8 consistent with the Plan and I think we should
9 move forward and hear from the Roper witnesses
10 on that point as well. And I would just say
11 the same thing as far as the competing
12 applications issue, that there is evidence
13 already to support the finding that these are
14 not competing applications but at this point I
15 think we should go forward and hear from the
16 Roper witnesses on that issue as well. And
17 lastly, I would just add that to the extent
18 that Mr. Summer did bring up whether or not the
19 Plan complies with the statute, I would
20 reiterate that that issue was not raised by
21 Trident to the staff to the during review and
22 once again I would reiterate that it is
23 Trident's burden of proof on this matter.
24 They have the burden of proof to establish that
25 they did raise it and they have not. That's

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1 it. Thank you, Your Honor.

2 THE COURT: Briefly in reply, Mr. Summer.

3 MR. SUMMER: Briefly, Your Honor.

4 REPLY - BY MR. SUMMER:

5 MR. SUMMER: I'm going to focus on what I think is
6 the clearest issue here and that is that the
7 bed transfer section can't be used because all
8 of the testimony was the only way Roper way
9 gets their hospital is through the bed transfer
10 section. That Department witnesses were
11 crystal clear on that, both of them agreed on
12 that point. I would remind the Court that our
13 Supreme Court in *Media General Commission,*
14 *Inc., versus The South Carolina Department of*
15 *Revenue* said the following: An agency's long-
16 standing interpretation of a statute is usually
17 entitled to be given deference and should not
18 be overruled by a reviewing Court in the
19 absence of cogent reasons. But the
20 interpretation will not be sustained if it
21 contradicts a statute's plain language. Also,
22 Your Honor, in *New York Times versus*
23 *Spartanburg County School District*, the Court
24 again said we cannot construe a statute without
25 regard to its plain and ordinary meaning. And

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1 this court may not resort to a subtle or forced
2 construction in an attempt to limit or expand
3 a statute's scope. And I would submit to the
4 Court that, and we've talked about this and
5 raised this issue in our motion for summary
6 judgment when the Court of Appeals chastised
7 the Department back in the Marlboro court case,
8 about ignoring plain language and ignoring law.
9 Here's the thing -- is that I don't care how
10 many times I read this and the Department's
11 witnesses actually acknowledged this, that if
12 you look at that language at the beginning of
13 II-9(J) it talks about facilities plural. It's
14 talking about two things that exist and it
15 contemplate that they exist. A transfer -- the
16 applicants, plural, two, must document with
17 patient origin the historical utilization of
18 the receiving facility. Even Mr. Shelton
19 acknowledged that receiving facility means it
20 exists. Now, he said my Board has said
21 something different but he acknowledged that.
22 And we painstakingly went through that it
23 refers to facilities plural and that there is
24 a receiving facility and that receiving
25 facility has to have historical data on its

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1 utilization, historical data on the patients
 2 who have come to it and used it. I don't know
 3 what else we can show about the English
 4 language that could be any clearer that this
 5 section does not say what Roper needs it to say
 6 in order to create a hospital in a cow pasture.
 7 And personally I don't put much credence in
 8 whether or not we have a pronouncement from a
 9 Board when we know that this Board has been
 10 chastised before for simply doing whatever the
 11 heck it wants to do. This is a policy that our
 12 legislature has said has to be promulgated at
 13 least, this Plan it's got to be promulgated at
 14 least once every two years. It's got to go out
 15 for public comments. How many times have they
 16 had an opportunity that if they wanted to put
 17 something different in it, they could, instead
 18 of shoot from the hip, being arbitrary, being
 19 capricious. They have two years to put a plan
 20 together. The other thing that I think is
 21 worthy of the Court's note on this is the
 22 notion that Mr. Shelton actually acknowledged,
 23 well gosh, there are no standards for a new
 24 hospital in the Plan, we only project for beds.
 25 There's nothing in writing in the Plan to

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1 create a new hospital. He's admitted that.
2 And we have to do an awful lot of work in order
3 to do that. That's what our legislature
4 contemplated that they'd do. And all we're
5 asking is to enforce the plain language of this
6 document. It's in English. It's not in DHEC
7 speak, it's not broad-brush, let you do
8 whatever you want to do, drop that hospital
9 wherever you want to drop that hospital. The
10 abdication of responsibility by DHEC where Mr.
11 Shelton says we think hospitals ought to tell
12 us where they ought to build hospitals is
13 counterintuitive and contrary to their mission
14 as an agency where they're supposed to guide
15 the establishment of these facilities. And so,
16 Your Honor, if there's other issues within the
17 case, if you don't believe they're competing
18 yet and you need more information or more
19 evidence, I certainly understand. I did not
20 couch this as a motion for directed verdict.
21 I'm familiar with the rule and the case law.
22 But Your Honor did say that you were in need of
23 additional information before making a ruling
24 on this. And Mr. Long has acknowledged that
25 you've heard all you're going to hear, he

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1 doesn't want his expert to have to testify on
2 it because doesn't want his expert to have to
3 read plain English language. I understand that
4 concept. But the bottom line is if you've
5 heard all you're going to hear on this issue,
6 I believe it's ripe for adjudication. And Your
7 Honor obviously doesn't have to do it from the
8 bench and do it now, I'm bringing these to the
9 Court's attention because I feel like your
10 prior rulings were directed to us to bring you
11 information to put evidence before the Court
12 and our position is we've heard what we need to
13 hear to say this is what the plain language
14 says. What they attempt to do is not expressed
15 here, is not contemplated here, cannot be
16 surmised from this, it can only be surmised
17 from we've done it before, we'll do it again,
18 and we like to keep it loosey goosey. That is
19 the statutory definition of a denial of due
20 process and being arbitrary and capricious.
21 And so, Your Honor, again, we renew the motion
22 for summary judgment that the bed transfer
23 section cannot be utilized for Roper to create
24 a new hospital and we'd ask for a judgment as
25 a matter of law.

1 THE COURT: I have a question. Mr. Long, don't read
2 too much into this, it's just for the sake of
3 satisfying part of my curiosity about this
4 particular issue. How would you respond, Mr.
5 Summer, to the notion that the statement by the
6 DHEC Board as a result of a remand by another
7 judge of this Court, had said yes, this is what
8 we meant. Does that not, in a sense, say what
9 they would, let me put it in another way, that
10 they thereby amended that State Health Plan?

11 MR. SUMMER: Can't do it, Your Honor. Can I get a
12 piece of the 44-7? I want to read the
13 statutory language to Your Honor so you'll see
14 it. If we look at 44-7-180 and if we look at
15 section C, Your Honor, it says upon approval by
16 the Health Planning Committee of South Carolina
17 the Health Plan must be submitted at least once
18 every two years to the Board for final revision
19 and adoption. Once adopted by the Board, the
20 Plan may later be revised through the same
21 planning and approval process. So the only way
22 that you can do it, if that was their intent,
23 would be to put it out for public comment again
24 and say we intend to utilize this section now.
25 So, Your Honor, I would say that statutorily

1 they're prohibited from that.

2 **THE COURT:** At least for the time being that
3 answered my question.

4 **MR. SUMMER:** And, Your Honor, I would submit to you
5 that with all due respect to the Board, I
6 understand that they're all well-meaning
7 people, but at the end of the day we are a
8 nation and a state of laws and we need to
9 follow those otherwise everything we do will be
10 arbitrary and capricious and subject to
11 manipulation, which is not why we have a
12 certificate of need program. You are not bound
13 by either prior judgments of this Court nor are
14 you bound by what the DHEC Board says. It is
15 your purview to determine what the law is and
16 to apply it appropriately. And so while I
17 understand why they want to, especially the
18 employees, I so have sympathy for those
19 employees when they have a Board directive.
20 They're not in a position where they can ignore
21 that Board directive even if they know in their
22 heart of hearts that noun is plural and that
23 receiving facility contemplates that one
24 exists, they can acknowledge that much but then
25 say but we must follow this policy. But the

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1 one other thing I did want to mention is that
2 he raises this issue that under the '04-'05
3 Plan that we can't do what we want to do. All
4 right. Well, first of all, you know, that to
5 me is again raising a Plan deficiency that they
6 never did. But they never -- I'm not aware,
7 and if counsel can show me at a break, I'll be
8 happy to take this back, they have to raise
9 that issue when it's in review in front of the
10 Department. They can't just come to this Court
11 and do it, they have to do it in front of the
12 Department. And I'm not aware that it was done
13 in this case. So I'll be happy to confer and
14 he can point out to me, you know, lines and
15 versus and chapters in that DHEC record that we
16 have where they said you can't do what you want
17 to do. But our situation is different, it's
18 very similar to the Seacoast case. And section
19 D in II-7 says that should there be a bed need
20 for additional beds for a hospital, then an
21 increase may be approved in order to provide
22 for a cost effective addition up to the greater
23 of 50 beds. We did that and we have a licensed
24 facility in Moncks Corner that we're putting it
25 in just like they did in Seacoast, Your Honor.

1 That's not a cow pasture. So, you know, we're
2 utilizing a different section of the Plan.
3 Again, the focus for me today is on what I
4 think, having heard Mr. Long we can agree on
5 it, is you've heard what you're going to hear
6 on the State Health Plan. And if that is the
7 case, then I think you're in a position to say,
8 okay, either the English language means what it
9 means and the rules of statutory construction
10 are that no matter what the Agency has always
11 done, it matters what the language says. You
12 can't ignore the plain and ordinary meaning.
13 And I would also say I think in this particular
14 case because of the statutory mandate of how
15 this thing is promulgated, I respectfully
16 disagree with the Department's position that we
17 need to keep this thing loosey goosey so we can
18 do what we need to do. The whole purpose of it
19 was to have concrete rules that could be
20 followed by all providers so that we don't have
21 favoritism, we reduce the role of politics and
22 we don't give special dealing. And so my
23 position would be that we can, all we have to
24 do is look at the statute to understand that if
25 we wanted this loosey goosey we would have a

1 State Health Plan at all much less a mandate on
2 how it's to be promulgated and the things that
3 it has to have in it. And even if the Court
4 doesn't want to address those issues about the
5 failings of the Plan, I think the Court can, as
6 far as the credibility of the witnesses are
7 concerned and the conduct of the Agency, we had
8 witnesses acknowledge, acknowledge to Your
9 Honor that they're ignoring statutory mandates.
10 Now, that, from my perspective, if you're
11 ignoring the directives of the legislature, I'm
12 not so sure that you deserve much deference in
13 how you're interpreting a document that you
14 didn't even do as you are required by law to
15 do. So I do think that this plays into this
16 equation and this calculus.

17 MR. LONG: Your Honor, can I just raise the issue
18 that he asked about because I can answer that
19 question very quickly about where we raised it
20 below.

21 THE COURT: You may.

22 RESPONSE - BY MR. LONG:

23 MR. LONG: Under the law, Marlboro Park was kind of
24 the standard back then. The issue has to be
25 before the Department below. It clearly was

1 before the staff, it was proposed by Trident as
2 the provision that they were applying under,
3 the staff referenced it in their letter. We
4 did respond to it in our letter to the DHEC
5 Board after the staff made their decision, so
6 it was before the staff. We raised it before
7 the Board and then we raised it in this Court
8 also. So I think it's preserved, our position
9 clearly is it is preserved.

10 **THE COURT:** Well, you two confer over the break and
11 see if you can satisfy it.

12 **RULING - BY THE COURT:**

13 **THE COURT:** I'm going to deny both motions at this
14 time. I want to hear the rest of the
15 testimony.

16 **MR. SUMMER:** Thank you, Your Honor.

17 **THE COURT:** It's 12:30, we'll recess until 2:00 p.m.

18 (Off the Record)

19 **MR. LONG:** May it please the Court. Your Honor, the
20 Respondents, Roper St. Francis, will call Karl
21 Gorrell to the stand.

22 **KARL GORRELL,** being duly sworn, testifies as follows:

23 **MR. GORRELL - DIRECT EXAMINATION BY MR. LONG:**

24 **Q:** Mr. Gorrell, I'm Jimmy Long. We met before in
25 the case, I think when we did your deposition.

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1 Just a couple housekeeping matters. Obviously
2 you do need to speak up for the court reporter
3 if you can. If you need to move a little
4 closer to the table and whatever, please feel
5 free to do so. We'll be talking about a few
6 documents during your testimony here today.
7 They'll appear on the screen right in front of
8 you, on that screen there, but if you'd like to
9 look at the hard copy of the documents, they're
10 up there and we can get those out for you. Mr.
11 Gorrell, can you state your full name for me?

12
13 A: Karl Edward Gorrell.

14 Q: And where do you currently live?

15 A: I live in Charleston, South Carolina.

16 Q: And where do you work?

17 A: At Doctors Hospital in Augusta, Georgia.

18 Q: Okay. And who's your employer?

19 A: HCA.

20 Q: All right. And so is Doctors Hospital in
21 Augusta an HCA facility?

22 A: Yes, it is.

23 Q: And were you employed with Trident Health
24 System prior to being employed in Augusta?

25 A: Yes.

1 Q: And what role did you serve in with Trident
2 Health System?

3 A: I was the CFO.

4 Q: So you were the chief financial officer for the
5 System, correct?

6 A: That's correct.

7 Q: And Trident Health System is two hospitals,
8 right?

9 A: That's correct.

10 Q: And their names are?

11 A: Trident and Summerville Hospitals.

12 Q: And Trident is Trident Medical Center, right?

13 A: Trident Medical Center and Summerville Medical
14 Center.

15 Q: All right. And when did you become the CFO at
16 Trident, for Trident Health System?

17 A: In July of '95.

18 Q: And then you stayed in that role until when?

19 A: Until April of this past year.

20 Q: Okay. And of course while you were there you
21 had an opportunity to work with Mr. Terry Gunn,
22 correct?

23 A: Correct.

24 Q: And Mr. Gunn was the CEO and the actual South
25 Carolina market president during the time that

1 you were there, right?

2 A: That's correct.

3 Q: So he was the chief executive officer over both
4 hospitals and all the hospitals in South
5 Carolina, right?

6 A: Yes.

7 Q: All right. Now, in regards to this CON
8 application that was filed for a hospital in
9 Moncks Corner, the Berkeley Regional Medical
10 Center; you're familiar with that, correct?

11 A: Yes.

12 Q: And in that -- now your role in regards to that
13 was fairly limited, correct?

14 A: That's correct.

15 Q: At the -- well, tell me in your words exactly
16 what you did in regards to the certificate of
17 need application that was filed.

18 A: I had the responsibility of reviewing the
19 financials that were submitted in the CON
20 application.

21 Q: Now, for -- your capable of doing the
22 financials for a certificate of need
23 application, right?

24 A: Yes.

25 Q: And you have that ability, you've done it in

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RECORD 002322

1 past, correct?

2 A: Yes.

3 Q: But in this particular CON the decision was
4 made to hire an outside consultant?

5 A: Yes.

6 Q: And what was that gentleman's name?

7 A: Steve Woodford.

8 Q: All right. And so what was Mr. Woodford's role
9 in regards to the CON?

10 A: He put the financials together.

11 Q: Okay. Let me ask you, if I could, I want to
12 walk through a few documents that came up in
13 the case that you, to ask you about. But as
14 far as the senior -- before I do that, as far
15 as the senior management team, would you
16 characterize yourself as being the number two
17 person at Trident Health System when Mr. Gunn
18 was there, during the time that Mr. Gunn was
19 there?

20 A: Not necessarily. In financial matters I would
21 be the number one or the number two, but an
22 operations issue it may be the COO and it may
23 be, if it's a clinical issue, the CNO.

24 Q: Okay. The COO is who?

25 A: The chief operating officer.

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1 Q: And the CNO is who?

2 A: The chief nursing officer.

3 Q: Okay. Thank you. Let's take a look at
4 Respondents' Exhibit Number 148, if we could.
5 All right. This is an email from Mr. Woodford
6 to you dated February 18th, 2008, correct?

7 A: Correct.

8 Q: And just to give you a little help with the
9 time line, this certificate of need application
10 was filed in August of 2008. Okay? Mr.
11 Woodford is the person we mentioned earlier
12 that did the financials?

13 A: Correct.

14 Q: Now he's not actually employed by Trident
15 Health System, was he?

16 A: No.

17 Q: But his experience had been with HCA?

18 A: Right.

19 Q: What role had he previously had at HCA?

20 A: At one point he was actually my division CFO
21 when I was at the division level.

22 Q: And did he leave HCA during this time period or
23 was he still employed with HCA or was he in a
24 different role?

25 A: This time, this time period, excuse me, this

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1 time period he was an independent contractor.
2 He was a consultant with us.

3 Q: Okay. And so he's sending you an email and Mr.
4 Rardin about a newspaper or an article that he
5 read in the newspaper that day regarding Roper
6 St. Francis, right?

7 A: Yes.

8 Q: And this email is he's bringing to your
9 attention that Roper St. Francis has purchased
10 the property at Carnes Crossroads, right?

11 A: Yes.

12 Q: Or Carnes Crossing?

13 A: Yes.

14 Q: And do you recall him bringing this information
15 to you or being aware of it at this time
16 period?

17 A: I remember this email, that's it.

18 Q: And do you remember what it was about the deed
19 that he was bringing to your attention?

20 A: No, sir, I don't.

21 Q: Okay. Could it have been the fact that the
22 deed contemplated that there would be a
23 hospital bought, built at that site?

24 A: It could have been but I never took it past
25 this email message.

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1 Q: Okay. But you were aware that Roper St.
2 Francis had purchased 66 acres or the
3 management team at Trident Health System was
4 aware that Roper had purchased 66 acres at
5 Carnes Crossing certainly by February of '08,
6 right?

7 A: Were aware, yes.

8 Q: Okay. All right. My next document I want to
9 show you is Respondents' Exhibit 130. This is
10 an invitation to you and many others to have a
11 meeting on a conference call on May 20th of
12 2008; do you see you're invited to that?

13 A: Yes.

14 Q: Along with numerous other people, right?

15 A: Yes.

16 Q: Most of the senior people at Trident Health
17 System, right? Let me roll through some of the
18 names and you can tell me. Terry Gunn, he's
19 the CEO for Trident Health Systems, for the
20 whole market actually, Trident Health Systems
21 and any other hospitals in South Carolina,
22 right?

23 A: That's correct.

24 Q: Chuck Hall is at the division level for HCA,
25 right, or the group level?

1 A: He is group level.

2 Q: So what was his responsibility at that time?

3 A: He oversees all of the hospitals and what was
4 the eastern group at that time, including
5 Trident and Summerville.

6 Q: And how many hospitals would that have been?

7 A: Gosh, 30-some I believe. I don't know the
8 exact number.

9 Q: Okay.

10 A: Thirty, 50.

11 Q: Of course you're Karl Gorrell. Mr. Rardin,
12 we've met him already, he was the chief
13 strategy officer at that time, I think, right?

14 A: That's correct.

15 Q: Okay. And then of course the attorneys are on
16 there also, right?

17 A: Correct.

18 Q: Donald Stinnett, do you know who he was?

19 A: That was Chuck Hall's CFO eastern group.

20 Q: Okay. Do you actually recall this meeting on
21 the 20th of May?

22 A: No, I don't. I think that's what I said in my
23 deposition, if I recall right, too. I could
24 have been there, I don't remember that meeting
25 distinctly.

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RECORD 002327

1 Q: Okay. Prior to this meeting on May 20th of
2 2008 did you participate in any discussions
3 about whether to file a CON application for a
4 hospital?

5 A: I could have. I don't recall.

6 Q: Did you participate in any discussions about if
7 a hospital was going to be applied for, where
8 it should be applied for?

9 A: If I was, I don't recall that.

10 Q: Okay. Were you asked to do any sort of
11 financial analysis in regards to the
12 construction of a hospital prior to that day?

13 A: I don't recall that. No, I don't.

14 Q: Okay. And did anybody ask you to prepare a
15 return on investment or for a capital, or for
16 a major capital expenditure in Berkeley County
17 prior to that day?

18 A: No, I was not asked to do that.

19 Q: Okay. Let's take a look at Respondents'
20 Exhibit 108. If you go down about halfway
21 down, particularly I want to draw your
22 attention to this email from Mr. Stinnett.
23 Okay? Now, Mr. Stinnett, you're on this email
24 chain, correct?

25 A: That's correct, I was cc'd.

1 Q: Jim is probably Mr. Rardin?

2 A: Yes.

3 Q: And Mr. Stinnett you've already identified as
4 the CFO for the group, right?

5 A: That's correct.

6 Q: And in there he's asking about this situation.
7 How is this different than the situation with
8 East Cooper and Roper out in Mount Pleasant?
9 I guess what I'm asking is how can Roper pull
10 off the same coup as they did in Mount
11 Pleasant, "trumping us" I mean, (trumping us)
12 and more importantly what can we do to prevent
13 it, Don. Do you recall responding to him in
14 regards to this email?

15 A: No, I do not.

16 Q: Do you recall any meetings or anything that
17 came out of that?

18 A: No, I do not.

19 Q: Okay. If you go to the top of the email,
20 you'll see that Mr. Rardin replied to the group
21 and he just says, "Don, I'll call you." Right?

22 A: That's what I'm reading.

23 Q: Okay. But you were on any conference call or
24 discussion regarding that; do you recall?

25 A: No, sir, not that I recall.

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1 Q: Now, in regards to the CON application itself,
2 Mr. Woodford did most of the work in regards to
3 the preparation of the CON, of the financials,
4 right, the pro forma?

5 A: Yes.

6 Q: All right. You also remember dealing with a
7 man named Mr. Davidson, Tom Davidson? Did you
8 ever deal with him?

9 A: I don't know that I dealt with him directly.
10 I may have seen his name in an email. It was
11 primarily Mr. Midgett and Mr. Woodford.

12 Q: That you dealt with?

13 A: That's correct.

14 Q: And did you ever deal with Mr. Richard Baehr?

15 A: Again, same, may have been on an email. Did
16 not deal directly with Mr. Baehr.

17 Q: Okay. When was the first time you met Mr.
18 Baehr?

19 A: Probably the first time I met him was at the
20 presentation in Columbia.

21 Q: Okay. Let me bring your attention, if I could,
22 to Respondents', I'm sorry, this is Petitioner,
23 Petitioner 174. Now, this is an email -- do
24 you want the book? Where did we put that? If
25 you want to look at the actual document stuff

1 it would be in this --

2 **MR. LONG:** Did you put the Joint Petitioner's out? I
3 apologize, Your Honor. Yeah, we need to get
4 the --

5 Q: Well, let me look at the email. If you want to
6 look at it we'll come find it. We can find at
7 least a copy of it for you. This is an email
8 from Mr. Woodford to you on July 19, 2008, it's
9 also to Mr. Midgett, correct?

10 A: Yes, it is.

11 Q: Take a second and refresh your memory on it.
12 And this would have been about a month, about
13 -- during the period of time that the
14 financials and the CON application was being
15 finalized, correct?

16 A: That's correct.

17 Q: Okay. And do you recall having a meeting with
18 Mr. Woodford and talking with him some about
19 the financials during that period of time?

20 A: Yes. Mr. Woodford and Mr. Midgett, yes.

21 Q: Okay. All right. Let's look over to the next
22 --

23 **THE COURT:** Before we go on, you asked this witness
24 when he first met Mr. Baehr and he says at the
25 meeting in Columbia and you said, oh, yes.

1 Both of you know when it was but the Court
2 doesn't know when it was.

3 MR. LONG: Thank you, Your Honor. I appreciate you
4 pointing that out.

5 Q: When you said the meeting in Columbia, were you
6 talking about the project review meeting at
7 DHEC?

8 A: Yes.

9 Q: All right. Where presentations were made to
10 the Department regarding the projects?

11 A: That's correct.

12 Q: And that would have been shortly before the
13 decision was made, I believe it was in -- would
14 May of 2009 sound about right to you?

15 A: Roughly that sounds correct, yes.

16 Q: Okay.

17 MR. LONG: Thank you, Your Honor.

18 Q: All right. Let's take a look, if we can here,
19 at the next page in the document, which is
20 Petitioner's 172, 174 of page Trident 226 on
21 the Bates. I particularly want to draw your
22 attention -- well first, this was the format
23 that Mr. Woodford submitted to you and Mr.
24 Midgett as to how to do the financials, right?

25 A: This, as I recall, was one of his base

1 documents numerically where he was reflecting
2 his assumptions.

3 Q: Okay. And Phoenix Hospital at the top is the
4 code word for the Moncks Corner hospital,
5 right?

6 A: That's correct.

7 Q: Y'all just called it that internally because
8 there was no name yet for it, so you named it
9 Phoenix, right?

10 A: That's correct.

11 Q: And he makes a number of different assumptions
12 on this document, right? He has an average
13 length of stay of 4.45, right?

14 A: Yes. I see that, yes.

15 Q: Okay. And you recall that originally he had
16 lower average length of stay but you suggested
17 to him that it be raised to 4.45, right?

18 A: I don't, I don't recall that. That's a
19 possibility.

20 Q: Okay. Do you recall it being raised?

21 A: No, I don't.

22 Q: All right.

23 A: We did discuss that.

24 Q: You do recall --

25 A: We discussed all the assumption, I just don't

1 recall raising the length of stay.

2 Q: Okay. I do want to bring to your attention at
3 the bottom of this page, he's got down here at
4 the bottom, the payer mix for the project,
5 right?

6 A: Yes.

7 Q: That little bottom part there, I'm starting at
8 -- yeah, all that. And what he's -- the payer
9 mix is the patients that come into the
10 hospital, whether they're inpatient or
11 outpatient, have different sources to pay for
12 the service, right?

13 A: That's correct. Those are split by the various
14 third-party payers.

15 Q: So usually when a patient comes into the
16 hospital, he'll be paid by the, the services
17 will be paid by a third party and those are the
18 major ones, right; Medicare, Medicaid, Champus,
19 commercial pay, HMO, PPO, those are like
20 insurance companies, right?

21 A: Right.

22 Q: Then charity is a separate item I want to talk
23 with you about in a minute, and then other,
24 right?

25 A: That's correct.

1 Q: Okay. Look over on the far right side. Okay?
2 And what is the basis of the payer mix? Isn't
3 the basis of the payer mix the Summerville
4 Medical Center facility?

5 A: As I recall the better part of the payer mix we
6 utilized what those percentages looked like in
7 the Summerville facility.

8 Q: Okay. And the reason you chose the Summerville
9 facility is because it's a community hospital,
10 right?

11 A: Right. Without some of the tertiary care
12 services, specialty services that are at
13 Trident.

14 Q: So you thought maybe if you used the Trident
15 Medical Center payer mix it might be a little
16 skewed because the services being offered at
17 the Berkeley Hospital would be different than
18 some of the services offered at the Trident
19 Medical Center hospital, right?

20 A: That's correct. It made more sense to make it
21 reflect more of the Summerville numbers than it
22 did Trident.

23 Q: Okay. And there was no analysis of trying to
24 figure out what the payer mix was for certain
25 zip codes or anything like that, right?

1 A: I don't recall that. I don't recall that. I
2 can't speak to what Mr. Woodford did completely
3 on his analysis.

4 Q: All right. Well, let me show you Respondents'
5 97. This an email from Mr. Woodford to Mr.
6 Midgett but during this time period you were
7 working closely with Mr. Midgett and Mr.
8 Woodford, right; you were overseeing their
9 work?

10 A: We met one time, the three of us together, to
11 go over the financials. So it wasn't a day-by-
12 day thing that I worked with them.

13 Q: But Mr. Midgett actually reported to you at
14 that time, right?

15 A: Yes, he did.

16 Q: He was the comptroller at the hospital, right?

17 A: That's correct.

18 Q: And you certainly assigned this project to him
19 for him to help Mr. Woodford with this, right?

20 A: Yes, I did.

21 Q: Okay. And you can see from this email, we'll
22 turn over to the second page, Mr. Woodford is
23 using the Summerville Medical Center as the
24 basis of the payer mix, isn't he?

25 A: What I'm -- I can see right here the different

1 payers, but I don't see anything on this. That
2 looks like their zip code.

3 Q: Well look at the email.

4 A: The 29431. Can we go back to the email?

5 Q: Yes.

6 A: Yeah, he speaks to Summerville in this email.

7 Q: So he speaks to the Summerville financial data.
8 And you certainly have in your decision to
9 support the system at the hospital the ability
10 to pull very specific financial information
11 about Summerville, right?

12 A: Yes.

13 Q: And/or Trident, right?

14 A: Yes, in terms of gross revenues. Yes.

15 Q: Well, you can also do net revenues too, right?

16 A: But there are other pieces and components where
17 the accounts receivable is just one system. So
18 you make the best estimates you can with that
19 DSS system, but it's not perfect.

20 Q: Well let's talk about it for a sec. Because
21 the financials are consolidated for the two
22 hospitals, right?

23 A: That's correct.

24 Q: And also for the ED in Moncks Corner, right?

25 A: Uh-huh (affirmative response).

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RECORD 002337

1 Q: So they all roll together to the same financial
2 statement, right?

3 A: That's correct.

4 Q: Okay. But the decision support people have the
5 ability to look at and to track revenue by
6 facility?

7 A: They can, yes.

8 Q: And they can also run reports that actually
9 calculate the contribution margin for each
10 service at each hospital, right?

11 A: Contribution margin, yes.

12 Q: And that involves them making some assumptions
13 in regards to the expenses, but they do that
14 and generate those reports for your review as
15 the CFO, right?

16 A: Yes.

17 Q: Okay. Now, let's go to -- let's take a look at
18 Joint Exhibit 1, pages 643, 644, 645, and 646.
19 This is the original pro forma, the pro forma
20 that was filed in the application. If you want
21 to look at the book, it would be this one right
22 here or you can look at it on the screen,
23 whichever is more convenient. Now, this
24 document is what was submitted to the
25 Department, right?

- 1 A: Well, the page number in the bottom right-hand
2 corner of the screen, does that match up?
- 3 Q: It will.
- 4 A: It says 653 and what I'm looking at here says
5 643. So it's --
- 6 Q: 643 would be correct.
- 7 A: It looks like the same numbers.
- 8 Q: If you look at 642, you'll see the letter from
9 Mr. Midgett.
- 10 A: Okay.
- 11 Q: Are you there?
- 12 A: Yes, sir, I am.
- 13 Q: Okay. This is the financials that were
14 submitted to the Department, correct?
- 15 A: Yeah, this looks like it.
- 16 Q: Okay. Now, this format, this formatted
17 document is different than what Mr. Woodford
18 submitted to you in the draft that we looked at
19 earlier, isn't it?
- 20 A: Yes.
- 21 Q: Why did you not submit the additional
22 information that Mr. Woodford had in the
23 documents that he had submitted to you in July
24 to the Department? Why did you not submit that
25 to the Department?

1 A: This is the way that we had always submitted
2 CON financial information to the Department.
3 This looked to be standard to me and that's
4 what we did on this particular CON.

5 Q: Okay. And part of your role in this process
6 was also to deal with Mr. Woodford in regards
7 to the assumptions, correct?

8 A: Yes. It was to oversee the assumptions that he
9 and Ronnie made in putting these financials
10 together.

11 Q: Okay. But those assumptions were not included
12 at that time but then they were given to the
13 Department later if you turn over to page 710.
14 Are those the assumptions?

15 A: Those look like Steve's assumptions, yes.

16 Q: Okay. Now, you've got three documents in the
17 pro forma. The first document, which is page
18 643, just take a minute, is Trident Health
19 System without having a hospital in Moncks
20 Corner. I'm going to ask you if this is
21 correct and then we'll give you the whole
22 thing. Page two, 644, is the hospital in
23 Moncks Corner alone and then three is what the
24 combined would be, Trident Health Systems,
25 including the hospital, right?

- 1 A: It looks like -- I'm looking at --
- 2 Q: 645 would be three, I'm sorry.
- 3 A: Oh, okay. It's on the back. So the page 6, it
- 4 looks like 645, it looks like 645 is the sum of
- 5 644 and 643.
- 6 Q: Okay. And 644 is the hospital in Berkeley,
- 7 right?
- 8 A: That's correct.
- 9 Q: 643 is Trident Health System without the
- 10 hospital, right?
- 11 A: That's correct.
- 12 Q: Okay. What do you usually like to see in
- 13 regards to operating margin for your hospitals,
- 14 certainly Trident Health System?
- 15 A: Operating margin?
- 16 Q: Right.
- 17 A: You're talking about the EBITDA line?
- 18 Q: Well, let me -- let's talk about that for a
- 19 minute. Isn't the key financial metric for you
- 20 as a CFO in regards to profitability the EBITD
- 21 line earnings before interest, taxes, and
- 22 depreciation?
- 23 A: Well, what's key to us in the field is you
- 24 focus on operations. I mean EBITDA is what's
- 25 key for us in the field, certainly pre-taxed

1 income tells you about your profitability. We
2 speak to EBITDA in the field.

3 Q: Right.

4 A: At the hospital level.

5 Q: EBITDA also gives you your cash flow, right?
6 You always want to make sure that your revenue
7 covers your expenses, right?

8 A: Oh absolutely.

9 Q: Let me -- all right. Your operating margin
10 would be your EBITDA as a percentage of net
11 revenue, right?

12 A: Well, I guess something I need to point out,
13 though, you just made reference to cash flow.
14 It's a little different with HCA in terms of
15 management fees. Those are -- I'm looking at
16 this line right here below the EBITDA line
17 entitled management fees. And of course for
18 management fees HCA makes allocations to
19 hospitals on that so it's just an expense
20 allocation. If we weren't part of the
21 corporation, we'd be writing checks for those
22 allocations.

23 Q: Well, let's talk about that. They make an
24 allocation to you it's based on your EBITDA,
25 isn't it?

1 A: Not necessarily. The corporate office
2 determines what they're going to allocate to
3 us, but it covers all kinds of things like
4 legal fees for the folks that are at the
5 corporate office, real estate fees, it's an
6 allocation that they send to the individual
7 hospitals. If we weren't part of HCA, we'd be
8 writing checks for those line items.

9 Q: Yeah, but you wouldn't -- they don't send you
10 a statement and say you spent this much on
11 legal this year so you have to pay this. That
12 number is an allocated number decided by
13 corporate based on what they want to assign to
14 the hospital, right?

15 A: But it does include those items I just spoke
16 to.

17 Q: I understand that's the justification for it,
18 but the actual calculation of the number is
19 typically a percentage of how successful the
20 hospital is, right?

21 A: Or it may be an amount per adjusted patient
22 days. I don't make those allocations though,
23 Mr. Long, I can't give you an exact answer on
24 what goes to each one of HCA's hospitals.

25 Q: Well, you've worked at several different

1 hospitals at HCA, right?

2 A: I've worked at four or five, yes.

3 Q: Yeah, and the number is not the same for all
4 the hospitals, is it?

5 A: Oh, no.

6 Q: It varies based on your size and how much money
7 you make, right?

8 A: It used to be adjusted patient days.

9 Q: Okay. Which is --

10 A: Which was an amount per adjusted patient day
11 which would be size and not necessarily how
12 much money you make.

13 Q: Well, adjusted patient days, though, the higher
14 the adjusted patient days, the higher the
15 revenue, the net revenue of the facility,
16 right?

17 A: But you can't, you can't make the assumption
18 that just because the hospital has higher
19 patient days it's going to be that much more
20 profitable than a facility that has lower
21 patient days or lower adjusted patient days.

22 Q: It's not based on profit, it's based on -- if
23 it's based on adjusted patient days --

24 A: It was at one time. Let me state that again.
25 It was as one time. Today I couldn't tell you

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1 if that was the case for sure. I don't make
2 those allocations, that's decided by corporate.

3 Q: Right. And you're the CFO at the hospital in
4 Augusta, right?

5 A: Uh-huh (affirmative response).

6 Q: Okay. So you're just given the number for
7 Nashville?

8 A: That's correct.

9 Q: Okay. But I just want to clarify, if it is
10 based on adjusted patient days, the higher your
11 adjusted patient days, the higher your net
12 revenue would be. Seeing more patients, more
13 revenue; isn't that correct?

14 A: No, not necessarily.

15 Q: Well, if it is -- it may not be different for
16 one --

17 A: You can see all the patients in the world but
18 if you're in a market that it's all Medicaid
19 and self-pay, you're not going to be reflecting
20 much net revenue at all.

21 Q: Have you ever worked in a hospital for HCA that
22 was all Medicaid and all self-pay?

23 A: I can't speak to you off the top of my head
24 right now about Colleton, but I know that's an
25 area that is not as rich with HMO/PPO

1 population as Trident is or downtown as Roper
2 is, and I can promise you that their net
3 revenue per adjusted admission looks a whole
4 lot different than it does in Charleston.

5 Q: I know. But, Mr. Gorrell, you just used a
6 different term for the Court, net revenue per
7 adjusted admission. In other words, that's the
8 percentage --

9 A: Net revenue, either cash net --

10 Q: -- of the cash --

11 A: -- revenue or --

12 Q: Generally more people being treated by the
13 hospital means more net revenue. You'd have to
14 agree with that, wouldn't you?

15 A: It's a very general term. In general terms you
16 would think that would be the case, but you
17 have to look at each individual facility to
18 make a determination of that.

19 Q: When I deposed you back a few months ago and I
20 asked you about the key metrics that you look
21 at as the CFO, you told me EBITDA was the key
22 metric and you also looked at this percentage
23 of EBITDA in that revenue. Those were the two
24 that you mentioned to me, right?

25 A: Operations in the field were held accountable

1 for EBITDA is the number that we look at.

2 Q: Right. And if EBITDA didn't have revenue,
3 what's the second one that you mentioned?

4 A: That's a parameter that we do look at. EBITDA
5 is the key though.

6 Q: Okay. Other than lawyers and real estate fees,
7 anything else you can think of included in the
8 management allocation that you received from
9 Nashville?

10 A: Let me see, real estate, attorneys, that's
11 going to be a big part of it. Off the top of
12 my head, I'd have to think about that a little
13 bit, but any corporate departments that are
14 there. IT is another big one that are there,
15 that service us in the field, would be in those
16 management fees and IT would be a big one.

17 Q: Well you have IT people at your hospital,
18 right?

19 A: Uh-huh (affirmative response).

20 Q: Yes or no?

21 A: Yes, we do.

22 Q: And those people's salaries are included into
23 your pro forma and your, the people that work
24 in a Trident Health --

25 A: That's correct.

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1 Q: -- Center, they're included in your financials,
2 right?

3 A: That's correct.

4 Q: And so you're talking about IT for people in
5 Nashville primarily, right?

6 A: Uh-huh (affirmative response).

7 Q: I'm going to need you to answer, if you could,
8 Mr. Gorrell, because I'm following you on --

9 A: Oh, I'm sorry.

10 Q: -- the nods of the head --

11 A: Oh, yes, yes.

12 Q: -- but she can't.

13 A: I'm sorry, the answer to that is yes.

14 Q: Okay. Now, this management fee that is
15 allocated, it's an allocation, correct, in
16 other words you don't actually write a check as
17 the CFO to Nashville for the amount, do you?

18 A: That is correct. We do not write a check to
19 them.

20 Q: And in regards to -- all right, let's talk
21 about depreciation. The depreciation expense
22 that's reflected on the financials for Trident
23 Health System, is that money put into an
24 account to be used for Trident Health System or
25 is it rolled up to Nashville?

1 A: I'm not sure that I'm following you on your
2 question. We know what our asset base is, we
3 know what useful lives they are, and there's a
4 depreciable cost for each one of those assets,
5 we book that. Do we separate out and put cash
6 to fund that, we don't do it in that manner,
7 no.

8 Q: Okay. And it's actually similar to the
9 management fee, it's really an allocation on
10 the sheet, isn't it, I mean, there's no
11 depreciation expense or check that you're
12 writing to Nashville or the government, right?
13 It's an allocation.

14 A: But you need to produce profits, you need to --
15 you're showing an expense because what's
16 happening is a piece of equipment that's ten
17 years old, it's \$100,000 and you're
18 depreciating that \$10,000 a year, chances are
19 you're going to have to replace it at that
20 particular point in time. So while there's no
21 cash outlay, it's definitely a recognizable
22 cost or expense.

23 Q: I didn't say it wasn't a recognizable expense.
24 I'm not -- the point is on that the decision as
25 to when you should replace that equipment or

1 that asset for Trident Health System is made by
2 corporate in Nashville, HCA, isn't it?

3 A: Corporate funds the larger projects but we do
4 get routine capital every year and on a local
5 basis you can make decisions about when your
6 routine equipment needs to be replaced.

7 Q: And that routine capital that you use at
8 Trident Health System is assigned to you by
9 corporate, HCA, in Nashville, right?

10 A: That is correct.

11 Q: Typically if you want to apply for a project or
12 to make a capital investment at the Trident
13 Health System, you would have to get, you would
14 have to apply, in effect, with HCA, right?
15 You've got to ask for the funds, right?

16 A: Initially that goes to our division office.

17 Q: Okay. And the division office, of course, has
18 oversight of a number of different hospitals?

19 A: That's correct.

20 Q: Trident Health System is part of a division
21 with many other hospitals, right?

22 A: That's correct.

23 Q: Okay. There have actually been times when the
24 division has turned down a project when you
25 were at Trident Health Systems, like the

1 diagnostic center, right?

2 A: It's possible, yes.

3 Q: That actually did happen, didn't it?

4 A: Uh-huh (affirmative response).

5 Q: There was a proposal to do a diagnostic center,
6 it was about a three to five million dollar
7 project, the division rejected that, didn't
8 they?

9 A: Yes.

10 Q: And typically when you're making that kind of
11 application to HCA or to the division you would
12 submit pro formas to them or financials to
13 support the project, right?

14 A: Uh-huh (affirmative response).

15 Q: You would?

16 A: Yes, sir.

17 Q: And as part of that you would calculate a
18 return on investment percentage, right?

19 A: No, not necessarily.

20 Q: Typically you would, though, right?

21 A: Not necessarily.

22 Q: The projects --

23 A: An ROI, no, not necessarily. You would do pro
24 formas but just to see whether it looked like
25 it was profitable or not.

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RECORD 002351

1 Q: Was the diagnostic center going to be
2 profitable?

3 A: We reflected that it would have been profitable
4 and I'm going very much on recall here, from
5 memory, because I haven't looked at those pro
6 formas for a long, long time.

7 Q: Okay. But you projected it would be
8 profitable, right?

9 A: Yes.

10 Q: Did you ever submit a project to HCA, to the
11 division that was not going to be profitable;
12 ask them to do a project that did not show
13 would have been profitable financially?

14 A: I don't recall. Did we submit some that were
15 much closer to break even? I'm sure we did.
16 I don't recall if we ever submitted anything
17 that was not profitable. I just don't remember
18 that.

19 Q: And typically when ROIs are calculated for a
20 project, you'd like to see a return on
21 investment in the 20 percent range or a little
22 more, right?

23 A: That's normally -- a benchmark is for 20.

24 Q: Okay. Let me talk about the taxes at Trident
25 Health System. Trident Health System doesn't

1 actually pay corporate income taxes, does it?

2 It's rolled up to HCA who pays them, right?

3 A: We don't pay it on the local level. We do pay
4 income tax but that is determined by our
5 corporate office.

6 Q: Wouldn't it be accurate to say it this way,
7 that Trident Health System's income or profit
8 is rolled up to HCA who then pays the taxes for
9 the whole corporation, right?

10 A: There, I really can't speak to that, Mr. Long.
11 I know that there are -- I don't, I don't
12 oversee the tax structure, for example, in the
13 state of South Carolina, and I know that it is
14 rolled up, it's handled on a corporate basis
15 and I cannot speak to how the taxes are paid.

16 Q: Okay. Let me show you, if I could, I need to
17 --

18 MOTION - BY MR. LONG:

19 MR. LONG: Your Honor, at this time -- Your Honor, at
20 this time I would ask the Court to revisit the
21 Court's decision in regards to the HCA
22 financials. The testimony in the trial to date
23 has been Mr. Gallati testified that he was HCA,
24 Mr. Gorrell has just testified that about how
25 the finances, these allocations are handled by

1 HCA, that the division is in charge of these
2 capital expenditures, and we had submitted --
3 at this time in the case I would have asked
4 him, I'm not going to do that because of Your
5 Honor's ruling, but I would like maybe to
6 proffer it if Your Honor's not willing to
7 change it, about the financials for HCA in
8 regards to how much their net revenue was and
9 how much their net income was. And so I just
10 need to --

11 **THE COURT:** You'll have to be more specific. Refresh
12 my memory.

13 **MR. LONG:** Your Honor, we had submitted as proposed
14 Exhibits the 10-Ks for HCA, which were the
15 financials for the parent corporation. And Mr.
16 Thomas had moved to exclude those and we had an
17 argument, of course, here in the courtroom,
18 about, I think at the pre-trial hearing on the
19 12th and Your Honor ruled that they were out.
20 And so I've respected that in the trial, but I
21 would ask that you revisit it or if not, then
22 I would at least need to proffer the
23 information.

24 **THE COURT:** But make the connection for me between
25 your asserted need for them and this witness'

1 testimony.

2 **MR. LONG:** Well, this witness would be the person who
3 would know. He was the CFO for Trident Health
4 System, he's certainly familiar with
5 financials. I asked him in the deposition,
6 showed the financials to him and he gave the
7 numbers. Now, I would say, obviously Mr. Knapp
8 is capable of reading those financials and can
9 state, can testify to them. I didn't not ask
10 Mr. Baehr because I felt like it was more
11 appropriate to come in in our case as opposed
12 to trying to get it in through cross
13 examination. But I do think Mr. Baehr's
14 testimony supports the Court considering them.

15 **THE COURT:** Well, what I was really asking was is
16 this witness' testimony, has it changed the
17 landscape from when I initially ruled to
18 exclude those 10-Ks?

19 **MR. LONG:** I think his testimony has, along with Mr.
20 Gallati's testimony on Tuesday, when he
21 testified that he was HCA and he talked about
22 the inner relationship between Trident Health
23 System and HCA and I think Mr. Baehr's
24 testimony also did because he often talked
25 about, he talked about -- he testified about

1 the institutions for HCA kind of competing for
2 capital dollars, that was one of them, and the
3 decision about whether to, whether the project
4 was financial feasible or not. He also
5 testified that he had considered in other
6 cases, that was my question about the open
7 heart case, the overall financial health of the
8 parent as a factor for the Court to consider on
9 the adverse impact issue.

10 **THE COURT:** The last thing you mentioned is the thing
11 that I remember most.

12 **MR. SUMMER:** Your Honor, can I respond?

13 **THE COURT:** Yes.

14 **RESPONSE - BY MR. THOMAS:**

15 **MR. THOMAS:** First of all, again, the guide book
16 we're looking at that is CON 61-15 and it sets
17 out the financial parameters for us. It
18 doesn't mention anything about corporate
19 financials, it doesn't mention anything about a
20 corporation's overall ability to take a hit,
21 DHEC never asks for them below. And I would
22 also say that this witness is not qualified to
23 speak to those 10-Ks. He doesn't prepare them.
24 He doesn't know how the allocations work. He
25 doesn't know about the distributions to stock

1 holders. Those things are prepared, they're
2 10-K filings with the Securities and Exchange
3 Commission. They're very complicated
4 documents, they're over 400 pages long when you
5 consider all of the appendices and indexes. So
6 this witness is not the witness to even talk
7 about these. He just said that in terms of the
8 taxes and how they're paid at the corporate
9 level he doesn't know the exact allocation. He
10 does know the taxes are paid because it's a
11 for-profit company. But this isn't the
12 witness. And, you know, we're not going to
13 bring the CFO from, I mean, HCA, Your Honor.

14 **THE COURT:** Mr. Long?

15 **REPLY - BY MR. LONG:**

16 **MR. LONG:** Well, I would say in regards to the
17 Nashville thing, I told them in the case I
18 wanted to depose some of those people, you
19 objected and I respected that. But now I would
20 say to the Court that, I mean, Mr. Knapp is an
21 expert -- the questions that I want before the
22 Court are really, the documents are fine, they
23 are very voluminous, I really just want the
24 very basic information that I got from him in
25 his deposition, which is the HCA net revenue

1 numbers and the HCA profit numbers, and the HCA
2 EBITDA number for the corporation. And I did --
3 he found those in the documents and testified
4 to them, I think correctly. If he -- my point
5 is that I would have one more line of
6 questioning, I should have asked that before I
7 brought this to the Court's attention, that's
8 page 641 of the application, which is how the
9 project would be funded. I could ask him one
10 or two questions about that I think which would
11 further show that it's HCA who's actually on
12 this issue. I would -- if Mr. Thomas will
13 allow me to proffer -- as long as the Trident
14 -- Mr. Thomas doesn't say through Mr. Knapp's
15 testimony that I should have asked somebody
16 else earlier in the case, I can defer, Your
17 Honor, if Your Honor would prefer to think
18 about it. I do think it's a fairly specific
19 fact that I want in that I want the Court to
20 consider. And I do think he can testify to it
21 and so can Mr. Knapp.

22 **RULING - BY THE COURT:**

23 **THE COURT:** I really think my original ruling was
24 correct so I'm going to deny your motion. Now,
25 if something else should appear later in the

1 testimony and you want to renew it, then I'll
2 hear it. But I just don't think that the 10-Ks
3 are material.

4 **MR. LONG:** Okay. Your Honor, what I would ask, what
5 I would like to do, if there's no -- if Your
6 Honor is permitting it, I would like to just
7 write out a proffer for it and submit it
8 because it's really -- the proffer, which I
9 would have him testify to, is just a few lines
10 in his deposition. I think we already actually
11 drafted it. Would that be fine to just submit
12 it as a proffer in writing.

13 **THE COURT:** Sure.

14 **MR. SUMMER:** Your Honor, obviously we can't object to
15 a proffer, by law he's entitled to have his
16 proffer, as long as Your Honor's not going to
17 admit it into evidence, a reasonable proffer is
18 something we can't prevent.

19 **THE COURT:** I agree with you. You at least want to
20 look at it, I presume.

21 **MR. THOMAS:** I've seen it. I've seen it.

22 **THE COURT:** Very well. You can offer it as a
23 proffer.

24 **MR. LONG:** In writing?

25 **THE COURT:** Yes.

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1 MR. LONG: Okay. We'll do that, Your Honor. We'll
2 probably bring that over tomorrow or something,
3 if that's okay, or later today.

4 MR. GORRELL - CONTINUED DIRECT EXAMINATION BY MR.
5 LONG:

6 Q: Mr. Gorrell, will you look at page 641 in the
7 application just quickly. The Berkeley, the
8 financing for the Berkeley Regional Medical
9 Center has been part of your purview in the
10 application, right, as part of the financials,
11 right?

12 A: Yes.

13 Q: How it would be paid for? And this letter was
14 obtained from HCA in regards to how it would be
15 paid for?

16 A: Yes.

17 Q: And HCA will actually pay to build the
18 hospital, correct? That's what this letter
19 says?

20 A: That is how we do it. It is paid by the
21 company.

22 Q: And that's typical of capital projects at
23 Trident Health System; is that correct?

24 A: Yes.

25 Q: Okay. Now, during your time as CFO at Trident

1 Health System you supported the hiring, the
2 employment of physicians?

3 A: Yes, I would. The employment of our own, yes,
4 physicians.

5 Q: And during that time there were surgeons who
6 were supportive to Trident and you supported
7 their employment in your role as CFO?

8 A: Yes.

9 Q: And at -- and during the time that you were at
10 Trident Health System I believe you testified
11 that typically any losses that might be
12 incurred from the employment of physicians
13 would typically be kind of offset by the gains
14 in the ambulatory surgery facility? That was
15 intended to kind of wash out on the balance
16 sheet?

17 A: Well, your hope, of course, is that the
18 physician, if their set of books reflects a
19 loss, that hopefully through surgeries that
20 they do or admissions and outpatient procedures
21 that they perform, that hopefully it will get
22 to a break even point or do a little better.

23 Q: Okay. And typically the physicians that were
24 hired during the time that you were there were
25 physicians who were already aligned with

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1 Trident, where physicians already intended to
2 use the facility?

3 A: I've got to speculate on that just a little
4 bit, Mr. Long, because I wasn't in charge of
5 that. I didn't make the call as to what
6 physicians were hired. In fact, we've got a
7 separate division of the company that actually
8 is in charge of physicians that are employed.

9 Q: And they actually go through the analysis of
10 whether to hire them, they approve the hiring
11 and determine what the package would be for the
12 purchase of the practice and the employment of
13 the physician, right?

14 A: They do work with the hospital on that, but
15 that's not anything I oversee.

16 Q: All right. Now, let's look at the Trident
17 Medical Center financials. Let's look at
18 Petitioner's, I mean Respondents' 151. And you
19 probably, you might want to look at the book on
20 this and I don't think it's in that one, I
21 believe it's in this one right here. Now,
22 Respondent, actually Respondent 150, if you go
23 back one Exhibit, when you get there let me
24 know.

25 A: I'm not there yet.

1 Q: Okay.

2 A: My numbering scheme is where for 151?

3 Q: 151 and then 150 is right before.

4 A: Okay. The 151 that I'm looking at looks
5 different than what I'm looking at here.

6 Q: You're looking at 150 on the screen. I'm
7 sorry. Can you go back one? All right. 150
8 is the, if you take a minute to look at it, is
9 the financials from 2007 through 2009; isn't
10 that correct?

11 A: What I see through -- and then through April of
12 2010.

13 Q: Well, the 2010 is Exhibit, is Petitioner's 151
14 that you were just looking at. So if you
15 would, let's just start with 150 and I'm going
16 to ask, I mean, I'm going to ask you a couple
17 quick questions on 150 and then I'm going to
18 switch over to 151. In regards to the income
19 statement for 2007, 8 and 9, is the bad debt
20 line above or -- is the bad debt expense above
21 or below the net revenue?

22 A: For '07 it is below. I'm just reading it
23 straight from the financials.

24 Q: Right. That's what I need you to do. Because
25 you're familiar with these; this is part of

- 1 your job to actually prepare those, right?
- 2 A: Yes. Seventy-nine million I'm looking at and
- 3 that's below the net revenue line for 2008.
- 4 And 2009, we're looking at 76 million, it is
- 5 below the line.
- 6 Q: Okay. Don't worry about '10, we'll go to the
- 7 other Exhibit on that. Because the '10 on that
- 8 Exhibit is not --
- 9 A: And that's the way that they are on these
- 10 particular, these particular financials.
- 11 Q: Okay. Now, take a look at the next Exhibit
- 12 which is Petitioner's 151 and tell me if the
- 13 bad debt expense, I'm sorry, Respondent 151, I
- 14 misspoke, Your Honor, and tell me on that
- 15 financial statement if the bad debt expense is
- 16 above or below the revenue line, the net
- 17 revenue line.
- 18 A: In the financials that I'm looking at on
- 19 Exhibit 151, they are above the line such that
- 20 you derive cash revenue.
- 21 Q: Right. So basically that bad debt on the
- 22 financial statement is an expense, right?
- 23 Those are uncollected charges, right?
- 24 A: They're --
- 25 Q: Let me ask you to define it. I'm sorry.

1 A: It's an estimate of your uncollected charges.

2 Q: Okay. And so sometimes on the financial
3 statement people put it above and consider it
4 like revenue and then sometimes people consider
5 it as an expense, right?

6 A: It can be used both ways.

7 Q: Why did you switch it from 2009 to 2010?
8 Because in 2007 through '09 you consider it as
9 an expense, below the net revenue line, but in
10 2010 you considered it as a part of revenue and
11 put it above the line.

12 A: It was a company decision, I mean, all the
13 financials that we pull down each month, each
14 year, switch to kind of a cash net revenue look
15 and it went from being an expense to being
16 included in your revenue deduction so that you
17 ended up with a net revenue number that
18 included the bad debt expense.

19 Q: Okay. So if you were to drop the bad debt
20 expense in 2010 below the line, the net revenue
21 for 2010 would increase by \$68,783,000,
22 wouldn't it?

23 A: Yeah. Mathematically if you chose to do that,
24 sure. It would come off of this line and it
25 would go on the expense line.

1 Q: Okay. And let's talk about charity. Is the
2 same thing occurring with charity; was there a
3 change from 2009 to 2010 in regards to the
4 charity expenses?

5 A: No, it should have really only been the bad
6 debt. That should --

7 Q: It was only the bad debt, wasn't it? The
8 charity was above the line --

9 A: Correct.

10 Q: -- in the earlier years, so there's no
11 difference there. So if you were going to
12 compare the net revenue from 2009 to 2010, you
13 would need to take the bad debt and drop it
14 below the line, wouldn't you?

15 A: And compare apples and apples --

16 Q: Yes.

17 A: -- sure.

18 Q: All right. Can you do the calculation for me
19 quickly of telling me what the 2010 net revenue
20 would be if you dropped the bad debt expense
21 below the line? I have a calculator here if
22 that helps you.

23 A: So for these financial statements that I'm
24 looking at for December 2010, just looking at
25 the net revenue line, you would take the

1 370,688 and you would add the 68,783 in the bad
2 debt to come up with 439,471 just to make a
3 comparison to a financial that would also
4 include bad debt above the line.

5 Q: 439,471?

6 A: 439,471.

7 Q: Okay. Can you do a favor for me? On a copy of
8 Respondents' Exhibit 160 could you write down
9 that number that you just calculated above the
10 net, write down the calculation that you just
11 did on that page? Can you write the numbers?
12 I can give them back to you if you need to. I
13 want a record on this sheet of paper for what
14 you --

15 MR. THOMAS: Let me ask you this, are you going to
16 submit this as a new Exhibit?

17 MR. LONG: I can or -- I can.

18 MR. THOMAS: We don't think you should be allowed to
19 modify the current Exhibit.

20 MR. LONG: Okay. I agree to that. So would you
21 agree with me submitting it as a new Exhibit,
22 his handwritten change?

23 MR. SUMMER: As long as we get to do the same math,
24 we'll play with it too.

25 MR. LONG: Sure.

- 1 Q: Yeah, would you make that -- do you have a pen?
2 I believe you said you took 370,688 plus 68
3 million, you want to take that 2010 number,
4 68,883 --
5 A: I'm looking at 370,688.
6 Q: Right. Plus --
7 A: You want me to -- oh, you want me to put a plus
8 next to this number?
9 Q: If you would, so it will be clear what the
10 calculation was that you did. And add the
11 68,783,000.
12 A: Okay.
13 Q: Write down the total of that, which is 439,000.
14 A: Can I just write it right next to it?
15 Q: Sure.
16 A: Okay. 439,471, is that the number that I gave
17 you from before?
18 Q: It is. I'm going to get you to do one more
19 calculation on the sheet, if you would. Would
20 you take the total revenue number that's listed
21 at the bottom and add another 68 million
22 783,000 --
23 A: You mean the expense number that's at the
24 bottom?
25 Q: The total net revenue number at the bottom.

1 A: Okay.

2 Q: Just add to that or you can mark through it and
3 write and add 68,783,000 to that and write down
4 the total of that number.

5 A: So, Mr. Long, you're speaking to the one
6 million 504?

7 Q: Correct.

8 A: And you want me to add that same 68,783?

9 Q: Yes, 68,783,000, and then if you would, tell me
10 or tell the Court what the total was.

11 A: I've got 504,243,431..

12 Q: 431?

13 A: Yes.

14 Q: So the total number would be one billion 504
15 million, 243,431, if you drop the bad debt
16 expense below the line?

17 A: Well --

18 Q: Did you not do the calculation -- you've got
19 the calculator.

20 A: Yeah. I don't know where the 1,504 -- that was
21 already on this piece of paper, I simply added
22 68,783 to it to come up with the 504,243,431.

23 MR. THOMAS: Did you say one billion?

24 MR. LONG: Yeah, because that's the total net
25 revenue for the four years.

1 MR. THOMAS: All right. I got you.

2 Q: Thank you, Mr. Gorrell. We would -- I guess
3 this would become Respondents' Exhibit?

4 COURT REPORTER: 167.

5 MR. LONG: 167.

6 THE COURT: Without objection.

7 (Respondents' Exhibit Number 167 was marked for
8 identification purposes.)

9 MR. THOMAS: No objection, I just need a copy later.

10 MR. LONG: Sure. We'll just leave that up here if
11 we would, we'll deal with that one. 167,
12 right?

13 Q: Now, the actual bad debt expense that's on the
14 financials is an estimate, correct?

15 A: Yes, it is.

16 Q: Now, tell me the difference on the financials,
17 on the Trident Health System financials, the
18 difference between charity care, the charity
19 line and the bad debt line.

20 A: The charity care, for the most part, you know
21 that the patient has no ability to pay and so
22 it's written off to charity.

23 Q: And how does Trident Health System determine
24 whether someone's charity or whether someone's
25 bad debt?

1 A: They normally go through an application
2 process.

3 Q: So each of the people that are listed on the
4 charity number there were, those are actual
5 patients who applied for the designation of
6 charity care, right?

7 A: That should be, for the most part, yes.

8 Q: You have an allocation at HCA as to how much
9 charity the individual hospital would accept?

10 A: I mean, it is -- it is what it is. There's --
11 I'm not aware of any HCA guidelines that
12 determine what our charity should be.

13 Q: Well, how does Trident Health System -- well,
14 who makes the decision as to whether somebody's
15 charity or not? Is it made in Nashville at HCA
16 or is it --

17 A: No.

18 Q: -- made locally?

19 A: It's determined locally. Either somebody
20 qualifies or they don't.

21 Q: Well what are the qualifications?

22 A: Income levels. I don't know what those are
23 specifically. It's usually look at Medicaid
24 and 200 percent of the poverty guidelines,
25 anything below that is normally a charity

1 account. But you determine that on the front
2 end. They sit with an individual patient
3 counselor and it's determined locally.

4 Q: Okay. If they receive the service before they
5 apply for charity, does HCA allow them to apply
6 later for charity or is that something that has
7 to be determined before the service is
8 rendered?

9 A: No, it could be determined retrospectively, I
10 believe.

11 Q: Okay. Do you know that for certain?

12 A: No.

13 Q: Okay. Thank you. I just have one --

14 MR. LONG: I just beg the Court's indulgence for a
15 moment, Your Honor.

16 THE COURT: Yes, sir.

17 Q: I did have another Exhibit here that I meant to
18 cover with you earlier, two more Exhibits that
19 I forgot earlier. Well, first, before I do
20 that, Mr. Gorrell, any time when you were the
21 CFO at Trident Health System did you ever make
22 any -- did you ever, personally or anybody that
23 was under you, make any sort of analysis to
24 determine what the impact would be financially
25 to the Roper Berkeley, to the Trident Berkeley

1 Regional Medical Center, Trident facility, if
2 both hospitals, the hospital in Moncks Corner
3 and the hospital in Carnes Crossroad are built?

4 A: Did we locally do an adverse impact analysis or
5 anything like that; is that what you're
6 speaking to?

7 Q: Well, you can answer that. That's not really
8 the question I asked you. I'll ask you that
9 one next. The question that I'm asking was
10 there any time that you or anybody locally that
11 worked for you or anybody that you're aware of
12 at HCA that ever did a determination or a
13 calculation as to what the impact would be if
14 both Trident Health System built a hospital in
15 Moncks Corner and Roper St. Francis built a
16 hospital in Carnes Crossroads; what the
17 financial impact would be?

18 A: No, we did not do that.

19 Q: Okay. And did you ever do, internally, you,
20 anybody that worked under you or anybody that
21 you're aware of at HCA corporate, do a
22 determination as to what the impact would be to
23 Trident Health System if a hospital was built
24 by Roper St. Francis at Carnes Crossroads?

25 A: No, we did not do that, but I did get a glance

1 at Mr. Baehr's analysis on that. But we did
2 not do that locally.

3 Q: Okay. But did you participate in that analysis
4 at all?

5 A: No. We relied on the consultant to do that.

6 Q: Was the first time you ever saw it at project
7 review?

8 A: I'll be honest with you, I don't remember
9 when's the first time I saw it. I know that
10 Mr. Baehr sent it over, maybe via email, and
11 that's when I looked at it. I don't believe it
12 was at that project review, but I don't recall
13 what that exact day was.

14 Q: It would have been shortly before, right?

15 A: Most likely.

16 **THE COURT:** Mr. Baehr's letter that you just
17 mentioned, that's in the record; is it not?

18 **MR. LONG:** Mr. Baehr's letter is and he's talking --

19 Q: You're talking about the PowerPoint
20 presentation that was presented at project
21 review or are you talking about the --

22 A: No.

23 Q: -- letter?

24 A: There was like an email and a one page document
25 that made reference to what the impact would

1 be.

2 Q: Okay. Do you remember if that was before or
3 after you went to project review?

4 A: I don't recall. About that same time. I don't
5 know if it was before or after, I don't recall.

6 Q: Okay. Now, after you did the -- after the CON
7 application was filed in August of 2008, I'd
8 asked you some questions earlier about your
9 dealings with Mr. Woodford, I wanted to show
10 you two Exhibits. Respondents' 105. Now, this
11 is an email from Mr. Ronnie Midgett, who you
12 testified earlier, worked for you as the
13 comptroller to you and Mr. Rardin, and he says,
14 he sends you, he forwards you an email from Mr.
15 Tom Davidson and says, "I just got a call from
16 this individual who's working with Andrea on
17 her Berkeley hospital CON and he's requesting
18 information related to our volume assumptions
19 for the project. I can dig through Steve's
20 worksheets and get him what he needs, but I
21 don't want to fax him anything until I'm sure
22 it's appropriate. Have either of you heard of
23 Tom Davidson and is it appropriate to give him
24 this information?" So in March of '09 Mr.
25 Midgett didn't know who Mr. Davidson was, did

1 he?

2 A: Obviously by this email, either he didn't know
3 who he was or he forgot that he worked with Mr.
4 Baehr.

5 Q: Did you know when you got this email who he
6 was?

7 A: As I testified to earlier, we did not -- we
8 worked primarily with Steve Woodford, Ronnie
9 and I did. We didn't have, throughout the
10 course of this, that much direct contact with
11 either Mr. Baehr or Mr. Davidson. So he could
12 have known him and forgotten about it or he
13 didn't know him at all.

14 Q: When you say testified earlier, are you talking
15 about today or in your deposition?

16 A: Both.

17 Q: Okay. On this email Steve is Steve Woodford,
18 right?

19 A: Correct.

20 Q: Steve's worksheets?

21 A: Yes.

22 Q: Okay. And next and final Exhibit would be
23 Respondents' 106. Now, this is an email
24 exchange between you and Mr. Rardin. This is
25 April of '09. And Jim, Mr. Rardin sends an

1 email to you and Mr. Midgett, "I really hate to
2 do this, however, since Steve Woodford is no
3 longer a paid consultant with us I will need
4 one of you to become the expert of the Berkeley
5 hospital numbers, that means going to Columbia.
6 I think we could bring Steve in one more time,
7 I'll take him out to dinner and go through the
8 assumptions. Guys, again, really sorry about
9 this time frame, as the project review will
10 most likely be late May." So that's Mr. Rardin
11 telling you you're going to have to get more
12 involved in the project, right, because Mr.
13 Woodford's out of the picture?

14 A: That's what he's saying in this email. That's
15 correct.

16 Q: And that's what happened, right? Mr. Woodford
17 wasn't involved.

18 A: Did anything really develop beyond this point
19 from this email, not really. I just made him
20 aware that I do what he needed me to do.

21 Q: Right. Because you actually respond to it, not
22 Mr. Midgett, and you say, "Let's meet and go
23 through it. After you speak to the lame duck
24 bring me up to speed, I'll need to be the one,"
25 right?

1 A: Yes.

2 Q: Okay. And that was the plan, that you would be
3 the person that would be the point person on
4 the financials, right?

5 A: Whatever Jim needed.

6 Q: In regards to the financials?

7 A: That's right.

8 Q: For the CON application?

9 A: That's correct.

10 Q: Okay. Thank you, Mr. Gorrell, I appreciate you
11 coming up here today for your testimony.

12 A: Yes, sir. Thank you.

13 Q: You're not finished yet. Mr. Thomas will have
14 some questions for you possibly.

15 MS. BIGGERS: Your Honor, I don't have any questions.

16 MR. LONG: Or Ms. Biggers.

17 THE COURT: Thank you, Ms. Biggers.

18 MR. THOMAS: I'd like to -- can I get a copy of that
19 Exhibit during a short break?

20 MR. LONG: No objection.

21 MR. SUMMER: He created an Exhibit and if the Court
22 doesn't mind, we'll take a short break and get
23 copies.

24 THE COURT: Well, let's just stay in place and step
25 and hand it out to the lady out at the desk and

1 have her copy it at my direction.

2 MR. LONG: I'll do that, Your Honor.

3 MR. GORRELL - CROSS EXAMINATION BY MR. THOMAS:

4 Q: Hello, Mr. Gorrell.

5 A: Hello.

6 Q: You're the CFO of Doctors Hospital in Augusta,
7 correct?

8 A: That's correct.

9 Q: That's an HCA facility?

10 A: That's correct.

11 Q: What's kind of unusual about that facility?

12 A: It's a little different in that it has a burn
13 unit there. It's a center point for burns in
14 the U.S., 70 beds and it makes it a little
15 different than your normal tertiary or med-surg
16 hospital.

17 Q: It's one of the largest burn units in the
18 world, isn't it?

19 A: Yes, it is.

20 Q: You were telling me the other day about a case
21 you had about five million dollars in charges;
22 do you remember that?

23 A: Yes.

24 Q: How much did you get paid on that one?

25 A: I think in the final analysis we'll end up --

1 on a six million dollar case getting about
2 \$700,000 most. We're still working on that.
3 It may be much less than that.

4 Q: Is that a very profitable unit for the
5 hospital?

6 A: It is, but it's a mixed bag. There are some
7 cases we get paid well on and there's a lot of
8 folks that go in that unit that run up a lot of
9 charges that we don't collect a dime on.

10 Q: You absorb those, right?

11 A: Yes.

12 Q: Now, Mr. Long talked to you a little bit about
13 consolidated financials for the system, the
14 Trident System, they are consolidated, correct?

15 A: That's correct.

16 Q: Okay. But Trident, in the division, doesn't
17 look at a project based on whether or not the
18 system can simply absorb those charges, does
19 it?

20 MR. LONG: Your Honor, I'd have to object. Now, I
21 mean, I did give him a little leeway on the
22 first couple questions, but I don't think it's
23 appropriate for Mr. Thomas to lead.

24 MR. THOMAS: Oh, I can lead all day, Your Honor, this
25 is cross examination.

1 MR. LONG: Well, Mr. Gorrell works for HCA, he's a
2 previous employee of Trident Health System and
3 I don't believe Ms. Biggers was allowed to lead
4 on the DHEC witnesses, to my recollection.

5 MR. THOMAS: Mr. Long led on Ms. Brandt all day long,
6 Your Honor.

7 MR. LONG: I'm allowed to lead DHEC because they're
8 not a party, they're not the same thing as my
9 party.

10 THE COURT: Do you want to cite me some law on
11 leading on cross examination.

12 MR. THOMAS: Cross-examination. Scope of cross
13 examination, the witness may be cross-examined
14 on any matter relevant to any issue in the case
15 including credibility. Leading questions
16 should not be used on the direct examination of
17 a witness. Ordinarily leading questions should
18 be permitted on cross examination. It's the
19 law.

20 THE COURT: What do you say, Mr. Long?

21 MR. THOMAS: If I may say something, that's a risk
22 you always take when you call the opposing
23 party's witnesses in your own case and that's
24 what Mr. Long's done here. He didn't have to,
25 but he did.

1 MR. LONG: Well, Your Honor, I just think -- I don't
2 have the case law, Your Honor. I thought -- I
3 believe the case law in South Carolina is that
4 if you call, if the witness is clearly not
5 hostile to you, even if it's cross examination,
6 the questions should not be leading. I didn't
7 bring the case with me today. I apologize.

8 THE COURT: Overruled.

9 MR. THOMAS: Thank you, Your Honor.

10 Q: I'm not sure you answered the question, Mr.
11 Gorrell, so I'll ask it again. Trident as a
12 system in the division, they don't look at the
13 project based on whether the system can simply
14 absorb the cost of a new project or the loss
15 associated with that project, do they?

16 A: That's correct. They do not look at that.

17 Q: Okay. And just for the record, Mr. Woodford,
18 you said, you know, that he was the division
19 CFO, can you explain to the judge what that
20 means? He was the division CFO when you were
21 the CFO of Trident?

22 A: Right. Right. At one time in the southeastern
23 division there was actually locally there in
24 Charleston, Mr. Woodford was in that role at a
25 division level. The hospitals report to the

1 division. I actually reported directly to him
2 at that point in time. So he was actually my
3 supervisor at one point in time.

4 Q: Okay. And wasn't he actually the CFO of
5 Trident Health System at one time?

6 A: Yes, he was.

7 Q: Okay. So a guy in charge of doing the
8 financials for this project had been a CFO for
9 Trident Medical Center and the division CFO
10 that included Trident, correct?

11 A: That is correct.

12 Q: Okay. And Mr. Midgett, who is he?

13 A: He was my comptroller. Ronnie was very, very
14 good. He was in the health system for several
15 years; was promoted throughout from a staff
16 accountant to a comptroller, I'm sorry,
17 assistant comptroller to controller, and
18 eventually became a comptroller. He's
19 currently the comp, I'm sorry, became a CFO,
20 the chief financial officer, and he's currently
21 the CFO at Colleton-Walterboro.

22 Q: So he was just -- he was promoted from
23 comptroller or comptroller at Trident to CFO at
24 Walterboro?

25 A: That's correct.

1 Q: And Mr. Woodford, after he was the consultant,
2 well, did he hold any other jobs as CFO in the
3 Charleston area?

4 A: Yeah. He at one point was at the Medical
5 University, I believe, in that capacity over
6 one of the psych units, I believe it was. He
7 did do some other work. He was also at Tenet,
8 he was the CFO there for awhile at East Cooper.

9 Q: Okay. Now, this wasn't just some random
10 consultant that had no --

11 A: Oh, no.

12 Q: -- connection to Trident; is that correct?

13 A: That's correct.

14 Q: All right. In this case you participated in
15 the financials by reviewing the work of Mr.
16 Midgett and Mr. Woodford?

17 A: That's correct.

18 Q: Okay. And you sat down with them and actually
19 went through the various expenses and revenue
20 line items, correct?

21 A: Yes, we did.

22 Q: And you found them to be reasonable and the pro
23 forma estimates to be reasonable?

24 A: Very much so.

25 Q: Now, the pro formas in the CON applications,

1 those comprise the financial analysis that was
2 done for the project, correct?

3 A: That's correct.

4 Q: You had no ROI, right? You didn't do an ROI
5 analysis?

6 A: That's correct.

7 Q: Were you asked to do an ROI analysis?

8 A: No, I was not asked to do an ROI.

9 Q: And the decision to determine the financial
10 feasibility of the project was made by the
11 division and for them to do that it was to do
12 the pro formas, right?

13 A: Correct.

14 Q: Based on information that you received from Mr.
15 Baehr and Mr. Davidson?

16 A: Correct.

17 Q: Now, if you had seen serious losses or
18 significant profits on the pro formas that Mr.
19 Woodford had done, would that have concerned
20 you?

21 A: Oh yes. Large, large, large profits I would
22 have been very concerned. I would have been
23 concerned on a loss too. So they seemed
24 reasonable to me.

25 Q: And if you'd seen unreasonably large profits or

1 serious losses on those pro formas for Berkeley
2 Medical Center, is that something you would
3 have brought to the attention of Mr. Rardin?

4 A: Oh, yes.

5 Q: But you thought the bottom line was reasonable?

6 A: Reasonable.

7 Q: And when you sat down to review these pro
8 formas did you have any indication whatsoever
9 that there would be another hospital CON
10 application was going to be filed --

11 A: No.

12 Q: -- for Berkeley County?

13 A: Not at that time, no.

14 Q: Do you recall testifying in your deposition
15 with Mr. Long that you would expect that
16 hospital operating in Moncks Corner with
17 another hospital operating in Carnes Crossroads
18 would have a significant financial impact on
19 Berkeley Medical Center?

20 **MR. LONG:** Objection, Your Honor. He just testified
21 on direct that he had no knowledge of that,
22 never did those calculations.

23 **MR. THOMAS:** I didn't ask him if he did a
24 calculation. I'm asking him if he thought, he
25 testified to this in his deposition, whether or

1 not it would have a significant financial
2 impact on Berkeley Medical Center.

3 **MR. LONG:** Which would call for speculation and an
4 opinion which he's not able to do because he's
5 not an expert and he would be speculating based
6 on the testimony.

7 **THE COURT:** Sustained.

8 **MR. THOMAS:** Your Honor, I'd like to respond because
9 Rule 701 allows fact witnesses to offer an
10 opinion. And this opinion by lay witnesses, I
11 could read it into the record, Your Honor.

12 **THE COURT:** Very well.

13 **MR. THOMAS:** If the witness is not testifying as an
14 expert, and, Your Honor, we do not designate
15 him as such, the witness' testimony in the form
16 of opinions or inferences is limited to those
17 opinions or inferences which are rationally
18 based on the perception of the witness, are
19 helpful to a clear understanding of the
20 witness' testimony or determination of a fact
21 at issue, and do not require special knowledge,
22 skill, and experience or training. But I would
23 tell you here, Your Honor, the chief financial
24 officer, at the time he was, of Trident Medical
25 Center, you know, he's been doing this a long

1 time, that what he testified to in his
2 deposition was that, he was asked specifically
3 what type of impact another hospital would have
4 in Berkeley County on Berkeley Medical Center,
5 he thought --

6 MR. LONG: Your Honor, I asked --

7 MR. THOMAS: -- there would be significant losses.
8 So that's something within his purview just
9 like Mr. Gallati got up there and testified as
10 well.

11 THE COURT: Well, if he had done any analysis, I
12 would agree with you that he could give an
13 opinion. But he said that he has not given an
14 analysis. Objection is sustained.

15 Q: Go to Petitioner 177, for me, Sara. Let's see,
16 I might need to get this for you. Let me ask
17 you this.

18 MR. THOMAS: And, Your Honor, I'm sure Mr. Long will
19 cut me off if I go too far.

20 Q: But when you learned that there was going to be
21 another hospital and it would be built in
22 Berkeley County at the same time as Berkeley
23 Medical Center, did that concern you?

24 A: Yes, it did.

25 Q: Why?

1 MR. LONG: Your Honor, I object. He's still asking
2 him for opinions.

3 MR. THOMAS: He's a fact witness in a --

4 THE COURT: I disagree strongly there. Overruled.

5 Q: Okay. Why did it concern you?

6 A: I knew that Roper is a well recognized name and
7 can be a fierce competitor. I mean, I would
8 worry greatly about them building a hospital in
9 the area.

10 Q: And why?

11 A: Those patients are already, for the most part,
12 seen by Trident Health System and in my mind
13 this would, they would be taking patients that
14 are currently being served by Trident Health
15 System to this competitor, Roper. That would
16 be a big concern of mine.

17 Q: The concern would be that there might have an
18 adverse impact on the Health System?

19 A: Oh, absolutely.

20 Q: I'm handing you what's been marked Petitioner's
21 177.

22 MR. THOMAS: It's going to show up there on the
23 screen, Your Honor.

24 Q: Okay. This is an email that's originally from
25 Ms. Brisbin from my law firm to you, correct?

1 A: Correct.

2 Q: And it says attachment Roper impact on Trident
3 Systems, correct?

4 A: Correct.

5 Q: Okay. Will you turn to page, to Trident 432 in
6 Exhibit 177? This bottom line there says
7 reduction in Trident System net income -- well,
8 first of all, let me ask you this. You
9 received this, correct, in June of 2009; is
10 that right?

11 A: June, that's correct.

12 Q: So this is an adverse impact analysis that Mr.
13 Baehr had done that you had seen; is that
14 right?

15 A: That's correct.

16 MR. THOMAS: Your Honor?

17 MR. LONG: Your Honor, I would object to that. It
18 doesn't say that. I mean, if he wanted to talk
19 about all this, he should have done that with
20 Mr. Baehr. It doesn't say it's from Mr. Baehr
21 and he obviously didn't -- there's no
22 foundation laid on his role with it. Somebody
23 just sent an email and said look at this and
24 he's getting ready to ask him his opinion on
25 it.

1 THE COURT: Mr. Thomas, your response?

2 MR. THOMAS: I can lay some more foundation.

3 Q: You received this from Ms. Brisbin?

4 A: Yes.

5 Q: Do you think she did that adverse impact
6 analysis?

7 A: No, I do not.

8 Q: What was your understanding of where this
9 document originally came from?

10 A: Where it originally came from was Mr. Baehr,
11 that was my understanding.

12 Q: And that might actually be because on the front
13 page it says from Richard Baehr, right?

14 A: Yes, sir.

15 Q: And the subject line is impact analysis; is
16 that right?

17 A: That's correct.

18 Q: Let's go to Trident 432, if you would, and it
19 says reduction in Trident System income
20 \$209,000. What's the reduction each of the
21 years, 2013, 2014, and 2015?

22 A: Seven million, 12 million, 14 million.

23 Q: Okay. So when you saw that was that something
24 that concerned you?

25 A: Yes, it did.

1 Q: Did you think that was a material adverse
2 impact on the Trident System?

3 MR. LONG: Objection, Your Honor, that is calling for
4 an opinion. And in regards to 701, the witness
5 actually, Your Honor, he hasn't met any of the
6 three characteristics of 701 to give opinion
7 testimony and he has to meet all three. Okay?
8 You roll through them here, these are not
9 rationally based on his perceptions. He didn't
10 do the document, he hasn't done any analysis of
11 it, he testified that he didn't do anything.
12 It's helpful to a clear understanding of the
13 witness' testimony or determination of fact at
14 issue, okay, this witness is here testifying as
15 a factual basis and he didn't do the
16 calculations on the adverse impact. And here's
17 the third one which is most important, and do
18 not require special knowledge, skill,
19 experience or training. Your Honor, we've got
20 three experts who have been sitting in this
21 courtroom for eight days with another five to
22 go, maybe. This is a subject matter that
23 requires special knowledge, skill, experience
24 and training.

25 THE COURT: Well, you've got a man here that's a CFO,

1 what do you say about it, Mr. Thomas?

2 **MR. THOMAS:** First of all, Your Honor, he's the CFO
3 of Trident, was the CFO of Trident Health
4 Systems and now a CFO to Doctors Hospital. He
5 was allowed to testify as to whether or not a
6 14 million dollar bottom line hit would be a
7 material adverse impact. Mr. Gallati testified
8 to that, he's the CEO of the hospital and Mr.
9 Long did not impose any objections at that
10 time. I would think that Mr. Gorrell would
11 actually be in a better position because he's
12 knowledgeable about the financial health of the
13 System.

14 **THE COURT:** What about meeting all three criteria of
15 701?

16 **MR. THOMAS:** I don't think he has to.

17 **THE COURT:** Well, educate me.

18 **MR. LONG:** Your Honor, it says "and". I mean,
19 opinion testimony about lay witnesses, Your
20 Honor, is limited under the Rules. I mean,
21 it's a very narrow time to do it and generally
22 what the, when we read the cases, it's about
23 somebody decides some actual, it's something
24 based on their perception or something very
25 special about what they particularly see here.

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1 THE COURT: Well, it seems to me that what his
2 perception is his viewing of these numbers,
3 reduction in Trident System net income, so I
4 think we've passed that hurdle. I think that
5 by virtue of his position as CFO that he has
6 some special training. Now, what's the third
7 one?

8 MR. LONG: Helpful to a clear understanding of the
9 witness' testimony or determination of a fact
10 at issue.

11 MR. THOMAS: One of the facts at issue is whether or
12 not there's going to be an adverse impact on
13 Trident, Your Honor..

14 THE COURT: Precisely. Objection overruled.

15 Q: All right, Mr. Gorrell, I'll try to ask that
16 question again. Based on the numbers that you
17 just reviewed, at the time you reviewed them
18 and you saw 14 million dollars, did you believe
19 that would have a material adverse impact on
20 the financial health of Trident Health System?

21 A: Yes.

22 Q: Okay. Was that number meaningful in terms of
23 what you might be able to do in terms of
24 capital reinvestment?

25 A: Yes.

1 Q: Why?

2 A: This is, I mean, that to me sparks the real
3 need to be there and be there first to build
4 the hospital, to be the first one there to
5 service those patients, for the most part which
6 we'd been doing and we'd been promising the
7 County since, gosh, I don't know, in the
8 seventies I guess, to carry out our mission and
9 to be able to build that hospital and keep the
10 competitor out by being the first there. That
11 was a big concern of mine.

12 Q: Is that because you were worried about the
13 financial losses?

14 A: Oh, yeah, just from a financial standpoint.

15 Q: And then I guess Roper, it's Respondents' 150,
16 go to page nine. So what's the net income
17 number here, Mr. Gorrell, you can see it on the
18 bottom for Trident Health System on 2009? Pre-
19 tax net income, excuse me.

20 A: Oh, I'm sorry, 56 million, two.

21 Q: Do you have that calculator up there still?

22 A: Yes, I do.

23 Q: Okay. Would you divide 14 into 56 and tell me
24 what you get?

25 A: Twenty-five percent.

1 Q: Okay. So is a 25 percent detriment on your
2 pre-tax net income a significant number to you?

3 A: Absolutely.

4 Q: When you saw that number of 14 million dollars
5 that was on Petitioner's 177, is that something
6 you would have discussed with Mr. Gallati?

7 A: Yes.

8 Q: And at project review I think Mr. Long also
9 asked you a question about whether or not you
10 had seen what the impact would be on one of the
11 hospitals if both were built, correct? Do you
12 remember that testimony?

13 A: Can you state that again?

14 Q: Yeah, if both were built at the same time, what
15 would the impact be on one another, Berkeley
16 Medical Center on Roper St. Francis Berkeley;
17 do you recall that?

18 A: I remember that discussion, I don't remember
19 the numbers around it though.

20 Q: Okay. Do you remember in project review that
21 Mr. Baehr dealt, actually --

22 A: Yes.

23 Q: -- showed a slide?

24 A: Yes.

25 Q: Okay. Do you remember that showed a three year

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1 period of a 58 million dollar loss?

2 A: I didn't recall the exact number but I knew it
3 was big.

4 Q: Okay. And that concerned you at the time?

5 A: Oh, yes.

6 Q: Now, I think this might have been something you
7 were just speaking about, but Mr. Long showed
8 you some dates and times of meetings. You
9 don't, you don't disagree that the decision to
10 apply for CON for the project, Berkeley Medical
11 Center project, that was made quickly, wasn't
12 it?

13 A: Yes.

14 Q: Okay. And Trident actually saw its ability to
15 serve the citizens of Berkeley County put in
16 jeopardy if Roper St. Francis decided to build
17 in Carnes Crossroads, correct?

18 A: That's correct.

19 Q: You just said that, didn't you?

20 A: That's correct.

21 Q: Now, in 2005 you were aware that East Cooper
22 built a, or applied to build a replacement
23 hospital for 150 million dollars, didn't you?

24 A: That's correct.

25 Q: And at the same time Roper also applied two

1 months after East Cooper did to put in another
2 150 million dollar hospital there, correct?

3 A: That's correct.

4 Q: Okay. And DHEC approved them both?

5 A: Yes.

6 Q: Okay. And that was troubling, was troubling to
7 Trident, wasn't it?

8 **MR. LONG:** Objection, Your Honor. He's got to lay -
9 - this is the problem with him leading his own
10 witness, Your Honor, I mean, he's not laying a
11 foundation for him to -- he cannot comment on
12 the Mount Pleasant applications in that manner.

13 **MR. THOMAS:** He can, Your Honor. Mr. Long actually
14 laid a lot of the foundation, when were you the
15 CFO, how long were you the CFO, I mean, he's
16 going to be aware of what's going on in the
17 market.

18 **THE COURT:** Overruled.

19 Q: Here's an email that I believe Mr. Long showed
20 you with yeah, Respondents' 108 up there.
21 I mean, that was a concern there and was
22 expressed to you on September 5th, '08. The
23 paragraph right above where Don signed, it says
24 -- he said, And how is this different than the
25 situation with East Cooper and Roper out in

1 Mount Pleasant? I guess what I'm asking is how
2 can Roper pull off the same coup they did out
3 in Mount Pleasant, trumping us, and more
4 importantly, what can we do to prevent it. You
5 got the email right?

6 A: Yes.

7 Q: Okay. And that was a concern of Trident's,
8 wasn't it?

9 A: Yes.

10 Q: I think Mr. Long asked you some questions about
11 EBITDA. Now, it is an important metric for
12 you, correct?

13 A: That's correct.

14 Q: And just to clarify because I think you said
15 this a couple times, and I want to clarify this
16 for Judge McLeod, you say it's important, it's
17 an important measure out in the field. Does
18 that mean it's an important measure because
19 that's how you're looked at just for the
20 expenses that are within your control?

21 A: That's correct. I mean, the division, the
22 corporate offices, they look for basically the
23 CEO and the CFO to hit that earnings target
24 that we both agree on through the budget
25 process in the beginning of the year. So it's

1 a very important metric to, what I say, us in
2 the field.

3 Q: And the earnings, even if you could keep all
4 your EBITDA, but that wouldn't be, at the end
5 of the year that wouldn't be what's in the
6 bank, would it?

7 A: No.

8 Q: Because taxes are a real expense, aren't they?

9 A: That's correct.

10 Q: Interest is a real expense, isn't it?

11 A: It is.

12 Q: Management fees are a real expense. Mr. Long,
13 I think he said something along the lines of
14 you don't write a check for it, do you?

15 A: That's correct.

16 Q: But somebody's got to write a check for it,
17 don't they?

18 A: Yes.

19 Q: You mentioned to us the depreciation. If
20 you've got a ten year life of say a piece of
21 equipment or a 30 year life of a building, when
22 that building is replaced somebody's got to
23 write a big check, don't they?

24 A: That's correct.

25 Q: So the idea is that the money is booked at some

1 point and that it's retained in some account;
2 is that right?

3 A: It's -- absolutely, that's correct.

4 Q: And just because you don't do it locally
5 doesn't mean that it's not done; is that right?

6 A: That's true.

7 Q: Okay. In addition to some of the other
8 services, I believe Mr. Long brought up the
9 management fee, reimbursement negotiation is
10 also done at the division and corporate level,
11 isn't it?

12 A: There are reimbursement personnel that put
13 together our cost reports both on a division
14 and corporate basis that would be in those
15 fees.

16 Q: Okay. And decision support, that's a very
17 large department within HCA which Trident
18 benefits from, correct?

19 A: Correct.

20 Q: There's a real estate office that helps out
21 too, isn't there?

22 A: That's correct.

23 Q: You have a very large architectural and
24 construction department in HCA, don't you?

25 A: That's correct.

1 Q: You rely on that a lot with all the projects at
2 Trident has done over the years, correct?

3 A: That's right. I believe I mentioned IT also.
4 That's a big cost.

5 Q: And Mr. Summer and I are here today with our
6 paralegal. That legal fee is booked at
7 corporate, isn't it?

8 A: Yes, it is.

9 Q: That's another check you don't have to write?

10 A: It, you know, I'm not positive about that.
11 Some legal fees are booked locally. There are
12 those attorneys that reside at corporate for
13 example, that's part of the management fee, so
14 there is a split on that. I would need to
15 check on that, Mr. Thomas.

16 Q: That's fine. But at the end of the day
17 management fees, depreciation, interest, that's
18 all got to be paid for, doesn't it?

19 A: Yes.

20 Q: Could you speak up, Mr. Gorrell?

21 A: Yes.

22 Q: Okay. And those expenses are beyond your
23 control, aren't they?

24 A: Correct.

25 Q: Okay. So that's why as a key metric for your

1 purposes in the field is EBITDA, right, because
2 that's what's in your control, operation?

3 A: That's exactly correct.

4 Q: And although the taxes are rolled up in HCA,
5 the government's going to make sure those get
6 paid, aren't they?

7 A: That's correct.

8 Q: Is it your understanding that DHEC, when they
9 evaluate financial success of a project it's
10 done on a net income basis?

11 A: That's correct.

12 Q: Let me ask you a couple additional questions
13 here. If you would go to Petitioner's 174.
14 All right. Maybe, and if you go to page two of
15 174, Mr. Long showed you this. I just want to
16 get some clarification here. I'd like to also
17 show you this as well. This is what we're
18 looking at here. All right. Mr. Long asked
19 you some questions about the pro forma and the
20 payer mix; do you recall that?

21 A: Yes.

22 Q: Okay. And he asked you about the payer mix and
23 whether or not it was based on, based strictly
24 on the Summerville Medical experience. If you
25 look on page, this is Trident 226 for the

1 record, but it's Petitioner's Exhibit 174.
2 Look here, Mr. Gorrell, if you could, this is
3 inpatient payer mix, correct?

4 A: Correct.

5 Q: Okay. It's got a utilization percentage, right?

6 A: Yes, it does.

7 Q: Okay. What does the line here at the far
8 right-hand side of the assumption say? Could
9 you read that into the record?

10 A: "Utilization is based on PSA for Phoenix during
11 2007. Net to gross is based on Summerville
12 Medical Center 2007 data."

13 Q: So your testimony before, you were actually
14 mistaken, weren't you?

15 A: Yes.

16 MR. LONG: Objection, Your Honor. I think that's an
17 improper question.

18 MR. THOMAS: Well, let me set it up differently.

19 Q: When you said earlier that the payer mix was
20 determined completely by what the payer mix was
21 at Summerville Medical Center, that was not
22 entirely correct, was it?

23 A: That's correct. That was not correct.

24 Q: This says utilization is based on the primary
25 service area, that's what PSA means, right?

1 A: Yes.

2 Q: For Phoenix during 2007. Phoenix is the name,
3 like Mr. Long said, the code name of the
4 project, correct?

5 A: That's correct.

6 Q: Okay. So what do you understand the actual
7 payer mix, it's over here on the left and
8 that's 47 percent Medicare care, 11.22
9 Medicaid, and so on and so forth. Based on
10 that assumption what is your understanding of
11 how the payer mix was derived?

12 A: He's talking about two different things here.
13 My apologies for confusing that a little bit,
14 but it was the net revenue piece. Net to gross
15 was based on Summerville. So he's looking at
16 revenue. But it clearly says here utilization
17 is based on the primary service area for
18 Phoenix during 2007. So he's obviously looking
19 at zips and some information that was provided,
20 I'm certain, by Mr. Baehr.

21 Q: Okay. And, Sara, would you go to Respondents'
22 97 for me and go to the next page. Okay. And
23 this is one example of the financial class by
24 zip code, isn't it? 29431, that's a Bonneau
25 zip code, isn't it?

1 A: That may be, I don't know. I'd speculate on
2 that. I better look at that.

3 Q: Okay. Let me go to, direct you to Joint
4 Exhibit 1, page 36.

5 A: That's correct. It's 29431 is Bonneau.

6 Q: Okay. Thank you. Now --

7 **MR. THOMAS:** Bear with me, Your Honor.

8 Q: Mr. Long asked you questions about employment
9 of physicians. When you left -- what year did
10 you leave Trident, Mr. Gorrell?

11 A: When did I leave Trident?

12 Q: Yeah.

13 A: Nine months ago.

14 Q: Okay. Do you recall how many employed
15 physicians had at the time?

16 A: Off the top of my head, no, but I could
17 speculate in the range of 25 or 30.

18 Q: Okay. How many of those were hospitalists?

19 A: A large of piece of that would be hospitalists.

20 Q: More than half?

21 A: Probably.

22 Q: Okay. And what is a hospitalist; can you
23 explain to the Judge, the Court, what a
24 hospitalist is?

25 A: It's really a primary care-type physician,

1 family practice-type of physician that resides
2 there in the hospital.

3 Q: They're actually in the hospital, correct?

4 A: Uh-huh (affirmative response).

5 Q: They're not out in the community and they don't
6 see patients in an office out in the community,
7 do they?

8 A: That's correct.

9 Q: They take care of an inpatient once they're
10 already in the hospital?

11 A: That's correct.

12 Q: Could you speak up a little bit?

13 A: Yes. That's correct.

14 Q: They're office is actually in the hospital,
15 isn't it?

16 A: All hospital-based, yes.

17 Q: And they don't do outpatient visits, they don't
18 see outpatient visits in the hospital, do they?

19 A: No, they don't.

20 Q: And I believe Mr. Long asked you about
21 Respondents' 106, just about it's an email
22 about you getting more involved in the project.
23 You didn't actually get involved with the
24 project with respect to the financials, did
25 you, at the project review?

1 A: I'm sorry, could you repeat that?

2 Q: Yeah. Let's go to the Respondents' 106. This
3 is the email where you say let's meet and go
4 through it all after you speak to the lame duck
5 and bring me up to speed. I'll need to be the
6 one, and you signed it Neo. You didn't
7 actually -- you weren't actually brought up to
8 speed, were you?

9 A: No. I make myself available for Mr. Rardin,
10 but we didn't really do anything different at
11 that point.

12 Q: Mr. Baehr came in and took over on the
13 financial piece at that time, didn't he?

14 A: Yes.

15 Q: I don't have any further questions. Mr. Long
16 may have a couple for you.

17 MR. LONG: Just a few, Your Honor.

18 MR. GORRELL - REDIRECT EXAMINATION BY MR. LONG:

19 Q: Mr. Gorrell, you just don't know what the payer
20 -- do you know the payer mix on the pro formas
21 that are in the application; how they were
22 calculated?

23 A: We were reliant upon the information that Mr.
24 Woodford put together along with Mr. Baehr.

25 Q: Okay.

1 A: And I trusted that. Did I look at that in
2 detail? No, I didn't, but I was relying on the
3 consultants for that.

4 Q: But you recall that there was use of the
5 Summerville Medical Center information because
6 they were similar hospitals, right?

7 A: On the net to gross piece.

8 Q: Okay. What about for the other parts of the
9 financials?

10 A: For the Health System, for example, it would be
11 what the current room rate was for Trident
12 Health System.

13 Q: Okay. Now, take a look at Respondents' Exhibit
14 150, if you would. Do you have that one up
15 there in front of you?

16 A: I'm looking at 150. Yes, I have this in front
17 of me.

18 Q: Tell me what the net income number is for 2007?
19 I'm going to let you use the net income number
20 on this, for 2007.

21 A: Net income number for 2007 is 56,662.

22 Q: Okay. And now if you'll give me the net income
23 number for --

24 A: That's before, you know, obviously on these
25 financials the taxes weren't taken out at this

1 point so that's really pre-tax.

2 Q: Well, the taxes are never taken out, they're

3 paid in corporate --

4 A: Right.

5 Q: -- HCA pays your taxes, right?

6 A: But by definition, I mean, that's not the true

7 at the end of the day, net income.

8 Q: So you have no way of knowing what the net

9 income is after tax for your facility because

10 you don't pay taxes for your facility, HCA pays

11 the taxes for the whole corporation --

12 A: That's --

13 Q: -- isn't that correct?

14 A: -- correct. But the pre-tax number is 56,662.

15 Q: And then the '08 number?

16 A: The '08 number is for pre-tax is 33,722.

17 Q: Okay. And so the difference between '07 and

18 '08 is a \$23 million drop, right?

19 A: Yes, according to the financials.

20 Q: Okay. So you have a \$23 million decrement from

21 '07 to '08 in regards to your net income, were

22 y'all at risk of closing the hospital?

23 A: I don't think so. No, sir.

24 Q: You still move forward in '08 with a capital

25 project to build a \$115 million hospital,

1 right?

2 A: Yes.

3 Q: In '08. With that --

4 A: Yes.

5 Q: With that financial year going on. Okay. Now,
6 about this check that you, that gets written
7 for the management fee, who writes the check?
8 There isn't a check written, is there, for the
9 management fee?

10 A: It is a corporate office expense that gets
11 allocated to the hospital. But a check, for
12 example, that is written is the attorneys that
13 are on the corporate payroll, they're paying
14 them a paycheck. There are examples of checks
15 that are written by the corporate office.

16 Q: Corporate expenses -- they're all -- and
17 depreciation, there's no account where Trident
18 Health System has money set aside for their
19 capital projects, do they? For Trident Health
20 System capital projects?

21 A: All the cash is transferred daily to our
22 corporate office and I'm sure our corporate
23 office is reserving funds for future capital
24 expenditures. It's handled by corporate though
25 and not on a local basis.

1 Q: And those funds would be for all hospitals at
2 corporate, right, at HCA, not just Trident?

3 A: I'm sure that to some degree they're co-
4 mingled, but I can't speak to that.

5 Q: Okay. Now, when you heard that Roper St.
6 Francis had applied to build a hospital at
7 Carnes Crossroads, that would have been in
8 December of 2008, right? Does that sound about
9 right to you?

10 A: Approximately.

11 Q: Okay. And between December -- and after that
12 time you didn't do anything in regards to the
13 analysis or anything about these two projects,
14 right? You didn't work on them again after
15 December of '08, did you?

16 A: My responsibility, I think we talked about it
17 before, was to oversee those financials. And
18 I personally, that was it, I didn't personally
19 do anything after that.

20 Q: Right. And that email that you got from Ms.
21 Brisbin with Mr. Baehr's numbers, that's all
22 you got, right, was just that one sheet that
23 had some final numbers on it?

24 A: You're talking about the analysis from Mr.
25 Baehr?

1 Q: Right.

2 A: That's, you know, I recall getting that. I
3 didn't do anything after with it.

4 Q: You didn't even call him on the phone and ask
5 him to explain it to you, did you?

6 A: That could have been done by Mr. Rardin or Mr.
7 Gallati, I don't know. I wasn't asked to do
8 anything from that point.

9 Q: But you didn't choose to do anything either,
10 right?

11 A: I didn't choose?

12 Q: You didn't pick the phone up and say Mr. Baehr
13 what does this mean? You didn't call him, you
14 never spoke to him about it, did you?

15 A: I think it was pretty self-explanatory though.

16 Q: But you didn't know how he calculated the
17 numbers, did you, because you didn't have any
18 back up information, there's just one sheet,
19 right?

20 A: I trusted him as a consultant, that the numbers
21 were accurate.

22 Q: But you didn't have any back up as to how he
23 made the calculations, right?

24 A: I didn't try --

25 MR. THOMAS: Your Honor, objection.

1 A: -- to get into detail.

2 MR. THOMAS: I'd like a quick objection. He keeps
3 saying it's one sheet and the Exhibit is four
4 sheets. I just want to clarify that. He's
5 actually saying something that's not accurate.

6 THE COURT: All right. The record will reflect that
7 it's four sheets rather than one sheet.

8 MR. LONG: We only looked at the one sheet, that's
9 what I was commenting on in the testimony.

10 Q: You didn't -- did you ask him about the
11 assumptions?

12 A: No, I did not. I relied upon his expertise as
13 a consultant. It was right there in front of
14 me.

15 Q: Okay. Why didn't y'all continue to use Mr.
16 Woodford until the conclusion of the
17 application?

18 A: I don't know. I really don't know the answer
19 to that.

20 Q: But he was let go, right? His contract was not
21 renewed during the review period, right?

22 A: I believe that's accurate.

23 Q: He did not come to project review, did he?

24 A: Not to my knowledge. I do not remember him
25 being there.

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1 Q: Pull up, can we pull up 160, please,
2 Respondents' 160? This is the summary that we
3 looked at earlier and Mr. Thomas was asking you
4 about some of the numbers on here. You would
5 agree with me, wouldn't you, that the Trident
6 Health System has significant swings in regards
7 to its revenue and its EBITDA from year to
8 year, doesn't it?

9 A: It has had some over the past few years, yes.

10 Q: But when you look at Respondents' Exhibit that
11 you created, the income, if you move the bad
12 debt line the income from 2009 to 2010
13 increases from 394 million to 439 million,
14 right? That's an increase, right?

15 A: Yes.

16 Q: Okay. And the EBITDA number drops considerably
17 from '07 to '08 and then increases considerably
18 from '08 to '09 and from '09 to '10, right?

19 A: Yes.

20 Q: Okay. Would you agree that Trident Health
21 System has significant swings in its EBITDA and
22 revenue?

23 A: In most recent years there has been some
24 significant swings, yes.

25 Q: Would you attribute that to its size? Larger

1 organizations tend to have larger swings in
2 regards to its revenue and EBITDA?

3 A: Not necessarily. I mean, there can be, in one
4 year there was a large disproportionate share
5 check that was a non-recurring item, some Tri-
6 Care funds, so there was some non-recurring
7 items in some of those years.

8 Q: Okay.

9 A: Many things can impact the bottom line.

10 Q: And that's the only one you can recall, that
11 one non-recurring?

12 A: Oh, off the top of my head. I mean, I'd have
13 to go back through all the financials for all
14 of these years to come up with the reasons for
15 the swings.

16 Q: During the four years from 2007 to 2010 did you
17 consider Trident Health System to be
18 financially successful?

19 A: Yes.

20 Q: I have no further questions.

21 **THE COURT:** Thank you.

22 **MR. LONG:** Your Honor, if we can get a five minute
23 break, we'll be ready to call our next witness
24 which we hopefully can complete this afternoon.

25 **THE COURT:** Let's take ten.

1 MR. LONG: Ten, that would be fine.

2 (Off the Record)

3 MS. HOLLINGSWORTH: If it pleases the Court.

4 THE COURT: Yes, ma'am. We're on the record.

5 MS. HOLLINGSWORTH: We'll be calling Lou Caputo as
6 our next witness.

7 THE COURT: Again, the name?

8 MS. HOLLINGSWORTH: Lou Caputo.

9 LOUIS F. CAPUTO, being duly sworn, testifies as
10 follows:

11 MR. CAPUTO - DIRECT EXAMINATION BY MS. HOLLINGSWORTH:

12 Q: Mr. Caputo, will you state your full name for
13 the record?

14 A: It's Louis Fred Caputo.

15 Q: Thank you. And we haven't met. My name is
16 Jennifer Hollingsworth and I'm one of the
17 attorneys representing Roper St. Francis and we
18 appreciate you coming down here this afternoon.

19 THE COURT: Spell your last name, please?

20 A: Spell it?

21 THE COURT: Yes.

22 A: C-A-P-U-T-O.

23 Q: Mr. Caputo, can you tell the Court a little bit
24 about your educational background?

25 A: Sure. I got my bachelor's degree from Sewanee,

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1 The University of the South, my Master's
2 degree, my MBA from Belmont University in
3 Nashville.

4 Q: Okay. And your undergraduate degree is in what
5 field?

6 A: Economics.

7 Q: Thank you. And now when did you start with
8 HCA?

9 A: October of 2001.

10 Q: Okay. And when did you graduate with your MBA?

11 A: It would have been May of 2001.

12 Q: Okay. Was HCA --

13 A: I'm sorry, May 2002.

14 Q: Okay. So you completed your Master's while you
15 started with HCA?

16 A: Correct.

17 Q: And when you first started with HCA you worked
18 in their decision support department; is that
19 right?

20 A: I did.

21 Q: Okay. And we've heard a lot about that during
22 the eight days or so now that we're in trial.
23 Can you tell the Court a little bit about what
24 you did while you were with decision support?

25 A: Sure. I was a decision support analyst and we

1 -- decision support is -- the essential
2 function was to maintain the cost accounting
3 database for the hospitals and so we would use
4 managerial and cost accounting to assign
5 accounting values to different functions that
6 could be used to determine managerial
7 accounting analyses in the operations of the
8 hospital.

9 Q: Okay. And you remember your deposition in this
10 case? I believe Mr. Long took your deposition.
11 And I think you told us at that time that you
12 performed data extraction and analysis. What
13 does that mean?

14 A: Oh, we would -- for the most part we would take
15 the financial data, the accounting data that
16 would come out of the cost accounting system to
17 analyze the performance of hospitals, service
18 lines, physicians, procedural analysis and so
19 forth. We would look at, you know, length of
20 stay and cost per day per case to provide the
21 administrative teams analyses around the day-
22 to-day operations.

23 Q: Okay. And I believe you told us that your data
24 extraction and analysis may be used sort of on
25 the ground in strategic planning and analysis

1 by the hospitals; is that fair to say?

2 A: It is. We would, we would use the state
3 utilization data at the time in Tennessee to
4 compliment the facility in their strategic
5 planning, so data to look at market share, in-
6 migration, out-migration, service line analysis
7 and so forth.

8 Q: Okay. So if a hospital within HCA was
9 contemplating a capital expenditure, would they
10 perhaps contact you to do a financial analysis
11 for the feasibility?

12 A: My experience, I never got into that part, but
13 they could.

14 Q: Okay. Is that something that you think persons
15 within decision support could do for a
16 hospital?

17 A: Not to the full extent. I think they would be
18 a piece of the team that would do that.

19 Q: Okay. And now have you calculated returns on
20 investments during your time with HCA?

21 A: I have not.

22 Q: So if they're needed -- if there was going to
23 be a capital expenditure project on an HCA
24 hospital and they contacted decision support,
25 you all could not help them calculate a return

1 on investment?

2 A: Typically that expertise does not lie with
3 decision support. They use the hospital CFOs,
4 the division CFOs and folks in accounting to do
5 that.

6 Q: Okay. All right.

7 THE COURT: Your voice is a little low.

8 A: Okay.

9 THE COURT: If you could speak up just a bit, please.

10 A: Yeah, decision support would not calculate ROI,
11 we would rely on folks in accounting to
12 calculate that.

13 Q: And when you say accounting, you mean the
14 hospital's financial department?

15 A: To be honest with you, I don't think decision
16 support would have any role in that calculation
17 at all. So it would vary depending on
18 hospital, division, and so forth who may do
19 that.

20 Q: Okay. Now, you rose pretty quickly within the
21 HCA system, didn't you?

22 A: Relatively speaking, yes.

23 Q: Okay. From starting out in decision support to
24 having a CEO position at a hospital within
25 what, I believe less than ten years?

1 A: Yes.

2 Q: Okay. Can you tell the Court about the
3 management development program that you
4 participated in?

5 A: Sure. It was, HCA calls it their COO
6 development program or chief operating officer
7 development program. And it was a program
8 designed from senior leadership within the
9 company and human resources within the company
10 to build a pipeline for future hospital
11 administrators.

12 Q: And so using the talent within HCA, for
13 example, you in decision support, and grooming
14 you up to senior management?

15 A: A little bit of both, internally and
16 externally.

17 Q: Okay. And so when did you first go into that
18 management development program?

19 A: Oh, goodness. It was I believe November of
20 2004.

21 Q: Okay.

22 A: With your role, your initial role in that
23 program is an associate administrator and I had
24 the opportunity to go to a hospital in
25 Kissimmee, Florida in that role.

1 Q: Okay. And then in 2007, so about three years
2 later, you sort of got your first senior
3 management position; is that right?

4 A: Correct. As the chief operating officer at
5 South Bay Hospital.

6 Q: Okay. And where is South Bay Hospital?

7 A: It is in Sun City Center, Florida, which is a
8 suburb of Tampa.

9 Q: Okay. Describe Sun City.

10 A: Sun City is a, Sun City is a, really a master-
11 planned, 55-plus community that roughly,
12 roughly about 50,000 people within the primary
13 service area. It's adjacent to Ruskin,
14 Florida, roughly as a crow flies, three miles
15 from the Tampa Bay.

16 Q: Okay. And these Sun Cities, I mean, those are
17 sort of a development that are all over the
18 country, aren't they?

19 A: My understanding is that is correct. I believe
20 there's one in Arizona.

21 Q: Yeah, my grandmother was there, so I know there
22 are other Sun Cities out there. I wasn't
23 allowed to stay long, I didn't meet the age
24 requirements. Okay. So you were a chief
25 operating officer at that hospital, right?

1 A: Correct.

2 Q: We're talking about the South Bay Hospital.
3 You talked to us in your deposition about a CON
4 that you were involved with while you were at
5 South Bay; do you recall that?

6 A: Yes.

7 Q: Okay.

8 A: It would be hard for me to recollect the
9 specifics because it's been awhile, but, yes,
10 I was involved.

11 Q: Generally you recall that it was for a
12 replacement hospital?

13 A: Yes.

14 Q: Okay. And just, again, just generally can you
15 tell the Court what was involved with that
16 application?

17 A: Certainly. Before my time, South Bay Hospital
18 had submitted a certificate of need to build a
19 new hospital roughly seven to eight miles north
20 of it's existing hospital in a community that
21 was expanding very quickly. We submitted an
22 application, I say we, the application was
23 submitted and approved and at that time that is
24 when I arrived shortly thereafter at South Bay.
25 The regulations in Florida changed in the

1 meantime that would allow for free-standing
2 ERs. And so we changed our position to keep
3 the existing hospital where it was and run it
4 as a free-standing ER, but replace it, replace
5 the beds in that location seven miles north.

6 Q: Building the new hospital seven miles north?

7 A: Correct.

8 Q: Right. And then was there someone contesting
9 your plans in South Bay?

10 A: Yes.

11 Q: And who was it that was contesting? Even if
12 you don't remember the entity, why were they
13 contesting it?

14 A: I don't know the specifics but I think
15 generally it was that there was not enough
16 need.

17 Q: Okay. Because there was a hospital across the
18 street that had already been approved for that
19 location?

20 A: No, we -- actually, when the initial
21 application for South Bay was approved to build
22 a new hospital at the same time there was an
23 application for the competing hospital that was
24 approved at the same time. So they literally
25 approved two hospitals in the same CON cycle

1 right across the street from each other.

2 Q: Okay.

3 A: So when, so at the time we were both contesting
4 each other's approval on the grounds that there
5 was not sufficient need for that many beds.
6 But when the regulations changed we thought
7 that it was a better strategy to continue to
8 provide that service for the folks of Ruskin
9 and Sun City and that south Hillsborough County
10 by leaving a free-standing ER but modernizing
11 the facility and putting it more at the
12 epicenter of our service area seven miles
13 north. It's very -- from where the hospital
14 was south was very rural. Most of our patients
15 came from that Sun City and Ruskin areas to the
16 east and west and then south from the area that
17 we were putting the hospital.

18 Q: Okay. And now I think you testified in your
19 deposition that you weren't sure sort of what
20 happened because you moved on at that point?

21 A: Correct.

22 Q: Do you recall anything different now?

23 A: I have no idea.

24 Q: Okay. All right. And then where did you go
25 next?

1 A: To Summerville Medical Center.

2 Q: Okay. And when was that?

3 A: It was August of 2009.

4 Q: All right. And you went from decision support
5 into the management program in about three
6 years, and then you had that associate, I
7 believe you called it, administrative position
8 for about two years and then a COO and then a
9 CEO; is that right?

10 A: Correct.

11 Q: All right. And that chief executive officer
12 position at Summerville, I mean, that was a big
13 promotion, wasn't it?

14 A: Certainly.

15 Q: Now, when you arrived in late 2009, the
16 applications that are involved in these
17 proceedings had already been filed, hadn't
18 they?

19 A: For --

20 Q: The Berkeley County --

21 A: -- Summerville's, correct.

22 Q: Berkeley County hospitals. They had been filed
23 and approved actually, right?

24 A: Correct.

25 Q: You came after the decision in June of 2009?

1 A: Yes, I came in August.

2 Q: Now, let's just talk about what you do at
3 Summerville. I believe you told us in your
4 deposition that you had a vice president of
5 operations; is that right?

6 A: Correct.

7 Q: And you had a chief nursing officer, correct?

8 A: Correct.

9 Q: But you did not have your own chief financial
10 officer?

11 A: Correct.

12 Q: So who did you use in that role?

13 A: The Health System chief financial officer. And
14 I would consider that our own chief financial
15 officer, I mean, that person's role is to
16 oversee the financial operations for all
17 entities of Trident, so Moncks Corner,
18 Summerville and Trident.

19 Q: Okay.

20 A: But they didn't physically sit in Summerville
21 Medical Center.

22 Q: Sure.

23 A: The vice president of operations and the chief
24 nursing officer do.

25 Q: And just to clarify for the record, when you

1 refer to the Health System, that's Trident
2 Health System, right?

3 A: Correct.

4 Q: Okay. And you said they don't sit at
5 Summerville, they sit about six miles away at
6 Trident's main campus?

7 A: Correct.

8 Q: Okay. So they're very accessible to you,
9 aren't they?

10 A: Yeah, very much so.

11 Q: Okay. And same with the chief operating
12 officer, right?

13 A: The chief operating officer at Trident is not
14 a Health System person.

15 Q: Okay.

16 A: But they do sit -- Trident Medical Center has
17 their own chief operating officer.

18 Q: Okay. Okay. Is your vice president of
19 operations sort of the same thing as the chief
20 operating officer?

21 A: Similar functions. But not --

22 Q: Would you say they're different at all?

23 A: By title, sure. Scope of responsibility is a
24 little less but some of that is because of the
25 complexity of the facilities. But on general

1 terms, that is the point person to oversee day-
2 to-day operations at Summerville and that's the
3 person to see day-to-day operations -- the COO
4 is the person that oversees day-to-day
5 operations at Trident.

6 Q: Okay. And then for Summerville it's the VP of
7 operations?

8 A: Correct.

9 Q: Now, you testified that as CEO, your
10 responsibility is the performance and
11 operations of Summerville Medical Center; is
12 that a correct statement?

13 A: Yes.

14 Q: Okay. And who do you report to?

15 A: Todd Gallati.

16 Q: Okay. And in what role does he have that you
17 report to him?

18 A: He is the president and CEO of Trident Health
19 Systems.

20 Q: Okay. And now he's also the CEO of Trident
21 Medical Center, correct?

22 A: Correct.

23 Q: Do you have any responsibilities for Trident
24 Medical Center?

25 A: I do not.

1 Q: Now, I believe you told us while you've been
2 CEO you've been active in recruiting new
3 physicians to the area to serve your patients;
4 is that right?

5 A: Correct.

6 Q: Is that something you continue to do since your
7 deposition?

8 A: Yes, ma'am.

9 Q: And would you consider physician recruitment an
10 important part of your job as CEO?

11 A: Yes.

12 Q: Now, if you wanted to run a financial analysis
13 on a capital project, and we discussed earlier
14 that decision support may not be who you go to,
15 who would you go to?

16 A: It would be a team of people. I would rely on
17 the CFO, the VP of finance, the comptroller.
18 I would utilize decision support depending on
19 the situation. I would use the resources
20 within HCA corporate and I would use our
21 department directors. It would all depend on
22 what the specific capital project was.

23 Q: Okay. But when you're looking into whether or
24 not you want to do a capital project, you
25 wouldn't just go out and first hire a

1 consultant for that, would you? You'd use
2 internal resources first?

3 A: It would depend on the project.

4 Q: Okay. In what way?

5 A: If it was something that I felt we had the
6 internal resources, expertise and capability of
7 doing, then I may look internally. I would
8 look at the bandwidth of our internal
9 operations to take on additional projects and
10 if we didn't have those capabilities, then I
11 may look to a consultant.

12 Q: And at the time you arrived at Summerville in
13 late 2009 there were no plans for capital
14 expenditures at Summerville, were there?

15 A: Give me -- I'm having to go back to --

16 Q: Sure.

17 A: -- my memory. When you say capital investments
18 are you speaking specifically to sort of de
19 novo projects or would you consider capital
20 equipment purchases in that as well?

21 Q: However you want to define it. My question is
22 just whether when you arrived at Summerville to
23 take on the CEO role, my understanding from
24 your deposition, and your recall may be
25 different, is that there were no plans for

1 capital expenditures at Summerville Medical
2 Center?

3 A: I'm not sure where in the deposition, if that
4 was taken out of context.

5 Q: Okay.

6 A: But to my recollection there were not any plans
7 for any sort of green-field projects, but we
8 have a capital equipment budget that we
9 continue to analyze and whether it's adding
10 equipment or replacing old equipment, that's
11 something that we do on an ongoing basis. So
12 I'm sure that that was in existence when I got
13 there in 2009 but in terms of, in terms of a 30
14 bed addition, so forth, there was nothing on
15 the table at that point.

16 Q: So when you walked in the door in August of
17 2009, is it fair to say you didn't walk into an
18 ongoing certificate of need project at
19 Summerville?

20 A: Yes, correct.

21 Q: There wasn't an expenditure that would have
22 triggered any of the CON provisions that you
23 would have --

24 A: Not --

25 Q: -- needed to file an application?

1 A: Not to my knowledge.

2 Q: Okay. All right. You mentioned the
3 Summerville expansion project so let's talk
4 about that for a little bit. And let's pull up
5 Joint Exhibit 9, please. Yeah, and, Mr.
6 Caputo, there will be, there are books in front
7 of you that have different labels on them. For
8 example, if you want to look at paper Joint
9 Exhibit 9 would be in this binder. I know you
10 have a lot of binders over there. Or you can
11 follow along to the screen. But if we get to
12 a page that's not clear, you may want to refer
13 to --

14 A: Okay.

15 Q: And as you'll see Joint Exhibit 9 is actually
16 portions of the certificate of need application
17 for the Summerville expansion project; would
18 you agree with that? Do you see that cover
19 page?

20 A: Yes, ma'am.

21 Q: And are you familiar with that application?

22 A: Yes.

23 Q: And, in fact, you signed that application,
24 correct?

25 A: Correct.

1 Q: Now, do you have any Jim Rardin equivalent at
2 Summerville Medical Center? My understanding
3 certainly on the Berkeley project he was the
4 point man for the Moncks Corner hospital
5 project.

6 A: I will say that Jim serves in the same role for
7 Summerville Medical Center as he does for
8 Trident. Can you be a little more specific in
9 a Jim Rardin, relative to this project or just
10 his role in general?

11 Q: My understanding is sort of his role as
12 business development, strategic planning, he
13 signed that application I'm sure is why you
14 would sign this one. No problem with it, just
15 curious about the difference.

16 A: You'd have to ask Mr. Rardin why he signed
17 Trident's. I did this because I felt like it
18 was my facility and within my responsibility.

19 Q: Okay. So would it be fair to say that you are
20 intimately familiar with this application and
21 what it says?

22 A: I don't know if I'd go that far.

23 Q: Okay.

24 A: I mean, I certified it, I'm the CEO of
25 Summerville Medical Center, I'm familiar with

1 the applications, but I rely on a lot of people
2 to help put this application together. So --

3 Q: Sure. Sure. But you certainly reviewed all of
4 the information that was put in the
5 application, correct?

6 A: To a certain extent, yes.

7 Q: And certainly if there was something that was
8 in the application that you didn't understand
9 or didn't agree with, you would have dealt with
10 that from whatever support person was helping
11 you in that regard?

12 A: Certainly.

13 Q: Okay. If you look on page seven of this
14 Exhibit, and finally I did try to write down
15 the Exhibit page, Joint 9, page seven. If we
16 can look at Bates, and my copy doesn't have
17 Bates labels on it, so let me get one that
18 does. And a Bates page, Mr. Caputo, is on the
19 bottom right hand corner of the page there will
20 be little numbers.

21 A: Uh-huh (affirmative response).

22 Q: So as I refer to that for the record, that will
23 be the number to look for, Bonnielyn will
24 follow along with us. Bates page six, please.
25 And I believe you'll see item G, what is the

1 total project cost for the expansion project?

2 A: \$26,961,556.

3 Q: Okay. And what does that project seek to do,
4 in short explanation?

5 A: Sure. It seeks to add capacity at Summerville
6 Medical Center to address capacity constraints,
7 clinical quality issues, patient satisfaction
8 issues, future growth, additional services.
9 Improve overall care.

10 Q: Okay. And now you're application mentions
11 Trident's Berkeley Medical Center application
12 that had been approved; do you recall that?

13 A: Specifically what are you referring to in how
14 it mentioned it?

15 Q: First full paragraph of Bates 25, 2009, I'm
16 reading from that page, "Trident Health System
17 received approval to development a 50-bed
18 hospital in Moncks Corner in Berkeley County."

19 A: Can you zoom out from there so I can see the
20 context of it?

21 Q: Sure.

22 A: Because I think --

23 Q: And again, it's in front of you in the notebook
24 if you wanted to look at it. It's Joint
25 Exhibit 9.

1 A: Sure. We -- what this portion of the
2 application was talking about was really
3 painting a picture of what this project was,
4 talking about it being really the addition of
5 48 beds but converting some of our semi-private
6 rooms to private rooms and what the bed
7 components would be. But then it goes a step
8 farther to put that in context of the history
9 of Trident Health Systems, specifically Trident
10 Medical Center and Summerville Medical Center.
11 And I heard some references of it earlier today
12 while I was sitting in here and our mission as
13 a health system has been to, one, to provide
14 compassionate care where healing occurs, but
15 also a commitment to that North Charleston,
16 Dorchester, and Berkeley County areas to
17 provide quality care for years to come in those
18 communities. So I think it was referring to us
19 fulfilling that mission by Trident bringing a
20 hospital with beds back to Berkeley County in
21 Moncks Corner, and continuing to fulfill that
22 mission in Dorchester County by adding beds
23 that will allow us to continue to provide
24 service for that community for years to come.

25 Q: Okay. And I don't know if we said for the

1 record, it was on the screen, what date was
2 your CON filed? When did you submit -- it's on
3 that it might be the very first page, it
4 certainly on your signature page of the
5 application.

6 A: I signed it on November 8, 2010. It looks like
7 it was stamped on November 9, 2010.

8 Q: Okay. So this is a little over a year from
9 when you came to the system?

10 A: Correct.

11 Q: And almost a year and a half after the
12 decisions in the Berkeley hospital cases,
13 correct?

14 A: Correct.

15 Q: Okay. To your recollection does your CON
16 application mention the 50 beds approved in
17 Goose Creek or Roper St. Francis Berkeley?

18 A: I don't recall it mentioning it specifically.

19 Q: Okay. You address adverse impact in your
20 application. If we look at, again, we're on
21 Joint 9, this is Bates page 42. You can see
22 that paragraph discussing lack of unnecessary
23 duplication, correct?

24 A: Correct.

25 THE COURT: Just a moment.

1 MS. HOLLINGSWORTH: Yes, Your Honor.

2 THE COURT: You said Goose Creek, really you mean
3 Carnes Crossroads.

4 MS. HOLLINGSWORTH: Carnes Crossroads, sir.

5 THE COURT: Please refer to it that way --

6 MS. HOLLINGSWORTH: Correct, Your Honor.

7 THE COURT: -- so it will be the same in the record,
8 please, ma'am?

9 MS. HOLLINGSWORTH: Absolutely, Your Honor. I will.

10 Q: Do you want to take a minute to look at that
11 paragraph, Mr. Caputo?

12 A: Yes, ma'am.

13 Q: And that paragraph that talks about unnecessary
14 duplication and that the project will not
15 result in unnecessary duplication, there's no
16 reference to the 50 beds approved for Carnes
17 Crossroads, is there?

18 A: There is not.

19 Q: And now are you familiar with the utilization
20 forecast that were used in this application?

21 A: I'm familiar with it but I would have to refer
22 to our expert for any detail.

23 Q: Okay. And some of this, though, I think you'll
24 recall certainly from your deposition and your
25 project review presentation, but isn't it

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1 correct that you assumed a two percent per year
2 increase in your market share for your
3 forecasting?

4 A: I don't remember saying that in my deposition
5 and, frankly, I don't remember if that's what
6 we were based upon. If I had a calculator I
7 could calculate it. But it sounds about right.

8 Q: Okay. Well, in the Berkeley hospital
9 application it's 100 percent redirection of
10 existing. Do you recall if your application
11 was based solely on redirection of existing
12 market share or did you have to move market
13 share slightly?

14 A: You'd have to ask Mr. Sullivan.

15 Q: Okay. But you agree that you signed this
16 application and approved his forecast in
17 utilization, correct?

18 A: I agree that I signed this application and
19 certified that it was ready to be filed. As I
20 said before, I rely on a lot of other people to
21 put this together and I think in my role as the
22 CEO it's no different than in -- I can't go in
23 and operate on a patient in the OR but I rely
24 on people that do that job very well to be able
25 to do that.

1 Q: Sure. But you would have made sure that you
2 were comfortable with what he said the forecast
3 in your utilization would be --

4 A: Sure.

5 Q: -- is that fair?

6 A: Yes. And I am comfortable with it.

7 Q: Okay.

8 MS. HOLLINGSWORTH: Excuse me for my delay, Your
9 Honor, I don't have the Bates pages.

10 Q: If we can look at the pro forma that's
11 contained in the application. Bates page 75,
12 if you'll look at the bottom right hand corner,
13 again, the way this exhibit was done, it's not
14 all the pages, but it should be pretty close to
15 it. Do you recall seeing this document before?

16 A: Yes, ma'am.

17 Q: Who prepared the pro forma?

18 A: There were a few people that were involved.
19 Mr. Gorrell, in collaboration with our expert,
20 our VP of operations, to pull together the key
21 components.

22 Q: Was Mr. Baehr your expert for this application?

23 A: Mr. Baehr?

24 Q: Yes.

25 A: He was not. Dan Sullivan was.

1 Q: Okay. Is there a reason you didn't use Mr.
2 Baehr?

3 A: I have no idea. Mr. Rardin made that
4 selection.

5 Q: Now, did you review this pro forma before you
6 signed the application?

7 A: I did, to get a level of comfort with it.

8 Q: You felt like you had that at the time you
9 filed the application?

10 A: Yes, ma'am.

11 Q: If we look at the 2010 projection for your
12 earnings before depreciation, interest, and
13 taxes, see if you can find that line on there.
14 And this would be a 2010 projection in your pro
15 forma. I think Bonnielyn has kindly
16 highlighted it for us so you can find it.

17 A: Got it, 89 million.

18 Q: Now, you actually earned almost 93 million with
19 EBITDA in 2010, didn't you?

20 A: I believe that's correct. And when you say
21 you, you mean Trident Health not Summerville
22 Medical Center, correct?

23 Q: Correct. Correct. Because your pro forma is
24 a combined system pro forma, correct?

25 A: Correct.

1 Q: You don't customarily separate them out?

2 A: Right.

3 Q: And in this pro forma, again, it's a combined
4 health system?

5 A: Correct.

6 Q: But for purposes of these questions, that's
7 exactly correct, the 89 million forecast and
8 the 93 million actual is the Health System
9 totals, correct?

10 A: Correct.

11 Q: Now, in your deposition we talked about the
12 project review presentation to the Department;
13 do you remember that?

14 A: Yes. I remember the project review.

15 Q: Maybe not the deposition per se.

16 A: Yeah.

17 Q: That's fair. That's fair. Let's take a look
18 at Respondents' 158, please. This should be,
19 unfortunately, the very last one.

20 A: That's all right.

21 Q: There's a lot of turning involved.

22 A: The very last tab?

23 Q: It is. Respondents' 158 would be the number
24 tab.

25 A: Okay.

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1 Q: And so as you said, you remember your
2 presentation to the Department, right?

3 A: Yes.

4 Q: And when was that held; do you recall? It
5 might surely be on that transcript.

6 A: August 12, 2011.

7 Q: And at the time of your presentation your
8 statements were truthful and they were your
9 honest opinion as to the statement you made to
10 the Department; is that correct?

11 A: Yes, ma'am.

12 Q: Now, in the presentation you made, you insisted
13 a number of times that Summerville is its own
14 hospital with its own needs and own population;
15 is that correct?

16 A: Correct.

17 Q: Does that remain your opinion?

18 A: Correct.

19 Q: And now

20 Q: You believe that Summerville is a separate and
21 distinct population from what's, I believe you
22 called it, the goings on in Berkeley County,
23 correct?

24 A: The purpose of those comments were to try to
25 keep me from being here because I could see the

1 writing on the wall that there was, that Roper
2 would try to leverage Summerville's need for
3 additional beds against the proceedings between
4 Moncks Corner and Carnes Crossroads. And so I
5 tried to make it very clear to DHEC that this
6 has nothing to do with that, it has to do with
7 Summerville Medical Center's need.

8 Q: Now, do you know if at the time you came in
9 August of 2009 whether there was a need for
10 Summerville Medical Center in the Health Plan?

11 A: I did not. When I showed up on the doorsteps
12 I did not.

13 Q: Okay. But you figured out later that there
14 was; is that right?

15 A: Certainly. We -- on an operational basis I
16 felt capacity constraints. There are days as
17 recent as last week where we were at 100
18 percent capacity or more. And as an operator
19 in my hospital I start thinking about what are
20 we doing to do in two or three years if our
21 services improve and this community grows, how
22 are we going to meet that need and where are
23 those patients going to go. So in
24 communications with Mr. Gallati and in seeing
25 what capacity constraints we had, in addition

1 to looking at what Summerville Medical Center
2 really was once I had a chance to be here and
3 be present and get a level of comfort with that
4 hospital and this market, I realized that we
5 needed to add beds because the industry
6 standard is private beds. There are infection
7 control issues with having semi-private beds.
8 There are patient satisfaction issues with
9 having semi-private beds. We don't have a
10 step-down unit. You have, you have, and I
11 apologize for rambling, you are limited as to
12 what services you can provide when you are only
13 94 beds. To expand your service capabilities
14 you have to cut your hospital up in many
15 different ways. So if you want to have a
16 dedicated orthopaedic unit or a pediatric unit
17 or a bariatrics unit or a step-down unit, it's
18 really hard to do that in a 94 bed hospital
19 that's 50 percent semi-private rooms. With all
20 those factors we said you know what, let's look
21 at the State Health Plan and see if there's a
22 need and then let's go and try to build some
23 beds onto this hospital.

24 Q: But you would agree with me that your concerns
25 about patient privacy, which you talked about

1 at your deposition and at project review, those
2 could have been addressed just with a
3 renovation project, correct? You could have
4 done a renovation and converted your rooms to
5 private rooms without adding beds?

6 A: On a simple level, yes, but we could not go
7 from a 94 bed hospital to a 70 bed hospital and
8 still have the ability to care for those
9 patients that were seeking Summerville Medical
10 Center's care.

11 Q: And you told us in your deposition when you
12 came to the Summerville market and took this
13 position on you had a discussion with, was it
14 Mr. Gallati; is that right? Is he one of the
15 people you interviewed with?

16 A: Yes, ma'am.

17 Q: And he told you some things about what the
18 landscape of the market looked like; is that
19 right?

20 A: Yes.

21 Q: And he specifically told you that I believe
22 MUSC and Roper were two other providers in your
23 sort of primary serving area, correct?

24 A: Correct.

25 Q: And you told us in your deposition that the

1 patients from the Summerville area that are
2 traveling to Roper St. Francis facilities you
3 believe will continue to go to Roper facilities
4 regardless of the expansion; is that right?

5 A: That's my opinion, yes.

6 Q: And you maintain that opinion?

7 A: Depending on our abilities to provide
8 additional services. Now, if they're going to
9 Roper because Summerville Medical Center
10 doesn't provide services that they could get at
11 Roper, there's the possibility that they could
12 come to Summerville Medical Center. But
13 generally speaking, all other things being
14 equal, certainly.

15 Q: Okay. And you would acknowledge that patient
16 loyalty can be constant; can it not?

17 A: To some extent.

18 Q: Okay. Can you expand on that since that's not
19 a yes or a no? Tell me what you mean.

20 A: If all things are equal, patient loyalty can be
21 constant. But all things aren't equal, the
22 markets and dynamics change over time. So if
23 you have variables in the market, then there
24 are other factors that would determine patient
25 loyalty.

1 Q: All right. So like adding a third more beds to
2 your facility could impact Roper's patient's
3 choice of healthcare services?

4 A: I don't think just adding beds would change
5 their choices, but it could be something like
6 a new road being built or expanded. It could
7 be, again, it could be a physician preference,
8 it could be a service that you don't offer that
9 you begin offering, it could be, frankly,
10 renovating your facility to make it nicer than
11 what your competitor down the road may have.
12 And that's another concern that I have is I
13 feel like with these limitations that
14 Summerville Medical Center has by being caught
15 up in appeals and hearings from an organization
16 that doesn't have a physical presence in
17 Dorchester County, I feel like there is some
18 competitive maneuvering going on because I feel
19 like if they do go to a hospital in Carnes
20 Crossroads, that they can use it as a
21 competitive advantage against Summerville
22 Medical Center. Why would you continue to go
23 to the facility that you've gone to forever if
24 they have semi-private rooms, if they have an
25 older facility, and so forth.

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1 Q: Let's look at Respondents' 166 for a moment, or
2 was it Petitioner's.

3 MS. HOLLINGSWORTH: Petitioner's 166, Your Honor.

4 Q: If we could go to 311. Mr. Caputo, this is
5 some data that was asked for by Trident Medical
6 Center that was produced regarding Roper St.
7 Francis Healthcare and the various zip codes
8 that they serve. And what we have here is the
9 non-specialty, non-tertiary patients served by,
10 I think it starts out with Bon Secours
11 Hospital. Now, just for the Court, a non-
12 tertiary, non-specialty hospital, which is what
13 the Berkeley hospital purport to be, is that
14 also what Summerville Medical Center is? Would
15 you agree with that?

16 A: Yes.

17 Q: You do not provide tertiary services?

18 A: Correct.

19 Q: You are a community based hospital?

20 A: Correct.

21 Q: And if we look, I believe all three of those
22 numbers on the first page, but do you recognize
23 those there zip codes?

24 A: The highlighted ones?

25 Q: Yes, sir. 29483, 29485, and 29484.

1 A: I do.

2 Q: And what are those zip codes?

3 A: Summerville zip codes.

4 Q: Now, if you'll see from those numbers, I
5 believe for 2010 there are 357 discharges for
6 the 29483, if I can read my writing, 20 for
7 29484, and 275 for 29485; do you see that?

8 A: Yes.

9 Q: And so in 2010, Bon Secours St. Francis saw 653
10 patients in those Summerville zip codes; do you
11 see that?

12 A: I do.

13 Q: Okay. If we go a couple more pages and we look
14 at Roper Hospital, which is the downtown
15 facility, and this is page 19 of the Exhibit.

16 **MS. HOLLINGSWORTH:** Petitioner's 166, page 19, Your
17 Honor.

18 Q: 29483 in 2010 were 371 patients seen, 29485 had
19 255, I believe we go to the next page, a few
20 pages, on page 21 of Petitioner's 166 you see
21 29484 had 10; do you see that Mr. Caputo?

22 A: I do.

23 Q: So again, for 2010 Roper Downtown saw 636
24 patients from the Summerville zip codes; is
25 that correct?

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1 A: Correct.

2 Q: And finally, even though it's a very short
3 period of time, I think there's just a little
4 bit of Mount Pleasant data that was requested
5 by Trident.

6 THE COURT: Excuse, Ms. Hollingsworth, is that based
7 on discharges?

8 MS. HOLLINGSWORTH: It is, Your Honor.

9 THE COURT: Thank you.

10 MS. HOLLINGSWORTH: It may be admissions, Your Honor,
11 but they are isolated events for that year.

12 Q: This is Roper St. Francis Mount Pleasant,
13 Petitioner's 166 page 32 of the Exhibits. And
14 those two highlighted zip codes, 29483 had two
15 in 2010 and 29485 had one in 2010; is that
16 correct?

17 A: Yes.

18 Q: So you were discussing with me some concerns
19 that you had that the impact of Carnes
20 Crossroads, this new hospital coming up, was
21 going to impact your patients who maybe didn't
22 want to go to Summerville, but in fact there's
23 a good number of patients in the Summerville
24 zip codes that choose to go to Roper St.
25 Francis facilities, don't they?

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1 A: Yes.

2 Q: Okay. And I believe you testified earlier you
3 anticipated that they would continue to do so;
4 is that right?

5 A: It's likely.

6 Q: Now, in the project review presentation, and
7 actually in your certificate of need you
8 discussed some economic development that's
9 going on in your market; is that right?

10 A: Correct.

11 Q: And you talked about some great things, I
12 think, that were happening around the time that
13 you were filing and certainly at project
14 review; do you recall that?

15 A: I do.

16 Q: Petitioner's 158.

17 COURT REPORTER: Excuse me, do you mean Respondents'
18 158?

19 MS. HOLLINGSWORTH: Yes, did I say that wrong? I
20 apologize. Respondents' 158.

21 COURT REPORTER: Thank you.

22 MS. HOLLINGSWORTH: Thank you very much.

23 Q: Mr. Caputo, was it your statements to the
24 Department, and if you can read actually, right
25 after 900,000 per bed on line 19, can you read

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1 the rest of that paragraph into the record?

2 A: "In any hospital that is having, any community
3 that has a project like this is going to help
4 their economic development and we're excited
5 about being a part of that for our community
6 with the additional jobs, additional tax
7 revenue on the rolls."

8 Q: Okay. And you would agree with me that just
9 like the Summerville community would benefit
10 from that economic development from the
11 construction, the Carnes Crossroad community
12 would also benefit from the construction of the
13 Roper St. Francis Berkeley facility?

14 A: I'm sure it would, as would Moncks Corner.

15 Q: And we also talked about economic development
16 in areas adjacent to Summerville; do you
17 remember that?

18 A: Economic development adjacent to Summerville?

19 Q: Yes. At project --

20 A: Yeah.

21 Q: -- review; do you recall that?

22 A: Yes.

23 Q: And we can show you some of that.

24 MS. HOLLINGSWORTH: For the record this is Roper St.
25 Francis- Respondents' Exhibit 158 page 25 of

1 the Exhibit.

2 Q: Mr. Caputo in this portion of your presentation
3 to the Department did you talk about the new
4 activities going on with Boeing in your area?

5 A: Yes, on line 21.

6 Q: Yes. And what were those things that were
7 going on?

8 A: "In terms of economic growth I just heard on
9 the news this morning that Boeing is accepting
10 applications tonight for their new plant that's
11 opening up. So you know at least some of that
12 growth we talked about is coming to fruition
13 right now."

14 Q: You would agree with me that at your
15 presentation you talked a bit about the growing
16 and the development that's going on in your
17 area; is that right?

18 A: Yes.

19 Q: That things were starting to change and
20 Summerville and that surrounding area was
21 having increased opportunities; is that fair?

22 A: Yes. I think that is a large -- it is a key
23 reason why we feel like we need that 30 bed
24 expansion in Summerville because of the because
25 of the population growth, Dorchester County has

1 very strong population growth relative to the
2 rest of the state of South Carolina and we want
3 to be able, we want to be prepared to meet that
4 need in years to come. And I think that's, I
5 think that's evident by the State Health Plan.
6 I think they see the use rates and population
7 growth and that's why we were one of the few
8 hospitals that had a designated bed need.

9 Q: And actually both Dorchester and Berkeley
10 County are two of the fastest growing counties
11 in South Carolina, aren't they?

12 A: I can't speak on Berkeley County, I'm more
13 familiar with Dorchester County, but I believe
14 so.

15 Q: Okay. So you don't feel like you have any feel
16 for the Berkeley County area in your role as
17 CEO of Summerville?

18 A: No, I have a feel for it but I'm more intimate
19 with Dorchester County for sure.

20 Q: Okay. You talked about Summerville was a
21 community hospital serving your community; is
22 that right?

23 A: Yes.

24 Q: And you said it was primarily the city of
25 Summerville; is that right?

1 A: I don't know if I said it serves primarily the
2 city of Summerville. I mean we share the
3 town's name. We're located physically in
4 Summerville, but the community that we serve
5 goes beyond just Summerville.

6 Q: Okay. Well, I guess to expand on that I
7 believe you stated that you get 70 percent of
8 your admissions from Summerville, Ladson, and
9 North Charleston, does that sound familiar?

10 A: Yes.

11 Q: Okay. So those would be three defined areas
12 that you would have discussed and explained in
13 your presentation; is that right?

14 A: I believe so, but I can't remember if it was
15 presentation or deposition.

16 Q: Well, let me just ask you, sitting here CEO of
17 Summerville Medical Center would you agree with
18 me that you get the majority of your patients
19 from Summerville, Ladson, and North Charleston?

20 A: Yes.

21 Q: And I believe you said you only get about ten
22 percent of your admissions from Berkeley
23 County, right?

24 A: I think it was ten percent that were wholly in
25 Berkeley County.

1 Q: Okay. Because you have that one --
2 A: Yeah, that crosses --
3 Q: -- piece that crosses over?
4 A: -- Dorchester County and Berkeley County, yes.
5 Q: And I believe we've talked about that, it's
6 29483 is that zip code, Your Honor. That zip
7 code right near your facility but actually kind
8 of extends all the way over to Berkeley County?
9 A: That's where I live.
10 Q: Okay. Now, given that only ten percent of your
11 admissions come wholly from Berkeley County, it
12 seems that Roper St. Francis Berkeley will not
13 have a material adverse impact on Summerville
14 Medical Center; do you agree with that?
15 A: No.
16 Q: Okay. And tell us why.
17 A: Because I'm sitting here right now.
18 Q: Okay.
19 A: They're already having an impact on Summerville
20 Medical Center by keeping us from adding these
21 30 beds. I think that -- I think that them
22 contesting our application apparent in their,
23 in the letter to DHEC as to why they oppose our
24 application, it's not about Summerville Medical
25 Center meeting a need, it's about the interest

1 in Berkeley County between Carnes Crossroads
2 and Moncks Corner. So I already feel like
3 they're having an adverse impact on Summerville
4 Medical Center. But there's no hiding the fact
5 that we already care for patients in that
6 community, we have for a long time. At Trident
7 in Summerville have done a very good job
8 meeting the needs of the folks in Carnes
9 Crossroads area, in Goose Creek and in Berkeley
10 County. So despite what they say in their
11 application that they will not have an adverse
12 impact on any other hospital, I feel like that
13 there are patients that we already serve and
14 have for a long time but that they may impact
15 us. And the patients that we see today that
16 sit in our ER a little bit longer than they
17 should or sit in surgery recovery a little bit
18 longer than they should because there's not a
19 bed available are going to feel that adverse
20 impact for years to come.

21 Q: And you would agree with me that Roper St.
22 Francis facilities serve a large number of
23 patients in all those same areas you discussed;
24 is that right?

25 A: Yes. Yes. By those numbers that you showed,

1 is it roughly 600?

2 Q: Those numbers we talked about earlier were
3 actually -- 653 for Bon Secours and 636 for
4 Roper Downtown, three for Mount Pleasant,
5 that's actually 1,292, isn't it?

6 A: Correct, yeah.

7 Q: And those are just three zip codes that we went
8 through, right?

9 A: Correct.

10 Q: And you would agree with me that there are
11 other areas within Berkeley County that we
12 serve a significant number of patients as well?

13 A: Correct. As we serve folks outside of
14 Summerville, Ladson, and North Charleston.

15 Q: You discussed at project review and again
16 during your deposition that Summerville has had
17 to transfer patients from Summerville to
18 Trident main when you don't have beds
19 available; is that right?

20 A: Yes. It is isolated but it occurs.

21 Q: All right. And then you also talked about that
22 there were times that you would have patients
23 coming out of the Moncks Corner ED that would
24 come to Summerville but you would redirect down
25 to Trident's main campus, correct?

1 A: If I said that, I may have misspoken. We would
2 never have a patient en route to Summerville go
3 to Trident. Now, there may be a call from
4 Moncks Corner that says, hey, we have a patient
5 and we want to transfer and we would say don't
6 bring them here, send them to Trident.

7 Q: Would there be instances where there would be
8 a patient and you got the call from Moncks
9 Corner that said we're going to bring them to
10 you, Summerville, because that's where they
11 want to go?

12 A: Certainly.

13 Q: Now, you stated at project review and in your
14 deposition that Summerville's uniqueness and
15 community-based nature would not have an
16 adverse impact on any existing or approved
17 projects; does that sound familiar?

18 A: It doesn't sound familiar, but I'll agree with
19 you if I said it. Yeah.

20 Q: Do you --

21 A: Yeah, it was a long time ago. But yeah, I
22 would agree with that.

23 Q: So you would agree that uniqueness and
24 community-based nature of Summerville will not
25 have an adverse impact on existing or approved