

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 projects?

2 A: I believe so. I think that -- and let me
3 clarify a little bit. I think that, I think
4 that in my heart I think that the right thing
5 to do is -- let me take a step back. When I
6 say that we won't have an adverse impact on
7 existing facilities, I don't take into
8 consideration a hospital in Carnes Crossroads.
9 We have got to, we have got to move forward
10 with Summerville Medical Center meeting its
11 needs. I hope that my expert, Dan Sullivan,
12 took all of those pieces into consideration
13 when he does his on use rates and so forth and
14 I also depend on DHEC and the State Health Plan
15 to take into consideration those use rates when
16 they do their analyses. I don't, as the CEO of
17 Summerville Medical Center, I don't really, and
18 this is going to sound a little bit cold and
19 don't take it the wrong way, but I don't really
20 care if we have an adverse impact on Carnes
21 Crossroads. I want to make sure that I'm able
22 to take care of the patients in the community
23 in my hospital for years to come. I hope all
24 of that other stuff is taken into consideration
25 in the State Health Plan and the utilization

1 data that's deep into the certificate of need
2 application. And my understanding is, is that
3 was done, that Mr. Sullivan did that.

4 Q: Okay. Now, other than these reasons related to
5 the litigation is there any other adverse
6 impact, material adverse impact from the Carnes
7 Crossroad facility project on Summerville? You
8 talked about the litigation and the delay, but
9 --

10 A: Yeah, I mean, I think that, I think that if I
11 lived, if I lived in Carnes Crossroad and
12 Summerville Medical Center was my hospital of
13 choice for years and there's a bright shiny new
14 hospital with private rooms and, you know, a
15 really nice facility, then I might consider
16 going there when I historically have gone to
17 Summerville Medical Center. I've seen, in the
18 market, I have seen Roper's strategy for
19 physician employment and deployment to provide
20 services in and around a hospital that they
21 would erect, as evidenced by what they have
22 done in Mount Pleasant. There's only a couple
23 ways you can do that and one is to get existing
24 physicians in that market to go there. And my
25 fear is that they would use similar strategies

1 to aggressively employ and buy physicians that
2 have historically served Summerville Medical
3 Center. And then staffing is a concern. You
4 know, they're going to have to staff the beds
5 in some form or fashion and my concern is that
6 I would lose nursing staff and clinical staff
7 and other staff to a new hospital.

8 Q: But again, you said that you only get about ten
9 percent of your admissions from zip codes
10 wholly in Berkeley County; is that right?

11 A: Yes.

12 MS. HOLLINGSWORTH: Your Honor, if I could just have
13 one moment.

14 Q: Mr. Caputo, to clarify something we were
15 discussing earlier when we talked about the
16 possibility of having done a renovation
17 project, I think you talked about changing it
18 to 70 beds, when in fact you could have done a
19 renovation project converting your semi-private
20 rooms to private rooms, keeping all 94 beds,
21 correct?

22 A: I don't think that would be possible.

23 Q: Okay. So you don't think you could have done
24 a renovation and expanded your campus in order
25 to create more rooms to put your 94 beds in and

1 make them private?

2 A: That's essentially what we're doing.

3 Q: But you're adding 30 beds.

4 A: We're actually adding 48 beds and then
5 converting semi-private rooms to private and
6 we're adding the ability to provide a step-down
7 unit which we haven't currently had. We're
8 adding the ability to meet the needs of our
9 labor and delivery unit by converting five of
10 our LDRPs to truly labor and delivery rooms.

11 **THE COURT:** When you use an acronym you need to
12 define it.

13 A: I'm sorry. Sorry. Sorry. We are expanding
14 our ability in labor, delivery, recovery and
15 postpartum rooms to make them just labor and
16 delivery rooms. Today we recover and
17 postpartum patients in our med-surg unit which
18 is not ideal for any woman that has had a baby.
19 So are we doing more than just converting our
20 semi-private rooms to private rooms? Most
21 certainly. But it's to improve the quality of
22 care, privacy issues, addressing infection
23 control issues, and at the end of the day meet
24 the needs of the community as designated in the
25 State Health Plan.

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RECORD 002466

1 Q: I understand that, Mr. Caputo, but my question
2 is simply is it not possible to have expanded
3 Summerville Medical Center, the physical,
4 geographic location, and using the 94 beds you
5 have create private rooms and address some of
6 those concerns. I'm just simply asking is it
7 not possible to have done a project to go to
8 the private rooms, address your infection
9 control and privacy issues without adding 30
10 beds?

11 A: It is possible but I would never have, I would
12 never have considered that. But it is
13 possible.

14 Q: If you would answer any questions that either
15 Ms. Biggers or --

16 **THE COURT:** Ms. Biggers?

17 **MS. BIGGERS:** I don't have any questions, Your
18 Honor.

19 **THE COURT:** All right. Before the cross examination
20 starts I want to go off the record for just a
21 moment.

22 (Off the Record)

23 **MS. HOLLINGSWORTH:** And, Your Honor, if I could
24 before Mr. Summer starts his cross examination,
25 I would like to revisit that issue about

1 whether or not leading can be used on cross
2 examination with a witness, a friendly witness.
3 And unfortunately we didn't have any
4 information at the time but we have since gone
5 and found case law to support what we believe
6 to be correct. That with a friendly witness
7 the need for leading questions is gone and is
8 not appropriate even on cross examination.

9 **THE COURT:** I'll be glad to.

10 **MR. SUMMER:** If we can take a 15 minute break, Your
11 Honor, I'd like the opportunity to read the
12 case and I'd be happy to respond.

13 **MS. HOLLINGSWORTH:** I can hand it to the Court as
14 well.

15 **THE COURT:** Yeah, I'm going to stay in place but we
16 can go off the record.

17 **(Off the Record)**

18 **MR. SUMMER:** The Rules of Evidence, to my
19 recollection, were adopted September of 1995
20 and the only case that they've cited is a 1972
21 case which, the language is convoluted at best,
22 but let's just take for a moment that that may
23 have been the law in 1972. I think that that
24 would have been superseded by the adoption of
25 the Rules. And under 611, I'm just looking at

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1 it, and it doesn't carve out any exceptions.
2 Leading questions should not be used on direct
3 examination of a witness, that's on direct,
4 except as may be necessary to develop the
5 witnesses testimony. Ordinarily leading
6 questions should be permitted on cross
7 examination. The difference in that is if I
8 had called a hostile one in my case, I get to
9 lead. But the general rule is, without
10 exception in the notes that I can find, is that
11 ordinarily leading questions should be
12 permitted on cross examination. I also would
13 say, Your Honor, even if we looked at the '72
14 case, it is within the sound discretion of Your
15 Honor. Now, I can get everything I want to out
16 of this witness in four or five hours or I can
17 lead him and get done in an hour. I did not
18 call this witness in my case. They called it
19 in theirs. And the Rule is pretty clear with
20 no exceptions. Ordinarily leading questions
21 should be permitted on cross examination. So
22 our position remains the same, Your Honor.

23 **THE COURT:** Well, they qualify it by saying
24 ordinarily, but I think that leaves it open to
25 question.

1 MS. HOLLINGSWORTH: And, Your Honor, if I may just
2 respond. Certainly this case has not been
3 overruled and there's certainly no indication
4 within Westlaw that it somehow supercedes. I
5 think this case makes complete sense with what
6 is written in Rule 611(c) on this issue. The
7 reason being just like we saw with Mr. Gorrell
8 we end up with a situation where Mr. Summer can
9 make whatever statement he wants, isn't that
10 right, and gets an affirmative or a denial and
11 it just becomes sort of absurd that the
12 testimony ends up not being the witness' direct
13 testimony. I mean, this is a current employee
14 of Trident Health System, a CEO of Summerville
15 Medical Center, and we just don't think that
16 it's appropriate to lead to the point that the
17 only testimony is that of the attorney in a
18 leading question.

19 THE COURT: Based on the case of *State v. Hoffman*,
20 186 S.E. 2nd 421, head note five witnesses, I
21 sustain your objection.

22 MS. HOLLINGSWORTH: Thank you, Your Honor.

23 MR. CAPUTO - CROSS EXAMINATION BY MR. SUMMER:

24 Q: A little bit about your project. I want the
25 Court to get an idea about what your project

1 entails. And for purposes of this let's turn
2 to, let's go to Joint 9 do you have that in
3 front of you?

4 A: Yes, sir.

5 Q: And let's just start, if you would, on page
6 seven which is Bates Number 24. First of all,
7 this is for more than just the additional 30
8 beds?

9 A: Correct. It is 48, net 48 bed construction,
10 but we will net 30 beds in the conversion of
11 some semi-private rooms to private rooms.

12 Q: The first thing I want to talk to you about is
13 the notion of semi-private versus private.
14 Would you explain to the Court what HIPAA is?
15 Just very briefly and in general terms.

16 A: Sure. It is patient privacy, patient privacy
17 of patient information.

18 Q: Is that a federal law?

19 A: Yes.

20 Q: Does it provide certain restrictions on how you
21 handle taking health information regarding a
22 patient?

23 A: It does. It essentially says hospitals must do
24 everything that they can to do just that, to
25 protect patient health information and patient

1 privacy.

2 Q: Okay. Now, the construction of your semi-
3 private rooms pre-dates the enactment of HIPAA
4 by the federal government?

5 A: Yes.

6 Q: What challenges on a day-to-day basis does
7 having semi-private rooms place on you
8 regarding patient privacy and HIPAA?

9 A: The most obvious would be a physician would
10 come in to a patient in room say 301A, and
11 there's another patient in bed B, and they
12 would be talking with patient A as to what
13 their ailments are, what their diagnoses may
14 be, what their plan of care may be. And my
15 biggest concern is if that's sensitive
16 information, do you really want somebody on the
17 other side of the curtain to be privy to that.

18 Q: As a practical matter HIPAA doesn't distinguish
19 under PHI, protected health information, it
20 doesn't distinguish between sensitive and non-
21 sensitive, does it?

22 A: It does not.

23 Q: Okay. So that's information that needs to be
24 protected?

25 A: Correct. There's a, there's a general rule

1 that's called need-to-know. And if somebody
2 needs to know the information to provide care,
3 then they can be privy to that information.
4 The patient on the other side of the curtain
5 doesn't need to know that information, they're
6 not part of the care team.

7 Q: Now let's talk about infection control. Okay.
8 Especially in the age of MRSA. What challenges
9 in today's world does having semi-private rooms
10 pose for you regarding infection control?

11 A: What is pressing now is, our federally funded
12 agencies and many commercial funding agencies
13 are starting to reimburse or penalize hospitals
14 financially for infection rates. But more so,
15 generally speaking, operationally and
16 clinically, not being a clinician, by having
17 two people in the same room raises the risk of
18 transfer of infection.

19 Q: For instance if you have a patient who has a
20 staph infection in one bed and a surgical
21 patient in the other bed, that increases the
22 risk of infecting the second patient?

23 A: Right. And we do whatever we can to separate
24 what we would call clean or dirty, or infected
25 patients and uninfected patients. But there

1 are times where you don't have a clear
2 diagnoses on somebody until they have been in
3 the bed for a day or two touching the same
4 guardrail, using the same sink, using the same
5 restroom and so forth.

6 Q: Is it fair to say that semi-private rooms are
7 no longer the standard of care in hospitals?

8 A: I believe in most states, but specifically in
9 South Carolina, you cannot build new beds that
10 are not private.

11 Q: Okay. That having been said, is there an
12 advantage to you, operationally and from a
13 patient care standpoint, in discontinuing the
14 use of semi-private rooms?

15 A: Yes.

16 Q: How does this application help you do that?

17 A: We cannot -- with our current utilization we
18 cannot convert our existing semi-private rooms
19 to private rooms without new construction. So
20 adding the additional capacity is our only
21 opportunity to do that and continue to serve
22 the population that we have been serving. And
23 if we're going to invest a significant amount
24 of money to do that, we look at it
25 strategically and say, okay, that's one piece

1 of it but there's also a capacity issue,
2 there's also a future growth issue that ties
3 into that capacity. And so if we're going to
4 invest the money, let's do it right to be able
5 to serve the need for years to come.

6 Q: I think you made a point that recently you were
7 at 100 percent occupancy?

8 A: Yes.

9 Q: If you simply took your existing 22 semi-
10 private rooms and converted them to private,
11 your total bed compliment would be 22 from 94?

12 A: Yeah. Seventy-two beds.

13 Q: Okay. Could you --

14 A: Thank you for help on the math.

15 Q: Could you function at 72 beds?

16 A: I mean, what -- we would not cease operations,
17 let's just say that. But we would be turning
18 -- we would be redirecting patients to other
19 healthcare facilities that have capacity.

20 Q: All right. So one facet of this new
21 application is to convert those rooms through
22 new construction and add those beds, correct?

23 A: Correct.

24 Q: Then you're going to add 30 beds because you
25 have that ability under the State Health Plan?

1 A: Yes.

2 Q: All right. We'll go to the State Health Plan
3 in a minute. Let's look at the rest of these
4 issues that I think we can run through on page
5 23. Can you explain to the Court what an ICU
6 is?

7 A: An ICU is an intensive care unit. It is where
8 you treat the most clinically advanced
9 patients.

10 Q: One of the things you refer to on your direct
11 examination was a step-down unit. Would you
12 please explain to the Court --

13 A: Sure.

14 Q: -- what a step-down unit is?

15 A: Yeah, you'll hear it referred to as a
16 transitional care unit at times or a
17 progressive care unit as well. But as a --
18 when you have a critical patient in the ICU, as
19 they improve the appropriate setting is for
20 them to move out of the ICU where you have the
21 sickest patients into a more appropriate
22 environment. Staffing is a little bit
23 different. You don't have the stimulation of
24 your sensory system that you have in an ICU but
25 it's a more therapeutic environment and a more

1 appropriate environment.

2 Q: Okay. And you currently don't have a step-down
3 unit?

4 A: We do not. We currently -- you know, frankly
5 we probably hold patients, I say hold, keep
6 patients in the ICU a little bit longer than we
7 probably should and on the flip side we
8 probably keep patients on the medical-surgical
9 units a little bit longer than we should for
10 evaluation to see if they really should go to
11 the ICU. If we had a step-down unit, it would
12 give you the ability to better manage those
13 patients and make a more timely clinical
14 decision for the appropriate setting for care.

15 Q: Okay. Let's now turn our attention to the OB
16 and nursery issues that this application
17 addresses. How are you going to improve things
18 through this application?

19 A: We -- Summerville Medical Center's women's
20 services unit was built to handle about five to
21 800 deliveries a year. Last year we did about
22 1,100 deliveries, the year before we did about
23 1,200. We do not have enough capacity for pure
24 labor and delivery patients. And those are
25 rooms where the only thing that the mom does in

1 there is labor and deliver the baby. Then you
2 have recovery and postpartum rooms where after
3 post-delivery a mom recovers and then
4 postpartum is -- once they've sort of recovered
5 they stay there for a day or two until she and
6 the baby are ready to go home. And we don't
7 have the capacity to handle the labor and
8 delivery side of things in our existing unit so
9 we, in just labor and delivery rooms, so we --
10 and additionally we don't have enough
11 postpartum rooms. So right now postpartum
12 mothers in our med-surg unit. So once again
13 you're taking moms and putting them on a med-
14 surg unit where you may have an isolation room,
15 a patient that has some form of infection and
16 that's there for being sick, where the mother
17 is there for giving birth and they're not
18 necessarily sick and it's not, one, it's not
19 the environment that moms want, but most
20 certainly I feel like it's putting us at a
21 competitive disadvantage with the additional
22 capacity in some of the competing hospitals.
23 And they're extremely nice. I mean St.
24 Francis, East Cooper, Mount Pleasant, very,
25 very nice women's services units. So for a

1 discretionary, for a discretionary section of
2 healthcare, for women who are looking to have
3 the best experience they can, I think it puts
4 us at a competitive disadvantage.

5 Q: Let's talk about that a little bit. You talked
6 a little bit about adverse impact. Okay? I
7 want to put this into context. First you made
8 reference to the fact that in this case, the
9 Trident case, Carnes Crossroads, Moncks Corner.
10 Your previous testimony was that originally
11 Roper St. Francis contended they wouldn't have
12 any adverse effect on the existing providers in
13 the market place; is that correct?

14 A: Yes.

15 Q: In this case, your case, the Summerville case,
16 the 30 bed addition with all its renovation,
17 did Roper write a letter of opposition?

18 A: Yes.

19 Q: And did Roper tell DHEC they're going to have
20 an adverse impact on our new hospital at Carnes
21 Crossroads?

22 A: They did.

23 Q: Okay. So you view that as a substantial change
24 of position?

25 A: I do.

1 Q: Okay. Let's talk about this from your
2 standpoint and running your hospital. By
3 holding you up in litigation for years, how
4 does that benefit them as a competitor in Mount
5 Pleasant and downtown and at St. Francis at
6 their new facilities?

7 A: I think it goes back to the discussion again
8 around -- I start with the semi-private rooms,
9 the aged facility. When you have a choice of,
10 either as a physician where to practice or a
11 patient where to go, there's something
12 attractive about being in a private room, about
13 being in a brand new, nice facility. I think
14 by keeping us from doing this, those patients
15 may be inclined to go elsewhere for care.

16 Q: Let's go to Joint Exhibit Number 4 and let's
17 look at Roman numeral II-18.

18 A: Do you think I'll be able to see it on this
19 screen?

20 Q: You may be. We're going to start first on II-
21 18 and look at the bed need for -- we're going
22 to look at the bed need for the Trident
23 facilities. Now, is this the Plan that
24 Summerville applied under for its 30 bed
25 addition?

1 A: Yes, I believe so.

2 Q: Okay. I think we've now established the 30 bed
3 addition is a lot more than adding 30 beds,
4 it's a modernization and a streamlining of the
5 operations of your facility, correct?

6 A: Correct.

7 Q: Okay. What's the expressed bed need in the
8 plan that you applied under?

9 A: Twenty-four beds.

10 Q: Okay. Is it your understanding DHEC allows you
11 to build up to 50?

12 A: Correct.

13 Q: And you chose 30; is that correct?

14 A: Correct.

15 Q: Looking at Trident Medical Center's bed need is
16 56; is that right?

17 A: Correct.

18 Q: So that's a total of 80 beds?

19 A: Yes.

20 Q: Okay. Is it your understanding that the growth
21 projections here are based upon increases of
22 population and your facilities historical
23 utilization rate?

24 A: I believe that that's the biggest component of
25 the State Health Plan determination, yes.

1 Q: You've attracted doctors, you've attracted
2 patients, you've had utilization of your
3 facility and DHEC says you need more beds?

4 A: Yes.

5 Q: All right. DHEC did not say the same thing for
6 any other provider in this service area, did
7 they?

8 A: They did not.

9 Q: Okay.

10 **THE COURT:** Mr. Summer, let me ask you just at this
11 convenient point. That 56 beds that Trident
12 has the need for, that's the source of the beds
13 for the Berkeley Medical Center, isn't it?

14 **MR. SUMMER:** Actually, it's a little -- we've been
15 referring to one Plan, there are actually two
16 Plans in play.

17 **THE COURT:** We'll come back to it then. I don't
18 want to break your train of thought.

19 **MR. SUMMER:** We can. But we actually filed the
20 application that's under review here, the
21 Moncks Corner, Carnes Crossroads, the Moncks
22 Corner facility application was filed under the
23 prior Plan. It also showed a bed need but that
24 bed need actually increased from the prior
25 year, it went up from the prior Plan. But for

1 ease of reference, it think all of us have been
2 kind of focused on this one Plan because this
3 is the last Plan at issue in this case. This
4 is the Plan that Roper filed under for their
5 facility.

6 **THE COURT:** Thank you.

7 Q: I think you testified that you actually started
8 on the job in August of 2009?

9 A: Yes.

10 Q: Okay. Was one of the charges or directions
11 that you had from Mr. Gallati to basically
12 assess your institution top to bottom?

13 A: Of course, yes.

14 Q: Is the 30 bed application and the renovations
15 expressed therein, is that basically the result
16 of your assessment?

17 A: Among many things, yes.

18 Q: Okay. Let's go back and talk a little bit
19 about this, your career. One of the things
20 that you were asked about was decision support.
21 It sounds like there was a bunch of number
22 crunchers there?

23 A: We were a little more than that. But yeah,
24 that's a lot of what we did.

25 Q: All right. I think since you worked at

1 corporate in Nashville, can you give -- first
2 of all, is decision support one of the many
3 services that are encapsulated in that
4 management fee we've been talking about?

5 A: I believe so, yes.

6 Q: All right.

7 A: I'm not an expert like Karl is, less of an
8 expert like Karl on the financials, but I
9 believe so, yes.

10 Q: Because management, those management fees
11 capture the overhead of the corporate office?

12 A: Right. And decision support may not be
13 specific to one facility. There may be a group
14 of individuals that support multiple hospitals
15 so they would allocate those expenses.

16 Q: Can you give the Court an idea about how large
17 that HCA campus is in Nashville?

18 A: The entire HCA, just the corporate campus?

19 Q: Just the corporate campus. Where that
20 management fee is paid.

21 A: Goodness gracious. There are probably dozens
22 of buildings scattered around Nashville --

23 Q: The size of the building we're in right now?

24 A: Yes.

25 Q: Dozens?

1 A: Dozens.

2 Q: Okay.

3 A: It's a 180,000 employees --

4 Q: In Nashville?

5 A: 170 hospitals -- well, in the company. They're
6 supporting 165, 170 hospitals. A lot of
7 people. It's a big campus. A lot
8 infrastructure.

9 Q: And all of that infrastructure supports the
10 hospitals in the field, right?

11 A: Yes.

12 Q: Okay. You talked a little bit about being
13 concerned about Roper's strategies. Do you
14 consider them to be predatory strategies?

15 A: I do in my market.

16 Q: Okay. You talked specifically about, I believe
17 you made reference to their physician hiring
18 policies in other parts of the county. Why
19 does that concern you, vis-a-vis, Carnes
20 Crossroads?

21 A: My perspective, Roper had a very aggressive
22 physician employment strategy to gain alignment
23 in the markets they serve, specifically to
24 support their hospital in Mount Pleasant. I
25 feel most of their activity around employment

1 was to align themselves to support a new
2 hospital and continue to manage patient flow
3 and access into their, you know, their three
4 main facilities.

5 Q: And that's been to the detriment of East
6 Cooper, hasn't it?

7 A: I believe so.

8 Q: There was some discussion with you about
9 exactly how much Carnes Crossroads could hurt
10 you. First of all let's talk about it in terms
11 of if your physicians are peeled away at
12 Carnes Crossroads; how would that hurt you?

13 A: Significantly. I'll -- you know, from a couple
14 perspectives, the foundation of any community,
15 the foundation of any hospital, the foundation
16 of any medical staff is your primary care
17 physicians. And if Roper employed primary care
18 physicians and aligned them with the hospital
19 in Carnes Crossroads, then you lose that
20 referral base that has supported your medical
21 center for years. What you also likely lose is
22 that referral to your specialists and, yeah,
23 Summerville Medical Center is a community
24 hospital, but we do provide specialists service
25 and in order to meet the needs of our

1 community, our growing community, we want to be
2 able to provide additional specialty services
3 in years to come. And I fear -- I feel with,
4 again, a brand new hospital in Carnes
5 Crossroads and aggressive employment strategy,
6 they're going to employ -- either acquire
7 physicians that have been loyal to Summerville
8 Medical Center for years or put competitive or
9 competing specialists and primary care
10 physicians in that market that would really put
11 some significant pressure on the existing
12 medical staff as it stands today.

13 Q: The fact of the matter is they're not going to
14 spend 100 million dollars for a hospital and
15 not spend the money necessary to recruit
16 physicians, correct?

17 MS. HOLLINGSWORTH: Your Honor, object to the
18 leading nature of the questions.

19 MR. SUMMER: I'll rephrase the question, Your Honor.

20 THE COURT: Thank you.

21 Q: As an administrator, if you had a brand new
22 hospital that cost over 100 million dollars,
23 what do you do to get physicians in there?

24 A: I would have a very detailed, a very detailed
25 strategy to recruit additional physicians to

1 provide the services that we want to provide
2 and build that volume to make sure that that
3 hospital was financially viable.

4 Q: If Carnes Crossroads is not successful in
5 peeling your doctors away but instead they
6 bring new physicians and drop them into the
7 community, how would that hurt your physician
8 practices and ultimately you?

9 A: There is increasing pressures on physicians
10 around reimbursement, around liability,
11 malpractice, around scope of services and I
12 think that's -- so there -- it is challenging
13 today as it is insuring or working with
14 physicians to make sure that they are as busy
15 as they can be so they can stay in practice for
16 as long as they can be. And if you dump
17 competing physicians into a market, there will
18 be a split of patient volume. So a physician
19 that may have seen, that may have had 3,000
20 active patients may now have 1,500 active
21 patients and they may say do I really want to
22 keep my doors open or can I afford to keep my
23 doors open in this market.

24 Q: Is it fair to say it would upset the
25 equilibrium?

1 A: Yes.

2 Q: Now, would Carnes Crossroads hurt Summerville
3 Medical Center more or would it hurt Trident
4 Medical Center more?

5 A: In my opinion it would hurt Trident Medical
6 Center more.

7 Q: Because it's closer?

8 A: Yeah.

9 Q: We've had a lot of discussion and just for the
10 Court's edification, there is a difference
11 between recruiting physicians and employing
12 them. From the Bowling standpoint I know they
13 intersect, but --

14 A: Right.

15 Q: -- can you explain to the Court your options of
16 attracting physicians?

17 A: Yeah. There are very specific regulations
18 around hospitals assisting in recruiting
19 physicians to a community. Every hospital does
20 a community-needs analysis periodically to show
21 where there are deficits for physicians, very
22 similar to what the State Health Plan does for
23 beds. And when there is a deficit you are
24 allowed to provide assistance to physicians,
25 some financial assistance to physicians to help

1 them start their practice in that community to
2 meet that need. Another option is employment
3 and to employ a physician does not carry with
4 it the same, the same limitations or
5 complexities as you might find with providing
6 financial assistance. Employment or
7 acquisition is obviously a much longer
8 commitment. Financial assistance is typically
9 limited to a certain time period, typically a
10 year or two. The other option is really just
11 to sell your community, sell your hospital, and
12 sell the need to physicians for the opportunity
13 to come to your community and practice.

14 **THE COURT:** May I ask this question? The recruiting
15 then would be just get physicians near your
16 hospital, to bring them into the community, and
17 employing would be where you get your
18 hospitalists from?

19 **A:** Employment can be much more complex than that
20 and it's not just limited, it's not limited to
21 just hospitalists and there are hospitalists
22 that are not employed. In Trident Health
23 Systems case our hospitalists are employed.
24 I've worked at other hospitals where you had
25 groups that were not employed but still serve

1 as hospitalists. They did not have outpatient
2 clinics, they just did work inside the
3 hospital. So you would have physicians from
4 the community that had outpatient clinics that
5 would let those hospitalists manage their
6 patients when they were inside the hospital.
7 But employment can go beyond just hospitalists,
8 you can employ general surgeons, OB/GYNs,
9 pulmonologists, depending on what your strategy
10 is and what your needs are and what your model
11 is. And it could be a combination of
12 employment and independent physicians..

13 **THE COURT:** I understand. Thank you, sir.

14 **Q:** It's probably a good time to talk about the
15 difference between a hospital-based physician
16 and a community physician. What are some
17 examples besides hospitalists of other
18 hospital-based physicians?

19 **A:** Sure. Your traditional ones are your
20 radiologists, your anesthesiologists, your
21 pathologists. Many markets have a
22 neonatologist that manages the nursery and the
23 NICU. Intensivists are becoming more en vogue
24 today. They typically just do work inside the
25 hospital and I would consider those your

1 hospitalists.

2 Q: Now, those hospital-based physicians have more
3 traditionally been directly employed by the
4 hospitals, right?

5 A: It's been a mix. I mean, if it's not
6 employment, it's by an exclusive professional
7 services agreement.

8 Q: All right. When we look at community-based
9 physicians, what are we talking about when we
10 talk about community physicians as opposed to
11 hospital-based?

12 A: Physicians that have practices, clinics out in
13 the community where if somebody's sick but they
14 don't need hospitalization, they go to their
15 doctor.

16 Q: So that would be primary care?

17 A: Uh-huh (affirmative response).

18 Q: Cardiology?

19 A: Yeah.

20 Q: What are some other specialists that are
21 typically community-based?

22 A: OB/GYN, cardiologist, urologist, pulmonologist,
23 orthopaedics, general surgeons.

24 Q: Okay. Now, when we talk about Roper's
25 aggressive employment strategies, we're talking

1 about community-based physicians, aren't we?

2 A: Correct.

3 Q: Okay. So you're talking about all those people
4 outside the hospital that refer in?

5 A: Correct.

6 Q: And that's what you're concerned about?

7 A: Most definitely.

8 Q: There was a lot of discussion about --

9 A: Can I expand upon that a little bit?

10 Q: Sure.

11 A: The reason that's most concerning is they're
12 the ones that typically refer patients to the
13 hospital. So if a physician -- a hospitalist
14 will not refer a patient to the hospital. A
15 pathologist will not refer -- they're there to
16 support the operations of the hospital. When
17 an organization employs community-based
18 physicians, one of the benefits and strategies
19 is to control the patient referrals.

20 Q: They capture them?

21 A: To capture them. Because you can tell that
22 employed physician you're going to refer your
23 patients to our hospitals. You are an employee
24 of us, this is where you will refer your
25 patients, and you do what you can to influence

1 them with ethics and integrity.

2 Q: When you say with ethics and integrity, if MUSC
3 is really the only place that patient can be --

4 A: Correct:

5 Q: -- seen or appropriately treated, ethically
6 that physician would have to refer them to
7 MUSC?

8 A: Correct. And additionally, I would hope that
9 no hospital or health system would terminate
10 the employment of a physician if they referred
11 somebody to another hospital for whatever
12 reason.

13 Q: We've had a lot of talk about dollars and
14 adverse impact. Okay? And you've been working
15 with HCA for many years, right?

16 A: Right.

17 Q: Mr. Gorrell testified about the material
18 adverse impact of the 25 percent reduction in
19 net income, were you here for that?

20 A: I was.

21 Q: Okay. Do you consider that material?

22 A: Yes.

23 Q: Would it influence or affect your ability to
24 operate your hospital?

25 A: Most certainly.

1 Q: Would it affect your ability to get new capital
2 for reinvestment?

3 A: Certainly.

4 Q: Okay. Would it affect your ability to get
5 capital to replace equipment?

6 A: Certainly.

7 Q: Would it impair your mission?

8 A: Definitely.

9 Q: Also a lot of discussion about when and if you
10 get an outside consultant to work on a project;
11 do you remember that line of questioning?

12 A: I do.

13 Q: What if any effect does it have on your
14 decision to use an outside consultant on the
15 likelihood they may have to testify?

16 A: That's a great question. I certainly want an
17 expert if it's going to be -- if somebody's
18 going to be testifying.

19 Q: And you want them from the beginning, don't
20 you?

21 A: Correct.

22 Q: Okay. So is it fair to say on these major
23 projects it's more typical to see the outside
24 consultant?

25 A: Definitely.

1 Q: Do you think Goose Creek has a hospital today?

2 A: I do.

3 Q: Okay. And what hospital is that?

4 A: Trident Regional Medical Center.

5 Q: I want to throw up one other Exhibit for you to
6 take a look at. This in Petitioner's 225. I
7 want to take you to Baehr 1871, and we'll put
8 it up on the screen. Do you remember all the
9 patients that Ms. Hollingsworth had you
10 identify from zip codes 29483 and 29485 on
11 those slides?

12 A: I do.

13 Q: And those were patients that were coming from
14 the Roper system, right, or were you going to
15 the Roper system?

16 A: Right.

17 Q: Let's just put this in perspective. For 29483,
18 for the same type of services, we're looking at
19 non-tertiary, non-specialty admissions, how
20 much market share in 2010 did the Trident
21 system have?

22 A: Is it 29483?

23 Q: Right.

24 A: 70.3 percent.

25 Q: Okay. So that means basically almost three out

1 of every four patients were selecting a Trident
2 hospital over MUSC or the Roper system or the
3 VA or whoever?

4 A: Yes.

5 Q: Okay. Or East Cooper. All right. Now, let's
6 do the same thing for 29485. How many, what
7 was Trident's market share there?

8 A: 67.6.

9 Q: Okay. Again, an overwhelming majority of these
10 people are choosing the Trident hospitals over
11 any of the other competitors, right?

12 A: Right.

13 Q: I just wanted to put that in perspective in
14 terms of the numbers. All right. I'm sure
15 that Ms. Hollingsworth is going to have some
16 more questions for you. My last question to
17 leave you with and with the Court is as a
18 hospital administrator in that community would
19 you please just share with the Court why it's
20 important for there not to be a hospital built
21 in Carnes Crossroads?

22 A: I'll tell you that Summerville Medical Center,
23 first of all, can't wait to do our expansion.
24 And we can't -- it's frustrating to be -- what
25 I would say, held hostage to a proceeding that

1 I feel does not involve what we're trying to
2 do. I feel like that community has been well
3 served for years by Summerville Medical Center
4 and Trident Medical Center. And I feel if you
5 put a new hospital that close to existing
6 hospitals, it does no good to anybody but the
7 person putting the hospital there. I think
8 it's bad state health planning, it sets a bad
9 precedent, that it will put significant
10 pressures and strains on the resources that
11 Summerville Medical Center has had around our
12 employees, around our medical staff and around
13 our patients. And I think, and I think you
14 can't have it both ways. I think you can't say
15 that you won't have a negative adverse impact
16 on someone else and claim that there's others
17 having an adverse impact on you. It's one way
18 or the other. But I believe in my heart of
19 hearts that if you put a new hospital by Roper
20 in that market, that it will have a significant
21 impact on my hospital, Summerville Medical
22 Center, and it's going to keep us from
23 providing the services that we want to provide
24 for the community that we've served for, while
25 we've only been open since 1989 our history

1 goes back many years in Dorchester County.
2 It's going to keep us providing a level of
3 clinical care and quality care that we want and
4 need to provide.

5 Q: And would a hospital in Carnes Crossroads help
6 Moncks Corner at all?

7 A: I don't see how. It doesn't improve access,
8 anything notably.

9 Q: Thank you.

10 MS. HOLLINGSWORTH: Your Honor, I have no further
11 questions.

12 THE COURT: No further questions. You may step
13 down, sir. We've reached the 6:00 hour. The
14 court reporter has asked me for a break or are
15 y'all ready to break for the day?

16 MR. LONG: We are, Your Honor. We told Mr. Gunn
17 that he probably would not get up today. He
18 went about an hour ago. So we will start with
19 him in the morning.

20 THE COURT: All right. We'll be in recess until
21 10:00 tomorrow morning.

22 MR. SUMMER: Thank you, Your Honor.

23 (There being nothing further, the hearing recessed at
24 5:58 p.m.)

25 DAY 9 - THURSDAY, FEBRUARY 9, 2012

1 MS. HOLLINGSWORTH: Your Honor, may it please the
2 Court.

3 THE COURT: Ms. Hollingsworth?

4 MS. HOLLINGSWORTH: We call Terry Gunn to the stand.

5 THE COURT: Mr. Gunn.

6 TERRY J. GUNN, being duly sworn, testifies as
7 follows:

8 MR. GUNN - DIRECT EXAMINATION BY MS. HOLLINGSWORTH:

9 Q: Good morning, Mr. Gunn.

10 A: Good morning.

11 Q: Thank you for coming here again. Sorry we
12 couldn't get to you yesterday.

13 A: That's fine.

14 Q: If you could, state your full name for the
15 record.

16 A: Terry J. Gunn.

17 Q: And if you could, just briefly tell the court
18 your educational background.

19 A: After high school, I went to the University of
20 Oklahoma, received a bachelor's degree in
21 marketing and then went straight to graduate
22 school, received a master's degree in health
23 administration at Washington University in St.
24 Louis.

25 Q: Okay. And that was in 1988, correct?

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1 A: That's correct.

2 Q: All right. And did you have a fellowship
3 related to that master's program?

4 A: Yes, did a fellowship at Baptist Memorial
5 Health System in Memphis, Tennessee. It lasted
6 about seven or eight months.

7 Q: Okay. And no other graduate work but you
8 actually have another fellowship; is that
9 right? Or at some point you were in the
10 American College of Healthcare Executives?

11 A: Yes.

12 Q: Did you do that?

13 A: The American College of Healthcare Executives
14 is a professional organization and I achieved
15 fellowship status within that, within that
16 organization.

17 Q: Now, following your fellowship for your
18 master's degree, you began your career with
19 HCA, correct?

20 A: I spent about five years with the Baptist
21 Health System and then went on to HCA after
22 that.

23 Q: Okay. And when did you first begin with HCA?

24 A: Started with HCA in 1993.

25 Q: And what was that first position that you held?

1 A: The first position was in Nashville with -- I
2 was the assistant administrator at Donaldson
3 Hospital and we ended up closing that hospital
4 but moving to a brand new facility, Summit
5 Medical Center in Nashville.

6 Q: And that was the replacement hospital, Summit?

7 A: Yes. It was a replacement hospital.

8 Q: All right. How would you describe what
9 Donaldson and Summit was in terms of size and
10 care?

11 A: It was a community hospital, about 214 beds, if
12 I remember correctly, and provided basically
13 all of the services that you would -- you would
14 anticipate at a modern suburban hospital with
15 the exception of open heart surgery.

16 Q: And then where did you go next?

17 A: I went -- from there, I became the CEO at
18 Stones River Hospital in Woodbury, Tennessee.

19 Q: Okay. And you were there about two years,
20 right?

21 A: About two years, yes.

22 Q: And your next position was at River Park
23 Hospital?

24 A: Right. I was CEO at River Park for about four
25 years.

1 Q: All right. And then where did you go next?

2 A: After that, in about 2001, I went to Doctors
3 Hospital in Augusta, Georgia as the CEO.

4 Q: And how long were you there?

5 A: I was there till October of 2004.

6 Q: Okay. And you recall your deposition in this
7 case, correct?

8 A: Yes.

9 Q: Mr. Long took your deposition?

10 A: That's correct.

11 Q: Okay. Do you recall testifying that at the
12 time you joined HCA that to your knowledge it
13 was the largest investor-owned hospital system
14 in the country?

15 A: I believe that's -- that was my recollection,
16 yes.

17 Q: Is that still your recollection today?

18 A: Yes.

19 Q: Okay. Now, in 2004 is when you came to
20 Charleston, right?

21 A: That's correct.

22 Q: And what position did you take here?

23 A: I started as the CEO for Trident Health System.

24 Q: Okay. And what happened after that?

25 A: About nine months into it or so, my

1 responsibilities expanded to where I was
2 president for the Carolina Market, which was
3 primarily all of our hospitals in South
4 Carolina.

5 Q: Okay. And you considered your move to Trident
6 Health System to be a promotion, correct?

7 A: Yes.

8 Q: All right. And I believe you talked to us at
9 your deposition that you believed you had a
10 skill set that was something that Trident
11 Health System could use; is that right?

12 A: Sure.

13 Q: Do you agree with that?

14 A: Yes.

15 Q: And the skills you discussed were developing a
16 service portfolio; is that right?

17 A: Well, yes, developing service lines that would
18 help the hospital grow even further and a
19 little more rapidly than it had been.

20 Q: And you talked about sort of developing a
21 strong physician base and building quality
22 outcomes, right?

23 A: Correct.

24 Q: And, now, you had talked about what it took to
25 build a strong physician base; recruitment,

1 offering educational opportunities and adding
2 and building off of what was already present.
3 Is that what you did when you got to Trident?

4 A: Yes.

5 Q: And did you feel you were successful in
6 building quality within Trident while you were
7 there?

8 A: Yes.

9 Q: Now, we've talked a lot during this case about
10 Trident Health System, and just briefly for the
11 court, that actually encompasses multiple
12 facilities, correct?

13 A: That's correct.

14 Q: And what are those?

15 A: Trident Health System is made up of Trident
16 Regional Medical Center based in North
17 Charleston, the Summerville Medical Center in
18 Summerville and the Moncks Corner Center over
19 in Moncks Corner and then there were various
20 outpatient sites throughout the community as
21 well.

22 Q: Okay. So during your tenure with Trident
23 Health System, you were actually the CEO of
24 both Trident Medical Center and Summerville
25 Medical Center while you were at Trident?

1 A: Well, the -- I was the CEO for Trident Health.
2 System which was the, if you will, the parent
3 for all of the -- for Trident Medical Center,
4 Summerville Medical Center, Moncks Corner
5 Medical Center, and then there was -- but I was
6 also the CEO for Trident Medical Center campus.
7 But I had a separate CEO for the Summerville
8 Medical Center and had an administrator for the
9 Moncks Corner Medical Center.

10 Q: Okay. Who was your CEO for Summerville Medical
11 Center while you were there?

12 A: There were two. It was Pearce Fleming was the
13 first one and then he left to take another
14 position and P.J. Johnson was the CEO after --
15 after Pearce.

16 Q: Okay. And these three different facilities
17 that we've talked about, Trident Medical
18 Center, Summerville Medical Center and Moncks
19 Corner Medical Center, were all operated under
20 a single license, correct?

21 A: Yes.

22 Q: And they all fell under the umbrella of Trident
23 Health System, right?

24 A: That's correct.

25 Q: And they were all owned by HCA, correct?

1 A: Right.

2 Q: Now, physician recruitment was a specific goal
3 that you had while you were CEO at Trident
4 Medical Center, wasn't it?

5 A: Yes.

6 Q: And when you arrived there were only about one
7 or two employed physicians?

8 A: That seems about right.

9 Q: Okay. Do you recall how many there were when
10 you left?

11 A: We -- we -- we employed several of the
12 hospitalists so that was -- that probably was
13 about ten or 12 physicians, if I remember
14 correctly. And we may have added another one
15 or two that we actually employed, but -- so
16 probably, just rough math, I'd say 18 or 20 at
17 the most that we employed.

18 Q: Okay. In your deposition you thought it was
19 more like 25 to 30.

20 A: It could be.

21 Q: Okay. So it's somewhere within that range?

22 A: Yes.

23 Q: But regardless, you grew that -- those
24 physician employment relationships while you
25 were there?

1 A: Yes, we did add employment relationships while
2 I was there.

3 Q: Okay. And isn't it true that physician
4 employment is -- it's not necessarily for a
5 competitive advantage but it's an alternative
6 in terms of providing recruitment incentives?
7 There's the option to employ or you could do
8 other recruitment incentives all to build that
9 physician base?

10 A: I wouldn't say that that's true in every case.

11 Q: Okay. Is it true in some cases?

12 A: Yeah, it's true in some cases. You can use
13 employment for a lot of different reasons.

14 Q: Okay. What are some other reasons?

15 A: You can use it for stealing market share,
16 competitive advantage, you can use it for in
17 lieu of recruitment incentives, you can use it
18 to bolster up a service that you're just trying
19 to establish that may not necessarily be
20 conducive to a freestanding practice at that
21 point. So there's a lot of reasons. I
22 probably missed a few.

23 Q: Okay. So when you significantly grew those
24 physician employment relationships during your
25 four years, did you do it to steal market

1 share?

2 A: No.

3 Q: Okay. And did you do it for a competitive
4 advantage?

5 A: In terms of quality of care, yes.

6 Q: And so like as you've told the court, after
7 about a year you had some additional
8 responsibilities put on you?

9 A: That's correct.

10 Q: And how did your job change when those
11 responsibilities were added?

12 A: Well, the job stayed basically the same. I was
13 still responsible for the same things I
14 originally was with Trident Health System, but
15 then I had the added responsibility of our --
16 the Grand Strand System up in Myrtle Beach as
17 well as the Colleton Medical Center in -- or in
18 Walterboro.

19 Q: When you arrived in 2004, who did you report
20 to?

21 A: Let's see. I reported to Michael Joyce who is
22 the division president.

23 Q: Okay. And then who would he report to?

24 A: He reported to Charlie Evans.

25 Q: And who was Charlie Evans?

1 A: Charlie Evans was the group president for the
2 eastern group.

3 Q: And so when we discussed how your
4 responsibilities changed, maybe in 2005; does
5 that sound about right?

6 A: Yes.

7 Q: 2006?

8 A: No, it was -- I think it was about mid-2005.

9 Q: Okay. And so whose position did you take? Did
10 you subsume that division president role for
11 your area?

12 A: It's hard -- I assumed pieces of it. My
13 reporting relationship changed to Charlie Evans
14 who was the group president. I still utilized
15 some of the division support services in
16 Michael Joyce's division. And then I had my
17 own support leadership functions for the
18 market. So it's -- I can't really say that I
19 was -- I was not a division president; I was
20 the market president and utilized some other
21 folks for support.

22 Q: Okay. But when you added that additional layer
23 in 2005, you kind of cut out a layer of
24 reporting and you went straight up to the group
25 president, correct?

- 1 A: I reported to the group president, yes.
- 2 Q: And what is your understanding of what the
- 3 group president's role was? What did they do?
- 4 A: The group president oversaw all of the
- 5 hospitals in the eastern part of the United
- 6 States for HCA, and that -- that primarily
- 7 included all of Florida, all of South Carolina
- 8 and all of Georgia.
- 9 Q: Okay. And when you were there, how many groups
- 10 presidents were there for HCA?
- 11 A: Three.
- 12 Q: And do you know how many -- when you were
- 13 reporting to Charlie Evans, do you know about
- 14 how many hospitals he had under his purview?
- 15 A: Let's see. I would guess 70 to 80.
- 16 Q: And then at some point while you were there,
- 17 Charlie Evans was replaced by Chuck Hall,
- 18 right?
- 19 A: That's correct.
- 20 Q: Okay. Do you recall about when that was?
- 21 A: I believe that was late in 2006.
- 22 Q: And did Chuck Hall remain who you reported to
- 23 directly the remainder of your time with
- 24 Trident Health System?
- 25 A: Yes.

- 1 Q: Okay. Now, when you first got to Trident, Jim
2 Rardin, who actually testified earlier in this
3 case --
- 4 A: Okay.
- 5 Q: -- he worked for you, correct?
- 6 A: Yes.
- 7 Q: And what was his role initially?
- 8 A: Initially Jim was the chief operating officer
9 for Trident Health System.
- 10 Q: And then at some point he moved over to a
11 senior vice president role of development?
- 12 A: Yes. When -- when I took over the role as
13 market president, Jim moved into the develop --
14 senior vice president for development and
15 worked with me throughout the market.
- 16 Q: Okay. And who was your CFO, your chief
17 financial officer?
- 18 A: It was Karl Gorrell.
- 19 Q: And was he your CFO the entire time you were
20 with Trident?
- 21 A: Yes, he was my CFO at Trident and then he moved
22 up with me to the market as the CFO for the
23 market as well.
- 24 Q: And if we could talk a little bit just about
25 sort of what Summerville and Trident Medical

1 Center were like while you were there. I
2 believe you told us in your deposition that of
3 all the hospitals you've ever been at,
4 Summerville Medical Center had the strongest
5 connection to its community; is that right?

6 A: Yeah, Summerville had a very, very strong
7 community connection. The CEOs, both Pearce
8 and P.J., were very involved in the community,
9 the community embraced them and they had a very
10 strong connection with the local community.

11 Q: Okay. Now, how far is Summerville Medical
12 Center from Trident's main campus?

13 A: It's about, oh, probably less than ten miles,
14 seven or eight miles maybe, something like
15 that.

16 Q: Maybe six miles?

17 A: Maybe six miles.

18 Q: Okay. And so in contrast to sort of the
19 community ownership nature of Summerville
20 Medical Center, Trident Medical Center didn't
21 have that same connection, did it?

22 A: Actually, you know, Trident had a good
23 connection with all the communities, you know,
24 that it served. You know, obviously, as
25 Summerville had a strong relationship in

1. Summerville, Trident Health System was also a
2. very visible and active player. You know, I
3. remember I would routinely go by Berlin Myers
4. Lumber store, that's the mayor of Summerville,
5. and we would have coffee together and visit so,
6. you know, things of that nature. So a lot of
7. times, even though it may be Summerville is the
8. -- kind of the vehicle that everybody saw, I
9. think they also -- there was a lot of carryover
10. in terms of how the Trident Health System or
11. Trident Medical Center, for that matter,
12. because it was the referral hospital, really
13. enjoyed a lot of those same strong
14. relationships in all of its communities,
15. whether that was, you know, Goose Creek,
16. Summerville, Moncks Corner, North Charleston,
17. you name it.

18. Q: But you have stated before that you felt like
19. Trident Medical Center was a hospital without
20. a community, didn't you?

21. A: That -- I think that's part of a bigger --
22. bigger thing that I have said. I think that's
23. taken a little out of context to twist it to a
24. negative connotation like that.

25. Q: Okay. But those were the words, correct?

1 A: Out of context, I will agree that that's what
2 I said.

3 Q: Okay. Now, in terms of your replacement when
4 you left, do you know who took over your
5 responsibilities at Trident Health System?

6 A: My role changed quite a bit after I left. The
7 role was really split back into two roles and
8 a dedicated CEO was hired for Trident Health
9 System. It kind of went back to the original
10 structure. And Todd Gallati, who I think has
11 been involved in the case up to this point,
12 took the CEO role. And Jamie Thomas took the
13 division president role and a new division was
14 created. So basically I was replaced by Jamie
15 as division president and Todd as the CEO for
16 the hospital.

17 Q: So Todd came into the position that you started
18 out at in 2004; is that fair?

19 A: That's a fair statement, yes.

20 Q: And, now, when did you leave Trident Health
21 System?

22 A: My official last day was September 30, 2008.

23 Q: And you say official last day. Did you sort of
24 cease day-to-day operations at some point
25 before that?

1 A: Yes. I don't remember the exact day that I
2 stopped coming into the office. There was
3 about a four month, four or five month
4 transition period where we were just working
5 through an orderly transition of power to the
6 new administration. So I'd say probably early
7 fall, you know, maybe around mid-August,
8 September, I was beginning to scale back the
9 number of days I was spending in the office.

10 Q: And so in September 2008 when you left Trident
11 Health System, did you leave HCA?

12 A: Yes, I left HCA as well.

13 Q: And have you worked for them since then?

14 A: No.

15 Q: Have you worked at any hospital since then?

16 A: Not -- no.

17 Q: Okay. Now, I believe you told us that your
18 decision to leave Trident Health System was you
19 just didn't want to relocate again; is that
20 right?

21 A: It was a mutual decision that Chuck and I --
22 Chuck Hall and I came to as he was -- explained
23 to me he was restructuring the market into a
24 division and I would have options to, you know,
25 either relocate within the group or what have

1 you at another hospital. And we really didn't
2 carry that discussion on beyond more than about
3 a 20 minute conversation where I said I just
4 was not -- where I had been willing to
5 relocate, as you heard earlier, you know, every
6 three or four years, I was just not willing to
7 do that with two teenage boys at home that
8 needed some stability, so I opted to leave the
9 company and the hospital at that point and find
10 another way to make a living and be able to
11 stay in Charleston.

12 Q: And now Trident Health System was successful
13 within the HCA system while you were there,
14 wasn't it?

15 A: Yes.

16 Q: And, in fact, even if you may have time when
17 volumes were flat, you still experienced
18 increased earnings?

19 A: That was my recollection. We always were able
20 to increase earnings.

21 Q: And Summerville was a good suburban hospital,
22 but you felt like Trident Medical Center was of
23 an even greater financial caliber; is that
24 right?

25 A: I didn't -- I wouldn't rank them in terms of

1 caliber based on financials. Trident was a
2 more complex, you know, what we could call in
3 the healthcare industry a tertiary hospital,
4 which basically means it provides all the
5 specialty services, the full range that you may
6 not necessarily have at a suburban hospital.
7 So -- so, yeah, I -- I viewed it as a much more
8 complex, larger, more comprehensive
9 organization than what Summerville offered at
10 the time.

11 Q: Right. And Summerville, just six miles away
12 though, was still a successful community
13 hospital, right?

14 A: Oh, yes.

15 Q: Okay. We're going to look at some documents
16 and you have notebooks in front of you and then
17 it should also be on the screen.

18 A: Okay.

19 MS. HOLLINGSWORTH: Bonnielyn, if we could look at
20 Respondent Exhibit 89.

21 Q: So if you'd like to look in the book, Mr. Gunn,
22 you can flip to the tab 89.

23 A: Okay. You're going to have to orient me on how
24 to use these.

25 Q: Sure. Sure.

1 MS. HOLLINGSWORTH: Your Honor, if I may.

2 Q: This would be Exhibit 1 to 75 and this is --

3 A: Okay.

4 Q: \ It there should be a numbered tab.

5 A: And you said 85?

6 Q: Eighty-nine.

7 A: Eighty-nine, okay.

8 Q: Take a moment to look at that.

9 A: Okay.

10 Q: This is Summerville Medical Center
11 Profitability by Financial Class and it covers
12 from January to December 2007; is that right?

13 A: Yes.

14 Q: Okay. And you were the CEO of Trident Health
15 System during 2007, correct?

16 A: That's correct.

17 Q: And you've seen reports such as this while you
18 were there?

19 A: This looks familiar, yes.

20 Q: Okay. Now, if we look at the information in
21 this report -- let's see, let me make sure I
22 can find it and direct you to the right place

23 --

24 A: Is this on? Do you need me to point this at
25 me?

1 COURT REPORTER: No, it's fine. You don't need to
2 worry about that.

3 A: Okay.

4 COURT REPORTER: Thank you, though.

5 Q: If you look --

6 MR. LONG: While we have a break, I don't know if I
7 told you yesterday but we put our exhibits over
8 there and if he wanted to look at a hard copy
9 of any of these documents, these notebooks are
10 over there. And they'll be on the screen also,
11 Your Honor, but I know you've sometimes been
12 looking in the book so I just wanted to make
13 sure you realized that.

14 Q: And, Mr. Gunn, do you see in the second to last
15 column titled EBDITA, do you see that?

16 A: Yes.

17 Q: And that number on the bottom, does that
18 reflect the inpatient earnings before
19 depreciation, interest and taxes for the year
20 2007?

21 A: Yes, EBITDA is earnings before depreciation,
22 interest, taxes and amortization expenses.

23 Q: Okay. And what's that number?

24 A: The total?

25 Q: Yes, sir.

1 A: It is \$10,276,947.

2 Q: Okay. And if you look at the next page of that
3 exhibit, you have a similar number for
4 outpatient. Can you read that number into the
5 record?

6 A: It is \$11,414,660.

7 Q: And so Summerville Medical Center had strong
8 financial performance while you were there,
9 correct?

10 A: Yes, they did fine.

11 Q: Let's look at Respondent's Exhibit 150.
12 Hopefully that's in that same notebook.

13 A: I've got it.

14 Q: We've talked about this quite a bit during the
15 trial but just for the record, the financial
16 statements, financial reports for the health
17 system were typically consolidated, correct?

18 A: They were consolidated, yes.

19 Q: Right. So that report we looked at for
20 Summerville Medical Center, that actually
21 wasn't the norm in terms of how you would do
22 reporting, correct?

23 A: That -- that was not the norm and those were
24 estimates that were --

25 Q: They were kind of pulled out --

1 A: -- generated out of calculations and
2 assumptions, so I wouldn't put a whole lot of
3 stock into what that number was, but.

4 Q: Well, it was based on information though
5 reported by the facility, correct?

6 A: Yes, but it's -- it took a lot of maneuvering
7 to get to those numbers and it, you know, the
8 key was you wanted to look at it over time so
9 you could see how it's moving, but yeah, just
10 -- just wanted to make sure that was clear.

11 Q: Sure.

12 A: I wouldn't make any investment decisions or,
13 you know, make definitive statements about
14 their -- their true financial performance based
15 on those numbers.

16 Q: You would look at the consolidated, combined
17 information?

18 A: I would look at the consolidated, those are
19 actual, as reported, numbers, yes.

20 Q: All right.

21 **THE COURT:** Excuse me, what exhibit?

22 **MS. HOLLINGSWORTH:** Your Honor, we're looking at --

23 **THE COURT:** You said 150?

24 **MS. HOLLINGSWORTH:** 150, Your Honor, Respondent's
25 150.

1 THE COURT: And what page of it?

2 MS. HOLLINGSWORTH: Page three is what we're going
3 to do, Your Honor.

4 Q: Do you recognize this document, Mr. Gunn?

5 A: Yes, it's familiar.

6 Q: Okay. And what is it?

7 A: This is a -- this is a financial statement and
8 operating indicators report.

9 Q: Okay. If you look on the third page, that
10 should be 2007's information.

11 A: Yes.

12 Q: Do you see what the combined system earnings
13 report, interest, depreciation and taxes is?
14 Do you see that number?

15 A: Which one do you -- you wanted the EBDIT
16 number? You don't want the EBITDA; is that
17 right?

18 Q: Well, this report gives us EBDIT, correct?

19 A: This -- this report gives us EBDIT, which is
20 different from what we were looking at earlier,
21 but yes.

22 Q: Sure. It's missing the one component of
23 amortization?

24 A: Correct.

25 Q: And what is that number on this report?

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1 A: For the year, it was \$82,999,822.

2 Q: So again, during your tenure with Trident
3 Health System, it was what you would consider
4 a successful, profitable health system for HCA?

5 A: Yes.

6 Q: You would agree it was a good investment for
7 the stockholders of HCA?

8 A: Yes.

9 Q: Now, when we talked in your deposition about
10 the information you liked looking at as a CEO,
11 when you were looking at performance you
12 preferred the raw data in terms of your
13 admissions, your outpatient procedures, the
14 information going on, the day-to-day within
15 your facilities, correct?

16 A: That's correct.

17 Q: You actually felt that the state's market share
18 information was stale; is that right?

19 A: It was stale and I -- I never really could get
20 anybody to give me an explanation of how you
21 come up with that information without a whole
22 lot of gyrations of manipulation and formulas,
23 so I put very little stock in the state
24 manufactured data.

25 Q: Right. You were more concerned about sort of

1 your actual patient experiences --

2 A: I wanted to go --

3 Q: -- right?

4 A: I wanted to see what was going on in my shops
5 on a -- on a regular basis.

6 Q: And financially you were doing well, correct?

7 A: Yes, we were doing well financially.

8 Q: Now, we had talked about what Trident Medical
9 Center and Summerville Medical Center offered
10 and you actually discussed sort of the unique
11 nature of Trident with that specialty in sports
12 medicine, right?

13 A: Say that -- say that again. I'm sorry.

14 Q: Sports medicine is something you thought was
15 unique about Trident Medical Center's
16 offerings?

17 A: I thought it was one we had a definite
18 advantage. I don't think it was unique. Other
19 hospitals had sports medicine, but I thought
20 ours was certainly the best in town.

21 Q: And same with you thought a strength of Trident
22 Medical Center was that strong primary care
23 network that was distributed throughout the
24 community?

25 A: Yeah, I would put our primary care network up

1. against anyone else's in town, yes.

2 Q: And, in fact, Palmetto Primary Care, which was
3 the -- is the largest primary care provider in
4 your area, was loyal to Trident, right?

5 A: Yes.

6 Q: Okay. And do you recall when you were there
7 how many physicians they had?

8 A: Wow. I think you asked me in my deposition, so
9 I want to say it was about 20, 25 maybe.

10 Q: Isn't it more like 50?

11 A: I think -- 50?

12 Q: More than 50 while you were there?

13 A: No, they didn't have that many while I was
14 there. They may have that many now, but I
15 don't remember it being 50, but.

16 Q: Okay. All right. But they had a heavy
17 presence around Trident's campus, didn't they?

18 A: They had a heavy presence on the campus, but
19 they were also -- they were throughout all the
20 communities we served, so they had a -- they
21 had a pretty even balance throughout our whole
22 service area.

23 Q: And they were around Summerville's campus as
24 well?

25 A: I think they had three offices, roughly, in the

1 Summerville community; they had a couple
2 offices in Goose Creek, Moncks Corner, Daniel
3 Island, North Charleston, Archdale. I mean
4 they -- they were kind of -- they were all over
5 our market, yes.

6 Q: Okay. And the next largest primary care
7 provider only had about five physicians, right?

8 A: Who you -- who are you referring to?

9 Q: Berkeley Family Practice.

10 A: Berkeley Family Practice, I can't remember if
11 they had -- I was thinking they might have had
12 about three, three and maybe a couple of
13 extenders, physician extenders.

14 Q: So when we say Palmetto Primary Care was the
15 largest primary care provider, by far they had
16 the most physicians, correct?

17 A: Oh, yes.

18 Q: Substantially larger?

19 A: In terms of primary care?

20 Q: Yes, sir.

21 A: Yes.

22 Q: Now, when we discussed competition, while you
23 were with Trident Health System you believed
24 that Roper's downtown facility competed with
25 Trident Medical Center, right?

- 1 A: Yes, I viewed Roper as a competitor.
- 2 Q: Okay. And that's because they're both a
- 3 tertiary care hospital, they perform those
- 4 higher acuity services; is that right?
- 5 A: Well, they both perform the services, but
- 6 anytime you lose a patient to another hospital
- 7 for whatever reason, whether it's physician
- 8 referral or patient preference, that's a
- 9 competitor, so.
- 10 Q: And, now, St. Francis you felt like was more of
- 11 a competitor of Summerville, right?
- 12 A: Yes, I believe they provided a similar level of
- 13 service and given the way Summerville kind --
- 14 the Summerville community, and especially
- 15 Dorchester County, kind of where the lines are,
- 16 you know, a good portion of Dorchester County
- 17 was almost equidistant between Summerville and
- 18 the Roper Hospital St. -- St. Francis, so.
- 19 Q: All right. And, now, in terms of Roper St.
- 20 Francis as an organization, you felt like they
- 21 were a competitor in your marketplace, right?
- 22 A: I felt they were a competitor and I definitely
- 23 felt the leadership was very aggressive in
- 24 terms of driving their competitive nature.
- 25 Q: Okay. And, in fact, in your deposition you

1 talked about an instance where a physician
2 practice moved their referrals from Trident
3 over to Roper a few years in your time; do you
4 remember that?

5 A: I don't remember us talking about that on the
6 deposition. You may have to refresh my memory.

7 Q: Do you recall the instance of that happening?
8 Do you recall while you were at Trident Health
9 System where a physician practice moved its
10 referrals over to Roper?

11 A: I don't remember that instance.

12 Q: Okay. And whether that did or not, I believe
13 you called it a blatant shift, and if we need
14 to pull out your deposition we can. But
15 regardless, there was no tremendous impact
16 while you were there on admissions related to
17 moves by Roper St. Francis, was there?

18 A: Say that one more time. I want to make sure I
19 --

20 Q: Do you recall any tremendous shift in
21 admissions while you were with Trident Health
22 System that you relate to Roper St. Francis?

23 A: You know, as I'm looking at bigger numbers, I
24 don't remember that standing out, but again I'm
25 looking at admissions every day, I'm listening

1 to what physicians are talking about in the
2 doctors lounge every day and if I lost one
3 patient to Roper, I viewed it as -- as big of
4 a loss as if I lost a hundred patients to
5 Roper.

6 Q: That's fair, but --

7 A: But I don't remember -- I don't -- to answer
8 your question specifically, I really don't
9 remember this far down the road --

10 Q: Okay.

11 A: -- there being a big blip of patients running
12 to Roper.

13 Q: Okay. And you do recall earning more money
14 every year while you were at Trident Health
15 System?

16 A: That's -- that's the way I recall it, yes.

17 Q: And while you were with Trident Health System,
18 you actively worked on recruiting physicians to
19 your health system, didn't you?

20 A: Yes, we recruited several physicians to the
21 campus.

22 Q: And there was never an objective analysis done
23 during your tenure to determine what Roper St.
24 Francis' impact was on Trident Health System,
25 was there?

1 A: Well, be a little more specific for me.

2 Q: Do you recall doing any sort of analysis to
3 look at Roper St. Francis' impact on Trident
4 Health System while you were there?

5 A: We constantly evaluated the impact. I don't --
6 I can't -- I couldn't point you to a document
7 that we methodically sat down and calculated
8 it, but we were constantly evaluating it.

9 Q: All right.

10 A: It's a dynamic market.

11 Q: All right. And you were CEO of the health
12 system when the decision was made to file the
13 certificate of need that's under review in
14 these proceedings, weren't you?

15 A: Yes.

16 Q: And it was your discretion to file the
17 application, correct?

18 A: Yes, it was my decision to do it.

19 Q: Okay. And you didn't have to satisfy any
20 particular criteria with HCA in order to file
21 the application?

22 A: I mean, I had -- you know, we had to discuss it
23 and I mean it was obviously -- I didn't just
24 act, you know, out of isolation, but I mean it
25 was an active discussion we were having. I

1 wouldn't have filed it if I didn't have support
2 to file it.

3 Q: Sure. But --

4 A: Or if I didn't think it could be funded or
5 something like that.

6 Q: Understood. But you didn't have to have any
7 checklist of things you have to mark off for
8 HCA before you can move forward with filing a
9 certificate of need?

10 A: No, we don't work with checklists at that
11 level, no.

12 Q: All right. But I mean this was a capital
13 expenditure of \$115 million, right?

14 A: How much?

15 Q: \$115 million?

16 A: \$115 million, now that's the number I remember,
17 yes.

18 Q: Okay. And so you had to get permission from
19 your boss, didn't you?

20 A: Oh, yes.

21 Q: And Chuck Hall was supportive of the
22 application?

23 A: Yes.

24 Q: Okay.

25 A: Yes. After -- after a few, you know, several

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1 phone calls, a few meetings showing him the
2 need that we were projecting and going back
3 into the whole history of just, you know, our
4 mission in Berkeley County and the fact that we
5 were -- we were very methodically, very -- in
6 a very structured and planned manner, you know,
7 meeting those needs as, you know -- you know,
8 we had gone back -- you know, if you want me to
9 go back, you know, we had gone back to the
10 early '70s when Dorchester and Berkeley County
11 consolidated -- closed their facilities and we
12 built a consolidated center with everyone's
13 support at the North Charleston campus, Trident
14 Medical Center. Which at that time, you know,
15 there wasn't a whole lot of stuff out there,
16 but that was -- that was the will of the people
17 at that time and -- and as we continued to grow
18 and reinvest back into those communities, we
19 began to build a facility in Summerville and we
20 were very methodically building a presence on
21 our Moncks Corner campus with outpatient
22 services, physician offices, a freestanding
23 emergency center, and with the ultimate hopes
24 that it would develop into a hospital at some
25 point for them as they were able to support a

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1 full-time hospital.

2 Q: And back to my question though, Chuck Hall
3 approved of the decision to file the
4 application --

5 A: Yes.

6 Q: -- correct?

7 A: Yeah. I'm sorry, I -- I diverged a little bit.
8 But once he had all of that information, saw
9 where we were coming from, saw how it was just
10 part of our orderly progression, yes, he
11 approved it.

12 Q: Okay. Let's look at Petitioner's 201.

13 **MS. HOLLINGSWORTH:** And, Your Honor, we'll only look
14 at it briefly and I don't know if the
15 petitioner's exhibits are --

16 A: Is that another book?

17 Q: It is a different book, but you'll be able to
18 see it on the screen.

19 A: Oh, okay.

20 Q: Do you recognize this document?

21 A: It looks like a business case narrative for the
22 Cane Bay project.

23 Q: And you've seen this document before, correct?

24 A: I've -- yeah, I'm sure I have. Yes.

25 Q: And we discussed it --

1 A: It's been a long time since I've been there,
2 so.

3 Q: Sure. Sure.

4 A: But yes, it looks like something I would have
5 seen.

6 Q: And we discussed it in your deposition, right?

7 A: We probably did, yes.

8 Q: And the Cane Bay, that's 20 acres of property
9 that you have in the Cane Bay area of Berkeley
10 County, correct?

11 A: Yes.

12 Q: And how would you describe where that's located
13 in Berkeley County?

14 A: It's a little bit further up the road from
15 Goose Creek on 176 I think is the road name,
16 but it's -- it's a large planned developed,
17 it's got a senior living center located in it
18 and was proposed -- and it had a few homes
19 built there initially, but it was proposed to
20 be a large home development, multi-levels and
21 all that.

22 Q: Okay. This 20 acres was purchased while you
23 were at Trident Health System, right?

24 A: Yes.

25 Q: Okay. And you liked that area of Berkeley

1 County, right?

2 A: Yeah, I was pretty attracted to it, yes.

3 Q: Okay. And now you testified at your deposition
4 that this business case narrative was the type
5 of document that you would prepare or have
6 prepared, when you were considering an
7 acquisition; is that right?

8 A: Internally, that's what -- that's the kind of
9 document we would go off of, yes.

10 Q: And this would be something you may pass up the
11 chain-of-command to have them look at and help
12 them consider the opportunities?

13 A: Yes. It's what I would use to -- once I've got
14 preliminary approval to put something like that
15 together and I've kind of got some buy-in, you
16 know, we would put a document like this
17 together to get, you know, a further level of
18 commitment from the corporate office and
19 ultimately, well not ultimately, but the next
20 step is to get that then to release the real
21 estate department to help us secure the land
22 through acquisition.

23 Q: Okay. If we can look at page three of the
24 document just to clarify what we were talking
25 about earlier. Page three of the exhibit, I'm

1 sorry. This would be Petitioner's 201-003.
2 And if we look down at the paragraph that says
3 division, Bonnielyn can blow that up for us a
4 little bit. And, Mr. Gunn, this is actually
5 where the quote, "Hospital without a
6 community," comes from, isn't it?

7 A: Well, can you drop it down just a little bit?
8 It's dropped off to the right. Let me have a
9 chance to read it.

10 Q: Sure. Take your time.

11 A: There we go. (Witness reviews document.)
12 Okay. And your question was?

13 Q: To confirm, we had discussed that quote
14 earlier, that Trident Medical Center was a
15 hospital without community, and I wanted to
16 make sure that you could remember the context
17 in which that quote came from. Do you see
18 that?

19 A: I see where you're quoting me and -- and I do
20 have a better feel for the context.

21 Q: Okay. And, now, this Cane Bay property, and
22 again we saw from the first page it was
23 entitled Cane Bay -- let's see, Cane Bay
24 Community Medical Center. I believe that's
25 right. Cane Bay Community Medical Center. You

1 actually had looked at this property as a
2 location to do what you described as a chassis
3 model of development; is that right?

4 A: Yes. If you look in our history, that's what
5 -- we started at Summerville with basically
6 physician offices, outpatient service center
7 and that grew into an emergency center and then
8 ultimately as it got busier and the community
9 grew, we built a hospital around that, just
10 attached it to it. Moncks Corner was
11 progressing the exact same way. And my thought
12 was we're at least going to start our
13 development. While this was really focused on
14 building an outpatient center and medical
15 office building --

16 THE COURT: You say this, you mean Cane Bay?

17 A: The Cane Bay, I'm sorry, yes. So our -- but my
18 intent, thinking well into the future, is I'm
19 not going to be shortsighted and just put up an
20 outpatient center. If that community takes
21 off, if it really grows, ultimately it needs to
22 have enough expansion capacity that we could
23 perhaps add an emergency room down the road.
24 Yeah, maybe it needs a hospital down the road,
25 I don't know; that wasn't necessarily my

1 intent. But I just didn't want to be
2 shortsighted and build too small of a chassis
3 that we couldn't have expansion options down
4 the road.

5 Q: And you bought 20 acres because you knew
6 ultimately you could put a hospital there if
7 you wanted to?

8 A: Twenty acres is pretty tight for a hospital, at
9 least in all the projects I've seen over my 20
10 year career in the hospital business, but it
11 was enough to expand it. Honestly, if we were
12 going to put a hospital on it, we'd have to
13 have a little more land than that.

14 Q: Okay. But you only optioned 21 acres in Moncks
15 Corner for the hospital that you filed an
16 application for, correct?

17 A: If the property is configured right, it can
18 work. But a lot of that has to do with how
19 many access points you've got coming in and,
20 you know, the street layout and just, you know,
21 is it a square or is it, you know, cut up.
22 And, you know, 20 acres would be enough to get
23 it going. Now, you know, we had planned ahead
24 on the Moncks Corner site. We can put a
25 hospital on 20, I think 21 acres plus what we

1 already had on Moncks Corner. That made it big
2 enough. But it at least gave us enough to work
3 with and expand and we probably could have
4 sited a hospital on it, but I would probably
5 want a little more land than that if I was
6 going to build a hospital right away.

7 Q: Okay. But you did testify at your deposition
8 when we asked you if you could put a hospital
9 on those 20 acres, you said you could, correct?

10 A: Actually, I looked at doing it. When -- once
11 I realized that Roper was trying to leapfrog us
12 and come out to build a hospital at their
13 Carnes Crossing site, as kind of a knee-jerk
14 reaction, I asked the planners, I said can you
15 -- can you fit a hospital onto that site and
16 they said yeah, we could -- we could get one on
17 it. So, yeah, I asked the question.

18 Q: Okay. And, in fact, you testified that you
19 liked this part of Goose Creek east of I-26,
20 Interstate 26, because it was a residential
21 area growing from timberland; is that right?

22 A: Yes, I was very impressed with the -- with that
23 location.

24 Q: And, in fact, you testified that it wasn't
25 easily served by your existing facilities, was

1 it?

2 A: It would not have been easily served by -- by
3 the Moncks Corner facility, so I felt like we
4 at least needed to get an outpatient presence
5 there. Because, you know, unlike a hospital
6 where people may drive a few miles to that, you
7 know, if you're going to get blood work or, you
8 know, just an outpatient scan, I mean that
9 needs to be very convenient and easy access to
10 either where you work or where you live. So I
11 felt like it at least needed to have that
12 development there.

13 Q: Okay. And so you felt like this Cane Bay area
14 of Goose Creek would increase that access,
15 correct?

16 A: To the outpatient services, yes.

17 Q: Okay. But ultimately you didn't build at Cane
18 Bay, did you?

19 A: That's correct.

20 Q: And, in fact, while you were CEO, the decision
21 was made to put the hospital in Moncks Corner,
22 right?

23 A: As we started really looking at the way things
24 were playing out and quite honestly, in
25 response to some of the predatory moves that

1. our competition was making, we felt like it was
2. best to invest those capital dollars in a more
3. concentrated way on the Moncks Corner campus,
4. give, you know, broader access both, you know,
5. from the hospital side, that was really what
6. drove that, so -- so we just felt it was a
7. better investment to move the money over there.

8. Q: Okay. And do you recall that it was about
9. \$100,000 an acre for the Cane Bay property?

10. A: I believe that was our handshake deal, yes.

11. Q: Okay. And so do you recall the purchase price
12. to be around a little over two million?

13. A: That's correct.

14. Q: Okay. And, now, it was your experience that
15. HCA didn't typically hold raw land, did they?

16. A: Not for long, no.

17. Q: Okay. Does it surprise you to know that
18. Trident Health System still owns the Cane Bay
19. property today?

20. A: It wouldn't surprise me or not. I don't really
21. pay attention to it.

22. Q: Now, to your knowledge, there was never any
23. analysis done by Trident Health System to
24. determine how many beds Berkeley County could
25. support, was there?

1 A: How many inpatient beds?

2 Q: Yes, sir.

3 A: I'm sure -- while I was there, no, we didn't do
4 an analysis to see how many beds it could
5 support. I clearly was aware of the -- the bed
6 need that was identified by the state planning
7 or the State Health Plan but no, I had not
8 tried to do another study on my own to
9 determine what needs were there.

10 Q: But you were aware of the growth that was going
11 on in Berkeley County while you were at
12 Trident?

13 A: Yeah. I was aware Berkeley County was growing.
14 I was aware that the state recognized that
15 Trident needed the or had a bed need that
16 needed to be fulfilled and I felt that Berkeley
17 County was a big driver of that, that need for
18 additional beds.

19 Q: But you didn't do any sort of study or analysis
20 of that population growth, but you knew it was
21 going on, you could see it happening?

22 A: My study and analysis was getting in my pickup
23 truck and driving around Berkeley County.

24 Q: Okay. All right. Let's look at Respondent
25 Exhibit 132. That should be in the notebook

1 right in front of you there.

2 A: Okay.

3 Q: Take a moment to look at this.

4 A: The whole document?

5 Q: Well, you just look at page one and two. The

6 rest of it's redacted. And I'm certainly not

7 going to ask you any questions about what's

8 inside of this document. I just want to ask

9 you a few questions about the timing.

10 A: Okay. Go ahead.

11 Q: All right. Now, this is an email to you,

12 correct? See that on the first page of the

13 exhibit?

14 A: On 132?

15 Q: This is from you? Yes, sir.

16 A: It's from me.

17 Q: From you.

18 A: To Chuck Hall, Jerry Rucker and Don Stinnett.

19 Q: All right. And what's the date of this email?

20 A: That would be January 21, 2008.

21 Q: Okay. And without telling us what's in it,

22 what are you forwarding attached to that email?

23 A: That is a -- that is a -- well, the RE line

24 says it's a legal analysis of certificate of

25 need requirements applicable to potential new

1 hospital in Berkeley County, South Carolina.

2 Q: Okay. And what's the date of that analysis?

3 A: That analysis is November 8, 2007.

4 Q: And that's from Parker Poe, right?

5 A: Parker Poe, yes.

6 Q: And now I think you told us after taking time
7 to review and understand it, you forwarded it
8 to your superiors, correct?

9 A: That's correct.

10 Q: All right. And so timing-wise, what was going
11 on during this time is you knew that Roper St.
12 Francis had purchased 66 acres in Carnes
13 Crossroads, right?

14 A: Timing-wise, I was aware of that. You've got
15 Thanksgiving and Christmas in there and --

16 Q: Right.

17 A: -- and then -- and then I'm forwarding it,
18 yeah.

19 Q: Sure. Time slips away as you kind of get to
20 the end of November --

21 A: It --

22 Q: -- and December, doesn't it?

23 A: It can.

24 Q: Okay. And, now, just a few days after you
25 forward this analysis in January of 2008, you

1 have an exchange with Mr. Hall and Mr. Rardin
2 and Mr. Gorrell. If we could look at
3 Respondent 131.

4 A: Okay.

5 Q: It should be right around where you are in the
6 notebook. Take a moment to look at that. And
7 as you know, for email chains you start at the
8 bottom and you work your way up.

9 A: Yes.

10 Q: And this exchange takes place January 25, 2008,
11 correct?

12 A: That's correct.

13 Q: And again, this is a few days after you
14 forwarded that analysis?

15 A: That's correct.

16 Q: And now Mr. Hall is actually directing some
17 questions to you and Mr. Rardin, isn't he? If
18 you start at the bottom.

19 A: Yes.

20 Q: Okay.

21 A: Yes, he asked a question about filing a
22 certificate of need for a freestanding ER.

23 Q: Okay. And he actually didn't ask you about the
24 Cane Bay property, did he?

25 A: You know, based on his wording here, it looks

1 like he wanted -- he was looking at maybe
2 popping an emergency room right at Carnes
3 Crossing.

4 Q: Carnes Crossing, which is the property -- which
5 is the location where Roper St. Francis had
6 just bought property, right?

7 A: Yes.. You know, I would -- I mean it's pure
8 speculation on my part because he doesn't say
9 that, but he was -- I think he had been in town
10 earlier. We were touring the different
11 properties, the Cane Bay property. I was
12 showing him the Carnes, I was showing him
13 Roper's site that they were wanting to abandon
14 down in Goose Creek, and I think he was
15 impressed with the site selection at the Carnes
16 Crossing and wanted to see if we were going to
17 have to go head to head, let's go head to head.

18 Q: But in response, Mr. Rardin explains to Mr.
19 Hall some of the requirements in South Carolina
20 about a freestanding emergency department,
21 right?

22 A: Right. At that time, we were under a Health
23 Plan that was -- that carried us through 2007,
24 if I remember -- remember right. Maybe it's
25 2008. I can't -- we were under an old Health

1 Plan and there were revisions that quite
2 frankly we were very concerned about that Roper
3 was behind the scenes manipulating and coercing
4 through political influence perhaps other
5 things that influenced the process, and we had
6 been seeing some drafts and hearing comments
7 that supported that suspicion. So we were, you
8 know, so we were drawing some conclusions that
9 we can't do that now, we may be able to do it
10 under the new Health Plan, but under the
11 current plan we couldn't, we would not be able
12 to put a freestanding emergency room in that
13 location. And it was our understanding, under
14 the old Health Plan, Roper couldn't either.
15 They were prohibited from doing it.

16 Q: Now, that information about the Health Plan,
17 that's just speculation on your part, correct,
18 that somehow Roper St. Francis was influencing
19 the terms of the Health Plan?

20 A: It was my educated opinion and I'm entitled to
21 that.

22 Q: Sure.

23 A: And I definitely -- I would consider it more
24 than speculation.

25 Q: Okay. Now, if we look at Mr. Rardin's

1 response, and again this is a conversation that
2 you're involved with, he responds to Mr. Hall
3 about the limitations on building an ER. Do
4 you see that?

5 A: Yes.

6 Q: And, in fact, he says the only way to have an
7 emergency room is to apply for a hospital as
8 Roper did in Mount Pleasant and will build
9 their hospital within a 30 mile radius of East
10 Cooper Hospital. Do you see that?

11 A: Yes.

12 Q: So there's a discussion about the only thing
13 you could do at the Carnes Crossroad or even
14 the Cane Bay property is build a hospital,
15 correct?

16 A: That -- that's the way I read it, yes.

17 Q: Okay. And you're aware that the way Mount
18 Pleasant was established was a bed transfer
19 from Roper Downtown?

20 A: I think it's laughable, but yes.

21 Q: So your answer's yes?

22 A: Yes, that's my understanding.

23 Q: And, now, this email references the Summerville
24 model and we've talked about it, but that's
25 that chassis idea, correct?

1 A: Yes.

2 Q: And so a chassis model of establishing
3 outpatient services and adding beds later,
4 right?

5 A: That was our -- that was our methodical,
6 planned, structured way of doing it, yes, as
7 the community grew.

8 Q: Okay. If you look at the top of the email, and
9 again Mr. Hall is just wanting to make sure,
10 would you agree, that the ER cannot be done?
11 And Mr. Rardin says, "bottom-line under the
12 current plan, no." Is that right? Can't build
13 an emergency room freestanding at that
14 location?

15 A: Yes, that's -- that's Mr. Rardin's response.

16 Q: And again, you were involved in all these
17 discussions, weren't you?

18 A: Yes.

19 Q: Now, to your knowledge, was an application for
20 a freestanding emergency room ever submitted?

21 A: No, because under the current Health Plan, it
22 was our understanding we couldn't do that.

23 Q: Right. But Mr. Rardin says in this email, let
24 me file one and let's see what happens, doesn't
25 he?

- 1 A: I believe he's saying -- he's asking if he
2 could.
- 3 Q: But it wasn't done, correct?
- 4 A: Well, it was -- it -- it was -- to my knowledge
5 it was not done.
- 6 Q: Okay. Let's look at Respondent Exhibit 136.
- 7 A: Okay.
- 8 Q: Okay. Now, the last conversation that we were
9 looking at was January 25, 2008. Now, we're a
10 few weeks later on February 18, 2008, correct?
- 11 A: Correct.
- 12 Q: And who's Colleen Little?
- 13 A: Colleen was my administrative assistant.
- 14 Q: Okay. And is she forwarding something on your
15 behalf?
- 16 A: Yes. I believe she's forwarding a handwritten
17 note that I had made.
- 18 Q: Okay. You can flip through that document and
19 familiarize yourself with it for a moment.
- 20 A: (Witness reviews document.) Okay.
- 21 Q: First of all, who is this forwarded to?
- 22 A: I believe it -- it was forwarded to Chuck Hall.
- 23 Q: All right. And at this time, he's your direct
24 supervisor, correct?
- 25 A: That's correct.

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1 Q: The group president; is that right?

2 A: Yes.

3 Q: And the second page of this exhibit,
4 Respondent's Exhibit 136, page two, is that
5 your handwriting?

6 A: Yes.

7 Q: What is it that you've written to Mr. Hall in
8 this note?

9 A: Well, I'm forwarding him a copy of an article
10 that ran in the paper the previous day and --
11 and I'm just outlining some of the points for
12 him.

13 Q: Okay. What specific points are you outlining?

14 A: Four points it looks like that -- you want me
15 to read those in?

16 Q: You can.

17 A: Okay. That, one, Roper must seek CON approval
18 to relocate existing ASC, which is an
19 ambulatory surgery center, in Moncks Corner to
20 new site within six months. Two, construction
21 of relocated ASC to be underway within one
22 year. Three, Roper must file documents to
23 build acute care facility on property by
24 12/31/2015. And then, four, if Carnes
25 Crossroads Associates complete 1,700

1 residential units by the close of 2012, then
2 the date moves to mid-2013. So that was
3 basically an outline of what was in the article
4 --

5 Q: Okay.

6 A: -- for Mr. Hall.

7 Q: And what did you understand those terms to be
8 related to?

9 A: Their -- their -- the covenants that they
10 agreed to when they purchased the land at
11 Carnes Crossing.

12 Q: Okay. And you knew they had purchased 66
13 acres, right?

14 A: I was aware of that, yes.

15 Q: A nearly nine million dollar investment?

16 A: I don't know how much it was, but --

17 Q: Okay.

18 A: -- it was a lot.

19 Q: And when you saw that Roper St. Francis bought
20 66 acres, you knew that a hospital was going to
21 end up there, correct?

22 A: I was pretty suspicious. I don't know why else
23 you'd buy 66 acres unless you've just got money
24 to burn.

25 Q: Right. And when you had these points written

1 down here, they just put in there the deadlines
2 within which Roper St. Francis has to file
3 certain documents, correct?

4 A: Yes.

5 Q: And these deadlines, though, they don't say
6 that it can't be done before 2015, does it?

7 A: You know, these aren't legal -- this is a
8 summary of a news article. But yeah, that's --
9 you know, I haven't seen the legal covenants,
10 but based on that article, yes, that's the way
11 I understood it.

12 Q: Okay. So you didn't read any of the
13 information or anything that you learned about
14 the Carnes Crossroad purchase by Roper St.
15 Francis to limit the time before which they
16 could file a certificate of need for a
17 hospital, did you?

18 A: Right. I felt like those were the outside time
19 limits and they could certainly do it quicker
20 if that was -- that it was their prerogative to
21 do it earlier.

22 Q: Okay. And now isn't the reason you didn't
23 build in Cane Bay because Chuck Hall just
24 didn't see what you saw in that property?

25 A: No. No. I mean that certainly -- well, one,

1 I wouldn't characterize it as he didn't see
2 what I saw.

3 Q: Okay.

4 A: He saw exactly what I saw because he was
5 sitting in the truck next to me when we drove
6 through it. As we started looking at where
7 could we best serve the patients in Berkeley
8 County in terms of with a hospital -- and
9 understand I bought that property to build an
10 outpatient center so access for an outpatient
11 center is different from outpatient to a
12 hospital. So in terms -- so now the discussion
13 has escalated to building a hospital. We sat
14 down, you know, cooler heads are prevailing as
15 we're, you know, really debating back and forth
16 what's the best way to meet our mission to
17 serve the citizens of Berkeley County, give
18 access to all citizens of Berkeley County, not
19 just the wealthy ones that are in Cane Bay or
20 Carnes Crossing where the anticipated high
21 income folks there, and take full advantage of
22 the location and reputation and all that we had
23 established already and it made sense to make
24 that -- to ultimately make that investment at
25 the Moncks Corner site, not in the more

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1 affluent Cane Bay or Carnes Crossing area.

2 Q: Okay. But as of yet, we haven't seen any
3 emails that talk about adding or purchasing
4 land in Moncks Corner, have we? All we've seen
5 is --

6 A: No.

7 Q: -- Roper's information and the Cane Bay
8 property, right?

9 A: You know, as the CEO of that market and that
10 health system, I dealt more in terms of face-
11 to-face conversation and those were meetings
12 and those were discussions and those were phone
13 calls and they were not a bunch of emails.

14 Q: Well, isn't it true that Chuck Hall tended to
15 correspond with you 1:00, 2:00, 3:00 in the
16 morning?

17 A: Well, I don't know about 1:00, 2:00 or 3:00.
18 Mr. Hall's workday is pretty extended and it
19 would not be uncommon for us to -- for him to
20 see something that might be going on at the
21 hospital or have a question and if it came at
22 4:00 in the morning, it came at 4:00 in the
23 morning or if it came at 10:00 at night, it
24 came at 10:00 at night, so.

25 Q: If it was at 4:00 in the morning or 10:00 at

1 night, he wasn't calling you on the phone, he
2 was emailing you and you were responding to
3 that, correct?

4 A: Sometimes he would call me on the phone at
5 those hours, too.

6 Q: Okay. Let's look at Respondent Exhibit 144.

7 A: Okay.

8 Q: They should all be in the same notebook. Who
9 is Ginger Tyra?

10 A: Ginger oversaw our marketing public relations
11 for the market.

12 Q: And you received this email from her, correct?

13 A: Yes.

14 Q: What is the date of this email?

15 A: I'm sorry? Say that again.

16 Q: The date of the email?

17 A: The date is April 29, 2008.

18 Q: Okay. And what's the subject?

19 A: The subject line says Roper St. Francis moving
20 on ten million dollar project.

21 Q: Okay. And does she forward you something with
22 that email?

23 A: Looks like it's an article from the Charleston
24 Business Journal with the -- on April 28th, the
25 day before.

- 1 Q: Okay. And what is the subject of that article?
- 2 A: The title of the article is Roper St. Francis
3 Moving on Ten Million Dollar Project.
- 4 Q: Okay. Let's look at Respondent Exhibit 137.
- 5 A: Okay.
- 6 Q: Take a moment to look at this. And this is a
7 May 8, 2008 email exchange, correct?
- 8 A: I'm sorry, I was reading. Say that -- say that
9 again.
- 10 Q: That's all right. May 8, 2008 is the date?
- 11 A: Yes.
- 12 Q: And this is a 4:00 a.m. email, isn't it?
- 13 A: It is one of the 4:00 a.m. emails, yes.
- 14 Q: You're emailing Mr. Hall and others at 4:00
15 a.m.?
- 16 A: May have been a sleepless night but yes.
- 17 Q: That's a lengthy email to tap out at 4:00 in
18 the morning, isn't it?
- 19 A: I don't know, I guess.
- 20 Q: I'm impressed. That's very good. What's the
21 title, subject, of this email that you're
22 sending on May 8, 2008?
- 23 A: Roper Move on Berkeley County.
- 24 Q: Okay. And this is not long after you received
25 some articles about our purchased property and

1 our begins to move the healthcare services to
2 Carnes Crossroads, correct?

3 A: Yeah. I think we were starting to hear
4 presentations that were being made, comments
5 that were being made in other settings that
6 people were relaying back to us from the
7 inside. So this is kind of my summary. And I
8 think we -- I think we probably had a call --
9 well, obviously we had a call coming up later
10 that day and I was just feeding some
11 information to Chuck that I thought would be
12 pertinent for us to discuss on that call.

13 Q: Okay. And didn't you recommend to Mr. Hall
14 that Trident, quote, "strike first with a
15 hospital certificate of need application"?

16 A: I -- yes, absolutely.

17 Q: Okay.

18 A: I was -- I was -- I was pretty shaken at what
19 they were doing. I was -- we all shook our
20 heads when we saw what happened in Mount
21 Pleasant. We couldn't believe it when the DHEC
22 Board allowed it to happen and we thought
23 pretty arbitrary in its decision and -- and
24 thought surely they wouldn't do that again.
25 And sure enough, we started seeing things

1 coming that way and daggummit, I was upset and
2 mad and afraid and -- and my first reaction as
3 an Oklahoma boy is to fight back.

4 Q: Okay. Now, when you were with Trident Health
5 System, you had worked on other certificate of
6 need projects, didn't you?

7 A: When I was at Trident Health System?

8 Q: Yes, sir.

9 A: Oh. Oh, yes.

10 Q: And one of them involved, I think, transferring
11 some beds from skilled nursing to acute care
12 beds; is that right?

13 A: Yes. Yes.

14 Q: You recall that conversion?

15 A: I vaguely remember that project.

16 Q: Okay. And so you had experience in looking at
17 what the State Health Plan allowed you to do
18 with the need and using some of that need at
19 your facility, correct?

20 A: Oh -- oh, I mean, you know, most of the states
21 I've worked in had been certificate of need
22 states, so I've made it a point to know what
23 the rules are and I play by the rules.

24 Q: And while you were with Trident Health System,
25 Summerville Medical Center had a bed need in

1 the Health Plan also, didn't it?

2 A: Yes, it did.

3 Q: But you didn't file any certificate of need for
4 Summerville Medical Center while you were
5 there, did you?

6 A: I don't recall ever filing anything at that
7 point.

8 Q: Now, if we continue looking in this exchange,
9 Mr. Hall responds to you at 5:48 a.m. needing
10 a refresher on why the freestanding emergency
11 room couldn't be located there, correct?

12 A: Correct.

13 Q: Okay. And, in fact, in response to his
14 question, you're the one that actually
15 responds, right, to Mr. Hall's question?

16 A: Yes, I responded to his question.

17 Q: Can you read into the record what you
18 responded?

19 A: Yes. My response was as follows, quote, "We,
20 along with Roper, are locked out of pursuing
21 that strategy because the existing Health Plan
22 does not allow freestanding ERs to be built
23 within a radius of existing ERs. Their only
24 options for development, per the Health Plan,
25 are ASC, diagnostic center or a transfer of

1 existing hospital beds," end quote.

2 Q: Okay. And let's look back down at that earlier
3 email for just a second.

4 A: Okay.

5 Q: The very first one where it says bottom line.
6 Don't you tell Mr. Hall, "Bottom line, if we
7 strike first with a certificate of need
8 application before the draft plan is adopted,
9 we stand a good chance of blocking Roper out of
10 our largest and most loyal patient base"?

11 A: Oh, that's the first sentence of that
12 paragraph, yes.

13 Q: Okay. Now, a series of conference calls took
14 place immediately following these exchanges,
15 correct?

16 A: I'm sure they did. I don't remember them, but
17 yes.

18 Q: Okay. Let's look at Respondent Exhibit 138.

19 A: Okay. I've got it.

20 Q: Okay. Did you at times use calendar
21 appointments in order to get the group together
22 for conference calls, meeting requests in your
23 calendar?

24 A: I'm not that tech savvy, but generally my
25 assistant would send out a meeting request,

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- 1 yes.
- 2 Q: Okay. And who's Mr. Stinnett?
- 3 A: Don Stinnett is the -- he was the chief
- 4 financial officer for the eastern group.
- 5 Q: Okay. So he would be above someone like Mr.
- 6 Gorrell who was the CFO within the health
- 7 system, correct?
- 8 A: Well, again, Mr. Gorrell was the CFO for my
- 9 market, so Mr. Gorrell reported to Mr.
- 10 Stinnett, I reported to Mr. Hall.
- 11 Q: Okay. Because Mr. Stinnett and Mr. Hall are at
- 12 the group level, right?
- 13 A: Right. And it's a matrix, so -- so Mr. Gorrell
- 14 reported to me --
- 15 Q: Sure.
- 16 A: -- but he also reported to a CFO at the next
- 17 layer up.
- 18 Q: Okay. And Mr. Stinnett is unable to attend a
- 19 meeting or a call and this is sent May 15,
- 20 2008, right? Do you see that?
- 21 A: Yes. I was just reading it.
- 22 Q: Sure. Take your time.
- 23 A: Yes, it looks like he's just giving me a heads
- 24 up that he can't make it to the meeting but to
- 25 proceed ahead without him.

1 Q: Okay. In fact, he says, "Sounds to me like we
2 better get something filed up there to protect
3 our status. It seems it would be a huge
4 strategic mistake to let Roper or MUSC jump
5 over us," correct?

6 A: Yes.

7 Q: And what's the subject of the meeting that he
8 couldn't attend?

9 A: CON Berkeley County/Roper Hospital issues.

10 Q: And that was your recommendation, correct, to
11 get a CON filed as quickly as you could?

12 A: Yes, it was.

13 Q: Okay. And you -- plans was to build up a
14 hospital at that point to prevent Roper St.
15 Francis from coming in?

16 A: I wanted to get anything filed that we needed
17 to file to protect the market and the people
18 that we were serving. It was our mission, it's
19 what we were mandated by the citizens of
20 Berkeley, and Berkeley County in this case, to
21 provide for them. And I wanted to get it done
22 before Roper further manipulated and maneuvered
23 the CON process.

24 Q: Okay. As of May 15, 2008, we still haven't
25 seen anything that talks about adding beds to

1 Moncks Corner, do we?

2 A: We probably had not -- I don't recall exactly
3 where we were in the process at that point.
4 But, let's see, this is May '08. If it hadn't
5 been decided at that point, it happened shortly
6 after it. I couldn't tell you if it happened
7 in April or May or June, but somewhere in that
8 time frame we were settling on the -- the
9 Moncks Corner site.

10 Q: Okay. Let's look at Respondent Exhibit 130.

11 A: Okay.

12 Q: Do you recall in your deposition talking to us
13 about this conference call? If you want to
14 take a minute to look at the appointment.

15 A: I vaguely remember something like it. I don't
16 know if it was this specific one, but I
17 remember having the -- I remember having a call
18 with these participants at some point.

19 Q: Okay. And the participants are you, Mr. Hall,
20 Mr. Gorrell, Mr. Rardin and then also David
21 Summer, Andrea with Parker Poe, correct?

22 A: Yes, Andrea was with Parker Poe.

23 Q: And then Mr. Stinnett is also on there; is that
24 right?

25 A: Correct.

1 Q: So you and your CFO, Mr. Gorrell, and then some
2 group leadership, Mr. Hall and Mr. Stinnett,
3 are on this call?

4 A: Yes, and Mr. Rardin.

5 Q: And Mr. Rardin, who is your chief development
6 --

7 A: Develop --

8 Q: -- vice president of development, correct?

9 A: Yes, senior vice president for development.

10 Q: Because at this point Mr. Rardin had taken on
11 that transition to the development role,
12 correct?

13 A: Yes.

14 Q: Okay. And the date of this call is May 20,
15 2008, correct? Do you see that?

16 A: Yes, on the 20th.

17 Q: And what was the subject of the call?

18 A: Same as what I'd said before, CON Berkeley
19 County/Roper Hospital issues.

20 Q: Now, at your deposition you told us that it was
21 during this call that the decision was made to
22 build the hospital at Moncks Corner; do you
23 remember that?

24 A: At this point I don't remember. I mean the --
25 my deposition was probably a year ago, so it

1 was probably a little fresher on my mind then,
2 but it may very well have been at this meeting.

3 Q: Okay. And we haven't seen any documents that
4 would tell us otherwise, correct?

5 A: If you don't have anything else that you're
6 going to surprise me with, then I would say
7 that's probably when it happened.

8 Q: No surprises.

9 A: Okay.

10 Q: Okay. Now, at this point you haven't done any
11 analysis to determine whether Moncks Corner was
12 the best location to put a hospital, had you?

13 A: Up to this point?

14 Q: That's right.

15 A: Well, if that's the meeting where we were going
16 to make that decision, like I said, you know,
17 my analysis is not going to be a whole lot of
18 numbers and Excel spreadsheets, it's going to
19 be driving around and seeing what makes sense,
20 looking at what we've done, taking the results
21 of probably a lot of other people's analysis.
22 But I can't imagine if that's where we made the
23 decision, I can't imagine I walked in not
24 knowing what I was going to do.

25 Q: Okay. But, now, when you walked into this

1 conference call May 20, 2008, the only place
2 you owned enough property to put a hospital in
3 Berkeley County was in Cane Bay, right?

4 A: You know, the timing is -- is -- is a pretty
5 good blur this far out. But we, you know, we
6 had options on the land. And quite frankly,
7 even though we had let those options expire on
8 the Moncks -- I'm talking about the Moncks
9 Corner property, we had a gentleman's agreement
10 with the landowner that we could get it back if
11 we -- if we needed it. So, no, I wouldn't say
12 that that was my only option.

13 Q: When you came to Trident Health System in 2004,
14 you held an option on the 21 or so acres in
15 Moncks Corner adjacent to the Medical Center,
16 correct?

17 A: Yes.

18 Q: And within a couple of years of you being at
19 Trident Health System, you allowed that option
20 to lapse, correct?

21 A: As an expense reduction move, yes.

22 Q: Sure. You were --

23 A: And it was shortsighted on my part to let that
24 happen but I also made sure that I had a
25 handshake agreement with the landowner that I

1 could get it back if I needed to.

2 Q: But he was no longer receiving money, a
3 substantial amount of money, every year on that
4 option renewal, was he?

5 A: Correct.

6 Q: Okay. And, in fact, you allowed that option to
7 lapse and instead invested over two million
8 dollars in Cane Bay, correct?

9 A: Separate. Separate issues, yes.

10 Q: Okay. And immediately after this May 20th
11 phone call, didn't Mr. Rardin go out and
12 reestablish some groundwork on that option for
13 Moncks Corner?

14 A: Like I said, we had that agreement and Mr.
15 Rardin went back and said we're ready to sign
16 back up for the option.

17 Q: Let's look at Respondent's 124.

18 A: Okay.

19 Q: On May 21, 2008, so the day after this
20 conference call, correct --

21 A: Correct.

22 Q: -- Mr. Rardin is reporting to you and others
23 that he had made contact with the owners of the
24 21 acres around Moncks Corner Medical Center,
25 right?

1 A: Yes.

2 Q: And he's providing to you some terms on which
3 those owners were willing to do a new option,
4 correct?

5 A: Yes.

6 Q: And those terms are actually richer than they
7 were on the option that lapsed, aren't they?

8 A: I don't know.

9 Q: Okay. Now let's look at Respondent 145.

10 A: Okay.

11 Q: You're actually lucky, Mr. Gunn, all these
12 documents are in one notebook so far. This is
13 a May 23rd of 2008 conference call, but I don't
14 see you on it. Do you recognize the people
15 that are on this call?

16 A: Some. I don't know who Colleen Quinlan is.

17 Q: Okay.

18 A: I did not know -- I know now, as of yesterday,
19 who Mr. Baehr is.

20 Q: Okay. Because you had never met Mr. Baehr,
21 correct?

22 A: We had never met up to that point.

23 Q: And you didn't work with him at all while you
24 were at Trident Health System?

25 A: Correct. I don't know who Tomgo is, and I

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1 don't know who Claudia Sage is.

2 Q: Okay. Great. Let's look at Respondent's 111.

3 A: Which one? I'm sorry.

4 Q: 111.

5 A: 111, okay.

6 Q: Yes, sir. And it's heavily redacted, but I
7 think we can take a look at it and explain to
8 the court what this is.

9 A: Okay. You want me to explain what it is?

10 Q: Yes. Can you tell us what this document is?

11 A: These appear to be the minutes from a board
12 meeting of Trident Health System.

13 Q: Okay. And what board?

14 A: It would have been the combined board. The
15 board of Trident Health System was a
16 consolidated board for the health system.

17 Q: Okay. And how would you describe their role
18 within the health system?

19 A: In terms of their scope of responsibility?

20 Q: Yeah. What did they do for you or for the
21 health system while you were there?

22 A: Well, it's not a fiduciary board because they
23 don't have any ownership. So in a small
24 respect, it's an advisory board, but it's much
25 more than that really. But their scope of

1 responsibility covered everything in the health
 2 system; the Medical Center campus, the
 3 Summerville Campus and the Moncks Corner
 4 campus, all the -- everything else. And then
 5 there are additional responsibilities that are
 6 delegated to that board by the Joint Commission
 7 on Accreditation of Healthcare Systems --
 8 Health -- Health Systems, which is what allows
 9 us to participate in government programs like
 10 Medicare, Medicaid and so forth, to monitor the
 11 quality of care that goes on, to oversee the
 12 credentialing of providers, so on and so forth.
 13 So it's much more than an advisory. I'm just
 14 trying to paint the picture.

15 Q: Sure.

16 A: It's not -- it's not just an advisory board,
 17 but it's not all the way up to a fiduciary
 18 board. But they do have accountability for
 19 quality of care that's delegated to them and
 20 the credentialing of providers.

21 Q: What about capital projects, would you discuss
 22 capital investments with the Board of Trustees
 23 at Trident?

24 A: From -- from -- generally, once a year I would
 25 discuss with them what our capital budget

1 looked like and what I intended to utilize on
2 our routine capital. But for -- and then for
3 a project that would require board approval for
4 a certificate of need, as an example, yeah, I
5 would give them a pretty good summary of that
6 capital investment and seek their -- their
7 approval to satisfy the certificate of need
8 requirements as I understood them.

9 Q: And did the Moncks Corner Berkeley Medical
10 Center need the Board of Trustees approval?
11 Did that project need approval from your Board
12 of Trustees, the certificate of need?

13 A: To file a certificate of need, yes.

14 Q: Okay. And now if you could, tell the court,
15 and I believe it's in the bottom right-hand
16 corner, what's the date of this meeting?

17 A: The date is May 28, 2008.

18 Q: Okay. What is the subject of what you're
19 talking to them about, the un-redacted portion?

20 A: It says executive updates and then it has me
21 presenting it and then the subject heading on
22 that particular update is called market share.

23 Q: Okay. And what is it that you presented, or I
24 believe it's called conclusion, what is the
25 result of that discussion?

- 1 A: Yeah, there's something redacted out so --
- 2 Q: Sure.
- 3 A: -- I couldn't tell you --
- 4 Q: No, that's fine.
- 5 A: -- what that is --
- 6 Q: Right.
- 7 A: -- because I couldn't remember it if I needed
- 8 to. But then it says Mr. Gunn informed the
- 9 board that there may be a need for a called
- 10 meeting in approximately two weeks to discuss
- 11 plans for increasing THS, which is Trident
- 12 Health System, presence in Berkeley County.
- 13 Q: Okay. So as of May 28, 2008, there's no
- 14 discussion about we're going to file for a
- 15 hospital in Moncks Corner, is there?
- 16 A: At the board meeting?
- 17 Q: Correct. As reflected by these minutes.
- 18 A: As reflected by this -- this, you know, I think
- 19 given the nature of that, we probably had not
- 20 discussed a hospital specifically in Berkeley
- 21 County.
- 22 Q: But on May 20, 2008, the decision had been made
- 23 to file a certificate of need for a hospital in
- 24 Moncks Corner, hadn't it?
- 25 A: Organizationally, yes, we had decided to do

1 that.

2 Q: Okay. And, in fact, consultants had been hired
3 or at least discussed, as we saw on another
4 conference call that you weren't on, correct?

5 A: Yeah. Yes.

6 Q: Now, as of this time period, late May, May 20,
7 2008, through this meeting, there had never
8 been to your knowledge and internal or external
9 analysis about the profitability of a hospital
10 in Moncks Corner, had there?

11 A: Not that I had seen.

12 Q: Okay. And there was no internal or external
13 analysis about the impact of two community
14 hospitals in Berkeley County, had there?

15 A: You're talking about what was going on in my
16 head about two different hospitals?

17 Q: No, I'm asking you whether an internal or
18 external analysis was conducted by the health
19 system on that issue?

20 A: No, there weren't any spreadsheets. I mean I
21 -- commonsense will tell you it's silly to put
22 two hospitals in Berkeley County.

23 Q: Okay.

24 A: I don't know how many spreadsheets you need to
25 prove that.

1 Q: Okay. In your deposition, you talked about a
2 face-to-face meeting with Chuck Hall sometime
3 in June 2008?

4 A: Yes.

5 Q: I believe he came to the area; is that right?

6 A: Yes, he came to Charleston, I think in June.

7 Q: Okay. It would have been after the conference
8 call that we looked at about establishing a
9 hospital in Moncks Corner, wouldn't it?

10 A: Yes.

11 Q: Okay. Because you were actively involved in
12 that call when the decision to build a hospital
13 or file a certificate of need for a hospital in
14 Moncks Corner, weren't you?

15 A: Yes, I believe that was well underway at that
16 point.

17 Q: Okay. And you had testified it was your
18 decision to move forward with that project,
19 correct?

20 A: That's correct.

21 Q: And you had Mr. Hall's consent for that
22 project, right?

23 A: Yes, I had his permission to proceed.

24 Q: Okay. But sometime after this May 2008 time
25 period was when you met with Mr. Hall and you

1 all had the discussion about your choice not to
2 relocate with HCA, correct?

3 A: No, that -- well, let's see. It -- I think it
4 may have been at that June meeting that --
5 where we had that face-to-face conversation.

6 Q: Okay. It was a face-to-face conversation where
7 y'all discussed your changed role and your
8 decision not to relocate again, right?

9 A: Yes.

10 Q: And then I believe your testimony is you kind
11 of phased out your responsibilities from the
12 time of that meeting late Summer of 2008 until
13 your official end date of September 30th of
14 2008?

15 A: Correct.

16 Q: But you were still going to the office every
17 day almost up till the end, correct?

18 A: Probably up until about the last three weeks or
19 so.

20 Q: Okay. But up until the last three weeks or so,
21 while you were actively going every day to the
22 facility of Trident Health System, you did not
23 have any analysis about the feasibility of a
24 Moncks Corner hospital, correct?

25 A: I don't remember reviewing any documents --

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1 Q: Okay.

2 A: -- at that point, no.

3 Q: And still up until the end of your time with
4 Trident Health System, you didn't see any
5 documentation or analysis about two hospitals
6 in Berkeley County, correct?

7 A: No, because I certain -- at that point -- you
8 know, a good planner plans for all
9 contingencies. That wasn't even a contingency
10 that I thought -- that I -- I mean I knew it
11 happened in Mount Pleasant, but honestly I
12 thought that was a fluke and logic and reason
13 and order would be restored back to the DHEC
14 process. Obviously, didn't.

15 Q: Okay. You knew in 2007 that Roper St. Francis
16 bought 66 acres in Carnes Crossroad, correct?

17 A: Yes.

18 Q: And you knew that those 66 acres would be
19 eventually developed into a hospital, correct?

20 A: I was -- I eventually came to that conclusion,
21 yes.

22 Q: And you knew that Roper St. Francis transferred
23 beds from downtown to establish the Mount
24 Pleasant Hospital, correct?

25 A: I don't think I knew that that's the policy

1 they were going to try to do it under, but --
2 but I -- so I can't say for certain. I can't
3 -- I couldn't answer that question totally yes.

4 Q: Okay. But we looked at an email where you told
5 Mr. Hall that the way that Roper St. Francis
6 could build a hospital on Carnes Crossroad was
7 to transfer beds, correct?

8 A: Yeah. Yes, I did put that down.

9 Q: Okay. And now you had no role in the
10 preparation of the certificate of need
11 application document, did you?

12 A: Other than authorizing it, no.

13 Q: Authorizing it be drafted, correct?

14 A: Correct.

15 Q: And Mr. Rardin quarterbacked the application?

16 A: Yes.

17 Q: And, in fact, he signed it, didn't he?

18 A: I believe he did.

19 Q: Okay. The application was filed in August of
20 2008. You were still the CEO of Trident Health
21 System at that time, correct?

22 A: Yes.

23 Q: And the CEO of Trident Medical Center, the
24 campus, correct?

25 A: That's correct.

1 Q: But you did not sign the application, did you?

2 A: I did not.

3 Q: You didn't participate in the drafting of it,
4 did you?

5 A: Other than getting verbal updates on how they
6 were progressing, no, I did not draft it.

7 Q: Okay. Did you review the pro formas that are
8 in the application?

9 A: No, not -- not -- not to any detail.

10 Q: Did you ever see them?

11 A: I don't remember if I saw them or if I just
12 asked for a summary of them. I may have just
13 asked were they -- were they positive, was it
14 -- was it going to make money by the third
15 year, etcetera, etcetera, things that I knew
16 that you had to have. But I don't recall
17 diving into the detail of the financials and I
18 may not have even saw them.

19 Q: By late June 2008 you knew you weren't staying
20 with HCA, correct?

21 A: Correct. I was wrapping up all the loose ends
22 that I could wrap up.

23 Q: Okay. So in July and early August of 2008 you
24 weren't spending your time drafting a
25 certificate of need application for a hospital,

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1 were you?

2 A: I didn't draft any of our certificates of need.
3 I mean that -- that -- that was not unusual
4 given the circumstances. It's just I had very
5 capable people who were probably more
6 knowledgeable than I was about how to draft it
7 and put it together and I asked that they do
8 that and I looked at the summary.

9 Q: Okay. Well, did you review the need analysis
10 for the Moncks Corner hospital, Berkeley
11 Medical Center?

12 A: Other than getting a verbal, no -- a verbal
13 update, no.

14 Q: You never spoke with Richard Baehr, correct?

15 A: Correct.

16 Q: And you never corresponded with him in any way,
17 did you?

18 A: No.

19 Q: And if he's the one that drafted the need
20 analysis, you wouldn't have had any role in how
21 that need analysis came together, would you?

22 A: No.

23 Q: Because you had no involvement with him,
24 correct?

25 A: You would have to ask Mr. Rardin what all was

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1 done to put that together.

2 Q: Okay. And so even though you were still the
3 CEO of the system, the application went off on
4 its own and your vice president of development
5 took care of it from there, correct?

6 A: My vice president whom I had very much
7 confidence in, yes.

8 Q: Absolutely.

9 MS. HOLLINGSWORTH: Your Honor, if I could have one
10 moment.

11 THE COURT: Yes, ma'am.

12 Q: Mr. Gunn, thank you so much. If you'd answer
13 any questions that Ms. Biggers or --

14 A: Be my pleasure.

15 Q: -- Mr. Summer may have.

16 THE COURT: Ms. Biggers?

17 MS. BIGGERS: I don't have any questions.

18 MR. SUMMER: Your Honor, could I get a five minute
19 break?

20 THE COURT: Okay. All right. Let's take ten maybe.
21 In recess for ten minutes.

22 (Off the Record from 11:30 a.m. until 11:40 a.m.)

23 THE COURT: Back on the record, please, ma'am.

24 MR. SUMMER: Thank you, Your Honor.

25 MR. GUNN - CROSS EXAMINATION BY MR. SUMMER:

1 Q: Mr. Gunn, I think I want with Respondent's
2 Exhibit 131. Can you find that one for me?

3 A: Yes. Okay.

4 Q: Do you remember the line of questioning
5 regarding this document?

6 A: Yes.

7 Q: Okay. Is it fair to say that Roper's purchase
8 of this property got your attention?

9 A: Yes, it startled me.

10 Q: Okay. Did it scare you?

11 A: Yes.

12 Q: Okay. You had mentioned Mount Pleasant and I
13 think you used the word manipulation. I want
14 to look at this sentence that we have in Mr.
15 Rardin's emails. Right at the very top where
16 he's responding to you and Mr. Hall and it's
17 dated 1/25/2008 and it's actually 11:50 in the
18 morning, isn't it?

19 A: Yes, that one is.

20 Q: All right. But there's this phrase, "With that
21 being said, the state can rule anyway they want
22 regardless of the Health Plan." You see that
23 language?

24 A: Yes.

25 Q: Okay. Is that part -- or was that part of your

1 fear?

2 A: Absolutely.

3 Q: Okay. And why?

4 A: I was appalled when I saw what happened in
5 Mount Pleasant.

6 Q: Okay.

7 A: I didn't have a dog in that fight. We didn't
8 really serve the Mount Pleasant area. But when
9 I saw that East Cooper was going to make a
10 significant investment into that community, new
11 jobs, big capital investment, I mean, it was
12 going to be a real boom for that town, and for
13 Roper to without, it appeared to us without any
14 logic, without any justification based on the
15 State Health Plan, was able to manipulate and
16 maneuver their way into there and divide up a
17 community that was being well served from what
18 it appeared to me, I was just appalled. I
19 thought, well, throw the daggum Health Plan out
20 if that's the way we're going to do things.
21 Because it appeared, if you've got enough money
22 and enough political influence, you can have
23 your way with the DHEC Board. So, yeah, when
24 I saw they were buying land in my territory,
25 I started saying, daggum, they're going to

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1 start poaching on my property. In Oklahoma we
2 might shoot people for that. But I certainly
3 wasn't excited about what we were going to do
4 having them just poach in on our property like
5 that.

6 Q: Okay. Do you know Mr. Bowling?

7 A: Yes.

8 Q: Do you know what position he holds with the
9 Health Planning Committee?

10 A: Yes. I knew that he was on the -- a member of
11 the Health Planning Committee, yes.

12 Q: Were you also aware of his efforts to change
13 the planning region in your neck of the woods?

14 A: I understood that Mr. Bowling had made comments
15 --

16 MS. HOLLINGSWORTH: Your Honor, if I could for just
17 a second. Mr. Summer can try not to give
18 information to the witness in his answer. He
19 can discuss Mr. Bowling's role based on his
20 knowledge, but I think it's going a little far
21 when he's trying to suggest efforts that Mr.
22 Bowling --

23 THE COURT: Your objection is that he's leading the
24 witness?

25 MS. HOLLINGSWORTH: He is, Your Honor, with

1 questions that have no foundation at all and
2 misleading.

3 **THE COURT:** Mr. Summer, I feel that you're in the
4 same position with this witness as Mr. Thomas
5 was with the one yesterday because of the
6 association with HCA.

7 **MR. SUMMER:** Your Honor, he separated employment
8 with my client almost four years ago.

9 **THE COURT:** Right. And I've been considering that
10 and anticipating this situation. That he is in
11 a position of defending actions that he took
12 back then as an employee. And I just think
13 that the human nature aspect of it is that he
14 would likely to be kinder to your client than
15 he would otherwise. That's my ruling and
16 you'll continue your examination as to what
17 qualifies as direct.

18 **MR. SUMMER:** Open-ended questions, Your Honor, I
19 will do that.

20 **Q:** What, if any, efforts were being led by Mr.
21 Bowling that you were concerned about with the
22 State Health Plan?

23 **A:** It was my under --

24 **MS. HOLLINGSWORTH:** Your Honor, if I could object
25 again. There needs to be an establishment of

1 foundation of this witness, how he knows these
2 things that's not based on hearsay.

3 **THE COURT:** Well, I'm sure Mr. Summer can do that.

4 **MR. SUMMER:** Well, we can lay a foundation. We've
5 got three weeks set aside, let's start.

6 Q: You ready?

7 A: Fire away.

8 Q: What was Mr. Rardin's job with your company?

9 A: He had several roles. The chief of which were
10 he had primary responsibility for all the
11 development activity, whether that's physician
12 recruitment, new sites, new contracts, you
13 know, anything new that we were doing. He also
14 oversaw our service lines that we've talked
15 about very early in my testimony. That was
16 something I wanted implemented in our market
17 were key strategic service lines. He also
18 oversaw that.

19 Q: Was he in charge of your certificate of need
20 projects for the system?

21 A: Yes, certificate of need was definitely one of
22 the things that would fall under the purview of
23 development because that's one of the necessary
24 processes you go through if you're going to
25 have any kind of major significant development

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1 in South Carolina.

2 Q: Did he provide you with periodic reports on
3 what was going on in the Health Plan and the
4 Health Plan process?

5 A: Yes. Mr. Rardin would attend, he would attend
6 meetings that were open with the Health Plan,
7 especially related to any changes in the Health
8 Plan that were coming down the road. He would
9 also track, either through the Hospital
10 Association or other sources of information
11 that he could gather, anything relating to
12 certificate of need or the health planning
13 process that would impact us directly.

14 Q: And was one of those things changing the
15 planning districts?

16 A: Yes. That was -- that was particularly
17 disturbing where Mr. Rardin --

18 MS. HOLLINGSWORTH: Your Honor. I apologize for
19 interrupting, Mr. Gunn. At this point, any
20 information that he is testifying to is
21 hearsay. Mr. Rardin was a witness in this
22 case, testified for an entire day. Could have
23 said anything that they wanted Trident Medical
24 Center could have put forward through Mr.
25 Rardin. At this point, Mr. Gunn is simply

1 testifying to hearsay statements of Mr. Rardin.
2 That's just not appropriate.

3 **MR. SUMMER:** Well, Your Honor, this is part and
4 parcel of his job. Mr. Rardin gives him
5 reports, reports he's entitled to rely on in
6 the conduct of his business. He's testified
7 that Mr. Rardin had that as his responsibility;
8 that he made review of the plan and attended
9 public hearings. Now I'm asking if there was
10 going to be a public policy change that he was
11 concerned about. And right now, that's
12 obviously an issue of public record. And what
13 I'm going to ask him about is, what was that
14 proposed policy change and why were you
15 concerned about it. I don't think that falls
16 under the definition of hearsay. It's
17 knowledge that he has from performing his
18 duties as chief executive officer of the
19 system.

20 **MS. HOLLINGSWORTH:** Your Honor, all of that
21 knowledge comes directly from Mr. Rardin. He
22 could have asked all of those questions from
23 Mr. Rardin and gotten firsthand information.
24 At this point, those are statements provided
25 that were out of court that he's now trying to

1 bring into court through a witness that's not
2 qualified to do that.

3 **THE COURT:** Sustained.

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

5 Q: Did you have any concerns that planning
6 districts may be changed in the Lowcountry?

7 **MS. HOLLINGSWORTH:** Your Honor, I would object that
8 there is no foundation for the question,
9 because the foundation is the hearsay
10 statements that you've just ruled on.

11 **THE COURT:** Well, I disagree with that. You can
12 object again if it gets across the line, but I
13 need to hear more of this before I can make a
14 ruling.

15 A: Yes, I was very concerned that a lot of changes
16 were being proposed in the new Health Plan that
17 was being drafted, in particular was the
18 redrawing of the districts where -- and in this
19 case it was a proposal to carve out Berkeley
20 County as a standalone community where
21 community need would be identified just with
22 that county. If that had passed, it would have
23 just been an open season on just haphazard
24 wide-open development. You'd have all kinds of
25 bed need established for Berkeley County;

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1 without consideration that it's part of a
2 larger community. And at the hearings Mr.
3 Bowling was directly arguing to have that
4 introduced into --

5 **MS. HOLLINGSWORTH:** Your Honor, I would object.
6 He's already testified he didn't go to these
7 hearings. He wasn't present. He didn't hear
8 any of this information with firsthand
9 knowledge by attending the hearings.

10 **MR. SUMMER:** Your Honor, Mr. Bowling's going to
11 testify. So as long as he can talk about that
12 he was concerned and it was a threat, that's
13 all I need to get in the record at this point
14 in time.

15 **MS. HOLLINGSWORTH:** That's fine, Your Honor, this
16 has gone beyond that at this point.

17 **MR. SUMMER:** We're done.

18 **THE COURT:** Well, I'll rule in your favor, yes, sir.
19 I think he can testify to that, but no further.

20 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

21 **Q:** Just so that we have it summarized for the
22 record. This was a concern and you viewed it
23 as a threat.

24 **A:** It was a concern and I, yes, I definitely
25 viewed it as a threat.

1 Q: Okay. Let's talk a little bit about -- I don't
2 know that we have to look at every one of
3 these, but since we've let all this other
4 hearsay in. Let's look at the hearsay that
5 they've put in, turn to Respondent's 136.
6 Okay. And let's look at your handwritten note.
7 This would have gone from your assistant to Mr.
8 Hall.

9 A: Yes.

10 Q: Okay. And if you could, let's look at first
11 your enumerated one. I believe, again, that
12 you said that this was just your handwritten
13 summary of what the newspaper article attached
14 said?

15 A: Yes.

16 Q: First, number one, you had Roper must seek CON
17 approval to relocate existing ASC in Moncks
18 Corner on new site within six months. Did
19 Roper have an ambulatory surgery center in
20 Moncks Corner?

21 A: Yes.

22 Q: Okay. Why would they need to move it to the
23 Carnes Crossroads property?

24 A: As I recall, they had already made statements
25 in public that they were going to shut down and

1 relocate that surgery center. Everybody I
2 talked to in Moncks Corner was mad about that
3 and felt like Roper was abandoning --

4 MS. HOLLINGSWORTH: Your Honor, I object to the
5 hearsay statements of conversations of Moncks
6 Corner citizens.

7 THE COURT: Sustained.

8 A: Okay. I understand. So, yes, it was my
9 understanding that Roper had committed to
10 relocate their ASC. It was my guess at that
11 point they were probably going to put it on
12 that site, and there was a specified window of
13 time they had to get that done.

14 Q: So they were withdrawing services from Moncks
15 Corner, not adding them?

16 A: That's correct.

17 Q: Okay. Your number three says Roper must file,
18 what is that next word?

19 A: Documents.

20 Q: to build acute care facility on property by
21 12/31/2015, right?

22 A: Yes.

23 Q: And this is your understanding from the
24 newspaper article, obligations they had to the
25 seller?

1 A: Yes, that was my understanding from the
2 article.

3 Q: So these are development obligations?

4 A: Yes.

5 Q: All right. An acute care facility, what does
6 that mean in your mind?

7 A: That means a hospital.

8 Q: Right. So you knew they were coming?

9 A: Yeah, I was pretty sure they were.

10 Q: And you were concerned about their ability to
11 get things approved?

12 A: Yes.

13 Q: Okay. What was your first reaction -- well,
14 before you do that, I'm going to ask you a
15 series of questions about the Cane Bay
16 property. And if you'll go to Petitioner's
17 201, there were a series of questions when you
18 were asked about Petitioner's 201.

19 A: Okay. Let's see. I'm sorry. That's online.

20 Q: Okay. I would like for you to have a copy, so
21 I think -- let's see what we can find.
22 Petitioner's 201 and tell me what's the date of
23 that document?

24 A: December 8, 2005.

25 Q: Far predates what we're dealing with here in

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1 2008, right?

2 A: Yes.

3 Q: Okay. And if you'll turn over to page two, can
4 you read the first sentence of the summary?

5 A: Cane Bay Community Medical Center will be a
6 comprehensive outpatient center located on a
7 4,000 acre planned development of Cane Bay
8 Plantation in Berkeley County, South Carolina.

9 Q: All right. Outpatient center, right?

10 A: Yes.

11 Q: The word hospital appear in this document in
12 any way?

13 A: I don't believe it did.

14 Q: Okay. When you bought the property, were you
15 at all contemplating that you were going to put
16 a hospital there?

17 A: I wanted to leave myself room to build one if
18 the time came, but no, that was not my -- that
19 was not my intent.

20 Q: Okay. And while we're here, I think the
21 language that was attributed to you was
22 actually out of this report. Did you write
23 this report or did somebody write it for you?

24 A: I think someone else wrote it for me.

25 Q: Okay. So the quote pertaining to you appears

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1 on page two where we were, but under the
2 vision section, "Currently Trident Medical
3 Center is a hospital without a community." You
4 see that language?

5 A: Yes.

6 Q: Okay. Do you believe that Trident has a
7 community that is serves?

8 A: Yes.

9 Q: Okay. Is Goose Creek part of that community?

10 A: Goose Creek's part of that community.

11 Q: Okay. Is the Cane Bay area part of that
12 community?

13 A: Yes.

14 Q: And is Cane Bay residents -- or do people
15 around Cane Bay have easy access to Trident?

16 A: They can get there, yes, easily.

17 Q: Okay. And Carnes Crossroads as well?

18 A: Sure.

19 Q: Okay. We went through a series of emails, or
20 you did in prior testimonies, where there's a
21 give and take between you and folks at
22 corporate. Do you remember those emails?

23 A: Yes.

24 Q: And there was an evaluation of what, if any,
25 role Cane Bay would have in this process?

1 A: Yes.

2 Q: Ultimately, you ruled Cane Bay out as an option
3 for a hospital?

4 A: Yes.

5 Q: Why?

6 MS. HOLLINGSWORTH: Your Honor, I would just ask
7 that the leading questions cease. Again, he's
8 directing the witness down the line where he
9 wants him to go.

10 MR. SUMMER: The next question was why. I mean, I
11 kind of had to set some things up. I'm really
12 just trying to summarize his prior testimony so
13 that we can get to a point of asking open-ended
14 questions. But, Your Honor, I'll withdraw it
15 and start over again, if you like?

16 THE COURT: Thank you, sir. She's correct.

17 MR. SUMMER: All right.

18 Q: Let's start over again. What, if any, role did
19 Cane Bay play in your analysis about where to
20 place a hospital?

21 A: Initially, it was a convenient plot of land
22 that we owned. And my knee-jerk reaction was
23 to see where in the heck can I place a hospital
24 to thwart this move by Roper. You know, I knew
25 I had -- I could probably get property back at

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1 the Moncks Corner site. And fortunately, the
 2 owner was willing to honor his word and let us
 3 buy that -- or get that property back under
 4 options. So that's ultimately what we did.
 5 But Cane Bay was not designed to be a hospital.
 6 That property was bought, primarily because
 7 you've got 4,000 -- if you've ever driven the
 8 site, it's got 4,000 people -- or 4,000 homes
 9 that were going to be built on that site. It's
 10 got a senior, an active senior adult living
 11 center by the same company that does Sun City.
 12 And you heard a comment in yesterday's
 13 testimony about how attractive those
 14 communities can be for a healthcare provider.
 15 And we wanted to have physicians offices,
 16 outpatient center, diagnostic services, maybe a
 17 surgery center right there in their
 18 neighborhood so they would have easy access to
 19 it. That's what you put on a 20 acre
 20 outpatient development like that which is in
 21 the middle of a shopping district. It was not
 22 intended to really be a hospital.

23 Q: And has Cane Bay ever been developed?

24 A: No.

25 Q: Okay. So it's still a dream?

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1 A: Yes.

2 Q: There appears to be a several month period of
3 time in these emails, which would be at the
4 beginning of 2008, where there's collaboration
5 and debate about what to do?

6 A: Yes.

7 Q: Okay. Who participated in this dialog?

8 A: Well, let me make sure I understand the
9 question. Who participated in all these
10 dialogs just going back and forth about how to
11 respond to this?

12 Q: Yes.

13 A: Okay. Dialog was going on between me and Karl
14 Gorrell, Jim Rardin, David Summer, Andrea
15 Brisbin, Deb Campo, Ginger Tyra. I mean, all
16 these are names that have come up, you know,
17 over time. It's all of my senior advisors,
18 internally, externally, in terms of our CON
19 legal counsel; and then above me at the
20 corporate office with Chuck Hall, Don Stinnett,
21 Jerry Rucker, I'm blanking on the guy's name
22 that was helping us with the land. But all
23 these advisors were coming together to give me
24 their perspectives, as facts were being
25 presented, in developing, to ultimately

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1 consummate in our final decision on what to do
2 and when to do it and how to get it done.

3 Q: All right. What, if any, influence did your
4 institution's history in the region play in
5 your site selection for a hospital?

6 A: It ultimately became the driving force. I
7 worked for an investor owned company that's
8 owned by two of the largest private equity
9 firms, one of which is very visible. You know,
10 there's just a lot of -- and there's a lot of
11 focus on earnings. That's what investor owned
12 facilities do. Yet our mission to serve the
13 citizens of Moncks Corner, even though it was
14 in a less affluent community, it was going to
15 give access to people that were even less
16 affluent than who are in Moncks Corner just
17 because of its central nature to the outskirts
18 of Berkeley County. The ultimate decision was
19 to go back to what we had originally committed
20 to do when Berkeley County gave up their
21 hospital facility so that Trident Medical
22 Center could be built, and that was meet the
23 healthcare needs of Berkeley County. The state
24 recognized that plan through the Health
25 Facilities Commission (or through the Planning

Commission or the State Health Plan. I recognized our historical commitment that had been made by my predecessors to that community. Our corporate office recognized that same commitment. And we ultimately decided we had a strong reputation there, we had a longstanding commitment to serve that community with services. And now, if we're going to need to build a hospital to continue to meet the needs of that community and prevent a predator from moving in from the outside to take those patients downtown and strip that community of its ability to grow with a balanced strong health system and other-things it needs for it to grow economically, so be it, we'll put it in Moncks Corner. It may not be the most profitable place, but it's the most appropriate place to put it.

Q: Would placing the facility in Moncks Corner increase access to healthcare for the residents of the county?

A: Oh, yes.

Q: Okay.

A: Yeah, it reaches way on out into the -- I mean, Moncks Corner is the hub of Berkeley County.

1 Berkeley County, for those who may not know, is
2 I believe the largest land mass county in the
3 state of South Carolina. So having a central
4 access point is critical. Putting it in the
5 high dollar rent district, who I'm no
6 developer, but, my gosh, high rent people don't
7 want access to some of those rural regions of
8 Berkeley County. Moncks Corner is the place to
9 reach those places, not just the pretty people.

10 Q: And does the environment around Carnes
11 Crossroads already have ready-access at
12 Trident?

13 A: Oh, yes. You can get -- frankly, you can get
14 from Carnes Crossing or Carnes Crossroads, you
15 can get to Summerville in no time at all,
16 Summerville Medical Center. And probably about
17 an extra two or three minutes down the road
18 you're at Trident.

19 Q: Based on your knowledge of the county, are
20 there medically underserved people in that
21 northern part of the county that are going to
22 get increased access if Moncks Corner is built?

23 A: Oh, yes.

24 Q: Okay. Let's talk about the issue of
25 duplication. Did in your collaboration with

1 folks, did the issue of duplicating your
2 resources at Cane Bay come up?

3 A: Say that one more time to make sure I
4 understand you.

5 Q: You understand the concept of duplicating
6 healthcare resources --

7 A: Yes.

8 Q: -- by overbuilding?

9 A: Yes.

10 Q: Okay. When you're having these discussions
11 about Cane Bay, were there any discussions
12 about how utilizing Cane Bay would be
13 duplicating Trident?

14 A: Yes. And, you know, as we started looking at
15 how the traffic flows and, you know, looking at
16 the distance, how the crow flies, means less
17 than, you know, traffic counts and stoplights
18 and natural barriers and, you know, which way
19 do people go to shop. We figured out pretty
20 quick that putting it at Cane Bay was going to
21 cannibalize a significant number and I couldn't
22 quantify it. I just know, you know, based on
23 physician referral patterns, but most
24 importantly, patient flow patterns, you can
25 just see it's going to put a significant hurt

1 on the Summerville Medical Center campus. And
2 just given historical nature of what we saw in
3 our experience with Roper, their physicians
4 would leapfrog the patients past the Trident
5 Campus and have them drive on downtown through
6 that traffic mess. So to answer your question,
7 yes, it definitely would be unnecessary
8 duplication, unnecessary capital expenditure to
9 put it there.

10 Q: Take a look at 137, this is Respondent's 137.

11 A: Okay.

12 Q: You have this reference at the top. Well,
13 first of all, let's go to the bottom of the
14 page.

15 A: Okay.

16 Q: This is in May 2008. This is that 4:00 a.m.
17 email that Ms. HOLLINGSWORTH was asking you
18 about. Fair to say you had a few sleepless
19 nights over this topic?

20 A: Absolutely.

21 Q: Okay. It might explain why you were up at 4:00
22 in the morning.

23 A: Probably so, worrying about it.

24 Q: I would like to go through and just talk to you
25 about some of the points that you're making.

1 First of all, let's read the first paragraph,
2 "We just got a tip --" Would you read that
3 into the record for me?

4 A: Yes. "We just got a tip that Roper is
5 organizing a meeting with the Berkeley County
6 Commissioners and key community leaders on June
7 21 to unveil their strategic plan to build a
8 hospital for Berkeley County. As we shared
9 with you, a couple of weeks ago, they filed a
10 \$10 million CON to move their Moncks Corner ASC
11 to their newly purchased land near our Cane Bay
12 property. We are contesting the ASC move as an
13 affected party and can certainly do the same
14 with the new hospital. Assuming they don't
15 attempt a legislative end run to circumvent the
16 CON process, we can probably hold them off for
17 18 to 24 months with CON appeals."

18 Q: Okay. So again, you viewed this hospital as a
19 threat to your system?

20 A: An aggressive threat.

21 Q: Then let's look at the next paragraph. Read
22 that into the record for me, please.

23 A: Okay. "As we've said in the past, the first
24 one to get a CON to build a facility in
25 Berkeley County will lock out anyone else for

1 at least seven to ten years due to the CON bed
2 need calculations."

3 Q: All right. Let me stop you right there.

4 A: Okay.

5 Q: Okay. Was it your understanding that there was
6 only enough need for one hospital in the
7 region?

8 A: Yes.

9 Q: Okay. Let's go to the next sentence.

10 A: "The proposed new CON Health Plan looks to pave
11 the way for Roper to more easily claim the bed
12 need in Berkeley County that is currently set
13 aside for us."

14 Q: Is that, from your prior testimony, the concern
15 you had about a change to the Health Plan?

16 A: That was it.

17 Q: Okay. Go to the next.

18 A: "As it stands today, that Health Plan will be
19 adopted anywhere from June to August."

20 Q: Okay. Now, go to the next sentence.

21 A: "Bottom line, if we strike first with a CON
22 application before the draft plan is adopted,
23 we stand a good chance of locking Roper out of
24 our largest and most loyal patient base. If we
25 follow Roper's lead, we stand a good chance of

1 not only allowing a competitor into our primary
2 turf and losing the opportunity to build our
3 own facility there, but also forfeiting the
4 additional bed need that has been designated
5 for Trident, thus cutting off any capacity
6 expansion for the foreseeable future. We need
7 to commit quickly to either compete solely with
8 our Trident asset or block/match Roper with a
9 secondary asset in Berkeley."

10 Q: Okay. And ultimately, what did you decide to
11 do?

12 A: Ultimately, we decided to expand on our Moncks
13 Corner chassis and build a hospital.

14 Q: There were a number of questions that you were
15 asked regarding both whether or not there was
16 corporate authority and I think commitment for
17 this project. And what I'd like to do is to
18 make sure that we're clear. Go to Joint 1.
19 Should have something up there that says Joint
20 1.

21 **MS. HOLLINGSWORTH:** Your Honor, I would object to us
22 going through the certificate of need
23 application because it's very clear from this
24 witnesses testimony he had no involvement, he
25 didn't review it, didn't sign it. This had all

1 taken place after his tenure had ended.
2 There's no foundation for him to just read
3 information out of the certificate of need into
4 the record.

5 **THE COURT:** The certificate of need is in the
6 record, is it not?

7 **MS. HOLLINGSWORTH:** It is, Your Honor. But he's
8 just going to parrot statements out of it as if
9 he has independent knowledge of it, which he
10 does not. Anything he learns will be from
11 reading a document that's in the record.

12 **MR. SUMMER:** I'm glad she's that clairvoyant. I
13 haven't asked the question yet, Your Honor.

14 **THE COURT:** Well, and that's my comment. You're
15 overruled.

16 **MS. HOLLINGSWORTH:** Okay.

17 **THE COURT:** But you may raise it again if it's
18 proper.

19 Q: Turn to page 650, please, sir.

20 A: Okay.

21 Q: First of all, do you attend board meetings?

22 A: Yes.

23 Q: Okay. And what is this letter right here?

24 A: This is a letter of support from Eric Bolster
25 indicating his support and the that the Board

1 of Trustees had unanimously approved the filing
2 of the certificate of need for the new hospital
3 in Moncks Corner.

4 Q: It's proof of board action, isn't it?

5 A: Yes.

6 Q: Okay. Thank you very much. And if you would,
7 turn back to page 641.

8 A: Okay.

9 Q: And all I want to do is ask you to take a look
10 at this letter. Take a few minutes to
11 familiarize yourself with it.

12 A: (Witness reviews document). Okay.

13 Q: Okay. Based upon your knowledge and your
14 experience with HCA, is that a commitment to
15 fund the project?

16 A: Yes.

17 Q: Those are the only questions I have for you out
18 of the CON application.

19 A: Okay.

20 Q: Let's look at, let's see if we can --

21 **MR. SUMMER:** Trying to get rid of a few things, Your
22 Honor.

23 Q: This is just an observation. You were asked
24 about Respondent's 138. Do you mind turning
25 over to that?

1 A: Okay. Okay.

2 Q: This is an exhibit that Ms. Hollingsworth asked
3 you about. This is Mr. Stinnett writing you to
4 say that he's got a conflict with an ethics and
5 policy committee meeting. Do you see that?

6 A: Yes.

7 Q: Can you explain one more time for us who Mr.
8 Stinnett is or was?

9 A: Yes. At that time Mr. Stinnett was the chief
10 financial officer for Chuck Hall and the
11 eastern group.

12 Q: Okay. There was a point in time in the summer
13 of 2008 where Mr. Rardin took the ball and ran
14 with it, didn't he?

15 A: Yes.

16 Q: Okay. Was that the normal course of business
17 for you with CON projects once they'd been
18 initiated?

19 A: Yes.

20 Q: And were you aware from your conversations with
21 Mr. Gorrell of all the folks who were working
22 in concert with him and Mr. Woodford on putting
23 the financials together for the CON?

24 A: I didn't know who all he relied on, but I just
25 relied on him to get it done. I trusted his

1 judgment to use whoever he needed to use.

2 Q: Did you have confidence in Mr. Rardin and Mr.
3 Gorrell to put together a good product?

4 A: Complete confidence.

5 Q: Would you have confidence in their ability to
6 project earnings?

7 A: Yes.

8 Q: If you'd please answer any questions that Ms.
9 Hollingsworth may have.

10 A: Sure.

11 **MS. HOLLINGSWORTH:** May it please the court, just a
12 few more questions.

13 **THE COURT:** Yes, ma'am.

14 **MR. GUNN - REDIRECT EXAMINATION BY MS. HOLLINGSWORTH:**

15 Q: Go to Petitioner's 201, please. Mr. Gunn, as
16 you recall, Mr. Summer asked you some
17 additional questions about this document,
18 correct?

19 A: Yes.

20 Q: If you'd just look at that paragraph that says
21 Vision; do you see that?

22 A: Yes, I do.

23 Q: What is that first sentence in that paragraph?

24 A: The first sentence?

25 Q: Yes, if you would read that into the record for

1 me.

2 A: "The Cane Bay project will allow us to fulfill
3 our strategic vision of providing increased
4 access to healthcare."

5 Q: And what is the very last sentence of that
6 paragraph?

7 A: "This will allow us to secure the west region
8 of the county where there is a substantial
9 amount of growth."

10 Q: And that Del Webb community that you spoke
11 about, that's up and running, isn't it?

12 A: The Del Webb is up and running and there are
13 some houses there as well.

14 Q: And they've built a second Publix in the area
15 close to that community, correct?

16 A: I believe I read in the paper that Publix was
17 the -- ended up moving in.

18 Q: And it's not your testimony that HCA or Trident
19 Health System owns Berkeley County, is it?

20 A: I think the citizens of Berkeley County own
21 Berkeley County.

22 Q: And you use the term Roper St. Francis
23 poaching. There's no ownership of the Berkeley
24 County area that Roper St. Francis could poach,
25 is there?

1 A: I think it's clear -- it was clear to me --
2 well, I'm not using it in a legal sense. I'm
3 not a lawyer. I use it in a -- I'm using it in
4 a hunting sense. That bed need that was
5 designated for Trident is the result of
6 demonstrated -- demonstrated need over time
7 that we had built because the citizens of that
8 area had come to Trident Medical Center or
9 Trident Health System in total for care. And
10 the state recognized and granted to us, through
11 their documentation through the State Health
12 Plan, beds that needed to be built by Trident
13 Health System to serve the needs of that
14 community. So when I see a hospital who has
15 got excess beds, I don't understand why the
16 state doesn't take them away. But for whatever
17 reason they don't. They're just sitting there
18 with beds that aren't used. And they try to
19 use those to jump over me where I'm trying to
20 meet a mission and a vision that was
21 established over 40 years ago just to profiteer
22 off of the most affluent community that was
23 being built or being planned for Berkeley
24 County, I was incensed, and I view it as
25 poaching.

1 Q: And this bed need that you're talking about in
2 the State Health Plan, that was for Trident
3 Medical Center, correct?

4 A: That's correct.

5 Q: But that need was not for Moncks Corner, was
6 it?

7 A: It absolutely was. That -- Moncks Corner was
8 an emergency room with an outpatient center and
9 physician offices. The bed need for Berkeley
10 County, for Dorchester County, for North
11 Charleston, the -- our predecessors, the
12 founding fathers of that community and DHEC,
13 got together and approved the closing of those
14 hospitals in the establishment of Trident
15 Medical Center back in the early '70s. I don't
16 know how easier to paint the picture that
17 Trident Medical Center, ultimately Trident
18 Health System, was the entity that served the
19 needs of those communities. As they grew, we
20 began to push services to increase access to
21 those communities and better serve their needs.
22 I don't see anybody that said we weren't doing
23 a good job at doing that. In fact, the state
24 was giving us the right under the State Health
25 Plan to do more of those services. They didn't

1 grant Roper St. Francis Health System the right
2 to do that because they didn't even have enough
3 beds to -- or they had more beds than they knew
4 what to do with. We didn't. We had -- we were
5 serving the needs of our community. They
6 jumped over us and poached on what had been
7 rightly given to us.

8 Q: And the growth was in Berkeley County, correct?

9 A: Well, there's growth all over that area.

10 Q: But you would agree with me that Berkeley
11 County was an area that you saw as growing
12 rapidly?

13 A: Berkeley County, yes, Berkeley County was
14 growing all over. I mean, you could look --
15 the poor parts of the county were growing.
16 There was a lot of speculation there was going
17 to be some rich parts of the county growing.
18 Boeing wasn't on anyone's radar at that point;
19 hindsight's great. But, yeah, all that has
20 proved to make Berkeley County a growing
21 community.

22 Q: And you knew that Roper St. Francis already
23 served Berkeley County residents, right?

24 A: Well, they were there, but like I said earlier,
25 they were pulling out. They were withdrawing

1 some of their services.

2 Q: Well, but you didn't have 100 percent of the
3 market in Berkeley County, did you?

4 A: Don't have a hundred percent in any market.

5 Q: Right.

6 A: Just like Roper doesn't have a hundred percent
7 of the market either.

8 Q: Sure. You share the market, right?

9 A: We share the market. But we're the dominant
10 player and we're the one that the state said if
11 you're going to build it, Trident's the one
12 that builds it.

13 Q: Trident Medical Center had a need for more beds
14 under the Plan, correct?

15 A: Yes, they did.

16 **MS. HOLLINGSWORTH:** Your Honor, one moment.

17 Q: Thank you, Mr. Gunn, for your time today. I
18 appreciate it.

19 **THE COURT:** Ms. Biggers?

20 **MS. BIGGERS:** Well, Your Honor, I didn't have any
21 questions.

22 **THE COURT:** Thank you. Since we started late, do
23 you want to start another witness and go to
24 1:00, or do you want to break for lunch now?

25 **MR. LONG:** It probably makes more sense to break,

1 Your Honor. I mean, the next witness isn't
2 going to be 30 minutes. It will be, you know,
3 a while. So I think -- I couldn't do it in 30
4 minutes.

5 THE COURT: We'll be in recess until 2:00 then.

6 (Off the Record from 12:25 p.m until 2:00 p.m.)

7 MR. LONG: Thank you, Your Honor. We will call Bret
8 Johnson to the stand.

9 BRET D. JOHNSON, being duly sworn, testifies as
10 follows:

11 MR. JOHNSON - DIRECT EXAMINATION BY MR. LONG:

12 Q: Can you state your full name, please?

13 A: Yes. Bret David Johnson.

14 Q: And, Mr. Johnson, where do you reside?

15 A: At 235 Oak Point Landing Drive, Mount Pleasant,
16 South Carolina.

17 Q: And who is your employer?

18 A: Carolinas Healthcare System, which is the
19 management company for Roper St. Francis
20 Healthcare.

21 Q: And where do you actually work on a daily
22 basis?

23 A: I work in Charleston, South Carolina at Roper
24 St. Francis Healthcare.

25 Q: You've got to speak up just a little bit. You

1 kind of faded there on me and the court. All
2 right. Can you -- what is your role at Roper
3 St. Francis Healthcare?

4 A: I'm the chief financial officer.

5 Q: And could you give the court your educational
6 background?

7 A: I have a bachelor of science degree from the
8 University of Iowa.

9 Q: Any additional education after that?

10 A: No.

11 Q: Okay. Do you have any degrees or
12 certifications?

13 A: I'm a certified public accountant and I belong
14 to the American Institute of Certified Public
15 Accountants and also the South Carolina
16 Association of Certified Public Accountants.

17 Q: Can you give us your work history since
18 college?

19 A: Okay. In July of 1989 I went to work in
20 Charlotte, North Carolina for Arthur Anderson,
21 which is -- was a large multinational public
22 accounting firm. I was with them for eight
23 years, specializing in audit of healthcare and
24 real estate. I left them in July of '97, went
25 to work for Roper CareAlliance, which was the

1 predecessor of Roper St. Francis Healthcare and
2 have been there ever since. Although in 2005,
3 upon my promotion to CFO, I did transfer
4 payrolls so to speak over to our management
5 company, Carolinas Healthcare System.

6 Q: Can you tell us again what your position was
7 prior to 2005?

8 A: All right. I was the director of finance. It's
9 sometimes called controller.

10 Q: Okay. And then you in 2005 because the chief
11 financial officer?

12 A: That's correct. March 1st.

13 Q: All right. Let me show you a document here,
14 Respondent's Number 9. I think this might give
15 us some -- I'm sorry, Respondent's 15. This is
16 Respondent's 15. Can you see it on the screen
17 there?

18 A: I can.

19 Q: All right. Do you recognize this?

20 A: It is an organizational chart for Roper St.
21 Francis Healthcare.

22 Q: Okay. Now, what is -- what exactly is
23 CareAlliance Health Services?

24 A: That is our legal name, although we have a
25 d/b/a or doing business as Roper St. Francis

1 Healthcare..

2 Q: Okay. And down here on the, I guess the bottom
3 part of the box of the -- of the organizational
4 chart it lists out -- can you describe for me
5 which one -- what each of these boxes is?

6 A: Okay. Well, the top box, if you want me to
7 start there, is our founding members. And we
8 have three founding members. The Medical
9 Society of South Carolina, they are the fourth
10 oldest medical society in the county. They
11 were founded in the late 1700s. And have been
12 involved in a lot of things. But since 1951,
13 pretty much the oversight of -- of Roper
14 Hospital and its subsequent entities. Bon
15 Secours Health System is a large faith-based
16 Catholic affiliated health system based in
17 Baltimore, about 3.3 million in revenue, and
18 they operate about 22 hospitals, if I'm getting
19 that number right, in multiple states on the
20 Eastern Seaboard. Carolinas Healthcare System
21 is the second largest nonprofit health system
22 in the county. They are based in Charlotte,
23 North Carolina; over 6 billion in revenues, and
24 they operate about 32 hospitals in North and
25 South Carolina.

1 Q: Is Roper St. Francis Healthcare a for profit or
2 not-for-profit entity?

3 A: We are a 501(c)(3) nonprofit entity.

4 Q: And all three of the founding members, are they
5 for -- any of them for-profit or are they all
6 not-for-profit?

7 A: The Medical Society and Bon Secours are not-
8 for-profit. Carolinas Healthcare System is
9 also not-for-profit. Although they are
10 technically a political subdivision of the
11 state of North Carolina.

12 Q: That's also sometimes referred to as what?

13 A: An authority.

14 Q: Or government -- so it's basically
15 governmental?

16 A: Yes, that's correct.

17 Q: That's sometimes the way people refer to it?

18 A: That's correct.

19 Q: And of course they're located in Charlotte
20 primarily, right?

21 A: Correct.

22 Q: Now, below that box you have what, the actual
23 --

24 A: Roper Hospital. Which was founded in 1829, I
25 believe.

1 Q: Let me slow down a second. Let me ask you
2 this. Does Roper St. Francis Healthcare own
3 the entities on this box -- on this page?

4 A: Let me clarify. Own is not a term that really
5 applies to nonprofits. Membership interest is
6 the term that really applies for nonprofits
7 because nonprofit are community assets. But
8 let me start with founding members if I can.

9 Q: Well, let's talk about what these boxes are at
10 the bottom and then come back up to the
11 founding members.

12 A: Okay. Roper St. Francis Healthcare, the parent
13 company, is the sole member of the boxes, the
14 rectangular boxes below.

15 Q: Okay. And what are those?

16 A: Roper Hospital; Roper St. Francis Mount
17 Pleasant Hospital, which we've talked a lot
18 about that opened its doors November of 2010;
19 our foundation, which is our philanthropic arm
20 of Roper St. Francis Healthcare; our Bon
21 Secours St. Francis Hospital, located in West
22 Ashley. It has been in the Charleston
23 community since I believe 1882, and was started
24 by the Sisters of Charity of Our Lady of Mercy,
25 and then in about 1989 then was transferred to

1 Bon Secours Health System. And then our Roper
2 St. Francis Physician Network, which is where
3 our employed physicians are, it's -- are
4 employed by that division.

5 Q: And then you have two other entities below
6 that, right?

7 A: That's correct. And the -- on this particular
8 sheet, the James Island Surgery Center is
9 inactive. We tried to syndicate a surgery
10 center and it just didn't take off, so that is
11 an inactive corporation. The West Ashley
12 Cancer Center is really just a real estate LLC
13 that we have with a group of oncologists that
14 office in that building.

15 Q: Okay. The Roper Hospital, where is it located?

16 A: It is at the corner of Calhoun and Courtnay in
17 downtown Charleston.

18 Q: And it's been in that facility -- been at that
19 address or that area of Charleston for how
20 long?

21 A: Since 1940.

22 Q: Since when?

23 A: 1940.

24 Q: Okay. And how long has Roper Hospital,
25 Incorporated been in existence?

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1 A: It was founded in 1829, I believe.

2 Q: 1829?

3 A: That's correct.

4 Q: Generally we refer to this entity as Roper
5 Downtown, right?

6 A: Correct.

7 Q: I know we've heard that term throughout the
8 case. The St. Francis Hospital, where is it
9 located?

10 A: For many, many years it was located also in
11 downtown Charleston within close proximity of
12 both the Medical University of South Carolina
13 and Roper Hospital. In 1996 it moved to a new
14 location in West Ashley.

15 Q: Okay. And you mentioned the Medical University
16 of South Carolina. Where is the Medical
17 University of South Carolina located relevant
18 to Roper Hospital?

19 A: Our campuses are contiguous. They're right
20 next to each other.

21 Q: Okay. And how many beds does the Medical
22 University have; do you know?

23 A: I --

24 Q: We can do that later if you're not sure.

25 A: Well, typically -- yeah, it is --

1 Q: We'll come back to it. We'll come back to it.

2 A: Okay.

3 Q: All right. How did -- now, when you started
4 working at Roper, did this organization that's
5 on this sheet here exist?

6 A: It did not. I went to work for Roper
7 CareAlliance, which consisted of Roper Hospital
8 and also a Roper Hospital North that was in
9 southern North Charleston.

10 Q: Okay. And then tell the court what happened in
11 the late 1990s that led to the creation of this
12 organization?

13 A: Okay. Well, for a number of years Roper and
14 St. Francis had thought about affiliating.
15 They had common missions, overlapping medical
16 staffs. There's a lot of efficiencies,
17 particularly in the back office, that they
18 could achieve by merging. So in August of 1998
19 those entities did merge. Upon the merger of
20 those two entities, CareAlliance Health
21 Services d/b/a Roper St. Francis Healthcare was
22 formed. And then the Medical Society
23 transferred into that new corporation the
24 assets of Roper Hospital and Roper Hospital
25 North, and for that they received a 63 percent

1 membership in the new Roper St. Francis
2 Healthcare. Bon Secours Health System
3 transferred in all the assets of St. Francis
4 Hospital into Roper St. Francis Healthcare,
5 into that new company, and for that they
6 received a 27 percent membership interest in
7 the corporation. And then Carolinas Healthcare
8 System was the managing member. They signed a
9 five year management agreement upon the
10 formation of those -- of NewCo, so to speak.
11 And they bought in with \$40 million in cash for
12 a ten percent membership interest. So the 63,
13 the 27 and the ten should get me to a hundred,
14 so.

15 Q: How did Carolinas Healthcare System become
16 involved in this?

17 A: They were -- Roper and St. Francis for many
18 years had talked about affiliating. And they
19 -- it just for a number of years couldn't get
20 done. There were other issues that Roper
21 CareAlliance had. At the time they were out of
22 network on the BlueCross contract, which is a
23 managed care contract, and there were some
24 other issues. And Roper Hospital -- the
25 Medical Society, which was the sole member at

1 the time of Roper CareAlliance, wanted
2 professional management brought in, and that is
3 why Carolinas Healthcare System was brought in.
4 And one of the goals that was given to
5 Carolinas Healthcare System was work with us to
6 get this merger accomplished. And it was
7 accomplished in August of 1998.

8 Q: Okay. Does that arrangement between these
9 three founding members still exist today?

10 A: It does.

11 Q: Have there been any changes to it?

12 A: Other than -- other than the addition of some
13 of these boxes we talked about earlier --

14 Q: Right.

15 A: -- no. The governance structure has been --
16 has been retained. And an interesting thing
17 about the governance structure, even though
18 Medical Society owns or is a 63 percent member,
19 none of our founding members has control at the
20 board level. Medical Society has six votes on
21 the board. Bon Secours has six votes on the
22 board. And Carolinas Healthcare System has
23 one. So no founding member has control, and I
24 think that makes our board very effective in
25 serving the community and not a founding

1 member.

2 Q: Are some of the employees from Charleston with
3 Roper St. Francis Healthcare actual employees
4 of Carolinas Healthcare System?

5 A: Yes. In the management agreement there is
6 language that the CEO and the CFO are employees
7 of the management company, Carolinas Healthcare
8 System. There is one other employee of
9 Carolinas Healthcare System, it is John
10 Sullivan, who is the CEO of Mount Pleasant
11 Hospital. The management agreement does not
12 call for that, but John has spent many, many
13 years with Carolinas Health Systems --
14 Healthcare System, and when he assumed
15 responsibility for the CEO role for Mount
16 Pleasant Hospital, he just retained his
17 employment with Carolinas Healthcare System.
18 He was in their benefit plan and it just made
19 sense to do that.

20 Q: Okay. All right. Let's talk about some of the
21 individual people, okay? Who is the CEO for
22 Roper St. Francis Healthcare?

23 A: Mr. David Dunlap.

24 Q: Okay. And you're the CFO, correct?

25 A: Correct.

1 Q: All right. Now, does each one of these
2 entities that are reflected here on the
3 organizational chart have its own CEO?

4 A: Yes.

5 Q: All right. Can you walk me through who those
6 people are?

7 A: Okay. Matt Severance is the CEO of Roper
8 Hospital. John Sullivan is the CEO of Mount
9 Pleasant Hospital. There isn't technically a
10 CEO of our foundation; our director is Susan
11 Kennan. Allen Carroll is the CEO of St.
12 Francis Hospital. And Doug Bowling is the CEO
13 of the Physicians Network.

14 Q: Okay. When did Mr. Bowling come to Roper St.
15 Francis Healthcare?

16 A: Approximately seven years ago.

17 Q: So it would have been around 2004?

18 A: Yes.

19 Q: Does that sound about right?

20 A: Yes.

21 Q: Right about the time you became CFO?

22 A: Shortly before I became CFO.

23 Q: When did Mr. Dunlap come to Charleston?

24 A: Approximately a year before Mr. Bowling.

25 Q: Okay. So around '03?

1 A: Yes.

2 Q: And did Mr. Bowling have another role in the
3 company in addition to being the CEO of the
4 physician department?

5 A: He does. He also carries the title of chief
6 strategy officer.

7 Q: And are there other -- are all of those
8 individuals what you would consider to be kind
9 of the senior management at Roper St. Francis
10 Healthcare?

11 A: In conjunction with our vice president of
12 admission and our senior nurse execs and our
13 chief information officer, I would say that --
14 and general counsel, that rounds out the team.

15 Q: What does vice president of admission do?

16 A: Well, as a nonprofit, and a faith-based
17 nonprofit, his job is to ensure that our
18 organization fulfills its mission to the
19 community.

20 Q: Okay. Let's talk about the -- a couple of the
21 -- let's talk about the founding members. You
22 mentioned Medical Society of South Carolina.
23 What exactly is the Medical Society of South
24 Carolina?

25 A: It was formed 1789, I believe. It is the

1 fourth oldest medical society in the country.
2 They've had a -- obviously with that long of a
3 history, a number of things they've done over
4 the years. I think they actually started
5 Medical University or they opened Medical
6 University years and years ago. Since 1951
7 their primary focus has been on running Roper
8 Hospital and then the, ultimately Roper St.
9 Francis Healthcare.

10 Q: And who is allowed to be members of the Medical
11 Society of South Carolina?

12 A: Doctors who are on Roper St. Francis
13 Healthcare's medical staff.

14 Q: If you're on the medical staff, are you
15 required to be a member of the Medical Society?

16 A: No.

17 Q: Are you automatically a member?

18 A: No.

19 Q: Okay. So is that something -- is there -- how
20 do you become a member then?

21 A: You apply, and there's an application process.
22 And then there are periodic meetings, and I
23 think there is a requirement to attend certain
24 number of meetings, but it's -- it's not a
25 rigorous set of restrictions required.

1 Q: Now, you testified earlier the Medical Society
2 is not-for-profit, right?

3 A: Yes.

4 Q: So do the individual physician members of the
5 Medical Society receive any income or
6 distributions by being a member of this
7 organization?

8 A: They do not. The board serves on a voluntary
9 basis. The Medical Society does have, I think,
10 three employees who would be paid at fair
11 market value rates as part of salary. But no,
12 as a nonprofit, no benefit could enure from
13 that nonprofit to private individuals. So, no,
14 the physicians do not participate in any
15 distributions.

16 Q: Well, what is the mission of the Medical
17 Society of South Carolina?

18 A: The mission of Medical Society is to promote
19 healthcare in the area, without being
20 competitive with Roper St. Francis Healthcare.
21 So it is -- said another way, they're really a
22 supporting organization of Roper St. Francis
23 Healthcare.

24 Q: Now, does Roper St. Francis -- Roper St.
25 Francis Healthcare make distributions to the

1 Medical Society?

2 A: We make an annual distribution to our founding
3 members. And it is split proportionate to the
4 membership interest I covered earlier.

5 Q: Okay. Now, again, Bon Secours, that's also not
6 -- that's a religious not-for-profit, right?

7 A: Correct. A faith-based nonprofit affiliated
8 with the Catholic church. They are owned by
9 the -- they were founded by the Sisters of Bon
10 Secours in, I think, 1983, and they are based
11 in Baltimore, Maryland. And they are a little
12 bit in excess of 3 billion in revenue per year.
13 And they own approximately 22 hospitals that
14 are along the Eastern Seaboard.

15 Q: And I might have misunderstood you. But I
16 think earlier in your testimony you said that
17 three or 33 million. But it's actually three
18 billion, right?

19 A: The annual revenues of Bon Secours are about
20 3.3 billion, yes..

21 Q: Okay. And just to back up on the Medical
22 Society of South Carolina. You're familiar
23 with their financials, right?

24 A: Somewhat, yes.

25 Q: Okay. And do you work closely with their

1 employ -- the managers of the Medical Society?

2 A: I do.

3 Q: And what does their balance sheet look like?

4 A: The biggest assets on their balance sheet would
5 be obviously their equity investment in Roper
6 St. Francis Healthcare, which is a paper number
7 so to speak. But they also maintain a large
8 investment portfolio. I'm guessing it would be
9 in the neighborhood of 110 to 120 million
10 today.

11 Q: When you say you're guessing, I mean are you
12 making -- you've seen the documents, right?

13 A: Yeah. It was over 100 million at year end. So
14 I'm guessing with good investment performance
15 recently, it's increased.

16 Q: All right. And tell me about Carolinas
17 Healthcare System and its -- I mean it's
18 publically available information, right?

19 A: Yes. They, as an authority, very similar to
20 the Medical University. They don't have all
21 the reporting requirements of a 501(c)(3), but
22 there's a lot of publically available
23 information. They own, lease or manage over 30
24 hospitals in North and South Carolina. They
25 are the second largest not-for-profit

1 healthcare in the country -- healthcare system
2 in the country. They are very financially
3 solid. They carry a double A minus credit
4 rating from Standard and Poor's.

5 Q: What does that mean?

6 A: It means that they are at almost the same level
7 as the U.S. government in terms of their credit
8 strength, a very solid organization. About six
9 point -- over six billion a year in revenue.

10 Q: And back to the Medical Society of South
11 Carolina. You said they have \$100 million in
12 their investment account. That money can't be
13 distributed to the physicians, so what's it
14 there for?

15 A: It is -- two -- two reasons. You know, they
16 are a supporting organization of Roper St.
17 Francis Healthcare, but they also are a member
18 of -- they're also a member of Roper St.
19 Francis Healthcare and should Roper St. Francis
20 Healthcare ever have to make a capital call to
21 its founding members, they need liquidity on
22 their balance sheet to meet that capital call
23 so that they wouldn't be diluted from an
24 ownership or membership perspective. So they
25 need to maintain some level of liquidity.

1 Q: Explain to me what you mean if they ever had to
2 make a capital call. What does that --

3 A: Well, today Roper St. Francis Healthcare enjoys
4 good financial health. Should we ever be in a
5 situation where we are losing money and need to
6 be recapitalized by the founding members and a
7 capital call were made, Medical Society would
8 have to be able to meet the demands of that
9 capital call or their membership interest could
10 be diluted.

11 Q: And the capital call would require them to do
12 what?

13 A: To pay cash into Roper St. Francis Healthcare.

14 Q: Okay. Has this merger been financially
15 successful?

16 A: I would say yes. I mean, one of the main
17 reasons for affiliating is to consolidate back
18 office functions. There is tremendous savings
19 that can result from that. Also, when you
20 combine forces, so to speak, you can receive
21 better, just by bigger scale, receive better
22 discounts on supply contracting. It's more --
23 a little more leverage with the managed care
24 companies. So, yeah, the affiliation has been
25 financially good for the Health System.

1 Q: And, now, after the merger went through, I
2 think -- what was the year again, ninety --

3 A: 1998.

4 Q: '98, okay. Was a decision made in regards to
5 Roper North?

6 A: Yes. And in the early 2000s it was decided
7 Roper North would be closed.

8 Q: Okay. And where was that hospital located
9 again?

10 A: It was within just a few -- it was within a few
11 miles of Roper Hospital. It was in the
12 southern tip of North Charleston so to speak.

13 Q: And you were -- you were employed there at the
14 time that was made, right?

15 A: I was, yes.

16 Q: What actually -- what were some of the problems
17 with regards to the facility at Roper North?

18 A: You know, the biggest problem was access. For
19 years we had worked with North Charleston to
20 try to get an off-ramp off of 26 because the
21 hospital was just off of Interstate 26, but you
22 -- it was hard to get to. It was hard to get
23 to for patients and hard to get to for our
24 physicians. Access was deemed to be an issue,
25 census was low in the facility, and it was

1 decided that we would close that facility. We
2 did work closely with the City of North
3 Charleston to make sure that services did
4 remain. And in discussions with the mayor, it
5 was decided that our Roper Northwoods facility
6 would open, which consisted of an emergency
7 room and also certain diagnostic services, and
8 that facility remains today.

9 Q: Okay. At the time that you started with Roper,
10 was there also a facility in Moncks Corner,
11 Berkeley County?

12 A: Yes.

13 Q: And can you tell the court about that facility?

14 A: Yeah, this is reaching back. But we did have
15 an emergency room in Moncks Corner. We offered
16 diagnostic services in Moncks Corner. And then
17 sometime in '97 or '98 I think is when we
18 brought ambulatory surgery services to that
19 site.

20 Q: So there are operating rooms located there?

21 A: That's correct.

22 Q: And how long has the emergency room or the
23 freestanding ED in Moncks Corner been in
24 existence?

25 A: I would say 20 years.

1 Q: Now, in regards to -- how are strategic
2 decisions made since you've become the CFO at
3 Roper St. Francis?

4 A: Well, we have an annual strategic planning
5 process and that is it culminates every year in
6 October with a board retreat where that is
7 presented to the board and then approved.

8 Q: Okay. And as the CFO of the organization, what
9 would you say your role was in regards to the
10 strategic planning?

11 A: Well, obviously the CFO has to make sure that
12 the organization is planning in a way that
13 enough profit is generated to adequately
14 reinvest in the business and then, you know, so
15 there is some oversight on the part of the CFO.
16 Additionally, the CFO's job it to ensure the
17 strategic plan is funded. You know, when the
18 ideas come forth from the CFOs each year,
19 there's always more -- they're all good ideas,
20 but there's more than can be funded at any
21 particular point in time. So things have to be
22 prioritized so they fit within the available
23 funding.

24 Q: Okay. And what kind of -- what is the most
25 important components in regarding -- in your

1 decision as to how to fund the strategic plan?

2 A: We have some -- some rules. You know, our
3 routine capital, which is replacement of --
4 when I say routine capital, I mean replacement
5 of OR instrumentation or replacing an x-ray
6 machine or something that already exists.
7 Routine is typically -- well, we use operating
8 cash flow to acquire that. And we don't --

9 Q: Can you explain what you mean by that?

10 A: EBITDA. We spend a lot of time talking about
11 EBITDA, and that's what I'm talking about.
12 Major strategic, which would include things
13 like the heart and vascular tower we added to
14 Roper Hospital a number of years ago or the new
15 Mount Pleasant Hospital, that major strategic
16 would be debt financed typically.

17 Q: Okay. So equipment would be handled through
18 the cash flow, the cash flow of the
19 organization, but major projects you borrow
20 money, right?

21 A: Correct. I mean in financial logic, you would
22 not want to use long-term debt to fund short-
23 term assets like OR instrumentation and things
24 like that. Really your operating cash is the
25 means to pay for that. And then you would, you

1 know, long-term debt is more appropriate for
2 four year projects like new hospitals.

3 Q: All right. Well, let's talk about how your --
4 about kind of operating your EBITDA or your
5 operating cash flow. First, in regards to
6 taxes, does Roper St. Francis Healthcare pay
7 taxes?

8 A: We pay lots of taxes.

9 Q: What kind of taxes do you pay?

10 A: We pay the healthcare provider tax, which is
11 put up for the disproportionate share match,
12 but it is a tax, and it is about 15 million a
13 year. We pay approximately \$10 million a year
14 in sales tax on supplies. Nonprofits in South
15 Carolina are not exempt from sales tax. And
16 then we pay at least two million dollars a year
17 in property taxes. So that, you know, we pay
18 -- that would get to about \$27 million a year
19 in taxes that we pay.

20 Q: What about state and federal corporate income
21 tax?

22 A: We do not. We are exempt from federal and
23 state income tax.

24 Q: And how do you -- well, what are the
25 requirements for you to be allowed to be exempt

1 from paying those taxes?

2 A: The role of a nonprofit is to -- we're a
3 charitable organization and we exist for the
4 benefit of the community.

5 Q: Okay.

6 **THE COURT:** Excuse me. Would you go over where you
7 get that 27 million figure from again for me?

8 A: I sure will. Yes, Your Honor. We pay \$15
9 million a year in what's called a hospital
10 provider tax, and we pay that to the state.
11 And then the state co-mingles that with all of
12 the other hospitals' provider taxes, and they
13 put that up to the federal government to get
14 the disproportionate share, matching dollars
15 from the Medicaid program. So that's 15
16 million. We pay, and I'm probably understating
17 the number a bit, but we pay \$10 million a year
18 in sales tax on our supplies that we purchase,
19 just like Trident would. And then we -- we pay
20 a lot of property taxes. The main campuses of
21 our hospitals, you know, on the four walls of
22 the hospital, so to speak, we do not pay
23 property tax; we're exempt. But we have a lot
24 of leases with our physician practices and we
25 have a lot of medical offices. Those are not

1 exempt from property tax. So obviously, I'm
2 guessing we're paying about two million dollars
3 a year in property tax. So you add those three
4 up and it's 27 million, which -- which is a bit
5 less than Trident. Trident was -- well more
6 than a bit. But Trident I saw in their
7 community benefit report recently, they pay 38
8 million in taxes versus our 27.

9 Q: Now, let's talk about the community benefit
10 that you provide. First, is there a
11 quantitative requirement, an actual number that
12 you're required to do as a community benefit to
13 maintain your not-for-profit status?

14 A: Yes. The IRS is not clear on that number.
15 I've spent time reading those regulations.
16 It's very qualitative. It is not quantitative.

17 Q: What do you mean by qualitative?

18 A: It's just -- I guess it's just language.

19 Q: Descriptive?

20 A: Not very descriptive.

21 Q: Okay.

22 A: And some states have tried to legislate
23 adequate levels for the provision of community
24 benefit for nonprofits. Texas is one. I think
25 through the I think it's called Public Health

1 and Safety Code they have legislated that
2 nonprofit hospitals provide five percent
3 community benefit, which would mean that their
4 community benefit divided by their revenues has
5 to equal five percent.

6 Q: That would be their net revenues?

7 A: Net revenues.

8 Q: And have other states also attempted to do this
9 besides Texas?

10 A: My understanding is North Carolina is working
11 on it with a similar five percent target, and
12 additionally, the Senate -- U.S. Senate Finance
13 Committee has proposed similar language and a
14 five percent adequacy threshold.

15 Q: Mr. Baehr testified about some hospitals in
16 Illinois that lost their not-for-profit
17 accreditation. Are you familiar with those?

18 A: I think he's probably referring to Provina.
19 Yeah, my under -- I'm not sure how accurate I
20 can quote. My understanding of Provina is that
21 the, their community benefit level as somewhere
22 in the one percent range, coupled with --

23 MR. THOMAS: Your Honor, I need to object. I'm
24 sorry. I don't think Mr. Long has really laid
25 a foundation as to how this witness knows any

1 of that. He's not an expert in this area. He
2 hasn't been designated as an expert or
3 qualified. So, I mean, at least we'd like to
4 know where he got the information from that
5 he's basing his understanding on. I mean --

6 **THE COURT:** Well, --

7 **MR. THOMAS:** -- this morning we couldn't have our
8 CEO talk about the state health planning
9 process.

10 **MR. LONG:** Your Honor, I think --

11 **THE COURT:** Are you going to cure it or do you want
12 me to rule on it?

13 **MR. LONG:** I can try to cure it. I mean --

14 **Q:** If you're talking about Provina, is that an
15 actual hospital that you're talking about?

16 **A:** It's a healthcare system in Illinois, correct,
17 if I'm getting that one right.

18 **Q:** And Mr. Baehr mentioned a healthcare system in
19 Illinois in his testimony, right?

20 **A:** He did, correct.

21 **Q:** All right. And how have you become aware of
22 that? Is that situation with that hospital
23 fairly famous in the healthcare world?

24 **A:** Yes. Very -- yes. It would have been
25 something that healthcare systems across the

1 county definitely educated themselves on.

2 Q: Okay. And, well, my next question would be
3 what -- from that, what is your understanding
4 of what their community benefit was percentage
5 relative to their net revenue?

6 A: My recollection is that it was in the
7 neighborhood of one percent or less, and it was
8 also coupled with some very egregious
9 collection practices where they went to great
10 lengths to secure payment from patients who
11 were not really able to pay in a more
12 reasonable financial -- they -- nonprofit
13 healthcare systems are required to have
14 financial assistant policies, and they were
15 apparently not following theirs and
16 implementing very egregious collection
17 practices.

18 Q: Okay. Let's take a look at Respondent's
19 Exhibit 164. And you have the notebooks up
20 there. Though, I'm not sure you have 164 in
21 there for the -- you may not. So let me give
22 you, I want to give you -- I think 160 -- you
23 know, I might have written this down wrong.
24 That's the one I want. That's 164, right,
25 Roper Hospital, Inc.?

1 THE COURT: Mr. Long, I don't have that in either
2 one of these books.

3 MR. LONG: Yes, Your Honor. That was one of the
4 later ones. Let me get you a copy of it.
5 Thank you, Your Honor.

6 Q: Now, let's -- well, first, Mr. Johnson, you may
7 have to go a little slow on this, okay? It's
8 got a lot of numbers on it, all right? So
9 let's -- first, would you tell me what
10 Respondent's Exhibit 164 is?

11 A: This is a Schedule H of the -- of our 990 Form.
12 We file --

13 Q: What's a 990?

14 A: We file a 990 Form with the IRS on an annual
15 basis. It is a requirement of a nonprofit
16 healthcare system to file this document
17 annually.

18 Q: Okay. What is it comparable to?

19 A: I would say it's a -- it's kind of a tax return
20 for a nonprofit.

21 Q: Okay. And this Schedule H is part of that 990,
22 right?

23 A: Yes. Schedule H was required to be filled out
24 starting in 2009. And, you know, there's been
25 a lot of oversight of -- or a lot of criticism

1 of nonprofits. And Schedule H was a, was
2 something that the IRS put together to provide
3 a uniform standard for hospitals to report on
4 their community benefits.

5 Q: Okay.

6 A: And then compare those results. And I think
7 ultimately from this, you'll probably see more
8 quantitative rules be developed about what
9 levels of community benefit are required of a
10 nonprofit.

11 Q: And do you file one of these Schedule H's for
12 all three hospitals in the Roper St. Francis
13 system?

14 A: Yes, we do.

15 Q: All right. Let me drive your attention first
16 to question, question number two is -- says
17 that you -- can you tell me what that question
18 is telling, saying there?

19 A: It's asking about our financial assistance
20 policy.

21 Q: And how it's applied?

22 A: Yes. Uniformly to all of our hospitals.

23 Q: What is your financial assistance policy?

24 A: We base it off of a percentage of the federal
25 poverty limit. And we provide a hundred

1 percent writeoff, or in other words, free care
2 for all patients who are eligible at 300
3 percent of the federal poverty limit or less.

4 Q: Okay. So what would 300 percent of the federal
5 poverty limit be roughly?

6 A: It's a matrix, so to speak, based on the number
7 of dependents in the household and then -- and
8 then income levels. But I also note here under
9 B that we provide a 90 percent discount for
10 eligible applicants up to 399 percent of the
11 federal poverty limit. And I believe for a
12 family of four, that would be an income of not
13 much below 80,000. It's generous.

14 Q: Okay. Now, if somebody believes that they need
15 financial assistance in regards to the payment
16 of a medical -- medical services at Roper St.
17 Francis Healthcare, how do they go about
18 obtaining that?

19 A: Well, when people present for service,
20 obviously we do ask what -- what sort of
21 payment they have, whether they're insured or
22 otherwise. We do steer patients to our
23 financial assistance counselors. Also, every
24 communication a patient gets from our billing
25 office, whether it be a summary statement of

1 services or a bill, has in large print on it,
2 you know, that we do have a financial
3 assistance policy if you need financial
4 assistance and you qualify, or if you think you
5 qualify, please work with us on the application
6 process. An we have probably close to a dozen
7 professionals employed to assist patients with
8 the financial assistance process.

9 Q: That are employed by Roper St. Francis
10 Healthcare?

11 A: That's correct.

12 Q: And so patients are not required to apply
13 before they actually receive the service? They
14 can apply later, right?

15 A: We would prefer them to. No, we retroactively
16 qualify a lot of patients.

17 Q: Now, at the bottom of the -- look at the bottom
18 of the sheet there. It actually has the
19 numbers, right?

20 A: Yes.

21 Q: Okay. Can you kind of walk me through here
22 what you reported on this Schedule H in regards
23 to your community benefit?

24 A: Yeah. I'll touch on the three biggest line
25 items. That might be the --

1 Q: Okay.

2 A: But I'll touch on anything you want me to. But
3 the three biggest are in line A, you know,
4 financial assistance at cost. I mean that is
5 charity care. And that 5.51 percent --

6 Q: Well, let's -- I'll ask you to do this because
7 it might be a little bit easier. Tell me what
8 the three biggies are.

9 A: Okay.

10 Q: And then we'll come back and talk about each
11 one in more detail.

12 A: Okay. Well, financial assistance is in line A;
13 that's our charity care. Unreimbursed
14 Medicaid, which is the cost of serving or the
15 expenses associated with serving Medicaid
16 patients minus the revenues that we collect
17 from the Medicaid program. And you see that's
18 a pretty small number of only 2.7 million. So
19 it reflects how efficient Roper St. Francis is
20 that we don't lose much money on Medicaid.
21 That's the second biggest one. And then the
22 third one at the bottom, I think line I, are
23 cash payments we make to other nonprofits in
24 the area who we think have similar missions to
25 us, and we financially assist them in carrying

1 out their mission. Those are the three
2 biggest.

3 Q: And that number is three million, is that -- am
4 I reading that correctly, or almost three
5 million dollars?

6 A: That's correct.

7 Q: Okay. And so the community health improvement
8 services and the subsidized health services,
9 those are in the hundred thousands, right?

10 A: That's right.

11 Q: Am I reading that correctly?

12 A: Correct.

13 Q: Okay. Financial assistance at cost, you said
14 that's your charity care. We talked a little
15 bit about in the trial about charity care.
16 Exactly what is charity care?

17 A: That is -- that is patients who qualify for
18 financial assistance under the financial
19 assistance policy that we talked about a few
20 minutes ago.

21 Q: And how do you calculate the benefit?

22 A: We have cost accounting systems in our decision
23 support area that can take that patient volume
24 and reduce it to cost.

25 Q: Okay. Well, we know -- what do you mean when

1 you say reduce it to cost? I mean is that what
2 you're charging them? Or is that --

3 A: It is not. It is a -- it is the expenses
4 associated with serving that population of
5 patients.

6 Q: So it's an expense driven number?

7 A: That is correct.

8 Q: Well, walk through -- let's talk about how are
9 healthcare facilities or systems like Trident
10 and Roper St. Francis Healthcare, how are they
11 paid? How are they -- how are they paid for
12 services in regards to their -- who typically
13 pays for your -- pays for the services provided
14 in your hospital?

15 A: Well, the big ones you have the governmental
16 payers, which are Medicare, Medicaid and then
17 Tricare, which serves the military population;
18 then you have the commercial insurance
19 carriers, like Blue Cross/Blue Shield, Cigna,
20 United, Aetna, and others; and then -- and then
21 you have patients who pay. And there are
22 patients who have the ability to pay and chose
23 not to carry insurance, and there are patients
24 who do not have the ability to pay and do not
25 have any other forms of insurance.

1 Q: Do you know many people who don't have any
2 insurance that can afford to pay for
3 sophisticated healthcare treatment?

4 A: There are a few, but not many.

5 Q: A handful maybe?

6 A: They're out there.

7 Q: And, now, hospitals actually charge for their
8 services, right? They have a charge amount
9 that they charge for the services, right?

10 A: That's correct.

11 Q: Okay. Is that what they receive from these
12 third-party payers?

13 A: No.

14 Q: Okay. And what do you typically receive?

15 A: Well, that depends. I mean, in many instances,
16 you know, the governmental payers like
17 Medicare, Medicaid and Tricare, they have fee
18 schedules, for lack of a better term, that tell
19 you what they pay you for certain services.
20 You don't negotiate with the government. They
21 set the fee schedules and -- and pay you based
22 on those fee schedules.

23 Q: So if you go in for some -- if you go in for
24 knee replacement surgery, they tell you what
25 they're paying you for the knee replacement

1 surgery?

2 A: The governmental payers do, yes.

3 Q: Okay. What about the commercial payers?

4 A: Those are negotiated rates. And they're -- and
5 all cases are less -- are negotiated at rates
6 less than charges.

7 Q: Do they -- do y'all receive very much
8 reimbursement today in the 2000s in the form of
9 a percentage of your charge?

10 A: No. We are -- it would be less than 5 percent
11 of the -- of the paying population.

12 Q: Pays a percentage of the charge?

13 A: That's correct.

14 Q: Or the total charge?

15 A: Of the contracted payers --

16 Q: Uh-huh (affirmative response).

17 A: -- it's less than five percent of that
18 population.

19 Q: At one time was that fairly common?

20 A: Yes, very common.

21 Q: Has it been common for decades or years?

22 A: I think that there are some very, very large
23 payers out there that may still -- hospitals
24 that may have some percent of charge contracts
25 that pay a percent of charge. For a number of

1 years, Roper St. Francis has not been paid
2 based on percentage of charge.

3 Q: All right. Now, when the governmental payers
4 -- are the governmental payers aware of how
5 much it costs you as a hospital system to
6 provide services to the patients?

7 A: They are. There -- there is what is called a
8 cost report that is filed every year with
9 Medicare and Medicaid, and that information
10 would be in that cost report.

11 Q: And it actually -- what kind of things would it
12 -- how does it actually work? What does it
13 calculate?

14 A: Well, since payment these days is fixed, it's
15 really an -- I don't want to overstate it, but
16 it's an informational document to a large
17 extent that Medicare and Medicaid use to
18 analyze costs and other information.

19 Q: Okay. What is the difference between Medicare
20 and Medicaid?

21 A: Medicare serves the population 65 and older.
22 And Medicaid serves the indigent population.

23 Q: And who runs the Medicare program?

24 A: Well, Medicare is a federal program. Medicaid
25 is a state -- is a federal program but is

1 administered by the states.

2 Q: Okay. And so does reimbursement for Medicaid
3 vary from state to state?

4 A: I would say -- I would say yes, but I don't
5 have much familiarity outside of South
6 Carolina.

7 Q: How would you characterize the reimbursement
8 from Medicaid in South Carolina?

9 A: Well, even though we're talking about an
10 indigent population, Medicaid in South Carolina
11 is an attractive payer, and it is volume that
12 the healthcare systems compete for. Medicaid
13 reimburses a very high percentage of fully
14 allocated costs in this state. And that makes
15 -- you know, it's not as good as the commercial
16 payers, but it's generally better than
17 Medicare. And, again, it's an attractive payer
18 and those patients are competing for in our
19 service area.

20 Q: Okay. Let's go back to the Schedule H then.
21 Can you kind of explain to me what you mean by
22 unreimbursed Medicaid in line B?

23 A: Well, for -- for patients that qualify for
24 Medicaid, what we're saying here is that we had
25 \$24,497,000 in cost associated with treating

1 those patients. We received 21,750,000 in
2 reimbursement for treating those patients. And
3 that left us a loss of 2,747,000. And just,
4 you know, by virtue of that fairly small loss,
5 again it shows the efficiency of Roper St.
6 Francis Healthcare.

7 Q: But how is that? Explain what you mean by the
8 efficiency of providing service.

9 A: That we -- that we treat patients efficiently,
10 we use our facilities efficiently, and that
11 results in what I think is a low cost per case.

12 Q: Okay. So you actually -- it costs you less
13 than -- you're efficient in how you provide the
14 service. Okay. Let me go on. Now, you're
15 actually showing here on this Schedule A that
16 there was \$2.7 million. You actually had a
17 cost greater than what you were reimbursed,
18 right?

19 A: That's correct.

20 Q: Okay. And of course the charges for those
21 services would have been substantially higher
22 than the cost, right?

23 A: Yes.

24 Q: Do you try to collect that money from the
25 individuals?

1 A: No.

2 Q: Why not?

3 A: Well, and Medicare is the same way. Well,
4 first of all, with Medicaid, those are indigent
5 patients which would easily meet your financial
6 assistant policy. So anything that you didn't
7 receive from Medicaid you would write off to
8 charity care.

9 Q: Okay. What about Medicare?

10 A: Medicare? The Medicare program has certain
11 amounts that are due from patients, but you are
12 not allowed to bill them for any amounts above
13 what the Medicare program says they owe you.
14 And even in -- even the Medicare population,
15 some still meet our financial assistance
16 criteria, and any amounts they owed would be
17 written off to charity. Or some Medicaid --
18 Medicare patients also qualify for Medicaid and
19 are what's known as dual eligible patients
20 because they qualify for both programs.

21 Q: Well, why aren't the financial assist -- why
22 isn't the financial assistance at cost column
23 or row, on number A, why aren't all those
24 people on Medicaid?

25 A: With Medicaid, I mean Medicaid is for the poor,

1 but you have to be poor and something. You
2 have to poor and pregnant or poor and a child
3 or poor and a mother or something along those
4 lines. Medicaid, you don't qualify for
5 Medicaid simply because you can't afford to pay
6 for healthcare.

7 Q: Is the Medicaid limit compared to the federal
8 poverty guidelines 300 percent in South
9 Carolina, or would it be lower than that?

10 A: Off the top of my head, I don't remember.

11 Q: And you said the other community benefit that
12 was the larger one was I, cash and in-kind
13 contributions to community groups. So what is
14 that?

15 A: We give money a lot of other nonprofits in the
16 community to support their mission. The
17 Barrier Island Clinic comes to mind. The, I
18 think, Sisters of Mercy, they run a clinic on
19 Johns Island for women who are expecting
20 babies. So it's an -- we consider a lot of
21 those organizations an extension of our
22 mission. We're not required to give to them,
23 but we do because we think it benefits the
24 community.

25 Q: What about this health professions education

1 and -- E and F, what are those two rows on the
2 --

3 A: I think a lot of those would be benefit fairs
4 and other things that are put on by the health
5 system to either provide screenings or
6 education to the population, health education
7 to the population.

8 Q: What kind of screenings would you be talking
9 about?

10 A: We offer a number of times, it could be as
11 simple as blood pressure checks. It can be,
12 you know, mammographies. It can be a number of
13 things.

14 Q: Do you think that's marketing?

15 A: I don't think it's marketing, no.

16 Q: All right. For Roper Hospital, what's the
17 total community benefit as a percentage of your
18 net revenue?

19 A: Well, on this particular schedule --

20 Q: 2010.

21 A: On this particular schedule, this is the
22 expense divided by total expenses.

23 Q: Okay.

24 A: Okay. But if you were to take -- well, let me
25 just stop there. This is expense divided by

1 total expenses. It's 7.79 percent, well above
2 that five percent adequacy level we talked
3 about earlier.

4 Q: All right. Let's take a look at the next
5 exhibit which is RSF 165.

6 MR. LONG: Your Honor, I'm just going to ask him one
7 question on these next two because it's the
8 other two hospitals.

9 Q: Which document is this?

10 A: This is the Schedule H for 2010 for St. Francis
11 Hospital.

12 Q: That's the one on West Ashley, right?

13 A: That is correct.

14 Q: And what was the percentage for West Ashley?

15 A: 9.55 percent. Make one more point here.

16 Q: Right.

17 A: This line A --

18 Q: Okay.

19 A: -- which is the charity care at 7.02 percent,
20 that's the number you would compare to Trident
21 Healthcare at about 1.5 percent.

22 Q: And that 7.02 percent on that line is
23 comparable to the charity line on the Trident
24 Health System financials that we've seen in the
25 trial?

- 1 A: Yes. And, now, one distinction that I don't
2 think matters really, but this is taking cost
3 divided by total expenses. On the face of
4 their financial, it's charges for charity care
5 divided by gross revenue. But if you converted
6 those to an apples and apples comparison, the
7 relationship in my opinion would be the same.
8 This 7.02 compared to about 1.5.
- 9 Q: All right.
- 10 A: And I'll point out that, you know, I've looked
11 at numbers for Medical University as well.
12 They're very similar to ours. And it's a bit
13 interesting that two providers have
14 commensurate levels of financial assistance,
15 while a large third provider is three or four
16 times lower.
- 17 Q: Okay. Let's look at the next document which is
18 166. This is the Mount Pleasant Hospital. I'm
19 sorry. Schedule H for Mount Pleasant also for
20 2010, right?
- 21 A: That's correct.
- 22 Q: And when did Mount Pleasant open?
- 23 A: November 1, 2010.
- 24 Q: So how many months of information is on this
25 Schedule H?

1 A: Well, two.

2 Q: And the numbers seem to be a little lower. Can
3 you explain why?

4 A: Well, not everyone applies for charity care on
5 the front end. A lot of it is qualified as the
6 billing process matures, so to speak. This was
7 based as of 12/31/2010. And, you know, a lot
8 of those accounts were still fresh and not --
9 had not been worked, so to speak. So I would
10 -- I would guess that number is substantially
11 understated simply due to that timing
12 difference.

13 Q: Okay. Let's take a look at Respondent's 9.
14 This is a -- well, the first page, of course,
15 is an email that sets out this is a community
16 benefit summary. Can you turn to the second
17 page, which is Roper Berkeley 569 on the -- and
18 it is a multi-page document. But you can look
19 in their book if you'd rather see the book.
20 But can you tell me what this memorandum is?

21 A: Yes. It's part of our community benefit
22 summary for 2008, and it lists out this
23 activity we have around health education and
24 community impact.

25 Q: Okay. And if you turn over to the second page,

1 which is Roper Berkeley 570, it shows -- what
2 does this show?

3 A: As I talked about earlier, there's a number of
4 organizations that are nonprofit that we feel
5 like are an extension of our mission that we
6 donate money to that they can then use for
7 mission-related purposes. And this is just a
8 listing of those, some of those companies or
9 nonprofits.

10 Q: Take a look at the third page. It's more of a
11 summary page. All right. The charity care
12 number listed here, is that the same thing that
13 we were discussing earlier?

14 A: Yes.

15 Q: What is unreimbursed and then the unreimbursed
16 cost of Medicaid?

17 A: Yes.

18 Q: Sponsorships is what you were just alluding to?

19 A: Yes.

20 Q: And then community. What is the total
21 community benefit Roper St. Francis Healthcare
22 provided to the community, for this year?

23 A: I'm assuming this -- this is 2008, so this is
24 several years ago. But \$33,561,399.

25 Q: And of course included in that is 11.4 million

1 in charity care?

2 A: Yes. And that number has grown substantially
3 since 2008.

4 Q: What was it for 2010? I guess it would be the
5 total of these three documents we looked at on
6 the Schedule H?

7 A: Yes.

8 Q: All right. Let's look at -- well, while we're
9 talking about financials, let's go ahead and
10 look at the Roper St. Francis financials for
11 2010. That's Petitioner's 162. We're just
12 going to spend a few minutes with this. But
13 can you identify this document for me,
14 Petitioner's 162.

15 A: Yes. This is our audited financial statements
16 for fiscal years ending December 31, 2010 and
17 2009.

18 Q: Okay. And can you turn to the, what would be
19 the income statement in the audited financials?

20 A: Okay.

21 Q: And then tell me what page number you're on in
22 the bottom right-hand corner.

23 A: I am on page three. Oh, I'm sorry, bottom
24 right-hand corner, it's 004291.

25 Q: Okay. And this -- is this the income statement

1 for 2010 and for Roper St. Francis Healthcare?

2 A: Yes, and 2009.

3 Q: And compares it to 2009?

4 A: Yes.

5 Q: And tell me, if you can, walk me through some
6 of what the key numbers are and what they mean
7 on the financial -- those financial statements?

8 A: Well, total revenues, which consist of net
9 patient service revenues, and that's net
10 patient service revenues. And then other
11 revenue equals for 2010, \$681,368,000. And
12 that other revenue is for things like our
13 cafeteria, and interest earnings on our cash
14 accounts, a few things like that.

15 Q: Is that cash?

16 A: Yes.

17 Q: Is that cash in the door --

18 A: Yes, it is.

19 Q: -- treated for accounting purposes, okay. And
20 the expenses?

21 A: \$655,066,000.

22 Q: Okay. Talk to me about -- now, in that expense
23 number you have included depreciation,
24 amortization and interest, right?

25 A: Yes.

1 Q: And, but no taxes, right?

2 A: Well, property taxes would be in here. Sales
3 taxes would be in here. The hospital license
4 tax would be in here. Yes. Those are the --
5 we are not responsible for paying federal and
6 state income taxes, but those other taxes would
7 be in this statement.

8 Q: So you don't -- on this income statement, the
9 way it is published, you don't actually publish
10 an EBITDA number, do you?

11 A: A lot of our internal financial reporting has
12 that EBITDA number shown. This financial
13 statement is required to be prepared in
14 accordance with generally accepted accounting
15 principles. So that presentation would not
16 conform to generally accepted accounting
17 principles. So, no, this doesn't have that
18 presentation.

19 Q: But if you were going to calculate what the
20 EBITDA number was to be apples to apples to
21 what we've talked about in the case, how would
22 you do that?

23 A: I would take our excess of revenue over
24 expenses of \$41,357,000. I would add to it
25 interest of \$12,358,000. And I would add

1 depreciation and amortization of \$37,454,000.

2 Q: Okay. Explain, if you would, what the non-
3 operating gains or losses are.

4 A: Those are predominantly the activity around our
5 investment portfolio, and also we have some
6 interest rate swaps, which are derivatives to
7 fixed interest -- to fixed interest rates
8 within our debt portfolio for our debt. And
9 that is predominantly what that is. The other
10 losses -- or other-net of \$4,026,000, that
11 could be a number of things. It's typically
12 losses on disposals on equipment.

13 Q: All right. Let's go back to -- let's talk
14 about the, after you became the CFO, did Roper
15 St. Francis Healthcare make a decision in
16 regards to constructing a new hospital as part
17 of its strategic planning?

18 A: Yes.

19 Q: All right. And where was that hospital
20 located?

21 A: Shortly after I became CFO we started talking
22 about Mount Pleasant Hospital.

23 Q: Okay. And did you as the CFO support the idea
24 to -- and the -- to go build a hospital in
25 Mount Pleasant?

1 A: Yes.

2 Q: Even though it was going -- it cost a fair
3 amount of money, right?

4 A: Yes.

5 Q: How much was it?

6 A: That project was 160 million.

7 Q: Well, as the CFO, how can you support spending
8 160 million to construct a new hospital in
9 Mount Pleasant?

10 A: Well, I think it's important that we offer
11 services for locations where our patients
12 exist. And Mount Pleasant was ready for a
13 second hospital. That is a 13,000 discharge
14 market. And when you take that level of
15 discharges, it can support another facility in
16 that market. I think DHEC made the right
17 decision.

18 Q: The Roper Downtown facility, how old is that
19 building?

20 A: That's a -- that's a complicated question. The
21 initial towers of that hospital were built in
22 1940. There were additional towers added in
23 1960 or '60s, early '60s. The Pettit Tower was
24 added in the early '80s. And then we added the
25 heart and vascular tower in the early 2000s.

1 And one thing, and this is important in that,
2 you know, if we keep expanding within Roper
3 Hospital, at some point we've got to go back
4 and renovate those 1940s and 1960s and '80s
5 towers. And it is significantly more expensive
6 to bring those old plants up to today's
7 standards than it is to go do a greenfield
8 project.

9 Q: Okay. What's a greenfield project?

10 A: A new hospital in Mount Pleasant is an example
11 of a greenfield project.

12 Q: Now, the hospital in Mount Pleasant opened in
13 2010, right?

14 A: November 1st, correct.

15 Q: November 1st of 2010?

16 A: Yes.

17 Q: How would you describe the hospital's
18 performance today financially?

19 A: Mixed. We've been very pleased with the
20 outpatient volumes that we've seen within that
21 facility. We have -- management's intent is
22 certainly to redirect patients to that
23 facility. That is important. But we -- as of
24 just, you know, for that 14 months ending
25 12/31/2011, we fell short of expectation in

1 terms of our ability to redirect inpatient
2 volumes.

3 Q: And as member of senior management, what do you
4 attribute that to?

5 A: Inpatient is always going to be the last thing
6 to redirect because physicians need to practice
7 in locations where they can see a lot of
8 patients. In a new hospital, you know, that's
9 a challenge for a new hospital. So, you know,
10 the cardiologists, the pulmonologists, the
11 neurologists, the urologists, you know, they
12 have to build practices in these new facilities
13 and it takes time; therefore, that does kind of
14 limit admissions during those -- that startup
15 phase. At some point we'll hit a tipping
16 point. Those doctors will be able to stay
17 full-time within that hospital and I think that
18 redirection will -- will occur. And that
19 redirection is very important. When someone
20 presents to Mount Pleasant Hospital and they
21 need a gallbladder surgery or their appendix
22 out or something like that, they don't want to
23 get sent downtown. It's a dissatisfier to our
24 patients. So management is very focused on
25 that redirection.

1 Q: Now, you've reviewed the pro formas in the CON
2 financial -- I mean, the pro formas in the CON
3 application for Mount Pleasant correct?

4 A: Yes.

5 Q: All right. Did you do the pro formas on the
6 Mount Pleasant CON; do you remember?

7 A: I did not.

8 Q: Okay. How does the first year compare to the
9 first year in the CON; do you know?

10 A: The bottom line loss for Mount Pleasant
11 Hospital was larger than appeared in the pro
12 forma in the CON.

13 Q: Okay. Well, how did you finish for the year in
14 regards to the Mount Pleasant Hospital
15 financials?

16 A: Well, EBITDA -- EBITDA, which is a number we
17 pay a lot of attention to, I was very pleased
18 that it on -- you know, from a negative cash
19 flow perspective, it was minus 2.4 million.
20 The bottom line loss, which includes
21 depreciation and everything, was closer to 11
22 --

23 Q: Okay.

24 A: -- million loss.

25 Q: Do you have a significant depreciation expense

1 on this new building?

2 A: Yes. It was in excess of eight million.

3 Q: And do you write a check for the depreciation?

4 A: We do not.

5 Q: Do you keep the money in a separate account or
6 anything like that?

7 A: We do not.

8 Q: Now, after the -- after the hospital -- all
9 right. You also were involved as a CFO in the
10 decision to purchase land at Carnes Crossroads,
11 correct?

12 A: Yes.

13 Q: So can you tell me how that decision was made
14 in the organization?

15 A: Well, --

16 Q: Or participated in the decision, I guess?

17 A: Yeah. I would say that was Doug Bowling would
18 have been the person that orchestrated that
19 transaction. I was certainly involved. But
20 the strategic decision for that location I
21 would probably say that was -- that was more in
22 Doug's court.

23 Q: Now, Roper St. Francis owns that land in Carnes
24 Crossroads, right?

25 A: We do not. The Medical Society of South

1 Carolina owns that land.

2 Q: All right. The Medical Society, of course, we
3 saw earlier is one of the founding members?

4 A: That's correct. They're warehousing it on our
5 behalf.

6 Q: But you chose to buy the land as opposed to do
7 an option or lease or anything like that,
8 right?

9 A: That's correct.

10 Q: Okay. And as the CFO -- well, how much did the
11 land cost?

12 A: I think it was in the neighborhood of nine --
13 I don't recall. I don't recall. I want to say
14 nine million, but I'm not sure.

15 Q: You think it's nine million?

16 A: I thought so.

17 Q: We'll show you a document in a minute; maybe it
18 will clarify that or refresh your memory. As
19 a CFO, how could you support the purchase of
20 nine million dollars worth of land in Berkeley
21 County?

22 A: Well, I think it's important that we be allowed
23 to build facilities in areas where we have
24 patients. And we have a book of business or
25 net revenue from Berkeley County of almost \$100

1 million a year.

2 Q: Explain what that means.

3 A: Patients from Berkeley County, the net revenue
4 associated with those patients is just short of
5 \$100 million. It is a substantial volume of
6 business we get from that community. And --

7 Q: And that's the Roper St. Francis Healthcare?

8 A: Yes.

9 Q: It's \$100 million to Roper St. Francis?

10 A: Yeah, and that's cash. That's net revenue.

11 Q: Okay. And so how does that factor into your
12 decision making?

13 A: I think it's important as -- I think it is
14 important that as the population grows that we
15 provide services where that population is to
16 serve our patients or patients that are loyal
17 to our health system. You know, it's a common
18 business practice. I live in Mount Pleasant,
19 and I've been there 15 years. As the
20 population has grown from where the bridge is
21 north, banks, gas stations, grocery stores,
22 everyone is replicating locations as a means of
23 maintaining a market share and serving their
24 patient -- or serving their population of
25 customers. And what we're proposing to do is

1 not out of the ordinary of any number of other
2 businesses.

3 Q: Now, once the decision was made to purchase the
4 land in Carnes Crossroads, did you become
5 involved in the manner, into how that land
6 would be purchased?

7 A: Yes.

8 Q: Okay. And who were you working with in that
9 regard?

10 A: Well, I would say I was working with Johnny
11 Jordan with the Medical Society. He's their
12 executive director. And Doug was working with
13 I believe a gentleman named Matt Sloan, who
14 represented the seller.

15 Q: And what were your options in regards to how
16 the land would be purchased?

17 A: Well, certainly Roper St. Francis Healthcare
18 could have bought the land. We probably could
19 have optioned the land, but we chose to buy it.
20 We also, through our founding member, Medical
21 Society of South Carolina, had the option or
22 had the ability for them to purchase it and
23 warehouse it on our behalf until it became
24 operational.

25 Q: Let me show you a document, Respondent's 20.

1 Tell me what Respondent's 20 is.

2 A: This is a white paper that I drafted, and I
3 think ultimately received board approval. And
4 this was a -- as I mentioned earlier, Medical
5 Society is a supporting organization of Roper
6 St. Francis Healthcare. They have a very
7 strong balance sheet. And this was a capital
8 planning strategy that Roper St. Francis worked
9 on jointly with the Medical Society to use
10 their balance sheet on our behalf.

11 Q: Okay. Well, why would Roper St. Francis need
12 or want to use the balance sheet of the Medical
13 Society?

14 A: Because by having Medical Society purchase this
15 land on our behalf, it allowed Roper St.
16 Francis to either preserve debt capacity or
17 cash, whichever one we would have used to buy
18 the land had we bought it.

19 Q: What do you mean by debt capacity?

20 A: To preserve debt. If we wouldn't had issued --
21 if we would have issued -- we avoided issuing
22 debt by Medical Society purchasing this land,
23 which preserves that debt capacity for Roper
24 St. Francis. Businesses do not have unlimited,
25 at least after 2008, businesses do not have

1 unlimited debt capacity, so.

2 Q: Well, you're basically talking about the
3 ability to borrow?

4 A: Yes.

5 Q: Now, at Roper St. Francis because of your
6 status, it's a little different than like when
7 I put something on my credit card, right?

8 A: Well --

9 Q: Can you briefly describe that?

10 A: It's really not.

11 Q: Okay, tell me.

12 A: Well, I mean if -- if you're -- we maintain an
13 investment grade credit rating of A minus from
14 Standard and Poor's and A3 from Moody's.
15 That's very similar --

16 Q: What does that mean?

17 A: It is very similar to your personal credit
18 score. When you go to get that credit card,
19 they're going to check your credit score to
20 determine your interest rate and how much
21 credit capacity they're going to give you.
22 That credit score is very synonymous with our
23 rating of A minus, A3. And that A minus, A3
24 determines what cost of capital we get or what
25 interest rates we get, and also how much the

1 markets are willing to give to Roper St.
2 Francis in terms of debt capacity.

3 Q: So how important is that rating to a CFO like
4 yourself?

5 A: Extremely important.

6 Q: And how do you focus on keeping -- maintaining
7 it high, or keeping it as high as you can?

8 A: Well, we try to maintain good earnings. We try
9 -- there's many, many factors through which
10 we're rated; the strength of our market, the
11 strength of our management team, the strength
12 of our strategic plan, the strength of our
13 balance sheet. Lots and lots of things go into
14 that rating. So we really try and manage all
15 those aspects in a way that allows us to
16 preserve our credit rating and access to
17 capital.

18 Q: Now, you mentioned a minute ago, you said
19 something about warehousing the land on the
20 Medical Society's member -- on their balance
21 sheet. Now, is that something that you would
22 hide?

23 A: Oh, no. We -- we -- you know, this is very
24 transparent. Our auditors know about this. In
25 fact, we work with our auditors on this as part

1 of structuring the transaction. We show this
2 to the rating agencies. We brag about it
3 because it shows our founding members are
4 supporting us, which is important. So, no,
5 it's -- and, you know, there is a negative
6 connotation to off balance sheet activity, but
7 that generally has to do with -- with large
8 uncollateralized liabilities that companies
9 push out that really still belong to them, and
10 that's nothing like what we're doing here.
11 We're taking a very valuable asset that's just
12 being warehoused in a -- at a founding member,
13 so.

14 Q: And the asset is what?

15 A: The land.

16 Q: The real estate?

17 A: Yeah, the real estate. Very transparent.

18 Q: All right. And you see this document here. So
19 let's look at the second and third page just
20 quickly. So what are you -- you said you
21 drafted this document. So what are you doing
22 in this document as far as --

23 A: Just laying the case for why it's beneficial to
24 Roper St. Francis to have Medical Society do
25 this on our behalf, and then also outlining

1 what type of -- what type of assets they could
2 hold on our behalf that would be beneficial.
3 The land with Carnes Crossroads is not the only
4 asset Medical Society is holding on our behalf.
5 We are starting construction of a data center,
6 a new data center for Roper St. Francis
7 Healthcare. Our current data center is at sea
8 level in the parking deck of the Roper Hospital
9 campus. That is a significant enterprise risk
10 to have your data center at sea level.

11 Q: Sea as in S-E-A?

12 A: S-E-A, as in ground zero. But we are
13 relocating or building a new data center in
14 North Charleston, and the Medical Society is
15 developing that and carrying it on our behalf.
16 The medical office building affixed to the new
17 Mount Pleasant Hospital is also owned by the
18 Medical Society, and they carry that on our
19 behalf. And this white paper just kind of set
20 all that up.

21 Q: All right. Did the Medical Society agree to
22 buy the land?

23 A: Yes.

24 Q: And, now, is there a -- let me show you this
25 document, Petitioner's 89. Now, can you tell

1 me what this document is; do you recognize it?
2 I can give you a copy of it here to make it
3 easier for you to follow.

4 A: Yes. This appears to be the contribution
5 agreement surrounding the acquisition of this
6 property by the Medical Society -- the Carnes
7 Crossroads property by the Medical Society.

8 Q: So is this a contract or agreement between the
9 Medical Society and Roper St. Francis
10 Healthcare?

11 A: Yes.

12 Q: As it pertains to the purchase of this land at
13 Carnes Crossroads?

14 A: Yes.

15 Q: Okay. The first page here sets out kind of
16 what we call the whereas clauses, right?

17 A: Yes.

18 Q: And can you read the whereas clause that says
19 "MSSC is a --"?

20 A: "Whereas MSSC --"

21 Q: What is that?

22 A: The Medical Society of South Carolina.

23 Q: Okay.

24 A: "-- is a corporation exempt from federal income
25 --

1 Q: I'm sorry. Go down two more.

2 A: Okay.

3 Q: Could you read the fourth one?

4 A: Okay. My apologies. "Whereas MSSC is a
5 founding member of RSFH," which is Roper St.
6 Francis Healthcare, "and as such supports the
7 charitable purposes of RSFH. And MSSC is
8 governed as to its relationship with RSFH by
9 the terms and conditions of that certain
10 affiliation agreement, which was entered into
11 on December 24, 1997, by and among MSSC and the
12 other founding members of RSFH all defined in
13 the affiliation agreement."

14 Q: All right. And then look at the next whereas
15 paragraph?

16 A: "Whereas MSSC and RSFH share a common mission
17 of supporting charitable, benevolent,
18 educational and scientific purposes, and each
19 desire to ensure that the activities each
20 conducts are used primarily to further its
21 exempt purposes."

22 Q: Okay. Now, you mentioned just a few moments
23 ago some of the benefits that Roper St. Francis
24 gets by having the Medical Society actually buy
25 the land. What benefit does the Medical

1 Society get from owning the land?

2 A: Well, as a -- well, there is an -- there is an
3 escalator built into the agreement whereby the
4 -- ultimately when we purchase this land back
5 from them they will have a gain on the purchase
6 so to speak. But the bigger issue is the more
7 than -- as 63 percent member of Roper St.
8 Francis, the more the Medical Society does to
9 increase our enterprise value, the better off
10 they are as the 63 percent member.

11 Q: All right. This land was purchased in '07, and
12 we know what happened in 2008, right? Do you
13 recall that?

14 A: Yes.

15 Q: Okay. Was there a period of time after 2008
16 where you recommended that Roper St. Francis
17 Healthcare make some changes in regards to its
18 balance sheet?

19 A: Well, 2008 was a difficult year for -- for
20 every company's balance sheet. That might be
21 too broad of a generalization. But our
22 investment portfolio had large losses. We were
23 embarking on strategies to employ physicians to
24 open the new Mount Pleasant Hospital. We had
25 purchased the land on Carnes Crossroads. And

1 as I said earlier, one of my primary jobs is
2 making sure we have a balance sheet to support
3 the strategic plan. And what I told the board
4 was we needed to take steps to strengthen our
5 balance sheet subsequent to the market issues
6 that occurred in 2008.

7 Q: Let's look at Respondent's 29. Can you tell me
8 what this document is?

9 A: Yes. This is a document that I drafted. This
10 is our plan for balance sheet recovery, and it
11 was approved by both our -- the Roper St.
12 Francis board and our founding members in
13 February 2010.

14 Q: Can you summarize for me what the plan is?

15 A: Well, it -- there's a lot to it. It is
16 basically a formal plan by which Roper St.
17 Francis would strengthen its balance sheet to
18 ensure we had the funding capacity to fund our
19 strategic plan.

20 Q: What are some of the ways which you can do
21 that?

22 A: Limiting our routine capital spend, limiting
23 the annual distribution we pay to founding
24 members, and keeping earnings strong.

25 Q: Okay. And what are the typical contributions

1 that -- I'm sorry, distributions to the
2 founding members? Typically, how is -- what is
3 their distribution?

4 A: Well, it's based on EBITDA. And there are
5 certain exclusions to that EBITDA. And then
6 it's a percentage of that resulting number.

7 Q: Okay. Now, did you prepare this document
8 because you were concerned about Roper St.
9 Francis' ability to construct a hospital in
10 Berkeley County?

11 A: It wasn't that I was concerned. I -- you know,
12 my job is to make sure we have the ability to
13 fund. And this plan was a plan similar to what
14 a lot of corporations were putting together in
15 response to the activity or the market meltdown
16 in 2008 to ensure you stayed financially
17 healthy.

18 Q: Do you have any concerns about Roper St.
19 Francis' ability to construct the hospital at
20 Carnes Crossroads?

21 A: No. And I never have. Even post -- even with
22 the events of 2008, never a concern.

23 Q: Okay. Have any decisions been made as to how
24 the project would be financed or handled?

25 A: Our founding members have committed to \$20

1 million of cash funding, and then we would
2 finance the remainder of it with a mixture of
3 cash and debt.

4 Q: Okay. So when you say the \$20 million cash,
5 can you explain that a little bit more?

6 A: Yeah. Our founding members have agreed to put
7 in \$20 million in equity into the transaction.

8 Q: They would each pay a percentage of the \$20
9 million?

10 A: Yes, based on their pro rata membership
11 interest. That's correct.

12 Q: Okay. So they would pay that cash and then you
13 would finance the remainder of the project,
14 right?

15 A: That's -- we probably would finance the
16 remainder of it, but we might put in some cash
17 as well.

18 Q: Okay. And did the founding members make that
19 commitment since 2008, since the --

20 A: Yes. It was part of the approval of balance
21 sheet recovery in February of 2010.

22 Q: In February of 2010?

23 A: Yes. It was always implied that founding
24 members -- the founding members have funded a
25 portion of all of our major strategics, so it

1 was certainly understood they would fund it,
2 but it was approved in February of '10.

3 Q: Did they do that for Mount Pleasant?

4 A: They did. Twenty-five million in the case of
5 Mount Pleasant.

6 Q: All right. We've talked about the employment
7 of physicians. All right. Now, and we
8 actually saw the organizational chart that the
9 physician network, Respondent's 15, is its own
10 separate entity under the umbrella of Roper St.
11 Francis Healthcare, right?

12 A: Yes.

13 Q: Okay. And Mr. Bowling is the CEO of that?

14 A: Yes.

15 Q: As you testified to earlier. All right. Why
16 do you have the physicians over in a separate
17 entity at Roper St. Francis Healthcare?

18 A: It certainly didn't have to be that way. I
19 think to a large extent it was driven by the
20 physicians. You know, just like employment, it
21 was driven largely by the physicians. And I
22 think it was somewhat symbolic. They wanted to
23 be -- they didn't want to be under the
24 hospital. They wanted to be on equal footing
25 with the hospital on the org chart. But they

1 could have been employed by the hospital. I
2 think symbolically they wanted their own
3 corporation.

4 Q: Okay. Now, on your internal financials do you
5 report the physician network as its own
6 separate entity?

7 A: Yes, we do.

8 Q: Okay. And what does it -- what does it show in
9 regards to how -- to its financial wherewithal?

10 A: We invest -- in 2011 we invested almost or
11 right at \$40 million in that division, which
12 means it had a net loss of \$40 million.

13 Q: Okay. As the CFO of Roper St. Francis
14 Healthcare, why would you support the
15 employment of physicians if there was a \$40
16 million loss?

17 A: It is what I would characterize as an
18 investment in quality. Very similar to Mr.
19 Gunn's earlier comments relative to employing
20 physicians for quality. It is important --

21 **THE COURT:** You've got to speak a little more
22 loudly, please, sir.

23 A: I'm sorry Your Honor. Similar to Mr. Gunn's
24 comments earlier, our reason for employing
25 physicians is largely around quality. You have

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1 to align hospital and physician incentives to
2 improve quality and really address the
3 requirements of healthcare reform, and that is
4 the reason behind it.

5 Q: And Mr. Bowling, is he more kind of -- is that
6 really more his area of --

7 A: Very much so. Very much so.

8 Q: But looking back on the financial part, do you
9 get involved typically in the negotiations of
10 the employment of physicians?

11 A: No, I do not. I don't even think I've seen any
12 physician employment contracts.

13 Q: Now, this is a question that's important. Are
14 hospitals -- are healthcare systems or
15 hospitals like Roper St. Francis allowed to buy
16 or pay for referrals?

17 A: No, they're not.

18 Q: Why not?

19 A: That is a violation of Stark law and the IRS
20 kickback rules and is a very serious violation.

21 Q: So what -- so, now, who would be the person
22 that kind of makes sure that Roper St. Francis
23 Healthcare doesn't violate those laws?

24 A: Well, Mr. Bowling is, as CEO, primarily
25 responsible for that, but he gets a lot of

1 support from Greg Edwards, our general counsel.
2 And then we also use a lot of external experts
3 to do fair market value analysis and also legal
4 analysis to ensure we're complying with the
5 law.

6 Q: Okay. Now, let's go back and talk about the
7 financials on the Physician Partners. Now, are
8 physicians -- we talked earlier, you talked
9 about how hospitals are paid by governmental
10 payers and insurance companies, right?

11 A: Yes.

12 Q: How are physicians reimbursed for their work --
13 their service and their work in regards from
14 governmental payers and insurance companies?

15 A: Well, yeah, the billing world is kind of split
16 out in two components. Hospitals get what's
17 called a facility fee, and physicians get
18 what's called a professional fee. So, you
19 know, if a patient presents to a doctor's
20 office for just a routine physical, they would
21 get a professional fee from the doctor but no
22 facility fee.

23 Q: Right.

24 A: If a patient comes into the hospital for
25 surgery and you have a surgeon, an

1 anesthesiologist, and that's getting -- that
2 procedure is taking place in the hospital, that
3 patient is going to get a bill from the
4 anesthesiologist, which is a professional fee;
5 they're going to get a bill from the surgeon;
6 they're going to get a facility fee from the
7 hospital. So again, the world is kind of split
8 between hospitals getting facility fees,
9 doctors getting professional fees.

10 Q: And so what happens in the case of a physician
11 being employed by the hospital?

12 A: That relationship does not change.

13 Q: So there's still a professional fee paid,
14 right?

15 A: Yes.

16 Q: Now, when you're doing the financials for
17 Physician Partners, where do you assign the
18 revenue from the professional fee?

19 A: To that division.

20 Q: Okay. What about the revenue from the facility
21 fee?

22 A: That goes in the hospital divisions.

23 Q: Okay. Now, the employees, what are some of the
24 costs that are inherent in employing
25 physicians?

1 A: Well, there's obviously salaries.

2 Q: Let me re-ask the question. How do you
3 allocate the cost of the physicians in the
4 physician network financially; what's included
5 as part of their expenses, just generally?

6 A: Well, there's obviously the salaries of the
7 physicians, their staffs. We provide benefits,
8 healthcare benefits and other benefits to those
9 employees. Their practices utilize supplies.
10 Many times there's rent for the office
11 location. And then in addition to that, the
12 parent company, Roper St. Francis Healthcare,
13 does make an allocation of corporate expenses
14 to that division as well.

15 Q: Okay. Now, and that allocation is also
16 considered as part of, in the calculation of
17 what you described as the loss, right?

18 A: That's correct.

19 Q: All right. Now, if a -- all right. You saw on
20 these financials earlier in the case about the
21 -- one second. You pay a -- does Roper St.
22 Francis Healthcare pay a management fee to
23 Carolinas Healthcare System?

24 A: Yes, we do.

25 Q: And what services does Carolinas Healthcare

1 System provide for that management fee?

2 A: Some IT support, legal support, some supply
3 contracting, managed care contracting. It's a
4 host of back office functions very similar to
5 what we also heard from the Trident side in
6 terms of their -- what they pay for from a
7 management fee perspective.

8 Q: What's the management fee paid to Carolinas
9 Healthcare System for Roper St. Francis?

10 A: Approximately six million dollars a year.

11 Q: Okay. Does Roper St. Francis have more net
12 revenue than the Trident Health System?

13 A: I believe that's correct.

14 Q: Okay. But it's only a six million dollar fee,
15 right? Not 25 million?

16 A: That's correct. And I should point out that
17 there's -- that fee is the management fee. Mr.
18 Dunlap and my salary are direct reimbursements
19 back of -- that's in addition to the management
20 fee.

21 Q: Okay...

22 A: That's in addition to the management fee.

23 Q: All right.

24 MR. LONG: Can I have one moment Your Honor?

25 THE COURT: Yes.

1 Q: Do you write a check to Carolinas Healthcare
2 System for that management fee?

3 A: Yes.

4 Q: It's not an allocation?

5 A: It's not. We write a check or it's wired
6 probably.

7 Q: Okay.

8 A: I think we send a bank wire, technically.

9 Q: All right. In regards to the -- what was your
10 role in regards to the certificate of need
11 application itself for the hospital at Berkeley
12 in Carnes Crossroads?

13 A: Very limited. I think during my deposition I
14 noted I took a brief look at Mr. Knapp's pro
15 forma. But other than that, no real
16 involvement.

17 Q: Is your understanding Mr. Knapp's pro forma is
18 an incremental pro forma?

19 A: I do.

20 Q: Can you explain what that means to you?

21 A: Well, it's -- I appreciate taking a very
22 conservative approach financially for CON
23 purposes. It's certainly not how a CFO is
24 going to look at it. As I mentioned earlier,
25 you know, we have \$100 million book of business

1 in Berkeley County. I'm very confident that
2 locating a 50 bed facility there is going to
3 result in a facility that makes, easily makes
4 enough money to recapitalize itself and remain
5 fiscally healthy.

6 Q: Okay. Well, when he -- we've heard this some
7 before, but it is a difficult concept. What
8 does it mean when you say incremental? What
9 are you actually -- what's the difference
10 between incremental and whatever else you're
11 talking about?

12 A: Well, in Mr. Knapp's pro forma he is looking
13 only at volume that is going to come from
14 growth in the market and increases in market
15 share for that facility. He's not looking at
16 the \$100 million book of business that already
17 exists there that's loyal to Roper St. Francis.

18 Q: So his pro forma is not a -- doesn't reflect
19 the hospital as a standalone facility, right?

20 A: That's correct.

21 Q: Now, in the financials, kind of in the internal
22 financials of Roper St. Francis, once the
23 hospital is open, will you consider it as a
24 standalone entity?

25 A: Yes.

1 Q: And so you'll be -- when you're talking about
2 Mount Pleasant's financials, you're talking
3 about that hospital as a standalone entity,
4 right?

5 A: That's correct. And it will be budgeted as a
6 standalone division, just like the rest of the
7 hospitals are.

8 Q: Okay. Well, you raised -- well, so to follow
9 up on that, is there any concern in your mind
10 as to whether the hospital at Berkeley as a
11 standalone entity will have positive cash flow?

12 A: There's -- you know, there will be a startup.
13 We will have to successfully redirect our loyal
14 patients to that facility, which will be a
15 priority. But no, I have no doubt that that's
16 going to be a very successful facility.

17 Q: Well, you were here for the two days that Mr.
18 Baehr, Richard Baehr, testified in the case,
19 right?

20 A: Yes.

21 Q: And did you go to the project review?

22 A: I did not.

23 Q: Okay. But have you seen some of the slides and
24 materials that Trident has submitted?

25 A: Yeah.

1 Q: At least you've heard -- well, let's just go
2 with his testimony. You're aware that Trident
3 has taken the position that not only will the
4 Moncks Corner Hospital not be successful if
5 both hospitals are built, but that the Carnes
6 Crossroads hospital will not be successful?
7 You've heard -- you understand that allegation?

8 A: Yes.

9 Q: Okay.

10 A: I don't understand it. I've heard it.

11 Q: Okay. Well, you've heard his testimony for two
12 days. And as a CFO of Roper St. Francis,
13 aren't you concerned about the possibility that
14 the hospital could fail if both are built?

15 A: Not in the least.

16 Q: Why not?

17 A: Because we have a very large, loyal patient
18 population in Berkeley County that we want to
19 serve. That is a rapidly growing market. I
20 have no doubts whatsoever that we will operate
21 a successful facility at that location.

22 Q: Now, do you think that the facility -- we also
23 heard in Mr. Baehr's testimony that facility
24 could make \$25 million per year in the next
25 several years. Do you think that the hospital

1 at Carnes Crossroad will make \$25 million?

2 A: I don't see how a 50 bed hospital could
3 generate that kind of bottom line. I don't
4 agree with that.

5 Q: Is it -- how imperative is it to Roper St.
6 Francis Healthcare that the facility have a
7 positive cash flow by year three?

8 A: As a community based nonprofit, you know, it is
9 important that we make money. You have to be
10 able to reinvest in your business, particularly
11 an expensive business like healthcare with a
12 lot of high tech requirements. But, you know,
13 but we have to make enough money each year to
14 fund our strategic plan. But, you know, we
15 don't have venture capital owners that require
16 a certain rate of return on their money. You
17 know, that Berkeley project is a long time
18 frame project. If we were profitable by the
19 end of year three, I would be happy with that.
20 Our time frame, it wouldn't be necessary for us
21 financially, but I'm confident it will be
22 profitable within that three year time frame.

23 Q: Now, when Roper St. Francis undertakes the
24 decision to do a capital project where it's
25 going to invest capital to -- or reinvest in

1 its facility, do you calculate like a return on
2 investment?

3 A: For some projects we do. Typically if it's a
4 new service line or a new piece of equipment
5 like our Cyberknife that we -- I think came up
6 earlier in the trial, we would computer an ROI
7 on that. For a project like Berkeley to
8 relocate assets to a population, we would not
9 necessarily run an ROI on that.

10 Q: Would you have minimum standards in regards to
11 return on investment that you are required or
12 require to be met?

13 A: No hurdle rates, no.

14 Q: All right. Mr. Johnson, thank you very much.
15 Would you answer any questions that the other
16 lawyers have?

17 THE COURT: Ms. Biggers?

18 MS. BIGGERS: I don't have any questions.

19 THE COURT: Mr. Thomas? Mr. Summer?

20 MR. THOMAS: Can we take a break before I get
21 started?

22 THE COURT: Time? What's the hour?

23 MR. THOMAS: A quarter to four, Your Honor. My
24 cross is easily going into tomorrow. So just
25 to let you know.

1 THE COURT: Well, let's take about a ten minute
2 break.

3 (Off the Record from 3:43 p.m. until 3:53 p.m.)

4 THE COURT: Mr. Thomas?

5 MR. THOMAS: Yes, sir.

6 THE COURT: Since you've indicated that you're going
7 to run into tomorrow, if you find a convenient
8 stopping place around 5:30 --

9 MR. THOMAS: Yes, sir.

10 THE COURT: -- I think that would be a good time to
11 break.

12 MR. THOMAS: I can do that. I'm going to try to get
13 as much done as I can today as possible.

14 THE COURT: And what do you anticipate tomorrow?

15 MR. THOMAS: Judge, I wish I could tell. This is a
16 pretty big fact witness for us and for them
17 obviously. And I had a pretty long deposition.
18 And he's aware of the financial status of
19 affairs there. And it just depends on how
20 quickly we go today. But I think probably by
21 the end of the day I can maybe give you an idea
22 of what tomorrow with hold.

23 THE COURT: Well, just let me put it this way.

24 MR. THOMAS: Yes, sir.

25 THE COURT: I have some other matters that have been

1 untended because of this hearing.

2 MR. THOMAS: Yes, sir.

3 THE COURT: Don't have to do them by tomorrow
4 afternoon. But if there's a convenient break
5 by midday that's not going to upset the
6 schedule of any of you men, ladies too, then I
7 would like the opportunity to get back to my
8 paperwork for a few hours tomorrow afternoon.
9 But I don't have to.

10 MR. THOMAS: Okay.

11 THE COURT: It's a matter of convenience.

12 MR. THOMAS: Well, I hope I'm done by mid -- by noon
13 tomorrow, sir.

14 THE COURT: And does it suit the rest of you to
15 knock off then at noon tomorrow?

16 MR. THOMAS: Sure.

17 MS. BIGGERS: Yes, sir.

18 MR. LONG: Yeah, Your Honor. I mean whatever the
19 court's pleasure.

20 THE COURT: No. As I said, I can do this --

21 MR. THOMAS: My wife would like that.

22 THE COURT: Sir?

23 MR. THOMAS: I said my wife would be happy about
24 that. I could actually get home for dinner.

25 THE COURT: Well, we'll see how it works out. If

1 you have to go over, then I'll understand.

2 **MR. THOMAS:** Thank you, sir.

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

4 **MR. JOHNSON - CROSS EXAMINATION BY MR. THOMAS:**

5 Q: Good afternoon, Mr. Johnson.

6 **THE COURT:** Just one other thing before I let you
7 start.

8 **MR. THOMAS:** Yes, sir. Yes, sir.

9 **THE COURT:** Mr. Long, Ms. Hollingsworth, I want you
10 all to be able when you redirect, to preface it
11 by a question, don't you remember testifying
12 about this.

13 **MR. LONG:** Yes, sir.

14 **THE COURT:** Do you understand what I mean?

15 **MR. LONG:** Absolutely, Your Honor.

16 **THE COURT:** Thank you.

17 Q: Mr. Johnson, you mentioned that you were at
18 Roper when the Baker Hospital was closed. I
19 believe you referred to it as Roper North?

20 A: That's correct.

21 Q: Okay. And I think you mentioned that it was
22 closed due to access issues because there
23 wasn't an off-ramp?

24 A: Yes.

25 Q: How long had that hospital been there before it

1 was closed?

2 A: Approximately 20 years.

3 Q: Twenty. Okay. So the patients had no problems
4 getting to that hospital for the 20 year period
5 it was able to stay open; is that correct?

6 A: It was, although Roper and Roper North weren't
7 always part of the same corporation.

8 Q: Okay. That's fine. And the other thing that's
9 kind of interesting about Roper North is that
10 its location is in one of the poorest
11 neighborhoods of Charleston, correct?

12 A: The very immediate area around that hospital,
13 yes. I would not say the service area of that
14 hospital.

15 Q: Okay. But the immediate area was North
16 Charleston and it's a very destitute
17 population, correct?

18 A: If you draw a half-mile circle around that
19 hospital, yes.

20 Q: Probably more than a half-mile, right?

21 A: The immediate area around that hospital, yes.

22 Q: Very poor. And where was the ED opened up with
23 respect to the Roper North Campus? You
24 mentioned an ED, right?

25 A: That's correct.

1 Q: That was open basically to kind of take the
2 place of Roper North?

3 A: That's correct.

4 Q: Okay. And where was that opened?

5 A: It was opened in the North Charleston, it was
6 located in the --

7 Q: Northwoods, right?

8 A: -- Northwoods Mall. That's correct.

9 Q: Okay. And how many miles away is that from
10 there?

11 A: I don't know off the top of my head. I'd guess
12 three or four.

13 Q: Okay. And that's your understanding of why
14 Northwoods ED was opened up; was because
15 basically to -- that's what you said, right?

16 A: Well, we worked or were in discussions with the
17 mayor. And it wasn't me personally, I just
18 recall this. I believe our CEO at the time was
19 in discussions with the mayor of North
20 Charleston. We did not want to remove
21 necessary services from that area and that was
22 how Northwoods ended up coming into being.

23 Q: All right. That's your understanding, correct?

24 A: That is my understanding.

25 Q: Didn't want to move services from that area,

1 but the ED is now located four miles away; is
2 that right?

3 A: Yeah. We wanted to continue offering necessary
4 services to the residents of North Charleston,
5 correct.

6 Q: You mentioned something about taxes. What
7 would be the biggest tax on net income that
8 Roper doesn't pay?

9 A: I would guess federal income tax.

10 Q: Okay. And then state would be next?

11 A: I don't know if state would exceed the hospital
12 tax or not, probably not.

13 Q: Well, the hospital tax, you get some of that
14 back, right?

15 A: We give a dollar to get very slightly more than
16 a dollar, yes.

17 Q: Okay. So you give a dollar in tax, but you get
18 something back, correct?

19 A: And Trident does as well, yes.

20 Q: Okay. Didn't dispute that. Just wanted to
21 make sure the judge knows that you're getting
22 something in return for paying something.

23 A: Yes.

24 Q: Okay. And Trident, when -- it didn't list
25 sales taxes on the -- on that sheet, did it,

1 that you're making a comparison to?

2 A: I thought it did.

3 Q: Okay. What document were you referring to?

4 A: It was a Community Benefit Report that was
5 published by Trident, I'm assuming.

6 Q: Do you remember when?

7 A: I thought it was 2010.

8 Q: Okay. You think it was 2010. You think it
9 includes sales taxes on there?

10 A: I thought it did, but I can't swear to it
11 sitting here.

12 Q: And do you think it included the unreimbursed
13 cost of Medicaid?

14 A: I think it did, yes. In the Community Benefit
15 Report, yes.

16 Q: In the Community -- where did you see the
17 report? That's what I guess I'm trying to get
18 at.

19 A: Somewhere along the process of reviewing
20 documents for this litigation I looked at it.

21 Q: It's not something you've seen in court, have
22 you?

23 A: No.

24 Q: Okay. I'm sorry, I may have asked you this,
25 but does Roper pay ad valorem taxes?

- 1 A: Do you mean property taxes?
- 2 Q: Yeah. On specialized equipment as well?
- 3 A: If it's within the walls of the hospital, we
- 4 typically do not. Equipment that exists in our
- 5 physician practices and in our medical office
- 6 buildings that are subject to *ad valorem* tax,
- 7 yes, we do pay that.
- 8 Q: But not on the campus itself, right?
- 9 A: Well, if on the campus you have a hospital and
- 10 a medical office building, we are typically not
- 11 paying it on the hospital but paying it on the
- 12 MOB.
- 13 Q: Fair enough?
- 14 A: Split the baby there.
- 15 Q: So if Roper made \$70 million a year in net
- 16 income, what do you think the state and federal
- 17 tax would be on that, if you had to estimate
- 18 for the court?
- 19 A: Well, I think HCA estimates 20 percent, so I'd
- 20 say 20 percent.
- 21 Q: You think it's 20 percent HCA?
- 22 A: I have -- I've been in nonprofits 25 years. I
- 23 do not profess to know corporate income Tax.
- 24 Q: Where did you see the 20 percent figure? I
- 25 think HCA would love to pay that.

- 1 A: I thought I saw it as part of numbers flashed
2 up on the screen this week.
- 3 Q: Okay. When?
- 4 A: I don't recall the specific time.
- 5 Q: In 2009 bad debts for the Carolinas System was
6 about \$90.7 million. Do you recall that?
- 7 A: Sounds reasonable.
- 8 Q: And in 2010 they went down to \$37.1 million,
9 right?
- 10 A: That's correct.
- 11 Q: Okay. Can you explain to the court why that
12 occurred?
- 13 A: Yes. We did a much better job of capturing
14 charity care in our health system and if you
15 read HCA's 10-Ks or 10-Qs, you'll see that they
16 --
- 17 Q: But those aren't in evidence, Mr. Johnson.
- 18 A: Okay.
- 19 Q: So if you'd just explain --
- 20 **MR. LONG:** Your Honor, I mean he gets to answer the
21 question. I mean, that was the basis of --
22 he's asked him a question and he's answering
23 it.
- 24 **MR. THOMAS:** I'm moving to strike that testimony,
25 Your Honor. The HCA 10-Ks aren't in. He can't

1 rely on them for his -- I asked him the
2 question, why did they change bad debt from
3 90.7 million to 37.1 million at Roper, which
4 has nothing to do with the HCA 10-K.

5 **THE COURT:** Overruled.

6 Q: So why did Roper chose to go from the \$90.7
7 million bad debt to -- just tell me about the
8 conversions.

9 A: Sure. We did a much better job of identifying
10 patients that would qualify for financial
11 assistance in 2010 and that's very similar to
12 actions hospitals across the country were
13 taking.

14 Q: Okay. But in 2009 the charity care numbers
15 look a little different, right?

16 A: Yes.

17 Q: Okay. In fact, I guess in 2008 there was a --

18 **MR. THOMAS:** Can you put up Respondent's 164 up?

19 Q: You remember this? Mr. Long was showing you
20 Respondent's 164.

21 A: Yes..

22 Q: And am I right that the net community benefit
23 expense was \$26.7 million in 2010?

24 A: Yes.

25 Q: Okay. And then in Roper Exhibit 9 that Mr.

1 Long flashed up on the screen, the total
2 community benefit was \$33.5 million. If you'd
3 go to page four in our document, that would be
4 Roper Berkeley 571. Total community benefit
5 was \$33.5 million in 2008?

6 A: Okay.

7 Q: Okay. So that was about a seven, eight million
8 dollar detriment from 2008 to 2010, according
9 to the 990 and this document; is that right?

10 A: Well, I think this document would be the health
11 system and that previous document you showed me
12 was just one of our hospitals.

13 Q: Okay. So this is the whole health system?

14 A: I believe so. It's not identified, but I
15 believe so.

16 Q: All right. So if we then added -- I can't find
17 the exhibit, but I'll take your word for that.
18 Now, did I hear you correctly, you said that
19 Medicaid was an attractive payer?

20 A: I think so.

21 Q: So that's really a population you're -- the
22 system is gravitating to?

23 A: I think all of the health systems in our area
24 compete for that volume. South Carolina is a
25 generous payer of Medicaid.

1 Q: Okay. So that's your testimony today,
2 Medicaid, that's the patients you're going
3 after?

4 A: I said that we all compete for that volume,
5 yes.

6 Q: When you say we all, who else are you including
7 in that?

8 A: Well, I think the Medical University seeks to
9 serve Medicaid patients, I think Roper St.
10 Francis does and I think Trident Health System
11 does.

12 Q: Do you think that in a perfect world you'd
13 rather that, the Medicaid patient would have
14 -- they'd have commercial insurance?

15 A: Well, from a social perspective, I wish no one
16 were indigent, if that's what you're asking me.

17 Q: Right. In terms of the collection amount on
18 charges for Roper, what's the cost to charge
19 ratio for Medicaid if you know it?

20 A: Well, the cost to charge ratio for our system
21 is somewhere around 30 percent, so I would
22 apply that to the Medicaid population.

23 Q: Okay. So on a thousand dollar charge, what do
24 you think Medicaid pays?

25 A: Medicaid generally pays, of our charges,

1 somewhere around maybe 25, 26 percent of
2 charges would be my -- you know, it's different
3 on the inpatient and outpatient side. I think
4 a blended rate would be in the mid 20s.

5 Q: Okay. What about Medicare?

6 A: Medicare is in the low 20s or maybe a bit less.

7 Q: Okay. All right. So Medicare, you're saying,
8 is actually less than Medicaid on charges, in
9 terms of reimbursement on a blended rate?

10 A: After the effects of disproportionate share,
11 yes.

12 Q: Okay. So you're bring into the fray the
13 disproportionate share --

14 A: It is --

15 Q: -- of the payment that you receive?

16 A: It is Medicaid reimbursement, yes.

17 Q: Okay.

18 A: I will point out one thing. The revenue per
19 discharge for Medicare may be higher, but those
20 are typically much more acutely ill patient
21 population. But from a percent of charge
22 comparison, Medicaid is generally higher.

23 Q: Fair enough. Now, I want to kind of go back on
24 something when you talked about that you got
25 \$100 million in net revenue you think from

1 Berkeley County.

2 A: Yes.

3 Q: Okay. Now, is it Roper's position that a
4 hospital should be able to locate in an area
5 where it sees patients and where it gets a
6 large amount of net revenue regardless of the
7 other existing providers in the area?

8 A: I think common business practice for many
9 industries is that they be allowed to -- that
10 they follow their patients. And to restrict a
11 provider to a certain geographical area when
12 they have a significant patient population in
13 a growing market would unfairly penalize that
14 business..

15 Q: You think MUSC has a good net revenue base in
16 West Ashley?

17 A: Sure.

18 Q: You think they see a lot of patients from West
19 Ashley?

20 A: Absolutely.

21 Q: Okay. Do you think they should be able to
22 locate a hospital in West Ashley based on that,
23 as long as they're seeing their own patients
24 and generating the same amount of revenue?

25 A: Well, Medical University outspends Roper St.

1 Francis three or four to one. And they have a
2 strategy of building these very large
3 outpatient centers where they house their
4 specialists and diagnostics, and they are
5 absolutely going out into the marketplace.
6 They're in North Charleston, They're in West
7 Ashley. They're building a 70,000 square foot
8 outpatient and specialist center in Mount
9 Pleasant. I mean, they are absolutely
10 implementing their strategy full speed to take
11 care of their patients.

12 Q: Okay. Roper's got a 50,000 square foot
13 facility in Moncks Corner, right?

14 A: That's correct.

15 Q: Okay. But my question was do you think that
16 MUSC, based on the reasonings that you gave,
17 should be able to go into West Ashley,
18 regardless of their strategy, and plunk down a
19 50, 85 bed hospital based on the utilization?

20 A: Well, for a hundred years we've competed with
21 the Medical University right next door, so why
22 would I -- why would I -- why would that bother
23 me?

24 Q: Okay. So are you saying it does or it doesn't?

25 A: If they had a significant patient population in

1 a growing market, I would support it.

2 Q: So your testimony differs from your CEO, David
3 Dunlap then, correct? Did you read his
4 deposition?

5 A: I did not.

6 Q: Okay. It's actually in the record. Your
7 general counsel, Mr. Edwards, is in the room,
8 right?

9 A: Yes.

10 Q: Okay. Is he an employee of CareAlliance --
11 excuse me, of Carolinas Healthcare System out
12 of Charlotte?

13 A: He is not.

14 Q: Okay. But Roper St. Francis would pay his
15 salary, correct?

16 A: Yes.

17 Q: Okay. Do you consider that part of the
18 management fee?

19 A: No.

20 Q: Okay. So that's a separate expense, correct?

21 A: Greg's or Mr. Edwards' salary is not part of
22 the management fee.

23 Q: Okay. Do you have decision support on the
24 Roper Campus?

25 A: Yes.

1 Q: Okay. That was in the, what, the parking
2 garage basement or something like that?

3 A: No. It is on the Roper Hospital campus and
4 reports up through me.

5 Q: Okay. Is that paid to the management fee to
6 Carolinas Healthcare System in Charlotte?

7 A: No.

8 Q: Is that part of it; no?

9 A: No.

10 Q: Okay. The buildings and all of the
11 infrastructure that's going to go up in, where
12 did you say, it's like Palmetto Commerce
13 Parkway or something along those lines?

14 A: Yes, our data center, yes.

15 Q: Okay. Is that something that's going to be
16 part of the management fee that's paid to
17 Carolinas Healthcare System?

18 A: That project is a capital project.

19 Q: Right.

20 A: It wouldn't be a fee of any nature, but --

21 Q: But everything's going to be, I guess, housed
22 there?

23 A: Our data center will be housed there to serve
24 our hospitals and facilities.

25 Q: And how many employees does that data center

1 have?)

2 A: I think it'll start -- I mean those employees
3 are currently employed by Roper St. Francis
4 Healthcare.

5 Q: Right.

6 A: But when it moves from the parking deck to
7 North Charleston, I would guess close to 50
8 employees.

9 Q: Fifty employees, but that wouldn't be part of
10 the management fee that's paid to Carolinas,
11 correct?

12 A: No.

13 Q: Fifty employees, that's a fairly significant
14 expense, isn't it?

15 A: Absolutely.

16 Q: Three or four million dollars maybe with
17 benefits?

18 A: Well, it would be -- I would guess your average
19 IT employee is probably making 65,000 a year.

20 Q: Yeah.

21 A: So you're looking at a little over three
22 million dollars.

23 Q: That's just salaries or that's salaries with
24 benefits?

25 A: That is not including benefits.

1 Q: So another 25 percent for benefits, roughly
2 four million dollars?

3 A: Twenty-two percent.

4 Q: Okay. But that's something that Roper bears
5 internally, correct?

6 A: Yes.

7 Q: As an expense.

8 A: And in terms of IT and construction oversight,
9 there are resources in Charlotte that we tap
10 into, and there is oversight from Charlotte.
11 Our IT function and our construction oversight
12 function is not mutually exclusive to
13 Charleston. But I've answered your questions
14 accurately.

15 Q: I think so, yeah. Now, do you recall the
16 decision in applying for the certificate of
17 need by Roper in terms of from the time Roper
18 St. Francis found out that Trident was going to
19 apply for the hospital in Moncks Corner, was
20 the decision made by Roper about three weeks
21 later to apply for one in Carnes Crossroads?

22 A: Can I ask you to repeat the question?

23 Q: Yeah. It was kind of garbled. In terms of
24 when you found out Trident Medical Center was
25 going to apply for a hospital CON in Moncks

1 Corner, which I guess was August 8th, around
2 that area, how many weeks was it before Roper
3 decided it was going to apply for a hospital in
4 Carnes Crossroads?

5 A: You know, I really don't know. You know, I was
6 not part of those discussions to file that CON.
7 That would have been between Mr. Bowling and
8 Mr. Dunlap.

9 Q: Okay. But they would have asked you about
10 funding and that type of thing, wouldn't they?

11 A: Well, as my deposition showed on multiple
12 occasions, you know, my thought process on the
13 funding was that we would be issuing debt in
14 2013, 2014. And I thought that from the very
15 beginning of this process.

16 Q: Understood. But in terms of decision, you
17 don't -- you weren't really involved in making
18 that decision?

19 A: No. They would probably have told me that the
20 CON was being filed. I'm sure there would have
21 been board discussion about it, but I was not
22 in those discussions to file that CON.

23 Q: Were you at the board meeting?

24 A: I would have been at the board meeting.

25 Q: So it was at the board meeting in August, late

1 August?

2 A: We do have August board meetings and I'm sure
3 I was there.

4 Q: Do you recall if that's when the decision was
5 made?

6 A: I do not recall that, but a project of this
7 size would require board approval.

8 MR. THOMAS: Sara, would you put a Roper St. Francis
9 DHEC Record?

10 Q: Did you say you were at the project review, Mr.
11 Johnson? Did you go to project review?

12 A: I did not.

13 Q: Well, this is a slide that was presented at
14 project review by Roper St. Francis, and it
15 states that the decision to place the inpatient
16 services in Goose Creek rather than Moncks
17 Corner was based on both internal and external
18 market analyses. It says, in both cases Moncks
19 Corner's population and growth would not
20 support the inpatient volume required to
21 justify the expense. Carnes Crossroads met the
22 test for population density and growth. I've
23 got a question for you here. Did you have
24 anything to do with the study in terms of the
25 internal or external market analyses?

- 1 A: I would not.
- 2 Q: Okay. Do you know who did?
- 3 A: That would be under Mr. Bowling.
- 4 Q: Did you ever -- were you ever asked to do any
- 5 financial analyses of what the Roper St.
- 6 Francis Moncks Corner Hospital would look like
- 7 in terms of an operational or financial model?
- 8 A: Not that I recall.
- 9 Q: Okay. Would you think you would recall
- 10 something like that if you were asked to do it?
- 11 A: Gosh, we -- that's hard to say. We're very
- 12 busy. I just don't recall that being done.
- 13 Q: Fair enough. But you weren't asked to do, as
- 14 far as you can recall, an internal or external
- 15 analysis or any kind of financial analysis
- 16 about what a Moncks Corner hospital would look
- 17 like for Roper St. Francis, right?
- 18 A: Not that I recall.
- 19 Q: Petitioner's 104, this is a slide set we got
- 20 from Roper St. Francis in discovery. It says
- 21 Roper St. Francis Healthcare in Berkeley
- 22 County. Have you ever seen this slide set
- 23 before?
- 24 A: It's not coming to memory, no. But if we get
- 25 into the body of it, I may begin to recall.

- 1 Q: Go to -- let me go to Roper Berkeley 2321.
2 Now, had you ever seen this analysis done?
3 That's in terms of it being the internal
4 analysis for a Moncks Corner Hospital site?
- 5 A: I mean, it's possible that when it was
6 presented I would have been in attendance.
- 7 Q: Okay. In terms of, you know, in terms of this
8 internal analyses, there's no financial data on
9 there, is there?
- 10 A: It appears to be market data.
- 11 Q: Okay. And do you know if you were ever asked
12 -- I'm just trying to jog your memory -- but
13 based on this charge that Moncks Corner would
14 only support 22 beds and Carnes Crossroads 100
15 beds, were you ever asked to do any kind of
16 financial analysis for this?
- 17 A: Not that I recall.
- 18 Q: Okay. Do you know, Mr. Johnson, if Roper St.
19 Francis ever looked at the possibility of
20 adding 50 beds to a 50,000 square foot site in
21 Moncks Corner?
- 22 A: Those discussions would have been between Mr.
23 Bowling and Mr. Dunlap. I --
- 24 Q: Fair enough. Then I guess my next question
25 would be, were you ever asked to look at what

1 that would look like financially if you just
2 added 50 beds at Roper St. Francis in Moncks
3 Corner?

4 A: Not that I recall.

5 Q: Okay. Do you have any idea of what the cost of
6 something like that would be, just a 50 bed
7 addition to an existing infrastructure?

8 A: Not off the top of my head, no.

9 Q: But as far as you know, Roper St. Francis never
10 looked at that alternative?

11 A: Not to my knowledge.

12 Q: Okay. Did you have any input -- let me ask you
13 this. In terms of the Carnes Crossroads sites,
14 did you ever do any kind of, prior to the CON
15 that Mr. Knapp did the pro formas for, did you
16 ever do any kind of financial projection, what
17 that site would look like in terms of, you
18 know, what it would generate and net income or
19 EBITDA?

20 A: I'm sorry, are we talking the Carnes Crossroads
21 site?

22 Q: Yes, the Carnes Crossroads, exactly.

23 A: I did not do any pro forma for that site. Mr.
24 Knapp performed a pro forma for that site.

25 Q: Okay. But you don't disagree with the slide,

1 though, that Roper St. Francis put up that its
2 study indicated that the utilization of that
3 site wouldn't justify the expense; is that
4 right? I mean, that's what was presented to
5 the state at project review?

6 A: Based on Roper St. Francis' average daily
7 census, I would agree.

8 Q: Okay. Go to Petitioner 93 for me. now, this
9 is a document that was produced by Roper St.
10 Francis Healthcare. Annual Update with
11 Moody's, March 1, 2010. Do you have anything
12 to do with these updates?

13 A: Yes.

14 Q: Could you just tell the Court, you know, what
15 you do in these updates.

16 A: Well, I'd mentioned, talked earlier about our
17 credit rating that we have with Moody's and
18 with Standard and Poor's. They annually update
19 our credit rating. They will typically call us
20 and tell us it's time for the update. We'll
21 discuss with them, you know, what they want to
22 hear about. We have some things on our end we
23 want to communicate. And that will generally
24 result in a 70 to 80 page presentation that
25 we'll then spend two to three hours on the

1 phone with them or in person walking through
2 that. After the presentation, they will digest
3 the information, they will send us back
4 additional requests for information. And then
5 at some point the analyst who has heard the
6 presentation will go to the committee within
7 Moody's or the committee within Standard and
8 Poor's and they will give us our ratings
9 result.

10 Q: And those ratings are pretty important to Roper
11 St. Francis, correct?

12 A: Very important.

13 Q: Okay. So the information you present in these
14 presentations are going to be true and accurate
15 to the best of your knowledge, correct?

16 A: Yes. Our credibility with the rating agencies
17 is important.

18 Q: Fair enough. I know you said they're like 95
19 pages each. And I'll promise we're not going
20 through each page like we did in the
21 deposition. But go to page 84, if you would,
22 we're skipping a lot of pages right there. And
23 this is Roper Berkeley 1402 for the record.
24 And this is a projection -- some actual numbers
25 and then a budget number of net revenue in

1 terms of the growth of the system from 2005 to
2 2010, correct?

3 A: Yes.

4 Q: Okay. Now, what was the actual net revenue in
5 2005?

6 A: \$455,110,000.

7 Q: Okay. And in 2008 when Roper did the internal
8 analysis regarding whether or not the
9 utilization would justify the expense in Moncks
10 Corner for a hospital there, what was the net
11 revenue?

12 A: \$618,016,000.

13 Q: Okay. And then you budgeted \$776,144,000 for
14 2010. Is that right?

15 A: Yes.

16 MR. THOMAS: Would you go to page 94 in this slide?

17 Q: Okay. And here's a slide that's in the same
18 Moody's presentation, Roper Berkeley 1412. And
19 is this an accurate portrayal of Roper St.
20 Francis' operating EBITDA at a compound annual
21 growth rate of about 10.3 percent from 2000 to
22 2009?

23 A: At the time this slide was prepared, yes.
24 Obviously we'd have an actual for 2010 now.

25 Q: Correct. Do you know what the actual was for

1 2010?

2 A: It would have been pretty close to that 87
3 million.

4 Q: Okay. So a pretty accurate reflection of the
5 operating EBITDA, correct, for that time
6 period? I mean, it's what it is, right?

7 A: Yes. Although, my recollection is coming back
8 a little bit more. I think operating EBITDA
9 was probably closer to 80 million in 2010
10 rather than 87 million.

11 Q: Okay. And I added up the numbers here in 2000
12 to 2009, that was -- it was more than a half
13 a billion dollars in operating EBITDA over
14 that time frame. Does that look about right?

15 A: Over the entire ten year period?

16 Q: Over the nine year -- yeah, from 2000 to 2009.

17 A: That would be close, yeah.

18 **MR. THOMAS:** Go to Roper St. Francis DHEC record 469
19 to 470, please.

20 Q: This is Joint Exhibit 2. It's your CON
21 application and some projections that were
22 made. And I guess this is the -- I believe
23 this is the projection from 2007 to 2017 or so,
24 without the Berkeley Medical Center. Do you
25 remember we discussed this in your deposition?

1 A: Yes.

2 MR. THOMAS: okay. And if you could go to the next
3 page for me, Sara, the DHEC record, which would
4 be 469.

5 Q: And so you made some projections here, 2012 to
6 2017. In terms of these projections and, you
7 know, the projected net income for 2012 is 69
8 million, but the EBITDA down here is 44.2
9 million; is that right? Actually, that
10 wouldn't be EBITDA, would it?

11 A: I can't see the left-hand side of this page.
12 I'm sorry.

13 Q: Yeah. I'm sorry. That's the way it was put in
14 the DHEC record. There we go. So the
15 operating income, that is not EBITDA, is it?

16 A: No.

17 Q: That's reflected on here?

18 A: No. It's not EBITDA.

19 Q: All right. And to get EBITDA, if I wanted to
20 get EBITDA, would I take this operating income
21 here -- all right. How about this, would it be
22 called an operating cash flow if I took the
23 operating income and added in the interest
24 expense and the depreciation and amortization?

25 A: That would be operating cash flow, that's

1 correct.

2 Q: Operating cash flow. Thank you. In terms of
3 the projections, I kind of remember the stuff
4 on the left because the DHEC record wasn't
5 presented that way. Do you think the
6 projections for 2012 through 2017 in this
7 document are close or accurate to what --
8 anything you've done since 2008?

9 A: What the -- as I mentioned a number of times in
10 my deposition, the model physically goes out
11 that far, but three, four years, and I don't
12 know exactly what dates I used in my
13 deposition, we were looking out really to that
14 end of balance sheet recovery, I believe, 2013.
15 So I think I mentioned numerous times in my
16 deposition that we were not relying on the late
17 years of this model, so.

18 Q: But this is what you gave to the state, right?
19 That's what you provided to the state of South
20 Carolina in your CON application?

21 A: Out to 2017?

22 Q: Yeah.

23 A: I don't recall.

24 Q: Okay. This is from your CON application?

25 A: Okay. Well, then, yes.

1 Q: But it's 2012 now, right?

2 A: Yes.

3 Q: Okay. And in terms of these projections, I
4 mean, have you done any projections for 2012,
5 2013, 2014, in the last --

6 A: We have.

7 Q: Okay. And what I'm asking is do these look
8 high, low, or about the same in terms of your
9 operating income and your net income and your
10 net revenue?

11 A: Okay. If you'll bear with me one moment.

12 Q: Sure.

13 A: These are going to be -- have more EBITDA and
14 more operating income than what we're currently
15 experiencing.

16 Q: Okay. Well, what did you experience for 2011?
17 Because we haven't seen those numbers, but I
18 imagine you would know that.

19 A: Okay. Well, this shows an operating income of
20 about 4.8 percent and we ended the year at, I
21 believe, 2.4 percent.

22 Q: Okay. Well, we've got 2010 numbers, right?

23 A: We have audited 2010 numbers, correct.

24 Q: Right.

25 A: These are projected.

1 Q: Right. But if we can make a projection, we can
2 make a comparison, right? I mean, the
3 operating income here is, what, \$34 million
4 projected for 2010?

5 A: Yes, projected.

6 Q: Okay. All right. And so the actual is what in
7 2010?

8 A: \$26,302,000.

9 Q: So you didn't hit the mark there, right?

10 A: We did not.

11 Q: Okay. And for 2011 do you know what your
12 operating income was?

13 A: I don't the number off the top of my head. I
14 think it was 2.4 percent on about 800 million
15 of revenue.

16 Q: Okay. Could you do that calculation?

17 A: Approximately 20 million.

18 Q: Okay. So, \$20 million. Did you get any
19 investment gains or anything like that?

20 A: Well, operating would not include any
21 investment gains.

22 Q: Thank you. What was your operating cash flow
23 in 2011; do you recall that?

24 A: It was 10.4 percent. It would have been in the
25 range of about 83 million.

1 Q: Okay. Eight-three million for 2011?

2 A: I think.

3 Q: Okay. Now, if get the operating cash flow in
4 2011 from this chart, if you could do this
5 calculation for me. 39.9 million.

6 A: Okay.

7 Q: Plus 14.9 million, plus 40.8 million.

8 A: Okay.

9 Q: And what does that come up to?

10 A: 95.6 million.

11 Q: So were you heavy in the projection then,
12 compared to the actual?

13 A: I believe so, yes.

14 **MR. THOMAS:** Petitioner's 162, page five for me.

15 Q: Okay. This is Petitioner's 162, 4291. What
16 was the net income or the excess of revenues
17 over expenses in this one for 2009 for Roper
18 St. Francis?

19 A: 2009 was 69,427,000.

20 Q: Okay. I should have asked you to write down
21 what was on the chart that we were just looking
22 at. I'll find it for you. Do you recall in
23 2009 -- do you have Joint Exhibit 2 here? I
24 think you do. This is it. There you go. If
25 you'd turn to page 468, you'll see some Bates

1 numbers down at the bottom. Yeah, there you
2 go.

3 A: Okay.

4 Q: Okay. And what was projected revenue over
5 expenses for 2009 in the Joint 2 of the DHEC
6 record?

7 A: 46,999,954.

8 Q: So the actual was about \$24 million more or so?

9 A: For 2009?

10 Q: Yeah.

11 A: Yes. And what generated most of that you can
12 see is that change in fair market value of
13 interest rate swaps.

14 Q: Uh-huh.

15 A: That is a non-cash mark to market book number
16 that we book to recognize the change in fair
17 market value of interest rate swaps. So that
18 is a -- you don't put that in the bank. That's
19 a book number.

20 Q: Okay. Well, what was the operating income for
21 2009?

22 A: It was 29,129,000.

23 Q: Okay. And so the number is pretty close then,
24 right?

25 A: Between what?

1 Q: Between the actual, the audited financial
2 statement and what you projected in your CON
3 application for 2011?

4 A: Yes, for operating income, correct.

5 Q: Okay. Now, you would agree with me, Mr.
6 Johnson, that a healthy profit margin is
7 important to a health system in order to have
8 a positive cash flow so you can reinvest that
9 back into the business?

10 A: Yes, that's important.

11 Q: And that's the same for for-profits and not-
12 for-profits, isn't it?

13 A: Yes.

14 Q: Okay.

15 **MR. THOMAS:** Would you put up Petitioner's 95 for
16 me?

17 Q: All right. This is another presentation to a
18 rating agency. At the bottom it shows June
19 2007. Would you have had a hand in the
20 financial piece of that?

21 A: Yes.

22 Q: Okay. And this is Petitioner 95.

23 **MR. THOMAS:** Would you go to page 89 for me?

24 Q: In terms of key metric trends, Roper St.
25 Francis Hospital earnings continue to remain

1 strong in comparison with the industry, right?

2 Is that what it says at the top?

3 A: Yes.

4 Q: Okay. Who do you compare yourself to in terms
5 of operating margin, operating cash flow in the
6 industry?

7 A: We are comparing ourselves to our --

8 Q: You -- oh, go ahead. I'm sorry.

9 A: -- Moody's median A peer group.

10 Q: Yeah.

11 A: And we also look at a blended rate on this
12 slide between HCA and Tenet.

13 Q: Okay. So you compare yourself to for profits,
14 right? HCA and Tenet blend, right?

15 A: Yes.

16 Q: Okay. And then although 2000, 2001, it looks
17 like you're a little bit below the for profits,
18 you started going higher than the for profits,
19 right, in terms of operating margin, operating
20 cash flow margin in '03 through budget '07?

21 A: Yes.

22 Q: Okay.

23 A: And I will add, I think if you split those out,
24 I remember this, HCA had very high margins and
25 Tenet had very low margins.

1 Q: Is that right?

2 A: And they blended into these numbers, but --

3 Q: But you're comparing yourselves to for profits
4 here, right?

5 A: To two for profits, yes.

6 Q: Okay. And those are obviously important or you
7 wouldn't have put them on the slide, right?

8 A: Yeah. I would say the comparison to our
9 Moody's peer group was probably more
10 important, but we looked at the for profits.

11 Q: Yeah. They're on the slide and you thought it
12 was important enough to include it to the
13 rating agency?

14 A: Yeah. The for profits are efficient operators.
15 We wanted to compare to them.

16 Q: All right. And you're actually doing better
17 than they are in the years 2003 to 2006 in both
18 operating cash flow, margin and operating
19 margin, right?

20 A: Yes.

21 Q: Okay. That's something you're proud of, right?

22 A: Yes.

23 Q: Now, I want to go back to the audited
24 financials and we're going to back to '07.

25 MR. THOMAS: Can you go to Petitioner's 97 for me?

1 Q: I'm going to give you a worksheet, kind of like
2 Mr. Long's exercise with Mr. Gorrell. I'm
3 going to ask you to help me out. Do you have
4 a pen that you can write with?

5 A: Yes.

6 Q: Okay. We were talking a little bit about
7 apples to apples earlier and I think for the
8 Judge and for the Court we need to do this.

9 MR. THOMAS: Would you go to page five for me in
10 this document?

11 A: All right. And this is Roper Berkeley 1899 in
12 Petitioner's 97. And what I'm trying to do,
13 Mr. Johnson, on the worksheet is for 2007 if
14 you could write down for me where it says net
15 revenues, the net revenue number on that line,
16 so 2007, and I think that would be 548,342,000.
17 Is that right?

18 A: Yes.

19 Q: Okay.

20 A: Okay.

21 Q: All right. And then what we're going to do is
22 this is way that Mr. Long did it for us, is I
23 want to get an EBITDA number for Roper. Not
24 just the operating income but I think what you
25 referred to as an operating cash flow, right?

1 A: Well, EBITDA and operating cash flow are
2 different. EBITDA includes our non-operating
3 activity.
4 Q: Okay.
5 A: So whichever you want.
6 Q: Well, don't we want to do -- how about this?
7 What would the operating income plus the
8 interest plus the depreciation be?
9 A: Okay. I'll point out that you have your -- you
10 have EBITDA on this worksheet and you just
11 asked me for operating cash flow..
12 Q: Okay. I apologize. Let's do EBITDA?
13 A: Okay.
14 Q: Can you do that on here?
15 A: Yes.
16 Q, So what did you get for 2007?
17 A: I got -- and I want to double check, but
18 105,229,000.
19 Q: And could you just tell the court how you came
20 up with that? What did you add?
21 A: Okay. I added operating income -- excuse me.
22 I added excess of revenue over expenses.
23 Q: Okay.
24 A: That was 64,250,000. And I added to that
25 interest of 10,932,000.

1 THE COURT: How much?

2 A: 10,932,000, Your Honor. And depreciation and
3 amortization of 30,047,000.

4 Q: Okay. 105,229?

5 A: Correct.

6 Q: Okay.

7 MR. THOMAS: So we can do 2008, let's go to page 33
8 in Petitioner's 97.

9 Q: I'm going to show you -- if you do the same
10 here and do the unrestricted -- excuse me, the
11 total unrestricted revenue, so that would be
12 net revenues, right?

13 A: Yes.

14 Q: Okay. And then what would your EBITDA be
15 there?

16 A: Okay. I would, again, take the deficit of
17 revenues over expenses of 29,529 which is a --
18 I'm sorry. Let me be more clear on that.
19 Negative 29,529,000. I would add to that
20 interest expenses of 13,208,000. And I would
21 also add depreciation and amortization of
22 34,206,000.

23 Q: Okay. Tell me what you get there.

24 A: Okay. I get 17,885,000.

25 Q: All right. Now, let's do --

1 MR. THOMAS: Go to Petitioner's 162 and go to page --

2 Q: Now, this is Petitioner's 162 and we're going
3 to go to page -- that's it. Is this the
4 consolidated statement of operations for 2009,
5 2010?

6 A: Yes.

7 Q: Okay. Could you do the same calculation and
8 fill in the worksheet for me there?

9 A: Do you want me to walk through it or just do
10 it?

11 Q: I think at this point since you've walked
12 through it, you can just quickly do it for us
13 and that will move us along. But if you just
14 tell us what the numbers are when you get them,
15 then we can put them down.

16 A: Okay. Well, net revenue for 2009 is
17 682,818,000. And net revenue for 2010 is
18 681,368,000.

19 Q: You can work that calculator pretty fast.

20 A: Okay. EBITDA for 2009, I have 116,391,000.

21 Q: Okay.

22 A: And then for 2010, I have 91,169,000.

23 Q: Okay. Now, I added up the total net revenue
24 myself, and you're welcome to do it, but I came
25 up with \$2,530,544,000.

- 1 A: That's what I get.
- 2 Q: Okay. Could you quickly do a total EBITDA
- 3 number there?
- 4 A: 330,674,000.
- 5 Q: All right. So that would reflect net revenue
- 6 addition of all those three years, or four
- 7 years, excuse me, and the EBITDA for those four
- 8 years; is that right?
- 9 A: Yes. I would like to double check my EBITDA
- 10 number, but I believe that's correct.
- 11 Q: It looked right.
- 12 A: Okay.
- 13 Q: Is that right?
- 14 A: Yes, sir.
- 15 Q: All right. Can you hand that to me?
- 16 MR. THOMAS: any objection if I make this an
- 17 exhibit?
- 18 MR. LONG: I need a copy. No objection.
- 19 MR. THOMAS: Okay. That will be Exhibit 240, Your
- 20 Honor, and we'll get copies for everybody.
- 21 THE COURT: And that's without objection?
- 22 MR. LONG: Without objection, Your Honor.
- 23 Q: All right. So that was the, that was extent of
- 24 the actual EBITDA and the net revenue over that
- 25 time, right?

1 A: Yes.

2 Q: Okay.

3 **THE COURT:** Have you handed it to the court
4 reporter?

5 **MR. THOMAS:** Yeah. I need to do that. I want to
6 make copies.

7 **THE COURT:** Trident's 240 admitted without objection.

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

9 Q: So just to be, just to be sure here, although
10 the total net revenue, at least even for '07
11 and '08 was on the order of a billion dollars,
12 the EBITDA was more than, you know, what was
13 it, over a \$122 million, the utilization of
14 Roper St. Francis Moncks Corner wouldn't have
15 justified the expense of building 50 beds
16 there; is that right?

17 A: I didn't follow you. I'm sorry. You were
18 quoting 2007 and 2008 and I've got '09 and '10
19 here. So I'm -- and I don't have the exhibit
20 anymore, so I'm kind of --

21 Q: Oh, okay.

22 **MR. THOMAS:** Madam Court Reporter --

23 **COURT REPORTER:** I'm sorry.

24 **MR. THOMAS:** That's all right. Yeah.

25 Q: '07 and '08, net revenues would be over a

- 1 billion dollars, right?
- 2 A: In '07 and '08, that's correct.
- 3 Q: Okay. And the EBITDA would be over \$122
- 4 million for those two years, right?
- 5 A: Yes.
- 6 Q: Okay. So even with those type of numbers, the
- 7 expense of the utilization of the facility at
- 8 Roper St. Francis wouldn't justify the expense
- 9 of building 50 beds in Moncks Corners; is that
- 10 right?
- 11 A: Well, I can't really answer that because I
- 12 wasn't involved in that decision.
- 13 Q: And you're not aware of any discussion about
- 14 that, are you?
- 15 A: I don't think I participated in any of that
- 16 discussion.
- 17 Q: Okay.
- 18 A: So I can't accurately answer your question.
- 19 MR. THOMAS: Go back to Petitioner's 162. Yeah.
- 20 That's it.
- 21 Q: What is the bad debt as a percentage of net
- 22 revenue, Mr. Johnson, for 2010?
- 23 A: Rounded, 5.5 percent.
- 24 Q: Okay. Have you looked at any Trident income
- 25 statements?

- 1 A: I believe so. I've seen some in the courtroom.
- 2 Q: This is Petitioner's 181. I'm taking you to
- 3 Trident 10160. Now, the bad debt here -- were
- 4 you in the courtroom when Mr. Long went through
- 5 this exercise where the bad debt, I guess, was
- 6 above the line?
- 7 A: Yes.
- 8 Q: Okay. If you took the bad debt out and did it
- 9 as a percentage of net revenue --
- 10 MR. LONG: Your Honor --
- 11 Q: -- how would you do that?
- 12 MR. LONG: Your Honor, if I could interrupt for just
- 13 one second. This is the same thing as
- 14 Respondent's 161, isn't it?
- 15 MR. THOMAS: Is it?
- 16 MR. LONG: I thought we had worked -- is this the
- 17 2010 Trident financial statement?
- 18 MR. THOMAS: Yeah.
- 19 MR. LONG: I mean, I thought we had worked all of
- 20 these out, Your Honor, but it's going to cloud
- 21 the record if we --
- 22 MR. THOMAS: Well, that's 161 right here, isn't it?
- 23 MR. LONG: 151. Respondent's 151 is the 2011
- 24 Trident financial statement.
- 25 MR. THOMAS: 2010.

1 MR. LONG: Yeah. The 2010. I'm sorry. I said
2 2011, didn't I?

3 MR. THOMAS: Okay.

4 MR. LONG: 2010. I just said 2011. 2010. I just -
5 -

6 THE COURT: And you're wanting to use what you say
7 is 151?

8 MR. LONG: Yes, just to point that out. If we're
9 going to use the -- I didn't realize the same
10 exhibit was on the sheet, but I thought we had
11 scrubbed that.

12 THE COURT: Well, what are we talking about? I've
13 got 181 on my notes.

14 MR. THOMAS: Yeah.

15 MR. LONG: Because Respondent's -- Petitioner's 181
16 is the same thing as Respondent's 151, and
17 we've been talking about Respondent's 151 for
18 eight days. I was a little concerned about
19 that happening and just thought it should be
20 brought to the attention of the court and the
21 record, it is the same exhibit.

22 THE COURT: All right. Is the record satisfactorily
23 clear now?

24 MR. LONG: It can be. However you want us to
25 proceed. Either use the 151 and withdraw the

1 181 or we need to --

2 MR. THOMAS: If I can just use the 181. I mean,
3 it's clear on the record now.

4 MR. LONG: Okay. Well, maybe I'm incorrect, Your
5 Honor. Maybe he needs to lay some foundation
6 on what Petitioner's 181 is.

7 MR. THOMAS: That's exactly what I was doing.

8 THE COURT: Do we need any further clarification?

9 MR. LONG: Are we looking at 2010 or --

10 MR. THOMAS: 2010.

11 MR. LONG: Oh, that's ours, yeah.

12 MR. THOMAS: And so is -- 181 is also the 2010
13 income statement.

14 MR. LONG: Okay.

15 MR. THOMAS: It's the same thing.

16 THE COURT: So we're using 181; is that right?

17 MR. THOMAS: Yeah. Let's use 181 because that's
18 what I've got here.

19 Q: And what I'm trying to do here, Mr. Johnson, is
20 figure if, you know, the bad debt is above the
21 line, so if I wanted to figure out for Trident
22 2010 as bad debt as a percentage of net
23 revenue, how would I do that?

24 A: And I need to familiarize myself with this
25 schedule, but there are -- I'm assuming that

1 cash revenue is the equivalent of net revenue.

2 Q: Right.

3 A: Is that correct? Can I ask you if that's
4 correct?

5 Q: Yeah. No, no, that's right. That's right.

6 A: Okay. Then I would take bad debts as they
7 appear on here --

8 Q: Right.

9 A: -- of 68,783, divided by cash revenue of
10 370,688,000 and I get 18.5 percent, 18.6
11 percent if you round.

12 Q: Okay. You have 18 percent?

13 A: 18.6.

14 Q: Okay. And what was Roper's for the same year?

15 A: Well, it was 5.6, I think, if I rounded.

16 Q: Okay.

17 A: And I'll expand a bit. To reconcile gross
18 revenue to net revenue, there are three
19 components. Component one is contractual
20 adjustments.

21 Q: Uh-huh.

22 A: That is an amount you've contractually agreed
23 to write off with managed care companies and
24 your governmental payers. Bad debts are
25 amounts you expect to collect. You're owed

1 those amounts; you didn't collect them. That's
2 very different from charity care, which are
3 patients that came through your health system
4 that qualified based on your financial
5 assistance policies.

6 Q: Okay. I didn't ask you anything about charity
7 care, did I? I just asked you about the bad
8 debt, right?

9 A: Well, I thought I'd reconcile between gross and
10 net revenue.

11 Q: Okay. That's fine. But --

12 A: Okay.

13 Q: -- in terms of these percentages, that's what
14 they are, right? That's the percent of net
15 revenue?

16 A: That's correct.

17 Q: Okay. Now, you mentioned something about the
18 2011 financial performance.

19 **MR. THOMAS:** Go to Petitioner's 167 for me.

20 Q: Let me ask you a quick question now. Are Roper
21 St. Francis' charges about three times net
22 revenue?

23 A: Yes.

24 Q: Okay. Is the actual operating EBITDA through
25 June, was that about \$40 million? I'm going to

1 have Sara blow this up for you so you can see
2 it. About 40 million, 39.6?

3 A: Yes.

4 Q: And what did you say it was for the year? Did
5 you say it was pretty close to 80?

6 A: Yes.

7 Q: Okay. And do you recall what the net revenues
8 were for the year?

9 A: Approximately 800 million.

10 Q: About 800 million, okay.

11 **MR. THOMAS:** And, go to page six for me in this
12 document, Petitioner's 167. Go to the bottom
13 here and just try to blow that part up.

14 Q: You mentioned the losses at Physician Partners,
15 right?

16 A: Yes.

17 Q: Did you say that ended up being about 40
18 million for 2011?

19 A: Yes.

20 Q: Okay. So about double from June?

21 A: Yes.

22 Q: Okay. And then the downtown -- on that 40
23 million, how many -- this is a good point --
24 how many physicians are employed by Physician
25 Partners now?

- 1 A: Approximately 200.
- 2 Q: Okay.
- 3 A: A little short of that number, but
- 4 approximately 200.
- 5 Q: Is that about -- what is that per physician in
- 6 terms of loss? If it's 40 million, it's about
- 7 \$500,000 per? Oh, no, no, 250,000?
- 8 A: Yeah. We've also got somewhere near about 60
- 9 mid-level practitioners as well. So you
- 10 should probably divide that number by 260
- 11 instead of 200.
- 12 Q: Okay. Well, what would I get?
- 13 A: Would you like me to take the six month number
- 14 or an annual number?
- 15 Q: Yeah, the annual number.
- 16 A: Okay. I get 153,846.
- 17 Q: \$153,000 per kind of either physician or
- 18 extender, like a nurse practitioner or a
- 19 physician's assistant?
- 20 A: Yes.
- 21 Q: Okay. And is that a subsidy basically that's
- 22 paid?
- 23 A: It's an investment we make in that division,
- 24 yes.
- 25 Q: An investment is a euphuism for a subsidy?

- 1 A: If you want to call it that, yes.
- 2 Q: Okay. And Roper's Downtown operation here,
- 3 that's Roper Hospital, right?
- 4 A: Yes.
- 5 Q: Okay. And those revenues on -- if it's 24.8
- 6 billion on net revenues, is about 190 at the
- 7 mid year; is that right?
- 8 A: Yes.
- 9 Q: And that's about a 13 percent margin. Do you
- 10 recall?
- 11 A: Are you calculating operating income or EBITDA
- 12 or what would you like me to do?
- 13 Q: Well, let's do EBITDA. I'm sorry. Do the
- 14 revenue over expenses that includes the
- 15 depreciation and the interest expense, if you
- 16 would.
- 17 A: I get 12.9 percent.
- 18 Q: So right under 13 percent?
- 19 A: Yes.
- 20 Q: Okay. Also, we've got the Mount Pleasant
- 21 operation. I think you said -- did you say
- 22 when Mr. Long was directing you that there was
- 23 about a \$11 million revenue over expense, a \$11
- 24 million loss?
- 25 A: Yes.

- 1 Q: Okay. So it ended up being about the same as
2 if I just would have doubled in June, right?
- 3 A: Approximately.
- 4 Q: Okay. Do you recall what the first year was
5 projected to be in terms of revenue over
6 expenses?
- 7 A: In terms of the CON or the budget?
- 8 Q: Yeah, in terms of what the CON said. I mean,
9 if you'd like to --
- 10 A: I think it was a loss of about eight million
11 versus 11.
- 12 Q: Okay. And are you sure about that?
- 13 A: I'm trying to recollect. I didn't they were
14 too far off, but they were several million off,
15 but.
- 16 Q: Where's the interest expenses for the Roper St.
17 Francis Mount Pleasant? Because I remember one
18 being in the Mount Pleasant CON.
- 19 A: It's at corporate, in the far left column.
- 20 Q: Okay. So it would be in this seven million
21 dollars somewhere?
- 22 A: Yes.
- 23 Q: Okay. Do you know how much of that seven
24 million dollars should be allocated over here
25 to the Mount Pleasant Hospital?

1 A: Very little because when a project is under
2 construction -- I'm sorry. Is this 2011?

3 Q: Yeah, it's 2011.

4 A: Yes, it is. I would estimate about, on an
5 annual basis, about four and a half million.

6 Q: Four and a half. So if we added that four and
7 a half million there, then that loss is going
8 to be looking closer to \$15 million?

9 A: Yeah. And I think you have to look at the fact
10 that when you issue debt you also preserve
11 investments. So if you're going to take the
12 interest expense over there, then we ought to
13 also take investment income as well.

14 Q: Okay. Did you do that in the CON application?

15 A: I don't believe so.

16 Q: Okay. Now, we talked a little bit about the
17 Roper St. Francis 50,000 square foot ED surgery
18 center, MOB complex. Did I hear you right, did
19 you say that the ASC, the surgery center, had
20 been in operation for 20 years?

21 A: No, I did not. What I testified to before was
22 that that facility has been there for 20 years,
23 and I believe it was about 1998 that we started
24 offering outpatient surgery.

25 Q: You don't think it was 2002?

1 A: It's a transaction that I was somewhat involved
2 with, and I thought it was shortly after I
3 started with them.

4 Q: It might be. We might look at something. But
5 were you involved in any way in the decision to
6 move the surgery center from Moncks Corner to
7 Goose Creek?

8 A: No.

9 Q: Were you asked about your -- anything having to
10 do with the financial aspects of it?

11 A: Not that I recall.

12 Q: So you didn't conduct a financial feasibility
13 study?

14 THE COURT: Excuse me. You said Goose Creek. Did
15 you mean Carnes?

16 MR. THOMAS: Yes, sir. I meant Carnes Crossroads,
17 Your Honor, which is I guess technically within
18 the city limits of Goose Creek.

19 A: I can't rule it out, but I don't recall it.

20 Q: Okay. Well, let's go -- this was going to be
21 about a \$10 million project, right? I think we
22 saw some articles today referencing that it
23 would be about a \$10 million project in Carnes?

24 A: Yes.

25 Q: Okay. And there was a CON -- was there a CON

1 actually done for the project?

2 A: My recollection was there was a CON filed.

3 Q: Did you do any of the work on the pro formas
4 for it?

5 A: Not that I recall.

6 Q: Do you know who would have?

7 A: I do not.

8 MR. THOMAS: Pull up Petitioner 164 for me.

9 Q: Okay. Did you have anything to do with this
10 document, the project review document that was
11 put together?

12 A: I did not, to my recollection.

13 MR. LONG: Your Honor, I'd move to withdraw that as
14 admitted until the appropriate can testify
15 about it.

16 MR. THOMAS: Wait a second. I haven't even asked
17 him about it, Your Honor.

18 MR. LONG: Well, he just said he had nothing to do
19 with it.

20 MR. THOMAS: That's all right. I can still ask him
21 about.

22 MR. LONG: Well, Your Honor, he's got to lay a
23 foundation on the document.

24 MR. THOMAS: I've got to get to the page, Your
25 Honor, before I ask him a question.

1 THE COURT: Well, you've got to get the question for
2 me to rule on. You're anticipating, Mr. Long,
3 but I'll hear your objection at the proper
4 time.

5 MR. LONG: Thank you.

6 Q: Did you have any understanding of why the
7 surgery center was moving from Moncks Corner to
8 Carnes Crossroads?

9 A: That would have been a discussion that took
10 place between Mr. Dunlap and Mr. Bowling.

11 Q: Well, let me ask you this. One of the -- the
12 second bullet here says insure the necessary
13 volumes to make the center financially
14 feasible, right?

15 MR. LONG: I'm going to object. He asked him, did
16 you have anything to do with this Power Point.
17 He said no. Did you have anything to do with
18 the decision on the relocation? No. Now he's
19 trying to impeach him with a document and he
20 just can't. Close the door. The door is
21 closed.

22 MR. THOMAS: I'll make it demonstrative.

23 MR. LONG: He should move on.

24 MR. THOMAS: I'll make it demonstrative.

25 MR. LONG: And I would move to -- I want to clear

1 for the record that it's not an exhibit.

2 **THE COURT:** I thought the agreement between you was
3 that anything that's mentioned becomes an
4 exhibit. Didn't I hear that at the
5 commencement of the proceeding?

6 **MR. LONG:** Yes, Your Honor. And that's why I stood
7 up because unless there's an objection.

8 **THE COURT:** Okay.

9 **MR. LONG:** And I do. And I just that's the reason.
10 And this is not an appropriate document for
11 this witness.

12 **MR. THOMAS:** I'm withdrawing the as far as the
13 reference becomes an exhibit, I'm not -- but I
14 do want to ask him about this because it talks
15 about financially feasible. He's the CFO of
16 Roper St. Francis, so I want to know a little
17 bit about that, Your Honor.

18 **THE COURT:** Can't you ask him about it without
19 referring to the document?

20 **MR. THOMAS:** I can.

21 **MR. LONG:** That's fine.

22 **MR. THOMAS:** Take the document down.

23 **Q:** All right. Did you have anything to do with
24 determining whether or not the surgery center
25 was financially feasible in Moncks Corner?

1 A: No, not that I recall.

2 Q: That wouldn't be in your purview?

3 A: You know, the center has operated there for 20
4 years. The surgery center has been -- the
5 surgery component has been there since, I
6 believe, the late '90s. We continue to operate
7 it.

8 Q: Okay. You said Doug Bowling is the person I
9 need to ask about that slide set then, about
10 the move of the surgery center and its
11 financial feasibility?

12 A: I would testify that discussions occurred
13 probably led by Doug Bowling on that, yes, sir.

14 Q: Okay. And as long as that's the understanding,
15 then we can get into that with Bowling.

16 MR. LONG: Your Honor, that's an improper statement,
17 question for the record. He just needs to ask
18 the witness questions. If the witness doesn't
19 know the answers, then let's move on. I mean,
20 that's just --

21 MR. THOMAS: I've got what I need, Your Honor.

22 Q: Now, do you work with the financials as the CFO
23 for the Roper St. Francis Physician Partners,
24 Mr. Johnson?

25 A: I am the CFO over the Health System, so I'm --

1 yes.

2 Q: Okay. So I can ask you some questions about
3 the financials of the Physician Partners?

4 A: I would defer to counsel on that, but --

5 Q: Actually, you can't.

6 A: Okay. Well, go ahead.

7 Q: Now, you would agree with me that before Roper
8 St. Francis Mount Pleasant was built, Roper
9 employed very few people in the East Cooper
10 area? That's the only question; a very few
11 physicians in the East Cooper area?

12 A: Yes.

13 Q: Okay. Now, would you agree with me that today
14 Roper St. Francis employs nearly half of all
15 the primary care physicians in Mount Pleasant?

16 A: Yes.

17 Q: Now, you mentioned something that -- I think
18 Mr. Long asked you a question, you can't buy
19 referrals, right? You said that the Stark law
20 prohibits that, correct?

21 A: Correct.

22 Q: But you do understand that the Stark law has an
23 exception that does allow you to actually
24 purchase physician practice. A hospital can
25 purchase a physician practice and employ the

1 physician, correct?

2 A: That's correct.

3 Q: Okay. That's your understanding. I know
4 you're not a lawyer. You would agree with me
5 that one reason that you would purchase the
6 physician practice is to actually gain market
7 share? I'm not saying that's the only reason,
8 but that is one reason?

9 A: Some health systems may choose to do that.
10 We've been employing physicians for four years
11 now. Market share in our market has been
12 static.

13 Q: Okay. What do you think it would have done if
14 you didn't employ the physicians?

15 A: Well, if you have -- physicians, and this is a
16 trend all over the country, are seeking
17 employment. If you have a group that is loyal
18 to your hospital system seeking employment --
19 and we've had this happen -- they come to Roper
20 St. Francis, we're loyal to you but we want to
21 be employed. You know, we don't want to be
22 independent anymore. Roper St. Francis, we
23 would like you to employ us, but if you don't,
24 we'll go somewhere else. For defensive
25 reasons, yes, it's important to employ those

1 groups.

2 Q: All right. And yet you actually lose \$40
3 million a year on those practices, right? I
4 mean, we just looked at the financials.

5 A: Our investment in partners is \$40 million a
6 year. That's correct.

7 Q: Okay. And Roper St. Francis also tracks the
8 referrals of its employed physicians, correct?

9 A: Well, we have a referral tracking system, but
10 the primary purpose of that system is to make
11 sure that when a patient presents and has a lab
12 test or has an MRI procedure or a CT, that the
13 results get back in the medical record. It is
14 a quality system primarily.

15 Q: It also allows you to determine whether or not
16 the physicians are actually referring to the
17 Roper St. Francis facilities, correct?

18 A: Referrals are tracked, yes.

19 Q: And Roper St. Francis requires by contract that
20 its employed physicians refer to its facilities
21 unless the patient expresses differently,
22 correct?

23 A: There are several exceptions to that, but yes.

24 Q: Okay. Well, let me ask you this. There's
25 nothing in the contract of that employed

1 physician who's contractually obligated to make
2 referrals that requires him or her to actually
3 state all the different options that may be
4 available for that patient, some of which may
5 be closer, is there?

6 A: Yeah. I think I testified earlier that I don't
7 think I've even read a physician employment
8 contract, so.

9 Q: Well, you just said there were several
10 different other options. How would you know
11 that if you --

12 A: Well, I've heard that verbally within our
13 health system. I've --

14 Q: Let me ask you this. Have you ever heard that
15 there, in a physician employment agreement,
16 that there is a requirement that the physician
17 notify the patient of all the different
18 options, healthcare options, including the
19 competitor options? That's not in there, is
20 it?

21 MR. LONG: Objection, Your Honor. It's calling for
22 hearsay.

23 MR. THOMAS: It's calling for -- it wouldn't be a
24 statement against interest. That wouldn't be
25 hearsay whatsoever.

1 MR. LONG: He asked him if he'd ever heard it?

2 MR. THOMAS: Yeah, from anybody at Roper St.
3 Francis?

4 THE COURT: Overruled.

5 A: No, I've not heard it.

6 Q: Okay. Thank you.

7 MR. LONG: Your Honor, if I could just renew that
8 and move to strike. How could a negative -- he
9 asked him a negative question instead of a
10 statement against interest. He never heard
11 somebody say something. So the absence of the
12 statement is a statement against interest.
13 That's what he did on the question, Your Honor.
14 And so I think it is -- it clearly is not a
15 statement against interest.

16 MR. THOMAS: I modified my statement to say if he'd
17 ever heard of anyone from the Roper St. Francis
18 System and that would be -- and, if he said
19 yes, that would be a statement against
20 interest. That's exactly what it would be.

21 THE COURT: Well, I certainly interpreted it as a
22 statement against interest.

23 Q: Now, Mr. Johnson, you're not aware of anything
24 that would prevent Roper St. Francis from
25 purchasing the Palmetto Primary Care Network,

1 are you? I mean, those physicians came to
2 Roper and asked to be employed and said
3 something that you would automatically say no
4 to?

5 A: I wouldn't be in the primary decision makers of
6 that decision.

7 Q: Are you aware of anything that would prevent
8 Roper St. Francis from purchasing that
9 physician practice, which I think Mr. Gunn
10 testified or someone testified had a pretty
11 good number of physicians?

12 A: I'm not aware of anything that would prohibit
13 it.

14 Q: Okay. And in 2009 Roper St. Francis purchased
15 Lowcountry Medical Group, right? Is it LMA?

16 A: Yes.

17 Q: Lowcountry Medical Associates?

18 A: Yes.

19 Q: And that was about an \$11 million practice
20 acquisition?

21 A: There were multiple acquisitions associated
22 with that transaction.

23 Q: Okay. Including some diagnostic pieces and
24 that type of thing?

25 A: Yes. The largest portion of those dollars went

1 for the diagnostic centers, correct.

2 Q: Okay.

3 MR. THOMAS: Put up Petitioner's 150 for me.

4 Q: I'm going to show you an email from you to Mr.
5 Bowling.

6 MR. THOMAS: If we can, blow it up. This is Roper
7 388 -- Roper Berkeley 3884, Petitioner's 150.

8 Q: And this is an email from Mr. Bowling to you
9 and Mr. Dunlap, right?

10 A: Yes.

11 Q: Mr. Dunlap, he's the system CEO, right, for
12 Roper St. Francis System?

13 A: Yes.

14 Q: Okay. So all the hospital CEOs report up to
15 him, right?

16 A: Yes.

17 Q: And you report to him, too, right?

18 A: Yes.

19 Q: Okay. Now, this is dated March 6th of 2008,
20 right?

21 A: Yes.

22 Q: Okay. And it's Mr. Bowling telling you about
23 the new market share numbers for 2006, right?

24 A: Yes.

25 Q: He says, "I'm afraid it's not good news across

1 the board. Roper continued to lose market
2 share and St. Francis stayed flat instead of
3 offsetting Roper's loss as it had in prior
4 years." And he says, "MUSC was the clear
5 winner picking up share across all service
6 lines and in all three counties." What's the
7 next line? If you could read the next two
8 lines into the record for me.

9 A: "Their aggressiveness in employing docs and
10 placing them in the community is clearly
11 driving market share. This makes their third
12 practice acquisitions this week even more
13 concerning."

14 Q: "This makes their three practice acquisitions
15 this week even more concerning." Right?

16 A: Yes.

17 Q: Okay. And then this was going to be presented
18 at the senior staff meeting; is that right?

19 A: That's what it says.

20 Q: And then you said, "Put a stop payment on
21 Doug's incentive check."

22 A: And I was joking.

23 Q: I know you were joking there, correct? Are the
24 executives at Roper St. Francis, I mean, is
25 there a financial -- I mean, is there a bonus

1 based, in part, on the financial performance of
2 the system?

3 A: There is a corporate scorecard that is prepared
4 annually and approved by the board, and some of
5 the metrics on that scorecard are considered
6 incentive measures and do drive incentives.

7 Q: Okay. Great. Now, I don't have the very next
8 page, but at the time what we're talking about
9 here, and you testified in your deposition, I
10 can show you that to you if you want, but you
11 may remember it, so we won't have to get into
12 it, but the concern was about a one percent
13 drop in market share for Roper Hospital and
14 about a one-tenth of a percent drop in market
15 share for Bon Secours, right? Do you recall
16 that from your deposition?

17 A: It sounds reasonable.

18 Q: Okay. And I'll gladly provide it to you, but
19 that's what I recall the testimony saying. But
20 you remember it being more than that?

21 A: I would have to look.

22 Q: Well, let's do that. I really don't want you
23 to testify about something -- start on 174,
24 line eight for me. And if you'll just read
25 down a little bit and confirm that that's we

1 were talking about. One percent at Roper and
2 about a tenth of a percent drop in market share
3 for Bon Secours.

4 A: Would you like me to confirm or read?

5 Q: Yeah. You can just confirm it. You don't have
6 to read it into the record unless you want to?

7 A: (Witness reviews document.) Yes.

8 Q: Okay. So that one percent -- you can keep that
9 up there for now. That one percent that Roper
10 and a tenth of a percent drop in market share,
11 that was somewhat of a concern to Roper St.
12 Francis back in March of 2008, wasn't it?

13 A: Yes.

14 Q: Now, about this time, would you agree with me
15 that 2008, 2009, and 2010, Roper itself started
16 aggressively acquiring physician practices?

17 A: I would say as a result of physicians coming to
18 Roper St. Francis.

19 Q: Okay. Well, this doesn't mention anything
20 about Roper St. Francis physicians coming -- or
21 physicians coming to Roper St. Francis, but
22 this is about MUSC acquiring practices, right?

23 A: Yes. As I mentioned earlier in my testimony,
24 MUSC has a model or a strategic plan where they
25 build very large, multi-speciality buildings,

1 populate those with specialists and they've
2 done that in West Ashery, North Charleston.
3 They have a 70,000 square foot building under
4 construction in Mount Pleasant. It's a
5 strategy they have to employ new physicians
6 into the marketplace and populate them in high
7 growth areas.

8 Q: All right. But this one just talked about some
9 physician practices here and resulting market
10 share losses of one percent at one place and a
11 tenth of a percent in another, right; this
12 email here on the screen?

13 A: Yes.

14 Q: Okay. Now, so Roper's strategy is to build
15 150,000 square foot hospitals and then put the
16 MOB there and get those physicians in at those
17 locations? Is that the Roper strategy?
18 Because you said the MUSC strategy is building
19 some MOBs and putting specialists in there,
20 right?

21 A: No, that's not our strategy.

22 Q: It's not?

23 A: We've, as I testified in my deposition, our
24 strategic planning around Mount Pleasant and
25 our hiring of physicians was, I would call,

1 exclusive strategies. Our strategic planning
2 materials, which have been provided relative to
3 Mount Pleasant, don't include reference to
4 employing physicians as part of a Mount
5 Pleasant Hospital strategy. I mean, that
6 documentation doesn't exist.

7 Q: Okay. Well, but this documentation does exist,
8 right, the email here?

9 A: That we're concerned about MUSC bringing new
10 physicians into the marketplace and populating
11 these large multi-specialty clinics. Now, that
12 was our concern.

13 Q: Well, that's not what this says. It just said,
14 "their aggressiveness in employing docs and
15 placing them in communities," are you saying
16 that those, that they weren't employing docs
17 already in the communities; that never
18 happens?

19 A: In my opinion, a lot of them pushing out into
20 the communities has been through employing new
21 physicians.

22 MR. THOMAS: Sara, go to Petitioner's Exhibit 235.

23 THE COURT: Petitioner's what?

24 MR. THOMAS: 235, Your Honor.

25 Q: This is pulled off the website, the Roper St.

1 Francis website. It's a map of I guess the
2 Tri-county area. It's got some circles in some
3 other places. But this is the physician
4 location map for Roper St. Francis Physician
5 Partners, correct?

6 A: Yes.

7 Q: What do the green dots represent?

8 A: Specialists.

9 Q: Okay. And so like MUSC, Roper has scattered
10 specialists throughout the communities,
11 correct? You've got them up there in Moncks
12 Corner. You've got them all over Mount
13 Pleasant, West Ashley, and of course downtown,
14 and on James Island, too, right?

15 A: Yes. And my opinion is if you would have put
16 this slide up two years prior, those practices
17 to a large extent were already there, they were
18 just independent.

19 Q: Okay. But you bought them, right?

20 A: We did.

21 Q: And now they're all employed, right?

22 A: Yes.

23 Q: Okay. These are Roper St. Francis Physician
24 Partners. These are employed physicians,
25 correct?

1 A: Yes.

2 Q: And they all have their employment agreement
3 and they've got that contract clause that says
4 they're required to refer, correct?

5 A: Yes.

6 Q: Now, not only are there specialists on this
7 board, but there are a lot of primary care
8 physicians, too, right?

9 A: Yes.

10 Q: And that would be represented by I guess the
11 red and the blue and the orange, correct?

12 A: Could I ask that this get blown up just a
13 little bit.

14 Q: Yes.

15 MR. THOMAS: Could you blow up the legend, Sara?
16 Right here.

17 Q: I was having a hard time reading it too. But
18 family medicine is red. Internal medicine is
19 orange. - You've got your OB/GYNs, right, those
20 are the purples. And the blues are pediatrics.

21 A: Yeah. My definition of primary care is
22 typically the red dot and the orange dot.

23 Q: Not the pediatrician?

24 A: And the pediatricians.

25 Q: Okay.

1 A: I thought that said podiatrist. I'm sorry.

2 Q: And Roper employs podiatrists, too, right?

3 A: Yes.

4 Q: And then there's some circles on here, aren't
5 there? There's Sumter, Murrells Inlet,
6 Walterboro, Varnville. Where is Varnville?

7 A: I guess southwest of Charleston.

8 Q: You don't know where Varnville is?

9 A: I guess it's down in the Beaufort area.

10 Q: It's in Hampton County, isn't it?

11 A: I'm sorry, yes. Correct.

12 Q: Why do you employ doctors in Sumter,
13 specialists in Murrells Inlet, specialists in
14 Beaufort, specialists in Bluffton?

15 A: Well, you know, Mr. Bowling is the strategic
16 architect of physician employment. I was not
17 involved in the strategic decision making for
18 these doctors, so I would defer to him on that.

19 Q: Let me ask you one question about it. What
20 this allows, and if you don't know, you don't
21 know, but doesn't this allow you to get the
22 high dollar specialty referrals, especially in
23 cardiology and surgery, from these communities
24 to Roper Hospital?

25 A: There are some of those referrals, yes.

1 MR. THOMAS: Go to Petitioner's 93 for me.

2 Q: Now, this is back to the update, annual update
3 of Moody's, March 1, 2010. And I'm going to
4 direct you to Roper Berkeley 1348. And this
5 says in March of 2010, we've got a slide here,
6 and you're telling Moody's future growth, 25
7 contracts pending signature, continued
8 expansion of primary care practices in
9 population growth areas, look to employ
10 proceduralists to provide specialty coverage
11 for the group, right? And that's surgeons,
12 urologists, gastroenterologists, ENT, and
13 OB/GYN. Is that right?

14 A: Yes.

15 Q: And Berkeley County is a population growth
16 area, isn't it?

17 A: Yes.

18 Q: Okay. And if Roper St. Francis gets to build
19 a hospital in Berkeley County, it's going to
20 put these type of doctors on its campus,
21 correct?

22 A: There's been no strategic decision to put
23 employed physicians on our campus in Berkeley
24 County.

25 Q: Okay. Well, don't you think it would look

1 something like the Roper St. Francis Mount
2 Pleasant campus that we just looked at?

3 A: No, I don't.

4 Q: You don't think it would look anything like
5 that?

6 A: I don't.

7 MR. THOMAS: Go back to 235 for me.

8 A: I don't think I can make that conclusion today.
9 That strategic decision has not been made.

10 Q: Well, let's just look at it. All of these dots
11 here in the East Cooper area, the full
12 conglomeration, where are all of those dots
13 located, Mr. Johnson?

14 A: Around our Mount Pleasant Hospital.

15 Q: Okay. All these dots downtown, all the green
16 ones, where are all of those located?

17 A: Around Roper Hospital.

18 Q: Okay. All these dots in West Ashley, where are
19 those located?

20 A: Around St. Francis Hospital.

21 Q: All these dots up in Moncks Corner, where are
22 they located?

23 A: Around our Moncks Corner facility.

24 Q: Okay. Is it your testimony here today that if
25 you build a hospital in Carnes Crossroads,

1 we're not going to see a lot of dots around
2 that area? Is that your testimony?

3 A: I can't --

4 Q: When every other place looks just like it?

5 A: I can't conclude that we would.

6 Q: Okay. That's fine.

7 A: The vast majority of the physicians in the
8 north area are independents. We would have no
9 benefit to saturating the market with
10 physicians. Pretty much all of the physicians
11 we've employed were already loyal to Roper St.
12 Francis Healthcare.

13 Q: Well, why did you spend and lose 40 million a
14 year to employ them if they're already loyal?

15 A: Because we have to align ourselves in response
16 to healthcare reform and improving quality.
17 And that's why we'd make that investment.

18 **MR. THOMAS:** Go to Petitioner 93, back to 93 for me.

19 Q: Let's see if that's what you tell Moody's?

20 A: Okay.

21 Q: Okay. But you're not denying that the more
22 specialists that you employ and the more
23 primary care physicians you employ, that means
24 more market share, doesn't it?

25 A: If those primary care doctors and those

1 specialists send everything to you to begin
2 with, no, it does not mean additional market
3 share.

4 Q: Go to your deposition there and find page 171?

5 A: I'm there.

6 Q: Okay. All right. Mr. Johnson, I'm going to
7 give you the original deposition. These are
8 the court certified copies. Give me one
9 second. I apologize.

10 MR. THOMAS: This is actually a good stopping point
11 for me, Your Honor, and it's 5:30.

12 THE COURT: Very well.

13 MR. LONG: Your Honor, wait. He was in the middle
14 of asking a question. Is he withdrawing the
15 question?

16 MR. THOMAS: Yeah. I withdraw that question, right.

17 THE COURT: It has occurred to me from the
18 standpoint of objections about limiting the
19 redirect that it may not be practical to stop
20 at 12:00 noon tomorrow while it's keeping it
21 fresh in your mind. What would you say to us
22 going on until we get through that point
23 tomorrow. And then if I don't finish what I
24 need to do after we finish tomorrow, then I can
25 take it up later in the week. Does that sound

1 reasonable?

2 MR. LONG: Yes, sir. In other words, you would let
3 us finish this witness tomorrow before we
4 broke?

5 THE COURT: Yes, sir.

6 MR. LONG: Yeah. I do appreciate that. I would
7 like to do that because obviously we wouldn't
8 want him to have to hang in that situation over
9 the weekend. I'd appreciate that.

10 MR. THOMAS: I don't have a problem with that
11 either, Your Honor.

12 MR. LONG: Does Mr. Thomas have any idea what he's
13 got, looking at?

14 MR. THOMAS: Yeah. A couple of hours, I would say,
15 Your Honor. I've got a few topics to get into.

16 THE COURT: All right. Well, let's start in the
17 morning at 9:30 and we'll go until we finish
18 this witness tomorrow.

19 MR. LONG: Okay. Thank you. Your Honor.

20 THE COURT: All right. We'll be in recess until
21 9:30 tomorrow morning.

22 (There being nothing further, the hearing recessed at
23 5:30 p.m.)

24 DAY 10 - FRIDAY, FEBRUARY 10, 2012

25 MR. THOMAS: We call Mr. Johnson.

1 MR. JOHNSON - CONTINUED CROSS EXAMINATION BY MR.

2 THOMAS:

3 Q: Good morning, Mr. Johnson.

4 A: Good morning.

5 MR. THOMAS: Permission to approach, Your Honor.

6 THE COURT: Yes, sir.

7 Q: Joint Exhibit 2 for me, the Roper DHEC record.

8 I just want you to quickly turn to pages 468
9 and 469 of Joint Exhibit 2.

10 A: Okay.

11 MR. THOMAS: Sara, could you actually call up on the
12 screen Petitioner's Exhibit 239?

13 MR. LONG: Your Honor, we should have -- I should
14 have addressed this with Mr. Thomas before we
15 started. 239 is a summary. I looked at the
16 summary this morning because I was anticipating
17 him bringing it up, but I can't accept the
18 summary as extracted because I think the
19 numbers -- I'm a big proponent of summaries.
20 I like to use summaries and use them, but I
21 think if you're going to use a summary, you
22 have to use the exact same language that's in
23 the underlying documents and you have to -- and
24 this summary doesn't do that. I think the
25 language would have to be changed because these

1 words don't match up with this sheet. And
2 secondly, I couldn't get the math to work. I'm
3 not sure about that, I just tried it a couple
4 different times, I just couldn't get it to
5 work. So it wasn't dramatically different, but
6 it was different.

7 **THE COURT:** Is this something you can take care of
8 on redirect?

9 **MR. LONG:** Well, it depends. I mean, the language -
10 - I think the summary is misleading because of
11 the way he's using the words. I guess we can
12 try to see how it goes with the witness, but --
13 so right now I do not consent to the admission
14 of 239 because I think the language on the
15 summary is different than the document.

16 **MR. THOMAS:** All right. Let's see what we can do
17 with -- I might be able to do it without the
18 exhibit to accommodate Mr. Long.

19 **MS. BIGGERS:** Will, I don't have 239.

20 **MR. LONG:** We have extra copies.

21 **MS. BIGGERS:** Thanks.

22 **Q:** That will be the table, just for the record,
23 Mr. Johnson, the table in 468 and 469 was the
24 projected Roper St. Francis Healthcare combined
25 statements of operations from 2008 through 2017

1 with the actual for 2007, correct?

2 A: Yes.

3 Q: Okay. Now, we can do this a couple of ways.
4 Maybe the easiest way to do it is if you take
5 the total revenue -- have you got your
6 calculator up there?

7 A: I actually did not bring it today. I'm sorry.

8 Q: Here we go. Looks like it's on.

9 A: Thank you.

10 Q: And we'll do an estimate here so we don't have
11 to get down to the thousands, but what I'd like
12 you to do if you could is could you project --
13 do a summary of the total revenue from 2008 to
14 2017 in just millions for me?

15 A: I've come up with 8,766,000,000.

16 Q: Okay. 8,766,000,000. Okay. And would you now
17 do the same thing for the revenue over
18 expenses? Would that be the equivalent of
19 untaxed net income?

20 A: That would be net income not subject to state
21 and federal taxes.

22 Q: Okay. Thank you. And again, if you just want
23 to do millions, that's fine by me.

24 A: I come up with 677 million.

25 Q: Okay.

1 MR. THOMAS: Judge, we can edit this exhibit at a
2 later time.

3 THE COURT: Well, tell me what that is and how it
4 was derived.

5 MR. THOMAS: Okay. What it is, Your Honor -- Sara,
6 would you put on the screen 468, the Roper St.
7 Francis DHEC record, Joint 2? Actually what
8 I'll ask, Judge, is the witness to explain what
9 he just did.

10 A: Your Honor, I added up the, horizontally, the
11 total revenue line from 2008 through 2017 and
12 then I also added the revenue over or under
13 expenses line, which is the very bottom line,
14 horizontally from 2008 through 2017.

15 Q: And this was from the projections in the Roper
16 St. Francis DHEC record; is that right?

17 A: Yes.

18 THE COURT: And then what did you do with them, did
19 you divide them?

20 A: No, I just communicated the totals of each of
21 those numbers to Mr. Thomas.

22 THE COURT: Total together?

23 A: The total for each line.

24 MR. THOMAS: For the net revenue, Your Honor --

25 THE COURT: Well, I've got the total revenue at

1 8,766,000,000 and then 677 million is the
2 second figure; is that right?

3 A: Correct.

4 Q: And that's the revenue over the expenses,
5 correct?

6 A: That's correct.

7 Q: Or as you said, the net income not subject to
8 state and federal income taxes?

9 A: That's correct.

10 Q: Okay. Thank you.

11 **THE COURT:** The revenue over expenses. Okay, thank
12 you.

13 Q: Mr. Johnson --

14 **MR. LONG:** Did y'all want to address Petitioner's
15 239 now?

16 **MR. THOMAS:** Yeah, I'm just going to withdraw that
17 exhibit at this time and present a summary,
18 based on Mr. Johnson's, later through an expert
19 or something along those lines.

20 Q: Mr. Johnson, if Roper St. Francis were suddenly
21 to lose \$15 million from its net income in
22 perpetuity, would that be a significant number
23 to you as a CFO?

24 A: It would be material. It would not be
25 materially adverse.

1 Q: But it would be material?

2 A: It would be material.

3 Q: Why?

4 A: Well, 15 million, it would be a -- we use our
5 cash flow to fund capital, to reinvest in
6 business, and 15 million is a sizable number.
7 So it would not jeopardize the ongoing
8 operations of our company, but it would be
9 material.

10 Q: Material to you as the CFO?

11 A: Yes.

12 Q: Material to Mr. Dunlap as the CEO?

13 A: Yes.

14 Q: Okay. Now, just so I've got it straight for
15 the record, yesterday was it your testimony
16 that you thought that Trident's taxes, state
17 and federal taxes, would equal about 20
18 percent?

19 A: I thought I'd seen that in something I'd looked
20 at, yes.

21 Q: Okay. But you don't remember what it was that
22 you looked at?

23 A: Well, it might have been a 10-K or a 10-Q, but
24 I understand that those aren't admissible, so.

25 Q: All right. Well, the fact is since you work

1 for a not-for-profit and Roper St. Francis
2 doesn't pay any state or federal income tax,
3 you're not really familiar with those tax
4 rates, are you?

5 A: No, I'm not.

6 MR. THOMAS: Could you pull up Petitioner's 93 for
7 me, Sara?

8 Q: Okay. We were talking a little bit about
9 physician employment yesterday and I'm probably
10 going to do more of that with Mr. Bowling, but
11 I did want to just ask you a couple of things.
12 This, again, is the update with Moody's that
13 you talked about yesterday that you testified
14 about, right?

15 A: Yes.

16 Q: Okay. Here on page 25, do you understand this
17 to be the bar graph that shows the number of
18 patient visits to Roper St. Francis Physician
19 Partners each year?

20 A: Yes.

21 Q: Okay. So in 2008 it was 96,024, right?

22 A: Yes.

23 Q: Okay. And in 2009 it went to 380,000 and some?

24 A: 380,414.

25 Q: And then over half a million patient visits in

1 2010; is that correct?

2 A: Yes.

3 Q: Is it fair to say that these physicians and
4 these patient visits, I mean, the physicians
5 who actually see these patients are
6 contractually obligated to refer patients to
7 Roper inpatient and outpatient facilities,
8 right? We established that yesterday, correct?

9 A: There is a clause to that nature in their
10 contract, yes.

11 **MR. THOMAS:** Would you go to Petitioner's 92 for me?

12 Q: Okay. Now, this is the annual update with
13 Standard and Poor's from July 14, 2009, it's
14 Petitioner's 92, you would have had some input
15 into this document, correct?

16 A: Yes.

17 Q: Okay.. Now, this is Roper Berkeley 1312 in
18 Petitioner's 92, and this is the managed care
19 update, correct, from Blue Cross Blue Shield
20 South Carolina subsidiaries?

21 A: Yes.

22 Q: Okay. And this line indicates the Physician
23 Partners increase -- and Physician Partners,
24 those are the Roper employed physicians; is
25 that right?

1 A: Yes.

2 Q: That there was a 30 percent initial year
3 including 65 percent evaluation and management
4 code increase, correct?

5 A: Yes.

6 Q: And that was for the actual reimbursement for
7 Blue Cross Blue Shield?

8 A: It appears to be, yes.

9 Q: Okay. And the next line here, 2010, 2011, says
10 increases are doubled or tripled professional
11 services CPI, correct?

12 A: Yes.

13 Q: Can you explain what the professional services
14 CPI is to the court?

15 A: I'm not -- I mean, I believe you have your
16 urban index CPI and things like that. I'm not
17 sure that I recollect a professional services
18 CPI. This slide would have been prepared by
19 Ellen Brown who is no longer with Roper St.
20 Francis. I'm not totally sure what she was
21 referencing there.

22 Q: Professional services consumer price index?

23 A: I'm not familiar with that, but if it exists,
24 then that's probably what she was referring to.

25 Q: Okay. But you would agree with me these are

1 pretty good increases in the managed care
2 reimbursement rates from Blue Cross, correct?

3 A: They are, yes.

4 Q: Okay. And that was due in part to Roper St.
5 Francis physician employment practices,
6 correct?

7 A: That's correct. Well, I think it's due to some
8 additional leverage. When physicians are in
9 groups of one or two, Blue Cross hands them a
10 fee a schedule at 80 percent of Medicare and
11 it's a take it or leave it situation. So some
12 additional leverage did lead to some higher
13 rates.

14 Q: Fair enough. And the fact is that the more
15 physicians Roper employs, the more leverage it
16 has to increase rates with the insurance
17 companies; is that a fair statement?

18 A: Yes.

19 Q: Okay. And the insurance company then would
20 pass -- passes along those rate increases to
21 the consumer, correct?

22 A: I don't know what the insurance companies do.

23 Q: Okay.

24 A: I don't know how they set their rates.

25 Q: Do you think they just eat the costs?

1 A: Well, costs is an interesting --

2 Q: Let me withdraw the question.

3 A: Okay.

4 Q: Do you think that they simply eat the
5 increases?

6 A: What you're discussing here is the burden on
7 the employer and in my opinion, Roper St.
8 Francis in our marketplace is not the highest
9 reimbursed entity in our -- healthcare provider
10 in our marketplace. So I don't think we're
11 responsible for putting the greatest burden on
12 the employer.

13 Q: Okay.

14 A: As a contrast, we talked yesterday about Roper
15 St. Francis Physician Partners losing 40
16 million. Medical University's equivalent to
17 our Physician Partners made 81 million last
18 year.

19 Q: Okay. Where did you get that document from?

20 A: It's in their annual report.

21 Q: Let me ask you this. This line indicates
22 you've got a 30 percent initial year increase
23 and then 65 percent E&M code increase, correct?
24 I mean, you're not denying that that's the
25 numbers on the page, are you?

1 A: No, those are correct.

2 Q: Okay. You would agree with me that one of
3 Roper's strategic goals is to actually increase
4 market share, isn't it?

5 A: I think our strategic goal is to secure fair
6 reimbursement for our employed physicians.

7 Q: Well, that's not the question I asked. I asked
8 you do you -- if it's one of Roper's strategic
9 goals to increase market share?

10 A: I'm sorry, I misunderstood your question. Is
11 one of our strategic goals?

12 Q: Yeah.

13 A: Sure, absolutely.

14 Q: All right. And in 2008 when Roper St. Francis
15 applied for its CON application, part of its
16 strategic position was an aggressive growth
17 strategy; is that a fair statement?

18 A: I missed the date of your question. Are we
19 talking about the Carnes Crossroads CON?

20 Q: Yes.

21 A: Was to increase market share?

22 Q: Well, no, one of its strategic, a component of
23 its strategic position was actually aggressive
24 growth, correct? It had an aggressive growth
25 strategy?

1 A: That's what our -- we have slides titled
2 aggressive growth.

3 Q: Right.

4 A: Our CON for Carnes Crossroads is to serve a
5 very large book of business in Carnes
6 Crossroads.

7 Q: I hear what you're saying --

8 A: But we want to grow, I mean, and we do during
9 our strategic planning process seek to grow.

10 Q: And you want to grow aggressively, correct?

11 A: We're in an industry where you have to grow to
12 survive.

13 Q: Okay. Look at Petitioner's 136 for me. This
14 is Roper Berkeley 35, the strategic position of
15 Roper St. Francis. What's the last bullet
16 point? And first of all, back in 2008 you were
17 the market leader in the primary service area,
18 correct?

19 A: May I ask where this document came from? Is
20 this from our ratings agency report?

21 Q: That I don't know. Where this document came
22 from was Roper St. Francis in discovery.

23 A: Okay.

24 Q: And so what I'm asking you is if you understand
25 this to be the strategic position back in 2008

1 of Roper St. Francis Healthcare.

2 A: Yes.

3 MR. LONG: Your Honor, this is -- first, I'm not
4 even sure exactly what exhibit he's on. He's
5 got to lay some foundation. The witness just
6 said he didn't even know what this meant.

7 MR. THOMAS: Your Honor, I asked him if he
8 understood whether or not this was the
9 strategic position and he answered yes.

10 MR. LONG: Here's the problem, Your Honor, okay, he
11 can ask him the question, but he's showing him
12 a document and saying -- and he's either got to
13 lay the foundation for the document -- he can
14 either ask the witness about the document or he
15 can ask the witness the question. I mean, it's
16 got to be one or the other.

17 MR. THOMAS: Your Honor, I asked him if he
18 understood. It's got Roper St. Francis
19 Healthcare on it and it says strategic position
20 and I asked him if he understood this was the
21 strategic position.

22 MR. LONG: And he said he doesn't know what he was
23 looking at and then you continued to ask him
24 questions about the document. So, I mean,
25 that's my point. It's got to be either a

1 question -- you can ask him like you just did
2 a minute ago, but --

3 MR. THOMAS: All right. Let me -- I can do this
4 another way.

5 THE COURT: You're going to withdraw the question
6 and start over?

7 MR. THOMAS: I'm going to withdraw the question and
8 I'm going to start over.

9 Q: Mr. Johnson, do you understand that part of
10 Roper's strategic position is to have an
11 aggressive growth strategy?

12 A: We strategize to grow, yes.

13 Q: Okay. Aggressively?

14 A: Well, aggressive needs to be put in context
15 because I'm assuming there are ratings agency
16 documents and other documents that talk about
17 aggressive growth. We wanted to very
18 accurately communicate to the rating agencies
19 that we were growing our Physician Partners
20 division quickly. So, you know, you saw those
21 slides that went from 96,000 visits to over
22 half a million visits with our employed
23 physicians. That aggressive growth
24 contextually also referenced the fact that we
25 were growing our Physician Partners division

1 very quickly. And that's different from market
2 share. I mean, that we have aggressive growth
3 in our Physician Partners division does not
4 necessarily correlate to market share.

5 Q: I didn't ask you that, did I?

6 A: Well, you asked me what we meant by aggressive
7 growth.

8 Q: Have you ever seen this slide before?

9 A: It doesn't seem to have the same font as what
10 came out of our ratings agency presentations,
11 but it looks like a slide that could have been
12 in one of those presentations. So I don't
13 know.

14 Q: Go back a page for me. Let me identify the
15 document. It was attached to an email from
16 David Dunlap to Mike Cassells. It says Roper
17 St. Francis Hospital strategy slides for Bon
18 Secours Hospital; is that right? And it says
19 please review the attached slide summarizing
20 Roper St. Francis Hospital's strategic position
21 and direction for inclusion in the BSHSI rating
22 agency presentation. So let me ask you this,
23 is that something that you would participate
24 in, the BSHI rating agency presentation?

25 A: I would not, no.

1 Q: Who would participate in that?

2 A: BSHSI is an acronym for Bon Secours Health
3 System. Cathy Arbuckle is their CFO, Rich
4 Stituto is their CEO and whoever else they
5 would invite to participate in that discussion.

6 Q: Okay. Let me ask you this. Is Roper St.
7 Francis the market leader in the primary
8 service area?

9 A: Market share data is limited, but we have a
10 very slight lead based on the state inpatient
11 market share data that's available. That's
12 correct.

13 Q: Okay. Is financial performance significantly
14 above A rated medians?

15 A: Not today.

16 Q: What is it now?

17 A: We ended 2011 at about 10.4 percent operating
18 cash flow margin. Moody's median A's are in
19 the ten percent range, 9.9, ten percent range.

20 Q: So are you above or below?

21 A: Slightly above.

22 **MR. LONG:** Your Honor, I've got interrupt for a
23 second just to clarify the record. 136, which
24 was that slide just a minute ago is not in
25 because we did not -- and I didn't stand up on

1 that. But he said he didn't have anything to
2 do with it and Mr. Thomas took it down. So I
3 assume he didn't mean for that to be in.

4 **MR. THOMAS:** I'll call David Dunlap then.

5 **MR. LONG:** Hold on one second. You're not going to
6 call David Dunlap. Your Honor, he's sitting
7 here -- this is unfair.

8 **MR. THOMAS:** There's nothing unfair.

9 **MR. LONG:** Your Honor, let me tell you what's
10 happening.

11 **THE COURT:** Wait, just stop a minute. I'll hear you
12 now, Mr. Long.

13 **MR. LONG:** Well, Your Honor, here's the thing.
14 We've got a lot of documents here. He chose to
15 put David Dunlap up in his case through a
16 deposition designation. He did that with five
17 other witnesses.

18 **MR. THOMAS:** Four.

19 **MR. LONG:** Four other witnesses.

20 **THE COURT:** Wait a minute. That --

21 **MR. LONG:** And here's the thing, Your Honor.

22 **THE COURT:** Just a minute.

23 **MR. LONG:** Yes, sir.

24 **THE COURT:** That sort of interruption will stop.

25 **MR. THOMAS:** I apologize, Your Honor.

1 THE COURT: You'll get your chance. Now, Mr. Long.

2 MR. LONG: Thank you. And so we've got these five
3 witnesses that are going to testify through
4 deposition. Mr. Dunlap's deposition is he put
5 -- we've got -- he probably put 60 or 70
6 percent of his deposition in before for Your
7 Honor to read. All right. The deal on that
8 was that we would do these witnesses through
9 the depositions and then now every time he has
10 a document like this he gives me the little
11 snide threat of, well, now I'm going to call
12 them to trial. Your Honor, we agreed --
13 actually he and I had a conversation about this
14 when we settled the David Dunlap stuff that
15 that was done, they're not coming. And that's
16 very -- so I don't want to have to put up with
17 that anymore. He should not have the right to
18 basically come back to me on these four
19 witnesses and say, well, now I'm calling them.
20 I don't know when he would call them, whatever,
21 they're not even under subpoena. He said all
22 along they were going to testify by deposition.
23 They've already testified. So --

24 THE COURT: Well, you've lost me because when did he
25 say that he was going to --

1 MR. LONG: He just said it a minute ago. He says to
2 me, well, I'm going to call David Dunlap now.
3 I don't know if he's trying to put me on some
4 sort of notice or whatever, but I mean, I just
5 think it's -- we've been going ten days now
6 and, I mean, for your --

7 MR. THOMAS: Your Honor, can I respond?

8 THE COURT: You're going to wait a second.

9 MR. THOMAS: Yes, Your Honor.

10 MR. LONG: And here's the thing, you know, I'm sorry
11 that Mr. Johnson doesn't know anything about
12 the document. That's not my problem. Okay?
13 Now, there are plenty of other witnesses around
14 here and stuff, but I just don't think -- I
15 just would ask that the court deal with this
16 now so that I don't have to be putting up with
17 kind of threats about whether witnesses are
18 going to be called in here after they've
19 already testified for six hours by deposition.

20 THE COURT: Mr. Thomas.

21 MR. THOMAS: First of all, Your Honor, Mr. Long
22 references the tenth day of the trial, and it
23 is. It's scheduled for 15 days. Okay? It's
24 a long case, it's 100,000 pages of documents.
25 And, you know, I think some of the objections,

1 I mean, that are frequent on this side, this is
2 a document that's got financial data in it,
3 that references financial data, it references
4 growth strategies, and I put it up on the
5 screen and I asked him if he knows things about
6 this. And I'm quite frankly shocked that he
7 knows nothing. Just because he didn't prepare
8 it doesn't mean I can't ask him questions about
9 it, you know, the strengths, the weaknesses,
10 and the strategies. He's the CFO of Roper St.
11 Francis Hospital System. He's essentially the
12 number two guy there. And for me to be
13 continually interrupted by Mr. Long's
14 objections based on foundation when it was
15 produced by Roper, it's got Roper's logo on it,
16 it's about the strategy and financial
17 performance of the system and this witness is
18 claiming I've never seen this before. Maybe it
19 hasn't seen it before, but that doesn't mean
20 that he doesn't know about it or that he's not
21 familiar with the strategies in the document.
22 So, you know, what I guess I'm getting a little
23 frustrated with is we're talking about putting
24 something up that these witnesses say maybe
25 they haven't seen the exact -- I mean, we're in

1 2012, it was created 2008. And, yeah, I'm
2 getting frustrated and I am saying things,
3 well, do I have to call your CEO. That's why
4 I did the deposition designations, so I
5 wouldn't have to do these types of things. But
6 you know what, Your Honor, actually I'll ask
7 Mr. Bowling about this. I see his name on
8 there. But what I'm afraid of is I put Mr.
9 Bowling on there and he's going to say I don't
10 know anything about the financial strategy,
11 that's Mr. Johnson's purview.

12 **THE COURT:** Let me settle this. It's my opinion and
13 I so rule that you can ask him questions about
14 it.

15 **MR. THOMAS:** That I can?

16 **THE COURT:** You may ask him questions about it. But
17 if he says he doesn't know, there's nothing you
18 can do about that.

19 **MR. THOMAS:** I understand that, Your Honor.

20 **THE COURT:** All right. Now, what about this thing
21 about calling witnesses whose depositions
22 you've proposed originally to --

23 **MR. THOMAS:** Well, my hope is I don't have to
24 because I did do a lot of deposition
25 designations so we wouldn't have to call

1 several of them.

2 **THE COURT:** That being the case, we will cross that
3 bridge down the road.

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

5 **MR. LONG:** I just for the record, Your Honor, I'm
6 going to strongly object to that. The
7 settlement of the deposition designations,
8 which we came over here on the third day of the
9 trial and we said we resolved the deposition
10 designations for you, that was based on those
11 witnesses not testifying. I withdrew
12 objections and withdrew objections that I had
13 to things that he had in the deposition to
14 avoid having to continue the trial and having
15 them basically double dip on the witnesses. So
16 we would have to revisit all of the deposition
17 designations again if he insists on going
18 forward with calling any of those people.

19 **MR. THOMAS:** Let's hope I don't have to.

20 **Q:** Now, yesterday you recalled testifying that
21 when Roper closed down Roper North or Baker
22 Hospital, which was located in a low income
23 neighborhood, you said that the Roper
24 Northwoods ED was opened to fill the healthcare
25 void for the area that Roper North served; do

1 you recall that testimony?

2 A: Yes. My understanding was there were
3 discussions with the mayor and that's the
4 services and site that was selected.

5 Q: Okay. And you believe that was a good
6 alternative to the Roper North site?

7 A: I don't understand the context of your
8 question.

9 Q: Okay. Well, do you think that was a good
10 alternative, opening up the ED in Northwoods as
11 the -- for closing down the Roper North site?

12 A: Well, the executives at Roper St. Francis
13 working with the mayor's office, I mean that's
14 the conclusion they came to. Are you asking
15 for my opinion?

16 Q: I'm just asking you, yeah, if you thought it
17 was a good alternative?

18 A: It sounds reasonable to me.

19 Q: Okay. And do you know where the Roper Hospital
20 North or Roper North was located, kind of right
21 next to is it Palmetto Behavioral Health, in
22 that general area?

23 A: There was a strip of medical services, like a
24 strip mall, so to speak, of medical services.
25 I don't remember if that service was in that

1 strip mall or not. It wasn't a mall, but --

2 Q: But do you recall whether or not Roper Baker or
3 Roper North was basically in the general
4 vicinity but on the other side of I-26 of the
5 Charleston Naval Complex; does that ring a
6 bell?

7 A: I know that Roper North was off of Cosgrove
8 Avenue in Charleston.

9 Q: Okay.

10 A: I guess it was across from the Naval Complex.

11 Q: Okay. I'm just handing you, and I took the
12 liberty of doing what is a Google search,
13 directions --

14 MS. BIGGERS: Will?

15 MR. THOMAS: Yes, I've got one for you.

16 Q: Now, you testified yesterday that you thought
17 that the Northwoods site for the Roper ED was
18 about four or five miles away from the old
19 Baker Hospital site, correct?

20 A: I do remember testifying to that yesterday.

21 Q: I did the Google search and I'm showing it's
22 closer to ten miles. Does that look about
23 right to you?

24 A: Yes, it does.

25 Q: Okay. I want to talk a little bit about the

1 pro formas in a CON application, if we could.
2 Would you agree with me that if you wanted to,
3 you could have done the pro formas for the
4 Roper St. Francis Berkeley Hospital CON
5 application?

6 A: I could have, yes.

7 Q: And that's something well within your skill
8 set, isn't it?

9 A: Yes.

10 Q: Okay. But Roper St. Francis chose, like
11 Trident did, to use an outside consultant; is
12 that a fair statement?

13 A: Correct.

14 Q: Okay. And who did Roper get to prepare the pro
15 formas?

16 A: Mr. Knapp.

17 Q: Okay. And what's your familiarity with Mr.
18 Knapp's background?

19 A: He's routinely considered an expert in the
20 preparation of pro formas for CONs and I
21 believe he's been engaged by Roper St. Francis
22 on several occasions.

23 Q: Okay. You do realize Mr. Knapp's never been a
24 hospital CFO before, right?

25 A: I'm not that familiar with his background.

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1 Q: Okay. Can you tell me today how he kind of
2 went about developing the pro formas?

3 A: I have spent very limited time with his pro
4 forma, but my understanding it was based on
5 incremental volume. Incremental defined as
6 incremental growth in the market coupled with
7 some modest market share growth.

8 Q: Do you know what payer mix he used?

9 A: I do not. I think he modeled it off of St.
10 Francis Hospital.

11 Q: Okay. Did you look to see if the numbers were
12 accurate?

13 A: I did not audit his work per se.

14 Q: Okay. Do you know if he did a payer mix by
15 non-tertiary utilization by zip code?

16 A: I think he did.

17 Q: You think he did?

18 A: I think. Since that's a non-tertiary facility
19 -- since it's a non-tertiary facility, I think
20 he looked at non-tertiary payer mix. I don't
21 know about zip code.

22 Q: Okay. Now, I think you testified at your
23 deposition that you're aware that DHEC wants to
24 see net income and not EBITDA for the pro
25 formas in the CON application; is that right?

1 A: Yes.

2 Q: Okay. And that's how DHEC judges the financial
3 feasibility of a project, right? They actually
4 look at the net income of the project as per
5 the CON regulations; is that your
6 understanding?

7 A: I'm not that familiar with the regulations. My
8 understanding is there's quite a bit of
9 latitude in how the numbers are presented.

10 Q: Well, you testified in your deposition that
11 DHEC wants to see that the new hospital could
12 be financially viable, a standalone, right?

13 A: Yes.

14 Q: Now, after Mr. Knapp prepared the pro formas in
15 the Roper CON application that are in Joint 2,
16 until just the time before your deposition you
17 actually never spoke to Mr. Knapp about the
18 assumptions that he used in the pro formas; is
19 that a fair statement?

20 A: I think that was my testimony in my deposition,
21 yes.

22 Q: Okay. And I believe you also testified in your
23 deposition that you merely glanced at the pro
24 formas when you received them from Mr. Knapp;
25 is that --

1 A: It was --

2 Q: -- fair?

3 A: It was a brief review.

4 Q: Okay. And you don't have any idea what a
5 standalone pro forma would look like for the
6 Roper St. Francis Berkeley Hospital, do you?

7 A: I have not prepared one.

8 Q: Okay. Has Mr. Knapp ever showed you one?

9 A: No.

10 **MR. THOMAS:** Put up Petitioner's 66 for me, Sara.

11 Q: Okay. Do you recognize this document? I can
12 get a looseleaf for you. Are you familiar with
13 this?

14 A: I am not.

15 Q: Okay. I'll represent to you that they're Mr.
16 Knapp's work papers, underlying work papers
17 that were produced during discovery. And I've
18 just got to ask you did you ever review any of
19 these work papers?

20 A: Not to my recollection.

21 Q: Okay. Do you have any idea why these work
22 papers weren't submitted to DHEC along with the
23 CON application?

24 A: No.

25 Q: Okay. And is it a fair statement that you had

1 no discussions with Mr. Knapp about the pro
2 formas and didn't exchange any emails about the
3 pro formas with Mr. Knapp until just about the
4 time of your deposition; is that fair?

5 A: To my recollection, that's fair.

6 Q: And just to be sure, you never did any kind of
7 an ROI or a return on investment or an internal
8 rate of return or hurdle rate for the project,
9 did you?

10 A: For the Carnes Crossroads project, no.

11 Q: Okay. And you haven't done one since, have
12 you?

13 A: No.

14 Q: Okay. And prior to my deposing you, you had
15 never seen the pro formas in the Trident CON
16 application, had you?

17 A: I don't think so.

18 Q: Okay. And I think you testified that right
19 before your deposition you spent less than an
20 hour reviewing Mr. Knapp's pro forma, right?

21 A: That's sounds right.

22 Q: Maybe you spent ten or 15 minutes on the phone
23 with him --

24 A: Yes.

25 Q: -- discussing it, okay. And is it fair to say

1 you never prepared any financial analysis to
2 see what the financial effect of what one of
3 the proposed hospitals would be on the other,
4 right?

5 A: I did no such calculation.

6 Q: As far as you know, Mr. Knapp didn't do one of
7 those either, did he?

8 A: I'm not aware of it.

9 Q: Now --

10 **THE COURT:** All right, well, now --

11 **MR. THOMAS:** Yes, sir.

12 **THE COURT:** You asked the effect of one hospital on
13 the other. Which hospitals are you talking
14 about?

15 **MR. THOMAS:** Oh, I apologize. I said proposed
16 hospitals, but I should have been more clear
17 for the record. The Carnes Crossroads
18 hospital on the Berkeley Medical Center
19 Hospital.

20 A: I'm not aware of such an analysis, but I'm not
21 sure I would be.

22 **MR. THOMAS:** Okay. Is that clear, Your Honor?

23 **THE COURT:** Yes, sir. Thank you.

24 Q: Now, did you realize that when Mr. Knapp did
25 his pro forma he actually assumed that 50

1 percent of the patients were incremental?

2 A: I know that he was assuming a, I think a 50
3 percent redirection rate, but I'm not -- I'm
4 not too -- like I said, I reviewed his numbers
5 for just a few minutes. I'm not really
6 familiar with the underlying assumptions.

7 Q: Okay. Did you read his deposition in this
8 case?

9 A: I have not read his deposition.

10 Q: Okay. So do you realize that 50 percent of the
11 patients aren't going to be incremental?

12 A: I'm not -- I mean, I'm trying to do the math in
13 my head, but I really need to sit down with
14 those projections if I was going to make a
15 conclusion like that. I'm just simply not
16 familiar with them.

17 Q: Okay. Well, let me ask you this because I know
18 you've done pro formas before and you're
19 familiar with them in effect. But if Mr. Knapp
20 had assumed incorrectly that 50 percent of the
21 patients were incremental, rather than say 46
22 percent, would you agree with me that the net
23 -- that the net revenue from the incremental
24 patients would have to be lower than what's
25 reflected in the financials?

1 A: If you're hypothetically asking me if volume
2 goes down does revenue go down?

3 Q: Yes.

4 A: I would say generally speaking, under that
5 scenario, yes, although there are a lot of
6 other assumptions, like acuity and payer mix
7 and things that affect revenue. So you
8 couldn't -- I mean, it's possible, but you
9 couldn't -- there's lots of assumptions that
10 affect revenue. So just changing one wouldn't
11 -- if one were off, that wouldn't necessarily
12 drive that answer, but it could.

13 Q: Okay. But that's not something that you looked
14 at and you didn't pick up on, did you?

15 A: No, I did not.

16 Q: Okay. Now, I think you testified yesterday
17 that patient redirection takes time to ramp up;
18 do you recall that?

19 A: Yes.

20 Q: Okay. And that's why Roper St. Francis Mount
21 Pleasant had a low ADC for the first year of
22 operations, in your opinion?

23 A: Well, there's a couple of reasons. When you
24 open a new facility, Medicare has six months to
25 accredit that facility and you don't get paid.

1 for governmental payers until you're
 2 accredited. So you're offering free care in
 3 that facility to all governmental payers during
 4 the initial six months. So you would not seek
 5 to redirect significant volume during the first
 6 -- until it was accredited. We were fortunate
 7 enough to be accredited I think within sixty-
 8 some days. But you wouldn't start changing
 9 referral patterns while you were offering free
 10 care to governmental payers. So there's a
 11 period of time beyond the opening date when
 12 that redirection would not rapidly occur. Once
 13 you're accredited, then you, yeah, you want to
 14 see redirection.

15 Q: So you opened -- that facility in Mount
 16 Pleasant opened in 2010 of November, right?

17 A: Yes.

18 Q: Okay. So you were accredited by January 1st,
 19 by your testimony, January 1, 2011?

20 A: It was in, I believe it was in January, yes.

21 Q: That's 60 days, right?

22 A: Yes.

23 Q: Go to Joint 9, 216. I want to show you Joint
 24 9 which is the Roper St. Francis Mount Pleasant
 25 application. Hold on, I think it's Joint 8, I

1 apologize. Almost showed you the wrong thing.
2 See if this is right. And maybe -- yeah, I
3 think you'll be able to read it on the screen
4 here. These are financial assumptions that
5 were made in the Roper St. Francis Mount
6 Pleasant CON. Again, this was something you
7 would have reviewed before it had been
8 submitted to DHEC, correct, the pro formas in
9 the Roper St. Francis Mount Pleasant
10 application?

11 A: Similar to the Carnes Crossroads project, I
12 probably took a brief look at them, yes.

13 Q: Okay. And in terms of, we've got here on the
14 screen 2009, we've got projected days at venue
15 and then cannabilized days and then incremental
16 days, right?

17 A: Yes.

18 Q: Okay. And cannibalized days, that's another
19 way of saying redirected days, isn't it?

20 A: Yes.

21 Q: Okay. So that's -- the expectation was that in
22 2009 there would be 2,924 redirected days and
23 then 7,159 I guess new patients; is that right?

24 A: I'm taking a moment to read --

25 Q: That's fine.

- 1 A: -- the schedule.
- 2 THE COURT: What page is that, Mr. Thomas?
- 3 MR. THOMAS: Yes, sir. It's Joint 8 at page 805.
- 4 THE COURT: Thank you.
- 5 MR. THOMAS: Trident 9127 for the record. If you
6 want me, Judge, to show you the book, that
7 might be better. Sometimes that screen is hard
8 to read. These books are not exactly easy
9 either. There you go.
- 10 A: Can I ask you to repeat your question?
- 11 Q: Yeah. In terms of the cannabilized days or
12 redirected days, I mean the projection was
13 there would be 2,924 redirected days in kind of
14 year one of operations of the facility, right?
15 And 7,159 incremental days or new patients; is
16 that right?
- 17 A: That's what it says, yes.
- 18 Q: Okay. Now, you would agree with me that Roper
19 St. Francis Mount Pleasant in its first year of
20 operations barely eclipsed 3,000 total patient
21 days for year one of operation, right?
- 22 A: That's correct.
- 23 Q: Okay. So your experts were off by about 7,000
24 patient days in year one?
- 25 A: Yes.

1 Q: And who were the people that -- who were the
2 experts that prepared this?

3 A: Richardson Knapp.

4 Q: Okay. Now, just a little bit more about Mount
5 Pleasant. Back in 2005 Roper St. Francis
6 applied to build the 85 bed hospital there,
7 correct?

8 A: Yes.

9 Q: Okay. And you were the CFO at the time?

10 A: I became CFO in March of 2005.

11 Q: Okay. So right about the same time. So a
12 couple months before Roper applied then; is
13 that right?

14 A: Yes.

15 Q: Now, Roper applied after East Cooper Regional
16 Medical Center applied to build the replacement
17 hospital with an additional 40 beds, correct?
18 Is that your recollection?

19 A: I don't really recall the exact timing of those
20 CONS.

21 Q: Okay. But do you recall they were submitted
22 about the same time?

23 A: Yes.

24 Q: And now Mount Pleasant has, what, two hospitals
25 that are seven miles apart from each other; is

1 that a fair statement?

2 A: Yes, that's correct.

3 Q: Okay. And you were here for the testimony of
4 Mr. Baehr who showed that only about 25 percent
5 of those beds over there in Mount Pleasant, if
6 you aggregate them all, those 225 beds, only 25
7 percent are full, right?

8 A: Yes, and I also heard that it was too early to
9 make any conclusions.

10 Q: Well, but there -- it says 225 beds. About,
11 what, 52 are full?

12 A: Well, that's a 13,000 discharge market. It can
13 support 225 beds in, my opinion. Medical
14 University has a very -- I don't think you can
15 look at just the impact of Roper St. Francis.
16 Medical University has a huge presence in that
17 market and sends a lot of discharges back
18 across the bridge --

19 Q: I agree with you.

20 A: -- downtown, so.

21 Q: Okay. And you don't think that's going to stop
22 anytime soon, do you?

23 A: Well, I do think Roper St. Francis is working
24 hard on the redirection issue.

25 Q: But for its own patients, right, because that's

1 what it said in the CON, not MUSC's patients?

2 A: Right, for our own patients we are working hard
3 to correct the redirection issue.

4 Q: But so far it's been a struggle, correct?

5 A: Yes. Yeah, with any new facility, that's going
6 to be the last volume that redirects.

7 Q: And you would agree with me that Mount Pleasant
8 at the time was an area of explosive growth; is
9 that a fair statement?

10 A: It still is. I mean, there are 8,700 I believe
11 permitted houses, apartments and condos in the
12 immediate area of that hospital, within just a
13 few miles of that hospital, so.

14 Q: Right. And you would agree with me that when
15 Roper St. Francis made a decision to place that
16 hospital there, Mount Pleasant had a household
17 income of north of \$100,000 a year, right?

18 A: I think so, correct.

19 Q: And are you aware that the average household
20 income for the state of South Carolina is
21 somewhere around \$42,000 a year?

22 A: Sounds about right.

23 Q: And I think you testified yesterday or at least
24 at your deposition, I don't want to recall from
25 yesterday, but that you expected the facility

1 to earn about \$11 million in operating cash
2 flow in the first year; do you recall that
3 testimony?

4 A: Yes.

5 Q: But it actually lost about two million dollars
6 in operating cash flow.

7 A: 2.4 million, correct.

8 Q: And you thought, I think you testified at your
9 deposition, that your expectation for Roper St.
10 Francis Mount Pleasant was that it was going to
11 break even in year one on a net income basis;
12 is that right?

13 A: I'm sorry, that was -- can you repeat the
14 question?

15 Q: Yeah. I think you testified at your deposition
16 that you thought that from I guess it was --
17 that the facility would break even in year one
18 from a net income basis; is that right?

19 A: You're asking if that was what I budgeted, or
20 what was budgeted?

21 Q: Yes, what you budgeted.

22 A: That would be pretty close, yes.

23 Q: Okay. But it lost \$11 million, right?

24 A: With depreciation expense, yes.

25 Q: Okay. And with interest expense I think we

1 established yesterday it would be about 16
2 million?

3 A: Yeah, 15. Fifteen probably.

4 Q: Fair enough. Would you go to 217 in this
5 document, in Joint 8. And this is the venue
6 pro forma for Mount Pleasant, correct?

7 A: I'm not familiar with the concept of venue.

8 Q: Standalone.

9 A: Okay.

10 Q: As opposed to incremental.

11 A: Okay.

12 Q: Okay. And do you recall you would have glanced
13 at this as well that Mr. Knapp prepared?

14 A: This would be have been six or seven years ago
15 and I could have.

16 Q: Okay. Well, let me ask you a couple questions
17 here. In the fifth year of operations, this
18 standalone facility with I guess Mr. Knapp
19 projected adjusted, or I don't know if Knapp
20 projected it, but Mr. Richardson projected
21 justification days of 46,000 and actual patient
22 days of 23,269; do you see that?

23 A: In year 2013?

24 Q: Yes, 2013.

25 A: Yes, I see that.

1 Q: Okay. And what's the revenue over expenses on
2 those number of patient days that we just
3 discussed?

4 A: Well, the revenue over expenses projected for
5 2013 is 14,393,461.

6 Q: Do you think that's realistic?

7 A: Well, I'll note that this pro forma appears to
8 have a full year of operations beginning in
9 2009 and the facility opened almost two years
10 later than that. So you've got a -- by the --
11 you've got a 2013 projection here that assumes
12 five years of operations.

13 Q: Right.

14 A: And we will have had, by the end of 2013,
15 really three years of operation, so no, I don't
16 think that is accurate.

17 Q: Well, I guess let me rephrase it then. So do
18 you think that after five years of operations
19 that the revenue over expenses of about \$14
20 million, that that would be a -- would that be
21 a reasonable and achievable goal?

22 A: At that facility?

23 Q: Yeah.

24 A: Yeah, that would be reasonable.

25 Q: What are the -- I think the incremental

1 adjusted patient days there in 2013, it's
2 33,109, right? Does that look right?

3 A: I'm sorry. Can you repeat the question?

4 Q: I'm sorry. Am I on the venue?

5 A: This is the venue.

6 Q: Go back to 254, there we go. What are the
7 adjusted patient days incremental there, Mr.
8 Johnson?

9 A: In which year?

10 Q: Let's go with 2013.

11 A: Total revenue on this schedule for 2013 is
12 57,698,131.

13 Q: What are the adjusted patient days incremental?

14 A: 33,109.

15 Q: Okay. If I wanted to do a net revenue per
16 adjusted patient day, how would I do that?
17 Could you do that calculation for us?

18 A: You would take your net patient service revenue
19 of 57,326,241 divided into the adjusted patient
20 day number of 33,109.

21 Q: What does that give you?

22 A: \$1,731 per day.

23 Q: Seventeen thirty-one per day. Go to Roper St.
24 Francis DHEC record page 461, if you would.
25 Mr. Knapp signed off on the pro formas in Joint

- 1 Exhibit 2, which is the Roper St. Francis DHEC
2 record, correct?
- 3 A: That appears to be correct.
- 4 Q: He said he's an accountant and he's responsible
5 for the financial portion, right?
- 6 A: Yes.
- 7 Q: But you glanced at these. Go to the next page.
8 You glanced at the pro formas, and this is the
9 actual pro formas for the Roper St. Francis
10 Hospital Berkeley on page 462, and you thought
11 they were reasonable. That was your testimony,
12 right?
- 13 A: Yes.
- 14 Q: Now, how many incremental patient days did Mr.
15 Knapp project in 2015?
- 16 A: 12,509.
- 17 Q: Patient days, not the adjusted patient days.
18 Could you do patient days for me?
- 19 A: 6,388.
- 20 Q: Okay. And if I wanted to do an adjusted
21 patient day -- let's do this, actually. Let's
22 go back to 2013. How many adjusted patient
23 days incremental are there?
- 24 A: 6,254.
- 25 Q: Okay. And what's the net revenue in 2013?

1 A: Net patient revenue is \$15,357,747.

2 Q: Okay. And could you give me a net revenue per
3 adjusted patient days like you did for the
4 Roper St. Francis Mount Pleasant for 2013?

5 A: 2,455. And if you round up, it's 2,456.

6 Q: So that's about 41 percent higher than the
7 Roper St. Francis Mount Pleasant pro forma for
8 the same year, right?

9 A: Possibly. I did not check the previous
10 calculation to make sure bad debts and charity
11 care were both subtracted from net revenue.

12 Q: Let's go back then to Joint 8, page 215, so --
13 I'd like to get that straight for the record,
14 and we're doing an apples to apples. Are those
15 assumptions that you just mentioned to me, the
16 bad debts, they're all kind of above the line,
17 aren't they?

18 A: Yes.

19 Q: Okay. Did you ever make that comparison in
20 terms of what the net revenue per patient day
21 said for 2013 in Mount Pleasant as opposed to
22 what the net revenue per patient day would be
23 in 2013 for Roper St. Francis Berkeley?

24 A: I did not.

25 MR. THOMAS: Okay. Go to Joint 2, page 262, for me,

1 Sara.

2 Q: In the year 2015 I'd like you to look at the
3 incremental patient days. Just the patient
4 days. And that's 6,388, right? Is that
5 correct?

6 A: Yes.

7 Q: All right. And that's about 17 patients per
8 day incremental every day in the hospital,
9 something called the average daily census; is
10 that correct?

11 A: Yes.

12 Q: Okay. And according to this pro forma, the
13 incremental pro forma, this hospital with 17
14 patients, incremental patients, were going to
15 make about \$285,160, right?

16 A: That's what the pro forma says.

17 Q: Okay. And that looked reasonable to you at the
18 time you glanced at it, right?

19 A: Yes.

20 Q: Okay. And in this year here, 2015 --

21 A: And I will say that you're calling this an
22 incremental pro forma, but it does have 100
23 percent of depreciation and interest in it is
24 my understanding as well. So it's a full load,
25 so to speak, of depreciation and interest, but.

1 Q: Those are fixed expenses, right?

2 A: Yes.

3 Q: Not variable?

4 A: Well, you can have debt with variable interest
5 rates.

6 Q: I understand.

7 A: But for purposes of this analysis, we'll call
8 it fixed.

9 Q: But in terms of this pro forma, depreciation
10 and interest, those are fixed expenses, they're
11 going with the hospital as part of the
12 hospital, correct?

13 A: Yes.

14 Q: They're not going to vary with the number of
15 patients --

16 A: No.

17 Q: -- that come into the hospital?

18 A: No.

19 Q: Okay. And just for the record, for the court's
20 edification, the inpatient revenue and the
21 outpatient revenue is pretty closely aligned,
22 correct? It's not quite one to one, but pretty
23 close?

24 A: And that's common, yes.

25 Q: Okay. And you may know this off the top of

1 your head, we can go back and actually look at
2 it, but the experience of Roper St. Francis
3 Mount Pleasant has been that the outpatient to
4 inpatient is about three to one, right, in
5 terms of revenue?

6 A: Well --

7 Q: For the last year?

8 A: Yeah. Because outpatient has redirected much
9 faster than inpatient yes.

10 MR. THOMAS: Go back to Joint 8, page 215.

11 Q: Okay. Well, at least in the first year of
12 operations Mr. Knapp assumed that inpatient
13 revenue and outpatient revenue would be about
14 the same, right; what he assumed in that pro
15 forma, didn't he?

16 A: Yes.

17 Q: Okay. But that didn't happen, did it?

18 A: No.

19 Q: Okay. Now, yesterday you testified on direct
20 that you thought Mr. Baehr's analysis, when he
21 was on the stand, when he concluded that Roper
22 St. Francis Mount Pleasant Hospital would make
23 over \$20 million a year, was not reasonable,
24 correct? You said that conclusion was simply
25 not reasonable.

1 A: I'm sorry, the Carnes Crossroads?

2 Q: Yes.

3 A: By year three I don't think that's reasonable.

4 Q: Okay. And by year three you know that --

5 **MR. THOMAS:** Go back to Roper St. Francis 462, Joint
6 2.

7 Q: Your understanding though is that in year three
8 of operations the hospital is projected to be
9 I guess at about 35 patients in it on an
10 average daily census?

11 A: We're looking at incremental.

12 Q: Right.

13 A: So year three incremental, 17.

14 **MR. THOMAS:** Go to the next page for me.

15 Q: Okay. Here we go. How about venue days,
16 12,775. What would that be, Mr. Johnson?

17 A: Thirty-five.

18 Q: Okay. So your testimony is that it would be
19 unreasonable to assume that the hospital, 35
20 patients a day, 50 bed hospital, would make \$22
21 million a year would be unreasonable, right?

22 A: Well, there's a lot that would play into that.
23 I mean, that number sounds very high to me, but
24 there's a lot that would play into that number.

25 Q: Okay.

1 A: Payer mix, the acuity of the services you
2 offer.

3 Q: Let's talk about payer mix. The payer mix is
4 going to be about the same as Bon Secours St.
5 Francis, right? That's what Mr. Knapp assumed,
6 correct?

7 A: That sounds reasonable.

8 Q: Okay. And the acuity here is going to be low
9 because it's a non-tertiary, non-specialty
10 hospital, right?

11 A: Presumably.

12 Q: Well, do you know of any tertiary --

13 A: Well, St. Francis has a very large spine
14 program. You know, St. Francis is a smaller
15 hospital with a very large spine program, so
16 that drives acuity.

17 Q: Okay. Well, do you expect there to be a large
18 spine program at Roper St. Francis Berkeley?

19 A: Well, most -- a lot of hospitals have centers
20 of excellence. I don't know what ultimately
21 would be there. But in the early years it
22 would probably be more of a general acute care
23 hospital.

24 Q: Okay. You read the application, there's no
25 mention of a center of excellence or a spine

1 center at Carnes Crossroads, is there?

2 A: No. If we're talking the first three years,
3 general acute care hospital would be
4 reasonable.

5 MR. THOMAS: Okay. Go to Joint Exhibit 8, pop back
6 to this one real quickly, and go to page 217
7 for me.

8 Q: Corporate admin expense here, now this is the
9 venue or the standalone pro forma for the
10 record in Joint 8, page, it looks like 806.
11 Corporate admin expenses here are about six,
12 seven hundred thousand dollars over that five
13 year period; does that -- does that look right
14 to you?

15 A: Yes.

16 Q: And again, what's corporate administration,
17 just for the record?

18 A: We have a number of back office functions that
19 serve the entire system -- accounting, legal,
20 HR, materials management -- and so we allocate
21 those costs to the divisions.

22 Q: Okay. Like Trident does with its management,
23 right?

24 A: I don't know. We take a dollar for dollar cost
25 and push that actual cost that we write checks

1 for out to the divisions. I don't know if
2 that's how Trident does it or not.

3 Q: Thank you, sir. Fair enough.

4 MR. THOMAS: Petitioner's 167, Sara.

5 Q: Okay. This is the Roper St. Francis financial
6 highlights for the first six months in 2011,
7 right?

8 A: Yes.

9 Q: Okay. And you've seen this before, right?

10 A: Yes.

11 Q: Okay. This might be easier just for you to
12 look at that. Petitioner's 167. If you turn
13 to the fifth page for me --

14 A: Okay.

15 Q: -- in this document. I think it's Roper
16 Berkeley 4368. I'm sorry, it's the sixth page,
17 4639. I apologize for that.

18 A: Okay.

19 Q: Okay. In terms of the corporate administration
20 expenses that were assigned to Roper St.
21 Francis Mount Pleasant, would you tell the
22 court what they were for the first six months
23 of 2011?

24 A: \$36,207,000.

25 Q: I'm sorry. How about for Roper St. Francis

1 Mount Pleasant Hospital?

2 A: Oh, I'm sorry, 2,474,000.

3 Q: Okay. And do you think that would have about
4 doubled for the second six months of 2011?

5 A: Yes.

6 Q: So about five or 4.9 million dollars or so?

7 A: Yes.

8 Q: Okay. Now, Mr. Knapp only allocated \$628,000
9 in the Roper St. Francis Mount Pleasant CON for
10 that, correct?

11 A: Yes.

12 Q: Okay.

13 MR. THOMAS: Would you go to Roper St. Francis DHEC
14 record, Joint 2, page 462 for me?

15 Q: Going back to Joint 2 here. Sorry I'm having
16 to flip back and forth. What's the corporate
17 administration expense for the Roper St.
18 Francis Berkeley CON application for those
19 three years, 2013 through 2015?

20 A: For 2013, \$403,432. For 2014, \$415,535. And
21 for 2015, \$428,001.

22 Q: Do those look a little bit low to you?

23 A: Well, this is an incremental pro forma, so I
24 don't know how these numbers were looked at by
25 Mr. Knapp to come up with these projections.

1 Q: You don't know because you never asked him,
2 right?

3 A: That's correct.

4 Q: Okay. Go to Petitioner's 95, if we could. Let
5 me show you the June 2007 presentation of
6 rating agencies and bond insurers. Go to the
7 next page for me, if you would. That's your
8 name right there, right, Bret Johnson? We know
9 you had something to do with this document,
10 correct?

11 A: Yes.

12 Q: Okay. And this is -- a large part of this
13 presentation was focused on the Mount Pleasant
14 Hospital, wasn't it? Do you recall?

15 A: That's been a part of all of our rating agency
16 presentations the last several years, yes.

17 Q: All right. And you made some financial
18 projections for the rating agencies, correct?
19 Go to page 35. You may have done a pro forma,
20 right? Do you recall this?

21 A: Yes.

22 Q: Okay. What are the corporate administration
23 costs you've got there in that pro forma, Mr.
24 Johnson?

25 A: Which year?

1 Q: How about the third year of operation?

2 A: \$4,939,874.

3 Q: Okay. And that's for an 85 bed hospital?

4 A: Yes.

5 Q: Okay. What do you think, estimating for us
6 today, it would be for a 50 bed hospital?

7 A: Well, this is a venue presentation instead of
8 an incremental presentation. This has
9 approximately 70 million of net revenue.

10 Q: Sure.

11 A: You know, a reasonable test would be to take
12 the 4.9 million corporate admin fee, divide it
13 by 70 million times, and that would be a very
14 general number, times the Berkeley expected
15 revenue.

16 Q: Okay. Can I ask you a quick question, just for
17 my edification as well as the court? Do you
18 look at corporate administration as a variable
19 expense or a fixed expense?

20 A: I don't think it falls under either category.
21 It's a book allocation that we make to take the
22 services that we have in the back office and
23 allocate them to the divisions. It can be --
24 I don't know how you characterize it as fixed
25 versus variable. As the health system grows,

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1 we add costs to those areas.

2 Q: Okay. But the fact of the matter is that you
3 included a corporate administration fee for the
4 rating agencies, correct, if you want to give
5 them an accurate picture of what this
6 hospital's going to look like financially,
7 right?

8 A: When we do projects we, our model does allocate
9 corporate admin.

10 Q: Okay. And that's important to do, right? I
11 mean, you include it on the pro forma, correct?

12 A: Yes, it's included on the pro forma.

13 Q: Okay. And your pro forma that you did projects
14 revenue over expenses of five point -- well,
15 almost six million dollars in your three years
16 of operations, correct, for the Mount Pleasant
17 Hospital?

18 A: Yes.

19 Q: Okay. And this pro forma was done back in
20 2007, right?

21 A: I'm not sure when the actual pro forma was
22 prepared. I mean, this appears to be a 2007
23 document. I don't know what iteration of our
24 projection model this one would have been
25 prepared in.

- 1 Q: You would agree with me you didn't use Rick
2 Knapp's pro forma, did you?
- 3 A: Not for this page, no.
- 4 Q: Okay. Rick Knapp's pro forma showed in year
5 three of operations that it was going to be \$11
6 million revenue over expenses, didn't it? And
7 we can go back to it if you want.
- 8 A: I remember that.
- 9 Q: Okay. So yours and Mr. Knapp's differ by five
10 million dollars?
- 11 A: It would appear, yes.
- 12 Q: Okay. And you don't know why you didn't use
13 Mr. Knapp's pro formas for the rating agency
14 presentation, do you?
- 15 A: No.
- 16 Q: But in any event you decided to use them for
17 the Roper St. Francis Berkeley project,
18 correct? The decision was made to do that,
19 wasn't it?
- 20 A: Well, we used Mr. Knapp's in the CON. We have
21 not shared with the rating agencies any pro
22 formas for Berkeley in a rating agency
23 presentation that I'm aware of.
- 24 Q: Well, I understand that. I was just talking
25 about after -- you decided not to use Mr.

1 Knapp's pro forma for the rating agencies. But
2 even so, you still decided to use them for the
3 Roper St. Francis Berkeley project, right?

4 A: We used Mr. Knapp's projections for the
5 Berkeley project, yes --

6 Q: Okay.

7 A: -- in the CON.

8 MR. THOMAS: Petitioner's 220 for me, Sara. Go to
9 page Baehr 1851, if you would.

10 Q: Mr. Johnson, were you in the courtroom on the
11 day Mr. Knapp presented -- strike that, I'm
12 sorry, Mr. Baehr. I was thinking Mr. Knapp.
13 The analysis where he showed what the actual
14 Roper system actual and projected net patient
15 --

16 A: I was here. I was in the back row and I didn't
17 get the benefit of much of that discussion.
18 The numbers were very small on the screen.

19 Q: Okay. Would it concern you if in 2016 Roper
20 St. Francis Berkeley's net revenue per adjusted
21 admission -- adjusted patient day was \$750
22 higher than the Roper system -- or excuse me,
23 the Bon Secours St. Francis and Roper
24 Hospital's net revenue per patient day -- per
25 adjusted admission? Excuse me.

- 1 A: I would have to understand the assumptions Mr.
2 Knapp used and, I mean, it's hard to conclude
3 on a blanket statement like that. I don't know
4 what he based those numbers off of. This was
5 -- I'm sure he's projecting this facility to
6 open down the road so there would have been an
7 escalator. So I would need to spend more time
8 with his projections to comment accurately.
- 9 Q: Okay. Well, do you understand that the net
10 revenue per adjusted patient day in 2016 for
11 the Roper St. Francis Berkeley as projected by
12 Mr. Knapp is \$2,720?
- 13 A: That's what it says on this sheet, yes.
- 14 Q: Okay. Did you ever go back to confirm that?
- 15 A: Is that adjusted patient day or patient day?
- 16 Q: Adjusted.
- 17 A: Adjusted patient day. I don't know if that
18 causes me concern or not. I could recompute
19 Mount Pleasant here. It might -- Mount
20 Pleasant for 2011 could be more than that
21 number. I don't know.
- 22 Q: You think it could be more than that number?
- 23 A: It's possible.
- 24 Q: You think you could do that right now?
- 25 A: Sure.

1 Q: I'll tell you what, Mr. Johnson, we can move on
2 from there.

3 A: Let me finish this.

4 Q: Okay.

5 A: Mount Pleasant net revenue per adjusted patient
6 day is almost \$2,800.

7 Q: Okay. And that's because it's got three times
8 as much outpatient revenue as inpatient,
9 correct?

10 A: I don't think that -- no, I think it's due to
11 low length of stay within that facility.

12 Q: You don't think it has anything to do with the
13 outpatient?

14 A: Mathematically?

15 Q: Yeah.

16 A: No.

17 Q: How did you do the calculation?

18 A: I took from page number Roper Berkeley 004639,
19 I took gross patient revenue of Mount Pleasant
20 Hospital at 47,766,000 --

21 Q: Right.

22 A: -- divided by Mount Pleasant Hospital inpatient
23 gross revenue of 13,018,000, that gets you a
24 conversion factor.

25 Q: Right.

1 A: I times that by patient days of, and this is on
2 004640, 1,570. And that gave me adjusted
3 patient days. And I divided that into net
4 patient revenue for Mount Pleasant of
5 16,069,000 and that gave me almost \$2,800 per
6 patient day.

7 Q: And you said that the average length of stay,
8 that one of the reasons for that higher figure
9 was that at Mount Pleasant it's about 2.7,
10 right?

11 A: I remember 2.8, but I'll --

12 Q: Fair enough. We'll go with that. But Roper
13 St. Francis Berkeley is projected to be at 4.25
14 average length of stay, right?

15 A: Yes.

16 Q: Okay. But it's much higher than what's at
17 Mount Pleasant?

18 A: But you asked me if this concerned me and I,
19 you know, if Mount Pleasant's running 2,800, I
20 don't know that I would be too concerned about
21 2,000 at Roper Berkeley. I would have to get
22 into the numbers.

23 Q: Okay. That's fine. Thank you. We'll let Mr.
24 Knapp do that. I want to talk a little bit
25 about the Carnes Crossroads purchase. And I

1 think you touched on this a little bit in your
2 testimony yesterday. You helped negotiate the
3 language on the timing of that purchase, right?

4 A: What I negotiated with Mr. Jordan was the use
5 of their balance sheet to warehouse it. The
6 timing of the -- the timing clauses relative to
7 the Carnes Crossroads development was something
8 Mr. Bowling I think worked with Mr. Sloan on.

9 Q: Okay. Well, when I deposed you I asked you if
10 the contract, did you help negotiate the
11 language with regard to the timing of the
12 contract and you said yes. So is it your
13 testimony today that you didn't?

14 A: Well, I don't want to --

15 Q: And that's fine --

16 A: I don't want to contradict it. I'm further
17 clarifying that in the discussion with Mr.
18 Sloan on the timing of the hospital, that was
19 predominantly Mr. Bowling. I may have
20 participated in some of that, but I was working
21 more on the contribution agreement, which was
22 another agreement associated with that land
23 with Mr. Jordan.

24 Q: Okay. Let's talk a little bit about the
25 contribution agreement. Roper St. Francis

1 Hospital CareAlliance does not own that piece
2 of property today, do they?

3 A: We do not.

4 Q: Okay. And that's because the Medical Society
5 does, correct?

6 A: That's correct.

7 Q: And essentially Roper St. Francis has an option
8 to purchase the property back from the Medical
9 Society, doesn't it?

10 A: That's correct.

11 Q: And Roper St. Francis pays the Medical Society
12 is it five percent a year; isn't that what we
13 discussed?

14 A: It's five or six. It might be six.

15 Q: And if you don't know, you don't know, but
16 Roper is not required to ever apply for a CON
17 to build a hospital on the Carnes Crossroads
18 project if it didn't want to, correct?

19 A: My recollection is if we didn't by a certain
20 date, then there were certain exclusive
21 protections that went away, so I think you're
22 correct.

23 Q: Okay. And what is your understanding, if you
24 have one, of what kind of a last day is for
25 those exclusives to go away?

1 A: For the hospital it might be 2015.

2 Q: Is it December 31, 2015?

3 A: That sounds reasonable.

4 Q: Go to Respondent 29 for me. I think you talked
5 a little bit yesterday about the plan for
6 balance sheet recovery; do you recall that?

7 A: Yes.

8 Q: I'm going to try to do this on the screen if we
9 could. If you'd go to page four of the actual
10 document. It's Roper Berkeley 4619. Let me
11 know if you're there.

12 A: I'm there.

13 Q: Okay. Now, on the first paragraph there it
14 mentions that given that Roper St. Francis
15 Hospital's projecting to generate approximately
16 \$569 million in EBITDA during fiscal years 2009
17 through 2013, the System must retain
18 approximately 30 percent of its EBITDA in order
19 to achieve a target liquidity by the end of
20 2013, correct?

21 A: Yes.

22 Q: Okay. And the idea was if you had that target
23 liquidity, then you could use those funds to
24 build the Roper St. Francis Berkeley project;
25 is that right?

1 A: No, I wouldn't characterize it that way. I
2 would say that hitting the balance sheet
3 metrics called for in the balance sheet
4 recovery plan would allow us to maintain our A
5 minus rating, or our current ratings level, and
6 maintain the balance sheet capacity to fund the
7 project.

8 Q: Okay. And the project would be funded, it says
9 right there, in about the years 2015, 2016, if
10 you look at the last bullet point.

11 A: Well, that's the component that our founding
12 members would fund and they would, yeah, fund
13 half in each of 2015 and 2016.

14 Q: Okay. During the construction of the project?

15 A: That's what was contemplated there, yes.

16 Q: Okay. And wasn't the plan, I mean, based on --
17 what's the date of this document, it's February
18 2010?

19 A: That's when it received board and founding
20 member approval, yes.

21 Q: Okay. And that's not inconsistent, these dates
22 of funding the hospital in 2015 and 2016, it's
23 not inconsistent with the schedule set out in
24 the Carnes Crossroads purchase agreement, is
25 it?

1 A: It doesn't sound like it, no.

2 Q: Okay. If you'd go to page eight for me. And
3 at the top you'll see Roper has experienced
4 significant growth and/or is projecting future
5 growth as a result of the following. What's
6 the first bullet? If you'd read that into the
7 record for me.

8 A: "Increase in the number of employed physicians
9 from three in 2007 to over 200 by the end of
10 2010."

11 Q: Okay. And what does the second bullet say?

12 A: "Referrals from newly employed physicians along
13 with other growth initiatives have increased
14 adjusted discharges within Roper Hospital and
15 Bon Secours St. Francis Hospital by over seven
16 percent in each of the past two years.
17 Significant volume growth is also projected for
18 both hospitals in 2010."

19 Q: Okay. And the last bullets says, "Opening of
20 the new Mount Pleasant Hospital in the year
21 2010," right?

22 A: Yes.

23 Q: Okay. And that has a little bit to do with
24 that aggressive growth strategy we were talking
25 about earlier, right?

1 A: I think going from three to 200 physicians is
2 a lot of growth, yes.

3 Q: Okay. I think you mentioned, I don't know if
4 you used the word or Mr. Long used the word,
5 but there's the idea of warehousing this
6 property on the balance sheet of the Medical
7 Society, the Carnes Crossroads property?

8 A: Yes.

9 Q: Okay. And that gave you a little bit more days
10 cash on hand, correct?

11 A: Yes. Or debt capacity, depending on how we
12 would have purchased the land.

13 Q: And that allows you to get a better credit
14 rating from the rating agencies?

15 A: I mean, if you isolate that transaction, I
16 mean, that -- you know, purchasing that land
17 would not have led to a downgrade of Roper St.
18 Francis Healthcare, but by the Medical Society
19 maintaining that piece of property on their
20 balance sheet, it did allow Roper St. Francis
21 to either maintain cash or debt capacity on its
22 balance sheet.

23 Q: Right. But it was important enough that you
24 did it, right?

25 A: Yeah. Yeah.

1 Q: Okay. And then on page ten of the document, if
2 you would turn to that for me. Right here at
3 the bottom, again, it says, "What is the
4 required level of growth in cash and
5 investments?" So Roper St. Francis -- it
6 states Roper St. Francis will need to increase
7 unrestricted cash investments by 169.8 million
8 by the end of 2013 in order to reach the target
9 level of days cash on hand of 150, right?

10 A: Yes.

11 Q: Okay. And Roper St. Francis has certain
12 obligations to its owners, correct; the Medical
13 Society of South Carolina, the Charlotte
14 Mecklenberg Hospital Authority, and Bon Secours
15 St. Francis?

16 A: Well, we pay an annual distribution to those
17 parties. I mean, obligations would indicate
18 debt. You might mean debt.

19 Q: I apologize. The profits.

20 A: We make an annual distribution to those
21 founding members, yes.

22 Q: And so I believe yesterday you said is it 63
23 percent remains in the state of South Carolina?

24 A: Yes.

25 Q: And the other 37 percent goes outside of South

1 Carolina?

2 A: Yes.

3 MR. THOMAS: Okay. Go to Petitioner's 144 for me.

4 There we go. That's better.

5 Q: This is an email from you to Greg Gombar?

6 A: Yes.

7 Q: Dated 10/24/2007. Now, that was -- that was
8 after the Carnes Crossroad property was
9 actually purchased, correct?

10 A: Yes.

11 Q: Okay. And what do you say here? You tell
12 Greg, "The earliest we plan to submit a CON for
13 a new hospital would be 2012." And then you
14 say, "I have no doubt it will be hotly
15 contested which will back up the approval
16 process a couple of years. If approvals are
17 ultimately obtained, we would issue debt in the
18 2014 to 2015 time frame." Correct?

19 A: Yes.

20 Q: That's pretty much consistent with the other
21 documents we've looked at, correct?

22 A: Yes.

23 Q: Why did you know it would be hotly contested?

24 A: Well, I didn't know that. That was certainly
25 my opinion.

1 Q: Okay. And you were right, correct?

2 A: Yes, sir.

3 MR. THOMAS: Go to Petitioner's 146 for me, if you
4 would. Again, if we can -- yeah, this is fine.

5 Q: And this is another email from you to, what's
6 it, Jim Andrews?

7 A: Yes.

8 Q: Is that Financial Services, FSA? What is that?

9 A: FSA is Financial, well, I can't remember the
10 acronym here, but --

11 Q: Is it Financial Security Assurance, there at
12 the bottom?

13 A: That's it. And they're our bond insurer.

14 Q: Okay. And so what you tell your bond insurer
15 back in April of '08, and this is before you
16 knew Trident was going to apply, correct, for
17 a hospital?

18 A: I would assume so.

19 Q: Okay. That our current long-term financial
20 projections contemplate having our balance
21 sheet ready for a fourth hospital in 2014; is
22 that right?

23 A: Yes.

24 Q: Okay. It wasn't going to be ready in 2008,
25 right, but 2014?

- 1 A: Well, that -- issued that in 2012. I mean,
2 that was feasible. I mean, we could have
3 funded this project from the day we bought the
4 land forward we could have funded this
5 hospital. That's never been a question. Could
6 we have done it at the A minus ratings level,
7 maybe, maybe not. That would have been up to
8 the rating agencies. But the ability to fund
9 this was never a question.
- 10 Q: I'm not asking that. You know you could fund
11 it. The total on the balance sheet would be
12 ready in 2014, correct?
- 13 A: Yeah. I'm implying there at our current
14 ratings level.
- 15 Q: In the email we just looked at, you stated that
16 the earliest plans to submit a CON for a new
17 hospital would be 2012 and that was in the
18 email, correct?
- 19 A: That's correct.
- 20 Q: Okay. Would you go to Petitioner's 148 for me?
21 This is an email from you to Mr. Cassells. Who
22 is Mr. Cassells?
- 23 A: He was our director of decision support for
24 about ten years. He left Roper St. Francis I
25 believe in 2010.

1 Q: Okay. Go to the next page for me. This says
2 Roper St. Francis Healthcare revision of long-
3 term projections 2008. Do you remember we
4 talked about this in your deposition?

5 A: Yes.

6 Q: Okay. Is this a document, your revision of
7 long-term projections, that you would have
8 presented to someone?

9 A: I am familiar with this document. I prepared
10 it along with Mr. Cassells. This would have
11 been something I believe I shared with the
12 board one time. As I mentioned during my
13 deposition, this had an extremely short shelf
14 life because this immediately preceded the
15 mortgage meltdown that occurred later in 2008
16 and this document probably had a three month
17 shelf life at which point it was superceded by
18 the balance sheet recovery plan which you
19 showed earlier today.

20 Q: Okay. So it's before the mortgage meltdown
21 when things were a rosier picture, right?

22 A: Yes.

23 Q: Okay. Go to page four for me, Roper Berkeley
24 3846, it would be the fourth page of the
25 document. So before the economy went south,

1 the idea for the time line on the original
2 initiatives was that Mount Pleasant was going
3 -- well, first of all, in 2006 to 2008 you have
4 a 63 bed Bon Secours St. Francis expansion,
5 right?

6 A: Yes.

7 Q: And did that occur?

8 A: Yes.

9 Q: Okay. And then in 2008 to 2010, that's about
10 the time when the Mount Pleasant Hospital was
11 built, right?

12 A: Yes.

13 Q: Because it was opened in November of 2010,
14 right?

15 A: Correct.

16 Q: And so 2014 to 2016, that's when Carnes
17 Crossroads hospital was going to be built,
18 right?

19 A: Correct.

20 Q: If you go to the fifth page in this document
21 for me, so turn the page, there's some
22 assumptions that you made at the time, right?

23 A: Yes.

24 Q: Okay. So in addition to the original
25 initiatives, you added the following

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1 initiatives, and this is back in '08. Assume
2 employment of 200 physicians with average
3 subsidy of \$75,000, right?

4 A: Yes.

5 Q: Okay. And assume practice acquisition costs of
6 eight million dollars in late 2008. But the
7 average subsidy, I think you testified
8 yesterday, if you include the physicians and
9 the extenders, is about \$150,000 per; is that
10 right?

11 A: Yes.

12 Q: Okay. So off a little bit here, right?

13 A: Well, the estimate was certainly light. I
14 mean, there are some things driving that
15 difference, but this estimate was light. Yes.

16 Q: Okay. If you go to the ninth page for me of
17 this document, that would be Roper Berkeley
18 3851. Let me know when you get there. The
19 second bullet there you said need to determine
20 if the timing of Carnes Crossroads project is
21 impacted by the additional initiatives,
22 correct?

23 A: That's what it says.

24 Q: Let me ask you this. At the time, I know we've
25 seen the 2010 balance sheet recovery plan, was

1 there an earlier balance sheet recovery plan?

2 A: No. No, we operated under -- we had spending
3 disciplines in place that had been in place for
4 ten years and had served us well. There was no
5 -- those spending disciplines had allowed the
6 balance sheet to stay strong up until the
7 meltdown of 2008.

8 Q: Okay. Fair enough. And the last bullet here,
9 "What opportunities for margin improvement
10 result through leverage created by vertical
11 integration?"

12 A: Uh-huh.

13 Q: And that is a part the physician practice
14 acquisition and employment, correct?

15 A: Yes.

16 Q: And we saw that there were some margin
17 improvements, at least in terms of the ability
18 to leverage reimbursement in terms from the
19 insurance companies, correct?

20 A: Yeah, seeking fair reimbursement for our
21 physicians is one way. The other way is
22 clinical. It's reducing infections. It's
23 reducing length of stay. It's reducing re-
24 admissions. It's a lot of things on the
25 quality side. We're in an industry whereas you

1 provide better quality to your patients, it's
2 also good financially for hospitals. So that
3 leverage would also mean better clinical
4 performance as well.

5 Q: And more referrals to Roper St. Francis
6 facilities, correct?

7 A: Well, most of the physicians that we've hired
8 have been loyal to Roper St. Francis
9 Healthcare. So, you know, to the extent they
10 were sending diagnostics to a small boutique
11 diagnostic company or something, maybe we
12 picked those up.

13 Q: They were loyal but they weren't loyal enough
14 to prevent you from spending all the money to
15 buy the practice and then subsidizing the
16 physicians to the tune of \$150,000 a year,
17 correct, Mr. Johnson? Is that a fair
18 statement?

19 A: Yes. And hospitals across the country are
20 making those investments.

21 Q: Now, in South Carolina, hospitals get something
22 called a disproportionate share payment, don't
23 they?

24 A: Yes.

25 Q: Can you explain to the court what a

1 disproportionate share payment is?

2 A: Well, there is the hospital tax we talked about
3 earlier, I testified to earlier that the
4 hospitals pay a hospital tax to the state, the
5 state puts that money up to the federal
6 government and that is matched and then given
7 back to DHHS. DHHS takes a lot of that money
8 and puts it in Medicaid base rates, but then
9 what's left over they allocate out to hospitals
10 based on what's called an upper payment limit
11 calculation.

12 Q: Okay.

13 A: So the pie is split based on that calculation.

14 Q: Okay. And in 2006, that's the year Roper
15 qualified for disproportionate share, isn't it,
16 about that time?

17 A: Yeah. It was federal fiscal year 2006 which
18 would have began October of 2005.

19 Q: Okay. Before that it just didn't have enough
20 Medicaid utilization or days to qualify; is
21 that right?

22 A: No, that's too -- that's too simple of a
23 statement to make. But our low Medicaid
24 utilization was a factor.

25 Q: Okay. And what these payments are intended to

1 do is encourage hospitals to treat indigent
2 patients despite the fact that they're going to
3 lose a little money on them, right?

4 A: Well --

5 Q: Is that not your understanding?

6 A: To take the Medicaid DSH calculation and
7 compare that to a nonprofit mission would not
8 be a correct comparison. The DSH calculation
9 includes losses on Medicare volumes, which are
10 compensated volumes that we compete for, it
11 includes losses on Medicaid volume, which is
12 compensated volume that we compete for, and
13 then it includes your truly unfunded indigent
14 population. You know, if you're inefficient in
15 the care of your patients and you lose a lot of
16 money on your Medicare and Medicaid volume, you
17 get more DSH money. There's lots of things
18 that impact that calculation that don't have to
19 do with serving indigent patients who have no
20 form of coverage. And again, Medicaid is a
21 good payer in this state.

22 Q: And if you treat disproportionately more of
23 those type of patients, you can also get a
24 bigger payment, correct?

25 A: If you treat a -- if you treat more Medicaid

1 patients in the state, yes, you could qualify
2 for more DSH funds, correct. And I need to be
3 -- DSH is, and I apologize for that acronym,
4 it's disproportionate share.

5 Q: And Roper pays a tax, right, a Medicaid or
6 disproportionate share tax, right?

7 A: It's a hospital tax paid to the state, correct.

8 Q: Okay. And you get back, what is it, two or
9 three times the tax?

10 A: No. We get back a little over a dollar for a
11 dollar that we pay.

12 Q: I apologize. But you do get more back than you
13 put in, right?

14 A: A little bit, yes.

15 Q: Have you seen this article before?

16 A: Oh, I'm very familiar with this article.

17 Q: Okay. I figured you would be. So there were
18 18 hospitals that got eight percent cuts,
19 correct?

20 A: Yes. That's what the article says.

21 Q: That's what the article says, right?

22 A: Yes.

23 Q: And Roper St. Francis and Bon Secours were two
24 of the 18 hospitals in the state that got a
25 cut, right?

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1 A: Yes.

2 Q: Okay. And what the article says, and I'm sure
3 you disagree, but it got its disproportionate
4 share payment cut because Roper and Bon Secours
5 were not doing enough in terms of uncompensated
6 care than the other providers who also received
7 disproportionate share payments, correct?

8 A: Yeah, that is factually incorrect. We met with
9 the *Post and Courier* on this article, they did
10 print a correction on this article, and we also
11 received an apology from one of their editors
12 about the misstatements in the article. We
13 obtained source data from DHEC that Ms. Dudley
14 used to write this article. The source data
15 from DHEC never shows the words uncompensated
16 care. That term was used completely
17 incorrectly in this article. The reason --
18 well, I'll stop there.

19 Q: Did you get an apology from the state? I mean,
20 did they give you your money back?

21 A: Well, no, the state based their decision off of
22 this upper payment limit calculation and where
23 you ranked in that calculation. But that
24 calculation is not a proxy of a nonprofit
25 healthcare system meeting its mission.

1 Q: I didn't say that it was. But Mr. Keck said
2 everyone was getting an equal proportion of the
3 money but that's not fair to hospitals doing an
4 unequal portion of the work, right?

5 A: Okay. Well, Mr. Keck is wrong in that
6 statement and we met with Mr. Keck on that.
7 Roper St. Francis gives a dollar to get a
8 dollar. Tenet Hospital east of the Cooper,
9 East Cooper Regional gives two dollars to get
10 a dollar. Other hospitals give a dollar, get
11 two or three dollars. That's not
12 proportionate. And he says proportionate. So
13 we met with him on that. I think he was either
14 taking it out of context or doesn't understand
15 his own program, so.

16 Q: Did he restore your eight percent cut?

17 A: No, that has not been restored.

18 Q: Okay. And Trident didn't get a cut, did they?

19 A: They did not. The mathematical reason that
20 boiled down a very complicated transaction, the
21 mathematical reason that Trident didn't get a
22 cut was they serve a higher percentage of
23 Medicare to their total volume. Roper Hospital
24 and St. Francis Hospital sit pretty close to a
25 very large children's hospital which is a large

1 draw for Medicaid patients. And again, we
2 compete for Medicaid patients. So boiling it
3 down, HCA did not get cut because they serve a
4 higher proportion of Medicaid patients, good,
5 well paid for patients than Roper or St.
6 Francis.

7 Q: Okay. Roper and St. Francis got a
8 disproportionate share payment cut, right?

9 A: We did. That is correct.

10 Q: Okay. And you met with Tony Keck and he didn't
11 restore it, right?

12 A: Well, we didn't ask him to.

13 Q: Tony Keck, he's the director of South Carolina
14 Department of Health and Human Services,
15 correct?

16 A: That's correct.

17 Q: Okay. And you would agree with me it's kind of
18 hard to see a bunch of Medicaid patients or to
19 get your uncompensated care payments up when
20 you're locating hospitals in areas with
21 household incomes of \$112,000 a year?

22 A: I think I remember St. Francis' self-paid payer
23 mix being in the 12 percent range. We're
24 serving a very high percentage of self-paid
25 patients in our Mount Pleasant facility.

1 Q: Go to Petitioner's 93.

2 A: And I want to say, again, this article was
3 factually incorrect. The words uncompensated
4 care that are being used in that article never
5 appear on the source data for that article.
6 That was a terrible article.

7 Q: But you didn't get your cut restored, right?

8 A: Well, we were trying to get our -- we were
9 trying to talk to the *Post and Courier* about
10 our reputation. We understand that, and I want
11 to make clear, we understand that Medicaid has
12 to make cuts. Everyone is getting cut.

13 Q: Well, I tried --

14 A: We weren't complaining about getting cut. We
15 were complaining about the way we were
16 characterized in the *Post and Courier* article;
17 it was very inaccurate.

18 Q: This is a slide from the Moody's presentation
19 here, correct?

20 A: Yes.

21 Q: All right. Mount Pleasant Hospital five mile
22 radius. What is the average household income
23 in 2008 in that five mile radius?

24 A: Well, \$112,613.

25 Q: Okay. I think you said you understood earlier

1 that the average household income in South
2 Carolina is about \$42,000, right?

3 A: That sounds about right.

4 Q: I'm sorry, I didn't hear you.

5 A: That sounds about right.

6 Q: Okay. So you located your hospital in an area
7 of demographics that is three times or a little
8 less than three times the household income is
9 for the state, right?

10 A: Yes.

11 Q: Okay.

12 A: In a market where we had a very large market
13 share already.

14 Q: Okay. Fair enough. I think you mentioned
15 yesterday, if I recall correctly, that the
16 community, and correct me if I'm wrong, did you
17 say the community owns the Roper St. Francis
18 Hospital property?

19 A: No. As a 501(c)(3) we are considered a
20 community asset and we exist for the benefit of
21 the community. So all those profits that we
22 talked about earlier, those are reinvested in
23 the community and they cannot inure to the
24 benefit of a private individual.

25 Q: We've been talking a little bit about community

1 benefit. Let's talk a little bit about
2 executive benefit. Now, first of all, does the
3 community that resides in the Tri-county
4 service area approve of the salaries of Roper
5 St. Francis management?

6 A: No, those are approved by our board and
7 compensation committee.

8 Q: Okay. And we talked a little bit about the 990
9 yesterday.

10 MR. THOMAS: Would you put up Respondent's 168.

11 Q: And what 990s do, they set out executive
12 compensation, don't they?

13 A: One of the schedules that is -- just like for
14 public companies, nonprofits have a disclosure
15 that lays out all the compensation that their
16 executive team gets, yes. That's true for
17 public companies and nonprofits.

18 Q: Okay. So this not-for-profit company
19 compensates its CEO, Mr. Dunlap, \$1.7 million
20 a year, doesn't it?

21 A: That was the reported compensation for two
22 thousand and --

23 Q: Ten, right?

24 A: -- ten. It was less than that for '09. There
25 was a -- there was a piece of deferred

1 compensation that matured in '11, so it was a
2 high number in '11, higher than average in '11.

3 Q: Okay.

4 A: '10, excuse me.

5 Q: All right. And the Roper Hospital CEO for a,
6 what is it, a 316 bed hospital right now, he
7 makes \$840,000 a year, doesn't he?

8 A: Yes.

9 Q: Okay. Go to the next page for me. And you
10 make \$763,000 a year, don't you?

11 A: Yes. That includes the benefit -- that's not
12 all cash. I mean, that's the value of the
13 benefits we receive; pension benefits,
14 healthcare benefits, all that rolled in, but
15 yes.

16 Q: But that's your compensation, isn't it?

17 A: Yes.

18 Q: Okay. And John Sullivan, administrator of an
19 85 bed hospital in Mount Pleasant, he's making
20 about \$540,000 per year, isn't he?

21 A: Yes, although I need to -- I mean, he is the
22 administrator of the Mount Pleasant Hospital,
23 but we have what's called a matrix management
24 model where the CEOs are also, for instance,
25 Matt Severance is responsible for emergency

1 services across the health system, Allen
2 Carroll is responsible for radiology across the
3 health system. So it's not just a -- they are
4 the figurehead leader of those hospitals, but
5 we do have a matrix model in place.

6 Q: Mr. Sullivan makes about \$60,000 per occupied
7 bed at Roper St. Francis Mount Pleasant,
8 doesn't he?

9 A: Yeah, for the start-up facility, I'll take your
10 word for that, yes.

11 Q: Okay. Mr. Bowling, he's doing pretty well.
12 What is that, \$580,000?

13 A: Yes.

14 Q: These are some of the highest salaries for
15 administrators across the state, aren't they?
16 Do you know of any higher?

17 A: Well, these salaries are set based on fair
18 market values for the industry. So people in
19 commensurately-sized facilities will make
20 approximately the same amount.

21 Q: And David Dunlap doesn't even actually have
22 direct control over one hospital, does he, he's
23 got three CEOs that are all paid very
24 handsomely that report up to him, don't they?

25 A: Yes. But, I mean, David does have direct

1 control over those hospitals. He's the
2 corporate, he's the system CEO.

3 **MR. THOMAS:** Go to the next page for me.

4 Q: He makes more than Dr. Steichen who's a
5 neurosurgeon, doesn't he?

6 A: Yes.

7 Q: Okay. So there's a pretty good incentive for
8 that aggressive growth strategy, correct?

9 A: Growth is one of the things management is
10 incented on, yes.

11 Q: Okay. And very well so, right?

12 A: Yes.

13 Q: Okay. Do you think that Mr. Dunlap could be
14 possibly one of the top five highest paid
15 people in the state of South Carolina?

16 A: I would have no way of knowing that. I doubt
17 it.

18 Q: And you're saying the benchmark, these salaries
19 are benchmarked in the industry. Are they
20 benchmarked to South Carolina not-for-profits?

21 A: No, they're national benchmarks that are
22 adjusted for cost of living differences and
23 things like that. But it is a national
24 benchmark.

25 Q: Do you know of another hospital administrator

1 in the state of South Carolina that makes
2 anything close to \$1.7 million?

3 A: I have not reviewed the 990s of other
4 hospitals. I wouldn't know.

5 Q: I've got one more question for you. Mr.
6 Johnson, isn't it fair to say, and we've looked
7 at some numbers, we've seen the projections
8 that Roper St. Francis has made, we saw the
9 balance sheet recovery program and the EBITDA
10 over the last few years, is it fair to say that
11 Roper St. Francis could have built 50 beds in
12 its Moncks Corner location and absorbed the
13 cost associated with any of those losses that
14 might have occurred because of less than
15 desirable utilization?

16 A: We've been serving the Moncks Corner area for
17 20 years. We have significant services in the
18 Moncks Corner area. We chose the Carnes
19 Crossroads property because that is where most
20 of the patients we serve are located.

21 Q: Okay.

22 MR. THOMAS: I'd like to strike that answer as non-
23 responsive, Your Honor.

24 MR. LONG: Your Honor, I object. He asked him a
25 question and he answered it. I think it was

1 entirely responsive.

2 MR. THOMAS: I'll ask it again, Your Honor.

3 THE COURT: I'll sustain the objection, it stays in
4 the record.

5 Q: I'm going to ask you the same question. Is it
6 fair to say that Roper St. Francis could have
7 built 50 beds at its Moncks Corner location and
8 absorbed the costs associated with any losses
9 that might have occurred because of less than
10 desirable utilization at that facility; is that
11 a fair statement?

12 A: Well, what you're asking me is would Roper St.
13 Francis constructing a 50 bed facility in
14 Moncks Corner materially adversely impact Roper
15 St. Francis' future financial health, I think
16 is what you're asking me.

17 Q: I don't think that is what I'm asking you.

18 A: Okay.

19 Q: The plan that I've seen that was rejected was
20 to add a 50 bed hospital wing at the Moncks
21 Corner location where you've got a surgery
22 center, where you've got an ED, where you've
23 got imaging, where you've got an MOB.

24 A: Uh-huh.

25 Q: And so what I'm asking you; is it fair that the

1 amount of money, the amount of revenue, the
2 amount of net income, is it fair to say that
3 Roper could have built those beds at Moncks
4 Corner and simply absorbed the costs associated
5 with any losses due to less than desirable
6 utilization at that location?

7 A: Well, with the amount of volume we had to
8 redirect, which is much less than Trident has
9 to redirect, we didn't think it was financially
10 feasible. Could we have built that hospital
11 and would it have led to the bankruptcy of
12 Roper St. Francis Healthcare, probably not.
13 But again, with the volume we had to redirect
14 with our market share, we didn't think it was
15 financially feasible. But again, we've got
16 significantly less share to redirect than
17 Trident does.

18 Q: Okay. Do you have any idea what your market
19 share capture rate would have been at that
20 location?

21 A: No, I do not.

22 Q: Do you have any idea what the assumptions were
23 at that location?

24 A: I do not.

25 Q: Thank you, Mr. Johnson.

1 THE COURT: Just so I'll understand. Your answer
2 wound up by saying probably not, but what you
3 meant was, yes, you could have built it and it
4 probably would not have bankrupted you to
5 absorb any losses connected with it?

6 A: Yes, Your Honor.

7 THE COURT: Is that correct?

8 A: Yes, Your Honor.

9 THE COURT: Thank you.

10 Q: Thank you, Mr. Johnson, that's all I've got..

11 THE COURT: All right. Are we ready for about a ten
12 minute break?

13 MR. LONG: Yes, Your Honor.

14 THE COURT: We'll be in recess for ten minutes..

15 (Off the Record from 11:25 a.m. until 11:38 a.m.)

16 THE COURT: Back on the record, please. Mr. Long,
17 redirect.

18 MR. LONG: Thank you, Your Honor.

19 MR. JOHNSON - REDIRECT EXAMINATION BY MR. LONG:

20 Q: Mr. Johnson, I'm going to ask you about some of
21 the things that Mr. Thomas raised with you. In
22 regards to HCA's tax, he was asking you some
23 questions about why you thought the HCA tax
24 rate was at 20 percent. What is an effective
25 tax rate?

1 A: It's an estimate of the percentage of taxes
2 you'll pay on a taxable number or a net income
3 number.

4 Q: And typically does an individual or corporation
5 pay less than the actual top tax rate that they
6 may fall into?

7 A: If they're -- my understanding is yes. I'm not
8 a corporate tax person, but I think the answer
9 is yes.

10 Q: So when you were talking about that number,
11 were you talking about the effective tax rate?

12 A: I was talking about the effective tax rate,
13 correct.

14 Q: Now, he asked you also about this CHS, about
15 the data center and the four million dollars
16 for the data center; do you recall that? Do
17 you recall him asking you about the cost of the
18 data center?

19 A: Well, I recall the data center discussion.

20 Q: How much is the data center going to cost as a
21 capital project?

22 A: Approximately 18 million.

23 Q: Okay. And so how would that be handled on the
24 expenses of the Roper St. Francis Berkeley --
25 I mean Roper St. Francis Healthcare?

1 A: Well, the data center is being developed and
2 owned by the Medical Society of South Carolina.
3 They are the developer and owner of it and they
4 are leasing it to Roper St. Francis Healthcare.
5 So that would show up as a lease or rent
6 expense on the books of Roper St. Francis.

7 Q: Okay. And would that be included in its own
8 separate line or would it also be included as
9 part of corporate administration?

10 A: It would probably fall, and we're not there
11 yet, but it will probably fall at the parent
12 company level in rent expense.

13 Q: In rent expense. Now, when you do -- so are
14 the --

15 MR. LONG: Hold on one second. Your Honor, I'm
16 trying to connect some things here so I don't
17 have to ask so many questions.

18 Q: When Roper St. Francis Healthcare pays for the
19 lease expense, will it write a check?

20 A: Yes.

21 Q: In the corporate overhead numbers that you
22 testified about on the Roper St. Francis side,
23 are those expenses or are they an allocation?

24 A: Well, they start as direct expenses. Those are
25 the direct salaries that are paid, the benefits

1 that are paid to employees of Roper St. Francis
2 Healthcare, the actual supplies expense and
3 other expenses that we cut checks for. So
4 those are cash dollars going out the door, but
5 then those expenses are allocated to the
6 divisions.

7 Q: Okay. And those actual expenses are expenses
8 incurred just for the three, just for the Roper
9 St. Francis Healthcare entities, right?

10 A: That's correct.

11 Q: All right. And there are no expenses for the
12 Medical Society or any other parent of Roper
13 St. Francis that would be included in the
14 corporate allocation, right?

15 A: No.

16 Q: Now, once you allocate that among the
17 facilities, how do you decide how to allocate
18 it?

19 A: Well, each department within the health system
20 has a statistic by which it's allocated. Human
21 resources could be allocated based on the
22 number of FTEs in each division. Accounting
23 could be allocated based on the revenues of
24 each division. Materials management could be
25 allocated based on the supply expense of each

1 division. There's just a relevant statistic
2 that's picked for each department.

3 **THE COURT:** FTE means full-time employee?

4 A: Yes, Your Honor. Full-time equivalent, yes.

5 Q: Let's look at Petitioner's 167 that you got
6 asked about. This was the page that Mr. Thomas
7 asked you about that reflects the -- and he was
8 asking you about the corporate allocation for
9 each of the different hospitals?

10 A: Yes.

11 Q: Is that the right page or am I looking at that
12 right? Get a little closer. I think it's the
13 next page.

14 A: I think it's the next page.

15 Q: It's the next page. Okay. So the bottom part
16 would show it, right?

17 A: Yes.

18 Q: Okay. So let's look at Roper St. Francis Mount
19 Pleasant. This is a six months statement,
20 right? This is January June?

21 A: Yes.

22 Q: This corporate allocation number for Roper
23 Mount Pleasant is how much money again?

24 A: \$2,474,000.

25 Q: For six months, right?

1 A: Correct.

2 Q: Now, if you were going to look at the Roper
3 Mount Pleasant Hospital and calculate the
4 incremental cost of the hospital to the
5 corporate overhead, would it be that high a
6 number?

7 A: No. We added very few resources to the parent
8 company when we opened Mount Pleasant.

9 Q: Explain what you mean by that.

10 A: Well, for instance, I think they added one
11 recruiter in HR. We didn't add anybody in
12 accounting. We didn't add anybody in the
13 billing office. We had to add a few people in
14 materials management at the corporate level.
15 IT or information technology added a few
16 resources, but it was a very few number of
17 resources.

18 Q: So if you were going to actually calculate the
19 incremental cost in regards to the corporate
20 overhead at the site of the Mount Pleasant,
21 would that number be -- how would it -- would
22 it be higher or lower compared to this four
23 million dollar -- four million plus?

24 A: I think it would be well below the 2.4 million.

25 Q: Okay. Let's go to Petitioner's 95. I don't

1 know if you have that in front of you there.
2 Actually, I think you do. This is the Moody's
3 report. You were asked about several of these
4 Moody's reports, right? --

5 A: Yes.

6 Q: -- on cross examination?

7 A: Yes.

8 Q: I don't have a copy of it, but you can take a
9 look at it in the book. It might be a little
10 easier for you. Okay. Now, who prepares these
11 reports to Moody's?

12 A: I'm very involved in the preparation of them.
13 A lot of the slides are actually prepared by
14 our director of decision support.

15 Q: And do you -- how much work do you put in when
16 you do these?

17 A: It's a significant amount of work. We dialogue
18 with the rating agencies about what they want
19 to hear about. We put together the materials
20 we want to tell them about because transparency
21 is important. And, you know, we invest a lot
22 of time in these presentations.

23 Q: Do they give you any guidance?

24 A: Yes. When we talk to them on the phone, they
25 do tell us the things they want to hear about.

1 So I would characterize that as guidance.

2 Q: Okay. And then when you present to them,
3 sometimes do you ever do that in person or
4 conference call or other ways?

5 A: In the last few years it's been by conference
6 call. But we also have had years where we
7 invite them down to see our facilities or they
8 will have us come to New York.

9 Q: And who all -- let's turn to the second page of
10 this. This is the June '07 Moody's report that
11 was done. It's Roper Berkeley 1463, page two.
12 Let's look at page two. Are these the -- who's
13 reflected on this page?

14 A: The participants that would have spoken to the
15 rating agencies that year for the presentation
16 shown.

17 Q: So all these people had a roll in the
18 presentation that year?

19 A: Yes.

20 Q: Take a look at pages three and four, 1464 and
21 1465 of the PowerPoint. Can you kind of just
22 quickly roll through for me the different, all
23 the different topics that you talked to Moody's
24 about during the call?

25 A: Okay. Well, we had an introduction. We had a

1 management and governance update. It's
2 important to them who the team still is, is
3 there continuity on the team. The project we
4 would have talked about. And then we have
5 what's called our five pillars that we a lot of
6 times will characterize things based on the
7 category of people, quality, growth, financial,
8 admission or service. And then we get into
9 what's called our pillar update where we talk
10 about the fact that we continue to maintain top
11 decile employee, patient and physician
12 satisfaction. If you'll turn the page, we talk
13 about our awards and our accreditations,
14 growth, quality, financial, and then we would
15 have spent some time on mission as well. And
16 then takeaway remarks are typically kind of a
17 summary of the presentation, but then also a
18 recap of what the rating agencies have asked us
19 for from a follow-up perspective.

20 Q: Okay. And this is -- you're presenting this
21 PowerPoint to them, right?

22 A: Yes. It's a formal presentation.

23 Q: All right. Take a look at the last page, and
24 we can put it on the screen to you. How many
25 pages is the PowerPoint; how many slides?

- 1 A: It's large. This one is 103 slides.
- 2 Q: 103 slide PowerPoint. Okay. Now, go to page
- 3 53 of the PowerPoint, which is going to be 1514
- 4 and 1515. You've got those two pages in front
- 5 of you?
- 6 A: I've got the one shown on the screen there.
- 7 Q: And then the next one?
- 8 A: Okay. Yes.
- 9 Q: Is this the physician recruitment employment
- 10 section of the PowerPoint?
- 11 A: Yes, it appears to be.
- 12 Q: Okay. How many pages is it? You can look in
- 13 the book if you need, or she can flip through
- 14 the couple of pages around it.
- 15 A: And may I ask which tab it is in the book?
- 16 Q: I'm sorry, we're at Petitioner's 95.
- 17 A: Well, in terms of physician recruitment and
- 18 employment, it's two pages.
- 19 Q: So out of 103 slides, how many are physician
- 20 and recruitment?
- 21 A: Well, it appears to be two.
- 22 Q: Okay.
- 23 A: But I've not flipped through the whole
- 24 document, but it appears to be two.
- 25 Q: How would you characterize the physician

1 recruitment portion of the PowerPoint to the
2 presentation as a whole?

3 A: Well, you know, being transparent with the
4 rating agencies and discussing with them our
5 physician employment strategies, I would
6 characterize it as important. It was certainly
7 one of many, many elements they analyze to give
8 you your rating.

9 Q: Okay. Let's take a look at Petitioner's 93.
10 You've got it in front of you?

11 A: Yes.

12 Q: Okay. This one didn't have a table of contents
13 to it, but how many actual PowerPoint slides
14 are included in the presentation?

15 A: It appears to be 99.

16 Q: Ninety-nine slides? Okay. Were the topics, do
17 you recall, presented to Moody's similar to the
18 one that we looked at in '07?

19 A: They would have been, yes.

20 Q: Did these -- do you recall the physician
21 recruitment piece being any larger or smaller
22 in 2010 in your presentation to Moody's?

23 A: Off the top of my head I would say that we
24 would be very consistent in how we presented to
25 each rating agency.

1 Q: You testified that the physicians that have
2 been -- well, first, how many employed -- you
3 recall how many employed physicians Roper St.
4 Francis had in 2007?

5 A: It was less than ten if I recall correctly.

6 Q: Okay. Of the 200 physicians that have been
7 employed by Roper St. Francis, are a
8 significant number of them in one group?

9 A: Well, we did acquire Lowcountry Medical
10 Associates which was, I believe, 54 primary
11 care physicians. That would have been our
12 largest acquisition.

13 Q: All right. What did you mean in your testimony
14 when you said to Mr. Thomas that the physicians
15 that have been employed by Roper St. Francis
16 were already loyal to you? What did you mean
17 by that?

18 A: That means that we're already receiving the
19 majority of their referrals, if not all of
20 their referrals.

21 Q: Why would a healthcare system employ a
22 physician that was already referring patients
23 to you or was already loyal to you?

24 A: Well, we talked about the issue of quality
25 several times, so there's that reason. And

1 then also I believe I mentioned it's defensive.
2 When a large group that is loyal to you
3 presents themselves to you saying they want to
4 be employed but if you don't employ them
5 they're going to go elsewhere, that's a threat.
6 And to preserve market share you need to employ
7 them. So there's certainly not a financial
8 benefit to employing physicians that are
9 already loyal to you.

10 Q: But can you just pay them anything that you
11 want or they want you to pay them?

12 A: Absolutely not. There is a lot of work done,
13 just like with executive compensation, a lot of
14 work done to determine fair market value of
15 physician compensation and physician
16 compensation is set on that fair market value.
17 And we've had very little issue with that.
18 Physicians in our market place, because of poor
19 managed care reimbursement, have made well
20 below national medians which is not fair to
21 them, but we've not had issues with physician
22 comp.

23 Q: Okay. Now, you testified that there was or he
24 had you do some calculations to calculate what
25 the subsidy of each physician?

1 A: Yes.

2 Q: What did you mean or what is the subsidy of
3 physician mean --

4 A: That is the --

5 Q: -- in finance?

6 A: That is the amount of expenses in their
7 practice that exceeds the revenues in their
8 practice, would be a simple way of saying that.

9 Q: Okay. And are you -- when you're doing the
10 calculations to determine how to allocate
11 expenses to the Physician Partners group or the
12 actual physicians, are you giving them an
13 allocation of corporate overhead?

14 A: Yes, we are.

15 Q: So kind of explain to the judge what that means
16 exactly or how that would differ from them
17 being employed independently.

18 A: Well, when we acquire a physician practice we
19 bring those physicians on, typically they're
20 employees because we have to bring them on at
21 our pay scales, our benefit plans. For their
22 employees, that's typically higher than what
23 the physician is paying them. We tend to
24 infuse a lot more technology into the practice.
25 You've heard about electronic medical record,

1 that's a significant cost to the practice. And
2 Mr. Bowling, who is the CEO of that division,
3 could talk a lot more about the expenses that
4 go into it. They also receive a corporate
5 overhead allocation that's either allocated, as
6 we talked about earlier, by FTE, by revenue,
7 things like that, so they get a share of that.
8 And all that is added to the expenses that they
9 would have had in their practice had they been
10 independent.

11 Q: So those expenses that you are showing on like
12 the financial highlights sheet for Physician
13 Partners are more than the actual expenses of
14 the actual offices themselves they incur?

15 A: Yes, very much so.

16 Q: Talk about the technology infusion into those
17 practices. What do you mean by that?

18 A: Well, there's -- part of healthcare reform is
19 linking the medical records of everyone, so
20 we're in process now of installing electronic
21 medical records throughout all of our employed
22 physicians so that their office systems can, so
23 to speak, talk to the hospital systems and
24 share data about medical records. If a
25 physician is in his office and a patient comes

1 in, he can access that practice record for that
2 patient but also tap into the hospital system's
3 as well and get the medical record information
4 for that patient.

5 Q: Have you -- how expensive is that?

6 A: Those are -- it's millions and millions of
7 dollars.

8 Q: Is it something that has been occurring
9 recently?

10 A: It is really in response to healthcare reform
11 and the demand that care be better coordinated.

12 Q: Are those costs affecting the Physician
13 Partners financials?

14 A: Absolutely. We've significantly ramped up IT
15 costs in the past several years and that is
16 absolutely, some of that is included in the
17 Physician Partners division.

18 Q: Could that improve in the future?

19 A: Well, I hope so. We are in a -- Roper St.
20 Francis, like a lot of healthcare systems our
21 size, will invest probably 100 million in
22 technology in the next seven to ten years. I
23 hope when those investments are made, yes, they
24 will get, the cost curve will decrease.

25 Q: Okay. What do you mean when you say the cost

1 curve will decrease?

2 A: I hope we're not spending as much on technology
3 after we get electronic medical records and
4 other technologies important to healthcare
5 reform installed.

6 Q: Okay. Let me go back and ask you another
7 question about the Moody's report, if I could.
8 I forgot to ask you a little while ago. Why
9 would you not hire -- do you hire outside
10 consultants to do your Moody's reports?

11 A: No.

12 Q: Okay. Tell me about the process of why you
13 would hire an outside consultant for the CON
14 and not hire one for Moody's.

15 A: Well, some of it, it's a practice we've had in
16 our -- in our corporation that we've just hired
17 outside experts for CON. I mean I guess I
18 take a lot more personal ownership of those
19 relationships with the rating agencies and I'm
20 very involved in those presentations. I'm
21 routinely in contact with the rating agencies
22 and it's just a relationship that I choose to
23 manage at my level as CFO.

24 Q: Do you think that's important in your job, to
25 have a relationship with the rating agencies?

1 A: Absolutely.

2 Q: And how do you think they would react if you
3 hired somebody to show up and do the
4 presentation for you?

5 A: That would not be acceptable.

6 Q: Okay. Why is that?

7 MR. THOMAS: Your Honor, I need to object. I don't
8 think I got into that level of detail about the
9 -- I just asked him if he did them or if Mr.
10 Knapp did them.

11 MR. LONG: He actually did ask him, he said why
12 didn't you hire Mr. Knapp?

13 MR. THOMAS: To actually do the pro formas.

14 THE COURT: We can't split that sort of hair. I'm
15 going to overrule the objection.

16 Q: Why do you think they would not want to hear
17 from a hired consultant as opposed to you?

18 A: Oh, they would reject that. I meant they're
19 there to meet with the management team, to hear
20 from the management team what is the strategic
21 plan, hear about the market. I mean, they want
22 to -- their evaluating the management team is
23 a big part of the rating and you could have a
24 -- some providers may choose to have a
25 consultant in the room for one matter or

1 another, but no, I mean those relationships are
2 between senior management of the organization
3 directly with those rating agencies analysts.

4 Q: Let's talk about that newspaper article that
5 Mr. Summer -- or Mr. Thomas asked you about.
6 What is uncompensated care?

7 A: Well, there's the definition that would apply
8 to a nonprofit and then there's a definition
9 that might apply to Medicaid. And they're both
10 very different.

11 Q: All right. How are they different?

12 A: What I would consider to be uncompensated care
13 for a nonprofit from a mission perspective
14 would be patients that present that have no
15 form of payment. Okay. They're indigent
16 patients who have no form of payment.

17 Q: Is that charity, what we talked about
18 yesterday?

19 A: Charity.

20 Q: Is that the same thing?

21 A: That's correct.

22 Q: Okay.

23 A: What Medicaid would consider to be
24 uncompensated care would be the difference
25 between costs and revenues on your Medicare

1 population, the difference between costs and
2 revenues on your Medicaid population. So if
3 you're inefficient in serving those
4 populations, Medicaid says, hey, you're --
5 that's more uncompensated care. Okay. In my
6 opinion when you get paid for a patient, that's
7 not uncompensated care. If you're not
8 efficient and you lose a lot of money on that
9 population, Medicare give -- Medicaid gives you
10 more credit for that.

11 Q: Well, let me ask you, I'm going to try to give
12 you an example here to help you kind of explain
13 this and see if -- and answer the question to
14 the extent you need to. But let's say somebody
15 came in the operating room, two hospitals, and
16 say had knee replacement surgery. Is Medicare
17 and/or Medicaid going to pay the same amount of
18 money to the hospital for that service?

19 A: No. They will not.

20 Q: Okay. Why not?

21 A: Well, it's based on different fee schedules
22 that each of those entities or programs
23 establishes.

24 Q: No. I didn't mean Medicare/Medicaid paying the
25 same amount. I meant would each of the two

1 hospitals be paid the same amount from Medicare
2 or Medicaid? In other words, do you get the
3 same amount from Medicaid -- do all hospitals
4 get pretty much the same amount of
5 reimbursement from Medicaid for the same
6 service?

7 A: You're getting into DRG reimbursement. But
8 there are differences in how each gets paid.
9 I mean if a knee were done at Roper and a knee
10 were done at Medical University, Medicare would
11 not necessarily pay the same thing.

12 Q: Okay. So it's more complicated than my example
13 would work. So let's try it this way. I want
14 you to talk about what you were just talking
15 about in regards to this concept of cost, okay?
16 How could one hospital have higher costs than
17 another hospital in performing the same
18 service?

19 A: One hospital could have a higher length of
20 stay. Discharge planning may not be very
21 effective within a certain hospital and
22 patients end up staying longer. With your
23 example with your knee, you know, getting that
24 patient up out of the bed and starting to rehab
25 that patient is important to the discharge

1 planning process. If you're slow about doing
2 that, you could have an extended length of stay
3 which would have higher costs. If your
4 facility is prone to higher infections or if
5 you're not careful and the patient slips and
6 falls and hurts themselves, that means the
7 patient is there longer. That's higher cost.

8 Q: And so if you have higher costs, then -- well,
9 how does that affect your Medicaid
10 reimbursement calculation?

11 A: If you -- the more money you lose serving
12 Medicare and Medicaid patients, the more money
13 DSH is going to give you.

14 Q: Okay. So the higher your costs --

15 A: The higher your costs and the more money you
16 lose on Medicare and Medicaid, the more money
17 DSH is going to pay you.

18 Q: Okay.

19 A: And in fairness, there is a component of DSH
20 that is based on patients who have no funding
21 mechanism, but it also includes these other
22 things which is why I say that that is not
23 consistent with -- you can't use Medicaid's
24 definition of uncompensated care as a mission-
25 related definition for nonprofits.

1 Q: So what did the *Post and Courier* do after they
2 ran that article and you met with them?

3 A: Well, we met with them about four times. They
4 ended up posting a very modest correction. But
5 we made our point clear and they did apologize,
6 one of their editors did apologize for
7 misstatements that were made.

8 Q: Let me go back and ask you --

9 A: And the *Post and Courier* did tell us that that
10 reporter, which was a young reporter, was --

11 Q: Well, let's not get into that.

12 A: All right.

13 Q: I think that's probably hearsay. All right.
14 Let me go back one more time to finish up on
15 something I just asked you about a minute ago
16 and that is about allocating corporate
17 overhead. Tell me what the difference is
18 between an allocation and a direct expense.
19 Can you do that?

20 A: Well, a direct expense, I'm assuming you're
21 talking about an expense that would actually be
22 paid by that division; I mean, that division is
23 cutting the check for that expense. An
24 allocation would be a non-cash transaction
25 whereby expenses would be allocated from the

1 parent company down to the divisions.

2 Q: Okay. And on the -- trying to compare apples
3 to apples, when you look at the -- you saw the
4 Trident Health System financials. Can you
5 compare their corporate, their management fee
6 that they pay to HCA to something that would be
7 comparable for Roper St. Francis?

8 A: Well, as --

9 MR. THOMAS: Your Honor, I don't think I asked him
10 about HCA's management fee. I asked him about
11 how their corporate allocation overhead.

12 MR. LONG: I thought he did. I mean, well the
13 implication in the questions was he was
14 comparing it, I thought, to his earlier
15 testimony.

16 MR. THOMAS: Your Honor, I never got into HCA's
17 management fee on cross.

18 MR. LONG: Your Honor, he may not have said the
19 words but he compared it to earlier testimony
20 about that.

21 THE COURT: Overruled.

22 A: Can you repeat the question, please?

23 Q: Yeah. If you were going to do apples to
24 apples, how would you compare the management
25 fee that Trident Health System pays HCA to a

1 comparable expense on the Roper St. Francis
2 financials?

3 **MR. THOMAS:** Your Honor, I'm sorry. This objection
4 is just based on lack of foundation. He
5 doesn't work for HCA. He doesn't know how
6 allocations work, how the expense is done. And
7 I actually asked him if -- I believe I asked
8 him, you know, if he knew how it was done on
9 cross and he said he didn't.

10 **THE COURT:** Ask your question again. Let me hear
11 the question again, please, sir.

12 **Q:** You heard the testimony about the allocation at
13 Trident Health System for the management fee,
14 the money that Trident Health System pays to --

15 **A:** Yes.

16 **Q:** -- HCA? Using an apples to apples comparison,
17 what would you compare that management fee as
18 paid to HCA to a comparable line item on the
19 Roper St. Francis financials?

20 **THE COURT:** Overruled.

21 **A:** Yeah, it would, I mean, if it is a management
22 fee, I'd compare it to the fee we -- I would
23 compare it to the fee we pay Carolinas
24 Healthcare System. But I, as I testified to
25 earlier, do not know how that fee is allocated

1 from HCA to the Trident facility.

2 Q: Okay. Now, you testified that your
3 understanding was that the Department, DHEC,
4 looks at the, looks at the third year of an
5 organization in reviewing the application?

6 A: That's my understanding, yes.

7 Q: Now, as a CFO in the hospital in reviewing a
8 hospital capital investment, what time frame
9 would you be focused on?

10 A: Well, I would certainly like to see it
11 profitable within three years, but our time
12 frame could be longer than that as a nonprofit.
13 But I have -- with the volume of business that
14 we currently have in Berkeley County and, quite
15 frankly, putting a small facility there, I have
16 no doubt that facility will be profitable in
17 three years and effectively be able to
18 recapitalize itself and be a healthy facility.

19 Q: Okay. In the -- let's look at the Roper St.
20 Francis financials for 2009 and 2008, which I
21 believe is -- well, you probably can do it
22 without looking at the document. Okay. In
23 2008 did Roper St. Francis have a negative
24 number on the revenue over expenses, the
25 bottom, actual bottom line number?

- 1 A: I know that we lost --
- 2 Q: In 2008.
- 3 A: -- a lot of money on the investment portfolio.
- 4 That is possible. Can we go to that exhibit,
- 5 please?
- 6 Q: Yeah, let's see if we can find it real quickly,
- 7 if I could just have a second. Take a look at
- 8 Petitioner's 96; we think that might be it. Is
- 9 that the Roper St. Francis financials?
- 10 A: Well, you're going to want the audited
- 11 financials for 2008, which look like this but
- 12 it will be for 2008.
- 13 Q: Right. It's 22. Take a look at, is it
- 14 Petitioner's 22 -- Respondent's 22. We can put
- 15 that up on the board. We'll have it on the
- 16 screen for you. This is Respondent's 23 which
- 17 will have '08 and '09 together, right?
- 18 A: Yes.
- 19 Q: Okay. That's Roper Berkeley 1957. Is that the
- 20 income statement for '09 and '08?
- 21 A: Yes.
- 22 Q: Okay. Now, that bottom line, the very bottom
- 23 line number, can you explain what that is?
- 24 A: That is the --
- 25 Q: Well, actually, let's do it this way. The

1 excess or deficits of revenues over expenses,
2 what is that line again?

3 A: That is as described. That is the net loss the
4 healthcare system experienced in 2008.

5 Q: Okay. So in 2008 Roper St. Francis actually
6 had a deficit, they had more expenses than
7 revenue, right?

8 A: Yes.

9 Q: And of \$29 million plus?

10 A: Yes.

11 Q: What was the driver on that? What caused that?

12 A: Well, a lot of it was losses experienced on our
13 investment portfolio that year and then a lot
14 of it was due to interest rates declining and
15 the fact that our swaps, interest rate swaps on
16 our debt, the market -- mark -- to market value
17 in those decreased and we had to recognize a
18 book loss associated with that.

19 Q: Okay. And those were significant numbers?

20 A: Material but not adverse.

21 Q: Okay. And was the hospital at risk -- was the
22 system at risk of closing in 2008?

23 A: No. And we maintained our A minus A3 credit
24 ratings that year.

25 Q: So even though you had a deficit of revenues

1 over expenses of nearly \$30 million, the rating
2 agency did not change your investment grade?

3 A: We maintained an A minus A3 rating, that's
4 correct.

5 Q: Okay.

6 A: And let me -- in the spirit of full disclosure,
7 there was one year along there where Standard
8 and Poor's changed our outlook from stable to
9 negative, but then they a couple years later
10 changed it back to stable. So I just want to
11 make sure I'm not leaving something out there.

12 Q: Okay. So is it typical in a larger -- well,
13 does Roper St. Francis consider itself to be a
14 large system?

15 A: Yes.

16 Q: Okay. Do larger systems have greater swings in
17 their revenue and EBIT earnings and revenue
18 over expenses?

19 A: Yes, we do.

20 Q: Okay. And what do you mean by that? Can you
21 explain what that means to say you have larger
22 swings?

23 A: Well, larger swings would mean that there was,
24 particularly with the investment markets of
25 recent years, you know, it's hard to predict

1 what your non-operating earnings are going to
2 be. I think management has better control over
3 operations and although there is some
4 volatility in operations, it's less than that
5 non-operating activity, which is predominantly
6 capital markets performance. And that has been
7 volatile the last few years. So it is hard in
8 healthcare to project EBITDA each year given
9 that volatility.

10 Q: Okay. What do you mean when you say, make
11 comments, "material but not adverse"?

12 A: Well, clearly these numbers are, a \$29 million
13 loss is material to our health system, but
14 adverse to me would mean that it jeopardizes
15 your ability to continue as a going concern,
16 and clearly that hasn't happened here. We
17 still maintain, even with a sizeable number
18 like 29 million, we maintained our investment
19 grade rating and back to business.

20 Q: Well, material is kind of a relative term, so
21 can you kind of explain to me -- well, let me
22 ask it this way. Are there any decrement
23 numbers that would not be somewhat material?

24 A: Well, losing money -- losing money is never a
25 good thing for a healthcare system.

1 Materiality is a judgmental concept. It's --
2 it can have many definitions. If you could be
3 a little more specific in your question.

4 Q: Well, is there a dollar amount; do you think a
5 million dollars is material to Roper St.
6 Francis?

7 A: It depends on the context. If, you know, our
8 earnings are, you know, if this number would
9 have been 28.5 instead of 29.5, I wouldn't have
10 put tremendous materiality on that. If there's
11 a million dollars in cash missing from the
12 cafeteria, I would put a lot of materiality on
13 that.

14 Q: Right.

15 A: So it's a contextual question.

16 Q: Okay. Now, what about the -- how would you
17 characterize, with your definition of material
18 and adverse, the \$40 million loss that you're
19 showing for Physician Partners?

20 A: Well, you know, it's an investment that we're
21 making. We walked into it with both eyes open,
22 we knew there were going to be sizeable
23 investments to recruit physicians, but we
24 cannot address the needs of healthcare reform
25 without making that investment and better

1 aligning our incentives with our physicians.

2 Q: Is it material?

3 A: So it is a material investment but a necessary
4 investment.

5 Q: Is it adverse to the company?

6 A: It is not.

7 Q: Let's talk about transparency from Roper St.
8 Francis. When you warehouse -- there was some
9 question about warehousing the Carnes
10 Crossroads property on the Medical Society's
11 books, right?

12 A: Yes.

13 Q: Did you -- were you transparent in that
14 transaction?

15 A: Well, it started with a white paper that was
16 approved by the Roper St. Francis Board and I
17 believe the Medical Society Board before any of
18 that work was done, just laying the foundation
19 for those transactions. Each of those
20 transactions has been approved by the Roper St.
21 Francis Board and the Medical Society Board and
22 we've shared each one with the rating agencies
23 and we brag about it. We say look how our
24 family members are supporting us. So we
25 characterize it as a very good thing.

1 Q: Okay. Now, you were asked some questions about
2 the executive compensation at Roper St.
3 Francis. Is Roper St. Francis transparent
4 about that?

5 A: Well, the 990 is a public document and it is
6 very transparent. Anybody in the world can
7 access that document.

8 Q: And do you know of any reasons as to why Mr.
9 Dunlap's compensation would have been higher,
10 because I think you said it was higher in 2010
11 than it was in 2009?

12 A: There is one particular deferred comp plan that
13 he participates in that he kept deferring
14 vesting in that plan. And I believe he hit a
15 certain age where he could no longer defer that
16 investment. So many, many or a number of years
17 of that deferral ended up getting recognized in
18 2011 for compensation purposes. So his
19 compensation in 2010 -- I'm sorry, I said '11
20 -- 2010 appears much higher than in previous
21 years --

22 Q: Okay.

23 A: -- because of that election on his part to
24 defer vesting in a particular component of
25 compensation.

1 Q: And much higher than 2009?

2 A: Yes.

3 Q: Okay. Do you have any idea about the
4 difference?

5 A: I would say his compensation was probably in
6 the million dollar range in 2009 versus the,
7 and this is just based on recollection, versus
8 the million seven in 2010.

9 Q: Okay.

10 A: And it could have been a little higher than a
11 million, but I don't know the exact number
12 offhand.

13 Q: All right. Do you know if Trident Health
14 System or HCA publishes -- if Trident Health
15 System publishes publicly the executive
16 compensation for their executives in their
17 system?

18 A: I believe that is part of filings made with the
19 Securities and Exchange Commission that are,
20 indeed, public.

21 Q: For the actual executives at Trident Health
22 System --

23 A: Oh, I'm sorry.

24 Q: -- as opposed to HCA.

25 A: No, it would be the HCA leadership, not

1 divisional leadership within HCA.

2 Q: Okay. Have you reviewed those before?

3 A: I do not think so.

4 Q: Okay.

5 MR. LONG: Your Honor, that's all we have for
6 redirect.

7 THE COURT: Thank you. You may step down.
8 Contradicting what I said on yesterday, is
9 there any desire to go on further this
10 afternoon or would you rather just take it up
11 Monday morning.

12 MR. LONG: Your Honor, there's no way we can finish
13 Mr. Bowling. I think we'd probably want to
14 wait until Monday. I mean, it is 12:20, people
15 have flights in the afternoon so after lunch --

16 THE COURT: What about starting time on Monday, you
17 want 10:00 to give you some office time before
18 you get here?

19 MR. LONG: I don't think we need that Monday, Your
20 Honor. We can start at 9:30 on Monday, I
21 think.

22 MR. THOMAS: That's fine with me, Your Honor. It's
23 the pleasure of the court.

24 THE COURT: 9:30 then. Very well. I wish you all a
25 good weekend. We'll recess until 9:30 Monday

1 morning.

2 (There being nothing further, the hearing recessed at
3 12:25 p.m.)

4 DAY 11 - MONDAY, FEBRUARY 13, 2012

5 THE COURT: Mr. Long?

6 MR. LONG: Thank you, Your Honor. We would call
7 Doug Bowling to the stand.

8 DOUGLAS W. BOWLING, being duly sworn, testifies as
9 follows:

10 MR. BOWLING - DIRECT EXAMINATION BY MR. LONG:

11 Q: Can you state your full name, please?

12 A: Douglas William Bowling.

13 Q: And, Mr. Bowling, where do you live?

14 A: 1491 Farmcrest Drive on Johns Island, South
15 Carolina.

16 Q: And who do you work for?

17 A: For Roper St. Francis Healthcare.

18 Q: And what is your position with Roper St.
19 Francis?

20 A: I'm the chief strategy officer and the CEO of
21 the Roper St. Francis Physician Partners
22 Network.

23 Q: And what are your responsibilities in your
24 position?

25 A: From the chief strategy officer's side, it's to

1 work on business planning, business
2 development, prepare the annual strategic plan
3 for presentation to the board, and then to
4 implement that strategic plan as approved by
5 the board. On the physician group, as a CEO
6 I'm responsible for the day to day operations,
7 the staffing, all the issues with regard to the
8 financials for that group.

9 Q: Okay. And how does the physician network
10 relate to Roper St. Francis?

11 A: The Roper St. Francis Physician Partners are a
12 separate 501(c)(3) not-for-profit organization
13 under the host, that not-for-profit which is
14 Roper St. Francis Healthcare. So we are an
15 individual corporation for the purpose of
16 employing and managing the physician group.

17 Q: And why would Roper St. Francis structure their
18 physician network that way?

19 A: There were a number of reasons. One of them
20 was certainly that we wanted to be able to
21 create a co-leadership model with the
22 physicians so that they would be responsible
23 their governance, their policy and procedures,
24 their rules making, all the quality issues and
25 be outside of the hospitals to do that. There

1 are some other regulatory issues as a separate
2 not-for-profit that we don't fall under; Joint
3 Commission oversight, which is a huge expense
4 in a physician practice if you have to adhere
5 to that. And, secondly, there are
6 complications with Medicare 72-hour rule. So
7 if a surgeon had seen a patient in their office
8 on a Tuesday and that patient got admitted on
9 a Thursday, if they're employees of the
10 hospital, you can't bill for that visit that
11 occurred on Tuesday. So it becomes really
12 difficult to monitor and the physicians just
13 felt it was better to be in a separate corp.

14 Q: Let's talk a little bit about your background.
15 Where did you grow up?

16 A: I grew up in Tulsa, Oklahoma.

17 Q: Okay. And tell us a little bit about your
18 background since you started college.

19 A: I attended Oklahoma State University with an
20 emphasis in broadcast journalism. I was there
21 for two years before I accepted a position with
22 a radio station as a news anchor and reporter.
23 I worked in the media, both in radio and
24 television, for about seven years and then went
25 into partnership with two other people in an

- 1 advertising and marketing firm. In my radio --
- 2 Q: What year was that?
- 3 A: That was in 1980.
- 4 Q: Okay.
- 5 A: We handled a variety of accounts doing their
- 6 business planning, marketing and advertising
- 7 and really did have somewhat of a focus on
- 8 healthcare related accounts. Represented the
- 9 Sisters of Mercy out of St. Louis on a number
- 10 of matters. And then in 1987 with the oil bust
- 11 in Oklahoma and Texas, we closed that marketing
- 12 firm and I ended up going to work for
- 13 Presbyterian Hospital in Oklahoma City as their
- 14 director of public relations.
- 15 Q: Okay. And who owned Presbyterian Hospital?
- 16 A: Hospital Corporation of America.
- 17 Q: HCA?
- 18 A: HCA.
- 19 Q: And what year did you start with them?
- 20 A: 1988.
- 21 Q: Okay. And is this the same company that owns
- 22 Trident Medical Center and Summerville Medical
- 23 Center?
- 24 A: It is.
- 25 Q: And where were you living when you started work

1 with HCA?

2 A: In Oklahoma City.

3 Q: And what positions did you have?

4 A: After I went to work for HCA, I went back to
5 school at Southern Nazarene University, got an
6 undergraduate degree in human resources and
7 organizational management. Then I went on from
8 there to get a master's degree in business
9 administration from Oklahoma City University
10 with emphasis in finance. When I completed the
11 master's degree, I was promoted to vice
12 president level at Presbyterian Hospital, which
13 that promotion occurred in 1994. And then
14 shortly after that, HCA and Columbia merged.
15 And in Oklahoma we created what was called the
16 Oklahoma division. There were 11 hospitals in
17 the state under HCA at that time. And I was
18 promoted to a vice president at the division
19 level when that merger occurred.

20 Q: And what were your responsibilities in that
21 position?

22 A: Very similar. I was the vice president of
23 business development for the Oklahoma division,
24 so looked at growth opportunities, new service
25 lines, new products. I was responsible for

1 assisting in the development of the annual
2 business plan for all 11 hospitals, reviewing
3 those business plans and making
4 recommendations. Also, while I was at the
5 division, we began employing physicians in the
6 Oklahoma division and ultimately I ended up
7 with responsibility for the employed physician
8 group for the Oklahoma division.

9 Q: Were your responsibilities similar to what you
10 heard Mr. Rardin testified his responsibilities
11 are for HCA today?

12 A: Very similar.

13 Q: Okay. Now, you said as part of your position
14 at HCA, did you develop projects for hospitals
15 in Oklahoma?

16 A: I did. And actually in Oklahoma we did two
17 greenfield or brand new hospital projects. The
18 first one that I worked on and was responsible
19 for was a hospital in Tulsa called Southcrest.
20 It's a growing area of Tulsa. It was part of
21 a joint venture that we did with Hillcrest
22 Hospital, that HCA did with Hillcrest Hospital,
23 which was a not-for-profit in Tulsa, Oklahoma.
24 And then we also developed a small rural
25 hospital in an area called Seminole, Oklahoma,

1 which was about a 25 bed hospital.

2 Q: Okay. Was the first hospital that you just
3 talked about similar to the hospital we're
4 talking about here?

5 A: I would say quite a bit larger. I think
6 Southcrest was over 200 beds. It was the
7 initial construction.

8 Q: And when you did those projects for HCA, did
9 those projects require a capital investment?

10 A: They did.

11 Q: What was the process that you would go through
12 when you were there to invest capital to
13 construct and develop a hospital or other
14 significant projects?

15 A: It was a very prescriptive process. We would
16 first write a white paper or a narrative on the
17 project, why we felt that we should consider
18 that opportunity, how we thought it would
19 perform, what patient base it would serve. And
20 ultimately we would do a financial pro forma
21 that had to show that the construction and the
22 result of that facility would be incremental to
23 shareholders.

24 Q: Was there ever a time at a HCA where a large --
25 where you worked on or knew of a large capital

1 project that was approved without any
2 financials being prepared?

3 A: No, never.

4 Q: How about without a business case narrative
5 being prepared?

6 A: I can't think of anything that was in excess of
7 even \$750,000 that wouldn't have required a
8 business case narrative.

9 Q: And was there often a return on investment
10 calculated?

11 A: There was either a return on investment, an
12 internal rate of return, or a payback period
13 that was calculated. At that time we did look
14 at hurdle rates because of the shareholder
15 component.

16 Q: Okay. Did you ever have a project, a
17 significant capital project, approved with a
18 one hour telephone call?

19 A: Never.

20 Q: Okay. Now, when did you leave HCA?

21 A: I left HCA in February of 2000. At that time
22 the government had sanctioned Columbia/HCA with
23 regard to some billing issues and it actually
24 resulted in the company downsizing and spinning
25 off two other companies. Those two companies

1 were Triad and Lifepoint. In Oklahoma, of the
2 11 hospitals, nine were in the spinoff and
3 either went to Triad or Lifepoint. Only two
4 remained with HCA at that time. And the
5 Oklahoma division was going to be closed. I
6 was offered a position to move to Denver and
7 chose not to take that and went to work for
8 Tenet at their corporate offices in Dallas in
9 a very similar role.

10 Q: What is Tenet?

11 A: Tenet at that time was the second largest for-
12 profit healthcare system in the country, I
13 think with about 90 hospitals at the time that
14 I went there.

15 Q: And you lived in Dallas?

16 A: I lived in Dallas and I was a regional director
17 for the Texas region over business development
18 and had 17 hospitals that I worked for.

19 Q: And when you were at Tenet, did you have a
20 process that you followed for major capital
21 investment projects?

22 A: A very similar process that I've seen
23 throughout my career. That is to write a
24 fairly comprehensive narrative as to why you're
25 doing it and what you expect from it and that

1 would be accompanied with a financial pro
2 forma.

3 THE COURT: Excuse me.

4 A: Yes, sir.

5 THE COURT: A moment ago you described that as a
6 prescriptive process. I assume that you mean
7 by that that there is a format prescribed that
8 you go through?

9 A: Yes, Your Honor. In both HCA and at Tenet, the
10 structure of that white paper was pretty well
11 formulated into, you know, what are you doing,
12 why are you doing it, where is it going. It
13 was a who, what, why, where, when with a
14 conclusion at the end, so.

15 THE COURT: One other matter. You've used the term
16 incremental to shareholders.

17 A: Yes, sir.

18 THE COURT: What sense did you mean incremental to
19 be accepted in?

20 A: Incremental meant that it couldn't result in a
21 loss of the shareholder value, so whatever you
22 do had to produce enough return on that
23 investment that it increased the value of the
24 shares, not decreased them.

25 THE COURT: Thank you.

1 Q: Now, did you -- in your career, did you work
2 with or know David Dunlap?

3 A: I did. When I went to Presbyterian Hospital in
4 1988, David Dunlap was the CEO there and in
5 late '94 when the merger occurred with
6 Columbia, he was promoted to a division
7 president over the Oklahoma division.

8 Q: Well, how did you get to Charleston?

9 A: In early 2004 I had made the decision that I
10 wanted to leave Tenet. I honestly had some
11 issues with the way Tenet operated as a for-
12 profit and began looking around. I was
13 actually looking at a job with Christus
14 Healthcare in Houston, Texas. And I called
15 David Dunlap because he had turned down a role
16 at Christus to go as a regional CEO for them,
17 and I was asking, you know, what should I know
18 about this company before I go down and meet
19 with them. And he asked that before I go meet
20 with Christus would I get on a plane and fly
21 out to Charleston.

22 A: Okay. And what happened after that?

23 Q: I flew out to Charleston ten days later, looked
24 at the facilities, had meetings with David and
25 the chairman of the board, and then Saturday

1 night had dinner with the board, and Sunday
2 morning they offered me a position.

3 Q: And have you been at Roper St. Francis since
4 that time?

5 A: I have. I started April 12th of 2004.

6 Q: And what's David Dunlap's role with Roper St.
7 Francis?

8 A: He is the president and chief executive officer
9 of the healthcare system.

10 Q: And in April of '04, what position did you
11 start with?

12 A: I was hired as the vice president of system
13 development and the only thing that's changed
14 about that, the name seemed to be confusing,
15 people thought I had something to do with IT
16 systems, so they changed the name to chief
17 strategy officer.

18 Q: Okay. And when did you take over the
19 responsibilities of the physician network?

20 A: It was in 2008. I had been working on the
21 development and some of the negotiations with
22 physicians from 2007, but I was asked to assume
23 the role of CEO of the group in 2008.

24 Q: Okay. Now, we've heard some testimony about
25 your role with the State Health Planning

1 Committee. What is the State Health Planning
2 Committee?

3 A: The Health Planning Committee is a group of 14
4 individuals that are appointed by the governor
5 to provide input and advice to both the DHEC
6 staff and the DHEC Board with regard to the
7 criteria and measurements that are put out in
8 the State Health Plan.

9 Q: And are you on the State Health Planning
10 Committee?

11 A: I am.

12 Q: And so how did you get chosen for that?

13 A: I think I was chosen because in, I believe it
14 was early 2006 I was asked to testify at
15 Senator Peeler's joint conference committee on
16 certificate of need because I had had -- most
17 of my career had been in two states that did
18 not have certificate of need, and I was asked
19 to testify on just what that was like, and it
20 would be the issues that occurred in states
21 without some regulatory process. After that I
22 was appointed by Governor Sanford to be on the
23 State Health Planning Committee.

24 Q: And are you still on it today?

25 A: I am.

1 Q: On the State Health Planning Committee, are
2 certain slots reserved for certain healthcare
3 providers?

4 A: It is. I think it's set up to be a cross
5 section of those of us who are involved in the
6 healthcare industry. There are providers on
7 that committee which are hospital facilities.
8 There are physicians on the committee. We
9 have, I think, a representative from the
10 insurance companies and we have a
11 representative from industry and business.

12 Q: Okay. And who do you represent or what slot do
13 you hold?

14 A: I represent the hospital facilities, the
15 providers.

16 Q: Are you the only person on there with --

17 A: I'm not. I think there are three of us that
18 represent providers.

19 Q: Okay. Now, are you free to vote on the
20 committee as you see fit or are you bound as a
21 healthcare provider?

22 A: I'm free to vote as I see fit.

23 Q: All right. How often does the State Health
24 Planning Committee meet?

25 A: It's been kind of ad hoc, but we typically meet

1 every other year and the Health Plan is for a
2 two-year cycle.

3 Q: Okay. Now, what authority does the State
4 Health Planning Committee have?

5 A: I don't think we have any authority. As I
6 said, we're in an advisory role. Staff will
7 present to us a template or, you know, the
8 draft of the Health Plan. We review it in a
9 first meeting. We go through and discuss
10 anything that's come up in the last two years
11 as an issue and make recommendations to staff
12 on things, you know, that we think might need
13 to be changed. Following that meeting we go
14 out to public hearings with the document, once
15 staff has incorporated the changes that they
16 feel are appropriate. And many of us on the
17 committee will attend a number of these public
18 hearings. They occur in Charleston and
19 Greenville and I think Florence and a few other
20 cities. And get public comment on the Plan.
21 We'll then have another meeting where we review
22 the public comment and decide what we will
23 recommend to the DHEC Board out of that. But
24 our role at that point is we make a
25 recommendation to staff and the DHEC Board.

1 Q: Okay. And does the DHEC Board sometimes change
2 what y'all recommend?

3 A: They do.

4 Q: Who's the staff person at the Department, at
5 DHEC, that you work with on State Health
6 Planning Committee?

7 A: Les Shelton is the one that organizes that.

8 Q: Okay. When the State Health Planning Committee
9 meets, is it a public meeting or a private
10 meeting?

11 A: They're all public.

12 Q: If you vote on an issue, it is by secret ballot
13 or is it public?

14 A: Public, usually just by a show of hands.

15 Q: Okay. Now, are there ethical rules regarding
16 on what issues you can vote on as a member of
17 the State Health Planning Committee?

18 A: There are. If the vote is going to affect only
19 your facility or your business and not be
20 generalizable [sic] to the healthcare community
21 overall, you're asked to recuse yourself from
22 that vote.

23 Q: Okay. Now, when you were appointed to the
24 State Health Planning Committee, did you ever
25 ask about the fact that the Tri-county -- about

1 the service area for inpatient hospital beds?

2 A: I did. At one of the very first meetings I
3 attended on the State Health Plan I asked why
4 there were only two areas in the state where
5 the service areas were combined -- Calhoun and
6 Orangeburg County; and the Tri-county with
7 Charleston, Dorchester and Berkeley Counties.
8 Mr. Shelton explained to me that he felt that
9 the Calhoun Orangeburg combination was a result
10 of the Health Resources and Service
11 Administration Program.

12 Q: Tell what that is briefly.

13 A: Briefly, they just looked at the population
14 needs within an area and combined some areas
15 for the purpose of serving specific
16 populations. And I believe in Orangeburg and
17 Calhoun that was done and created The Regional
18 Medical Center there.

19 Q: So do both those counties run that hospital
20 together?

21 A: Yes.

22 Q: Is that the understanding?

23 A: That is.

24 Q: All right. What about the -- and then did you
25 ask about the Tri-county area?

1 A: I did ask about the Tri-county area and Mr.
2 Shelton said he had no idea why those three
3 ended up being combined. And I did pursue it.
4 I asked, well, you know, is that something that
5 we can consider separating those counties
6 because, you know, it just didn't make sense
7 why the Charleston area wouldn't be at a
8 minimum treated like the Lexington Richland
9 Counties where the service areas weren't
10 combined but you looked at the use rate across
11 the counties. And Mr. Shelton said that we
12 might look at that in the future but he would
13 rather not deal with it in the State Health
14 Plan that year and then we moved on.

15 Q: Okay. Did you make any motions or anything
16 regarding that?

17 A: I did not.

18 Q: Was there anything put in the State Health Plan
19 or the Draft Plan to put out about the Tri-
20 county service area for comment?

21 A: I don't believe so.

22 Q: Okay. Now, were you a member of the State
23 Health Planning Committee when the Parkridge
24 case we've discussed, I guess over a week ago
25 now, was working its way through the courts?

1 A: I was, and we watched that carefully. That
2 was, I believe, Judge Kittrell that made the
3 ruling on that initially, and then ultimately
4 sent it back to the Department, the DHEC Board,
5 for their view of how they have implemented the
6 Plan.

7 Q: And were you, as a member of the State Health
8 Planning Committee, surprised by the DHEC
9 Board's decision in the Parkridge case?

10 A: Not at all.

11 Q: Okay. And why not?

12 A: That's the way the Plan had been implemented
13 for as long as I had been in the state. And
14 really with the way the general hospital
15 section of the State Health Plan is written,
16 there is no language in there with regard to
17 existing hospitals. And the bed is the unit of
18 measurement that's in the Health Plan to define
19 a hospital, and a hospital is defined as any
20 place where there are overnight stays. So, you
21 know, in the absence of being able to transfer
22 beds to create a new facility, I'm not sure how
23 it would ever been done in the state.

24 Q: Well, why would you use the bed as the unit of
25 measure for a hospital in the State Health

1 Plan?

2 A: Well, the hospital is defined as an inpatient
3 overnight stay and so that does require a bed
4 for the stay. And then with that there's
5 criteria about what it takes to be a hospital.
6 So you know that with a bed come all the
7 services within that room from, you know,
8 oxygen to dietary to diagnostic imaging
9 services. Everything that's required to
10 evaluate and treat a patient in an overnight
11 stay would be necessary to accompany a bed.

12 Q: Okay. Now, did you believe, as a member of the
13 State Health Planning Committee, that the bed
14 transfer language in the State Health Plan
15 needed to be clarified or explained after the
16 board's decision in Parkridge?

17 A: I did not.

18 Q: Okay. Why not?

19 A: I think it was very clear how that language had
20 been applied and the board further emphasized
21 that that's what their expectation and
22 understanding was.

23 Q: Okay. Now, during your career, in your entire
24 hospital career, have you interacted with
25 physicians?

1 A: I have.

2 Q: And are physicians an important part of the
3 success of a hospital?

4 A: They're critical to the success of a hospital.

5 Q: All right. Why is that?

6 A: They are the ones that utilize our facilities.
7 They decide that the patients will be admitted
8 there. They determine what will be needed in
9 order to properly evaluate a patient. They
10 determine what they'll need to properly treat
11 a patient. So they guide us in virtually every
12 aspect of the care that we provide.

13 Q: Okay. Let's talk a little bit about some of
14 the different types of physicians. What is a
15 primary care physician?

16 A: We view a primary care physician as a family
17 practice physician, which that's a physician
18 that's gone through a residency and been board
19 certified in family medicine; an internal
20 medicine physician, same thing, board certified
21 in internal medicine, very much a
22 diagnostician; and then a pediatrician, so
23 those three subspecialties.

24 Q: Now, can you explain the concept of a
25 gatekeeper to the judge -- physician as a

1 gatekeeper?

2 A: Yeah, a gatekeeper is a primary care physician
3 who rather than just see a patient when they're
4 sick and on incremental visits, actually takes
5 responsibility for the overall health of that
6 patient and they guide the patient not only in
7 the medications they take and the lifestyle
8 they want to see, but they determine, you know,
9 what specialists they may need to see and how
10 frequently. So they really, they manage that
11 patient's health to a greater degree than just
12 going in for the sick visit.

13 Q: Is that something that is more that you see in
14 the industry now?

15 A: It is. It's becoming more and more common and
16 there is a program right now that's being
17 promoted by the government through the Centers
18 for Medicare and Medicaid services called
19 Patient-Centered Medical Home. And that's
20 where patients do select a primary care
21 physician to serve as their medical home and
22 then that physician ultimately is reimbursed to
23 some degree for maintaining the health of that
24 population.

25 Q: Now, where do primary care physicians typically

1 treat their patients?

2 A: In the office.

3 Q: And what is a hospitalist?

4 A: A hospitalist is typically an internal medicine
5 physician with a lot of training in inpatient
6 care and they take over the treatment of that
7 patient while they're an inpatient in the
8 hospital.

9 Q: Explain to the judge how a primary care
10 physician and a hospitalist interact with each
11 other in the treatment of a patient.

12 A: Well, the primary care physician is going to
13 treat the patient in the office and if that
14 patient has an illness or an injury that's to
15 the degree that they need to be hospitalized,
16 then they hand off that patient to the
17 hospitalist for the care within the hospital.
18 And then once that patient's discharged, the
19 hospitalist refers them back to their primary
20 care physician. It really is a way to create
21 greater efficiency and actually a much higher
22 quality of care for the patient while they're
23 in the hospital.

24 Q: Well, explain that. How does it create
25 efficiency and increase quality of care?

1 A: The way it creates efficiency is, you know, 20
2 years ago most physicians followed their
3 patients into the hospital. So you'd have a
4 family practice doc and say, you know, Mrs.
5 Smith, I'm going to admit you and that doctor
6 would a round on the patient early morning,
7 order tests and, you know, look at the chart.
8 Then the physician would go to the office and
9 practice all day in the office seeing patients
10 and then go back at the end of the day and see
11 what the tests showed and try to determine what
12 the next course of action for that patient
13 would be. The problem with that is there's an
14 eight to ten hour lag between the test being
15 ordered and when the physician has the ability
16 to start reacting to it. With the
17 hospitalists, they're there so as soon as the
18 results from that test are back, then they can
19 evaluate them and begin a treatment plan with
20 the patient immediately. It definitely lowers
21 the length of stay. Patients don't have to be
22 in the hospital as long. And hospitalists,
23 because that's where they work all day, they
24 become much more familiar with the systems and
25 the procedures and are able to navigate them

1 more efficiently.

2 Q: Okay. So in today's world do primary care
3 physicians admit as many patients as they used
4 to?

5 A: Well, they do send as many patients to the
6 hospital.

7 Q: Right.

8 A: The hospitalist is technically the one that is
9 responsible for the admission even though it
10 was referred to them by a family physician or
11 internal medicine doctor.

12 Q: Okay. Well, let's talk about, what is a
13 specialist?

14 A: Specialists have a greater level of training
15 and it usually is focused in a single area;
16 one, you know, body system or organ. So, you
17 know, an example would be an endocrinologist.
18 And endocrinologists specialize in pancreas,
19 diabetic issues and thyroid, and that's kind of
20 the extent of their issue. They're not going
21 to fix a broken arm.

22 Q: Okay. And they're different -- what about are
23 there different types of specialists in regards
24 to surgical, medical?

25 A: There are.

1 Q: Explain that.

2 A: There are a number of surgical subspecialties
3 from general surgery, orthopaedic surgery,
4 neurosurgery and GYN and the list goes on, and
5 they are the physicians who spend a great deal
6 of their time in the OR doing surgical
7 procedures. We also have medical sub-
8 specialties, those that tend to deal with
9 medical issues and illnesses like a
10 pulmonologist, the endocrinologist,
11 nephrologist. They're more of a medicine-
12 oriented physician, not procedural.

13 Q: So do specialists treat patients in the
14 hospital or the office or both?

15 A: Both. I think you see the surgeons spend
16 probably a little more time in the hospital
17 than they do their office; and for the medical
18 sub-specialties, it's just a little more time
19 in the office than they do in the hospital.

20 Q: How do specialists get their patients?

21 A: They get their patients because typically a
22 primary care physician or another physician has
23 referred that patient to the specialist. So if
24 you have a patient in a family practice office
25 that's had knee pain for a number of years or

1 they've tried to treat it medically and they've
2 tried to treat it with physical therapy and
3 that just doesn't work; then that's probably
4 going to result in a referral to the
5 orthopaedic surgeon to see if there's a
6 surgical solution for that.

7 Q: Now, where do primary care physicians tend to
8 locate their offices?

9 A: They're going to locate their office closest --
10 as close to the patients as they can be. So
11 they follow the population.

12 Q: Okay. Now, what happens -- in your career have
13 you done work in areas where the population
14 either grew in an area or kind of migrated to
15 a different area?

16 A: I have. That is always a concern when you have
17 a healthcare system. Traditionally what we've
18 seen is the hospitals used to be built right in
19 the downtown area of cities and then as the
20 population grew out away from the center of the
21 city you started to see the services migrate to
22 follow the population. The first service to
23 migrate is always primary care. They want to
24 be close to their patients and they have the
25 least capital investment to move. They usually

1 just -- they can rent another office space and
2 be there very quickly and it's important to
3 them to be close to that expanding population.
4 And then what happens after that, the
5 specialists, in order to keep those
6 relationships tight, will start to follow the
7 primary care out into the community. And, you
8 know, across the country you can see the
9 erosion of the downtown hospital as populations
10 migrate.

11 Q: Well, that's my question. What happens to the
12 older population center where the --

13 A: They start to lose business. Fewer and fewer
14 patients will come into a downtown setting.

15 Q: I'll show you this chart right here which is
16 Respondent's Exhibit Number 75, which we've
17 done it on a big chart here. It's also up on
18 the screen. You're familiar with -- this is
19 our population and bed chart that we've done
20 here. Can you kind of explain to the court
21 what you're seeing about the Charleston area?

22 A: Well, in the Charleston area, you know, you
23 have the majority of beds in Charleston County
24 are on the peninsula all within just a few
25 hundred yards of each other. The peninsula

1 population really hasn't grown in years. It's
2 been very static. But the growth is occurring
3 out in Dorchester and Berkeley County. One of
4 the things that makes that population sprawl
5 and the movement of the physicians even more
6 dramatic in the Charleston area is we're
7 dealing with a semicircle.

8 Q: Explain that.

9 A: Well, in most cities, the downtown's pretty
10 much center to the population and as the town
11 grows, it tends to grow, you know, in 360
12 degrees in a full circle unless there's some
13 geographic barrier. And our geographic barrier
14 is the Atlantic Ocean. So the population
15 cannot grow to the southeast. It has to grow
16 to the northwest.

17 Q: When you got to Charleston in 2004, what did
18 you find in regards to this issue we're talking
19 about?

20 A: Well, the first thing that became crystal clear
21 was that the primary care physicians had left
22 the peninsula. And there's some family
23 medicine, internal medicine at MUSC, but the
24 private practicing family medicine doctors had
25 moved to West Ashley and Mount Pleasant and

1 James Island. I think actually in 2004 I don't
2 think we had one -- that we had one single
3 family practice doc that's still officed on the
4 peninsula.

5 Q: What about today?

6 A: Today there are two.

7 Q: So there are two family practice, two doctors
8 on the peninsula?

9 A: Uh-huh.

10 Q: And how many are in these other areas -- West
11 Ashley, Mount Pleasant, James Island?

12 A: You know, I think in Mount Pleasant there are
13 about 50 primary care physicians; West Ashley,
14 gosh, 50 to 60 at a minimum; James Island
15 probably has 30, 35 family practice, internal
16 medicine physicians.

17 Q: Well, did this circumstance look familiar to
18 you when you arrived in 2004?

19 A: It did. It did. It looked very similar to
20 what I had dealt with at Presbyterian Hospital
21 in Oklahoma City, which was a downtown hospital
22 where you see the family practice start to
23 leave and then the specialists try to hang on
24 but they have lost their referral source.

25 Q: And so as a result, what did they do?

1 A: They begin taking cases either out to the
2 community hospitals. They tend to follow the
3 primary care ultimately.

4 Q: Okay. Let's talk about market share. Can you
5 kind of explain to the judge what market share
6 is?

7 A: Very simply, it's just a percent of the
8 inpatient business that you had during that
9 reporting period. So with Roper St. Francis
10 Healthcare with about a 36 percent market share
11 just means that 36 out of 100 inpatients in the
12 Tri-county area elected to use our facility.
13 So it's a simple percentage.

14 Q: Well, what's the market share for Berkeley
15 County? You said 36 percent, but that's --

16 A: That's the Tri-county area.

17 Q: That's the Tri-county area.

18 A: In Berkeley County, we're between 23 and 24
19 percent market share.

20 Q: Now, what are the drivers of market share?

21 A: There are a number of factors that go into it.
22 I think brand recognition and reputation are
23 very important. The physicians on your medical
24 staff, just how many there are in raw numbers
25 and their utilization of your facility. There

1 is a component of marketing that helps that
2 out. And then there's just the consumer
3 pattern that develops over time, word of mouth
4 and those patients that have used you in the
5 past liked the service they received and will
6 use you again.

7 Q: Does distance, geographic distance, affect it?

8 A: It does.

9 Q: How's that?

10 A: People just will try to go to a near provider
11 if it's possible and if they feel they can get
12 the same level of service.

13 Q: I'm going to show you an exhibit. I think Mr.
14 Johnson was asked about Petitioner's 150. It's
15 an email. It's Petitioner's 150.

16 MR. LONG: Can you blow that up a little bit?

17 Q: All right. On the email below, that's your
18 email to -- you're sending that email, right?

19 A: I am.

20 Q: What's the date on it?

21 A: That is March 6th of '08.

22 Q: Okay. And who are you sending it to?

23 A: Sending it to David Dunlap and Bret Johnson.

24 Q: And David Dunlap is the --

25 A: CEO and president.

1 Q: And we heard Mr. Johnson last week, right?

2 A: He's the chief financial officer of the health
3 system.

4 Q: All right. Can you kind of read the email if
5 you would and go ahead and publish it?

6 A: Yes. What I'm saying is here are the new
7 market share numbers for 2006. And you'll note
8 the state runs a little more than a year behind
9 on their market share data. So we're getting
10 the numbers for 2006 in the first quarter of
11 2008. And I say I'm afraid it is not good news
12 across the board. Roper continued to lose
13 market share, which we'd talked about. I mean,
14 you know, we had seen that pattern developing.

15 Q: Is Roper, what is Roper when you say Roper?

16 A: Roper Hospital downtown.

17 Q: Okay. So that's the hospital on the peninsula?

18 A: Right.

19 Q: Okay.

20 A: So they've been struggling and losing little
21 bits of market share over the years, and we
22 expected that to some degree because we have
23 been transitioning some of our business from
24 Roper Hospital downtown to St. Francis Hospital
25 in West Ashley. Some of it was just focusing

1 on services at St. Francis and business moving
 2 that way. We'd seen the obstetrics program
 3 move really from the peninsula out to West
 4 Ashley. So we expected to see some decline at
 5 Roper, but we also expected to see an
 6 offsetting improvement or more at the St.
 7 Francis Hospital. And why I'm saying it's not
 8 good news is that Roper Hospital continued to
 9 lose a little, but St. Francis had stayed flat
 10 instead of offsetting the loss that we'd seen
 11 at Roper. I say MUSC was a clear winner, that
 12 they did pick up market share in all three
 13 counties in that year. And then I talk about
 14 their aggressiveness in employing physicians
 15 and placing them in the community is clearly
 16 driving market share. And we'd seen UMA, which
 17 is University Medical Associates, become very
 18 active at not only increasing the size of their
 19 faculty but also employing community physicians
 20 under the University.

21 Q: What is UMA?

22 A: University Medical Associates, it is the
 23 physician group for MUSC.

24 Q: Is it comparable to the physician network for
 25 Roper St. Francis but for the Medical

1 University of South Carolina?

2 A: Yes, it is. And then I say this makes their
3 three practice acquisitions this week even more
4 concerning.

5 Q: Okay. We've heard testimony about the ways a
6 healthcare provider can be on the offensive to
7 gain market share. Is there another component
8 of market share that's important to a provider?

9 A: Yeah. I think, you know, there's definitely
10 the defensive side protecting the market share
11 that you have and that's critical because we
12 make our capital investments, we size the
13 infrastructure of our organization based on the
14 expectation that that market share will at a
15 minimum continue and hopefully grow.

16 Q: And does the state guarantee you a market
17 share?

18 A: No, they don't.

19 Q: Okay. Well, how do you -- and is market share
20 important to Roper St. Francis in particular in
21 this project?

22 A: It is. I mean, this, you know, when we look at
23 Berkeley County, we've had a long history of
24 having just about one in four patients from
25 that county choose a Roper St. Francis

1 Healthcare facility. It's, as you heard Bret
2 Johnson testify, it is a large book of business
3 for our healthcare system and we think that
4 there is a real risk of seeing a loss to that
5 market share because it is so distant from our
6 facilities. And as the growth occurs and the
7 traffic becomes more congested in Charleston,
8 it's becoming more and more difficult for those
9 patients to get from Berkeley County to the
10 downtown area or even to West Ashley.

11 Q: You mentioned earlier about the medical staff.
12 Tell me exactly what a medical staff is.

13 A: The medical staff is that group of physicians
14 that have been granted privileges and approved
15 for membership to perform within your hospital.

16 Q: Okay. So how does a physician obtain
17 privileges for Roper St. Francis?

18 A: They would apply to the staff and have to meet
19 the requirements set forth in medical staff
20 bylaws. They'd submit their credentials, which
21 there's a group there that would review their
22 education, their experience, their malpractice
23 history. And then they would be granted
24 privileges on the hospital staff.

25 Q: If I'm a physician in the Charleston area and

1 I do not have privileges at Roper St. Francis
2 Hospital, what does that mean in regards to
3 being able to practice there?

4 A: You wouldn't be able to practice at one of our
5 facilities.

6 Q: Can a physician who does not have privileges
7 admit patients?

8 A: They cannot.

9 Q: Now, how many physicians are on the Roper St.
10 Francis staff at this time?

11 A: I think it is about 800 physicians in total on
12 all three medical staffs.

13 Q: Now, does a doctor have to choose which
14 hospital or hospital system he wants to have
15 privileges at or can he have multiple
16 privileges?

17 A: He can choose to apply to multiple hospitals
18 for privileges.

19 Q: And do you see that?

20 A: We do some.

21 Q: Now, Mr. Gallati testified that the Trident and
22 Roper St. Francis medical staffs were separate,
23 intended to be kind of distinct for the two.

24 A: I would agree with that.

25 Q: And so is there much overlap or how much

1 overlap is there?

2 A: There really is very little overlap. If I were
3 to take an educated guess, out of our 800
4 physicians we may have as many as 50 that have
5 active privileges at Trident or Summerville.

6 Q: And are there very many Trident Summerville --
7 their medical staff is -- do you know how large
8 it is?

9 A: I believe it's close to 500.

10 Q: Okay. And are there many physicians on their
11 medical staff that have privileges at Roper St.
12 Francis?

13 A: Probably about that same 50.

14 Q: Now, what are the two primary ways that
15 patients access a healthcare system?

16 A: One is certainly through the emergency
17 department. I think about 40, between 40 and
18 45 percent of our admissions, depending on the
19 hospital, end up coming through the emergency
20 department. The other patients come to us by
21 seeing a primary care physician and either
22 being admitted through the hospitalist or being
23 referred to a specialist that would admit them.

24 Q: So if you're a physician who has privileges at
25 Roper St. Francis and you're a patient that

1 needs to go to the hospital, where are you
2 going to send them?

3 A: To Roper or St. Francis.

4 Q: And what if you have privileges at Trident
5 Medical Center and your patient needs to go to
6 the hospital, Trident Health Systems?

7 A: Trident or Summerville.

8 Q: Now, let's talk about EDs for a second. Are
9 there -- how many -- are there emergency
10 departments in Berkeley County?

11 A: There are two.

12 Q: All right. And where are they located in
13 relation to each other?

14 A: They're both in Moncks Corner and I believe
15 it's less than two miles apart.

16 Q: Now, are they comparable in regards to the
17 services they offer there?

18 A: I think so. Yeah, I certainly know ours is a
19 24/7 full service ED with diagnostic
20 capability, and I understand that theirs is
21 also.

22 Q: Now, are they freestanding?

23 A: They are freestanding.

24 Q: What does that term mean?

25 A: A freestanding emergency department means that

1 it is not co-located with inpatient hospital
2 beds.

3 Q: So there's no hospital there with it?

4 A: No hospital.

5 Q: All right. Now, do patients have a choice on
6 the emergency department that they go to?

7 A: Yes, of course.

8 Q: And even if they're in an ambulance, how does
9 that work?

10 A: In an ambulance, EMS, first question to a
11 patient is is there, you know, a hospital you
12 prefer to be taken to or an emergency room.
13 You know, there -- I think there are trauma
14 cases and serious issues where they'll go to
15 the emergency room that provides that service.
16 But if the patient's awake, they usually ask
17 them where they would like to go.

18 Q: Okay. Now, what would you expect to happen if
19 after the hospital in Moncks Corner is
20 constructed -- there will be an ED attached to
21 that hospital, right?

22 A: Yes.

23 Q: So what would you expect to happen if the
24 choice for patients is between a freestanding
25 ED at Roper St. Francis and an emergency

1 department that's located in a brand new shiny
2 hospital?

3 A: I think you'll see a shift of some volume to
4 the hospital and, you know, that will
5 definitely be patient directed. If you have a
6 mother-to-be that's pregnant and having early
7 labor symptoms, she's going to choose the
8 hospital that offers, you know, the ED that's
9 associated with obstetrical services. That
10 will clearly be a shift. And you'll have other
11 patients who assess the degree of illness and
12 decide they'd rather go to a hospital than a
13 freestanding ER.

14 Q: If the patients are more sick, where would you
15 expect them to go?

16 A: Where there's an inpatient bed.

17 Q: Is that also connected to the word or concept
18 we've heard earlier in the trial, acuity?

19 A: It is.

20 Q: What does acuity mean again?

21 A: Acuity is just a scale related to how sick or
22 injured a patient is.

23 Q: Let's take a look at our -- this is the one
24 that has all the zip codes on it. This is the
25 Trident projected market share board, but it

1 also -- which is Respondent's 76. But this
2 also has the zip codes on it. And I also want
3 to go to Respondent's 41, probably on the
4 screen. All right. This is a multi-page
5 document. I don't know if you want to look at
6 the book of if you're familiar with it, but
7 this is the document that was produced in
8 discovery that gives the ED visits to the Roper
9 St. Francis Emergency Department in Berkeley
10 County by zip code. So let's go over to the
11 third page I think, if we could, maybe it's the
12 fourth page. I'll have to look at it. There
13 we go.

14 A: I have it here.

15 Q: Let's look at our zip code kind of map here.
16 What we're looking at the -- is the emergency
17 department, Roper St. Francis Emergency
18 Department, located near where the proposed
19 Trident Moncks Corner Hospital will be located?

20 A: Like I said, less than two miles away.

21 Q: Okay. What's the number one zip code for
22 patients coming to the emergency department in
23 -- Roper St. Francis Emergency Department in
24 Moncks Corner?

25 A: It is from the Moncks Corner zip code, 29461.

1 Q: Is that the zip code where the facility is
2 located?

3 A: It is.

4 Q: And what about -- what's the next biggest?

5 A: It looks like St. Stephen, 29479, is the second
6 largest.

7 Q: Okay. And that's located where on this map
8 relative to Lake Moultrie?

9 A: It's kind of on the north side of the lake.

10 Q: Is it kind of northeast above the lake --

11 A: Yes.

12 Q: -- or right around the lake? All right.
13 What's second on the -- what's third on the
14 list?

15 A: It looks like that's going to be Bonneau at
16 29431.

17 Q: Where is Bonneau located relative to Lake
18 Moultrie? This one here?

19 A: Yes.

20 Q: It's directly east

21 A: It's directly east of the lake, just north of
22 Moncks Corner.

23 Q: North of the Moncks Corner facility, okay.
24 What about the next largest we see on the page
25 there?

- 1 A: It looks like Cross at 29436.
- 2 Q: Okay. How many visits does Cross have?
- 3 A: Nine hundred and eight.
- 4 Q: All right. Where is Cross located?
- 5 A: That's going to be on the -- is that the east
- 6 side of the lake?
- 7 Q: Well, I think about it as being west.
- 8 A: West, I'm sorry, west side of the lake.
- 9 Q: And so that's -- but it is also on Lake
- 10 Moultrie?
- 11 A: It is.
- 12 Q: And would it be north northwest of the
- 13 facility?
- 14 A: Yes.
- 15 Q: All right. And then the next one?
- 16 A: The next one I think is Pineville.
- 17 Q: Okay.
- 18 A: 29468.
- 19 Q: And where is 29468?
- 20 A: I'm trying -- it's hard to see from here. The
- 21 very northwest side of the lake.
- 22 Q: Directly north of the lake, right? And would
- 23 it be north also of the facility --
- 24 A: Yes, it would.
- 25 Q: -- in Moncks Corner? All right. Of these zip

1 codes, we've look at the top ones so far.
2 We're going to get to the next ones. Every one
3 of these zip codes touches Lake Moultrie,
4 doesn't it?

5 A: They do.

6 Q: Now, let's take a look at the -- and Cross is
7 908 visits, right?

8 A: Right.

9 Q: All right. Let's take a look at Goose Creek
10 zip code, 29445.

11 A: Okay. Three hundred and sixty-four visits.

12 Q: Okay. And that may be about the next one,
13 right, or it's right there at it a couple --

14 A: I think actually there's a Summerville that was
15 slightly larger than that.

16 Q: 29483?

17 A: Yes.

18 Q: Okay. Let's look at those two.

19 A: Uh-huh.

20 Q: 29483 is the zip code, that's the Summerville
21 zip code, right?

22 A: Yes.

23 Q: And what's unusual about this zip code?

24 A: It's split between Berkeley and Dorchester
25 County.

1 Q: The county line runs right through it, right?

2 A: Uh-huh.

3 Q: All right. And then 29445 is, what community
4 is primarily located in that zip code?

5 A: That's Goose Creek.

6 Q: Okay. Now, does Goose Creek have a much larger
7 population than these other zip codes around
8 the lake?

9 A: Considerably larger.

10 Q: And does 29483 have a larger zip code?

11 A: Much, much larger.

12 Q: All right. So what does this tell you in
13 regards to your emergency department located at
14 your Moncks Corner facility in regards to the
15 patient utilization of the facility?

16 A: Well, in healthcare we say patients don't
17 travel from a more suburban area to a more
18 rural area for their healthcare. They don't go
19 upstream. And that indicates to me that even
20 though Goose Creek is right next to the 29461
21 zip code, they're not traveling back to Moncks
22 Corner for healthcare because that's a very,
23 very small percentage of a large population.

24 Q: Okay. Now, are there some employers that could
25 also affect these numbers? /

1 A: They could. I think there are people that live
2 in Goose Creek and Summerville that probably
3 work at Santee Cooper and some of the other
4 businesses in the Moncks Corner area. That
5 wouldn't surprise me if those are the patients
6 that we're seeing is the folks who actually
7 work in Moncks Corner but live elsewhere.

8 Q: How big an employer is Santee Cooper in that
9 area of the --

10 A: That's the largest employer. I don't know what
11 the employee count is.

12 Q: Let's take a look at Respondent's 38. This is
13 also a chart or whatever that was produced in
14 discovery. You can see this shows the
15 emergency department visits for Roper St.
16 Francis Berkeley in Moncks Corner and then the
17 transfers out of the ED.

18 A: Uh-huh.

19 Q: Would you expect a patient that's transferred
20 out of the ED to be -- where would you expect
21 them to be transferred to?

22 A: We would expect them to be transferred to Roper
23 St. Francis in many cases because of the nature
24 of the patients that present in the ED there.
25 And those patients have clearly made a choice,

1 whether they were wanting to go to a Trident
2 facility or a Roper St. Francis facility. That
3 being said, the first question a patient is
4 asked before transfer is, you know, what
5 hospital would you prefer to be transferred to.
6 That's an open question, you know, and
7 typically they chose us so they're going to say
8 us.

9 Q: But if they choose Trident Medical Center,
10 where do they go?

11 A: They go to Trident Medical Center.

12 Q: And if they choose Summerville Medical Center,
13 where are they going?

14 A: They would go to Summerville.

15 Q: And if you look at the percentage there of
16 transfers, how many -- in 2010 how many ED
17 visits did the Berkeley Roper St. Francis
18 Moncks Corner Emergency Department have?

19 A: 15,137.

20 Q: And how many patients were transferred?

21 A: 1,109.

22 Q: So would you assume that those are going to be
23 admitted to a hospital?

24 A: Uh-huh. Oh, if they're transferred, they're
25 going to be admitted.