

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 Q: Mount Pleasant. Well, I'll tell you what.
2 Let's go to -- if you pop over, if we could, to
3 Joint 8, page 217. I'm going to show you the
4 Roper St. Francis Mount Pleasant CON
5 application. Now, this is your venue pro
6 forma, correct?
- 7 A: I don't see the title. I believe it is.
- 8 Q: Okay.
- 9 A: Yes, it is. Yes, it is.
- 10 Q: And the venue means, I think Mr. Long
11 established this with you, it is a standalone
12 pro forma, correct?
- 13 A: Correct.
- 14 Q: All right. And so let's look here at 2009,
15 which is the first year, full year of
16 operations. What was your interest expense
17 there?
- 18 A: \$5.4 million.
- 19 Q: Okay. So if we added \$5.4 million, which is
20 what you estimated the interest to be, to about
21 the \$11 million, we know Mount Pleasant lost
22 without the interest expense, that's about a
23 loss of \$16 million, correct?
- 24 A: Correct.
- 25 Q: Okay. Now, what did you, for the first year of

1 operations, what was your net income
2 estimation?

3 A: Four million dollar loss.

4 Q: Okay. So a four million dollar loss, the
5 actual \$16 million, that's a difference of \$12
6 million, right?

7 A: That -- that is correct. Now, one thing I
8 would point out is that even though this is a
9 venue pro forma, the corporate administration
10 is indeed presented in an incremental fashion.

11 Q: Okay. Why did you do that?

12 A: Because I thought it was important to reflect
13 the reality that the home office, if you will,
14 or the corporate staff arising from the
15 presence of Mount Pleasant Hospital as opposed
16 to not having Mount Pleasant Hospital would be
17 fairly minimal.

18 Q: Okay. But that's not how Roper does it, right?

19 A: That is -- that is correct. That's not how
20 they do it.

21 Q: Okay. So just based on your projection that
22 went to DHEC and what the actual projection is,
23 you over projected by over 300 percent,
24 correct? Well, pardon me. You underprojected
25 the losses by 350 percent, correct?

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1 A: With the caveat about corporate administration
2 being incremental even though this is a venue
3 pro forma.

4 Q: Okay. Fair enough. That's going to still be
5 quite a difference even if you added that back,
6 right?

7 A: Mr. Thomas, not to quibble with you. If you
8 could share with me the -- the other -- I see
9 the 4,000,141 which is in the venue pro forma
10 bottom line.

11 Q: Right.

12 A: And what was the revised -- I just want to make
13 sure your 300 percent assertion is correct. It
14 probably is. You're good in math, so.

15 Q: Well, what we have here is corporate
16 administration expenses of 2.4, correct?

17 A: Correct. Now, I think you had annualized this
18 six month number and then you I think
19 superimposed an interest expense component on
20 top of that and came up with a number that I
21 think I concurred with.

22 Q: Right.

23 A: But I can't remember what I concurred to.

24 Q: Was it 16 million?

25 A: I'm not sure.

1 Q: Yeah. That's what it was.

2 A: Okay.

3 Q: Now, would you agree with me -- are you doing
4 something over there?

5 A: I am.

6 Q: Okay.

7 A: Yeah. I agree with your 300 percent assertion.

8 Q: Okay. Thank you. Now, and I believe the
9 testimony that's come down in the trial is that
10 the reason indicated for the first year loss
11 was that the Roper St. Francis Mount Pleasant
12 volumes were -- were off by quite a bit in year
13 one, correct?

14 A: I think that's a fair statement, yes.

15 Q: Okay. Do you recall the average daily census
16 for Roper St. Francis Mount Pleasant was, the
17 actual was about nine, but the projection was,
18 what, 28?

19 A: Something along those lines, yes.

20 Q: Okay. And where did you get the information
21 for the Roper St. Francis Mount Pleasant pro
22 forma?

23 A: It would have been the same. Through Mike
24 Cassells on the revenue side and looking at
25 year to date expenses.

1 Q: How about the volume inputs that you based the
2 revenue projections off of?

3 A: I would have relied on Mr. Richardson for
4 those.

5 Q: And for the Mount Pleasant application as well?

6 A: Yes.

7 Q: Okay. And that's who you relied on in this
8 case that we're all here today for, correct?

9 A: That's correct.

10 Q: I'm going to take you back to Joint 8, which
11 again is the -- I'm sorry, bear with me. There
12 we go, back to the venue projection. What's
13 the depreciation expense that you have here?

14 A: For year one it would be -- actually for all
15 the years, just short of seven million dollars.

16 Q: Okay. Let's go back to 167 if we could. What
17 was the actual annualized depreciation expense
18 for Roper St. Francis Mount Pleasant?

19 A: Looks like the six month number is 4,153,000,
20 doubling that 8.3 million.

21 Q: Okay. So that's -- you were off by about 1.34
22 million there?

23 A: Yes.

24 Q: Okay. Let's go to Petitioner's 220 if we
25 could. I'm going to show you Petitioner's 220.

1 Now, did you ever have an opportunity to look
2 at Mr. Baehr's analysis that appears on
3 Petitioner's Exhibit 220? It's Baehr 1851.
4 Did you study that? Let me know if you can't
5 read it, Mr. Knapp.

6 A: I think I can read it. I just need a minute to
7 digest it. I actually think I saw some of
8 these numbers on a bar graph.

9 Q: Okay. So you didn't look at the underlying
10 calculations that Mr. Baehr made for those bar
11 graphs?

12 A: I did not.

13 Q: Okay. And so you don't know that he took these
14 numbers right off your draft, I guess the
15 drafts of the pro formas that you submitted in
16 discovery, right?

17 A: Yeah. I think this exhibit that I'm looking at
18 right now or page in an exhibit really harkens
19 to two different things. It harkens to the
20 draft that you alluded to --

21 Q: Right.

22 A: -- correctly. It also harkens to the Roper St.
23 Francis gross and net revenue by financial
24 class that I believe was in Knapp 72 through
25 81, which was a work paper set that was

1 provided to you via discovery.

2 Q: Right. And then it's got the actual numbers
3 from the Roper St. Francis Berkeley CON
4 application, correct? The 2,456, the 2,599 --

5 A: Yes.

6 Q: -- and the 2,750?

7 A: Yes.

8 Q: And those are net revenues per adjusted patient
9 day, right?

10 A: That is correct.

11 Q: Okay. And those, do those look right to you?

12 A: Yes, they do.

13 Q: Okay.

14 A: You're talking about the Roper St. Francis
15 final numbers?

16 Q: Correct.

17 A: Do they look right to me?

18 Q: Yes.

19 A: Okay. I'm not speaking to every dollar amount
20 in this page.

21 Q: Well, you don't know about the other dollar
22 amounts because you didn't check the
23 calculations, correct?

24 A: Well, I actually did because I kind of reverse
25 engineered what Mr. Baehr did.

- 1 Q: Okay.
- 2 A: I think I understand what he did.
- 3 Q: Okay. Are the numbers right?
- 4 A: No, they are not.
- 5 Q: These basic numbers on here are not correct?
- 6 A: I would direct your attention to the combined,
- 7 the 1.8 percent.
- 8 Q: All right.
- 9 A: I don't get that number.
- 10 Q: Okay. So you did the calculations?
- 11 A: Yes, sir.
- 12 Q: Did you submit them in discovery?
- 13 A: No. I just did this within the last week or
- 14 so.
- 15 Q: How about the last two lines? That's what I'm
- 16 interested in.
- 17 A: The draft?
- 18 Q: The Roper St. Francis draft.
- 19 A: And final?
- 20 Q: And the final.
- 21 A: The final is accurate. The draft I assume is
- 22 accurate.
- 23 Q: Okay. That's what I needed to know. Now, what
- 24 was the net revenue per adjusted patient day
- 25 assumption that you made, the increase when you

1 were doing your draft pro formas? So not your
2 finals. I think you said there was some kind
3 of charge increase.

4 A: There was a three percent patient charge
5 increase assumption in the draft.

6 Q: Okay. Why did you use three percent?

7 A: Three percent was a, kind of a default initial
8 effort. It's a percentage that I have used in
9 other engagements.

10 Q: Okay. So it's something you were just going to
11 use, but then you were told to change it,
12 right?

13 A: Well, I wasn't told to change it. I was -- I
14 was -- I got some additional information from
15 Shannon Cantwell that indeed the expectation
16 for the foreseeable future was going to be
17 something on the order of a seven percent
18 increase in charge master prices.

19 Q: In gross charges?

20 A: That's correct.

21 Q: Okay. And did she say why that was going to
22 occur?

23 A: I'm sure she did. I don't recall.

24 Q: Well, let's go, if we could, back to Joint 2 on
25 page 462. This is the Roper Berkeley CON

1 application. And is there a way, can you tell
2 me, Mr. Knapp, what the increase is in net
3 revenue per adjusted day from say 2013 to 2014?

4 A: I'm sorry, Mr. Thomas. I am in the wrong Joint
5 Exhibit. This is Joint 2?

6 Q: Yes.

7 A: I'm sorry.

8 Q: No problem.

9 A: And you're asking me is there a way to
10 determine the rate of increase?

11 Q: Yes.

12 A: Yes, sir.

13 Q: Okay. Could you do that from 2014 to -- or the
14 2013 to 2014 net revenue per adjusted patient
15 day increase?

16 A: Yes, sir. If you give me a few minutes, I can
17 do it. It looks like it's approximately a 5.8
18 percent increase.

19 Q: Does that sound reasonable to you?

20 A: Yes.

21 Q: Okay. And if the next year was also 5.8
22 percent, would that also be reasonable to you?

23 A: In my opinion, yes.

24 Q: Okay. What is the inflation rate for
25 healthcare?

1 A: Healthcare cost to hospitals?

2 Q: Yeah.

3 A: I'd say probably between two and three percent.

4 Q: And that's what you testified to I think back
5 in, back in your deposition as well?

6 A: I believe so.

7 Q: Now, is it your experience as a healthcare
8 financial expert that Medicare and Medicaid
9 have been increasing their reimbursement rates
10 at over twice the underlying rate of healthcare
11 inflation?

12 A: No, not for Medicare and Medicaid.

13 Q: Okay. And Mr. Bowling testified yesterday I
14 believe that Medicare is by far one of the
15 single biggest payers for the Roper St. Francis
16 system, correct?

17 A: It probably is the single biggest, yes.

18 Q: And has Medicare been increasing its rates by
19 six percent a year?

20 A: No.

21 Q: Okay. And we know Medicaid hasn't either,
22 right?

23 A: Correct.

24 Q: Okay. In fact, I think Mr. Severance testified
25 just this morning there has been downward

1 pressure on reimbursement rates. Do you agree
2 with that statement?

3 A: In certain situations, yes.

4 Q: Okay.

5 Q: Let's go to Petitioner's 59 for me. Do you
6 recognize this document, Mr. Knapp?

7 A: Yes, sir, I do.

8 Q: Okay. And it's from you to Mr. Richardson,
9 correct?

10 A: That is correct.

11 Q: Okay. And so what's the payer mix in terms of
12 Medicare and Medicaid for -- and this -- well,
13 is this the payer mix for Roper St. Francis
14 Berkeley?

15 A: The right-most column is, yes.

16 Q: Okay. And what did you assume for Medicare and
17 Medicaid?

18 A: Forty-nine percent for Medicare, five percent
19 Medicare HMO, and 16 percent for Medicaid.

20 Q: Okay. And so that's about 70 percent, isn't
21 it, Medicare and Medicaid all together?

22 A: It is. It is.

23 Q: All right. And as for as a payer mix, can you
24 tell the court what payer mix means?

25 A: Yeah. Payer mix is an array of the various

1 sources of green dollar bills to the hospital;
2 insurance companies, Medicare, Medicaid,
3 Champus, self-pay, things of that nature.

4 Q: Okay. And so if the payer mix is 70 percent
5 Medicare, Medicaid and you have say a thousand
6 patients that, you know, have inpatient visits
7 for the year at a hospital, how many of those
8 will pay with Medicare or Medicaid?

9 A: Approximately 70 percent.

10 Q: Seven hundred, right? And three percent, you
11 got three percent there for self-pay correct?

12 A: Correct.

13 Q: And at the end of the day self-pay doesn't
14 really pay, does it?

15 A: It pays a little.

16 Q: But a lot less than, at the end of the day,
17 what Medicare and Medicaid would pay?

18 A: Yeah, that's a fair statement. The collection
19 rate for self-pay would be fairly low.

20 Q: Okay.

21 A: The increase might be fairly significant, but
22 it would go from a really low number to really
23 a somewhat low number.

24 Q: Okay. What has been the typical Medicare and
25 Medicaid reimbursement rates over the last few

1 years for hospitals?

2 A: They've been in the two to two and a half
3 percent range absent any what CMS calls the
4 coding creep, you know, the ICD-9 CM, the DRG
5 codes that are assigned to the patients.
6 That's a phenomenon that continues on.

7 Q: Okay. So if 70 percent of your payers are
8 going to be doing two percent and three percent
9 less than, that leaves -- and you've got three
10 percent, the self-payers, and they don't really
11 pay a lot, that basically leaves 27 percent
12 left over, correct?

13 A: A couple of things. On the Medicare side
14 you've also got what I alluded to a minute ago
15 as far as coding creep and basically, as time
16 goes on, hospitals become more and more
17 sophisticated in terms of the ICD-9 CM codes
18 that are assigned to the various patients.
19 Those collapse into DRGs and there's coding
20 creep phenomenon. For example, if you have a,
21 let's say a two and a half percent rate
22 increase, your -- the amount that you actually
23 receive may be more like three and a half or
24 four percent due to enhancements in coding, if
25 you will. On the self-pay side, even though

1 the collection rates are low, collections rates
2 can increase at a fairly substantial rate if
3 they go from extremely low to just somewhat
4 low.

5 Q: Okay. Have you seen that experience at Roper?

6 A: I have not specifically no.

7 Q: And that's not something you've studied, right?

8 A: That's correct.

9 Q: And do you think Roper St. Francis, as a fairly
10 sophisticated provider, is just kind of behind
11 the ball on the whole phenomenon of coding
12 creep?

13 A: No. I would characterize it was an ongoing
14 search for excellence.

15 Q: Okay. Well, let's just -- I'd like for you to
16 assume for me that 73 percent of your payers
17 are actually increasing what they will pay,
18 what they will reimburse, correct?

19 A: Uh-huh (affirmative response).

20 Q: About two, two and a half percent a year,
21 right? Is that correct?

22 A: You're including self-pay in there too.

23 Q: Well, let's go with 70 percent, yeah, because
24 self-pay is going to be actually less, right?

25 A: Well, actually it could be more. Once again,

1 you could have a -- you could in theory have a
2 hundred percent increase going from a very,
3 very low collection rate to barely a somewhat
4 low collection rate.

5 Q: All right. You've studied the numbers because
6 that's -- is that what is happening at Roper
7 St. Francis?

8 A: I don't know.

9 Q: Okay. So if you've got 70 percent of your
10 reimbursement rate going up less than three
11 percent a year, and you've got 27 percent in
12 the other category, which is HMO, PPO, other
13 and commercial insurers, do you have any idea
14 how much you're going to have to increase those
15 rates in order to get up to the six percent
16 rate that you projected for net revenue?

17 A: 5.8 percent.

18 Q: 5.8 percent?

19 A: And you want me to assume no coding creep?

20 Q: I don't want you to assume coding creep because
21 that would be constant as far as I see.

22 A: Well, I would disagree with that, but.

23 Q: All right. Have you studied what the rate
24 increase would have to be for the commercial
25 insurance?

1 A: No, I have not.

2 Q: You haven't looked at that, have you?

3 A: Well, I've looked at it a little bit. I think
4 I alluded to in my deposition that Mr. Johnson,
5 in I believe this is one of the presentations
6 to the bond rating agencies -- well, it was, it
7 was his work product, I don't know who the
8 audience was -- where they were looking at six
9 to eight percent increases in managed care
10 reimbursement.

11 Q: And that's my question. Is that going to
12 happen year over year so their charge is going
13 to double every nine years?

14 A: It's certainly possible.

15 Q: Okay. Is that something you've seen happen in
16 other hospitals, eight percent increases in
17 managed care charges year, after year, after
18 year?

19 A: Sometimes, yes.

20 Q: Okay. And you think that's going to happen at
21 Roper St. Francis?

22 A: I think it's a -- it's within the realm of
23 possibility. It's a reasonable expectation.

24 Q: Do you think the payment rates are also going
25 to increase by six, seven percent a year?

1 A: For what payer?

2 Q: For the commercials.

3 A: Yes.

4 Q: Year after year, no questions asked?

5 A: I think that's a reasonable expectation.

6 Q: But that hasn't been the experience of Roper
7 St. Francis before, right?

8 A: Actually that's not necessarily the case. For
9 example, if you look, I think this is the same
10 information Mr. Baehr looked at, if you look at
11 the 2007 to the stub period for 2008, which is
12 the eight months ending August 31, 2008,
13 according to my numbers, my calculations, I
14 think they're right; there was actually a 4.6
15 percent increase in net revenue per patient
16 day.

17 Q: Okay. You think that was your calculation for
18 that time period?

19 A: That's correct.

20 Q: Okay. And have you confirmed that with anyone;
21 that that's Roper's, this not-for-profit
22 community benefit hospital, that they're going
23 to try to increase their charges 5.8 percent on
24 -- it's going to be higher for commercial,
25 doesn't it? Medicare or Medicaid, 70 percent

1 of the payers are doing two and a half percent,
2 what -- do you know what the percentage would
3 have to be for the other 27 percent to bring
4 you up to 5.8 percent?

5 A: No, I don't know. And again, you're assuming
6 there's no coding creep. I don't know the
7 answer to your question.

8 Q: Okay. If there's no coding creep and
9 everything else is constant, do you think it
10 would have to be higher than 5.8 percent?

11 A: Yes, mathematically it would have to.

12 Q: It would have to? Do you think it would be
13 higher than ten percent?

14 A: I haven't done the math.

15 Q: Okay. And if it's higher than ten percent, is
16 that something you think is reasonable and
17 achievable for Roper St. Francis to do year
18 after year, get a ten percent reimbursement
19 rate increase?

20 A: Three things. Number one is I believe Mr.
21 Baehr characterized the rate -- or the rate of
22 increase in revenue per patient day from 2007
23 to 2008 at Roper St. Francis at 1.8 percent.
24 I believe the data supports the notion that it
25 was actually 4.6 percent. The second data

1 point I would bring your attention is that the
 2 Mount Pleasant, as poorly as Mount Pleasant may
 3 be doing bottom line wise its first six months,
 4 or I guess it's months three through eight
 5 inclusive, their net revenue per patient day
 6 extrapolated or trended forward to the year
 7 2015 is actually about 18 percent greater than
 8 the \$2,750 net revenue for patient day
 9 contemplated in the Roper St. Francis year
 10 three pro forma. The third thing I would point
 11 out is that the Trident Health System non-
 12 tertiary contribution margin per adjusted
 13 admission -- now, I appreciate that there's an
 14 expense component to contribution margin as
 15 well as revenues -- increased a little over ten
 16 percent from 2009 to 2010. So those kinds of
 17 increases do not offend my sensibilities in
 18 terms of do they represent a reasonable
 19 expectation.

20 Q: And so that's what your -- that's your
 21 reasonable expectation here today. And I'm
 22 asking your opinion.

23 A: Yes.

24 Q: Or if you've heard that Roper St. Francis, a
 25 not-for-profit, is going to be increasing their

1 rates, their reimbursements rates, what they're
2 able to get from the insurance companies,
3 Cigna, United, Aetna, all these different, by
4 ten percent a year or more.

5 A: I haven't -- I haven't done the math. I don't
6 know if it's ten percent or not. Again that
7 assumes no coding creep by Medicare.

8 Q: Now, one error you've actually admitted, I
9 think it was one of the first things you did
10 here today, was that in your pro formas that
11 you assumed the wrong number of incremental or
12 new patient days on which you based your
13 financial projections. Is that a fair
14 statement?

15 A: It is a fair statement.

16 Q: Okay. And I think you testified at your
17 deposition that 54 percent of the patients
18 should have been considered redirected and 46
19 percent maybe should have been considered
20 incremental. Does that sound right?

21 A: I think that comports with my deposition, yes.

22 Q: Okay. And if you've got some pen and paper
23 there --

24 A: I do.

25 Q: Okay. We know from Mr. Richardson's analysis

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1 that I believe it was 1,775 patients would be
2 considered redirected, correct?

3 A: I have no rebuttal of that.

4 Q: Okay. So I mean, do you know? I mean, you did
5 the financials based on --

6 A: On Mark's numbers, what I thought were Mark's
7 numbers. Yeah.

8 Q: Okay. Do you want me to -- let's make sure we
9 do this right. Okay. In Joint 2, if you'll go
10 to page 30 for me. Just for the record, you
11 weren't -- you weren't absolutely sure that it
12 was 1,775 redirected days, correct?

13 A: I'm sure I wasn't sure of that, yes.

14 Q: Okay.

15 A: I'm sorry. What page on --

16 Q: On page 20. Excuse me, page 30 of the --

17 A: Thirty.

18 Q: -- of the Roper DHEC record.

19 A: Yes, sir, I'm there.

20 Q: Okay. And here you see number three, and these
21 are Mr. Richardson's assumptions, it says 1,775
22 Roper St. Francis aligned non-tertiary, non-
23 specialty discharges, right?

24 A: Correct.

25 Q: One half redirection, correct?

1 A: Correct.

2 Q: Okay. Now, Mr. Richardson -- well, do you know
3 what average length of stay Mr. Richardson
4 assumed in the CON application?

5 A: I believe it was 4.25.

6 Q: Okay. So 1,775 patients that are being
7 redirected, how many patient days is that? If
8 you could --

9 A: 7,544 patient days.

10 Q: Okay. And do you recall in his deposition --
11 or did you read Mr. Richardson's deposition?

12 A: I did not.

13 Q: He testified that there would be a mix of
14 patient redirection for Roper for those
15 patients expected to in-migrate from areas
16 outside of Berkeley County. Has he ever
17 mentioned that to you?

18 A: He may have. I tend to not get into the weeds
19 so to speak in terms of health planning, but
20 merely am interested in the outcome.

21 Q: But you were in the courtroom yesterday when
22 Mr. Bowling testified, right?

23 A: For most of the day, yes.

24 Q: Did you hear him when he said that most of the
25 patients that are in-migrating, those 329 in-

1 migrating patients were going to be redirected
2 patients?

3 A: I didn't hear him say that, but I'm sure he
4 did.

5 Q: Okay. Well, write down 329 for me.

6 A: Done.

7 Q: And rather than assume all of those are going
8 to be redirected, why don't we just assume 50
9 percent. Okay? And that would be -- that
10 would be about 165 redirected patients,
11 correct?

12 A: Correct.

13 Q: Okay. So how many patients days do I get from
14 that?

15 A: Seven hundred and one.

16 Q: All right. So that's 701 patient days.

17 A: Correct.

18 Q: So if I add that to my one half redirected
19 patient days from Berkeley County, what do I
20 have as a total number of redirected patient
21 days?

22 A: Okay. Let me make sure I get my math right.
23 I'm taking 1,775. Now, that's an admission
24 number.

25 Q: I added --

1 A: 1,775.

2 Q: -- 7,544 patient days plus 701 patient days and
3 came up with 8,245 patient days. That would be
4 redirected.

5 A: Your math is faster than mine. Let's see --
6 8,245?

7 Q: Right.

8 A: Yes.

9 Q: Okay. Now, I believe Mr. Richardson assumed --
10 I know there was a cap that he used of, I think
11 it was 12,775 patient days. Do you recall
12 that?

13 A: I think he gives effect to the 70 percent
14 occupancy, yes.

15 Q: Okay. But I think he actually assumed the
16 total of 13,991 days in his analysis that would
17 then be capped. Do you recall that?

18 A: I don't. But I'll accept that as accurate.

19 Q: Well, I don't want you to accept it as
20 accurate. I want you to know that's what it
21 is. If you go to the next page, this is DHEC
22 Roper called Joint 2, page 31. If you look at
23 number five right, total 2015 Roper St. Francis
24 Hospital Berkeley non-tertiary, non-specialty
25 patient days. Do you see that?

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1 A: I do.

2 Q: And how many does he say?

3 A: 13,991.

4 Q: Okay. And that's the number that's capped,
5 right, at a, what is it, 65 percent occupancy
6 rate or 70 percent occupancy?

7 A: I believe it's at 70 percent, yes.

8 Q: Okay. So if that's the total number of days
9 and 8,245 patient days are going to be
10 allegedly redirected, what is that percentage
11 of total redirection?

12 A: Almost 59 percent.

13 Q: Okay, 59 percent.

14 A: Almost 59.

15 Q: Almost. Can we go with 59 just to keep it --

16 A: I think we can, yes.

17 Q: All right. So that means there's going to be
18 41 percent, if you go by these numbers,
19 incremental; is that correct?

20 A: Correct, 100 minus 59 would give us 41, right.

21 Q: Okay. But you assumed -- you assumed a 50/50
22 split, correct?

23 A: That is correct.

24 Q: Okay. So rather than 6,388 patient days that
25 you assumed would be new, what's the actual

1 number, if you know, if we used 41 percent? I
2 guess we got to use the 12,775 number, right,
3 that's been capped? If you applied 41 percent
4 to 12,775.

5 A: Yes, sir. That would give rise to 5,238
6 incremental days.

7 Q: So you were off about 1,150 patient days in
8 terms of what was incremental; is that a fair
9 statement?

10 A: It's a fair statement given the 701, yes.

11 Q: Given the 701. And we actually took half of
12 what Mr. Bowling said he thought would be
13 redirected, didn't we?

14 A: I believe so, yes.

15 Q: Okay. And we're giving the benefit of doubt to
16 you. Now, let's go to, back to Roper 462 -- or
17 Joint 2, page 462.

18 A: I'm there, sir.

19 Q: All right. And this is your -- this is the pro
20 forma, correct?

21 A: Correct.

22 Q: All right. In 2014 we've got how many
23 incremental patient days?

24 A: 2014?

25 Q: Yes.

- 1 A: 5,475.
- 2 Q: Okay. So that's 5,475. And how much on an
3 incremental basis is Roper St. Francis Berkeley
4 losing in terms of revenue over expenses?
- 5 A: 3.3 million loss.
- 6 Q: Okay. So if the actual number of redirected or
7 of incremental patient days or new patient days
8 is 5,238, you're going to be somewhere in
9 between 3,194 at the top and 5,475, correct?
- 10 A: I am not following Mr. -- I don't disagree with
11 you. But if you could run that by me again,
12 please.
- 13 Q: Yeah. If the actual number for the calculation
14 we did of new patient days was 5,238 --
- 15 A: Uh-huh (affirmative response).
- 16 Q: -- okay, wouldn't it be you would fall
17 somewhere in between from the incremental 2013
18 to the incremental 2014, you'd fall somewhere
19 in between those two numbers, correct?
- 20 A: Much closer to the 2014 number. But, yes, I
21 agree it would be between those.
- 22 Q: Okay. So if that was a 2015 number, we would
23 be looking at a loss rather than a 285,000
24 gain, correct?
- 25 A: I would agree.

1 Q: Okay. Now, if that was the actual number, you
2 wouldn't have been able to show in your
3 incremental pro forma -- by the way, you
4 worship at the altar of the incremental god,
5 correct?

6 A: That is true.

7 Q: All right. You wouldn't have been able to show
8 a positive net income by year three of
9 operations, correct?

10 A: That's correct.

11 Q: And you would agree with me too that this
12 corporate administration expense here of 2015
13 of \$428,000 is understated, isn't it?

14 A: No, sir, it's not.

15 Q: You don't think it's understated?

16 A: No, I don't.

17 Q: You think that would be the allocation by Roper
18 St. Francis?

19 A: Again, as you appropriately characterized it, I
20 worship the altar of incremental god and the
21 428,000 is indeed a function of an incremental
22 presentation.

23 Q: Is that right?

24 A: Yes.

25 Q: Go to Joint 8, page 215 for me. I'm going to

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1 take you back to your East Cooper pro formas.
2 Let's look at the incremental corporate
3 administration expense for Mount Pleasant,
4 Roper St. Francis Mount Pleasant, that you
5 showed to DHEC in each of these years. Okay.
6 Do you see those numbers?

7 A: I do.

8 Q: 627, 652, 678, 706, 734. And this is your
9 incremental pro forma, correct?

10 A: That is correct.

11 THE COURT: Mr. Thomas?

12 MR. THOMAS: Yes, sir.

13 THE COURT: Before we proceed --

14 MR. THOMAS: Yes.

15 THE COURT: -- would you please explain to me the
16 connection with the Mount Pleasant figures to
17 your case, what you're driving that right now?

18 MR. THOMAS: Certainly. Your Honor, Mr. Knapp is
19 saying that -- I'm trying to show that some of
20 the expenses on his pro forma in this case are
21 maybe understated and I'm using this Mount
22 Pleasant CON application where the pro formas
23 have -- are very similar in terms of the
24 expense and revenue categories. And the way
25 he's characterizing the corporate

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1 administration expense as being incremental or
2 rather than a standalone version, I'm trying to
3 actually show the court that Mr. Knapp isn't
4 really being consistent.

5 **THE COURT:** Inconsistency then?

6 **MR. THOMAS:** Yes, sir.

7 **THE COURT:** All right.

8 Q: Okay. So this is your incremental model,
9 correct?

10 A: That's correct.

11 Q: Okay. And your corporate administration
12 expenses, you've got those there, 627, 652,
13 678, 706, 734?

14 A: Yes, sir.

15 Q: Okay. Now go two pages over. All right. And
16 this is your venue pro forma in the Mount
17 Pleasant work, correct?

18 A: It is.

19 Q: And what's your corporate administration
20 expense line there?

21 A: The same that's in the incremental pro forma.

22 Q: So you basically have identified the
23 incremental and the venue as being the same
24 exact expense, correct?

25 A: Correct.

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1 Q: But that's not how Roper St. Francis does it in
2 their income statements, is it?

3 A: They allocate -- they allocate that, in effect,
4 the home office costs to the individual
5 hospital.

6 Q: Okay. Go to 167. Petitioner's 167 for me.
7 And what was Roper Mount Pleasant Hospital's
8 corporate administration expense if we
9 annualized it for last year?

10 A: Almost five million dollars.

11 Q: Almost five million dollars?

12 A: Correct.

13 Q: Okay. And that's for an 85 bed hospital,
14 correct?

15 A: Correct.

16 Q: And so the allocation for a 50 bed hospital is,
17 what would you expect that to look like?

18 A: Well, it might be instructive to explain the
19 relationship between corporate administration
20 and net revenues. Corporate administration
21 allocation, as I understand it, is a function
22 of many statistical data points. It's not
23 unusual for people to characterize corporate
24 administration allocation as a percentage of
25 net revenue.

1 Q: So how would you do it?

2 A: Well, when I do it, again I worship the altar
3 of the incremental god, so I what I would do is
4 present it in a fashion as to how many -- what
5 are the additional home office resources that
6 would be necessary arising from the presence of
7 the Mount Pleasant Hospital as opposed to not
8 having the Mount Pleasant Hospital.

9 Q: And what I'm asking you is to do a venue pro
10 forma, a venue projection for the corporate
11 administration expense like Roper does it here.
12 What do you think they would allocate?

13 A: I would expect -- let me take Roper Hospital.
14 I notice that Roper Hospital is about 11.5
15 percent. Looks like Mount Pleasant is about
16 just over 15 percent.

17 Q: Does it looks like we're using a percentage of
18 net revenue?

19 A: No. I don't believe they do that. I think
20 they allocate it on a number of statistics at
21 the hospital.

22 Q: How did you come up with the -- didn't you use
23 the ratio to -- for Roper St. Francis Berkeley
24 based on what the 85 bed Mount Pleasant
25 Hospital was?

1 A: Incremental. Incremental to incremental
2 proportional, yes.

3 Q: What did you do there? How did you do that?

4 A: Determined how many incremental FTEs would be
5 necessary at the home office because of Roper
6 Hospital.

7 Q: Who told you that number? Was that Mike
8 Cassells?

9 A: Wow, that's back in 2005. I'm not sure.
10 Somebody at Roper, but I'm not sure.

11 Q: Okay.

12 A: But, again, it would be on an incremental basis
13 not an allocated basis.

14 Q: Okay. But you would agree with me that tif
15 it's allocated it's going to be probably
16 somewhere in the order of millions of dollars,
17 correct?

18 A: I would agree.

19 Q: Okay. Is it fair to say in your pro forma --
20 let's go back to Joint 2, 462 -- you did not
21 determine payer mix based on proposed service
22 -- the proposed service area of Roper St.
23 Francis Berkeley?

24 A: That's a fair statement. I looked at non-
25 tertiary St. Francis and Roper for the eight

1 months ending August 31, 2008.

2 Q: Okay. So you didn't even just break it down to
3 Berkeley County, did you?

4 A: Did not. Now, I did give effect to the OB mix,
5 a higher proportion of OB beds at the proposed
6 hospital relative to Roper and St. Francis.

7 Q: Okay. But determining the payer mix by the zip
8 codes that Roper St. Francis Berkeley would
9 have served wouldn't have been a difficult
10 thing to do, would it?

11 A: Probably not. You know, the issue that you
12 always get into is sample size. Of course,
13 there can be a benefit to doing what you're
14 suggesting. The downside would be that you
15 would have a smaller sample size that is more
16 subject to outliers; not outliers necessarily
17 in a reimbursement sense, but atypical cases.

18 Q: Are you telling me that Roper just doesn't see
19 enough patients from Berkeley County to allow
20 you to make a payer mix determination from a
21 non-tertiary basis per zip code?

22 A: No, sir. All I'm saying is that all else
23 equal, a bigger sample size is an attractive
24 notion to me.

25 Q: Okay. You don't think it would be attractive

1 to know what the actual payers from the zip
2 code, what their payer mix might be?

3 A: That would've been a fine thing to do. I did
4 not do that.

5 Q: Pardon me, sir?

6 A: I said that would be a fine thing to do. I did
7 not do that.

8 Q: And you heard Bret Johnson say a hundred
9 million dollar book of business comes out of
10 Berkeley County, correct?

11 A: Correct.

12 Q: Okay. But that would that be a good enough
13 sample size for you?

14 A: It would.

15 Q: Okay. But you didn't do that, correct?

16 A: That's correct.

17 Q: Now, for self-pay, I believe we've already
18 looked at the document that was Petitioner's
19 59. We don't have to go back unless you just
20 don't remember.

21 A: Three percent, I believe.

22 Q: Yeah. You assume the same exact self-pay
23 percentage as Roper St. Francis actually
24 experienced, correct?

25 A: I don't know --

1 Q: Or is that for the system?

2 A: I don't know if the OB tweak impacted that
3 number or not. Perhaps we could go to that
4 exhibit that you were alluding to.

5 Q: Okay. Self-pay --

6 A: OB tweak did not impact anything, so I agree
7 with your statement.

8 Q: Okay. So you assume the same exact self-pay
9 as, what is this, the Roper St. Francis entire
10 experience rather than seeing what the self-pay
11 might have been from Berkeley County, correct?

12 A: Non-tertiary Roper St. Francis, yes.

13 Q: Okay. And do you understand that Berkeley
14 County actually has the highest unemployment
15 rate in the Tri-county area?

16 A: I believe you indicated that or you asked me
17 that line of questioning in my deposition and
18 I have no way of knowing that. I assume that's
19 correct.

20 Q: Okay. And does a higher unemployment rate --
21 is it fair to say a higher unemployment rate
22 could mean a higher uninsured rate?

23 A: It may or may not. It could.

24 Q: Okay. Is it fair, it could?

25 A: It could.

1 Q: Okay. And could it mean more Medicaid patients
2 as well?

3 A: It could.

4 Q: Although I understand those are just fantastic
5 payers these days.

6 A: Well, it's a -- it's a good payer. It's not as
7 good as managed care. But yeah, it's a decent
8 payer.

9 Q: You're not getting ten percent annual increases
10 out of Medicaid, are you?

11 A: No, sir.

12 Q: Okay. And the OB tweak, I think you testified
13 you made some allowances for that, the
14 obstetrics services, because -- and if I get
15 this correct, there's a higher percentage of OB
16 beds at Roper St. Francis Berkeley; is that
17 right?

18 A: That's correct.

19 Q: Okay. Than there are at Roper -- or at Bon
20 Secours; is that right?

21 A: At Bon Secours than at Roper, correct.

22 Q: Okay. Now, did Mr. Richardson ever give you
23 any data in terms of how many of those beds
24 would be full, OB beds?

25 A: Did not.

1 Q: Now, Mr. Knapp, hospitals sometimes have to pay
2 for call coverage, don't they?

3 A: They do.

4 Q: Okay. And is that something that you asked
5 anyone about at Roper St. Francis, whether or
6 not they would need to pay for call coverage at
7 Roper St. Francis Berkeley?

8 A: Did not.

9 Q: And if that was an added expense, that would
10 decrease the bottom line, wouldn't it?

11 A: Unless the call coverage was in the 2008
12 baseline expenses.

13 Q: Okay. But that's not something you checked
14 into, right?

15 A: No. I assume it would be in there, but I don't
16 know for sure.

17 Q: Okay. Well, in terms of the bad debt number in
18 your expenses, let's go back to 462, Joint 2,
19 what was your provision for bad debt for say
20 2015?

21 A: 4.3 percent of gross revenues.

22 Q: Okay. And that was based on the experience of
23 the Roper St. Francis System or Bon Secours?

24 A: Roper St. Francis System.

25 Q: Okay. And is that non-tertiary bad debt?

- 1 A: Correct.
- 2 Q: Okay. And, again, you could have looked at the
- 3 bad debt that was coming out of Berkeley
- 4 County, correct?
- 5 A: Probably could have, yes.
- 6 Q: Okay. And that would give you a more accurate
- 7 presentation of exactly what that expense would
- 8 be, wouldn't it?
- 9 A: It might.
- 10 Q: Well, isn't that what this application's about,
- 11 Roper St. Francis Berkeley?
- 12 A: It is.
- 13 Q: You read the application, didn't you?
- 14 A: I did.
- 15 Q: And you know they're serving Berkeley County.
- 16 That's what they say, right?
- 17 A: Correct.
- 18 Q: Now, how about charity care, did you also
- 19 assume for that the Roper St. Francis System or
- 20 did you look at Berkeley County?
- 21 A: System.
- 22 Q: Okay. And, again, if there's more unemployment
- 23 and less insurance, that number for Berkeley
- 24 County could be higher, correct?
- 25 A: Except for one thing. It's about 22 percent

1 higher than the Berkeley Regional Medical
2 Center pro forma reflects, so I feel very
3 comfortable that the 2.2 percent of gross
4 represents a reasonable expectation.

5 Q: Okay. But you didn't check to see what Roper's
6 experience was, right?

7 A: That's correct.

8 Q: Okay.

9 A: Well, Roper's experience in Berkeley, did not.

10 Q: Right, yeah. Thank you.

11 A: Correct.

12 Q: Now, you would agree with me that all things
13 being equal, the more physicians a hospital can
14 employ, it's going to help the hospital's
15 negotiating ability with insurance companies,
16 correct?

17 A: All else equal, I would agree.

18 Q: Okay. And you would agree with me that a
19 hospital like Roper employs so many physicians
20 because there's an expectation of incremental
21 inpatient and outpatient volume arising from
22 those physicians, correct?

23 A: Actually that doesn't comport with the
24 testimony that I heard.

25 Q: Okay.

1 A: The testimony that I heard was that the bulk of
2 the physician purchases were related to
3 physicians that were already admitting almost
4 exclusively at Roper St. Francis.

5 Q: All right.

6 MR. THOMAS: Bear with me for one minute, Your
7 Honor.

8 Q: You would not agree with my statement what I
9 just said, Mr. Knapp?

10 A: I would not agree that the major motivating --
11 if you could repeat your question again.

12 MR. LONG: I just want to object here. If he's
13 going to intend to impeach him, I don't see how
14 you could impeach someone's answer when they
15 say based on the testimony I heard in the
16 courtroom. How can you impeach?

17 MR. THOMAS: You know, that's the most frivolous
18 objection I've ever --

19 MR. LONG: How do --

20 THE COURT: Wait a minute.

21 MR. LONG: He can't go to a deposition and say you
22 testified differently than you did in the
23 courtroom when the answer is, based on the
24 testimony I heard in the courtroom I would say
25 this. I mean he just said, based on the

1 testimony I heard in the courtroom the employed
2 physicians were already loyal to Roper St.
3 Francis in response to Mr. Thomas' question.
4 Now, he's saying, well, you remember what you
5 said in the deposition two months ago. I mean
6 that's not an impeachment.

7 **MR. THOMAS:** Isn't that the definition -- that's the
8 definition of impeachment.

9 **MR. LONG:** No, no. The definition of impeachment is
10 saying something different than what you've
11 testified to in a deposition. He said, based
12 on new information I would say this.

13 **MR. THOMAS:** He basically contradicted himself, Your
14 Honor.

15 **MR. LONG:** He cannot contradict himself.

16 **THE COURT:** Well, I'm going to overrule. Let's see
17 what he said in his deposition.

18 **MR. THOMAS:** All right.

19 **Q:** I asked you, Mr. Knapp, you would agree that a
20 hospital like Roper employs so many physicians
21 because there's an expectation of incremental
22 inpatient and outpatient volume arising from a
23 physicians, correct?

24 **A:** And I believe I answered correct.

25 **Q:** Okay.

1 A: I don't believe that I answered that that was
2 the only reason or the major reason. But that
3 that --

4 Q: Well, you didn't say correct. You said you'd
5 heard different testimony in the courtroom,
6 correct? That's why Mr. Long just objected,
7 isn't it?

8 A: Yes, sir.

9 Q: Okay.

10 MR. LONG: Well, Your Honor, I'll point out he
11 changed the question.

12 MR. THOMAS: No as a matter of fact, I didn't.

13 THE COURT: Wait a minute. You all are talking over
14 each other. Now hold on. Mr. Long, what are
15 trying to object to?

16 MR. LONG: Well, he's asked him two questions. The
17 first answer to the first question was all else
18 being equal, yes. Then he said, based on the
19 testimony I heard, I would say that the
20 employed physicians at Roper St. Francis
21 already were referring patients to them. Now
22 he's asked him a question and trying to
23 apparently impeach him when the answer with the
24 first question which was all else being equal,
25 yes. I mean it sounds like to me that's

1 consistent.

2 **THE COURT:** Well, I thought he had answered the
3 question. If he said something else on the
4 deposition then I think it ought to go in the
5 record. Objection overruled.

6 **MR. THOMAS:** Thank you, Your Honor. And just to
7 clarify the record, the first question I asked
8 was -- and this is great, Your Honor, because
9 I've written the questions out. The first
10 question I asked, "You would agree that all
11 things being equal, the more physicians a
12 hospital can employ it's going to help the
13 hospital's negotiating ability with insurance
14 companies, correct?" And Mr. Knapp said yes.
15 The second question I asked was, "You would
16 agree that a hospital like Roper employs so
17 many physicians because there's an expectation
18 in incremental inpatient and outpatient volume
19 arising from the physicians, correct?" And
20 that's when he objected. That's the question
21 he objected to.

22 **THE COURT:** That's when he responded, "That's not
23 what I remember the testimony being."

24 **MR. THOMAS:** Correct.

25 **Q:** All right. Now, Mr. Knapp, I'm going to hand

1 you your certified copy of your deposition.
2 I'd like for you to look at 117.

3 A: Yes, I'm there.

4 Q: All right. And what we'll do is we'll read the
5 -- if you look at line three, I'll read the
6 question and -- page 117.

7 A: I'm there.

8 Q: All right. 117, line three. I asked you,
9 "What is your understanding as a qualified
10 expert in healthcare finance or at least
11 previously qualified expert in healthcare
12 finance --" I think you said on your
13 application 100 times or so?

14 A: Yes.

15 Q: All right. "-- of why Roper would employ so
16 many physicians to realize this kind of loss
17 of \$38 million if you annualized it?" And what
18 was your answer?

19 A: "Well, obviously there's an expectation of
20 incremental volume arising from the Physician
21 Partners."

22 Q: Question: "Incremental inpatient and
23 outpatient volume, right?"

24 A: "Yes."

25 Q: Okay. Does that refresh your memory as to your

1 testimony?

2 A: It does. And also my answer does not comport
3 with testimony in this trial.

4 Q: Okay. But your answer as an expert was that,
5 correct?

6 A: Yes. I would point out, and I probably should
7 have pointed this out in deposition, that's
8 really very close to a health planning kind of
9 notion as opposed to a finance notion. But I
10 didn't raise that objection during deposition,
11 so I agree.

12 Q: Okay. And you've been doing this of work a
13 long time, haven't you?

14 A: I have.

15 Q: Okay.

16 A: I think as long as Mr. Baehr, at least.

17 Q: Now, we talked a little bit about this
18 incremental to venue conversion. Do you recall
19 that?

20 A: In deposition?

21 Q: Yes.

22 A: Yes.

23 Q: Well, I think we talked -- there was a little
24 bit of talk about it today. And I think you
25 said that Mr. Baehr came up with some kind of

1 \$24 million number?

2 A: Yes. Yes. I'm with you now.

3 Q: All right. Now I'd like to kind of go through
4 an exercise, if we could, that we did in the
5 deposition.

6 A: I recall.

7 Q: Okay. Because Mr. Baehr had nothing to do with
8 that exercise from your deposition, correct?

9 A: Correct.

10 Q: All right. Now if --

11 MR. THOMAS: What we want to do here, Your Honor, is
12 we're going to take this incremental pro forma
13 and we're going to convert it into a venue pro
14 forma.

15 THE COURT: Tell me the purpose for doing that?

16 MR. THOMAS: Well, the purpose of doing that is it's
17 going to show that there's -- you heard Roper's
18 CFO on the stand stated that if this hospital
19 showed it would make, you know, over \$20
20 million as a standalone, that just wouldn't be
21 reasonable. Fifty bed hospitals with 35
22 patients can't make that kind of money. So
23 let's see what it looks like on a standalone
24 basis.

25 MR. LONG: Your Honor, I object.

1 THE COURT: I asked the question. Let him finish.

2 MR. LONG: I'm sorry. I thought he had.

3 MR. THOMAS: I just finished.

4 THE COURT: All right. I understand.

5 MR. LONG: I don't think that's an accurate
6 description of the testimony though, Your
7 Honor.

8 THE COURT: I didn't say it was accurate testimony.
9 I just asked him what he was trying to prove by
10 it.

11 MR. LONG: Thank you.

12 Q: All right. So, Mr. Knapp, in your deposition
13 and if you want to, you can go along as well if
14 you want --

15 A: If I could, please.

16 Q: Yeah. I think it starts on page 118.

17 A: Yes, sir, I'm there.

18 Q: All right. And if you look at lines, I guess
19 line 13 -- or excuse me, line ten, "In terms of
20 the revenue column, we would basically double
21 everything here." And you say?

22 A: "Correct."

23 Q: Correct. So in net revenues, if we could write
24 down here -- and this would go on the total
25 revenue line, correct?

- 1 A: Correct.
- 2 Q: All right. You told me to write down 69
3 million, right?
- 4 A: Correct.
- 5 Q: Okay. So the actual number, if we'd double it,
6 though, would be -- let's go ahead and do it,
7 and do it right, 69,777,726.
- 8 A: You want it take it to the nearest dollar?
- 9 Q: Sure.
- 10 A: Okay. All right.
- 11 Q: I want to dollarize.
- 12 A: Okay. All right.
- 13 Q: And then tell me what you got and then I'd like
14 you to write down in the column because
15 eventually it's going to be an exhibit.
- 16 A: Okay. I've got 69,072,000. But you're wanting
17 to take me into the nearest dollar, right?
- 18 Q: That's not going to be hard to do. Net revenue
19 times two, right?
- 20 A: Correct. For some reason my calculator is
21 freezing up.
- 22 Q: There's another one there if you need to use
23 that.
- 24 A: I got sixty-nine million oh-seventy-seven, I'm
25 including other revenue in there, seven two

1 six.

2 Q: Okay. And I believe on page 118 I asked you,
3 "What would be the standalone version for the
4 labor for 2015? And we can just round this one
5 off." You told me that at the top of 119 of
6 your deposition, you say you think it's like
7 \$19 million, correct?

8 A: Right. I don't know if that's including
9 benefits or not. But yes, that's what I said.

10 Q: Okay. Well, labor expense in your pro forma
11 for incremental would be salaries with
12 benefits, correct?

13 A: In the incremental pro forma, yes.

14 Q: Okay. So if you'd write down \$19 million for
15 me by your labor expense.

16 A: Okay.

17 Q: All right. And then I believe you told me that
18 the purchase services are 90 percent fixed.
19 And then you told me basically to take that
20 third year number 2,029,671 and multiply it by
21 .9, right?

22 A: Yes, sir.

23 Q: Okay. And what do you get if you do that?

24 A: 1,827,000.

25 Q: Now, I thought it was 2,029,671. So you

1 wouldn't divide that by .9? Yeah, I think you
2 multiplied.

3 A: Mr. Baehr was right. You multiplied that by --

4 Q: Okay. And so that, what does that give us?

5 A: 1,826,000.

6 Q: Mr. Baehr, wouldn't you take 2,029,671 and
7 divide it by .9?

8 THE COURT: No, let's get the record right. Mr.
9 Knapp.

10 MR. THOMAS: Oh, yeah. I'm sorry.

11 A: Oh, I'm sorry. I thought you were talking to
12 Mr. Baehr.

13 Q: So if these are 90 percent fixed --

14 A: Yes.

15 Q: -- wouldn't you take 2,029,671 and divide it by
16 .9?

17 A: Well, if you did that, then you'd -- 2,256,000.

18 Q: Right. Wouldn't that be -- wouldn't that be
19 the number?

20 A: Yes.

21 Q: Okay. And what did you get?

22 A: 2,256,000.

23 Q: 2,256,000? We're just going to say zero, zero,
24 zero?

25 A: Yeah, let's.

- 1 Q: All right. We can move it along. All right.
2 And supplies, is that a fixed expense?
3 A: No, that's a variable expense.
4 Q: Okay. So you double that one, right?
5 A: Yeah. There would be some fixed, but it's
6 mostly variable.
7 Q: All right. And in your deposition you said to
8 double it, right?
9 A: I did, yes.
10 Q: Okay. So what does that get us about if you
11 want to -- 10.56 million?
12 A: 10.427. No, I'm sorry. I'm looking at the
13 wrong line item. I'm sorry. 10,568,000.
14 Q: Okay. And write that down for me in the
15 column.
16 A: I did.
17 Q: Okay. And the other expense I believe you said
18 was fixed, correct?
19 A: Correct.
20 Q: So that's going to stay the same right?
21 A: Right.
22 Q: 2,059. And corporate administration --
23 A: Right.
24 Q: -- you're going to keep that at 428, right?
25 A: Well, if you're -- if you're looking at an

1 allocated management fee, then you would not
2 keep it at 428.

3 Q: Well, how did you do it in Mount Pleasant?

4 A: Mount Pleasant purely incremental.

5 Q: Well, in your venue pro forma that you
6 submitted to the State Department of Health and
7 Environmental Control, how did you do it?

8 A: I did it incremental.

9 Q: Okay. So we're going to stay consistent.

10 A: Had I done that over again, I probably would
11 have put a fully loaded --

12 Q: So now it's changed? Now you're going to do it
13 fully loaded --

14 THE COURT: Wait a minute.

15 MR. THOMAS: I'm sorry.

16 THE COURT: Wait a minute. Let him finish.

17 MR. THOMAS: Okay.

18 THE COURT: Might have put a fully loaded what?

19 THE WITNESS: Corporate allocation expense.

20 THE COURT: Thank you.

21 Q: Well, I'd like to stay consistent with your
22 testimony here from your deposition.

23 A: Okay. That's fine.

24 MR. LONG: Your Honor, he doesn't get to decide. I
25 mean, he asks the questions, he gives the

1 answers, right? So I would object to Mr.
2 Thomas telling him how to answer.

3 **THE COURT:** That's not an objection.

4 **MR. LONG:** I think there's not a question and answer
5 here, Your Honor. That's my objection. He's
6 telling him what to do.

7 **MR. THOMAS:** Well, Mr. Long, how would you like to
8 do it?

9 **THE COURT:** Just a moment.

10 **MR. THOMAS:** I'm sorry.

11 **THE COURT:** It is cross examination and he can lead
12 on cross examination. Now, beyond that, I
13 sustain the objection.

14 **MR. THOMAS:** Okay.

15 **Q:** So, Mr. Knapp, which one are you going to
16 choose for your venue pro forma?

17 **A:** For a venue pro forma I would do a fully
18 allocated management fee.

19 **Q:** Okay. So you're admitting today that the venue
20 one you submitted to DHEC for the Roper St.
21 Francis Hospital was off by about four million
22 dollars, right?

23 **A:** Yeah, I would agree.

24 **Q:** Okay. And that's a pretty big mistake,
25 correct?

1 A: It is.

2 Q: Because that would have shown your revenue over
3 expenses in the venue pro forma to DHEC back in
4 2006 as being a negative eight million dollar
5 loss, correct?

6 A: Correct.

7 Q: In the first year?

8 A: Correct.

9 Q: Okay. So what do you think the corporate
10 allocation would be?

11 A: Well, one option would -- reasonable option
12 might be to look at the Mount Pleasant P&L for
13 the six months ending June 30, 2011, where the
14 corporate allocation is 15.4 percent of net
15 revenues.

16 Q: All right. Tell me what you get there.

17 A: 10,638,000.

18 Q: You get ten million dollars off of -- so wait,
19 15 percent of net revenues?

20 A: That was the Mount Pleasant, looking at Mount
21 Pleasant for the six months ending June 30,
22 2011.

23 Q: Okay. And so what would 15 percent of total
24 revenues for Roper St. Francis Berkeley be?

25 A: I think we -- a few minutes ago we had doubled

1 the net revenues to 69,077,000. And I'm just
2 taking 15.4 percent times 69,077,000 and I get
3 10,638,000.

4 Q: What do you get now, Mr. Knapp?

5 A: 10,638,000.

6 Q: So that's going to be your corporate
7 administration expense for Roper St. Francis
8 Berkeley?

9 A: Again, I haven't done a venue pro forma for
10 Roper St. Francis Berkeley. But if indeed the
11 allocation methodology at Roper St. Francis
12 Berkeley comports with the allocation
13 methodology for Mount Pleasant, Roper St.
14 Francis Mount Pleasant for the six months
15 ending June 30, 2011, then it would be
16 10,638,000.

17 Q: 10,638,000?

18 A: Correct.

19 Q: But that's not what you testified to in your
20 deposition, is it?

21 A: Actually, I think I raised the issue of fully
22 allocated vis-a-vis incremental. And then
23 together we decided to use the six month -- six
24 month number, not our 12 month number, and we
25 both missed it for Mount Pleasant, and

1 substituted that in there.

2 Q: Okay. So depreciation and interest stays the
3 same, right?

4 A: Correct.

5 Q: I've got a question for you.

6 A: Okay.

7 Q: The \$24 million that you came up with the first
8 time we did this in your deposition, do you
9 recall that?

10 A: That was before the discussion about corporate
11 allocation.

12 Q: Okay.

13 A: Right.

14 Q: That \$24 million expense -- or excuse me, that
15 24 million in net revenue, that's something you
16 came with, correct?

17 A: Well, yeah, but my deposition reflects two or
18 three caveats where that really looks high. In
19 fact, Mr. Baehr, to his credit, alluded to it
20 in his direct examination, that I wanted to
21 look at it in more detail. It didn't sound
22 right.

23 Q: Okay.

24 A: It sounded too high.

25 Q: So just for the record, now we're going to

1 include the corporate administration expenses,
2 a fully loaded expense in a venue, correct?

3 A: Which we did during my deposition, but we both
4 missed the fact that the Mount Pleasant number
5 was a six month, not a 12 month number.

6 Q: Well, I didn't miss it, did I?

7 A: No.

8 Q: Okay.

9 A: No, I missed it.

10 Q: Okay. Bear with me, Mr. Knapp.

11 A: Yes, sir.

12 Q: Can I get this back?

13 A: Yes, sir.

14 MR. LONG: Does the witness still have sheet?

15 MR. THOMAS: No. I took it from him.

16 MR. LONG: Well, I would ask that that not be --

17 MR. THOMAS: Here, I'll give it to you.

18 MR. LONG: Well, did he -- was the witness writing
19 on it?

20 THE WITNESS: No, I wasn't writing on it.

21 MR. THOMAS: Thank you.

22 Q: Mr. Knapp, do you recall your testimony in the
23 Grand Strand versus Loris case, which was
24 actually before this court and this judge some
25 five years ago?

1 A: Yes, sir.

2 Q: Maybe six?

3 A: Yes.

4 Q: Do you recall what that case was about?

5 A: Yes, sir, I do.

6 Q: Okay. And it was about a 50 bed hospital
7 called Seacoast Medical Center, a proposed
8 hospital, located in the primary service area
9 of Grand Strand Regional Medical Center,
10 correct?

11 A: That's correct.

12 Q: Okay. And Grand Strand Regional Medical Center
13 was about 15 miles away, wasn't it?

14 A: Yes, sir.

15 Q: From the Seacoast. Or excuse me, 13 miles away
16 from the proposed Seacoast location, correct?

17 A: I believe so.

18 Q: Okay. Do you recall in that case you actually
19 opined about whether the proposed Seacoast
20 Medical Center project was financially feasible
21 and what the adverse impact would be on Grand
22 Strand?

23 A: I do.

24 **THE COURT:** May I ask on whose behalf you testified?

25 **THE WITNESS:** Yes, sir. I testified on behalf of

1 Grand Strand, working with Mr. Thomas and Mr.
2 Summer.

3 Q: I'm going to hand you what's been marked
4 Petitioner's 215. And it's your prefiled
5 testimony from the Grand Strand case. And do
6 you recognize that document?

7 A: I do, yes, sir.

8 Q: Okay. And, in fact, when you were placed on
9 the stand, but I think it was on this side of
10 the room at that time, you had to attest to the
11 information in here as being correct, right?

12 A: That's correct.

13 Q: And you were -- you were sworn in that case
14 just like you were here, correct?

15 A: Yes, sir.

16 Q: Okay. And if you would go to page ten for me.
17 Because there's just some background.
18 Basically you had to give your qualifications,
19 just like you did in this case, correct?

20 A: Yes, sir.

21 Q: Okay. And if you'd look at page ten for me,
22 lines 11 and 12. You know, I asked you if you
23 had an opinion regarding the financial
24 feasibility as described in Regulation 61-15
25 regarding the proposed project, and you said --

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1 A: I said yes.

2 Q: Yes. And then a couple lines down I said, "Do
3 you have an opinion regarding whether Loris'
4 project, proposed project, would have an
5 adverse impact on any existing provider?" What
6 did you say?

7 A: Yes.

8 Q: And I said, next line, "What is that opinion?"
9 If you'd read that for me.

10 A: "In my opinion the proposed project would
11 generate a significant adverse impact on Grand
12 Strand. It also generates a significant
13 adverse impact on Loris Community Hospital,
14 which is one of the main drivers of the severe
15 erosion in Loris Healthcare System and Seacoast
16 Medical Center profitability when the proposed
17 project comes online."

18 Q: Okay. So in this case you did opine that the
19 50 beds at Seacoast, 13 miles away from Grand
20 Strand, would have an adverse impact on Grand
21 Strand, correct?

22 A: Correct.

23 Q: Now, in that case who did the estimation for
24 you as to the kind of the volume detriment?

25 A: Mr. Richardson.

1 Q: Okay. And he's in the room with us today,
2 correct?

3 A: He is.

4 Q: If you turn and look at Petitioner's 215 to
5 page, it looks like 12 of your actual pre-filed
6 testimony.

7 A: I'm there.

8 Q: And did you come up with an adverse impact of
9 doing a -- a contribution margin?

10 A: I did.

11 Q: Like Mr. Knapp does? Or excuse me, like Mr.
12 Baehr does? Pardon me.

13 A: Yes.

14 Q: Okay. And do you recall what your range was?

15 A: It looks like it was between 3.3 million and
16 4.6 million pre-tax.

17 Q: Okay. And I asked you in your pre-filed
18 testimony why you believed this to be a
19 material adverse impact. Do you recall that?

20 A: I do.

21 Q: And you recall what you said? Well, go to page
22 -- go to page 14 of the actual document.

23 A: I'm there.

24 Q: Okay. And I asked you, you can read the
25 answer. I said, "Why do you believe that a

1 \$3.3 million to a \$4.6 million adverse impact
2 would be material as to Grand Strand?" What
3 did you say?

4 A: "It's difficult to imagine a credible argument
5 that will embrace the notion that 3.3 to 4.6
6 million is not material. No hospital
7 administrator would be indifferent to a loss of
8 that magnitude. Even though Grand Strand will
9 continue to be profitable, it must have
10 considerable profits to reinvest in its
11 delivery system. For example, it's the only
12 tertiary care provider in the county and it has
13 recently applied to add a third comprehensive
14 cardiac catheterization at considerable
15 expense. A reduction of 3.3 to 4.6 million in
16 annual profit reduces this tertiary care
17 provider's ability to meet the needs of the
18 community. Every year Grand Strand has medical
19 equipment and facility needs that carry a
20 substantial price tag."

21 Q: Okay. And if you'd go back one page for me,
22 Mr. Knapp, to page 14.

23 A: Yes, sir, I'm there.

24 Q: And at the top, at the first full sentence,
25 starting with "also", you make a comment about

1 your 3.3 million to 4.6 million dollar range,
2 don't you?

3 A: Yes, sir, I do.

4 Q: What do you say?

5 A: "These amounts are conservative in that they
6 address only non-tertiary inpatient adverse
7 impact. In addition, there may also be adverse
8 impact pertaining to outpatient volume and
9 tertiary volume."

10 Q: Okay. So that was your testimony in Grand
11 Strand, correct?

12 A: Correct.

13 Q: Now, you would agree with me that in the Grand
14 Strand testimony you don't mention anything in
15 this pre-filed testimony and you don't recall
16 mentioning anything about the ability for Grand
17 Strand to withstand a hit or to otherwise
18 financially be able to absorb the adverse
19 impact, do you?

20 A: I don't believe so.

21 Q: Now, in terms of the adverse impact that was
22 developed by Mr. Baehr in this case, and I
23 understand that you merely dollarize what Mr.
24 Richardson gives you, but would you agree with
25 me that if Mr. Baehr is correct in his

1 analysis, that a \$16 million pre-tax loss on
2 pre-tax net income of \$70 million would be a
3 material adverse impact to Trident?

4 A: Yes.

5 Q: And that's because management would likely have
6 to consider taking significant action with
7 respect to that loss, wouldn't it?

8 A: They would have to consider that, yes.

9 Q: Okay. And you would agree with me that an
10 adverse impact of \$16 million would be in
11 addition to the normal swings in healthcare,
12 correct; the healthcare market that causes
13 income to fluctuate on a year to year basis?

14 A: It would be additive relative to the normal
15 cycles that would otherwise happen, yes.

16 Q: But you would agree with me that if Mr. Baehr
17 is correct, it's a permanent additive, isn't
18 it, to some degree?

19 A: I believe Mr. Baehr was speaking to year three.

20 Q: Right.

21 A: I don't know that he spoke to year four, five,
22 six, seven, eight.

23 Q: Okay Well, he actually spoke to year one, two
24 and three, right?

25 A: He did, you're right. The 16 mil, though, I

1 think comports with year three.

2 Q: Okay. Fair enough. But it's a permanent
3 additive effect, correct? It's not mercurial,
4 is it?

5 A: I suspect it's not a one time event, but I
6 don't know that for sure.

7 Q: And you had some testimony regarding Mr.
8 Baehr's slides, correct?

9 A: Correct.

10 Q: Okay. If we could go to Respondent's 73. Let
11 me get my copy so I can actually see it. Okay.
12 If I understand what you've done here, Mr.
13 Knapp, you simply made Berkeley Medical
14 Center's contribution margin per adjusted
15 admission the same as the Trident Health
16 System's as a whole; is that right?

17 A: Trident Health System non-tertiary as a whole
18 for the twelve months ending June 30, 2010,
19 yes.

20 Q: So just made them even-steven, correct?

21 A: That's a fair statement.

22 Q: Okay. Now, did your contribution margin per
23 adjusted admission that you calculated take
24 into account the fact that the payer mix for
25 Trident's Berkeley Medical Center is not the

1 same as the payer mix for the rest of Trident
2 Health System?

3 A: Would you repeat that again, please? I didn't
4 quite get that.

5 Q: Yes.

6 A: I'm sorry.

7 Q: Did your contribution margin per adjusted
8 admission take into account the fact that the
9 payer mix for Berkeley Medical Center is not
10 the same as the payer mix for the Trident
11 Health System as a whole?

12 A: No.

13 Q: Okay. You didn't do that calculation, did you?

14 A: No. I relied on the THS non-tertiary decision
15 support report.

16 Q: Okay. But the payer mix for Berkeley Medical
17 Center, if it was lower, okay, if it was not as
18 healthy as Trident's, that could have an effect
19 on contribution margin, couldn't it?

20 A: It could.

21 Q: Okay. Now, Mr. Knapp, does your contribution
22 margin per adjusted admission that you
23 calculated take into account the fact of payer
24 mix for -- well, let me strike that. Have you
25 looked at what the payer mix for Berkeley

1 Medical Center is?

2 A: Yes.

3 Q: Okay. Have you compared it to Trident Health
4 System's?

5 A: I've compared it to Roper St. Francis Berkeley.

6 Q: Okay. You've compared the BMC payer mix to the
7 Roper St. Francis Berkeley payer mix?

8 A: Correct.

9 Q: But you haven't compared the Berkeley Medical
10 Center payer mix to the Trident Health System
11 payer mix overall, have you?

12 A: I have not. But I would point out the fact
13 that the 4,985 is adverse impact allegedly
14 caused by Roper St. Francis Berkeley and Roper
15 St. Francis Berkeley has a payer mix that is
16 not dissimilar with respect to Berkeley
17 Regional Medical Center.

18 Q: But that's not the question I asked you, is it?
19 I asked you if you looked at the Berkeley
20 Medical Center payer mix and compared it to the
21 Trident Health System payer mix.

22 A: I did not.

23 Q: Okay. So you don't know whether or not the
24 Berkeley Medical Center payer mix is more
25 favorable or less favorable than say Trident

1 Health System as a whole, do you, because you
2 haven't looked at it, right?

3 A: That's correct.

4 Q: Okay. Do you know how the Berkeley Regional
5 Medical Center's payer mix was derived?

6 A: I do not.

7 Q: Okay. You said you didn't look at Mr.
8 Woodford's underlying, I guess, work papers,
9 kind of like you had underlying work papers,
10 right?

11 A: If I looked at them, it was very, very briefly.

12 Q: Okay. Well, when you did your contribution
13 margin per adjusted admission calculation, did
14 you take into account the fact that much of the
15 Berkeley Medical Center outpatient volumes and
16 the resulting revenues were excluded from the
17 Berkeley Medical Center pro formas?

18 A: Yes, sir. By virtue of the adjusted admission
19 statistics, that does give effect to
20 outpatient.

21 Q: Okay. So you think you made that calculation?

22 A: Yes.

23 Q: Now, if you didn't, would you agree with me
24 that the exclusion would serve to lower the
25 actual contribution margin?

1 A: That I don't know. It could increase it or
2 lower it. I did note that in Petitioner's
3 Exhibit 219, and this is in Baehr 1846, that
4 his restatement of the Midgett pro forma seemed
5 to embrace the approach that I used, as well as
6 giving effect to an additional layer of
7 outpatient volume.

8 Q: Do you think when you made that calculation you
9 took into account the fact that the outpatient
10 volumes and the resulting revenues had been
11 excluded; do you think you did that?

12 A: The what --

13 Q: From Berkeley Medical Center, when you did your
14 contribution margin.

15 A: I have given effect to the outpatient activity
16 by virtue of using the adjusted admission
17 statistic.

18 Q: Okay. But you didn't look at what the revenues
19 gross and net were for the outpatient,
20 incremental outpatient for Berkeley Medical
21 Center, did you? Did you take that into
22 account in your analysis?

23 A: If, in fact, it's contemplated in the Berkeley
24 Regional Medical Center pro formas, I did.

25 Q: Okay. You think you did?

1 A: Yes.

2 Q: Okay. Would you agree with me that the average
3 margin for non-tertiary, non-specialty services
4 for the Trident System might not be the same as
5 in a 50/ bed hospital like Berkeley Medical
6 Center because the patients treated at Trident
7 may be of a higher acuity, even though they
8 would still be considered non-tertiary?

9 A: But if that turns out to be the case, then Mr.
10 Baehr's adverse impact analysis is wrong
11 because he's quantifying at a 4,985
12 contribution margin per adjusted admission
13 volume that Roper St. Francis Berkeley would
14 allegedly pull out.

15 Q: That's your testimony?

16 A: Yes.

17 Q: Let me ask you this. If, in fact, your
18 contribution margin per adjusted admission, I
19 guess the difference here on page Knapp
20 Berkeley 461 --

21 A: Yes, sir, I'm there.

22 Q: -- okay, of 1,752, is incorrect, that it's
23 incorrect, would you agree with me that every
24 other page in this document of Respondent's 73
25 would be flawed and also incorrect because it

1 relies on that difference of \$1,752; is that a
2 fair statement?

3 A: It may be. If I could look at -- if I could
4 look at a hard copy version, that would be
5 helpful.

6 Q: Not a problem.

7 A: Thank you. So your question is if, in fact,
8 the \$1,752 is incorrect?

9 Q: Right.

10 A: If it's higher or lower?

11 Q: Right.

12 A: Okay. It wouldn't have any impact on page two.

13 Q: Page two is a worksheet, right?

14 A: Yeah. It underpins.

15 Q: On page three it would, wouldn't it?

16 A: I didn't talk about page three. Let's see,
17 page four is a function of the 1,752. Page
18 five is a function of the 1,752. So, your
19 question is, would pages --

20 Q: So the garbage in --

21 A: -- basically four and five --

22 Q: Okay.

23 A: -- be compromised, if, in fact, the -- I'm
24 repeating the question not for your benefit,
25 but to make sure I understand your question

1 correctly. And it would certainly depend on
2 the magnitude of the incorrectness, if you
3 will. In other words, if it's not 1,752, but
4 it's 1,699 or if it's 1,803, the numbers will
5 be different on pages four and five, but not
6 profoundly different.

7 Q: And if it's zero, what would it be?

8 A: If it's zero?

9 Q: Yeah.

10 A: Yeah. That would certainly compromise pages
11 four and five.

12 Q: If the number is, say, instead of 1,700, it's
13 300, would that make a difference?

14 A: It would.

15 Q: Okay. And just in terms of the third page,
16 Knapp Berkeley 463, wouldn't this be somewhat
17 compromised because you do add the \$6,389,499
18 under the BRMC you've got baking in actual
19 estimated 4,985 non-tertiary CMPAA?

20 A: Yes, I would agree with that. I would also
21 point out that Mr. Baehr, in Petitioner's
22 Exhibit 219, actually generated a pro forma
23 that improved Mr. Midgett's pro forma something
24 on the order of \$5.1 million. Not quite as
25 much as I did, but it looked like he was doing

1 something along the lines of what I did.

2 Q: Okay. But I guess my question for you was
3 wouldn't the numbers on this page change too,
4 on page Knapp Berkeley 463, if your number is
5 wrong, the difference in the contribution
6 margin per adjusted admission?

7 A: Yes. And, again, it would go to -- in my
8 opinion it would go to the magnitude of the
9 alleged wrongness.

10 Q: Correct. And you would agree that if Roper St.
11 Francis Berkeley doesn't redirect the patients
12 in the manner predicted by Mr. Richardson and
13 it is, in fact, less, that Trident Medical
14 Center would be impacted more significantly,
15 correct?

16 A: Well, if I understood your question correctly,
17 two things would arise from that phenomenon.
18 I think what you -- and again, I hate to do
19 this, but I want to make sure, because this is
20 important stuff, I want to make sure I
21 understand your question. If, in fact, the
22 redirection volume is less and therefore the
23 incremental volume is more, that will give rise
24 to more adverse impact to THS. I would agree
25 with that. But it would also add to the bottom

1 line of RSFB's pro forma.

2 Q: Would you agree with me that Trident Health
3 System, without the presence of Roper St.
4 Francis Berkeley, would actually be better off
5 than they otherwise would have been?

6 A: Yes, I would agree with that.

7 Q: And did you ever do an adverse impact analysis
8 to determine what the Roper St. Francis
9 Berkeley adverse impact would be on Trident
10 Health Systems in the event that Roper St.
11 Francis Berkeley captures 65 percent of the
12 market share in the seven mile radius around
13 Roper St. Francis Berkeley?

14 A: Did not. But, again, that would give rise to
15 two things. It would have an impact, I'm sure,
16 an adverse impact. But, again, it would also
17 enhance or sweeten the bottom line of Roper St.
18 Francis Berkeley.

19 Q: Okay. Did you ever do an adverse impact
20 analysis in terms of what would happen to
21 Trident Health Systems if Roper St. Francis
22 Berkeley captured 50 percent market share?

23 A: No, sir.

24 Q: How about a 15 percent market share capture?

25 A: No, sir. Mr. Richardson may have. I did not.

1 Q: Right. You were never asked to dollarize
2 anything?

3 A: That's correct.

4 Q: And you would agree with me, Mr. Knapp, that
5 the actual definition of adverse impact in the
6 State Health Plan -- or excuse me, Regulation
7 61-15, are you familiar with it?

8 A: Not as familiar as you are, but I'm somewhat
9 familiar with that.

10 Q: You would agree with me it doesn't mention
11 anything about the ability of the health system
12 to take a hit, correct?

13 A: I don't know that it does or it doesn't. I
14 just don't know.

15 Q: You don't know, right?

16 A: That's correct.

17 Q: Okay. And in terms of financial feasibility,
18 the definition of financial feasibility
19 mentions the proposal itself, doesn't it,
20 whether or not the proposal will be financially
21 feasible?

22 A: I believe it does, yes.

23 Q: Okay. You would agree with me that when
24 Trident Medical Center submitted a CON
25 application for the Berkeley Medical Center,

1 when it did its financial pro formas, it did
2 them on the basis that they would be the only
3 hospital applying in Berkeley County, correct?

4 A: Yes.

5 Q: Did you study Mr. Baehr's adverse impact
6 analysis?

7 A: I think I did.

8 Q: Would you agree with me that he looked at what
9 the adverse impact of Roper St. Francis
10 Berkeley was going to be to the Trident Health
11 System as a whole?

12 A: Yes, that's what it purported to do, yes.

13 Q: If you're going to do that, wouldn't you use
14 the contribution margin of the health system?
15 Isn't that what you did in Grand Strand?

16 A: Yeah. What I'm hearing through your
17 questioning is that there may be a disconnect
18 between the kinds of patients that Roper St.
19 Francis Berkeley will attract and the kinds of
20 patients that Berkeley Regional Medical Center
21 will attract, and I'm not seeing that.

22 Q: Okay. Well, Berkeley Medical Center actually
23 looked at the per zip code service area
24 analysis, correct?

25 A: I believe so.

1 Q: And that's a different service area in terms of
2 zip codes than the entirety of Trident Health
3 System zip code service area, correct?

4 A: I would agree.

5 Q: Okay. Thank you. All right, Mr. Knapp.
6 That's all the questions I have for you.

7 **THE COURT:** Mr. Long, we'll take five minutes before
8 you start.

9 **MR. LONG:** Thank you, Your Honor.

10 (Off the Record from 6:55 p.m. until 7:05 p.m.)

11 **THE COURT:** Back on the record. Mr. Long?

12 **MR. LONG:** Thank you, Your Honor.

13 **MR. KNAPP - REDIRECT EXAMINATION BY MR. LONG:**

14 Q: Mr. Knapp, who pays Trident Health System's
15 taxes?

16 A: Well, the taxes are paid by corporate HCA.
17 Everything gets aggregated out to corporate HCA
18 and they file a corporate income tax return.

19 Q: So Trident Health System doesn't actually pay
20 the taxes on their net income. They pay the
21 taxes on the net income with interims?

22 A: That is correct. It's paid by -- it's
23 aggregated at the corporate level and paid at
24 that level.

25 Q: Let's talk about the Grand Strand and Loris

1 case for a minute. Was the situation with
2 Loris Hospital a little different from the
3 situation here in Berkeley County?

4 A: There were some differences, yes, sir.

5 Q: Can you tell us what some of those differences
6 were?

7 A: Yeah. One of the differences was Loris was a
8 kind of a weak financial outlook, profoundly
9 different from the two applicants in this case.
10 Trident is very strong financially. Roper St.
11 Francis is very strong financially. That's one
12 difference. Another difference was that Grand
13 Strand was the only tertiary provider in the
14 county. That's not the situation in Charleston
15 County. Another consideration was that while
16 Grand Strand had a healthy pre-tax income, as
17 I recall, it was about half of what Trident's
18 pre-tax income was, for example, for 2010.

19 Q: So is Trident a more successful system than
20 Grand Strand is looking at their financials?

21 A: Looking at the Grand Strand financials of five
22 years ago relative to recent Trident, yes, I
23 would agree with that.

24 Q: Now, you've testified in a lot of cases in
25 regards to adverse impact, right?

1 A: I have.

2 Q: Have you testified in other cases in other
3 courts about the context of adverse impact?

4 A: I have.

5 Q: And when you use that phrase in your direct
6 examination about their ability to take a
7 punch, can you remind the court what you were
8 talking about in terms of that?

9 A: Yeah. Incremental adverse impact is one thing.
10 It's also, I think, important for the
11 administrative law judge to consider how strong
12 the entity is that's claiming adverse impact.
13 In other words, are they basic. Are they kind
14 of weak, they're breaking even, maybe a little
15 better than breaking even, or are they
16 thriving? Are they doing really, really well?
17 Can they take a punch?

18 Q: And you testified to that in other
19 circumstances in other courts?

20 A: Yes, sir, I have.

21 Q: And is your testimony that you gave in the
22 Loris case inconsistent with that?

23 A: No.

24 Q: Now --

25 MR. THOMAS: Your Honor, I need to object to that

1 last line of questioning. He said that his
2 testimony wasn't inconsistent with that, but it
3 actually was. He didn't offer any testimony in
4 Loris on the issue of the ability to take a
5 punch or not. And so that doesn't look clear
6 in the record. It looks like that he may have
7 actually testified that there was the ability
8 to --

9 **THE COURT:** I don't understand the question nor the
10 answer in that light. Overruled.

11 Q: Were you asked -- in your pre-filed testimony,
12 were you asked by Mr. Thomas -- the pre-filed
13 testimony is drafted before the trial, right?

14 A: Correct.

15 Q: Were you -- in the question and answer, were
16 you asked about the context of the adverse
17 impact?

18 A: I believe that I was.

19 Q: I asked you the question.

20 A: I believe I was.

21 Q: But did you use exactly the same language that
22 you've used today?

23 A: No.

24 Q: Do you think the language you're using today is
25 inconsistent with what you did in that pre-

1 filed testimony?

2 A: In my opinion it is not.

3 Q: Now, if a project has a material adverse
4 impact, in your opinion can the project still
5 be -- have a material adverse impact on
6 existing providers, can the project still be
7 approved?

8 A: Absolutely.

9 Q: Okay. And what are some of the things that you
10 would consider to determine whether the project
11 should be approved or not?

12 A: Financial feasibility is one issue that DHEC
13 needs to consider, but it's not dispositive.
14 There are other issues; access, improvement in
15 quality of care, is there need for the project.
16 So there's a balancing and weighing of the
17 various criteria, one of which is financial
18 feasibility.

19 Q: Now, in Mr. Baehr's adverse impact analysis --
20 Mr. Thomas asked you about that -- does he
21 calculate adverse impact to Trident Medical
22 System or Trident Health System from inpatient
23 revenue, from loss of inpatient revenue?

24 A: Yes, sir.

25 Q: Does he calculate loss of outpatient revenue?

1 A: Yes, sir, he does.

2 Q: And does he even calculate loss of tertiary
3 revenue from the non-tertiary hospital?

4 A: Yes, sir, he does.

5 Q: Okay. So would you characterize that as a
6 conservative approach to calculating adverse
7 impact or about the most aggressive that you
8 do?

9 A: It's certainly is not conservative. It's very
10 aggressive.

11 Q: Okay. Now let's look at this thing about the
12 contribution margin. Mr. Thomas asked you some
13 more questions about that, okay? I'm just
14 trying to touch on that again. Mr. Baehr used
15 -- well, first, the Trident project in Moncks
16 Corner is a hundred percent redirect, right?

17 A: For inpatient, that's correct.

18 Q: For inpatient. And I think what were the
19 percentages?

20 THE COURT: For what?

21 MR. LONG: A hundred percent for inpatient.

22 THE COURT: Inpatient.

23 Q: And do you remember the percentage for
24 outpatient?

25 A: I do not. I don't.

1 Q: Pretty high, though, right?

2 A: I believe so, yeah.

3 Q: And so wouldn't you expect that all those
4 patients have to be the same patients that are
5 going to Trident Health System now?

6 A: They are. By definition, that's what
7 redirection is.

8 Q: And so wouldn't those patients be basically
9 kind of baked into the payer mix of Trident
10 Health System?

11 A: Yes, sir.

12 Q: And so would you expect the payer mix to be
13 particularly different?

14 A: I would not.

15 Q: Now, explain to the court what you meant when
16 you said, well, the Trident -- the Roper St.
17 Francis facility at Carnes Crossroads and you
18 looked at payer mix for Carnes Crossroads in
19 Moncks Corner.

20 A: Right.

21 Q: Okay. What did you conclude on that?

22 A: I concluded that they were not dissimilar.
23 They were fairly the same.

24 Q: Okay. So therefore, would that mean -- what
25 would that mean in regards to the type of

1 patients that maybe Roper St. Francis and
2 Carnes Crossroads would be taking that might
3 otherwise go to Trident?

4 A: Well, what that means is all else equal that
5 the Roper St. Francis Berkeley patients would
6 be very much Berkeley Regional Medical Center
7 like, BRMC-like.

8 Q: Did you see any sort of detailed payer mix
9 analysis in the Trident CON application?

10 A: There may have been, but I don't independently
11 recall.

12 Q: In the actual application itself?

13 A: Oh, in the application itself, no.

14 Q: I'm talking about the discovery.

15 A: No, sir.

16 Q: Now, if Mr. Baehr uses -- in your opinion, is
17 there a difference between the contribution
18 margin that Mr. Baehr uses for adverse impact
19 and the contribution margin that is reflected
20 in the pro forma in the application?

21 A: There's a profound difference. There should
22 not be in my opinion, but there is.

23 Q: And in your opinion should the party be
24 consistent in the way that they treat the
25 contribution margin?

1 A: In my opinion, yes.

2 Q: Okay. Have you ever heard of the phrase using
3 something as a sword and a shield?

4 A: I may not be familiar with that.

5 Q: All right. Well, let's try a different route
6 with it. Let's just look at the actual
7 information itself. Is Mr. Baehr using a
8 higher -- which one of those two contribution
9 margins is higher, the one that's the actual
10 contribution margin reflected on decision
11 support or the one that's in the pro forma?

12 A: The pro forma one is definitely a lot less than
13 the contribution margin per adjusted admission
14 contemplated in Mr. Baehr's adverse impact.

15 Q: So therefore the one that comes from decision
16 support is higher, right?

17 A: That's correct.

18 Q: Okay. So Mr. Baehr uses the higher
19 contribution margin for adverse impact; is that
20 correct?

21 A: That's correct.

22 Q: And he uses the lower contribution margin in
23 regards to calculating the feasibility of the
24 project?

25 A: Yeah, although just to be -- maybe I'm picking

1 hairs here. Mr. Baehr I think did not author
2 or generate the pro forma. He reviewed it and
3 felt comfortable with it, but it was actually
4 generated by Mr. Woodford.

5 Q: Which pro forma is he using when he does his
6 calculations to determine impact of lost cases
7 on the Roper Berkeley project?

8 A: He's using the higher contribution margin per
9 adjusted admission coming off the decision
10 support system for non-tertiary THS patients
11 for the 12 months ending June 30, 2010.

12 Q: And is that consistent?

13 A: That is not consistent.

14 Q: And what is the effect of the inconsistency?

15 A: The effect of the inconsistency is that the pro
16 forma is, as I call it, extremely modest. It's
17 very much understated and it gives rise to an
18 understated projected net income.

19 Q: So in your opinion will Roper -- will the
20 Moncks Corner facility make more money than is
21 projected on the pro forma?

22 A: Absolutely.

23 Q: With the same utilization?

24 A: Absolutely.

25 Q: And in your opinion can the Moncks Corner

1 facility have much less utilization than is
2 projected in the pro forma and still make
3 money?

4 A: Yes, sir.

5 THE COURT: By that, you mean Berkeley Regional
6 Medical Center?

7 MR. LONG: Berkeley Regional Medical Center, yes,
8 Your Honor.

9 Q: If the redirection at the Roper St. Francis
10 Berkeley facility is greater than is even
11 projected in the pro forma, will that have a
12 less or greater impact on Trident Health
13 System?

14 A: That will have less of an impact. Because
15 basically under that scenario Roper and St.
16 Francis are feeding their proposed hospital.

17 Q: And let me show you, let me give you back this
18 sheet that Mr. Thomas gave you with a venue of
19 2015 on it. Did you write those numbers down?
20 You've got your deposition in front of you
21 there, if you want to -- but I want to finish
22 this out, if we can.

23 A: Surely.

24 Q: Okay?

25 A: I think I can speak to it.

1 Q: All right. And I think it was on page 119 --
2 118 in your deposition, if you've got it up
3 there in front of you.

4 A: Yes, sir, I'm there.

5 Q: Let's kind of quickly roll through this and use
6 the complete exercise.

7 A: Yes, sir.

8 Q: Okay. You said to do a venue pro forma for
9 Roper St. Francis you would double the net --
10 double the total revenue, right?

11 A: That is correct.

12 Q: And so that number would -- you would double
13 the -- well, let's look, we're going to look at
14 2013 venue, right, yeah three?

15 A: Yes, sir.

16 Q: If you doubled the 34,538,863, what number
17 would be the total revenue?

18 A: I'm going to round off to the nearest thousand,
19 if it's okay. 69,077,000.

20 Q: Okay. Will you write that on the sheet,
21 please, right there under the venue 2015
22 column?

23 A: Do you want me to write it directly on this --

24 Q: Right on the sheet if you would, yes, please.

25 A: Yes, sir.

- 1 Q: Do you have a pen there?
- 2 A: I do.
- 3 Q: Okay. All right. Then on the labor expense I
- 4 believe you did a calculation to determine what
- 5 you thought would be the venue labor expense.
- 6 A: Right. Nineteen million.
- 7 Q: Nineteen million, will you write that number
- 8 down?
- 9 A: I did.
- 10 Q: Okay. Then on the purchased services, do you
- 11 recall what number you calculated with Mr.
- 12 Thomas in that regard?
- 13 A: 2,256,000.
- 14 Q: Okay. How about supplies?
- 15 A: 10,568,000.
- 16 Q: Other expenses?
- 17 A: No change, 2,060.
- 18 Q: And then on corporate administration you did
- 19 your calculation and you concluded that the
- 20 outpatient should be how much? What did you
- 21 conclude the outpatient should be for corporate
- 22 administration?
- 23 A: 10,638,000 which comports with the relationship
- 24 that Mount Pleasant, for the six months ending
- 25 June 30, 2011, ratio of fully allocated

1 corporate allocation to Mount Pleasant net
2 revenues.

3 Q: Depreciation, what would that number be?

4 A: It'd be unchanged, 7,058,000.

5 Q: And then interest?

6 A: 4,320,000, unchanged.

7 Q: Can you total up the expenses for the hospital
8 under the venue approach?

9 A: I will. 55,900,000.

10 Q: Okay. Can you take the revenue number and then
11 subtract the expense number and tell me what
12 the revenue over expenses would be for a venue
13 pro forma at Roper St. Francis?

14 A: 13,177,000.

15 MR. LONG: Your Honor, we would ask to introduce
16 this as Respondent's 171.

17 THE COURT: Mr. Thomas.

18 MR. THOMAS: Your Honor, could I object to this?
19 There is a blatant inaccuracy. I don't get a
20 chance to re-cross, here. And I heard the
21 testimony. The entire exhibit would be
22 prejudicial to this case and I'd like to
23 explain. The Roper St. Francis Mount Pleasant
24 Hospital corporate administration expense for
25 ten months -- excuse me, for six months is \$2.4

1 million. If you annualize that to a year, that
 2 would be \$4.8 million. Somehow, Mr. Knapp came
 3 up with ten million dollars, which would not be
 4 reflective with what's on the chart, so I'm
 5 just -- that would be a highly -- the
 6 prejudicial value would be much more than its
 7 probative value, Your Honor, if it's sitting in
 8 there with a revenue over expenses line item
 9 that would be well over five million dollars
 10 off.. Very easily, that's something that could
 11 be corrected now so we don't have to waste a
 12 bunch of time with Mr. Baehr in rebuttal.

13 **MR. LONG:** Your Honor, he elicited all of the
 14 testimony. Walking completely through the
 15 chart. I didn't even ask him hardly anything
 16 more. He just didn't -- he just didn't have
 17 him finish it and everything he just said he
 18 asked him on cross examination. And Mr. Knapp
 19 gave him a very clear reason as to why he used
 20 the ten million dollar number instead of the
 21 one that Mount Pleasant, because it's based off
 22 revenue. And the first year revenue at the
 23 Mount Pleasant facility is a lot lower than
 24 what the third year revenue would be at the
 25 Berkeley facility, so the allocation would

1 clearly be higher on the venue pro forma. Your
2 Honor, I think this is important testimony he
3 -- just because he didn't like the answer is no
4 reason for it to be prejudicial.

5 **THE COURT:** That goes right to the point. The
6 objection is overruled. You will have to deal
7 with it on rebuttal, Mr. Thomas.

8 **MR. LONG:** Thank you, Your Honor.

9 **COURT REPORTER:** That was 171.

10 **THE COURT:** 171 is admitted over objection.

11 **MR. LONG:** Thank you, Your Honor.

12 **Q:** Mr. Knapp, I'm looking at Respondent's 171.
13 You see the revenue over expenses is thirteen
14 million -- what did you say it was?

15 **A:** 13,177,000, rounded off to the nearest
16 thousand.

17 **Q:** Now, is that a, in your opinion, is that a
18 reasonable venue pro forma for the Roper St.
19 Francis Berkeley facility?

20 **A:** Yes, sir, it is.

21 **Q:** Is that a number that you would expect to see
22 if you were doing a venue 2015 calculation for
23 these volume projections for that hospital at
24 that location?

25 **A:** Yes, sir.

1 Q: And with that pro forma there, is the hospital,
2 under just that pro forma, is the hospital
3 financially feasible?

4 A: It is indeed.

5 Q: Okay. Mr. Thomas asked you about Roper St.
6 Francis increasing its charges year after year
7 after year; do you remember that line of
8 testimony?

9 A: I do.

10 Q: Is there a reason that these pro formas are
11 done three or five years out as opposed to
12 being done ten or 20 years out?

13 A: Yes. Ten or 20 years out, I mean the erosion
14 in precision increases dramatically that many
15 years out. As Mr. Baehr indicated, and I
16 certainly agree with him, a pro forma is an
17 estimate. It's a series of assumptions. It's
18 not a science. It's probably not as precise as
19 we'd like it to be, but if you're going out
20 five, six, seven years, that's clearly not
21 going to be as precise as one or two years out.

22 MR. LONG: One second, Your Honor. I just wanted to
23 check.

24 Q: Thank you, Mr. Knapp.

25 MR. SUMMER: Your Honor, might I ask one indulgence?

1 THE COURT: Certainly.

2 MR. SUMMER: I have had a number of clients that
3 have not had access to me. I have one in
4 particular that needs to talk with me in the
5 morning. Would it be an inconvenience for the
6 other counsel or the court to start at 10:00
7 a.m. in the morning instead of 9:00?

8 THE COURT: Fine with me. I understand your
9 situation.

10 MR. LONG: Your Honor, I guess I'm fine with that.
11 I just would like some help on the rebuttal.
12 Are we going to finish -- I mean Mr. Richardson
13 will take the stand tomorrow. He's our last
14 witness. Hopefully, he'll be going tomorrow
15 and he'll be finished. Do they anticipate Mr.
16 Baehr being more than a day?

17 MR. SUMMER: No, we would not. What we would ask --

18 MR. LONG: That includes cross.

19 MR. SUMMER: I understand that. Here's where we are
20 in terms of rebuttal. Obviously there would be
21 some. At this point in time, I don't think we
22 would have anybody other than Mr. Baehr to take
23 the stand in rebuttal. And, obviously,
24 rebuttal is limited to things that occurred in
25 their text, not mine. Consequently, tomorrow's

1 witness is a very important witness for them,
2 Mr. Richardson. It would not be possible for
3 us to confer in the men's room and put Mr.
4 Baehr up tomorrow afternoon, but I do believe
5 that we could conclude Mr. Baehr on Thursday.
6 I do not see any problem with direct and cross
7 and redirect concluding on Thursday.

8 **THE COURT:** All right. Very well, then we'll be in
9 recess until ten o'clock in the morning. We'll
10 go off the record.

11 (There being nothing further, the hearing recessed at
12 6:00 p.m.)

13 DAY 13 - WEDNESDAY, FEBRUARY 15, 2012

14 **MR. SUMMER:** Your Honor, might I take a minute? We
15 have some local officials from Berkeley County
16 here and I just want to take a minute and
17 introduce them if counsel doesn't have any
18 objection. They drove a long way, Your Honor.

19 **COURT REPORTER:** On the record?

20 **THE COURT:** Yes, ma'am.

21 **MR. LONG:** I didn't do that earlier in the week. I
22 don't know if that should be --

23 **MR. SUMMER:** Well, they drove a long way this
24 morning. If it's all right with the court, I'd
25 just like to recognize the mayor of St.

1 Stephen, Mr. Bobby Hoffman.

2 **THE COURT:** Mayor Hoffman.

3 **MR. SUMMER:** And then three members of town council
4 from St. Stephen; Mr. Robbie Ballentine, Mr.
5 Jerry Thrower, and Mr. John Rivers.

6 **THE COURT:** Good to see you. And, Mr. Rivers, how
7 are you doing? See you in the back there.

8 **MR. RIVERS:** Thank you very much, Your Honor.

9 **THE COURT:** Thank you, sir. Mr. Long.

10 **MR. LONG:** Thank you, Your Honor. Before we call
11 our first witness, I'd like to hand up to the
12 court and to opposing counsel, earlier in the
13 trial we took the testimony of Mr. Karl
14 Gorrell, and we've made a proffer in regards to
15 how much the net income and basically how much
16 money HCA makes and Your Honor ruled that out,
17 but we've done a written proffer that we would
18 submit, and we had submitted it to the other
19 side earlier, so I'll hand that to the court
20 reporter for her to keep.

21 **THE COURT:** That would be fine, yes, sir.

22 **COURT REPORTER:** Are we going to mark this? Mr.
23 Long, do you want to mark this as an exhibit to
24 -- as a proffered exhibit?

25 **MR. LONG:** Well, it's a proffer, we can either do it

1 as an exhibit, or we can treat it like the
2 deposition designations.

3 COURT REPORTER: Okay.

4 MR. SUMMER: As long as it's labeled as a proffer.

5 MR. LONG: Yeah, it's got in on there.

6 COURT REPORTER: Okay.

7 MR. LONG: Thank you, Your Honor. We would call
8 Mark Richardson to the stand, please.

9 MARK M. RICHARDSON, being duly sworn, testifies as
10 follows:

11 MR. RICHARDSON - DIRECT EXAMINATION BY MR. LONG:

12 Q: Can you state your full name, please?

13 A: Certainly, my name is Mark Monroe Richardson.

14 Q: And what is your address, Mr. Richardson?

15 A: My address is 22 Virginia Lane, Cohasset,
16 Massachusetts.

17 Q: And where is that near?

18 A: Just south of Boston.

19 Q: And where are you employed?

20 A: I am employed by Richardson Knapp and
21 Associates.

22 Q: And what is Richardson Knapp and Associates?

23 A: It's a management consulting firm focusing on
24 the healthcare industry.

25 Q: Can you give the court your educational

1 background starting with college?

2 A: Sure. I received in 1977 a bachelor's degree
3 from Colby College up in Waterville, Maine.
4 Following that I received a master's in
5 business administration in 1979, from Cornell
6 University. At the same time as my MBA from
7 Cornell, I also received certification from
8 Cornell's Sloan program in healthcare
9 management, so it was MBA with a dual
10 certification in the healthcare track as well.

11 Q: Can you give me your employment background?

12 A: Sure. Right out of graduate school I moved to
13 Atlanta to work with the firm of Kurt Salmon
14 and Associates. Kurt Salmon is a medical based
15 multi national multi industry firm. I worked
16 in the health services division so I was a
17 candidate and started in Atlanta with a
18 healthcare consulting. They are a consulting
19 firm, a healthcare consulting firm.

20 Q: How long were you with them?

21 A: I was with Kurt Salmon for about four years.

22 Q: Okay.

23 A: Following that I went with a couple of folks
24 from Kurt Salmon and started the firm of FLR
25 Health Resources in Atlanta. Was there for

1 about six years where I was working in Atlanta,
2 but also in charge of the development of their
3 Dallas office as well. In Kurt Salmon and at
4 FLR my work was healthcare planning. My
5 clients were healthcare providers primarily, a
6 little bit of insurance or supplies, but mostly
7 healthcare providers, and the vast majority of
8 the work was in the Southeast United States.

9 Q: Okay. When did you leave FLR?

10 A: I left FLR in '89, '88 or '89, and spent a year
11 with Laventhol and Horwath, which was one of
12 the old Big Eight accounting firms. I started
13 in Atlanta and then moved to their Boston
14 office where I headed up their healthcare
15 consulting practice.

16 Q: All right. And then went to work for
17 Richardson and Knapp after that?

18 A: Yes.

19 Q: And when did that business start?

20 A: In 1990 I started Richardson Knapp and
21 Associates with Mr. Knapp, started the firm in
22 Atlanta, and about ten years ago or so moved to
23 Boston where I continue my practice there.
24 With Laventhol as well as with Richardson
25 Knapp, my practice really is the same and

1 actually a lot of the same points from way back
2 when I've carried forward through the various
3 firms, healthcare planning primarily healthcare
4 providers, and the vast majority in the
5 Southeast United States.

6 Q: What kind of work do you do for healthcare
7 planning in regards to your clients?

8 A: It ranges. It ranges from doing market
9 assessments in terms of how much market
10 potential there might be. I work with helping
11 clients to determine whether it makes sense or
12 whether there are opportunities to develop new
13 services. We'll do demographic analyses, we'll
14 do forecast of volume. And in states where
15 there is regulation such as Georgia or Florida
16 or South Carolina, the vast majority of that
17 transfers into a certificate of need issue when
18 a decision is made to move forward and the
19 project is reviewable by the various agencies.
20 Differences in every state in terms of what's
21 regulated and what's not regulated, but a lot
22 of what we do goes into the CON issue.

23 Q: Are you a member of professional associations
24 or hold any certificates?

25 A: Sure. I'm a member of the Society of

1 Healthcare Planning and Marketing, a member of
2 the Academy for Healthcare Research.
3 Certifications from Health Insurance
4 Association in managed care and health
5 insurance. That probably carries it.

6 Q: And as part of your work with Richardson and
7 Knapp, do you testify in court cases?

8 A: Yes, I do. I've testified in venues like this
9 in multiple states in terms of administrative
10 level. I've also testified in state and
11 federal court as well, and the vast majority of
12 the time qualified as an expert in healthcare
13 planning.

14 Q: And have you been qualified as an expert in
15 healthcare planning in South Carolina?

16 A: Yes, I have.

17 MR. LONG: Your Honor, at this time we would move to
18 designate Mr. Richardson as an expert in
19 healthcare planning.

20 MR. SUMMER: Without objection, Your Honor.

21 THE COURT: Without objection, so qualified. Thank
22 you, sir. Just one moment, Mr. Richardson,
23 your voice is so modulated that it --

24 MR. LONG: You don't have a mic there --

25 THE COURT: It's on the low side. If you would

1 speak a little more loudly, please, sir.

2 A: I will attempt to do that.

3 Q: I'm not sure that mic is not working, so you're
4 going to have to do it without a microphone.
5 So, yeah, if you could speak up a little bit,
6 thank you. Mr. Richardson, can you describe
7 for the court your experience in preparing CON
8 applications for new and replacement hospitals?

9 A: Sure. The new replacement hospitals would
10 probably total 20 or 25 projects over the last
11 ten to 20 years, ranging from brand new
12 hospitals to replacement hospitals in terms of
13 just picking them up and moving them to a new
14 spot.

15 Q: And have you done that -- you said you've done
16 that in other states.

17 A: Yes, I have. The majority of that would be
18 down in Florida.

19 Q: Are there similarities kind of between the
20 states in regards to how they regulate the
21 hospitals?

22 A: Yes, there are. The detailed regulations are
23 a bit different in every state, but from the
24 planning side that I work in, it's really
25 pretty similar in terms of it's identifying a

1 geographic area for study and often the state
2 will define, you know, what the geography is.
3 For example, here it's the three county area.
4 In some areas there is defined planning areas
5 and in some areas there's not. So define the
6 geography, look in terms of what's occurring
7 within that marketplace today in terms of
8 population, in terms of healthcare usage, and
9 what the existing providers are doing. And the
10 major part of a CON in any state is to identify
11 an issue that will be resolved with the
12 proposed project, and simply to prove out what
13 the need is for the project. That's what
14 certificate of need is all about.

15 Q: Can you kind of explain the process that you
16 follow when you approach your work and develop
17 an analysis for a new or replacement hospital?

18 A: Sure. And it's similar to an analysis for most
19 every service that I look at. The first part
20 is to define the appropriate geography, is it
21 one county, is it multi-county, is it a defined
22 part of the state that a given agency may
23 define. Once you've defined geography, then
24 you need to look in terms of what's the -- are
25 there any barriers or is anything different or

1 funny within that geography. Then look at
2 population, both historical to see what it's
3 done historically, and also to see what it's
4 forecasted to do in the future. Also look in
5 terms of whatever the service we are looking
6 at, let's look at what's happening with the
7 utilization, in terms of how much utilization
8 is occurring today, how much utilization may be
9 expected to occur out into the future. And
10 then from that, basically looking at a service
11 specific that usually becomes -- if you have a
12 full pie of potential business in terms of how
13 many patient days or admissions or open hearts
14 or whatever, the real question becomes in terms
15 of what portion of that pie can you truly
16 expect to be served in your proposed service or
17 your proposed hospital. So it's define the
18 geography, define what the potential is, and
19 then trying to determine what portion of that
20 pie could reasonably be served in the proposed
21 either hospital service or product.

22 Q: And did you follow those steps in this case?

23 A: Yes, I did.

24 Q: Now, as part of the certificate of need
25 process, you actually have to fill out the

1 application?

2 A: Yes, you do.

3 Q: All right. And from your -- as a planner,
4 what's your primary focus in the application;
5 where's the majority of your work located in
6 the application itself?

7 A: The vast majority of my work tends to be in the
8 need section, which here in South Carolina is
9 question B11.

10 Q: Yeah, let's go to Joint 2, Bates 18, and just
11 get you to identify that if you can, but we're
12 not going to walk through it yet, I'm just --

13 A: Bates stamp 18?

14 Q: Yes. Would it be kind of accurate to call the
15 need analysis to be -- I'm sorry, page 15. You
16 at page 15?

17 A: Yeah. B11 starts on page Bates stamp 15.

18 Q: Is this kind of the heart of the CON
19 application, is that what -- how would you
20 describe it?

21 A: I think it's an important part of the CON
22 application. It basically identifies what you
23 expect to occur with the proposed new service
24 or facility.

25 Q: And B11 is actually a question that you have to

1 answer, right?

2 A: Yes, it is.

3 Q: It's on page 15 here? .

4 A: Yes, sir.

5 Q: And can you kind of summarize that for me as to
6 exactly what they're asking you, what the
7 Department is asking -- what the state's asking
8 you in the question in the application?

9 A: I'll just go through it quickly. The question
10 asks, that you need to demonstrate that the
11 proposed project is needed or projected as
12 necessary to meet an identified need of the
13 public. This shall address at a minimum:
14 target population, the degree of unmet need,
15 projected utilization of existing services and
16 facilities, past utilization of those services
17 and facilities, justification that the project
18 will not unnecessarily duplicate existing
19 services, and then says that you must show all
20 assumptions, data sources, and methodologies,
21 and that the population statistics must be
22 consistent with those generated by the state
23 demographer from the State Budget and Control
24 Board.

25 Q: And just to give us some perspective, how many

1 pages is the B11 in the CON application
2 roughly?

3 A: It's a good bit of it. It runs from 15 on
4 through to 38.

5 Q: Are you the primary drafter of this section of
6 the application?

7 A: Yes, I take responsibility for this. There was
8 input from folks over at the hospital, but I'll
9 take responsibility for this.

10 Q: Who else would have assisted you on it, besides
11 yourself, from Roper St. Francis?

12 A: The folks at Roper St. Francis that I worked
13 with, really there were really three folks, one
14 would be Shannon Cantwell, next would be
15 Elizabeth Player, and last would be Doug
16 Bowling.

17 Q: Okay. And what kind of help did they give you
18 in regards to the B11 and the CON?

19 A: They would provide information. We would
20 discuss per the ongoing development of the need
21 side. They were a big part of the team in
22 terms of helping me get to where we ended up in
23 this application.

24 Q: All right. When were you retained to help
25 Roper St. Francis with this application?

1 A: I believe it was late August or early September
2 in 2008.

3 Q: Okay. So when you were contacted, had the land
4 at Carnes Crossroads already been purchased?

5 A: I believe it had.

6 Q: Okay. And when you were contacted, had a
7 decision been made about filing the application
8 itself, a strategic decision to go forward with
9 it?

10 A: Yes, it had.

11 Q: Okay. Now, had you worked with Roper St.
12 Francis before?

13 A: Yes.

14 Q: In what capacity?

15 A: I had worked with them before on the Mount
16 Pleasant project, in terms of their satellite
17 hospital over in Mount Pleasant. And I don't
18 think we ended up with any ultimate result, but
19 I know there was another analysis that we
20 worked years before. I believe it was looking
21 at a rehab type issue, but that would have been
22 late '90s and the early part of 2000 or so.

23 Q: And, now, the Mount Pleasant hospital, did it
24 go to litigation?

25 A: It did not.

1 Q: Okay. So were you ever deposed in that case,
2 or anything like that?

3 A: No, I was not.

4 Q: Now, when you were contacted by the folks at
5 Roper St. Francis to become involved in this
6 project, what is some of the initial work that
7 you did when you first got the call and started
8 work on it?

9 A: Well, the initial work would be what I would do
10 looking at any need assessment. It would be to
11 start looking at the population within Berkeley
12 County, would be to start looking at the
13 utilization within Berkeley County, looking in
14 terms of who the providers were within the
15 area, looking at the Health Plan to try to get
16 some guidance in terms of what the state was
17 directing for this area. So it would have
18 been, first off, would have been sort of an
19 overview for public information.

20 Q: Did you make a site visit?

21 A: Yes, I did.

22 Q: All right. Tell us more about that, please.

23 A: I made a two to three days site visit to Roper
24 St. Francis. As part of that I spent the day
25 with folks from Roper St. Francis' Moncks

1 Corner facility, basically driving the county.
2 Looking in terms of the proposed site, looking
3 in terms of the existing Roper St. Francis
4 facilities in Moncks Corner. Drove up to the
5 Trident Moncks Corner facility as well, drove
6 up around the lake. So that it was twofold.
7 One to get sort of a hands-on observation and
8 to understand what was going on there within
9 the county. The second, to work across the
10 table with the Roper St. Francis folks, rather
11 than just on the phone or via email.

12 Q: Now, just quickly kind of taking us forward to
13 today in regards to other work that you've done
14 in the case, did you stay involved after the
15 application was completed in regards to the
16 review process?

17 A: Yes, I did. Once the CON application was
18 approved, the state held a project review
19 meeting or hearing.

20 Q: After it was filed?

21 A: After it was filed, yes.

22 Q: Okay.

23 A: After it was deemed complete.

24 Q: Right.

25 A: And I was part of that assessment. I met with

1 the Roper St. Francis folks before that and was
2 there at the project review.

3 Q: Did you present?

4 A: Yes, I did, I presented a portion of the
5 presentation.

6 Q: Okay. And did you review the materials that
7 Trident was submitting in regards to its
8 application to the Department during that time?

9 A: Yes, I did.

10 Q: Since then have you been involved in the
11 litigation, since the decision from the
12 Department?

13 A: Yes. There's been a bunch of discovery that's
14 been sent back and forth on this. I believe I
15 looked at the majority of the planning
16 materials that may have come back and forth,
17 either from Roper to Trident or Trident to
18 Roper. I was deposed on this case. I sat and
19 listened to Mr. Baehr and Mr. Davidson, who was
20 working with Mr. Baehr, for the depositions.
21 So, yes, since the decision I've been involved
22 in this process as well.

23 Q: And of course you've been here for the trial?

24 A: Yes, I have, every day.

25 Q: Every day, good, we're on day 13. What's Mr.

1 Knapp's role in regards to your company and
2 this application, I mean, his role with this
3 application?

4 A: He basically is in charge of or in control of
5 the financial portions of the CON. I work the
6 planning side.

7 Q: Okay. And so just kind of give the court some
8 division, how do y'all divide the work as to
9 what's planning and what's financial?

10 A: Typically, anything that has a dollar sign on
11 it would be Mr. Knapp's, in terms of assessment
12 or reimbursement or financial forecasts or
13 those type issues.

14 Q: Okay.

15 A: I get involved in terms of trying to determine
16 what the size and volumes and utilizations
17 would be for a given service.

18 Q: And do you provide him that kind of information
19 for him to, I believe the word he used
20 yesterday was to dollarize it?

21 A: Yes.

22 Q: Now let's look at a couple of exhibits if I
23 can. Just quickly if you can kind of tell the
24 court as to why you would have reviewed this
25 information in preparing the application.

1 Let's look at Respondent's Exhibit Number 7,
2 and you should have a Respondent's book up
3 there --

4 A: I do.

5 Q: -- if you want to follow in the book. What is
6 Respondent's Exhibit 7?

7 A: Respondent's Exhibit 7 is information from the
8 state of South Carolina; it's a series of
9 population projections that is showing a July
10 2015 estimate, so this likely was the
11 information that we used when we first started
12 the application back in 2008.

13 Q: Okay. We're going to talk about population in
14 a minute, but I do want to ask you a couple of
15 quick questions about Berkeley County. How
16 does the state project population?

17 A: Basically what you have is that the -- the only
18 true population count you have are when the
19 census goes out and polls the folks and
20 actually runs the census. So we have a hard
21 number for 2000. And what happens from 2000
22 going forward are that various agencies or
23 folks will basically predict what they expect
24 to have happen out into the future. So what
25 you have here on this table is that you have

1 the state, and everyone knew what the 2000
2 population numbers were for each county, but
3 there was an estimate in terms of what they
4 expected to be happening into the future. The
5 2010 census wasn't here, wasn't available at
6 this point in time, so this really was all
7 based on the 2000 census.

8 Q: Okay. And then on the second page, did they
9 actually make projections even further out than
10 the next census?

11 A: Yes, they do.

12 Q: All right. Now, what is Claritas? This is the
13 state of South Carolina, right?

14 A: Right.

15 Q: Okay. What is Claritas?

16 A: Claritas is a private corporation that also
17 provides demographic forecasts out into the
18 future. There are probably two major groups
19 out there that provide the vast majority of the
20 demographic data for planners or for marketers.
21 That would be Claritas and ESRI; they are the
22 two companies that do that. Both use the same
23 2000 start point, both have their black box
24 inputs that they use to forecast out. But they
25 are both commercial demographic forecasting

1 groups as well.

2 Q: Do they have a -- do they do something that the
3 state doesn't do in regards to projecting
4 population?

5 A: Yes, they do.

6 Q: What do they do?

7 A: Claritas or ESRI will basically look at
8 population either historically or forecasts of
9 a geographic area more discreet than a county
10 level than the state. The state only looks at
11 the county level, but the private folks will go
12 down to the zip code or block group or census
13 tract, whatever you may want.

14 Q: Do they also look at it by age?

15 A: Yes, they do.

16 Q: Okay. So what's the difference there?

17 A: The state looks only at county. The state has
18 some level of age profiling, but recently the
19 available information from the state in terms
20 of age forecasts has not been -- it's been
21 missing. Hopefully with the new 2010
22 population, the state will start forecasting
23 out population growth and population size by
24 age, but currently that's not available.

25 Q: But Claritas and ESRI, they have that

1 information?

2 A: Yes, they do.

3 Q: Are all of these sources acceptable in
4 healthcare planning?

5 A: Yes, they are.

6 Q: Do you use them?

7 A: I typically use state data wherever I am, I use
8 Claritas or I use ESRI.

9 Q: Okay. Is that typical of all the healthcare
10 planners that do these cases and work in the
11 CON arena?

12 A: Yes.

13 Q: All right. Let's take a look quickly at
14 Respondent's Exhibit 30 and 31. Is this some
15 of the data that you would have been looking at
16 to help prepare your application?

17 A: Yes.

18 Q: I mean prepare the B11?

19 A: Yes.

20 Q: Tell me what 30 and 31 are.

21 A: Thirty basically is information that is
22 available publicly from the Office of Research
23 and Statistics here in South Carolina. And
24 what Exhibit 30 is, let me make sure it's all
25 the same, appears to be a profile of the

1 inpatients that are served for the residents --
2 gives presentation data showing how the
3 residents of Berkeley County receive inpatient
4 care.

5 Q: Okay. Do you have 31?

6 A: Thirty-one is from the same source. And what
7 31 does, again, is an inpatient profile, here
8 by an individual hospital, Trident Medical
9 Center, which identifies where patients that
10 Trident treats, where they are from and in what
11 services they treated.

12 Q: All right. And you also looked at other data
13 in helping prepare the B11, too?

14 A: That is correct.

15 Q: All right. Do you have an opinion, based on
16 the work you performed, do you have an opinion
17 regarding the need for the proposed project for
18 Roper St. Francis Berkeley at Carnes
19 Crossroads?

20 A: Yes, I do.

21 Q: Can you tell the court what that opinion is?

22 A: Sure. I still feel comfortable with the
23 opinion that I made back in 2008 that the
24 project is needed, and based on updated
25 information I still remain convinced that the

1 project is needed.

2 Q: Let me show you from Joint Exhibit 2, which is
3 the Roper St. Francis application, turn to page
4 1262, if you could. Can you tell the court
5 what pages 1262 through 1265 are?

6 A: Just a second. 1262 to 1265 is the letter from
7 DHEC to Shannon Cantwell, who was the
8 authorized representative for Roper St. Francis
9 on this, and this is the letter that I describe
10 as the decision letter, basically stating that
11 the decision was made that the application
12 should be approved.

13 Q: And do you see in the first paragraph here that
14 Ms. Brandt determined that these applications
15 were not competing applications?

16 A: That is correct.

17 Q: In your opinion, is Ms. -- or do you agree with
18 Ms. Brandt's decision?

19 A: Yes, I do.

20 Q: In your opinion are these competing
21 applications?

22 A: My opinion is they are not competing
23 applications.

24 Q: In the second paragraph here, she makes a
25 decision regarding approval of the CON

1 application for the hospital at Carnes
2 Crossroads. Do you agree with her -- in your
3 opinion, was her decision correct?

4 A: Yes, I believe this application should have
5 been approved.

6 Q: Well, let's turn to this issue about whether
7 these applications are competing. Let's spend
8 a little time talking about that. All right.
9 Now, you certainly know from the letter, and
10 from the trial, the Department deemed these
11 applications not to be competing, right?

12 A: Yes.

13 Q: Now, let me show you -- I don't know if we have
14 a copy of it we can show up on the screen, so
15 you may have to -- are you familiar with the
16 definition of competing applications as found
17 in the South Carolina regulations? Have you
18 looked at that before?

19 A: I have, yes.

20 Q: Let me show you Section 61-15 103(6), which is
21 the definition of competing applications. Are
22 you familiar with that?

23 A: Yes, I am.

24 Q: In regards to how you analyze whether these
25 applications are competing, can you kind of

1 just walk through, for the judge, in your
2 opinion what the issues are and in regards to
3 the definition?

4 A: Sure. I'll start by saying that this is an
5 agency decision. This is not something that I
6 can demand or try to demand. But basically,
7 the big issues here, competing applicants mean
8 two or more folks, so that's pretty
9 straightforward to be expected, who are
10 applying for a CON to provide similar services
11 and/or facilities in the same area, and whose
12 applications if both, and it doesn't say, but
13 if both were approved would exceed the need for
14 this facility or service.

15 Q: Okay. So in your opinion, what's the key focus
16 for the Department in determining whether these
17 two applications are competing applications
18 under that definition?

19 A: I think really three things come into play. I
20 think the first is, is just the construct or
21 what these projects are. You have Roper St.
22 Francis basically transferring existing bed
23 capacity within the planning area --

24 Q: Well, transferring existing beds, right?

25 A: Exactly.

1 Q: The actual beds?

2 A: Exactly.

3 Q: Okay.

4 A: Nothing new. This basically, this is their bed
5 license that's being shifted to a new spot.

6 Q: Okay.

7 A: Versus Trident, which basically is taking a 17
8 bed need in the applicable Plan that they were
9 reviewed on, bringing that up to 50 beds, as
10 discussed in the Plan, and moving that 17 to 50
11 bed need to a new site as well. So I think the
12 construct of these two projects and who they
13 are is one distinguishing factor.

14 Q: Okay. And why would that lead you to believe
15 they are not competing?

16 A: Nothing new is being added in the planning area
17 regarding the beds for Roper St. Francis.

18 Q: Okay. What other issues do you think are
19 important?

20 A: Well, I think another issue really would be the
21 fact that I truly believe that these are --
22 though from statute they are in the same Tri-
23 county area, but I think in terms of if you
24 drill down in terms of the county, I believe
25 that they truly are two distinct portions of

1 Berkeley County. You've got the Moncks Corner
2 hub -- Berkeley County basically is a big
3 geography. You've got the lake to the north.
4 But the population concentrations or the
5 population hubs are -- if you had a sandbox,
6 where the mounds would be in terms of
7 population are Goose Creek and Moncks Corner.
8 You really have two distinct areas. And I
9 think basically the location of Trident's
10 facility in Moncks Creek and Roper's in --
11 Trident in Moncks Corner, I had problems with
12 that before, I'm sorry, Your Honor, and Roper
13 St. Francis over in Goose Creek, I think they
14 are located in two distinct and differentiable
15 areas. The third issue, basically, in terms of
16 is there adequate need to support both, couple
17 of things. Today, based on existing volume,
18 Roper St. Francis could fill their hospital
19 today with patients that are now Berkeley
20 County residents, that basically are being
21 served down and at least 30 more minutes away
22 down on the peninsula or St. Francis. So just,
23 to be real clear, Roper's got enough today to
24 fill their facility. Trident has more than
25 enough. Trident's got a couple times enough

1. volume from Berkeley County to fill their
2 facility. So today as we sit there, both of
3 these folks have more than enough to create,
4 and establish and to fully occupy each of these
5 proposed facilities. Not even considering the
6 business that now goes to either MUSC or East
7 Cooper or some going out of the area, so more
8 than enough today. Into the future, there's
9 forecasted population growth, there is
10 forecasted volume growth, so out into the
11 future, even more than enough to cover both
12 facilities. So in terms of would the need
13 exceed -- would these two projects exceed the
14 need, the answer is no. Today, even before
15 forecasting, these two facilities could be
16 built and could be full.

17 Q: Are there other facts that also you've heard in
18 the case or you've seen during discovery that
19 would support that these applications are not
20 competing?

21 A: The other, I think, is a relatively unique
22 situation here, which I knew of before trial,
23 but really what has just focused here from
24 testimony at the trial, is the fact that, one,
25 there truly are two distinct medical staffs.

1 Often, and I'm working on a project now where
2 there's probably 90 percent overlap on medical
3 staffs, where the doctors are on two or three
4 hospitals all within the area. That's not the
5 case here. You have a Roper St. Francis
6 medical staff and you have a Trident medical
7 staff. And it appears that there's very little
8 overlap among those two entities, such that
9 once a patient decides to go or obtain care
10 from a Roper or from a Trident doctor, they go
11 separate paths. One side goes to Roper St.
12 Francis, one side goes to Trident. In
13 addition, what it looks like is that the ED
14 volume, when folks hit the emergency room,
15 similar; the vast majority of folks into the
16 Moncks Corner Roper St. Francis ED follow into
17 the Roper St. Francis system, similar for
18 Trident, so once they hit there they go there.
19 All this leads me to believe that there truly
20 are two separate healthcare network systems
21 within the county and drives me to believe that
22 that provides information that these are not
23 competing applications.

24 Q: Are these large medical staffs?

25 A: Yeah, they are. I don't remember the exact

1 number, but there are five or six hundred on
2 each side with little overlap.

3 Q: And in your experience that is a large medical
4 staff? I mean, other hospitals have -- is that
5 typical for hospitals to have 500 physicians on
6 them -- on their medical staff, or six or eight
7 hundred?

8 A: It's not the biggest I've seen, but it is up
9 there in the large range.

10 Q: All right. Let's go back and look -- let's
11 talk about the service area for a second, all
12 right? Now, what is the service area for
13 hospitals in this area of the state?

14 A: The State Health Plan defines service area or
15 planning area as the three county area;
16 Charleston, Dorchester and Berkeley County.

17 Q: Okay. Now let's look at Respondent's Exhibit
18 75, particularly Roper Berkeley 704, this map,
19 okay. It's up on the screen. I've also got a
20 board here for you to look at if you want to,
21 all right. Tell me what is reflected on this
22 map if you could.

23 A: Well, first off, it shows visually the three
24 county area. What you have there is Charleston
25 County in red, Dorchester County in green, and

1 Berkeley County in light blue.

2 Q: Okay.

3 A: So it gives you a visual of what's there.
4 Second, what it has there, it has the 2010
5 census population for each county, basically
6 showing that Charleston County 2010 is about
7 350,000 folks, Dorchester about 136,000 or
8 137,000 folks, Berkeley 177,000 or 178,000
9 folks.

10 Q: That's from the 2010 census?

11 A: That is correct. So these are good numbers
12 versus forecasts we've had before, which folks
13 do the best they can, but these are the real
14 numbers.

15 Q: Okay.

16 A: So we know that to be good. Also what's here
17 is a presentation of the number of beds in each
18 county. And really what this shows is that --
19 and again, it's discussed there to the right of
20 that map -- is that you have 95 percent of the
21 three county beds are located in Charleston
22 County, yet only 53 percent of the service area
23 population resides in Charleston County. And
24 that's changed. Where back in '70 it was about
25 74 percent of all of the Tri-county area was in

1 Charleston County, but due to faster growth,
2 more rigorous growth up in Dorchester, Berkeley
3 County, what you find is that the, as you see
4 in a lot of areas, what you find is that the
5 population concentration basically downtown is
6 diluting as folks move out to the growing
7 suburbs here into Dorchester and Berkeley
8 County and up to the right up there into Mount
9 Pleasant as well.

10 Q: And in this chart, and just to clarify, this
11 map is based on the 2010 census, which is
12 Respondent's Exhibit 59, reflected in that, and
13 then these bed numbers that you've got are from
14 the 2010-2011 State Health Plan?

15 A: That is correct.

16 Q: That's Joint Exhibit 5. I believe, Joint
17 Exhibit 5, all right. In your opinion what is
18 the status of the service area in regards to
19 distribution of beds in the Tri-county service
20 area?

21 A: The status of the distribution of beds is
22 clear. There is significant maldistribution of
23 beds in Charleston County versus where you'd
24 hope to have would be a reasonable distribution
25 of beds out to where the population now is

1 based. So basically you've got 95 percent of
2 the beds in one county, which a long time ago
3 may have made some sense, but where you are now
4 though is that with population growth, those
5 beds have not followed the population, and
6 that's a maldistribution. You'd like best to
7 have the beds distributed out among these three
8 counties pretty much equally so you'd have sort
9 of a relatively constant bed to population
10 ratio. You need some tertiary care which would
11 serve all of it in terms of the very high end
12 type work. But for the majority of the non-
13 tertiary work, you'd like to have those beds
14 distributed to the population.

15 Q: And is this circumstance that the Tri-county
16 area finds itself in, is it unique?

17 A: No, it's not. Personally, I've worked in real
18 similar situations in Atlanta, in Miami, and
19 Tampa where basically the same thing in terms
20 of core population in the downtown or the
21 historic hub and that's where all the beds
22 were, that's where all the beds were developed,
23 all the hospitals were developed. But as
24 population grows to the outside, there is a
25 need and a push to move beds and healthcare

1 capacity out to meet those needs.

2 Q: Okay. Let's take a look at Respondent's
3 Exhibit 70, Richardson Berkeley page 683. Can
4 you tell me what Respondent's 70 is?

5 A: Sure. Respondent's 70 is an exhibit that I put
6 together that basically profiles what has
7 happened to the population in the Tri-county
8 area, for the counties from 1970 to 2010, and
9 for the cities and towns from 1980 to 2010.

10 Q: Does it also have all of your, or many of your
11 opinions in the case contained in this Exhibit
12 70 here on the next several pages?

13 A: I think one of the basic core sort of pillars
14 of my opinion is that Berkeley County basically
15 is experiencing -- has experienced strong
16 growth and I expect it will experience strong
17 growth into the future, such that the --
18 there's an innate maldistribution of assets now
19 that should be fixed, that needs to be fixed
20 from a planning perspective, and I think that
21 the Roper facility solves at least part of that
22 problem.

23 Q: Okay. Let's take a look at just this first
24 page here. Do you have the exhibit in front of
25 you, the book?

1 A: I do.

2 Q: Okay. And it is a multi-page exhibit, right?

3 A: That is correct.

4 Q: All right. On the first page here, the focus
5 is on population?

6 A: That's correct.

7 Q: And is some of the backup for this exhibit
8 located at, and I don't know how big the book
9 is, but Exhibit 59?

10 A: They are in this book.

11 Q: Can you turn to tab 59 real quick, and then
12 we'll come back to Respondent's 70. I want to
13 make sure that you've identified some of where
14 your information is coming from.

15 A: Fifty-nine is census information, so this would
16 be the updated census information.

17 Q: How about 60?

18 A: Sixty is information from one of the
19 proprietary groups, ESRI, again, the source
20 information that I would have looked at.

21 Q: How about Respondent's 62?

22 A: Sixty-two, yeah, 62 is, again, this is from the
23 Office of Research and Statistics, this is
24 another set of data that I would have reviewed
25 in terms of looking at where Trident Medical

1 Center's patients come from and in what
2 services they receive care.

3 Q: How about Respondent 63?

4 A: Sixty-three would be the same, this would
5 basically be census data from 1960 through 1990
6 by county, from the census.

7 Q: Okay. Would you also have census data from the
8 individual -- listed by county?

9 A: Sixty-three is by county, correct.

10 Q: How about 64?

11 A: Sixty-four presents information by
12 municipality, again from the US census.

13 Q: Historical census information?

14 A: This is, yes, that appears to be 2000.

15 Q: And how about Respondent's Exhibit 65?

16 A: Sixty-five is information by race from -- and
17 this is again from the state of South Carolina,
18 this is from their statistical abstract, but a
19 similar source. This is information that is
20 updated to the 2010 census.

21 Q: And how about Respondent's 68 and 69?

22 A: Sixty-six would be information that I looked at
23 as well, that would be census data for South
24 Carolina.

25 Q: Okay.

1 A: Sixty-seven would again be census data, 68
2 would be census data, 69 would be census data
3 as well.

4 Q: Okay. Now, so having reviewed all this census
5 information and the other population
6 information, let's look at your Respondent's 70
7 on the first page here. Let's just look at the
8 top part in regards to the county population
9 data. What exactly are you showing here at the
10 top of the document here?

11 A: What I am showing actually is the reported data
12 for each census data collection. So this is
13 what the census reported for 1970, '80, '90,
14 2000, and 2010 showing total population over
15 that multi-decade time frame.

16 Q: Just for the three counties in the service
17 area?

18 A: That is correct.

19 Q: I did some totals on this. I mean, it appears
20 that the population has almost doubled since
21 1970.

22 A: Approximately.

23 Q: Does that sound about right?

24 A: Yes, it is.

25 Q: And you testified earlier about the

1 distribution of the population among the
2 counties of the service area. In 1970 when
3 Trident was built, what was the ratio in
4 population Berkeley/Dorchester to Charleston?
5 I'm not sure I'm saying that right.

6 A: Right. It would be approximately about 26, 27
7 percent total population 1970 was in Berkeley
8 and Dorchester County.

9 Q: And the remainder in Charleston?

10 A: That is correct.

11 Q: And then now in 2010, what's the percentage of
12 the total population for Berkeley and
13 Dorchester?

14 A: I believe that Charleston's now 53, 54 percent
15 so the remainder would be 45, 46, 47 percent.

16 Q: How would you categorize the growth in Berkeley
17 County since 1970?

18 A: It's been strong. You basically had in 1970 to
19 2010, you've had about a tripling of the volume
20 or growth of approximately 120,000 folks during
21 that time frame.

22 Q: And how about Dorchester, has it grown?

23 A: Sure has.

24 Q: Can you describe that?

25 A: The percentage of growth would be higher. The

1 absolute growth would be just a little bit less
2 at about 100,000 population.

3 Q: And do these statistics contribute to your
4 opinion about the maldistribution of beds in
5 the service area?

6 A: Very much so.

7 Q: Let's look at these communities, these four
8 communities here. Why did you choose these
9 four communities in the town population data?

10 A: These are the major population hubs broken out
11 by municipality in Berkeley County, and with
12 North Charleston and Summerville basically
13 being the overlap areas to the south and
14 southwest of Berkeley County.

15 Q: All right. Were you able to find 1970 data?

16 A: I spent a lot of time trying to find it, and
17 could not find it.

18 Q: Okay. So what was the earliest year, '80 was
19 the earliest year you found on the census?

20 A: That's correct.

21 Q: Okay. So the hospital, Trident Medical Center,
22 I think, do you recall what year it opened?

23 A: I believe Trident was opened in the '70s.

24 Q: Around '75 or so?

25 A: Mid-decade, yes, sir.

1 Q: All right. So in 1980 what was the -- of the
2 four communities of Goose Creek, Moncks Corner,
3 North Charleston, the City of North Charleston,
4 and the Town of Summerville, what's the largest
5 population concentration among those four
6 communities?

7 A: By far, North Charleston.

8 Q: Okay. I mean, it's actually, it almost doubles
9 or more than doubles the other three, right?

10 A: Yes, sir. If you add those other three up,
11 North Charleston is more than double the base
12 from that.

13 Q: So when HCA built the hospital in the '70s,
14 where did they place it in regards to
15 population?

16 A: They placed it in North Charleston.

17 Q: Okay. And what's unique about that?

18 A: It was the population hub.

19 Q: Now, these other three communities, let's
20 forward ahead to 2010, what do you see in
21 regards to these four communities?

22 A: I think what you see is that all the
23 communities have had pretty substantial growth
24 in terms of Goose Creek about doubling, Moncks
25 Corner just a little less than doubling, North

1 Charleston picking up about 35,000 population,
2 and Summerville itself has grown dramatically.

3 Q: If you compared North Charleston to the other
4 three communities, okay, is its share of the
5 population shrinking compared to the other
6 three?

7 A: Yes, it is. While there is growth shown in
8 North Charleston, the growth around North
9 Charleston is catching up and in absolute
10 numbers is well above what happened in North
11 Charleston.

12 Q: Okay. As a health planner, when you see these
13 maps, the map that you looked at plus this
14 population data on this page here, do you have
15 an opinion on what would be the best approach
16 to serve the Tri-county population in regards
17 to hospitals and beds?

18 A: Yes, I do. I do have an opinion.

19 Q: What is your opinion?

20 A: Is that I think from a planning perspective a
21 redistribution of beds and services to the
22 growing counties would make sense and should be
23 established, developed and approved.

24 Q: And how does that benefit the residents of
25 those areas in North Charleston and Berkeley

1 County?

2 A: Basically what you have is that by
3 repositioning existing assets, you basically
4 are bringing the services to the population,
5 enhancing access.

6 Q: Okay. Let's talk about the 2010 census for a
7 second. I want you to go back and look at
8 Respondent's Exhibit 7.

9 A: Seven?

10 Q: Yes.

11 A: I got it.

12 Q: Okay. Now, you said the hard numbers are the
13 census numbers, right?

14 A: That is correct.

15 Q: So when we look at Respondent's Exhibit 7, and
16 let's just look at Berkeley County, these
17 population numbers on the first page here for
18 each year, is that a hard number or how would
19 you describe these numbers from between 2005
20 and 2010?

21 A: I think the heading defines exactly what they
22 are. For 2005, that's an estimate, so that
23 means that this publication was likely created
24 in 2005 where they were estimating what the
25 population would be during that year. And

1 again, this is not hard data. You had a 2000
2 census and this is all sort of best estimate,
3 best forecast of what's happening. But the
4 estimate would be in 2005 what they expected,
5 what they predicted to have for population in
6 that year 2005.

7 Q: When each applicant prepared their CON
8 application, was this the best data available
9 to you?

10 A: I believe it was. Yeah, in terms of total
11 market size, this appears to be the range of
12 information we had.

13 Q: What did the state estimate that the population
14 of Berkeley County would be on July 1, 2010?

15 A: 162,370, so 162,000.

16 Q: And what was the actual population?

17 A: 177,000.

18 Q: So what happened?

19 A: The state basically under-forecast the growth
20 that would occur within Berkeley County from
21 2000 to 2010.

22 Q: And what does that show you or say to you as a
23 health planner?

24 A: Well, basically it says to me as a health
25 planner is that we based all of our information

1 based on the prior information, the older
2 information, what I now know is that Berkeley
3 County in 2010 was larger than I anticipated it
4 to be, so in terms of, looking in terms of what
5 the distribution of beds are and what the
6 volume should be, the population side of that
7 equation basically undershot.

8 Q: And did Mr. Baehr and Trident also
9 underestimate the population in their
10 application?

11 A: Yes.

12 Q: I also want you to look at this other page, I
13 think this is interesting too, if you go over
14 to the third page of this document, Roper
15 Berkeley 499. Let's look at Berkeley County on
16 this line. This shows projections apparently
17 all the way out to 2035, right?

18 A: That is correct.

19 Q: So this is the state estimating -- what's the
20 state estimating here for Berkeley County on
21 this sheet right here?

22 A: Again, for 2010, they estimated 162,000 versus
23 177 real. Interesting, five years further for
24 2015 the state projected 172,000, 173,000
25 population which is less than there actually

1 was in 2010.

2 Q: So the 2015 projection is lower than what
3 actually occurred for 2010, right?

4 A: That is correct. What you see is that the
5 actual census information would likely fit
6 somewhere between the 2015 and 2020 projection
7 that the state had.

8 Q: And what does the state project going forward
9 for Berkeley County in 2025 and 2030, 2035?

10 A: Basically continuing growth out into the
11 future. But relative to where we are in 2010,
12 I would expect likely low.

13 Q: And are hospitals built to last for a few years
14 or many years?

15 A: No, the hospitals are a hard asset that -- you
16 don't build a hospital for two, three or five
17 years of operation. Basically, you know,
18 putting a hospital in place, you're building it
19 for the long term.

20 Q: How would you describe this population growth
21 in Berkeley County?

22 A: I think, based on the information that I've
23 seen, that Berkeley County has had rigorous
24 growth. You know, it's not the highest I've
25 ever seen, but it's strong growth here. It's

1 doing well.

2 Q: Now, can you explain to the court why as a
3 healthcare planner, why increasing population
4 is important to you for healthcare planning.

5 A: Sure. Population factors into -- I'm trying to
6 forecast what the volume will be out in the
7 future.

8 Q: When you say the volume, what do you mean by
9 that?

10 A: Well, specifically, you know, I'm trying to
11 forecast, specific to this project, I'm trying
12 to forecast out what will be the number of
13 patients that I expect or predict will be
14 treated at a hospital as an inpatient, so these
15 are the inpatients. But rather than looking at
16 all patients, I'm carving out those patients
17 that are the tertiary and specialty stuff. So
18 I'm carving out transplants. I'm carving out
19 interventional cardiology. I'm carving out all
20 the behavioral stuff. I'm carving out the high
21 end baby, the NICU care.

22 Q: Why are you carving that out?

23 A: I'm carving all of that out.

24 Q: Why?

25 A: Why? Because I don't think that those patients

1 will be served at this proposed 50 bed
2 hospital.

3 Q: Because why?

4 A: Because the extent of resources and equipment
5 and specialties will not be at a 50 bed
6 hospital. Those are the patients that I expect
7 will continue and still go to the tertiary
8 providers.

9 Q: Are either one of these applicants proposing
10 that they would treat those kind of patients?

11 A: No, they're not.

12 Q: Okay. So going back, so you are calculating
13 patients. I'm sorry I interrupted you.

14 A: Yes, I'm calculating patients, but specifically
15 I'm trying to calculate into the future how
16 many Berkeley patients, strictly resident
17 patients there will be that will obtain care in
18 this non-tertiary type business that we propose
19 to do.

20 Q: And why is the population data important in
21 making that determination?

22 A: Basically, the basic construct of a forecast is
23 to determine what a current use rate is in
24 terms of how many folks per thousand
25 population, for example, are using the service

1 today, so how many folks are using non-tertiary
2 services today per thousand population. The
3 next step is to say, okay, that's our base line
4 today, and you then apply that to future
5 population to give an estimate or a forecast of
6 what the growth will be in that -- in the
7 population that will then drive growth in here,
8 the non-tertiary patients being served at
9 hospitals.

10 Q: Well, generally, if you have a greater
11 population in the future, does that mean you're
12 going to have more patients or less patients?

13 A: All things equal, you'll have more patients.

14 Q: Is that what you would expect in this
15 situation?

16 A: Yes, it is.

17 Q: Now, does this population growth and the
18 maldistribution -- we talked about
19 maldistribution. Does the population growth
20 that's occurring in Berkeley County, is that a
21 fact that the Department -- that supports the
22 Department's finding that the CON applications
23 are not competing?

24 A: Yes.

25 Q: All right. Well, let's go to Joint Exhibit 2,

1 well, let's just talk about the B11 analysis.
2 You did this analysis, the B11 analysis you
3 testified about, which is the need analysis,
4 right?

5 A: That's correct, which presents a profile of the
6 geography, presents a profile of the population
7 demographics, presents a profile of the
8 existing utilization within Berkeley County,
9 and then goes through and forecasts what we'd
10 expect to occur at the proposed new hospital.

11 Q: And what part of the -- there was a percentage
12 of the population that you did not consider,
13 right?

14 A: That is correct.

15 Q: And those are which cases?

16 A: Those are the tertiary and specialty patients
17 that -- trying to get -- when I'm defining the
18 potential, I'm trying to get it so it truly
19 does match what could be served at either one
20 of the hospitals.

21 Q: And those are the same kind of cases you just
22 spoke about, about a minute ago, right?

23 A: Yes, they are, and a similar set of cases that
24 Trident used when they were doing their work.

25 Q: And how far out do you forecast for the

1 hospital?

2 A: I like to forecast, typically, out to at least
3 the third year of operation of the hospital or
4 five years from where we sit today. In this
5 instance, I think we forecast out to 2015 on
6 the original application. I believe that was
7 one of the -- the turning points expected to be
8 the third year of operation. We've had a delay
9 since then. I think today, as we sit here
10 today, it will be 2017, best case, the third
11 year of operation. Probably 2018.

12 Q: Okay. How long does it typically take to
13 construct a hospital?

14 A: Generally, once Trident or Roper St. Francis
15 gets clear approval to go, typically they can
16 be 12 to 18 months in terms of permitting, plan
17 design, getting everything ready to start
18 building on site. Then again, depending on how
19 it's set up, another 15 to 24 months after that
20 before you will get clear occupancy and have
21 the ability to move into the facility.

22 Q: Now, how did you structure your analysis in
23 regards to try to determine the patients that
24 will be seen at this Roper St. Francis
25 Hospital?

1 A: From a general perspective, so at that the top
2 level, what I did was first looked in terms of
3 I defined the geography that we're going to
4 look at as Berkeley County, so that's the
5 geography. And from that, my assumption was
6 that 90 percent of the patients that will be
7 served in the Goose Creek Roper facility would
8 come from Berkeley County, and another ten
9 percent would come from outside. And that
10 outside could be folks traveling through the
11 area, it could be part-time folks visiting
12 folks, or it could be folks from Dorchester
13 County or up north up from the Colleton area as
14 well. So 90 percent coming from the county,
15 ten percent would be coming in.

16 THE COURT: From Colleton did you say?

17 THE WITNESS: Yes, sir..

18 Q: What are some of the other counties that people
19 might come from besides Colleton?

20 A: Well, I think you have the counties to the
21 south and west, which would be Dorchester,
22 North Charleston as well.

23 Q: Okay. So 90 percent from Berkeley County,
24 right?

25 A: Correct.

1 Q: All right. And what other assumptions did you
2 make in determining who these patients would
3 be?

4 A: The two other assumptions I made, the -- and,
5 first, in my updated information I forecast out
6 to 2017, which that's the quickest will be the
7 third year of operation, might be year four,
8 but just I went to 2017. Other two issues
9 there in terms of my assumption was that of the
10 patients to be served in the new hospital, is
11 that half of the patients predicted in 2017,
12 that if the facility wasn't here, would go on
13 down to Roper St. Francis facilities or Mount
14 Pleasant facilities. So half of the folks that
15 live in Berkeley County and either currently or
16 would be expected to go down and use Roper St.
17 Francis facilities would stay in county to
18 receive care at the new facility. And, again,
19 that was of that non-tertiary subset. So I've
20 already carved out the big stuff. So one out
21 of two folks that could use the hospital will
22 use the hospital.

23 Q: Okay. Go ahead.

24 A: The next step is, to use my assumption, was
25 that of the patients from Berkeley County that

1 aren't served by Roper St. Francis, Roper St.
2 Francis has about 24 percent of those non-
3 tertiary, non-specialty patient Berkeley County
4 residents, so 24 out of a hundred currently go
5 down -- I think it's 23.9 percent -- about 24
6 out of a hundred now go down and use Roper St.
7 Francis or go over to Mount Pleasant.

8 Q: Mount Pleasant or downtown?

9 A: They go to all three.

10 Q: Right.

11 A: So 23.9 percent, 24 percent of Berkeley County
12 residents now are going to and using Roper St.
13 Francis facilities. So what's left there is
14 about 76, 77 percent of the market. So 24
15 percent goes there, so 77 percent are served by
16 somebody else, mostly Trident and MUSC, then a
17 little bit for everybody else. The way I
18 assumed that was that with the new facility,
19 that ten percent of that 77 percent would also
20 come to the new facility. So I've got Roper
21 St. Francis patients, one out of two would
22 stay. And with the new facility, I am assuming
23 that ten percent of what's left, or about seven
24 or eight percent more market share, would come
25 to the new facility as well.

1 Q: And with that calculation, what do you conclude
2 in regards to the number of patients that would
3 be seen at this new hospital in Carnes
4 Crossroad?

5 A: Well, based on that, my conclusion is is that
6 the Carnes Crossroad facility basically will be
7 full, that hospital is fully utilized, you
8 know, well utilized and well on its way.

9 Q: Okay. Let's talk about the concept of the
10 hospital being full, okay.

11 A: Okay.

12 Q: I've said numerous times during the trial,
13 hospitals aren't like hotels, are they?

14 A: No, they are not.

15 Q: Okay. Can you explain to the judge about the
16 occupancy of a hospital?

17 A: Sure. As I heard a lot of the hospital
18 administrators talking, there's big variation
19 in terms of when patients come to hospitals and
20 how many folks they have over time. Someone
21 was talking about their peak time tends to be
22 Monday, Tuesday, Wednesday, and that's what I
23 am used to seeing. Volume is down on weekends,
24 it's down on holidays. So with all that
25 variation, you can't assume that they will have

1 a constant same number of patients every day.
2 As a result, in terms of planning for new
3 facilities, what you basically do is that you
4 apply a factor in terms of what's the real
5 annual occupancy, so an average over the year,
6 what's the annual occupancy that a hospital
7 could achieve, and what's really the highest
8 annual occupancy that's realistic to operate a
9 hospital. And what happens is that with small
10 hospitals like this one versus a bigger
11 hospital, that variation has more impact. So
12 what you see, and what I believe, and what the
13 state has in their Health Plan, is that the
14 smaller hospitals have a lower target occupancy
15 rate and the larger hospital is able to
16 withstand more of the variation and have a
17 higher occupancy rate.

18 Q: Is this related to this idea that hospitals
19 have to be flexible in regards to the number of
20 patients they have?

21 A: They try to be flexible, yes. They try to be
22 able to absorb those patient variations.

23 Q: How does the emergency department affect their
24 need to be flexible?

25 A: A patient coming through an emergency

1 department, a good portion of them require
2 immediate inpatient care. So you want to
3 basically have an available bed for that
4 unexpected occurrence.

5 Q: And how important to a hospital is the
6 emergency department as a source of patients?

7 A: It's one of the two major sources. For
8 hospitals, really, in terms of what drives
9 their volume, are patients that are admitted
10 through the emergency room, and patients that
11 are basically directed or admitted by a
12 physician. Now, you can only get into a
13 hospital on a physician order, but those orders
14 come two ways. One is going to a physician in
15 the community and being referred in. Second is
16 coming into the emergency room and being
17 admitted by one of the local in-house
18 physicians.

19 Q: What is the occupancy percentage that the state
20 uses in the State Health Plan for small
21 hospitals like these two hospitals that are
22 proposed?

23 A: At 65 percent the state looks at adding new
24 beds.

25 Q: Okay. And what do the applicants propose in

1 regards to their kind of top occupancy in their
2 applications?

3 A: Both Roper and Trident both anticipated a 70
4 percent occupancy, so on an annual basis. And,
5 again, there are times it will be higher than
6 that, but overall average on the year, that 70
7 percent would be sort of their effective cap.

8 Q: And how many inpatients would that be if you
9 had a 70 percent occupancy on a 50 bed
10 hospital?

11 A: Thirty-five beds on average over the year would
12 be in the bed.

13 Q: So 35 people in the hospital every day on
14 average, is the hospital full?

15 A: I believe it is. I believe it's effectively
16 full.

17 Q: Is that consistent with Trident's application
18 also?

19 A: Yes, it is.

20 Q: All right. Are these small hospitals?

21 A: Yeah, they are. A 50 bed hospital is at the
22 low end of hospital sizing. Ten, 15 years ago
23 I would truly question in terms of does it make
24 sense, but in terms of with the wrap around of
25 the not inpatient bed services, I think 50 beds

1 is, you know, it's at the small end. These are
2 not big things, these are not major
3 enterprises.

4 Q: Well, let's talk about that. Ten to 15 years
5 ago, were 50 bed hospitals very common?

6 A: No.

7 Q: Are they common now around the country?

8 A: More and more so.

9 Q: Are systems successful with these 50 bed
10 hospitals?

11 A: Yes.

12 Q: And do they -- are they able to generate
13 revenue and cash flow and keep themselves open?

14 A: Yes.

15 Q: And in your experience, if a 50 bed hospital
16 was too small to be profitable, would hospitals
17 continue to build them?

18 A: No.

19 Q: Okay. Now, is the fact that these hospitals
20 are small, is that a fact that supports the
21 Department's decision that these applications
22 are not competing?

23 A: I think it is. You look in terms of magnitude.
24 Together these hospitals will bring 100 beds
25 into Berkeley County. When you look in terms

1 of the magnitude of beds available in the three
2 county area right now, that's not much.

3 Q: Because how many beds are on the peninsula
4 right now?

5 A: I think the map showed that there were 1,500 or
6 1,600? 1,645.

7 Q: So today on the peninsula of Charleston there
8 are 1,645 beds, right?

9 A: That's correct.

10 Q: And both these applications total a hundred?

11 A: When you add them, 50 and 50 total to 100, yes.

12 Q: And Dorchester County, is this population
13 larger or smaller than Berkeley?

14 A: Dorchester County is smaller than Berkeley.

15 Q: And it has 94 beds.

16 A: It has the Summerville facility with 94 beds.

17 Q: Now, I think you've already touched on it a
18 little bit, but just to -- you talked about the
19 patients that have traditionally gone to Roper
20 St. Francis Downtown or West Ashley or now
21 Mount Pleasant.

22 A: Right.

23 Q: So can you kind of explain how that -- well,
24 just explain the concept of redirected
25 patients.

1 A: Sure. The basic assumption is is that the
2 patients that are now deciding either through
3 a physician or going to an ED or going to the
4 hospital are deciding to use a Roper St.
5 Francis facility, they are now traveling from
6 Berkeley County, 30 minutes, or north areas,
7 well beyond 30 minutes, going down to Roper St.
8 Francis facilities. The expectation here is
9 that one out of two of those folks who are the
10 appropriate to going there would stay and
11 receive their Roper St. Francis care at the
12 Roper St. Francis Goose Creek facility.

13 Q: Okay. Well, let's take a look at Petitioner's
14 Exhibit 221, Baehr 1853.

15 THE COURT: I want to make sure that you didn't
16 transpose something. You said that Roper St.
17 Francis Goose Creek facility. Did you mean
18 Carnes Crossroad?

19 THE WITNESS: I'm sorry, yes, I use those
20 interchangeably, but I'll try to keep those --

21 THE COURT: Use Carnes Crossroads, please.

22 MR. LONG: Yeah, we have been. Thank you, Your
23 Honor.

24 Q: All right. Let's take a look at this document.
25 This is Petitioner's Exhibit 221, Baehr 1853.

1 Now, is this your document or is this Mr.
2 Baehr's document?

3 A: This is Mr. Baehr's document.

4 Q: Who's Mr. Baehr again?

5 A: Mr. Baehr is the health planning, health
6 finance expert for Trident Health System. He's
7 the person that put together the CON needs side
8 and the financial side for Trident.

9 Q: All right. What has he done in regards to his
10 calculations on this slide right here?

11 A: Mr. Baehr, basically, has identified the 2010
12 non-tertiary, non-specialty, Berkeley County
13 patient days that were served at the Roper
14 system and at the Trident system for 2010.
15 He's then forecast out to 2017 what the
16 expectation would be for the number of Berkeley
17 County resident patient days, again non-
18 tertiary and non-specialty, to occur out to
19 2017.

20 Q: Okay. And so the column on the left, Roper
21 System, these are the Roper St. Francis
22 patients from Berkeley County?

23 A: That is correct.

24 Q: And the column on the right says Trident
25 System, those would be the Trident Health

1 System patients from Berkeley?

2 A: Berkeley County residents, yes.

3 Q: What about the patients that go to MUSC?

4 A: They are not on here. The MUSC and others have
5 about approximately the same volume as does
6 Roper, so you've got -- there's a whole other
7 set of volume that's there about the same size
8 as Roper.

9 Q: And, now, of the MUSC and the other providers,
10 who's the dominant provider of the other group
11 of hospitals?

12 A: It's MUSC.

13 Q: And are they -- do you know kind of -- what is
14 there market share, their percentage of
15 patients? What would the MUSC number be
16 relative to the Roper number; would it be close
17 to that number?

18 A: It would be close to that number. It -- they
19 vary somewhat.

20 Q: All right. Let's take a second and talk about
21 patient days, okay? How would you -- what does
22 patient days represent?

23 A: Patient days are I go to the emergency room
24 today, and say I'm admitted into the hospital,
25 patient days basically are all the days that I

1 would be in the hospital. If I go in today,
2 today's Wednesday, and come out on a Saturday,
3 so I have my three days. But for every patient
4 who is admitted as an inpatient, it's a
5 summation of all of the days of care they have.
6 So we talk about admissions, which are people
7 getting admitted, this also adds on the factor
8 that you don't just stay one day, you stay,
9 two, or three, or four, or five, sometimes
10 eight or ten days. So the patient days are
11 basically the, you know, the in bed utilization
12 that's either occurring or forecasted to occur
13 for Berkeley County residents.

14 Q: And we also have the term average daily census,
15 right?

16 A: Right.

17 Q: So what is the average daily census?

18 A: Average daily census, basically, is taking the
19 patient days that occurred over the year and
20 dividing by 365 to basically, to strike an
21 average. In terms of on any average day, the
22 average daily census would be the patient days
23 shown divided by 365. It's just another sort
24 of a valutive that I use, and most everyone
25 uses, to look at sort of how well a facility is

1 used and what sort of volume is there.

2 Q: Now, you heard Mr. Severance yesterday, the CEO
3 of Roper Downtown, and he said the census was
4 the heads on the pillow at midnight. Do you
5 recall that testimony?

6 A: I do.

7 Q: Do you agree with him on that; for a health
8 planner is that what a census is for a
9 hospital, the daily census?

10 A: Yes, the inpatient census, that's correct.

11 Q: And so can you take this patient days number
12 and calculate out the average daily census?

13 A: Sure.

14 Q: Okay. And how do you do that?

15 A: In terms of looking at the 2010 Berkeley County
16 patient days for the Roper system, it shows for
17 2010 that -- and, again, these are just the
18 non-tertiary subset -- is that there were
19 13,829 patient days, so these would be the
20 number of inpatient days that Berkeley County
21 residents had in the Roper facilities, divide
22 that by 365, and that shows that on average
23 over 2010, on any given day there were 37 or 38
24 Berkeley County residents in a Roper St.
25 Francis facility, in a Roper St. Francis bed.

1 Q: Now, do you agree with Mr. Baehr's projections
2 on this slide? In other words, where he
3 projects what the patient days will be for
4 2017?

5 A: Yes, I've gone through his analysis, and I
6 think it's reasonable, it's similar to what I
7 would do.

8 Q: Okay. What's the average daily census that Mr.
9 Baehr projects that Roper would have in 2017?

10 A: I would divide 16,934 by 365, and that will
11 show the average number of Berkeley County
12 residents in a Roper St. Francis bed during
13 2017 to be 46.4.

14 Q: So 46 Roper St. Francis patients from Berkeley
15 County on average daily --

16 A: Yes.

17 Q: -- or would be traveling to another hospital.
18 If you redirected all of those patients, every
19 one of these non-tertiary patients, instead of
20 driving all the way down the peninsula or to
21 West Ashley, went to the hospital that was
22 right there in the county, what would be do to
23 the hospital at Carnes Crossroads?

24 A: The hospital could not take care of all of
25 those patients, it would be over the top.

1 Again, this is 2007 forecast that there would
2 be 46 patients on average. The reality is that
3 if you look in terms of what in real life most
4 50 bed hospitals can do is the 35 average daily
5 census or 35 patients on average across the
6 year. You know, you're 11 average daily census
7 above what's realistic to be taken care of.

8 Q: So if Roper just simply redirected its own
9 patients, would it need any patients from any
10 other hospital?

11 A: No. If Roper redirected its own patients,
12 either in 2010 or 2017, it wouldn't need any
13 volume or patients coming from out of the
14 county, and it would not need to take any
15 patients from other non Roper St. Francis
16 sources.

17 Q: Well, you heard Mr. Bowling testify that Roper
18 St. Francis has 1,200 patients a year -- I
19 believe that was the number, wasn't it -- from
20 Dorchester County?

21 A: It was 1,100 or 1,200, yes.

22 Q: So would you expect some of those patients to
23 want to come to Carnes Crossroads?

24 A: I would.

25 Q: Would there be room for them, if all of these

1 patients chose to go to Carnes?

2 A: No. No, there would not.

3 Q: Well, let's look at Trident, okay. Mr. Baehr
4 -- let's just look at the growth for Trident,
5 he projects that Trident's patient days will
6 grow, right, for 2017?

7 A: That is correct.

8 Q: All right. Let's do this, let's calculate the
9 Trident Health System patient days for 2017.

10 A: As reflected here from Mr. Baehr's information,
11 the expectation or the forecast is that in 2017
12 Berkeley County residents obtaining non-
13 tertiary, non-specialty care, that there would
14 be 36,418 days of care provided in a Trident
15 facility. That would either be in Trident
16 Medical Center or Summerville.

17 Q: What's an average daily census for that?

18 A: Average daily census for that is 99.8 or
19 approximately 100 average daily census.

20 Q: So just the Trident patients in 2017 in
21 Berkeley County is 100 every day?

22 A: Yes, it is, for 2017.

23 Q: And do you think that's sufficient to support
24 a 50 bed hospital in Berkeley County?

25 A: Very much so. Again, the Trident Berkeley

1 County hospital needs a 35 average daily census
2 to effectively be full. This is showing that
3 the expectation is is that Berkeley County will
4 basically need -- will have an average daily
5 census of 100 in the future. This is -- and
6 this is part of the issue that I scratched my
7 head on, in terms of at trial I've heard HCA
8 Trident basically say we can't build out there
9 because there's not enough. There certainly is
10 enough. As we sit here today, the 2017
11 forecast of Berkeley County non-tertiary
12 patient days is an average daily census of
13 99.7. If you use a 70 percent occupancy on
14 that, Trident today would need 140 to 150 beds
15 to take care of those patients, so the --

16 Q: Just Berkeley County?

17 A: Just Berkeley County. It would be appropriate
18 for Trident to operate a 140, 150 beds in
19 Berkeley County.

20 Q: Well, what about the MUSC patients in Berkeley
21 County, do you expect some of them to go to a
22 hospital in Berkeley County, even if it wasn't
23 MUSC?

24 A: I think you could have some. I think the fact
25 that the tertiary work and specialty work has

1 been carved out, I expect that's the stuff that
2 will go to MUSC regardless, but we are not
3 talking about that here. This really is just
4 the folks that should be applicable and
5 appropriate for these two hospitals, so yes, I
6 think there will be some shift there as well.

7 Q: All right. Let's look at -- now, you said in
8 your -- in the Roper St. Francis application
9 you estimated that only one half of the Roper
10 St. Francis patients that currently drive to
11 the peninsula or to West Ashley would come to
12 the hospital in Berkeley.

13 A: That is correct.

14 Q: All right. Well, what did Trident say in
15 regards to where its patients would come from
16 in regards to its application?

17 A: Two things. One is, in terms of the overall
18 construct, Trident expected that 100 percent of
19 their patients would otherwise be served at a
20 Trident facility. The way they achieve that --

21 **THE COURT:** Excuse me, the door slamming prevented
22 me from hearing that last --

23 A: Mr. Long was asking how Trident constructed
24 their forecast, and I said really two things.
25 First off is that on an overall basis the

1 expectation for Trident is that 100 percent of
2 their patients that will be served at the new
3 hospital would otherwise be served at a Trident
4 facility. So, versus Roper St. Francis, where
5 we said it's about half and half would come
6 from either our redirection of our existing
7 patients or coming from the increased market
8 share. Trident basically said 100 percent will
9 be coming from their own book of business. In
10 looking at their book of business from Berkeley
11 County, that makes sense. The way they got
12 there is that Trident basically went through
13 the county and really in various bands they
14 ended up basically forecasting what portion of
15 their existing book of business would they
16 expect to come to the new hospital versus
17 continuing to go over to Trident or
18 Summerville.

19 Q: Well, you talk about that forecast, is it this
20 chart right here that we've shown numerous
21 times in the trial, the Trident projected
22 inpatient market share?

23 A: Yes, it is.

24 Q: Okay.

25 A: And what this shows is that -- and the heading

- 1 that I put on this is a little bit -- I mean
2 just for me to make clear, this basically is
3 the percentage of forecasted Trident patients
4 that would come from those various zip codes
5 that would be sort of redirected or served in
6 county. What it basically shows is that the
7 pink up around the lake, is that Trident
8 expects that 50 percent or one out of two, just
9 like we have, of the patients coming from up
10 around the lake, from their patients, would
11 stay and be served at their proposed facility.
- 12 Q: All right. Well, what's Trident's total
13 percentage of patients in these zip codes
14 around Lake Moultrie?
- 15 A: Overall Trident has about a mid 50 percent
16 market share. I would expect it's probably
17 around 50 percent.
- 18 Q: Okay. So what are they -- let's just take the
19 community of St. Stephen, okay, which I believe
20 is 29479.
- 21 A: Yes, it is.
- 22 Q: Okay. And it's to the northeast of the lake,
23 right?
- 24 A: Right.
- 25 Q: What is Trident saying about the people that

1 live in St. Stephen, and what percentage of
2 those people will use the hospital in Moncks
3 Corner for Trident?

4 A: Of all the potential folks that could use a
5 hospital like we are proposing here, Trident
6 estimates that 25 percent of those folks would
7 be served in the proposed Moncks Corner
8 facility.

9 Q: So three-quarters of the people in St. Stephen
10 would drive by the Moncks Corner hospital?

11 A: Yes.

12 Q: And go somewhere else?

13 A: Yes.

14 Q: And what would their options be?

15 A: Well, their options would be the, if the Roper
16 St. Francis facility is added, that would
17 likely be the next closest facility; or to
18 drive like they do now over down to either
19 Trident, Summerville or down to the southern
20 facilities.

21 Q: All right. Now, based on these market share
22 projections, the 25 percent around Lake
23 Moultrie, all of the pink, they just projected
24 they would get 25 percent of the patients at
25 this Moncks Corner facility with zip codes in

1 the pink, right?

2 A: They projected they would get half of their
3 market share, so half of it. Full pie, they
4 get approximately half of that, and they assume
5 that half of that again would go to the new
6 facility, so it is 25 percent, but it's half of
7 their business.

8 Q: Okay. Well, with these projections that they
9 made in their application, is the hospital at
10 Moncks Corner full?

11 A: Yes, it is.

12 Q: Okay. Now, do you think that, as a healthcare
13 planner, that more than 25 percent of the
14 people in St. Stephen will go to a hospital in
15 Moncks Corner?

16 A: I think it's likely that the Trident facility
17 will capture more of their affiliated patients
18 than just the 50 percent, and I'd expect that
19 they would, by having a new hospital up at that
20 facility, I would expect that they would serve
21 even more than their patients, I think they
22 would serve patients that are now going to
23 Roper St. Francis, MUSC, or Mount Pleasant. So
24 I think they would get more of their own than
25 they forecasted, and I think they would

1 probably gain some market share as a result of
2 that as well.

3 Q: Well, how would you describe their projection
4 in regards to what they expect their patients
5 to be in the application for this hospital at
6 Moncks Corner?

7 A: I find it very low, especially in light of a
8 lot of what we've heard today in terms of the
9 reason they are doing this is to provide better
10 access to folks up north and around the lake.
11 It doesn't square. You know, their projected
12 we can only serve 25 percent and yet that's
13 sort of the big reason that they're doing this,
14 so I think they'll get more from there.

15 Q: But if they are full, can they get all of it?

16 A: No, if they are full, basically the patients
17 would still need to follow on likely to where
18 they've gone in the past.

19 Q: So Trident projected that its entire
20 application will be 100 percent redirected; is
21 that what you testified to earlier?

22 A: That's correct.

23 Q: All right. And you did 50. Why didn't Roper
24 St. Francis do 100 percent redirection?
25 Because you've got the patients, right?

1 A: They could have in terms of it may have
 2 minimized some of the fight among the various
 3 parties. Basically what I'm doing in the
 4 forecast is trying to get a best estimate of
 5 what will occur. And it is a forecast. I
 6 heard the other side talk in terms of, you
 7 know, these are planning forecasts, they're
 8 estimates, they're projections, and they
 9 certainly are. But I think that for the Roper
 10 St. Francis facility, you know, I think they
 11 may get some more rather than just one out of
 12 two folks staying. But I think there will be
 13 some shift in market share as a result of
 14 having a new facility in that proximate
 15 setting.

16 Q: But if Roper St. Francis and Carnes Crossroads
 17 hospital redirects more patients than the 50
 18 percent that you projected, will there be less
 19 of the other patients for them to take from the
 20 other providers?

21 A: Yes, there will. With a defined capacity and
 22 expecting that you're going to have
 23 approximately half and half patients coming
 24 from Roper St. Francis itself and coming from
 25 outside, you're going to get more from Roper

1 St. Francis. The only thing that may happen is
2 that there is less from the outside.

3 Q: Are there any other factors or some of the
4 factors that you mentioned earlier, would they
5 also suggest that each of these hospitals would
6 be able to redirect patients, each of these
7 systems would be able to redirect patients to
8 these hospitals?

9 A: Yes. I think that the distinct and separate
10 nature of the medical staffs and the
11 concentrated redirection of patients from their
12 emergency rooms, emergency departments, to
13 either the Trident Emergency Room going down to
14 Trident and the Roper St. Francis Emergency
15 Room going down to Roper St. Francis, both of
16 those things I think show basically again you
17 have two parallel delivery systems there in
18 Berkeley County. And I think that basically
19 also solidifies the provider's ability to
20 redirect more of their own or to allow them to
21 stay closer to where they live.

22 Q: How about the actual locations of the
23 hospitals, is that a fact that would suggest
24 redirection?

25 A: I think it would be, yes.

1 Q: Okay. Why is that?

2 A: I think how proximate or how close the facility
3 is to the patients that are now either going
4 down to Roper St. Francis or going across to
5 Trident, I think that would have an impact in
6 terms of the magnitude of draw. All things
7 equal, if the facility is closer to you, I
8 think that would have an impact to drive more
9 folks to stay local versus going downtown to
10 Roper St. Francis. Versus if it was further
11 away, we're still traveling, so maybe I ought
12 to continue to go downtown.

13 Q: Let's take a look at this exhibit and slide
14 right here which is Respondent's 76, so Roper
15 Berkeley 4713, what does this slide represent?
16 Can you see what I've got here?

17 A: I can. This basically arrays by zip code where
18 the current Roper St. Francis patients come
19 from. And this basically is arrayed by zip
20 code, and this shows that the highest number of
21 Roper St. Francis patients come from what I'll
22 call the area from central Berkeley County,
23 which is right about Moncks Corner area, on to
24 the west and to the south. So the majority and
25 the largest numbers of Roper St. Francis

1 patients come from the area really runs from
2 Moncks Corner on down to Carnes Crossroads,
3 Goose Creek, down to Summerville.

4 Q: Okay. And then the second, these are grouped,
5 right?

6 A: Yes, they are.

7 Q: And by number of patients. So what does the
8 orange color represent, which is the color
9 right down in the southernmost part of the
10 county?

11 A: That's the next largest number of patients that
12 are there, and it basically shows that by far,
13 the North Charleston, I think it's the Ladson
14 area down there, that they have 500 to 750, so
15 it's less patients being served down at the
16 existing facilities than in the pink but still
17 a pretty good book of business.

18 Q: And then how about the yellow and the green,
19 what do they show?

20 A: They show lower volumes of patients that are
21 now traveling or being served at the Roper St.
22 Francis facilities.

23 Q: All right. Now, these are Roper St. Francis
24 patients only, right?

25 A: That is correct.

1 Q: So these are patients that are going to West
2 Ashley, Mount Pleasant or Roper Downtown?

3 A: That is correct.

4 Q: And would the numbers for Trident Medical
5 Center or Summerville Medical Center be higher
6 in these zip codes than the numbers for Roper
7 St. Francis?

8 A: I would think so. Trident basically in terms
9 of the overall county market share, Trident's
10 got about double, they treat about two to one
11 the number of patients that Roper St. Francis
12 does. So I would expect that their volume from
13 those zip codes would likely also be higher.

14 Q: Now, talking about this issue of redirecting
15 your patients to the hospital, roughly what is
16 the distance from Trident Medical Center to the
17 proposed hospital at Moncks Corner? Do you
18 recall that one or do I need to help you with
19 that?

20 A: My recollection of being out there, that's a 20
21 to 30 minute drive, but if you have something,
22 that might help.

23 Q: Well, let's look at it -- we can do it this
24 way, okay. Looking at where the patients are
25 coming from --

1 A: Right.

2 Q: -- you've also looked at the emergency
3 department volume at the emergency departments
4 that are located in Moncks Corner, right?

5 A: Yes, I have.

6 Q: Okay. So as far as the zip codes that are
7 being used in those -- of the patients that are
8 being seen in those emergency departments,
9 where are those patients primarily coming from?

10 A: It looks like for either emergency department
11 the majority of the patients being served
12 really are coming from the area sort of
13 immediately around Moncks Corner and then up
14 north and up around the lake. So it's a
15 distribution from the central part of the
16 county around Moncks Corner up north, northeast
17 and east.

18 Q: And do you see very many patients from the
19 southern part of Berkeley County driving to
20 Moncks Corner to use their emergency
21 department?

22 A: No. The data shows that there is not a
23 substantial level of flow from Carnes
24 Crossroad, Goose Creek, Summerville going up to
25 Moncks Corner to obtain emergency room care.

1 Q: Okay. So if you were to place the Roper St.
2 Francis Hospital in Moncks Corner, okay,
3 looking at where their patients come from and
4 where the hospitals are located, would it be
5 more difficult to redirect those patients or
6 less difficult, Moncks Corner to Carnes
7 Crossroads?

8 A: I think if Roper St. Francis located their
9 facility in Moncks Corner, it would be more
10 difficult for them to redirect the patients
11 from the large areas where the largest number
12 of their patients currently originate.

13 Q: And why is that?

14 A: One, it's further away from the core of that --
15 of that patient concentration. But secondly,
16 too, I think that's just the issue in terms of,
17 all things equal, traditionally patient flow
18 tends to follow work, retail, the normal
19 transport flow, which appears here to be
20 primarily from off the highway or over to
21 Moncks Corner on down into North Charleston and
22 into Charleston itself.

23 Q: Okay. Well, why would you think then that
24 Trident -- or do you think the Trident Health
25 System can redirect patients to Moncks Corner?

1 A: I think they can redirect a lot of patients to
2 Moncks Corner from north and up around the
3 lake. I think as you come down from Moncks
4 Corner towards the Trident, Summerville
5 facilities, the further you head down into that
6 area, the less likely it is that they will
7 redirect patients up to the new facility.

8 Q: Okay. But is the fact that these proposed
9 hospitals are located in these different
10 communities in regards to the redirection, do
11 you have an opinion as to their ability to
12 redirect the patients that they have?

13 A: Yes. I think that the area that's closer to
14 those hospital sites in terms of Moncks Corner
15 or Carnes Crossroads, I think they'll have --
16 I think either facility will have an easier
17 time redirecting patients that are closer to
18 those facilities than further away.

19 Q: Okay. And it would be -- well, how would you
20 describe the distance from Roper Downtown to
21 Moncks Corner?

22 A: It's a long ways. Thirty, 45 minutes.

23 Q: Okay. Now, is this fact about the -- that
24 you've just been talking about in regards to
25 the ability of the applicants to redirect

1 patients, is that a fact that supports the
2 Department's decision to find that the
3 applications are not competing?

4 A: I think it is. I think if the -- if and when
5 both facilities were built, I think basically
6 you would have sort of catchment areas that
7 would be different. Moncks Corner would be
8 Moncks Corner area up and beyond. And the
9 Roper St. Francis facility would be more
10 proximate from Moncks Corner on down to likely
11 the county line.

12 Q: Okay. Let's go back to your Exhibit 70. This
13 is your trial exhibit.

14 A: Right.

15 Q: It just kind of shows some of these same issues
16 that we've been talking about in regards to the
17 forecast.

18 A: Okay.

19 Q: Now, this is Richardson Berkeley 685 in your
20 exhibit, page section three.

21 A: I'm there.

22 Q: Are you there?

23 A: Yes.

24 Q: Okay. Now, can you tell me what this slide
25 shows to the court and why you think it's

1 important or what the purpose of this --

2 A: Sure.

3 Q: -- slide is for the court.

4 A: This is the actual volume forecast that was
5 included in the CON application back in 2008.
6 And the purpose of this was to try to give a
7 forecast or an expectation of whether or not
8 there's enough volume to be served at the
9 proposed new Roper St. Francis facility in
10 Carnes Crossroads. So that's the purpose of
11 this is to -- is to basically say it doesn't
12 make sense, can this facility fill -- does the
13 model show that that is needed.

14 Q: And when you look at the bottom there, this is
15 your forecast for 2015 that you actually did in
16 the application in -- that you completed in
17 2008, right?

18 A: That's correct, yes.

19 Q: And you projected -- and you're using
20 discharges here, right?

21 A: Correct, yes.

22 Q: So what does a discharge represent?

23 A: A discharge would be the person basically that
24 gets admitted into the hospital and then
25 discharged. So it's -- it's a patient. So if

1 I go in tomorrow, I'm one patient. I may stay
2 five, six, seven, eight days, but I'm still
3 considered one patient.

4 Q: Okay. And when you do the calculations, you
5 said 50 -- the 50 percent of the Roper St.
6 Francis patients.

7 A: Right.

8 Q: And that got you, in the application you
9 projected how many patients?

10 A: 1,775 patients, Roper St. Francis patients,
11 would decide to stay utilizing the new
12 facility.

13 Q: All right. And then you've got the ten percent
14 capture of the non Roper St. Francis patients,
15 right?

16 A: That is correct.

17 Q: And that would be how many people?

18 A: That would be 1,188.

19 Q: Okay. And then you have the in-migration from
20 the other counties?

21 A: That is correct.

22 Q: How many patients?

23 A: 329.

24 Q: And so when you do those three numbers, it
25 comes up to what?

1 A: It comes up to 3,292 potential discharges.

2 Q: Okay. Now, did you actually reduce that?

3 A: I did.

4 Q: And why is that?

5 A: Because my expectation is is that that 3,292
6 discharges is too much business for the
7 hospital. They won't have the ability to take
8 care of those patients.

9 Q: Okay.

10 A: So what I've done at the bottom there, I
11 basically said okay, what we're really going to
12 have to do is cap the volume at the 12,775
13 patient days which is a 35 average daily census
14 which is a 70 percent occupancy overall. And
15 the way you get there is that I would expect
16 that either -- that one of those subheadings or
17 those sums above would end up being less. And,
18 again, this is an estimate. This is my best
19 estimate of how this will occur, but it's an
20 estimate. Anyone that really can tell you with
21 precision it's going to be this to the exact
22 number is not correct. You know, you do the
23 best you can. You give a best estimate, and
24 this is. But if someone says it's going to be
25 exactly, you know, 2,017 or 2,050, there's

1 variance built into any forecast and all
2 forecasts. So if you cap that to 70 percent,
3 that would be 12,775 days. Using the length of
4 stay in the CON, that would be 3,006 discharges
5 could be served there. And the way I square
6 that is, fine, that means that either a small
7 portion of Roper St. Francis patients will be
8 redirected -- and I don't think that's likely;
9 I think a good book of business will be
10 redirected -- or a smaller portion of patients
11 from other providers will be treated, or fewer
12 patients from outside the service area will be
13 treated. So the -- either one of those things
14 could occur. The bottom line is that using the
15 model, there's more than enough to fill the
16 hospital.

17 Q: Based on the testimony about the medical staffs
18 from all of the hospital administrators, would
19 you expect the Trident Health System doctors to
20 be using the hospital at Carnes Crossroads?

21 A: No.

22 Q: And wouldn't that be the ten percent of non
23 Roper St. Francis tertiary volume would be
24 people going to doctors or other providers?

25 A: Yes, either Trident or MUSC primarily.

1 Q: Okay. Your total number at the bottom there,
2 3,006 discharges, right?

3 A: Yes.

4 Q: Okay. So that's 3,000 inpatients and the
5 hospital is full?

6 A: In the third year of operation the hospital is
7 full.

8 Q: All right. Let me add -- you heard the
9 testimony of Mr. Knapp yesterday, right?

10 A: Yes.

11 Q: Okay. Does a 50 bed hospital have to be full
12 to be profitable?

13 A: Does not.

14 Q: Okay. And based on the testimony you heard
15 yesterday, do you recall what Mr. Knapp
16 projected as the break even of the Moncks
17 Corner hospital, how many -- what its average
18 daily census would need to be?

19 A: I'm afraid I don't. I may have stepped out for
20 that.

21 Q: Was it in the twenties?

22 MR. SUMMER: I'm going to object now because he's
23 asking the witness to speculate and he says he
24 doesn't know, Your Honor.

25 THE COURT: Sustained.

1 Q: Well, let me show you the exhibit that's in
2 evidence here. Respondent's 73.

3 THE COURT: Excuse me, did you get my sustained?

4 COURT REPORTER: Yes, sir, I did. Thank you.

5 A: Why don't you give me a minute so I can get the
6 exhibit.

7 Q: Sure. It will take her a second to pull it up.

8 MR. SUMMER: Your Honor, I would have an objection
9 to him asking this witness any question about
10 this exhibit and the reason would be as
11 follows. They chose to use two separate
12 experts. The expert who prepared this exhibit
13 and who testified about this exhibit was Mr.
14 Knapp who was qualified as an expert in
15 healthcare finance. Mr. Richardson has not
16 been qualified as --

17 MR. LONG: Your Honor, I hate to interrupt him, but
18 if he would just let me ask --

19 THE COURT: Don't interrupt him.

20 MR. SUMMER: Thank you, Your Honor. This witness
21 has only been qualified as an expert in
22 healthcare planning. So even before Mr. Long
23 launches into a question, I would have an
24 objection with him asking about this exhibit to
25 this witness. Thank you.

1 THE COURT: I'm going to overrule the objections
2 which you may renew if the questions are
3 objectionable.

4 MR. SUMMER: Thank you, Your Honor.

5 THE COURT: I trust that you will -- trust that you
6 will phrase your questions so they won't be,
7 Mr. Long.

8 MR. LONG: I don't intend for them to be
9 objectionable, Your Honor.

10 Q: Okay. Looking at Mr. Knapp's Exhibit Number
11 73, you were here when he testified regarding
12 this exhibit, right, yesterday?

13 A: Yes. The entire time. I'm not sure why I
14 missed that.

15 Q: Okay. If you will look on line -- I'm sorry,
16 we want to go to Knapp Berkeley 465.

17 A: I'm there.

18 Q: Okay. Do you see this line 12?

19 MR. LONG: Can you blow that up a little bit for me
20 so you can see the number?

21 Q: Okay. Do you see line 12 says actual patient
22 days necessary to achieve break even.

23 A: Yes, sir.

24 Q: 8,799.

25 A: That is correct.

1 Q: Okay. Can you give me the average daily census
2 for 8,799 patient days?

3 A: It would be an average daily census of 24.

4 Q: Okay. And when you do the calculation that you
5 just testified to of a little over 3,000
6 discharges, what's the average daily census of
7 that?

8 A: The average daily census -- well, the cap
9 volume that I expect will be reached by year
10 three is an average daily census of 35.

11 Q: So 35 is the hospital being full, right?

12 A: Yes.

13 Q: So this number right here in Mr. Knapp's
14 exhibit is 24 I think you said?

15 A: Yes.

16 Q: Is 24 patients per day.

17 A: That's correct.

18 Q: Okay. Thank you. All right. Let's look over
19 at -- can you explain what market -- if you
20 could, just give us a definition. We've used
21 the term already, but can you give us a
22 definition of what market share is?

23 A: Sure. Simplistically, market share is that if
24 you have a pie business, it's what slice or
25 what portion of that pie is controlled or

1 served by a given provider. For example here,
2 for every hundred patients, non-tertiary, non-
3 specialty, that come out of Berkeley County,
4 what portion of that is served by Trident or
5 served by St. Francis or MUSC or others. So
6 that -- it's basically what portion of the book
7 of business is currently served or captured by
8 a given provider or individual.

9 Q: Okay. Well, going and looking at -- so in this
10 calculation you did in the -- you used the
11 market share -- you have the market share
12 number in about the middle of the page?

13 A: Yes, I do.

14 Q: It's also at the top I see. All right. So
15 what was your market share for 2006 for the
16 Roper St. Francis Carnes Crossroads hospital?

17 A: Looking at non-tertiary, non-specialty
18 residents patients alone, it was 23 percent.

19 Q: Okay. And what about the market share that you
20 used for 2015 in the forecast?

21 A: I kept that market share stable at 23 percent.
22 I used what it was with the information we had
23 at the time and assumed it would stay stable
24 into the future.

25 Q: Okay.

1 A: Which is a reasonable way of doing it.

2 Q: All right. And I also see that you used down
3 here when you're calculating out your patient
4 days, you say 4.25 ALOS. What does ALOS mean?

5 A: ALOS means average length of stay. And what
6 that basically says is that on average for all
7 the patients that are served by a hospital the
8 -- if I'm admitted, on average I would stay
9 4.25 days in a bed.

10 Q: Okay. Now, is that a reasonable estimate of
11 average length of stay?

12 A: I think it is. As a point of reference, I
13 think that Trident in all their forecasting
14 used 4.2 length of stay.

15 Q: Okay. So both applicants in their forecasting
16 in the application -- in their forecasting in
17 their application and in their forecasting for
18 this trial, are they using basically the same
19 average length of stay?

20 A: Yes, they are.

21 Q: And in your opinion -- the projects have been
22 delayed because of the litigation, right?

23 A: That is correct.

24 Q: Okay. In your opinion does this delay in time
25 make it more likely that the projects will be

1 successful or less likely?

2 A: I think in terms of will there be a larger
3 population there in Berkeley County, I think
4 that would drive it to have it be more
5 successful. I think in terms of some of the
6 changes that may have occurred in use rates in
7 terms of how many folks are using certain
8 things, it looks like there's been a little bit
9 of decline there. I think overall when you
10 combine that, I think -- I think the overall
11 market will be bigger in 2017 than we forecast
12 in the CON. I think that either hospital would
13 have an easier ability or an easier expectation
14 to obtain full utilization. Book of business
15 is going to be bigger in the forecast where we
16 sit today versus what it was, and I think that
17 as a result, both hospitals are more likely to
18 achieve their volume forecasts.

19 Q: Let me ask you about -- let me go back and ask
20 you about population. I probably should have
21 asked you earlier, but I wanted you to look at
22 this map and comment on it, that we've done.
23 This is Respondent's 76. And we've got two
24 pages here, 4711 and 4710. Do you have those
25 in Respondent's 76?

1 A: I've got them on my screen.

2 Q: Okay. Tell me what Roper Berkeley 4710
3 represents on this map.

4 A: 4710 basically presents or graphically presents
5 the 2000 population, again, arranged by zip
6 code. And what this shows is that the zip
7 codes with the largest population of 39,000
8 plus are identified in pink. So the next
9 highest population zip codes are there in the
10 orange from 26,000 to just under 39,000. The
11 other zip codes have smaller populations
12 ranging from yellow, 13,000 to 26,000, and the
13 green is less than 13,000 population, resident
14 population in those zip codes. Again, this is
15 the actual 2000 count, not one of the estimates
16 or forecasts, so these should be real numbers.

17 Q: Okay. And so if the population is growing in
18 a certain zip code, how would the colors change
19 when we go to 2010?

20 A: What you'd see is that the population is
21 growing. You'd see the orange going to pink.
22 You'd see the yellow going to orange and you'd
23 see the green going to yellow.

24 Q: Take a look at 2010. What do you see?

25 A: What you see is just that. What you see is

1 that you have population growth going up into
2 Mount Pleasant to the south and going up into
3 Berkeley County in the southern and southwest
4 portion of Berkeley County.

5 Q: Okay. And do these two charts -- what can you
6 conclude from these two maps?

7 A: What you conclude from these maps is that from
8 2000 to 2010 the population growth was moving
9 out of the peninsula and out of the core of
10 Charleston either northeast into Mount Pleasant
11 or north-northwest up into Berkeley County.

12 Q: Okay. And is this a fact that supports the
13 Department's decision that these hospitals are
14 not competing applications?

15 A: I think it is.

16 Q: Your Honor, at this time, we've been going for
17 about two hours and I'm probably at a place to
18 transition. This might be a time for a break
19 if Your Honor is inclined.

20 THE COURT: We will be in recess for about ten
21 minutes.

22 (Off the Record from 11:55 a.m. until 12:10 a.m.)

23 THE COURT: Mr. Long?

24 MR. LONG: Thank you, Your Honor.

25 Q: Mr. Richardson, we've looked this morning at

1 the service area, the Tri-county service area.
2 But I'd like to take a minute and look at
3 Berkeley County alone as a kind of a standalone
4 county for a moment. First, do you have an
5 opinion as to whether Berkeley County, in
6 geography and in population, is large enough to
7 support two 50 bed community hospitals?

8 A: I think it does on either parameter.

9 Q: Both geography and population?

10 A: Yes.

11 Q: Let's take a look at Respondent's Exhibit 70,
12 Richardson Berkeley 684.

13 A: I have it.

14 Q: As part of your work on this case -- well, tell
15 me what page 684 is?

16 A: 684 basically looks at the Berkeley County
17 volume, the volume that would be generated by
18 Berkeley County residents in total for 2010,
19 2017 arrayed along a couple ways. One is just
20 the total discharges, and that includes the
21 specialty and the tertiary stuff too. Subset
22 of that is the non-tertiary discharges which is
23 sort of the sandbox that they were playing in.
24 That actually shows the Roper St. Francis and
25 the Trident book of business of Berkeley County

1 in 2010, 2017.

2 Q: Okay. Are you using a similar or the same
3 formula that the state uses in the State Health
4 Plan in this? You've got a bed need on here.
5 So before we get to that, are you --

6 A: Basically what I've done here is that I've used
7 the actual 2010 information. I then forecast
8 that out in terms of the total discharges and
9 the tertiary discharges. I basically used a
10 2.52 percent per year growth. And what that is
11 is that when you look at Berkeley County
12 overall in terms of -- and you apply population
13 growth, the fact that there's aging in the
14 population, what you expect overall is that the
15 volume -- that volume in the county is going to
16 grow by 2.5 percent per year. So it's not, you
17 know, huge; it's not going to -- it's not going
18 to double every couple years, but pretty
19 healthy growth.

20 Q: Okay. Let's look at the numbers for looking at
21 2010.

22 A: Right.

23 Q: So the first number here you tell the court --
24 let's look at the second column, non-tertiary
25 discharges, since you said that's the sandbox

1 we're playing in.

2 A: Right.

3 Q: Okay. So what do you calculate in regards to
4 just looking at Berkeley County alone? What do
5 these numbers show?

6 A: What this shows is that there were 13,568 non-
7 tertiary, non-specialty discharges from the
8 residents of Berkeley County. If you apply a,
9 assume a 4.2 length of stay, basically that
10 results in 55,629 patient days, non-tertiary
11 patient days, for residents of Berkeley County.
12 And what's shown, what that translate into an
13 average daily census is an average daily census
14 I believe of 152.4. Let me just make sure
15 again. 152.4. If you apply a 65 percent
16 target occupancy, which is what it would be for
17 the small hospitals, you end up with a bed need
18 of 234. If you apply a 70 percent occupancy,
19 it would show a bed need of 218.

20 Q: Okay. And did you also do those same
21 calculations just looking at what the Roper St.
22 Francis patients, what their bed need would be
23 and what the Trident Health System bed need
24 would be?

25 A: Yes. And that's another way of looking in

1 terms of today what sort of volume or book of
2 business is coming from Berkeley County to
3 Roper St. Francis facilities.

4 Q: Okay..

5 A: What you see there is 3,200 discharges, 1,500
6 patient days --

7 Q: Thirteen thousand?

8 A: I'm sorry. 13,280 patient days and a 56 bed
9 need using the 65 percent occupancy.

10 Q: And, of course, that's greater than the 50
11 applied for?

12 A: Yes, it is. And this is similar to what we
13 talked earlier in terms of just looking at that
14 Roper St. Francis current book of business,
15 they can fill that hospital.

16 Q: Look at the Trident Health System numbers.

17 A: Similar analysis. This is non-tertiary for
18 Trident. Basically showing 7,000 discharges;
19 29,000, 30,000 patient days, or an overall bed
20 need of 125 beds in 2010 to treat Trident's
21 patient days being generated from Berkeley
22 County residents.

23 Q: Okay. And let's take a look at what you
24 forecast for 2017.

25 A: Right.

- 1 Q: Now, when the state -- before we do that, when
2 the state forecasts bed need in the State
3 Health Plan, does it forecast it in the future?
- 4 A: Yes, it does.
- 5 Q: So does it do a similar type -- take the
6 current data and then forecast it out?
- 7 A: Yes, it does.
- 8 Q: Okay. So what do you project the bed need for
9 Berkeley County to be in 2017? Let's look at
10 the big number because that would include --
11 that includes everything, right?
- 12 A: That's right.
- 13 Q: The first number here?
- 14 A: That would include all acute care utilization.
- 15 Q: Including the tertiary?
- 16 A: Yes, it would.
- 17 Q: All right. And what would the bed need be in
18 2017 for a hospital with all the patients?
- 19 A: Using a 65 percent occupancy factor, that would
20 be a need for 327 beds to take care of all of
21 Berkeley County residents.
- 22 Q: Non-tertiary?
- 23 A: Non-tertiary, there would be a bed need, again,
24 using the 65 percent occupancy of 286. Again,
25 2007 into the future looking just at the non-

1 specialty, non-tertiary, that book of business
2 would require 286 beds with a 65 percent
3 occupancy.

4 Q: A little more than a hundred?

5 A: Lot more than a hundred.

6 Q: Okay. And the Roper St. Francis and the
7 Trident Health System numbers?

8 A: Calculated the same way, Roper St. Francis bed
9 need based just on Berkeley County residents
10 would be 68 and the Trident Health System bed
11 need, non-tertiary, again based just on
12 Berkeley County residents, would be 155.

13 Q: Okay. What conclusion do you draw just from
14 this sheet alone in regards to the bed need of
15 Berkeley County?

16 A: A couple things. I really use this as a
17 sideways check to -- we're proposing to build
18 two 50 bed hospitals and I think that both
19 hospitals can be built and can achieve their
20 volumes. But I really did this to try to get,
21 one, to try to get a check in terms of what's
22 the bed need for the individual providers,
23 Roper St. Francis and Trident, but also to give
24 sort of a validation in terms of what's the
25 overall book of business for the county. If,

1 in fact, you show need for two hospitals, 50
2 bed each, 100 beds total, if you looked at
3 total county need, it was, you know, 120, 150
4 or pretty close, I think you'd start to worry
5 in terms of is your modeling correct. But here
6 in terms of, you know, if you look in terms of
7 the discrete Berkeley County residents, you're
8 at upper two-hundreds non-tertiary, three
9 hundreds full book of business.

10 Q: Okay.

11 THE COURT: For the purpose of the record, could you
12 explain how you intend discrete to be defined?

13 THE WITNESS: I'm trying to recall how I used it.

14 THE COURT: I think you said discrete Berkeley
15 County residents.

16 THE WITNESS: Thank you. This is -- this is just --
17 if you look at all the Berkeley County
18 residents, and that's all, in terms of if you
19 just took the only Berkeley County population,
20 only Berkeley County utilization, and you put
21 a ring around it, put a fence around it, what
22 you would need were the beds as shown here.

23 Q: Let me ask two more questions to help with that
24 in the record. So when you do these bed need
25 calculations, are you considering any of the

1 people that live in North Charleston?

2 A: No, I'm not. Not that are out of Berkeley
3 County, no.

4 Q: And when you looked at the population data
5 earlier, North Charleston has a population of
6 almost, do you remember the size? Do you need
7 to see it again?

8 A: I've got it right here. North Charleston has
9 close to 100,000 population.

10 Q: Okay. And where is Trident Medical Center
11 located?

12 A: In North Charleston.

13 Q: Okay. With 100,000 people?

14 A: Yes.

15 Q: And then are you including in this bed need
16 calculation of residents who live in Dorchester
17 County?

18 A: No, I'm not.

19 Q: All right. And how many people live in
20 Dorchester County?

21 A: 136,000 in 2010.

22 Q: Okay. And where is Summerville Medical Center
23 located?

24 A: In Dorchester County.

25 Q: Okay. And then population, of course, for

1 Berkeley for this calculation.

2 A: Correct. 177,000 in 2010.

3 Q: Okay.

4 A: With growth.

5 **THE COURT:** Would it be correct then to say that
6 your definition was that discrete means set
7 apart?

8 A: Exactly. Would be.

9 Q: Let's look at Respondent's 75 which are some
10 maps that have been prepared for the litigation
11 here. So first, on the -- looking at this map
12 here, the sources of this map and these maps
13 that we're getting ready to look at, can you
14 tell the court what the sources are?

15 A: Sure. The sources are the beds identified in
16 the 2010-2011 South Carolina State Health Plan.

17 Q: Which I think is Joint 5 which came in earlier
18 today.

19 A: Okay. And also on this map is a presentation
20 of population, 2010 population for each county
21 taken from the census, so it's the real
22 numbers.

23 Q: And the real numbers that we talked about this
24 morning that came into evidence this morning.

25 A: That's correct.

1 Q: All right. Is there a hospital located in
2 Berkeley County?

3 A: No, there is not.

4 Q: Does either applicant claim in their
5 application that there is a hospital in
6 Berkeley County?

7 A: No.

8 Q: Let's look at the other counties in South
9 Carolina that don't have a hospital on this
10 map.

11 A: Right.

12 Q: Okay. Can you tell me what conclusion you draw
13 from -- what the counties are and what
14 conclusions you draw from this map?

15 A: Sure. There are three other counties in South
16 Carolina without a hospital, without hospital
17 beds. I think the important compare and
18 contrast is you look at the population in those
19 counties, it would be real tough for those
20 counties to support a hospital. You know, you
21 have McCormick at 10,000 or Lee at 19,000 or
22 Saluda at 19,000. The reality is that's not
23 enough population base to support the
24 development of a hospital.

25 Q: And how does Berkeley compare to these other

1 counties?

2 A: A huge magnitude of difference. Berkeley with
3 177,000 in 2010. As we've just seen, they can
4 support hospital beds and hospitals.

5 Q: And just for the record, this is Respondent's
6 75. That was page 4701. Let's look at 4702.
7 You see in the left-hand corner there. Can you
8 tell the court what this map --

9 A: Sure.

10 Q: -- shows?

11 A: What the next two maps show basically are an
12 array of counties with different sort of
13 population bands. 4702, the next one, has --
14 identifies the counties with either at least
15 50,000 population going up to 100,000
16 population, so about half of what Berkeley has
17 in population, and the number of beds that are
18 in each of those counties.

19 Q: Okay. And can you kind of identify some of
20 these counties that you find interesting or
21 important to the court.

22 A: Sure. Look at Georgetown County, for example,
23 there are 255 beds really adjacent to two
24 population hubs, Horry County and Charleston
25 County. So adjacent to big pop centers, yet at

1 60,000 they've got 255 beds. Some of the other
2 areas, Cherokee County up to north of Lancaster
3 County, really both going in terms of -- and
4 Lancaster County probably more, going in terms
5 of that's a suburb of Charlotte. 76,000 beds.
6 You know, less than half of what's in Berkeley.
7 So it's 76,000 population, less than half of
8 what is in Berkeley with 217 beds.

9 Q: Can -- go ahead.

10 A: I mean, it shows that population bases of about
11 half of what Berkeley has are clearly
12 supporting hospitals in all but one of these
13 situations are supporting at least 100 beds.

14 Q: Okay. What about Darlington County? Do you
15 think it's relevant in regards to its location
16 to its surrounding counties, Florence and other
17 counties?

18 A: I do in terms of -- that's another one that
19 really is adjacent to a major hub, healthcare
20 hub, in terms of Florence.

21 Q: And it has how many beds?

22 A: With 68,000 population it has 165 beds. So,
23 again, half the population, less than half the
24 population of Berkeley, you've got 165 beds.

25 Q: Let's look at 4703. Can you tell the court

1 what this map of South Carolina on 4703
2 purports to represent?

3 A: This really is the next band of population.
4 This identifies counties with at least 100,000
5 up to 200,000 population, which is where
6 Berkeley County falls. And what you see here
7 is that the counties in this common population
8 band end up with a good number of beds. I
9 think the smallest number is Dorchester, as
10 shown there, with 94 beds. But, again, I think
11 it just shows some of the misallocation of beds
12 that likely should be in Berkeley County.

13 Q: Let's take a look at a couple of counties.
14 Anderson County. And could you comment on the
15 similarity between Anderson County and Berkeley
16 County?

17 A: Sure. You've got Anderson County up next to
18 sort of the Greenville/Spartanburg hub so it's
19 adjacent to a big population area. 187,000
20 folks. Pretty similar to Berkeley. Yet
21 they've got four or five hundred beds.

22 Q: Okay. Almost five hundred?

23 A: 495 beds, yes.

24 Q: And how about Florence County?

25 A: Florence County is showing there with 136,000

1 population, about a quarter less than Berkeley
2 and they've got over 800 beds. So, again, it
3 just shows the issue in terms of misallocation
4 of beds in this three county area with nothing
5 there in Berkeley County.

6 Q: And Sumter County and its relationship to
7 Richland and other counties?

8 A: Sumter, much smaller population, 107,000, with
9 two to three hundred beds. Again, relatively
10 adjacent to a major population hub similar to
11 as we have here. It's just another telltale
12 that things are not right in Berkeley County.

13 Q: Okay. Would you also draw an opinion as to
14 whether the counties in South Carolina, whether
15 it would be unique for a county like Berkeley
16 to have a hundred hospital beds?

17 A: The establishment of a hundred hospital beds in
18 Berkeley County would make Berkeley County, you
19 know, similar to the other distributions of
20 beds and likely still low on a comparative
21 basis to a bed to population ratio.

22 Q: Okay. The next slide is 4704. We've talked
23 about this one already this morning, right?

24 A: Correct.

25 Q: All right. And looking at the next several

1 slides, I'd just like to quickly roll through
2 them. And if you could look on the left, you
3 can see what these like 4705 purports to
4 represent and then -- what 4705 represents and
5 the ones coming after it.

6 A: This basically is the raw material that drives
7 into the population band maps. It really goes
8 to what I was talking about. For example, on
9 4705, Anderson County or Pickens County, you
10 know, both with 164 or 495 beds really adjacent
11 to a pretty large metropolitan hub just like
12 Berkeley County.

13 Q: And how many beds does Greenville County have?

14 A: Greenville County has 1,300 beds.

15 Q: Okay.

16 A: And Spartanburg about 700.

17 Q: And are these divided up -- I think it says
18 here DHEC Region I. Can you explain to the
19 court what that is?

20 A: Sure. DHEC in the State Plan identifies,
21 unlike the three county area, the next regional
22 area are DHEC regions as defined in the State
23 Health Plan. That's what these next maps
24 segment the state to follow the DHEC regions.

25 Q: Okay. Next page 4706, what does this purport

1 to represent?

2 A: Basically again showing where the -- where the
3 hospital beds are located. Again, a good
4 example here would be Lexington County, you
5 know, a suburban area similar to Berkeley, 400
6 beds. Lancaster County, even York County, two,
7 three hundred beds, right adjacent up to the
8 Charlotte area.

9 Q: Okay. And that would be Region II; is that
10 right?

11 A: That is correct.

12 Q: And how about 4704?

13 A: 4704 is Region III which basically shows sort
14 of the -- includes the Georgetown example that
15 we talked about prior, 4707.

16 Q: 4707, right.

17 A: The Georgetown example that we talked about
18 prior and the counties that are adjacent to or
19 next to Florence County as well.

20 Q: And Horry?

21 A: Horry County? The 269,000 population, over 600
22 beds.

23 Q: Okay. And 4708?

24 A: 4708 is the last DHEC Region IV which basically
25 includes the area we're talking about here

1 today.

2 Q: Okay. And then -- then I think 4709 is a --

3 A: 4709 presents the entire state just arrays in
4 terms of the brighter the number are the number
5 of existing licensed beds in those counties.

6 Q: Did you hear the testimony of Baehr and some of
7 the Trident witnesses that Berkeley County --
8 that Trident Medical Center should be
9 considered as part of Berkeley County?

10 A: I did.

11 Q: And do you have an opinion on whether the court
12 or should the court -- well, do you have a
13 response to that or reaction to that?

14 A: I think factually Trident Medical Center is not
15 within Berkeley County. I also heard in the
16 court that Trident Medical Center basically was
17 established back in the '70s to serve the
18 population that appeared to be located in the
19 North Charleston area and that it served what
20 else was out there at that point in time. That
21 situation has changed dramatically. To
22 basically assume that the consolidation of two
23 facilities in 1970 basically makes one conclude
24 that Berkeley County is fully served today is
25 wrong.

1 Q: And when you look at the data, where does
2 Trident Medical Center get its patients from?

3 A: Trident Medical Center gets its patients from
4 really the three county area. They get
5 patients from Berkeley County. They get
6 patients from Dorchester County. And they get
7 patients from the northern portions of
8 Charleston County. And they get about another
9 nine, ten percent of patients from beyond that
10 geography as well.

11 Q: Okay. All right. Let's talk a minute or two
12 about some of the calculations that you've done
13 in the case and in the CON application. In
14 some of your analysis in the, I believe in the
15 application, you look at a seven mile radius.
16 Do you recall that and some of the testimony on
17 that? Can you tell the court why you did that?

18 A: Sure.

19 Q: What's the purpose of looking at a seven mile
20 radius?

21 A: Sure. I think there was some
22 mischaracterization of the seven mile radius
23 for the certificate of need. Basically, the
24 service area for the proposed Roper St. Francis
25 Hospital is Berkeley County with ten percent

1 coming out, but basically it's Berkeley County.
2 The service area is not just any seven mile
3 radius. It's the entire county. I utilized
4 the seven mile radius in some of my analyses to
5 try to get an idea in terms of what is the mass
6 of population or how many folks are within a
7 seven mile radius when I looked at comparing
8 both Moncks Corner and Carnes Crossroads. And
9 I used that basically to try to develop a
10 comparative in terms of what sort of -- what's
11 the size of the populations. I first attempted
12 to use municipalities looking at Moncks Corner
13 versus Goose Creek, but what you find is that
14 the municipal definitions don't fit very well
15 with where the population is. And I thought
16 that that sort of misspoke in terms of just
17 what the difference of population was from
18 Moncks Corner to Goose Creek. Because there's
19 population right outside the municipal limits,
20 and looking at just the municipal definition
21 you ignored a lot of that. So basically using
22 a seven mile radius around both facilities or
23 both proposed sites, I used that to do a
24 compare and contrast in terms of how many folks
25 are going to be relatively proximate to each

1 hospital. And that was the purpose that I used
2 the seven mile radius. It was not used for a
3 service area. Now, full disclosure, early on
4 in some of the drafts that we did we started to
5 look at that in terms of a seven mile radius
6 but rejected it because a seven mile radius
7 from Carnes Crossroad basically excludes the
8 book of business that Roper St. Francis now
9 draws and treats in its Moncks Corner facility
10 and in that area. So I want to be very clear
11 in terms of the service area for this facility
12 that my plan for what I think is appropriate is
13 old Berkeley County.

14 Q: Okay. And so what is the service area in the
15 application for Roper St. Francis?

16 A: Berkeley County.

17 Q: Okay. Now, you didn't -- so you used the
18 county instead of zip codes, right?

19 A: That is correct.

20 Q: Okay. You heard the testimony. Is it
21 appropriate to use a county as a service area?

22 A: Oh, I think definitely it is.

23 Q: Okay. And what's your reaction to Mr. Baehr's
24 testimony about their using zip code and Roper
25 St. Francis not using a zip code?

1 A: I've used both. And if you can define a good
 2 target geography by zip codes, I think that,
 3 you know, may make some sense. And I talked
 4 about this point. However, when you go down to
 5 the -- the smaller you go down in geography in
 6 terms of from county on down to zip code or if
 7 you go down even smaller, for example, census
 8 tract, the smaller you get in geography really
 9 the less precise your results are going to be.
 10 Again, in terms of if you're looking at a
 11 population of some of these zip codes are
 12 eight, ten thousand population, and some of
 13 them are much larger than that, but getting
 14 down to a zip code specific level, the -- you
 15 lose precision. And, again, I think if anyone
 16 would tell you or the court that I can
 17 guarantee you or I can predict with any
 18 confidence or precision that there will be this
 19 many patients coming from a given zip code, you
 20 know, within ten or 20, you need to be real
 21 cautious. So all these are forecasts, all
 22 these are estimates. I did countywide. I
 23 think it is as appropriate as the zip code
 24 level that Mr. Baehr did.

25 Q: Okay. The history of the market share for the

1 different facilities in this region, how would
2 you characterize it over a period of time
3 leading up to these applications?

4 A: There's been some small variation. I think Mr.
5 Bowling was talking about Roper Hospital lost
6 a little bit, Trident was about stable, and
7 MUSC gained a little bit. I know he was
8 talking about that was a -- that was a big
9 deal. But from outside looking in, basically
10 market shares have been relatively stable over
11 time here in the Tri-county area in terms of --
12 in terms of the overall area. And Roper has
13 got maybe a little bit more than 30 percent,
14 Trident is a little less, and MUSC probably
15 about the same. So it's market share --
16 there's a little bit every year. Market share
17 has been relatively stable.

18 Q: Okay. And does that fact -- what does that
19 fact suggest to you as to what will happen in
20 the future when these hospitals are built?

21 A: I think basically is that the looking forward
22 market shares I think basically is, you know,
23 I think it's likely that they will stay the
24 same. If nothing is done, neither of these
25 hospitals are built up there, I'd expect the

1 market shares will stay relatively the same.
2 I'd expect long-term Roper would -- Roper St.
3 Francis would lose market share as the
4 population builds up north and that population
5 gets tougher and tougher to come downtown. But
6 in terms of sort of a planning horizon in the
7 next three, four, five, six years, I'd expect
8 that the market shares without these new
9 facilities would stay pretty stable. With the
10 development of the new hospitals, there may be
11 a little bit of shift in terms of more folks
12 going to the new hospital in both locations.
13 But status quo without anything new, I think
14 the market share will stay the same, maybe a
15 slight shift with the new facilities.

16 Q: Now, let me show you Respondent's Exhibit 38,
17 which is the Roper St. Francis Berkeley
18 Emergency Department visits and transfers.
19 What does this exhibit show?

20 A: This exhibit shows the patients that were seen
21 at Roper St. Francis Moncks Corner Emergency
22 Department. Excuse me -- how many patients
23 were served in that emergency or seen in that
24 emergency department and how many transfers
25 were made to various hospitals.

1 Q: Okay. And these numbers are from '07 to 2010,
2 right?

3 A: That's correct.

4 Q: Okay. And these numbers appear to be fairly
5 stable to you or do see a variance there?

6 A: A little bit ED patient volume is going up.
7 Transfers down a little bit. But relatively
8 stable on both sides.

9 Q: Okay. What does this transfer number
10 represent?

11 A: Transfer represents patients that were
12 initially seen at the Roper St. Francis Moncks
13 Corner ED and were transferred to a hospital
14 and in my opinion, as I think we heard,
15 predominately for inpatient admission at that
16 hospital.

17 Q: So that's 1,109 patients in 2010?

18 A: That is correct.

19 Q: Where would you expect most of those patients
20 to be transferred to after the hospital is
21 constructed at Carnes Crossroads?

22 A: I would expect the majority of those patients
23 would be transferred to the proposed new Carnes
24 Crossroads Roper St. Francis facility. There
25 will be some that will wild card out in terms

1 of, you know, for cardiac intervention or if
2 there's any major trauma, things that the
3 hospital won't treat. But I would expect that
4 the majority of those would go on down to the
5 new facility.

6 Q: Well, just overall in a hospital system, what
7 is -- we talked about tertiary and non-tertiary
8 in these specialized cases, tertiary. What
9 roughly is the percentage that you might see in
10 the hospital between tertiary and non-tertiary;
11 is it like 50/50?

12 A: No.

13 Q: Or what? How does it work or what would you
14 expect to see?

15 A: Globally, looking in terms across all
16 hospitals, what I tend to see is about 15
17 percent of the book of business that's
18 performed systemwide for acute care hospitals
19 falls into that tertiary bucket. And that
20 includes -- interventional cardiology is the
21 big deal in terms of open heart, cath,
22 angioplasty. High end trauma falls into that.
23 Neonatal care, you know, there's a lot of sick
24 babies, I would include in that as well. Also
25 some acute care hospitals also take care of

1 behavioral and mental health patients, you
2 know, substance abuse or mental health
3 patients, so you want to carve those out too.
4 Typically about 15 percent of the total volume
5 would be considered in that tertiary bucket.

6 Q: Okay. Now, an ED is, you said I think the
7 emergency department is one of the main sources
8 of patients for a community hospital.

9 A: Yes, it is.

10 Q: Okay. Would you -- is the Trident -- the two
11 EDs in Moncks Corner, how close are they?

12 A: A couple miles apart.

13 Q: And there are a number of visits that each of
14 the EDs have. Are they similar or is one ED
15 much busier than the other?

16 A: I looked at that information.

17 Q: I don't have it right here before me either.

18 A: Either similar or Trident is a little bit
19 larger. I can't give you the exact number, but
20 I recall that comparison.

21 Q: All right. Now, would you expect patients to,
22 if you've got a freestanding ED two miles from
23 a hospital ED, would you expect patients to --
24 how would you expect patients to choose or
25 would they potentially change their pattern of

1 choice, with that comparison?

2 A: I think making a change in the Moncks Corner
3 area to basically where they now have two free-
4 standers to where there would be one free-
5 stander, which would be Roper St. Francis and
6 then there would be the Trident ED as part of
7 the hospital, I think that the Trident facility
8 would likely -- that would cause some of the
9 Roper St. Francis patients to go across. I
10 don't think that, you know, it's not half, but
11 I expect there would be some slippage across to
12 the new facility.

13 Q: Okay. And let's take a look at Respondent's
14 Exhibit 45.

15 A: Okay.

16 Q: What do these numbers on this document, why is
17 this important or why did you consider this
18 information? Excuse me, let me re-ask the
19 question. Why do you think the court should
20 consider this information?

21 A: This basically arrays or presents information
22 that shows how many patients each hospital
23 system, Roper Hospital, Bon Secours and then
24 Mount Pleasant, it shows how many patients they
25 treat from each county and then there's the

1 total discharges in the county. What this
2 allows you to do is create those calculations
3 at the bottom of this exhibit which shows the
4 market share for 2010 for the Roper entities in
5 Berkeley, Charleston and in the three county,
6 Tri-county, area.

7 Q: Ms. Hollingsworth has helped me here. Let's go
8 back and look at Respondent's 182 -- I'm sorry,
9 Petitioner's 182. Petitioner's 182.

10 A: I see it.

11 Q: You see now what the -- this is the Moncks
12 Corner ED numbers.

13 A: Yes, I do.

14 Q: Okay. So based on this data here in this
15 Petitioner's 182, does that help you answer the
16 question as to the comparison between the two
17 EDs?

18 A: Sure. They're relatively similar.

19 Q: Take a look at, if we can, let's look at real
20 quickly at Respondent's 41. Go to the third
21 page, if you would.

22 A: I'm sorry. What exhibit?

23 Q: This is 41. Maybe it's the fourth page. You
24 know what, I'm sorry. I apologize, Your Honor.
25 Let's go to Respondent's 50. It's a much

1 better exhibit than 41 for our purposes today.

2 Do you have 50?

3 A: I do.

4 Q: What does Respondent's 50 show in regards to
5 the emergency department in Moncks Corner for
6 Roper St. Francis?

7 A: Respondent's 50 shows the origin or the
8 residence of patients for patients that use the
9 Roper emergency department up in Moncks Corner.

10 Q: Okay. And looking at where these patients are
11 coming from, can you draw any conclusions as to
12 where the Moncks Corner ED patients are coming
13 from?

14 A: Sure. I think it's very clear is that Moncks
15 Corner, the local Moncks Corner zip, which is
16 a big zip, is sort of the predominate source of
17 the emergency department visits, with St.
18 Stephen to the north, Bonneau by the lake and
19 Cross by the lake and Pineville. So basically
20 your -- the patient draw for the Roper St.
21 Francis Moncks Corner ED is basically Moncks
22 Corner up around the lake.

23 Q: Would you expect a hospital in Moncks Corner to
24 have a similar draw?

25 A: Yes.

1 Q: Or emphasis in its patient draw?

2 A: Yes.

3 Q: Is that a fact that, in your opinion, supports
4 the Department's decision that these
5 applications are not competing?

6 A: I think it does. I think that the -- showing
7 the draw here shows that the ED is drawing from
8 Moncks Corner on up north and northeast versus
9 the we saw the map prior that basically shows
10 that the existing book of business for Roper
11 St. Francis is from Moncks Corner heading down
12 over towards Goose Creek and Summerville.

13 Q: Okay. Let's take a look quickly at
14 Respondent's 82.

15 A: I need to change books just a second. I've got
16 it.

17 **THE COURT:** Before you go on, I just want to make
18 sure I understood your contention there. And
19 could it be summarized, and don't agree with me
20 just because I'm the Judge and correct me if
21 I'm mistaken, but you're saying in support of
22 these applications being non-competing, at
23 least one factor of it is that the emergency
24 room draws from the Moncks Corner and the upper
25 county area supports the non-competing

1 argument; is that right?

2 **THE WITNESS:** Yes, it does. The Moncks Corner sort
3 of upper county area I think compares and
4 contrasts to the expectation of where the Roper
5 patients are being served now, which is the new
6 Berkeley County, the description we heard,
7 which would be from Moncks Corner heading down
8 towards --

9 **THE COURT:** So I did not mischaracterize it?

10 **THE WITNESS:** Not at all, sir.

11 **THE COURT:** Thank you.

12 Q: And so these would also be patients, though,
13 that are going to the emergency department,
14 right?

15 A: That's right. And the emergency department is
16 a major portion of patients being served by a
17 hospital.

18 Q: Okay. Now, this document here, Respondent's
19 82, is the Trident Emergency Department.

20 A: Correct.

21 Q: It's titled Moncks Corner by Zip Code Inpatient
22 Discharges. So would this be the inpatient
23 discharges through the Moncks Corner Emergency
24 Department?

25 A: This appears to be the patients that were

1 discharged through the Trident Health System
2 that started at the Moncks Corner ED.

3 Q: And then went to a hospital?

4 A: Went to a hospital, yes, went to a Trident
5 Hospital.

6 Q: A Trident hospital. And where are the majority
7 of those patients coming from?

8 A: Really similar --

9 Q: Where do they reside?

10 A: Really similar in terms of the sort of the
11 biggest band of population is Moncks Corner,
12 St. Stephen, Bonneau and Cross.

13 Q: Okay. Well, look at the Goose Creek number,
14 the Goose Creek zip code, the 29445, and where
15 is 29445 located?

16 A: 445 is located proximate to the Roper St.
17 Francis Carnes Crossing.

18 Q: Okay. How many people were admitted to Trident
19 Health System hospitals through the Moncks
20 Corner ED from Goose Creek?

21 A: Seven. Seven total, but what that shows is
22 that there was one in 2007, one in 2008, five
23 in 2009 and none showing here in 2010.

24 Q: Okay. You heard Mr. West's testimony in the
25 trial?

1 A: I did.

2 Q: Old Berkeley County, new Berkeley County?

3 A: Yes.

4 Q: Does the emergency department volume -- the
5 emergency department utilization, the people
6 that are using the two emergency departments in
7 Moncks Corner and where they reside, does that
8 support this idea about Mr. West's language
9 about the county being split?

10 A: I think it does. I think you have basically a
11 strong draw proximate to the Moncks Corner
12 area, so Moncks Corner zip, and then the --
13 what Mr. West, Mayor West was talking about,
14 the old Berkeley County which would be up
15 around the lake.

16 Q: Okay. And is that a fact that would support
17 the Department's conclusion that these
18 applications are not competing?

19 A: I think so. I found Mr. West's discussion
20 interesting. I sometimes drown in data in
21 terms of just all these numbers. But I think
22 the simplistic, a simplistic definition that
23 Mr. West said basically, you know, the county
24 is divided in two. You've got old Berkeley
25 County which is Moncks Corner up county, and

1 you've got new Berkeley County which is he said
2 incoming from North Charleston up into the sort
3 of the southwest portion. The draw, the
4 distinct draw from those two areas I think very
5 much supports that and supports that these
6 really would be two distinct operations and
7 that they're not competing.

8 Q: Okay. All right. Let's turn our attention now
9 to the issue of adverse impact. You heard the
10 testimony about the adverse impact. Where is
11 the adverse impact -- where does Trident or how
12 does Trident propose or purport that the
13 adverse impact will occur in this case, in this
14 situation?

15 A: It appears that Trident states that the
16 development of the 50 bed Roper St. Francis
17 facility in Carnes Crossroads, that those 50
18 beds will basically result in a \$16 million
19 adverse impact.

20 Q: And what exactly is adverse impact?

21 A: There's adverse impact and material adverse
22 impact.

23 Q: Okay. Can you explain the difference?

24 A: Sure. Adverse impact is, in any situation,
25 you've got -- you get less than you do right

1 now. So in terms of if my bank account is a
 2 thousand bucks and all of a sudden I get a
 3 check that I deposited, there, wasn't enough
 4 money in it from where it was drawn and my
 5 checking account goes down to \$500, that was an
 6 adverse effect on me. Now, is that material?
 7 No. I hope not for me. Hopefully I've got
 8 enough other assets to make that work. But if
 9 all that I have, if all the assets I have is
 10 that thousand bucks, then that could be a
 11 material adverse impact as well.

12 Q: Okay. And so how is that difference between
 13 adverse impact and material adverse impact
 14 important to a health planner and to the
 15 Department?

16 A: From a health planning perspective, to me,
 17 material adverse impact is a change in
 18 circumstances such that a provider is not able
 19 to continue to provide its community benefits,
 20 it's mission service. And that would be the --
 21 every hospital provides care and services that
 22 they lose money on. It's a given. Emergency
 23 departments tend to be, especially trauma
 24 centers tend to be a large area where folks
 25 lose a lot of money. On sick babies often is

1 an area where folks lose money. Providing
2 clinics to low income folks tend to be areas
3 where folks lose money. But, again, from a
4 planning perspective, material adverse impact
5 is something's changed so that I cannot afford
6 to do the good stuff for the community that
7 I've been doing in the past.

8 Q: Okay. Now, in regards to this lawsuit, what
9 are the two or what are the facilities that
10 Trident Health System contends will be
11 adversely impacted by Carnes Crossroads?

12 A: Trident Medical Center and Summerville Medical
13 Center.

14 Q: All right. And even if the Department or you,
15 as a planner, were to conclude that the adverse
16 impact was material, does that mean that the
17 application should be denied?

18 A: No. The adverse impact falls into sort of a
19 comparative bucket of you compare good things
20 and bad things. So you compare the issue in
21 terms of adverse impact to a new service,
22 higher quality service, a new development.

23 Q: Okay. Let's take a look at Respondent's 70
24 again. If you'll read page number 689.

25 A: What number is this now, 689?

1 Q: That's Respondent's 70, 689. The last page of
2 your trial exhibit.

3 A: I have it.

4 Q: Okay. First, what does this page or this
5 analysis show to the court?

6 A: Basically what I've done here or attempted to
7 -- hopefully attempted to do here is basically
8 show that the volume that would be lost to
9 Trident Health System, so Trident Medical
10 Center and Summerville together, is that the
11 volume that would be lost to either the
12 proposed Roper St. Francis facility, so -- so
13 the volume they'd lose to Roper St. Francis'
14 new facility or the volume they'd lose to the
15 proposed Moncks Corner facility, or even
16 combining those two facilities, the loss to
17 Trident Health System. This analysis shows
18 that there is little or no -- there will be
19 little or no volume lost to Trident Health
20 System when you look at where they stand today
21 and where they will stand in the future. And
22 I think that I'll come back to that adverse
23 impact issue. I heard from all of the folks
24 talking in terms of lost money and all those
25 type things. Well, you know, comparing \$16

1 million to whatever the -- again, I'm not a
2 financial person -- the EBITDA, cash flow, net
3 revenue, all those things, they were basically
4 comparing 16 million to where they were today.
5 And what I'm trying to do here is say, okay,
6 let's compare where Trident is today to where
7 they will be in the future with the development
8 of these new facilities.

9 Q: Okay. And before we walk through some of the
10 numbers, if the Roper St. Francis at Carnes
11 Crossroads hospital redirects enough patients
12 to fill the hospital, just redirects them, I
13 know you didn't propose that, I'm just
14 suggesting, would there be any impact at all on
15 Trident Health System?

16 A: There would be zero impact on Trident Health
17 System.

18 Q: Okay. Now, let's look at some of your analysis
19 and just kind of walk the court through the
20 four things that you have here and what your
21 data shows.

22 A: Sure. Section one basically identifies the
23 fact that Trident Berkeley Medical Center is
24 forecasting 2,998 discharges in their third
25 year of operation. That translates to about a

1 69 percent occupancy which is about where
2 Trident capped their forecasts.

3 Q: Okay. So that's the Moncks Corner Hospital
4 projection, right?

5 A: That is correct.

6 Q: So the Moncks Corner Hospital projects that it
7 will have almost 3,000 patients in 2017?

8 A: That's correct. And the assumption in the
9 application is that all those will be
10 redirected from the Trident Health System.

11 Q: Right. Because the assumption in the
12 application is zero growth -- I mean, I'm
13 sorry, zero from other providers.

14 A: That's correct.

15 Q: So all the patients that currently go to MUSC
16 -- would they attract any patients in that
17 total or patients who would otherwise go to
18 Roper St. Francis, MUSC or any other provider?

19 A: The assumption here is that there would be zero
20 patients from other providers that would be
21 served at this facility. I don't think that
22 will happen. I think Trident will redirect a
23 vast majority of their patients. Is it going
24 to be a hundred percent? No.

25 Q: Okay. But they're projecting the hundred

1 percent redirection, so 2,998. All right.

2 Look at number two.

3 A: Number two identifies what Trident basically is
4 showing in terms of the Trident Health System
5 total volume growth, and they are forecasting
6 from 2010 to 2017.

7 Q: Okay. So what are you showing there?

8 A: I'm showing there for non-tertiary volume
9 alone, so I'm still keeping the tertiary stuff
10 aside, that from the three county area, Trident
11 is forecasting that Trident Health System's
12 non-tertiary volume will grow by 3,770
13 discharges.

14 Q: Okay. So this is just Trident Health System,
15 not the whole county or not the whole area,
16 right?

17 A: This is Trident Health System in the three
18 county area. This is in -- in the planning
19 area the state sets, this is their total
20 volume.

21 Q: 3,770.

22 A: Yes.

23 Q: The growth from 2010 to 2017.

24 A: That is correct.

25 Q: And what's the next number, the 4,143?

1 THE COURT: Before you proceed, am I correct that
2 these numbers, for instance, this 3,770 are
3 Trident's numbers?

4 THE WITNESS: Yes, sir.

5 THE COURT: They're not some speculation on your
6 part; is that right?

7 MR. LONG: Well --

8 MR. SUMMER: Your Honor, it's forecasted to 2017.
9 It most certainly is speculation.

10 MR. LONG: Well, it's not speculation, Your Honor.
11 It's a forecast.

12 THE COURT: But they're numbers are advanced by your
13 client, right, Mr. Summer?

14 MR. SUMMER: They were prepared by this witness.

15 THE COURT: This exhibit was prepared by this
16 witness, but what about the 3,770 number, was
17 that not taken from something that Trident --

18 MR. LONG: Your Honor, the 17,560, which is the
19 total Trident -- Mr. Richardson, correct me,
20 is the total Trident Tri-county discharges; is
21 that right?

22 A: Correct. For 2010.

23 Q: For 2010?

24 A: Right. Yes.

25 Q: And that's the number we have, right?

1 A: Yes.

2 Q: So that's both Trident -- THS is both
3 hospitals?

4 A: Yes.

5 Q: Okay. And so the total discharges at the two
6 hospitals is 17,560.

7 A: That's correct.

8 **THE COURT:** But where did that number come from is
9 what I'm asking you.

10 **MR. LONG:** It comes from the data, Your Honor, that
11 we have in the case.

12 **MR. SUMMER:** We would not dispute the 2010 number,
13 Your Honor.

14 **THE COURT:** All right. Thank you.

15 Q: And so the 2010 number is an actual number.

16 A: Right.

17 Q: Okay. So what's the 2017 number?

18 A: The 2017 number is a forecast of where the
19 Trident business will be in the future. I do
20 want to raise one issue. It says apply a 2.25
21 percent CARG, and I apologize. That is
22 actually 2.52 percent and it should be CAGR,
23 compound average growth rate. And what that is
24 is that you add -- every year you add 2.5
25 percent of that, so it's compounding like you

1 do with interest instead of straightforward.
2 And that 2.52 percent came from Trident's
3 forecast model that forecasted a 2.52 percent
4 per year admission growth through the time
5 frame.

6 Q: And that came from Trident?

7 A: The growth rate did. I calculated this number,
8 but the growth rate did.

9 Q: All right. So the difference between those two
10 numbers is what?

11 A: Is 3,770 discharges.

12 Q: Okay.

13 **THE COURT:** Just let me say that I now understand
14 that the last three numbers in the column
15 beginning with 21,330 and those below it are
16 estimates or speculative. Thank you.

17 A: And the ones that I did, I made those
18 calculations. These are not taken directly
19 from Mr. Baehr's.

20 **THE COURT:** That's what I wanted to hear. Thank
21 you.

22 Q: And then the next number, 4,143, is a little
23 higher than the 3,770. So what does that
24 number represent?

25 A: Well, that gives effect -- Trident serves about

1 nine percent of its total patients are
2 residents from counties beyond the three county
3 area.

4 Q: Okay.

5 A: If you look at -- we saw before some of the
6 State Office of Research and Statistics
7 information. That actually presents actual
8 data that shows where Trident's business comes
9 from. And nine percent of Trident's business
10 comes beyond the three county area.

11 Q: Okay.

12 A: And so what I've done then is that I basically
13 marked up the 3,770 discharges from the three
14 county area to what I would expect the growth
15 to be in the three county area and beyond.

16 Q: And let's go down to -- so that number is what?

17 A: The total, including the out of area volume, is
18 4,143 discharges.

19 Q: Okay. So those are actual patients?

20 A: Patients.

21 Q: Those are patients. Let's look at section
22 three.

23 A: Go back one time in terms of I think it's
24 important to note that I believe Trident's
25 volume will increase beyond this --

1 Q: Okay.

2 A: -- because of the tertiary and specialty stuff.
3 In some of the analyses I've seen, Trident/Mr.
4 Baehr assumed about 13 percent of their
5 business is tertiary. So what I would do in
6 terms of looking at the whole volume growth of
7 Trident Medical Center, I would need to again
8 increase the 4,143 patients to include growth
9 in the tertiary work too. That's not shown
10 here, but it's at least ten percent more volume
11 in the tertiary. I think it's probably higher,
12 but there's at least ten percent more. So if
13 you add the tertiary side in there, you'd add
14 approximately another 400 patients in terms of
15 that. But 4,143 total all served everywhere
16 volume growth, non-tertiary, probably around
17 4,500 in terms of total.

18 Q: Okay. Let's look at number three.

19 A: What I've tried to do here in number three
20 really is to try to give what I think will
21 really happen. And number three really follows
22 the assumptions that we have in the CON
23 application. What I have here in the updated
24 CON information, there is the expectation that
25 Roper St. Francis would serve 1,229 Berkeley

1 discharges that would be redirected from other
2 providers. So we have approximately half being
3 redirected from ourselves and half being
4 redirected from other providers. If, in fact
5 -- then you need to try to figure out what
6 portion of that would Trident likely have
7 patients shifted from. Because the 1,229 --

8 Q: Slow down for a second. This 1,229 is not the
9 redirected patients that are the Roper St.
10 Francis patients, right?

11 A: The 1,229 are the patients that are expected to
12 come not from Roper St. Francis but from the
13 rest of the market.

14 Q: Okay.

15 A: And right now those patients basically are a
16 mix of Trident, MUSC and other folks.

17 Q: Okay.

18 A: But if you compare the non Roper St. Francis
19 book of business and you look in terms of what
20 portion of that Trident treats or what their
21 market share is in that remaining portion, it's
22 approximately 73 percent. So of the work that
23 Roper St. Francis doesn't do, Trident gets
24 about 73 percent of it. So the assumption that
25 I would make and I think is reasonable is apply

1 that 73 percent to the patients that would be
2 served at the new Roper St. Francis Carnes
3 Crossroads facility.

4 Q: Uh-huh.

5 A: So 73 percent of 1,229 equals that 897 that's
6 shown there.

7 Q: Okay. So you're projecting about 3,000
8 patients total at the Carnes Crossroads
9 facility, right?

10 A: Correct.

11 Q: And this 897 would be the Trident portion of
12 that?

13 A: The patients that would otherwise be served at
14 Trident if Roper St. Francis Carnes Crossroads
15 was not developed.

16 Q: Okay. Take a look at the -- what's the 2,998
17 number represent?

18 A: The 2,998 number is the volume of cases that
19 Trident says it will shift from mothership to
20 the new satellite facility. So that's the
21 volume that Trident will shift over to the new
22 Moncks Corner facility. You add those two
23 together, you get a total of 3,895 --

24 Q: Okay.

25 A: -- cases that would be shifted from Trident to

1 both Roper St. Francis Carnes Crossroads as
2 well as Trident Hospital.

3 Q: And how much is the growth? And let's put two
4 and three together, if we can.

5 A: Yeah. The growth that you see there is at
6 least 4,000 discharge growth.

7 Q: Uh-huh.

8 A: Likely more than that if you go ahead and you
9 add the non-tertiary work to it.

10 Q: So you're most likely scenario, what do you
11 conclude is the actual number of lost cases for
12 Trident from the hospital being constructed at
13 Carnes Crossroads and a hospital being
14 constructed in Moncks Corner?

15 A: My conclusion is is that Trident Health System
16 will have more volume in 2017 than it does
17 today even with the establishment of both
18 facilities.

19 Q: Okay. And if the lost cases here is zero, is
20 there any adverse impact from that?

21 A: I don't think there is because in terms of the
22 -- basically in terms of -- again, we've been
23 comparing the big bucket, the \$16 million that
24 Mr. Baehr says is the loss of revenue, to how
25 Trident is doing today. Well, the reality is

1 is that I expect Trident to have more volume
2 into the future than they do today even with
3 the establishment of these two facilities. So,
4 you know, might they have been able to make
5 more money? Yes. But in terms of are they
6 whole from where they are today? And they're
7 real healthy today, but are they whole where
8 they are today? The answer is yes.

9 Q: Okay. Did you also look at this from what you
10 characterize at the bottom of the page as the
11 worst case scenario?

12 A: Yes, I did.

13 Q: And what's different about the worst case
14 scenario compared to the likely scenario?

15 A: The worst case scenario assumes that --

16 Q: First, who is it worst case for?

17 A: Worst case, worst adverse impact to Trident
18 Health System.

19 Q: Okay.

20 A: And what this basically assumes is that of the
21 1,229 patients that Roper expects to get, those
22 are not the Roper St. Francis redirected,
23 that's the other side, that all of those would
24 come out of Trident's side. So rather than
25 assume that 73 percent of them would be shifted

1 from Trident, all of them would come from
2 Trident's side. You add that 1,229 to the
3 volume that's going to be shifted from Trident
4 to the new Moncks Corner, brand new Moncks
5 Corner facility, that's a total of 4,227
6 discharges or cases that would be lost. If you
7 compare that to just the non-tertiary growth
8 anticipated by Trident Health System, it means
9 that Trident would lose 84 cases. If you
10 compare that total loss of 4,227 to the
11 expected non-tertiary and tertiary volume
12 growth, again there would be zero lost cases.

13 Q: If you did not factor in the hospital in Moncks
14 Corner and you just looked at Carnes
15 Crossroads' impact on Trident Medical Center
16 and Summerville Medical Center without
17 considering the HCA Trident Health System
18 projects, what conclusions do you draw about
19 adverse impact under that scenario?

20 A: Very simple, very black and white. If you
21 don't develop the Trident Moncks Corner
22 facility and you just develop the Roper St.
23 Francis Carnes Crossroads facility, the cases
24 that would be shifted to the Roper St. Francis
25 Carnes Crossroads facility are well less than

1 the forecast growth anticipated by Trident
2 Health System. So whereas on this worst case
3 scenario it's about a wash, if you're just
4 looking at the Roper St. Francis Carnes
5 Crossroads facility establishment, I guess
6 black and white based on these forecasts that
7 Trident Health System will have more volume
8 into the future than they do now. You know, if
9 they're healthy now financially, they'll be
10 healthy down into the future.

11 Q: All right. Let's look at what Mr. Baehr did in
12 regards to his adverse impact analysis. We'll
13 put it up on the screen. And I'm going to go
14 ahead and hand you Petitioner's 46, pages 1621,
15 22, 23 -- 1623 and 1624. I don't have a book
16 for that so I'll just hand you these sheets
17 here.

18 A: Thank you.

19 Q: Okay. Can you kind of call out the page number
20 on the sheets and kind of walk through what you
21 think is important in regards to Mr. Baehr's
22 calculations on these four pages in his
23 exhibit.

24 A: Sure. At 1621, this is a forecast by Trident
25 Health System by Mr. Baehr in terms of what

1 would be the Trident Health System growth out
2 to 2017 assuming no market share change. This
3 basically is the market shares --

4 Q: That's the fourth area? Can you call out for
5 her so she can blow it up for everybody what
6 the title is? Is it Forecast Growth in Trident
7 System Utilization? Is that what you were --

8 A: No. I'm calling out the title on it. Says
9 Assuming No Increase in Trident Market Share.
10 I'm starting with that.

11 Q: Okay.

12 A: And then if you go to the third block, yes. Go
13 down one more, please.

14 Q: Okay.

15 A: Okay. This is a block titled Forecasted Growth
16 in Trident System Utilization. And this
17 basically says from the three county area what
18 will be the Trident Health System growth. This
19 is again Mr. Baehr. From 2010 to 2017 this
20 shows that Trident Health System itself
21 anticipates that its volume will grow by 50.9
22 average daily census.

23 Q: Okay. So it would be 50 more patients per day?

24 A: On average per day.

25 Q: Just for Trident Health System?

1 A: That is correct.

2 Q: Okay. In 2017 than there is in 2010?

3 A: Yes.

4 Q: We have the actual numbers for 2010, right?
5 You did that comparison, right? Just answering
6 the judge's question earlier.

7 A: Yes. Yes.

8 Q: All right. So this is Mr. Baehr's forecast?

9 A: Yeah. This -- I don't touch this. This is
10 basically -- this was what -- information
11 published by Mr. Baehr.

12 Q: Okay. So 50.9 patients per day.

13 A: Correct.

14 Q: Okay. And why is that important to or where do
15 we go next to look at this?

16 A: First of, again, the qualifier, this is just
17 non-tertiary. So the expectation is is that
18 Trident Health System would have more growth
19 than this. But the 50.9 is just non-tertiary,
20 non-specialty bucket of care that will be
21 provided by the hospital.

22 Q: Okay. And when you look at the total on the
23 other sheet where you did the calculation, you
24 calculate I think 897 patients that would be
25 the maximum Trident -- or the total Trident

1 redirected patients without considering growth,
2 897; is that right?

3 A: Let's see.

4 Q: Respondent's 70.

5 A: My best estimate is that 897 of the total
6 redirected patients from other providers would
7 come from Trident Health System.

8 Q: And what is the ADC of that?

9 A: 897 patients, assuming a 4.2 length of stay,
10 would be 3,767 patient days or an average daily
11 census of ten.

12 Q: Okay. So ten patients that might otherwise go
13 to Trident Health System would go to Carnes
14 Crossroads per day?

15 A: That is correct.

16 Q: And they're going to grow by how many patients
17 per day between 2010 and 2017, just Trident
18 Health System?

19 A: 50.9. So basically what you -- and what you
20 see there is that based on Trident's forecast
21 themselves, they'll have a 40 average daily
22 census increase in 2017 versus where they are
23 today with the development of the Roper St.
24 Francis Carnes Crossroads facility.

25 Q: Even with the hospital being open?

1 A: Even with the hospital being open.

2 Q: Okay. What else is in the pages that you think
3 is important?

4 A: The next page, which is 1622, presents a very
5 similar analysis, but it's basically an
6 analysis that is published prepared by Mr.
7 Baehr that shows the assumption that the
8 Berkeley County market share would increase by
9 three percent by 2017.

10 Q: Okay. And what is that based on based on your
11 review of the record in this case?

12 A: It appears to be based on the assumption that
13 both the Trident Moncks Corner facility and the
14 Summerville facility would be established.

15 Q: And in the Summerville CON application for the
16 30 beds, what did Trident assume in regards to
17 its increase in market share?

18 A: I believe this reflects the anticipated market
19 share.

20 Q: Okay. So what does this show?

21 A: Again, it's a very similar analysis when you go
22 down to that fourth block. This is titled
23 Forecast Growth and Trident System Utilization
24 for the various counties and that's subtotaed
25 for the Tri-county area. This shows a forecast.

1 growth of 56.4 average daily census for Trident
2 Health System, and again, once again, that is
3 non-tertiary only. If you add in tertiary, I
4 would expect it to be higher than that.

5 Q: Okay. So 56 new patients per day?

6 A: Correct.

7 Q: Okay. What about pages 1623 and 24?

8 A: I find these, 1623 and 1624, instructive. This
9 is an analysis that I heard Mr. Baehr talk
10 about in terms of what he would expect as
11 adverse impact from Roper St. Francis on the
12 Trident System. And he also has an adverse
13 impact of what he would expect would be the,
14 sort of the shift of patients or the shift of
15 care from Trident Health System to the new
16 Trident Moncks Corner facility. So he did an
17 assessment in terms of what he thought would be
18 the impact of the new Roper St. Francis
19 facility as well as the new Trident Moncks
20 Corner facility on Trident Health System. So
21 sort of the before and after of that. What
22 this shows, the first page of this, which is
23 1623, if you go down to the bottom towards
24 there, what it states is the impact of Roper
25 St. Francis Berkeley required Berkeley County

1 utilization on Trident Medical System. So this
2 basically is a forecast by Mr. Baehr of how
3 many patient days -- and these are patient
4 days, not discharges, so we're back to patient
5 day level -- the forecast of Mr. Baehr, that's
6 6,257 patient days would be shifted from
7 Trident Health System to Roper St. Francis
8 Carnes Crossroad if it were opened. If you
9 translate that 6,257 patient days, that's an
10 average daily census of 17. Comparing the
11 shift of 17 patients to Roper St. Francis
12 Carnes Crossroads to either the 50 or the 56
13 average daily census growth forecast by Mr.
14 Baehr, black and white shows that Trident
15 Health System will have more volume into the
16 future in 2017 even with the establishment of
17 Roper St. Francis Carnes Crossroad.

18 Q: Well, what's your reaction to the idea that
19 there would be 17 patients per days transferred
20 from Trident to Carnes Crossroads?

21 A: I don't think that's -- I think that's too
22 high. That's what Mr. Baehr forecast, he
23 thought was correct. But I think my analysis
24 is more reasonable.

25 Q: Why is that? What is Mr. Baehr not doing or

1 doing that you think would cause his number to
2 be too high?

3 A: Basically what you have there is that the -- if
4 you go further down in that same block, Mr.
5 Baehr assumes that 2,909 patient days would be
6 shifted from the Roper system. And what that
7 is, if you compare the days he expects to be
8 shifted from the Roper system to the actual
9 number of total Roper volume, so if I compare
10 the 2,909 patient days that Mr. Baehr says will
11 be shifted from the Roper system to the new
12 Roper St. Francis Carnes Crossroads facility,
13 what that basically is is that is -- that's
14 only 25 percent. The resulting conclusion is
15 that Mr. Baehr expects that only 25 percent of
16 the Roper St. Francis volume will be
17 redirectioned from Roper St. Francis patients,
18 which I think is incorrect. He's basically
19 assumed that there will be no allegiance or
20 there will be no consistency in terms of the
21 patients that will be served to their existing
22 ties to Roper St. Francis or Roper St. Francis
23 physicians or Roper St. Francis emergency
24 departments.

25 Q: Well, is he assuming that there will be any

1 change in the patterns of the patients in
2 Berkeley?

3 A: None at all. None at all.

4 Q: So all these thousands of people that are
5 driving to peninsula and West Ashley, what's he
6 assuming that they're going to do?

7 A: He's assuming that that flow will stay static
8 and that the development of the new hospital
9 will do nothing to keep Roper St. Francis
10 aligned with docs, using the ED patients, will
11 do nothing to change the level of folks that
12 will stay in county and use the new facility.

13 Q: How likely do you think it is that all of these
14 patients will drive all the way down to the
15 peninsula from Berkeley County an ride by this
16 new hospital?

17 A: I think my assumption that one out of two
18 patients would stay local I think is
19 reasonable.

20 Q: And what did Trident assume in regards to its
21 -- about its redirection in its application?

22 A: Trident assumed, if you remember the maps, the
23 area up north and around the lake, so Moncks
24 Corner and the area up around the lake, Trident
25 assumed that 50 percent of their patients would

1 shift and go to the Moncks Corner facility
2 instead of going to Trident or Summerville. So
3 the geography that Trident used, the geography
4 that's closer to the new facility, they assume
5 that 50 percent would be redirected or would
6 choose to use the new facility instead of going
7 on down to Summerville or North Charleston,
8 just as we do. I think those numbers are
9 probably correct and may be light.

10 **THE COURT:** May be what?

11 **THE WITNESS:** Light.

12 **THE COURT:** Light?

13 **THE WITNESS:** Small.

14 Q: Well, can you comment for the court on how the
15 sizes of these hospitals, the 50 bed hospitals,
16 and how that relates to Trident's contention
17 that it will be adversely impacted by the
18 Carnes Crossroads hospital?

19 A: Basically we've discussed this. This is a 50
20 bed hospital. This will not be a -- it's a
21 small number of beds and will not be a full
22 overlap of the services that are available at
23 Trident Medical Center and even over to
24 Summerville Medical Center. So this will be a
25 small development working just on that non-

1 tertiary piece of the business, which again
2 leads me to believe that while there may be
3 some constraint in terms of future growth and
4 future profit enhancement, my expectation is
5 that Trident will make as much money as they
6 are today out into the future and that their
7 volumes will increase.

8 Q: And the project, the construction of this
9 hospital at Carnes Crossroads as set out in the
10 application and what you've heard in the
11 testimony, is designed for Roper St. Francis to
12 do what? What is it designed to do?

13 A: Basically to provide a local proximate better
14 access to the Roper St. Francis patients, for
15 the Berkeley County residents that are now
16 deciding to drive to either Roper Hospital St.
17 Francis or go to Mount Pleasant.

18 Q: And is that an adverse impact on the Trident
19 Health System to serve the Roper St. Francis
20 patients?

21 A: In terms of serving just their own patients?

22 Q: Just the focus of the project.

23 A: No, it's not. Even if you looked in terms of
24 the way the anticipated volume was split in
25 terms of some being redirection and some being

1 shifted in market share, I think it's clear
2 that a small 50 bed hospital -- we talked about
3 a ten percent market share increase, but that's
4 actually 7.7 percentage points. So it's not --
5 this is not a major market upheaval. And, as
6 a result, I think that the new proposed Moncks
7 Corner facility will have minimum impact. I
8 think they've shown here in terms of Trident's
9 own forecast that they'll be doing much better
10 in the future even with -- than they are today
11 even with the establishment of this facility.

12 Q: Okay. In your opinion, will the construction
13 of the hospital at Carnes Crossroads have a
14 material adverse impact on Trident Medical
15 Center or Summerville Medical Center?

16 A: I don't think it will and, even going further
17 to the next page of Mr. Baehr's exhibit --

18 Q: Right.

19 A: -- even if you add in the impact on Trident
20 Medical Center from its new proposed facility,
21 on 1624 Mr. Baehr makes the assumption or makes
22 -- has the resulting calculation, that 6,013
23 patient days would be shifted to the new Moncks
24 Corner, Trident Moncks Corner facility with the
25 establishment of that. So even if you add both

1 -- if you add both adverse impacts on Trident,
2 if you add the adverse impact that Mr. Baehr
3 has set as estimated or forecast for as a
4 result of the St. Francis Carnes Crossroad
5 facility, that is 6,257 patient days, and add
6 to that the 6,013 patient days that he expects
7 will be the impact of the new Trident facility
8 moving the patient volume from one to the
9 other, that's a total of 12,270 patient days.
10 Average daily census of 33. You have to
11 compare that. Mr. Baehr forecast that the
12 Trident Health System will grow by either 50 or
13 56 average daily census. So, once again, out
14 to the future, I think this analysis clearly
15 shows that Trident Health System will have more
16 volume into the future than they do today even
17 with the establishment of one -- of either one
18 or both.

19 **MR. LONG:** Your Honor, at this time, I maybe have 30
20 more minutes or so. But it's 1:30, so I
21 appreciate the court's indulgence on that
22 section of the direct, but I think I probably
23 have about a half an hour more or 45 minutes.
24 But maybe we should break for lunch.

25 **THE COURT:** Let's recess until 3:00.

1 (Off the Record from 1:30 p.m. until 3:00 p.m.)

2 THE COURT: Back on the record, please, ma'am. Mr.
3 Long.

4 MR. LONG: Thank you, Your Honor.

5 Q: Mr. Richardson, a couple of things I want to do
6 before we take our last couple of topics.
7 Going back to some of the information you have
8 reviewed in the preparation of the certificate
9 of need application, let me show you Joint
10 Exhibit 11. This is JAR information for -- I
11 don't know which one this one is.

12 A: It's Trident 2007.

13 Q: Trident Medical Center 2007. Is this -- what's
14 a JAR?

15 A: It's a joint annual report. It's the annual
16 sort of data submission that all various -- all
17 hospitals specifically send into the state
18 outlining their volumes, capacities, services
19 and those type things.

20 Q: Is this the kind of document you reviewed to
21 help prepare the CON application?

22 A: Yes, it is and it was.

23 Q: Okay. And let's look at Joint Exhibit 12.
24 This is the one for Summerville Medical Center
25 I believe, right?

- 1 A: Yes, for 2007.
- 2 Q: Same thing?
- 3 A: Yes.
- 4 Q: Joint annual report?
- 5 A: Yes.
- 6 Q: Would you have also reviewed this?
- 7 A: Yes.
- 8 Q: Okay. And just for the record, these are
- 9 actually JARs. You would have looked at like
- 10 '07, but these JARs actually run all the way
- 11 through 2010 in the exhibit.
- 12 A: Right. And I believe I also looked back at
- 13 2006 as well. So it would have been prior as
- 14 well.
- 15 Q: And let's take a look at Respondent's Exhibit
- 16 45. Is this information that you would have
- 17 reviewed to help prepare the CON application?
- 18 Well, this is 2010 information, but is the
- 19 information you rely on for your opinions
- 20 today?
- 21 A: Yes.
- 22 Q: Market share data for Berkeley County?
- 23 A: Yes. This shows the Roper system market
- 24 shares.
- 25 Q: For Roper St. Francis, right?

1 A: That is correct. Yes, the Roper St. Francis
2 system.

3 Q: Okay. And let's look at Respondent's Exhibit
4 52. Can you tell me what this data represents?

5 A: This data shows the non-tertiary volume served
6 at Roper St. Francis Hospitals from Berkeley
7 County and then also gives a total in terms of
8 the total patients, inpatients served.

9 Q: And so this shows the 3,463 inpatients to Roper
10 St. Francis in 2010?

11 A: That is correct.

12 Q: From Berkeley County alone?

13 A: That is correct.

14 Q: And let's look at Respondent's Exhibit 53. Can
15 you tell the court what this information is and
16 whether you would have reviewed information
17 similar to this?

18 A: Yes. This is information that documents or
19 arrays the Berkeley County patient -- or, in
20 other words, what zip codes Roper St. Francis
21 patients came from within Berkeley County. It
22 looks like it's for 2010 calendar year and then
23 partial year 2011.

24 Q: Okay. And Respondent's Exhibit 82.

25 A: This is titled Moncks Corner --

1 Q: I think actually -- I apologize. I think we've
2 already -- I've already questioned you about
3 this one. I apologize. I already questioned
4 you about this one. This one is already in
5 evidence. These are the Moncks Corner
6 discharges that you testified this morning --

7 A: Yes.

8 Q: -- for the Moncks Corner ED. All right. Let's
9 talk now about the Mount Pleasant, the Roper
10 St. Francis Mount Pleasant certificate of need
11 application. Did you work on that application?

12 A: Yes, I did.

13 Q: What was your role in regards to the
14 preparation of that CON application?

15 A: That one really was much more supportive.
16 Compare and contrast. The Roper St. Francis
17 Carnes Crossroads B11 was mine; I was driving
18 that. Mount Pleasant I was actively involved
19 in that but really working more with the
20 direction set by Mr. Bowling.

21 Q: Okay. And in the Mount Pleasant B11 analysis,
22 did you all use zip code analysis?

23 A: Yes. We were able to define by zip code the
24 Mount Pleasant specific zips.

25 Q: Why did you choose to use Mount Pleasant zip

1 code -- why did you choose to use a zip code
2 analysis for the Mount Pleasant CON and not for
3 the Berkeley Carnes Crossroads CON?

4 A: Basically you had the ability to define a
5 little more precise detail, so a small
6 definable and separate geography in terms of a
7 crossover there in Mount Pleasant. So it's
8 distinct and apart from the peninsula. And so
9 we were able to define a geography there to
10 give a reasonable estimate in terms of what may
11 happen. In that case, Charleston County would
12 not make sense in terms of what you had in
13 Mount Pleasant, and then --

14 Q: Right.

15 A: -- you had the rest of the peninsula and then
16 West Ashley and North Charleston. So that you
17 could not use a countywide analysis. You had
18 to use the Mount Pleasant, and that's what we
19 did.

20 Q: Okay. Well, that hospital is how many beds?

21 A: That hospital is 85 beds I believe.

22 Q: It's larger than this one?

23 A: Yes. More than half again as large.

24 Q: All right. And the analysis for Mount
25 Pleasant, how did -- what assumptions did you

1 make in regards to the redirection of Roper St.
2 Francis patients?

3 A: We assumed that it would be two-thirds of the
4 Roper St. Francis patients who would be
5 redirected to the new Roper Mount Pleasant
6 Hospital.

7 Q: And why did you assume two-thirds as opposed to
8 half, which you did in this case?

9 A: A lot of that was lead by the hospital driving
10 the two-thirds. But one of the real issues was
11 that the market share over in Mount Pleasant I
12 believe was around 35 plus percent or so, so a
13 good bit above where we had 23 percent, where
14 Roper St. Francis had 23 percent under Berkeley
15 County. In addition, when the CON was being
16 put together, there was just -- at that point
17 it was the start of getting some of the Roper
18 St. Francis doctors were actually operating
19 over there. They had set up offices, satellite
20 offices, and were active in that market place.
21 So a higher market share, already have
22 physicians practicing there. Thought that the
23 redirection would be at the two-thirds level.

24 Q: Okay. You've heard a lot of the testimony this
25 week about the Mount Pleasant utilization.

1 numbers for the first year of the hospital. Do
2 you have any opinion as to how important or
3 relevant those numbers are for the court's
4 determination in this case?

5 A: All my analyses really have gone to the third
6 year of operation. That's sort of the approach
7 that I take to establish what I expect will
8 happen. And I still feel confident that the
9 Roper Mount Pleasant facility can reach good
10 volume by their third year of operation. It
11 basically appears that the startup has been
12 slower than was expected. It doesn't bother
13 me. I don't put an awful lot of weight on the
14 first ten, 12 months of operation for that
15 facility. I think long term things will change
16 and they'll do well. I also look in terms of
17 the issue in terms of that hospital opened up
18 its first year of operation really within the
19 huge financial downturn. You know, bad timing
20 for Roper Mount Pleasant in terms of coming out
21 of the ground, coming into the market when
22 housing starts dropped, housing growth stopped,
23 it was declined, population wasn't growing as
24 it had before. It was the worst of all times
25 to start that hospital. And with that, you

1 know, they're doing okay. On the inpatient
2 side, they have not met targets. Outpatient
3 side they look to be pretty good. You know, in
4 spite of the situation and the environment
5 they're working in, they're okay and I still
6 feel confident that they'll come out good.

7 Q: Well, you heard Mr. Severance's testimony
8 yesterday that the outpatient redirection, in
9 his testimony, I think had been significant
10 from Roper Downtown out to Mount Pleasant,
11 outpatient.

12 A: He said that about a third of his Mount
13 Pleasant outpatient business had shifted to the
14 new facility.

15 Q: And is that instructive in your mind as to what
16 will happen in the future in regards to the
17 Mount Pleasant hospital?

18 A: I think it is. I think in terms of the
19 evolution, the outpatient shift is much easier
20 than the inpatient. So I think the fact that
21 there's been a third shift in just this first
22 year bodes well that I think the inpatient will
23 follow.

24 Q: Okay. Let's talk about two other issues.
25 Let's look at Respondent's Exhibit 104. And

1 earlier in your -- or before you were contacted
2 about this particular CON application, were you
3 asked to -- did the Roper St. Francis folks ask
4 you about looking at the feasibility of placing
5 beds in Berkeley County and Moncks Corner?

6 A: During the Mount Pleasant analysis -- 104?

7 Q: 104.

8 A: Respondent's or Petitioner's?

9 Q: I bet it's Petitioner's 104, I apologize.
10 Petitioner's 104. I think you may recognize
11 104. Do you remember this PowerPoint
12 yesterday?

13 A: I do.

14 Q: Okay. Turn over to the last two pages I think
15 if you would. Well, first, just looking at
16 this PowerPoint, Petitioner's 104, did you
17 prepare this document?

18 A: No.

19 Q: Let's go over to the page before that is --
20 okay, next page. I'm sorry. There we go. But
21 this is the bed need compare contrast --

22 A: That's correct.

23 Q: -- page in the PowerPoint?

24 A: Correct.

25 Q: Okay. Did you provide some input into these

1 numbers?

2 A: Likely would have provided the use rate, the
3 111 admits per thousand. The seven mile
4 population, that would have come from the
5 hospital. They were -- they had that ESRI
6 information that allowed them to do that.
7 Likely the use rate side, but beyond that, this
8 really -- I may have talked to Mr. Bowling
9 about this, but I did not construct this.

10 Q: Right. Well, looking at the analysis itself,
11 is that the way you would actually go about --
12 is that similar to what you did to calculate
13 the number of beds which you have in the bed
14 need with the calculation of patients and then
15 doing the percentages?

16 A: The overall macro approach in terms of
17 forecasting population and then determining how
18 many admits there would be is reasonable and is
19 what I would do. Seven mile radius, I think a
20 hospital will draw from beyond that, so I think
21 that's probably pretty light as it stands
22 there. And a 3.7 length of stay seems low.

23 Q: Okay. Why is that?

24 A: The Mount Pleasant project, when we put that
25 together, was about 4.5 or 4.6 anticipated

1 length of stay. We had 4.25 in the CON. I've
2 recast that to 4.2, which matches what Trident
3 had in their models. 3.7 just doesn't seem to
4 be right. It seems too low.

5 Q: If you increase the average length of stay from
6 3.7 to 4.2, would it have the effect of
7 increasing the occupancy or decreasing the
8 occupancy?

9 A: It would increase the forecasted average daily
10 census.

11 Q: For both population groups, right?

12 A: Yes.

13 Q: Okay. Let me ask you about the issue of
14 accessibility. Will the Roper St. Francis
15 project improve accessibility?

16 A: I think it will.

17 Q: Okay. Why do you think that?

18 A: I think it will improve accessibility for the
19 Roper St. Francis patients that now are
20 traveling beyond Berkeley County to obtain
21 Roper St. Francis care at either Roper or Mount
22 Pleasant or St. Francis.

23 Q: Okay. And is that an appropriate purpose for
24 a project, to improve accessibility?

25 A: I think it is appropriate to improve

1 accessibility. I think especially in the
2 situation where there's no new bed need but
3 basically it's just a repositioning of existing
4 assets.

5 Q: Okay. Now, do you have an opinion as to
6 whether the improved accessibility for the
7 Roper St. Francis patients is -- whether it
8 outweighs or is outweighed by any material
9 adverse impact on the Trident Health System?

10 A: First off, I don't think there's any material
11 adverse impact, as we went through before the
12 break. I think that Trident will have more
13 volume out into the future even with the Roper
14 St. Francis Carnes Crossroads facility. So,
15 you know, I don't think that there will be
16 material impact. But, if there were, I think
17 you would need to balance access enhancements
18 and improvements with adverse impact.

19 Q: Do you anticipate -- do you find that there is
20 or do you have an opinion that there is access
21 improvements?

22 A: I believe there are access improvements, yes.

23 Q: Do you have an opinion as to whether the Roper
24 St. Francis Hospital at Carnes Crossroads is an
25 unnecessary duplication of existing facilities

1 or services?

2 A: I think where it is a transfer of existing
3 capacity to better serve existing patients, I
4 do not think it's duplication.

5 Q: Now, do you have an opinion on whether this
6 project is financially feasible?

7 A: Based on what I've heard from Mr. Baehr and
8 from Mr. Knapp and from St. Francis CFO, it
9 would be my opinion that this is a -- that the
10 proposed project is financially feasible.

11 Q: And in your opinion as a healthcare planning
12 expert, do you agree with the Department that
13 the Roper St. Francis application is consistent
14 with the 2008-2009 State Health Plan?

15 A: Yes, I do.

16 Q: Do you think it's consistent with the CON Act
17 and its regulations?

18 A: Yes, I do.

19 Q: And in your opinion, was the Department's
20 decision in this matter in regards to the
21 applications being -- that the applications
22 were not competing; is that correct?

23 A: I believe it was correct.

24 Q: And your opinion was the Department's decision
25 to approve the Roper St. Francis CON

1 application for the hospital at Carnes
2 Crossroads, was that decision correct?

3 A: I believe that was correct as well.

4 Q: Okay. Thank you, Mr. Richardson.

5 MR. SUMMER: Give us a couple minutes just to change
6 over equipment, Your Honor.

7 THE COURT: Yes, sir.

8 MR. RICHARDSON - CROSS EXAMINATION BY MR. SUMMER:

9 Q: Mr. Richardson, how are you today?

10 A: Hello, Mr. Summer.

11 Q: I think that's the first time I've ever heard
12 you testify and you didn't open a State Health
13 Plan. Why don't we start easy and let's start
14 with things that we can agree upon.

15 A: Okay.

16 Q: You would agree that in states that have
17 certificates of need that the Plan is generally
18 the seminal document that you utilize in
19 providing advice to your clients?

20 A: It is one of the keys. It would be the State
21 Health Plan, state regulations and in some
22 locales there's actually local regional plans
23 too. But it's one of those, yes.

24 Q: You would agree me with as a health planner you
25 have to have a solid working knowledge of the

1 State Health Plan, correct?

2 A: It is important.

3 Q: Okay. And you also have to have a good
4 understanding of the healthcare regulations and
5 the statutes in a particular state as well,
6 correct?

7 A: That's important as well, yes.

8 Q: And you've testified on several occasions in
9 South Carolina; have you not?

10 A: Yes.

11 Q: And even more so, you've provided advice to
12 your various clients regarding certificate of
13 need issues in South Carolina for the better
14 part of two decades; have you not?

15 A: Sure.

16 Q: So you would consider yourself to be very
17 familiar and knowledgeable on the statutes,
18 regulations and the State Health Plan regarding
19 certificate of need in South Carolina?

20 A: Not to the extent that a lawyer may, but I'm
21 aware and conversant and know where they are.

22 Q: Would you agree with me that as a planner you
23 have to have a good command of those documents,
24 don't you?

25 A: You need to be aware of what they're saying and

1 where they're going.

2 Q: Because one of your jobs is to advise your
3 clients on how to comply with the certificate
4 of need law, correct?

5 A: Yes and no. The lawyers I work with tend to be
6 the ones that are guiding the clients in terms
7 of the precise issues.

8 Q: All right. Well, maybe we're not going to be
9 able to do easy stuff. Let's talk a little bit
10 about the types of engagements that you do.
11 You do a lot of market work with clients, don't
12 you, market analysis?

13 A: Some, yes.

14 Q: That includes sometimes dealing with
15 certificates of need, right?

16 A: Yes, sir. In states where it's regulated.

17 Q: You're often retained by clients to provide
18 them advice regarding certificate of need as it
19 pertains to their strategic planning, aren't
20 you?

21 A: If I'm involved in strategy with them, often
22 that's a topic that comes up, yes.

23 Q: And when you do that, you will refer to the
24 State Health Plan when you do?

25 A: Sure, wherever I am, yeah.

1 Q: Okay. And when you do that, you'll also refer
2 to state regulations regarding certificate of
3 need, correct?

4 A: Sure. When I'm working with folks, I'll make
5 sure I try to stay within those.

6 Q: Let's talk about some other things that we can
7 probably agree on. You've been present for the
8 entire trial; have you not?

9 A: Yes, I have.

10 Q: Thus far?

11 A: Thus far.

12 Q: Okay. And you've heard, I think, from a number
13 of witnesses regarding the history of the
14 Trident Health System, haven't you?

15 A: Yes.

16 Q: Okay. And you now know that Trident was
17 literally formed in collaboration with
18 Dorchester County, Berkeley County and DHEC?

19 A: I know that Trident was formed through the
20 ultimate closure of the two hospitals.

21 Q: Okay.

22 A: There was discussion that DHEC was involved.
23 I don't know that to be yes or no. But that
24 was a discussion.

25 Q: Well, you would agree with me there's been

1 testimony to that effect?

2 A: Yes. Yes, there has.

3 Q: I'm not asking you what you know of your own
4 personal knowledge. I'm just trying to see if
5 we can at least agree what's been said in the
6 courtroom for the last three weeks?

7 A: Yeah. What I heard in the courtroom was it
8 appeared there were two public hospitals, so
9 there was some sort of a public hospital board.
10 The two public hospitals closed. A new Trident
11 was established in North Charleston.

12 Q: Okay. And you would agree with me that the
13 Trident witnesses described Trident's mission;
14 did they not?

15 A: They have.

16 Q: Okay. And Trident's mission includes providing
17 services to both Dorchester and Berkeley
18 Counties, correct?

19 A: Yes, and I would say where it's located in
20 Charleston County, it's also Charleston County,
21 the northern parts of that.

22 Q: That's fair. That's a good place maybe for us
23 to start. Let's take a look at, if you'd go to
24 Respondent's 75, I'd like to go the very -- go
25 to the very last page, 75, 09. You've got a

1 copy of that?

2 A: I do. Which one of those are you at?

3 Q: The last page, 09.

4 A: Okay.

5 Q: Let's take a look at -- do you know where
6 Trident is located on this map?

7 A: I know that Trident would be in the, it's in
8 the northern portions of Charleston County, so
9 it would be up in that the neck sticking up
10 there.

11 Q: That little teeny neck right there, that's
12 where Trident is, isn't it?

13 A: I believe it is.

14 Q: Okay. In fact, it's in just the position --
15 really the epicenter of those three counties,
16 isn't it?

17 A: It's between the two counties. And, yeah, it's
18 on the southern portion of Berkeley and
19 Dorchester, but it's about in the middle.

20 Q: It's the epicenter of the three counties, isn't
21 it?

22 A: Not exactly but pretty close. It's in that
23 area.

24 Q: It's where the three counties meet?

25 A: The three counties, it's where the three

1 counties meet, yes.

2 Q: Okay. Now, we've talked a lot about -- we can
3 just leave this up for a while because we're
4 going to come back to that -- of things that we
5 can agree on. I think we can agree on this.
6 I'm going to talk a little bit about
7 prepositions. We can agree that there is not
8 physically located within Berkeley County a
9 hospital. There's not a hospital physically
10 located in the boundaries of Berkeley County.
11 Can we agree on that?

12 A: Yes, we can.

13 Q: But we can also agree, based upon the history
14 and the mission of the Trident Health System,
15 that it is a hospital for Berkeley County; is
16 it not?

17 A: I think it is a hospital for Berkeley County,
18 but it is not -- it should not be perceived as
19 the only hospital that will be for Berkeley
20 County.

21 Q: That's fair. Just as Roper services other
22 counties besides Charleston.

23 A: Sure, sure does.

24 Q: Same concept. So we can agree that there's not
25 one in, but there is certainly hospitals, two

1 hospitals, Trident Hospitals for Berkeley
2 County. And the other thing we have to think
3 about too is, is the State Health Plan and
4 planning regions. And I want to talk a little
5 bit about that with you, so let's go ahead and
6 grab the 2008-2009 Plan, which I believe is
7 Joint 4. It would be in that book. Sure would
8 be. You with me?

9 A: I am.

10 Q: We're going to be referring to this eventually,
11 so I'll go ahead and give you a copy. It's a
12 copy of 61-16 which is -- you've already read
13 from 61-16.

14 **THE COURT:** Did you say 61-160?

15 **MR. SUMMER:** Fifteen, sorry, Your Honor. Sixteen is
16 the licensure reg. I apologize. My error.

17 Q: Regulation 61-15, you've already talked the
18 definition section of that today. Before we
19 jump to the State Health Plan, let's just look
20 real quickly once again at purposes of health
21 planning and the CON Act in South Carolina and
22 that's Regulation 61-15 101. Do you see that?

23 A: Yes. It's the first paragraph in the
24 discussion.

25 Q: And this is the purpose of the Act. Would you

1 read that for me, please?

2 A: Sure. "The purpose of these regulations is to
3 promote cost containment, prevent unnecessary
4 duplication of healthcare facilities and
5 services, guide the establishment of health
6 facilities and services which will be best
7 serve public needs and ensure that high quality
8 services are provided in health facilities in
9 this state."

10 Q: And then the rest of 61-15 are basically the
11 rules, if you will, of healthcare planning in
12 South Carolina, right?

13 A: The rules of the regulation, the regulatory
14 review of projects, yes.

15 Q: Okay. Well, it also pertains to the
16 promulgation of a State Health Plan as well,
17 right?

18 A: Yes.

19 Q: Okay. All right. And so the State Health Plan
20 then in South Carolina is kind of your Rosetta
21 Stone, isn't it?

22 A: Again, it's not the only reference or point of
23 reference, but it is one, certainly.

24 Q: You didn't mention this until the last words of
25 your testimony, but if you look in 61-15,

1 section 801 -- excuse me, 802, need. See that
2 under number one?

3 A: 802(1), yes.

4 Q: And what does it say?

5 A: It says (1), need. "The proposal shall not be
6 approved unless it is compliance with the State
7 Health Plan."

8 Q: That is the threshold question of any review of
9 any certificate of need application in the
10 state of South Carolina, isn't it?

11 A: I agree.

12 Q: If it's not in compliance with the Plan, it
13 should be denied, correct?

14 A: I think that's the way that the agency does it,
15 yes.

16 Q: Okay. Now, the Plan itself is promulgated
17 pursuant to certain statutory requirements,
18 isn't it?

19 A: I believe so.

20 Q: You're familiar with the public comment period,
21 right?

22 A: I know there is one.

23 Q: Right. And you're familiar that's it reviewed
24 and approved by a State Health Planning
25 Committee, correct?

1 A: I know the State Health Planning Committee is
2 involved with the ultimate final product, yes.

3 Q: You were here for Mr. Shelton's testimony,
4 correct?

5 A: Yes.

6 Q: And you would agree with me that he is the
7 person at the agency in charge of promulgating
8 that State Health Plan; is he not?

9 A: I believe he is either the or the person in
10 charge of all that, correct.

11 Q: And we know that we have to have a Plan once
12 every two years, correct?

13 A: I believe that's what the guidance says, yes.

14 Q: And that we have to publish that Plan for
15 public comment, correct?

16 A: I know that it is published for comment, so I'm
17 assuming that that follows.

18 Q: And the Health Planning Committee then makes a
19 recommendation to the board for the final
20 approval of the Plan, correct?

21 A: I believe that is correct.

22 Q: So you would agree with me that there is a
23 formal process that is utilized in South
24 Carolina for the promulgation of the Plan?

25 A: It appears there is.

- 1 Q: Okay. When we look at the State Health Plan,
2 let's start our discussion, if you don't mind,
3 with -- if you could go back to the map we had
4 up. The map, this is Respondent's 75, page
5 nine. Let's go back to the Plan and look at
6 Roman Numeral II-18 and II-19. You would agree
7 with me that this is the Plan that Roper
8 applied for under its Carnes Crossroad
9 facility?
- 10 A: That's correct, and Trident filed under the
11 prior Plan.
- 12 Q: Trident filed under the prior Plan. But let's
13 just for simplicity purposes talk about our
14 Plan issues with one Plan, all right? And the
15 first thing I want to do is talk about how the
16 bed need is calculated. Now, there are two
17 factors in how bed need is calculated in South
18 Carolina, and those two factors are use rate
19 and population. Would you agree with me on
20 that?
- 21 A: Yes. It basically is the historical
22 utilization of a facility and then with an
23 expectation of how much will that grow.
- 24 Q: Right. And the assumption there is that
25 historical performance is an indication of

1 future performance, correct?

2 A: Yes. Everything is held constant in the
3 forecast except for population.

4 Q: Okay. So we were going to look at historically
5 how do these facilities utilize the assets that
6 they have, fair statement?

7 A: Yes, sir.

8 Q: Okay. So if we look at this Plan, we can see
9 that it starts off with the Trident facilities.
10 First of all, what is the planning region?

11 A: The planning region is the three county area of
12 Charleston, Dorchester and Berkeley County.

13 Q: Charleston, Dorchester and Berkeley County.
14 Let me go to, in terms of maps, why don't we
15 take a look at 75-A, the one right before it.
16 There's your planning region right there, isn't
17 it?

18 A: What Bates stamp is that?

19 Q: This is, I think this is Respondent's Number
20 75.

21 A: Okay. And --

22 Q: And it is number eight.

23 A: Does it have a Bates stamp on the bottom right?

24 Q: It's not Bates stamped. It would have a legend
25 on the top right-hand corner. It's one of

1 those exhibits we just didn't have Bates on.

2 A: I've got it, it appears to be Bates 4708.

3 Q: Okay. All right. So you see the three county
4 planning region right there and you see the
5 number of beds that are expressed there,
6 correct?

7 A: Yes.

8 Q: And what's the total number of beds?

9 A: 1,739.

10 Q: 1,739, okay. And you would agree with me that
11 Berkeley County residents utilize a large
12 number of those beds in various facilities
13 throughout the service area, correct?

14 A: To some extent, yes.

15 Q: Some extent. And the vast majority of the
16 Berkeley County residents that seek hospital
17 care are going to get it in that service area;
18 are they not?

19 A: Well, they are going to get it in the service
20 area, but in terms of are they going to use all
21 the beds and facilities, no. There's not a lot
22 of flow going on down to Mount Pleasant, for
23 example.

24 Q: That's correct. But they do have the access to
25 and utilization of the various facilities in

1 the service area, correct?

2 A: Yes.

3 Q: Now, while we're here, because we had all this
4 discussion about county, the county is not --
5 is not recognized by DHEC as the planning
6 region for this service for Carnes Crossroads,
7 is it?

8 A: No. That's correct. It's a three county
9 service area, which is why a transfer from one
10 county to another is allowed.

11 Q: You would agree with me that there are 1,739
12 beds in that service area?

13 A: Yes.

14 Q: You'd also agree with me that there are no toll
15 gates on Highway 52 that would impede people
16 from leaving Berkeley County and going .9 miles
17 over the county line to Trident Medical Center,
18 would you?

19 A: No toll gates or a fence.

20 Q: Okay. And that's a concept I want to talk
21 about because we can use it as an analogy here.
22 And because it's in the epicenter, you may or
23 may not know this, but Trident is actually less
24 than one mile from the Berkeley County line;
25 did you know that?

1 A: I knew it was relatively close. I wasn't sure
2 of the exact.

3 Q: Okay. Now, while we are on this notion of
4 boundaries and borders, and since we know there
5 are no armed guards and no toll gates that
6 prevent people from leaving the county and
7 utilizing hospitals, in a similar fashion, I
8 want to talk to you about this concept that
9 you've discussed about Roper only patients or
10 for that matter Trident only patients. But you
11 would agree with me that once a hospital is
12 built at Carnes Crossroads, Roper patients are
13 not going to be required to wear arm bands for
14 admission, are they?

15 A: No, they're not. The Roper patients that we
16 expect to have will be the Roper patients that
17 historically have decided to use Roper doctors
18 or facilities or ED and in the future you'd
19 expect the same to happen.

20 Q: Roper doesn't have -- issue membership cards,
21 does it?

22 A: I'm not aware they do.

23 Q: We don't expect them to show up with a card in
24 their pocket, right?

25 A: No.

1 Q: They don't have a Roper Rewards Program, do
2 they?

3 A: Not that I know of.

4 Q: And as a matter of fact, it's a bit of a
5 misnomer to infer and insinuate that if you're
6 a Roper patient you're always a Roper patient,
7 correct?

8 A: On a pure 100 percent positive will Roper
9 patients forever remain Roper patients?
10 There's no guarantee 100 could. But I think in
11 terms of where there has been pretty constant
12 market shares and a distinction in terms of the
13 medical staffs, I think it's reasonable to
14 expect the vast majority of Roper patients
15 would stay Roper patients and Trident patients
16 would stay Trident patients.

17 Q: You would agree that this is what I would refer
18 to as a mature urban area, the tri-county area
19 is relatively urban compared to the rest of
20 South Carolina, isn't it?

21 A: In the Charleston area it's relatively urban.
22 There is still pretty significant growth going
23 up into Berkeley County.

24 Q: Let's talk about patients and how they present.
25 A lot of times patients present at EDs, don't

1 they?

2 A: Yes.

3 Q: If I'm having an acute myocardial infarction,
4 am I going to get on the phone, call my family
5 practitioner, ask him what hospital did you
6 want me to show up at; EMS is going to take me
7 to the closest hospital that can take care of
8 you, isn't it?

9 A: If, in fact, it is a categorical, must go to
10 closest hospital, for example, a STEMI patient?

11 Q: Yes.

12 A: -- that would go to the closest one.

13 Q: Right.

14 A: If it's a patient that is not an automatic
15 going to the designated hospital, then
16 proximity and closeness comes into play, but
17 also patient preference I think comes into play
18 as well.

19 Q: True. But if I'm having, you know, if I have
20 an acute attack of appendicitis and I'm at work
21 in downtown Charleston, I could easily end up
22 Roper, but my doctor and my home could be in
23 Summerville.

24 A: Could.

25 Q: So the notion that these patients somehow are

1 programmed to use one hospital or another is
2 simply, I don't want to say it's a fiction, but
3 it is a construct, if you will, of the dialog
4 that we're having regarding where patients may
5 go

6 A: It is part of a construct of this dialog, but
7 it's based on the expectation that market
8 shares will stay pretty constant out into the
9 future, which I think that's pretty much
10 happened and I think it will continue to happen
11 in the future.

12 Q: Okay. All right. Let's go back to our State
13 Health Plan and let's talk a little bit about
14 how this is done. You would agree with me that
15 on Roman Numeral II-18, if we look there,
16 Trident Medical Center has basically a
17 historical use rate that is multiplied by a
18 population in the future to come up with a
19 positive bed need; is that a fair statement?

20 A: Yes, it basically is patient days from a
21 historical time frame expanded by expected
22 population growth.

23 Q: Okay. And you would agree with me that under
24 the Plan, the way that it is written, only
25 Trident Medical Center can apply for those 56

1 beds that are there, correct?

2 A: Yes.

3 Q: Okay. And we'll talk a little bit later about
4 why because there's some other parts of the
5 Plan we have to read in conjunction with this.
6 In similar fashion, Summerville's experience
7 that utilization of its assets creates a use
8 rate that we apply to a future population, here
9 it's a 2013 population, right?

10 A: Right.

11 Q: And that creates a positive bed need of 24,
12 correct?

13 A: Yes.

14 Q: All right. And you would agree with me that
15 Summerville can apply for those 24 beds, but no
16 one else in the service area can apply for
17 those beds, can they?

18 A: Sure. Like Trident Summerville can apply for
19 those beds if they think they need more
20 capacity.

21 Q: Correct. But those beds and that projection
22 belonged to Summerville, right?

23 A: Yeah. I don't believe you could have an
24 outside entity come in and say they have need,
25 therefore I want to build a new community

1 health systems hospital.

2 Q: Right. And neither could the Medical
3 University. The Medical University cannot lay
4 claim to those beds either, can they?

5 A: I don't believe so.

6 Q: Okay. Let's look down next at the Medical
7 University. Now, they've just built a bright
8 new shiny hospital in down -- over on the
9 peninsula. They have an excess of 65 beds,
10 right?

11 A: In this Plan, yes.

12 Q: Again, we look at the Medical University's
13 historical use rate and then we apply it to a
14 future population in 2013. That's our planning
15 horizon under this Plan, right, 2013?

16 A: That is correct.

17 Q: Okay. And that means that there's no need for
18 the Medical University to apply for beds
19 anywhere, correct?

20 A: Yes. To be compliant with the Plan, Medical
21 University cannot add additional bed capacity.

22 Q: Okay. We can say the same thing for Roper and
23 Roper St. Francis Mount Pleasant. They're
24 combined into one, but they have more beds than
25 they're currently using and their use rate does

1 not justify adding any new beds, correct?

2 A: I'm not sure about if they have more beds than
3 they currently are using, because I would
4 expect that they are using all that square
5 footage and a lot of that capacity, but they
6 cannot apply and be consistent with the Plan to
7 get more beds.

8 Q: And we're applying the same rules to Roper that
9 we are to everybody else in the service area;
10 are we not?

11 A: Sure. The Plan need shows no need at Roper.

12 Q: And basically the utilization of those assets
13 has not risen to a level where the state
14 projects need in the future, correct?

15 A: That's correct. Roper has not -- does not have
16 a forecasted volume that when applying a 75
17 percent occupancy standard it shows more beds.

18 Q: And again, just like MUSC cannot apply for
19 Trident's beds, Roper cannot apply for
20 Trident's beds, can it?

21 A: I don't believe they can.

22 Q: And if we look down at Bon Secours, they also
23 have a bed excess, correct?

24 A: Yes.

25 Q: And that is part of the Roper system, correct?

1 A: Yes.

2 Q: All right. And then East Cooper, they also

3 have a bed excess?

4 A: Yes.

5 Q: Now, this is important because we're going to

6 go look at some provisions in the Plan, but

7 there are excess beds for the whole region; are

8 there not?

9 A: They sum them up, yes.

10 Q: Right. And are there excess beds for the whole

11 region?

12 A: Yes.

13 Q: Okay. How many?

14 A: The printing's tough. It looks like 46.

15 Q: May be 48? See if my copy helps you any.

16 A: It is eight because it's nine minus one.

17 Q: Okay. Forty-eight excess beds.

18 A: Yes.

19 Q: That's basically one too many 50 bed hospitals,

20 isn't it?

21 A: Forty-eight excess beds, it's about a match.

22 Q: Okay. Let's go look now at the methodology

23 section of the Plan. If you would, turn back

24 with me and let's start over on -- the bed

25 section really starts on Roman Numeral II-4;

1 does it not?

2 A: It looks like general hospitals start II-4, sub
3 (a).

4 Q: Okay. Just for a point of clarification, this
5 is one of those things where I think we're
6 going to see more on this in the future, but a
7 hospital is defined as a place where there is
8 overnight care. Do you see that?

9 A: If you'd direct me to it?

10 Q: Definition section, 1(a). A hospital means a
11 facility organized and administered to provide
12 overnight medical or surgical care. Do you see
13 that?

14 A: Yes, as well as the wrap around of diagnostic
15 treatment facilities as well.

16 Q: Surely you can go to the hospital and get
17 outpatient treatment too?

18 A: Sure.

19 Q: Right. But the notion of overnight and if you
20 at it, hospital beds is then defined. The
21 reason I want to ask you this question, do you
22 remember the discussion that Mr. Severance had
23 about, well, my ADC is down. I think he said
24 it was 187. But on any given night I've got 20
25 observation patients.

1 A: Okay.

2 Q: There's nothing in the Plan that distinguishes
3 between your ADC for purposes of Medicare and
4 your ADC in terms of how many bodies are in the
5 hospital at 12:01 midnight, or 12:01 a.m.
6 There's nothing in the Plan that makes that
7 differentiation, is there?

8 A: I'm not sure there is, other than the bed need
9 volume is based on the JARS which are based on
10 inpatient volume and utilization.

11 Q: Correct.

12 A: I also go back too is that the -- I don't know
13 the specifics here in South Carolina, but there
14 are outpatient facilities that will have a
15 patient overnight as long as they're not kept
16 more than 24 hours.

17 Q: Yeah. The point in asking you this question
18 is, is that observation beds are really a
19 function of reimbursement, aren't they?

20 A: Folks won't get reimbursed for them. And
21 they're not categorically patients that are
22 included in licensed bed volume count.

23 Q: Well, there's nothing in the Plan that says we
24 won't count observation patients as being
25 inpatients, is there?

1 A: I think if you go to the JARS, I think there is
2 a definition of inpatients, which means is a
3 patient was admitted to an inpatient unit.

4 Q: Okay. Nevertheless, they're spending the night
5 in a hospital, aren't they?

6 A: They're spending a night in the hospital.
7 They're typically spending extended time from
8 like maybe 12 to 24 hours.

9 Q: Well, the horror stories are there's some
10 observation patients that are there for four
11 and five nights with no reimbursement?

12 A: Which I hope never happens, but it does. The
13 majority of them are not 24 hour stays. The
14 majority of them are, I think an example was
15 example was a cardiac rule-out. Now I've had
16 that done. Basically where you're held for
17 eight, ten hours.

18 Q: Let's turn over and go over to Roman Numeral
19 II-6, number four. We've had some reference to
20 this previously, but this is basically the
21 utilization threshold for projecting future
22 need, correct?

23 A: Yes. This is the guidance that the -- this is
24 what the state uses in performing their bed
25 need forecast.

1 Q: I think we've plowed this ground with numerous
2 witnesses. The methodology itself that you and
3 I've previously discussed in the inventory
4 section is over on Roman Number II-7(a) and
5 (b), correct?

6 A: A and B. And then the netting out of the need
7 and the existing follows, yes.

8 Q: And again, we have individual need and we have
9 area need, correct?

10 A: There is an individual need and then there's a
11 summation.

12 Q: Service area need? Or excess?

13 A: Yes, sir.

14 Q: Okay. And in the Tri-county area, and I'm
15 going to just refer to the Tri-county area as
16 being Berkeley, Dorchester and Charleston.

17 A: Sure.

18 Q: It's also know as the Trident, but we'll call
19 it the Tri-county area.

20 A: Okay.

21 Q: In the Tri-county area, there are only two
22 institutions with positive bed needs, right?

23 A: Yes. Both of them out of the historical common
24 core.

25 Q: Okay. Now let's look first at D.

1 MR. SUMMER: And can you put D up for me, please,
2 ma'am?
3 Q: Roman Numeral II-7(d).
4 A: Okay.
5 Q: All right. This talks about there being a
6 surplus of beds in the county, right?
7 A: Yes.
8 Q: It says if a county indicates a surplus of
9 beds, which is not the case in the Tri-county
10 area, right?
11 A: If the county indicates a surplus of beds.
12 Q: But you will agree with me there's no surplus
13 in the Tri-county area, right?
14 A: I think you directed me to that. It looks like
15 there is a surplus.
16 Q: Excuse me, you're exactly right. All right.
17 If a county indicates a surplus of beds, then
18 no additional beds will be approved. Do you
19 see that?
20 A: Yes.
21 Q: Unless an individual hospital in the county
22 indicates a need for hospital -- for additional
23 beds?
24 A: Right.
25 Q: Okay. Should an individual hospital indicate

1 a need for additional beds, then a maximum of
2 the actual projected bed need or up to 50
3 additional beds may be approved, correct?

4 A: Right.

5 Q: Okay. And so that's in counties where there is
6 a surplus. Let's go to E.

7 A: Okay.

8 Q: The next section is E. If there is a need for
9 additional hospital beds in the county, then
10 any entity may apply to add these beds within
11 the county and any entity may be awarded the
12 CON for these beds. Do you see that?

13 A: Yes.

14 Q: So if we had a positive bed need in the Tri-
15 county area, instead of it being a negative 48,
16 if it was a positive 48, then Beaufort County
17 Memorial Hospital could come up and apply for
18 those beds; could they not?

19 A: They could apply to add additional beds to the
20 system, yes.

21 Q: In the service area?

22 A: Which is the three county area.

23 Q: Right.

24 A: But this opens the door for new bed capacity to
25 be added to the system.

1 Q: Correct. But you've got to have a positive bed
2 need to do it, right?

3 A: Yes, sir.

4 Q: And that positive bed need could be a handful
5 of beds and DHEC will let you apply for up to
6 50, correct?

7 A: Looks -- an exact reading here, if there's one,
8 you can get 50.

9 Q: Right. Okay. And the notion there is, is that
10 would allow other competitors like let's say
11 HMA out of Naples, Florida, they could come to
12 West Ashley and apply for 50 beds and put a
13 hospital up in West Ashley if they wanted to
14 apply, they could seek to get that permission,
15 correct?

16 A: Yeah. It appears that if there's area need,
17 they could be assessed in terms of does it make
18 sense further.

19 Q: Okay. You would agree with me that E doesn't
20 apply because we don't have a bed need for the
21 planning region, do we?

22 A: I would agree that E, allowing additional bed
23 capacity to be added to the system, is not in
24 play here.

25 Q: Okay. Let's go over now to J and take a look

1 at J. I think you've been on both sides of
2 this fight before, haven't you?

3 A: Changes in the delivery system, yes.

4 Q: Yeah. J is known as the bed transfer section;
5 is it not?

6 A: Yes.

7 Q: Okay. Now, let's look at how that's written.
8 The first sentence is, "Changes in the delivery
9 system due to healthcare reform have resulted
10 in the consolidation of facilities and the
11 establishment of provider networks." Do you
12 see that language?

13 MR. LONG: Your Honor, I want to object to the line
14 of questioning that we're having. I made this
15 objection earlier in the case and Your Honor
16 had indicated I think he was reconsidering it.
17 But I don't think it's appropriate for Mr.
18 Summer to ask the experts what these provisions
19 mean. That's what's for Your Honor to decide
20 through statutory analysis. So to walk him
21 through a series of questions asking him what
22 do these words mean and what does that mean and
23 try to get him to opine on what the meaning of
24 the language is I think is irrelevant to Your
25 Honor's determination.

1 THE COURT: Well, I think that my ruling in the case
2 of Mr. Baehr, if I remember correctly, was that
3 he could give an opinion vis-a-vis his position
4 as a healthcare planner, but no further. And
5 so I sustain your objection except for that.

6 MR. LONG: Thank you, Your Honor.

7 Q: All right. I'm not asking you as a lawyer.
8 Asking a healthcare planner, okay. You are
9 familiar with this section; are you not?

10 A: Yes, sir.

11 Q: And you've been on both sides of this fight,
12 haven't you?

13 A: Not exactly. I've been on both sides of
14 transfer, but specifically different issues.
15 One is a transfer of need like Trident is doing
16 to a new site.

17 Q: Right.

18 A: And so very different from the issue in terms
19 of a transfer of existing capacity as we are
20 here today.

21 Q: Well, let's take a look at the language. And
22 you would agree with me that this refers to, as
23 a healthcare planner, you look at facilities as
24 being plural; do you not?

25 A: Consolidation of facilities. You can't

1 consolidate one.

2 Q: Right. You've got to have two.

3 A: To consolidate, yes. Correct.

4 Q: And these consolidations and agreements may
5 lead to situations where affiliated hospitals,
6 that's more than one, correct?

7 A: That's what it states here. I'll respond as a
8 planner though, hospitals to me is the newly
9 developed hospital and the one that's going to
10 be giving up volume and capacity.

11 Q: That's the DHEC Board's position; is it not?

12 A: I believe it is.

13 Q: But you would agree with me that the way that
14 this is written, the plain English language,
15 these consolidations and agreements may lead to
16 situations where affiliated hospitals, plural,
17 may wish to transfer beds between themselves.
18 Do you see that?

19 A: I do.

20 **MR. LONG:** Your Honor, can I ask you -- that's where
21 he's crossing the line. That's the question
22 that I think is objectionable. Because he just
23 said that's DHEC Board, he answered as a
24 planner and then he says what does it mean or
25 say.

1 **THE COURT:** Well, I'm considering his response only
2 as a healthcare planner, so I overrule the
3 objection. Let me say at this point that I
4 indicated, I think, after Mr. Baehr's testimony
5 that we would revisit that issue. I had the
6 court reporter print out that portion of the
7 testimony for me. I see no reason to go back
8 and rehash it as I am considering it not as a
9 legal opinion but only as a statement by a
10 healthcare planner in respect to what he -- how
11 he applies this in the healthcare planning
12 sense.

13 **MR. SUMMER:** Thank you, Your Honor, I appreciate it.

14 **MR. LONG:** Your Honor, then just for the ease of the
15 day, can my objection then be viewed as kind of
16 a running objection in regards to this, so we
17 don't -- as I understand what Your Honor is
18 saying that --

19 **THE COURT:** Yes.

20 **MR. LONG:** I'm probably going to object to some more
21 questions, but if it could just be a running
22 objection.

23 **THE COURT:** That's fine with me.

24 **MR. SUMMER:** And for the record, I note your
25 continuing objection

1 MR. LONG: Thank you.

2 Q: The court's indulgence. We have been passing
3 a cold around the courtroom for the last two
4 weeks and I'm starting to succumb to it. All
5 right. These consolidations and agreements may
6 lead to situations where affiliated hospitals,
7 that's plural, isn't it?

8 A: It is plural. Again, from a planning
9 perspective, that's the proposed and the
10 facility they'll be giving up. But it is
11 plural, which I think still fits.

12 Q: Okay. You agree with me the word proposed
13 doesn't fit. You don't see that word in there
14 anywhere, do you?

15 A: No, it doesn't say proposed. But in terms of
16 a -- if you're trying to do good for changes in
17 the delivery system, then basically from a
18 planning perspective you need to be
19 transferring assets, services to where they're
20 best used, and I think that a proposed facility
21 fits within this issue.

22 Q: From a public policy perspective, as a
23 healthcare planner, would you agree with me
24 that the Health Plan is drafted as a document
25 to provide the providers, okay, with guidance

1 on basically the development of a healthcare
2 delivery system in South Carolina?

3 A: I think the Plan, as used by the staff and the
4 board, all come into play in terms of providing
5 guidance. I agree with you with those three
6 pieces.

7 Q: And if the board intended for this to be used
8 for proposed facilities, all that would be
9 required is to amend it as such at the next
10 planning cycle, correct?

11 A: It could.

12 Q: But to this date, the board has not chosen to
13 do that, has it?

14 A: I do not believe they have and I don't know
15 why.

16 Q: Neither do I. All right. So now we're going
17 to look at a proposal to transfer or exchange
18 hospital beds requires a certificate of need
19 and must comply with the following criteria, if
20 you'll turn over to Roman Numeral II-10.

21 A: There.

22 Q: Okay. All right. Let's look at number two.
23 Such transfers may cross county lines; however,
24 the applicants must document with patient
25 origin data the historical utilization of the

1 receiving facility. Do you see that?

2 A: Yes.

3 Q: Okay. Receiving facility means that there is
4 a facility there to receive the beds, right?

5 A: I understand this as the receiving facility
6 would be the facility that would be established
7 with the transfer.

8 Q: Okay. Where does it say the proposed or to be
9 established facility? Do you see that language
10 in there anywhere?

11 A: I don't. I'm giving you the way that I read
12 this and I read the historical utilization is
13 what's been happening right now. For example,
14 in 2010 for Roper St. Francis patients in
15 Berkeley County that are now going down to
16 Roper St. Francis.

17 Q: All right. Let's flip over real quick to Roman
18 Numeral II-18 and II-19. Hold your spot
19 because we're coming back.

20 A: Got it.

21 Q: Okay. All right. In order to project a
22 positive bed need for Trident Medical Center,
23 okay --

24 A: Yeah.

25 Q: -- the Department had to look at historical

1 utilization to determine a use rate, correct?

2 A: That is correct.

3 Q: Okay. So we use historical utilization to
4 create a use rate and then we apply it to a
5 population, a projected population in the
6 future, and we get a positive bed need for
7 Trident Medical Center, right?

8 A: That's how it works, yes.

9 Q: Okay, great. And we've done that for MUSC and
10 the Roper Hospitals and the East Cooper and
11 Summerville. We've done it for everyone.
12 Where does it say here Carnes Crossroads? Do
13 you see Carnes Crossroads listed anywhere?

14 A: No. What I see basically is that the -- that
15 will be the to be established hospital that
16 will receive the beds. That will be the to be
17 established hospital that we've provided
18 historical utilization in terms of the patients
19 coming from Berkeley County that we expect to
20 serve. We then forecast it out to future
21 utilization.

22 Q: You basically transposed utilization from
23 Roper's downtown facility up to Carnes
24 Crossroads, correct?

25 A: Exactly. We have brought -- we have allowed

1 the patient utilization to be provided at the
2 home or the site of the patient.

3 Q: It's kind of interesting because if we look,
4 Roper has had insufficient utilization to
5 deserve any new beds, correct?

6 A: Yes, and Roper St. Francis is not applying for
7 new beds.

8 Q: But they've had insufficient utilization.
9 Their historical performance where they
10 physically are located doesn't give them any
11 new beds, correct?

12 A: Agreed.

13 Q: All right. Again, there is no provision here
14 that says there's been historical utilization
15 at the site, okay, of Carnes Crossroads. We
16 can agree on that?

17 A: I disagree. I think in the application there
18 was information that discussed in detail the
19 historical utilization from Carnes Crossroad
20 and Berkeley County residents within the Roper
21 St. Francis system.

22 Q: How many surgeries were performed at Carnes
23 Crossroads last week?

24 A: None.

25 Q: Zero, correct?

1 A: Correct.

2 Q: Okay. Each hospital that is listed here has a
3 physical address. It is a physical entity.
4 There are bricks, there are mortars, there are
5 doctors, there are nurses. Can we agree on
6 that?

7 A: In the bed need calculations, yes.

8 Q: Right. And the bed need is calculated upon the
9 utilization at each one of those physical
10 addresses, correct?

11 A: Sure.

12 Q: And you will agree with me that there is no
13 utilization at the physical address of the
14 Carnes Crossroads as we sit here today?

15 A: That's correct. Though there is full
16 definition and disclosure of the patients that
17 are now served at Roper St. Francis that are
18 anticipated to be served at that site
19 historically and forecast into the future.

20 Q: Basically what you're telling me is, is that
21 you are adopting the Department's
22 interpretation that this language contemplates
23 the creation of a new hospital.

24 A: I'm saying that I think that this Plan allows
25 and it's the state's actions and positions that

1 the transfer of beds does allow for the
2 creation of a new hospital, yes.

3 Q: Okay. Let's look at number five.

4 A: Got it.

5 Q: Got it?

6 A: Yeah.

7 Q: The facility receiving the beds must
8 demonstrate the need for the additional
9 capacity. Can you agree with me that at Carnes
10 Crossroads today there is no existing capacity,
11 is there?

12 A: Right. And the additional capacity is the 50
13 we're trying to establish.

14 Q: But you will agree with me that there is no
15 existing capacity there today, correct?

16 A: There are no bricks and mortar there today,
17 correct.

18 Q: And the facility receiving the beds, it doesn't
19 say a facility to be established in the future,
20 does it?

21 A: No, it doesn't say it's not that either.
22 That's the way that I read it.

23 Q: It doesn't say it's a proposed facility?

24 A: No, it doesn't say it's not a proposed
25 facility. And, again, the planning perspective

1 demonstrated the need for the additional
2 capacity. I think that the documentation of
3 historical and forecasted Roper St. Francis
4 volume from that area does demonstrate the need
5 for additional capacity based on historical and
6 projected utilization.

7 Q: Okay. While we're here, let's look at this
8 facility giving up the beds may not use the
9 loss of these beds as the justification for a
10 subsequent request for the approval of
11 additional beds. If you would look at Joint 2,
12 975, please? Do you recall this letter?

13 A: 975, Mr. Summer?

14 Q: Yes.

15 A: Let me get to it. I'm there.

16 Q: This is Mr. Severance's letter in which he says
17 the following: "As required by the State
18 Health Plan, this letter acknowledges in
19 writing that this exchange is permanent and
20 confirms that Roper Hospital will not use the
21 loss of these beds as justification for a
22 subsequent request for the approval of
23 additional beds." Do you see that?

24 A: Yes.

25 Q: Okay. When I asked Mr. Severance did that mean

1 that he would have to show a bed need of 51 in
2 order to add beds, his testimony was to me that
3 DHEC might take that position and that he
4 thought that was reasonable. Do you remember
5 that testimony?

6 A: I do.

7 Q: Okay. You would agree with that, wouldn't you?

8 A: I really don't know where he was going or what
9 DHEC may do. I read this in terms of the --
10 you can't go back and say I need new beds to
11 refill what I've just given away. And I think
12 the letter says, you know, as it states, will
13 not use the loss of the beds as justification
14 for a subsequent request for the approval of
15 additional beds.

16 Q: You would agree with me that in five years
17 there could easily be a positive bed need at
18 Roper Downtown because they're going to have so
19 few beds, correct?

20 A: May. I don't think they will. I think that
21 with the continued repositioning or relocation
22 of population from the peninsula up, they may,
23 but I don't think so.

24 Q: They're giving up 50 beds. We can agree on
25 that?

1 A: Yes, we can.

2 Q: Okay. The Health Plan says that needs to be a
3 permanent reduction, correct?

4 A: I think the Health Plan says that the facility
5 giving up the beds may not use the loss of
6 these beds as justification for subsequent
7 requests for approval of additional beds.

8 Q: Correct. We do a new Health Plan every two
9 years, correct?

10 A: Yes, that's correct. Right.

11 Q: And each time we're going to be extrapolating
12 from current use rates projected against future
13 populations. We can agree on that?

14 A: Yes.

15 Q: Okay. And so based upon that, there will come
16 a time, if history is any indication, if
17 historical precedence is any indication,
18 there'll come a time where Roper will have a
19 positive bed need again, correct?

20 A: They may. I think it's much less likely now
21 than it was, but they may.

22 Q: The only way for the Department to enforce this
23 provision is to say that you're going to have
24 to have 51 beds because we've said you can't
25 replace what you're giving up. Fair statement?

- 1 A: I don't know.
- 2 Q: You don't know?
- 3 A: I don't know.
- 4 Q: Or you don't have an opinion as a health
5 planner?
- 6 A: My advice to Roper would be don't use the net
7 50 loss and come in and tell the state you need
8 more beds. But I have no idea what the agency
9 would do.
- 10 Q: Okay. Criteria eight says that each facility
11 giving up beds must acknowledge in writing that
12 this exchange is permanent. Do you see that
13 language?
- 14 A: Yes.
- 15 Q: Now, there's nothing that would prohibit the
16 beds from going back if they were to file a CON
17 and send them back, right?
- 18 A: If Roper St. Francis wished to send the beds
19 back to Roper Hospital Downtown?
- 20 Q: I'm just reading what number eight says. I
21 mean, this is, "Each facility giving up beds
22 must acknowledge in writing that this exchange
23 is permanent." We can agree that that's what
24 that says, can't we?
- 25 A: Sure.

1 Q: Okay. Any further transfers would be subject
2 to the same process, correct?

3 A: Any future transfers, the same process to me
4 would be the CON process under this review.

5 Q: Correct. Thank you. Look at number four. The
6 applicants, single or plural?

7 A: The word here is plural.

8 Q: And that contemplates more than one, doesn't
9 it?

10 A: As written here. But in this context, the
11 applicants to me basically are talking about
12 what is the impact or the interaction between
13 Roper Downtown and a new facility, and can
14 Roper Downtown stay viable or continue to
15 provide good care.

16 Q: In this case we only had one applicant.

17 A: We have the applicant -- again, we have the
18 applicant, but we also have, to me, the
19 proposed facility where the beds are being
20 transferred to and that utilization has been
21 defined and forecasted.

22 Q: You would agree with me there are not two
23 applicants; would you not?

24 A: I would.

25 Q: Okay. You would?

1 A: I would. I think as part of the applicant,
2 there is contemplation of the new to be
3 established facility and the existing Roper
4 facility.

5 Q: All of this language that you're telling me,
6 the proposal, the establishment of a new
7 facility, all of that language could have been
8 placed in the Plan and it would have been
9 clear, correct?

10 A: It could have been placed in there. I don't
11 think this is all that unclear, but yes, it
12 could have been placed in there.

13 Q: Okay. Let's take a look at Joint 2, page 1107.
14 Joint 2 is the Roper Application; is it not?

15 A: I believe it is.

16 Q: We can agree on that, can't we?

17 A: Yes, we can.

18 Q: All right.

19 A: What page are you on, Mr. Summer?

20 Q: Let's start on 1107.

21 A: There.

22 Q: Okay. This is what we refer to as the deemed
23 complete letter, isn't it?

24 A: I'm sorry, I'm on 1007. 1107?

25 Q: 1107, please.

1 A: I'm at 1107 now, sorry.

2 Q: Great. Isn't this what we refer to as the
3 deemed complete letter?

4 A: Yes.

5 Q: And this is what begins the review cycle,
6 right?

7 A: Yes.

8 Q: And if we look at page 1108, there is a list of
9 relative criteria, right?

10 A: Yes.

11 Q: And they're listed in their order of
12 importance; is that correct?

13 A: That's what it states.

14 Q: Now, if we -- staying in the State Health Plan,
15 if we look at Roman Number II-11, the Health
16 Plan identifies what should be considered the
17 most relevant criteria for the review of the
18 application of the new hospital beds, correct?

19 A: Let me go to it real quick. The II-11
20 identifies seven criteria that says are
21 considered to be the most important in
22 evaluating CON projects.

23 Q: You notice that cost containment was left off
24 of the letter. Did you see that?

25 A: Looks like it.

1 Q: Yeah, so DHEC never considered cost
2 containment.

3 A: I don't know whether they did or they did not.
4 It's not listed here in terms of the more
5 important criteria. But easily it could have
6 because the cost containment is part of the
7 overall evaluation..

8 Q: The benefits -- now let's read this section
9 below on II-11.

10 **MR. SUMMER:** If we can blow that up, no the bottom
11 section, the very bottom paragraph. All right,
12 there we go.

13 Q: General hospital beds are located within
14 approximately 30 minutes travel time for the
15 majority of the residents of the state and
16 current utilization and population growth are
17 factored into the methodology for determining
18 general hospital beds. Is that correct?

19 A: That's what it says.

20 Q: That's what it says. The benefits or improved
21 accessibility will be equally weighed with the
22 adverse effects of duplication in evaluating
23 certificate of need applications for these
24 beds. Do you see that?

25 A: Yes.

1 Q: And you've previously testified under oath that
2 that 30 minutes is a standard in the State
3 Health Plan, haven't you?

4 A: I don't think I have. Going back through my
5 information, I believe the 30 minutes is a
6 reasonable guideline. I think that it is very
7 appropriate to review and access populations
8 along that. In terms of is it the travel
9 standard, I'm not sure.

10 Q: Well, I'm looking -- let's see. You did
11 testify in this court in the Seacoast case; did
12 you not?

13 A: Yes, I did.

14 Q: Let's take a look at Petitioner's Exhibit 214.
15 This is pre-filed testimony that you provided
16 to this court back in 2006, isn't it?

17 A: That is correct.

18 Q: And here you were basically opining regarding
19 the adverse impact and the duplication that the
20 Seacoast facility would have on Grand Strand,
21 correct?

22 A: That was part of it. The major focus of this
23 entire analysis, though, was the duplicative
24 services of Loris taking a 40 census and
25 putting it into two hospitals and the adverse

1 impact on Loris itself, though Grand Strand was
2 part of the case.

3 Q: Grand Strand was part of the case. Let's look
4 at page 17, if you will, of this testimony
5 which is Trident 10560. The previous question
6 that was posed to you was what was your opinion
7 regarding accessibility. This starts on line
8 one. Would you read this into the record for
9 me?

10 A: Sure. "My opinion is that there are currently
11 no accessibility issues within the local market
12 that would support the approval of the proposed
13 new project." Keep going?

14 Q: Yes, please.

15 A: "No new services or programs are proposed to
16 resolve any service accessibility issues. No
17 financial accessibility issues were raised by
18 the applicant. While the applicant raised
19 travel access issues in the application, there
20 is reasonable access to acute care services
21 without the proposed project. The standard set
22 forth on page II-9 of the 2003 State Health
23 Plan is that general hospitals beds are located
24 within approximately a 30 minute travel time
25 for the majority of the residents of the state.

1 The vast majority of the residents of Horry
2 County are within a 30 minute travel time to
3 existing acute care services."

4 Q: Those are your words, the standards set forth
5 on page II-9 of the 2003 State Health Plan,
6 right?

7 A: That's what it says here. And I think if you
8 go further, potentially in the cross or re-
9 cross of that, my further discussion of that
10 was I think 30 minutes is a reasonable
11 standard, the standard as in a planning
12 standard. Is that a requirement in the Plan,
13 I think not. I think that in the Plan itself,
14 as a descriptive observation, is that hospital
15 beds are within 30 minutes. And I agree with
16 that from a planning perspective, planning
17 standard, I agree with that. But in terms of
18 is it -- is it a must be 30 minutes, I think
19 not.

20 Q: Okay. Let me hand you what is Roman Numeral
21 II-9 of the '03 Plan. Would you agree with me
22 that it is -- and that's Joint 7. Would you
23 agree with me that that language is identical
24 to the language we've been looking at in Joint
25 4, which is the '08-'09 Plan, Roman Numeral II-

1 11?

2 A: I will. And the first sentence is a
3 declaration that the general hospitals are
4 located within an approximately 30 minute
5 travel time.

6 Q: But you will agree with me that it is identical
7 language in the two Plans, correct?

8 A: I would agree 100 percent.

9 Q: And you would agree with me, at least at one
10 point in your testimony or your life, you
11 referred to this as a standard; did you not?

12 A: Lower case S, standard in terms of a planning
13 standard. Not a requirement for the Plan.

14 Q: Did you type this?

15 A: Yes, I did. And sent it to a law firm office.
16 That was from my computer.

17 Q: So your testimony here today is, is that you
18 put it with a lower case S to give yourself the
19 wiggle room to testify here today?

20 A: Distinctly just the opposite. In all
21 discussions, prior to the development of that
22 direct testimony, with your law firm, there was
23 discussions in terms of does a 30 minute travel
24 time make sense. My conclusion then and now is
25 that it does. I believe we had discussions on

1 the fact that does this declaratory statement
2 in the Plan translate to a must-be standard?
3 I think I've been consistent that it does not.

4 Q: Well, since we can agree that it makes sense,
5 you can also I hope agree that the testimony
6 that Mr. Bowling gave us is, is that all of the
7 population within a seven mile radius of the
8 Carnes Crossroads site is within 30 minute one-
9 way travel time of a hospital today.

10 A: It's within 30 minute travel time of either
11 Trident or Summerville.

12 Q: Okay.

13 A: Now, is there available capacity in Trident or
14 Summerville, I don't know. Both of those
15 facilities are before the Agency right now
16 saying they need additional capacity. So the
17 question becomes in terms of do they have the
18 ability to take additional volume.

19 Q: All right. We can plow this ground all day
20 long. How many times have -- are you aware
21 that Trident has refused patients or not had
22 beds for patients?

23 A: No, I'm not. What I'm aware of is that Trident
24 is telling the state they need additional bed
25 capacity.

1 Q: Well, wait a minute. Isn't the state telling
2 Trident they need additional bed capacity?

3 A: The state identifies potential need. Trident
4 has said we agree and we need additional
5 capacity. They've applied to the state for
6 additional beds.

7 Q: Are you aware of one human being that you know
8 of today that could not get access to either of
9 the Trident facilities?

10 A: No, I don't.

11 Q: So it's pure speculation on your part?

12 A: It is not speculation at all. Trident Medical
13 Center and Summerville both have an application
14 before the state that says they need additional
15 capacity to do whatever they're doing.

16 Q: And the State Health Plan agrees.

17 A: I think it's the other way. I think the State
18 Health Plan opens the door and Trident and
19 Summerville basically said we think we do have
20 needs and we are going to try to get more beds.

21 Q: Going back to what we can agree on. We can
22 agree that everyone within that seven mile
23 radius of the proposed Carnes Crossroads site
24 is currently within 30 minute one-way travel
25 time of a hospital, correct?

1 A: Of a hospital with questionable availability,
2 but of a hospital, yes.

3 Q: Okay. Other than your speculation, do you have
4 any material evidence of patients being turned
5 away from either of the Trident hospitals?

6 A: I have no physical evidence. It is not
7 speculation, however, the fact that Trident and
8 Summerville have applied to add new beds and
9 have told the state they need more capacity.

10 Q: Okay. Now, if we're going to look at this
11 balancing test that has to be struck between
12 improved accessibility, all right, and adverse
13 impact.

14 A: Correct.

15 Q: Okay. If we consider 30 minute one-way travel
16 time as being reasonable, you would agree with
17 me that there is no improvement under that goal
18 or standard with the construction of the Carnes
19 Crossroads hospital?

20 A: If you're looking at a 30 minute guideline as
21 reasonable, as I do, I think that there is no
22 -- the enhancement -- there is no enhancement
23 if you utilize the Trident facilities. If, in
24 fact, you look at the positioning of where
25 Roper St. Francis patients now travel, I think

1 there is an access enhancement.

2 Q: You have to acknowledge, though, three out of
3 four patients in Berkeley County choose
4 somebody other than Roper St. Francis?

5 A: Correct. And 25 percent is a good bit that
6 decide to go downtown or --

7 Q: Well, it's not quite 25 percent. It's more
8 like 24 percent. Agreed?

9 A: Agreed.

10 Q: So three out of four, if it were gum and
11 dentist, okay, would be Trident, right? The
12 bottom line is it's Trident, MUSC, other
13 providers, but three out of four of those
14 people pick somebody else to go to?

15 A: That is correct.

16 Q: So it's not an issue of access to the care;
17 it's an issue of access to Roper?

18 A: It's an issue of access to the Roper system,
19 its physicians and its ED.

20 Q: Anything here -- I'm just looking at this
21 phrase, improved accessibility, as it appears
22 on Roman Numeral II-11. Improved
23 accessibility. There's nothing there that
24 talks about improved Roper accessibility, is
25 there?

1 A: No. But there's nothing that says that
2 improved Roper accessibility should not be
3 considered.

4 Q: Okay. There's nothing in there that says
5 enhancement of institutional accessibility?

6 A: No. But there's also nothing that says that
7 that's not an issue that may be considered.

8 Q: Okay. That's an interesting concept because
9 I've heard you say this several times now and
10 I've heard other witness say is there's nothing
11 in the Plan that prohibits it, right?

12 A: Correct.

13 Q: Which makes it very easy to make your rules up
14 as you go along?

15 A: I don't think so. I think you've got a traffic
16 cop in terms of the DHEC staff or DHEC Board.

17 Q: A traffic cop?

18 A: It doesn't let you make up the rules as you go.

19 Q: We had this conversation with several witnesses
20 about the notion of where could MUSC drop beds
21 if they wanted to go drop beds. And Mr.
22 Bowling recoiled at the thought that MUSC could
23 go drop beds in Mount Pleasant, right? Do you
24 remember that testimony?

25 A: I think he said he would not be happy, but he

1 felt that they may be able to.

2 Q: There are no limits on this concept of the Plan
3 doesn't prohibit it. There are no limits on
4 how many beds or where they can be put.

5 A: I think there are limits. If, in fact -- and
6 I'll use an illogical example. If, in fact,
7 there was a geography where Roper St. Francis
8 had no patient draw --

9 Q: Right.

10 A: -- and decided to put a 50 bed hospital and it
11 only had, and again the illogical extreme, a
12 couple hundred patients, they may have the
13 ability technically to move to a new facility,
14 but if they don't have the patient base to
15 support it, it doesn't fly.

16 Q: In the rules according to Richardson, that all
17 makes sense, but that's not written any where
18 in the State Health Plan?

19 A: I'll leave that for the legal side. It may not
20 be written that way, but I think it can be
21 interpreted that way. And, again, not a
22 lawyer, a planner.

23 Q: Why don't we just have a free market system if
24 we're going to allow people to put hospitals
25 wherever they want to put them?

- 1 A: I don't think that what we're talking about
2 allows hospitals to be put wherever they want.
3 There must be a bed transfer, you must take
4 existing capacity out of an existing facility,
5 you must move it either within the same county,
6 if the county is the planning area, or the Tri-
7 county area as we are here. And then you must
8 be able to sustain or support the fact that
9 that hospital can be reasonably utilized by
10 your patients.
- 11 Q: Okay. But, again, you have to be able to read
12 the Plan to say things that are not expressed
13 in order to make that happen?
- 14 A: I interpret it, as a planner, to allow it.
- 15 Q: Let's talk about duplication. You'd agree with
16 me that everything that's going to be built at
17 Carnes Crossroads will be duplicative of what
18 is at both Trident hospitals?
- 19 A: Yes. I don't think there are any new
20 technologies or services or equipment that is
21 not at Trident or Summerville.
- 22 Q: So they will -- let's make sure we understand
23 each other. The facility as built at Carnes
24 Crossroads will duplicate services and beds
25 that are already available at the two Trident

1 hospitals?

2 A: They will duplicate them. I don't think it
3 will go to unnecessary duplication, but they
4 will duplicate.

5 Q: That's the next question.

6 A: Okay. I thought it might be.

7 Q: So we can all at least agree that this is a
8 duplication of existing facilities; no doubt
9 about that, right?

10 A: I think you're right. Again, in the portfolio
11 of services or technology at either the new
12 Roper Hospital or the Trident Hospital, they,
13 you know, they are available at Trident Medical
14 Center or Summerville Medical Center.

15 Q: Okay. And what we have to determine is what
16 would actually be unnecessary, right?

17 A: That's the next step, yes.

18 Q: That's the next step. What is unnecessary?

19 THE COURT: Excuse me, Mr. Summer.

20 MR. SUMMER: Yes, sir.

21 THE COURT: I believe we are at 4:30; are we not?

22 MR. SUMMER: We are, Your Honor.

23 THE COURT: Let's take about a ten minute break.

24 MR. SUMMER: All right. Thank you, Your Honor.

25 (Off the Record from 4:32 p.m. until 4:42 p.m.)

1 THE COURT: Back on the record. Mr. Summer.

2 MR. SUMMER: Thank you, Your Honor.

3 Q: What we're going to do now, Mr. Richardson, is
4 do a historical walkthrough, if we can, of your
5 work with this client. Do you participate at
6 all in strategic planning with this client?

7 A: I have in the past, but it's not been recently.

8 Q: And when you say not recently, not within the
9 last five years?

10 A: No.

11 Q: The first thing I want to turn your attention
12 to is going to be Petitioner's Exhibit 88. We
13 don't need to hand you a copy, we'll look at
14 the screen. First of all, Petitioner's 88 is
15 the Purchase and Sale Agreement for the
16 purchase of the Carnes Crossroads property. Do
17 you see that?

18 A: It's titled Purchase and Sale Agreement.

19 Q: And if you'll look over on page 16,
20 Petitioner's Exhibit 16, Roper Berkeley 1209,
21 just, if we can, just blow up the signature
22 blocks. I just want to be able to establish
23 that this agreement was finalized and executed
24 in July of 2007, correct?

25 A: Yes, that appears to be correct. Looks like

1 the seller signed the end of June and then Mr.
2 Dunlap, July 20, and then the escrow agent,
3 July 27.

4 Q: So we can agree that in July 2007 Roper had
5 made a commitment to purchase the property.
6 Okay? The 66 acres on that Carnes Crossroads
7 property, have you been to it before?

8 A: Yes.

9 Q: Sixty-six acres is plenty enough property to
10 build a hospital on, right?

11 A: I would think so.

12 Q: And you've seen the prior testimony that they
13 basically committed to apply for a certificate
14 of need to construct a hospital on that
15 property; you've heard that testimony, correct?

16 A: In construct of maintaining exclusivity, they
17 had to do that. If they didn't do that, they'd
18 lose exclusivity, but -- but in context of
19 having exclusivity, that is correct.

20 Q: You haven't heard anybody in this courtroom
21 deny that Roper wants to put a hospital at
22 Carnes Crossroads, have you?

23 A: No.

24 Q: Okay. And as far as we know, based upon the
25 testimony we've heard thus far, it is Roper's

1 intent to put a hospital on the Carnes
2 Crossroads property, isn't it?

3 A: I agree with that.

4 Q: Good. Now, you were asked to perform an
5 analysis for the client. I would refer to
6 Petitioner's Exhibit 104. Just the title page
7 for now. I think Mr. Long asked you a few
8 questions about this, remember that?

9 A: Yes.

10 Q: Now, the prior testimony on this particular
11 document is that in early 2008 it was presented
12 to community leaders in Berkeley County and
13 Moncks Corner; do you remember that?

14 A: I believe that's correct, right.

15 Q: Including the Chamber of Commerce and community
16 leaders throughout the county, right?

17 A: I know this was presented to the community.
18 There may have been a couple of different
19 presentations, but this was presented to the
20 community is my understanding.

21 Q: All right. And we know that it was not in 2008
22 because it's based on 2007 data, isn't it?

23 A: Could I see that?

24 Q: Sure, let's flip through it. Let's go, just so
25 that we can look and see what we're talking

1 about in terms of 2007, go to page four of the
2 exhibit, which is 2313 of Petitioner's 104.
3 Got full year 2007 data on there, right?

4 A: It appears that way, yes. Yeah.

5 Q: Turn over if you would to page 11. Now, by
6 2008 Roper was committed to its Carnes
7 Crossroads property, and one of the purposes of
8 this presentation was to explain why resources
9 were being moved from Moncks Corner to the
10 Carnes Crossroads site, correct?

11 A: It appears that's correct, yes.

12 Q: All right. And they refer -- and when I say
13 they, I think Mr. Bowling testified regarding
14 this document -- to an independent analysis
15 conducted by Mark Richardson, partner
16 Richardson Knapp and Associates, Inc, is that
17 you?

18 A: I believe it is.

19 Q: Okay. And then they tell the community that
20 you have 26 years of healthcare consulting
21 experience. Was that true?

22 A: At that point, yes.

23 Q: Okay. Your areas of expertise included
24 strategic business planning and strategic
25 marketing. Is that true?

1 A: Yes.

2 Q: And it says that he has been qualified as an
3 expert witness in healthcare planning,
4 ambulatory care planning and healthcare finance
5 in various states. Is that true?

6 A: Yes.

7 Q: So everything on this slide is true, right?

8 A: Yes.

9 Q: Okay. Then they present your analysis which is
10 on page 12, the bed need compare contrast. Do
11 you see that?

12 A: I do.

13 Q: Okay. And based upon this, it says the stats
14 based on a seven mile radius of site, 65
15 percent market share. Do you see that?

16 A: I do.

17 Q: Okay. And what it basically concludes is that
18 total market forecasted admissions would be
19 2,204 admits times the 65 percent market share
20 would be 1,432 admissions for Moncks Corner.
21 Is that what it says?

22 A: It appears to be correct, yes.

23 Q: All right. It contrasts that with the Carnes
24 Crossroads site where it's projected that 65
25 percent market share would garner you or garner

1 Roper 6,435 admissions. Do you see that?

2 A: I do.

3 Q: And then based upon that, at 65 percent
4 occupancy, you'd basically only need 22 beds at
5 Moncks Corner, but you'd need a hundred beds at
6 Carnes Crossroads, right?

7 A: Right.

8 Q: Okay. Now, one of the reasons that they're
9 contemplating a hundred bed facility at Carnes
10 Crossroads at this time is that it's in
11 anticipation of Mr. Bowling getting the State
12 Health Plan changed, correct?

13 A: I have no idea if that's correct or not.

14 Q: Okay. Because if Mr. Bowling was successful in
15 getting the State Health Plan changed, you
16 could, as a planner, then ignore the fact that
17 there are 390 beds for Berkeley County and
18 you'd have plenty of need to put a hundred bed
19 hospital in Berkeley County if it was its own
20 service area and ignored 1,749 beds in the rest
21 of the planning region, correct?

22 A: I have no idea what Mr. Bowling was doing or
23 what his intent was. I have no idea that this
24 was created to show a hundred bed need to
25 support that. I have no awareness.

1 Q: What it's basically created for was as an
2 apologist to the Moncks Corner community about
3 why assets were being moved, wasn't it?

4 A: I don't know why it was created or why it was
5 presented. I know it was in part of the
6 process in terms of telling folks that Roper
7 St. Francis would be establishing at Carnes
8 Crossroads.

9 Q: You would agree with me that in early 2008 no
10 one in the Roper system was aware of Trident's
11 intent to apply for a certificate of need for
12 a new hospital, were they?

13 A: It sounds like it was spring/summer when
14 Trident announced. Whenever they gave their
15 announcement.

16 Q: You would also agree with me that if Mr.
17 Bowling had been successful in convincing the
18 State Planning Committee to go to a single
19 county planning district, that based upon your
20 work, there would be needs for hundreds of beds
21 within Berkeley County?

22 A: There would be needs for hundreds of beds as
23 we've discussed here today. But in terms of --
24 I'm going to counter. You said if that was
25 what Mr. Bowling was doing. I have no

1 knowledge that Mr. Bowling was doing any of
2 that.

3 Q: Mr. Bowling's already testified that he was.
4 But let's do this.

5 A: I disagree. I don't think Mr. Bowling
6 testified that he was trying to change the Plan
7 to have it strictly Berkeley County
8 specifically. I don't think that's what I
9 heard.

10 Q: Okay. We're going to let the record speak for
11 it. I'm going to rephrase the question, okay.
12 And here's my question to you. If Berkeley
13 County were the planning region in isolation,
14 without considering the beds at Trident, your
15 work that you've already testified to would say
16 that there would be hundreds of beds needed for
17 the residents of Berkeley County, correct?

18 A: On total tertiary, yes, it would be hundreds.

19 Q: It would be hundreds?

20 A: Yes, sir. And I do believe that. I do believe
21 that the residents of Berkeley County can
22 support and utilize hundreds of beds.

23 Q: In fact, they are. They are utilizing, to
24 varying degrees, 1,749 beds in the service
25 area.

1 A: That's correct, with a quarter of them
2 utilizing Roper St. Francis, and deciding to
3 use that system with those doctors and those
4 EDs, even though it is not proximate.

5 Q: Now, let's get this straight. Are you aware of
6 people laying in the street dying because they
7 can't get access to a hospital in Berkeley
8 County today?

9 A: No. What I'm saying is that I'm aware that a
10 quarter of the folks are deciding to go beyond
11 the closest facility. And what this project
12 is, is a repositioning of existing assets to
13 help resolve that.

14 Q: Now, let's get back to this slide, okay. If
15 the planning region were Berkeley County, there
16 would be no problem in applying for a hundred
17 beds because Roper would not have to use any of
18 its existing beds downtown. It could apply for
19 all new beds. Anyone could go apply for all
20 new beds in Berkeley County, correct?

21 A: They probably could as long as they could
22 justify the utilization of the new facility.

23 Q: Well, to hear you tell it, there's enough room
24 for three hospitals in Berkeley County?

25 A: I'm not sure I looked at that. I'd feel

1 strongly there's a need just in terms of the
2 existing book of business for at least a
3 Trident and a Roper St. Francis hospital.

4 Q: All right. Let's look at this because this is
5 very interesting. At this point in time, when
6 there's no Trident application on the horizon
7 and we're talking to community leaders and
8 we're talking about building a hundred bed
9 hospital, there's no analysis of, oh, we're not
10 going to hurt Trident and we're not going to
11 hurt anybody else, and we only want our one
12 little piece and we're only going to take care
13 of our patients. There's a blatant statement
14 here that we anticipate a 65 percent market
15 share. That's what it says, doesn't it?

16 A: That's what it says. I don't think it will
17 occur.

18 Q: Okay. But that's what this says and your name
19 is on it.

20 A: Right. And as I said before, my name is on it,
21 I did not do this.

22 Q: So are you telling me that Mr. Bowling and
23 Roper went up to Berkeley County and lied to
24 the people up there?

25 A: No. What I'm saying is that Mr. Bowling and I

1 had discussions in terms of modeling, in terms
 2 of use rates, but in terms of the -- in terms
 3 of comparative, in terms of what's the market
 4 potential, 100 to 22, this -- this is a very
 5 valid, valid presentation. And in the Roper
 6 St. Francis application, we presented a seven
 7 mile comparison that shows that the population
 8 within seven miles is multiples more at the
 9 Carnes Crossroads site than it is in Moncks
 10 Corner. So strongly I believe that type of
 11 analysis is appropriate. And as I said at the
 12 start today, I don't think a bed need analysis
 13 on a seven mile radius is what I would do.

14 Q: This is very interesting when we look at this
 15 forecasted average daily census. Basically 14
 16 and a half patients at Moncks Corners; 65
 17 patients at Carnes Crossroads. There's a lot
 18 more money to be made at Carnes Crossroads,
 19 isn't there?

20 A: There's a lot more volume to be had at Carnes
 21 Crossroads.

22 Q: Are you going to deny that you'd make more
 23 money at Carnes Crossroads with a hospital than
 24 you would at Moncks Corner?

25 A: I don't know. In looking at comparative

1 financial payer class for -- looking at
2 comparative financial payer class for the
3 proposed Roper St. Francis Hospital versus the
4 Trident Moncks Corner Hospital, Roper St.
5 Francis Carnes Crossroad has higher Medicaid
6 and higher charity care, so I don't know that.

7 Q: Let's go to Joint 2, 1178.

8 A: Joint 2.

9 Q: 1178. I'm going to put it on the screen for
10 you.

11 A: Thanks.

12 Q: Second paragraph. This is Roper's presentation
13 to the DHEC Board. I'm just trying to find out
14 who's telling the truth and when.

15 A: 1178?

16 Q: 1178.

17 A: Thanks.

18 Q: You just testified that you think you can make
19 money at Moncks Corner. What does this slide
20 say?

21 A: Let's look here. 1178. It says in both cases
22 Moncks Corner population growth would not
23 support the new patient volume required to
24 justify the expense. And I would agree with
25 that. With the -- with half the market share

1 of Trident Health System, the book of business
2 that's available to Roper St. Francis at this
3 site is well less than it is at the Carnes
4 Crossroads and that -- that's one answer. But
5 you've mixed and matched. But in terms of can
6 Moncks Corner, with a full hospital, be as
7 profitable as Carnes Crossroad? The forecast
8 in terms of payer mix, assuming the volume's
9 the same, the payer mix forecast for Trident
10 Moncks Corner, basically are a better payer mix
11 than is forecast at the Roper Carnes
12 Crossroads.

13 Q: Your answer is non-responsive. I've not asked
14 you to think about Trident's application. Let's
15 go back to the notion of whether or not Roper
16 can make money at Moncks Corner.

17 A: I think it would be difficult for Roper St.
18 Francis to make money at Moncks Corner because
19 they don't have the volume.

20 Q: Right. And that's what -- so, okay. Good,
21 we've got that established. Now let's go back
22 to Petitioner's 104 and let's go back to page
23 12, which is Roper Berkeley 2321.

24 MR. SUMMER: And can we just blow that slide up a
25 little bit so I can see it better? I'm getting

1 blind.

2 Q: So back to my line of questioning. You can't
3 get but 14 and a half patients, you're making
4 the determination here you can't make money at
5 Moncks Corner. That's why Roper's moving
6 everything down to Carnes Crossroads. They're
7 moving the surgery center to Carnes Crossroads
8 and they're going to build a hundred bed
9 hospital at Carnes Crossroads.

10 A: Well, they did not move the ambulatory surgery
11 center down. They have not applied for a
12 hundred beds. And in terms of the volume here,
13 I believe this supports the contention from
14 Roper St. Francis that their book of business
15 in Moncks Corner is not enough to have a
16 hospital stay full.

17 Q: They want to go where they can make money?

18 A: That may be your statement. My statement is
19 they want to go where they can effect a
20 reasonable and effective and good utilization
21 of their assets.

22 THE COURT: Excuse me, Mr. Summer.

23 MR. SUMMER: Yes, Your Honor.

24 THE COURT: Mr. Richardson, the response you just
25 gave, is that based on the difference in the

1 market share that Roper has?

2 THE WITNESS: Yes.

3 THE COURT: Vis-a-vis Trident in Moncks Corner?

4 THE WITNESS: Across the county really. It's about
5 a two to one in terms of --

6 THE COURT: I understand that.

7 THE WITNESS: And the market share translates in to
8 how many patients, so across the board Trident
9 has about twice as many.

10 Q: Actually, Trident's best market share in all of
11 Berkeley County is in Moncks Corner proper,
12 isn't it?

13 A: Trident's market share?

14 Q: Excuse me, Roper's market share. Its best
15 market share in Berkeley County is in the
16 Moncks Corner vicinity around its ED and its
17 ambulatory surgery center?

18 A: They draw well there. I don't know the exact,
19 but my contention -- my opinion would be is
20 that Trident itself still has a materially
21 larger market share in that zip code.

22 Q: So this is all about getting Trident's
23 patients, isn't it?

24 A: No, it's not all about getting Trident's
25 patients, as we've talked all along.

1 Q: Well, let's look at the 65 percent market
2 share. Right now -- let's do a little math.
3 You would agree with me, would you not, that
4 county-wide, right now, that Roper's market
5 share is about 23 percent?

6 A: I think about 23 to 23.9, somewhere in between
7 23, 24. Yes.

8 Q: Can we just say 23 for the --

9 A: Sure.

10 Q: All right. So our current market share is 23.
11 In order to get the 65 percent, you're going to
12 have a gain in market share of how much?

13 A: That would be 42.

14 Q: Do you need a calculator?

15 A: No.

16 Q: Okay. You might before I get done. Got to
17 have an increase of 42 percent, don't I?

18 A: Yes.

19 Q: The only place that's going to come from is
20 from other existing providers in the market
21 place, right?

22 A: If you achieve that. I don't think that Roper
23 St. Francis would achieve that.

24 Q: Then why would you lie to Moncks Corner and say
25 that you would?

1 A: It doesn't matter. No matter what market share
2 you have there, you basically would have a
3 comparative difference where the Carnes
4 Crossroads forecasted volume would be four to
5 five times higher.

6 Q: We can agree on this much. We can agree that
7 Roper presented this information to public
8 leaders in Berkeley County, can't we?

9 A: Yes, they did.

10 Q: And they represented to public leaders in
11 Berkeley County that they could get 65 percent
12 market share, didn't they?

13 A: I don't know. I know that it says this model
14 showing comparative, as it says, compare and
15 contrast. Shows a forecasted volume of 2,204
16 admits from the Moncks Corner seven mile radius
17 and 9,900 admits for the Carnes Crossroad.
18 There is a 65 percent here, but it really
19 doesn't matter in terms of looking at the
20 comparative. Based on this analysis, there's
21 no way that a seven mile analysis, there's no
22 way that a Moncks Corner facility, because even
23 if you went 100 percent, you would be still
24 less than 50 beds.

25 Q: I want to focus on the Carnes Crossroads

1 projections, okay?

2 A: Yeah.

3 Q: Let's just look at that. What Roper is
4 presenting to the public is that there's
5 insufficient volume for them to be, even at 65
6 percent, to be in Moncks Corner. Can we agree
7 on that?

8 A: Yes. Even if a hundred percent of that seven
9 mile radius were retained, there's not enough
10 for 50 beds.

11 Q: Now, whether or not that's true, that's what
12 they represented to the community, fair
13 statement?

14 A: Well, that's what it shows here. If you look
15 at the calculation it's 2,204 admits for a 4.2
16 length of stay is 9,000 plus patient days,
17 which is not enough to support.

18 Q: Well, the record's going to speak for itself in
19 where this was presented on what occasions it
20 was presented. But let's look at what they
21 told the community about Carnes Crossroads. Is
22 that if we had a Carnes Crossroads facility, we
23 would do a hundred bed hospital and we would
24 have a forecasted average daily census of 65
25 patients. Do you see that?

1 A: That's what this shows, but that's not what
2 Roper St. Francis did.

3 Q: It's not what they did. But it's evidence of
4 what their intent was in early 2008. It's also
5 evidence of what they're telling the public.
6 Now, I agree with you, they never told DHEC
7 this. This is what they're telling the public
8 in Berkeley County in 2008, isn't it?

9 A: My take away of this is a compare and contrast.
10 Basically showing a comparison that the Carnes
11 Crossroads could support approximately five
12 times as much bed load as Moncks Corner.

13 Q: Okay. Let's go and take -- because this is
14 very convenient now if we're dealing with a
15 hundred beds. And so it's fortuitous for a
16 number of reasons, not just what intent was,
17 but in our ability today here in the courtroom
18 to talk. I want to go to Respondent's Exhibit
19 70 and I want to go to page seven. Now, I'm
20 not going to go through your need analysis
21 because I don't understand it. I'll be honest
22 with you. I've been doing this for the better
23 of part three decades and I get lost every time
24 somebody tries to take me through it. But what
25 I am going to do is look at your last page and

1 talk about whether or not -- let's do it this
2 way. Let's take number three. If we use your
3 methodology here for the likely scenario where
4 we take 73 percent instead of the 42 percent.
5 shift, okay, what's 73 percent of 42 percent?
6 A: Seventy-three percent of 42?
7 Q: Uh-huh (affirmative response).
8 A: It's 30 percent.
9 Q: Well, it's actually 30.7, isn't it?
10 A: 30.66.
11 Q: All right. We'll leave at 30.66. That's going
12 to give me in terms of -- here what you are
13 basically saying, that 73 percent was basically
14 what was going to come out of Trident, correct?
15 Berkeley discharges redirected from Trident,
16 right?
17 A: The 73 percent was the actual portion of the
18 non-Roper St. Francis patients that was served
19 by Trident hospital.
20 Q: So here, if we utilized the methodology that
21 the public was told back when Roper thought
22 they were going to a hundred bed hospital at
23 some point in time, what you'd really be
24 looking at on the hundred bed hospital is a
25 30.7 ADC, right?

1 A: I don't see how you get that? And also, I
2 reject that Roper or anybody would get -- well,
3 Trident may get a 65 percent market share.
4 Trident, where they're now at, at mid-50s, may
5 be able to get a 65 percent market share.

6 Q: I appreciate that you want to reject this.

7 A: I think what I want to do is say I don't think
8 this was proposed or used for what you're
9 trying to drive us through.

10 Q: Let's go back. You don't have to move
11 anything. I'm going to leave what I've got on
12 the screen on the screen. Okay. Roper told
13 the public that you completed an independent
14 analysis, correct?

15 A: Right.

16 Q: They touted, they touted your expertise about
17 how good you are at what you do, how
18 professional you are at what you do, how expert
19 you are at what you do. And the very next
20 slide is telling the public, we need a hundred
21 bed hospital at Carnes Crossroads; we can only
22 do 22 beds at Moncks Corner, and that is why
23 we're making the decision to go to the Carnes
24 Crossroads property.

25 A: I don't know if that's the case. First off, I

1 don't know whether that's the case or whether
2 it was just to compare what the potential among
3 the two is. Second, as I've stated all along,
4 I provided pieces of this to Mr. Bowling. I
5 did not create this analysis.

6 Q: Okay. So basically they've misled the public
7 with this slide, haven't they?

8 A: I don't know whether they've misled the public
9 or not. As I've said, I provided pieces of
10 that analysis. But I would reject the fact
11 that Roper St. Francis would have the ability
12 to get a 65 percent market share.

13 Q: I understand why you want to get the
14 difference. Because if this 3.7 ADC is coming
15 -- 73 percent of Trident, if that 30.7 ADC,
16 okay, is coming from Trident, how many total
17 patient days would that be?

18 A: Well, first off, 30.7 ADC would be that 88
19 percent of the business at the hospital would
20 not be coming from Roper St. Francis patients,
21 I reject that. However, if you go through and
22 look in terms of how many patient days that
23 would be, is that what --

24 Q: Times 365?

25 A: That would be 11,206.

1 Q: Run that math one more time.

2 A: 30.7 ADC?

3 Q: Right.

4 A: Times 365 is 11,206.

5 Q: Eleven thousand --

6 A: 206 days.

7 Q: I can see why you want to run away from these
8 numbers.

9 A: I'm not running away from those numbers. I
10 think that's a gross mischaracterization. I
11 will say, however, even if there's an 11,000
12 swing, Trident Health System still has more
13 volume in the future than they have today.

14 Q: We're going to get there. We're not done yet.

15 A: Okay.

16 Q: Let's go to your worst case scenario. If we go
17 to the worst scenario in number four, okay, if
18 you go to the worst case scenario number four,
19 we wouldn't take the 73 percent discount. We'd
20 just assume that it will all come out of them.
21 And so that would then be 42 times 365; what
22 would that be?

23 A: Say again?

24 Q: It'd be 42, right, times 365, what would that
25 number be, worst case?

1 A: Do you want me to multiply 42 times 365?

2 Q: Right. The ADC would be, that would come from
3 Trident would be the full 42. Worst case
4 scenario assumes 100 percent market
5 redirection.

6 A: I don't agree with anything you're doing. But
7 if you multiply those two pieces together, it's
8 15,330.

9 Q: You would agree with me that this would have a
10 substantial adverse impact on Trident Medical
11 Center, wouldn't it?

12 A: If this is correct, and I do not believe it is,
13 I believe it's flawed, that would mean that
14 Trident would reduce patient days by 15,330
15 which means that their patient day growth would
16 only be by 3,000 over the time frame.

17 Q: Now, whether they build a hundred beds or not,
18 even if it's only 50 beds, I think we've
19 established that once you're in the Roper
20 system it's like the Hotel California, you're
21 not getting out until you get a bill. Would
22 you agree with that?

23 A: Folks get out without a bill. But for the
24 majority of patients, once they are -- once
25 they go to a Roper St. Francis physician or

1 emergency room, they stay within the system.

2 Q: Did you hear Mr. Severance testify yesterday?

3 A: I did.

4 Q: Do you know what the most shocking thing he
5 testified to was?

6 A: I don't know that.

7 Q: When I asked him if you have peak censuses like
8 you had on 21 different days, 21 different days
9 in 2007, and you have extra patients and you
10 don't have beds, where are you going to send
11 them, and he said St. Francis or Mount
12 Pleasant. Do you remember that testimony?

13 A: I do.

14 Q: MUSC is across the street. The notion that he
15 would put a patient in an ambulance and ship
16 them to another hospital 14 miles away just to
17 keep them in the system and not roll them
18 across the street, isn't that an indication
19 that this is all about margin, not mission?

20 A: No. I strongly disagree for a couple of
21 examples. First off, a patient moved from
22 Roper to MUSC will be in an ambulance just
23 whether they're across the street or whether
24 they're to a new hospital. Second, in terms of
25 to ensure continuity of care with the physician

1 that's taking care of that patient all along,
2 they must stay within a Roper St. Francis
3 facility. The MUA basically controls the vast
4 majority of the physician control and practice
5 at MUSC.

6 Q: But we can --

7 **THE COURT:** Excuse me just a second. Your reply has
8 become somewhat impassioned and your speech has
9 sped up. You meant to say that you strongly
10 disagree. It sounded like you said I strongly
11 agree. Which did you mean?

12 **THE WITNESS:** I strongly disagree with Mr. Summer.

13 **THE COURT:** That's what I thought.

14 **THE WITNESS:** And the points that back that up is,
15 one, whether a patient is transferred across
16 the street or to another hospital, they'll put
17 them in an ambulance. Second is, in order to
18 make sure that the patient stays -- that the
19 patient has continuity of care of its doctors,
20 the patient will stay within the Roper St.
21 Francis system. And those are good things.

22 **THE COURT:** And if you will, slow it down a little
23 bit.

24 **THE WITNESS:** I get excited.

25 **THE COURT:** Excuse me, Mr. Summer.

1 MR. SUMMER: It's all right.

2 Q: Continuity of care. We cannot get -- Roper
3 cannot get the downtown doctors to cover out at
4 Mount Pleasant. How is there going to be
5 continuity of care? We've got a census of nine
6 at Mount Pleasant. How do you have continuity
7 of care when those doctors don't go out there?
8 You're going to ship the patient but there
9 won't be a doctor there to take care of them.

10 A: I think the discussion that we've had here
11 during the trial is that every day physician
12 coverage and especially coverage at Mount
13 Pleasant is better and that's part of the
14 reason why their volume is still in the
15 formulative stage. It's -- they're working on
16 that to get it done, which is sort of a
17 compounding issue in terms where they'll get
18 the ultimate volume.

19 Q: Let's talk a little bit about Mount Pleasant
20 while we're here. You worked on the Mount
21 Pleasant application, didn't you?

22 A: Yes, I did.

23 Q: I heard you try to get distance from that
24 during your direct testimony. But you did the
25 B11 analysis, didn't you?

1 A: I don't think I tried to get any distance from
2 that. My comment was is that Mr. Bowling took
3 the initial lead on that and I followed. I
4 took full responsibility for the B11 then and
5 I still do now.

6 Q: Okay. So let's talk about it a little bit.
7 Now, we can agree that healthcare demand is
8 inelastic. We've heard that testimony. Do you
9 agree with that?

10 A: I think that there's some potential for delay
11 based on lack of resources, but ultimately, if
12 you're going to need to have your knee
13 replaced, you're going to need to have your
14 knee replaced.

15 Q: Correct. So by and large, it may not be
16 recession-proof, but it's recession-resistant.
17 Fair statement?

18 A: Yes.

19 Q: Okay. People get sick, they got to be cared
20 for. And as we've heard, with all of these
21 hospitals, regardless of ability to pay,
22 correct?

23 A: Right. And my observation of the recession is
24 that there is some volume down now during the
25 recession as folks don't have the ability to

1 basically fund the elective things. That sure
2 would be nice because my hip hurts badly, but
3 they'll put it off, put it off longer. I
4 believe that is occurring. But on a long-term
5 basis, is that going to basically drive
6 utilization down? I don't think so.

7 Q: We've heard nearly three weeks of testimony now
8 and the testimony's been consistent that the
9 average daily census at Mount Pleasant is
10 running right at nine. You've heard that
11 testimony, correct?

12 A: I have and I believe, as discussed in my
13 deposition with Mr. Thomas, I believe that that
14 was the annual for whatever time frame. I know
15 that there were points toward the end of that
16 where it was up ten, 11. So it's not 40 or 50,
17 but I believe it was above that average for
18 that time period.

19 Q: But you would agree with me that you haven't
20 heard any testimony in this courtroom other
21 than the ADC being nine at Mount Pleasant,
22 correct?

23 A: No, I have not. But I have seen the monthly's
24 that fall into that and towards the end it is
25 higher.

1 Q: Okay. Consistent with prior testimony with an
2 ADC at nine, the projection in your B11 was
3 that first year of operation you would have an
4 ADC of 28, correct?

5 A: Yes.

6 Q: Okay. And in second year of operation you
7 would have an average daily census of 44,
8 correct?

9 A: The analysis was that year one would be half of
10 the ultimate year three and then year two would
11 be in the middle between those two.

12 Q: You would agree with me that if you divide the
13 patient days projected in year two in the Mount
14 Pleasant application, it's 44 ADC?

15 A: It's about that.

16 Q: Now let's look at what you've experienced. In
17 year one, nine ADC, that's what the testimony
18 has been. You were off by over 300 percent on
19 that, weren't you?

20 A: What was the forecast year one?

21 Q: Year one forecast was 28 ADC, actual was nine.

22 A: Yes.

23 Q: Over 300 percent.

24 A: Three hundred and eleven, right.

25 Q: Now you also heard the testimony that over a

1 quarter of the actual ADC was attributable to
2 Mount Pleasant OB/GYN purchase. Remember that
3 testimony yesterday?

4 A: Yes.

5 Q: Okay. All of that, we discounted it for the
6 ten percent that stayed at East Cooper. But
7 Roper did was they grabbed the OB/GYNs from
8 East Cooper and took them to their new hospital
9 in order to get two more ADC, 2.3 I think is
10 what the math was. If there had not been that
11 redirection, it would only have been, and again
12 that redirection was because of employing
13 physicians, the census would only have been
14 seven. Do you remember that testimony?

15 A: If those deliveries were not replaced by other
16 physicians doing them, right. If --

17 Q: If we haven't stolen physicians from somewhere
18 else, correct?

19 A: Or if existing Roper St. Francis OB/GYNs
20 decided to go there instead.

21 Q: So if it was actually seven based upon your
22 projections, you missed it by 400 percent,
23 didn't you?

24 A: Yes.

25 Q: Okay. Nowhere, and I've looked through the

1 application, nowhere did you project in that
2 Mount Pleasant application that purchasing
3 physicians at other hospitals and relocating
4 volume was going to be a driver for that
5 hospital, was it?

6 A: I don't believe that was in there.

7 Q: In fact, what you said was fully two-thirds of
8 what was going to be in that hospital was going
9 to be redirected from Roper, correct?

10 A: That is correct. I believe that was discussed
11 in detail, for example, with Mr. Severance in
12 terms of what his experience and expectations
13 were.

14 Q: Let's move to year two, okay. And if we look
15 at that nine ADC as to 44? If the ADC is nine,
16 you missed it by 500 percent, didn't you?

17 A: If there's no growth.

18 Q: And if you take away the two ADC from the Mount
19 Pleasant OB/GYN, you missed it by 600 percent,
20 didn't you?

21 A: Yes, if there's no growth.

22 Q: So if historical performance is an indication
23 of future performance, you're not doing real
24 well in this planning region right now, are
25 you?

1 A: Roper St. Francis is basically a new provider
2 in Mount Pleasant, they have not hit their
3 targets. On the outpatient side, it looks like
4 they are hitting their targets. On the
5 inpatient side, they're not. I think, as I
6 stated before, we're real early in the process
7 of trying to declare a winner or a loser. But
8 as it stands now, they're below forecast. I
9 would agree with that.

10 Q: They are abysmally below forecast.

11 A: On the outpatient side, they're right about at
12 forecast. We heard Mr. Severance talk about
13 the fact that five percent of his inpatient
14 business from Roper St. Francis has been
15 shifted through the calendar year, so I think
16 that that's telling us something as well.
17 They're low, I agree, in terms of actual versus
18 forecast.

19 Q: That's an interesting concept. Outpatient
20 they're doing okay. Inpatient is abysmal.
21 Agreed?

22 A: Inpatient is below target.

23 Q: How about this? Inpatient is significantly
24 below target?

25 A: Sure.

1 Q: Okay. You could have built an outpatient
2 center out there for a fraction of what you
3 paid for a hospital, couldn't you?

4 A: You could build an outpatient center for less,
5 you can.

6 Q: You could have built a wonderful state of the
7 art outpatient center for ten million dollars,
8 couldn't you?

9 A: Roper St. Francis could have.

10 Q: Roper could have, couldn't they?

11 A: I'm not sure ten million, but it would be well
12 less than the price tag on that facility.

13 Q: It would be a tenth of what they paid on that
14 Taj Mahal facility, wouldn't it?

15 A: Well, one, I would not agree to characterize it
16 as a Taj Mahal facility.

17 Q: Have you been in it?

18 A: I have been in it. And it basically is as I
19 would expect for the vast majority of new
20 hospitals built by proprietaries or not-for-
21 profits.

22 Q: It's a beautiful hospital, isn't it?

23 A: They have something to be very proud of.

24 Q: Right. And if you're going to be treating
25 people who have average incomes of six figures,

1 you better make it nice, hadn't you?

2 A: Yes. And as part of that is that the folks
3 that have average incomes of less than \$20,000
4 from the north take every advantage of that as
5 well because it's open to all.

6 Q: I want to talk to you a little bit about some
7 of your statements, and we're going to start
8 with your Exhibit 70 which is Respondent's 70.
9 You and I have been doing this for a long time,
10 so a lot of times you just see things when
11 you're sitting in court. And when you were
12 testifying about page one of your exhibit, I
13 just made some observations and I'd like to
14 discuss them with you. Respondent's 70, page
15 one.

16 A: I have it.

17 Q: Thank you. First of all, you prepared this
18 document; did you not?

19 A: Yes.

20 Q: Okay. Once again, you're focused on
21 population, population, population, correct?

22 A: In this one I'm focusing on the relative
23 distribution and growths of population, yes.

24 Q: There are beaucoup people in Berkeley County
25 and therefore they need a hospital. That's

1 basically your testimony, isn't it?

2 A: I think my testimony was, one, yes, there's
3 beaucoup population in Berkeley County. There
4 has been significant growth. And as a portion
5 of the larger Tri-county area, the Berkeley
6 County population I think has grown from 17 to
7 27 percent.

8 Q: Your testimony was based on no hospital in
9 Berkeley County, correct?

10 A: This information in terms of the moving
11 distribution of population has nothing to do
12 with it. This is basically just showing in
13 terms of things have changed, in terms of
14 there's been a significant shift.

15 Q: But you would agree with me that most of your
16 testimony has been about the fact that there's
17 no hospital in the county?

18 A: Only specific to looking at what the Berkeley
19 County need may be, which is not all of this.
20 It's just a small portion.

21 Q: And we can agree that Trident is there for
22 Berkeley County, can't we?

23 A: I can agree that Trident is there for Berkeley
24 County, but Trident is not the only facility
25 that does or should treat Berkeley County. But

1 part of what they do is work with Berkeley
2 County, agree a hundred percent.

3 Q: Well, they've got in excess of 55 percent
4 market share in Berkeley County, don't they?

5 A: They sure do.

6 Q: That's huge.

7 A: It's huge, and basically it shows that they're
8 treating a lot of folks. It doesn't mean that
9 no one else can treat those patients.

10 Q: No, it doesn't. Lexington Medical Center only
11 has about 52 percent market share in Lexington
12 County.

13 A: Good for them.

14 Q: Right. But my point simply is, is that those
15 are very good numbers in a competitive
16 healthcare market. Fifty-two percent is a very
17 healthy market share, isn't it?

18 A: It's a good healthy market share. It is pretty
19 much what I would expect to see with those
20 facilities being within probably 20 minutes
21 closer than anything else.

22 Q: Let's look at this population. You would agree
23 with me that Trident was not there in 1970, was
24 it?

25 A: I believe they came in the mid-70s, '74, '75,

- 1 '76, somewhere in there.
- 2 Q: Okay. So let's look at, let's start with 1980,
3 county population only. That's all I want to
4 do.
- 5 A: Okay.
- 6 Q: Add for me the county population for Berkeley
7 and Dorchester County.
- 8 A: For what year?
- 9 Q: 1980. What do you get?
- 10 A: Let me run it again to make sure. 153,488.
- 11 Q: Okay. Now, we know that Trident was built with
12 200 beds, you heard that testimony, right?
- 13 A: I believe that's correct.
- 14 Q: Okay. So divide 200 beds by 153,488.
- 15 A: By 200 by that?
- 16 Q: Two hundred divided by 153,488. That's
17 basically a beds to population ratio, isn't it?
- 18 A: I'm going to per 153,000 to do it per thousand.
19 Is that okay?
- 20 Q: You know, yeah, go ahead, if you want to do it
21 by thousands, that will work for me too. You
22 can do 200 to 153,000?
- 23 A: Yeah, 153.488.
- 24 Q: What do you get?
- 25 A: 1.3 per thousand.

- 1 Q: 1.3 per thousand. Okay. Now let's fast
2 forward to 2010 and the Trident system now has
3 390 beds, doesn't it?
- 4 A: Yes.
- 5 Q: Okay. So now let's go and do our math and
6 divide 390 by the total of the population in
7 2010. So you'll need to add 177,843 and
8 136,555. If we were to round down again, it
9 would be 314; would it not?
- 10 A: I run them twice to make sure. So that would
11 be 314,398 and so we're dividing that into 390?
- 12 Q: Yeah, round down again. If you rounded on the
13 other, you've got to be consistent with me.
- 14 A: I'd be glad to.
- 15 Q: Thank you.
- 16 A: I actually ran out as a decimal point the whole
17 way.
- 18 Q: Okay.
- 19 A: That would be 1.24 per thousand.
- 20 Q: 1.24 per thousand. Now, you will agree with me
21 that the demand for inpatient beds and the
22 average length of stay in terms of a use rate
23 is substantially lower in 2010 than it was in
24 1980?
- 25 A: It's lower.

1 Q: We've done a wonderful job of doing most
2 surgical procedures on an outpatient basis.
3 The majority is done on an outpatient basis,
4 isn't it?

5 A: Yes.

6 Q: The majority of surgery is done on -- which was
7 not the case in 1980, was it?

8 A: I started working am-surg in the late 70s,
9 early 80s. It was likely 60, 65 percent then.

10 Q: Okay. So the bottom line is you would agree
11 with me that 1.3 beds per thousand in 1980 and
12 1.24 beds per thousand in 2010 is a very
13 consistent number from a health planning
14 perspective, isn't it?

15 A: It is.

16 Q: Okay. Now, let's look at it this way. Why
17 don't you go ahead and add the 80 beds that
18 Trident has applied for and been approved for
19 and divide it again by the 2010 population.

20 A: So I'm adding the 50 beds --

21 Q: And the 30 beds.

22 A: -- in this case and then the subsequent 30 beds
23 for Summerville?

24 Q: Correct. It would bring it to 470, wouldn't
25 it?

1 A: 470, yes.

2 Q: And what's that going to give me in beds per
3 thousand?

4 **THE COURT:** Divided by what?

5 **MR. SUMMER:** We're dividing by 314,000, Your Honor.

6 A: That would be 1.49.

7 Q: Right. Health planning seems to be working
8 okay here, doesn't it?

9 A: Well, you're ending up with a higher bed per
10 thousand population, yes. Is that enough? I
11 would challenge I think that that may be
12 enough. That also assumes that none of Trident
13 should be allocated to Charleston County and I
14 think the fact that Trident Medical Center
15 specifically located in North Charleston, a
16 portion of their beds are used for Charleston
17 County.

18 Q: That's a very small market share that Trident
19 has in Charleston County, isn't it?

20 A: It probably is, but in terms of the percentage
21 of their patient days is not a minimal -- is
22 not a minimal level.

23 Q: You don't know what their -- you refer to them
24 as a North Charleston hospital and you don't
25 know what their market percentage is in

1 Charleston County?

2 A: I've looked at that. My take on Trident
3 Medical Center is they're a North Charleston
4 provider. I don't expect they get down very
5 much at all down to treating none at Mount
6 Pleasant and very little down at the peninsula.
7 It's mostly the, sort of that northern sector
8 of the county.

9 Q: Let me just ask you this question. Is Trident
10 System's market share in Charleston County
11 greater or lesser than five percent?

12 A: I don't know. But that's not the analytic that
13 I would look at in terms of trying to determine
14 what portion of Trident's beds should be
15 allocated to be used for Charleston County.
16 The question that I would look, in terms of
17 what percentage of their total volume is
18 basically used to treat -- what segment of
19 their total volume is treating Charleston
20 County residents.

21 Q: You're painting this picture of Trident as
22 being on the peninsula. You literally
23 testified they were on the peninsula.

24 A: No. I think what I've testified all along is
25 that the Trident is part of Charleston County,

1 it's in Charleston County, which factually is
2 correct. I've said they're located in North
3 Charleston County, which we discussed in the
4 population as shown here. I would expect that
5 a reasonable portion of their book of business
6 is taking care of Charleston County residents.

7 Q: I wrote your testimony down, and give me a
8 minute because I'm going to find it, because I
9 was quite shocked at it. If you give me a
10 minute, I'll find it. You testified that there
11 were 1,645 beds on the peninsula in Charleston.
12 Do you remember that testimony?

13 A: I don't believe that's correct. Because I know
14 that the Mount Pleasant facilities are not on
15 the peninsula and I know that West Ashley, that
16 St. Francis is not. So it would have been
17 Charleston County.

18 Q: Right. We need to clear that record up, okay?
19 Because that is your testimony. Now what I
20 want to go back down is let's look at the State
21 Health Plan real quick. Let's talk about
22 what's on the peninsula and not.

23 A: Where is that State Health Plan?

24 Q: I would look in the State Health Plan, which is
25 Joint 4 and I would turn your attention to

1 Roman Numeral II-18, and just get your
2 calculator out and we can figure this out real
3 fast.

4 A: Okay.

5 Q: You don't look at the VA, South Carolina
6 doesn't look at that. So the only hospitals
7 that are on the peninsula are MUSC and Roper
8 Downtown, correct?

9 A: Right.

10 Q: And you're going to have back beds out because
11 the Mount Pleasant beds are embedded in the
12 Roper Downtown numbers, correct?

13 A: I agree with that.

14 Q: So you've got to back out 85 of the 401,
15 agreed?

16 A: Correct.

17 Q: What is that?

18 A: 316.

19 Q: Okay. And then add it to MUSC's 604 beds and
20 what do you get?

21 A: 316 plus 604 are 920.

22 Q: Okay. While we're here and talking about
23 distribution, if we go way out on Ashley River
24 Road in West Ashley, out at the intersection of
25 Ashley River Road and 526, that's where Bon

- 1 Secours is, correct?
- 2 A: It's on 526, yes.
- 3 Q: And how many beds are out there?
- 4 A: Bon Secours has reported 204.
- 5 Q: 204. So west of the Ashley you've got 204
- 6 beds. And then let's go look and see where
- 7 beds are east of the Cooper, more beds than
- 8 anybody wants to use apparently right now. How
- 9 many beds are at East Cooper?
- 10 A: East Cooper has 140.
- 11 Q: All right. And add that to the 85 that Roper
- 12 has. So east of the Cooper River there are now
- 13 a total of how many beds?
- 14 A: 125 -- excuse me, 225.
- 15 Q: Looks like pretty good distribution to me.
- 16 Doesn't it look like good distribution to you?
- 17 A: Within Charleston County it does, yes.
- 18 Q: Well, I mean, we're back to this whole notion
- 19 of, I like the way Mr. Long puts it is, unless
- 20 we're going to create a hospital for Kevin
- 21 Costner in Waterworld, you know, that's where
- 22 we got to start, at the Atlantic Ocean and work
- 23 our way in, right?
- 24 A: Population will not shift to the ocean side at
- 25 all.

- 1 Q: There you go.
- 2 A: It would be to the north, northwest or west.
- 3 Q: So we've got nice strength down the coastline
- 4 and access to those hospitals. We go inland 15
- 5 miles and we've got Trident. We've got Trident
- 6 which is at that epicenter of the three
- 7 counties. And we have Summerville. How many
- 8 beds are up there?
- 9 A: Trident and Summerville?
- 10 Q: Yeah.
- 11 A: We've done that before, let's look here.
- 12 That's 296 plus 94, 390.
- 13 Q: Okay. So I've got beds to the north, I've got
- 14 beds to the east, I've got beds to the west,
- 15 and I've got beds at the highest concentration
- 16 of population on the peninsula, don't I?
- 17 A: You have the highest concentration of beds on
- 18 the peninsula, but not the highest
- 19 concentration of population.
- 20 Q: Well, we also have two very important tertiary
- 21 care centers that are on that peninsula as
- 22 well, right?
- 23 A: Yes. Two centers I think that provide things
- 24 that the whole network and system is dependant
- 25 upon, yeah.

1 Q: I learned a new phrase from you and it's
2 quaternary, is that what it is?

3 A: Quaternary.

4 Q: Quaternary.

5 A: Which is a step more specialized than the
6 tertiary.

7 Q: Okay. It's one more better, right?

8 A: And I would think that would be some of the
9 MUSC services we've talked about.

10 Q: Correct. Like transplants for instance?

11 A: Transplants, yes.

12 Q: Experimental treatments, for instance?

13 A: Could be.

14 Q: Could be. Because they are a teaching medical
15 center, aren't they?

16 A: Yes.

17 Q: All right. So you would agree with me that
18 contrary to the prior testimony that there was
19 1,645 beds on the peninsula, there is actually
20 distribution across the service area of beds,
21 correct?

22 A: If I said they were all in the peninsula, that
23 is incorrect. They are all in Charleston
24 County.

25 Q: Okay. Dorchester has beds?

- 1 A: Yes, they do. I think we're talking in terms
2 of the issue of are they all on the peninsula,
3 I think that description, I think we've talked
4 about, that's the distribution within
5 Charleston County.
- 6 Q: Let's look at geographically. Let's be
7 practical. Let me get this -- I'd like one of
8 those maps. Go to Respondent's 75.
- 9 A: And what page number?
- 10 Q: It's going to be next to the last page and the
11 page number is eight, if you look at the top
12 corner.
- 13 A: That's not on it. It looks like it's Bates
14 stamped 4708.
- 15 Q: Mine's not stamped so I have to go by what's
16 there.
- 17 **MR. SUMMER:** If you could, let's just blow that map
18 up a little bit for me, please, ma'am. Great.
19 And can you go inside of it and let's just look
20 at our planning region, just three-county area.
21 Can you do that? You can't go inside of it and
22 blow it up anymore? That's fine. Thank you.
- 23 Q: This notion that somehow Charleston, and I know
24 because I was born there and I know what people
25 think about it, is that they've got everything

1 and nobody else has anything, when we look at
2 how beds are distributed, I've got beds -- two
3 hospitals up here.

4 A: East of the Cooper, yes.

5 Q: Yes, you do. Two hospitals there. I've got
6 two hospitals on the peninsula, don't I?

7 A: Yes.

8 Q: I then have a hospital over here in West
9 Ashley?

10 A: On Loop Road, yes.

11 Q: Okay. And then up here in the epicenter of the
12 three counties I've got Trident, correct?

13 A: Yes.

14 Q: And then over here in Dorchester I got
15 Summerville, right?

16 A: Yeah. I think you may have gone too far into
17 Dorchester County, but it's over in that
18 general area.

19 Q: I flunked navigation. Okay, I did, I really
20 did. So when we look at Charleston County, it
21 runs the coastline and that is where
22 development occurred first. From a historical
23 perspective you understand that, right?

24 A: Yes. And it's now continuing up --

25 Q: It's continuing up.

1 A: -- east of the Cooper and up.

2 Q: Right. But, so we've got a good distribution.
3 along the coastline. We've got distribution up
4 into the north and now we have a question of
5 where and if to place a hospital in Berkeley
6 County. Fair statement?

7 A: Or two.

8 Q: I think it's going to be one. So, just because
9 they're all in Charleston County, from a
10 geographic standpoint, Charleston County runs
11 along both of the other counties and provides
12 access, folks in Dorchester County, a lot of
13 them have good access to the Bon Secours St.
14 Francis System, don't they?

15 A: Relatively, yes.

16 Q: Yeah. And they're close. Okay. And there are
17 plenty of folks in Berkeley County. Granted
18 it's rural, I understand that. But this whole
19 corridor here has access into the Mount
20 Pleasant hospitals if they choose to go,
21 correct?

22 A: There could be some access. There doesn't seem
23 to be much flow for whatever reason. But there
24 could be.

25 Q: Well, you would agree with me that the

1 applications for both of those Mount Pleasant
2 hospitals included Berkeley County zip codes.

3 A: The adjacent zip codes, right on the edge.

4 Q: Right. Okay. And so you at least told DHEC
5 that you were looking at some of those
6 patients?

7 A: And I think they're getting some of those
8 patients.

9 Q: Good. All right. Let's go back to where we
10 were with your exhibit. Now, it's interesting,
11 when I look at your exhibit, we start on the
12 second page of Respondent's 70 and you start
13 with your bed need estimates. Do you see that?

14 A: Yes.

15 Q: Okay. You're not doing a bed need estimate for
16 the three county planning region, are you?

17 A: No.

18 Q: You're doing it for Berkeley County only?

19 A: Yes, I am. As I stated, as a sideward check to
20 see whether the sizing makes sense. This is
21 Berkeley County only.

22 Q: Correct. And you would agree with me that
23 looking at Berkeley County only is inconsistent
24 with the planning region in the State Health
25 Plan, agreed?

1 A: I would agree with that.

2 Q: So what this basically is is a pitch for beds
3 in Berkeley County only. Fair statement?

4 A: No. I think, as I said, this shows a couple of
5 things. One, it shows that the sizing of two
6 50 bed hospitals looks like it could fit one,
7 sort of another analysis to confirm that that
8 could work. Second, this is an analysis that
9 talks about the Roper St. Francis patient base
10 and the Trident patient base of Berkeley County
11 resident volume.

12 Q: All right. You will remember your prior
13 testimony when we were looking in Joint 4,
14 which is the 2008-2009 Plan and we were looking
15 at pages 18 and 19, Roman II-18 and 19. We've
16 been plowing that ground all day today, right?

17 A: Got it right here. Yes.

18 Q: And we've already established that the way the
19 state of South Carolina projects need in the
20 State Health Plan is on two variables. One is
21 actual utilization, historical utilization by a
22 hospital, okay?

23 A: Yes.

24 Q: All right. And then number two, future growth,
25 correct?

1 A: There is a forecaster of future growth,
2 correct.

3 Q: There are two variables in this formula.
4 Variable one is going to be the use rate of the
5 particular institution, agreed?

6 A: You start -- it's the historical utilization.

7 Q: Historical utilization, okay.

8 A: Yeah.

9 Q: Variable number two is future population,
10 agreed?

11 A: It's the rate of population growth, yes.

12 Q: Rate of population growth, okay. The only way
13 you can express need in the State Health Plan,
14 the only way to express need is through an
15 increase of one or both of historical use rate
16 and future population, agreed?

17 A: The only way -- I'm sorry. The only way you
18 change the result is to --

19 Q: The only way that you can project future need
20 in South Carolina to get a positive bed need,
21 the only way to get a positive bed need, one or
22 both of the variables will have to increase.
23 Either an increase in utilization and/or an
24 increase in population. All other things being
25 equal, it will remain status quo, correct?

1 A: I think I'm agreeing with you. But in terms of
2 if there's already a need and volume goes down,
3 you may still have a need. And, you know, you
4 could have volume going up and population less,
5 so it could go either way. But those are -- I
6 agree, those are the two pieces that drive what
7 the state shows it to be.

8 Q: All right. Let's kind of -- let's talk in the
9 abstract. Put the Plan down for a minute.
10 Let's talk in the abstract about how the
11 methodology works. If I have a constant use
12 rate, or in other words it's not changing, and
13 the only way that I'm going to see an increase
14 in need in the future is with population growth
15 -- and it's real easy. I mean when we look at
16 the way they do it, Joint 4, II-18 and II-19,
17 they take an existing 2006 population, an
18 existing number of 2006 patient days, there's
19 my utilization.

20 A: Right.

21 Q: Okay. I extrapolate from that what the use
22 rate is to the population, then I look at a pop
23 in the future. Here it's 2013. Agreed?

24 A: Yes.

25 Q: And I project using that use rate, that current

1 use rate from 2006, to what I would have to
2 have in terms of beds in the future. Can we
3 agree with that?

4 A: The forecast patient days which are then
5 translated into whatever the appropriate
6 occupancy is.

7 Q: Correct. So let's think about this for a
8 minute. In South Carolina, if the use rate
9 remains constant --

10 A: So if the volume of the hospital remains
11 constant?

12 Q: Correct.

13 A: Yes.

14 Q: Then the only way that I'm going to project any
15 of the future is with increased population.
16 Fair statement?

17 A: You may have enough volume today in that they
18 don't need growth, so -- but your example will
19 create need, yes.

20 Q: I want to make sure that we have no ambiguities
21 on the record. So now let's assume that I have
22 zero bed need, okay?

23 A: Right.

24 Q: I have zero bed need based upon my 2006
25 numbers. It's zero. So my utilization matches

1 up with the number of beds that I've got and
2 I've got zero bed need. The only way I'm going
3 to show a bed need in the future, if that
4 utilization rate is going to remain constant,
5 the only way that I'm going to show it in the
6 future is through growth of population, agreed?

7 A: Forecasted growth, yes.

8 Q: Great. So when I look at Trident Medical
9 Center's use rates, and I look at Summerville
10 Medical Center's use rates, and I take those
11 and project them onto the 2013 population, we
12 can see that based upon the utilization of
13 those existing facilities, they are projected
14 to have a need in 2013. Fair statement?

15 A: Correct. Based on historical utilization, it's
16 forecasted well enough such that they'll need
17 more beds.

18 Q: Great. And if I didn't have growth in
19 population, I wouldn't have need. Fair
20 statement?

21 A: If there wasn't population growth, you're
22 exactly right.

23 Q: Now, let's go back to your Exhibit 7, page two.
24 Richardson Berkeley 684 is what's the legend on
25 the bottom of the page.

1 A: Right.

2 Q: What I want to look at right now is you've
3 isolated Berkeley County and we can agree that
4 that's not a valid service area under the South
5 Carolina State Health Plan. Agreed?

6 A: Sure. It's one of three counties in --

7 Q: One of three counties. A non-valid service
8 area, but for purposes of making this
9 examination, let's utilize the same methodology
10 that we would looking at use rates, utilization
11 and population. So the first thing I want to
12 turn your attention to is non-tertiary care
13 discharges. Will you look at those for me?

14 A: In what year?

15 Q: I am looking in 2010 first.

16 A: Okay.

17 Q: All right. So my actual patient days -- you've
18 got estimated, but you actually used actual
19 2010 numbers, didn't you?

20 A: I think it was 2010 numbers for the discharges,
21 and applied, I believe, a 4.1 length of stay.

22 Q: Okay. We'll get to that in just a minute. All
23 right. But those discharges or estimated
24 patient days were actual, correct?

25 A: The discharges were actual and the estimate

1 would be of something that happened.

2 Q: Okay. Now let's take that number, which is
3 55,629. If you'll just hold that for me. Look
4 at that, go down to 2017 and you made a
5 projection; did you not?

6 A: I did.

7 Q: And that number is 67,830, about what your
8 estimated patient days for non-tertiary would
9 be?

10 A: Right.

11 Q: What's the difference between those two
12 numbers?

13 A: 12,201.

14 Q: All right. And since those are patient days,
15 so that we can get to ADC, would you divide
16 that by 365 for me?

17 A: Sure. That's an ADC of 33.4.

18 Q: An ADC of 33.4. So what we can say is, if we
19 look at the way the state of South Carolina
20 looks at it, there's a bed need of 33.4. But
21 let's go ahead and apply the 65 percent
22 occupancy number. So you would divide 33.4 by
23 65, wouldn't you?

24 A: Yes.

25 Q: Okay. What is that number?

1 A: 51.4.

2 Q: South Carolina projects on utilization and
3 growth, using your numbers for Berkeley County,
4 there's enough need for one hospital in
5 Berkeley County.

6 A: If you look at pure only growth, that is
7 correct.

8 Q: And you would agree with me that we just
9 applied the same methodology that the state of
10 South Carolina uses to generate its bed need,
11 correct?

12 A: That's correct. However, as I've gone through
13 all of my analysis, my expectation is that the
14 new hospitals will serve growth as well as
15 existing business, which is why the transfer of
16 existing beds versus adding new.

17 Q: I understand that that's the Health Plan
18 according to Richardson.

19 A: No, but that's the Health Plan according to
20 what is expected at the Roper St. Francis
21 facility.

22 Q: I understand. Fine. Then that's the Health
23 Plan of Roper St. Francis. But the Health Plan
24 of South Carolina, the methodology utilized by
25 our Department, says one new 50 bed hospital is

1 needed for that utilization and growth. You
2 did it county-wide, you're looking just at
3 growth, it's a 51 bed hospital.

4 A: The growth alone shows a 51 bed hospital.
5 However, what you don't know in terms of may
6 there be more bed need for the baseline as
7 well. Basically what you have here is that you
8 have an estimate of 234 non-tertiary beds
9 needed at the baseline. On top of that you
10 have an estimate of 51.4 additional beds.

11 Q: Okay. Bottom line is, okay, is that utilizing
12 your bed need estimates -- we've gone through
13 this. There are hospitals for Berkeley County.
14 They're part of a planning region with 1,749
15 beds in it. There is no shortage of beds in
16 that three-county planning region, is there?

17 A: No. And that's why I think it makes sense to
18 redistribute the existing beds from Roper St.
19 Francis there.

20 Q: And your own methodology, if we utilize South
21 Carolina's growth methodology that you just
22 testified to, South Carolina State Plan
23 methodology would say that there's a need for
24 51 beds. Can we agree on that?

25 A: If you look at growth alone. What you don't

1 know in terms of there may be a baseline.
2 There are hospitals in here that even without
3 population growth show bed need.

4 Q: Let's run real quick and go over to
5 Petitioner's 231 for me, please. To make
6 matters worse, the use rate is actually
7 declining in this market, isn't it?

8 A: The patient days use rate -- well, you really
9 don't know. Well, you do know. You do know
10 that the absolute volume is down. As presented
11 by Mr. Baehr, I don't know whether this is a
12 reasonable presentation or not. I will agree
13 that the book of business in terms of Berkeley
14 County discharges from 2009 -- well, actually
15 from 2009 to 2010, the actual discharges went
16 up a little bit.

17 Q: Bottom line, if we look at historical from '07
18 to 2010, your baseline is actually declining.

19 A: The baseline actually is declining through 2009
20 in terms of looks like it's stabilizing,
21 increasing a real little bit, but a little bit
22 in 2010.

23 MR. SUMMER: Your Honor, it's about 6:00. I
24 probably got about another hour with Mr.
25 Richardson. If you want to plow, I can plow or

1 we can start back up in the morning.

2 THE COURT: Mr. Long?

3 MR. LONG: I'm fine staying. It's up to the witness
4 and Your Honor.

5 THE COURT: I'm fine.

6 THE WITNESS: I'm okay. The late start helped this
7 morning.

8 MR. SUMMER: Okay. Can I take about five minutes to
9 talk with my expert and I think we'll try to
10 wrap it up in an hour. Is that all right, Your
11 Honor?

12 THE COURT: Yes. Recess for five minutes.

13 (Off the Record from 6:00 p.m. until 6:05 p.m.)

14 THE COURT: Back on the record. Mr. Summer.

15 MR. SUMMER: Thank you, Your Honor.

16 Q: Mr. Richardson, I wanted to ask you a few more
17 questions about -- if I can find it. You want
18 to look at also on your exhibit on page seven,
19 which is Respondent's 70, page seven.

20 A: Is yours Bates stamped at the bottom?

21 Q: It does, it is Richardson Berkeley 689.

22 A: Thanks.

23 Q: The first question I've got is, is that this is
24 your cut at an adverse impact analysis right?

25 A: Yes.

1 Q: Now at the top, you're looking at the non --
2 number two.

3 MR. SUMMER: Can we pull up Number Two please?

4 Q: In particular, I want to look at that 4,143
5 number. Do you see that?

6 A: Yes.

7 Q: That 4,143, tell me what that number is.

8 A: That's taking the Tri-county volume and
9 expanding that to give effect to the reality
10 that Trident gets at least nine percent of
11 their business from outside the three-county
12 area.

13 Q: You know, we can establish this much, can't we
14 -- well, we'll go -- just look at that for a
15 minute. So that's not isolated to Berkeley
16 County; that's Trident's growth every where?

17 A: Yes.

18 Q: Okay. But when you go down into number three,
19 you're basically using the Berkeley County
20 facilities and trying to mitigate loss to
21 Trident by juxtaposing it against growth in the
22 other two counties, correct?

23 A: Well, what I'm comparing is the expected loss
24 from Roper St. Francis' Carnes Crossroad
25 facility to the overall growth of Trident,

1 wherever it may be.

2 Q: Right.

3 A: So I'm trying to say -- the question I'm
4 asking, will Trident stay whole no matter what
5 it does with the addition of the proposed
6 Carnes Crossroads facility.

7 Q: You're using Summerville growth to offset
8 Berkeley County injury, aren't you?

9 A: I am using Trident systemwide growth, no matter
10 where it is, to offset -- I'm trying to compare
11 -- my value that I'm trying to look at is will
12 Trident at least be where it is today in the
13 future with the development of this facility.

14 Q: The fact of the matter is, is that you're
15 taking a Berkeley County analysis, but you're
16 trying to offset the adverse impact by looking
17 at, for instance, Summerville. We know the
18 State Health Plan projects growth for
19 Summerville. What you're basically doing is
20 trying to lay claim to that growth as a
21 mitigating factor to what you're doing in
22 Berkeley County, aren't you?

23 A: No. I'm trying to lay claim to anything. I'm
24 basically saying is that if a small 7.7 percent
25 market share increase in Berkeley County

1 occurs, will Trident Health System have more
2 business in the future with the development of
3 that program than we do today. And the answer
4 is yes.

5 Q: That's your opinion.

6 A: Yes, it is.

7 Q: Because we don't know what's going to happen in
8 the future.

9 A: No, we don't. But in terms of my opinion and
10 looking at Mr. Baehr's analysis, both lead to
11 the conclusion that Trident will have more in
12 the future than it has now.

13 Q: All right. Well, your opinion was we have 44
14 patients at Mount Pleasant today and we don't,
15 do we?

16 A: No, we don't. And I think that what you see is
17 that the construct of the Berkeley Medical
18 Center facility does not have the same -- it
19 basically has brought back or constrained those
20 assumptions that were in place in Mount
21 Pleasant.

22 Q: I will agree with you it's constrained. Let's
23 look at a couple of other things. I'm
24 interested in your testimony in the Seacoast
25 case. Would you look at Petitioner's Exhibit

- 1 214 for me, please?
- 2 A: I have it.
- 3 Q: Okay. Turn, if you would please, to page 15.
- 4 There's so many page numbers on this thing. It
- 5 actually says Trident 10558 at the bottom; are
- 6 you with me?
- 7 A: It's page 15 of the document.
- 8 Q: Correct.
- 9 A: Yes.
- 10 Q: All right. You were asked, and this is pre-
- 11 filed testimony, "Do you have an opinion
- 12 whether Loris' project unnecessarily duplicates
- 13 existing research as in the proposed service
- 14 area?" Do you see that?
- 15 A: Yes.
- 16 Q: And you said you did have an opinion, right?
- 17 A: That is correct.
- 18 Q: And let's put into context for the court what
- 19 was going on there. Grand Strand is a tertiary
- 20 care medical center; is it not?
- 21 A: Yes, it is.
- 22 Q: And it is the only tertiary care medical center
- 23 in Horry County, correct?
- 24 A: At that point in time, yes.
- 25 Q: There are other hospitals that service the

1 county, Loris, Conway and Waccamaw right over
2 the border in Murrells Inlet, correct?

3 A: Waccamaw was not a player. Those other ones
4 were a factor in this.

5 Q: So there are other hospitals in the
6 marketplace, but Grand Strand is the one that's
7 going to lose the most market share. They had
8 65 percent market share in Little River, didn't
9 they?

10 A: They had the majority.

11 Q: Okay. It was 65 percent, wasn't it?

12 A: Maybe. They were the largest provider in that
13 area.

14 Q: Okay. And what Loris was going to do is build
15 a 50 bed community hospital in Little River, 13
16 miles away from Grand Strand.

17 A: That is correct.

18 Q: Okay. And when I asked you about duplicating
19 services, your opinion was what?

20 A: Yes, there would be duplication of service to
21 -- comparing to the three existing Horry County
22 hospitals.

23 Q: Okay. Do you mind reading me your opinion?
24 Let's start on the bottom of 15 and continue
25 for the first -- through the first full

1 sentence on page 16, please.

2 A: Sure. When I wrote -- sentences can go a long
3 ways. Starting with further?

4 Q: "My opinion is," line 20, page 15.

5 A: "My opinion is that the proposed project will
6 unnecessarily duplicate existing services and
7 facilities. There are adequate acute care
8 resources available within the local market to
9 meet local needs at the three existing Horry
10 County hospitals. Further, the development of
11 the proposed project will add no new services,
12 programs, technologies or techniques that are
13 not already available within the market."

14 Q: Next sentence, please.

15 A: Next sentence. "The proposed project is simply
16 the replication of existing services and
17 facilities."

18 Q: And the next sentence, please.

19 A: "In addition, at a cost of tens of millions of
20 dollars, the project will only redirect
21 patients who are currently being served at
22 existing hospitals."

23 Q: Okay. Would you agree with me that in the case
24 today at hand, in the Tri-county planning
25 region there are adequate acute care resources

1 available within the local market to meet local
2 needs at the existing hospitals? Would you
3 agree with me on that?

4 A: I would agree there are available beds, as we
5 discussed prior, the question whether there are
6 truly available beds where there's bed need
7 defined in terms of the two Trident facilities,
8 but there is available capacity within the
9 three county area.

10 Q: And it's within 30 minutes travel time of the
11 population within a seven mile radius of the
12 Carnes Crossroads site, correct?

13 A: If, in fact, the Trident facilities have
14 capacity in that their bed addition does not
15 indicate problems.

16 Q: This is a new issue for me. I've never heard
17 until your testimony today that you in any way
18 challenged whether or not there was sufficient
19 capacity at the Trident facilities. I've asked
20 you previously on cross examination, name me
21 one human being who's been denied access to a
22 Trident hospital. You can't do that, can you?

23 A: I cannot do that. As I've said before and I'll
24 repeat, whereas the state has shown there is a
25 potential to open the door to add beds,

1 basically Trident Health System, in the new
2 Plan, had a bed need for 17 beds. They're
3 proposing 50 beds. So basically they are
4 telling the state that they need additional
5 beds. That's sort of the question that I'm
6 raising.

7 Q: You have no evidence on any day in the last
8 five years, you have no evidence that either
9 one of those hospitals was full, do you?

10 A: I don't have evidence they were full. I think
11 that the applicants will be presenting or did
12 present information that they needed addition
13 capacity to take care of their existing need.

14 Q: Great. Now, do you know what diversionary
15 status is?

16 A: Yes.

17 Q: Okay. Explain to the court what diversionary
18 status is.

19 A: Diversionary status is when a hospital
20 emergency room basically cannot take incoming
21 patients. So basically it's, you know, it's
22 the red light's put up to EMS.

23 Q: All right. Divert EMS from coming to the
24 hospital because they're full, correct?

25 A: Typically because they are full or there's a

1 problem somewhere in the systems, but the
2 majority is when they're full.

3 Q: Okay. How many days in the last 12 months has
4 either of the Trident hospitals gone on
5 diversionary?

6 A: I don't know.

7 Q: So your testimony regarding capacity and
8 ability to treat and access of care at the
9 Trident hospitals is purely speculation on your
10 part?

11 A: Again, we've gone through this before. It is
12 not speculation. It's basically is that
13 Trident Medical Center in Summerville basically
14 telling the state that for whatever reason that
15 they need more capacity.

16 Q: Let's rephrase it, because obviously you're not
17 going to agree with me that you're speculating.
18 You will agree with me that you have no
19 evidence of the fact?

20 A: The evidence I have is that the applications
21 have been signed by the administrative director
22 of each hospital.

23 Q: That they're applying for new beds?

24 A: And inherent with applying for new beds is an
25 inherent argument that they need more capacity.

1 Why else would you add more beds?

2 Q: And from that you're making the conclusion that
3 they're full and they are turning patients
4 away?

5 A: No. I'm making the conclusion that I think
6 it's not a given that they will have enough
7 capacity in the future to treat their current
8 and forecasted growth.

9 Q: It's a very convenient argument. Did you
10 advise Roper to oppose the Summerville project?

11 A: No. I was not part or parcel of any of that.

12 Q: Those beds would be under construction today if
13 Roper didn't oppose the Summerville project,
14 wouldn't it?

15 A: I don't know. I'm not exactly sure of the
16 exact timing on that.

17 Q: You had no idea, do you?

18 A: I know Summerville's applied.

19 Q: And you know that Roper is challenging that?

20 A: Yes, I do.

21 Q: Would you agree with me that the development of
22 the Carnes Crossroad project will add no new
23 services, programs, technologies or techniques
24 that are not already available within the
25 market?

1 A: Putting access aside, we just talked about, but
2 in terms of is there a duplication of the
3 technology, services and all, yes, there is.

4 Q: The proposed projects, Carnes Crossroads
5 project, is simply a replication of existing
6 services and facilities. You would agree with
7 that, wouldn't you?

8 A: Yes, it is, via a transfer of existing capacity
9 versus the development of new beds.

10 Q: And it's going to be at a cost in excess of a
11 hundred million dollars, won't it?

12 A: Sure.

13 Q: And it will only serve patients that are
14 already being served, correct?

15 A: Yes. Primarily patients that are already being
16 served by Roper St. Francis.

17 Q: That's your projection?

18 A: Yes, it is.

19 Q: And it's probably as good as the projections
20 you made in Mount Pleasant, isn't it?

21 A: I think that the Mount Pleasant projections
22 will turn out pretty well and I think that it's
23 reasonable to expect one out of two patients
24 will stay within, you know, 20 minutes, 30
25 minutes closer in Berkeley County, just as Mr.

1 Baehr has made that same forecast assumption.

2 Q: Okay. You also believed that the Loris project
3 was going to have an adverse impact on Grand
4 Strand, didn't you?

5 A: Yes. I believed that Loris would take cases
6 that would otherwise be served at Grand Strand
7 and constrain their growth.

8 Q: And Mr. Knapp dollarized that in that case,
9 didn't he?

10 A: He did.

11 Q: But your opinion was that it was material,
12 wasn't it?

13 A: Substantial. I said it was like 700 to 1,000
14 cases that they would lose to Seacoast. I
15 think also, as you see in there, is that I did
16 expect that Grand Strand would grown in spite
17 of that loss of patients.

18 Q: But you opposed the Loris project, didn't you?

19 A: Yes, I opposed the Loris project on behalf of
20 Grand Strand for two reasons. One is I thought
21 that there would be some lost cases. It would
22 not have driven them below where they were in
23 terms of financials. The other significant
24 reason was I believe that from a community
25 perspective the establishment of the new Loris

1 Hospital splitting a 40 average day census
2 between two facilities would just not make
3 sense.

4 Q: It's interesting. Are you aware of any firm
5 commitments by the physicians to utilize the
6 hospital at Carnes Crossroads?

7 A: I've seen a good book of letters of support
8 from physicians in terms of supporting the
9 development.

10 Q: You had those in Mount Pleasant too, didn't
11 you?

12 A: There were some, yes.

13 Q: Right. And so far that hasn't worked, has it?

14 A: As I've stated, they're below forecast. I
15 expect they'll be okay.

16 Q: That's your opinion.

17 A: That's my opinion, and a similar opinion as I
18 heard discussed by the two folks that are
19 actually operating that facility or developing
20 that facility, Mr. Severance and Mr. Bowling,
21 and the CFO as well.

22 Q: All right. So your projection is that there
23 should be 44 patients in that hospital today,
24 shouldn't there?

25 A: Based on my projections, no, not 44 patients

1 today.

2 Q: We're in the 17th or 18th month of operation,
3 aren't we?

4 A: November -- so November, December, January,
5 February --

6 Q: We're in year two, aren't we?

7 A: We're still in month 15. In terms of the --
8 that's nowhere near -- you know, I'll agree
9 that year one is below, but year two saying
10 that they should today be at 44 ADC, you know,
11 is not real. That's not what any of the
12 analysis showed.

13 Q: They should be somewhere between 28 and 44
14 today?

15 A: Yes, they should.

16 Q: And they're not?

17 A: No, they're not. On the inpatient side they're
18 below and on the outpatient side they're about
19 where we thought they would be. I expect, as
20 the Roper folks said, that come the end of year
21 three, which is the forecast that we have, they
22 will be okay.

23 Q: You know, when we look at this notion of need
24 in Berkeley County, I've taken you through
25 looking at the growth and the way South

1 Carolina does it and that there is a 51 bed
2 need based upon your population projections and
3 utilization. Do you recall that testimony?

4 A: Sure. Pure need -- excuse me, pure population
5 growth or growth of volume shows twelve
6 thousand and some patient days which is a 51,
7 52 bed need.

8 Q: Utilizing the methodology of the South Carolina
9 State Health Plan?

10 A: Using the forecast methodology. But you don't
11 know -- as I've said before, that baseline
12 could be showing bed need today.

13 Q: We do know what the baseline says today because
14 we have the three county planning region. And
15 in the three county planning region, there is
16 an excess of 48 beds. Correct?

17 A: Exactly so, which is why a new applicant adding
18 new beds to Berkeley County cannot be
19 established, but I think that a transfer of
20 existing beds can.

21 Q: Let's talk about what the rules really are.
22 You were talking about whether or not it's
23 competing. Competing means if they exceed the
24 need. I think we can agree that all of the
25 other criteria of 61-15 that defines a

1 competing application are clearly met in this
2 case. The only one that is a question is
3 whether or not approving the location of a new
4 hospital at Carnes Crossroads would exceed the
5 need, agreed?

6 A: I think technically the projects are different
7 as well. One is a new bed need and one is a
8 transfer. So I think that that needs to come
9 into play. But I think the need also is a part
10 of it.

11 Q: All right. We're going to this and we're going
12 to do it with everything that you say. Did you
13 get a copy of 61-15?

14 A: I've got it.

15 Q: Would you go to the definition of competing?

16 A: Sure. Could you direct me to the page? This
17 is the document that was from Ms. Tyler, so it
18 should be the same one as you have.

19 Q: It would be page five, 61-15, Section 103(6).

20 A: I'm there.

21 Q: Can you see the language, "Whose applications,
22 if approved, would exceed the need for this
23 facility or service?" Do you see that?

24 A: Yes.

25 Q: Okay. I'm looking for the language that you

1 just said where this is a transfer so it
2 doesn't matter. There's no reference here
3 about transfer, is there?

4 A: No. But I think in terms of at the start of
5 that sentence, who provides similar services or
6 facilities. I think there is a context there
7 in terms of bed add versus bed transfer.

8 Q: Both DHEC witnesses testified that these are
9 applications for the same or similar services
10 or facilities. Is your testimony different
11 than the Department witnesses?

12 A: My read would be I think that the issue that
13 one is a transfer and one is a bed add needs to
14 come into play.

15 Q: Show me the language here -- and again I
16 understand, if it doesn't prohibit it, it must
17 be implicit in the language. But show me where
18 is it implicit here that bed transfers don't
19 count?

20 A: Again, planning, not legal, it's plain that the
21 similar services and facilities would mean the
22 same concept, same approach, same technique and
23 that's not the case here.

24 Q: All right. Let's go to the applications.
25 We're going to do it, every page. Let's start

1 with services that are to be offered and let's
2 start with the Trident record, please.

3 A: Where would I find that?

4 Q: Pardon?

5 A: Where would I find that?

6 Q: Trident record is Joint 1. There's a nice list
7 on page nine of Joint 1. Could you pull that
8 up, please? And what I want to look at is the
9 list of services.

10 MR. SUMMER: So if we could just blow up --

11 A: Bates stamp nine?

12 Q: Yes. Bates stamp nine. Let's go through line
13 by line. Now, let's compare. This facility's
14 proposed to be in Moncks Corner, South
15 Carolina; is that correct?

16 A: Correct.

17 Q: And we can agree that Moncks Corner is in the
18 center of the county, correct?

19 A: Right.

20 Q: And then the Carnes Crossroads facility is
21 going to be -- it's in the same county, but
22 it's in a totally different place. It's down
23 in Carnes Crossroads, which is in the southern
24 part of the county, which is totally different
25 from the center of the county, correct?

1 A: Yeah. They are totally different sort of
2 geographic hubs. One is center, one is
3 southwest.

4 Q: Right. And one's only going to take care of
5 Roper patients and one's only going to take
6 care of Trident patients, right?

7 A: I think the reality is that both will take a
8 little bit of each other's as well.

9 Q: That's right. We have no idea who's going to
10 show up at these things until we open the door,
11 do we?

12 A: No. But I think we do know that historic
13 market shares have held stable and that it's
14 reasonable to predict that historic market
15 shares are going to stay stable in the future.

16 Q: All right.

17 A: So I think with that, I think we have a good
18 indication or a guide of what patients will do.

19 Q: Historical performance is a predictor of future
20 performance, correct?

21 A: Can be.

22 Q: All right. And your historical performance is
23 the Mount Pleasant application, isn't it?

24 A: My historical performance for the first ten
25 months of volume for inpatient is well low, for

- 1 outpatient is about on track.
- 2 Q: Let's take a look at the services that are
- 3 going to be offered. You would agree with me
- 4 that there will be emergency medicine services
- 5 offered at both Carnes Crossroads and Mount
- 6 Pleasant, right?
- 7 A: Yes.
- 8 Q: Both will have an ED, correct?
- 9 A: Yes.
- 10 Q: Both are going to provide endocrinology
- 11 services, correct?
- 12 A: Yes.
- 13 Q: Boy I hate this word. Both will provide
- 14 otolaryngology -- you pronounce it?
- 15 A: ENT.
- 16 Q: Thank you. Both will provide ENT, right?
- 17 A: Correct.
- 18 Q: Both will provide gastroenterology, right?
- 19 A: Yes.
- 20 Q: Both will provide general medicine, right?
- 21 A: Yes.
- 22 Q: Both will provide general services?
- 23 A: Yes.
- 24 Q: Both will provide OB/GYN services?
- 25 A: Yes.

- 1 Q: Both will provide orthopaedic services?
- 2 A: Yes.
- 3 Q: Both will provide plastic services?
- 4 A: Yes.
- 5 Q: Both will provide pulmonary medicine?
- 6 A: Yes.
- 7 Q: Both will have physical rehab?
- 8 A: Yes.
- 9 Q: Both will have urology?
- 10 A: Yes.
- 11 Q: Both will have medical imaging?
- 12 A: Yes.
- 13 Q: Both will have diagnostic imaging, CT, MRI,
- 14 mammography, x-ray and ultrasound?
- 15 A: Correct.
- 16 Q: Both will have a laboratory?
- 17 A: Correct.
- 18 Q: Both will have respiratory therapy?
- 19 A: Yes.
- 20 Q: Both will have pharmacy?
- 21 A: Yes.
- 22 Q: Now, can we agree that when we go back and look
- 23 at competing applicants, it means two or more
- 24 persons and/or healthcare facilities, as
- 25 defined in this regulation, who apply for

1 certificates of need to provide similar
2 services and/or facilities in the same service
3 area? Can we agree that both of these
4 applicants do that?

5 A: Yes. Both provide similar services and
6 technology. They are both in the Tri-county
7 service area. But I think in terms -- but,
8 again, I still think that it's appropriate to
9 look at the differential in terms of bed add
10 versus bed transfer. Though I would agree that
11 the facilities have the same portfolio of
12 services.

13 Q: This concept about transfer making a difference
14 is not addressed in the statutory, regulatory
15 definition, is it?

16 A: It doesn't say specifically transfer versus bed
17 add.

18 Q: Right. This goes back to this notion of if
19 it's not addressed, it must be permissible.

20 A: My comment is that it doesn't have transfer or
21 bed addition defined.

22 Q: Okay. Despite the fact that every other
23 witness who has testified in this case says the
24 only issue is whether or not it exceeds the
25 need, your testimony is?

1 A: Is that I think that the fact that the basic
2 construct of the two applications, firstly, is
3 there is no bed addition, no bed add at all, if
4 we were to look at St. Francis, and there is
5 really a pretty aggressive bed add for Trident
6 for a 17 bed need shown grossed up to a 50 bed
7 need allowed.

8 Q: Your Exhibit 70-2, your bed add, your Exhibit
9 70, page two, your bed add, you're the one who
10 said we're going to look at Berkeley County
11 only, and when we look at Berkeley County only
12 and we apply South Carolina's bed need
13 projection methodology, there is only enough
14 need for 50 beds in Berkeley County based on
15 your numbers.

16 A: Based on looking solely at population growth,
17 you're correct. But I think -- but I think
18 there's more -- but I agree, looking solely at
19 population growth in terms of -- that's what
20 you have.

21 Q: Now, this notion of competing applicant. You
22 also -- there's a lot of other stuff that you
23 put in here that I just want to go over. One
24 of the reasons you said they're not competing
25 is you said they were in separate portions of

1 Berkeley County. Do you remember that
2 testimony?

3 A: I think separate population hubs or population
4 concentrations.

5 Q: Where do you see that language in the
6 regulation?

7 A: You don't.

8 Q: The regulation speaks only to the service area,
9 correct?

10 A: Correct.

11 Q: The service area is the Tri-county service
12 area, the three counties, correct?

13 A: That's in terms of the overall service area,
14 yes. In terms of, yes, I agree that the three
15 county area is the service area, but I think in
16 terms of looking in terms of the actuality of
17 will they be competing, I think that the
18 differential makes them distinctly different.
19 But in terms of they both are in the three
20 county service area, I agree a hundred percent.

21 Q: Okay. If the legislature wanted you to
22 evaluate whether or not they might be treating
23 separate populations, the legislature could
24 have put that language in the regulation,
25 right?

1 A: I suppose they could have.

2 Q: Then the other thing that you had was that they
3 are small hospitals and because they are small
4 hospitals, they're really not competing.
5 Remember that language?

6 A: I think I used small hospital to say that I
7 would expect minimal adverse impact on Trident
8 Health System, but also in terms of the small
9 hospitals in terms of do they exceed the
10 overall need, that probably would go there too.

11 Q: Is there anything in this competing applicant
12 definition that says small hospitals are
13 excepted?

14 A: No. I think what it says is that would what's
15 proposed exceed the need, and, you know --
16 excuse me, you have two small 50 bed hospitals,
17 so overall you're talking about 100 bed need.

18 Q: We have to figure out what the need really is,
19 don't we? That's one of the things this
20 court's going to have to do is figure out what
21 the need is.

22 A: Sure. I think to figure what the need is for
23 Trident, I think the court needs to say whether
24 the transfer of beds with no addition figures
25 into the need.

1 Q: Okay. In determining what the need is, the
2 court is going to have to evaluate in terms of
3 whether or not this argument, this construct
4 that you've created, is consistent with the
5 State Health Plan; wouldn't you agree?

6 A: The court will have the final decision on this.
7 Yeah, that's why we're here.

8 Q: So whatever it is, whether it's need
9 methodology as according to Mr. Bowling, need
10 methodology as according to Mr. Richardson, the
11 real issue is, is what you propose, is what
12 Roper proposes, is that consistent, is it in
13 compliance with the State Health Plan, agreed?

14 A: I think that's the opening yes or no, and then
15 if it's yes, you go beyond that.

16 Q: Right. So in order to be compliant with the
17 State Health Plan, need, the number one way we
18 determine need is is it consistent with the
19 State Health Plan? Can we agree on that?

20 A: Yes. With need, and again, I sound like a
21 broken record, but the -- there are -- and I
22 agree as well, I feel the same way, is that
23 there is no bed addition with the Roper St.
24 Francis facility.

25 Q: So I think it's fair to say that while you had

1 concepts such as it's a separate patient
2 population, if we're just redirecting, that's
3 all well and good, but in the final analysis,
4 what this court has to determine is is there a
5 need for both projects. Fair statement?

6 A: Fair statement.

7 Q: And we start that inquiry about whether or not
8 there's a need for both projects is, is the
9 proposal, is it in compliance with the State
10 Health Plan. Because if it's not, there's a
11 legislative mandate that it is to be denied,
12 correct?

13 A: Agreed.

14 Q: Okay. You would also agree with me that if
15 there is a material adverse impact, that there
16 is no improvement in accessibility that would
17 justify this project, the Carnes Crossroad
18 project?

19 A: I disagree. I think that there is enhancement
20 in accessibility for the patients that are a
21 part of the Roper St. Francis network.

22 Q: All right. Let's go back to the Plan again.
23 I understand that we have all of these concepts
24 that are either Roper concepts, or Richardson
25 concepts, Knapp concepts. But the fact that

1 you didn't open the State Health Plan in your
2 direct testimony is an indication that there's
3 nothing in the State Health Plan to support
4 what it is you're trying to do in this case, is
5 it?

6 A: I didn't open. I didn't bring any or open any
7 documents other than my exhibit.

8 Q: That's true. Not a regulation, nothing, did
9 you?

10 A: Everything that I thought I would need to have
11 would be provided to me.

12 Q: And you thought you needed to have would be --
13 let's take a look at Roman Numeral II-11 in
14 Joint 4 which is the '08-'09 Plan.

15 A: I've got the Plan again. Which section?

16 Q: Roman Numeral II-11 please.

17 A: I've got it.

18 Q: All right. You have agreed that everyone
19 within a seven-mile radius of the Carnes
20 Crossroads property is already within 30 minute
21 one way travel time of an existing hospital,
22 correct?

23 A: Of an existing hospital, a question of are
24 there bed -- is it available to them. But an
25 existing hospital, yes, I would agree.

- 1 Q: It's a question in your mind, correct?
- 2 A: I think the question should be in the state's
- 3 mind in terms of does that existing capacity at
- 4 those hospitals meet the need when they say
- 5 they need more.
- 6 Q: Great. If it's in the state's mind, where is
- 7 it in the record?
- 8 A: I'm not sure.
- 9 Q: It's never been raised in the record. That
- 10 issue has never been raised before today.
- 11 A: It was raised in the Grand Strand case.
- 12 Q: But you didn't raise the issue of whether or
- 13 not Trident could provide accessibility until
- 14 your testimony here today.
- 15 A: That's correct. I have not raised it
- 16 elsewhere.
- 17 Q: Until today. So it was not presented to the
- 18 Department, was it?
- 19 A: It was not presented to the Department.
- 20 Q: Thank you. Now, let's take a look at -- you
- 21 will agree that there are hospitals within 30
- 22 minute one way travel time, agreed?
- 23 A: Yes.
- 24 Q: You will also agree that there's no improvement
- 25 to access if your standard is 30 minute one way

- 1 travel time by creating a hospital at Carnes
2 Crossroads, agreed?
- 3 A: Other than for the St. Francis patients who are
4 now traveling to St. Francis' existing
5 facility.
- 6 Q: That's a convenience issue. That's not an
7 access issue, is it?
- 8 A: It's improving the access for those patients.
- 9 Q: But that's not how the state defines it in this
10 document on page Roman Numeral II-11, is it?
- 11 A: It appears that this is more of a community-
12 based access issue. But I think it is
13 important to note that in terms of, again, no
14 bed add, enhanced access, I think that's
15 something to be considered.
- 16 Q: You described this as a standard when you
17 testified in Grand Strand, did you not use that
18 word?
- 19 A: As a planning standard, which I would. I think
20 that a 30 minute travel time is a reasonable
21 guidance and the patients that are going
22 downtown to Roper St. Francis are not within
23 that.
- 24 Q: And you would agree that what one has to do by
25 the State Health Plan, in order to be

1 consistent with it, is you must weigh the
2 benefits of improved accessibility; will be
3 equally weighed with the adverse effects of
4 duplication in evaluating certificate of need
5 applications for these beds. That's what it
6 says, doesn't it?

7 A: That's what it says.

8 Q: So that if there is a material adverse impact,
9 okay,, it will not be outweighed by improved
10 accessibility, correct?

11 A: I think it may.

12 Q: Because you're going to invent whatever
13 standard it is you need to use in order to make
14 that opinion, correct?

15 A: No. What I'm going to do is look at, as I've
16 said all along, I'm going to look at the
17 patients that are traveling beyond 30 minute
18 travel time in Berkeley County to Roper St.
19 Francis facilities. And the trade-off there is
20 that the establishment of a facility and the
21 repositioning of existing assets would provide
22 that enhancement.

23 Q: All right. You would agree with me that folks
24 in Pineville are not within 30 minute one way
25 travel time of a hospital, are they?

1 A: I would agree.

2 Q: Folks in St. Stephen, folks who were here this
3 morning, are not within 30 minute one way
4 travel time to a hospital, are they?

5 A: I would agree.

6 Q: In fact, Mr. West said it could take you 45
7 minutes to an hour to get from way up there
8 down to Trident, correct?

9 A: I recall that that was sort of his
10 characterization. Most of all Berkeley, yes.

11 Q: Yeah. Bonneau is not within 30 minute one way
12 travel time of a hospital, is it?

13 A: Probably not.

14 Q: Alvin's not within 30 minute one way travel
15 time of a hospital, is it?

16 A: No.

17 Q: Jamestown's not within 30 minute one way travel
18 time of a hospital, is it?

19 A: I don't know Georgetown. But to the Tri-county
20 hospitals, no.

21 Q: The fact of the matter is the vast majority of
22 that side of the county will only see improved
23 access to hospital services if a hospital's
24 built in Moncks Corner; isn't that true?

25 A: No, it's not. Either new hospital will provide

1 enhanced access. The development of the Roper
2 St. Francis facility will basically put this
3 facility probably 20 minutes closer to those
4 areas. So is there enhanced access with just
5 Roper St. Francis? Yes, there is. Is there
6 additional enhanced access with the Moncks
7 Corner facility? Yes, there is.

8 Q: If we're trying to get people within 30 minute
9 one way travel time, only the Moncks Corner
10 project puts those folks in the western part of
11 the county within 30 minute one way travel time
12 of a hospital, correct?

13 A: I think the travel time analysis showed that --

14 **THE COURT:** You mean the northeastern part of the
15 county?

16 **MR. SUMMER:** You're right, Your Honor. It is the
17 northeastern. Day is late. I'm sorry.

18 Q: Your answer is?

19 A: Is I believe the travel time analysis showed
20 that, for example, for the communities to the
21 northeast of there, they would be brought in
22 within 30 minutes, but there are still portions
23 out beyond the lake that would still be beyond
24 30 minutes.

25 Q: You would agree with me that there are

1 significant populations of medically
2 underserved folks in that northeastern part of
3 the county? Do you agree with me on that?

4 A: There are populations, they're not very dense,
5 there's not a lot of them, but there are
6 populations that are outside. And by dense, I
7 don't mean mental. I mean just the population
8 concentration.

9 Q: I understand what you meant.

10 MR. SUMMER: Beg the court's indulgence.

11 Q: There's another slide that was attributed to
12 you in -- there's an earlier -- another slide,
13 a subsequent slide, that was attributed to you.
14 Let's go to 102, Petitioner's 102. Do you know
15 who the Roper Berkeley Advisory Council is?

16 A: I don't know the exacts, but I would imagine
17 that it's a local advisory board.

18 Q: For Roper St. Francis. And this is a
19 presentation, and I'm sorry this is the only
20 way it was produced to us. This is a
21 presentation of May 19, 2008. Do you see that?

22 A: I see some slides.

23 Q: All right. We blew up the slide -- or let's
24 just say we expanded the slide which is the
25 fourth slide on page 2252 of this exhibit. And

1 let's put that up, 242, this is Petitioner's
2 242. Again, there were the same slides to --
3 with the bed need contrast on it. If you'll
4 look on page three, I just want to -- there is
5 the same independent analysis slide. Do you
6 see it on page three at the bottom left-hand
7 side of the page? I don't know what you're
8 looking at? Let's go back to 102. Do you see
9 the bottom left-hand side? That's the same
10 slide that describes your expertise. Do you
11 see that?

12 A: I do.

13 Q: And that slide says that you provided an
14 independent analysis, correct?

15 A: Yes.

16 Q: And then the following slides were presented as
17 part of your analysis. Do you see that?

18 A: I do.

19 Q: Okay. I want to ask you about this one slide
20 that we've blown up at Exhibit 242. On this
21 one you assumed a 50 percent market share,
22 correct?

23 A: That's what this slide shows.

24 Q: Did you not do this?

25 A: No.

1 Q: Roper represents to its advisory board that
2 you've done this independent analysis and that
3 you're the latest and greatest expert in
4 healthcare and you didn't do it?

5 A: If I had done this, it would have been during
6 the Mount Pleasant analysis and looking here in
7 terms of 50 percent market share -- I do recall
8 during the Mount Pleasant dates, which would
9 have been '05, '06, '07, in terms of looking at
10 Moncks Corner and my conclusion from that was
11 that an overall bed need following the Mount
12 Pleasant profile would be a bed need of 30, 40,
13 50, somewhere in there.

14 Q: Are you testifying that you never prepared this
15 exhibit?

16 A: I'm testifying that that information that I
17 prepared and looked at would have been '05,
18 '06, '07. I'm not sure whether this pulls that
19 or replicates that. But in terms of the page
20 before the slide before, in terms of the seven
21 mile radius population --

22 Q: Yes --

23 A: -- I was part of that. I've seen that all
24 along. In terms of what the population is
25 within each seven mile radius, that was one of

1 the first things I looked at in terms of trying
2 to look at what the, sort of the magnitude of
3 the population was.

4 Q: So what you're saying is that what Roper told
5 its board, its advisory board, on May 19, 2008,
6 is not your work product?

7 A: I don't know whether it is my work product from
8 years before or not.

9 Q: You don't know?

10 A: No.

11 Q: Let's go back to Petitioner's 104. I want to
12 make sure that I understand your testimony.
13 And your testimony is, as to Petitioner's 104
14 --

15 MR. SUMMER: And go to, please, Ms. Tyer, to page
16 12, 2321.

17 Q: That is your work product, right?

18 A: No. I did not create any document that said
19 there would be a 65 percent market capture.

20 Q: So this was a fabrication?

21 A: I don't know what it was. I know it's --

22 Q: It's attributed to you.

23 A: It appears to be attributed to me and likely
24 some of the pieces from that I did provide, but
25 I did not prepare that slide.

1 Q: Let me just ask you, I want you to identify,
2 because I'm going to have a few questions about
3 this, Petitioner's Exhibit 156. This is an
4 earlier iteration. Do you have a copy of
5 Petitioner 156?

6 A: I think I have --

7 Q: This is your work product, is it not? This is
8 an earlier version of the application that was
9 never filed with the Department.

10 A: Yes. This appears to be my work which would be
11 an early draft which we did not follow through
12 with.

13 Q: Because you changed your assumptions from this
14 draft, didn't you?

15 A: Yes. We changed from just looking at a seven
16 mile radius to go to the total county to be
17 able to include the book of business that Roper
18 St. Francis had from the Moncks Corner area.

19 Q: Right. You also changed it in such a way that
20 you minimized or attempted to minimize the
21 adverse impact on other providers too, didn't
22 you?

23 A: I don't know. I'm not sure about that.
24 Because there was a larger non-Roper St.
25 Francis market share redirection in the seven

1 mile. But the total book of business outside
2 the whole county was in fact larger. So I
3 don't know if that occurred or not. That was
4 not the intent.

5 Q: Look at page 4199.

6 A: I've got it.

7 Q: All right. First of all, the assumptions are
8 your assumptions. They begin on page 4192,
9 don't they?

10 A: Yes. This is a first draft in terms of looking
11 just at the seven mile radius.

12 Q: And those are your assumptions; are they not?

13 A: They were draft assumptions which I rejected.

14 Q: I understand that, but did you draft them?

15 A: I probably did.

16 Q: This is your work product?

17 A: Yes, it is.

18 Q: Okay. And if you look on page 4199, the total
19 Roper cases is only 1,393, right?

20 A: Yes.

21 Q: Okay. And the subsequent application that was
22 filed with DHEC, that number was much larger,
23 wasn't it?

24 A: It was about 1,700.

25 Q: Okay. So what that does is it increases the

1 amount of redirection from Roper, thereby
2 decreasing cases taken from other providers,
3 correct?

4 A: Yes, to give effect to the expectation that
5 redirection from the Moncks Corner would occur
6 based on the existing Roper St. Francis
7 operation there.

8 Q: The bottom line is what you were trying to do
9 through all these various different attempts at
10 modeling, from the 65 percent that we saw in
11 the PowerPoint down to this and then your final
12 product, is you're trying to minimize the
13 adverse impact on other providers; are you not?

14 A: No. That's basically wrong. What I've tried
15 to do is establish what I expect to be a
16 reasonable forecast of what the volume would be
17 at the proposed facility and where it will come
18 from. And I think that the ultimate end result
19 we had, I think, reflects more correctly the
20 situation that Roper St. Francis had there in
21 Berkeley County.

22 Q: All right. Please answer any questions that
23 Mr. Long might have.

24 A: Thank you, Mr. Summer.

25 MR. LONG: Want to keep going, Your Honor?

1 THE COURT: Sir?

2 MR. LONG: Want to keep going?

3 THE COURT: What's your pleasure?

4 MR. LONG: I do need to, probably need like three to
5 five minutes. I think Ms. Biggers wants to
6 chat with me for just a second. So probably if
7 I could have five minutes maybe just to get my
8 questions organized. I don't think it's going
9 to be a long redirect..

10 THE COURT: Y'all all right with that?

11 MR. SUMMER: Press forward? Yes.

12 THE COURT: Let's try to finish. Recess five
13 minutes.

14 (Off the Record from 6:55 p.m. until 7:05 p.m.)

15 THE COURT: Back on the record. Mr. Long, redirect.

16 MR. RICHARDSON - REDIRECT EXAMINATION BY MR. LONG:

17 Q: Okay. Mr. Richardson, just to clarify for the
18 court, I know it's been a long day, but is
19 Trident Medical Center located in Berkeley
20 County?

21 A: No, they are not.

22 Q: Okay. And when Mr. Summer had you perform
23 calculations regarding the bed need analysis in
24 your Exhibit 70, on the bed need analysis, was
25 he ignoring the population in North Charleston?

1 A: He was ignoring the fact that Trident Medical
2 Center and Summerville do treat and serve the
3 North Charleston population.

4 Q: And is the population in North Charleston
5 significant?

6 A: Yeah, it is in terms of the -- when we look and
7 see, North Charleston is one of the larger
8 metropolitan municipalities in that area.

9 Q: And actually, I think on your sheet of
10 population, the population in North Charleston
11 is nearly a 100,000 people, right?

12 A: I believe that's correct.

13 Q: You got 70 there in front of you?

14 A: Yeah. Yeah, North Charleston is 97,000 which
15 is, among these listed municipalities, by far
16 the largest.

17 Q: In your opinion as a health planner, if North
18 Charleston didn't have a hospital, do you think
19 that the people in North Charleston might be
20 wanting a hospital with a population of
21 100,000?

22 A: They likely would.

23 Q: Okay. And right now in North Charleston,
24 Trident Medical Center has -- how many beds
25 does North Charleston have?

1 A: I believe it's 296 at the Trident facility.

2 Q: Now, when Mr. Summer had you do the
3 calculations regarding the 51 average daily
4 census from the growth showed on the next page,
5 page two, in your bed need analysis --

6 A: Yes.

7 Q: -- okay, he's ignoring some things in that
8 calculation, isn't he? Do you know what I'm
9 talking about? When he had you calculate the
10 growth between the two thousand --

11 A: I think where he was, was a 33 -- to make sure
12 I have this correct, was a 33, 34 average daily
13 census and about a 51 bed need.

14 Q: Correct. And a 51 bed need.

15 **THE COURT:** Please, sir, enunciate more clearly.

16 A: I'm just trying to correct Mr. Long. I think
17 he said a 51 average daily census and it
18 actually was a 51 bed need.

19 Q: All right. And is that 51 bed need based
20 solely on the growth from 2010 to 2017?

21 A: Yes. As I discussed with Mr. Summer, that's
22 purely squeezing and looking just at the
23 growth, not at all in terms of the existing
24 population there within Berkeley County.

25 Q: So would therefore he be ignoring in that

1 calculation the 55,629 patient days that exists
2 in 2010 in calculating that bed need?

3 A: Yes. Basically he just does not consider the
4 existing volume patient -- non-tertiary volume
5 that is generated by Berkeley County residents.

6 Q: And what's the average daily census for 55,629
7 patient days?

8 A: That's an average daily census of 152.4.

9 Q: Okay. And so how would that 65 percent
10 occupancy, how many beds is that?

11 A: That's 234 beds.

12 Q: So that's the 234 bed number there, right?

13 A: Yes.

14 Q: Okay. All right. You also were asked a number
15 of questions about the bed capacity at Trident
16 Medical Center and Summerville. I just wanted
17 to ask you if you kind of clarify for the court
18 again what exactly your point is in regarding
19 mentioning the fact that Trident Medical Center
20 and Summerville Medical Center have applied for
21 these certificate of needs?

22 A: My point is, is that in some of the questioning
23 it seemed like it was put to me in terms of
24 isn't Trident and Summerville just an available
25 alternative. You know, can't they do

1 everything that the proposed hospital will do?
2 And while the services and the technology and
3 all will likely be the same between the two,
4 what I've been trying to say is that the -- it
5 is a fact that both Trident Medical Center and
6 Summerville have both proposed to the state to
7 expand their capacity, to add beds. Inherent
8 in that, there must be a management or an
9 organization or a facility decision that they
10 need more capacity to better treat or to be
11 able to treat their existing and their future
12 book of business. So the fact that they're
13 telling the state that they need more, I think
14 has to bring in, at least at some level, sort
15 of a challenge in terms of are they a true
16 available alternative to the book of business
17 that we're proposing to serve at -- that Roper
18 St. Francis is proposing to serve at the new
19 Carnes Crossroads facility.

20 Q: If a facility has a bed need under the State
21 Health Plan, do they automatically get the
22 beds?

23 A: No. Let's talk about Trident itself. Trident,
24 in the State Health Plan that they were
25 reviewed on, had a bed need for 17 additional

1 beds. That's what the state calculated. A
 2 hospital doesn't need to do anything with that.
 3 That's just an indication that the state says,
 4 we think that you may need 17 additional beds.
 5 The decision that Trident made is they said,
 6 okay, we think we need an additional 50 beds.
 7 So that under the statute, the way you can sort
 8 of round up from whatever number up to a 50 bed
 9 unit size. So they took the 17 bed need
 10 defined in the State Health Plan, brought it up
 11 to 50 beds and said, told the state, we need
 12 that. So they took sort of the opening that
 13 the State Health Plan provided them and acted
 14 on it and basically told the state that, you
 15 know, not only the 17 that you showed we need,
 16 we think we need a full 50 bed addition. So
 17 that the fact that that is a need identified in
 18 the Plan does not mean automatically that
 19 hospitals just get them. There has to be a
 20 hospital management or hospital operator
 21 decision that they agree with that and that
 22 they feel they need to expand their capacity.
 23 State Health Plan opens the door; the
 24 management makes the decision.

25 Q: Okay. Now, is Roper St. Francis applying for

1 additional beds with its CON application?

2 A: No, they're not. It's a transfer of existing
3 bed capacity.

4 Q: All right. And is that an important fact for
5 you as a health planner in determining whether
6 these applications are competing or not?

7 A: I think it is. They, you know, as per the
8 discourse with Mr. Summer, I think that that is
9 a distinguishing factor.

10 Q: And you were also asked a number of questions
11 about the 30 minute travel time --

12 A: Yes.

13 Q: -- and in regards to that. Does the -- as a
14 health planner, does the State Health Plan
15 limit that -- or does the state -- can the
16 State Health Plan say that only hospitals can
17 be built if they're providing access to people
18 who don't live within 30 minutes of a hospital
19 at this time?

20 A: No, not at all.

21 Q: Have there been a number of hospitals approved
22 and built in South Carolina in the last, say,
23 ten years?

24 A: Yes.

25 Q: Okay. And were those hospitals only in regions

1 where people did not have access to a hospital
2 within 30 minutes?

3 A: No, not at all.

4 Q: Okay. All right. Do you still have the
5 regulation up there? Mr. Summer asked you a
6 question and he said something to the effect
7 of, in regards to the competing issue, as to is
8 there a need for both projects. Do you recall
9 that?

10 A: I believe so, yes.

11 Q: But I wanted to point out to you exactly what
12 the language says. I think it's a little
13 subtle, but it is different, okay. What does
14 the regulation in 103(6) in regards to the
15 proposals in need? Does it say that there's --
16 is the question is there a need for both or is
17 the question worded a little bit differently?

18 A: It basically says, "And whose applications, if
19 approved, would exceed the need for this
20 facility or service.

21 Q: So the approval of both has to exceed the need?

22 A: That's correct.

23 Q: For this facility. And of course, in your
24 opinion, would the approval of both these
25 applications exceed the need?

1 A: No, it would not.

2 **THE COURT:** And is that because it's a transfer and
3 there's no increase in the Roper beds?

4 **THE WITNESS:** I think that provides that there's --
5 that it does not exceed the need. And I think
6 in terms of looking in terms of the local
7 market, I think even if -- if Roper was trying
8 to add beds, I think that both could be
9 approved as well. I think there's enough need,
10 even if it was a 50/50 add. I think that both
11 would not exceed the need. But in this
12 situation where Roper is just transferring,
13 that's not an addition. So I would consider
14 this just a 50 bed addition.

15 **THE COURT:** Well, at some point during your
16 testimony, and I think it was on questioning by
17 Mr. Summer, it was said that the transfer would
18 be the only way that Roper could justify this
19 new hospital.

20 **THE WITNESS:** That was Mr. Summer's statement to me,
21 correct.

22 **THE COURT:** Do you disagree with that?

23 **THE WITNESS:** No. I don't. In terms of Roper,
24 Roper does not have a bed need and therefore
25 from the State Health Plan, sort of the

1 threshold need assessment, they can't add beds.
2 But in terms of the competing side, in terms of
3 the two competing sides, I think that the local
4 market has enough wherewithal to support both.
5 I think that the fact that there's a transfer
6 really just almost applies a wild card to that.

7 Q: Well, is it a very important fact in trying to
8 analysis whether the approval of both exceeds
9 the need?

10 A: Well, I think it is. I think the fact that
11 these are existing beds within the service
12 area, staying within the service area, I think
13 that's important.

14 Q: And you saw in the decision letter that Ms.
15 Brandt specifically referred to the fact that
16 it was a transfer in her decision that they
17 were not competing, right?

18 A: Yes, that is correct.

19 Q: In your opinion, was that a sound decision on
20 her part?

21 A: I think it was.

22 Q: And was it appropriate for her to cite to that
23 fact in making her decision?

24 A: I think it was.

25 Q: Okay. Mr. Summer asked you about the people,

1 about when y'all were talking about the access
2 issue, he asked you about the people traveling
3 from Berkeley County to Roper St. Francis. And
4 I think he implied that three-quarters of the
5 people in Berkeley County choose now to go to
6 Roper St. Francis. Do you recall some
7 testimony on that?

8 A: Yes, I do.

9 Q: What's the market share for Trident Health
10 System in Berkeley County?

11 A: Market share for Trident in Berkeley County is
12 54, 55, 56 percent.

13 Q: Okay. And so how many people then are leaving
14 Berkeley County and not using Trident Medical
15 Center facilities?

16 A: Forty-five, 46 percent of the folks are not
17 going to the closest facility which would be
18 Trident.

19 Q: Okay. Or Summerville Medical Center?

20 A: Yes, the Trident Health Systems, so it would be
21 the two facilities.

22 Q: Okay. So, will approving the Carnes Crossroads
23 application improve access to the 45 to 47
24 percent of the people in Berkeley County who
25 choose not to go to the Trident facilities?

1 A: Yes, it would.

2 Q: Now, Mr. Summer asked you some questions about
3 how under -- about whether applicants could try
4 to move a great number of beds around in a
5 service area, do you recall that?

6 A: Yes, I do.

7 Q: Okay. And that numerous applicants could do
8 that if they wanted to. First, to transfer
9 beds, do you have to get a certificate of need?

10 A: Yes, you do.

11 Q: So you got to get the state's permission,
12 you've got to go through the process right?

13 A: Yes. You need to justify -- in addition to
14 moving the existing beds, you need to justify
15 the fact that that facility is needed and makes
16 sense and can be operated effectively and
17 efficiently.

18 Q: And up in Spartanburg, Spartanburg Regional
19 Medical Center is a provider in that area of
20 the state, right?

21 A: Yes, it is.

22 Q: And it's on the other end of the state from
23 Berkeley County, right?

24 A: Sure is.

25 Q: And if Spartanburg Regional Medical Center had

1 basically zero patients from Berkeley County,
2 which is something that might be likely, right?

3 A: Very likely.

4 Q: Okay.

5 A: There might be one or two, but it's not
6 material at all.

7 Q: Okay. Let's say it's less than five, okay, and
8 they decided that they wanted to build a
9 hospital in Berkeley County and transfer beds
10 to Berkeley County to do that, think it's
11 likely the state would approve that?

12 A: No. If it were possible in terms of they open
13 the door to transfer, the fact that that
14 there's no historical or forecast patient base
15 to support that transfer would not be there,
16 and I think it would be denied.

17 Q: And is that really the key factor when you're
18 trying to analysis transfer, or one of the key
19 factors, is this historical base of patients?

20 A: I think it is. I think basically you need to
21 show that it makes sense and that there really
22 is a good match in terms of the business,
23 there's enough business that you're trying to
24 serve to support the beds that you are
25 transferring.

1 Q: Okay. And in regards to the bed transfer
2 language, you're aware of the board's decision
3 in the Parkridge case, right?

4 A: Yes, I am. I reviewed that.

5 Q: And you reviewed that?

6 A: Yes.

7 Q: As a health planner, you became aware of that
8 too as health planning?

9 A: Yes.

10 Q: Is it clear to you as a health planner whether
11 the State Health Plan allows you to transfer
12 beds to construct a hospital now in light of
13 the DHEC Board's decision?

14 A: In the light of the Agency's recent decisions
15 to allow that and the DHEC Board's
16 confirmation, you know, my observation is that
17 that is allowable as we sit here today.

18 Q: And so it is necessary to change the language
19 of the State Health Plan, as a health planner,
20 from your perspective, on this issue?

21 A: I don't think so.

22 Q: Okay. Now, I think Mr. Summer asked you or
23 made some comment about Les Shelton
24 promulgating the State Health Plan. I mean,
25 who actually puts together the State Health

1 Plan and approves it?

2 A: There is a Health Plan development -- I'm not
3 sure of the exact title. There's a Health Plan
4 Development Board with Mr. Shelton acting as
5 staff to that.

6 Q: Okay. Mr. Summer asked you about the
7 transferring of bed need a couple of different
8 places on his cross examination in the 2008-
9 2009 State Health Plan. But I'd like to look
10 at that under the '04-'05 Plan.

11 A: Okay.

12 Q: Which Plan did Trident actually apply under?

13 A: Trident has applied under the 2004-2005 Plan.

14 Q: Okay. Let's look at Joint Exhibit 3, page II-
15 7. Let's look at section D on II-7. It's on
16 the screen, too, Mr. Richardson, if you want to
17 -- she'll blow it up for you.

18 A: I've got it here on paper.

19 Q: Okay. All right. Can you read subsection D?

20 A: Sure. "Should there be a need shown for
21 additional beds for a hospital, then an
22 increase may be approved. In order to provide
23 for a cost effective addition up to the greater
24 of 50 beds or the actual projected number of
25 additional beds may be approved, provided the

1 hospital can document and demonstrate the need
2 for additional beds."

3 Q: This is the provision that Trident applied
4 under to build the facility at Moncks Corner,
5 right?

6 A: Yes.

7 Q: And this is the Health Plan that they filed
8 under, right?

9 A: That is correct.

10 Q: And as a health planner, does it say anywhere
11 that you can construct a hospital by using a
12 bed need at a facility?

13 MR. SUMMER: Your Honor, I must interpose an
14 objection, Your Honor. Two grounds, Your
15 Honor. The first ground is, is that I did not
16 go into this Plan at all and I did not ask him
17 a question about this at all on cross. More
18 importantly, nowhere has Roper challenged
19 Trident's ability to build a hospital with the
20 Department below. There's nothing in the
21 record that I can find where they've challenged
22 our application on its merits. They've not --
23 and the Department below, they didn't say the
24 Plan doesn't allow you to do what you're going
25 to do. So my position would be that the

1 testimony is being elicited for two reasons the
2 court should not allow. First is that it seeks
3 to go into an area and into a Plan that I did
4 not take the witness on cross examination. The
5 second, and perhaps more importantly, in
6 Marlboro Park and National Healthcare, this
7 court is allowed to plow ground on any issue
8 raised in the Department below and take new
9 evidence. It could be evidence that didn't
10 even exist at the time the Department reviewed
11 it. But it has to be an issue that was raised
12 at the Department below. And nowhere, no time
13 did Roper challenge Trident's ability to create
14 a new hospital under its license at the Moncks
15 Corner facility. So that would be my
16 objection, Your Honor.

17 **THE COURT:** Mr. Long?

18 **MR. LONG:** Yes, Your Honor. The issue absolutely
19 was raised below. But here's the difference.
20 Mr. Summer keeps saying that like we had to
21 raise it, as in Roper had to say to the
22 Department, okay. The reality is, is the issue
23 in Marlboro Park is was the issue before the
24 Department below. It absolutely was. Ms.
25 Brandt cited to this provision in her decision.

1 And it was an issue as they came to the
2 Department and said we're entitled to do this
3 under ths provision. We were an affected
4 person, we went through the whole review
5 process with them. We raised it with the DHEC
6 Board on the -- at the next level. And we
7 clearly put it into this court. But here's the
8 thing. Now, under the new law, Your Honor, I
9 mean, I haven't had any cases with that
10 particular issue yet. The legislature has
11 modified that I think somewhat. But this case
12 is under the old law. And under the old law
13 when you look at Marlboro Park, it's not a
14 matter of do you have to raise it below, it's
15 was it before the Department below. All right.
16 And if it's before the Department, it was, and
17 the Department -- it clearly was. Ms. Brandt
18 refers to the provision in her letter, so I
19 don't know how they can say it's not before the
20 Department. It's the whole basis of the
21 application. Now, on the other issue about
22 going beyond the scope of cross, I mean, Mr.
23 Summer asked him about this provision in
24 regards to the other Plan, I mean, and so all
25 I'm doing is trying to juxtapose and just

1 asking him about the same provision he raised,
2 but just in the appropriate Plan. I mean, he
3 -- I mean, and so I think that --

4 **THE COURT:** Be more specific, because I'll be frank
5 with you, that I don't remember it being raised
6 in cross examination.

7 **MR. LONG:** He asked him early on in the cross
8 examination about Trident applying for a bed
9 need and having a bed need and looking at
10 subsection D in regards to building their
11 facility and it's a different subsection in the
12 other Plan, but it's the same language. Okay.
13 But he referred to -- just saying that he also
14 talked about the next paragraph where he didn't
15 have a bed need. So I mean he did mention it
16 very early on. I think it was right at the
17 beginning of his cross examination, he went
18 through. I will agree it's in the other Plan.
19 But I only have a couple more questions on it,
20 Your Honor, but I think that it's the same
21 issue; can you transfer bed need to a
22 greenfield and try to build a hospital. I
23 mean, that's -- and that's what they're trying
24 to do in their application, so.

25 **MR. SUMMER:** May I respond, Your Honor?

1 THE COURT: Yes.

2 MR. SUMMER: In the '08-'09 Plan, the language is
3 substantially different. And the purpose of
4 taking the witness through the various
5 iterations was not as to Trident at all. But
6 what is my recollection was to say and take him
7 down to J, section J in the bed transfer
8 section, to show that the only way, which he
9 has confirmed, that Roper can get a hospital
10 anywhere is through an attempt with the
11 transfer language. Of course we say that plain
12 English is plain English and that it's not
13 there. But the purpose of that line of
14 questioning was not as to Trident, but was as
15 to Roper. Was not in the '04-'05 Plan, I don't
16 believe I ever opened that Plan or looked in
17 it. And so again, Your Honor, I don't believe
18 it's proper because I don't get a chance to
19 redirect -- or re-cross.

20 MR. LONG: This is my last comment, Your Honor. He
21 -- they've done this consistently throughout
22 the trial. They refer to the '08-'09 Plan like
23 it's their Plan. It's not. They're in the
24 '04-'05 Plan. And so I think that's what he
25 was doing with the witness. He was trying to

1 circumvent around the '04-'05 Plan and act like
2 their applications are in the '08-'09 Plan and
3 it's just not. It's the '04-'05 Plan. So
4 that's why I think he opened the door for
5 redirect.

6 **THE COURT:** I'm going to sustain the objection.

7 **MR. LONG:** Thank you, Your Honor.

8 Q: As a health planner, did you file a CON
9 application that you did not believe complied
10 with the State Health Plan?

11 A: No.

12 Q: Okay. And is that pretty consistent for all
13 health planners?

14 A: I think so. I think that it would be our job
15 to give advice to a client if he felt it did
16 not meet the Health Plan.

17 Q: Okay. Now, from a health planning perspective,
18 is there any benefit in continuing to operate
19 beds at one location when they could be --
20 where there's excess capacity, to where they
21 can be relocated to another area where there
22 was a growing population?

23 A: I think there are significant positives with
24 sort of the, to fixing the maldistribution by
25 moving beds to new areas. The only issue that

1 you may raise is in terms of can you operate
2 the new facility efficiently. And I think the
3 evidence is, is that those 50 bed facilities
4 can be operated efficiently and effectively.

5 Q: And you were asked a few questions about
6 whether the bed transfer was permanent?

7 A: Yes.

8 Q: Okay. And is there anything in the Health Plan
9 that allowed -- that says how long that
10 transfer lasts? Let me ask it this way. In
11 regards to applying for a future bed need at
12 the facility that is the transferring facility,
13 okay, what's the important criteria for that in
14 the regulation -- I mean in the State Health
15 Plan?

16 A: Is that they're permanently transferred and
17 that they cannot, that transfer of beds cannot
18 be used to document or show need for additional
19 beds.

20 Q: Right. And so in regards to the permanent part
21 of that, okay, from a health planning
22 perspective, would the purpose of that be to
23 prevent a system like Roper from manipulating
24 its licensed beds just based on its census?

25 A: It appears to be that it's basically -- once

1 you do it, it's done and you can't just throw
2 them, you know, put it back to the other side
3 and keep swapping them. It's a one time
4 occurrence.

5 Q: And if you were going to seek additional beds
6 or try to transfer beds in the future back
7 between these facilities, do you have to apply
8 for a certificate of need?

9 A: Yes, you do.

10 Q: And people could come to the Department and
11 object to that, affected persons, if they
12 wanted to, correct?

13 A: Sure. Sure, very much so.

14 Q: And they could file lawsuits and ask judges to
15 decide, right?

16 A: That's not me. I don't know.

17 Q: Okay. You were asked some questions about
18 Roper moving beds to make money, okay; do you
19 recall that?

20 A: Yes, sir.

21 Q: Have you looked at the payer -- and you started
22 to talk about the payer mix. Have you looked
23 at the payer mix between the Moncks Corner
24 facility and the Carnes Crossroads facility?

25 A: Yes.

1 Q: Okay. Tell the judge what payer mix is.

2 A: Payer mix is that if you look all the patients
3 that you're going to serve, what percentage of
4 those patients are in Medicare, Medicaid,
5 insurance or charity. Those are the major
6 categories. So the payer mix in terms of
7 what's the blend or what's the distribution a
8 patient shall serve by the folks who are going
9 to eventually pay your bills or not pay your
10 bills.

11 Q: Okay. And what categories do poorer people or
12 poorer South Carolinians tend to fall into in
13 regards to the payer mix?

14 A: They would fall into either the charity
15 category or the Medicaid category.

16 Q: And we heard testimony earlier this week and
17 last week about charity care, right? That's
18 when people -- do they pay any money for their
19 healthcare?

20 A: Charity care folks that come in and the
21 expectation from day one is the fact that there
22 will be no money received. It's not can we get
23 your co-pay or we go beat them for the money;
24 it's an awareness that from point zero there'll
25 be no money coming in associated with this.

1 Q: And so if the population has higher charity
2 care and higher Medicaid, which is also --
3 what's the Medicaid program for?

4 A: The Medicaid is for low income folks.

5 Q: And if you have higher percentages of those, is
6 the payer mix considered to be less favorable
7 or more favorable?

8 A: The higher the charity or Medicaid percentage,
9 the less favorable payer mix is what you have.

10 Q: And is Carnes Crossroads comparable to Moncks
11 Corner in regards to payer mix?

12 A: Specifically to Medicaid and charity, the
13 Carnes Crossroads facility has a higher
14 percentage in those categories than does the
15 Moncks Corner facility.

16 Q: Okay. You were asked about the Loris case that
17 you testified in in this court several years
18 ago. Can you explain some of what was going on
19 in the Loris case and some of the differences
20 between the Loris case and this case here?

21 A: In my mind the major difference was Loris was
22 attempting to basically split their volume from
23 their existing shop in Loris to a small
24 facility in Seacoast.

25 Q: What was their volume in Loris?

1 A: The average daily census was in the forties, so
2 44, 45. It's now down to 41 or 42.

3 Q: Okay.

4 A: So the concept there was to take a small book
5 of business and really divide it into two
6 smaller books of business, which is very
7 different than this. This is taking beds from
8 Roper Hospital, you know, good, established,
9 ongoing volume. Even with the shifting of the
10 beds and the volume to Carnes Crossroads, Roper
11 is going to be a large efficient operation.

12 Q: So is Roper's transferring facility, which is
13 Roper Downtown, is it a much different facility
14 than Loris?

15 A: Yes, it is, very much so.

16 Q: And in your mind, is that an important
17 difference between these cases?

18 A: Yes, it is. And the other difference is, is
19 that Loris was basically taking the Trident
20 approach of taking a five bed need, being
21 allowed to add 50 beds and so then taking that
22 the five bed need and the 40 on top of that and
23 moving that need to the Seacoast situation.

24 Q: And of course why was that different in our
25 case here?

- 1 A: Our case here, this is -- that's the situation
2 that Trident's attempting to do in this
3 situation. Which Roper St. Francis is
4 basically transferring beds, which was
5 identified as a major difference in that case
6 and it is different in this case as well.
- 7 Q: You heard Mr. Baehr testify last week in
8 regards to Mount Pleasant, didn't you?
- 9 A: Yes, sir.
- 10 Q: And do you recall his testimony when he said it
11 was too early to tell in Mount Pleasant?
- 12 A: Yes.
- 13 Q: Do you agree with him?
- 14 A: I do.
- 15 Q: Now, you were asked about the PowerPoints, I
16 think Petitioner's 104 and 102 that have come
17 into evidence that were presented to community
18 leaders. Did you go to those meetings?
- 19 A: No, I did not.
- 20 Q: Were you aware of them?
- 21 A: Not really.
- 22 Q: Have you ever read a transcript or anything
23 about what was said?
- 24 A: No.
- 25 Q: Do you have idea what was said at any of those

1 meetings?

2 A: No idea at all.

3 Q: In your opinion, will the Roper St. Francis
4 Carnes Crossroads hospital improve access for
5 patients in Berkeley County?

6 A: Yes.

7 Q: When you weigh the enhancement of access
8 against the potential impact of the Trident
9 Medical Center or Summerville Medical Center,
10 what is your opinion in regards to that
11 weighing, a comparison?

12 A: My opinion is that there is an enhancement in
13 access that should or could be compared to
14 adverse impact.

15 Q: Okay.

16 A: But I don't see any real adverse impact.

17 Q: Explain that to the court again.

18 A: Again, as we've gone through my analysis and
19 Mr. Baehr's analysis, it looks like Trident is
20 forecast to grow by 50 to 56 average daily
21 census in 2010 to 2017. The most that -- if
22 Roper St. Francis is developed, their total
23 hospital will serve a 35 census. So
24 illogically, if a hundred percent of the Roper
25 St. Francis patients came out of Trident's

1 side, Trident would still have more volume in
2 2017 than they do in 2010. I don't think
3 that's going to happen. I think the examples
4 that I've given, and looking at Mr. Baehr's
5 analysis, basically shows that the development
6 of the Roper St. Francis Carnes Crossroads
7 facility, all that will not come out of
8 Trident, and that smaller level will again
9 result in Trident having more business in the
10 future than they do today.

11 Q: And when you conclude that they'll have more
12 business in the future than today, does that
13 also include outpatient volume?

14 A: Yes, sir.

15 Q: They'll have a greater outpatient volume in
16 2017 than they do today?

17 A: Yes. The analysis was performed on bed days or
18 inpatient days, but that analysis extends to
19 the full book of business that's provided by
20 Trident.

21 Q: And Mr. Baehr includes tertiary cases too in
22 his analysis, right?

23 A: He adds a tertiary case add on adverse impact,
24 yes.

25 Q: But will any tertiary cases be done at the

1 Carnes Crossroads hospital?

2 A: No.

3 MR. SUMMER: I am going to have to object, Your
4 Honor. I never asked a question about tertiary
5 services.

6 MR. LONG: He asked about two hours of questions, or
7 at least an hour of questions on adverse
8 impact.

9 MR. SUMMER: Your Honor, I'm sorry, but I never
10 mentioned the word tertiary care services.

11 MR. LONG: I'll move on, Your Honor.

12 THE COURT: All right. Then I'll sustain the
13 objection since he's moving on.

14 Q: In all areas will Trident Medical Center be
15 stronger in regards to its volumes in 2017 than
16 they are in 2010?

17 A: It appears that they will be, yes.

18 Q: And in your opinion, are these two applications
19 at Moncks Corner and the one at Carnes
20 Crossroads competing applications?

21 A: In my opinion, they are not.

22 Q: And if they are not competing applications,
23 should they be valued separately? In fact,
24 should they be evaluated and reviewed
25 separately and stand on their own merits?

1 A: I think they both can be reviewed separately to
2 stand on their merits, yes.

3 Q: But if they're not competing?

4 A: Right. Because they're not competing, both can
5 be reviewed individually.

6 Q: And is that the appropriate way for the
7 Department to do that?

8 A: I think in this situation it is, yes.

9 Q: And in your opinion, should the Roper St.
10 Francis application at Carnes Crossroads be --
11 should the Department's decision be affirmed in
12 regards to the Roper St. Francis Hospital at
13 Carnes Crossroads?

14 A: I think as I started with maybe eight, nine
15 hours ago, yes. I felt that the application
16 was approveable and should be approved when we
17 first filed. I still feel that way today.

18 Q: Thank you for your time today, sir.

19 MR. LONG: Thank you, Your Honor.

20 THE COURT: One last thing. In respect to Mr.
21 Summer's objection about redirect examination
22 on subsection D, and I forget the rest of the
23 section citation, I should have been more
24 specific that I sustained that objection based
25 on my recollection of it not having been raised

1 on cross. I would find that Ms. Brandt's
2 letter did sufficiently bring it within the
3 raised below.

4 **MR. LONG:** Okay. Thank you, Your Honor. Thank you
5 for clarifying that one, Your Honor.

6 **THE COURT:** All right. What's your pleasure for The
7 morning? 9:30?

8 **MR. LONG:** Your Honor, first, we are finished. So
9 the Respondents do rest and --

10 **MR. SUMMER:** We have one rebuttal witness, Your
11 Honor, at this point and time, and that's Mr
12 Baehr. But the hour is late and our ability to
13 prepare tonight with him for tomorrow is
14 limited. And what I would propose is that we
15 come in at 1:00 tomorrow and I don't believe
16 we'll take more than two to two and half hours,
17 do you think counselor? About that. That
18 would leave sufficient time for your cross and
19 redirect and we could finish tomorrow.

20 **MR. LONG:** I object to that, Your Honor. We'll
21 never finish if we start at 1:00 with Mr.
22 Baehr. I think 10:00 or 10:30 at the latest.
23 I mean, Your Honor, we're all tired. I've been
24 up late many nights and so have they. I mean,
25 that's the way these witnesses roll. And I

1 think Mr. Baehr knows exactly what he's going
2 to say tomorrow and they've been here so -- and
3 it's rebuttal. So I would like to start. I
4 propose 9:30 but 10:00 maybe, but I do object
5 to 1:00 now.

6 **THE COURT:** What do you say to 11:00, Mr. Summer?

7 **MR. SUMMER:** Your Honor, could I ask for Friday
8 morning? I was trying to play a compromise.
9 I mean, you know, yes, we can do it 11:00, but
10 1:00 I think will be sufficient and we would
11 finish with the witness. There's nothing else
12 left to do. So I don't see where there's any
13 prejudice. If it weren't 8:00 at night I
14 wouldn't be asking for it. But it is late and
15 I know that -- I can't get anything
16 accomplished tonight. I'm going to have to get
17 up early in the morning to get it done.

18 **THE COURT:** I understand that.

19 **MR. SUMMER:** So 1:00 I think is a reasonable
20 request, Your Honor.

21 **MR. LONG:** I don't think we'll finish, Your Honor,
22 and I don't think you're entitled to a big
23 break. I mean, when we finished their case, we
24 rolled right into mine. I mean that's the way
25 it is when you practice law. Your Honor's been

1 very accommodating on some times, on some
2 things in regards to breaking earlier in the
3 day and all, but I really would like to finish
4 this case tomorrow and I'm very concerned that
5 if we blow the morning, we will not; we'll be
6 rolling over into Monday.

7 **THE COURT:** 11:00 then.

8 **MR. LONG:** Yes, Your Honor.

9 **MR. SUMMER:** 11:00, Your Honor?

10 (There being nothing further, the hearing recessed at
11 7:40 p.m.)

12 **DAY 14 - THURSDAY, FEBRUARY 16, 2012**

13 **THE COURT:** On the record. You were through, I
14 believe, Mr. Long.

15 **MR. LONG:** I was through, Your Honor. Maybe we
16 should take up a housekeeping matter on
17 Exhibits before we start today --

18 **MR. SUMMER:** Sure.

19 **MR. LONG:** -- to let the court know what we talked
20 about. Your Honor, as you know, we have lots
21 of notebooks here for Your Honor. Not all of
22 these proposed exhibits have come in or will
23 come in. So I think what we're going to --
24 what we propose to do is at the end of the
25 trial we will read into the record the exhibits

1 that we have that have been admitted. Just
2 read the numbers into the record. And then our
3 paralegals or legal assistants will need to
4 come over here with the court reporter and pull
5 out the exhibits that have not been admitted
6 from the notebooks. And then we could just
7 leave the notebooks with the court and the
8 court reporter, however y'all want to handle
9 it. And if you need two sets, we'll be happy
10 to do that for you too. I mean, whatever's
11 most convenient for the court on that regard.
12 And then that will be -- those will be the
13 exhibits for the case, the official record of
14 the exhibits.

15 **THE COURT:** Thanks. We'll take that up at the end
16 of the testimony.

17 **MR. LONG:** Yes, sir.

18 **MR. SUMMER:** The only thing I would add to that is
19 we would also go over the designations, the
20 depo designations, to make sure those are
21 clearly a part of the record as well.

22 **MR. LONG:** Yeah. They need to be -- yeah, I mean --

23 **MR. SUMMER:** We need to at least do name, page and
24 line number so that it's clear.

25 **MS. HOLLINGSWORTH:** I thought we were submitting a

1 document.

2 MR. LONG: We're submitting a document.

3 MR. SUMMER: That's fine. We can submit a document.

4 As long as it's in the record, that's fine.

5 MR. LONG: We're submitting the document.

6 THE COURT: Mr. Summer.

7 MR. SUMMER: All right. Your Honor, Trident would
8 call Mr. Richard Baehr in rebuttal.

9 RICHARD BAEHR, being duly sworn, testifies as
10 follows:

11 MR. SUMMER: I respectfully ask counsel if we could
12 all stipulate to his expertise so I don't have
13 to requalify him?

14 MR. LONG: I don't -- he's already been admitted as
15 an expert.

16 MR. SUMMER: I just want to make sure the record
17 reflects that he is an expert in healthcare
18 planning and healthcare finance.

19 MR. BAEHR - DIRECT REBUTTAL EXAMINATION BY MR.
20 SUMMER:

21 Q: Mr. Baehr, you've been here for the whole
22 trial; have you not?

23 A: Except for one afternoon when I was discharged
24 after my testimony was completed. I wasn't
25 feeling very well.

1 Q: Okay. Did you get a transcript for that period
2 of time that you missed?

3 A: I did. I did.

4 Q: And did you review that transcript?

5 A: I have.

6 Q: Okay. What I'd like to do is to basically
7 focus on issues and testimony in Roper's case.
8 And I'm going to try to do this in an orderly
9 fashion. The first thing I'd like to talk
10 about, in terms of issues raised by Roper, deal
11 with Mr. Knapp, the financial witness for Mr.
12 Roper. Do you recall his testimony?

13 A: I do.

14 Q: Okay. And do you also recall a line of
15 questioning in which Mr. Knapp took issue with
16 how you had computed the contribution margin
17 for the Moncks Corner Berkeley Medical Center
18 only? Do you remember that?

19 A: Yes, sir.

20 Q: I'm going to hand you two exhibits. Actually,
21 you may already them. The first exhibit is
22 Respondent's 73.

23 A: I do have that.

24 Q: All right. The other exhibit I'm going to ask
25 you to refer to is Petitioner's Exhibit 219.

1 A: Correct.

2 Q: My recollection is that Mr. Knapp made
3 reference to each of these documents when he
4 was critiquing your adverse impact analysis --
5 excuse me, your contribution margin number for
6 Berkeley Medical Center, correct?

7 A: Correct.

8 Q: Would you please share with the court your
9 opinion about whether or not Mr. Knapp's
10 critique was accurate?

11 A: I think his calculations are accurate, but his
12 interpretation is flawed.

13 Q: All right. And would you explain why to the
14 court?

15 A: Yeah. Basically, what Mr. Knapp was doing was
16 comparing apples and oranges. What he did was
17 he compared a contribution margin which was
18 developed by the Trident Medical Center,
19 Trident Health System, to determine what their
20 contribution margin was for a one year period
21 ending June 30, 2010 for all of the non-
22 tertiary volume that was seen either at Trident
23 Medical Center or Summerville Medical Center.
24 What Mr. Knapp attempted to do was to compare
25 that contribution margin to the contribution

1 margin that he calculated for the Berkeley
2 Regional Medical Center, which he tested as of
3 the year 2012. So he was looking at the 2010
4 number for the contribution margin for the
5 entire system, and the 2012 number for Berkeley
6 Regional Medical Center. And what we found was
7 that the contribution margin was higher for
8 Trident Medical Center. He then carried those
9 numbers forward to 2017, which is the last year
10 of our projection. And what he said was,
11 they're actually going to make more money. If
12 they have the same contribution margin at
13 Berkeley Regional Medical Center as is appears
14 to be the case at the Trident System as a
15 whole, then the new hospital in Moncks Corner
16 will make more money. And what that means is,
17 the way he used that information was to say,
18 well, Mr. Baehr developed a slide that showed
19 that there would be significant harm to both
20 hospitals' projections if both hospitals are
21 approved. Each hospital projected, both the
22 Roper St. Francis Berkeley and the Moncks
23 Corner facility, projected financial
24 performance assuming they were going to be the
25 only hospital serving the market. All right?

1 So I put together a table in which I examined
2 what I believe would be the implication of both
3 hospitals being built. And if both hospitals
4 are being built, and there's not enough need
5 for both, neither hospital meets its
6 utilization forecast and they suffer financial
7 losses.

8 Q: Was that in Petitioner's 46?

9 A: Yes, it was.

10 **MR. SUMMER:** Could you pull up Petitioner's 46?

11 Q: It's 1619?

12 A: Yes, I believe that's the page.

13 **MR. SUMMER:** Let's pull that up.

14 Q: Would it be helpful for you to refer to this?

15 A: Sure. Sure. Because this really is the start
16 for what Mr. Knapp is doing.

17 Q: Okay.

18 A: Whoa, you went too far. That's it.

19 Q: Okay.

20 A: And just to understand what this slide shows,
21 is each hospital projected volume and in the
22 third year, if you'll look at this at the very
23 bottom of this slide you see 2017 RSFB net
24 income and 2017 BRMC net income. The 2017 BRMC
25 net income, 69,533, is based on the model Mr.

1 Woodford, who was the consult for the Trident
2 System, put together, it's based on 11,717
3 patient days in that year. Above that, right
4 before this, you see a slash and you see 6,388.
5 This is Mr. Knapp's forecast of incremental
6 volume at Roper. Now, remember, Mr. Knapp only
7 forecast basically half a hospital. He assumed
8 half the hospital was incremental, half the
9 hospital was redirected. Those numbers are
10 wrong. He used the wrong percentages. But for
11 the purposes of this table, we followed what he
12 has in his projections.

13 Q: So that's his number?

14 A: Yeah. The 6,388 is essentially equivalent to
15 12,775 patient dates, all right. The reason
16 the numbers on the top are smaller is it
17 represents Mr. Knapp's incremental volumes.
18 The real volume at the hospital is double that
19 number. And so, for instance, if there's a
20 change from 6,388 to 5,000, the way these
21 numbers are calculated reflects a drop not just
22 in the incremental, but also a drop in the
23 redirected volume. So it would be twice as
24 much, twice as many days as seem to be
25 reflected on the top. But since the only thing

1 the Department ever saw was the incremental,
2 we've used those incremental numbers.

3 Q: All right. Now, just so I can understand and
4 for the record, you referred to RSFB, that is
5 the Carnes Crossroads hospital, correct?

6 A: That's Carnes Crossroads. And these are the
7 numbers in their application.

8 Q: All right. And then the line below would be
9 the Moncks Corner proposed hospital?

10 A: Right. And only the first column reflects
11 what's in the application. Every other
12 scenario here reflects that the hospitals don't
13 do as well as they projected because of the
14 fact that there are two hospitals instead of
15 one, and there's not enough volume to go
16 around.

17 Q: Okay. All right. So let's talk about what Mr.
18 Knapp's extrapolations or criticisms are?

19 A: Right. Mr. Knapp basically runs through a
20 model and he says because of the fact that I
21 should have used the higher contribution margin
22 for Berkeley Regional Medical Center that we
23 knew was the case for the Trident, for the
24 Trident Health Systems, that really instead of
25 making \$269,000, Mr. Knapp says in reality the

1 Berkeley Regional Medical Center will make
2 \$6.6, \$6.7 million in year three. That's what
3 he claims..

4 Q: And that's expressed in Respondent's Exhibit
5 73; is that correct?

6 A: Right. It's on the first page, which is kind
7 of a summary. It's Knapp Berkeley 000461. And
8 what's of interest is what he does with that
9 number. He basically argues, if you turn to
10 page 464, that because Moncks Corner will be
11 swimming in money because their forecast was
12 too modest, that's the word he kept using, that
13 really Moncks Corner Hospital doesn't need
14 12,470 days; they only need 9,000 days to get
15 the same net income. That told me one thing
16 first. There was never any testimony offered
17 challenging my conclusions about how many days
18 each hospital would lose. There was no
19 alternative evidence offered saying, the losses
20 would actually be X or the losses would
21 actually be Y. My testimony is the only
22 testimony so far that's been offered about what
23 the impact is of the two hospitals. Given that
24 that's damaging, it shows that the Moncks
25 Corner facility is going to lose money. It

1 explains why the Moncks Corner facility, the
2 decision was made not to be built. It shows
3 that the Roper facility will lose money. This
4 is offered essentially to lessen the pain. It
5 says, at least in the case of the Berkeley
6 Regional Medical Center, they won't get hurt
7 quite so bad because they're really making more
8 money than they're showing.

9 Q: Is he correct in those assumptions?

10 A: He's not. And the reason is because of what I
11 just said, apples versus oranges. And this is
12 where you get into the next set of pages that
13 Mr. Knapp talked about yesterday, which is,
14 Petitioner's Exhibit 219, pages 1844 to 1847.
15 And here I guess my criticism of Mr. Knapp is
16 we've heard the word cursory examination a lot
17 of times in this trial. Like Mr. Johnson gave
18 a very cursory look to the financials that Mr.
19 Knapp put together, that Mr. -- a lot of
20 cursory examinations of what we put together,
21 what Trident put together in their forecast.
22 It looks like it's kind of a cursory
23 examination of what the Berkeley Regional
24 Medical summary numbers are, because the are
25 not a full hospital. You cannot compare the

1 Berkeley Regional Medical Center contribution
2 margin, which is based on all the outpatient
3 volume, but only about half of the outpatient
4 volume. Because there's already outpatient
5 volume --

6 Q: Excuse me. Half the inpatient?

7 A: All the inpatient, half the outpatient. Sorry
8 if I misstated that. The model that Mr.
9 Woodford built up says this, right now there's
10 a -- Trident has facilities in Moncks Corner.
11 They have an emergency department, they have
12 outpatient facilities, they have diagnostic
13 facilities, and those facilities are already
14 there. We built up a model, the demand
15 forecast, the B11 section that we put together
16 projects overall volume for the Trident Medical
17 Center, both inpatient and outpatient. Mr.
18 Woodford, who did the financials, took all of
19 our inpatient numbers, with the exception of a
20 small adjustment he made in year three because
21 there weren't enough Trident System days to
22 support it in terms of growth, but for the
23 outpatient, he didn't use all of our volume
24 projected. He looked at the difference between
25 what we'd projected and what was already there.

1 So he only did an incremental model on
2 outpatient.

3 Q: Otherwise he would have counted it twice?

4 A: Otherwise he would have counted it twice. Now,
5 Mr. Knapp has made a lot of comment, which I
6 agree with. That hospitals that build up
7 volume over time, their margin can increase
8 because there's a basic core staff and as you
9 add additional volume, there are improvements
10 in your margin. In addition, and this is where
11 a more careful examination of the Berkeley
12 Regional Medical Center numbers might have been
13 helpful, the ratio of net revenue to gross
14 revenue for outpatient for the Berkeley
15 Regional Medical Center is higher than it is
16 for inpatient. Adding another layer of
17 outpatient going forward into the future is
18 positive. And when you make the adjustment --
19 Mr. Knapp went through these tables and he
20 didn't seem to understand what actually is in
21 them.

22 Q: Well, let's do that. What's the first page?

23 A: The first page is what's in the application.

24 Q: Okay. That's in the CON application?

25 A: That's in the CON application. It's the

1 Berkeley forecast numbers for five years and it
2 goes out to year five, but we've been relying
3 on year three up to now.

4 Q: Okay. The second page was --

5 A: The second page is essentially a restatement of
6 what Mr. Knapp did with the Berkeley numbers.
7 And, again --

8 Q: Well, let's look at the top of the page. I
9 think he attributed this as your work product.
10 What is the legend at the very top?

11 MR. SUMMER: Could we pull that up, the legend at
12 the very top of the page, please?

13 A: This is admissions and adjusted admissions by
14 year.

15 Q: Right.

16 A: Okay.

17 Q: But whose analysis is it?

18 A: Yeah. These are numbers pulled from basically
19 the Berkeley -- from the Berkeley Regional
20 Medical Center statements with essentially a
21 tweak that Mr. Knapp gave it, which I thought
22 what he did was fine. I mean, I understood
23 what he did. He was trying to take our final
24 year expense numbers, dis-inflate them,
25 essentially bring them, carry them back to see

1 what they would have been equivalent to in the
2 year 2012.

3 Q: Present value.

4 A: Present value. And then compare it to revenues
5 and come up with essentially what the
6 contribution margin was in 2012 that's implicit
7 in the Berkeley Regional Medical Center
8 numbers. It takes a lot of work. I think he
9 was careful doing the work. His number comes
10 out to be correct, based on what he did, okay.
11 And that's the number in the far-right column.
12 The reason why I have more columns than Mr.
13 Knapp does, I also calculated essentially what
14 that contribution margin would be in 2012,
15 going back from each of the intermediate years,
16 okay, 2013, '14, '15, and so on. But just
17 concentrate on the bottom right-hand number.
18 That's the number Mr. Knapp used, okay, the
19 3,853.

20 Q: Correct.

21 A: Where the problem comes in is in the next page.
22 When Mr. Knapp was testifying on page 1846, he
23 said this looks more like it. This is a more
24 profitable Berkeley Regional Medical Center
25 financial. It's the kind I'd expect. You

1 know, what's in the application's too modest.
 2 This is the -- what's in the application and
 3 adding in the part of the hospital that's not
 4 in the incremental forecast. It's essentially
 5 putting in all the outpatient. And when you do
 6 that, you come up with more profitable numbers.
 7 And we did the same exact analysis Mr. Knapp
 8 did on the following page to see what that
 9 translates to into a contribution margin back
 10 in 2012 using the full hospital numbers. And
 11 if you'll look at the bottom right on page 1847
 12 --

13 Q: Right.

14 A: -- 5,071. So if you look at the full hospital,
 15 that's the contribution margin for Berkeley
 16 Regional Medical Center, 5,071. Not the 3,853,
 17 which Mr. Knapp correctly calculated but he did
 18 it essentially for three-quarters of a
 19 hospital. And he said the three-quarters of a
 20 hospital should be the same as the Trident
 21 Medical, the entire Trident System. And that's
 22 just wrong. It shouldn't be the same. You
 23 wouldn't expect it to be the same.

24 Q: Why?

25 A: Well, there's a number of reasons. One is

1 because of the fact that you want to have full
2 hospital versus full hospital. What are the
3 Trident Health System numbers? Summerville
4 Medical Center plus the Trident Medical
5 Center, plus it has the piece of the Moncks
6 Corner facility not included in the Berkeley
7 statement. And then for Berkeley, you've got
8 the full inpatient and the incremental
9 outpatient, those two should not be comparable.
10 That's the first reason. Second reason the
11 payer mix is different between the Berkeley
12 Regional Medical Center and Trident Health
13 System. It's a little more favorable for the
14 Trident Health System overall than it is for
15 Berkeley Regional Medical Center. Why is that?
16 When Mr. Woodford developed his forecast for
17 payer mix, he looked at specific zip codes.
18 The zip code is something that the Roper people
19 have stayed away from. We've been very
20 careful. We've looked at zip codes, not only
21 in trying to make assessments of how many
22 patients might be redirected, but also to look
23 at where the patients are coming from for the
24 new hospital in building our forecast model.
25 And the new hospital, we assumed the big zip

1 codes would be those around the lake, would
2 Moncks Corner, and would be that dual county
3 zip code, 29483. Remember where the Roper
4 Hospital is, it's in 29461, the Moncks Corner
5 zip code, on the border of that 29483. Mr.
6 Woodford took all of the non-tertiary patient
7 volume from the eight zip codes, north and
8 central. Moncks Corner and the zip codes
9 around the lake and the 29483. He looked at
10 their historical payer mix and it turns out
11 it's a little bit less favorable on average
12 than the Trident Health System overall. That
13 won't have an impact. And the last is that you
14 would never expect a 50 bed community hospital
15 to have the same average intensity of services
16 as Trident Medical Center would, which is the
17 dominant provider within the Trident System.
18 It's more than -- you know, it's roughly three-
19 quarters of the -- over three-quarters of the
20 beds.

21 Q: Where the sicker people go.

22 A: Okay. It's where the sicker people go. And
23 even if you pull out tertiary volume, the non-
24 tertiary volume that's left is going to be on
25 average higher acuity, more intense than you're

1 going to get at a 50 bed hospital that's built
2 in Moncks Corner. All of those three reasons
3 are valid reasons why; if you just do what Mr.
4 Knapp did, and then you compare it to the
5 Trident System, you'd come up with a different
6 number. The biggest factor turns out to be the
7 exclusion of all of that outpatient volume,
8 revenue and expense. But even what's left, and
9 I calculated a difference of roughly about \$300
10 that remains in the year 2012, and that's a new
11 exhibit, a summary exhibit I prepared.

12 Q: Well, let's just look at the summary.

13 MR. LONG: Your Honor, can I object? That's not an
14 exhibit. There's not one single reference on
15 that exhibit to an underlying document. A
16 summary exhibit is a voluminous underlying
17 document that's compiled for the benefit of the
18 court. That is a summary of his testimony,
19 okay. I've looked at the document this morning
20 and talked to Mr. Knapp briefly about it, but
21 look at it. There isn't a single reference to
22 anything on it. There are calculations on here
23 which cannot be determined from the document
24 itself. It's not a summary.

25 THE COURT: I sustain. Just let him testify, Mr.

1 Summer.

2 MR. SUMMER: Well, I haven't even offered it, Your
3 Honor.

4 THE COURT: I understand.

5 MR. SUMMER: I mean, demonstrative exhibits, I could
6 have brought a poster in and had him testify
7 about it. So I appreciate the objection, but
8 if and when I offer it for evidence, I'll argue
9 about that then.

10 THE COURT: Okay.

11 Q: If you would, let's just walk through this--

12 A: Sure.

13 Q: -- to explain to the court your calculations
14 and what you've done on this demonstrative
15 exhibit.

16 A: Sure. The 4,985 number is not new to this
17 case. It's been in many of the exhibits that
18 were part of my presentation when I was here
19 for three days last week. And --

20 Q: And that's found in Petitioner's Exhibit 46,
21 correct?

22 A: Correct.

23 Q: All right.

24 A: And that reflects the contribution margin that
25 was calculated by Trident Health System for the

1 year ending June 30, 2010, for all of their
2 non-tertiary volume.

3 Q: All right. Well, first of all, did Mr. Knapp
4 or anyone take issue with that number?

5 A: No.

6 Q: Okay. All right. Go ahead.

7 A: Second is in Mr. Knapp's own analysis, he
8 inflates the numbers, the margin going forward
9 by three percent a year so he can have
10 comparable years, all right. So if I inflate
11 by the two and a half years to get to the 2012
12 number, that 4,985 gets bigger. It becomes
13 5,367 in the year 2012, assuming contribution
14 margin grows three percent a year, exactly the
15 same assumption Mr. Knapp made in his Exhibit
16 73, I guess Respondent's 73. Okay. The 5,071
17 number, well, that's a number that appeared
18 again in the tables that Mr. Knapp discussed in
19 his testimony. They're my exhibits that I
20 prepared, but Mr. Long questioned Mr. Knapp
21 about them. That 5,071 comes right off of
22 Petitioner's Exhibit 219, page 1847. All
23 that's left to do is to compare 5,367 to 5,071
24 and subtraction is pretty basic, 296 is the
25 difference.

1 Q: Okay. So what you're doing is comparing apples
2 to apples?

3 A: That's what we're doing here, yes. Correct.

4 Q: All right. And, again, this is only as to the
5 contribution margin for the Berkeley Regional
6 Medical Center in Moncks Corner, right?

7 A: Correct. And if what I am saying here is
8 correct, that basically the full hospital model
9 for Berkeley Regional Medical Center is almost
10 the same, it's a couple hundred dollars less
11 than the contribution margin for the Trident
12 System and whatever difference is left is
13 explainable between the acuity issue and the
14 payer mix issue, no change whatever is required
15 to the exhibit I offered on what the financial
16 impact is of the two hospitals both being
17 approved and both being built.

18 Q: So do you believe that your -- that the
19 projections for the Berkeley Regional Medical
20 Center are accurate?

21 A: I do.

22 Q: Okay. All right. While we're on this, let's
23 just keep talking about Mr. Knapp a little bit.
24 Let's look at that 4,985 number there. If that
25 comes from --

1 MR. SUMMER: Can we pull up Petitioner's 46? And
2 go, I think it's actually expressed on the last
3 page of Petitioner's 46.

4 Q: Now, you remember Mr. Knapp's testimony about
5 taking a hit? Do you remember that testimony?

6 A: Correct.

7 Q: Okay. These are your work papers. Just
8 explain to the court what that \$4,985 number
9 is?

10 A: That is the contribution margin per adjusted
11 admission for the non-tertiary volume for the
12 Trident System. In other words, if you lose an
13 inpatient admission or an equivalent outpatient
14 admission, if you look at the equivalent amount
15 of revenue and associated services that would
16 make the two equivalent, it's about roughly
17 \$5,000 per adjusted admission, which means
18 that's the increment with more adjusted
19 admissions, it's a decrement if you lose
20 adjusted admissions.

21 Q: Okay.

22 A: And adjusted admissions, again, Your Honor, is
23 for someone who's not a professional in the
24 field, I understand this is all, can be what is
25 this all about. Adjusted admissions simply is

1 a way to take account of the fact that
2 hospitals are not just inpatient facilities.
3 They are increasingly outpatient facilities.
4 And in the case of the Roper System, it's about
5 one to one. So if there's a loss -- if you're
6 going to lose one inpatient admission because
7 of adverse impact, you'll lose the equivalent
8 of a second one --

9 Q: In revenue?

10 A: -- equivalent of revenue because of the loss on
11 the outpatient side. So we draw the two in
12 together and we try to make essentially the
13 best estimate you can to account for all the
14 volume of the hospital. And you look at that,
15 all the volume lost compared to the
16 contribution -- compared to the, essentially
17 income that's lost.

18 Q: All right. All your prior testimony regarding
19 Mr. Knapp dealt with contribution margin at
20 Berkeley Regional Medical Center?

21 A: That's correct.

22 Q: Now what I want to do is I want to move to the
23 next line of questioning, which deals with Mr.
24 Knapp's testimony regarding the hit, okay?

25 A: That's fine.

1 Q: All right. Mr. Knapp did not take any issue
2 with your computation of contribution margin,
3 did he?

4 A: He did not.

5 Q: Okay. So let's continue to use that number.

6 A: Okay.

7 Q: Now, first of all --

8 A: And nor, by the way, did he take -- have any
9 issue with the contribution margin for tertiary
10 business.

11 Q: But what I want to focus on is that non-
12 tertiary per case number. Because isn't that
13 the one that's most relevant to our inquiry
14 here today?

15 A: Yes. Because if the Roper St. Francis --
16 there's two different adverse impacts. The one
17 is the one we just discussed, which is what
18 happens if both hospitals are built. And my
19 conclusion is if both hospitals are built,
20 neither one will come close to the numbers that
21 are in their projections that they submitted to
22 the Department. And I thought the Department
23 should have considered that as an issue before
24 they made their decision.

25 Q: All right.

1 A: Especially considering there's only need for
2 one hospital. The second adverse impact is
3 different, and that is assuming Roper St.
4 Francis is the only hospital that's built, what
5 adverse impact will be suffered by the Trident
6 Health System as a result of Roper's being
7 approved.

8 Q: Okay. All right. So now our focus is going to
9 be -- let's assume that only Carnes Crossroads
10 is built.

11 A: Correct.

12 Q: Do you remember Mr. Knapp's testimony regarding
13 the hit? The first thing I want to ask you is,
14 in your profession what is -- is that a
15 technical phrase?

16 A: No, it's actually more associated with the HBO
17 Series The Sopranos. But I understood what Mr.
18 Knapp was getting at.

19 Q: Okay. One of the things was he tried to
20 minimize that the hit in the Grand Strand case.

21 A: Uh-huh (affirmative).

22 Q: Can you tell me was the magnitude of the hit in
23 the Grand Strand case?

24 MR. LONG: Objection, Your Honor. You've got to lay
25 a little foundation. He wasn't involved in it.

1 MR. SUMMER: I'm happy to lay the foundation for it,
2 Your Honor.

3 THE COURT: Thank you, sir. Please.

4 MR. LONG: If he knows.

5 Q: All right. The first thing I want to do is
6 talk to you about what you did in this
7 engagement, because we're going to have to go
8 back several years now, okay?

9 A: Sure.

10 Q: Let's just talk about in terms of this
11 engagement. In the beginning, what do you have
12 to do to familiarize yourself with a project
13 like this? What do you do?

14 A: You become familiar with the hospital system
15 you're working with. You become familiar with
16 its competitive environment, you become
17 familiar with the State Health Plan, you become
18 familiar with the demographics in the service
19 area.

20 Q: Okay. And then you then use your expertise to
21 help folks create a certificate of need
22 application?

23 A: Correct.

24 Q: After that process is done and we go into the
25 appeal process, what's the kind of work that