

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

Appellate Case No. 2014-000973
Case No. 2012-ALJ-07-0090-CC

Grand Strand Regional Medical Center, LLC Respondent,
v.

South Carolina Department of Health and
Environmental Control.....Respondent below.

Case No. 2012-ALJ-07-0091-CC

Grand Strand Regional Medical Center, LLC Respondent,
v.

South Carolina Department of Health and
Environmental Control and Carolina Regional Cancer Center, LLC... Respondents below,

Of whom Carolina Regional Cancer Center, LLC is the Appellant.

RECORD ON APPEAL – VOLUME 2 OF 10

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1 email, but that was the original plan all along
2 was to put it in -- in the -- in the main
3 hospital.

4 Q: Let's look at 15 -- I'm sorry, CRCC 115.

5 A: Yes, sir.

6 Q: Okay. This is an email from Adam Rudd to you
7 on the same day reporting on the land being
8 removed ---

9 A: Yes, sir.

10 Q: --- from the report. So this is the day that
11 y'all were told to remove it from the
12 documents, right?

13 A: I don't know that that's the day we were told
14 to remove it. Was that the day of the email we
15 looked at a minute ago? I don't know when we
16 were told to ---

17 Q: Yes.

18 A: --- remove it, but it was around this time.

19 Q: And look at CRCC 116.

20 A: Okay.

21 Q: And you're asking the construction team to give
22 you site plans for the hospital location, and
23 he writes you back and said we never did any
24 site plans for the hospital.

25 A: Can I read this real quick?

1 Q: You can.

2 A: Yeah, I said can you quickly send me the site
3 plan. Okay. Okay. Yeah, it says we did not
4 actually prepare a site plan for this scheme
5 but can draw a box -- probably draw a box on an
6 aerial if that would be helpful for your call.

7 Q: So on May 25th, you still had not driven any --
8 prepared any site plans for putting a linear
9 accelerator at the hospital, correct?

10 A: Or at South Strand, correct.

11 Q: Okay. Let's look at Exhibit 121.

12 A: All right.

13 Q: CRCC 121. There was a conference call, if you
14 look down here on the bottom of the email, it
15 goes onto the next page.

16 A: Yes, sir.

17 Q: Between the management team and others that,
18 apparently, you did not participate in, right?

19 A: Yes, sir.

20 Q: You're aware of that, right ---

21 A: Am I aware of what?

22 Q: You're aware about this conference call about
23 this project on the 16th of June, but
24 apparently, you did not participate in it?

25 A: In reality, I'm aware of it. If you went over

1 it in my deposition, I was aware of it then,
2 and I hadn't thought about it again. So today,
3 I'm aware of it again because it's in front of
4 me.

5 Q: Okay. And then there's an email from you -- to
6 you from David Was the next day, June 17th,
7 summarizing the call for you, right? I mean,
8 this is my question to you. I'm just trying to
9 get you ---

10 A: Okay.

11 Q: --- show you where we are.

12 A: Okay.

13 Q: And then you responded back to him, this really
14 means they are not hip on financing this
15 project. What does that mean?

16 A: What does my sentence mean?

17 Q: Yes.

18 A: It means that whatever I read below here, which
19 I haven't had time to read today or at the
20 deposition, whatever was said obviously gave me
21 the impression that David Wass, who is a -- at
22 this point, a very green behind the gills, very
23 inexperienced hospital administrator wannabe,
24 is summarizing the results of this conference
25 call, and whatever I read there, I'm opining

1 that it means that the corporate people are not
2 really excited about using HCA capital to do
3 the project.

4 Q: And isn't the reason because they thought it
5 was too expensive?

6 A: I don't know -- well, at that point it was if
7 we still had -- was it -- I haven't read it
8 again, Mr. Long. Is this -- is this talking
9 about doing it on property we buy from Dr.
10 Holt?

11 Q: You can look at the -- you can look at the
12 call.

13 A: Okay. You want me to look ---

14 Q: I mean, you can look at his summary for you
15 too.

16 A: Let me look at his summary real quick. Yeah,
17 I was probably pessimistic at that point
18 because they were giving us 99 different new
19 tasks to do in the -- in the way of getting
20 this project financed, which is not unusual in
21 HCA to get beat and battered in the process of
22 trying to get ten million dollars from their
23 capital to do a project.

24 Q: Okay. Let's look at ---

25 A: And being a bit curt with David Was because he

1 made notes, you know, little tiny notes you had
2 to have a microscope to read on every
3 conversation, every phone call, everything he
4 ever did about anything. So he was much too
5 detailed.

6 Q: Next Exhibit CRCC Exhibit 122.

7 A: Yes, sir. I'll be dern, I was wrong. Chuck
8 gave us the go forward.

9 Q: Okay.

10 A: So they were hip on financing the project.

11 Q: And provided, if you read down below, they want
12 the capital costs reduced on the project,
13 right?

14 A: Yes, sir, by 500 to 1,000 to a million.

15 Q: And he says down here, no longer purchases land
16 and builds a building attached to Dr. Holt,
17 right?

18 A: Correct.

19 Q: And they suggested at this time the South
20 Strand property, right?

21 A: Let's see ---

22 Q: Which you rejected ---

23 A: No. No, sir. They say that they had
24 considered it. This is not -- they were not
25 proposing the South Strand here.

1 Q: If you'll look at 123.

2 A: All right.

3 Q: You have it confirmed that's it's for the main
4 campus, right?

5 A: Yes, sir.

6 MR. THOMAS: Your Honor, I don't see him Mr. White -
7 - Respondent 123?

8 A: I'm reading this email ---

9 THE COURT: Hold on. Hold on ---

10 A: --- talking about on the email so ---

11 THE COURT: Stop, sir.

12 MR. WHITE: I'm sorry.

13 MR. THOMAS: I'm just not seeing Mr. White on the
14 email here that he received this or ...

15 Q: You would agree, Mr. White, that it was
16 confirmed to the design and construction team
17 that the project was now going to be at the
18 main campus on June 17th?

19 A: Well, design and construction team. This email
20 is from the architect to Jason Whinham, who is
21 a -- I'm not even sure of his title. Yeah,
22 director HCA planning. So no, he's not design
23 and construction. But generally speaking, this
24 appears to be a confirmation of the location of
25 where the project would be from Jason Whinham

1 to the architect.

2 Q: Well, Marc Rowland is the guy -- is the
3 gentleman who signed the application. We
4 looked at his letter earlier. He's the
5 architect on the project, right?

6 A: Yes, sir. Yes, sir.

7 Q: Okay. And then CRCC 124.

8 A: All right.

9 Q: June 20th, Jamie Thomas telling y'all we're a
10 go for the main campus, cut the capital cost to
11 the bone in the new pro forma, right?

12 A: Yes, sir.

13 Q: Is your testimony still for the Court that Dr.
14 Holt's property -- of doing a freestanding
15 facility at Dr. Holt's parking lot was just a
16 flash in the pan, something that y'all briefly
17 considered?

18 A: Yes.

19 Q: That's your testimony?

20 A: Absolutely.

21 Q: Well, isn't the truth is that you knew that the
22 key to this project for Grand Strand is to get
23 Dr. Holt's patients to come to your linear
24 accelerator, and you knew that because you know
25 the market better than anybody who was involved

1 in this?

2 A: Well, I don't think it is the key to the
3 success of the project, as I've testified over
4 and over. And during my deposition I believe
5 I said it is key that we have Dr. Holt's
6 support for the project. We don't anticipate
7 getting all of his patients, but without them,
8 the project wouldn't work.

9 Q: But the beginning of the deposition, I went
10 through all of the areas that you delegated in
11 regards to the project.

12 A: Yes. Yes, sir.

13 Q: But you did spend your time, energy, and effort
14 as the CEO of the hospital in sending numerous
15 emails ---

16 A: Uh-huh (affirmative response).

17 Q: --- about the location of the project being a
18 freestanding building in Dr. Holt's ---

19 A: That's right.

20 Q: --- location?

21 A: I wasn't disinvolved. I never said I was
22 disinterested or disinvolved in the process.
23 The scut work, the detail work is done by the
24 CFO, the planner, and the COO.

25 Q: Right. And what you considered to be the most

1 important part of the project was making sure
2 that Dr. Holt was on board for the project?

3 A: Never said that.

4 Q: I didn't ask you whether you said it. I asked
5 you if that's what you did, because that's what
6 you did consider to be the most important part.
7 That's what you spend your time on. Isn't that
8 correct?

9 A: No, sir.

10 MR. THOMAS: Objection.

11 A: That's not correct.

12 MR. THOMAS: Compound question, Your Honor.

13 Q: It's not?

14 A: You'd like for it to be true but ---

15 THE COURT: Whoa, whoa.

16 MR. WHITE: I'm sorry.

17 THE COURT: Stop, stop. His objection is compound
18 question.

19 MR. THOMAS: There were two questions and I think --

20 -

21 THE COURT: I heard the last part but I didn't ---

22 MR. THOMAS: Yeah, if you could just restate the
23 question, that would be helpful.

24 THE COURT: I heard the last one.

25 MR. LONG: But I think that was the question.

1 THE COURT: Well, let's go with that then to make
2 sure it's clear. Let's make sure it's clear
3 what the question was.

4 MR. LONG: Your Honor, do I need re-ask it or can he
5 answer?

6 THE COURT: Yeah.

7 MR. WHITE: I don't remember it, so.

8 MR. LONG: Okay. Then I guess I'll re-ask it.

9 Q: During this process ---

10 A: Yes, sir.

11 Q: --- you delegated all these responsibilities to
12 others. But you personally, as the CEO at Grand
13 Strand, spent your time sending emails and
14 working on the location of the project and the
15 freestanding building at Dr. Holt, that's where
16 you considered to be -- you considered to be
17 important; isn't that correct?

18 A: Yes. I even went to Dr. Holt's office and
19 talked to him about it.

20 Q: Right. And out of all these people that are
21 involved in this decision, Jamie Thomas, all of
22 them, Chuck Hall, Adam Rudd, who's been at the
23 hospital since 2010, Chuck ---

24 A: Right.

25 Q: --- Mr. Grace, who's been there since 2011 or

1 2010 or 2009, you have the most experience
2 about this market; isn't that correct?

3 A: Yes, sir.

4 Q: And you know these physicians, right?

5 A: I know Dr. Holt pretty well. I wouldn't know
6 Dr. Karpenko if he walked in the room. I don't
7 think I would know a female oncologist if she
8 walked in the room. I do know that Dr.
9 Goldberg because he drives a Bentley. And I
10 know Dr. Paudel because my wife used to play
11 tennis with her.

12 Q: But Dr. Holt is the leader of that group, isn't
13 he?

14 A: By far.

15 Q: And that's where you spent your energy and
16 effort in regards to this application is with
17 dealing with him, right?

18 A: I spent some energy and effort, but I spend my
19 energy and effort on a multitude of tasks every
20 day and big picture, long-term strategy issues.
21 I spent a very, very, very small percentage of
22 my energy and time in limited intellectual
23 capital on Dr. Holt during this process.

24 Q: Let me ask you, let's talk about some terms
25 that you testified about on direct.

1 Interdisciplinary care.

2 A: Yes, sir.

3 Q: Interdisciplinary care is when a group of
4 physicians, it's usually specialists ---

5 A: Right.

6 Q: --- meet and talk about specific cases, usually
7 complex cases, in regards to getting the best
8 treatment for the patient, right?

9 A: Yes, sir.

10 Q: And for people who have cancer or a cancerous
11 tumor, that's commonly referred to as a tumor
12 board, isn't it?

13 A: Yes, sir. We have a tumor board.

14 Q: That's right. And so every month at Grand
15 Strand right now, specialists meet and discuss
16 care for patients with complex cases, right?

17 A: Yes, sir, they do.

18 Q: And the CRCC radiation oncologists go to the
19 tumor board meetings and participate, don't
20 they?

21 A: They sure do.

22 Q: And you have -- it's not just radiation
23 oncologists, you have radiation oncologists,
24 you have medical oncologists, they attend,
25 right?

1 A: Yes, sir.

2 Q: Pathologists, they would attend, right?

3 A: Yes, sir.

4 Q: Radiology, they would ---

5 A: Yes, sir.

6 Q: --- be there, right?

7 A: Uh-huh (affirmative response).

8 Q: And you also would have surgeons there?

9 A: All of those doctors except the radiation
10 oncologists actively practice in the hospital.
11 The rad oncs don't.

12 Q: Well, the medical oncologists are Dr. Holt's
13 group, because almost all of the medical
14 oncologists practice with Dr. Holt, right?

15 A: Yes, sir.

16 Q: So their office is in the building that we've
17 been talking about for the last 45 minutes or
18 so, right?

19 A: Yes, sir.

20 Q: Okay. Now, the doctors go to those meetings
21 and then they go back to their offices and
22 treat patients, don't they?

23 A: Yes, sir.

24 Q: Now, that's interdisciplinary care. A
25 comprehensive cancer center is when a hospital

1 or other provider brings all of the parties who
2 treat cancer under one roof.

3 A: Uh-huh (affirmative response).

4 Q: That's a cancer center, right?

5 A: Among other things, yes.

6 Q: And that would be chemotherapy, radiation
7 therapy, surgery, lab, PET/CT, all of those
8 services would be part of a comprehensive
9 cancer center, right?

10 A: Social work, preventive care, family
11 counseling, hospice care, palliative care, a
12 host of different programs would be in that
13 same -- under, in the same building.

14 Q: And just to be sure ---

15 A: Or in the same building, I'm sorry.

16 Q: And you're -- and you know that even if the
17 Court were to award you a linear accelerator at
18 Grand Strand, you would not have a
19 comprehensive cancer center at Grand Strand?

20 A: Unequivocally we would not start with one, but
21 it, as I've said multiple times today, would be
22 the foundation, the building block for a
23 comprehensive -- world class comprehensive
24 cancer center that can't even start until we
25 had a linear accelerator in the hospital.

1 Q: Well, I understand your -- well, I understand
2 your position. But there's another reason why
3 it can't start and it has to do with CRCC
4 Exhibit 110, if you would turn to that.

5 A: 110. Is that in the same notebook?

6 Q: Yes, I believe it is, 110.

7 A: All right.

8 Q: And that's an email from you back in May, 2011,
9 to the construction design team and Adam Rudd,
10 and they're asking you about putting infusion
11 or chemotherapy treatment at the hospital or
12 including that as part of the project. And you
13 said the chemo infusion service will be
14 minimum. Dr. Holt does this in the building
15 next door. Are you looking at CRCC 110?

16 A: There you go again. We're not talking about
17 the hospital building. This is talking about
18 the freestanding building next to Dr. Holt's
19 office, not where the comprehensive cancer
20 center it was contemplated.

21 Q: Okay. But my point, Mr. White, is that Dr.
22 Holt is going to continue to do chemotherapy at
23 his office, because he has a large chemotherapy
24 infusion center ---

25 A: Yes, sir.

1 Q: --- right in his office, right?

2 A: He will continue to do some, not all. That's
3 why we have on our plans rooms to administer
4 chemo.

5 Q: Well, the only people you're going to do
6 chemotherapy to would be people who are very
7 sick, inpatient service, right? That would be
8 in the hospital?

9 A: Or patients that don't have insurance or
10 patients whose insurance directs them to our
11 facility or inpatients who are acutely ill and
12 can't do it on an outpatient basis.

13 Q: Another very important part of a comprehensive
14 cancer center is PET/CT?

15 A: Yes, sir.

16 Q: Right?

17 A: Yes, sir.

18 Q: And that is also a service that Dr. Holt does
19 at his location?

20 A: Right.

21 Q: Okay. So that will not be part of Grand Strand.
22 It'll be at Dr. Holt, just like the
23 chemotherapy will be. Isn't that correct?

24 A: The hospital provides PET/CT services now.

25 Q: Well, you have a mobile unit right now, right?

1 A: Correct.

2 Q: Okay. It won't all be under the same roof
3 because Dr. Holt does the PET/CT for his
4 patients at his facility in his building?

5 A: Incorrect. Incorrect, Mr. Long. Just because
6 other providers offer the service doesn't mean
7 we're not going to provide the service.

8 Q: And ---

9 A: And we had PET/CT before Dr. Holt had it.

10 Q: Don't you -- and also are you planning to hire
11 -- if you get a linear accelerator, you believe
12 that you're going to hire new doctors to come
13 to the area ---

14 A: Yes, sir.

15 Q: --- and practice?

16 A: Yes, sir.

17 Q: And don't you think those doctors are then
18 going to refer patients to your linear
19 accelerator?

20 A: If they have patients with a cancer diagnosis,
21 yes, sir. They -- or we would hope they would.
22 We don't require them to.

23 Q: Well, you're talking about hiring cancer
24 doctors, so they're probably going to be
25 treating cancer patients, right?

1 A: If that's the doctors you're talking about,
2 you're correct.

3 Q: Well, I'm asking you what you're talking about.
4 Aren't you talking about hiring cancer-related
5 doctors because you're ---

6 A: We are, but that wasn't your question. Your
7 question was aren't you thinking about
8 recruiting more doctors here. And more doctors
9 can mean everything from general surgeons to
10 gynecologists to orthopaedists. It can mean
11 any -- again, since our trauma program started,
12 our heart program started, we've grown since
13 1995 from 95 doctors to 270 doctors. And they
14 all don't do hearts or trauma, but it's
15 partially because of the increase in complexity
16 of services we offer.

17 Q: The physicians that you talked with Mr. Thomas
18 about on direct ---

19 A: Yes, sir.

20 Q: -- that you want to hire.

21 A: Yes, sir.

22 Q: Those were cancer-related physicians you were
23 talking about, right?

24 A: Okay. I understand what you're talking about.
25 Yes, sir.

1 Q: That's what I was referring to, okay?

2 A: I'm sorry. I understand.

3 Q: And wouldn't we expect those cancer-related
4 physicians to refer patients to Grand Strand
5 for linear ---

6 A: I would hope they -- I would hope they would.

7 Q: For a linear accelerator?

8 A: I would hope they would.

9 Q: And was the purpose of your testimony earlier
10 today in regards to the market share at MUSC
11 and at Grand Strand was that you will increase
12 your market share if you have a linear
13 accelerator ---

14 A: I don't recall that portion of my testimony.

15 Q: Don't you remember when you looked at those
16 charts and you looked at the market share?

17 A: Uh-huh (affirmative response).

18 Q: For MUSC and the market share for Grand Strand?

19 A: For all patients or for -- for cancer
20 diagnosis, primary and secondary?

21 Q: For cancer diagnosis.

22 A: Yeah, absolutely we would hope to increase our
23 market share.

24 Q: Which would, therefore, lead to more patients
25 at the hospital, right?

1 A: It would also keep people like my dad from
2 being hauled back and forth to Charleston and
3 all over Myrtle Beach for cancer care.

4 Q: But most of it, in fairness to -- let's talk
5 about that for a second.

6 A: Okay.

7 Q: Most of those patients that are going to MUSC
8 are probably going there for surgery, right?
9 They're not going there for ---

10 A: I would not -- I would not say that
11 unequivocally.

12 Q: They're not going there for radiation therapy?

13 MR. THOMAS: Object to the form.

14 Q: Right?

15 A: I ---

16 MR. THOMAS: Your Honor, that calls for speculation.

17 He's asking him what do these patients ---

18 THE COURT: Wait ---

19 MR. THOMAS: --- or why those patients are going
20 down there. He hasn't laid any foundation. He
21 doesn't know.

22 MR. LONG: I'm talking about the --- I'll lay some
23 foundation.

24 Q: Do you recall the exhibit this morning that you
25 looked at ---

1 A: Yes, sir.

2 Q: --- in regards to comparing the -- the MUSC
3 market share and the Grand Strand market share?

4 A: Yes, sir.

5 Q: Isn't the -- and your hospital administration,
6 those patients, wouldn't you agree with me that
7 those patients are mostly surgical patients?
8 They're not radiation therapy patients?

9 A: No, I wouldn't agree with you. I don't know
10 why they're going ---

11 Q: You don't have any idea?

12 A: I know they're going down there for services
13 they can't get here.

14 Q: Well, isn't the typical arrangement what
15 happened with your father, which is you went to
16 MUSC because you had a very serious cancer with
17 a very sophisticated surgery, and so you had
18 that done in Charleston?

19 A: Yes, sir.

20 Q: And then you did the radiation therapy at CRCC,
21 right?

22 A: That's correct.

23 Q: Okay. All right.

24 MR. LONG: Your Honor, if I could have just one
25 minute.

1 MR. WHITE: Your Honor, this is good for me today,
2 retiring tomorrow. I was starting to get a
3 little sad, but now I'm feeling better.

4 MR. LONG: I appreciate your support on this, Your
5 Honor.

6 THE COURT: My support or forbearance?

7 MR. LONG: Forbearance, much better, Your Honor.

8 Q: All right. Last couple of questions.

9 A: Yes, sir.

10 Q: CRCC Exhibit 78.

11 A: Okay.

12 Q: Take a look at CRCC -- Grand Strand Exhibit
13 Number 32. Do you recognize these physicians
14 in Exhibit 32? Wait a minute.

15 A: I must have a different -- oh, I ---

16 Q: Turn the page.

17 A: Turn the page. Say when. This directory, Mr.
18 Long?

19 Q: Yeah, that directory.

20 A: Okay. I got it.

21 Q: Who are those doctors?

22 A: Okay.

23 Q: I'm not looking for a name, just is that your
24 medical staff? Supposed to be?

25 A: These guys are on our medical staff -- Brian

1 Adler, I don't think he's on our medical staff.

2 Q: Well, isn't that a list of physicians that are
3 on your medical staff, if you turn some of the
4 pages? That's the Grand Strand medical staff?

5 A: I have never seen this document before. I have
6 no idea where it came from. These are doctors
7 on our medical staff, but I have no idea what
8 this document is.

9 MR. LONG: Your Honor, it's a Grand Strand exhibit
10 produced to us in discovery. Grand Strand
11 6,000 -- in the 6,000s, but --

12 Q: You do recognize the names, that those are
13 physicians on your medical staff?

14 A: Yes, sir, they are -- most of them are but ---

15 MR. THOMAS: We'd stipulate that ---

16 A: --- some of them are not on our medical staff.

17 MR. THOMAS: We'd stipulate that that was the
18 medical staff list that came off the internet,
19 Your Honor.

20 MR. LONG: From Grand Strand.

21 MR. THOMAS: Grand Strand.

22 MR. LONG: Thank you. Thank you, Mr. Thomas.

23 Q: Wouldn't you expect the physicians on your
24 medical staff to refer patients to you and your
25 linear accelerator?

1 A: I would hope that they would refer patients to
2 it. I would not expect all of their patients
3 to be referred to us, but I would hope that
4 some of them would be.

5 Q: All right. Let's look at CRCC Exhibit Number . .
6 78.

7 A: I think I pulled that out.

8 Q: You did, got that out.

9 A: Okay.

10 Q: This document is a policy that was implemented
11 in 2000 when you were the CEO at Grand Strand
12 ---

13 A: Yes, sir.

14 Q: --- for the purpose of transporting inpatients
15 at Grand Strand to CRCC to receive radiation
16 therapy services; isn't that right?

17 A: A very limited type of patient on very limited
18 occasions over there to the CRCC that need
19 radiation therapy.

20 Q: But that's what that document is; it's a policy
21 ---

22 A: Yes, sir.

23 Q: --- that was implemented ---

24 A: Written at my direction.

25 Q: Written at your direction in 2000?

1 A: Yes, sir.

2 Q: And that was the practice even before that
3 policy, that was what was happening when you
4 got there in the '90s, that patients were being
5 transported to CRCC, inpatients to receive
6 radiation therapy, right?

7 A: Mr. Long, they were being transported over
8 there and federal law was being violated on a
9 regular basis with transportation and billing
10 of those patients. I had a conversation with
11 Dr. Bass as soon as I got here because he was
12 not billing the hospital for the care of those
13 patients. He was billing Medicare directly.
14 And he was doing it innocently in error because
15 he is as ethical and honest a guy as I've ever
16 met, but in fact, it was a willy-nilly process
17 with no control whatsoever. This policy a
18 couple years later was my attempt to get some
19 foundation around the policy to -- so everyone
20 knew what everything, everybody was doing. Dr.
21 Bass went back to Medicare after I alerted him
22 to what he was doing and ended up paying --
23 reimbursing them some money that he had
24 received in error for billing of those
25 patients. And we struck an agreement at that

1 time to transport certain patients over that
2 meet the criteria that are in this policy.

3 Q: Let's take a look at CRCC Exhibit 23.

4 A: Is that in the same book or ---

5 Q: You might just want to glance at it on the
6 screen.

7 A: Okay. I will. That's fine. That's fine.

8 Q: These are patients, inpatients that were
9 treated at your facility for 2010, 2011, and
10 2012, correct?

11 A: No, sir, that's 2010. There's three pages.

12 Q: Yes, three pages. 2011, 2012.

13 A: So now I'll say yes.

14 Q: Okay. And you'd agree with me that it's not a
15 very list, is it?

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

17 Q: Most of the people that are inpatients that
18 receive radiation therapy treatment are very
19 sick, aren't they?

20 A: I wouldn't say that.

21 Q: You don't know that?

22 A: I don't know that for a fact.

23 Q: Well, the fact is in of May of 2012, you were
24 angry about the results of this CON fight, and
25 so you unilaterally rescinded that policy and

1 stopped transporting inpatients to CRCC for
2 treatment, right?

3 A: May of 2012?

4 Q: No, in November of 2012, you stopped doing
5 that, right?

6 A: I think I told you earlier why we stopped doing
7 it.

8 Q: Yes, you did. But you unilaterally made that
9 decision, right?

10 A: No, I made it after consultation with my boss,
11 Jamie Thomas.

12 Q: You told him what you were going to do?

13 A: Yes. I consulted with him, and he could have
14 said don't do that, Doug, and I wouldn't have
15 done it.

16 Q: Okay. And when you made that decision, you did
17 no research onto -- about the clinical effect
18 of what your decision was, did you? That's
19 what you told me in your deposition.

20 A: The clinical effect?

21 Q: Yeah, the medical impact on the patient. You
22 didn't do any research on that, did you?

23 A: It's the -- I didn't do any research on it, no.

24 Q: Okay. And ---

25 A: There was none necessary.

1 Q: Right. And you -- even though that process had
2 been going on in your hospital, that policy had
3 been in existence for 13 years ...

4 A: Uh-huh (affirmative response).

5 Q: ... almost 13 years, you stopped doing it. And
6 now you discharge those patients and made them
7 go to Trident or any other -- McLeod or MUSC to
8 have radiation therapy treatment, right?

9 A: Incorrect.

10 Q: You discharge them if they have to have the
11 service, right?

12 A: If the patient is in our facility and has to
13 have the service, we transfer those patients
14 using Medicare transfer rules. The vast
15 majority of patients never land in our facility
16 because they do what they should have done for
17 the last 13 years, and that is, if they need a
18 service that our hospital doesn't provide, they
19 admit the patient in a hospital that provides
20 all the services.

21 Q: Okay. But most of those patients are not
22 admitted for radiation therapy treatment.
23 They're admitted for other reasons and they
24 need radiation therapy because of ---

25 A: Incorrect. None of our patients are admitted

1 for radiation treatment.

2 Q: That's what I said; they're not admitted for
3 that?

4 A: You said most of them are not. None of them
5 are.

6 Q: None of them are. You are transporting
7 patients even now to Trident to receive
8 radiation therapy, right?

9 A: Not only Trident. We're transporting them to
10 MUSC, Florence, Duke, New Hanover. A number of
11 different facilities.

12 Q: And you're doing that because you're mad about
13 this CON case, isn't that right?

14 A: No, I'm not doing it because I'm mad. I'm
15 doing it because it's the wrong thing to do to
16 send CRCC the message that it is the practice
17 we're going to continue when they're denying
18 our patients the ability to access the
19 comprehensive cancer center that we would like
20 to start with the linear accelerator as a
21 building block.

22 MR. LONG: That's all I have, Your Honor. Thank
23 you.

24 MR. THOMAS: I have some redirect, Your Honor.

25 THE COURT: I'm going to take a short break.

1 MR. THOMAS: Short break? Yeah, that would be
2 great.

3 (Break from 4:35 p.m. until 4:43 p.m.)

4 MR. WHITE - REDIRECT EXAMINATION BY MR. THOMAS:

5 Q: Mr. White, just a few questions for you just
6 for verification purposes otherwise. Mr. Long
7 brought up a comparison, I think, or at least
8 he started talking about the open heart program
9 and how Grand Strand had a monopoly on that.
10 How many open heart cases does Grand Strand do
11 on average a year, if you know?

12 A: We'll do about 450.

13 Q: Four hundred and fifty, so, you know, less than
14 two a day?

15 A: Yes.

16 Q: Okay. Can you talk a little bit about why on
17 a -- comparing open heart to a center that may
18 lose six or seven, you know, or four or five
19 thousand treatments of linear accelerators is
20 not an apples to apples comparison?

21 A: Well, to do open heart surgery, and I think Mr.
22 Long made this point a few times when he was
23 representing Providence, keeping -- trying to
24 keep Lexington from starting open heart, the --
25 and Providence does substantially more hearts

1 per year than we do, there is a very high
2 degree of expertise that's required on the part
3 of not only the surgeon, but cardiac
4 anesthesiologist, the perfusionist, critical
5 care nurses, respiratory care staff. Their
6 competence depend on -- are dependent upon a
7 minimum volume level on a regular basis and a
8 variety of cases to ensure that they can
9 maintain their competence and improve and stay
10 up to date with new procedures. With radiation
11 therapy treatments, it would seem to me that
12 it's a -- I know that it's a fairly repetitive
13 type procedure. It's certainly critical to the
14 patient's well-being, but it's not invasive,
15 and I would venture to opine that at some
16 minimum level, whether it's 4,000, 8,000,
17 12,000, 20,000, whatever it might be, that you
18 could have a sudden loss of a significant
19 volume of your cases without affecting the
20 quality that you might be providing. And heart
21 surgery, it's just a scientific fact that the
22 less hearts you do below a certain level,
23 typically in the industry 175 is talked about,
24 the less hearts you do, the more chance of bad
25 outcomes you get.

1 Q: And to your knowledge, has CRCC made any
2 assertions that their volumes because of Grand
3 Strand were going to come down so low as to
4 harm the volume -- their service?

5 MR. LONG: Objection, Your Honor. I know that's
6 beyond the scope of the cross. I didn't ask
7 him what he knew about our facility and
8 quality.

9 MR. THOMAS: He was making a comparison between open
10 heart and radiation therapy and that at some
11 kind of analogy that if Grand Strand came into
12 the market, Your Honor, that they would bring
13 CRCC down to some low quality level. So I'm
14 just trying to explore that with my witness.

15 THE COURT: Mr. Long?

16 MR. LONG: He sure can't lay a foundation on it
17 because he doesn't know anything about the
18 service. I let the earlier question go, but
19 Your Honor, he doesn't -- he's never been at a
20 facility in his entire career that had
21 radiation therapy. And, you know, I let the
22 other question go, but he's just asking him to
23 give opinions about quality on a service that
24 he's never been in the hospital at.

25 MR. THOMAS: That's not what I asked. I asked the

1 question, Your Honor, of what knowledge he had
2 of CRCC in this case saying that they would be
3 brought below some threshold of quality,
4 because I hadn't heard it.

5 THE COURT: Well, I guess you could ask him that,
6 but I don't know what -- how it's pertinent.
7 You can certainly make that argument based on
8 the paperwork that's already in the file what
9 -- what knowledge he has of it would be even
10 less ---

11 MR. THOMAS: That's fine.

12 THE COURT: --- probative of the actual, the file,
13 or the assertions that have been made.

14 MR. THOMAS: That's fine, Your Honor. I'll move on.

15 Q: Mr. Long asked you some questions bout the
16 alleged nasty relationship between Dr. Bass and
17 the urologists and started asking you questions
18 about the quality of care and maybe some type
19 of quality of care issues that may have come up
20 there. But I guess I'm -- the question I would
21 ask, Mr. White, is do you think a physician who
22 is upset about a business deal should let that
23 control where they send the patient for cancer
24 care or otherwise affect their treatment
25 decisions?

1 A: I would think that they -- absolutely think
2 that they shouldn't do under any circumstances
3 do that. Does it occur? Yes, it does occur
4 unfortunately.

5 Q: Okay.

6 A: But I don't know that it adversely affects the
7 quality of patient care across the board.

8 Q: Mr. Long asked you some questions about
9 delegating duties on the certificate of need
10 application. Have you served on the South
11 Carolina Hospital Association Board before?

12 A: I sure have.

13 Q: Okay. With other CEOs?

14 A: Yes.

15 Q: Do you know of one single CEO that drafts a CON
16 application?

17 A: No.

18 Q: Do you know of one CEO that would do the
19 financial aspects of a CON application?

20 A: Absolutely not. I'm responsible for the CON
21 application document, and I have to sign it.
22 But I'm not responsible for completing it, and
23 it's a huge process.

24 Q: And that's why you delegate those services,
25 correct?

1 A: Correct.

2 Q: All right. Let me ask you a question. I'd
3 like you to turn to Petitioner's 43, if you
4 would. Let's see if I can find that for you.

5 A: All right.

6 Q: It going to be in this book.

7 A: Okay. I'll find it. Okay.

8 Q: Now, Mr. Long asked you some questions about
9 market share and how your, you know, what --
10 how many patients you saw from various zip
11 codes; do you recall that?

12 A: Inpatients, yes, sir.

13 Q: Yes, sir. Inpatients, right?

14 A: Uh-huh (affirmative response).

15 Q: And I believe he highlighted on a screen that
16 showed kind of the top five zip codes and maybe
17 29526, which is the Conway zip code was in
18 there; do you recall that?

19 A: Yes, sir.

20 Q: Okay. On 29526, would you tell me how many
21 inpatient cancer care -- inpatients you got
22 from 29526 for cancer care in 20 -- looks like
23 2012? That's the second column.

24 A: According to this report?

25 MR. LONG: Your Honor, I've got to object because he

1 just mischaracterized the exhibit. It's just
2 for three months.

3 MR. THOMAS: It says first quarter 2012 to fourth
4 quarter 2012, Your Honor. That's a year.

5 MR. LONG: Oh, I stand corrected. I thought it was
6 for the first four months of the year.

7 THE COURT: All right.

8 A: That -- this chart indicates, and it came from
9 the State ORS, that from 29526 there were 16
10 patients discharged from Grand Strand with a
11 cancer primary/secondary diagnosis.

12 Q: And in the CON application and at least for
13 2010, I think there were 872 discharges,
14 inpatient discharges by zip code from 29526.
15 And if you want to go to Joint 2, maybe we can
16 -- if you look in here at Joint 2, if you
17 would.

18 THE COURT: To Joint 2?

19 MR. THOMAS: Yes. Joint Exhibit 2, Your Honor.

20 It's the Grand Strand's DHEC record.

21 A: Okay.

22 Q: Would you go to page 30 of that DHEC record.

23 A: All right.

24 Q: Okay. So look in the chart there, Mr. White.
25 29526, how many inpatients were discharged?

1 This is 2010, this is in the CON application,
2 but were discharged from Grand Strand from that
3 zip code?

4 A: There were 872 patients discharged from that
5 zip code in 2010.

6 Q: Okay. And then back on Joint 43 -- I mean,
7 excuse me, Petitioner's 43 and 29526, I think
8 you said there were 16 actual inpatients with
9 cancer, correct?

10 A: Correct.

11 Q: So that's basically two percent of cancer
12 patients -- I mean, 16 is basically, it was a
13 little bit less than two percent of the 29526
14 total discharges, correct?

15 A: I'm not that great at percentages, but that
16 sounds correct.

17 Q: Well what, if anything, does that tell you in
18 terms of what kind of cancer patients are
19 coming from 29526 as a percentage of the whole?

20 A: A very, very small percentage of the total
21 patient population cancer diagnosis from
22 Conway.

23 Q: So would it be proper to apply your inpatient
24 market share to an outpatient service of linear
25 accelerator?

1 MR. LONG: Objection, Your Honor. I think he's
2 asking him -- he's asking an opinion and
3 question appropriate for an expert, the last
4 question.

5 MR. THOMAS: He just asked him several questions
6 about the inpatient market share and whether or
7 not, you know, wouldn't you expect more from
8 this area, and I'm asking him a very similar
9 question.

10 THE COURT: Give it to me again. You said wouldn't
11 you expect ---

12 MR. THOMAS: I said -- I don't know if I said
13 wouldn't you, but maybe I said -- I said would
14 you expect ---

15 THE COURT: Would you. Okay.

16 MR. THOMAS: Yeah, would you expect a similar number
17 in a similar market share for your radiation
18 therapy service line from 29526 as what your
19 inpatient ---

20 THE COURT: I'll overrule that. I think you asked
21 him that.

22 MR. LONG: I did. I think that question was
23 different, though, Your Honor.

24 MR. THOMAS: Olay. I apologize. That's what I
25 meant.

1 Q: Did you get the question?

2 A: I would expect it to be similar, but I don't
3 know that it would mirror.

4 Q: But you would agree with me that the 29526 had
5 16 cancer patients?

6 A: Very small.

7 Q: I think Mr. Long asked you some questions about
8 the fact that there was going to be -- go in
9 your Grand Strand DHEC record to page 135, 136,
10 if you would.

11 A: You're going to have to point.

12 Q: Oh, I'm sorry. It's Joint Exhibit 2, Doug.
13 It's this one right here.

14 A: Okay. What page?

15 Q: 135, 136.

16 A: Okay.

17 Q: All right. Mr. Long asked you some questions
18 about the fact that there was an architectural
19 narrative, he had you read something, the area
20 -- into the record regarding the fact that the
21 addition is designed to accommodate a future
22 linear accelerator addition to the northwest
23 corner of the building; do you recall that
24 testimony?

25 A: Yes, sir.

1 Q: Why would an architect design a building like
2 that, Mr. White, if you know?

3 A: Well, I thought I testified earlier, but just
4 as we did with the heart tower, we designed and
5 added and actually built, with DHEC's
6 permission, a third floor shell to minimize the
7 cost of what we felt might meet a future need
8 when a CON was obtained, which we subsequently
9 obtained. In this case, the expense of
10 building an additional vault would be
11 minimized, and Mr. Long pointed out and
12 educated me on the fact that two of the three
13 -- four concrete walls would already be built.
14 So it minimizes the cost of a -- of any
15 potential additional vault in the future.

16 Q: Okay.

17 A: Which is one of the State Health Plan criteria
18 that we try to adhere to.

19 Q: Let me ask you this. If you got the linear
20 accelerator service and another need for a
21 linear accelerator came up where you have the
22 volumes to expand, what if anything, would you
23 have to do with respect to the State of South
24 Carolina ---

25 A: We'd still -- we'd still have to obtain a CON

1 before we could do it. So, again, I described
2 earlier the steps in developing a new project.
3 Number one, is to determine if there's a need
4 delineated in the State Health Plan.

5 Q: Have you ever driven from Grand Strand to Dr.
6 Holt's office or Dr. Holt's office to Grand
7 Strand? Or do you just walk through the woods
8 when you ---

9 A: I don't walk through woods. Snaky. I've
10 probably driven over there five times in 18
11 years.

12 Q: How long does it take?

13 A: Probably two minutes.

14 Q: Mr. Long asked you -- it's Respondent's 97.
15 Respondent's 97, I think it's that Eastern
16 Group Visit that you had with Mr. Hall.

17 A: Okay. I can just look on the screen at it.

18 Q: Yeah, let's see if --

19 MR. THOMAS: Roshel, can you go to -- one second
20 here. Go to our Exhibit -065. All right,
21 let's see here. Hopefully we can see this one.

22 Q: It says product line development and a series
23 of bullet points here. First of all, just so
24 we can kind of get the record straight. Under
25 linear accelerator CON, plan to file the CON by

1 May 1st, 2011. First of all, did that happen?

2 Did that occur?

3 A: No.

4 Q: Okay. And the third bullet here, it said,
5 Conway is also planning to file an application
6 for a linear accelerator in Conway. Was that
7 correct?

8 A: No. I think I explained before, because we put
9 things here, it's subject to scrutiny and
10 review and approval, disapproval. And, you
11 know, we have the best information we think at
12 the time to put in the document for talking
13 points on service lines with the group. But,
14 you know, I don't think they ever did file..

15 Q: On the second kind of arrow where it says Grand
16 Strand Regional location, did any of these
17 three bullet points actually take place or come
18 true?

19 A: No.

20 Q: Okay.

21 A: Nor are they in our application. And the land
22 cost of one million is incorrect, so.

23 Q: Mr. Long also asked you about a page, I think
24 it had some market share in there, and
25 hopefully I'll find it. I wanted to get some

1 clarification for the record. Let's see.

2 MR. THOMAS: I'm sorry, Your Honor. For some reason

3 we included these blacked out pages in here.

4 Q: Yeah, go to 3081 in that exhibit.

5 MR. THOMAS: And Roshel, that would be -024. Okay.

6 Q: Are you there, Doug?

7 A: Yeah, I can see it.

8 Q: Okay. First of all, what service area does
9 this market share apply to?

10 A: Hold on here.

11 Q: If you can tell?

12 A: That's the primary service area and secondary
13 service area.

14 Q: So that's not a three county service; it's not
15 the service area for the linear accelerator?

16 A: Not at all.

17 Q: Okay. And then on the oncology market share
18 line, Mr. Long indicated that, you know, things
19 are kind of steady, but 2008 what was the
20 number?

21 A: For oncology?

22 Q: Yeah.

23 A: 24.47.

24 Q: And that was for your primary and secondary
25 service areas, correct?

1 A: Correct.

2 Q: Is that right, Mr. White?

3 A: Yes, yes.

4 Q: There was an email and I, you know, the ones
5 that Mr. Long went over with you. I think it
6 was Respondent's 122, but I think it said
7 something along the lines of cut capital cost
8 to the bone, correct?

9 A: Yes, sir.

10 Q: Okay. Grand Strand's project costs are still
11 over nine million dollars though, isn't it?

12 A: Correct.

13 Q: Was that your idea of cutting capital costs to
14 the bone?

15 A: I think they are cut to the bone without
16 sacrificing quality or -- and building a world
17 class building a foundation for a comprehensive
18 cancer center, we've cut all the capital costs
19 we can cut.

20 Q: Okay. But you're still spending four million
21 dollars more than CRCC, correct?

22 A: Yes.

23 Q: Now, Mr. Long talked to you about being a CEO
24 of a hospital. How many -- just estimating,
25 how many emails do you get a day?

1 A: On average, probably between 150 and 200.

2 Q: How many do you send to -- for work?

3 A: Probably 50.

4 Q: I counted roughly ten to 15 emails that
5 discussed, that Mr. Long went over with you to
6 discuss the property location, and you
7 mentioned one call to Dr. Holt and one visit,
8 correct?

9 A: Correct.

10 Q: In the grand scheme of things, how much work is
11 that for a CEO at Grand Strand Medical Center?

12 A: It's a very small portion of the total time I
13 spent in the first half of 2011, on this
14 project, much less with Dr. Holt and even less
15 as that site as a potential site.

16 Q: I mean, that's like basically four emails a
17 month on average, right? If you average them
18 out.

19 A: Based on what we saw today, it looks pretty
20 correct. Some of the emails I was not even
21 involved in that we looked at.

22 Q: Now, you mentioned the hospital. The hospital
23 does have a PET/CT scanner; is that correct?

24 A: A mobile service, yes, sir.

25 Q: Where is that one located?

1 A: I'm not quite sure. I think South Strand's
2 where the trailer comes, but I'm not sure how
3 many days a week it comes. We certainly would
4 anticipate shifting that service up to the main
5 campus if and when we get a CON for a linear
6 accelerator.

7 Q: Just to clarify the record, Mr. Long asked you
8 some questions about the inpatient transfers
9 and how you decided that you didn't want to
10 continue that, correct?

11 A: Uh-huh (affirmative response).

12 Q: The decision in this case was made in December
13 28, 2011, correct? You know, the approval
14 letter from Ms. Brandt? We can go to ---

15 A: The decision, what decision?

16 Q: The decision letter by DHEC to deny Grand
17 Strand.

18 A: Oh, okay. Somewhere along there; I can't say
19 for sure.

20 Q: Okay. Well, in DHEC, Grand Strand's DHEC
21 record 925.

22 A: Where would that be?

23 Q: Joint Exhibit 2.

24 A: 925. All right.

25 Q: Okay. What's the date of the decision letter

1 denying -- to you denying the linear
2 accelerator?

3 A: December 28th, 2011.

4 Q: When did you actually make the decision to stop
5 sending inpatients over to CRCC for the reasons
6 that you've given?

7 A: I think it was December 2012 or January 2013.

8 Q: So a year later, correct?

9 A: Yes.

10 Q: It wasn't something that you did right away?

11 A: Wait a minute. Yeah, yeah, that's correct.

12 No, it wasn't done right away.

13 Q: Now, Mr. Long asked you some questions, I think
14 he referenced the Grand Strand medical staff
15 list. And just for clarification, all the
16 people on Grand Strand's medical staff, they're
17 not employed by Grand Strand, correct?

18 A: Heavens no.

19 Q: Okay.

20 A: A very small minority of them.

21 Q: And there are at least five urologists on your
22 Grand -- on your medical staff that you don't
23 expect to get any referrals from to your linear
24 accelerator, correct?

25 A: Not unless they try to sneak in patients

1 without insurance, I would not expect to get
2 any.

3 Q: Okay. And is there anything saying that if
4 you're on the Grand Strand medical staff that
5 you can't be on another medical staff?

6 A: Absolutely not.

7 Q: And am I correct that in terms of your
8 unemployed medical -- the non-employed medical
9 staff members of your hospital, can you require
10 them or direct them to send referrals to your
11 facilities, your outpatient facilities?

12 A: No, and we can't require employed physicians to
13 send them to our facility.

14 Q: But you can request employed physicians to send
15 them to your facility?

16 A: I request to all physicians to send every
17 patient to us, but they don't comply or I would
18 have retired a long time ago.

19 Q: Okay.

20 A: You try to provide a service that makes the
21 physician choose your service over another
22 service because of the quality of care it's
23 providing to the patients and the convenience
24 that it's providing, to the physician and to
25 the patient.

1 Q: Okay.

2 MR. THOMAS: One second, Your Honor. Your Honor,
3 that's all the redirect questions I have for
4 Mr. White. I'd like to dismiss him as a
5 witness so he can ---

6 THE COURT: Let's see. Any new matter raised?

7 MR. LONG: Thank you.

8 MR. THOMAS: I was very careful not to raise any new
9 matters.

10 THE COURT: Okay.

11 MR. LONG: I have no questions.

12 THE COURT: Okay. Oh, Ms. Biggers.

13 MS. BIGGERS: Your Honor, I don't have any questions
14 either.

15 THE COURT: I'm sorry. You're so quiet over there.
16 You can step down. Any objection to him being
17 dismissed?

18 MR. LONG: No, Your Honor.

19 MS. BIGGERS: No.

20 THE COURT: You're dismissed.

21 MR. WHITE: Thank you very much, sir.

22 THE COURT: All right.

23 MR. THOMAS: Your Honor, Petitioner would request that
24 we call it a day if we could.

25 THE COURT: That's fine with me. Are we still on

1 your schedule?

2 MR. THOMAS: Yes, sir.

3 THE COURT: That's good.

4 MR. THOMAS: Yes, Your Honor, I guess we'll have two
5 witnesses tomorrow, we've emailed you. That's
6 kind of what I was anticipating before the
7 trial started anyway.

8 THE COURT: Good. All right, y'all have a good
9 night. 9:30 tomorrow.

10 MR. LONG: Thank you.

11 MR. THOMAS: Thank you.

12 (There being nothing further, the hearing recessed
13 for the day at 5:09 p.m.)

14 DAY 2 - FRIDAY, SEPTEMBER 13, 2013:

15 THE COURT: I thought you had something to say.

16 MR. LONG: I do, Your Honor, but I wanted to ...

17 THE COURT: Well, I can be logging on ---

18 MR. LONG: I didn't want to be presumptuous.

19 THE COURT: I can be logging on while you speak.

20 MR. LONG: Are we on the record? Okay. Before we
21 start the testimony today, having had an
22 opportunity to think about it overnight and
23 consult with my co-counsels here, we would move
24 this morning to strike the testimony yesterday
25 of Doug White about Grand Strand's intent to

1 purchase a TrueBeam linac. We think that
2 should be stricken from the record, and we
3 would move to prohibit Grand Strand from having
4 any witnesses testify about such an intent.
5 Some of the reasons that we basically would
6 make that motion today is the superiority of a
7 TrueBeam linac, which is our machine that we
8 are planning to put in Conway was considered by
9 the Department and identified in the decision
10 letter and analysis supporting the decision
11 that clearly said our machine was superior.
12 That was one of the reasons when they did the
13 comparison that our application should be
14 approved over the Department. It was also
15 identified in Mr. Thomas -- I mean, in Grand
16 Strand, Mr. Thomas on behalf of his clients, a
17 request for a contested case, and he made the
18 statement in that document that the advanced
19 equipment was immaterial to the decision.
20 Almost all the witnesses in the case that have
21 any knowledge about this have been deposed on
22 this issue. Grand Strand repeatedly asked our
23 witnesses about well, isn't the Clinac iX
24 basically the same as a TrueBeam, there's
25 really no difference, it's immaterial; they

1 continued to take this position all through the
2 discovery. They never produced any
3 documentation of any quote, intent to buy a
4 TrueBeam, to do -- they never produced a
5 document about it. There's no exhibit
6 identified. The exhibit deadline is long past
7 to have exhibits. There was no -- I mean
8 really there was nothing provided to us until
9 Mr. White testified to that yesterday on the
10 stand. It's extremely prejudicial for them to
11 come in and basically do that to us at that
12 stage of the trial. So, Your Honor, that
13 testimony, that portion of the testimony should
14 be stricken from the record, excluded from
15 consideration of the Court. And I would also
16 ask, because I know Mr. Rudd was involved in
17 the equipment issue, and he's going to be our
18 first witness today.

19 THE COURT: Mr.?

20 MR. LONG: Mr. Rudd.

21 THE COURT: Okay.

22 MR. LONG: And he's going to be our first witness
23 today, and he was involved in the equipment
24 issue, he should not be permitted to testify
25 about their intent to change the application

1 and purchase a different machine.

2 THE COURT: All right.

3 MR. THOMAS: Your Honor, last time I checked these
4 were de novo trials. A lot of new information
5 comes in, a lot of new information about
6 utilization, 2012. They're going to try to
7 tell you that they're 2013 utilization is down
8 from 2012, because over the passage of time,
9 things change. So as far as I'm concerned, if
10 Mr. Long wants to say the fact that they are
11 likely able to purchase a TrueBeam because the
12 price has really come down on these over the
13 last two years, just like anything else with
14 technology, Your Honor, that because the price
15 that they're aware of for the TrueBeam that
16 their sister facility Trident is getting down
17 in Charleston is almost the same price as what
18 the Clinac iX unit is that they're -- you know,
19 that they got a quote for two years ago, and
20 then the fact that if this Court approves Grand
21 Strand for a CON, they won't actually be able
22 to install that for 18 months from the approval
23 date, and let's face it, we're going to get a
24 record, you're going to give us some time to do
25 orders and, you know, hopefully the CON program

1 will be reinstated at that point so you can
2 direct the CON program to do what you need to
3 direct them to do, and we're talking 18 months
4 from that point. So that's another -- we're
5 talking, so we're almost talking four years, so
6 a lot has happened. And Grand Strand knows,
7 and Doug White didn't say this, didn't say that
8 they could just go and willy-nilly, well, we're
9 going to install this piece of equipment. We
10 know that we would have to go to DHEC and just
11 say is this okay, but you also know as a judge
12 and the case law that you've written that the
13 Department is not going to deny someone to put
14 in something superior in technology, especially
15 if they can get it at the same or lower cost as
16 what they were originally planning to do
17 because of the passage of time. That makes no
18 sense. That would be contrary to the State
19 Health Plan, Your Honor. So the testimony
20 should not be excluded. Nobody said we're
21 definitely installing a TrueBeam, but you can
22 as a judge consider that if the price is right,
23 they would install one because that's what
24 their sister facility is doing 100 miles to the
25 south, and why would they do any different if

1 they can get the same price that they would for
2 and the technology that, by the way, the last
3 time CRCC replaced a linear accelerator in its
4 facility in 2011, it was with the very type of
5 machine Grand Strand is asking to put in its
6 application, the Clinic iX. So, Your Honor,
7 this came about very recently when they got a
8 quote, that Trident got a quote and they found
9 out about it, very recent ---

10 THE COURT: Can I stop?

11 MR. THOMAS: Yes, sir.

12 THE COURT: Can you give me -- I can't remember, I
13 can pull my order up -- but the statute of
14 regulations that addresses the substantial
15 change issue.

16 MR. LONG: I can, Your Honor. Well, first, Your
17 Honor, when you did, when you addressed this
18 issue ---

19 THE COURT: Well, I don't want to get into argument.
20 I just want to ---

21 MR. LONG: No, I just want to -- there are two
22 different -- there are a couple different regs.
23 In the case Your Honor did, you were looking at
24 a CON that had already been issued and ---

25 THE COURT: Yeah.

1 MR. LONG: --- and so I think you were looking at

2 Reg 605, I think is -- but 310 --

3 THE COURT: 61-605?

4 MR. LONG: Yeah. 31 -- I mean, 61-15(310) is the

5 substantial change, project changes during

6 review period. Now, your case that you did

7 over ten years ago ---

8 MR. THOMAS: Which is immaterial.

9 MR. LONG: Well I -- just to show you, there's a

10 different criteria. My only point was there's

11 a different criteria that says project changes

12 after receipt of certificate of need.

13 THE COURT: Okay.

14 MR. LONG: So there are two different ones that

15 address substantial change. One of them is

16 before the -- during the review process; the

17 other is after the certificate of need. So

18 it's 305 -- it's 310 --

19 THE COURT: 61 ---

20 MR. THOMAS: --- and 605.

21 THE COURT: 61(310)?

22 MR. LONG: 61-15.

23 THE COURT: Oh, let me get it.

24 MR. LONG: 310.

25 THE COURT: 61-15(310). And the other one is 61 ...

1 MR. LONG: 61-15(605).

2 THE COURT: All right. Okay.

3 MR. LONG: And we would -- I mean, I think 605

4 clearly does -- we're in the review period

5 obviously and we have an issue.

6 THE COURT: All right.

7 MR. LONG: But, Your Honor, our argument -- well, I

8 don't want to cut him off.

9 THE COURT: Well, Mr. Thomas, now that I know that,

10 if you could address, continue to address this

11 issue, because I interrupted you ---

12 MR. THOMAS: No, that's fine. I mean ---

13 THE COURT: --- and add whatever viewpoint you have

14 on the applicable provisions.

15 MR. THOMAS: Well, I didn't bring those with me. I

16 didn't realize I was going to be arguing the

17 motion, Your Honor, but ---

18 THE COURT: Neither did I.

19 MR. THOMAS: As I said, I think we all know that

20 this is de novo, and I think you as the court

21 can consider the fact that they have an

22 opportunity to purchase this technology, which

23 is a later generation technology for the same

24 price they got the Clinac iX, and yes, they

25 would have to go to DHEC and get permission,

1 but I think we all know the law, and Beverly
2 Brandt will be testifying as the Department's
3 witness, as well as two different experts who
4 also know that if you have a change, it's got
5 to be considered substantial. The Court knows
6 what is a substantial change based on the order
7 that you wrote regarding the ten percent
8 thresholds. That's my argument.

9 THE COURT: Well, I tell you what, at this point in
10 time, I'm not going to rule on your motion
11 because I want to make sure I look at the law,
12 but I will say, I haven't heard -- do you wish
13 to weigh in on this, Ms. Biggers?

14 MS. BIGGERS: No, Your Honor.

15 THE COURT: All right. From a matter of public
16 policy, I'll just start with that, in looking
17 at the law, it would seem strange to me that
18 the law would set forth that as you go through
19 this process that takes time to go through it
20 that you would restrict someone from getting a
21 more advanced medical equipment that could
22 benefit the public without much additional
23 cost. I just, that sounds foreign to me right
24 off the cuff that I would say oh, I'm going to
25 make you stick with this machine. So, but I'll

1 think through it and I'll allow you, and as I
2 said earlier, I really -- for whatever aspect
3 that this argument is new, my ruling will be
4 that it's not timely because it could have been
5 made yesterday, but I still think you made the
6 motion yesterday. It's just the result you now
7 seek is, because you objected to him going into
8 it and you asked that the case be remanded. So
9 remanding, striking the testimony, I think are
10 along the same path, but it is a different
11 result. So at this point in time, I'm going to
12 deny it in that regard, whatever wasn't raised
13 yesterday because that's not timely. All
14 right.

15 MR. THOMAS: Your Honor, Grand Strand would call its
16 next witness, Adam Rudd, Chief Executive --
17 Operating Officer, to the stand.

18 ADAM RUDD, being duly sworn, testifies as follows:

19 THE COURT: All right. How do we want to handle
20 this here on out? Mr. Long, would you be
21 comfortable with me just allowing you to have
22 a continuing objection along this line of
23 testimony, or do you wish to just make sure you
24 preserve your objection each time it comes up?

25 MR. LONG: Your Honor, you know, that's always been

1 a little unclear to me under the appellate
2 rules.

3 THE COURT: That's why I'm asking.

4 MR. LONG: Really, I think the people that wrote
5 that rule probably had forgotten what it's like
6 to try cases. But we did move this morning as
7 part of that not only to strike but to in
8 limine to prohibit ---

9 THE COURT: Yeah.

10 MR. LONG: --- him from testifying about it. So I
11 want to make sure that's clear on the record.
12 I guess I'll just probably the first time it
13 comes up, I'll make the objection and then
14 maybe that'll be sufficient for the record
15 hopefully.

16 THE COURT: Okay. Well, I bring that up because I
17 recognize from being a trial lawyer myself it
18 could put you in a little bit of a quagmire.

19 MR. LONG: Right.

20 MR. THOMAS: As fair warning, I do intend to touch
21 on it briefly.

22 THE COURT: I'm not surprised.

23 MR. RUDD - DIRECT EXAMINATION BY MR. THOMAS:

24 Q: Mr. Rudd, would you please state your name for
25 the record?

1 A: Adam Rudd.

2 Q: Where do you live?

3 A: Myrtle Beach, South Carolina.

4 Q: Tell us a little bit about your family.

5 A: I have a wife that we've been married 11 years.

6 She's a nurse and avid exercise buff. I have
7 two children, both adopted from China, five and
8 six, and they're both a handful.

9 Q: Are you taking at least one or both to the
10 Braves game tomorrow?

11 A: Tomorrow, both are going to the Braves game,
12 which ought to be entertaining.

13 Q: First major league baseball game?

14 A: It is.

15 Q: Could you basically give us kind of a little
16 bit about your education?

17 A: I have an industrial engineering degree from
18 Georgia Tech with a degree in math. I was in
19 a dual degree program. I went to school in
20 David Lipscomb in Nashville, Tennessee. I also
21 have an MBA from the University of Colorado.

22 Q: Okay. And why don't you take us through your
23 employment history, I believe starting when you
24 were working in the consulting world.

25 A: I started with a small consulting firm out of

1 Nashville. We did a lot of consulting work in
2 healthcare planning but also operations
3 improvement consulting with Columbia, which
4 turned into HCA. I traveled the country with
5 a guy named Mike Gould, who basically I was
6 young enough that I could carry his back. He
7 had a lot of healthcare concerns, and he would
8 draw things on the back of napkins and my job
9 was to make them happen, somehow put them
10 together into plans and we'd do that. Did a
11 lot with emergency room management and building
12 programs for hospitals around the country for
13 HCA, or Columbia at that time.

14 Q: What kind of work did you do at Duke Medical
15 Center?

16 A: I was, had kind of a dual role there. I was a
17 management engineer and also an associate
18 administrator, so I worked out of the
19 administrator's office and did a lot of project
20 planning for them. We worked in clinical
21 service units, which were major service lines,
22 whether it was, you know, cardiac, oncology,
23 children's, and oncology was one of the service
24 lines that I worked with there where we did a
25 lot of planning with how we were going to do

1 business development and how we were going to
2 implement large strategic plans.

3 Q: Does Duke have a comprehensive cancer center?

4 A: They do.

5 Q: You have a stint at Bay Medical Center?

6 A: I did. I had one of my friends, who was the
7 CEO there, he fired his CNO and CFO and needed
8 somebody he could trust to come help just kind
9 of stabilize operations, so I spent a year
10 there doing that, which was quite educational.

11 Q: Okay. Tell us a little bit about what you did
12 at Saint Luke's in Colorado.

13 A: Presbyterian Saint Luke's was my first HCA job.
14 We went out there. I was an associate
15 administrator/management engineer out there. I
16 went out there to start with labor management
17 and really help them kind of get back in line
18 but got into more business development,
19 strategic development. We started building the
20 Rocky Mountain Children's Hospital and Rocky
21 Mountain Cancer Center, so we started that plan
22 while I was there.

23 Q: Okay. And then what did you do after that?

24 A: Went to the division office in Tampa.

25 Q: The HCA?

1 A: HCA division hospital. It's responsible for 16
2 hospitals that are around Tampa, Orlando, and
3 just south of Tampa. And my job there was,
4 again, to manage emergency rooms, operating
5 rooms and labor budgets for those 16 hospitals,
6 and I was kind of the special projects person,
7 so anything that came up with our division
8 president, I spent a lot of time again doing
9 strategic planning and business planning and
10 making sure our business plans were done.

11 Q: Okay. When did you arrive at Grand Strand
12 Regional Medical Center?

13 A: Three years ago, so it would be September of
14 2010.

15 Q: And what's your official capacity there?

16 A: I'm the chief operating officer.

17 Q: Tell the Court a little bit about what you do
18 in that role.

19 A: Which means that anything the CEO doesn't want
20 to do, I do. No, but I have about half the
21 hospital, everything except nursing, and my job
22 is to make sure that, you know, day-to-day
23 operations run smoothly, physician
24 relationships, but also building all the
25 strategic plans, building all the business

1 plans, physically building them in PowerPoint,
2 but also working with the division office and
3 locals admin team to make sure that we know
4 what we're doing, building them and putting
5 them in play.

6 Q: Okay. Can you tell the Court about any
7 significant projects you've worked on since
8 you've arrived at Grand Stand in 2010?

9 A: Implemented the 50-bed project. We, as Doug
10 alluded to yesterday, \$50 million in building
11 a new emergency room and a new cardiac tower.
12 We've also opened and start -- or planned,
13 started a trauma program that started shortly
14 after I got there. I hired physicians. I
15 hired staff and built a trauma program that has
16 actually done very well. Pediatrics, which
17 we're launching here soon, we worked on a 32-
18 bed addition, but also a whole service line
19 planning. We've done the prelim launch of an
20 eight bed pediatric unit, so all the planning
21 business that goes along with that, and just
22 general operations.

23 Q: Is that Level II trauma, was that a new
24 service?

25 A: It was. American College of Surgery came in

1 and verified us. We were one of the few..
2 American Impact was second. The only American
3 College of Surgery Level II trauma and the
4 second one in the state. MUSC was the first,
5 a Level I.

6 Q: And how did you go about kind of recruiting
7 staff for the Level II trauma?

8 A: The first we did was hire a program director,
9 and we got -- we started looking for the best
10 of the best, and we pulled her out of south
11 Florida. She came from Fort Lauderdale. Most
12 of our surgeons, I think three or four of those
13 have all come from south Florida. We used
14 local -- we had two physicians on staff that
15 turned into trauma surgeons. All of the
16 support staff that came with that, there wasn't
17 trauma expertise in the area, so we pulled them
18 from the outside, meaning outside the state in
19 almost all cases.

20 Q: What other CON projects have you worked on at
21 Grand Strand?

22 A: Obviously this one. I worked on a 37 bed.
23 I've worked on an EP lab. We've worked on a
24 rehab floor. I think that's it.

25 Q: And what health planner do you normally work

1 with?

2 A: We used Dan for all those, Dan Sullivan.

3 Q: Okay. Do you think Dan's familiar with the
4 market for Grand Strand?

5 A: Oh, he knows the market well. You know, he did
6 our 50-bed CON when we did that one. He's done
7 just -- I've worked with him for years, so he
8 tends to know the market anywhere he is,
9 especially with the 50-bed CON, he knew all the
10 market area very, very well so we really felt
11 comfortable with him.

12 Q: Do you meet with him often?

13 A: More by email. He lives in Atlanta, so instead
14 of having him flown in and do those kind of
15 things, we'll do email and phone calls and
16 conference calls when e's needed. He generally
17 asks for a data set that we pull, and he is
18 very specific, and since we've worked together
19 before and, you know, again, he knows the
20 market pretty well, there's not a lot of
21 explanation needed for kind of a zip code
22 analysis and the service line analysis he does.
23 He works with HCA all over the country.

24 Q: What was your role in this CON process that's
25 at issue here in this courtroom?

1 A: I was kind of the point person at Grand Strand,
2 and so I would work with design and
3 construction. I would work with our attorneys,
4 with Parker Poe. I'd work with Dan Sullivan to
5 make sure he had the information that he
6 needed, and kind of work internally to make
7 sure all the points were used. You know, we
8 used -- Parker Poe kind of helped us with
9 making sure we had all the elements of the CON
10 application, but then we went internally and
11 just organized the letters of support and all
12 those things that needed to be done and checked
13 the boxes on the application.

14 Q: What type of documents would Dan Sullivan
15 request from you?

16 A: They were decision support documents, so it
17 would be data that we'd pull out of our -- out
18 of our information systems or state run data.
19 So I would make the request through our
20 decision support office, which is in
21 Charleston, and he would give us a list of the
22 things he was looking at, admission by zip code
23 or service line by zip code, and we would give
24 it to him in the raw form so that he could
25 manipulate it as he thought needed and apply

1 the models that he thought would represent, you
2 know, the service that we were trying to do.

3 Q: What, if any, involvement did you have with his
4 data analysis and projections in the CON Act?

5 A: I didn't have to do any of that. He knows the
6 market so well, we don't have to do that. So
7 we send him the data and let him build those
8 things.

9 Q: Let's talk a little bit about the process of --
10 did you -- well, what if any, work did you do
11 in procuring the equipment for the project?

12 A: I spent a lot of time talking to our sister
13 hospital in Charleston, Trident. They have a
14 fairly successful cancer center there. And we
15 talked to our Sarah Cannon Center in Nashville,
16 which is, you know, they're not -- their name's
17 not as recognized as MD Anderson and some of
18 those, but it is -- it has more research than
19 any other cancer center in the country, and so
20 they're very well known and very well
21 respected, and we have immediate access to
22 those guys. Brian Marger is the guy that we
23 used, and he spent a lot of time helping us
24 through some of those things. We have a
25 physician expert as well, Dr. Mun, who has

1 worked out of -- works in Nashville and he's
2 based out of Fort Lauderdale that's kind of a
3 technology expert that helps us with a lot of
4 those things.

5 Q: Tell us about your interaction with Dr. Mun.

6 A: Dr. Mun's a great guy. He's very entertaining
7 to deal with, but he's also kind of a political
8 quagmire for us. He does a lot of the
9 negotiations from the corporate office, so my
10 interaction with him is I'm fairly careful
11 with being just from the mere fact of he's got
12 particularly companies that the company likes
13 to use and they're sometimes different than
14 where we want to go and you just kind of have
15 to lead him in the direction you want to go
16 and, you know, he's very -- but he's very well
17 known, very well established in the company.

18 Q: Okay. Who ultimately chose the equipment,
19 Varian Clinac iX ,for the application?

20 A: I think it would be a combination. I mean,
21 obviously -- obviously the hospital had to make
22 that decision ultimately, but it was within
23 from the folks at Trident, the folks at Sarah
24 Cannon and Dr. Mun.

25 Q: Okay. And why was the Varian Clinac iX chosen

1 at the time?

2 A: At the time, it was the technology that we
3 could get inside our price range, and we had a
4 lot of trouble with Varian getting quotes. You
5 know, the first quote came in north of four
6 million dollars. I think that we even went to
7 the other company, Elekta, and spent a whole
8 lot of time talking to them and kind of using
9 them as leverage to get the Varian price down.
10 You know, our company has so many accelerators.
11 I mean, we have 80 across the country with 40
12 different sites, and so we have some of the
13 Elekta, we have some of the Varian, and so we
14 got in to try to leverage our size. And so we
15 started talking to both companies, kind of set
16 that up and hopefully Varian will start --
17 start negotiating with us. So we spent a lot
18 of time. It was -- it was -- I don't
19 particularly care for the sales guy with the
20 Varian guy, you know, so we ended up fighting
21 with them a lot.

22 Q: I pulled up what's ---

23 A: Yoel.

24 Q: Okay. Respondent 112 on the screen for you.

25 If you can read that, let me know; if you

1 can't, and I can get you the paper copy.

2 THE COURT: If y'all could stop for just a moment.

3 MR. THOMAS: Sure. Judge, just let me know when
4 you're ready.

5 THE COURT: I will.

6 (Pause)

7 THE COURT: That's Respondent's what, 112?

8 MR. THOMAS: Yes, sir.

9 THE COURT: It's taking a second.

10 MR. THOMAS: It took me 12 minutes to boot up my
11 computer; it's very frustrating.

12 THE COURT: All right.

13 Q: Mr. Rudd, is this is an email from you to
14 Robert Grace Monday, May 23rd, 2011?

15 A: It is.

16 Q: Okay. And is it attaching an email?

17 A: It is.

18 Q: And who's that from, the attached email?

19 A: That's from the sales guy at Varian. His name
20 is Yoel.

21 Q: Is that Bakas maybe?

22 A: Bakas.

23 Q: I'm taking a stab at that.

24 A: B-A-K-A-S.

25 Q: Let me get out 112 for you.

1 MR. THOMAS: That's not it, that's not the document.

2 It'd be the next page of the Exhibit 112.

3 Okay. Are you there, Your Honor? Just want to
4 make ure.

5 THE COURT: Yes.

6 MR. THOMAS: Okay. It looks like we've got it on the
7 screen too.

8 Q: Can you describe for the Court what this
9 document is, Mr. Rudd?

10 A: Yeah. This is the quote from Varian that talks
11 about everything that's going to be on the
12 machine, all the different bells and whistles
13 and the software, accessories if you need them,
14 and all the things that are incorporated in the
15 machine.

16 Q: Okay. What was the price quoted to you on,
17 looks like I guess May 19th, 2011m for the
18 Clinac iX?

19 A: It was four million, my recollection, I haven't
20 got -- 4.1 maybe.

21 Q: If you look on Grand Strand 651, it might be
22 there.

23 A: 651. Yeah, \$4,118,726.

24 Q: Were you pleased with that amount?

25 A: No.

1 Q: Why not?

2 A: Because it was significantly higher than what
3 one of our sister facilities had bought almost
4 the exact same machine just months earlier.

5 Q: Okay. In that notebook, could you turn to
6 Respondent 126 for me. Do you recognize that
7 document, the email from you to Dr. Mun and
8 some others in the company on June 22nd, 2011?

9 A: I do.

10 Q: Okay. Can you describe for the Court, you
11 know, what you're doing there, what you're
12 saying to Dr. Mun?

13 A: Yeah, I'm trying to -- I'm trying to get him to
14 help me put some pressure on Varian. I think
15 that, you know, we -- I quoted some facilities
16 that we had recently gotten in the new National
17 Group so that he would know that this was a
18 bigger problem than just Grand Strand. Both
19 Lewis Gale and Clinch Valley are on the East
20 Coast. They're in National Group, and what I
21 was trying to get him to do is say I need some
22 help here. We were, you know, Varian was the
23 -- was the machine we wanted the whole time.
24 It was just that we needed to get the pricing
25 to something that we could get, and I knew if

1 I could get his support to start helping me
2 that the price would come down magically, and
3 it did.

4 Q: Just for the record, is Varian the manufacturer
5 of the Clinac iX?

6 A: Yeah.

7 Q: Can you speak up for the record?

8 A: Yes. Okay, sorry.

9 Q: She's got to take everything down over there.
10 All right. And so that -- what's the date on
11 the email from you to Dr. Mun?

12 A: June 22nd, 2011.

13 Q: Okay. I'd like you to turn over to Respondents
14 127, so it's the next tab, and describe that
15 document. Is it an email from whom to who?

16 A: It is from Yoel Bakas, if that's how you say
17 his name, to me and to Tammy, however you say
18 her last name, W-O-T-R-I-N-G, who I think is
19 our national account rep who deals with HCA,
20 and then a quote attached.

21 Q: And this particular quote is for what?

22 A: It's for the Clinac machine.

23 Q: Okay. Is this the Clinac iX that is in the
24 application for Grand Strand?

25 A: It is.

1 Q: Now, what is the price there, what's the quote
2 for the Clinac iX, which I guess came what,
3 about a week after you initially got the four
4 million dollar quote?

5 A: Right. It's for 2.8 million.

6 Q: Were you, at that time, pleased with this
7 price?

8 A: I was. It's exactly what I wanted.

9 Q: Okay. Yesterday, Mr. White mentioned that
10 Grand Strand might have an opportunity to
11 install a TrueBeam given the passage of time
12 and a later install date. What is your
13 understanding of that? And let Mr. Long make
14 his objections.

15 MR. LONG: Your Honor, I renew my objection again,
16 and just for the record, I know we talked about
17 this already this morning, our objection's
18 really based on three things going forward.
19 First, it's based on the prejudice, the fact
20 this information is coming as late as it is.
21 Secondly, it's based on the fact that it's a
22 substantial change, and therefore, that's a
23 change in the project; it'd have to be remand
24 back to the Department. And then the third
25 issue is that the issue goes to the -- is one

1 of the factors, one of the important factors
2 that the Department considered in the
3 comparison of the two machines, and so
4 therefore, to interject this new fact into
5 that, this is not what the Department compared
6 as part of its analysis. So we move that he be
7 prohibited from testifying about their intent
8 to change the equipment from the application.

9 MR. THOMAS: Your Honor, I just want to address the
10 third point of his argument because I don't
11 think he made it earlier and just for the
12 record if I could.

13 THE COURT: Yeah.

14 MR. THOMAS: Yes, the Department did compare the
15 machines, and the beauty of it you know where
16 the Department would stand on the machine. If
17 they believe that the TrueBeam, as they've done
18 in their approval letter for CRCC, is superior
19 to the Clinac iX, well then if you would find
20 that Grand Strand would likely get a TrueBeam,
21 then you know that in a de novo trial that that
22 would be a wash, and that's what you're allowed
23 to do. If it's a TrueBeam versus a TrueBeam
24 and you know how the Department would feel,
25 then there probably would be absolutely nothing

1 to really consider there, and that's all I
2 would put on the record there.

3 THE COURT: Well, I'd also recognize again that, as
4 you said earlier, this is a de novo, so. But
5 as far as the door being opened yesterday and
6 any objections that were made at that time, I
7 deny any new objections, but take the other
8 objections under advisement.

9 MR. THOMAS: Thank you, Your Honor.

10 Q: So what is your understanding of how this
11 TrueBeam, the idea of getting a TrueBeam came
12 about?

13 A: That means I can answer?

14 Q: Yes.

15 A: Trident, our sister hospital, just received or
16 signed a quote for the TrueBeam machine that
17 they in fact are installing now, and it was
18 just under 3.1 million. Given that we're going
19 to have some time before this project launches
20 and we buy, we think that we're -- we feel very
21 confident that we can get the quote in that
22 three million dollar range. I think by the
23 time we buy this thing, personally, that it
24 will be below the quote that's actually in the
25 CON.

1 Q: What, if anything, would you need to do with
2 DHEC if the decision was made to purchase the
3 TrueBeam instead of the Clinac iX?

4 A: Obviously we would need to notify them to make
5 sure that they're comfortable with the change.

6 Q: What, if anything, did you have to do with the
7 staffing section of the CON application?

8 A: I spent a lot of time reviewing that with our
9 folks in -- at Trident and folks in Nashville.
10 And you know, given my background with
11 staffing, we tend to, the three of us kind of
12 made that decision.

13 Q: Okay. And just for the record, I think that's
14 B-21 in the application, Joint Exhibit 2. Go
15 to Bates page 40 for me. I want to make sure
16 I get this for the record. Is this the
17 staffing chart that you would have forwarded to
18 Parker Poe for inclusion in the CON
19 application?

20 A: It is.

21 Q: And there at the bottom of the page, would you
22 read that sentence regarding the physicist?

23 A: "The physicist contracted and budgeted in the
24 attached project pro formas in the line item
25 of contract services."

1 Q: Okay. So that's also, physicist is also a
2 member of the staff that you would need to
3 initiate a radiation therapy program, correct?

4 A: Yes, sir.

5 Q: All right. How do you -- tell the Court a
6 little bit about how you would actually plan to
7 staff, actually staff the radiation therapy
8 center, so not just on paper, but how do you go
9 about staffing a center like that
10 contractually?

11 A: I think that you spend -- you look for
12 expertise that we already have inside the
13 hospital, which given our size, we have 1,600
14 employees, there are going to be nurses and
15 folks that have, you know, oncology experience
16 throughout there. We will look and try to find
17 the director that is -- that is a true rock
18 star from outside the area that can come in and
19 provide some strategic direction. Those people
20 when they come always know people and people
21 come with them, very similar to our trauma
22 program. The trauma director brought several
23 people with her. And I would expect that the
24 director that we hire would bring some folks.
25 We would obviously do the paper and do a

1 national search to get the highest qualified
2 people possible.

3 Q: How would you go about getting or recruiting
4 your physician, your radiation oncologist?

5 A: You know, same kind of deal. We have, you
6 know, huge resources with 174 hospitals across
7 the country. We have a lot of national
8 recruiting resources and, you know, like again
9 like the trauma program, we went to where the
10 programs were very well respected and started
11 talking to those people there, hopefully to
12 bring -- hopefully talking them into coming to
13 our place.

14 Q: Are you considered the staffing officer for ---

15 A: I am.

16 Q: Can you explain a little bit what that means to
17 Judge Anderson.

18 A: What it means is that daily, we do daily
19 reviews of staffing through the hospital, so
20 every day at 2:00 we have a system called Plus,
21 and it's a labor management system. It takes
22 all the hours that are dropped into the
23 hospital, and we get reports about each unit,
24 each department, based on what their volume is,
25 what their hours are, what their overtime hours

1 are, what their contract labor hours are and
2 every so often, we start making adjustments
3 based on volume. But it also, you know once a
4 year, multi times a year, we'll sit down and
5 look at what are the resources that provide
6 service inside the hospital and work with
7 Robert and we sit down and try to figure out
8 the dollar attached to it and the hours
9 attached to it with staffing grids and other
10 things like that.

11 Q: Are you involved with physician recruitment as
12 well?

13 A: I am.

14 Q: Can you give the Court kind of an idea of how
15 you go about recruiting a board certified
16 radiation oncologist for your program?

17 A: The first thing we would do is get with the
18 recruiters putting applications out there or a
19 need in papers or on the internet and those
20 kind of things. We send people to the various
21 schools that have these folks coming out,
22 talking to the experts around the country,
23 hoping that, you know, not only will somebody
24 coming out of school want to come but maybe,
25 like a lot of times happens, the people we're

1 talking to say that sounds like a great idea.
2 There are a lot of folks out there that like
3 starting programs, and we have found -- we're
4 starting a graduate medical education program
5 in a couple, in a couple of years, and it's
6 amazing how many people with these when you
7 start asking who's the best, they say well, you
8 know it sounds great, can I start that program,
9 and you'll get the teachers that come down and
10 say I'd really like to start a program because
11 they get to go back to my roots and those kind
12 of things.

13 Q: Does Grand Strand plan to directly and actively
14 solicit staff from CRCC to staff its linear
15 accelerator program if it's approved?

16 A: Absolutely not.

17 Q: Tell the Court a little bit -- tell the Court
18 what you had to do with the construction and
19 the design piece for this particular project.

20 A: We have an architect firm out of Nashville, and
21 we have the design and construction team that's
22 in Nashville as well. Those guys have come
23 down. We would walk multiple sites. We would
24 go through the drawings, go through the
25 construction budgets, go through the pros and

1 cons, spend you know, an enormous amount of
2 time making sure how it fits into the strategic
3 plan going forward for Grand Strand.

4 Q: You heard a lot of testimony yesterday from Mr.
5 White about the site location. I don't want to
6 go deeply into that, but I do want to touch on
7 it. What is your recollection of kind of the
8 site location for the linear accelerator?

9 A: I think -- I think initially, you know, we
10 wanted to put a linear accelerator on campus,
11 you know, exactly where it ended up being.
12 And, you know, what happens in every project we
13 ever do is that, you know, we have several
14 people that want to look at all the options,
15 and so we will ad nauseam go through every
16 single option, go through all the possibilities
17 so that, you know, as being fiscally
18 responsible, we go through all the options that
19 make sense and then choose the best one for all
20 the goals of the project.

21 Q: What were some of the advantages to the Dr.
22 Holt location?

23 A: You know, for the patient, there's several. I
24 mean, they could go and literally walk to the
25 next area of treatment, and they -- it was just

1 proximity for the patient. You know, the med
2 oncs, medical oncologists and those guys being
3 so close together, it would just offer the
4 patient a better -- a better experience, if you
5 will.

6 Q: Okay. What concerns did you have about Dr.
7 Holt's or Coastal Cancer's property?

8 A: The biggest one was price. You know, 1.4
9 million, that we had -- even at fair market
10 value, you know, my biggest concern was to get
11 Holt all cranked up about we're going to buy
12 this property at fair market value coming in at
13 \$700,000 and then not only could we not do the
14 project, but it was one of those things that
15 would, you know, damage our relationship with
16 Dr. Holt. You know, he was trying to sell his
17 property. I don't know what the fair market
18 value would come in because we never did it,
19 and you know, then you get into are we putting
20 something on his property that, you know, could
21 potentially cause us some, you know, problems
22 downhill with a referral source and those kind
23 of things. And then you had the -- then you
24 had the whole issue of if we did it, the number
25 of inpatients that we had, how would we get

1 them over there. There were transport issues
2 still.

3 Q: Let me ask you this on the fair market value
4 thing that you referenced a couple times. Why
5 can't you just pay Dr. Holt what he wants for
6 the property?

7 A: It's not -- it's against the law.

8 Q: Is that something called a kickback ---

9 A: It is.

10 Q: --- paying more than fair market value?

11 A: It is. And, you know, it is something that,
12 you know, HCA errs on the side of caution with
13 because it's something we do not want to get in
14 the middle of.

15 Q: Other than the, I guess the Coastal Cancer
16 property, were there other, any other locations
17 off campus considered?

18 A: We talked about South Strand briefly, and you
19 know, that one was ruled out pretty quickly.
20 Not only was there the Murrells Inlet craziness
21 that was going on down there where they have
22 two that was approved down there, which you
23 know, just didn't want to get in the middle of
24 that. And then now we had some electrical and
25 some water issues that we were going to have at

1 South Strand. Our South Strand location is
2 about ten miles south of the hospital, and the
3 property for us is something we're always
4 trying to figure out what to do with it. We
5 have a freestanding emergency room there. We
6 have now a wound care center that's just
7 opened, and it's just one of those properties
8 that we always consider ways to better utilize,
9 but you know, again, it didn't make sense
10 because the Murrells Inlet didn't make sense
11 because of the construction issues.

12 Q: How close is your South Strand location to
13 Waccamaw Hospital?

14 A: I don't know, seven miles, not far, six miles.

15 Q: So what, if any, part did cost play into the
16 ultimate location of Grand Strand's radiation
17 therapy center?

18 A: Any project we do, cost is something that we
19 consider. I mean, it's something that's in the
20 CON requirements. I think that we often will
21 spend an enormous amount of time trying to
22 reduce the cost to a minimum just to make the
23 project go. I think that, you know, it's a
24 difficult balance to manage cost and quality,
25 but I think one that we have proven

1 historically we do pretty well.

2 Q: Are you pleased that the radiation therapy
3 center is going to be in the hospital?

4 A: Absolutely.

5 Q: Why?

6 A: I think it's the -- it's the -- it kind of
7 completes, it's a building block, but it also
8 starts our service line of cancer inside the
9 facility. I think, you know, right now we
10 treat breast cancer and we treat lung cancer.
11 We have probably one of the best physicians I
12 think in the country doing breast care surgery.
13 I think we have some lung surgeons that are
14 really good at what they do, and I think this
15 would complement the complete service that we
16 do, and I think that if we had, you know,
17 radiation therapy in-house, we could start
18 really getting serious about providing that
19 oncology cancer care that could become world
20 class like the other things we've done at Grand
21 Strand.

22 Q: Do you attend tumor board meetings?

23 A: I do.

24 Q: How often do you see the radiation oncologists
25 that are in the area attend these meetings?

1 A: You know, just -- they're three meetings and
2 just to clarify what, you know, there's a tumor
3 board that meets once a month at night, and so
4 that's one meeting, but there are operational,
5 multidisciplinary teams that meet in the
6 morning and there's two of them. There's a
7 lung operations meeting, and then there's a
8 breast care meeting. The breast care meeting
9 is the breast care general surgeons, the
10 pathology, radiology, and the medical
11 oncologist. In the breast care meeting, I
12 can't remember ever seeing those guys attend.

13 Q: You said those guys. Could you clarify that
14 for the record.

15 A: I've never seen -- and I got the doctor's name
16 -- Dr. Francke. Dr. Andrews has spoken at a
17 meeting, but it wasn't a breast care meeting,
18 and the lady, I don't know her name. But those
19 three we have never -- we have never seen
20 attend the breast care meeting. The lung
21 meeting, I have missed a couple of those
22 meetings. To my knowledge, the only time that
23 anybody has been there is Dr. Andrews spoke one
24 time.

25 Q: And do you keep logs of who attends these

1 meetings?

2 A: We do.

3 Q: Okay. Is it Dr. Edwards Bennett, is that the

4 ---

5 A: That's a female doctor.

6 Q: That's the female physician you were speaking
7 of?

8 A: Uh-huh (affirmative response). Very well
9 respected.

10 Q: Okay. Tell the Court a little bit about
11 letters of support. Did you have anything to
12 do with that, getting support for the project?

13 A: I did. We spent a lot of time making sure that
14 we had enough physicians that would support the
15 project because it's a DHEC requirement, so we
16 drafted a letter and then went out to I guess
17 first the med oncs, the medical oncologists, to
18 make sure they supported the project. We
19 talked to the GYN/OB docs because it's very
20 important for them to support the project, the
21 general surgeons and the breast surgeons
22 specifically, and then the medical community at
23 large just to make sure that, one, they knew
24 what was going on, and that they thought it was
25 a good idea.

1 Q: And is there any requirement that you're aware
2 of that you have to get physician support for
3 the project?

4 A: There is, the CON requirement.

5 Q: What was kind of the starting point for the
6 physician support letters?

7 A: The starting point?

8 Q: Yeah, where did you go first?

9 A: The med oncs.

10 Q: Why did you go -- just for the record, med oncs
11 means medical oncologists?

12 A: I'm sorry.

13 Q: That's all right.

14 A: I need to make sure I don't ---

15 Q: Hospital lingo.

16 A: It is.

17 Q: Acronyms.

18 A: Too many acronyms.

19 Q: Why is it important to start with the medical
20 oncologists?

21 A: They would be one of the referral sources that
22 we'd have to have.

23 Q: And why? Why is that?

24 A: Because they do provide, they are the ultimate
25 stop for somebody that has cancer, so if they

1 don't support our program, it probably won't
2 go.

3 Q: And did medical oncologists give Grand Strand
4 letters of support?

5 A: They did.

6 Q: Do you know if they gave them to the other
7 projects?

8 A: I think they did the Conway project as well.

9 Q: And when you're getting these letters, what if
10 any, commitments did you get in terms of
11 definite patient referrals to the Grand Strand
12 project?

13 A: None, nobody ever gives you definite anything.

14 Q: Now, CRCC as you're aware, they've alleged that
15 Grand Strand shouldn't be approved over CRCC-
16 Conway because Grand Strand doesn't have any
17 experience in the radiation therapy business.
18 What are your thoughts about that accusation?

19 A: I think the company HCA has the experience. I
20 think we have 80 machines, 40 locations, and a
21 cancer center in Nashville that is nationally
22 recognized for its work. I think that we have
23 proven as a company and as a hospital that any
24 service line we get into, not only do we do
25 very well at it, but we become world class at

1 those kind of operations.

2 Q: How do you think that Grand Strand will achieve
3 the treatment projections in the CON
4 application?

5 A: I think it will be difficult. I think that,
6 you know, historically we have -- we had come
7 in with a service that nobody else had. I
8 think that in this particular arena, we're --
9 one, it's an outpatient business so it's going
10 to be a little bit different than our inpatient
11 business, but the outpatient business has, you
12 know, really significant competition, and I
13 think it's very well established, very well
14 respected competition. And I think for us,
15 we're going to have to be very good at what we
16 do, but we're going to be competing against a
17 center that's very good at what they do. And
18 I think that if we are able to hit the
19 projections that we've made, that we have been
20 very successful.

21 Q: Did you have anything to do with the financial
22 pro formas in the application, Mr. Rudd?

23 A: I didn't.

24 Q: Okay. Who worked on that piece?

25 A: Robert Grace.

1 Q: Okay.

2 THE COURT: Did you say you did or didn't?

3 MR. RUDD: Did not. Did not. I'm sorry, Your
4 Honor.

5 THE COURT: Okay.

6 Q: You might want to speak up just a little bit.

7 Did Mr. Grace ever send you any pro formas?

8 A: Several.

9 Q: Do you recall getting one in January of 2011?

10 A: I do.

11 Q: What, if anything, do you recall about that?

12 A: I remember that earlier in the year we'd had a
13 visit from our group officials, and Chuck and
14 Mike, and they, along with our division, had
15 decided in our strategic meeting that we needed
16 to move ahead with the linear accelerator, and
17 they had asked us for a pro forma very quickly.
18 I know December, January, as the end of the
19 year comes, we've got other things going on and
20 multi projects going on that we had not
21 addressed it as quickly as we needed to, and we
22 had gotten some pressure to make that thing
23 happen very quickly, the pro forma.
24 Q: Do you recall if that January pro forma
25 included the health planner's projections?

1 A: It did not.

2 Q: Do you recall in January if you'd even informed
3 Robert that a health planner was involved in
4 the project?

5 A: We had -- we had several projections going on,
6 so if I did, he would have easily confused it
7 with something else and it -- to my knowledge,
8 he didn't know that we were doing it, but maybe
9 I did.

10 Q: Yesterday, and if you don't recall it, just let
11 me know but there was an email, I believe it
12 was a Respondent's 83, that was sent to Mr.
13 White from I guess your division head, Jamie
14 Thomas. Actually, it's up on the screen, good.
15 And you were copied on that email, correct?

16 A: Yes.

17 Q: And this email, just for the record again, was
18 sent way back in November 10th, 2010, correct?

19 A: Yes.

20 Q: All right. Now, you -- there's a reference in
21 this, I think it's the very last line,
22 employing the medical oncologist might be a
23 part of this progression, correct?

24 A: Right.

25 Q: I think you stated earlier in your testimony

1 that you physically build the business and
2 strategic plans for Grand Strand?

3 A: Yes.

4 Q: Okay. So I'm going to ask you, are you aware
5 of any business plans or strategic plans to
6 purchase the assets of Coastal Cancer Center or
7 employ the physicians who are partners in
8 Coastal Cancer Center?

9 A: There are no plans that we have made.

10 Q: What, if anything, Mr. Rudd, do you know about
11 the medical oncologists being estranged from
12 21st Century as stated in this email?

13 A: I don't know a whole lot about it. I think
14 that it's not a -- it's not a scuttlebutt.
15 It's a very common and I don't know much about
16 it all.

17 Q: Have you heard anything about any estrangement
18 in the past two, three years?

19 A: In the testimony that we talked about.

20 Q: Okay.

21 A: Depositions that I've attended and witnessed.

22 Q: Are you familiar with CRCC's analysis stating
23 that Grand Strand would capture in radiation
24 therapy treatments, which is an outpatient
25 service, something along the lines of a its

1 inpatient market share?

2 A: Yeah.

3 Q: What, if any, thoughts do you have about that?

4 A: I think it's a completely different market. I
5 think that it's, you know, comparing apples and
6 oranges. You know, the inpatient business is
7 completely different than the outpatient
8 business. I think to assume that what we're
9 going to do on the inpatient side carries over
10 into the outpatient business in a environment
11 where we have a formidable competitor and, you
12 know, who has a high quality service is
13 ridiculous.

14 Q: How long has that competitor been practicing in
15 the market ---

16 A: Thirty-three years is what I learned yesterday.

17 Q: Are you referring to the competitor Georgetown
18 or CRCC?

19 A: CRCC.

20 Q: And Mr. Rudd, just finally, why should Grand
21 Strand prevail over CRCC's Conway application
22 if the Court finds that the applications are
23 competing?

24 A: I think ours is different. I think that we are
25 trying to offer a new service to the community.

1 I think that, for us, we have historically
2 stepped up in many different ways, not only
3 offering open heart, which was new to Grand
4 Strand and new to Horry County, trauma which
5 was new to Horry County, and now we're talking
6 about a comprehensive cancer center. And I
7 think that that will help us better serve the
8 community and be even a larger footprint in
9 Horry County. I think this comprehensive
10 health center, you know, you can't glaze over
11 that because, you know, we have lots of
12 patients that are doing cancer surgery and
13 chemo and radiation oncology and, you know,
14 some of these patients are older and, you know,
15 going multiple places is difficult. And I
16 think that if we can establish a place that is
17 one place, it's the doctors you know, it's the
18 path you know, it's the parking you know, I
19 think that there's a tremendous advantage to
20 Horry County. So, in my view, I think that if
21 you think the residents of Horry County deserve
22 to stay in their area to get all the treatment
23 patterns that they need, I think that it just
24 makes sense.

25 Q: Is Horry County a destination for retirees?

1 A: It is. We have a lot of folks that are older,
2 a lot of blue hairs. They cause the driving to
3 be very dangerous. They love to make the left-
4 hand turns from the right lane, so.

5 Q: Well, that's a stereotype.

6 A: Well, but it also provides trauma business.

7 Q: That's all the questions I have for you, Mr.
8 Rudd. Thank you.

9 MR. LONG: Your Honor, can I take a break before the
10 cross so I can consult with my co-counsel on
11 evidentiary issues?

12 THE COURT: All right.

13 MR. LONG: Thank you.

14 (Break from 10:21 a.m. until 10:35 a.m.)

15 MR. LONG: Thank you, Your Honor. May it please the
16 Court.

17 MR. RUDD - CROSS-EXAMINATION BY MR. LONG:

18 Q: Mr. Rudd, I'm Jimmy Long. We've met before.
19 Now, you started at Grand Strand in September
20 of 2010, so three years ago, right?

21 A: Right.

22 Q: But at the time that this work was being done
23 in regards to the application, you'd been there
24 basically a year, right?

25 A: Yes.

1 Q: Because most of this work was done in 2011?

2 A: Yes, sir.

3 Q: All right. Let's talk about some of the things
4 that you did not work on, okay? You did not
5 prepare the internal documents to seek approval
6 of the project from Nashville, right?

7 A: Which documents?

8 Q: The Capital Asset Management document or the
9 Request for Capital document?

10 A: I did not.

11 Q: You didn't work on those?

12 A: No.

13 Q: Other people did, Mr. Grace and Mr. Was were
14 the ones who worked on those documents, right?

15 A: Mr. Grace was responsible for those documents.

16 Q: Right. And that is separate from the CON
17 application. That's the internal documents
18 that are sent to the division and then also to
19 the group to get approval for the project,
20 right?

21 A: Yes.

22 Q: And those are internal and private documents.
23 They're not, certainly not shared with the
24 Department, right? You don't give your Capital
25 Asset Management out to the Department?

1 A: Not typically.

2 Q: And your competitor and other people, right?

3 A: Not typically.

4 Q: You didn't have anything to do with the, what
5 we call the B-11 need analysis, right?

6 A: I did not.

7 Q: Mr. Sullivan did all of that, right?

8 A: Yes, sir.

9 Q: You also had nothing to do with the assumptions
10 of where the patients would originate at the
11 linear accelerator, right?

12 A: I did not.

13 Q: Mr. Sullivan did all of that?

14 A: Yes, sir.

15 Q: You didn't have anything to do with the
16 projections that Mr. Sullivan made in the
17 application, did you?

18 A: I did not. That was the area he did not need
19 my help with.

20 Q: All right. You did not have any conversations
21 with Mr. Sullivan about referral sources?

22 A: I did not. Again, he knows the area and knows
23 the market. He's an expert.

24 Q: And you didn't do anything in regards to, you
25 didn't work on the financials. Mr. Grace did

1 that, right?

2 A: I did not.

3 Q: Okay. And you deferred to the consultants on
4 the letters that were sent to the Department
5 during the review process, the additional
6 information and then the comments in regards to
7 the project review criteria, the letters?

8 A: Which letters are you talking about?

9 Q: The letters which went from Grand Strand to the
10 Department during the review process setting
11 out your position after the application was
12 filed.

13 A: I actually don't know which letters you're
14 talking about.

15 Q: Okay. That would probably mean that you didn't
16 work on them. All right.

17 MR. THOMAS: Objection, Your Honor.

18 Q: Did you work on them?

19 A: I don't know what letters you're talking about.
20 Can you show me one?

21 Q: Okay.

22 A: I mean, I don't have any idea what you're
23 talking about. I can't tell you ---

24 THE COURT: We took care of it.

25 Q: If we can pull up Joint Exhibit 2. Turn to

1 page 875. You can look at the book if you want
2 to, Joint Exhibit 2.

3 A: This one?

4 Q: Page 875, or you can look on the screen. This
5 is a letter from Mr. Sullivan to the Department
6 in November of 2011, which would have been
7 about a month before the decision. Did you
8 work on that letter?

9 A: I did not.

10 Q: Okay. Thank you. All right. Did you have any
11 conversations with Dr. Holt or his group about
12 the project?

13 A: We asked for their report.

14 Q: I'm talking about you personally.

15 A: I did not.

16 Q: Did you ever talk to Dr. Holt or anybody in his
17 group ---

18 A: I did not talk to Dr. Holt.

19 Q: --- about the project?

20 A: I did not.

21 Q: Okay. And actually, during the time in 2011
22 when you were working there, you were, as you
23 told me in your deposition, more focused on the
24 37-bed pediatric addition than you were the
25 linear accelerator application?

1 A: No, the rehab, yes.

2 Q: You testified this morning on direct that you
3 emailed Mr. Sullivan, right?

4 A: I did.

5 Q: Okay. There are no emails in the production
6 between you and Dan Sullivan, none. Do you
7 have any explanation as to why there would not
8 be any emails from Adam Rudd to Dan Sullivan in
9 the entire 5,000 page production by Grand
10 Strand?

11 A: Well, the request -- so he would request DSS
12 decision support documents, and the only way he
13 could have gotten them if I sent them to him,
14 and so he would -- either the lady from the
15 decision support sent them to directly to her
16 and I was copied on them, or they're missing.
17 I would -- the way that it's done is he would
18 send -- he sends through Will, or through
19 Parker Poe, the list of things that he wants us
20 to pull. We call decision support in
21 Charleston. They pull the information. They
22 send it back up to us to review the information
23 and make sure we think it looks right, and then
24 it goes out to the health planner.

25 Q: So is your testimony then that Dan Sullivan

1 would tell Mr. Thomas what he wanted, then Mr.
2 Thomas would email you what he wanted, and then
3 you would email it to Mr. Thomas, and then Mr.
4 Thomas would email it to Mr. Sullivan?

5 A: Yes.

6 Q: That's the information you had?

7 A: Yes.

8 Q: And you're saying that that occurred a number
9 of different times?

10 A: I'm saying it occurred some time. I don't know
11 the number. I don't have any idea what the
12 number is.

13 Q: Okay.

14 A: If it was three or four or ten files. I don't
15 know how many files there were.

16 Q: Did you withhold any emails in the discovery
17 process?

18 A: Of course not. Why would we?

19 Q: Because there were none produced. None.
20 There's not a single email between you and Mr.
21 Sullivan ---

22 MR. THOMAS: Objection, Your Honor.

23 Q: --- or Mr. Thomas ---

24 A: It's an Excel spreadsheet.

25 Q: --- in the production. Not one.

1 A: An Excel spreadsheet. I can't answer the
2 question.

3 Q: Okay. Now, despite the things we just went
4 through about what you worked on, you were the
5 lead person at the hospital in regards to the
6 CON application, right?

7 A: Yes, sir.

8 Q: And you worked on pages seven and eight of the
9 application, we can pull it up real quick,
10 which we call the B-2 description of the
11 project. You did recall that you worked on
12 those two pages, right?

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

14 Q: But you're not sure who drafted it, right?

15 A: We had a number of CON applications going on
16 that we had submitted. I was responsible for
17 putting the final draft that goes in together.

18 Q: And Parker Poe was the law firm or the people
19 who actually assembled the application, right?

20 A: They assembled the application, that is
21 correct.

22 Q: All right. Let's take a look at CRCC Exhibit
23 Number 119.

24 A: This book? Page 119?

25 Q: If you want to look in the book, it's 119 of

1 this one.

2 A: I can look in the book, correct?

3 Q: You can look in the book.

4 A: 119, okay.

5 Q: I want to look particularly at the email, not
6 the email from Mr. Earnest yet. I want to look
7 at the first email about midway down the page
8 from Jamie Thomas to yourself and Robert Grace.

9 A: Okay.

10 Q: Okay. And the date of that is June 17th, 2011,
11 right?

12 A: It is.

13 Q: That was right about the time the final
14 decisions were being made in regards to the
15 application. Y'all filed in early July, right?

16 A: We did file in early July.

17 Q: Okay. Mr. Thomas is talking to you and Mr.
18 Grace and it says, from the call of Will. Now,
19 he's not referring to Will Thomas. He's
20 referring to Will Earnest, right?

21 A: He is.

22 Q: And Will Earnest is a gentleman who works for
23 HCA, worked in the group, knows -- has a lot of
24 experience with cancer and is somebody that
25 y'all relied upon as a consultant kind of

1 person; is that right?

2 A: He is. I don't know Mr. Earnest myself.

3 Q: Okay. First thing Mr. Thomas is telling you is

4 ---

5 A: Just for clarification, I think he was somebody

6 Jamie had worked with in the past, and I think

7 that Jamie knew him. I don't think that Robert

8 or I knew him, no.

9 Q: Okay. And of course, to remind the Court,

10 Jamie Thomas is Mr. White's direct supervisor.

11 He's the division head at HCA, right?

12 A: Right.

13 Q: He's in charge of all of the hospitals in South

14 Carolina, plus Jacksonville?

15 A: Yes, sir.

16 Q: All right. He's telling you that you may be a

17 million high on the linear accelerator because

18 of his conversation with Will Earnest, right?

19 A: I actually don't know if he's talking about

20 Will Earnest or Will Thomas. I mean, he could

21 be talking about either. I would assume Will

22 Earnest, but I don't know.

23 Q: Well, he's copying with the email Will Earnest.

24 A: Okay.

25 Q: So you ---

1 A: Is he talking about Will Thomas or -- I don't
2 know.

3 Q: And then he says, he's telling you and Mr.
4 Grace that you need to start with one radiation
5 oncologist and add a second one when the daily
6 volumes reach the low 30s, right?

7 A: Where is that?

8 Q: The next sentence.

9 A: Okay.

10 Q: You see that?

11 A: I do.

12 Q: Okay. Then he also tells you, did you have any
13 conversation with him about whether that was
14 appropriate or not, or did you accept that?

15 A: I don't remember a conversation based off this
16 email.

17 Q: Okay. But you accepted his direction that you
18 should start with one radiation oncologist and
19 then add one when you got your volumes up
20 around the mid 30s or low 30s, the daily
21 volume?

22 A: I'm not sure I even know how to answer that
23 question. Did I take his direction? I don't
24 think that this is a directive to do that. I
25 think this is more of a strategic discussion on

1 this is -- these are the things that we need to
2 get -- we need to get the project in. I mean,
3 this is not an operational discussion.

4 Q: Well, you have to tell the Department how many
5 radiation oncologists are going to be working
6 at the center, right, in the application?

7 A: We did.

8 Q: And didn't you tell them you were going to have
9 one?

10 A: We did.

11 Q: All right. Now he also says here that the
12 average treatments per patient is conservative
13 at 25, 21 would be ultra conservative. Did you
14 have any conversation with him about that?

15 A: Did not.

16 Q: I want to go back and do some quick math with
17 you. I'm going to give you a calculator, all
18 right. But you'd agree with me on one of the
19 ways to kind of look at your utilization at a
20 linear, radiation therapy center is to look at
21 the number of treatments per day, right?

22 A: Uh-huh (affirmative response).

23 Q: And that's at least talking about when he says
24 daily treatment volumes would be in the low
25 30s, right? In other words, low 30-35

1 treatments per day, right?

2 A: Is that patients, or I assume he's talking
3 about treatments, yeah. I don't know if he's
4 talking about patients or treatments.

5 Q: Right, but it would be each patient gets one
6 treatment per day, right?

7 A: Yes.

8 Q: Okay. So when we're talking 30 treatments per
9 day or 30 patients per day, it's basically the
10 same number, right?

11 A: Right.

12 Q: All right. If you're doing most linear -- your
13 radiation therapy center is open pretty much
14 five days a week, right?

15 A: We don't have one.

16 Q: Well, if you got one. You're going to be the
17 chief operating officer there. Isn't it going
18 to be open five days a week?

19 A: I think it probably depends on demand. It
20 could be open seven days a week. It depends on
21 demand.

22 Q: Okay.

23 A: I mean, just like our operating room, just like
24 our emergency room, just like all our inpatient
25 units, just like my radiology, just like CT,

1 just like MR, just like all of our services
2 that are open 24/7, based on depend.

3 Q: Do you think your radiation therapy center is
4 going to be open 24/7?

5 A: It depends.

6 Q: Do you know of any radiation therapy center
7 that's open seven days a week?

8 A: I know that there are instances that we might
9 have to have radiation therapy for patients on
10 the weekend after hours. There are instances
11 that that will happen.

12 Q: Aren't you aware that most -- that at Trident
13 their radiation therapy centers are open five
14 days a week?

15 A: And they're on call and they can come in.

16 Q: Okay. They look at it in terms of being five
17 days per week, right?

18 A: But they also -- they also can adjust those
19 hours based on demand, and they would do that
20 if they had to.

21 Q: Well, let's just assume for a moment then that
22 we'll do the five days because you can be open
23 more if you want, okay?

24 A: I mean, just like the 21st Century is not open
25 8:00 to 5:00. I mean they're ---

1 Q: I'm talking about days, not hours, days.

2 A: But they're open days, but they're open from
3 what, 6:00 a.m. until midnight and that's ---

4 Q: Mr. Rudd, here's what I'm trying to get -- the
5 point I'm trying to make. If you're open five
6 days a week, the center is going to be open
7 about 250 days a year, right?

8 A: In general, yes.

9 Q: Okay. Will you do 250 times 30 for me?

10 A: 7,500.

11 Q: Okay. So you are averaging 30 treatments a
12 day, then that would be 7,500 treatments a
13 year, right?

14 A: That's what 30 times 250 is.

15 Q: And that's what Mr. Thomas says when y'all need
16 to start adding a second radiation oncologist,
17 right?

18 A: That's what the email ---

19 Q: That's what he just told you in this email
20 right here?

21 A: That's what that email says, yeah.

22 Q: Let's go to your application, page 619.

23 THE COURT: That's Exhibit 1?

24 MR. LONG: I'm sorry, yes, Grand Strand's.

25 MR. THOMAS: Joint Exhibit 2, Your Honor.

1 MR. LONG: Grand Strand's CON -- actually, I'm sorry

2 Your Honor, it's Exhibit 2.

3 Q: So we go to page 619, and I want you to look at
4 the expense page, the expense number on the pro
5 forma there at the bottom. It says other
6 operating expenses; you see that?

7 A: I do.

8 Q: You see that in year one it's 515,000; year two
9 is just 51,000; and then year three is 536,000?
10 You see those numbers?

11 A: I do.

12 Q: Do you know there's a difference in those
13 numbers because year one is the recruitment of
14 a radiation oncologist and year three is the
15 recruitment of a second radiation oncologist?

16 A: I don't know that that's true.

17 Q: Do you recall Mr. Grace's deposition about
18 that?

19 A: I don't recall.

20 Q: Do you have any explanation to why that number
21 would be over 550 and then over 500?

22 A: I actually don't know.

23 Q: All right. Let's take a look at CRCC Exhibit
24 Number 124.

25 A: Which book am I in? This one?

1 Q: The exhibit book, yes. All right. Okay.

2 Exhibit 120 ---

3 A: 120?

4 Q: --- 4, is June 20th, 2011, email. Now, let me

5 go -- let's go ---

6 MR. LONG: Excuse me, Your Honor, just give me a

7 second. I might try to lay a better foundation

8 on this.

9 Q: All right. Just looking at this. Let's look

10 at 124. This is a conversation with you and

11 Rodney VanPelt and Jerry Rooker, right?

12 A: Yes.

13 Q: You drafted this email here at the bottom?

14 A: Yes.

15 Q: And ---

16 MR. THOMAS: I just want to object. It's not a

17 conversation. It's an email.

18 THE COURT: Email conversation.

19 Q: Mr. VanPelt is with the division office, right?

20 A: He is. He's the division CFO.

21 Q: Right, and Mr. Rooker is the controller at the
22 group level, right?

23 A: He is.

24 Q: Okay. And you're discussing, this is the first
25 time that there's been discussion away from you

1 about South Strand, right, here in June of
2 2011?

3 A: That's not the first discussion. That may be
4 the first email.

5 Q: Okay.

6 A: There had been several discussions and several
7 walks with the construction team and all those
8 things by June.

9 Q: Okay. And in the first comment you said here
10 about why you did not think that going to South
11 Strand made the most sense, you said, Our CON
12 consultant and attorney comment -- both think
13 that the strength of our application over the
14 others in the market is the tertiary campus
15 where patients already come for services and
16 complete the continuum of care; they don't
17 think South Strand would have a good chance of
18 being accepted. So your advice internally was
19 that the CON at South Strand would be less
20 likely to be approved, right?

21 A: It is. The one thing that I was concerned with
22 is the construction cost at South Strand was --
23 I was afraid was going to come in low and lower
24 than the one on the main campus, and the main
25 campuses is the place we needed to put -- and

1 I'm trying to sell that we need to make this
2 thing on the main campus.

3 Q: Right, over South Strand?

4 A: Yeah.

5 Q: And South Strand, there's an empty building
6 over there, right?

7 A: Not empty. We see 25,000 ER visits.

8 Q: No, there's a building over there. I thought
9 the ambulatory service center ---

10 A: It is.

11 Q: --- is vacant basically.

12 A: It is. It's not anymore, but yeah..

13 Q: But you could have in 2011 ---

14 A: At that time, we could have used it.

15 Q: Could have used it to build a vault and put the
16 center there, right?

17 A: That was the electrical and water issues. We
18 couldn't put a vault there. It wasn't real
19 easy to do. You know, where you were going to
20 put it, the construction part of it was going
21 to be painful, and we did not think that the
22 electric -- we thought the electrical load from
23 the accelerator was going to actually cause a
24 big problem in the building, so we didn't do
25 that.

1 Q: I particularly want to direct your attention to
2 the second comment, Dr. Holt's support. Dr.
3 Holt, that's the Coastal Cancer Center's group,
4 their patients would have to drive past 21st
5 Century two to three miles to get to South
6 Strand. The bulk of our pro forma is based on
7 capturing the volume that is located next to
8 the hospital, right? That's what your project
9 is based on, capturing the volume that's
10 located next to the hospital?

11 A: I think that -- is there a question?

12 Q: Yeah, isn't that what you said?

13 A: Dr. Holt, his whole group, it is definitely
14 important that we capture a portion of his
15 volume in this center or it won't go.

16 Q: Okay. Look at pages 71 to 72 of the CON
17 application. Hang on, I'm sorry, not the CON
18 application. I want to talk to you about a
19 couple comments you made in the deposition.
20 You recall in your deposition that I asked you
21 whether you had done any analysis of the number
22 of treatments needed for the linear accelerator
23 to be viable at Grand Strand?

24 A: I do.

25 Q: And you stated that you had not, right?

1 A: As far as the breakeven analysis, that's what
2 I can remember the discussion being about.

3 Q: And do you recall the reason as to why you said
4 that you didn't need an exact number for your
5 linear accelerator?

6 A: I don't remember.

7 Q: That everything you've done at Grand Strand has
8 exploded?

9 A: It has.

10 Q: Okay. And you never ---

11 A: Let me make a comment on that, because there's
12 some specifics to that. You know, one of the
13 things that -- the reason that Grand Strand has
14 been successful is because we have a track
15 history of offering a whole lot of success and
16 a high quality program, you know trauma being
17 the specific. You know, trauma is a service
18 that the community needed, and what we did, we
19 just didn't have an average trauma program. We
20 have a world class trauma program. And CV and
21 cardiovascular center, you know, when we
22 brought the surgeon in, we didn't just bring
23 somebody average in. We brought a world class
24 guy in. And so when I say it's explosive, what
25 I'm talking about is it's such high quality the

1 doctors want to refer there. You know, in this
2 particular instance, you know, our competition
3 is going to be completely different. It's not
4 going to be inpatient business that we've
5 always done. This is going to be outpatient
6 business competing with a center that is well
7 established and is a high quality program, and
8 so wildly successful to me will be getting the
9 projections that Dan Sullivan has made.

10 Q: That's not what you told me in the deposition.

11 A: Clearly ---

12 Q: Let's read your deposition if we can I'm going
13 to ask you some questions and comment on what
14 your testimony was.

15 MR. LONG: Your Honor, may I open it?

16 THE COURT: Yes.

17 Q: This is your deposition, Mr. Rudd.

18 A: Okay.

19 Q: If you would, turn to page number 71, and I'll
20 read the questions if you could read your
21 answers to me in the deposition. Starting on
22 page 71 with line -- well, let's go back to
23 page 70, the first question. I think it
24 actually started on line 23 on page 70. My
25 question: "Is there any doubt in your mind

1 about whether the machine is viable or not at
2 Grand Strand?" Your answer on page 71?

3 A: I'm sorry, no.

4 Q: Question: "What do you think would be the
5 minimum number of treatments that a machine
6 would need to do for it to be viable at Grand
7 Strand?" Your answer?

8 A: "I don't know that I have a breakeven analysis.
9 I know we had talked about one, I don't know
10 that we did one."

11 Q: If you could just speak up a little bit when
12 you're reading, Mr. Rudd, okay.

13 A: Sorry.

14 Q: "In your mind, do you have any expectation as
15 to how many you would need to do for it to be
16 viable?"

17 A: "I don't have an exact number. The one thing
18 that I'll tell you is everything we've done at
19 Grand Strand has exploded. We've never had a
20 program that's not exploded."

21 Q: My question: "That predates you, right?"

22 A: "Trauma doesn't."

23 Q: "I'm just saying that statement you're saying
24 is not just in the three years that you've been
25 there? You're talking about --" -- your

1 answer?

2 A: "Sure."

3 Q: "Everything you know about the facility." Your
4 answer?

5 A: "Everything. Every new service line we've been
6 in has been very successful."

7 Q: Every service line we've ever done has been
8 very successful, right? That's the answer?

9 A: It is.

10 Q: Okay. "What do you attribute that to?" Your
11 answer?

12 A: "Excellent medical staff, it's a clear
13 differentiator."

14 Q: Question: "What do you mean by that?" Your
15 answer?

16 A: "When you cannot create, you cannot create a
17 great hospital without physicians, and we have
18 great physician staff at our hospital, and we
19 build a service -- when you build a service,
20 patients will gravitate to the great physicians
21 that we have."

22 Q: You didn't say anything about Mr. Sullivan and
23 his projections or that it would be difficult
24 to hit your projections, did you?

25 MR. THOMAS: Objection, Your Honor. Mr. Long didn't

1 ask him any questions about that ---

2 MR. LONG: Your Honor ---

3 MR. THOMAS: --- about what constitutes explosive.

4 I'm just saying he's being argumentative right
5 now. That's my objection.

6 MR. LONG: Your Honor, I'm not being argumentative.

7 I'm just asking questions on cross. He's just
8 trying to disrupt the flow of the cross by
9 objecting.

10 THE COURT: I don't agree with that. You're asking
11 whether or not he gave an answer in a certain
12 area on a deposition, so.

13 MR. LONG: It's just a yes/no question.

14 MR. THOMAS: But that's like he didn't ask him how
15 the Gamecocks are going to do this season, Your
16 Honor, I mean ---

17 THE COURT: Well, but I'm going to let him go into
18 it. You can address that on redirect.

19 MR. THOMAS: Sure.

20 Q: You didn't say anything in that conversation
21 about barely hitting Dan Sullivan's
22 projections, did you?

23 A: I don't know that you asked me that.

24 Q: And -- well, I asked you about the minimum
25 number of treatments that you'd need to be

1 viable.

2 A: And I told you I hadn't done the calculations,
3 so I wouldn't know how to answer that.

4 Q: But you were never concerned about it, were
5 you? That's what you said in the deposition
6 because you're going to be -- it's going to
7 explode is the word you used, right?

8 A: And I think explode needs some defining. I
9 mean, explode -- an explosive product line,
10 explosive, I mean, if you look at going from
11 zero to the treatment -- to the treatment plan
12 in Dan Sullivan's plan will be, you know, 85-90
13 percent utilized, that's explosive. That is
14 the definition of explosive, zero to 90
15 percent. If I could do that, if I could build
16 my pediatric unit that we're opening in six or
17 eight months and three years later it's at 90
18 percent occupancy, explosive.

19 Q: Explosive would also be hiring a second
20 radiation oncologist in year three like the pro
21 forma says, wouldn't it?

22 A: It could be. I don't know if that's what that
23 is or not. I'll have to ask somebody that.

24 Q: You also didn't attribute -- you attributed the
25 explosive growth to, not to your ability to

1 build it but to the current medical staff that
2 you had at the hospital?

3 A: Medical staffs make great things, and if you
4 look at what -- what drives our medical staff
5 and what's going to drive this comprehensive
6 cancer center is, it's going to be the breast
7 surgery we do, it's going to be the lung
8 surgery that we do, and it's going to be the
9 complete care that drives this. And that's
10 what's going to drive patients here is they can
11 come here and get everything they need in one
12 place at one time with one medical team
13 overseeing every aspect of their care. That
14 just makes perfect sense.

15 Q: And you were very confident about all that in
16 the -- those comments in the deposition even
17 though you had not done anything to analyze Mr.
18 Sullivan's projections, right?

19 A: I've worked with Dan Sullivan since I was in
20 the division office in Tampa. I've worked with
21 him on a number of projects before. His 50-bed
22 application seemed to work out well. His
23 projections on all things that we've done with
24 him, all my history would suggest if he gives
25 me a projection, it's one that I can depend on.

1 Q: But as far as the specifics, you had no
2 knowledge? Like when I asked you why the
3 projections would project that more patients
4 would come from Calabash, North Carolina, than
5 from Conway, you had no idea, right?

6 A: Based on my experience with Dan Sullivan and
7 based on my operational knowledge and based on
8 my tenure at HCA, I have found that when we get
9 something from a health planner that has the
10 knowledge of the market, the expertise that Dan
11 Sullivan has and all the things that he's
12 analyzed is that we can bank a project on it
13 and it will be something we can operationalize
14 and do.

15 Q: Yesterday you were here for Mr. White's
16 testimony, correct?

17 A: I was.

18 Q: Okay. And you saw where I went over at least
19 20 exhibits with him that discussed planned or
20 proposed building a freestanding linear
21 accelerator facility on Dr. Holt's parking lot?

22 A: I did.

23 Q: Are you aware that during that same time period
24 that stretches from like late January to May
25 that there is no email or document discussing

1 putting a linear accelerator at the hospital?

2 A: I think in our deposition, we, you and I
3 actually discussed that there is an email from
4 late December of 2010.

5 Q: I said between January and May.

6 A: Oh, but in ---

7 Q: There's none?

8 A: --- five days earlier, there is email right, so
9 the late, I think it's the 27th or the 28th of
10 December like you and I discussed in my
11 deposition, there is an email from me to
12 planning talking about that.

13 Q: Right. And then in January, it moved to Dr.
14 Holt, in late January to his location, and from
15 there on, there are no emails about it being at
16 the hospital; are you aware of that?

17 A: I'm not aware of it. I'll take your word for
18 it.

19 Q: There's seven emails that were testified to
20 yesterday discussing the freestanding option at
21 Dr. Holt's property that you're on, you're
22 copied on. You're a recipient of those emails,
23 okay? And there are no responses from you
24 saying we should put it at the hospital. Are
25 you aware of that?

1 A: I am.

2 Q: Okay. And those dates range from January 21st
3 with Exhibit 90 to April 22nd Exhibit 99,
4 right? That same time frame?

5 A: I don't know the numbers are correct, but I'll
6 give you the benefit of that.

7 Q: Let's take a look at Exhibit 109.

8 THE COURT: Which one?

9 MR. LONG: I'm sorry, CRCC Exhibit 109.

10 Q: Okay. This is an email from David Was to
11 yourself and Mr. Melvin dated May 18th, 2011,
12 where he specifically says that the new
13 building housing the linear accelerator will be
14 8,000 square feet. It will be behind Dr.
15 Holt's Coastal Cancer Center office location on
16 Rourk Street. The hospital's not on Rourk
17 Street. Dr. Holt's on Rourk Street, right?

18 A: Is the question is it on Rourk Street?

19 Q: Yeah, is Dr. Holt's office on Rourk Street?

20 A: It is on Rourk Street.

21 Q: The hospital's on 82nd Avenue?

22 A: It is.

23 Q: So he's saying in that email to you on May 18th
24 in a very definitive tone that the location
25 would be at Dr. Holt's property?

1 A: David wouldn't make any of those decisions, so
2 okay.

3 Q: But you didn't respond to anybody saying slow
4 down, wait, no, it may not be at his office?
5 You didn't respond at all, right?

6 A: I don't know that I didn't make a phone call.
7 I don't think I responded in email. I
8 typically don't.

9 Q: Okay. Let's take a look at CRCC Exhibit 115.
10 This is your first email that talks about, in
11 2011 or after, we stated the first week of
12 January 2011, that talks about the location
13 being at the hospital, right, and that's dated
14 May 25th, 2011 right?

15 A: My cross ---

16 Q: It says AR down there. That's your email,
17 right?

18 A: It is my email. I don't know if it's my first
19 one or not. I can't speak that it's the first
20 one. Just -- I mean, I may need a calculator
21 for this one. I get 200 emails a day as well,
22 and we're talking about -- we're talking about
23 ten emails. I don't know what the percentage
24 of that is, but you're talking about 20 emails
25 over six months at 200 a day times all those

1 days. You're talking about less than, maybe I
2 don't need a calculator, less than one percent.

3 Q: Well, it may be less than one percent, but the
4 percent of the number of emails that talk about
5 the hospital is zero, right?

6 A: Well, I think that there are one or two in
7 December, and you keep trying to exclude those,
8 from us talking about the planning. The other
9 side of it too is, you know, all these drawings
10 and stuff were done at this point, so I'm not
11 sure. I mean, we can talk about this, but
12 every project that we do, there are multiple
13 options. We had three different options. We
14 went through everything we went through. We
15 went through the campus. We went through Dr.
16 Holt's property. We went through South Strand.
17 We tried and tried to make all three options
18 work, knowing full well at the very beginning
19 we were going to put it back at the main
20 campus, and that's exactly what happened.

21 Q: Mr. Rudd, this is CRCC Exhibit Number 7.

22 MR. THOMAS: I need to object Your Honor, just in
23 terms of the flow chart of the timeline coming
24 in as an exhibit. Mr. Long is fine to use that
25 as a demonstrative exhibit, but I don't think

1 it could come in as it summarizes a bunch of
2 different ---

3 THE COURT: Well, he's holding it now, he hasn't
4 offered it, so right now it is demonstrative.
5 It doesn't ---

6 MR. LONG: No, Your Honor. I mentioned it. It's in
7 ---

8 MR. THOMAS: Yeah.

9 MR. LONG: --- unless he objects.

10 THE COURT: Oh, oh.

11 MR. THOMAS: Remember that Federal rule thing.

12 MR. LONG: It comes in. But Your Honor, the reason
13 ---

14 THE COURT: Well, it's not in because he's objected,
15 so.

16 MR. LONG: He just objected.

17 THE COURT: Yeah.

18 MR. LONG: Your Honor, this is not a demonstrative
19 exhibit. It's a summary of all of these emails
20 that came in yesterday, and these emails are in
21 evidence and we -- we worked through this and
22 we gave this to them pursuant to the deadlines,
23 and I think the timeline does come in. It is
24 a classic summary under Rule 1000 --- I think
25 it's Rule 1001. It's all of the emails, and it

1 tracks them out over time.

2 THE COURT: Are they all in?

3 MR. LONG: Yes, sir.

4 MR. THOMAS: First of all, Your Honor ---

5 MR. LONG: And they all are -- every one of the ones

6 that we used, now some of them are like the

7 dates of the application, those are in.

8 Everything is in, and everything was disclosed

9 to them in advance, and we gave them this

10 several weeks ago, so it's no surprise or

11 anything about the issue. It's just a -- it's

12 a classic summary, Your Honor. I'm not trying

13 to -- timelines, we use them all the time.

14 They come in evidence as summaries.

15 MR. THOMAS: Here's what's different about this

16 timeline. They've got an attorney, in each one

17 of these it's an attorney description of what

18 it is, okay? It's not the re line; it's not

19 the subject line. What I would tell you, Your

20 Honor, is that if -- if all these emails are

21 already in, they've got -- they've got it --

22 you know, they've got the emails in. They've

23 got the underlying exhibit. But this is a

24 demonstrative exhibit. It's not a summary of

25 numbers or anything like that. This has got

1 their written descriptions on it, Your Honor,
2 and that's basically, you know, what their
3 opinion is of what the email says. Let the
4 emails speak for themselves. I'm glad for Mr.
5 Long to use this with this witness. This
6 should not come into evidence.

7 MR. LONG: Your Honor ---

8 THE COURT: Any response to that?

9 MR. LONG: Yes, Your Honor. That's the whole thing
10 about summary exhibits, he's not supposed to
11 wait until the day of the trial and then start
12 raising his objections. The comment, the
13 email, the language tracks the emails, that's
14 where it's coming from. It wouldn't be a
15 summary if I had to put every single email on
16 the board. Then it wouldn't be a summary. But
17 the key is is that it's a summary and the most
18 important part about it of course is the dates,
19 but it gives what it is and it cites very
20 specifically to the document pages or whatever
21 is what's involved. So, Your Honor, I just,
22 it's a classic summary. I mean, it just -- and
23 summaries are favored under the law, under Rule
24 1006. This is helpful to the Court. And he
25 can certainly cross-examine on it. He can

1 argue before Your Honor about it. Your Honor
2 can choose to use it to the extent you want to,
3 but I think it's appropriate to be included in
4 the record.

5 THE COURT: All right. Let me read 1006 real quick.

6 It's not one that comes up very often.

7 MR. THOMAS: Well, we would also add ---

8 THE COURT: Well here, I'm going to go with first
9 Mr. Thomas objecting to the summary doesn't
10 reflect the contents because it says the
11 contents of voluminous writings may be
12 presented in the form of a chart, but his
13 assertion is that your exhibit goes beyond that
14 of reflecting the content by having paraphrased
15 or whatever phraseology we want to use
16 descriptions of the documents.

17 MR. LONG: Yeah, but Your Honor, we were very
18 careful. I know the rule, okay. I can't write
19 stuff in there that would be argumentative or
20 whatever. That's not what it is. It's
21 language from the emails, and see here's the
22 thing, we were over here Monday talking about
23 objections to exhibits. He didn't raise this
24 one. He's had it for weeks, and he brings it
25 up now. This is the whole point of having the

1 summary and the reason you don't sandbag
2 somebody at the trial over it. This document's
3 been sitting over there in their office,
4 Exhibit Number 7, for three weeks. It doesn't
5 -- it doesn't have lawyer commentary on it.

6 THE COURT: Well, that's what I'm asking about.

7 MR. LONG: It does not. I mean, it doesn't. It
8 just states what was on the emails.

9 THE COURT: Well, Mr. Thomas, show me which one ---

10 MR. THOMAS: I've got a good example of one where
11 they're ---

12 THE COURT: Okay.

13 MR. THOMAS: Where it says Robert Grace seeking
14 financing --

15 THE COURT: Now, wait a second, you're reading --- I
16 can't ---

17 MR. THOMAS: Oh, I'm sorry. Let me show you that.

18 THE COURT: Both of you ---

19 MR. THOMAS: May 11, Robert Grace seeking financing
20 letter. CON is complete. Attorneys are
21 waiting on financing letter.

22 MR. LONG: That's what the email says.

23 MR. THOMAS: The CON wasn't complete at the time,
24 Your Honor. It hadn't been completed. In
25 fact, Mr. Long ---

1 MR. LONG: I know -- okay, he ---

2 MR. THOMAS: Can I talk? Mr. Long has already

3 introduced exhibits proving that the CON wasn't

4 ready, and so had I -- I've also introduced

5 exhibits, for instance, the quote for the

6 linear accelerator, remember, the 4.0, the four

7 million dollar quote? And then back in June

8 later the \$2.8 million quote? Well, the \$2.8

9 million quote went into the CON application;

10 therefore, the CON application was not complete

11 at that time, but that says it does. Or maybe

12 the email says it, but that's wrong, okay? And

13 so you can't just put it in there. The other

14 thing is Mr. Long is trying to get in several

15 exhibits on this thing that aren't in evidence

16 yet, so he's trying to summarize exhibits that

17 haven't been mentioned in this courtroom under

18 our Federal rule thing that we're doing.

19 Lastly, Your Honor ---

20 THE COURT: Well, that's not in so I --

21 MR. LONG: I don't think so, Your Honor. I waited.

22 I didn't do this with Mr. White because these

23 exhibits are in now. But, Your Honor, I put --

24 let's look at 103, okay. That's the whole

25 point of the summary, the email says, it's

1 right here on the screen, that it is
2 incomplete. I mean ---

3 MR. THOMAS: It says not sure of exact time frame,
4 our attorneys are waiting for us.

5 MR. LONG: Everything else in the CON is complete,
6 and see that's the point, Your Honor, if I had
7 said ---

8 MR. THOMAS: Everything else in the CON.

9 MR. LONG: --- if I had said the CON isn't really
10 complete or commented that the email was wrong
11 or whatever, that would not be appropriate for
12 a summary. This is a summary of voluminous
13 writings, and so I have to repeat what it says.
14 I'm not saying that -- I mean, we can argue
15 about that, but I mean it -- we were very
16 careful not to put commentary from the lawyer.
17 I know what we're doing. Your Honor, this is
18 the way it's to be done.

19 THE COURT: Let me read that real quick again. I've
20 got this email. Let me see the comment first.

21 MR. LONG: The comment.

22 MR. THOMAS: Yeah, it's right here.

23 MR. LONG: It says here Robert Grace seeking
24 financing letter. CON is complete. Attorneys
25 are waiting on finance letter. That's what it

1 says.

2 MR. THOMAS: Then it says pretty much everything
3 else in the CON is complete. Your Honor, may
4 I make one other comment. A, it says
5 voluminous writings. I don't know that these
6 -- this would constitute voluminous writings.
7 And I don't understand, if Mr. Long can get
8 everything in, he's trying to get these emails
9 in through witnesses, why is it so important
10 for him to have this summary timeline that does
11 have what we've already seen is incorrect
12 information if you look at CRCC 103.

13 THE COURT: One last time and I'm going to make a
14 ruling.

15 MR. LONG: Okay. Well, the point I would say is the
16 reason you want it in is because it is
17 difficult to follow the timeline without having
18 it in some sort of chart or ability to do it.
19 That's the reason we do it. That's the reason
20 the summary should be approved, and that's a
21 good question. All the emails are in, why is
22 Mr. Thomas fighting it to come in? Using it as
23 a demonstrative is fine to talk to the witness,
24 but then later when the Court's making the
25 decision and when the case could be going up on

1 appeal, it's not in the record. And so this is
2 in the record, this needs to be in the record
3 as an exhibit to help the Court make their
4 decision and then whatever ---

5 THE COURT: Well, if it's going to be in the record,
6 then anything that is not accurately quoted or
7 leads to a question as to the quotation from
8 the document which it relies should be
9 redacted. So looking at May 11th, I mean, I
10 can see that doesn't completely capture the
11 gist of that statement. Is there any other ---

12 MR. THOMAS: I haven't gone through and looked at
13 each one. I thought he was going to use this
14 as a demonstrative exhibit, Your Honor.

15 THE COURT: Yeah.

16 MR. THOMAS: I didn't know that he was going to try
17 to get it in.

18 THE COURT: At this point in time, I'm going to
19 allow you to use it as demonstrative. I want
20 to think through it a little bit further
21 because I don't have to make a ruling right now
22 on this one. You can use it, and we'll worry
23 about whether it actually comes in later on.
24 All right. Although I don't want to extend
25 this argument further, I can tell you that.

1 MR. LONG: Okay.

2 THE COURT: From the appellate standpoint, I don't
3 see why you would necessarily -- you've got all
4 the documents in evidence. I don't understand
5 why it would be necessary to have it for the
6 record. Can you tell me ---

7 MR. LONG: Well, I think on appeal, Your Honor, you
8 would -- if that exhibit is in the record, when
9 you're writing your brief and you're arguing to
10 the court, instead of having to cite the 25
11 different exhibits, you would just cite the
12 seven and -- or to make the point that you,
13 whatever point that was going to be made,
14 that's the point of the summary.

15 THE COURT: Well, I'm okay with the summary, but --
16 except I want it to just accurately reflect
17 that which it summarizes. So that's where I
18 want to be very comfortable with. But other
19 than that, I'm fine with the summary. All
20 right.

21 MR. LONG: Well, thank you, Your Honor. I think the
22 process for a summary exhibit is that the other
23 side, that's why we give it to them way in
24 advance so we don't have this issue today, the
25 burden is on them to show basically what should

1 be -- if something should be redacted.

2 THE COURT: I don't know about that now.

3 MR. LONG: Well, Your Honor, I'm presenting it. I

4 think the information correctly describes the
5 information. We have no changes to make to it.

6 THE COURT: I'm just not sure. I find that an
7 interesting argument that there is a burden
8 shifting that occurs when you give someone the
9 document in advance. I think you always have
10 the burden. It does reduce any prejudice that
11 they may argue about because they've had
12 advance notice, so it doesn't shift the burden.

13 MR. LONG: Okay. Thank you, Your Honor.

14 Q: This is the timeline that we have prepared of
15 the conversations regarding the location of the
16 building of where the building would be, and
17 during all of this period ---

18 A: Can I just get closer to it?

19 THE COURT: Yes.

20 Q: Okay. The linear accelerator from back here in
21 February when Doug White is forwarding
22 information about putting it at Dr. Holt's
23 property, starting January 21st all the way to
24 May 25th, this project was a freestanding
25 project at Dr. Holt's property; isn't that

1 correct?

2 A: It's missing some emails. I mean, the email
3 that you and I discussed at my deposition in
4 late December to the architects isn't on here.
5 It would be here. Where are those?

6 Q: Well, this is January 21st.

7 A: Oh, I'm sorry.

8 Q: Starting January 21st, 2011 ---

9 A: I was following the red line ---

10 Q: --- to May 25th.

11 A: Well, I was following the red lines down here,
12 and the red line, if I put my December one
13 here, I would have an email that was sent to
14 construction asking for us to build and to
15 start architecting a center on campus at Grand
16 Strand.

17 Q: You didn't interact with -- Doug White did most
18 of the interaction with the architects, right?

19 A: I'm in charge of the CON.

20 Q: Okay. Let me ask you this. Why were there no
21 site plans coming from the location at the --
22 you need to --- .

23 A: Sorry.

24 Q: Why were there no site plans done for the
25 location at the hospital until after May 25th?

1 A: I think that there probably were.

2 Q: You didn't see the email yesterday where the
3 architects said we didn't prepare the site
4 plans for the hospital location?

5 A: I'll have to see that again. There is no
6 possible way that from May 25th to July 11th we
7 got an architectural budget and site plans done
8 without having them already 90 percent done.
9 No possible way that it happened that fast, no
10 way, and get construction bids. Because the
11 email, the email that Doug sent at some point
12 that we reviewed yesterday said go with it, and
13 the go with it was about getting the actual
14 bids for construction, not actually doing all
15 the construction -- all the architectural
16 drawings and all those things.

17 Q: So your testimony is that despite all of this.
18 testimony about the location, that you were not
19 putting, you were not doing a freestanding
20 location at Dr. Holt's property during that
21 spring of 2011, during the winter and spring of
22 2011?

23 A: You'll have to repeat the question. I'm not
24 sure ---

25 Q: So it's your testimony here for the Court that

1 y'all were not building a freestanding location
2 at Dr. Holt's property during the time period
3 of January to May?

4 A: Okay. Just so that we're clear on what my
5 testimony is. My testimony is that we had a
6 division, we had a division visit in the fall
7 of 2010. We talked about linear accelerator
8 projects being -- that it's something we needed
9 to do. In November/December, there was lots of
10 discussion about where and how. In December,
11 we sent an email to construction, design and
12 construction saying let's start the process of
13 putting it on campus, where are we going to do
14 it? Where are we going to put it? What are we
15 going to do? From January to June, there was
16 a visit from the group. There was lots of
17 division discussion. We were supposed to
18 analyze three options like we do in every
19 project that we ever do. In any project that
20 I do, rehab, peds, all these things, we have
21 talked about -- we talk about multiple
22 locations multiple times. We go down many
23 rabbit holes trying to figure out what is the
24 best business decision. So we went through the
25 one on campus; we went through the one on South

1 Strand; we went through the one on Dr. Holt's
2 campus. And we will make -- I can go through
3 the advantages and disadvantages of each, but
4 at the end of the day, the most cost effective
5 best thing for the patient, best thing for the
6 program and the best use of our resources was
7 on campus at the hospital, period.

8 Q: Pull up Exhibit 117, CRCC 117. This came in
9 yesterday with Mr. White. Look at the email at
10 the bottom of the page. It's from Marc
11 Rowland, the architect, to Doug White with
12 copies to you and Jason Whinham. This is when
13 Doug informed him about moving back to the
14 hospital on May 25th, and he says to you, I've
15 attached the document we discussed months ago.
16 We did not actually prepare a site plan for
17 this scheme but could probably draw a box on an
18 aerial if that would be helpful for your call.
19 There was no site plan done on May 25th for the
20 hospital location, that's what Mr. Rowland is
21 telling you in the email; isn't that correct?

22 A: I honestly don't know the first time I saw the
23 drawing. I don't have a -- I don't have a
24 clue. Could he have been --- could we be
25 talking about something completely different?

1 I don't know.

2 Q: And there was his linac initial drawings at the
3 top?

4 A: Yeah, and there's something dedacted (sic) out.

5 I don't know what that was. There were
6 multiple projects going on at the same time.

7 I don't know what's under the red box.

8 Q: And neither did we. We didn't redact it. And
9 then secondly, there were site plans drawn for
10 Dr. Holt's location?

11 A: Not specifically. I mean, they were just one-
12 page drawings so that we could get an idea.

13 Q: Well, it was a lot more than drawing a box on
14 an aerial?

15 A: But we never did a fair market value -- see,
16 and that's the thing, I mean, we keep talking
17 about this, but before we -- before we could do
18 a plan there, we would have to do a fair market
19 value analysis on Dr. Holt's land that would
20 take at least two months, maybe three months,
21 and then the negotiations for the land before
22 we could even think about putting into the
23 project. And the fair market value analysis,
24 the actual site planning, actual going and
25 looking to see if there were sinkholes under

1 the property or whatever, never even happened.

2 It never was a consideration.

3 Q: Mr. Rudd, let's talk about that for a second,
4 about the fair market value, okay. It's an
5 appraisal of his property. That's what you
6 would have to do is appraise what that property
7 would be worth?

8 A: Right.

9 Q: And you know and Dr. Holt knows and everybody
10 in healthcare knows that you can't pay more
11 than the appraised value. Everybody knows
12 that, don't they?

13 A: Everybody?

14 Q: Yeah, in healthcare?

15 A: Everybody should ---

16 Q: Dr. Holt knows that.

17 A: Everybody should know that, yes.

18 Q: Dr. Holt knows you can't get an appraisal --
19 that you can't pay him more than the appraised
20 value, so he may say 1.4 million, but like you
21 said, if it came in at 750, he would know right
22 then that's all you could pay is 750?

23 A: I do not agree with that statement.

24 Q: Do you think you can pay more than the
25 appraised value?

1 A: I can tell you in every physician asset
2 purchase that we do, it comes down to real
3 estate and what they think their property is
4 valued at and what the fair market value is is
5 often times what differentiates whether we do
6 a deal or not. We have a number of deals that
7 made perfect strategic sense that today are not
8 in play because they thought their office
9 building and their assets were more valuable
10 than they were, and honestly, they're projects
11 that didn't go through and there's bad blood
12 between us because of it.

13 Q: And the reason the projects don't go through is
14 because the appraisal comes in and you can only
15 pay the appraisal and they want more, so they
16 turn you down?

17 A: And it's a multi month process.

18 Q: Isn't that right?

19 A: It's a multi month process that takes time, and
20 we had not even started it. We didn't contact
21 anybody. We didn't talk to anybody. Nobody
22 walked the land. Nobody did anything.

23 Q: All right. Let's move to equipment. One of
24 the items that you did work on was the
25 equipment, right?

1 A: It is.

2 Q: All right. And you talked to Brian Marger at
3 the Sarah Cancer Center, right? Would that be
4 correct?

5 A: Marger, but yes.

6 Q: Marger, right?

7 A: I did.

8 Q: But there are no emails between you and Mr.
9 Marger?

10 A: There are not.

11 Q: Do you know why?

12 A: I called his cell phone. I've known him for
13 seven, eight years. We're buddies.

14 Q: Okay. You thought the Varian quote, Mr. Thomas
15 informed you that the Varian quote was too high
16 in that email that we looked at earlier, right?

17 A: It wasn't a Mr. Thomas. I don't know that he
18 told me that.

19 Q: I'm not talking about Will Thomas. I'm talking
20 about Jamie Thomas.

21 A: I mean 4.1 million was off the charts. I mean,
22 is that what you're talking about?

23 Q: Yes.

24 A: I knew that when it came in because I had
25 talked to Trident and Trident had bought one

1 significantly cheaper.

2 Q: Okay.

3 A: That's the whole thing that Yoel still didn't
4 like me over, because I called his boss in
5 Nashville to get a better quote for a Varian.

6 Q: And during that process of dealing with Mr.
7 Bakas, Yoel Bakas, I guess we're all going to
8 torture that, one of the things that you did
9 during the process is you had them revise the
10 quote because you made changes to the machine,
11 right?

12 A: We did.

13 Q: You deleted the Gated RapidArc and the S1000
14 imaging panel, right?

15 A: We did.

16 Q: Correct?

17 A: Yes.

18 Q: You removed the medical oncology module for the
19 Aria, A-R-I-A, right?

20 A: The medical module, which is a software
21 package, yes.

22 Q: Okay. You removed the following components
23 from Eclipse, which were nice to have but you
24 didn't -- decided you didn't need: the 4-D
25 planning, removed that, right?

1 A: All stuff that we could add later, yes.

2 Q: Electron Monte Carlo?

3 A: Yes.

4 Q: The SmartSegmentation, right?

5 A: Yeah.

6 Q: If I'm saying that right, and the beam
7 calculator, the external beam calculator for
8 Acuros?

9 A: We had sat down and decided that if we needed
10 these things as the center grew that a lot of
11 them were software, which is not a capital
12 expense. Some of them are capital that we can
13 put in our region capital. This is a very
14 common practice that when we get into a CON and
15 we only have a certain amount of dollars that
16 we buy machines that are expandable and we
17 expand upon those.

18 Q: But the reason that the price was moving down
19 was because you were removing these software
20 items and other items from the machine, and
21 they were giving you better quote?

22 A: We were getting better quotes because of our
23 leverage. So that was a piece of it, but the
24 leverage was the other piece.

25 Q: Let's look at CRCC Exhibit 124. We looked at

1 this just a minute ago, but I'm going to ask
2 you about the top part of this email, which is
3 from Jamie Thomas to you and Jerry Rooker and
4 Rodney VanPelt.

5 A: Uh-huh (affirmative response).

6 Q: On June 20th, he's informing you we are a go
7 for the main campus, cut capital costs to the
8 bone in the new pro forma, right?

9 A: Yeah.

10 Q: Those are the instructions from the division?

11 A: The instruction is let's get it done.

12 Q: Well, the instruction is to cut capital costs
13 to the bone, right?

14 A: That is. And it's in every project we ever do
15 and everything that we ever do. The division
16 president's job is to make it as cost effective
17 as possible.

18 Q: Okay.

19 A: What he didn't say that he means is, it's still
20 got to be the high quality service that every
21 HCA company and every HCA hospital has and that
22 we have proven time after time after time. It
23 does not mean do something that's stupid. It
24 means get it as cheap as we can get it and get
25 it done. And so that directive to me means you

1 need to put in the CON that is going to make
2 this project successful, and this is your job
3 to make it happen.

4 Q: And let's look at CRCC Exhibit 126. Now, this
5 is after -- this is June 22nd. So this is
6 after, it's like the day after Mr. Thomas told
7 you to cut the capital costs to the bone, and
8 you're emailing to Dr. Mun, which you testified
9 about on direct, and you're telling them the
10 three things that you stripped out of the
11 proposal to reduce the costs, right? Software,
12 right?

13 A: Some of it is, yeah.

14 THE COURT: This is 126 you said?

15 MR. LONG: Yes, Your Honor.

16 Q: The day after you were told to cut the cost to
17 the bone. Now, you ultimately settled on the
18 Clinac iX. That's in the application, correct?

19 A: Yes.

20 Q: And but in your deposition, you told me that
21 you wanted a TrueBeam because it's the biggest
22 and best technology on the market?

23 A: I did, and it is.

24 Q: Okay. And your CON application is filed in
25 July of 2011, right?

1 A: Yes.

2 Q: And the CRCC-Conway application was filed in
3 March of 2011, right?

4 A: I guess. I don't know y'all filed.

5 Q: It was before yours.

6 A: I didn't have that knowledge. I don't know.

7 Q: Well, don't you know -- you knew at the time
8 you were doing this CON application that we
9 were putting a TrueBeam in at Conway?

10 A: I knew that there were three applications going
11 in. The timing of them, I don't know. I know
12 that we -- I know that we always have time to
13 get them in. If it was you or it was going in
14 the north market, I don't know.

15 Q: But you knew. You'd seen those applications;
16 you'd seen there was a TrueBeam at Conway,
17 right?

18 A: Today, I've seen that. I did not know -- I did
19 not know it at the time.

20 Q: Well, you could have looked in the application
21 and seen it, or somebody could have, right?

22 A: They could have, I guess. It would have made
23 no difference in what we did.

24 Q: Well, you agree that -- okay. That's fine.
25 Now, does Grand Strand have a quote for a

1 Varian TrueBeam? Does Grand Strand have a
2 quote from Varian for a TrueBeam?

3 A: Can I check my email?

4 Q: No.

5 A: I think in the last 72 hours, I have a quote
6 for Grand Strand, yes.

7 Q: Have you given that quote to your lawyer?

8 A: No.

9 MR. LONG: Can I have one moment Your Honor? Your
10 Honor, it's kind of a -- I want to go, can we
11 pull up CRCC Exhibit 71.

12 Q: These are the Grand Strand inpatient admissions
13 for 2011, correct?

14 A: Yes.

15 Q: And this is the kind of document and reports
16 y'all have at Grand Strand, right?

17 A: It is.

18 Q: Okay.

19 A: Inpatient, correct, admits?

20 Q: Inpatient admits, correct. Let's pull up CRCC
21 Exhibit 73.

22 MR. THOMAS: Is 71 already in?

23 Q: This is your Grand Strand physician list,
24 right?

25 A: I can't see it. Is this the web one that we

1 talked about actually having?

2 THE COURT: Wait a second, let's just stop. We've
3 got a question about whether 71 is in.

4 MR. THOMAS: You mentioned it, so I wasn't sure if
5 it was in.

6 MR. LONG: Well, I just put it in, 71. I'm sorry,
7 Your Honor. I mean, we just looked at 71.

8 MR. THOMAS: Well, hold on. You just said Exhibit
9 71, and then you moved on to another exhibit.

10 MR. LONG: No, he confirmed it.

11 MR. THOMAS: I don't even know ---

12 MR. LONG: I'm sorry, I'll redo it.

13 THE COURT: I missed ---

14 MR. LONG: Yeah, I'll just do it again, if that's
15 okay. Apparently, Mr. Thomas didn't hear the
16 question.

17 THE COURT: I missed it -- I was trying to grab 71
18 too when you referred to it and then you moved
19 to something else, and I moved on ---

20 MR. LONG: To be clear about where we are, there are
21 some exhibits on here and most of it deal with
22 data and maybe we can just -- and I thought
23 they needed to come in through a witness. I'm
24 really not intending to question him about it.

25 MR. THOMAS: Okay. Well, that's fine.

1 MR. LONG: They need to come in, because I know I'm
2 going to Mr. Sullivan about it. If we can
3 agree that data can come in through the
4 experts, then I'll just, I might move on.

5 MR. THOMAS: I'm fine with that, yeah. Absolutely.

6 THE COURT: Okay.

7 MR. LONG: If ---

8 THE COURT: All right. So the stipulation is that
9 data will come in through the experts?

10 MR. THOMAS: That it can come in through the
11 experts, and so both sides have decision
12 support capabilities, Your Honor, at corporate
13 levels where they can get data, so I'm fine
14 with that as long as they're fine with ours
15 coming in like that.

16 THE COURT: All right. Did you hear that, Mr. Long?

17 MR. LONG: Yes, I did. Thank you, Your Honor. So
18 that should help us out. I just need a second
19 here, and I apologize for not being more
20 organized about this. I thought I was
21 organized, but I have realized now after
22 looking at this, we thought we had fixed this
23 but we had not. We apparently each have the
24 Grand Strand physician medical staff as
25 exhibits. Yesterday we looked at the Grand

1 Strand exhibit.

2 THE COURT: That was 73, right?

3 MR. LONG: Which was Grand Strand, I think it was,
4 might have been 73. That was the one that we
5 had to ---

6 MR. THOMAS: No, I think ours -- ours was 32, Your
7 Honor.

8 MR. LONG: 32.

9 THE COURT: Well, there was one of them like that
10 that was offered and ---

11 MR. LONG: Right.

12 THE COURT: --- there was an objection because it
13 didn't have everyone in there, but ---

14 MR. LONG: Well, it was that exhibit and that's
15 true. Mr. White testified that he was not sure
16 about it. He wasn't very clear on it, so we
17 can -- why don't we pull it up and ask Mr.
18 Rudd.

19 Q: Mr. Rudd, this is Grand Strand 32.

20 THE COURT: Whoa, whoa, Grand Strand?

21 MR. LONG: I mean, I'm sorry, is that right? Is it
22 Grand Strand?

23 THE COURT: I've got Respondent's 73.

24 MR. LONG: Well, I think Grand Strand 32 and
25 Respondent's seventy ---

1 THE COURT: Three are the same.

2 MR. LONG: --- three are the same document, are the
3 same information.

4 THE COURT: Okay.

5 MR. LONG: So maybe we need to go and confirm that
6 with a witness or at least -- CRCC 73.

7 Q: Let's look at CRCC 73. Mr. Rudd, is this your
8 medical staff, these physicians here?

9 A: Dr. Armstrong is on our medical staff.

10 Q: Well, it's a multi-page document, so you may
11 want to just glance at it. Here's 73.

12 A: It doesn't look our document for our staff. It
13 does look like the -- it does look like the
14 entire medical staff.

15 Q: Okay. So 73 is your medical staff, correct?

16 A: Uh-huh (affirmative response). Looks like it
17 is.

18 MR. LONG: Your Honor, with the understanding that
19 the data produced by the parties can come in
20 through experts, then we would not have any
21 more questions for Mr. Rudd.

22 MR. THOMAS: Just got a few on redirect, Your Honor.

23 THE COURT: All right.

24 MR. RUDD - REDIRECT EXAMINATION BY MR. THOMAS:

25 Q: Mr. Rudd, is radiation therapy primarily an

1 impatient service or an outpatient service?

2 A: Outpatient service.

3 Q: Do you have any idea what your market share is
4 for outpatient services?

5 A: I don't.

6 MR. LONG: Your Honor, I didn't ask him anything
7 about market share.

8 THE COURT: I don't remember that.

9 MR. THOMAS: I'll withdraw the question Your Honor.

10 That's fine.

11 Q: Let me ask you this. Mr. Long showed you an
12 email that you cut capital costs to the bone,
13 correct?

14 A: Yes.

15 Q: Or in instruction from your division director
16 asking you to cut capital costs to the bone,
17 what's the ultimate final price of the cost of
18 the project?

19 A: It's nine million dollars.

20 Q: Okay.

21 A: Nine million plus.

22 Q: And so if CRCC's is five million dollars, does
23 that mean they cut it to the marrow?

24 A: (No answer.)

25 Q: Okay. Was there ever an appraisal done on the

1 Dr. Holt land?

2 A: No.

3 Q: Okay. Do you know -- how much money does a
4 commercial appraisal cost, do you know?

5 A: How much money does it cost to do an appraisal?

6 Q: Yeah.

7 A: It's expensive.

8 Q: Can you do one in an day or a week?

9 A: No, it takes some time.

10 Q: Look in your book there. I think it's going to
11 be Respondent Number 98. Respondent Number 98.
12 I've just got a couple of questions about this
13 one.

14 A: 98.

15 Q: Okay. This is the email I think Mr. Long
16 referenced ---

17 MR. LONG: Your Honor, I did not ask him about 98.

18 MR. THOMAS: He referenced the exhibit. I wouldn't
19 have written it down on my pad. He referenced
20 the exhibit in his cross-examination of Mr.
21 Rudd.

22 THE COURT: Any response to that?

23 MR. THOMAS: He referenced the site plan several
24 times.

25 MR. LONG: I didn't ask any questions about the

1 exhibit, Your Honor.

2 MR. THOMAS: It's also in his demonstrative.

3 MR. LONG: It is admitted. It is an admitted
4 exhibit.

5 THE COURT: Okay.

6 MR. LONG: But I didn't ask any questions.

7 THE COURT: Well, he's saying you referenced it.

8 Let's just proceed. I'm going to overrule the
9 objection.

10 Q: Mr. Rudd, Mr. Long referenced site plans for,
11 I think, Dr. Holt's property and then asked you
12 about site plans for Grand Strand's property,
13 correct?

14 A: Right.

15 Q: Okay.

16 MR. THOMAS: Roshel, could you go to page three of
17 this exhibit. All right.

18 Q: Are these the site plans, Mr. Rudd, that are
19 attached to the email?

20 A: Yes.

21 Q: For the potential linear accelerator project
22 for the Grand Strand to be on Dr. Holt's
23 property?

24 A: Yes.

25 Q: Okay. What do these consist of? Are these

1 complicated drawings?

2 A: They're not.

3 Q: These are little red boxes placed on the
4 property, correct?

5 MR. LONG: Your Honor, he's leading him, which is
6 particularly unfair since I didn't ask any
7 questions to him about the document, about this
8 area.

9 THE COURT: I'll sustain that objection.

10 MR. THOMAS: Okay.

11 Q: What does this site plan portray, Mr. Rudd, the
12 three options there?

13 A: It's just basically our site campus with what
14 looks like PowerPoint cues put on the drawing.

15 Q: What shapes are the drawings?

16 A: Looks like the state of Oklahoma.

17 Q: Are these schematic drawings?

18 A: Not at all.

19 Q: Are these complicated drawings?

20 A: No.

21 Q: How long do you think it took the architect to
22 actually do them?

23 A: About 32 seconds.

24 Q: Are you aware of any schematic drawings for Dr.
25 Holt's property?

1 A: I'm not.

2 Q: By schematics, I mean architectural plans?

3 A: We do not have any detailed drawings for the
4 project.

5 Q: You never got that far with Dr. Holt's
6 property?

7 A: We did not.

8 Q: Never got an appraisal?

9 A: We did not.

10 Q: Didn't get a fair market value analysis from a
11 lawyer?

12 A: Definitely did not.

13 Q: Let me ask you this. Mr. Long made reference
14 to various there's not an email on this;
15 there's not an email on that. Okay. Are you
16 required to communicate with your corporate
17 division by email?

18 A: No, actually we do it more by phone. We get so
19 many emails during the day that phone call
20 conversations typically get things done a
21 little bit faster.

22 Q: Do you memorialize every phone conversation you
23 have in an email?

24 A: I do not.

25 Q: Let's go to Exhibit 109. Mr. Long referenced

1 that exhibit from David Was to you, correct?

2 A: Yes.

3 Q: All right. The new building housing the linear
4 accelerator will be 8000 square feet. Is that
5 the square footage of the new building?

6 A: I actually don't know.

7 Q: All right. Let's go into, you should have a
8 DHEC record there.

9 A: CON?

10 Q: Yeah. I want to direct you to a page. Okay.
11 Turn to page 127 of Joint Exhibit 2, if you
12 would. Tell me when you get there.

13 A: I'm there.

14 Q: First of all, who is David Was again?

15 A: He's an associate administrator that was with
16 us for about a year.

17 Q: Okay. So he mentioned that the new linear
18 accelerator building would be 8,000 square
19 feet. What is the actual square footage of the
20 new linear accelerator building?

21 A: It's 9,600.

22 Q: Okay.

23 THE COURT: How much? I couldn't hear you.

24 A: I'm sorry. 90 -- total building is 9,619
25 square feet.

1 Q: So was Mr. Was correct in his estimation there
2 in this email?

3 A: He was not.

4 Q: Okay. It says the location will be behind Dr.
5 Holt's Cancer Center office location on Rourk
6 Street. Is that where the location is?

7 A: It's not.

8 Q: David Was in his email was wrong on not one but
9 two occasions, correct?

10 A: He was.

11 Q: And you heard some discussion with this
12 demonstrative exhibit that Mr. Long and Mr.
13 Mullins held up for you. On May 11th, was the
14 CON complete?

15 A: It was not.

16 Q: Had you even gotten a quote yet for the linear
17 accelerator?

18 A: I don't think so.

19 Q: May 11th, there were still some emails
20 contemplating Dr. Holt's property, correct?

21 A: There was.

22 Q: Is Jamie Thomas a health planner?

23 A: He is not.

24 Q: By trade?

25 A: He is not.

1 Q: In terms of radiation oncologists, you were
2 asked about, you know, if you would add a
3 second radiation oncologist after a certain
4 amount of time based on daily treatments. I
5 think Mr. Long had you do some calculations,
6 correct?

7 A: He did.

8 Q: Okay. Would there be any other reason to add
9 a second radiation oncologist a couple years
10 after you add a first?

11 A: Yeah, as a comprehensive part of our program
12 we'd need that.

13 Q: Okay. What about back up for the first
14 radiation oncologist?

15 A: And that.

16 Q: Is it expensive to -- are you familiar with the
17 term locum tenens?

18 A: I am.

19 Q: Are those cheap to hire to replace a physician
20 who goes on vacation or gets sick?

21 A: They're astronomical, and I don't think rad onc
22 you'd be able to find.

23 THE COURT: I still didn't hear you.

24 A: I'm sorry. The rad onc, I don't think you can
25 hire them. Locum tenens is the temporary

1 doctors that we use when a sole source goes
2 down. And so there's some that you can find.
3 I think this is one of them that they don't
4 exist to come in for six or seven weeks or two
5 weeks or three weeks.

6 Q: How much prostate volume do you expect to get
7 at your radiation therapy center?

8 A: Almost zero.

9 Q: So is that why it's important to get some of
10 the medical oncology volume?

11 A: It is.

12 MR. THOMAS: No further questions for this witness,
13 Your Honor.

14 MR. LONG: Your Honor, I think I do have one, couple
15 additional ones.

16 THE COURT: On a new matter?

17 MR. LONG: On a new matter that he raised on
18 redirect.

19 MR. THOMAS: Wait a second. I'd like to know what
20 those new matters were because I'm very
21 specific when I do this, Your Honor.

22 MR. LONG: Exhibit 98, when he asked questions about
23 the site plans when I had not gone through that
24 exhibit, and then he used that.

25 THE COURT: Well, I'll allow you to go into that.

1 MR. LONG: Thank you. That's all I'm going to go
2 into. Exhibit 99, Your Honor.

3 MR. THOMAS: He just talked about 98 and now he goes
4 to 99.

5 MR. LONG: 99 goes with 98 you'll see in a second,
6 Your Honor, why it's relevant.

7 MR. THOMAS: Your Honor, I asked about 98. He went
8 into 98.

9 MR. LONG: And that's why 99 is going to impeach 98.

10 THE COURT: I'll allow him to do that, subject to if
11 I find that it doesn't address 98, then I'll
12 move -- I'll allow it to be stricken.

13 MR. THOMAS: And also that I get a chance to re-
14 redirect, Your Honor.

15 THE COURT: Going into 99, yeah.

16 MR. THOMAS: Okay.

17 THE COURT: All right.

18 MR. LONG: Just a second, Your Honor. You have it?

19 MR. RUDD: I'm good. Thank you.

20 MR. LONG: Does Your Honor have it?

21 THE COURT: No, because I had closed the window, but
22 I'll just look at it on the screen.

23 MR. LONG: Yeah, we'll get her to get it up.

24 THE COURT: It's Respondent's 99?

25 MR. LONG: CRCC 99. Here it is, Your Honor.

1 MS. RUDD - RECROSS-EXAMINATION BY MR. LONG:

2 Q: This is an April 22, 2011, email to you and to
3 Doug White, right?

4 A: On 99?

5 Q: Yeah, Exhibit 99.

6 A: Okay, yes.

7 Q: And it's from Jason Whinham, who's one of the
8 architect design people, correct?

9 A: Is this the same email from 98 or is this
10 different?

11 Q: No, it's different.

12 A: So it's a different email from 98?

13 Q: It is. Yes, this is April 22nd. The other
14 email was March 17th.

15 A: Okay.

16 Q: Let's look at the attachment, if we can just go
17 page by page. 2915. This is a letter from
18 Littlejohn Engineering Associates. This is a
19 detailed site plan, isn't it?

20 A: I'll have to look at it. Hang on. I know what
21 it is. What's the question?

22 Q: That's a detailed site plan, isn't it, for a
23 linear accelerator building at Dr. Holt's
24 property?

25 A: I don't agree this is a detailed site plan.

1 This is not what we'd use for construction.

2 Q: Would you turn over to page 2919, put it on the
3 screen there. What does it say at the bottom?

4 A: It says a detailed site and utility plan.

5 Q: Right. Change your mind?

6 A: No, I still don't think it's a detailed plan.

7 This is not something you can use to do fair
8 market value. This is not something -- you'd
9 have to redo all of this to do any further
10 planning to put something on this building.

11 You could not take this document, these
12 documents right here and turn that into
13 anything to build anything on. This was
14 initially -- I'm not -- you couldn't do this,
15 you couldn't do much with this. We'd have to
16 redo all of it.

17 Q: You would redo all of this work that Littlejohn
18 Engineering Associates has done?

19 A: For a fair market -- for a fair market value,
20 absolutely.

21 Q: I'm not talking about fair market value. I'm
22 talking about site plan for a linear
23 accelerator of a freestanding building at Dr.
24 Holt's property.

25 A: We could not build a building on Dr. Holt's

1 property with this alone. There would be
2 significant work done after this to actually
3 prove that you could do it other than this
4 document.

5 Q: Mr. Rudd, is this a detailed site plan?

6 A: I do not think it is, but I think that this is
7 a utility plan, but that's my -- don't know.

8 Q: It addresses everything about the building,
9 right? Zoning, additions, utilities, parking,
10 gives a description.

11 A: It doesn't mark the property. It doesn't give
12 you dimensions. It doesn't give you soil
13 samples. It doesn't give you all those things
14 that you'd have to do to build a building.

15 Q: It does give you dimensions and it draws three
16 or four photographs that are pretty detailed.

17 A: These are not something you could buy, not only
18 property off of or actually build a building
19 with.

20 Q: And the date of that is April 22nd, and the
21 letter says it was revised on April 21st, 2011.
22 Littlejohn letter on page 2915.

23 THE COURT: You said 2915?

24 MR. LONG: GSRMC 2915. It's the second page after
25 the email.

1 Q: It's right there at the top. Revised April
2 21st, 2011, Littlejohn Engineering Associates.
3 It has a project number, right?

4 A: Yeah, that's what the letter appears to be.

5 Q: Okay. So when David Was wrote you in Exhibit
6 109 on May 18, 2011, and told you that it was
7 going to be at Dr. Holt's property on Rourk
8 Street, he wasn't wrong?

9 A: He was wrong.

10 Q: That's what the site plan that had just come
11 out 20 days before had the property.

12 A: I do not agree with that assessment. That is
13 not accurate.

14 Q: Okay.

15 MR. LONG: No further questions.

16 MR. THOMAS: May I ask one follow up, Your Honor, or
17 maybe more than one?

18 MR. RUDD - REDIRECT EXAMINATION BY MR. THOMAS:

19 Q: Again, this is little colored block drawings on
20 a site plan that Dr. Holt provided to
21 Littlejohn Engineering, correct?

22 A: Oh, it is.

23 Q: That's what it is, isn't it?

24 A: It is.

25 Q: Colored block drawings on a site plan?

1 A: It is.

2 Q: Okay. And the first page and the second page
3 Grand Strand Regional Medical Center 2915, the
4 zoning, that's stuff they pulled off a website
5 for zoning, isn't it?

6 A: It is.

7 Q: There are no schematic drawings in this email
8 or attached to this email to begin to even look
9 like construction documents are there, Mr.
10 Rudd?

11 A: No, there are not.

12 MR. THOMAS: That's all I've got.

13 THE COURT: You may step down. Is now a good time
14 for lunch break?

15 MR. THOMAS: That would be great. I'm hungry, Your
16 Honor. I've got one witness this afternoon and
17 I think we'll get through him and ---

18 THE COURT: Okay.

19 MR. THOMAS: --- we're on schedule, I think.

20 THE COURT: When do y'all want to come back?

21 MR. THOMAS: Say 1:30?

22 THE COURT: That's fine with me.

23 (Lunch break from 12:01 p.m. until 1:27 p.m.)

24 MR. THOMAS: Ready?

25 THE COURT: Yes.

1 MR. THOMAS: Grand Strand would call Mr. Robert
2 Grace as our next witness.

3 ROBERT GRACE, being duly sworn, testifies as follows:

4 MR. GRACE - DIRECT EXAMINATION BY MR. THOMAS:

5 Q: Mr. Grace, could you state your full name for
6 the record, please?

7 A: Robert Lawrence Grace.

8 Q: Where do you live?

9 A: In Myrtle Beach, South Carolina.

10 Q: You got any kids?

11 A: I do. I have two boys, a 20 year old and a 19
12 year old.

13 Q: Okay. That's a handful. Tell me a little bit
14 about your educational background, Mr. Grace.

15 A: Sure. I have a bachelor of science major in
16 accounting from the University of South
17 Florida, and I have a master's in business
18 administration from University of Phoenix.

19 Q: Okay. And give us some background about your
20 employment starting with Edward White Hospital,
21 if you would.

22 A: Okay. Back in 1981, I started with them. I
23 actually started out as a dishwasher. That was
24 an HCA facility. I just kind of worked my way
25 up over the years, did supply chain stuff,

1 receiver, printer, driver and ended up being an
2 accountant in New Port Richey Hospital about
3 seven years later and worked my way up through
4 the accounting department as a staff
5 accountant, chief accountant, senior
6 accountant, system controller, controller, and
7 then finally got a shot to become the CFO after
8 about seven years at New Port Richey Hospital
9 in New Port Richey, Florida. Then left Florida
10 and went to California with HCA and was
11 actually CFO of two small hospitals in north of
12 San Francisco, about an hour and a half. One
13 was in Sebastopol, California, called Palm
14 Drive and one was in Healdsburg, California,
15 called Healdsburg General, and I was there for
16 about two and a half years, was CFO of both
17 hospitals at the same time. Then left to go to
18 Southern Medical Center of Santa Rosa, which
19 was a larger town in Sonoma County, and I was
20 CFO at Southern Medical Center in Santa Rosa
21 for about two and a half years, and then left
22 California to move back to Florida as a CFO
23 again, where I was CFO at Oak Hill Hospital in
24 the West Florida Division for ten years, and I
25 got a chance at what I would consider a

1 promotion to go to Grand Strand, at which point
2 I've been here four years in September.

3 Q: So you've been here since about 2009 then?

4 A: September of 2009.

5 Q: Okay. And what are your duties as the chief
6 financial officer at Grand Strand, Mr. Grace?

7 A: Other than stereotypical stuff that people
8 think, you close the books and do all the
9 financial stuff all the time, that's not
10 exactly right. I have the supply chains to all
11 supplies in the hospital. I'm responsible for
12 the flow of them. I'm responsible for what
13 would typically be called the business office.
14 We call it patient account services,
15 registration of patients and dealing with their
16 bills, so on and so forth. I'm responsible for
17 a group of about 20 nurses called case
18 management. We assist patients with their
19 after care, home health, providing durable
20 medical equipment, going to nursing homes,
21 going home and getting whatever it is they need
22 and then the matter of social issues, so on and
23 so forth. I have information technology and
24 services reports to meet, so any computer
25 issue, compliance issue with the use of

1 computers, the internet, whatnot. I'm the
2 ethics compliance officer for the hospital, so
3 all issues involving any matter that involves
4 an employee or interaction with any of the
5 vendors or whatnot would come to me. I do the
6 budget for the hospital. I have accounting
7 reports, assist Adam with the strategic plan
8 preparation, file maintenance. Any budget
9 capital item comes through me for approval and
10 numerous unending interactions with the
11 division office and group office.

12 Q: Let's talk a little bit about that. Who is
13 your direct report at the hospital?

14 A: Doug White until today.

15 Q: Okay. Do you report to anyone at the, what's
16 I believe has been called the South Atlantic
17 Division office?

18 A: Yes, currently it's a person named Teresa
19 Finch, she's the division CFO. Previously it
20 was a gentleman named Rodney VanPelt.

21 Q: What happened with Mr. VanPelt?

22 A: He retired recently.

23 Q: Are you familiar with the CON filed by Grand
24 Strand that's at issue today?

25 A: Yes.

1 Q: Why we're here. Okay. What were you asked to
2 do with respect to that certificate of need
3 application?

4 A: Nothing directly with the certificate of need,
5 but provided financial pro formas and a
6 document called the Request for Capital. It's
7 a Word document that describes the market and
8 plan for implementing the program.

9 Q: Okay. But the request for capital doesn't go
10 into the CON application, does it?

11 A: No.

12 Q: Okay. When do you recall kind of being asked
13 to get started on the project?

14 A: 2010.

15 Q: Was it late 2010 or early 2010; do you
16 remember?

17 A: It would be early 2010, I think. I'm not
18 exactly sure.

19 Q: Okay. All right.

20 A: I'm sure it's in these documents, so.

21 Q: All right.

22 A: When I first started getting emails and things
23 like that.

24 Q: What, if any, experience did you have working
25 on financial pro formas for linear accelerator

1 projects as a CFO? You went through a long
2 list of places you've worked. What experience
3 do you have for linear accelerator projects?

4 A: This was the first linear accelerator project.

5 Q: How did you approach the project initially when
6 you were asked to do a request for capital?

7 A: There's a gentleman named David Was. He's an
8 associate administrator at the hospital, and I
9 was told by Doug, Doug White the CEO, that
10 we're looking at doing a linear accelerator
11 project. I know that Trident in Charleston has
12 a linear accelerator program, so I called their
13 CFO, and I also talked to a gentleman named
14 Trenton Mullis, and that's where I began to
15 gather some information for the project.

16 Q: Okay. Do you recall the CFO's name at Trident?

17 A: His name was Carl Durrell.

18 Q: Okay. I'm going to -- you've got a notebook in
19 front of you.

20 A: Uh-huh (affirmative response).

21 Q: It's got some exhibits in it. I think that's
22 right. I want you to go to CRCC Exhibit 86 for
23 me if you would.

24 A: Okay.

25 Q: All right. This is an email from Frankie

1 Knight to yourself, correct?

2 A: Yes.

3 Q: All right. And let me ask you a question here.

4 It said, Mr. Knight said some of the issues we
5 might need to discuss prior to meeting include
6 number of patients expected first year. I
7 believe we decided 400 close to warrant two
8 linear accelerators, correct?

9 A: Yes, that's what he said.

10 Q: Okay.

11 A: In the email.

12 Q: And where do you think -- where did he get that
13 number?

14 A: I'd probably had some discussion. I got off on
15 a wrong tangent when I first started this
16 project, which we can talk about, but it was a
17 number that I had come up with as an initial
18 estimate, and basically took about 25 percent
19 of the market, divided by ten, came came up
20 with a report which was 4000 divided by ten,
21 came up with 400, a nice round number. It
22 wasn't exactly ten, but I made it 400.

23 Q: What was that ten supposed to represent?

24 A: Your number of treatments per patient.

25 Q: Okay.

1 A: Was my initial wrong estimate based on
2 discussions I had had with people at Trident.
3 Given that I was not well versed in this, there
4 was a lot of stuff being discussed very
5 quickly, and it may be one particular type of
6 linear accelerator treatment of a patient that
7 takes ten, and it might be 40 for a different
8 type, but for whatever reason, I picked up ten.
9 Again, it was a wrong estimate.

10 Q: Okay. At this point, were you working with a
11 health planner such as Mr. Sullivan?

12 A: Not at this time, no.

13 Q: What if any knowledge at this point did you
14 have that Grand Strand would get a health
15 planner to assist with the CON application?

16 A: None at this time.

17 Q: At some point, did you learn that a health
18 planner had been retained by Grand Strand?

19 A: Yes.

20 Q: Do you recall when that was?

21 A: Not exactly. Later, a few months later I think
22 when he came in, thank goodness.

23 Q: All right. We're going to kind of jump around
24 the notebooks today. I'm going to ask you next
25 to go to Petitioner's 11. Let me get this

1 notebook.

2 A: Okay.

3 Q: You can put that off to the side. That's
4 CRCC's. Go to tab 11 in there, if you would.

5 A: Okay.

6 Q: Okay. Is this an email from you to Rodney
7 VanPelt, I think you mentioned him earlier, and
8 various other folks in the HCA divisional
9 office?

10 A: Yes, all except one, Debbie Monk. She's my
11 controller.

12 Q: Okay. And what is this document, sir, that
13 you've attached to the email?

14 A: This one is my initial estimate. It's called
15 a Request for Capital. It's a Word document
16 that's required at HCA when you do new
17 projects. So it's a Word file on the linear
18 accelerator. It's the initial document that I
19 sent to division, and that's it.

20 Q: What was the date of the email when you sent
21 it?

22 A: January 18, 2011.

23 Q: Can you just kind of tell me generally about
24 what you did in this document.

25 A: Sure. Based on some financial information that

1 I gathered, like I said, from Trident and David
2 and I working on this, we basically described
3 the market in Horry County, what the product
4 would entail, probably even some initial
5 estimates of volumes, probably even some
6 initial estimates of volumes, how we would
7 arrive at certain revenues and expenses and so
8 on so forth.

9 Q: Okay. Turn to, I think it's -- you'll see the
10 Bates label down at the right hand, just like
11 in your deposition if you recall that with Mr.
12 Long. It says GSRMC at the bottom, 1894. So
13 it would basically be the fourth page of the
14 document.

15 A: Okay.

16 Q: All right.

17 A: Uh-huh (affirmative response).

18 Q: I want you to read this second full paragraph
19 into the record for me.

20 A: Starting with beyond?

21 Q: Correct.

22 A: "Beyond its existing trauma, heart,
23 neuroscience programs, GSRMC is well positioned
24 for continued growth in the market. GSRMC is
25 accredited by the Commission on Cancer of the

1 American College of Surgeons. By expanding on
2 this accreditation through a radiation therapy
3 program, the hospital believes that it will
4 achieve the next step in becoming a
5 comprehensive tertiary care provider."

6 Q: And why did you think this? What was important
7 about the radiation therapy development?

8 A: Well, there's numerous elements to treating
9 cancer patients, and radiation therapy is a
10 major element.

11 Q: Okay. Look at the fourth paragraph for me.

12 A: Starting with currently?

13 Q: Yes.

14 A: Okay.

15 Q: All right. Would you read that in the record?

16 A: "Currently the hospital refers its cancer
17 patients needing radiation therapy to 21st
18 Century Oncology located just miles away from
19 the hospital on Oleander Drive. Approval of
20 the linear accelerator project would enable
21 medical oncologists to be able to more
22 conveniently provide their services to
23 hospitalized patients."

24 Q: Do you have any idea how many patients per
25 year, I'm not sure if you were here when that

1 exhibit was introduced, but that actually get
2 transferred as inpatients from the hospital to
3 CRCC when you wrote this?

4 A: Thirty-five, 40 maybe.

5 Q: Okay.

6 A: Something in that range.

7 Q: Does Grand Strand just intend to serve
8 inpatients at their radiation therapy center?

9 A: No, the vast majority will be outpatients.

10 Q: You say the vast majority, how many are you
11 talking about percentage-wise, more than 90?

12 A: Yes, 95, 97, 98.

13 Q: At the time that you drafted this -- well, I
14 tell you what, let's go, go to the next page,
15 1895 if you would.

16 A: Okay.

17 Q: There's some equipment, building, fixed
18 equipment and movable equipment costs. What's
19 the total there?

20 THE COURT: Hold on a second.

21 MR. THOMAS: Oh, I'm sorry.

22 A: Almost \$11 million and that, there's a total --

23 -

24 Q: Okay. And the \$11 million, where did those
25 numbers come from at this time?

1 THE COURT: What page are you on?

2 MR. THOMAS: I'm sorry, Judge. Grand Strand 1895.

3 THE COURT: All right. I'm there.

4 MR. THOMAS: Okay.

5 Q: And then I'm talking about the cost, kind of at
6 the top of the page there.

7 A: It would be initial estimates of what it would
8 take to do this. There was probably a quote
9 for the equipment at this time. I'm not sure,
10 but ...

11 Q: And there's a timeline under there. It's got
12 various dates. I guess these are sort of
13 action items ---

14 A: Uh-huh (affirmative response).

15 Q: --- something along those lines?

16 A: Yes.

17 Q: First of all, I see number two, January 31st,
18 2011, CON application submitted to DHEC; did
19 that occur?

20 A: No.

21 Q: Okay.

22 A: This is a formatted document. Timeline is a
23 section of the document under number one in
24 this particular area called project
25 justification, and I fill these in and then

1 modify them as I go. The initial estimate of
2 the project hadn't been approved yet.

3 Q: Okay. Turn over to if you would, sir, page I
4 think it's Grand -- GSRMC 1897 for me.

5 A: Okay.

6 Q: All right. And what's the, what's kind of the
7 heading of this page?

8 A: Volume assumptions.

9 Q: All right. And can you tell the -- take the
10 Court through what you did on this. I know you
11 said it was erroneous but take them through
12 what you did initially to come up with, it
13 looks like there's some projections here on the
14 bottom grid of the page.

15 A: There is. At this point, unfortunately, I was
16 actually putting estimated number of patients
17 on here, which is wrong to do to begin with as
18 I subsequently found out, but I basically took
19 about 25 percent of the market, that was my
20 best estimate of what the market was and said
21 if you got 25 percent of that market would
22 represent X number of procedures and divided it
23 by ten.

24 Q: Okay.

25 A: Essentially.

1 Q: So how did you come up with 25 percent?

2 A: It's my best estimate going forward given that
3 we're pretty strong in the market, figuring
4 that's not, you know, something that -- when
5 I'm just coming up with numbers, I have to
6 start somewhere, 25 percent would say well, the
7 competitor would still have 75 percent.

8 Q: Okay. At this time, were you working with Mr.
9 Sullivan's numbers or projections?

10 A: I was not.

11 Q: Okay. And at this time when you did these kind
12 of initial volume projections, which I know you
13 said were erroneous, but did you have an
14 appreciation for where the urologists were
15 referring their patients in the market for
16 radiation therapy treatment?

17 A: No, I did not.

18 Q: I want you to turn back. I wanted to ask you
19 a question I skipped over on Grand Strand,
20 GSRMC 1894, sorry.

21 A: I'm back there.

22 Q: Okay. And I want you to go up one paragraph
23 there where it says linear accelerator project.

24 A: Yes.

25 Q: Okay. Could you read that into the record?

1 A: "The linear accelerator project would require
2 an additional space. The new equipment would
3 be located in the building adjacent to the
4 cardiac rehabilitation wing of the current
5 hospital. The proposal is to construct a
6 facility on campus of approximately 8,000
7 square feet."

8 Q: Where's the -- in the CON application submitted
9 to DHEC, where is the location of the proposed
10 radiation therapy center?

11 A: Attached to the hospital.

12 Q: Okay.

13 A: Adjacent to the cardiac rehab wing.

14 Q: So basically, where this document says it was
15 going to be when it was written back in January
16 of 2011, correct?

17 A: Yes. Yes, that's correct.

18 Q: Okay. Go to Grand Strand 1890, I'm sorry 1898
19 for me and Petitioner's 11.

20 A: Okay.

21 Q: All right. And you've got some financial
22 projections here, and where do the assumptions
23 come up? Where did you come up with the
24 assumptions for the financial projection?

25 A: For outpatient type one here?

1 Q: Yeah.

2 A: I probably had gotten something from Trident as
3 far as what the usage rates would be.
4 Obviously they were wrong, like I said before.
5 They were just my best estimates at the time.
6 Like I said, I took 25 percent.

7 Q: Okay.

8 A: Of the volume that was in existence, or what I
9 thought was.

10 Q: I gotcha. Mr. Grace, on this initial
11 Petitioner 11, this Request for Capital, how
12 quickly did you put this together?

13 A: Under two weeks.

14 Q: Is this something you worked on night and day
15 for two weeks?

16 A: Hot and heavy. I don't know about night and
17 day, but I put a lot of hours into it and I got
18 in done in a shorter period of time than I
19 would have liked to.

20 Q: Why did you have to get it done in a shorter
21 period of time?

22 A: Because people from the group office and the
23 division office, but mostly the group office,
24 had said let's move forward with the linear
25 accelerator campus project, get it done.

1 Q: Okay.

2 A: So I turned my attention to it and got it done.

3 Q: All right. I want you to go to Petitioner's,
4 let me make sure I've got this right. I'm
5 sorry, Respondent's 89. That's going to be in
6 the CRCC book to your right there, right there.

7 A: All right. What page?

8 Q: Well, let's bring up the email first at the
9 Grand Strand 2810 at the bottom.

10 THE COURT: You said it was Respondent's 89?

11 MR. THOMAS: Yes, sir.

12 A: 89?

13 Q: Yes, sir.

14 A: Okay.

15 Q: I'm sorry.

16 A: 2810, I'm there.

17 Q: Okay. This is a January 20, 2011, email from
18 you to Mr. Rudd and some folks that are cc'd,
19 correct?

20 A: Yes.

21 Q: All right. And what have you -- and you've got
22 an attachment here in this email. What's the
23 attachment?

24 A: The attachment is what I would refer to as the
25 CON pro forma.

1 Q: Okay. And why did you do this document? Why
2 did you draft this document?

3 A: My understanding is it's required in the CON at
4 some part of it, and it has a format different
5 than what our -- what our CAMS format is. It's
6 slightly different. It adds a couple of the
7 expenses in, but, so I provided the information
8 I had at the time. The CAMS bred into this.

9 Q: Okay. Turn the page over to 2811 for me.

10 A: Uh-huh (affirmative response). I'm there.

11 Q: Okay. Now the linear accelerator treatments,
12 read those for 2012, 2013, 2014 if you would.

13 A: 402, 563, and 647.

14 Q: Where did you get those numbers from?

15 A: Same type of thing, out of my CAMS project
16 based on patients and the treatments and the
17 information's wrong. It was the first wash at
18 this thing.

19 Q: So these are based on the Request for Capital
20 we were looking at earlier in Respondent's, or
21 excuse me, Petitioner's 11?

22 A: Yes.

23 Q: So do you have confidence in these numbers, Mr.
24 Grace?

25 A: No, they're wrong.

1 Q: In the same notebook, if you'd turn to
2 Respondent's page 100 for me, excuse me,
3 Respondent's Exhibit 100, same notebook.

4 A: Okay.

5 Q: All right. We're jumping ahead a few months
6 here. It's an email from you to Mr. Rudd and
7 David Was, correct, and subject ---

8 A: Yes.

9 Q: --- a couple of CON financials.

10 A: Yes.

11 Q: All right. If you turn the page for me to
12 GSRMC 2764 in Respondent's 100.

13 A: Okay.

14 Q: Okay. Now, I don't know, maybe -- I know we're
15 not going to be able to do this because we
16 don't have a split screen, but we were looking
17 at Respondent's 89 from several months earlier,
18 maybe you can kind of look at the -- at the pro
19 forma there for me and tell me if anything's
20 changed in it in that four month period.

21 A: No, they're basically identical.

22 Q: So the same pro forma you sent back in January,
23 you sent back to Mr. Rudd in May?

24 A: Same volume, same net revenue, same EBITDA
25 within \$1,000.

1 Q: And what, if anything, was going on during that
2 four month period with respect to the linear
3 accelerator project?

4 A: Nothing, I don't think. There was probably
5 stuff going on that I didn't know about, maybe
6 with the CON but in my world, there wasn't
7 anything after that.

8 Q: Okay. So you were waiting to hear something?

9 A: I was. I was waiting to hear either responding
10 to my submission or make changes or we got
11 approved or whatever.

12 Q: Were there any other projects that Grand Strand
13 was working on in the spring of 2011 that you
14 can recall?

15 A: Probably, could have been a rehab, could have
16 been trauma, let's see, trauma was May '10, so
17 yes, there was likely other projects.

18 Q: Now, At this point in time, had you received
19 anything, any projections from Mr. Sullivan,
20 the health planner?

21 A: Not yet.

22 Q: Flip over to tab 105 for me, Respondent's 105,
23 same notebook.

24 A: Okay.

25 Q: What's the date on this one?

1 A: May 13th, 2011.

2 Q: Is this an email from you to Rodney VanPelt and
3 Mr. Rudd?

4 A: Yes.

5 Q: And what do you -- what do you tell Mr. VanPelt
6 there?

7 A: Attached are the two files that make up the
8 CAMS project, which would be the Request for
9 Capital and I'm assuming the CAMS pro forma.

10 Q: I think it's only on this one that says the
11 Request for Capital.

12 A: This is just the RFC, okay.

13 Q: Yeah. Okay. I'd like to turn to in this
14 exhibit to the attachment, the Request for
15 Capital attachment and look at this particular
16 RFC. Has anything changed in this Request for
17 Capital and I guess May 13th from the one that
18 we looked at back in ---

19 A: It looks -- it looks like the same one. It's
20 got 402. I'd say it's the exact same one.

21 Q: So the same linear accelerator treatments on
22 Grand Strand 1556?

23 A: Yes.

24 Q: The 402, the 503, so on and so forth?

25 A: Yes, sir.

- 1 Q: Okay. Did you get a response from Mr. VanPelt
2 on this, from this email; do you recall?
- 3 A: I don't believe so. I think he reviewed it and
4 sent it in to the group office.
- 5 Q: Okay. Turn to Respondent 106 for me. It's the
6 next tab in that notebook that you were just
7 looking at.
- 8 A: Okay.
- 9 Q: This is an email from Jerry Rooker to you and
10 Mr. Rudd, correct, dated May 13th, 2011.
- 11 A: Yes.
- 12 Q: Do you recognize this email?
- 13 A: Yes, I do.
- 14 Q: Can you tell the judge what's kind of going on
15 in this email, what is Mr. -- well, first of
16 all, who is Mr. Rooker? Who is Mr. Jerry
17 Rooker?
- 18 A: Jerry Rooker at the time was the National Group
19 controller for HCA, which would review all such
20 CAMS submissions.
- 21 Q: And where is his office located; is he also in
22 Charleston?
- 23 A: No, he's in Nashville. He's at the group.
24 He's a step above the division.
- 25 Q: What does he -- what is he doing in this

1 particular email?

2 A: Well, Jerry basically went through the project.
3 He probably has knowledge of a lot of other
4 linear accelerator projects, so when he looked
5 at, he pointed out a variety of questions that
6 he had about the numbers and the accuracy.

7 Q: When you say the project, is he critiquing the
8 Request for Capital, the first ever one you'd
9 done on a linear accelerator?

10 A: Yes, very much so.

11 Q: Okay. Were you surprised when you got the
12 email from Mr. Rooker?

13 A: Yes, surprised and disappointed.

14 Q: Why were you disappointed?

15 A: Because I had made a lot of errors, and I
16 probably hadn't done my research the way I
17 should have, and I don't like that.

18 Q: Okay. Let's look at, for instance, the very
19 first bullet point there, if you would.

20 A: Okay.

21 Q: Okay.

22 A: Where it says Horry County?

23 Q: Yeah, Horry County.

24 A: Okay.

25 Q: I guess he stated something there, and then he

1 asked you, he asked you a question, how
2 confident, could you read that into the record?

3 A: Say it again exactly where you're looking, I'm
4 sorry.

5 Q: It looks like it started with "how confident"
6 in the third line, under the very first bullet
7 point.

8 A: Where it says volumes Horry County and total
9 volumes were estimated; is that where you're
10 saying?

11 Q: Yeah.

12 A: Okay. For year one market share for the new
13 center was estimated as a straight-line 25
14 percent. Aren't the other programs well
15 established at this point? Do we have enough
16 physician support to gain 25 percent in year
17 one? How many transfers are taking place that
18 we can capture, and, like you said, how
19 confident are you that we will get 25 percent
20 market share?

21 Q: Okay.

22 A: And I wasn't very confident once he started
23 pointing this stuff out.

24 Q: Where it says, aren't the other programs well
25 established at this point, what are your

1 thoughts on that?

2 A: They are. The CRCC program is dominant, so
3 that should have been taken into consideration.

4 Q: Go to the second bullet point. I want you to
5 read that one into the record, and then I'm
6 going to ask you a question about it.

7 A: Okay. Your pro forma moves from 402 case,
8 4,154 treatments in year one to 783 cases or
9 8,081 treatments in year five. RFC shows 760
10 cases, but I am working off of the pro forma.
11 If you assume that the Horry County cases of
12 1,610 will grow at four percent per year for
13 the next five years, then the ending case count
14 would be 1,883. Therefore, at 1,783 in year
15 five, we are assuming that we will have 42
16 percent of the market share. Do you feel
17 confident that we can move ourselves to 40
18 percent of the market share by year five. What
19 are the drivers for this growth, volume growth?

20 Q: Well, let's talk about that. Do you feel
21 confident that you'll be at 40 percent of the
22 market share in year five of this project?

23 A: No, that's not going to happen.

24 Q: And why not?

25 A: Well, when I did this, I didn't have this

1 knowledge, but I know that the market is
2 controlled currently by CRCC, and I know that
3 the urologists refer all their cases over
4 there, which is a large 45 or six or 50 percent
5 or something of their cases over there, so
6 those would have to be taken out. And we're a
7 new program. Start-up programs don't jump in
8 and usually take over, and you have to
9 establish physician relationships and the
10 existing physician relationships they already
11 have and we wouldn't have. So it would take
12 time and there's no way we would get to that.
13 Like I said, the research hadn't been done by
14 me. Not my finest moment, but that's what was
15 in there, which I changed later.

16 Q: Okay. Well, let's talk about that. Let's go
17 to Petitioner's Number 5, Petitioner Exhibit 5,
18 if we could.

19 A: This one here?

20 Q: Yeah. Hold on.

21 A: I got it.

22 Q: All right. This is, this was Exhibit 1 I think
23 in your deposition as well, but again, this is
24 -- title is the Request for Capital document.
25 Is this a document you would have done?

1 A: Yes.

2 Q: Now, in this document, what has changed, Mr.
3 Grace?

4 A: In this particular document, by now our outside
5 consultant had been hired, or had provided me
6 numbers. He might have been hired previously,
7 but -- and I was using the numbers from Dan
8 Sullivan, our outside consultant, who's in the
9 courtroom.

10 Q: And who do you understand Dan Sullivan to be?

11 A: He's a consultant in -- that HCA hired to
12 assist with the, this particular project, and
13 he works in other projects with HCA with market
14 expertise and works through you also, through
15 Parker Poe.

16 Q: And that's a question I had for you. If you
17 turn on page 6 under volume assumptions.

18 A: Yes.

19 Q: Okay. Look at it, it says outpatient volumes
20 based on the projected utilization date
21 provided by Parker Poe, LLC, and then CRCC's
22 counsel made a big note to point that out
23 yesterday. Did I provide you or anyone at
24 Parker Poe provide you with this analysis?

25 A: No, it's just my reference. They all came from

1 Dan, and I just used it. It's through Parker
2 Poe. If I have something to send to him, I
3 send it to you and you send it on to him.

4 Q: Okay.

5 A: So, no, it's not by Parker Poe is the answer.

6 Q: Okay. And go back if you would, and I'm sorry,
7 I don't think this is individually paginated,
8 but if we go to the fourth page of the actual
9 document.

10 A: All right. Just give me a -- it says page
11 three in the upper left corner?

12 Q: Oh, yeah. It actually does. I guess it is
13 paginated, yeah.

14 A: Yes.

15 Q: Okay. At this point, you've got a land cost in
16 there. What does that tell you?

17 A: That would tell me that this would include the
18 cost of land to build the building over by Dr.
19 Holt's office.

20 Q: Okay. What is that initial capital expenditure
21 total there?

22 A: What is it? \$12,916,000.

23 Q: Yes.

24 A: What is it?

25 Q: I was just going to ask you, yeah, what's the

1 total amount?

2 A: Yeah, \$12,916,000 consisting of land,
3 equipment, building the building, and some
4 other stuff that you put in the building.

5 Q: Okay. Was that the final project cost for this
6 particular project?

7 A: No. No, it wasn't the final cost or the
8 location.

9 Q: Okay. All right. If you go back to the chart,
10 where it says -- under your volume assumptions
11 on page 5.

12 A: Yes.

13 Q: In terms of the market shares, the projected
14 Grand Strand -- GSRMC radiotherapy market
15 shares, who came up with those?

16 A: The outside consultant, Dan Sullivan.

17 Q: Okay.

18 THE COURT: Which ones again?

19 MR. THOMAS: I'm sorry Your Honor. If you look down
20 in the grid there, the second category
21 projected.

22 THE COURT: Radiotherapy market share?

23 MR. THOMAS: Yes, sir. Yes.

24 Q: Now, you, I guess you originally assumed, I
25 think you said, 25 percent, correct?

1 A: Yes, sir.

2 Q: Do you know why Mr. Sullivan's numbers are
3 lower than yours?

4 A: Well, he is the expert. He did a lot of
5 research on what was currently happening in
6 Horry County and Williamsburg and Georgetown
7 Counties. He knew more about the physician
8 layout, the urologist, so on and so forth, so
9 that's what he thinks.

10 Q: Do you have confidence in his projections?

11 A: Absolutely. That's why we hire him and pay an
12 outside expert.

13 Q: Again, so if you look on page 6. It's the very
14 next page.

15 A: Yes.

16 Q: And this is a grid here under number three, I
17 guess under total outpatient linear accelerator
18 treatments, where do those numbers come from?
19 The 3234, the 4011, and the 4620?

20 A: They come from Dan Sullivan's study.

21 Q: And whereas before you had something along the
22 lines of 400 ---

23 A: Yes.

24 Q: -- 500, 600?

25 A: Right, they were wrong.

1 Q: All right. Let's turn to page 8 of the
2 document.

3 A: Okay.

4 Q: All right. And there's some financial data
5 there. I think there's some payer utilization
6 percentages on number three. Where do those
7 numbers come from?

8 A: I used the existing payer utilizations from
9 Trident Medical Center in Charleston.

10 Q: Okay. And why did you use those numbers?

11 A: Because they have an existing program, and the
12 patients that are in a particular product line
13 like linear acceleration and ortho and neuro or
14 whatever it might be, it's typical to use
15 something from a sister facility.

16 Q: Okay.

17 A: And they're close to us.

18 Q: All right. And so at this point in time, let
19 me see if I can find the reference here.

20 You've got Mr. Sullivan's numbers. Are you
21 more confident about the analysis now?

22 A: Yes, very.

23 Q: Okay.

24 A: Very comfortable.

25 Q: Now, in that same notebook, would you turn over

1 to Petitioner's 7. The document range is
2 pretty long.

3 A: Okay.

4 Q: It's GSRMC 436 through GSRMC 506.

5 A: Okay.

6 Q: All right. Are you there?

7 A: Yes, sir.

8 Q: Okay. It's an email, I guess from -- you're
9 cc'd on several of these but there's a
10 document, several documents attached, correct?
11 I think if you turn the page to go to Grand
12 Strand 437.

13 A: Okay.

14 Q: There's several different files listed there.
15 What are all those files?

16 A: Let's see, CAMS file, there's a "what if" CAMS
17 file. There is probably the RFC, a couple
18 different RFCs.

19 Q: Again, RFC stands for?

20 A: Request for Capital.

21 Q: Okay.

22 A: It's a Word file that describes the project,
23 the market, the strategy, the what happens if
24 you don't do the project, description of the
25 revenues, expenses, utilization, so on so

1 forth.

2 Q: Let me ask you this. I meant to ask you this
3 earlier. Under your last four years at Grand
4 Strand, has the hospital been successful
5 financially?

6 A: Yes, it has.

7 Q: Let's look at the very first document there.
8 It says, I know it's small type, Your Honor.
9 It says May 2011 final submission to purchase
10 linear accelerator and CT simulator, and if you
11 turn the page to Grand Strand 439.

12 A: Okay.

13 Q: Okay. Now, at this point in time, it's labeled
14 Final Submission CAMS, correct?

15 A: It's a title, yes, sir. It is labeled that,
16 but it is the title of the file itself. While
17 it may seem like it's final, that's just my
18 naming convention. Let's be clear about that.

19 Q: And on 439, you still have a land cost
20 incorporated into the CAMS?

21 A: I do.

22 Q: Okay.

23 A: At that time, I must not have known exactly
24 where it was going to be and this would be
25 purchasing the land from Dr. Holt.

1 Q: Is there a land cost associated with the
2 project today?

3 A: No, there's no land cost. We own the land
4 where we would put the linear accelerator.

5 Q: If you'd turn over to Grand Stand Regional
6 Medical Center 445 for me.

7 A: Okay.

8 Q: All right. And at the top of the page there,
9 there are several numbers from 2013 to 2017.
10 Where did you get those numbers, and I guess
11 underneath it says linear accelerator
12 treatments, correct?

13 A: Yes. Those are the numbers straight out of Dan
14 Sullivan's analysis.

15 Q: Okay.

16 A: Which will tie back to the Request for Capital
17 document, Word document.

18 Q: That we were just looking at?

19 A: Yes, sir.

20 Q: So just tell me a little bit about this. I
21 know at the bottom of the page it says, I can
22 hardly read it. It says inputs. Why do you do
23 this document here?

24 A: It's a fancy Excel file in layman's terms. You
25 go through, I don't know how much accounting

1 you want to know, but ---

2 Q: Not too much.

3 A: Okay. You input the volumes for whatever types
4 of volumes you have for this particular
5 project. You can see there were three types,
6 and then that, you have to put how much revenue
7 per type. It computes the revenues, and then
8 there is an expense section that I go through
9 and I put in the individual assumptions for
10 each expense, starting with salaries and
11 benefits and rent lease and repairs and
12 maintenance, contract services, other fees, so
13 on and so forth. That's what this is. This is
14 the top part of that where I started filling in
15 volumes and then under each volume showing what
16 the utilization is. Utilization referring to
17 the type of payer.

18 Q: Okay. Very good. All right. And go to GSRMC
19 450 for me.

20 A: Okay.

21 Q: Is this the RFC that ties to the input section?
22 Take a look at it.

23 A: Yes.

24 Q: Okay. And then it looks like -- I'd like you
25 to turn to GSRMC 464 for me, and there's about,

1 I don't know, ten pages there.

2 A: I'm there.

3 Q: What is that document?

4 A: This is from Dan Sullivan's information. It
5 looks like it's from the State Health Plan, but
6 this is Dan's stuff, I think.

7 Q: Is this the document that appears in B-11 of
8 the CON application?

9 A: Yes.

10 Q: All right. And I'd like you to turn to GSRMC
11 482 for me.

12 A: Okay.

13 Q: You recognize that document?

14 A: Yes.

15 Q: What is that document?

16 A: It's the mega voltage radiotherapy and
17 radiosurgery information of, I believe, the
18 State Health Plan.

19 Q: All right. I think there's a project budget,
20 but then what I want you to look at for me is
21 Grand Strand 500, if you would.

22 A: Okay. I'm there.

23 Q: And what is this document here?

24 A: This is a variation of the CON pro forma.

25 Q: Is it exactly what appears in the CON

1 application?

2 A: No.

3 Q: So there were still adjustments that you were
4 making at the time?

5 A: Yes, there were still adjustments at this time.

6 Q: All right. I want you to turn to the very next
7 page for me.

8 A: Okay.

9 Q: And this is a document down here, it says
10 7/30/212. It looks like a footer on it. Did
11 you create this document on July 30th, 2012?

12 A: That's a print date.

13 Q: Okay.

14 A: I'm not sure that's when the document was
15 created. I seriously doubt it.

16 Q: Okay. So read that bottom tag though at the,
17 on the footer of the page, if you will.

18 A: Submission to purchase linear accelerator and
19 CT simulator CAMS "what if" file.

20 Q: What is a -- describe for the Court for me what
21 a "what if" file is.

22 A: A "what if" file is my version of when the
23 group office wants to see an aggressive
24 variation of a pro forma, I create a what if
25 file, what if the volumes are this.

1 Q: Okay.

2 A: That's a "what if" file.

3 Q: Let's talk about this particular "what if"
4 file.

5 A: Okay.

6 Q: All right. And if you turn the page to Grand
7 Strand Regional Medical Center 504 for me.

8 A: I'm there.

9 Q: All right.

10 THE COURT: Wait a second.

11 MR. THOMAS: Yes, sir.

12 THE COURT: You're on page 501, right?

13 MR. THOMAS: I was on page 501, Your Honor, and then
14 I asked the witness to go to 504.

15 THE COURT: I'm missing the "what if" file.

16 MR. THOMAS: No, this is it. I'm sorry, Your Honor.
17 If you look at the bottom here, and it's very
18 difficult to make out, so on the footer it will
19 say submission ---

20 THE COURT: Oh.

21 MR. THOMAS: --- yeah, to purchase.

22 THE COURT: Oh, I see, "what if."

23 MR. THOMAS: Yeah.

24 Q: Okay. On this "what if" file, what volumes did
25 you assume? I'll direct you to 504, because I

1 think that's what it says.

2 A: Yeah, I basically took Dan's volumes and ramped
3 them up, nearly doubled them.

4 Q: Okay.

5 A: Assumed an additional 15 percent of the market
6 share.

7 Q: Okay. So that would bring you up to 30 percent
8 of the market share, right?

9 A: That's it.

10 Q: Essentially?

11 A: Yes.

12 Q: And what basis did you have for doubling it?

13 A: Only that I know -- I had no basis other than
14 I know that my group office is going to want to
15 see what would happen if you had more volume
16 than what was in the outside expert's plan.
17 It's a more aggressive version of what was in
18 the plan, which is an accurate description of
19 what's really happening.

20 Q: Do you typically do a "what if" file for your
21 corporate office?

22 A: Yes.

23 Q: Now, just because you doubled the numbers of
24 your health planner, does that mean it's going
25 to be the actual result that would come true?

1 A: No, it would not be very likely, but they like
2 to see what would happen if it did happen.

3 Q: Okay.

4 A: What would the numbers look like; what would
5 the expenses look like; what would EBITDA look
6 like.

7 Q: All right. And then to just tie it together,
8 if you go to page Grand Strand 502.

9 A: Okay. Back two pages?

10 Q: Yes.

11 A: Okay.

12 Q: If you plug the volumes in, is this the income
13 statement for the "what if" file?

14 A: Yes, it is.

15 Q: 502. Okay. Well, what do you expect, do you
16 expect something closer to the income statement
17 in the CON pro forma or the income statement on
18 Grand Strand 502?

19 A: I expected ---

20 MR. LONG: Objection, Your Honor. They are what
21 they are, okay? He's not -- he's asking him
22 for an opinion as to which one he expects. He
23 prepared two different proposals for the client
24 to review, they've got different numbers,
25 different projections and all in them. I don't

1 think you can ask him for his opinion as to
2 which one he thinks might happen in the future.

3 MR. THOMAS: I can ask him what he expects and why.

4 I think I can ask him exactly what he can
5 expect and why.

6 THE COURT: I think -- this doesn't call for an
7 expert opinion. He's asking for his opinion
8 based on the numbers he prepared.

9 MR. LONG: Well, he's asking him what he thinks is
10 going to happen in the future.

11 MR. THOMAS: I just laid the entire foundation.

12 THE COURT: Well, I assume that's based on the
13 numbers he prepared.

14 MR. THOMAS: Right, that's exactly right.

15 THE COURT: Well, let's just make the question more
16 exact, so we'll all be clear, because I was
17 making an assumption there myself.

18 MR. THOMAS: Okay.

19 Q: There's some numbers that you prepared in your
20 "what if" analysis whereby you just testified
21 you doubled Dan Sullivan's numbers, correct?

22 A: Yes.

23 Q: Okay. And those were 6300, 7245 and 7854 in
24 the first three years of operation, correct?

25 A: Yes, that's correct.

1 Q: And then there are numbers based on the pro
2 forma of the CON application on Grand Strand
3 304 as a pro forma based on Dan Sullivan's
4 numbers, correct?

5 A: That's also correct, yes.

6 Q: Based on what you did, and as you just
7 testified, doubling Mr. Sullivan's numbers with
8 no basis and what Mr. Sullivan did, which
9 outcome do you expect would be accurate from a
10 financial perspective?

11 A: Given that Dan is an outside expert, that the
12 market already has a strong participant in it,
13 that it takes a lot of time to ramp up any
14 program, I would expect that the outside
15 expert's numbers will be accurate and the "what
16 if" file is exactly that, it's what would
17 happen if you have some aggressive inputs is
18 all.

19 Q: Okay. Thank you. I'd like you to turn to
20 Petition Number 6 for me, and that should be in
21 the same notebook.

22 A: I'm there.

23 Q: Now, what is this file? First of all, do you
24 recognize this document?

25 A: Yes.

1 Q: And can you tell the Court what this file is?

2 A: Sure, this is the CAMS document. It stands for
3 Capital Asset Management System. It's an HCA
4 Excel file that, where I created the pro forma
5 that is now in the CON.

6 Q: CON application?

7 A: Yeah, the application.

8 Q: All right. Let's go to the, if you would turn
9 in the document, and they aren't paginated --
10 sorry, Your Honor -- the fourth page of the
11 document.

12 A: In the upper right-hand corner there's a
13 number.

14 Q: Oh, yeah, I don't have that copy.

15 A: Okay. So ---

16 Q: Now I do.

17 A: Okay. What's the number in the upper right-
18 hand corner?

19 Q: It should say ---

20 A: Three? Four?

21 Q: Hold on, I'll tell you, yeah, four.

22 A: Four, okay, I'm there.

23 Q: And there's outpatient volume linear
24 accelerator treatments, and what do those
25 numbers represent?

1 A: Those are the numbers from Dan Sullivan, the
2 outside expert.

3 Q: Okay. And if you'd turn back to me -- for me
4 excuse me, to the second page of the document..
5 So there should be a two in your right-hand
6 number there.

7 A: Yes.

8 Q: In terms of the EBITDA there, I guess it states
9 2013, can you read those into the record for
10 the first three years of operation.

11 A: Sure, 2013 would be 511,000; 2014 is 1,369,000;
12 2015 is 1,390,000.

13 Q: And is that what the EBITDA is in the pro forma
14 in the CON application?

15 A: Yes.

16 Q: If Grand Strand achieves this EBITDA, do you
17 consider the project as financially feasible?

18 A: Yes.

19 Q: And are you confident in this pro forma?

20 A: I am very confident in it, using outside expert
21 and knowing now what I know and the numbers
22 that he used, I'm very confident.

23 Q: Okay. I want you to go back, I'm sorry, again
24 shuffling notebooks here.

25 A: Okay.

1 Q: To Respondent's 120 please, Mr. Grace.

2 A: I'm there.

3 Q: All right. Okay. Do you recognize this
4 document? It's already come into evidence, I
5 believe.

6 A: Yes.

7 Q: And it's -- is this discussion based on the
8 what if model with Mike Marks, Jerry Rooker,
9 and Jamie Thomas?

10 A: Yes.

11 Q: Are you the RG that appears in the, off to the
12 left there? I think there's like an RG, an AR?

13 A: Yes, that's me.

14 Q: Read this line into the record for me, if you
15 would, starting the first RG, if you'd just
16 read that little paragraph.

17 A: Starts with GSRMC?

18 Q: Yeah.

19 A: "GSRMC wants to be in a leadership role as a
20 provider of oncology services; in line with our
21 strategy. Dr. Holt upset with 21st Century
22 Oncology, Carolinas Regional Cancer Center.
23 Our volume derives from taking a look at
24 outside consultant, Sullivan via Parker Poe,
25 and taking 15 percent of market share, new

1 incremental volume in 2013 plus given
2 Doug/hospital relationship with Dr. Holt adding
3 15 percent of existing volume."

4 Q: All right. Now, Doug's no longer with the
5 hospital as of 5:00 this afternoon, correct?

6 A: That's correct.

7 Q: Okay. And so you state adding 15 percent of
8 existing volume. Is that what you did in your
9 "what if" model?

10 A: That's exactly what I did.

11 Q: Who is MM? It's the very next two initials
12 down. MM.

13 A: MM is Mike Marks. He's the group CFO.

14 Q: So is he in Nashville?

15 A: He's in Nashville, he is.

16 Q: Okay.

17 A: He is my boss' boss, basically.

18 Q: All right. Turn the page for me, if you would.

19 A: Okay.

20 Q: And there's RG. Would you read in the line
21 there under RG, by RG?

22 A: Defined, starting with defined?

23 Q: Yes.

24 A: Defined number of new patients is 1,008.

25 26,461 treatments at 21 -- excuse me,

1 treatments per patient. Predicted a growth of
2 volume of three percent annually with 20
3 percent growth over a five year period. Adding
4 about 1,000 procedures per year, 6,300
5 treatments in year one, 300 patients.

6 Q: Okay.

7 A: So actually a doubling of what the -- Dan
8 Sullivan has provided.

9 Q: So that first year, that 6,300, would that tie
10 in with your "what if" analysis or Mr.
11 Sullivan's expert analysis?

12 A: It's identical to my what if. That's what I
13 was discussing here.

14 Q: Okay. And then, the next initial is JR. Who
15 is JR?

16 A: Jerry Rooker. He would be the group controller
17 that reviews the project and analyses it.

18 Q: Okay. And what did you tell -- what did you
19 tell JR after he asked you what's our market
20 share percentage?

21 A: Exactly what the outside expert had determined,
22 which was 15 percent. I said 15 percent, one
23 percent, one percent which means 15 percent of
24 Horry County, one percent of Georgetown, one
25 percent of Williamsburg.

1 Q: Okay. What does your group CFO in Nashville
2 come back, what does he hit you with next?
3 What does he say?

4 A: On this right here literally?

5 Q: Yeah, MM, what does he say?

6 A: He says how much volume does Dr. Holt have.

7 Q: No, no, that's not what he said.

8 A: Oh, I'm sorry. I'm so sorry.

9 Q: Yeah.

10 A: I went down one. Are we bunting or trying to
11 hit the ball.

12 Q: Okay. And what do you say to him?

13 A: Well, it's at 74 percent ---

14 Q: No, no, no, no.

15 A: I'm sorry.

16 Q: After he says are we bunting or trying to hit
17 the ball ---

18 A: Yeah, also going -- I'm just trying to read
19 what's on here.

20 Q: Yeah.

21 A: Also going to attack with another 15 percent to
22 get 300 total procedures in 2013, 15 percent
23 not too aggressive, is what I said.

24 Q: Okay.

25 A: And then these guys in Nashville, they expect

1 an aggressive approach. I knew that. I had
2 already done a what if file, so I was prepared
3 for whatever discussion we were going to have
4 with them. They've seen me use what if files
5 before, and they'll see them again in the
6 future, but they also know, as you can see by
7 Jerry's question, what our market share is and
8 analysis financially.

9 Q: Okay. But Mike Marks said are we bunting or
10 trying to hit the ball, right?

11 A: That's pretty typical of Mike. He's always
12 wanting to see the best case scenario and maybe
13 not always accepting the realistic picture at
14 the local level.

15 Q: Does your group CFO drive you hard?

16 A: Absolutely, that's part of his role, push,
17 push, push.

18 Q: Okay. I want to go back because there, in the
19 very first RG here in this document, and it
20 said, Dr. Holt upset with 21st Century
21 Oncology. Did you have any firsthand knowledge
22 of that, Mr. Grace?

23 THE COURT: Where are you?

24 MR. THOMAS: I'm sorry. Go back to GSRMC 2325. So
25 it's the first page of the exhibit we're

1 looking at, 120.

2 A: Okay. I'm there. No, I don't have any
3 firsthand -- I've never met Dr. Holt actually.
4 Just what I hear from discussions.

5 Q: Okay.

6 A: No direct knowledge, no.

7 Q: All right. Are you aware of any other of the
8 cancer specialists over in Coastal Cancer
9 Center that are upset with 21st Century?

10 A: No.

11 Q: Okay.

12 A: I know now because I've read all this stuff,
13 but back then, I had no clue.

14 Q: Okay. On June 17th, that was how many years
15 ago?

16 A: How many years ago was it? It was two years
17 and three months.

18 Q: Okay. So do you know anything about whether or
19 not Dr. Holt is still upset with 21st Century?

20 A: No.

21 Q: When was the last time you spoke to Dr. Holt?

22 A: I don't believe I've ever spoke to him. I
23 might have said hello to him as he passed by.
24 If he walked in this room, I don't think I'd
25 know who he was.

1 Q: Okay.

2 A: He passes through quickly on his way to Doug's
3 office a couple times since I've been there in
4 four years.

5 Q: Let's go to Joint Exhibit 2. So that's going
6 to be the bound volume there.

7 A: Okay.

8 Q: I'll ask you to go to the DHEC record page 304
9 on Joint 2.

10 A: Three year budget linear accelerator only?

11 Q: Correct.

12 A: Okay.

13 Q: Well, first of all, let's go to 302 if we
14 could.

15 A: Okay.

16 Q: What is this letter here?

17 A: It's a letter that's required to be sent to the
18 South Carolina DHEC stating what's in -- what's
19 in here.

20 Q: Okay.

21 A: These projections are reasonable and premised
22 on reasonable assumptions about the linear
23 accelerator program in this case.

24 Q: And the volumes came from where?

25 A: They came from Dan Sullivan's outside

1 independent analysis.

2 Q: And do you trust those volumes from your
3 outside expert?

4 A: Yes.

5 Q: Do you believe they're reasonable?

6 A: Yes, they are.

7 Q: Okay.

8 A: Based on the, like I said previously, the
9 market share that currently exists with the --
10 what would be the competitor, being a start-up
11 program, not having done this before, physician
12 relationships, they're accurate.

13 Q: Okay. Let me ask you this. Why didn't you put
14 the "what if" file numbers in the CON
15 application, Mr. Grace?

16 A: Because I don't believe that's not going to
17 happen, and I should not submit that or attest
18 to it to the Department of Health and
19 Environmental, whatever the C stands for.

20 Q: Control.

21 A: Control. I have to attest to what I think is
22 really going to happen.

23 Q: Let me ask you this. On DHEC record page 304,
24 there's a line item saying inpatient revenues,
25 and there are no revenues there, correct?

1 A: There are none.

2 Q: Okay. And you stated earlier you thought that
3 maybe there would be 30, 35 inpatients a year
4 that y'all might treat on the linear
5 accelerator if you got it?

6 A: Yes, probably, something like that.

7 Q: Okay. Well, can you explain to this Court why
8 there are no inpatient revenues on that line
9 item?

10 A: Sure. Patients that come into the hospital and
11 get treated for inpatient care are not paid
12 specific to one particular type of treatment,
13 like radiology treatment or physical therapy
14 treatment or ---

15 THE COURT: When you say they are not paid, do you
16 mean the hospital is not paid?

17 A: Yes, the -- I'm sorry, the hospital isn't paid
18 based on an individual type of treatment. So
19 whatever the treatments are for the particular
20 illness of that patient, when that patient
21 arrives at the hospital is how the patient is
22 paid. So, for example, Medicare pays based on
23 what we call the DRG, which stands for
24 diagnostic related group, and if you're
25 determined to need hip surgery, then they're

1 going to pay you the cost of that hip surgery.

2 If you subsequently also happen to have some
3 sort of cancer treatment going on at the time
4 and you need to go over, in our case to CRCC
5 currently or wherever, then you don't get paid
6 anymore. So, therefore, I wouldn't put any
7 inpatient revenue specific to a linear
8 accelerator treatment in the pro forma because
9 it wouldn't make sense.

10 Q: Okay.

11 A: Does that make sense?

12 Q: I think it was a good explanation, sir.

13 A: It's the same for Medicaid. They pay basically
14 on DRG, and it's pretty much the same for HMOs,
15 PPOs, CIGNA, AETNA, Humana, whatever in the
16 state of South Carolina.

17 Q: Okay. Now, do you have the funding commitment
18 from your corporate leadership for this project
19 projections set forth in the CON application?

20 A: I do indeed, yes.

21 Q: Okay. I want you to turn to the Joint 2 DHEC
22 record page 306, okay, it's going to page,
23 maybe two pages after the pro forma where we
24 just ---

25 A: Yeah, I'm there.

1 Q: These are your budget assumptions, correct?

2 A: Yes.

3 Q: Number two, that's the payer utilization?

4 A: It is.

5 Q: Okay. And again, you state there, what is your
6 payer utilization numbers, what are they based
7 on?

8 A: They're based on Trident Medical Center's
9 utilization for their linear accelerator
10 program.

11 Q: Okay. And so you've got Medicare 51.8 percent?

12 A: Yeah.

13 Q: What do you got for Medicaid?

14 A: Basically 52 percent Medicare, six percent
15 Medicaid, 31 percent HMO/PPO and eight percent
16 other, which is commercial. Well, what we
17 refer to as commercial but that's a industry
18 term. People in the industry refer to
19 commercial as HMO/PPO, by the way but -- so
20 it'd be VA, workers' comp, stuff like that,
21 other federal payers. That's all lumped in the
22 other, and then the rest is self-pay or ---

23 Q: Okay. To try -- go ahead.

24 A: Non-paying, self pay is another way of say non-
25 paying patients.

1 Q: Okay. What's a good way, what would have been
2 a good way to test these numbers in terms of
3 what your payer utilization is?

4 A: To test them out against what actually was
5 occurring in our market?

6 Q: Right.

7 A: CRCC, for example, which I didn't have that
8 data right then.

9 Q: Okay. Well, turn over if you would for me to
10 in the DHEC record to page 909. The Grand
11 Strand, this is Joint Exhibit 2 DHEC record,
12 Bates 909.

13 A: Okay. I'm there.

14 Q: All right. And this is a comparison that DHEC
15 made of CRCC's payer utilization and Grand
16 Strand's payer utilization, correct?

17 A: Yes, it is.

18 Q: And what do you think about your decision to
19 use Trident's payer utilization numbers?

20 A: I think it turned out well. It's pretty close,
21 54 percent Medicare for CRCC, 52 percent,
22 that's remarkably accurate for a majority, more
23 than 50 percent. And then Medicaid, they got
24 three and I got six. My self pay is a little
25 high, a little higher than what they're

1 experiencing. I'd be okay with that. It's a
2 little bit conservative maybe, but that'd make
3 me feel good actually.

4 Q: Okay.

5 A: But I'm very comfortable with it.

6 Q: What would the rest be? If you add these
7 percentages together, they don't add up to 100
8 percent, right?

9 A: No, it would be HMO, PPO and "other."

10 Q: All right. HMO, PPO is that -- and Blue Cross
11 Blue Shield, is that ---

12 A: Blue Cross Blue Shield, Aetna, CIGNA, Humana
13 and a few others, but those are the big ones.

14 Q: Are those private insurance companies?

15 A: They are.

16 Q: Now, in terms of revenue that comes in, do you
17 -- even though that's a smaller percentage, the
18 private pay, what do you expect in terms of
19 revenue when comparing to what the government
20 payers do?

21 A: They pay a higher rate typically.

22 Q: Okay.

23 A: Than the government does, and we establish that
24 through individual contracts with them.

25 Q: So you have to negotiate with each PPO, HMO,

1 insurance provider?

2 A: Yes, we do.

3 Q: What is your understanding, Mr. Grace, if any,
4 about what Grand Strand's reimbursement will be
5 from CMS, I think we call them Medicare as
6 compared to say what a freestanding clinic like
7 CRCC would be?

8 A: Ours would be higher.

9 Q: Okay.

10 A: Basically, because we offer -- the hospital is
11 always open, and they recognize that, I think.
12 Their overhead is obviously more and they would
13 pay us more.

14 Q: Okay. Is your ED always available to all
15 comers?

16 A: All hours ---

17 MR. LONG: Objection, Your Honor. He's giving the
18 policy reasons behind why he thinks they should
19 be paid more, which he has no foundation for
20 and it's also irrelevant. The fact that he
21 asked a -- fair question, who's higher, I think
22 policy reasons as to why that might be are not
23 appropriate for this witness.

24 THE COURT: Is your ED number, and then what's the
25 rest of it?

1 MR. THOMAS: Well, I asked if there ---

2 THE COURT: It was something like that.

3 MR. THOMAS: --- the ED emergency department was
4 open all the time.

5 THE COURT: I'll ...

6 MR. THOMAS: I think that is relevant to why they
7 may pay a little bit more. He made the issue
8 out of payments, what they get, Your Honor, not
9 me.

10 MR. LONG: It is an issue. I don't know why the
11 federal government pays more for hospitals than
12 for freestanding, neither does he, okay. So
13 this is just ---

14 MR. THOMAS: Gosh, Mr. Long, is incredible ---

15 MR. LONG: He can't ---

16 MR. THOMAS: --- he's sitting here and defining
17 something without a question ---

18 MR. LONG: I don't know why they ---

19 MR. THOMAS: --- being asked.

20 MR. LONG: --- they don't do it. I know this
21 witness ---

22 MR. THOMAS: Awesome.

23 MR. LONG: --- there's no -- he's not an expert.

24 He's not been qualified as to the reasons as to
25 why that would occur. Maybe there are other

1 witnesses in the trial who can. I just think
2 that he can't ---

3 MR. THOMAS: Let me ask him another question.

4 MR. LONG: --- he hasn't laid the foundation to ask
5 him any more questions about this issue.

6 THE COURT: He's going to ask another question.

7 Q: Mr. Grace, are you familiar why, about the
8 reasons why as a CFO who has been doing this --
9 how long have you been a CFO, Mr. Grace?

10 A: Since '95, 18 years.

11 Q: Okay. Before that, were you involved in the
12 financial aspects of healthcare?

13 A: Yes.

14 Q: Okay.

15 A: For another eight.

16 Q: Okay. So 26 years involved in the financial
17 aspects of healthcare. Do you have reasons or
18 any knowledge as to reasons why a hospital-
19 based facility would be reimbursed from CMS
20 over a freestanding or outpatient facility?

21 MR. LONG: It'd have to be hearsay, Your Honor.

22 MR. THOMAS: I don't think so. I think ---

23 THE COURT: As to why, you are asking ...

24 MR. THOMAS: I don't think so, Your Honor. I mean,
25 everything he says is hearsay. Everything he

1 has said on this stand he got from something
2 else, okay. But as an experienced person, as
3 CFO and before that eight years in financial
4 management, he may have reason to know exactly
5 why his hospital-based reimbursement is higher
6 than a freestanding reimbursement.

7 THE COURT: Well, my response to that would be that
8 if he was an expert, I certainly think he could
9 testify to that because that's knowledge --
10 that is information that's common -- from what
11 you're saying, information that's commonly
12 relied on by an expert in his field, but ---

13 MR. THOMAS: You don't think that a CFO with 26
14 years experience would know -- I'll withdraw
15 the question, Your Honor.

16 THE COURT: Well, I mean, my response would be to
17 your partial question would be probably yes, he
18 could give the opinion, probably, but he's got
19 to be qualified to give it.

20 MR. THOMAS: I think 26 years as a CF -- 18 years as
21 a CFO and dealing with CMS and ---

22 THE COURT: Do you wish him qualified?

23 MR. THOMAS: No, I don't actually.

24 THE COURT: Okay.

25 MR. THOMAS: I'm not going to go through with that

1 right now, Your Honor. It's Friday afternoon.

2 I know he probably wants to get done on the
3 stand.

4 THE COURT: Okay.

5 Q: Let me ask you this, Mr. Grace. In terms of
6 reimbursement, so you know that the
7 reimbursement would be higher, but you don't
8 know why apparently, but you know that it'll be
9 a little bit higher in terms of an outpatient
10 clinic. What about for private payers like
11 Blue Cross, Aetna, and United? Do you have any
12 knowledge about whether those particular payers
13 are going to be higher than CRCC?

14 A: I would say that when, if we're granted the
15 right to enter the market, that there's a
16 distinct possibility that given the competition
17 between us and another one, a Blue Cross or
18 United or a Humana or a CIGNA, Aetna, may come
19 in and actually negotiate rates that are
20 slightly different than what they're currently
21 getting paid, and so they may be higher than
22 CRCC's, but overall, the rates may decline for
23 these managed care payers, possibly.

24 Q: Okay.

25 A: Competition could do that in the market.

1 Q: Mr. Grace, what, if any, reason do you believe
2 that Grand Strand, or do you have to believe
3 that Grand Strand will be the largest volume
4 single linear accelerator operator in the state
5 of South Carolina by year three of operation?

6 A: No, that's not going to happen.

7 MR. THOMAS: That's all I've got for this witness,
8 Your Honor.

9 MR. LONG: Your Honor, you want to keep going or
10 take a short break?

11 THE COURT: I think we're going to tough it out,
12 unless you need one.

13 MR. LONG: I don't think I need one right now, Your
14 Honor. Hopefully, we won't be too long.

15 THE COURT: You have a significant input into that.

16 MR. LONG: Not 100 percent.

17 THE COURT: That's true, but hence the phrase
18 "significant."

19 MR. GRACE - CROSS-EXAMINATION BY MR. LONG:

20 Q: Mr. Grace, you've been at Grand Strand, I think
21 you said since 2009; is that right?

22 A: Yes, sir.

23 Q: So at the time that you were working with this
24 linear accelerator program project, you'd been
25 there for a couple of years, right? This is

1 all occurring in 2009.

2 A: A year and half-ish, yes.

3 Q: All right. Now, and of course, Adam Rudd, who
4 we heard from, and Doug White and yourself and
5 then the chief nursing officer which is vacant,
6 y'all are the management team at the hospital,
7 right?

8 A: Yes, we are.

9 Q: Y'all meet on a regular basis, right?

10 A: Not as often as we should probably, but we
11 meet.

12 Q: Okay.

13 A: We work in the same office every day.

14 Q: And if a hospital wants to spend money on a
15 capital project, certainly one as large as this
16 capital project, you've got to get approval
17 from Nashville, right?

18 A: Yes.

19 Q: And that's really what this Request for Capital
20 document and the CAM document are, right?
21 Those are the mechanisms for you to get
22 approval in Nashville, correct?

23 A: Yes.

24 Q: All right. And just to make sure, it's two
25 documents but they go together, right? You

1 always submit both of them to the people to
2 look at in Nashville, right?

3 A: You're talking about the Word file and the
4 Excel file?

5 Q: Right.

6 A: As in the dollar amount of the project.

7 Q: Okay.

8 A: The one you're speaking with, or two in this
9 particular case, the answer is yes; not always,
10 but when you're over five million dollars,
11 actually over three million dollars, the answer
12 is yes.

13 Q: Okay. So we would certainly be over those
14 thresholds in this case. So you were working
15 on both those documents, the Word document and
16 the CAM file, and your initial submission was
17 in January, right?

18 A: I believe so. That's what we were looking at,
19 yes.

20 Q: And we went through those documents, and I can
21 pull them up again if you want to. I'm just
22 trying to kind of get an idea about the
23 timeline.

24 A: Yes, time's right.

25 Q: It was January, about the middle of January.

1 And then from your perspective, because that
2 was your role, was to work on those two
3 documents and the pro forma, right?

4 A: Yes, sir.

5 Q: That was your role with the whole project?

6 A: Yes, sir.

7 Q: There really wasn't a whole lot of activity
8 until May, right, from your perspective?

9 A: That's correct. I did my initial assessment
10 and then not a lot happened for a couple
11 months, yes.

12 Q: Okay. Let's look at CRCC Exhibit 103. Can I
13 help you with that?

14 A: I think I've got it so far.

15 Q: All right. If we could do the top part of this
16 email.

17 A: Okay.

18 Q: This is an email from you to Jerry Rooker May
19 11th ---

20 A: Okay.

21 Q: --- of 2011 and you are writing him, and you
22 can look of course further down on the next
23 page, but you're initiating a conversation with
24 him because you need for the lawyers to give
25 the financing letter saying that HCA is going

1 to finance the project. That's got to go in
2 the CON application, doesn't it?

3 A: Yes, there has to be a letter in the
4 application saying it'll be financed, yes.

5 Q: And it's usually submitted by somebody like
6 yourself, a CFO, saying that the applicant is
7 committed to the project financially, telling
8 how they're going to do it, right?

9 A: Yes.

10 Q: And you don't have authority as just the CFO at
11 Grand Strand to do that without getting some
12 approval up the chain, right?

13 A: I cannot commit to that at the hospital level.

14 Q: All right. Especially at that amount?

15 A: No, I cannot.

16 Q: So you contacted Jerry Rooker, and you also
17 copied Rodney VanPelt telling them, reminding
18 them about the project and that you needed that
19 letter and asking their permission, right?
20 That's what this email stream is about, right?

21 A: Okay. Yes, I would say that's right.

22 Q: You agree with that?

23 A: Seems to be, yeah.

24 Q: And then of course, you submitted, you went
25 ahead and forwarded what you had done back in

1 January to, and it eventually went up to Mr.
2 Rooker, and that's when he wrote you the email
3 back on May 20th where he pointed out the
4 questions and the issues about the CAM and the
5 Request for Capital document that you went
6 through on your direct, right?

7 A: Maybe. When I was looking at the other
8 documents, I'd have to look at them with the
9 email that I sent up there, it seems like Jerry
10 got back to me really quick like in a day or
11 so. I can't remember the exact day I sent it
12 up. There's no files, I don't think, attached
13 to this one here, or maybe just a small little
14 letter to the DHEC or something.

15 Q: Take a look at 106.

16 A: Okay.

17 Q: CRCC 106.

18 A: There you go, May 13th. Okay.

19 Q: Right. You forwarded those documents on to him
20 pretty quickly right after that email on May
21 11th, and he wrote you back, right?

22 A: Yes, okay. I would agree, 11, 13, okay.

23 Q: Okay. Let's look at CRCC 111, and this is, at
24 the bottom part of this email you went through
25 earlier, this is the email from Jerry Rooker on

1 May 20th, okay, pointing out the issues with
2 the CAM and the Request for Capital document,
3 right?

4 A: Yes, I made the corrections and I also included
5 a "what if" file.

6 Q: Right. Let's talk about that for a second. So
7 you worked on the -- when you got that back
8 from him, you worked, started working on that
9 right away, right? You didn't ...

10 A: Didn't have much time. They wanted it turned
11 around, so I got it done.

12 Q: They wanted it turned around quickly. And you
13 either had by that time or were creating a
14 "what if" file, right?

15 A: Yes.

16 Q: Okay. And so the very next day, you forwarded
17 on May 21st to Jerry Rooker in Nashville the
18 "what if" file, right?

19 A: The very next day after what?

20 Q: After he wrote you on May 20th.

21 A: He wrote me on May 13th? May 20th. Right now,
22 haven't had a chance to review. He originally
23 wrote me on the 13th, and then he ---

24 Q: Right, and then a week later followed up with
25 you.

1 A: Followed up, yes.

2 Q: Right. And then the very next day on the 21st,
3 you told him we've been working on this. I
4 guess you'd been working on it all week, right?

5 A: It looks like I had coincidentally sent it to
6 Rodney on the 20th when he asked me, because I
7 said, I sent everything to Rodney late
8 yesterday afternoon. So I sent it to the
9 division office, the revisions, on the same day
10 coincidentally that Jerry followed up with me.

11 Q: And you also included the "what if" file in it,
12 right?

13 A: I sent it to Rodney, yes.

14 Q: And Jerry?

15 A: Well, as you can see, I said I sent everything
16 to Rodney late yesterday afternoon and Rodney
17 probably followed it up.

18 Q: And you also said, you let him know though that
19 there was -- I included a "what if" file, Excel
20 and CAMS file that required some explanation.
21 Thanks for the follow up. We'll be talking
22 soon, right?

23 A: Yes.

24 Q: All right. So that's where the project is now.
25 And you forwarded that "what if" file over to

1 him, okay? Then let's turn over to ---

2 A: Just for clarity, I think it went to Rodney.

3 I don't know if it's not significance, but it
4 might be for you. I think, I'm saying I sent
5 it to Rodney.

6 Q: Okay.

7 A: Okay. And he was ---

8 Q: Now, let's look over at 118.

9 A: Unless you had something in here that shows
10 that I did send it to Jerry, but I think I sent
11 it to Rodney.

12 Q: Well, Rodney VanPelt would have forwarded it on
13 to Jerry Rooker, right?

14 A: Yes, he would.

15 Q: Okay.

16 A: After he reviewed it though.

17 Q: Okay.

18 A: And he especially would have probably reviewed
19 it because, if you recall, the first one I sent
20 was full of errors.

21 Q: All right.

22 A: And Rodney wasn't none too happy about that
23 himself either. Okay.

24 Q: Let's look at 118, the top part of this email
25 redacted, but if you look down at the email,

1 there's an email from you dated -- from you to
2 Rodney VanPelt June 1st, 5:00 telling him
3 here's the updated linAc file that we discussed
4 this morning, right?

5 A: Okay.

6 Q: We're going to talk about this with the group.

7 A: Okay.

8 Q: And then when you turn over two pages to GSRMC
9 document 391, that's your CAM file, right? The
10 financial file, right?

11 A: It is a -- see input for a CAMS file, yes, sir.
12 I don't know if it's the exact one of this, but
13 you can probably assume that.

14 Q: It's the one attached to the email.

15 A: Was it attached?

16 Q: Twelve pages, right? See at the bottom, one of
17 12, two of 12, three of 12.

18 A: In the email, is there a file attached here?
19 I don't see a file attached to this particular
20 email. You'd see a ---

21 Q: It was attached. You can see the page numbers.
22 It was produced as the attachment.

23 A: You're talking about 389 ---

24 Q: Let's look at ---

25 A: That's you're asking me about, right? 389?

1 Q: Yes.

2 A: There's no file attached to that.

3 Q: Okay. You're saying here is the updated linac
4 file.

5 A: Okay.

6 Q: And then attached to that in the production was
7 this file right here.

8 A: Okay.

9 Q: That starts on 391 and continues until 402.

10 A: Okay.

11 Q: What I want to ask you about that document is,
12 what you sent Mr. VanPelt ---

13 A: Okay.

14 Q: --- on June 1st ---

15 A: All right.

16 Q: --- of 2011 was the "what if" file.

17 A: Okay.

18 Q: The little footer on the bottom there, you see?

19 A: Yes.

20 Q: What if.

21 A: Okay. I'm with you. This is the input
22 section, but yes, go ahead.

23 THE COURT: What page are you on?

24 MR. LONG: This is GSRMC 391.

25 THE COURT: All right. I'm there.

1 Q: Okay. And then if we turn over to GSRMC 398
2 and we look at the treatment numbers at the top
3 below that first line.

4 A: Yes, I'm there.

5 Q: Okay. So on June 1st, you're communicating
6 with Rodney VanPelt at the division office,
7 who's also talking to the Nashville office, and
8 you're talking about getting approval for the
9 project, and the document that you send him,
10 the updated file has projections in year three
11 at 7,854 treatments and ---

12 A: It's one of the files that I sent to him, yes.

13 Q: And -- well, actually in that email you just
14 sent him one, because it says here is the linac
15 file.

16 A: Okay. He got the file.

17 Q: Updated linac file we discussed.

18 A: Okay.

19 Q: And the one that you sent him was 7,854 in the
20 treatments in year three and 8,659 in year
21 five; isn't that correct?

22 A: The numbers that you just cited are the numbers
23 that are in the file, yes, that I sent to
24 Rodney that were sent to Jerry.

25 Q: Okay. And that was June 1st. Now, on June

1 16th, let's look at Exhibit Number 120, and Mr.
2 Thomas went through this with you. This
3 conversation on June the 16th was the
4 conversation with the Nashville folks, the
5 division and the group folks, to seek approval
6 of being able to do the project, right?

7 A: In part, yes.

8 Q: Well, what other role would it have?

9 A: Discussion on what the strategy is, how we got
10 there, what do we think is going on with it.

11 Q: Okay.

12 A: There's all kinds of stuff that was discussed,
13 as you can see.

14 Q: Well, you're aware the approval was made the
15 next day? Are you aware of that?

16 A: I'll take your word for it whichever ---

17 Q: We can switch over to Exhibit 122 if you want
18 to look and you'll see ---

19 A: Okay.

20 Q: --- the actual thing. So the conversation was
21 on the 16th.

22 A: Okay.

23 Q: And the approval occurred on the 17th.

24 A: Okay. I agree with that.

25 Q: And that's -- so you'd agree with me that's a

1 pretty important meeting since it was the
2 meeting before the approval was made to do the
3 project, correct?

4 A: It's important to have discussions about what's
5 going on with the project and all what's
6 involved, yes, I would agree that that's
7 important.

8 Q: And in that meeting, you consistently told your
9 superiors in Nashville that you could obtain --
10 you've only talked really about the "what if"
11 file market share numbers, right?

12 A: I submitted on another occasion the other file,
13 so yes, I've talked about both.

14 Q: Not in this conversation.

15 A: Maybe. They're well aware.

16 Q: There were aware of both?

17 A: Absolutely.

18 Q: Okay. And where in this conversation did you
19 tell them that you weren't going to be able to
20 do the "what if" market share numbers?

21 A: I didn't say it in this conversation.

22 Q: And where in the conversation did you tell them
23 you thought Mr. Sullivan's projections were too
24 aggressive?

25 A: I didn't say Mr. Sullivan's projections were

1 too aggressive.

2 Q: I'm sorry, let me rephrase it. When in this
3 conversation did you tell them Mr. Sullivan's
4 projections were correct?

5 A: I would assume if they hire an outside expert
6 and pay for it that they know the projections
7 are going to be accurate. That's why we get an
8 outside expert to do it. They'd also like to
9 know if we exceed those projections, what it
10 would look like.

11 Q: Well, do you think that the people in Nashville
12 make a decision on a prayer, or do they make
13 the decision based on what they expect the
14 project to do?

15 A: You're asking me if I think that the people in
16 Nashville that are experts in healthcare make
17 decisions based on prayers, the answer is no,
18 I don't expect that.

19 Q: Right. And so when you give them a "what if"
20 file, they think that is very possible to
21 occur, right? They don't think that's just
22 something that just is made up?

23 MR. THOMAS: Object to the form, calls for
24 speculation. He's asking what they all think
25 up there ---

1 MR. LONG: They ---

2 MR. THOMAS: --- not only ---

3 MR. GRACE: They're well aware ---

4 THE COURT: Whoa, whoa, stop. Both of you stop.

5 MR. LONG: I'll rephrase the question, Your Honor.

6 MR. THOMAS: All right.

7 Q: Okay?

8 A: Uh-huh (affirmative response).

9 Q: When you gave them in the information in the
10 "what if" file, did you just tell them hey, I
11 just made this up?

12 A: They were well aware of what was in that file,
13 yes. They know ---

14 Q: Did you tell them that you made it up?

15 A: That I made it up?

16 Q: Yeah.

17 A: That's an interesting way of putting it. Yes,
18 I disclosed that had I doubled the market
19 share.

20 Q: Yeah, but you didn't ---

21 A: It says right in these documents that I added
22 another 15 percent, so is it made up? It's an
23 estimate that's put in as what would the
24 financial results be if we did indeed have an
25 additional 15 percent. So the answer to your

1 question, yes, I guess if you consider that
2 made up, then I disclosed to them that I made
3 it up.

4 Q: Did you tell them that it had no basis?

5 A: That is has no basis? They understand what a
6 what if file is.

7 Q: Well, if -- why are they most interested in the
8 "what if" file?

9 A: They like to see what a project would look like
10 if you exceed expectations and if you
11 aggressively cut numbers.

12 Q: Okay. Now, a couple other comments about this
13 conversation. If you look over on the second
14 page on 2326. Mr. Rooker, who's the controller
15 in Nashville and has had a lot of experience
16 with linear accelerators, he questioned your
17 reimbursement numbers for Medicare and Medicaid
18 ---

19 THE COURT: Hold on one minute. I'm sorry. I've
20 got to take a break. I've got to take a
21 certain phone call.

22 (Break from 3:00 p.m. until 3:14 p.m.)

23 Q: Can we go back to Exhibit 120, CRCC 120. I
24 just want to ask you about a couple of comments
25 in this exhibit. First, if you go down to the

1 next to the last where it says MM down at the
2 bottom there. That's Mike Marks, of course,
3 and in the conversation that y'all were having.

4 THE COURT: What page?

5 MR. LONG: Sorry, this is page GSRMC 2325.

6 A: Five, okay, I'm on 25.

7 Q: He says in regards to the equipment -- you know
8 who Dr. Mun is, right?

9 A: Yes, I know who Dr. Mun is. I've met him once,
10 I think.

11 Q: He says, review with Dr. Mun. If not ten
12 million, then we can get the cost down to at
13 least the six to nine million range if we chop
14 off options. Can drop the price with Varian
15 given the Eastern Group's purchasing of several
16 linacs. So that was certainly one of the
17 things that y'all did after this meeting, is
18 you chopped off some options on the linear
19 accelerator, right?

20 A: I don't know. Adam was probably working on
21 that with Mike and maybe someone from
22 purchasing, but I heard you talking earlier
23 today and it sounds like they probably dropped
24 some options.

25 Q: Turn over to the second page, GSRMC 2326.

1 Again, at the top of the page, your comments.
2 He asked you what the market share was. You
3 gave him the Dan Sullivan numbers, and then
4 when he asked you whether you were bunting or
5 hitting the ball, using a baseball analogy, you
6 did not say, did you, that those are strong
7 numbers or correct numbers; you said also going
8 to attack with another 15 percent to give 300
9 total procedures. You're talking about
10 patients there, right?

11 A: Yes.

12 Q: In 2013, 15 percent not too aggressive, right?

13 A: Yes, I said that.

14 Q: Okay.

15 A: According to the notes.

16 Q: And then you and he entered a conversation
17 about Dr. Holt's practice, which you're very
18 familiar with his volumes and market share,
19 right, because you answered the questions very
20 specifically?

21 A: I just want to make one more comment.

22 Q: Sure.

23 A: These notes, I think are from David Was' notes;
24 is that right? I think that's what these are
25 from.

1 THE COURT: He can't answer your questions.

2 A: He doesn't answer, okay.

3 THE COURT: Well, he can't.

4 A: Okay. I'm sorry. And so if that is the case,

5 I don't know if this is exactly what I said.

6 I mean, you're asking me is that what it says.

7 That's what it says here but I can't ---

8 Q: You're not going ---

9 A: --- I can't remember if that's exactly what was

10 said or not, but that's what David wrote down

11 apparently and if that's how he interpreted it,

12 yes.

13 Q: And it apparently was done very contemporaneous

14 because the email right above it is just the

15 next day, right?

16 A: What do you mean by contemporaneous?

17 Q: Go back to 2325.

18 A: Okay.

19 Q: He's forwarding this information over to Doug

20 White and yourself on June 17th and including

21 his notes from the conference call.

22 A: Okay.

23 Q: So it was obviously drafted contemporaneously

24 with the call or shortly thereafter.

25 A: Closely thereafter, is that what you mean by

1 contemporaneous?

2 Q: Right. And you're not denying any of these
3 comments that you said, are you?

4 A: No, I don't think I could deny them, but I'm
5 not sure I said them exactly how he noted them
6 too, but okay so ---

7 Q: Let's go back to 2326.

8 A: Okay.

9 Q: You're having a conversation with Mr. Marks
10 about Dr. Holt's volume, and you're very
11 familiar with how much volume he has and that
12 he's the only medical oncologist in town,
13 right?

14 A: It says RG, JT. I don't think I would have
15 known that 74 percent. I don't know where that
16 comes from. I can't attest to that. JT would
17 be Jamie. So I don't know why David would have
18 put me with Jamie. If Jamie was speaking, I
19 definitely would not have been.

20 Q: Okay. And then shortly thereafter, Mr. Thomas
21 says we don't control urology, but we do
22 general surgery and neuro. General surgery
23 would be the surgeons right, because you employ
24 surgeons at Grand Strand, right?

25 A: Yes, we employ them.

1 Q: And you also have surgeons that practice at
2 your facility very regularly. They do your
3 surgery there, right?

4 A: Yes, not all of are employed, but yes.

5 Q: And you have neurosurgeons that are employed,
6 right?

7 A: Yes, they're both employed.

8 Q: And urologists?

9 A: Yes, they're employed. I'm not sure if they
10 were at this time. They were an independent
11 group at one point. I think they're still
12 independent here. I can't recall, but now we
13 employ them.

14 Q: All right. If you could, I want to ask you too
15 about something Mr. Rooker said. Mr. Rooker is
16 the controller in Nashville. He's very
17 experienced in finances for the company and
18 certainly would be familiar with linear
19 accelerator finances, right?

20 A: I think so. I don't know how many he had done,
21 but I would assume he's probably seen that
22 stuff before. He tore my stuff up pretty
23 quick, so I'm assuming he must have some
24 knowledge.

25 Q: Okay. And he says to the group, strange that

1 Medicaid and Medicare are reimbursed on the
2 same rate.

3 A: Where are you at exactly?

4 Q: About halfway down. JR rate CT revenues per
5 stat once all in.

6 A: Okay.

7 Q: And he said strange that Medicaid and Medicare,
8 so he's looking at your projected reimbursement
9 ---

10 A: Okay.

11 Q: ---- that you have in there, and he's
12 commenting that that seems unusual to him,
13 isn't he?

14 A: Yeah, it looks like that's what he's saying,
15 yes.

16 Q: All right. And then down a little bit further,
17 Mr. Thomas says, we're going to change the
18 recruitment from one to two radiation
19 oncologists to one to start and then add the
20 second one in year three, right?

21 A: Yes, sir.

22 Q: And that's exactly what you did on the pro
23 forma, isn't it?

24 A: Yes, there is one in year one and one in year
25 three.

1 Q: Right. And that's why the other expense number
2 on the pro forma changes so much because of the
3 recruiting and the hiring of that radiation
4 oncologist, right?

5 A: In year three, yes, sir.

6 Q: Okay. All right. Let's take a look at the
7 next document, 122. That's the approval,
8 right, the next day?

9 A: Yes, it's an email from Jamie.

10 Q: I wanted to ask you, turn over to the other
11 page, Mr. Rooker's email here, the very -- he
12 says that, he says the current NPV is 1.4.
13 That's a very positive number. That's the net
14 present value, right?

15 A: Yes, that's the net present value index.

16 THE COURT: Are you in 122 now?

17 MR. LONG: I'm sorry. I'm at 122 on page 644, the
18 very last bullet.

19 Q: Return on investment for the project is 32.8
20 percent, right?

21 A: Yes, that's what he says.

22 Q: That's a pretty healthy return on investment,
23 isn't it?

24 A: It's pretty good.

25 Q: Yeah, and then the payback ---

1 A: The numbers look pretty good.

2 Q: Payback is 6.3 years, so you're going to spend
3 about nine million dollars and you're expecting
4 to be able to pay it all back within six years
5 from the revenue generated by the linear
6 accelerator, right?

7 A: Depending on what the volumes are.

8 Q: Okay. And that's the expectation. That's what
9 he's saying. And then here's the thing, those
10 should prove with the changes noted above. So
11 that wasn't good enough for the group in
12 Nashville. They want to make changes to
13 improve it, right, the return?

14 A: I'm not sure exactly what you're asking, to be
15 honest with you.

16 Q: Well, doesn't his comment there, that should
17 improve with the changes noted above -- in
18 other words, if we do some of the changes
19 above, if you turn over to the page before
20 you'll see his changes, drop the capital cost,
21 drop expenses.

22 A: Yes, if you drop expenses and you drop the
23 investment amount, based on not having land or
24 taking something off software or some other
25 element of the linear accelerator, it would

1 improve the overall financial picture of the
2 project, yes.

3 Q: Now, as you were going -- let's go back and
4 look at Grand Strand Exhibit Number 6. Now,
5 when I deposed you in the summer -- it's in the
6 Grand Strand book.

7 A: I'm on Exhibit 6.

8 Q: Okay. In your deposition, you came to the
9 deposition, which I think was in July of this
10 year, and brought me Grand Strand Exhibit 5 and
11 Grand Strand Exhibit 6 and handed them to me
12 the morning of the deposition. Do you recall
13 that?

14 A: Okay.

15 Q: Well, I think your lawyer did, but ...

16 A: Okay.

17 Q: All right. And you proceeded to tell me that
18 these were very important documents that had
19 not been produced in discovery, right?

20 A: Okay.

21 Q: Isn't that correct?

22 A: Sounds right, yes.

23 Q: Yes, okay. And then you said to me that what
24 if -- your testimony of course was that the
25 what if -- these were the important documents

1 regarding the approval of the project, right?

2 A: I don't know if I used the term important, but
3 they're all important. These are the ones, the
4 ones that you're talking about, Number 6 in
5 this book, are the ones you're using the
6 volumes from Dan Sullivan's analysis.

7 Q: Well, we just saw in the email exchange that
8 the approval of the project by Mr. Hall was on
9 June 17, 2011, right?

10 A: Okay. If that's what we were looking at
11 before.

12 Q: And let's look at the tag line on the documents
13 that you brought to the deposition.

14 A: Okay.

15 Q: The date on that says updated June 20th. These
16 documents were done after the decision was made
17 to go forward with the project, right?

18 A: No, print date. You're talking about the print
19 date?

20 Q: No, sir.

21 A: I make changes, I make a variety of changes,
22 small changes in files all the time, so it
23 might -- I might save it under another name.
24 If it was for Will, I might put updated.
25 That's just the name of the file.

1 Q: No, I understand, but the print date is
2 7/7/2011.

3 A: Okay.

4 Q: Isn't that correct? You told me that's the day
5 you printed it out.

6 A: Yeah, I printed it ---

7 Q: So that's right about the time of the filing of
8 the CON.

9 A: Okay.

10 Q: But the updated date is June 20th, which was
11 after the decision had been made by Nashville
12 to go forward with the project, right? We just
13 established that.

14 A: I don't know if anything was changed in the
15 file. If you're asking me if the name of the
16 file includes the word "updated," the answer is
17 yes. If you're asking me if any specifically
18 changed in the file, I don't know. I'm not
19 sure exactly what you're asking.

20 Q: Well, the file that was reviewed and discussed
21 on the conversation on June 16th was the "what
22 if" file.

23 A: Okay.

24 Q: But this is the for Will Thomas file dated June
25 20th.

1 A: I had this file long before that I'm sure.

2 Q: You did?

3 A: Whenever I got Will's or Dan Sullivan's
4 numbers, I put them in a file.

5 Q: But this isn't the CAM file that you used to
6 talk to Nashville about approving the project?

7 A: They had this file, absolutely.

8 Q: It was just never discussed?

9 A: I'm sure I discussed it with them.

10 Q: How could they have had a file that was dated
11 June 20th ---

12 A: With Rodney, I would discuss with Rodney and
13 submit the file to him and Alex, go over it,
14 review it, then he sends it up to corporate.

15 Q: Do you know how they could have reviewed a file
16 prepared on June 20th for a conversation that
17 occurred on June 16th?

18 A: It was prepared before that. I appreciate the
19 insinuation, but that wouldn't be possible.

20 Q: Okay. Well, just to confirm your testimony
21 earlier about the radiation oncologists, can we
22 look at Grand Strand CON pages 138 and -- I'm
23 sorry, Grand Strand CON pages 619, Joint
24 Exhibit 2, please.

25 A: Okay.

1 Q: When you look at the bottom on the expense
2 page, the other expenses, other operating
3 expenses right above the total operating
4 expenses line.

5 A: Yes.

6 Q: The reason that number, those numbers are
7 dramatically different is because of the
8 recruitment of a radiation oncologist, right?
9 Year one ---

10 A: If you are referring to 2015 being less, being
11 536,000, that is a second oncologist in year
12 three and only one in year 2013.

13 Q: All right. Let's take a look at ---

14 THE COURT: Say that again where I can be clear now.
15 Repeat that again.

16 A: This pro forma he asked me about on page 619 is
17 the CON pro forma.

18 THE COURT: I understand.

19 A: And he was asking me specifically about the
20 line that says other operating expenses.

21 THE COURT: All right.

22 A: And inquired as to why it's 515,000 in the
23 first year of the project, which is 2013, and
24 there's one oncologist, the recruitment of one
25 oncologist and the cost of that in that line

1 along with a couple of other small things and
2 other operating expenses. Then in 2014 is only
3 the stuff excluding the recruitment of an
4 oncologist, so no additional recruitment there,
5 and then year three 2015, 536,000 for the
6 second oncologist.

7 THE COURT: All right.

8 Q: You saw the email from Mr. Thomas earlier today
9 that the second oncologist should come on board
10 when y'all got up to 7,500 treatments for the
11 year, right?

12 A: Since I've been up here?

13 Q: No, from this morning.

14 A: I probably wasn't paying attention, but he may
15 have an email that says that. If you can show
16 it to me, I can see.

17 Q: Let's take a look at Exhibit 119.

18 A: Same book?

19 Q: CRCC.

20 A: The map?

21 Q: No, no, I'm sorry. You're in the CON
22 application. I'm at the exhibits, CRCC
23 exhibits.

24 A: Okay.

25 Q: In that email Mr. Thomas sent on June 17th,

1 which was the same day of the approval that we
2 confirmed.

3 A: Okay. I'm with you.

4 Q: Okay.

5 A: Yes, sir.

6 Q: He says to you we'll hire the second radiation
7 oncologist when our daily volume gets to in the
8 low 30s, right?

9 A: Yes, he says that.

10 Q: And 30 times 250 is 7,500 treatments.

11 A: I recall you doing that with Adam, yes, sir.

12 Q: Okay. And you added a second radiation
13 oncologist in the third year of the pro forma,
14 right?

15 A: I did add it in the third year, but it has
16 nothing to do with being at 7,500 treatments,
17 if that's what you're asking me.

18 Q: Well ---

19 A: You need a -- if I can expand. First of all,
20 having one physician for any particular product
21 line is difficult in and of itself. You're
22 going to be on call all the time; you're going
23 to have to cover everything yourself. At some
24 point, you're going to have to add another
25 radiation oncologist. I had two in in one of

1 my files, two to start with. I think the
2 decision was made, well, probably don't need
3 two then. Don't know exactly when we'll need a
4 second one, but I could have perhaps waited
5 until year four, year five, year six, whatever.
6 I like to get the cost in there, so I put it in
7 year three. Was it specifically that Jamie
8 said you're going to have 30 patients a day or
9 whatever; I want you to put it in there? No,
10 sorry, that's not why I put it in.

11 Q: Well, Mr. Thomas told you when you needed the
12 second radiation oncologist ---

13 A: He did not.

14 Q: --- in that email right there the day of the
15 approval?

16 A: I appreciate that, but what I'm telling you is
17 that Jamie Thomas, the division president, does
18 not work with the CFO at the local level and
19 say put this in the pro forma, put that in the
20 pro forma. That's just not how it works Mr.
21 Long, I'm sorry. But I appreciate your email
22 that's saying what Jamie's saying. I didn't do
23 anything in this pro forma based off a number
24 of patients per day, that just wasn't.

25 Q: You didn't include any inpatient revenue in

1 your pro forma, right?

2 A: I did not.

3 Q: For the reasons you explained earlier, but you
4 also told me in the deposition that it would
5 make no sense to have a linear accelerator that
6 only treats inpatients, right? That would make
7 no financial sense, right?

8 A: I don't know about no financial sense, but I
9 can't speak for another hospital, but I don't
10 think it would be very profitable.

11 Q: Okay. Let's take a look at Exhibit Number 69.

12 MR. THOMAS: Which one, Respondent?

13 MR. LONG: I'm sorry, it's the CRCC Exhibit 69.

14 A: Mine starts at 86?

15 Q: This is also in the CON application.

16 A: Page 69?

17 Q: Well, actually I take that back. Let's go to
18 75 first, then we'll go back to 69.

19 A: Okay.

20 THE COURT: So we're going to 70 now?

21 MR. LONG: 75.

22 THE COURT: 75.

23 Q: This is your payer mix for the hospital, right?
24 Inpatients by financial class?

25 A: Yes, it looks like that.

1 Q: Okay.

2 A: Excluding normal newborns, and just to qualify
3 and make sure that you're clear, there's a
4 variety of ways in HCA to gather data. One of
5 them is through an entity called decision
6 support services that uses a system that pulls
7 data from various other systems and is
8 relatively accurate most of the time. So, yes.

9 Q: Okay.

10 A: In answer to your question, that's what --
11 16,006 admits looks pretty close, although I
12 would have to check. For all I know, it says
13 discharge dates. It's probably discharges and
14 not admits, but it's pretty close. What you
15 admit in a given year you should probably
16 discharge, but there could be a slight
17 variance.

18 Q: Okay. And while these are in a number of
19 different categories, the two main one lists
20 Medicare, which is the number one payer for the
21 hospital, right?

22 A: Yes, sir.

23 Q: Okay. And Medicare would be numbers one and 12
24 on this chart, right?

25 A: Yes, 12 is managed Medicare.

1 Q: And if you were to total those up and compare
2 to the total for, say, 2012, the Medicare would
3 be probably about 55 percent, right?

4 A: Give or take, yes, sir.

5 Q: And that's what the hospital does is about 55
6 percent Medicare, and then these other ones are
7 either commercial or Medicare or other, right?

8 A: Medicaid.

9 Q: Categories? Medicaid.

10 A: Yes, Medicaid, yes, managed care, charity, self
11 pay, other, yes, sir.

12 Q: All right. Now, let's go back to 69. This is
13 also in Joint Exhibit 2. This is your
14 assumptions regarding your reimbursement in
15 regards to what you'd expect with the linear
16 accelerator, right?

17 A: Yes.

18 Q: Okay. And you were estimating that the
19 Medicare patients would only reimburse in 2013
20 at \$324 per treatment, right?

21 A: Yes, sir.

22 Q: And so if a typical patient had say 25
23 treatments or 21 treatments, 25 treatments
24 would be about \$8,000 ---

25 A: Okay.

1 Q: --- what you'd state for the treatments; does
2 that sound about right?

3 A: Yes, sir.

4 Q: You didn't make any differentiation at all in
5 regards to reimbursement for conventional
6 radiation treatment and IMRT, did you?

7 A: No, sir, I did not.

8 Q: Okay.

9 A: My understanding is IM would be slightly
10 higher.

11 Q: You just think IMRT is slightly higher?

12 A: Higher.

13 Q: And did you know it's like three times higher?

14 A: Okay, no.

15 Q: You did not know that?

16 A: No, not when I did this.

17 Q: All right. Did you know that -- let's turn to
18 the Grand Strand CON.

19 A: What page, sir?

20 Q: Page 599 of the Grand Strand CON, just that one
21 book, Joint Exhibit 2.

22 A: Okay.

23 Q: Did you look at the sentence under the chart
24 there. Did you realize that your expert was
25 projecting -- the paragraph under the chart,

1 there we go. Did you realize that your expert
2 was projecting that 60 percent of the
3 treatments would be IMRT?

4 A: No, I didn't include that in here.

5 Q: And that 50 percent would be IGRT, right?

6 A: Okay.

7 Q: And wouldn't you agree with me that if your
8 reimbursement number from Medicare only
9 includes conventional radiation treatment and
10 does not include IMRT treatments that you have
11 underestimated the revenue for your project?

12 A: Yes, I would agree with that.

13 Q: Okay. Let's look at Exhibit Number 72.

14 A: Which wouldn't be too late to change. It's
15 just a file. You could put it in there and
16 revise it again, as well as move in a medical
17 oncologist to year four, five, six, seven,
18 whatever. Yes, I would agree.

19 Q: Can we look at -- you would agree that it would
20 be ---

21 A: Understated.

22 Q: Understated?

23 A: Based on that fact, yes, and if that occurred,
24 it would be understated.

25 Q: All right. Exhibit 72, CRCC Exhibit 72.

1 A: Okay.

2 Q: These are the financials for the hospital?

3 A: Yes, sir.

4 Q: Correct?

5 A: Yes.

6 Q: Could you tell the Court what the net income of
7 the hospital was in 2012?

8 A: Yes, it was \$61,601,762. But I need to qualify
9 something, as long as you asked me to state
10 that. You'll notice on these income statements
11 that there's nothing shown for income taxes,
12 and that's because HCA books their income taxes
13 after this financial statement is prepared, so
14 approximately 38 percent of that would be paid
15 to income taxes here, so this, while this shows
16 61 million, it would be approximately 38
17 percent less.

18 Q: Well, income taxes are paid by HCA; they're not
19 paid by Grand Strand, right?

20 A: Well, they're paid on income earned at Grand
21 Stand, yes, sir. It's definitely very close.
22 I have worked in a hospital in HCA where they
23 do require, the state requires audited
24 financial statements and HCA does push the
25 income taxes to the hospital, so I'm sure they

1 have documents that would show how much income
2 taxes were paid under income made specifically
3 at Grand Strand.

4 Q: But that isn't on the financials, is it?

5 A: No, sir, it is not. That's why I made the
6 point.

7 Q: So the net -- the net income is 61 million.
8 What's the net revenue for the hospital?

9 A: For this same time period?

10 Q: 2012.

11 A: \$270,513,000.

12 MR. LONG: Your Honor, if I could have just a
13 moment?

14 THE COURT: One second. The 61 million was the
15 what?

16 MR. GRACE: That was the net income that he asked me
17 about.

18 THE COURT: Oh, the net income.

19 MR. GRACE: But it excludes income taxes.

20 THE COURT: Okay.

21 MR. LONG: Your Honor, that's all we have. Thank
22 you.

23 MR. THOMAS: Just got a few, Your Honor.

24 MR. GRACE - REDIRECT EXAMINATION BY MR. THOMAS:

25 Q: Mr. Grace, keep that open right to that income

1 statement if you would, Exhibit 72.

2 A: I already moved it. Ready.

3 Q: Okay. And you mentioned something about income
4 taxes.

5 A: Okay. I'm here.

6 Q: I've got a calculator for you.

7 A: Okay.

8 Q: I want you to go back to 2012.

9 THE COURT: What page are we going to be on?

10 MR. THOMAS: We're going to look at, Judge, Grand

11 Strand 2960 in Exhibit 72, Respondent's 72.

12 THE COURT: I'm in Respondent's --

13 MR. THOMAS: Bates 2960.

14 MR. GRACE: In 72.

15 THE COURT: I'm back in 72. What page?

16 MR. THOMAS: 2960, sir.

17 THE COURT: All right.

18 MR. THOMAS: All right. Are you there, Your Honor?

19 THE COURT: Yes, sir.

20 MR. THOMAS: Oh, I'm sorry.

21 Q: Mr. Grace, what's the income taxes that Grand
22 Strand paid on the 2012 -- that were paid on
23 the 2012 money that rolled up to HCA?

24 A: Approximately 38 percent.

25 Q: Okay. Well, could you do the calculation for

1 me, what's left over in terms of net income
2 after the income tax provision?

3 A: That's a nice calculator you've got here.

4 Q: It's from 1989, my first year in college.

5 A: Approximately 38.2 million.

6 Q: Okay. So that's what's left over, right? Let
7 me ask you this. In terms of -- this is for a
8 whole hospital, correct?

9 A: Yes.

10 Q: Is this for -- is this all the things, is this
11 the income and revenue from all of Grand
12 Strand's service lines and offerings? For
13 instance, would it include ED?

14 A: Yes, ED, open heart, neuro, oncology,
15 orthopedics.

16 Q: Keep going.

17 A: OB/GYN, vascular surgery, outpatient surgery,
18 outpatient labs, outpatient radiology,
19 respiratory therapy, physical therapy,
20 occupational therapy, speech therapy, all the
21 overhead costs from housekeeping, plan ops,
22 administration.

23 Q: Okay. Let me ask this. So how many service
24 lines are you aware of Grand Strand has? More
25 than 20?

1 A: A lot, 30, 40, 50. A lot.

2 Q: Okay.

3 A: I knew you were going to ask that, I would have
4 -- a lot of them.

5 Q: Okay. No, that's fine. All right. Let's see
6 here, Respondent's 118. Mr. Long asked you
7 some questions about Respondent 118, and --

8 A: Same book?

9 Q: It's in the Respondent's, so if you look for a
10 tag you'll see 118. That's what I'm going to
11 ask you to go to.

12 A: Okay. I've got two of the Respondent's books.

13 Q: It's going to be in the 80 to 129.

14 A: Here's your beautiful calculator.

15 Q: Thank you.

16 A: Don't want to break that thing.

17 Q: It's unbreakable. Tell me when you get to 118.

18 A: All right. I'm to 118.

19 Q: Okay. And just for the record, this is the
20 "what if" file that Mr. Long was asking you
21 about, correct? I'll direct your attention to
22 the footer.

23 A: I'm sorry, yes.

24 Q: Is it the "what if" file?

25 A: Yes, sir, it's the "what if" file.

1 Q: And I'd like you to go to DHEC 120. Mr. Long
2 asked you a lot of questions about the notes
3 from David Was.

4 A: I'm there.

5 Q: Okay. Let me ask you this. Do these notes
6 reflect every single thing that was said in the
7 conversation?

8 A: Absolutely not. There was a lot of discussion
9 in a very rapid pace with a lot of things said
10 and a lot of items discussed and a lot of
11 possibilities and locations and position
12 strategies and market discussions and costs.
13 There was a lot of discussion over a very short
14 period of time and intense, sometimes bantering
15 back and forth, what could be done, what
16 couldn't be done, how fierce the competition
17 was in the market, whether or not the cost of
18 the equipment was able to be negotiated better,
19 so on and so forth. It was a lot discussed in
20 these calls, and we don't have a lot of calls
21 with the group office, but when we do, we try
22 to get everything in and present our case, at
23 the local level of course we ...
24 Q: Okay. Here's the question I have. If you look
25 at the bottom where it says MM.

1 A: Yeah.

2 Q: Mike Marks.

3 A: Mike Marks.

4 Q: On that page, it says, how are we going to
5 build the volume? How many cases in the market
6 today? See that? What did you say, under RG?

7 A: Defined number of new patients is 1,008.
8 26,461 at 21 treatments per patient. Predicted
9 a growth volume of three percent, 20 percent
10 growth over five year, 6,300 treatments in year
11 one, 300 patients.

12 Q: Is there any strategy in there, in that?

13 A: No.

14 Q: About how to build the volume?

15 A: No, there isn't.

16 Q: What you told him is basically you're going to
17 double the market share, correct?

18 A: Yes.

19 Q: Robert Grace said he was going to double it?

20 A: Yeah, that's what I did.

21 Q: All right. Look right down to -- you'll see
22 JR, where it says Jerry Rooker, what's our
23 market share. What did you say?

24 A: Fifteen percent. Quoted it directly out of
25 what Dan Sullivan had presented us, and

1 informed him right there exactly what the
2 market share was, 15 percent.

3 Q: So they were aware of what Mr. Sullivan's
4 market share was?

5 A: Absolutely.

6 Q: Mike Marks asked here, are we bunting or trying
7 to hit the ball, what did you say?

8 A: I said we were going to attack with another 15
9 percent.

10 Q: Okay. How are you going to do that?

11 A: We'll get -- I didn't give him a strategy of
12 how we were going to get there.

13 Q: Okay.

14 A: I didn't have one at that point. I still
15 don't.

16 Q: Let's go down where Jamie Thomas says, read
17 what he says into the record, please.

18 A: Where it starts with, we don't control urology?

19 Q: Correct.

20 A: We don't control urology. We do general
21 surgery and neuro. We did at one time put a
22 bid in for 30 million for 21st -- which means
23 21st Century, which we lost by 15 million. In
24 this dynamic, if we enter the market, a lot of
25 discussion will follow because we provide so

1 much risk to them, them being 21st Century,
2 given that medical oncology controls 74 percent
3 of referrals. This is one of MUSC's biggest
4 markets.

5 Q: Okay. This is one of MUSC's biggest markets,
6 all right. Now, let me ask you this. He says
7 we control general and neuro, correct? Does he
8 mean the employed physicians?

9 A: Yes.

10 Q: Okay. And he says we don't control urology.
11 It also says he doesn't -- he also says --
12 what's another major group he doesn't mention
13 in terms of what Grand Strand controls? It's
14 referenced in the same paragraph.

15 A: I'm sorry. We don't control the radiation
16 oncologists.

17 Q: Do you control the medical oncologists?

18 A: No, we don't.

19 Q: Okay.

20 A: Absolutely not.

21 Q: Nowhere in there did Mr. Thomas say that, did
22 he?

23 A: No, he didn't.

24 Q: In terms of the discussion that Mr. Long had
25 with you about the payer mix, and I think that

1 he started talking about conventional versus
2 IMRT, did Mr. Long's discussion, if you're
3 incorrect and I think you said you may have not
4 included the IMRT, what does that mean in terms
5 of your revenues that are coming in on your pro
6 forma, so the judge will know?

7 A: It means that if I go back in this file and put
8 in, as he suggested, based on Mr. Sullivan's
9 analysis of the different types of radiation
10 therapy treatments that IMRT treatments are at
11 X percent, and that that particular percentage
12 should perhaps either be segregated and put in
13 a separate line at a higher rate, or at least
14 weight the overall reimbursement for radiation
15 therapy treatments at a higher rate because
16 they pay at a higher rate, and that would
17 increase our net revenues.

18 Q: Okay. So that's a pleasant surprise?

19 A: It's great. It's fantastic.

20 Q: So, again, does that also, the fact that you
21 didn't know to include that IMRT, is that a
22 symptom of the fact that this is the first time
23 you'd ever done one of these for a linear
24 accelerator?

25 A: Absolutely, and you can't know everything.

1 These things are pretty complex. There's a lot
2 to them. Sure. Absolutely. Next time I know.

3 Q: Back to 120. I'm sorry to jump back.

4 A: Okay.

5 Q: In terms of the Horry County area, Mr. Thomas
6 said this is one of MUSC's biggest markets.

7 What does that mean to you?

8 A: It means that a lot of patients that need
9 cancer treatment in Horry County go to MUSC.

10 THE COURT: Where is that that you're referring?

11 MR. THOMAS: I'm sorry, Your Honor, Exhibit 120,

12 GSRMC 2326, second page of that exhibit.

13 A: Horry County sends a lot of patients from
14 various product lines to MUSC for treatment.

15 Q: One of the things you want to do is reverse
16 that with the radiation therapy center?

17 A: Absolutely. The patients and family members
18 having to drive two hours to get treatment is
19 not optimal and worst case very, very costly to
20 them, disruptive to the family, and we can
21 present just as high a quality program if not
22 better.

23 Q: Okay.

24 MR. THOMAS: No further questions, Your Honor.

25 MR. LONG: Nothing.

1 THE COURT: All right. You may step down. Does
2 that bring us to the end for today?

3 MR. LONG: Yes.

4 MR. THOMAS: It does.

5 THE COURT: All right. We'll be back Monday at
6 9:30.

7 MR. THOMAS: Yes, sir.

8 THE COURT: All right. Y'all have a good weekend.

9 MR. THOMAS: Thank you.

10 (There being nothing further, the hearing recessed
11 for the day at 3:54 p.m.)

12 DAY 3 - MONDAY, SEPTEMBER 16, 2013:

13 MR. CARTIN: Grand Strand calls Dr. William Collins.

14 THE COURT: Oh, no, y'all, I've got to take a quick
15 break.

16 MR. CARTIN: Okay.

17 (Off the Record)

18 WILLIAM A. COLLINS, III, M.D, being duly sworn,
19 testifies as follows:

20 DR. COLLINS - DIRECT EXAMINATION BY MR. CARTIN:

21 Q: Dr. Collins, please state your full name for
22 the record.

23 A: William A. Collins, III.

24 Q: And, Dr. Collins, where do you currently live?

25 A: I live at 48 Church Street, Charleston, South

1 Carolina.

2 Q: And have you brought anybody with you today?

3 A: My wife came with me.

4 Q: Okay. And what is your profession?

5 A: I'm a radiation oncologist.

6 MR. CARTIN: Let's go ahead and bring up

7 Petitioner's Exhibit 21.

8 Q: And, Dr. Collins, do you recognize this

9 document?

10 A: Yes, I do.

11 Q: What is this document?

12 A: It's my resum,

13 Q: And did you create it?

14 A: Yes, I did.

15 Q: Is it current and accurate?

16 A: Yes, it is.

17 Q: Okay. Dr. Collins, where did you go to

18 undergraduate?

19 A: Duke University.

20 Q: And what was your -- what did you study?

21 A: Zoology.

22 Q: And where did you go to medical school?

23 A: Medical University of South Carolina.

24 Q: And did you specialize in anything while you

25 were in medical school?

1 A: I took just general medical course. I took
2 some electives in radiation oncology, among
3 other electives we were allowed to take our
4 fourth year.

5 Q: And when you graduated from medical school,
6 what did you do?

7 A: I did an internship in internal medicine
8 followed by a residency in radiation oncology.

9 Q: Where did you do your residency?

10 A: At the Medical University of South Carolina.

11 Q: And describe for me what types of things you
12 did during your residency.

13 A: During residency, we treated patients under the
14 direction of an attending, essentially all
15 types of cancer patients to get a general
16 education in radiation oncology. We would, you
17 know, see patients, evaluate them, examine
18 them, decide if they should have treatment, and
19 if so, we would plan out treatment and then
20 care for them during the course of treatment.

21 Q: And were you involved in conducting any
22 research?

23 A: Yes, I was.

24 Q: What type of research?

25 A: I did research in stereotactic radiosurgery,

1 treating brain tumors with high dose focused
2 radiation.

3 Q: And let me ask you ---

4 A: I mean ---

5 Q: --- what does it mean to be board certified?

6 A: To be board certified means you have to
7 complete your residency in radiation oncology,
8 and then you have to take both an oral
9 examination followed by a written examination.

10 Q: And are you board certified?

11 A: Yes, I am.

12 Q: Okay. What's the name of the board that
13 certifies you?

14 A: It's the American Board of Radiology.

15 Q: Okay.

16 A: I actually have a time limited certificate,
17 which means I have to be re-certified every ten
18 years.

19 Q: And when's the next time you have to be re-
20 certified?

21 A: 2016.

22 Q: Okay. Are you required to take any kind of
23 continuing education classes?

24 A: Yes.

25 Q: And what kind of classes do you generally take?

1 A: Well, I take all types of continuing medical
2 education classes. Most of them involve, you
3 know, radiation oncology and different sub-
4 specialties in that field. For the purposes of
5 maintenance of certification, a certain number
6 of those have to be what they call self-
7 assessment continuing medical education
8 requirements, which means I have to read an
9 article, view a lecture online, something like
10 that, but I have to pass a test on it
11 afterwards.

12 Q: What's the last class that you took, just as an
13 example of the kind of things that you've
14 studied in your continuing education?

15 A: I took -- recently I've taken classes on both
16 lung cancer and prostate cancer treatments.

17 Q: Now, Dr. Collins, when you finished your
18 residency, where was the first place you went
19 to work as a physician?

20 A: I worked in Bradenton, Florida.

21 Q: And can you describe what type of facility it
22 was and the kind of things that you did there?

23 A: Yes, that was a freestanding radiation therapy
24 facility. It was about a block from the county
25 hospital in Manatee County, that was Manatee

1 Memorial Hospital, and it was a general
2 radiation oncology practice.

3 Q: And when you were done there, where was the
4 next place that you were employed?

5 A: I was then employed at Myrtle Beach Radiation
6 Therapy Center, which is now called the
7 Carolinas Regional Cancer Center.

8 Q: And who did you work with while you were there?

9 A: I worked with Dr. Steve Bass.

10 Q: And what was Dr. Bass's relationship to CRCC?

11 A: He was the owner.

12 Q: And you treated patients while you were there?

13 A: Oh, yes.

14 Q: Okay. And what other types of activities did
15 you do?

16 A: I was on the cancer committee at Grand Strand
17 Hospital, you know, in support of their cancer
18 program.

19 Q: And where was the next place you were employed?

20 A: Where I am currently employed at Radiation
21 Oncology Associates of Charleston. We are a
22 private practice, and we contract with Trident
23 Regional Medical Center to provide radiation
24 oncology services.

25 Q: And are you an owner of that practice?

1 A: Yes, part owner.

2 Q: Who are your other partners?

3 A: Dr. Margaret MacDowell is -- she's another part
4 owner, co-owner of the practice. We also have
5 -- just took on another associate, Dr. Todd
6 Williams ---

7 Q: Where was Dr. Williams ---

8 A: --- a year and a half ago.

9 Q: Where was Dr. Williams previously employed?

10 A: At Carolinas Regional Cancer Center, Myrtle
11 Beach.

12 Q: Do you have any idea what the bed count at
13 Trident Medical Center is?

14 A: Don't know exactly. It's about 250.

15 Q: Is Trident a tertiary care hospital?

16 A: Yes.

17 Q: Can you explain for the judge what tertiary
18 care is?

19 A: Tertiary care just means it's a major hospital
20 that provides all types of services where
21 patients may be referred to from smaller
22 outlying hospitals if they need more advanced
23 services.

24 Q: Okay. So in all, how long have you been a
25 radiation oncologist?

1 A: I started my residency in 1992, so 19 years.

2 MR. CARTIN: Your Honor, at this time based on the
3 witness's education, knowledge, training, and
4 experience, I'd ask the Court qualify Dr.
5 Collins as an expert in radiation oncology.

6 MR. MULLINS: Your Honor, no objection with regards
7 to the qualifications as a ---

8 THE COURT: Radiation oncologist.

9 MR. MULLINS: --- an expert on the practice of
10 radiation oncology, if that's the umbrella
11 under which he's going to testify.

12 THE COURT: All right. Well, he's so qualified.

13 Q: Can you explain for the Court, Dr. Collins,
14 what radiation therapy is?

15 A: Yes, radiation therapy is one of the three
16 major modalities used to treat cancer, along
17 with the other two being surgery and general
18 systemic chemotherapy-type treatments, which
19 are delivered by a medical oncologist. There
20 are different surgical specialties involved in
21 the treatment of cancer. There's medical
22 oncology that delivers chemotherapy and other
23 types of systemic treatments, and then there's
24 radiation therapy, which is a local treatment
25 as opposed to chemotherapy. Radiation doesn't

1 -- it's not a systemic treatment where it
2 treats your whole body. It treats a focal area
3 where we aim the radiation at a tumor or at a
4 place where you're having concern the tumor may
5 recur. So it's a local treatment, but it's
6 non-surgical.

7 Q: And what percentage of cancer patients will at
8 some point during their experience with cancer
9 undergo radiation therapy?

10 A: At least half will at some point, 50 to 60
11 percent of patients.

12 Q: And will radiation therapy usually be used in
13 combination with other types of treatment, like
14 you mentioned earlier?

15 A: Yes, frequently -- more frequently over the
16 past years it's been used in combination with
17 chemotherapy. Chemotherapy will sensitize a
18 tumor to the radiation and help the radiation
19 work. And it's also used either before or
20 after surgery to make the surgery -- to
21 facilitate the surgery by shrinking the tumor,
22 making the surgery less extensive, or after
23 surgery to reduce the risk that the cancer
24 could recur.

25 Q: Now you mentioned chemotherapy, surgery, and

1 radiation therapy. What types of settings are
2 those three typically provided in?

3 A: Surgery is usually performed in a hospital
4 obviously. Chemotherapy can be given as an
5 outpatient -- in an outpatient infusion center
6 or as an inpatient infusion center in a
7 hospital either as a -- if the person's an
8 inpatient in the hospital or is coming as an
9 outpatient to an infusion center that's
10 hospital based. Radiation therapy can be
11 delivered in a hospital-based department where
12 patients can come for outpatient treatment or
13 inpatients can come and be treated in an
14 inpatient radiation therapy department or a
15 hospital-based radiation therapy department.
16 Radiation center can also be a freestanding
17 center separate from the hospital.

18 Q: And what other types of physicians are
19 generally involved in providing cancer care to
20 patients?

21 A: Well, besides surgeons ---

22 Q: Besides radiation oncologists.

23 A: Besides radiation oncologists, there's medical
24 oncologists that give chemotherapy; there's
25 surgeons, and there are different surgical

1 specialties, such as general surgeons that
2 treat breast cancer, urologists that treat
3 prostate cancer, neurosurgeons that treat
4 tumors of the brain.

5 Q: And with regard to performing radiation
6 therapy, can you explain for the Court what
7 types of equipment are involved in providing
8 that treatment?

9 A: Yes, radiation therapy, in general, is usually
10 delivered by what's called a linear
11 accelerator. Basically, that's a big x-ray
12 machine that delivers high energy x-rays that
13 penetrate better than diagnostic x-rays.
14 Diagnostic x-rays make better pictures or lower
15 energy. Radiation therapy machines put out
16 higher energy radiation that's good at
17 penetrating to reach a tumor. And they can
18 rotate 360 degrees around the patient to treat
19 from any angle. Usually takes about 15 minutes
20 to give the radiation treatment. In addition,
21 for radiation planning is usually done from a
22 specialized CT scan; it's called a CT
23 simulator. It's where you kind of enter the
24 coordinates of the patient's body, the tumor,
25 the nearby vital structures that you want to

1 avoid. And that's all entered into a planning
2 system, and the treatment is planned out before
3 treatment's started.

4 Q: How many treatments will say -- let me ask you
5 this. What different types of cancer do you
6 treat?

7 A: We treat all different types of cancer, mostly
8 solid tumors as opposed to leukemias, say,
9 which are mostly treated with chemotherapy.
10 But with radiation, we treat pretty much any
11 type of solid malignancy.

12 Q: What are some of the most common types of
13 cancer that you see?

14 A: Breast cancer, prostate cancer, lung cancer.
15 We treat a lot of metastatic cancer, which is
16 cancer that has spread from its primary site.
17 And that's usually a palliative type treatment
18 where we're trying to provide pain relief or
19 relieve some type of problem the tumor's
20 causing as opposed to a curative type
21 treatment. But curative cancers that we treat
22 often are breast cancer, prostate cancer, lung
23 cancer, throat cancer, tumors of the brain,
24 tumors of the GI tract, kidney cancers.

25 Q: And with regard to those different types of

1 cancer, does each different type require a
2 different number of treatments, radiation
3 therapy treatments?

4 A: Yes, in general, depending on the type of
5 cancer, the stage it is, the size of the tumor,
6 the numbers of treatments can vary.

7 Q: So, for example, take prostate, how many
8 treatments might on a national average a
9 prostate cancer receive from radiation therapy?

10 A: Prostate cancer we've done dose escalation
11 studies with the newer treatment techniques,
12 newer imaging techniques, better targeting
13 techniques. We've been able to go to higher
14 doses with prostate cancer than previously.
15 And so we now treat prostate cancer with an
16 average of 40 to 45 treatments for an average
17 course.

18 Q: How about brain cancer?

19 A: About 30 treatments, six weeks, 30 treatments.

20 Q: And bladder cancer?

21 A: Bladder cancer is about 30 treatments also, 30
22 to 35.

23 Q: How about gynecologic cancer?

24 A: Gyn malignancies we usually treat five weeks,
25 and then do what we call a brachytherapy boost

1 where you load brachytherapy sources, you load
2 radioactive sources around the tumor itself to
3 give a higher dose, to give a boost. You don't
4 do that boost then you're still looking at, you
5 know, five and a half to six weeks of
6 treatment.

7 Q: How about lung cancer?

8 A: Lung cancers, in general, go from 33 to 35
9 treatments is what you try to treat a lung
10 cancer to, if you can, while respecting the
11 tolerance of the normal structures around it.

12 Q: And how many treatments for lymphoma?

13 A: Lymphomas are more sensitive than most other
14 types of solid tumors, so we can usually get by
15 with a little lower dose to a lymphoma. The
16 average is probably around 20 treatments.

17 Q: And you mentioned metastatic cancer, how many
18 for that?

19 A: With metastatic cancers we're not trying to
20 cure or completely eradicate the cancer, we're
21 just trying to alleviate pain or some problem
22 the tumor's causing. We go to a lower dose,
23 lower number of fractions to try to minimize
24 it, also inconvenience on the patient, and it's
25 usually in the range of 10 to 15 treatments.

1 Q: And how many treatments for skin cancer?

2 A: Skin cancer can vary depending on the size of
3 the lesion, where it is, if it's near a
4 sensitive structure or not. Skin cancers can
5 be treated from anywhere from 15 treatments up
6 to 30 treatments.

7 Q: And breast cancer?

8 A: Breast cancers are usually treated for about
9 six weeks or 30 treatments.

10 Q: Head and neck cancer?

11 A: Head and neck cancers we try to go to seven
12 gray, which is seven weeks of treatment.

13 Q: And gastrointestinal, how much?

14 A: Gastrointestinal can vary. A gastric cancer
15 you usually treat postoperatively for a five
16 week treatment course. Say a rectal cancer,
17 you treat usually preoperatively for five and
18 a half weeks.

19 Q: Do you ever treat inpatients?

20 A: Yes.

21 Q: And how many treatments does the typical
22 inpatient receive?

23 A: Well, that depends. I mean, that just varies
24 depending on what we're trying to accomplish,
25 you know, whether it's a definitive case, a

1 palliative case. But an inpatient can -- it
2 just depends on how long they're in the
3 hospital for basically, because you can come as
4 an outpatient or an inpatient. It just depends
5 on how long they're in the hospital for.

6 Q: Would two to four be a fair range?

7 A: Two to four treatments for an inpatient? Yes,
8 I mean, you know, they're usually in the
9 hospital maybe a week, which would be five
10 treatments, maybe a little less. You know, we
11 try to get patients out of the hospital as soon
12 as we can these days. So yeah, I think that's
13 a fair answer.

14 Q: What other types of medical professional do you
15 work with in providing radiation therapy?

16 A: We work with nurses. We work with physicists,
17 closely with the physicists who calibrate the
18 machines; they do all types of double checks on
19 the dose that the machine's putting out, make
20 sure it's putting out the dose that we've
21 prescribed, make sure the machines are in
22 working order. We work with dosimetrists.
23 They actually run treatment planning computers
24 and help us plan out our treatments. And we
25 work with radiation therapists who actually run

1 the treatment machines, set the patients up,
2 take alignment imagining, make sure the
3 patient's lined up before they actually give
4 the treatment.

5 Q: And as a radiation oncologist, do you supervise
6 all of those different professionals?

7 A: Yes.

8 Q: And do you have a practice administrator?

9 A: We have a director of the department that is an
10 administrative hospital employee actually.

11 Q: Is it your understanding that around the
12 country other radiation therapy centers have
13 similar staffing?

14 A: Yes.

15 Q: And you rely on these -- and do you rely on
16 these individuals to provide your treatments?

17 A: Yes.

18 Q: Let's talk a little bit about inpatient
19 radiation therapy. Can you describe for me
20 what benefits, if any, there are for having an
21 inpatient radiation therapy program?

22 A: Yes, I think one of the main benefits -- well,
23 there are several, but one of the main benefits
24 is that if a patient requires to be in a
25 hospital, they require acute hospital care but

1 need radiation therapy at the same time, then
2 they can be treated without having to be
3 transported out of the hospital to a
4 freestanding facility. So that's the
5 convenience aspect for the patient. They don't
6 have to be transferred to an ambulance, driven
7 down the road, transferred back out from the
8 ambulance into a radiation therapy center.
9 It's a comfort issue. When we treat an
10 inpatient they're transported on a hospital
11 transport gurney, which is cushioned, wider,
12 and more cushioned than an ambulance gurney.
13 They don't have to be seatbelted in if they
14 went for an ambulance ride. I think there's a
15 safety issue involved. Patient's sick enough
16 to be in a hospital, you're always taking a
17 little risk when you take them out of that
18 hospital environment. I think there's a cost
19 issue involved too. Ambulance transport is
20 expensive. I don't know how much, but I know
21 it does add cost to the overall treatment. Our
22 cancer patients -- a lot of cancer patients,
23 especially nowadays that we're using combined
24 therapy, chemotherapy and radiation, a lot of
25 times they will become ill, their blood counts

1 can drop, and they'll wind up requiring
2 hospital admission. And with having a
3 radiation machine in the hospital, that doesn't
4 cause an interruption in their treatment.

5 Radiation -- it's been well documented that
6 radiation therapy loses its effectiveness if
7 the course is interrupted. It's more effective
8 if it's given all in one uninterrupted course.

9 Q: Are there any types of patients that can only
10 receive radiation therapy in an inpatient
11 setting?

12 A: Yes, a patient in the intensive care unit on a
13 ventilator ---

14 Q: Do you have any examples from your experience?

15 A: --- cannot be transported out of the hospital
16 because they require a big team of ancillary
17 care professionals just to transport the
18 patient out of the intensive care unit. For
19 instance, I had a patient recently who was in
20 his 50s with a -- which is kind of on the young
21 side for a lung cancer patient. He was
22 otherwise healthy, but he had a big large lung
23 cancer that was obstructing his airway and
24 knocked him over into respiratory failure
25 requiring mechanical ventilation on a

1 ventilator. And the pulmonary doctors were
2 unable to wean him off the ventilator. And so
3 kind of as a last resort, they asked us to
4 treat him while he's on the ventilator in order
5 to try to shrink his tumor enough that he could
6 be taken off the ventilator. So we transported
7 this man from the intensive care unit down to
8 our department, which is on the same floor of
9 the hospital right down the hallway. We
10 treated him, and he was able to be weaned off
11 the ventilator after shrinking his tumor from
12 the radiation. He then went on to receive a
13 full course of radiation therapy once he was
14 discharged from the hospital and was able to be
15 treated as an outpatient and went on to -- had
16 a good response, went on to have surgery, had
17 his cancer removed, and is currently doing
18 well; whereas, if he was not able to have the
19 treatment, I think there's a good likelihood he
20 would never have come off that ventilator and
21 never been able to talk to his family again.

22 Q: Can you describe how your cancer center is set
23 up at Trident?

24 A: We have two linear accelerators, those are the
25 radiation therapy treatment machines. We have

1 a CT simulator. We have exam rooms where
2 there's our nursing desks and exam rooms. All
3 of this is off of the waiting room, of course.
4 We are on the first floor of the hospital.
5 Down at the end of our hallway past our exam
6 rooms, we have an infusion center where
7 patients come as outpatients to have
8 chemotherapy and blood products, for instance.

9 Q: And before I move on, what percentage of your
10 patients are inpatients?

11 A: We've looked at for the first six months of
12 this year, we had 4.5 percent of our patients
13 treated were inpatients.

14 Q: Does that seem typical to you for other years?

15 A: Yes. Yes, if I had to guess I was guessing
16 probably around five percent. And so we
17 actually ran the numbers and it came out to
18 right about 4.5 percent. Now that was when
19 they started treatment. That does not include
20 patients who had started treatment as an
21 outpatient, but then became sick and had to be
22 admitted and then we could continue their
23 treatments on. So I don't have any way to
24 actually pull that data, but that I think would
25 add another percentage point or two to that

1 total.

2 Q: Now, Dr. Collins, you said you've worked in
3 both a freestanding clinic that provides
4 radiation therapy as well as a hospital. In
5 your experience, have you found that when you
6 have a hospital-based linear accelerator you
7 perform more treatments on inpatients?

8 A: Yes. Yes, I have definitely noticed that.
9 Where I worked in Florida, we were very close
10 to the hospital. We were one block from the
11 hospital, but it still requires the same
12 production to transport a patient. An
13 inpatient in the hospital requires a medical
14 transport to leave that hospital even if it's
15 -- they're going a block away. So they have to
16 have an ambulance transport take them there.
17 So -- and where I worked at Myrtle Beach it was
18 a little further from the hospital, but still
19 required the same ambulance transport if you
20 were going to treat someone who was an
21 inpatient. Where I work at Trident, as soon as
22 I got there I noticed that we -- the number of
23 inpatients we treat at Trident is significantly
24 higher percentage than -- than at either one of
25 the freestanding centers I've worked at. And

1 our new associate, Todd Williams, who came from
2 Carolinas Regional Cancer Center; maybe he'd
3 worked there -- I think he's been with us a
4 year and a half, he has commented ---

5 MR. MULLINS: Objection, Your Honor.

6 A: -- how the --

7 MR. CARTIN: Your Honor, he's an expert.

8 THE COURT: Yeah, he's an expert who can give an
9 opinion, but unless the statement by the other
10 individual, and you has lay the groundwork, is
11 one that he relies on in reaching an opinion,
12 then that cannot be offered. It's a hearsay
13 statement.

14 MR. CARTIN: Well, I think it's his opinion that
15 when you have ---

16 THE COURT: He said Todd Williams?

17 DR. COLLINS: Todd Williams, right.

18 MR. MULLINS: And Your Honor, I want to be careful
19 about, you know, Mr. Cartin laying out the --
20 what the intent is here. There was never any
21 indication that there was information relied on
22 by anyone in issuing an opinion during his
23 deposition, so we just think this is a backdoor
24 way of presenting hearsay testimony.

25 THE COURT: Well, I'm not going to deny it because

1 of that. If he can lay the groundwork, I'll
2 let him go with it. At this point in time, I
3 sustain your objection.

4 A: I was just saying, yes, I have noticed that we
5 treat more inpatients at the inpatient-based
6 facility I'm working at now than at the
7 freestanding centers I've worked at previously.
8 And I'm not the only one who's noticed that.

9 Q: Okay. What does IMRT stand for?

10 A: Intensity modulated radiation therapy.

11 Q: And can you explain for the Court what that
12 means?

13 A: Yes, intensity modulated radiation therapy is
14 kind of one of the newest ways to both plan and
15 deliver radiation treatment. It's computer
16 planned. And after we do the planning CT scan,
17 we outline the tumor, the target we want to
18 treat, we outline the nearby normal tissues we
19 want to spare, and we tell the planning system
20 that we want to give a treatment dose to this
21 target, we want to minimize the dose to these
22 surrounding organs, and the computer generates
23 a plan of how to deliver that treatment. And
24 then the treatment machines -- it's called
25 intensity modulated, because the treatment --

1 the machine can rotate around the patient while
2 it's treating, it can vary the intensity of the
3 radiation as it's rotating around, it can vary
4 the shape of the beam as it's rotating around
5 in order to accomplish that planned goal. And
6 it's -- the end result is we can shape the
7 radiation dose a lot better than we used to.
8 We can actually make concave radiation
9 distributions wrapping around critical organs,
10 such as the spinal cord.

11 Q: What types of cancer are commonly treated with
12 IMRT?

13 A: There -- different types are. One of the most
14 common is prostate cancer is treated with IMRT.
15 Certain pelvic cancers where we can treat nodal
16 structures and spare the surrounding bowel.
17 Lung cancers.

18 Q: What's considered the standard of care for
19 prostate treatment?

20 A: Standard of care for, if you're using radiation
21 is IMRT.

22 Q: Are you familiar with the phrase "comprehensive
23 cancer program"?

24 A: Yes.

25 Q: What does that mean?

1 A: A comprehensive cancer program is a cancer
2 treatment facility or complex that has all the
3 major specialties involved in treating cancer
4 available.

5 Q: And what type of physical plant would you
6 expect to see with regard to a comprehensive
7 cancer program?

8 A: Well, ideally, it would -- you would have all
9 those specialties under one roof.

10 Q: And what types of doctors are required for A
11 comprehensive cancer program?

12 A: Well, there's medical oncologists, radiation
13 oncologists, surgical oncologists, diagnostic
14 radiologists, and pathologists.

15 Q: And what types of equipment are required to
16 establish a comprehensive cancer program?

17 A: You need radiation therapy equipment that we
18 discussed earlier, a linear accelerator and a
19 treatment planning machine, usually a CT-based
20 simulator, treatment planning software
21 equipment.

22 Q: What is interdisciplinary care?

23 A: Interdisciplinary care is cancer care that
24 requires multiple cancer specialists to be
25 involved in the care of a patient.

1 Q: And can you give us an example of the benefits
2 that comprehensive cancer care -- or excuse me,
3 that interdisciplinary care provides to a
4 patient?

5 A: Well, more and more patients are being treated
6 with multi-modality treatments. In other
7 words, with combination of chemotherapy and
8 radiation and possibly surgery. So if you have
9 all those specialists together, the patient
10 benefits from not just having access to that
11 care, but also having interaction between the
12 doctors who are caring for the patient so they
13 can discuss the nuances of the case, certain
14 complicating factors that, you know, would
15 require input from more than one specialty.

16 Q: Does having a comprehensive cancer program
17 promote interdisciplinary care?

18 A: Yes.

19 Q: And can you give me, again, an example of maybe
20 from your experience as a radiation oncologist
21 where that's occurred?

22 A: There's -- I can give a lot of examples.
23 There's -- you know, if I'm treating a patient
24 and he's having chemotherapy as part of his
25 treatment, and he's having a problem, a medical

1 problem, radiation oncologist for example, we
2 don't admit patients to the hospital, he might
3 be having a problem related to his blood
4 counts, and I can discuss that with his medical
5 oncologist who can then decide if he needs to
6 be admitted to the hospital or just have some
7 fluid, hydration, resuscitation that way.

8 Another example is, especially pertaining to
9 radiation therapy since we are a localized
10 treatment as opposed to systemic chemotherapy,
11 a large part of what we do with our treatment
12 planning is based on diagnostic imaging. We
13 rely on diagnostic CT scans, MRIs, those type
14 of studies to know where to treat, to know
15 where that tumor is and where to target. And
16 if there's any question, you know, I'm not a --
17 I'm not a trained diagnostic radiologist, but
18 we look at scans all the time, and we're
19 reading the radiologists report. And a lot of
20 times there's something in there that's not
21 clear to me and I don't understand exactly --
22 it may be talking about the extent of this
23 tumor, a lymph node that may look enlarged or
24 suspicious nearby, and I may have trouble
25 seeing where that is, I can walk across the

1 hallway and -- to radiology, diagnostic
2 radiology and have the radiologist pull it up
3 on their computer screen and point out
4 information to me. I can't tell you how many
5 times I've been shown things by a diagnostic
6 radiologist that helped me immensely in
7 planning the patient's treatment.

8 Q: And because of that, is your care more
9 effective?

10 A: Definitely.

11 Q: Could you explain for the Court what a tumor
12 board is?

13 A: Yes, a tumor board or cancer conference is a
14 meeting of all the specialties involved in
15 cancer care where we discuss difficult cases.
16 Or any of us can bring a case to the cancer
17 conference that's put on the schedule, and the
18 doctor who brings the case will give a history,
19 then the diagnostic radiologist will usually
20 show on a slide projector, will show the
21 important scans, point out important findings
22 on the scans. The pathologist will then show
23 microscopic photographs of the biopsies,
24 explain in detail what type of tumor this is.
25 And then we can all discuss what are the

1 treatment options and what are the best
2 approaches for that case.

3 Q: And is it vital for radiation oncologists to
4 participate in tumor boards?

5 A: Yes.

6 Q: Is that a -- is participation in tumor boards
7 an important part of providing comprehensive
8 cancer care?

9 A: Yes, absolutely.

10 Q: In preparing for your testimony, were you able
11 to review portions of Grand Strand's CON
12 application?

13 A: Yes.

14 Q: What portions did you review?

15 A: I reviewed the portions explaining what Grand
16 Strand had proposed as far as developing a
17 comprehensive cancer program, is mainly what I
18 ---

19 Q: Were you able to review the linear accelerator
20 quote?

21 A: Yes.

22 Q: With regard to Grand Strand's statements about
23 its intent to build a comprehensive cancer
24 program, do you have an opinion as to whether
25 Grand Strand is seeking to establish a

1 comprehensive cancer program?

2 A: There's no question that's what they're seeking
3 to establish, yes.

4 Q: When a hospital such as Grand Strand or Trident
5 endeavors to create a comprehensive cancer
6 program what affect, if any, does that have on
7 the recruitment of specialists and sub-
8 specialists?

9 A: I think it's -- it's invaluable. I think
10 almost any prospective physician that you're
11 trying to recruit would want to and expect to
12 have a comprehensive cancer program to be part
13 of.

14 Q: Is that something that helps bring kind of the
15 highest quality doctors in the country to a
16 particular area?

17 A: Yes.

18 Q: Let me change gears a little bit. What parent
19 corporate entity is Trident affiliated with?

20 A: HCA.

21 Q: By Trident, I mean Trident Medical Center.

22 A: Yeah.

23 Q: How long has Trident been affiliated with HCA?

24 A: As long as I can remember. Longer than I have
25 been there.

1 Q: Okay. Does HCA make available to Trident
2 certain resources with regard to radiation
3 oncology?

4 A: Oh, yes. Yes.

5 Q: What are those resources that they provide to
6 your practice?

7 A: Well, they provide the equipment, they provide
8 the staffing, and they also provide some help
9 with recruiting physicians. They've been very
10 helpful as far as helping us keep up with the
11 latest technology. Radiation therapy equipment
12 is expensive ---

13 MR. MULLINS: Your Honor, I was going to let that --
14 I'm going to object. I don't think what HCA
15 does with Trident has any relevance to the case
16 that's before you, so.

17 MR. CARTIN: Your Honor, HCA owns Grand Strand as
18 well.

19 THE COURT: I recognize that.

20 MR. CARTIN: They have a centralized cancer --
21 radiation oncology program called the Sarah
22 Cannon Center in Nashville and ---

23 THE COURT: We haven't got there yet. Are you
24 intending to go there?

25 MR. CARTIN: No, no, I was not. I was actually

1 going to stop right there and move on to
2 something else.

3 THE COURT: Well, then if you're stopping I'll tell
4 you at this point in time you're objecting to
5 going forward or when we got right ---

6 MR. MULLINS: Your Honor, I was going to let it go
7 too, but he kept continuing, so that's why I
8 objected. If we're stopping then I will ---

9 THE COURT: That's what I figured. Okay.

10 Q: What is your understanding of the linear
11 accelerator Grand Strand applied to place in
12 its cancer program?

13 A: The quote I looked at was for a Varian Clinac
14 iX, which is a very good linear accelerator.
15 It's a good all around what we call workhorse
16 machine. It's very reliable, very dependable,
17 and it can perform most -- it can perform all
18 conventional cancer treatments.

19 Q: What are some of the features of that machine?

20 A: Some of the features?

21 Q: Uh-huh (affirmative response).

22 A: Well, it has -- we talked about intensity
23 modulated radiation therapy, it has that
24 capability. It also has image guided, what
25 they call IGRT, image guided radiation therapy,

1 which is a way to image -- take images of the
2 tumor while the patient's on the table to
3 assure proper alignment before each treatment.

4 Q: And is the Clinac iX a widely-used machine in
5 your industry?

6 A: Yes.

7 Q: And is the Clinac iX, is it able to provide
8 treatment to vast majority of cancer cases?

9 A: Yes.

10 Q: Are there certain cases that the Clinic iX
11 cannot provide treatment to?

12 A: It can -- it can provide most treatments.
13 There are certain machines that might be more
14 suitable for highly specialized treatments, but
15 -- such as stereotactic radiation therapy,
16 stereotactic radiosurgery, but the Clinac iX is
17 used quite commonly to delivery those types of
18 treatments.

19 Q: Would that be a small number of treatments in
20 the overall spectrum of things?

21 A: Yes, that's a small percentage.

22 Q: In your opinion, could Grand Strand establish
23 a high quality radiation therapy program using
24 the Clinac iX?

25 A: Yes.

1 Q: Are you familiar with the Varian TrueBeam?

2 A: Yes, a little bit.

3 Q: Okay.

4 A: Yeah, I -- I've never used one, I haven't
5 worked with one, but you know, I've gone to
6 seminars where they've talked about the
7 features of the machine.

8 Q: Can you explain some of the advantages of the
9 Varian TrueBeam?

10 A: The Varian TrueBeam can treat at a higher dose
11 rate than any other machine on the market,
12 basically, which means it can put out radiation
13 at a faster rate. So for certain treatments,
14 such as stereotactic-type treatments, the
15 patient would be on the table less time, which
16 is always good, especially when you're
17 delivering a high dose of treatment. For
18 standard conventional treatments, it's not any
19 difference that I know of. It's a newer
20 platform for -- it's Varian's newer platform.
21 It's an all digital machine. So that ...

22 Q: Based on your experience, could you establish
23 a high quality radiation therapy program with
24 either the Clinac iX or the TrueBeam?

25 A: Yes.

1 Q: How often do linear accelerators actually break
2 down?

3 A: Very seldom. Very seldom.

4 Q: When they do, could you describe what the
5 service response is like?

6 A: Very good. Varian and the other makers
7 understand the importance of not interrupting a
8 patient's cancer treatment, so they come right
9 away. If you have a problem with a machine,
10 they come right away and usually fix it the
11 same day. If not, they will stay there
12 overnight until it's fixed. You've got very
13 little down time.

14 Q: Has it been your experience that you have
15 Varian reps, Varian maintenance personnel that
16 are on campus around your linear accelerator
17 and available on a frequent basis?

18 A: Yes, I mean, they're not -- they don't stay
19 there on the hospital campus, but they get
20 there very quickly.

21 Q: But the service contracts are such that, is it
22 fair to say that there's limited down time when
23 linear accelerators break down?

24 A: Yes, there's limited -- very limited downtime.
25 I think Varian has over 99 percent uptime.

1 Q: In your opinion, are there any quality of care
2 issues with having a single linear accelerator
3 program?

4 A: Quality of care issues?

5 Q: Any problems with having a single linear
6 accelerator program?

7 A: If the machine does go down, it would be
8 advantageous if you had another machine that
9 you could maybe switch patients over. You can
10 only do that if they were identical machines or
11 what they call beam-matched machines. But, you
12 know, very few -- very few radiation therapy
13 departments start out with more than one
14 machine; you usually always start with one
15 machine.

16 Q: So it's common in the industry to begin that
17 way; is that fair to say?

18 A: Yes.

19 MR. CARTIN: We're going to beg the court's
20 indulgence for just one moment.

21 Q: One last question then Mr. Mullins will have
22 some questions for you. Are you employed by
23 Trident Medical Center?

24 A: No.

25 MR. CARTIN: Thank you, Dr. Collins.

1 THE COURT: Wait a minute. Okay, proceed.

2 MR. MULLINS: We're getting our computer hooked up,
3 Your Honor.

4 THE COURT: Well, while we wait, so if a department
5 had a Clinac iX and then later obtained a
6 TrueBeam, would those be beam-matched or would
7 you have to -- in other words, could a patient
8 go from one to the other?

9 DR. COLLINS: Yes. Yes. You would specify to
10 Varian, the vendor, that you wanted the
11 TrueBeam to be matched to the iX and they would
12 do that.

13 THE COURT: Oh, okay.

14 DR. COLLINS - CROSS-EXAMINATION BY MR. MULLINS:

15 Q: Good morning, Dr. Collins.

16 A: Morning.

17 Q: You and I talked, I guess, a little over a
18 month ago in your deposition; do you recall
19 that?

20 A: Yes.

21 Q: And at that time, you didn't really know much
22 about the case that's before this Court, did
23 you?

24 A: That's correct.

25 Q: And I believe you testified that you weren't

1 even aware of its existence until the attorneys
2 had called you and asked you to testify about
3 six weeks before that?

4 A: That's right.

5 Q: And you talked a little bit about in direct and
6 we discussed your understanding that you were
7 going to be asked to testify about the benefits
8 of an inpatient radiation therapy department
9 based in a hospital versus a freestanding
10 center, correct?

11 A: Yes.

12 Q: And then, essentially, what we talked about in
13 your deposition, you hadn't really done
14 anything until a couple of weeks before the
15 deposition and you presented some -- a couple
16 pages of notes at the deposition, correct?

17 A: Yes.

18 Q: And those notes dealt with the benefits
19 relating to an inpatient in the hospital
20 receiving treatment at a radiation therapy
21 program within a hospital, correct?

22 A: Right.

23 Q: And I think Mr. Cartin had asked you in terms
24 of specifically related to this case that you
25 had reviewed the Grand Strand application. I

1 think you said that you had skimmed it looking
2 for references to the comprehensive cancer
3 program that Grand Strand intended to propose,
4 correct?

5 A: Yes.

6 Q: And other than a reference in the application
7 that it intended to propose a comprehensive
8 cancer center, there's really not much more
9 that you know about what Grand Strand intends
10 to do; is that correct?

11 A: Right. Yes.

12 Q: You also said that, and we'll look at it in a
13 second, you did look at both of the quotes, the
14 equipment quote for Grand Strand, the equipment
15 quote for CRCC, correct?

16 A: Yeah.

17 Q: All right. We've got -- let's pull up CRCC
18 Exhibit 86. I don't know what you've got in
19 front of you there. I think that's Grand
20 Strand. Flip to 86. Actually, go all the way
21 to the text at the bottom. You can -- on the
22 screen you might have better success looking at
23 the actual email.

24 MR. CARTIN: Objection, Your Honor. This witness is
25 not anywhere on this email.

1 MR. MULLINS: I think the exhibit is already in
2 evidence. I'm just going to ask a few quick
3 questions.

4 THE COURT: It's already in.

5 MR. MULLINS: It's already in evidence.

6 MR. CARTIN: It's already in evidence?

7 MR. MULLINS: Yeah.

8 THE COURT: It's in.

9 MR. CARTIN: Okay. I'll withdrawal.

10 Q: If you look at the bottom of that page, there's
11 an email to -- and you can flip over and glance
12 at the next page -- there's an email from Trent
13 Mullis to Frankie Knight; you see that?

14 A: Uh-huh (affirmative response). On the next
15 page?

16 Q: Right. See that?

17 A: Yes.

18 Q: All right. Who is Trent Mullis?

19 A: He was the director of our department at
20 Trident, radiation therapy department at
21 Trident.

22 Q: Okay. And he was the operations guy for your
23 -- the radiation department at Trident?

24 A: Yeah. They call him the director, which is an
25 administrative position. They, you know, work

1 for the hospital and they're kind of, I would
2 say, kind of go-between between our department
3 and the hospital administration.

4 Q: Okay. And he was that -- he was the director
5 at this time. Is he the director now?

6 A: No, he's not.

7 Q: All right. And do you know who -- he is
8 communicating with Frankie Knight; do you know
9 who that is?

10 A: No.

11 Q: All right. And if you look above there's some
12 -- the top email it looks like Trent and
13 Frankie, Mr. Mullis and Frankie Knight have had
14 some communication, and then Frankie Knight is
15 communicating with a Robert Grace and a David
16 Was and an Adam Rudd; do you see that at the
17 top?

18 A: In the to?

19 Q: Right.

20 A: Where it says to?

21 Q: Right.

22 A: Yes.

23 Q: And do you know any of those gentleman?

24 A: No.

25 Q: Okay. Never talked to any of them about a

1 program at Grand Strand, correct?

2 A: Correct.

3 Q: Okay. And look down just quickly in the email
4 in the middle, the paragraph from Frankie
5 Knight, there's some bolded language at the
6 bottom of that paragraph. The last sentence in
7 that paragraph that begins with I believe; you
8 see that?

9 A: Uh-huh (affirmative response).

10 Q: Will you read that? Read that out loud.

11 A: That's from Frankie Knight?

12 Q: Right.

13 A: "I believe we need to involve someone,
14 physician, physicist, who is radiation therapy
15 knowledgeable and able to clarify exactly the
16 services we are planning to offer."

17 Q: Okay. Did anybody ever communicate with you,
18 did Mr. Mullis or anybody from Grand Strand
19 ever communicate with you about the services
20 that they intend to provide?

21 A: No, they did not.

22 Q: To your knowledge, did anybody communicate with
23 any of the other radiation oncologists in your
24 department about this?

25 A: Not to my knowledge.

1 Q: Okay. All right. Let's talk about some of the
2 issues that you do know and that you have
3 testified about. I want to make sure I
4 understood -- I'm going to run back over these.
5 In your direct, you were discussing -- Mr.
6 Cartin had asked you about the various types of
7 cancers and typically the number of treatments
8 for those specific types; you recall that?

9 A: Yes.

10 Q: Okay. Let me make sure I've got this right.
11 I think you indicated that with prostate that
12 generally there's 40 to 45 treatments?

13 A: Yes.

14 Q: All right. And with brain cancer, generally
15 there are about 30 treatments?

16 A: Yes, for primary brain tumor, yes.

17 Q: All right. And for bladder cancer, there's
18 generally between 30 and 35 treatments per
19 patient?

20 A: Yes.

21 Q: And for gynecological malignancy, between 25 to
22 30 treatments per patient?

23 A: Yes.

24 Q: All right. And lymphoma, and I think you said
25 generally you don't treat -- lymphoma is not

1 something that you -- that is ordinarily
2 treated with radiation therapy? There's some
3 ---

4 A: No, I think I said leukemia ---

5 Q: Okay.

6 A: --- is something we don't normally treat. It's
7 not a solid tumor. Lymphoma's we do treat a
8 good bit.

9 Q: Okay.

10 A: But it's -- what I said was it's more sensitive
11 to radiation. It's a more radiosensitive tumor
12 so we can treat to a lower dose. And it's
13 usually somewhere around 20 treatments instead
14 of 30.

15 Q: And breast cancer, generally the average number
16 of treatments per patient is 30?

17 A: Yes.

18 Q: And head and neck, the average number of
19 treatment per patients is 35?

20 A: Yes.

21 Q: Okay. Gastro ---

22 THE COURT: Wait a second, head and neck was how
23 many?

24 A: Thirty-five.

25 THE COURT: Okay.

1 Q: Gastrointestinal cancers, the average number of
2 treatment was 25?

3 A: Twenty-five, 28.

4 Q: Twenty-five to 28?

5 A: Some people do 30.

6 Q: Okay.

7 A: I mean, 25 to 30.

8 Q: Okay.

9 A: You know, these aren't -- they're not all set
10 in stone. I mean, that's ---

11 Q: Right. I know. We're just talking about
12 average ---

13 A: Yeah.

14 Q: --- number of treatments. All right. And
15 rectal I think you said 25 to 28 as well?

16 A: Yes.

17 Q: All right. Did I miss any of them? I think I
18 wrote them all down. Any other cancers that
19 you can think about and we can just discuss
20 what the average number of treatments?

21 A: To get an idea of treatment time?

22 Q: Right.

23 A: Soft tissue sarcomas, you can go to six to
24 seven weeks, 30 to 35 treatments for soft
25 tissue sarcomas.

1 Q: Okay.

2 A: Pancreatic cancers, usually about 28. Very
3 common treatment number given there.

4 Q: Okay.

5 A: I think we talked about metastatic cancers
6 being palliative ---

7 Q: Right.

8 A: --- treatments, you give fewer treatments.

9 Q: Right. Okay. All right. That's helpful. You
10 provided some testimony for the Court relating
11 to inpatients. I want to talk a little bit
12 about inpatients. You generally agree with me
13 that the goal of the hospital for an inpatient
14 is to get that patient discharged out of the
15 hospital as soon as possible?

16 A: Yes.

17 Q: All right. And I think you stated, but I want
18 to make sure the Court understands that an
19 inpatient, when we're talking about a treatment
20 of an inpatient, for the most part, there are
21 only going to be a few treatments where they're
22 treated on an inpatient. They'll be discharged
23 and the remainder of their treatment is going
24 to be outpatient?

25 A: Yes, yes. They may start as an inpatient,

1 usually they'll -- you don't have to be in the
2 hospital to have radiation therapy, so once
3 they're discharged from the hospital, yes, then
4 they would be coming as an outpatient.

5 Q: Right.

6 A: And then, you know, it kind of may happen the
7 other way around. They may start their
8 treatment as an outpatient, have some kind of
9 medical problem and have to be admitted and
10 have their treatment continued while they're an
11 inpatient. But, you know, hopefully they'll be
12 discharged soon and resume as an outpatient.

13 Q: Yeah, I think you said in your deposition, I
14 mean, generally if that were the case it'd be
15 a short period of time. For the most part ---

16 A: Yes.

17 Q: --- patients that receive treatment while an
18 inpatient is a short period of time and that
19 they would generally be discharged and receive
20 the rest of those treatments as an outpatient?

21 A: For the most part, yes.

22 Q: Okay. And if you will look at the notebook
23 that is in front of you, and let's pull up
24 Petitioner's Exhibit 20.

25 A: This notebook you just gave me?

1 Q: No, I'm sorry, the green one.

2 A: Oh, the green one.

3 Q: Grand Strand exhibit.

4 A: Y'all work with some big notebooks. I'm
5 getting a workout here. It's Exhibit 20?

6 Q: Correct.

7 THE COURT: They get paid by the pound.

8 A: All right. These are my notes.

9 Q: Okay. Exhibit 20 are your -- the notes that
10 you took that we were just talking about in
11 connection with your testimony as an expert,
12 correct?

13 A: Correct.

14 Q: All right. And the first page is -- we'll talk
15 about this a little bit more in a minute, are
16 those factors that relate to the inpatients,
17 treatments of inpatients, the benefits to the
18 inpatients, correct?

19 A: Yes.

20 Q: All right. I want to look at the second page,
21 because I -- and I just want to make sure that
22 I understand. In your direct, I think you said
23 that you had taken a look at the first six
24 months of 2013 in trying to determine the
25 percentage of inpatients that you treat,

1 correct?

2 A: Yes.

3 Q: All right. And this is the -- these are the
4 notes that support that testimony, right?

5 A: Right.

6 Q: Okay. And this says, if I'm understanding your
7 notes, that the first six months of 2013,
8 Trident treated -- now is these -- are these
9 your treatments or are these all the treatments
10 that occurred in Trident's hospital-based
11 program?

12 A: Yeah, all the treatments in our department.

13 Q: All right. Now these -- you're looking at this
14 in terms of patients, right, not treatments?

15 A: Yes.

16 Q: All right. And let's -- I want to just for
17 purposes of trying to take a closer look at
18 this when we -- when we're talking about an
19 inpatient, on average how many treatments would
20 that patient receive before it's discharged?
21 Is it fair to say a week, is that enough?

22 A: Yes.

23 Q: Okay.

24 A: Yes.

25 Q: All right. Okay.

1 A: That could vary. It could be less, it could be
2 more, but I think that's fair to say for
3 average.

4 Q: All right. Let's use, because I was interested
5 in the -- in the number of treatments, average
6 number of treatments per patient for all of
7 these cancers. For purposes of this, let's
8 just use 25 treatments as the average number of
9 treatments; is that fair?

10 A: Uh-huh (affirmative response).

11 Q: Does that sound -- does that sound about right?

12 A: Yes.

13 Q: All right. I'm going to hand you a calculator
14 and ask you to do a little bit of quick math.
15 So for 285 patients, which is what you list,
16 how many treatments is that if we're using 25
17 as an average?

18 A: 7,125.

19 Q: All right. Now, the 13 that were inpatients,
20 if we said that they received treatment for a
21 week, that's five treatments, correct?

22 A: Yes.

23 Q: All right. So how many -- how many inpatient
24 treatments is that patient, or these patients
25 receiving?

1 A: Thirteen times five?

2 Q: Right.

3 A: Sixty-five.

4 Q: Okay. Sixty-five treatments. What is
5 percentage-wise 65 treatments if we're
6 converting these treatments, what's the
7 percentage of treatments that are being done on
8 an inpatient basis?

9 A: Sixty-five divided by -- what was it, 7125?

10 Q: 7,125.

11 A: Percentage of -- .009.

12 Q: Okay. If you round that up ---

13 A: Times --

14 Q: --- it's one percent.

15 A: --- times, yeah, one percent.

16 Q: All right. Okay. We'll talk about inpatients
17 again in a minute. Let's talk about the
18 equipment. I think I heard you say that you
19 had never treated on a TrueBeam; is that right?

20 A: Correct.

21 Q: Okay. And your understanding is is that Grand
22 Strand is proposing a Clinac iX, correct?

23 A: That's the quote. It was an old quote.

24 Q: Right. Right.

25 A: So.

1 Q: That's -- that's ---

2 A: What we have to go by.

3 Q: --- what we discussed and that's what we have
4 to go by, right?

5 A: Right.

6 Q: Okay. And you've never treated on a Clinac iX,
7 have you?

8 A: Not exactly. I treat on a Clinac 2100C that's
9 been upgraded with IMRT, IGRT capabilities, so
10 it's similar.

11 Q: It's similar, but you -- and we talked about
12 this in your deposition, you're not entirely
13 sure what the -- what the differences or --
14 what the differences may be between a Clinac iX
15 and your modified 2100 that you have?

16 A: Yeah. Correct. Yeah.

17 Q: Okay.

18 A: There may be some subtle differences.

19 Q: All right. At your time with Trident you've
20 really -- you really haven't been involved in
21 the selection of the equipment. It's really
22 just been more on a service level; is that a
23 fair statement?

24 A: I've been involved. I've gone on site visits
25 to look at different machines.

1 Q: Okay. All right. You recall in looking at the
2 equipment the -- and discussing the various
3 capabilities of the TrueBeam and the Clinac iX,
4 we had a discussion about that in you
5 deposition; do you remember that?

6 A: (Nods head affirmatively.)

7 Q: Okay. Well, you do recall ---

8 A: I don't remember the details.

9 Q: --- don't you, that there were certain
10 capabilities of the Clinac iX that had been
11 removed, certain add-on features that had been
12 removed; do you recall that?

13 A: No, sorry.

14 Q: The Gated RapidArc, are you familiar with that?

15 A: Gated RapidArc.

16 Q: Do you know what Gated RapidArc is?

17 A: Yes, I do.

18 Q: All right. The Clinac iX that's proposed by
19 Grand Strand in its quote does not have the
20 Gated RapidArc, does it?

21 A: Okay. I don't remember the details of that but
22 ...

23 Q: All right. Do you have -- do you believe that
24 it is included or is not?

25 A: I really don't remember the details of the

1 quote but I would ...

2 Q: All right. So do you know whether it's
3 included, yes or no?

4 MR. CARTIN: Objection, Your Honor. He could show
5 him the quote if he ...

6 THE COURT: He could also -- I think he may have
7 already answered the question, but as far as
8 your objection, I overrule it.

9 A: What's the question?

10 Q: Do you know whether Gated RapidArc feature is
11 included on the Clinac iX or not?

12 A: I don't think it is, but I don't ---

13 Q: All right.

14 A: --- remember exactly.

15 Q: And do you believe that the Gated RapidArc is
16 included on the TrueBeam? Do you know?

17 A: I don't know.

18 Q: Okay.

19 A: I really don't -- I don't remember the details.
20 I didn't look at the machines in that much
21 detail.

22 Q: Okay. Well, maybe let's pull up DHEC record
23 636. I'm sorry, CRCC Joint Exhibit 1.

24 THE COURT: All right, now, CRCC or Joint Exhibit?

25 MR. MULLINS: It is Joint Exhibit. I'm sorry, Your

1 Honor. Joint Exhibit 1. It is the CRCC DHEC
2 record.

3 THE COURT: You want to help him with this?

4 Q: Are you there? Are you there? I'm sorry.
5 Page 636, you see the Bates numbers at the
6 bottom?

7 A: 636?

8 Q: Yeah. That is a letter from a Dr. Mantz
9 relating to the TrueBeam versus the Varian. Do
10 you recall looking at that?

11 A: Yes.

12 Q: Okay. And read the -- well, the middle section
13 of that letter, there are bullet points that
14 specify advantages of the TrueBeam over the
15 Varian ---

16 A: Yes.

17 Q: --- correct?

18 A: Uh-huh (affirmative response).

19 Q: Okay. And we went through those, and if you
20 want to take a minute to review them, but
21 essentially, you agree with the advantages that
22 have been specified in this letter, don't you?

23 A: Yes, I think I pointed out that this letter
24 mentions the superior treatment couch
25 positioning and accuracy, but from my reading

1 of the Grand Strand's quote for their machine,
2 they had the exact same couch.

3 Q: All right. That's right. And that's the third
4 bullet point, right?

5 A: Right.

6 Q: And why don't you read that third bullet point.

7 A: "TrueBeam is capable of treating smaller tumors
8 such as brain tumors more reliably than an iX
9 machine by virtue of its superior treatment
10 couch positioning and beam accuracy."

11 Q: All right. You agree that it is capable of
12 treating smaller tumors, correct?

13 A: Yes.

14 Q: Okay.

15 A: I think it's ---

16 Q: Because of the beam accuracy ---

17 A: Yes.

18 Q: --- and you agree with that?

19 A: Yeah.

20 Q: Your issue is that you're not sure that the
21 couch positioning is more advanced ---

22 A: Yeah, I think ---

23 Q: --- as a reason?

24 A: Yeah, the Grand Strand quote they had the same
25 couch as far as I could tell from my ...

1 Q: Okay. And, but you don't disagree with any of
2 the other statements made in the letter, do
3 you?

4 A: No.

5 Q: Okay. And read the sentence after that third
6 bullet point there.

7 A: "Therefore, TrueBeam offers superior radiation
8 treatment over Clinac iX with regard to
9 technical performance, patient comfort, and
10 patient safety."

11 Q: All right. You agree with that, don't you?

12 A: Yes, for certain specialized treatments, but
13 not for a conventional radiation treatment.

14 Q: All right. But in terms of the -- radiation
15 therapy treatment as a whole in terms of
16 comparing the two machines, you don't disagree
17 with that statement that is made in this
18 letter, do you?

19 A: No. If I, you know, if I had a choice of one
20 machine or the other, I would pick the
21 TrueBeam.

22 Q: Okay. In fact, yeah, I think that's what you
23 said ---

24 A: Yeah.

25 Q: --- right, in your deposition?

1 A: Yes. Right.

2 Q: All right. And I think you said if -- if money

3 ---

4 A: It does have some advantages.

5 Q: --- were no object ---

6 A: Yes.

7 Q: I think you said anybody would pick the

8 TrueBeam, didn't you?

9 A: Uh-huh (affirmative response).

10 Q: Is that a yes?

11 A: Sure.

12 Q: Okay.

13 A: Yeah, I mean, it's the newest machine.

14 Q: And in this case, and if we want to look at it

15 the --- well, why don't we do that. Why don't

16 we look at Grand Strand's -- let's just look at

17 the first page of the quote. It's just the

18 Grand Strand Joint Exhibit 2, 489. That's

19 going to be -- 489. I just want you to look --

20 what's the price quoted there for the -- for

21 Grand Strand's Clinac ix? Go ahead, I just ---

22 A: Is this it?

23 Q: The first -- yeah, on 489, what's the quote?

24 A: Oh, 2,812,000.

25 Q: All right. Two point -- about 2.8, right?

1 A: Yeah.

2 Q: Okay. And I've handed you Joint Exhibit 1,
3 record 163. That's the TrueBeam quote. What's
4 the -- what's the price quoted for the, CRCC's
5 TrueBeam?

6 A: 2.4 million.

7 Q: Are you looking on page -- I want to make sure
8 you're -- right. What's the -- what's the
9 price?

10 A: 2.4 million.

11 Q: And some change, right?

12 A: Yeah.

13 Q: Okay. So going back to your statement about if
14 money were no object, you think anybody would
15 pick the TrueBeam -- in this case, the price of
16 the TrueBeam is cheaper than the price of the
17 Clinac -- anybody would pick TrueBeam over the
18 Clinac, right?

19 A: I don't know how that could be. I don't know
20 how that could be. It's a lot more expensive
21 machine, I know that.

22 Q: Well ---

23 A: A lot more.

24 Q: --- I understand. I want you to assume based
25 on what you've read, based on what you've read,

1 anybody would pick the TrueBeam over the Clinac
2 iX; is that right?

3 A: Yes. But having said that, I think there are
4 a lot more Clinac iX's out there being used for
5 treatment than there are TrueBeams.

6 Q: The TrueBeam is the latest technology coming
7 from Varian, isn't it?

8 A: Yes.

9 Q: Okay. All right.

10 A: Is there any way we could get this deal? Can
11 I get a copy of this?

12 Q: You're going to have to talk to the -- talk to
13 the director about that.

14 A: Take it to the Varian people?

15 Q: Let's talk about your testimony related ---

16 A: Is anybody from Varian here?

17 Q: All right. I'll let you make a call after, but
18 let's talk about your testimony relating to the
19 comprehensive cancer program, okay.

20 A: Okay.

21 Q: All right. And I think you were a little bit
22 more expansive today. In your deposition, I
23 asked you to define comprehensive cancer
24 program. And in essence, you said it's when
25 different specialists get together to see the

1 patients sort of in the same setting, was your
2 definition. Do you agree with that?

3 A: Yes.

4 Q: All right. And in your deposition, I want to
5 make sure I understand because you list a bunch
6 of specialists, but in terms of that
7 comprehensive cancer program, the specialists
8 that you're referring to are mainly the
9 radiation oncologists and the medical
10 oncologists, correct?

11 A: No, I don't think that's what I meant. I meant
12 all the specialties, surgeons, diagnostic
13 radiologists, and pathologists. Those are kind
14 of the main.

15 Q: Okay. All right. Well, but you don't disagree
16 that the medical oncologist is a significant
17 referrer, so it makes sense that a lot of the
18 interaction would be between a medical
19 oncologist and a radiation oncologist?

20 A: Yes.

21 Q: Okay. And you stated in your direct testimony
22 that ideally, that having this comprehensive
23 cancer program ideally would be under one roof,
24 right?

25 A: Ideally.

1 Q: Okay. And in our deposition we were talking
2 about that a little bit more, and we were
3 talking about the physical setting, and the
4 medical oncologist -- I think you said in your
5 direct that infusion is performed in the
6 hospital at Trident?

7 A: Yes, we have an infusion center in our
8 department.

9 Q: If the infusion were performed in the medical
10 oncologist's office, then you don't have the
11 true comprehensive cancer program that you're
12 talking about; is that right?

13 A: It's still a comprehensive cancer program.
14 Ideally, it would all be under the same roof.
15 Technically it doesn't have to be to meet the
16 definition of a comprehensive cancer program;
17 it doesn't have to be. It has to be available,
18 but ideally, it would be all in the same roof.

19 Q: But in this particular case, do you have
20 specific knowledge as to whether infusion is
21 going to be performed in the hospital or
22 whether it's going to be performed outside of
23 the hospital in the medical oncologist's
24 office?

25 A: I don't know. I don't know. That's a good

1 question. I don't have specific knowledge of
2 that.

3 Q: But you would agree with me if the -- if the
4 chemotherapy is performed outside the office
5 then the program can still exist, but it's not
6 this ideal program that you're talking about in
7 terms of comprehensive cancer program, right?

8 A: It's still a comprehensive cancer program. In
9 fact, at Trident, I mean, most of the
10 chemotherapy is performed in the medical
11 oncologist's office. It's not all performed in
12 our infusion center. We just do have that
13 capability there for certain cases, but
14 actually, the majority is performed in the
15 medical oncologist's office.

16 Q: Okay. And turn to Petitioner's 110, if you
17 will. I'm sorry, Respondent CRCC's 110, that's
18 the blue notebook. Sorry about bouncing back
19 and forth.

20 THE COURT: All right. We're at Respondent's what?

21 MR. MULLINS: 110.

22 Q: If you just look at the top email there from
23 Doug White. You know who Doug White is, don't
24 you?

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

1 Q: And he's indicating that the chemo infusion is
2 going to be performed with Dr. Holt in the
3 building next door, right? See that?

4 A: He says the infusion service should be minimal,
5 Dr. Holt does this in the building next door.
6 It implies that there will be some infusion
7 service.

8 Q: For inpatients maybe?

9 A: I don't know.

10 Q: Anyway, but you do agree a program does not
11 have to be solely hospital based to be in a
12 comprehensive cancer program; you agree with
13 that?

14 A: Yes.

15 Q: And I think you stated that you had -- you
16 worked for what at the time was called Myrtle
17 Beach Radiation Therapy, which is now called
18 CRCC?

19 A: Yes.

20 Q: You worked for them prior to coming to Trident?

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

22 Q: And you're actually familiar with the fact that
23 historically CRCC has participated in a
24 comprehensive cancer program, aren't you?

25 A: Yes.

1 Q: CRCC participated in the tumor boards while you
2 were there, correct?

3 A: Yes.

4 Q: Okay. And the tumor boards, you talked about
5 that in direct, that is a pretty significant
6 part of the interdisciplinary care that you
7 were talking about where the physicians, the
8 different specialists get together and discuss
9 cases that any of the physicians may present to
10 the board, correct?

11 A: Yes.

12 Q: All right. Now, getting back to your
13 definition of the comprehensive cancer program,
14 and I want to talk about the medical
15 oncologists. I think the physical proximity of
16 the medical oncologists to the hospital, you're
17 aware -- at the time you weren't aware, you
18 believed they were right adjacent to the
19 hospital, correct?

20 A: (Nods head affirmatively.) Yes.

21 Q: And we discussed the fact that it was, at least
22 in their application, that they had referenced
23 that it was a three minute drive to the
24 hospital for the medical oncologists; do you
25 recall that?

1 A: Yes.

2 Q: Okay. And if we could pull up Respondent
3 CRCC's Exhibit 24. I don't know if you can see
4 that from the screen. See that?

5 A: Yes.

6 Q: Okay. That's an overview of Grand Strand
7 Hospital I'll represent to you. And I can't
8 recall whether we looked at this in your ---

9 A: It's changed a lot since I was there.

10 Q: The Coastal facility is identified below that
11 parking lot, the red roof there.

12 A: Uh-huh (affirmative response).

13 Q: All right. And to get to the hospital, that's
14 on a different road, it would have to drive
15 down a different street, around, and actually
16 the proposed Grand Strand Radiation Therapy
17 Center would be outside of that picture to the
18 north of that picture, okay. And what we
19 talked about was the fact that it would be a
20 three minute drive, that's what's represented
21 in the application; do you recall that
22 discussion?

23 A: Uh-huh (affirmative response).

24 Q: All right. And then I asked you, okay, well,
25 what specifically is unique about or what

1 advantage does the hospital have by virtue of
2 its program over what occurs now with medical
3 oncologists maybe driving another mile, two
4 miles, down the road to CRCC, and essentially,
5 your opinion was well, the main benefit of a
6 hospital-based radiation therapy program is to
7 the inpatients, correct?

8 A: Yes.

9 Q: And that was the only -- the only difference
10 that you could point to, correct?

11 A: Well, also what I just pointed out was that the
12 radiation oncologist can walk right across the
13 hall to diagnostic radiology and get a better
14 idea of where their target is.

15 Q: Right, I heard that. And I didn't hear you say
16 that in your deposition when I asked you if
17 there was any other. That's just something
18 that you've thought of since the deposition?

19 A: Yes.

20 Q: All right. And you would agree with the
21 radiation -- a large part of radiology practice
22 is done digitally through telemedicine and
23 through transcribing images from computer to
24 computer in different offices, different
25 hospitals, different states, different

1 countries; do you agree with that?

2 A: I've heard that. I haven't seen that in
3 action. You know, in our hospital, the
4 radiologists are right there.

5 Q: All right. There's no reason that you couldn't
6 have that communication, that that image could
7 be emailed to a physician and that same
8 conversation could take place? There's no
9 reason why that couldn't occur, is it?

10 A: Yeah, because you couldn't point out on the
11 screen what ---

12 Q: Couldn't use your finger ---

13 A: --- my question would be and what their answer
14 would be.

15 Q: All right. You couldn't -- you wouldn't --
16 okay. Fair enough. Fair enough. All right.
17 Well, outside of being able to walk across the
18 room to the radiologist, what your conclusion
19 is is that the central benefit of this
20 hospital-based program is to the inpatient,
21 correct?

22 A: It's to the inpatient that is able to be
23 transported is inconvenienced. To the
24 inpatient who is on a ventilator that's unable
25 to be transported, it's a potentially life

1 threatening denial of care.

2 Q: Right. And you acknowledged that that is a
3 very rare occasion that that occurs?

4 A: It happens several times a year in our
5 department.

6 Q: Two to three times a year?

7 A: Two to -- yeah, something like that, yes.

8 Q: Okay.

9 A: Over a decade, that's 20 to 30 patients denied
10 vital care.

11 Q: All right. You're aware that Grand Strand is
12 currently transporting inpatients to Trident,
13 to your department; you're aware of that,
14 right?

15 A: They have. I don't -- they have transported a
16 few patients down to Trident. I don't think
17 that's still occurring.

18 Q: Oh, they stopped doing that?

19 A: I haven't -- as far as I know, I haven't seen
20 that. That happened a few times and ---

21 Q: All right. Well, let's talk about this ---

22 A: --- it hasn't happened recently.

23 Q: Let's talk about those few times, okay. Now
24 you -- you're aware, you would agree with me,
25 you're aware by virtue of your practice at

1 Myrtle Beach Radiation Therapy, which is now
2 CRCC, that for years those patients were
3 treated -- were transported to CRCC and treated
4 at CRCC; you agree with me?

5 A: Yes.

6 Q: Okay. And that practice stopped last year;
7 you're aware of that, right?

8 A: I did not know that.

9 Q: All right.

10 A: I knew a few patients were transported.

11 Q: Okay. We can pull out your deposition, but at
12 your deposition you said that it was your
13 understanding that that practice stopped last
14 year.

15 A: I don't think I said that, because I was not
16 aware of why ---

17 Q: I'm not talking about why.

18 A: --- the practice was even happening.

19 Q: I'm not talking about why. I'm just talking
20 about it occurring. Let me state it a
21 different way, that you were aware that Trident
22 began receiving transfers of inpatients about a
23 year ago?

24 A: Yes.

25 Q: Okay.

1 A: Yes, I -- yeah, a few patients were transferred
2 there, but yes.

3 Q: And that had never occurred before, to your
4 knowledge?

5 A: To my knowledge, no.

6 Q: Okay. And you agree that this has a negative
7 impact on the ability to offer comprehensive
8 cancer care to that patient; you agree with
9 that, don't you?

10 A: No, I haven't ...

11 Q: You don't?

12 A: I think it -- I think it has a negative impact
13 for the patient to be, you know, not able to be
14 treated there right at Grand Strand.

15 Q: Well, let me ask you this. If a patient --
16 let's just use a patient that has some sort of
17 cancer that's being treated by the medical
18 oncologist in Myrtle Beach, is admitted as an
19 inpatient to Grand Strand and that patient is
20 then transferred to Trident. Are you saying
21 that it does not have a negative impact on the
22 ability of that medical oncologist to consult
23 with the radiation oncologist down in
24 Charleston two hours away, 100 miles away?
25 There's no negative impact on that

1 interdisciplinary team approach that you were
2 talking about?

3 A: Well, they can still consult, but yeah, I would
4 say it's not an ideal situation.

5 Q: All right. Not an ideal situation?

6 A: Yes.

7 Q: Has anybody from Grand Strand or anybody at all
8 ever consulted with you prior to any of these
9 patients being transported to Trident?

10 A: I didn't treat any of these patients. None of
11 them were my patients, so I really don't have
12 much knowledge about -- I don't have any
13 detailed knowledge about the cases of these
14 patients at all.

15 Q: Okay.

16 A: I didn't see any of them.

17 Q: You don't have any specific knowledge that
18 anyone from Grand Strand ever consulted with
19 either one of your other -- your other partner
20 or the other associate about the propriety of
21 transferring those patients to Trident?

22 A: I don't know. I don't know.

23 Q: All right. And I just want to clear up the
24 record with regards to inpatients when we were
25 discussing -- when you were running through the

1 average number of treatments for the specific
2 cancers, at the end of that you listed
3 inpatients and you said two to four. Those are
4 just patients -- the treatments that that
5 patient would receive as an inpatient. That
6 patient would receive additional treatments as
7 an outpatient?

8 A: Are you talking about if we were treating an
9 inpatient how many treatments they might have
10 while ---

11 Q: Right.

12 A: --- they're an inpatient?

13 Q: Well, I just want to -- I want to make sure
14 that -- well, yes. Let's just clarify that.
15 The two to four treatments you were talking
16 about were merely the treatments that that
17 patient was being received as an inpatient?

18 A: I don't remember exactly the conversation. For
19 the calculation, we used the number five.

20 Q: Okay. But you're -- okay. You don't have any
21 specific knowledge as to the number of
22 inpatients that Grand Strand currently --
23 strike that. You don't have any specific
24 knowledge as to how many inpatients Grand
25 Strand is proposing to treat as part of its

1 program, do you?

2 A: No, I don't.

3 Q: And you're not in any -- you haven't been asked
4 to review, nor have you reviewed how many
5 inpatients that you think Grand Strand will do
6 if it is granted this linear accelerator?

7 A: No.

8 Q: You had some testimony in your direct about the
9 ability to recruit specialists and sub-
10 specialists to a comprehensive cancer program,
11 correct?

12 A: Yes.

13 Q: You didn't discuss that in your deposition at
14 all in terms of the advantages of a hospital-
15 based program, did you?

16 A: I don't think I was asked about that.

17 Q: You were asked to identify all the advantages
18 that would result as a result of the hospital-
19 based radiation therapy program. You didn't
20 list that as one of the advantages, did you?

21 A: No, I didn't.

22 Q: And your notes -- your notes do not reflect
23 that as a factor or an advantage, do they?

24 A: There are probably a lot of other advantages
25 that I'll think of later also.

1 Q: Unfortunately, this is the time we have.

2 A: I did the best I could.

3 Q: All right. And there certainly could be other
4 reasons why specialists or sub-specialists
5 aren't being successfully recruited to an area.
6 They may not -- the hospital may not be
7 recruiting properly, they may not be devoting
8 the resources to getting those specialists; is
9 that a reason?

10 A: Sure.

11 Q: There may not be the cases available for a
12 specialist or sub-specialist for whatever that
13 may be, is that ---

14 A: Absolutely.

15 Q: Okay. All right. Thank you, Dr. Collins.

16 A: Thank you.

17 MR. CARTIN: Your Honor, I beg the Court's
18 indulgence for one moment. I may have a few
19 questions.

20 DR. COLLINS - REDIRECT EXAMINATION BY MR. CARTIN:

21 Q: Just a few more questions, Dr. Collins, then
22 we'll get you out of here. What are the
23 benefits that outpatients can receive from
24 receiving treatment in a comprehensive cancer
25 program?

1 A: Outpatients have the benefits of all the
2 different cancer specialists putting their
3 heads together, discussing the case, reviewing
4 the radiology scans, reviewing the pathology
5 slides.

6 Q: So in your opinion, there is a benefit to
7 outpatients as well as inpatients?

8 A: Yes.

9 Q: Do you recall a meeting where Mr. Adam Rudd and
10 Doug White visited Trident?

11 A: Yes.

12 Q: And did they tour your facility?

13 A: Yeah, I don't know who Adam Rudd is, but I know
14 Doug White from when I worked in Myrtle Beach,
15 and yes, I saw them come through the facility.

16 Q: And do you recall what the purpose of their
17 visit was?

18 A: I had no idea what the purpose of their visit
19 was.

20 Q: Do you know who Dr. In Mun is?

21 A: Yes, I know who he is.

22 Q: Who is he?

23 A: He is an HCA -- he's a scientist.. I don't
24 think he's a physicist; I think he's actually
25 a chemist. But he advises HCA on radiation

1 therapy equipment purchases, as far as I know.

2 Q: And let's talk about this Clinac iX and the --
3 what type of machine do you have now at
4 Trident?

5 A: We have two machines, but our Varian machine is
6 a 2100EX, which has been upgraded with IMRT and
7 IGRT capability. And I've been told that that
8 makes it like an iX.

9 Q: And were you told that by a medical physicist
10 or some other staff member?

11 A: Yeah, by our physicist.

12 Q: And is a physicist a type of medical
13 professional that you depend on in your
14 industry to give you information about what
15 machines are capable of?

16 A: Yes.

17 Q: If Grand Strand were able to get a TrueBeam for
18 the same cost as a Clinac iX, would it be
19 reasonable for them to get ---

20 MR. MULLINS: Your Honor, I'm going to object to
21 that. I mean, we're getting back into this
22 issue. There was no -- he hasn't been
23 identified to talk about Grand Strand's use of
24 the TrueBeam. It was not before us. It did
25 not become an issue at all until Doug White

1 stated that they might be getting a TrueBeam,
2 and to have an expert testify after this issue
3 has been introduced for the first time in the
4 middle of the trial without having any
5 opportunity to explore what his opinions may be

6 ---

7 MR. CARTIN: Your Honor ---

8 MR. MULLINS: --- it's not appropriate. And I, you
9 know --

10 THE COURT: Hold on, let him finish.

11 MR. MULLINS: Your Honor, I know that -- and I'm not
12 asking you to open back up this issue right
13 now, because I think you've made it clear your
14 ruling and what you intend to do with that, but
15 I mean, the -- and I understand your concern
16 about the policy aspect of advancements, but
17 Your Honor, there's got to be some order to
18 this process. And the statute does say that
19 the issues are limited to the issues that are
20 presented before the Department. And they
21 obviously, for whatever reason, have determined
22 that they want to shift what's before you and
23 say that they're going to be -- that the
24 TrueBeam is going to be introduced into the
25 Grand Strand project. That issue is not before

1 the Department. The issue that was before the
2 Department was the Clinac versus the TrueBeam,
3 and they're presenting an expert here today,
4 and I presume he's going to ask him questions
5 about what HCA, what the difference would be if
6 HCA had a TrueBeam, and I just don't think
7 that's appropriate.

8 THE COURT: All right.

9 MR. CARTIN: That's not the questions I'm going to
10 ask at all, Your Honor. Technology, they just
11 made it an issue by wanting to compare the
12 TrueBeam with the Clinac iX. I'm going to ask
13 Dr. Collins whether, number one ---

14 THE COURT: Well, I overrule the objection as to the
15 question was already asked in cross-examination
16 comparing the two machines and the cost factor,
17 so I will allow you to proceed.

18 MR. CARTIN: Thank you.

19 THE COURT: Solely responsive to the questions that
20 he asked in cross. So if you go beyond that,
21 I'll entertain an objection.

22 MR. CARTIN: Thank you, Your Honor.

23 THE COURT: Following that, Mr. Mullins?

24 MR. MULLINS: Fine, Your Honor.

25 Q: Dr. Collins, if a provider were able to get a

1 Varian TrueBeam for the same cost as a Clinac
2 iX, would it be reasonable for them to get a
3 Varian TrueBeam?

4 A: Yes.

5 Q: And is it important in radiation therapy for
6 you to keep up with advanced technology?

7 A: Yes.

8 Q: So as the technology changes over time, is it
9 reasonable, in your opinion, for providers to
10 seek to get the latest and greatest technology
11 that's out there?

12 A: Yes, I mean, it's not always possible to afford
13 the new technology as soon as it comes out, but
14 usually, as we all know, the cost tends to go
15 down with time and then you can upgrade when
16 you can afford to but ...

17 Q: Now, the Clinac iX quote that you reviewed, do
18 you recall what year it was dated?

19 A: It was about three years ago. I don't remember
20 the exact year --

21 Q: So it's -- and I think you even made a ---

22 A: It was a long time ago.

23 Q: And I think you even made comment about this,
24 but is that an outdated quote in your world?

25 A: Yes. Yes, definitely.

1 Q: Do medical oncologists round at the hospital?

2 A: Yes.

3 Q: When they round at the hospital, do you have
4 any interaction with them?

5 A: Not always, but a lot of times, yes, they will
6 stop by the department to discuss patients. If
7 they -- a lot of times they'll -- their patient
8 will be down in our department as an inpatient
9 getting their radiation therapy, and so when
10 they first round on them they come by and visit
11 them there.

12 Q: So that's an opportunity for you to discuss
13 patient care with these guys when you might not
14 otherwise have that opportunity?

15 A: Yes, absolutely.

16 Q: In your opinion, is attendance at tumor boards
17 a critical aspect to providing cancer care?

18 A: Yes.

19 Q: And when you're at these tumor boards, is there
20 any kind of way that they record your presence
21 at these tumor boards?

22 A: Yes. Yes.

23 Q: What is that?

24 A: Well, there's attendance taken at every tumor
25 board. We sign in. We have to sign in to a

1 tumor board.

2 Q: Any why is that important?

3 A: Well, because it's -- all the specialties are
4 supposed to be represented.

5 Q: I'm going to bring up Petitioner's 2 at page
6 127. Let's see what we've got up here.

7 THE COURT: What was that again, I was writing?

8 MR. CARTIN: Joint Exhibit 2, I'm sorry. Excuse me,
9 I'm sorry. Joint Exhibit 2 at 127.

10 MR. MULLINS: Your Honor, I guess we can see what
11 the question is, but this exhibit was not
12 referred to, the space program, the physical
13 plant of the Conway ---

14 MR. CARTIN: But medical infusion services were.

15 MR. MULLINS: --- the Grand Strand facility was not
16 discussed at all.

17 MR. CARTIN: But medical infusion services were.

18 THE COURT: Well ---

19 MR. MULLINS: All right.

20 THE COURT: I'll hear the objection when we get
21 there.

22 Q: Dr. Collins, if you'll look at the top left-
23 hand corner you'll see some language there.
24 What does that say?

25 A: Space allocation program.

1 Q: Okay. And what does the line immediately under
2 that say?

3 A: Grand Strand Regional Medical Center.

4 Q: And what's the next line?

5 A: Linear accelerator.

6 Q: Okay. Turn with me to page 129. Are you
7 there?

8 A: Yes.

9 Q: And if you'll look at the bottom there you'll
10 see it says "medical oncology."

11 A: Uh-huh (affirmative response).

12 Q: And can you just read that to yourself? Review
13 that briefly.

14 A: Out loud?

15 Q: No, just to yourself.

16 A: Okay.

17 Q: From what you're looking at here in the portion
18 immediately below medical oncology, does it
19 appear that Grand Strand will provide some
20 infusion services at its program?

21 A: Yes.

22 Q: Okay.

23 MR. CARTIN: One moment, Your Honor.

24 Q: And one final question. Can a hospital even
25 begin to establish a comprehensive cancer

1 center without having radiation therapy?

2 A: No.

3 Q: Okay. Thank you.

4 THE COURT: Recross on a new matter.

5 MR. MULLINS: None, Your Honor.

6 THE COURT: You may step down.

7 DR. COLLINS: Thank you.

8 MR. THOMAS: Can we take a short break, Your Honor?

9 THE COURT: We may. Do y'all wish to have this ---

10 MR. CARTIN: Yes, we dismiss the witness.

11 THE COURT: Any objection?

12 MR. MULLINS: No.

13 THE COURT: You're also dismissed.

14 DR. COLLINS: Thank you.

15 (Break from 11:18 a.m. until 11:28 a.m.)

16 DANIEL J. SULLIVAN, being duly sworn, testifies as

17 follows:

18 MR. THOMAS: Your Honor, just for the record, Grand

19 Strand just called Dan Sullivan to the witness

20 stand.

21 THE COURT: Okay.

22 MR. SULLIVAN - DIRECT EXAMINATION BY MR. THOMAS:

23 Q: Mr. Sullivan, can you state your full name for

24 the record?

25 A: Daniel Joseph Sullivan.

1 Q: And where do you live right now?

2 A: 2090 Bethany Way, Alpharetta, Georgia.

3 Q: What do you do for a living, Mr. Sullivan?

4 A: I'm a healthcare management consultant
5 specializing in healthcare planning and
6 healthcare finance.

7 Q: Do you have your own company?

8 A: I do.

9 Q: You work for yourself then?

10 A: I do, yes.

11 Q: Could you give us a little bit of background on
12 your education starting in college, Mr.
13 Sullivan.

14 A: Undergraduate degree in economics and public
15 policy studies from Duke University and a
16 master in health administration from Duke
17 University.

18 Q: Okay.. And can you give the Court some
19 background about what you did after college in
20 terms of employment?

21 A: Sure. After college I got a job at the Duke
22 University Medical Center and started off in a
23 variety of administrative roles. Towards the
24 latter part -- I was there for about six years,
25 the last two of I was going to grad school, so

1 I was working about 30 hours a week, and I was
2 doing more planning-oriented things at Duke.
3 And then after graduating from graduate school,
4 that's when I embarked on a consulting career.

5 Q: Can you talk a little bit about your consulting
6 career?

7 A: Sure. My first job was in 1980, so that was 33
8 years ago, with a firm called Amherst
9 Associates, and Amherst was a national
10 healthcare manager consulting firm involved in
11 financial feasibility studies, strategic
12 planning, market analysis, other types of
13 planning activities. That was about the same
14 time that the certificate of need program was
15 sort of ramping up in all the various states,
16 including South Carolina, and just kind of a
17 natural progression from what we were doing
18 otherwise, got involved in certificate of need
19 matters. And so over the years at Amherst, I
20 was there for about eight years starting as an
21 entry-level consultant and became a regional
22 vice president, I was involved in a whole host
23 of different kinds of planning work from
24 strategic plans, product specific planning for
25 something like open heart surgery or radiation

1 therapy, things like that. Also involved in
2 preparing CON applications. I've been doing
3 financial projections, both for external
4 purposes such as official statements for tax
5 exempt bond issues and for internal purposes
6 for hospitals.

7 Q: Talk a little bit about CON -- your CON
8 experience in general. In what states have you
9 done CON work?

10 A: I mean, over the years it's probably, you know,
11 I'm old enough that there were still CON
12 programs in every state when I start.
13 Generally now most of the states east of the --
14 I mean west of the Mississippi don't have full-
15 blown CON programs anymore, they might have
16 very limited review, but probably over the
17 years probably 25 to 30 states I've done CON
18 applications in at various times in my career.

19 Q: And in terms of the CON application work, could
20 you just expand on that, kind of the work you
21 did?

22 A: Sure. Really it's the whole gamut of what
23 healthcare planning is about. I mean, I
24 started off primarily involved with nursing
25 homes and hospitals because those were the

1 predominant models of care delivery back in the
2 early '80s. And then as the healthcare
3 industry evolved, ambulatory surgery centers
4 came in bout 1983. I was involved in some of
5 the early ambulatory surgery center projects.
6 MRI services, for example, really kicked off in
7 the early 80s, and I was involved in some of
8 the early MRI CON applications in various
9 states. Radiation therapy has been around for
10 quite a while, and I was involved in radiation
11 therapy projects back in the '80s and sort of
12 consistently over the -- over the years in that
13 regard. In fact, in the last seven or eight
14 years there's been a real concentration of my
15 work in the area of radiation therapy. But
16 I've been involved in hospice services, home
17 health services, other type of technology like
18 PET scanners, really the whole gamut of
19 healthcare activities.

20 Q: Have you been involved in any other the linear
21 accelerator CONs, CON applications that have
22 been filed in the state of South Carolina?

23 A: I have. The first one I recall is I worked
24 with Georgetown Memorial Hospital, which is the
25 same planning area as this project. I think

1 that started in the late '90s, as I recall. At
2 that time, Dr. Bass' group had the only linear
3 accelerator in the three county area.

4 Georgetown applied because they believed that
5 there was a need for better geographic access
6 in Georgetown County. Most of the patients in
7 Georgetown were either driving long distance to
8 Myrtle Beach or would drive into -- you know,
9 long distances to Charleston to get care.

10 Because of opposition by Dr. Bass' group, we
11 had to file I think three different times
12 before we were ultimately approved for
13 Georgetown to develop a linear accelerator.

14 I've been involved with Trident Medical Center,
15 and they recently got approval to expand from
16 two to three linear accelerators because of
17 their volume. And I think I was involved
18 several years ago in an effort by Hilton Head
19 Medical Center radiation therapy.

20 Q: Okay. You may have mentioned this already, but
21 in terms of the development of hospital
22 financial pro formas for CONs, is that
23 something that you typically do in your
24 experience?

25 A: I do for both CON applications and for internal

1 purposes. Early in my career we were involved
2 in doing feasibility studies that were used in
3 connection with tax exempt bond issues, but I
4 don't do that work anymore. But I still do
5 financial projections quite regularly.

6 Q: Are you familiar with the service area market
7 here, and when I say service area for linear
8 accelerators, it's Williamsburg, Georgetown,
9 and Horry County?

10 A: I am. I've worked in that market for a number
11 of years.

12 Q: Can you give the court a little bit of
13 background of your work in this service area?

14 A: Sure. With Georgetown, in addition to the
15 radiation therapy project, we were involved
16 when they were first trying to establish the
17 new hospital in Waccamaw up in Murrells Inlet,
18 and so we wrote that application and were
19 involved. I think it ultimately got settled
20 before it went to hearing, but they were in
21 preparations for hearing in that case. I was
22 involved with Grand Strand in a series of
23 projects. One was for a 50-bed tower, and I
24 think subsequently there was one for a 30-bed
25 tower. After that time, I worked with them on

1 an application for inpatient rehabilitation
2 services and this project. And I also had the
3 opportunity to work with a physician group, it
4 was an orthopaedic group just located just
5 adjacent to the Grand Strand campus that was
6 seeking to develop both an ambulatory surgery
7 center and obtain an MRI unit. I worked with
8 them on those two projects. I think that was,
9 I'm trying to think, maybe the early 2000s. So
10 over the last 15 years or so, I mean, I've kind
11 of worked consistently in this area. I'm
12 pretty familiar with the demographics and the
13 distribution of existing providers and types of
14 services that are offered.

15 Q: Are you familiar with the applicable South
16 Carolina Health Plan for these projects?

17 A: I am.

18 Q: Are you familiar with the health plan that was
19 published after the health plan that gave rise
20 to this case?

21 A: I am.

22 Q: Have you been qualified in the past as an
23 expert in healthcare planning and healthcare
24 finance?

25 A: I have in South Carolina and I think 12 or 13

1 other states as well.

2 MR. THOMAS: Okay. Your Honor, at this time we
3 would offer Mr. Sullivan as an expert witness
4 in the areas of healthcare planning and
5 healthcare finance.

6 MR. LONG: No objection, Your Honor.

7 THE COURT: He's so qualified.

8 Q: Tell the Court, Mr. Sullivan, how you got
9 involved in this particular project for Grand
10 Strand.

11 A: I believe you called me in January of 2011 and
12 asked me if I was available to assist Grand
13 Strand in this application, told me generally
14 what it was about, and I was somewhat aware
15 that there were other applications being filed
16 as well. You know, I knew that other parties
17 were looking at developing freestanding
18 radiation therapy centers in Horry County, and
19 I also knew that there was an effort on the
20 part of both CRCC and Georgetown to relocate
21 units to the Waccamaw area. And so in January
22 I sort of, I guess I was engaged, though I
23 didn't really begin to do any substantive work,
24 as I recall, until about March or April of that
25 year.

1 Q: What were you specifically asked by Grand
2 Strand to do, Mr. Sullivan?

3 A: Basically to write the -- a need portion of the
4 application, which is question B-11 of the
5 application, and then also to provide some
6 general review of the remainder of the
7 application, and recognizing we were going to
8 be in a competitive situation with two other
9 applicants for new units, asked to review the
10 other two competing applications and then be
11 prepared to participate in the project review
12 meeting that was going to occur, you know, at
13 a later date.

14 Q: And did you do all those things?

15 A: I did.

16 Q: Okay. In terms of -- let me ask you this. Can
17 you describe generally the process about how
18 you go about developing a need analysis?

19 A: Sure. Well, I mean, the starting point usually
20 is the geography and understanding, you know,
21 where my client's located, where the existing
22 providers are located, and trying to first get
23 a sense of where there might be a need in a
24 particular community looking geographically,
25 and then also looking -- the next step would be

1 to look at the demographics of the population
2 to try to determine where there's areas of
3 particular growth, both geographically and in
4 terms of age categories in the population. And
5 so, typically, I would look at doing some
6 detailed analysis of population at the outset.
7 The next step would be to look at utilization
8 of existing providers, try to get a sense of
9 how much capacity was being utilized currently,
10 and then also the rate at which services are
11 being consumed in a particular service area.
12 And then I would try to come up with the best
13 metrics I could in terms of projecting that
14 need into the future for the population as a
15 whole. And then, you know, probably the most
16 critical assumption, you know, in most of the
17 CON applications is determining what reasonable
18 market shares would be for a particular
19 applicant to capture in terms of meeting that
20 need that was identified for the -- for the
21 service area as a whole. And then sort of
22 putting all that into a, you know, a logical
23 framework, you know, for presentation to the
24 DHEC folks.

25 Q: In terms of this case, I mean, I assume you

1 started with the State Health Plan?

2 A: I did.

3 Q: Okay. And what was your understanding of what
4 the 2010-2011 South Carolina Health Plan showed
5 for linear accelerators?

6 A: It showed a need for one additional linear
7 accelerator in the three-county area. And that
8 was a result of the high -- of utilization of
9 the existing units as well as the projected
10 growth in population.

11 Q: Okay. In terms of the documents that you
12 reviewed to kind of put together your need
13 analysis, what were they?

14 A: You know, it was a wide variety of things in
15 addition to the State Health Plan, which is a
16 good primary source because it has utilization
17 data for all the various providers, I mean, not
18 just in the three-county area, but the entire
19 state. I also wanted to look at population
20 data, and the starting point usually for that
21 is the Office of Research and Statistics in
22 South Carolina, but because that population
23 data is a little more limited in terms of the
24 ability to look at zip codes and also to get
25 very detailed age group breakdowns on the

1 projections, I oftentimes use a source, I did
2 in this case, Claritas, which is a national
3 company that sells demographic information. So
4 I pulled their Claritas data, looked at various
5 trends in population for different geographic
6 areas. You know ---

7 THE COURT: Spell that.

8 MR. SULLIVAN: C-L-A-R-I-T-A-S.

9 THE COURT: Just like it sounds.

10 A: And another source is the Joint Annual Reports
11 that hospitals file with DHEC, and specifically
12 in this case, I was interested in the existing
13 providers of radiation therapy services, of
14 which there were only two, Georgetown and CRCC.
15 So I gathered their Joint Annual Reports for
16 three or four years prior to the time of the
17 application. In this case, because cancer was
18 the primary and the only disease that we're
19 really targeting in this -- in this
20 application, I wanted to get information about
21 cancer incidence rates, which I obtained from,
22 again from the DHEC website, they have a fairly
23 sophisticated system for being able to download
24 information about cancer incidence in various
25 areas and age groups and so forth. And so I

1 gathered information on that and looked at
2 long-term trends in cancer incidence and cancer
3 cases in Horry, Georgetown, and Williamsburg
4 County. And I -- you know, the problem with
5 radiation therapy from a health planning
6 standpoint is there's not a tremendous amount
7 of publicly available data out there about what
8 existing providers are doing. They report
9 their total volumes on the Joint Annual
10 Reports, but they don't give you a breakdown by
11 zip code or by county or anything like that.
12 And so you're really having to look at sort of
13 secondary measures to determine, you know, if
14 we knew that, you know, for example, that CRCC
15 treated 800 patients, we don't know how many of
16 those came from Horry County or we don't know
17 how many of those came from the area along the
18 coast in Horry County near where Grand Strand
19 is located. So, you know, just trying to
20 gather as much information as I could from all
21 the public sources in order to be able to
22 develop a framework for the analysis.

23 Q: Did you have any telephone calls with Adam
24 Rudd, the COO?

25 A: I did, a few different -- I don't remember

1 exactly how many, probably at least five or six
2 calls with him. I had one phone call with --
3 I can't remember if Adam was on the call, but
4 Doug White was on the call, Dr. Holt, who was
5 discussed at some length in this hearing, was
6 on the call.. I don't recall anyone else other
7 than yourself who was on that call. But
8 anyway, I was trying to get a sense of what
9 they were trying to accomplish with the
10 project, sort of where they thought the
11 referral sources would come from in terms of
12 their particular project. Dr. Holt had been
13 identified as a medical oncologist and then a
14 potential source of referrals. I know from my
15 past work that medical oncologists are usually
16 one of the two or three key sources of patients
17 for radiation therapy services. Medical
18 oncologists, urologists are usually the two
19 largest, and then to a more limited extent
20 various type general surgeons and other type
21 folks. So I just try to get a sense of within
22 their medical staff where they thought that
23 they might be able to get referrals, because I
24 knew that this was going to be, you know, a
25 challenge for the -- for Grand Strand because

1 they were coming into a market where there was
2 an existing provider operating three units that
3 had been entrenched for three decades. I was
4 pretty familiar with CRCC's operations from my
5 prior work with Georgetown and was pretty, you
6 know, pretty concerned about the fact that they
7 would need to be able to document that they
8 would have a substantial base of physician
9 support for the project in order to be able to
10 demonstrate the ability to get to the volumes
11 required in the State Health Plan.

12 Q: Okay.

13 A: And so Dr. Holt, I had a relatively brief
14 conversation with him that might have lasted 30
15 to 45 minutes, and he talked about the fact
16 that his group would be supportive of the Grand
17 Strand project, not that he committed to send
18 all their patients there, but just that they
19 would be supportive and that some patients he
20 thought would choose to use the Grand Strand
21 service.

22 Q: Let me ask you this real quick. I want you to
23 go to Joint Exhibit 5. Let me see if I can
24 find that. Tab 5.

25 A: Okay.

1 Q: And turn over to -- first of all, can you
2 identify that document for me?

3 A: Sure, this is the 2012-2013 South Carolina
4 Health Plan.

5 Q: So this is something you typically rely upon in
6 your line of work, Mr. Sullivan?

7 A: I do. I pretty routinely read drafts of it
8 when they're first released and, you know,
9 refer to the actual document many times in the
10 course of my work.

11 Q: All right. Turn to IX 9-8, if you would.
12 Okay.

13 A: I'm there.

14 Q: And what does the -- what's the projection
15 there in terms of ---

16 THE COURT: Wait a second. What page number is
17 that?

18 MR. THOMAS: It's IX-8, Your Honor.

19 THE COURT: Oh, oh, I see it. All right.

20 Q: Okay. In terms of the service area at issue in
21 this case, what does the 2012-2013 State Health
22 Plan indicate?

23 A: It indicates that there's a need for one
24 additional unit. It shows that there were five
25 units, and it doesn't say this, but I think

1 there were four existing and one approved unit,
2 which would constitute that five. And it shows
3 the need for one additional unit beyond five.

4 Q: Okay. Thank you. In addition to State Health
5 Plans and some of the other documents you
6 referenced, did you review in its totality the
7 Grand Strand DHEC record and the CRCC DHEC
8 record?

9 A: I did.

10 Q: We're going to be jumping around in some
11 documents today, but let's see here. Let's
12 look at Petitioner 36 if we could.

13 A: Okay.

14 Q: What does this particular small spreadsheet --
15 the spreadsheet show?

16 A: This is just a summary of the information that
17 was in Joint Exhibit 5. We were just looking
18 at -- it shows the total treatments in the
19 area, the average number of treatments per
20 linear accelerator in the three-county area.
21 There's a footnote there that it's the third
22 highest ratio of treatments per linear
23 accelerator in the state of South Carolina.
24 And it looks at the planning area capacity,
25 whether there would be an unmet need, and what

1 the capacity would be with the -- with the
2 approval of another unit.

3 Q: Where is -- we were looking at, I guess, in
4 Joint Exhibit 5 a need analysis based on 2011
5 numbers, volumes in the service area. What is
6 this Petitioner 36 based on?

7 A: This is based on 2012 numbers. And if -- just
8 to compare the two, if you look at in the 2012-
9 2013 Health Plan, the number of total
10 treatments in the area was a little bit higher,
11 it was 31,902. In this case, the number is
12 28,140. But because the projected utilization
13 would still be above 80 percent, then there
14 would be sufficient demand to support another
15 unit.

16 Q: Okay. Turn over the page, if you would, Mr.
17 Sullivan. I think go to the next tab in that
18 notebook would be Petitioner's 37.

19 A: Yes.

20 Q: Okay. What does this exhibit show?

21 A: This simply looks at the trend in radiation
22 therapy treatments at CRCC between 2009 and
23 2011. And the second line on here measures the
24 increase from 2009 to 2010 and then the
25 increase from 2009 to 2011. What we can see is

1 that CRCC had pretty phenomenal growth over
2 that short period of time. My understanding is
3 it was early part of 2010 when CRCC acquired
4 ownership of the facility -- or, I'm sorry,
5 that wasn't -- I guess when they bought the
6 facility and then also when they entered into
7 an agreement with -- or 21st Century entered an
8 agreement with the urologist to come on board
9 as employees. And so we saw a 34 percent
10 increase between 2009 and 2010 and then another
11 30 plus percent increase by 2011. So between
12 2009 under the old ownership to 2011, there was
13 almost a two-thirds increase in the
14 utilization.

15 Q: What was going on in the state of South
16 Carolina at that time in that same period?

17 A: Well, if you look at the bottom half of this
18 chart, it tracks the number of treatments in
19 South Carolina then it backs out CRCC
20 treatments. And so South Carolina as a whole
21 was only growing at a little over two percent
22 a year in terms of linear accelerator
23 treatments. So the trend in -- at CRCC was
24 definitely far outstripping what was going on
25 in the state as a whole.

1 Q: Okay. Let me ask you to go back to Joint
2 Exhibit 2.

3 A: Okay.

4 Q: Which is Grand Strand's CON application in the
5 DHEC record.

6 A: Okay.

7 Q: And I would ask you, Mr. Sullivan, because you
8 mentioned that you did the B-11 analysis,
9 correct?

10 A: I did.

11 Q: Turn to page 18 in that DHEC record for me,
12 Joint Exhibit 2.

13 A: Okay.

14 Q: And just the need analysis goes from I guess
15 page 18 to, let's see here, 36. Is that your
16 work product?

17 A: It is.

18 Q: Okay. If you'd look in the notebook, and kind
19 of keep that open right there because we're
20 going to come back to it, but I'd ask you to
21 look at Petitioner's 16 real quick for
22 reference. And I'd ask you to identify those
23 documents for me, if you would?

24 A: These are my work papers.

25 Q: And what are they -- where do they come from?

1 A: They came from me. I mean, they came from my
2 computer files that I produced to you.

3 Q: But in terms of some of the documents in there,
4 where did you get them?

5 A: Oh, I'm sorry. Well, the first document is the
6 ACR Practice Guidelines for Radiation Oncology.
7 That's on GSRMC 4395. And that -- that's a
8 fairly standard reference in the radiation
9 therapy world. I've been using this since
10 probably the mid-'80s as a source. And it's
11 the practice guidelines, the professional
12 practice guidelines for radiation oncologists.
13 And specifically what I was looking for is
14 there's a reference in here in terms of the
15 number of patients who require radiation
16 therapy, and it's pretty consistently talked
17 about between 50 and 60 percent of the patients
18 who have cancer require radiation therapy. So
19 that was sort of a foundational assumption that
20 I used in looking at the number of cancer
21 patients in the service area. I picked a
22 midpoint of that range, and I said 55 percent.
23 And that's, I think, generally consistent with
24 what most people's understanding is of what
25 proportion of the cancer population requires

1 radiation therapy.

2 Q: Is the other data in the background for your
3 utilization analysis?

4 A: It is. It's historical utilization, cancer
5 incidence rates, population data from Office of
6 Research and Statistic, and Claritas is in
7 here. There's some files that I got from Grand
8 Strand, which I think comes from their decision
9 support services that show the number of cancer
10 patients that they serve by zip code in various
11 years. But I think there's -- I think that's
12 primarily what these documents entail.

13 Q: Okay. If you go back to Joint Exhibit 2 for
14 me, page 18.

15 A: Okay.

16 Q: So this is where B-11 starts. I guess there's
17 the first, page 18 and 19, five standards that
18 are listed there. Can you explain to the Court
19 what you needed to show there?

20 A: Sure. I mean -- quite honestly these are more
21 definitional standards. It's just talking
22 about the capacities that the State Health Plan
23 assigns to different types of units. That's in
24 one, two, three, and four. And then number
25 five talks about the 13 service areas for

1 radiation therapy. And so, you know, I believe
2 the project to the extent that you can be
3 consistent with these standards is consistent
4 with these standards in that we acknowledge
5 that these are the standards and that we are
6 applying in one of the 13 recognized service
7 areas.

8 Q: Let me ask you quickly, so you've got Standard
9 6-A as the next one there on the Grand Strand
10 DHEC record, page 19. What is Standard 6-A;
11 what does it say?

12 A: This really gets into the need for additional
13 radiation therapy units. And the first
14 requirement is that all existing units in the
15 service area perform at a combined use rate of
16 80 percent of capacity for the year immediately
17 proceeding the application.

18 Q: Okay. And was it your understanding that that
19 was the case?

20 A: That was -- that was the case based on what was
21 in the State Health Plan, as well as my own
22 independent review of the Joint Annual Report
23 of these providers.

24 Q: Okay. Let's go to page 20, kind of 20 and 21
25 is what I have opened, but what -- what's

1 happening here on page 20 and 21?

2 A: Well, as I mentioned earlier, typically what I
3 like to do is just look at the geography, look
4 at the distribution of providers. I try to get
5 a sense of where things lay from a -- just from
6 an access and geographic standpoint. And you
7 can see that there's one unit in Georgetown,
8 there's three units currently located in Myrtle
9 Beach at CRCC, and then I put Grand Strand on
10 the map just to try to depict what was going on
11 in the service area. And then we talked about
12 the fact that underneath the map that there was
13 an effort underway by Georgetown to relocate
14 its cancer center from the Georgetown area up
15 to the Waccamaw area. And then CRCC was also
16 submitting an application to relocate one unit
17 down to that same area.

18 Q: Let me stop you real quick. What's your
19 understanding of kind of where that is in the
20 grand scheme of things, the relocation project?

21 A: They were both approved to relocate within
22 about a half a mile of each other. And it's
23 currently under appeal and I think I heard
24 someone say that it's probably going to be
25 heard sometime next year.

1 Q: All right. Take us through Exhibit 2, if you
2 could.

3 A: Sure. Exhibit 2 just looks at the historical
4 utilization of the two existing providers. And
5 for whatever reason, a number of patients
6 weren't reported by CRCC in 2005 through 2007,
7 so I can see how many treatments they had, but
8 I can't really see how many patients they had
9 and what was going on there. But what we --
10 what we see is that if you look at the middle
11 part of that chart, CRCC up until 2009 was
12 relatively flat in utilization. They were
13 highly utilized because they had three units,
14 and they were operating at over 5,000
15 treatments per unit, but they weren't, you
16 know, they weren't growing to any great extent.
17 Georgetown showed some growth, a little bit of
18 a drop off between eight and nine, but overall
19 the area as a whole had only a slight increase
20 in radiation therapy treatments, but it was
21 well utilized based on the available capacity.
22 And then the bottom part of the chart looks at
23 the number of treatments per patient. And ---
24 Q: Let me ask you, are those projected number of
25 treatments or actual number?

1 A: These are actual number of treatments per
2 patient. And, you know, as we see in
3 Georgetown, we have data over the whole period.
4 Their number of treatments per patient went
5 down from 27 to a little over 20 over that
6 period of time. I don't know what the trend
7 was at CRCC, I just know that their number was
8 around 21 in the two years of data that I had
9 at the time I was preparing the application.
10 So the area as a whole experience was a little
11 over 21 treatments per patient.

12 Q: What's your understanding in terms of what that
13 number of treatments per patient may have done
14 over the last couple of years at CRCC?

15 A: My understanding is it's gone up. During this
16 time, and I don't know all the details, but I
17 know that because of a prior CON battle, the
18 urologists were not referring significant
19 numbers of patients to CRCC. And urologists
20 tend to have the highest number of treatments
21 per patient, 40 to 45 I think we heard the
22 testimony earlier in this case. And so if you
23 pull the urology cases out, obviously the
24 number of treatments per patient is going to go
25 down, and I think that's what happened here.

1 But at the time I did this, I was trying to
2 look at the most recent historical data and use
3 data assumptions in my projections that were
4 based on that most recent data.

5 Q: Would you turn the page in Joint Exhibit 2 to
6 Bates 22 for me.

7 A: Okay.

8 Q: Can you explain to the court what you -- what
9 your analysis is on this page?

10 A: Yeah, I was -- in addressing the standard, I
11 was trying to show what the level of
12 utilization was in the -- in the service area.
13 CRCC had two conventional linear accelerators
14 and had one tomo machine, which is a more
15 specialized unit. And so according to the
16 State Health Plan, they should have a total
17 capacity of 19,000 on those three units. So
18 CRCC in two thousand -- this is 2010 data,
19 which -- which I did obtain, and it showed
20 that, and I believe I got it out of the
21 applications of CRCC and out of Georgetown,
22 because the JARS, as I recall at the time I
23 started this, were not yet available for 2010.
24 And so CRCC was operating at 110 percent of
25 capacity at that time. Georgetown, and I guess

1 there's been some debate about what the
2 capacity of the Georgetown unit is. The State
3 Health Plan says if you're doing a significant
4 number of IMRT or IGRT treatments that your
5 capacity instead of being 7,000 should be 5,000
6 on a -- based on my review of Georgetown's
7 application, it appeared that they were doing
8 a substantial volume of IMRT and IGRT
9 procedures, so I thought it was reasonable to
10 assume a 5,000 capacity. I believe DHEC
11 assumes a 7,000 capacity for them. But in any
12 event, in combination both of the -- the four
13 units in the area were highly utilized whether
14 you use 5,000 for Georgetown or 7,000 for
15 Georgetown.

16 Q: In fact, would they -- they would be still at
17 over 100 percent utilization?

18 A: Absolutely.

19 Q: All right. So that's from 6-A. And then what
20 is Standard 6-B, could you ...

21 A: Yeah, I mean, essentially what it says is the
22 applicant has to be able to project that
23 they're going to reach at least 50 percent of
24 capacity annually within three years of
25 initiating the service, and at the same time

1 they can't drop the utilization of the existing
2 machines in the area below 80 percent. So, in
3 essence, I mean, that's the second part of the
4 need standard and probably, you know, the most
5 significant as far as this case is concerned in
6 terms of projecting utilization what the impact
7 of this project is going to be.

8 Q: Well, just kind of in summary, if Grand Strand
9 were the only applicant approved in this case,
10 would they have dropped the existing providers
11 under 80 percent?

12 A: No, I can't see any scenario where that would
13 happen.

14 Q: Okay. And we'll talk a little bit about that,
15 but under 6-B you've got some language there,
16 and could you explain to the Court what you're
17 doing here on page 23?

18 A: Yeah, I mean, the first part of this discussion
19 under 23 is really just providing some
20 background information about the project and
21 talking about the request for a Varian Clinac
22 ix. Talks about the fact that Grand Strand
23 already is accredited by the American College
24 of Surgeons as a community hospital cancer
25 program, and also that in 2010, based on some

1 data that I obtained internally from Grand
2 Strand, that they had 4,860 patients who
3 contacted the hospital as an inpatient,
4 outpatient, emergency department patient that
5 had a primary or secondary diagnosis of cancer.

6 Q: Okay. Can I stop you real quick?

7 A: Sure.

8 Q: Is that the data that's found in Petitioner 22?
9 You can flip there real quickly. I just want
10 to make sure that the underlying data is in the
11 record.

12 A: That is the data.

13 Q: Okay. All right.

14 A: And again, just to get the sense that there are
15 a lot of people who come to Grand Strand now
16 that are affected by cancer and that Grand
17 Strand would be an appropriate place to have
18 radiation therapy services in order to be able
19 to augment what they could do now for those
20 patients that come to their hospital. And at
21 the time we were preparing this, we recognized
22 that the Coastal Cancer Center medical
23 oncologists were supportive of the project, so
24 we talked a little bit about Coastal Cancer
25 Centers and what they -- the fact that they had

1 five offices and they provided a range of
2 services in their offices, including
3 chemotherapy, which is that we heard earlier
4 one of the three main forms of treatment of
5 cancer, and that one of Coastal's offices is
6 located at the property adjacent to the Grand
7 Strand site.

8 Q: Well, let me just stop you real quick, because
9 you lists some other sites. Now, where are the
10 other Coastal Cancer Center office sites
11 located in the service area?

12 A: They're north, they're in Loris, and then over
13 the border in Supply, North Carolina, which is
14 that southeastern corner of North Carolina,
15 then also in Conway and Murrells Inlet.

16 Q: All right. If we turn the page there, first of
17 all, you mentioned earlier that you did speak
18 with Dr. Holt, correct?

19 A: I did.

20 Q: Did you have any other conversations with Dr.
21 Holt other than that conversation?

22 A: I did not.

23 Q: Okay. What, if any, comments did he make about
24 referrals to Grand Strand specifically?

25 A: That he felt that his group was supportive of

1 the idea of having a radiation therapy center
2 located in the hospital, that he thought that
3 some of their patients would choose to use that
4 unit if it were approved. I think there was
5 some discussion about the fact that if patients
6 lived closer to other providers, you know, for
7 example, if these two units are relocated in
8 Murrells Inlet and they had patients who lived
9 in Murrells Inlet, it was unlikely they were
10 going to come to Grand Strand, and you know,
11 similarly, if there was one in Conway then they
12 probably wouldn't come to Grand Strand from
13 Conway. So, you know, it was -- provided, you
14 know, I think some assurance that there was
15 general support, which I felt was important
16 because medical oncologists, as I said before,
17 are one of the key referral sources. And, you
18 know, we had a somewhat unusual situation in
19 Horry County at this time in that the other
20 significant referral sources the urologists,
21 were sort of off the table with respect to
22 Grand Strand's program, that because they were
23 employed by CRCC, I couldn't really envision
24 getting any material number of referrals or
25 really any referrals from the urology group.

1 And so we're really looking at a, if you think
2 about it as a pie, a slice of that pie had
3 already been taken out before Grand Strand was
4 even starting its analysis.

5 Q: On that phone call, did Dr. Holt speak
6 maliciously or in any way ill will of CRCC?

7 A: He did not. I don't recall him saying anything
8 one way or the other about CRCC.

9 Q: Did he mention anything about becoming employed
10 by Grand Strand?

11 A: He did not.

12 Q: Or anyone in his practice?

13 A: No.

14 Q: On page 23 of the DHEC record there's a
15 reference here to Grand Strand coordinating
16 care for cancer patients with the medical
17 oncologist?

18 A: Yes.

19 Q: Is it your understanding that Grand Strand is
20 the only hospital in the service area that does
21 that?

22 A: No, they're not. I know from talking to Dr.
23 Holt and then just from looking at the
24 distribution of their offices that they're
25 located, you know, near the Waccamaw Community

1 Hospital, located near the Loris Hospital,
2 they're located near the Conway Hospital. And
3 so, you know, I'm sure that there's some
4 coordination of care going on for cancer
5 patients in those hospitals as well.

6 Q: Is it your understanding that the physicians at
7 Coastal Cancer Center are on other medical
8 staffs?

9 A: Yeah, I undertook an analysis of where all the
10 physicians who were referring patients to CRCC
11 currently had medical staff privileges, and the
12 medical oncologists at Coastal were probably
13 more Catholic, if you will, in their privileges
14 in that many of them had privileges at three
15 and in some cases four different hospitals in
16 the service area. So they tended to cover a
17 lot of geography in terms of medical staff
18 privileges.

19 Q: Would you look in your notebook, hopefully it's
20 that one right there, Petitioner's -- I think
21 it's the one down by your side ---

22 A: Okay.

23 Q: -- there, 30, I think it's basically
24 Petitioner's 30 to 35. And if you could
25 identify those documents for the record, Mr.

1 Sullivan?

2 A: Yeah, these are downloads from the websites for
3 various hospitals. 30, Exhibit 30 is Conway
4 Medical Center's medical staff; 31 is
5 Georgetown Hospital System's medical staff; 32
6 is Grand Strand; 33 is McLeod Health, which
7 includes the Loris and the Little River
8 Hospitals; and 34 is Waccamaw Community's; and
9 then 35 is Medical University of South
10 Carolina's medical staff.

11 Q: Why did you look at Medical University of South
12 Carolina?

13 A: Well, I knew from my past work that there was
14 patients who were going from this area down to
15 MUSC for cancer treatment. Georgetown Memorial
16 has a relationship with MUSC and the Hollings
17 Cancer Center. That was part of when we were
18 developing that project that was, I thought, a
19 real plus that Georgetown was able to enter
20 into an agreement with MUSC in order to enhance
21 its ability to provide a comprehensive level of
22 care on that campus. But for many patients who
23 want to go to a facility where there are not
24 only radiation therapy and chemotherapy
25 services, but also highly specialized oncology

1 physicians, surgeons, and so forth, some
2 patients were traveling from the service area
3 down there to MUSC. And, you know, we saw data
4 subsequently that showed market shares of
5 inpatient oncology discharges and showed that a
6 significant percentage of patients who were
7 receiving inpatient services involving oncology
8 diagnoses were going to Medical University.

9 Q: And is it your understanding that the other
10 five offices referenced on Joint 2 page 23 for
11 the Coastal Cancer Center also provide some
12 level of chemo services?

13 A: It's my understanding that they provide chemo
14 in all of the offices. I believe that the
15 Myrtle Beach office is the largest provider,
16 but I think all the offices provide some.

17 Q: Would you turn the page please, to DHEC --
18 Grand Strand's DHEC record page 24 on Joint
19 Exhibit 2.

20 A: Sure. One second. Okay.

21 Q: And on that first full paragraph on that page,
22 can you talk a little bit about the
23 comprehensive cancer setting that you described
24 there?

25 A: Sure. I wrote that so I -- something that I've

1 learned to appreciate over the years in working
2 with various types of providers that, you know,
3 cancer care can be very fragmented for
4 patients, and it's very difficult, particularly
5 for elderly patients, when they have to face
6 fragmented care and they're having to go to a
7 different site and a different provider for
8 each element of care that they need. And so
9 being able to provide services in a
10 comprehensive setting has a benefit of
11 minimizing travel and also facilitates
12 consultation. Dr. Collins, I think, touched on
13 some of that this morning when he talked about
14 being able to walk across the hall and talk to
15 the radiologist. At the time I was writing
16 this, I had just finished working on a project
17 in Raleigh, North Carolina, where a group of
18 medical oncologists got together with radiation
19 oncologists and formed a comprehensive cancer
20 center in Raleigh. And they had been very
21 successful and had, you know, very good results
22 from that. And so, I mean, you know, I know
23 there's been a lot of discussion about what a
24 comprehensive cancer center means. You know,
25 there's sort of a spectrum. You know, the

1 National Cancer Institute certifies cancer
2 centers, and I believe it's a level one center,
3 and that would be places like Duke, Sloan-
4 Kettering, UAB, University of Texas, and those
5 are the most comprehensive, and they have
6 everything. They do all the clinical services.
7 They have the research, you know, they have all
8 of the clinical trials. They have all of those
9 things. In a community setting you're talking
10 about a comprehensive cancer center being
11 something that's a little bit less than that.
12 And obviously, if you're a hospital that has no
13 radiation therapy services you're -- you're on
14 the first step when you're adding the radiation
15 therapy on the way to becoming a comprehensive
16 center. You wouldn't expect a hospital on day
17 one who's adding a radiation therapy center to
18 have everything in-house that they could
19 possibly have for the treatment of patients
20 with cancer. But this is the first step, and
21 as I think has already been talked about by
22 other witnesses, it's a building block that
23 let's you then expand the other specialties
24 that are on your medical staff. Because if you
25 have more cancer patients coming to your

1 facility, there's going to be a greater
2 interest in like specialized breast surgeons,
3 specialized general surgeons, specialized, you
4 know, neurological -- neurosurgeons and
5 neurologists who could deal with breast cancer.
6 They're going to be more willing to come to an
7 area if you have a program like this. And
8 that's a differentiator from a freestanding
9 center, because a freestanding center is really
10 just providing radiation therapy. I mean, I'm
11 not trying to denigrate that, I mean, but
12 that's what they do, they provide radiation
13 therapy. A hospital provides a wide range of
14 services, and so they're trying to provide all
15 three legs of the treatment process, that being
16 radiation oncology, medical oncology, and
17 surgery. And so, you know, I saw this as an
18 important first step. Grand Strand had already
19 taken some initial steps by getting
20 accreditation from the American College of
21 Surgeons, but they needed to add the other
22 services to its array of offerings to patients
23 in order to be able to effectively
24 comprehensive treatment. And I think it's a
25 clear differentiator in, you know -- and the

1 reason I put it in here is because I thought
2 DHEC was looking at three applications, two of
3 them were for freestanding centers and one was
4 for a hospital-based, which I thought could be
5 a more comprehensive provider of services.

6 Q: Are only inpatients able to take advantage of
7 a comprehensive cancer center?

8 A: No, obviously not. The vast majority of people
9 that receive cancer services receive them on an
10 outpatient basis, and it's the outpatients that
11 really benefit from it, because as Dr. Collins
12 was alluding to this morning, a number of
13 people who have radiation therapy are getting
14 concurrent chemotherapy. And the chemotherapy
15 isn't quite as burdensome from a travel
16 standpoint. Typically they're only getting
17 that one or two days a week. But the idea that
18 you would have to go to one site and then, you
19 know, receive your radiation treatment and then
20 go some distance to get to the second site, see
21 a different group, for that, you know, it just
22 adds a little layer of complexity. You know,
23 this -- it's not all under one roof at Grand
24 Strand, but having it three minutes away is a
25 lot better than having to drive ten or 15 or 20

1 minutes down the road to go to the CRCC
2 facility for radiation and then come back and
3 have your medical oncology services after that.
4 So, you know, there's an advantage to having
5 everything co-located even if it's not all
6 under one organization umbrella. I mean,
7 obviously the ideal is to have everything under
8 one organization, but for a community hospital
9 offering an array of services that's a better
10 solution than having only one option, which is
11 freestanding. There's nothing wrong with
12 freestanding radiation therapy. I think there
13 needs to be a balance in every community. And
14 some communities are too small to have both,
15 they can either have freestanding or they can
16 have hospital-based.

17 Q: Well, let me stop you there. Could you turn to
18 Petitioner's 14 in your ---

19 A: Sure.

20 Q: --- Grand Strand notebook. Okay. Tell the
21 Court about this chart.

22 A: Sure. I mean, one of the things that was, you
23 know, surprising to me when I first got
24 involved in radiation therapy services ---

25 MR. LONG: Your Honor, I'm going to have to object

1 to this one if he doesn't lay a little better
2 foundation. As I recall, Mr. Thomas said in
3 his opening it has a typo on it.

4 MR. THOMAS: All right. Pardon me. We'll do that.

5 MR. LONG: And, of course, this witness would need
6 to correct it to be able to testify about it.

7 MR. THOMAS: We can do that, Your Honor.

8 Q: Mr. Sullivan, Mr. Long is exactly right. I
9 think in Charleston County there is the
10 existence of ---

11 MR. LONG: Okay, Your Honor. Stop. Your Honor,
12 objection. Okay. That's what I was talking
13 about my objection. He's getting ready to
14 educate the witness on what the typo is.
15 That's ---

16 THE COURT: Well, is your objection that he's
17 leading?

18 MR. LONG: He's leading, thank you, Your Honor.

19 THE COURT: Sustained.

20 Q: Are you aware of any typos on this document,
21 Mr. Sullivan?

22 A: Yes. Charleston County, there are eight
23 hospital-based and three freestanding linear
24 accelerators.

25 Q: Okay. Thank you. All right. When we made

1 this correction can you explain ---

2 THE COURT: Give me the exhibit number again.

3 MR. THOMAS: That's Exhibit Number 14, Petitioner's

4 14, Your Honor.

5 THE COURT: Thank you.

6 MR. THOMAS: Bates Grand Strand ---

7 THE COURT: That's fine, I've got it.

8 MR. THOMAS: We'll also submit it to the court

9 reporter in corrected fashion.

10 THE COURT: Well, is that -- is that acceptable?

11 MR. LONG: Yes, Your Honor. We need to be -- yes,

12 it would need to be corrected before it was

13 submitted.

14 THE COURT: Okay.

15 Q: Mr. Sullivan, did you create this chart?

16 A: I did.

17 Q: Okay. Can you explain the significance of the
18 chart, if any?

19 A: Sure. As I said, it was somewhat unusual that
20 an area the size of Horry County would have
21 only freestanding centers. I mean, I'm used to
22 seeing a mix in larger population areas between
23 hospital-based and freestanding. And when we
24 looked at the four other counties in South
25 Carolina that are larger than Horry County --

1 Greenville, Richland, Charleston, and
2 Spartanburg -- we saw just that, that there
3 were hospital-based and freestandings in each
4 of those markets. And that makes sense,
5 because some patients may want to go to a
6 hospital facility and some patients may
7 definitely not want to go to a hospital
8 facility to receive their treatment. In Horry
9 County today, they don't have that option.
10 They can drive 40 miles to Georgetown, even
11 though that's technically a freestanding center
12 on the campus of Georgetown, or they can drive
13 to Wilmington, North Carolina, which is, I
14 don't know the exact mileage, close to 100
15 miles to the north, or they can drive 100 miles
16 to the south to Charleston. And so when I was
17 first looking at this project in the context of
18 the two other competing applications, I thought
19 it was a pretty clear choice for DHEC to make
20 to differentiate between a hospital-based
21 program and then approving additional
22 freestanding units.

23 Q: Okay. And just for the record, is it your
24 understanding that chemo can be offered at
25 Grand Strand's linear accelerator project?

1 A: Sure. I mean, there are -- there are treatment
2 rooms on the plans for medical oncology
3 infusion services to be offered. You know, I
4 think that's something that will evolve over
5 time. I mean, until they have the program and
6 see what the needs of the patients are, you
7 know, I don't think they can evaluate exactly
8 what the number of those treatments are going
9 to be, but certainly they have the capability
10 within the floorplan to do that.

11 Q: Okay. If we could go back to Grand Strand's
12 DHEC record ---

13 A: Sure.

14 Q: --- on Joint Exhibit 2.

15 A: Okay.

16 Q: Page 24 for me.

17 A: Okay.

18 THE COURT: Are we getting close to a break here?

19 MR. THOMAS: Let's see, Your Honor. I think we can
20 make that happen for you. In fact, if you want
21 to just break now we can just come back and
22 start him on this page.

23 THE COURT: All right.

24 MR. THOMAS: I'm fine with that. I'm hungry too.

25 THE COURT: Well, when are we going to come back,

1 1:45 or 2:00?

2 MR. THOMAS: The court's preference, Your Honor.

3 MR. LONG: It's really Your Honor's preference, I
4 think.

5 THE COURT: Well then I'm going to give it a shot at
6 1:45.

7 MR. THOMAS: All right.

8 (Lunch break from 12:24 p.m. until 1:43 p.m.)

9 THE COURT: All right. Mr. Sullivan, you're still
10 under oath. Okay.

11 MR. LONG: Your Honor, just one housekeeping matter
12 before we start back. At lunch today we, CRCC,
13 we decided that we would take down one of our
14 witnesses, Dr. Mantz. After hearing the
15 testimony this morning and the way the trial's
16 developed, we think his testimony may be
17 cumulative. So he lives in Florida and would
18 have to fly up here and all that, so that helps
19 us in our scheduling a little bit. I don't
20 think it saves us a tremendous amount of time
21 but ---

22 THE COURT: Okay.

23 MR. LONG: --- it would help us. We had kind of
24 penciled him in for Thursday anyway, so we just
25 wanted to let the Court know that. We informed

1 Mr. Thomas right before I told you.

2 THE COURT: So when you say take down, you mean in
3 the -- take him off on the list, we're not just
4 going to take him down?

5 MR. LONG: Yeah, I don't -- yeah. That's what I
6 meant.

7 MR. THOMAS: All right.

8 Q: All right. Back on the record. Mr. Sullivan,
9 I believe we were on page 24 of Joint Exhibit
10 2.

11 A: Yeah.

12 Q: And you've gone through some of your opinions
13 on the comprehensive cancer setting. The
14 second paragraph there you've got an Exhibit 4
15 on the page. Can you explain to the court what
16 you did there?

17 A: Sure. As I mentioned earlier, one of the
18 things I wanted to look at was what was
19 happening in terms of number of cancer cases
20 and cancer incidence in Horry, Georgetown, and
21 Williamsburg Counties. So I gathered some
22 information from DHEC that reflects --
23 reflected in Exhibit 4 that shows what's
24 happened in terms of new cancer cases between
25 '96 and 2007. And that was the most recent

1 period, 2007, at the time I did the
2 application. And what this shows is that the
3 number of cases -- the bottom line is Horry
4 County and there's been pretty significant
5 growth in the number of new cancer cases in
6 Horry County, and also in the three-county
7 service area as well. And I believe that
8 that's a function of the overall growth in
9 population that's occurred in Horry County as
10 well as the aging of the population, because
11 older individuals have higher rates of
12 incidence for cancer.

13 Q: Is that the age adjusted incident rate that's
14 reflected on the next page, page 25?

15 A: It does, you know. And that was just to get a
16 sense of what the comparisons were among these
17 counties. And, you know, the age adjusted
18 rates aren't really useful for projecting
19 future utilization because of the fact that
20 they are age adjusted. You know, for example,
21 an area might have a relatively high absolute
22 rate of new cancer cases, but because they have
23 an older population, the rate is adjusted to
24 the US standard population distribution in
25 terms of age categories. And so it's a way of

1 comparing counties across each other and kind
2 of an apples and apples basis, but they're not
3 good for projecting. And we talk about that at
4 the bottom of page 25. And so we got -- we
5 then went and got the crude cancer incidence
6 rates.

7 Q: And that's reflected on page 26 of Joint 2?

8 A: It is. And if you look at this for, you know,
9 any one county or, you know, for the -- for the
10 three-county area or South Carolina, you can
11 see that there's almost an exponential growth
12 in incidence of cancer between the under 45
13 population, moving to the 45 to 64 population,
14 and then again going up to the 65 plus
15 population. So clearly unfortunate fact is
16 that the older you are, the greater the
17 likelihood of you're going to get cancer. So
18 we wanted to specifically reflect that in our
19 projections, the age-specific demographic
20 trends in the market.

21 Q: Okay. In Exhibit 7 you set out population,
22 estimated and projected population. Can you
23 just tell the court what you did there on to
24 page 27 as well.

25 A: Sure. What I did is, and this was occurring

1 right at the time the US census was releasing
2 its results from its -- for the 2010 census,
3 and so the South Carolina Office of Research
4 and Statistics data was lagging a little bit
5 behind the census data, but what I did I just
6 did a comparison. Exhibit 7 shows what the
7 projections were for 2015 and the estimate for
8 2010. And then in Exhibit 8 I compare that to
9 -- to what the US census came up with for 2010.
10 And we can see that the total for the three-
11 county area is the same virtually, though the
12 -- SCORS had underestimated the Horry County
13 population by a little bit.

14 Q: You say SCORS here ---

15 A: South Carolina Office of Research and
16 Statistics.

17 Q: Okay. Thank you.

18 A: And had slightly overestimated the Georgetown
19 and Williamsburg populations. So anyway, I was
20 just trying, you know, trying to, again, just
21 sort of establish a basis for doing future
22 projections. The exhibit at the bottom of page
23 27 just shows that the vast majority of the
24 population is concentrated in Horry County. No
25 big surprise.

1 Q: For 2015 is more than four times the people in
2 Horry County than there would be in Georgetown?

3 A: That's true.

4 Q: Okay. All right. Take the court through your
5 exhibits on pages 28 and 29, please.

6 A: Okay. Twenty-eight and 29, as I mentioned
7 earlier there's some limitations with the --
8 with the SCORS data in terms of being able to
9 get very specific data at the zip code level
10 and age-specific categories, and so that's
11 where I used Claritas data. And the Claritas
12 data is summarized on Exhibit 10. And again,
13 it shows very similar trends to what we looked
14 at a minute ago in terms of what SCORS was
15 projecting, but the numbers are a little bit
16 different. But what it shows, and if we look
17 over on page 29 at the last little box down
18 there, you can kind of see what the growth
19 rates are. And we see that in terms of total
20 population, Horry County is projected to grow
21 between 2010 and 2015 by 2.5 percent. And the
22 population in all the other -- in Williamsburg
23 it would be slightly negative and in Georgetown
24 less than one percent. So again, in terms of
25 future demand for radiation therapy services,

1 there was a strong indication that the need
2 would be greatest in Horry in the future. And
3 if we look at the aging population, the 65 and
4 older category, that's the fastest growing
5 component of the population, and it's growing
6 faster in Horry County than in the other
7 counties.

8 Q: And just at the bottom of page 29, what do you
9 reference there?

10 A: The projected utilization?

11 Q: Right. Yeah. And what, if any, significance
12 is the fact that Grand Strand's a regional
13 provider have in this case?

14 A: One of the, you know, one of the elements I
15 think of a comprehensive healthcare system, not
16 just cancer care, but comprehensive healthcare
17 system, is having certain providers that serve
18 as a regional hub and can provide very complex
19 services that can't be supported in every
20 community hospital or in smaller counties. And
21 Grand Strand serves that role to a larger
22 extent today in this three-county area. And so
23 it would be logical for a provider that
24 provided comprehensive services and a range of
25 other product lines to also offer a

1 comprehensive range of services in the cancer
2 arena as well. And so that was the starting
3 point of my analysis.

4 Q: Okay. And turn the page to page 30, and there
5 is an Exhibit 11, page 30 of Joint 2. Why did
6 you include this exhibit?

7 A: Well, primarily because DHEC always asks for
8 this data. This is just general inpatient
9 origin data by zip code. Almost every
10 application I've done, if I don't provide the
11 inpatient origin data, they ask me for it when
12 they review the application. I don't think
13 it's directly relevant to what the projections
14 will be for a start-up service like radiation
15 therapy that's primarily an outpatient service,
16 but just to kind of set the stage in knowing
17 that DHEC wanted to see it, this presents what
18 the acute care distribution of patients are by
19 zip code and then what the service area for
20 Grand Strand would look like. And that's
21 presented in Exhibit 12.

22 Q: Okay. At the bottom of page 31, you make
23 reference to medical oncologists at Coastal
24 Cancer Center. Tell the Court why you did
25 that.

1 A: Sure. We knew that the medical oncologists
2 were significant referrers of cancer patients.
3 We knew from the conversation I had with Dr.
4 Holt that most of their patients went to CRCC
5 and that CRCC was very highly utilized. And in
6 that conversation I had with Dr. Holt, he
7 reported that there were times when patients
8 were having to get services late in the
9 evenings on many days. And so there was
10 clearly a need for additional capacity in Horry
11 County, and the Coastal doctors had indicated
12 that if that capacity was at Grand Strand that
13 they would refer some patients to Grand Strand.

14 Q: Okay. On page 32, if you turn the page there,
15 it's an Exhibit 13. Can you explain to the
16 Court what Exhibit 13 is?

17 A: Sure. This is just doing some simple math, we
18 saw earlier what cancer incidence rates were by
19 various age categories, and then I applied
20 those incidence rates to the age-specific
21 components of the population in each of the
22 three counties in the three-county service area
23 to project how many new cancer cases we could
24 expect to see going forward in 2011, '12, '13,
25 '14, and '15. And what we see on this chart is

1 that there was projected to be growth of total
2 cancer patients of about three hundred --
3 cancer cases of about 352. Assuming that -- if
4 you see that in the middle of that chart
5 there's an assumption, the percent requiring
6 radiotherapy was 55 percent for the reasons I
7 mentioned earlier from the American College of
8 Radiology report, and just from my own
9 experience, then we would project that there
10 would be growth in the three-county area of
11 about 194 new radiation therapy cases between
12 2010 and 2015. And that was important, you
13 know, for a couple of reasons, one, in terms of
14 showing that there was going to be additional
15 volume out there and that the new capacity
16 could be well utilized; and two, to show that
17 a new program coming in wouldn't necessarily
18 have a significant detrimental impact on
19 existing providers because the impact would be
20 mitigated by the growth in the total number of
21 radiotherapy patients in the future.

22 Q: Okay. Turn the page to 34 in Joint 2.

23 A: Okay.

24 Q: And I know I think the discussion starts first
25 with this exhibit on 33,

1 A: Sure.

2 Q: Could you take the Court through your Exhibit
3 14 on page 34.

4 A: Okay. The starting point is -- the top part of
5 the chart is taken from the projections that
6 were done on Exhibit 13, and that's just the
7 total number of radiation therapy patients we
8 projected by county. And then we had come up
9 with estimates of market share for the -- for
10 Grand Strand. And those numbers are reflected
11 in the second part of that chart. And we can
12 stop ---

13 Q: How did ---

14 A: --- and talk about that for a minute. Yeah.
15 Okay. You know, as I said at the beginning of
16 my testimony, that's one of the key assumptions
17 and, you know, probably the most difficult
18 assumption that you make as a healthcare
19 planner is what market shares will be. And so
20 thinking about this and this analysis is
21 focused on the three-county area, so I'm
22 looking at broad geographic area, looking at
23 Horry County. The backdrop to this is is I
24 know that Georgetown has a program to the
25 south, so the likelihood is we're not going to

1 draw very many patients out of Georgetown
2 County. I also know from my work with both
3 Grand Strand and Georgetown that they have
4 somewhat distinct medical staffs and different
5 referral patterns, so I wouldn't expect there
6 to be a tremendous amount of activity in terms
7 of referral patients from Georgetown up into
8 Horry. Williamsburg is even farther away from
9 Grand Strand than Georgetown is, and so my
10 assumption was that any market share we've got
11 in those counties would be relatively small.
12 It would be just because somebody wanted to
13 come to the Grand Strand to get those services,
14 not because it would be particularly convenient
15 or whatever. And so I assumed that for those
16 two counties that only one percent of the cases
17 would come from those two counties. And then
18 for Horry County then, you know, that was
19 really the crux of where we're going to get
20 most of our patients from. And, you know, the
21 starting point I think when you think about it
22 is there were three units at CRCC, where are we
23 going to get a fourth unit? You know, all
24 things being equal, maybe we could get 25
25 percent because we would have one-fourth of the

1 capacity in the community. But it struck me
2 that that wasn't very likely to occur,
3 particularly in the early years, for a couple
4 of different reasons. I mean, first of all,
5 CRCC is a well-established provider, has got
6 referral relationships with folks, and I would
7 assume has -- had good working relationships
8 with a number of its referral sources. So just
9 because Grand Strand opened its doors doesn't
10 mean everybody's overnight going to change
11 their referral path. Secondly, I knew that
12 there had been this employment agreement
13 between CRCC or 21st Century and the urology,
14 Atlantic Urology Group. I didn't know how many
15 patients they had or how many treatments they
16 had at this point in time because that number's
17 not public. Just from my work in other areas,
18 I was estimating that maybe that would be 25 or
19 30 percent of the market. I didn't know what
20 the number was, it was just a starting point.
21 And so that effectively put a cap on how much
22 market share we could get. And so my thought
23 was if I ratcheted back, you know, let's say 25
24 percent was kind of what I was thinking would
25 be the maximum market share that we could get

1 in the beginning, could I -- I decided to
2 ratchet that back based on the fact that we
3 wouldn't have the urology referrals, we didn't
4 have the history, operating history of CRCC,
5 and we would be a start-up operation and we
6 would have to prove ourselves essentially to
7 the medical community and show that we could
8 have good outcomes with patients and they could
9 provide good service and good turnaround and so
10 forth. You know, doctors are very finicky
11 about, you know, where they send their
12 patients, and if they don't get good results or
13 they get negative reports from the patients
14 about how they were treated when they went to
15 a particular place then they're not likely to
16 continue to refer there. So Grand Strand's got
17 to build their reputation over time. So my
18 assumption was given that Grand Strand is a
19 regional provider, even though it has support
20 of medical oncologists and a number of other
21 doctors who wrote letters of support, that we
22 could get a reasonable market share, but we
23 wouldn't be able to come in and be on equal
24 footing with CRCC, particularly during the
25 first three years and particularly since the

1 pie in terms of total patients had been shrunk
2 down by the urology piece being taken off the
3 table. So my assumption was that we would
4 start at 15 percent in Horry, go to 18 by the
5 second year, and then 20 percent by the third
6 year. And I think that would be a reasonable
7 expectation for a start-up program with the
8 resources that Grand Strand has.

9 Q: Why wouldn't you just apply the inpatient
10 market share?

11 A: Well, if you look at the inpatient market
12 share, it's -- inpatient market shares actually
13 vary, even at Grand Strand among product lines.
14 For example, in cardiology, they have a very
15 high market share, because they provide the
16 only interventional cardiology program in the -
17 - in Horry County. And so they get all the
18 open heart patients, they get the elective
19 angioplasty patients, and they have a whole
20 range of services. So they have very high
21 market shares in cardiology, for example. In
22 other service lines they're not necessarily
23 that high because the specialization that they
24 offer isn't that much different from what's
25 available at Conway or would be available in

1 Georgetown and so forth. And so -- but their
2 overall market share reflects their operations
3 over decades; it reflects significant
4 competitive advantage that they enjoy by the
5 size and scope of their operations. They have
6 a very deep medical staff at Grand Strand
7 relative to the other hospitals in the area;
8 and they've got a reputation that they've built
9 over time in terms of providing inpatient
10 services. They had none of that as it related
11 to radiotherapy services.

12 Q: Okay. Could you finish taking the Court
13 through Exhibit 14.

14 A: Sure. And so at this point it's more of a math
15 exercise. If I take 15 percent in 2013 of the
16 1,008 projected radiation therapy patients in
17 Horry County, then that gives me 151 and so
18 forth, you just do that math. And then it
19 comes up with an estimate of 154 patients in
20 2013 from the service area, 191 in 2014, and
21 220 in 2015. I know from just looking at Grand
22 Strand's patient origin data that there's sort
23 of two things in play, one is that some
24 patients from North Carolina just come down to
25 get services at Grand Strand, so that wasn't

1 included in my three-county analysis so I
2 wanted to give some effect to that. And it's
3 a big vacation destination and part-time
4 resident destination in Horry County. And just
5 looking at, again, they're inpatient data, they
6 did get patients from all over the country.
7 But as a start-up program, again, with a single
8 linear accelerator, I thought that that in-
9 migration percentage wouldn't be great in the
10 early years, so I set that at five percent.
11 And so we pick up a few more patients with the
12 in-migration, but the total projection was
13 going -- starting at 162 patients in the first
14 year going to 232 by the third year.

15 Q: Okay. In terms of meeting Standard 6-B, how
16 does this analysis figure into that?

17 A: Well, if you continue on down the table, I
18 assume the 21 treatments per patient, which was
19 the actual experience in the area in 2009, by
20 the third year I'm projecting 4,620 patients.
21 And with a capacity of 5,000 we'd be operating
22 at 92.4 percent utilization. The standard in
23 the State Health Plan requires that you be at
24 at least 50 percent utilization by the third
25 year. So clearly the project based on these

1 projections would meet the 50 percent standard.

2 The second part of the standard is that you

3 wouldn't bring existing programs below 80

4 percent, and I talk about that at the bottom of

5 page 34 and the top of page 35. And if you

6 remember, we were talking about the growth in

7 the area a little while ago, there was an

8 increase in new cancer patients of 194 over the

9 period between 2010 and 2015, and we're

10 projecting from the service area 220. So the

11 discussion at the top of page 35 talks about

12 the fact that the difference between 194 and

13 220 is 26 patients. So basically the net loss

14 that existing providers would have after you

15 account for the growth would be 26, and if we

16 multiply that by 21, that would be a loss of

17 546 treatments. And with a utilization rate of

18 over 100 percent in the four existing linear

19 accelerator units and with a base of well over

20 20,000 treatments, a loss of 546 treatments was

21 only going to drop the utilization by about two

22 or three percentage points. So there was no

23 chance that the existing providers would fall

24 below 80 percent as a result of approval of the

25 project.

1 Q: All right. And would you take the Court there,
2 it looks like three more standards left ---

3 A: Okay.

4 Q: --- and take the court through the standards.

5 A: Number seven really talks about expansion of
6 existing service, which isn't applicable to
7 this project. Number eight talks about
8 documenting the source of the referrals for the
9 patients, including letters of support from
10 physicians and healthcare facilities. We did
11 have a number of letters of support that were
12 included with the application and filed
13 subsequently, so I believe that the project
14 complies with that. And then number nine is
15 the applicant has to affirm that it will meet
16 a number of sort of programmatic requirements
17 in terms of having a board certified radiation
18 oncologist, having a physicist, having
19 simulation equipment, and having block and
20 design and cutting systems. In addition,
21 there's one final requirement that the
22 institution have its own tumor registry or
23 actively participate in a central tumor
24 registry. And the responses in here I think
25 all indicate that Grand Strand would comply

1 with those standards.

2 Q: In your opinion, does Grand Strand's project
3 meet the -- or satisfy the radiotherapy
4 standards that are set forth in the applicable
5 State Health Plan?

6 A: In my opinion, it does.

7 Q: Did you have an occasion to review the
8 remainder of Part B?

9 A: I did have occasion.

10 Q: Would you turn over to DHEC record 40 in Joint
11 2.

12 A: Okay.

13 Q: In terms of the staffing and the way Grand
14 Strand plans to staff the project, what if any
15 opinions, do you have about staffing plan?

16 A: Just that I have worked on a number of CON
17 applications for new linear accelerator
18 projects, and this staffing plan appeared to be
19 very consistent with what I've seen in other
20 projects, particularly given the projected
21 volumes. And so starting with two radiation
22 therapists, for example, in year one and going
23 to three seemed consistent with the volumes.
24 And then the other physicians, they seemed to
25 have covered all of those adequately that would

1 be needed to operate the center.

2 Q: Okay. Would you turn to page 59 in the DHEC
3 record for me.

4 A: Okay.

5 Q: Joint 2. In terms of the project costs, were
6 there any concerns there?

7 A: No, I mean, again, I'm not an architect, but as
8 it relates to my experience in other centers,
9 the cost of construction for a facility, and
10 these are specialized facilities because they
11 require special shielding in the walls for the
12 vault and so forth, the cost of \$246 roughly
13 per square foot certainly fell within the range
14 of what I would expect to see for a project
15 like this.

16 Q: In terms of -- would you turn to page 125 in
17 the record, Joint Exhibit 2.

18 A: Okay.

19 Q: And what is on that page?

20 A: This is a floor plan for the proposed facility.

21 Q: How does this compare, this floor plan compare
22 to other projects you may have worked on,
23 linear accelerators?

24 A: It's very similar in design. In fact, not long
25 after I worked on this I had an opportunity to

1 go to a brand new radiation center in Tennessee
2 and noted that the layout there was very
3 similar to the one that Grand Strand had. They
4 appeared to have all the necessary spaces.

5 Q: And part of that spacing includes the space for
6 chemotherapy?

7 A: It does. There were two rooms included in here
8 for chemo.

9 Q: Okay. Would you turn to page 176 for me. I'm
10 just going to ask you to identify some of these
11 documents. It's a long range of these pages,
12 176 to 298.

13 A: Okay.

14 Q: Can you identify for the Court what these
15 documents are?

16 A: These are all documents that were used by me in
17 developing the projections in the application.

18 Q: All right. If'd you turn to page 303 of the
19 DHEC record.

20 A: Okay.

21 Q: I know you didn't prepare the pro formas, but
22 did you have a chance to review them?

23 A: I did.

24 Q: And if you'd look at page 304 for me.

25 A: Yes.

1 Q: What, if any, opinions do you have about the
2 EBIDTA and the operating income of this
3 enterprise?

4 A: I mean, certainly as it relates to the issue of
5 financial feasibility, I mean, the project is
6 projecting to generate, you know, significant
7 level of EBIDTA and operating income, you know,
8 in the third year; 1.3 million in EBIDTA and
9 about 880,000 in operating income. So it shows
10 the project is definitely financially viable.
11 The volumes that were -- this was based on the
12 volumes that I had projected, you see that at
13 the top of the page, which I think are
14 realistic volumes. And I would expect a
15 project that was doing 4,600 treatments a year
16 to be profitable, based on my experience in
17 working with other centers.

18 Q: You heard testimony of Mr. Grace, Grand
19 Strand's CFO, last week where I think Mr. Long
20 was asking questions about IMRT rates and
21 whether or not he included those, and he said
22 he didn't. What, if any, effect would that
23 have on the pro formas had Mr. Grace included
24 the proper rates for the IMRT treatments that
25 are proposed to be done?

1 A: I mean, it would only boost the bottom line,
2 both the EBIDTA and the net income, you know,
3 the operating income numbers. So it would just
4 enhance the overall feasibility of the project.

5 Q: And do you recall your assumption of how many
6 IMRT treatments were, or percentage of IMRT
7 treatments Grand Stand could do?

8 A: I think it was 60 percent.

9 Q: If you'll look on page 304 ---

10 THE COURT: If you could hold on one moment.

11 MR. THOMAS: I'm sorry.

12 THE COURT: Go ahead.

13 Q: Also on DHEC record 304 in Joint 2 there's --
14 what's stated there for inpatient revenues?

15 A: Zero.

16 Q: And what's your understanding of that, of why
17 that is?

18 A: You know, I heard Mr. Grace's testimony at that
19 point, and I agree with him that -- that by and
20 large, Medicare, for sure, is not going to pay
21 any incremental revenue for an inpatient
22 receiving radiation therapy. The patients are
23 covered under a DRG payment for their principal
24 reason for being admitted to the hospital. And
25 radiation therapy, if it were provided, would

1 be like any other service, it would all be part
2 of that bundled payment. So if they had no
3 radiation therapy treatments or five radiation
4 therapy treatments, the hospital would still
5 get reimbursed the same amount. So I think it
6 was appropriate not to include that. Many
7 managed care plans adopt Medicare reimbursement
8 approaches in terms of DRG-based reimbursement.
9 There's very few left today that reimburse on
10 the basis of charges or on a per diem basis or
11 certainly on a per service basis; I don't know
12 very many that do that. So you wouldn't expect
13 there to be any material inpatient revenue.

14 Q: Do you think that's reflective of the volume of
15 inpatients at all that Grand Strand may do at
16 its facility if it's approved for a linear
17 accelerator?

18 A: I don't think you can read anything at all into
19 the financial projection as it relates to how
20 many inpatients would be done, so.

21 Q: Okay. Turn over to page 596 for me if you
22 would. And would you identify this document
23 for the Court?

24 A: Sure. This was a response to request for
25 additional information from DHEC that I

1 authored some of the information in here I
2 gathered from -- from folks at the hospital.
3 But generally this was -- this was an
4 attachment to a longer letter, I think, that
5 you authored responding to additional
6 information. So this was really just
7 addressing information related to need
8 projections and utilization and so forth.

9 Q: Okay. And on page 596 there's a question there
10 about redirecting, the number of patients going
11 to be redirected from CRCC. What did you do
12 there in response to that?

13 A: Well, I reiterated something that I said in the
14 original application, I wouldn't expect there
15 to be any impact on Georgetown Memorial
16 Hospital because of the different medical
17 staffs, the different referral patterns that
18 were in place. And then I also reiterated what
19 I discussed in the original application about
20 the fact that there would be growth of 194 new
21 cases. We were projecting 220 new cases in the
22 original application, and then in this document
23 I do some additional projections based on zip
24 codes. And so I -- on page 596, I talk about
25 the fact that this would be a slightly bigger

1 loss, 29 patients and 609 treatments, but
2 again, that would not raise any concerns about
3 dropping existing providers below 80 percent.

4 Q: And why did you do a zip code analysis?

5 A: Because DHEC asked me to.

6 Q: And how did you go about doing that?

7 A: Well, as I mentioned earlier, there's not very
8 good public information available on radiation
9 therapy patients. I don't know how many
10 radiation therapy patients they serve
11 historically in each of the zip codes in the
12 three-county area. So I do -- I can estimate,
13 I think, with some degree of precision the
14 number of cancer patients in those zip codes
15 based on incidence rates. As I mentioned
16 earlier, while the service area for radiation
17 therapy would be similar to Grand Strand's
18 inpatient service area, I think it would be
19 smaller, and because of the presence of
20 Georgetown, because of the existence of CRCC.
21 And so rather than rely simply on inpatient
22 acute care utilization, which I don't think
23 would be a good indicator of where patients
24 would come from for radiation therapy, I did
25 something which I'll call a draw rate. A draw

1 rate -- I don't want to get too far down in the
2 weeds on this, but basically, when you don't
3 know what the total size of the market is in
4 something, but you know how many patients that
5 you've served historically in a market, you can
6 just calculate the rate of patients you served
7 over the population. So let's say, for example
8 -- and what I was looking at here was the
9 number of inpatient cancer patients that Grand
10 Strand had served. And I thought that would be
11 a reasonable indication of where they were
12 likely to get referrals for outpatient cancer
13 services because that's where they were getting
14 referrals for inpatient cancer services. And
15 let's say that in a particular zip code they
16 had ten patients and there were 1,000 patients,
17 a 1,000 residents in that service area, my draw
18 rate would be ten. . It would be ten per 1,000.
19 So we've got ten patients for 1,000 population
20 in that zip code. And I did that for every zip
21 code where Grand Strand got at least three
22 patients on an inpatient oncology service. And
23 then I could look at the draw rates. And what
24 the draw rates tell you is not only how many
25 patients you've got, but what the reliance of

1 that population is on your particular service.
2 So, for example, if you had a rate of ten in
3 one area and then you had a rate of one in
4 another area, that would say most of the people
5 in that area don't rely on you for that
6 particular service because you're only getting
7 one out of 1,000, whereas another area you're
8 getting ten out of 1,000. And the underlying
9 assumption is that the use rate in each of
10 these zip codes is roughly the same. And I
11 don't know if I'm making it clearer or less
12 clear, but the idea was -- is to give a way of
13 ranking the zip codes that Grand Strand has
14 served, specifically for cancer patients, in a
15 way that I could divide those up into a primary
16 and secondary service area. And it may be
17 easier to actually look at the exhibits.

18 Q: Yeah. So, that's what I was going to ask. Are
19 the exhibits for your draw rates attached at
20 Joint 2, page 600 through 617?

21 A: They are.

22 Q: Okay.

23 A: And if we look at page 601, that's probably the
24 best place to look at. If you see, there's a
25 column there that says "2010 cases." That's

1 inpatient cancer patients of Grand Strand. The
2 next column is the population in that zip code.
3 And then the last one is the draw rate, which
4 is simply dividing the population by the
5 population -- dividing the cases by the
6 population divided by 1,000. So, for example,
7 in 29572 the draw rate is 3.67. And that was
8 the highest draw rate of any of the zip codes.
9 So I felt pretty confident that that would be
10 a primary service area zip code. We get a fair
11 number of patients from there, and it appears
12 that patients in that area rely on Grand Strand
13 for cancer services, at least for inpatient
14 cancer services. And I did that all the way
15 down for the, I believe, it was 19 zip codes.
16 And the area that's sort of shaded, you can't
17 see the color here, but is what I call the
18 primary service area. That's where we had
19 material draw rates, and you can see there was
20 a bit of a break point, it went from 1.31
21 dropped all the way down to .82. And so I
22 called everything .82 and below the secondary
23 service area thinking that we would, from a
24 projection standpoint, we would not expect to
25 see as many patients from those secondary

1 service area zip codes for the outpatient
2 radiation therapy service.

3 Q: Okay. And is there a page that kind of
4 summarizes your conclusions from the draw rate
5 analysis?

6 A: It is. And basically, I go through the same
7 steps I did in -- in the three-county analysis.
8 And if we go over -- there's a lot of detail in
9 here -- if we go over to page 617, I first
10 project out how many cancer patients are going
11 to be in the -- sorry, the number of patients
12 requiring radiotherapy in the primary service
13 area and the secondary service area. But
14 because I'm dealing now not with county level
15 data, but I'm dealing with smaller geographic
16 regions, my assumption is that I can have a
17 little bit higher market share in that smaller
18 area because I don't have to worry so much
19 about taking patients away from Georgetown, you
20 know, where they've got several referral
21 patterns or Loris where they're affiliated with
22 McLeod and maybe sending some patients into
23 Florence or Conway. My assumption is that
24 hospital doctors who are on the staffs of other
25 hospitals aren't going to be that excited about

1 sending patients to Grand Strand. There's a
2 certain amount of competition that exists among
3 medical staff members in a community like this,
4 and I think as Mr. White testified for Conway,
5 for example, there's very little medical staff
6 overlap between Grand Strand and Conway. So my
7 assumption was we could do better in our
8 primary service area than I was projecting we
9 could do in Horry County as a whole. And I
10 assumed we could do as well as 25 percent in
11 that primary service area. Our primary service
12 area still included the CRCC facility to the
13 south, about three miles to the south. And
14 still the urologists were employed by CRCC, so
15 again, we couldn't get a huge market share just
16 because a portion of the market was not in
17 play. And I thought we could get a little bit
18 higher market share in the secondary service
19 area than I assumed for Georgetown and
20 Williamsburg Counties. Anyway, doing all the
21 math, I came up with numbers that were a little
22 bit different than what I had before. It
23 projected 223 patients in the third year for
24 the Grand Strand program. I guess one other
25 thing I should note, because I shrunk down the

1 area, the service area over the three-county
2 area, I assumed that our in-migration instead
3 of being five percent would be ten percent
4 because it would be a bigger area to draw from
5 outside the primary and secondary service area
6 zip codes. And so the bottom line is I
7 projected a slightly higher volume of radiation
8 therapy treatments with this approach, but
9 still very close to what I had in the original
10 application, projecting to reach 93.8 percent
11 utilization in the third year.

12 Q: What, if anything, did that provide in terms of
13 confidence in your original projection?

14 A: It gave me some confidence that taking a
15 completely different approach could come up
16 with somewhat similar numbers, and again, I
17 also felt like this was reasonable for a start-
18 up program, having worked with other start-up
19 programs and being familiar with what other
20 single linac operators were doing in South
21 Carolina.

22 Q: Would you turn to Respondent's 13 for me,
23 Exhibit 13.

24 A: Okay.

25 Q: You might have to ...

1 A: Okay.

2 Q: Are you familiar with this document?

3 A: I am.

4 Q: Okay. What is the title of the document?

5 A: It's Analysis of Sullivan Draw Rate.

6 Q: Did you have an opportunity to review it?

7 A: I did.

8 Q: Okay. What, if any, opinions do you have about
9 this document?

10 A: I have a few. One of the ---

11 MR. LONG: Your Honor, I just want to raise a point
12 of order here. This is an exhibit prepared by
13 Mr. Tolbert, and I'm perfectly fine with him
14 asking about it, but it would be inappropriate
15 for him to call him in reply and ask him again.
16 If he's going to go through these Tolbert
17 exhibits like this and give opinions on them,
18 I think he's probably well qualified, I mean,
19 he can do that, but he shouldn't get two bites
20 at the apple.

21 MR. THOMAS: In terms of anything new, if anything
22 new comes out of Mr. Tolbert, I'm fine with
23 that.

24 THE COURT: Well ---

25 MR. THOMAS: But I get a rebuttal ---

1 MR. LONG: That's definitely going to be two bites
2 at the apple, Your Honor ---

3 THE COURT: The bottom line is I will rule on that
4 at the appropriate time. You're setting forth
5 your theory of a reply, and I can't rule in
6 advance on that because I don't know what's
7 going to happen. Reply is to address new
8 matter raised, if he goes to it, or refers or
9 addresses it in the case in chief, then unless
10 there is new matter raised that was different
11 than his testimony, then it certainly wouldn't
12 be -- I wouldn't allow him to have a second
13 bite of that testimony, although I don't know
14 what may happen down the path.

15 MR. LONG: Well, I appreciate that, Your Honor, but
16 I just want to clarify, this is not Mr.
17 Sullivan's document. So he's going to be
18 testifying about work that was done by somebody
19 else, and obviously, that person's going to
20 come in and testify about his work and then Mr.
21 Thomas is going to have him plow through it
22 again or other exhibits in reply and say, oh,
23 well, Mr. Tolbert testified about it, so I get
24 to do reply. So either he can -- we can
25 enforce kind of a foundation, which would mean

1 that Mr. -- he can't testify about it based on
2 a foundation matter, or it would not be in
3 reply, but the two bites of the apple is not
4 appropriate.

5 MR. THOMAS: Your Honor, I think we're entitled to a
6 rebuttal case, and it's a competing application
7 case as well. So, I mean, Mr. Sullivan is an
8 expert, he can look at the analysis of another
9 expert and offer an opinion on it. And to the
10 extent I -- I don't think Mr. Long's got any
11 case law here, to the extent that I want to
12 address something that Mr. Tolbert brought up
13 that perhaps we didn't anticipate, I think I'm
14 well within my rights to do that.

15 THE COURT: Well, and that's how I would rule most
16 probably down the line is, as with any
17 rebuttal, anything that he addresses at this
18 point in time, he cannot readdress. But
19 anything that is new that he -- for which he
20 could not have anticipated in this document,
21 then I'll address that later.

22 MR. LONG: Your Honor, I want to raise the second
23 point of my objection, which is ---

24 THE COURT: Okay.

25 MR. LONG: -- there's no foundation for this. I

1 mean, he's getting ready to ask Mr. Sullivan --
2 he's getting ready to have Mr. Sullivan
3 criticize an exhibit prepared by Mr. Tolbert,
4 and Mr. Tolbert hasn't even testified about the
5 exhibit, so in effect it's ---

6 THE COURT: I'll sustain that, if that's what you
7 want.

8 MR. LONG: So I'm going to object to him going into
9 Mr. Tolbert's exhibits if he intends to refer
10 to them on rebuttal.

11 THE COURT: It's not admitted into evidence at this
12 point in time is basically what he's
13 presenting.

14 MR. THOMAS: Well, I guess I'm confused, Your Honor,
15 because, you know, again a competing
16 application case, this is an issue that was
17 brought up, the document, I think, speaks for
18 itself, and again, I'm fine with that ground
19 rule as long as Mr. Tolbert doesn't come up
20 with some alternate explanation for what's
21 clearly -- and this is a number analysis. So
22 I'm going to ask Mr. Sullivan if he understands
23 the analysis and have him comment on it.

24 THE COURT: Well, there again, Respondent's 13 is
25 not in evidence. I assume that -- he hasn't

1 laid it out specifically, but he said you
2 hadn't laid a foundation.

3 MR. THOMAS: All right.

4 THE COURT: So.

5 Q: Mr. Sullivan, do you recognize this document,
6 Analysis of Sullivan Draw Rate?

7 A: I do.

8 Q: And do you understand the methodology that Mr.
9 Tolbert used?

10 A: I listened to his deposition testimony
11 describing that.

12 Q: Okay. And can you explain for the Court what
13 methodology Mr. Tolbert used?

14 MR. LONG: Objection, Your Honor. I mean, this is
15 the problem, Your Honor, it is a non-jury case;
16 we can do it anyway you want to. I've had
17 plenty of non-jury cases where the court said,
18 hey, you're not going to go into rebuttal,
19 again, you don't get two bites at the apple and
20 then we tried a case that way. Or he can put
21 all of this response to Mr. Tolbert in his
22 rebuttal case. I mean, it's just it's one or
23 the other. This is patently unfair. He's just
24 getting -- I mean, Mr. Tolbert hasn't even
25 testified about it, and because he gets to go

1 first and he gets to close because he has the
2 burden.

3 THE COURT: That's how it works.

4 MR. LONG: Okay? That's how it works, but he
5 doesn't get both. He doesn't get to go into a
6 lot of evidence on the first time, then listen
7 to us testify about it and then go again on the
8 same evidence. That's not proper and it's just
9 patently unfair. So either the ---

10 THE COURT: Do you think that the rules of evidence
11 are patently unfair?

12 MR. LONG: No, Your Honor, but I don't think the
13 rules of evidence allow him to testify -- those
14 questions are inappropriate for Mr. Sullivan
15 because he doesn't have the knowledge to
16 testify about it. So, in other words, we can
17 -- in a non-jury case, we can basically agree
18 that he can go ahead and try to get out the
19 evidence he wants for the sake of judicial
20 economy, but apparently, Mr. Thomas intends to
21 go through this twice and I'm just -- so I
22 don't think Mr. Sullivan should be allowed to
23 testify about any of Mr. Tolbert's exhibits in
24 their case in chief. He can talk about it in
25 rebuttal if that's going to be their position

1 that they get two bites at the apple. I mean,
2 that's just my -- that's just my point.

3 MR. THOMAS: Well, now I'm confused, because first
4 Mr. Long said that we could talk about it now,
5 but not in rebuttal if we did talk about it
6 now. And I said, Your Honor, you know, to the
7 extent Mr. Tolbert says something that's not
8 evident by the document, then that's something
9 we would want to raise, something new, but
10 again, the document speaks for itself. It's a
11 mathematical ---

12 THE COURT: I can't find it right now, the rebuttal
13 provision, but that's my understanding of the
14 law concerning rebuttal, is you present what
15 you want in your case in chief and then as to
16 any matter, new matter raised, you can address
17 the new matter.

18 MR. THOMAS: And I guess as to the foundational
19 issues, Your Honor, I mean, you know ---

20 THE COURT: But he's still objecting to that.

21 MR. THOMAS: I understand that, and that's what I'm
22 saying. I mean, Mr. Tolbert testified in a
23 deposition that Mr. Sullivan was allowed to
24 listen in on it, and he's also had the benefit
25 of the actual deposition testimony. So, you

1 know, we understand what he did in his
2 analysis. But yeah, I mean, I intend to go
3 through a lot because I don't want to spend a
4 whole of time in rebuttal, but to the extent
5 there's a lot of new testimony that we're not
6 aware of, I think we're allowed to do that.

7 THE COURT: All right. Anything else?

8 MR. LONG: No, Your Honor.

9 THE COURT: You can proceed. If Mr. Long has any
10 objections to insufficient foundation, I will
11 hear those objections.

12 MR. THOMAS: Okay. Let me see where I left off,
13 Your Honor.

14 THE COURT: You were talking about him having heard
15 the deposition testimony.

16 MR. LONG: Can I have one moment, Your Honor?

17 THE COURT: Yeah.

18 MR. THOMAS: May I have a moment with my witness,
19 just to ...

20 MR. LONG: Your Honor, wait ---

21 THE COURT: Yeah, I ---

22 MR. LONG: Is he asking him ---

23 MR. THOMAS: I'm asking him what days he's available
24 for a rebuttal notice.

25 THE COURT: Oh ---

1 MR. LONG: That's improper for him to talk to him
2 during the testimony.

3 MR. THOMAS: Your Honor, I'm trying to ask him about
4 what days he's available because that's
5 actually an issue that we have, and it's not
6 anything about the substance of his testimony,
7 so it's not improper. The rule is very
8 specific.

9 THE COURT: I know. Let them get through.

10 MR. LONG: Thank you, Your Honor.

11 THE COURT: All right. Mr. Long, I don't see any
12 prejudice to you if he asks in open court when
13 the witness would be available to be recalled,
14 or we could have him step down and let him have
15 that discussion because he would be permitted
16 to.

17 MR. LONG: That's fine, Your Honor. I mean, I'm
18 having a conference with my other lawyer ---

19 THE COURT: I know. I've ---

20 MR. LONG: --- and the lawyer is talking to the
21 witness.

22 THE COURT: And stopped him at that.

23 MR. LONG: I appreciate that.

24 MR. THOMAS: And, Your Honor, I would never talk
25 about the substance of his testimony. Can we

1 take a short break so I can ask him about that,
2 because if this is going to be a giant issue,
3 I want to be able to at least figure out what

4 ---

5 THE COURT: Okay.

6 MR. LONG: Your Honor, why don't you just ask him
7 question and we just move on?

8 THE COURT: Well, mean, do you want privacy in this?

9 MR. THOMAS: Yeah, I'd like it.

10 THE COURT: Okay. Well, then let's take a break,
11 but it's going to be a short one.

12 (Break from 2:35 p.m. until 2:41 p.m.)

13 THE COURT: Thanks to y'all, I've gone and
14 researched and learned more about rebuttal
15 evidence. I thought there was some specific
16 law addressing rebuttal evidence in case in
17 chief. Oh, well, still stand by my ruling
18 based on what I've read. Where do we stand on

19 ---

20 MR. THOMAS: I guess, could you remind me of the
21 official ruling, Your Honor.

22 THE COURT: The official ruling?

23 MR. THOMAS: Yes, I just ---

24 THE COURT: How about the previous ruling?

25 MR. THOMAS: Yes, sir, that would be great.

1 THE COURT: The ruling was that you can address --
2 if you can lay the foundation, you can address
3 this issue in your case in chief. Now, he can
4 -- apparently he's heard the testimony in the
5 deposition, he's got the exhibit before him; so
6 therefore, he cannot present any rebuttal
7 evidence at this point in time unless Mr. --
8 whoever the expert we're -- what's his name.

9 MR. LONG: Mr. Tolbert.

10 THE COURT: Tolbert, unless Mr. Tolbert presents a
11 new theory or new evidence for which is not
12 reflected in the exhibit and for which he has
13 not heard. And at that point in time, he can
14 respond to that, but only that.

15 MR. THOMAS: Okay.

16 THE COURT: So, in other words, my effort is to not
17 hamstring you and prevent you from not being
18 allowed to address something new, but in
19 accordance to Mr. Long's request, which I think
20 is legitimate, is not to allow a witness to
21 have two bites at the apple.

22 MR. THOMAS: Okay. I think I understand, Your
23 Honor.

24 THE COURT: I think I can make both parties happy at
25 the end of the case by following my theory, but

1 we'll see.

2 MR. THOMAS: And the only reason I requested a
3 conference with Mr. Sullivan is because he has
4 somewhat of a limited schedule next week. He
5 could be available for rebuttal on Monday, but
6 then not on Tuesday or Wednesday, but then on
7 Thursday and his -- the way that comes is I
8 understand Mr. Tolbert is not available for the
9 Court on Thursday. So, I guess ---

10 MR. LONG: Thursdays.

11 MR. THOMAS: Yeah. But that was my concern is it's
12 going to -- could it somehow push out our
13 ability to even offer a rebuttal case, so I'm
14 kind of balancing a couple of things with
15 respect to ---

16 THE COURT: Well, I don't want to say that that's
17 not my problem.

18 MR. THOMAS: I understand that.

19 THE COURT: I think the problem lies more with your
20 abilities to get your witness here when the
21 time is -- when he is required to be here.

22 MR. THOMAS: I understand. And I guess my question
23 to the Court would be is I know the case was
24 originally scheduled for last week, this week
25 and the following week.

1 THE COURT: Yeah.

2 MR. THOMAS: So if for some reason my witness can't
3 be here on Monday, is there any way we can make
4 an allowance for Thursday where we would come
5 back? Because I don't think the case will
6 still be going on at that time. But you know,
7 I think at that point, Respondents would have
8 rested.

9 THE COURT: Okay. I'm open. I'll address that
10 issue at the appropriate time.

11 MR. THOMAS: Okay. And I think what we'll probably
12 try to do is address some of the ...

13 THE COURT: All right. Proceed.

14 Q: Mr. Sullivan, you've got before you
15 Respondent's 13.

16 A: Yes.

17 Q: All right. And, again, you've heard the
18 deposition testimony of Mr. Tolbert?

19 A: I did.

20 Q: Okay. And have you had an opportunity to study
21 the document?

22 A: I have.

23 Q: Do you understand the document?

24 A: I believe I do.

25 Q: Can you explain your thoughts on the document?

1 A: Sure. What I understand Mr. Tolbert's
2 deposition testimony to be is he felt the
3 service area that I define using my draw rate
4 analysis was too narrow and -- and so he
5 calculated a draw rate based on Grand Strand's
6 2010 inpatient discharges per 1,000 population,
7 and then he came up with what he thought would
8 be a capture rate or a market share, if you
9 will, for each of those zip codes based on what
10 the inpatient draw rate was. So if it was 70
11 OR greater, the capture rate would be 40
12 percent and then we've got that little chart on
13 the right-hand side of this document that
14 describes that. So, basically, he recast the
15 projected volumes for Grand Strand's program
16 and came up with, if you look at the bottom
17 line on the last column, the full column, he
18 came up with 258.9 projected patients for Grand
19 Strand's program.

20 Q: And what, if any, opinion do you have about Mr.
21 Tolbert's use of the inpatient discharge, using
22 inpatient discharges rather than what you did
23 was cancer patients?

24 A: Okay. A few different opinions about that.
25 First of all, as I said before, there's no

1 reason to think that the service area and the
2 penetration rates into different zip codes
3 would be the same for radiation therapy as it
4 would be for inpatient services. I won't
5 repeat all of that, but basically, Grand Strand
6 has been providing inpatient acute care
7 services for many years and has several
8 competitive advantages in that which they don't
9 enjoy on the outpatient side in radiotherapy.
10 Secondly, he has not accounted in any way for
11 the fact that the urologists are employed by
12 21st Century and aligned with CRCC. And we
13 know that they're a material percentage of the
14 referral market. And so, right off the bat,
15 you would expect our market shares to be lower
16 for radiation therapy than they would be for
17 general acute care services because there's no
18 such restriction in that regard. And so the
19 other thing is you really don't need to
20 calculate a draw rate for inpatient discharges
21 because we know what the market -- you know, we
22 can calculate the market shares for inpatient
23 discharges, and which Mr. Tolbert didn't do.
24 You have access to that data through the South
25 Carolina Office of Research of Statistics. And

1 so he could have calculated what the market
2 shares were and compared those to what we
3 projected in those individual zip codes. He
4 chose not to do that, for whatever reason,
5 instead calculating a draw rate. The only
6 reason I calculated a draw rate for cancer
7 patients is because I didn't know the total
8 universe of cancer patients getting radiation
9 therapy. So I was just trying to come up an
10 approach that would define a service area that
11 I think would be logical. And he also assumes
12 that we're going to capture, in some zip codes,
13 40 percent of the business and in others 35, in
14 others 30 and 25 and so forth. I think his
15 high end of his market shares are way too high
16 for a single unit provider up against
17 entrenched competition without the benefit of
18 being able to access the urology market. So I
19 think the analysis is flawed in several
20 respects. I just don't think it yields any
21 meaningful results.

22 Q: Okay. Would you go to in Joint Exhibit 2 --
23 put that aside, and go to page 822 for me.

24 A: Okay.

25 Q: I'm showing you Grand Strand's, I guess,

1 project review slides. Did you attend the
2 project review meeting for this particular
3 case?

4 A: I did.

5 Q: Did you present at the project review meeting?

6 A: I did.

7 Q: There are a number of slides there, and I'm
8 going to ask you to go to your portion at the
9 project review meeting that starts on Exhibit
10 834.

11 A: Okay.

12 Q: And can you take the Court through what you did
13 at project review kind of generally, I don't
14 want you to rehash the whole thing to the
15 extent you don't have to.

16 A: Sure. My focus was on the review criteria.
17 The Department, when it sends out a complete
18 letter on an application indicating the
19 application is complete and accepted for
20 review, it lists in order of priority the
21 review criteria that are going to be implied to
22 a particular project. And so my effort here in
23 this presentation was to address each of those
24 review criteria and to talk about how the Grand
25 Strand project complied with those criteria.

1 Q: Okay.

2 A: And just generally, without getting into great
3 detail, I think we've already talked at some
4 length about the State Health Plan and the
5 reasons why I believe the project is consistent
6 with the requirements in the State Health Plan.

7 Q: Okay.

8 A: And I think that takes us over to page 845.

9 Q: Right.

10 A: And that talks about community need, and I just
11 talk generally about the fact that Grand Strand
12 has a large number of cancer patients that it
13 serves now for services other than radiation
14 therapy, that Grand Strand would offer an
15 alternative in Horry County where all of the
16 services are currently concentrated in a single
17 provider. And the projections indicate the
18 facility would be well utilized and that the
19 campus is adjacent to Coastal Cancer Center's
20 Myrtle Beach campus. They're the largest
21 medical oncology practice in the area, so it
22 would offer an opportunity to provide
23 comprehensive services between the medical
24 oncologists and the hospital.

25 Q: Okay. Would you turn over to 847 for me ---

1 A: Sure.

2 Q: --- in Joint 2, a little bit about the
3 distribution and, in parentheses,
4 accessibility.

5 A: Sure. Accessibility, I mean, first of all, I
6 think the focus that I've heard from CRCC, and
7 to some extent that was included in DHEC's
8 decision, is that the CRCC project will improve
9 the distribution in terms of geographic access
10 by putting a unit in Conway. And I disagree
11 with that that having a unit in Conway would
12 mean that people who live in Conway would be
13 closer to a radiation therapy unit. But what
14 I think maybe wasn't considered by DHEC in its
15 decision was that right now there's no access
16 to a hospital-based comprehensive cancer
17 program in Horry County. And so in terms of
18 distribution, there's zero availability of
19 that. We have one model of care delivery, and
20 that is a freestanding radiation therapy model
21 where a provider, rather than trying to develop
22 a concentrated comprehensive cancer center, is
23 apparently going to a distributed model of
24 radiation therapy treatment where it's
25 decentralizing its services. It wants to move

1 one unit out of Myrtle Beach down to the
2 Murrells Inlet area; it wants to put another
3 unit in the Conway area. So rather than trying
4 to develop a cancer center, what their strategy
5 appears to be is trying to provide blanket
6 geographic coverage in the area. And so I
7 think when you're looking at the distribution
8 of -- I think it's important to consider that
9 this is a unique service in Horry County and
10 that that should be given great weight, I
11 think, in the review of these two projects.

12 Q: Okay.

13 A: In terms -- do you want me to just walk through
14 some of these other ones?

15 Q: Well, I was going to direct you to 854.

16 A: Okay.

17 Q: Because I think we've talked a lot about some
18 of the other ones.

19 A: Okay.

20 Q: There's a reference to cost containment in
21 here, can you ---

22 A: Sure.

23 Q: --- express your opinions on cost containment?

24 A: Sure. You know, cost containment has, you
25 know, a lot of different facets to it. I mean,

1 I don't think there's any dispute that the raw
2 capital costs of the two projects, that CRCC
3 proposes a lower capital cost. And I don't
4 think that's where the analysis of cost
5 containment, you know, begins and ends. CRCC
6 is proposing something much different. They're
7 talking about taking an existing building which
8 was temporarily used for a radiation therapy
9 center many years ago, and I had the
10 opportunity to tour that building several years
11 ago, but it's not a state of the art facility.
12 I mean, it's an older modular type building.
13 And so it's a little bit of apples and oranges
14 comparison. And also it would just be
15 providing radiation therapy services at that
16 site. What Grand Strand is building is a
17 larger radiation therapy center that would have
18 other support spaces and so forth included in
19 it. When we talk about cost savings, having
20 Coastal Cancer Center and Grand Strand close to
21 each other would result in some cost savings
22 for patients where they'd be able to get the
23 services jointly pretty quickly just traveling
24 three or four minutes from one campus to the
25 other. There's not currently any real price

1 competition in Horry County as it relates to
2 radiation therapy services. There's one single
3 provider, that was the only provider in the
4 whole three-county area for many years.
5 Georgetown has now entered the market. But
6 within Horry County, there's not the ability
7 for payers, if they want their patients to stay
8 in Horry County and have radiation therapy
9 treatment to negotiation more than one
10 provider. And generally, having more than one
11 provider will provide price competition and
12 hopefully that would result in some cost
13 containment as well. There's, you know,
14 there's also an issue related to cost
15 containment that's not on this page, and that's
16 the issue of the urologist who have financial
17 interests in the operations of CRCC. I've been
18 involved in radiation therapy planning for a
19 long time and there's been an ongoing concern
20 with urologists having a financial incentive to
21 utilize radiation therapy services and that
22 that could result in patients receiving more
23 expensive radiation therapy as opposed to less
24 expensive other types of treatment. I'm not
25 saying that's particularly true in this case,

1 but that's a general concern that's been around
2 in the industry for several years.

3 THE COURT: Say that again, so I make sure I heard
4 it right.

5 A: When urologists have a financial stake ---

6 THE COURT: Oh, okay, I see. Now I understand. I
7 didn't catch the urologist part.

8 A: Okay. Sure. And so to the extent that this
9 would provide an alternative setting, I think,
10 again, it's not where the urologist don't have
11 a financial incentive provides another option
12 for patients and for referring physicians.

13 Q: I think during discovery you were asked why
14 there wasn't any kind of a direct comparison
15 between CRCC and Grand Strand in this -- in
16 your project review analysis. Explain what
17 your answer to that would be.

18 A: Quite honestly, I didn't think that there was
19 much of a possibility that DHEC would approve
20 CRCC's project.

21 Q: Why?

22 A: One, they control all of the linear
23 accelerators in the -- in the service area, in
24 Horry County currently. I assumed that DHEC
25 would see the benefit of having another

1 competitor enter the market, particularly given
2 the size of the population. Two, the two
3 organizations other than CRCC that were
4 applying were both affiliated with hospitals.

5 In the case of Grand Strand the unit would
6 actually be in the hospital. In case of NSROC,
7 it would be on the campus of a hospital. And
8 they were really providing -- proposing to
9 provide a different type of service that would
10 have provided. So, you know, my assumption was
11 -- obviously erroneously, is that DHEC would be
12 choosing between putting a unit up in Little
13 River at the NSROC facility or at Grand Strand
14 because, in either case, that would inject more
15 competition and that would result in a hospital
16 related radiation therapy service in the area.

17 Q: If you look on page 860, you've got a few
18 conclusions there. Do you still agree with the
19 conclusions on that page?

20 A: I do. I believe the project is the superior
21 alternative with the two remaining competing
22 applications.

23 Q: Well, did you have the occasion to submit
24 something post project review to the
25 Department?

1 A: I did.

2 Q: Would you turn to 866 for me.

3 A: Okay.

4 Q: In Joint 2.

5 A: Okay.

6 Q: In this letter, what is -- what are you
7 responding to Ms. Brandt for?

8 A: There was actually two different things I
9 believe that I was responding to. One, she
10 asked for an index of support letters, and then
11 she wanted it to be categorized for physicians
12 and healthcare facilities and indicate which,
13 you know, who was going to refer to the Grand
14 Strand project and to quantify the expected
15 annual referral volumes. So we did provide the
16 index of letters of support, but we were
17 explaining that there's really no practical way
18 to be able to quantify for individual referral
19 sources what they might provide to a
20 freestanding -- I mean, to a hospital-based
21 radiation therapy center two or three years
22 down the road. It was obviously going to be
23 something that would have to be evaluated at the
24 time when the center opened and so forth. So
25 we talked about all of the things that would

1 indicate that Grand Strand would be able to
2 achieve a reasonable level of utilization, and
3 also talked about the fact that there was some
4 sort of atypical referral pattern in the
5 county, in Horry County with Atlantic Urology
6 being affiliated with CRCC, and despite the
7 presence of that relationship, that we still
8 felt that we could attain a sufficient volume
9 to be able to meet the standard.

10 Q: Is it your understanding that CRCC presented
11 any expected referral volumes to the
12 Department?

13 A: They did not, based on my review of the record.

14 Q: Would you turn to page 875 of the DHEC record

15 ---

16 A: Yes.

17 Q: --- and describe for the Court what this is and
18 the date of this letter.

19 A: This is dated November 28th and this is -- this
20 is essentially a response to the issues raised
21 at the project review meeting. And at the
22 project review meeting, you know, one of the
23 issues, and I think it may be the first time
24 that it was addressed during the review
25 process, we -- Grand Strand discussed the fact

1 that there would be the potential to approve
2 two linear accelerators rather than one given
3 the current volumes and the projected growth
4 and utilization in the area. And so this
5 letter is sort of responding to several issues
6 that came up. Those are summarized on the
7 bottom of page 875.

8 Q: Okay. And if you'd turn to 877 for me.

9 A: Okay.

10 Q: Can you describe what you're laying out there
11 for the Court.

12 A: Sure. I was just trying to demonstrate to DHEC
13 that with the projected volume in 2015, that
14 you could have -- you know, the top of the
15 chart, the top part of the chart says that
16 based on the projections that we did and the
17 capacities that we were using, that with the
18 approval of one unit that the existing capacity
19 would be operating at about 105 percent
20 utilization. Now if you want to substitute
21 7,000 for 5,000 for Georgetown, you can do that
22 and that would mean that it would drop to about
23 100 percent.

24 Q: Okay.

25 A: But we show that with the addition of two units

1 that the utilization in the area would still be
2 well above 80 percent, and we projected 89
3 percent here. And I think, again, if you
4 adjusted the Georgetown number, maybe it would
5 drop to 86 or 87 percent.

6 Q: Okay.

7 A: You know, we were demonstrating to DHEC that
8 there was plenty of volume out there, you know,
9 based on the information that we had at that
10 point in time.

11 Q: Then the top of page 878, Joint 2, is that what
12 you were referencing in terms of two linear
13 accelerators being possible?

14 A: It is. You know, and the statement that I made
15 there was that CRCC was arguing for only one
16 additional unit in an effort to limit
17 competition where I felt that the utilization
18 projections clearly supported two.

19 Q: If you look down, I think, under your bullets
20 there on page 878, there's a paragraph, and
21 what were you saying there in the last sentence
22 of that paragraph?

23 THE COURT: You said below the bullets?

24 MR. THOMAS: Yeah, I guess the little arrow bullets,
25 Your Honor.

1 A: What I'm saying is that there was a greater
2 need for the type of program that Grand Strand
3 was proposing than there was for the sort of
4 small improvement in geographic access that a
5 center in Conway would provide as CRCC had
6 proposed and that the Grand Strand project
7 should be approved, but if DHEC determines
8 there's a need for two linear accelerators,
9 then the next logical site would be for CRCC to
10 put a center in Conway. So in terms of
11 priority, I think the Grand Strand project
12 should be approved first, but if there is a
13 need for two, then I didn't see a problem with
14 having the CRCC project in Conway.

15 Q: Okay. Would you turn over to page 882 for me.

16 A: Okay.

17 Q: There's some bullet points there and I wanted
18 you to talk to the second bullet point, is that
19 what you were explaining earlier about the cost
20 containment issue?

21 A: I was. I was talking about the benefits in the
22 offering choice providers and managed care
23 company is a choice providers negotiate.

24 THE COURT: That's the bullet point that starts with
25 CRCC fails?

1 MR. SULLIVAN: Yes.

2 MR. THOMAS: Fails to acknowledge, yes, Your Honor.

3 Q: All right. Mr. Sullivan, I'd like you to turn
4 over to Grand Strand DHEC record 937 for me,
5 just in Joint 2, same exhibit. Actually, I'm
6 sorry, go -- just so we can identify what the
7 document is, if you'd go to Grand Strand 925
8 for me.

9 A: Sure. This is the DHEC decision letter on the
10 Grand Strand project.

11 Q: Does it include references to CRCC and North
12 Strand as well?

13 A: It does.

14 Q: Okay. And, obviously, North Strand is not
15 involved in the case, so we'll glean over that
16 if we could. And if you'd go to 937 for me
17 which is where Grand Strand Regional starts.

18 A: Yes.

19 Q: Well, first of all, let's start with an easy
20 one. Do you agree with the Department's
21 decision letter?

22 A: I do not.

23 Q: Generally, can you explain why not?

24 A: Well, I guess for two reasons, two large
25 reasons. I disagree with a lot of other things

1 they said in here, but first of all, I don't
2 agree that CRCC was the superior applicant if
3 you take the approach that only one linear
4 accelerator can be approved. I think that
5 Grand Strand should have been approved under
6 that analysis; however, I think that DHEC erred
7 in determining that these were competing
8 applications and the two couldn't be approved,
9 and I believe they should have been approved
10 two at the time of the decision.

11 Q: Okay. I want to switch gears real quickly, but
12 I want you to kind of keep that open there.
13 Can you go to Joint 1 for me. Let's see, here
14 it is, CRCC application.

15 A: Okay.

16 Q: And if you'd turn to page 623 for me in that
17 DHEC record. Joint 1, 623.

18 A: Okay.

19 Q: And what is this document?

20 A: This is Mr. Tolbert's letter on behalf of CRCC
21 responding to the project review presentations
22 that were made by the other applicant.

23 Q: And I want to focus on a specific exhibit here
24 that starts on page 642 of Joint 1.

25 THE COURT: You're going to page 642?

1 MR. THOMAS: Yes, sir.

2 THE COURT: Okay.

3 A: Okay.

4 Q: Okay. And what do you understand this chart to
5 be?

6 A: This is showing the number of patient referrals
7 by referring physician for the previous 12
8 months. In this case, that was November 2010
9 through October 2011 to CRCC for radiation
10 treatment.

11 Q: So that's a 12 month period?

12 A: It is.

13 Q: For patients on treatment, correct?

14 A: Yes.

15 Q: What is the total number there on page 646?

16 A: On 646, the total number is 1,000 even.

17 Q: Okay. What does that tell you as a health
18 planner?

19 A: Well, that's -- that was significantly more
20 patients than they had reported in 2010 on
21 their Joint Annual Report, or in 2009 for that
22 matter. So, you know, it was apparent that
23 there was a significant increase between 2010
24 and 2011 in CRCC's utilization.

25 Q: Do you think the Department appreciated that

1 when it wrote its decision letter?

2 A: It did not appear to. It made no mention of
3 it.

4 Q: If you'd you go to DHEC 937 for me.

5 A: Okay.

6 Q: Under compliance with the South Carolina Health
7 Plan, do you have any comments about the
8 Department's decision, a portion of the
9 decision letter here?

10 THE COURT: Hold on one moment.

11 MR. THOMAS: I'm sorry.

12 THE COURT: All right.

13 A: I mean, I agree with Ms. Brandt's statement
14 that Grand Strand's addressed all the standards
15 in the plan. And then she had some narrative
16 in here specifically related to Standard 8,
17 which we talked about earlier which was
18 quantifying the number of referrals by
19 physician. I guess I would just say that,
20 again, I think that that's a very difficult
21 thing to do when you haven't had a service in
22 the past, so therefore, you have no historical
23 basis for projecting referrals by physicians.
24 And so I think that it's -- I'm not sure what
25 the -- what the import of the discussion is in

1 there in the overall evaluation of the project,
2 but I do think that it's sort of imposing an
3 impossible standard on applicants.

4 Q: But she did mention it in the letter though,
5 didn't she?

6 A: She did.

7 Q: Is it your understanding that applicants are
8 required to do that in the new State Health
9 Plan, in Exhibit 5, the 2012-2013 State Health
10 Plan?

11 A: They are not. That standard was changed.

12 Q: If you'd look at the DHEC decision letter on
13 page 938.

14 THE COURT: I didn't see the provision that you were
15 just referring to on page nine ---

16 Q: Okay. Look at -- first of all, look at Joint
17 Exhibit 4 for me, Mr. Sullivan.

18 THE COURT: No, I'm on the page exactly where he was
19 referring, I just don't ---

20 MR. THOMAS: Yeah, I'm going to ---

21 THE COURT: --- 937; I'm just trying to get the
22 paragraph.

23 MR. THOMAS: Well, I think probably -- I'd like to
24 provide a little clarity for the Court, Your
25 Honor.

1 Q: Okay. In Joint Exhibit 4, which is the 2010-
2 2011 South Carolina Health Plan, Standard 8,
3 can you read that into the record Mr. Sullivan.

4 THE COURT: Let me get there.

5 MR. THOMAS: Yes, sir.

6 THE COURT: Joint Exhibit 4, Standard 8?

7 MR. THOMAS: Yes, sir.

8 MR. SULLIVAN: That's on page IX-6..

9 MR. THOMAS: Yeah, IX-6, Your Honor.

10 THE COURT: All right.

11 Q: Okay. So, Mr. Sullivan, what are you -- what
12 is your understanding of what this standard
13 requires an applicant to do?

14 A: That's the document referral sources for
15 patients within its area, including letters of
16 support from physicians and healthcare
17 facilities indicating a willingness to refer
18 patients to the proposed service, with expected
19 annual referral volumes.

20 Q: Okay. And you informed the Department that
21 would be a difficult thing to do, correct?

22 A: Yeah, I did.

23 Q: Okay. Now, if you turn over to Standard 5.

24 MR. THOMAS: Oh, I'm sorry, Your Honor, Joint
25 Exhibit 5, which is the 2012-2013 State Health

1 Plan and look at Standard Number 8.

2 A: Sure. It's essentially the same except the
3 requirement that you would quantify the
4 expected number of referrals was big enough.

5 Q: Okay. Do you know the reason for that?

6 A: I don't know for sure. I know that we had
7 raised that issue with DHEC subsequent to
8 project review.

9 Q: All right. If we'd go to page 938 of Joint 2.
10 I want to talk about a few paragraphs here, Mr.
11 Sullivan. The second paragraph of that page,
12 do you have any comments regarding Ms. Brandt's
13 verbiage there?

14 A: You're talking about the one that starts
15 "according to"?

16 Q: Yeah, according to. Sorry.

17 A: I don't, other than she was reciting the
18 information that was presented in the
19 application.

20 Q: Well, let me ask you a question.

21 A: Okay.

22 Q: The indication here is Grand Strand had 4,860
23 -- 4,860 patient with for primary and secondary
24 cancer diagnosis, currently referring them to
25 CRCC or other providers.

1 A: I'm sorry. Yeah, that phrase is incorrect,
2 4,860 patients were patients who received some
3 type of inpatient or outpatient treatment at
4 Grand Strand. There's no -- and first of all,
5 Grand Strand doesn't refer patients to CRCC or
6 any other radiation therapy center. Those are
7 all referrals made by physicians. Secondly,
8 this includes newly diagnosed patients,
9 patients who had cancer at some point in the
10 past, so there's really no correlation between
11 this 4,860 number and the number of referrals
12 that went to CRCC.

13 Q: Okay. In paragraph three, Ms. Brandt makes
14 some comments regarding your adverse impact
15 analysis. What, if any, opinions do you have
16 on that?

17 A: I think she may have misunderstood the
18 analysis. As I mentioned earlier in my
19 testimony, we had projected that from the
20 three-county area there would be growth of a
21 194 additional patients. Ms. Brandt focused
22 only on Horry County and said there would be
23 173 patients in Horry County, and then she was
24 comparing that to the projected number of Horry
25 County patients, but she wasn't given effect to

1 the growth that was going to occur in
2 Georgetown and Williamsburg County. So I
3 believe that, as a result of that, she
4 overstated what the impact would be on existing
5 providers because, in effect, there would be
6 growth not only in Horry County but in the
7 other two counties as well and that would
8 mitigate some of the impact of the Grand Strand
9 project.

10 Q: If you go on to the next kind of section there
11 on the same page of Joint Exhibit 2, 938 under
12 distribution.

13 A: Yes.

14 Q: What, if any, comments do you have regarding
15 that first paragraph there regarding the
16 staff's concurrence about cancer care?

17 A: Again, I think that this was a
18 misinterpretation on the part of DHEC. She
19 says, however, GSRMC does not propose any
20 inpatient treatments according to their pro
21 forma. Again, I think it was just a
22 misunderstanding that the pro forma didn't
23 reflect inpatient revenues because of the
24 reimbursement system, not that Grand Strand
25 wouldn't treat inpatients. I think we stated

1 at the project review meeting and elsewhere in
2 our filings that one of the benefits of the
3 project would be to serve inpatients at the
4 facility.

5 Q: Okay. And on the second paragraph under
6 distribution about the effect that Conway and
7 Loris will not refer patients for radiation
8 therapy to Grand Strand, do you have any
9 opinions about her conclusions there?

10 A: Sure. First of all, hospitals don't refer
11 patients, so I think she was maybe just off
12 base a little bit in that comment. It's not
13 surprising that they didn't write letters of
14 support since, Loris, for example, had a
15 competing application, so I didn't expect them
16 to write a letter of support. Conway is a
17 significant competitor of Grand Strand, and
18 they wouldn't typically write a letter of
19 support either. This says there's a reasonable
20 concern and could limit accessibility. I'm not
21 sure why -- I mean, if patients of physicians
22 who live in the Loris area wanted to go to
23 Grand Strand, I don't believe that their
24 physicians would preclude them from going to
25 Grand Strand, but the likelihood is that those

1 patients would go to CRCC. My belief is that
2 Grand Strand would primarily draw from an area
3 around its hospital with physicians who are on
4 its medical staff and who have supported Grand
5 Strand in the past, and based on that, I
6 believe there's adequate volume to utilize the
7 unit.

8 Q: Okay. Thank you. If you'd turn over to Grand
9 Stand 939 for me.

10 A: Okay.

11 Q: And there's a section there at the bottom I
12 direct your attention to. It says Adverse
13 Effects on Other Facilities and Ms. Brandt
14 cites, I think, 23a of the regulation. But can
15 you expound on this and provide an opinion
16 whether or not you agree with her conclusions
17 here.

18 A: I don't agree with her conclusions. You know,
19 I had mentioned in some of the submissions I
20 made to DHEC that we expected a significant
21 percentage of the Coastal Cancer Center
22 patients to be referred to Grand Strand, but we
23 also reflected how many total patients we
24 expected to serve and what that would be. And
25 that put a, you know, put a limit, if you will,

1 on what the impact would be, and that impact
2 would be largely offset by the growth in the
3 market, which Ms. Brandt didn't give any effect
4 to in this particular passage. And she seemed
5 to be concerned about the impact on CRCC, but
6 CRCC is a very large provider, I believe in
7 2011 was the largest provider of radiotherapy
8 services in the state of South Carolina. The
9 level of impact of a single unit, start-up unit
10 could have on CRCC when they are the only game
11 in town, if you will, just doesn't seem to rise
12 to the level of being a significant enough
13 concern that she would find that there would an
14 adverse impact. So I just -- I mean any time
15 you introduce competition into an area where
16 there is none now, there's always going to be
17 an impact on the existing provider. But the
18 question is do the benefits that accrue to the
19 healthcare system from inflicting that impact
20 result in greater benefits than the loss of
21 volume by a particular provider. In this case,
22 I think clearly that balance is that the
23 community would benefit from having Grand
24 Strand approved and that the impact on CRCC
25 would be relatively small. That paragraph

1 continues on the top of the next page, which is
2 940.

3 Q: You're anticipating my next question.

4 A: Okay.

5 Q: Yeah, what, if any, opinions do you have
6 regarding the adverse impact Grand Strand's
7 proposed project would have on Georgetown?

8 A: As I've said already, I believe it would be
9 negligible. Georgetown is located 40 miles
10 away from Grand Strand and Georgetown has its
11 own referral pattern; it has a separate medical
12 staff. Grand Strand, I don't see why opening
13 a unit on Grand Strand's campus, which is some
14 distance away from Georgetown, when most of the
15 referrals from the doctors who practice at
16 Grand Strand, as I understand it, are going to
17 CRCC, I don't know why there would be any
18 impact at all on the Francis Ford Cancer Center
19 in Georgetown.

20 Q: How about on the relocated Francis Ford Center?

21 A: Well, that's very interesting that DHEC was
22 concerned because Grand Strand had six zip
23 codes that overlapped with what was presented
24 in the Georgetown application for the
25 relocation to Murrells Inlet, yet it approved

1 CRCC to move a unit a half a mile away from the
2 proposed relocated facility and didn't find
3 that there would be an adverse impact
4 associated with that approval, so ---

5 Q: Let me stop you there.

6 A: Okay.

7 Q: Because I wanted you to look at Petitioner's 28
8 for me.

9 A: Okay.

10 Q: Okay. And let me know when you get there. Did
11 you have an occasion to review this letter in
12 preparation for your testimony?

13 A: I did. This is the decision letter approving
14 the CRCC Murrells Inlet project to relocate one
15 linear accelerator from Myrtle Beach to
16 Murrells Inlet.

17 Q: Would you turn to, I guess, Grand Strand 5941
18 for me.

19 A: Okay.

20 Q: I think it's the fifth page of the document.

21 A: Okay.

22 Q: And under project review criteria analysis, I
23 guess the second paragraph under that, there's
24 a reference to adverse impact, could you read
25 that into the record.

1 A: Sure. "The Department also considered adverse
2 impact. Both projects reflect a shift in
3 current patients that is a redirection of
4 existing patients based on current patient
5 distribution. Population shifts were
6 considered. It is noted that in its August 26,
7 2011, response, CRCC made this comment
8 regarding the Ford Cancer Center. Patients in
9 the Murrells Inlet area are being referred by
10 physicians employed by or with a very high
11 loyalty to Georgetown Hospital System. It is
12 not likely that CRCC's presence in Murrells
13 Inlet will change those referral patterns,
14 which are due to existing economic and
15 professional relationships."

16 Q: In terms of those existing economic -- existing
17 economic and professional relationships, how
18 does Grand Strand impact those if it gets a
19 center?

20 A: Obviously, to a much lesser degree than a
21 center that would be located a half a mile
22 away. So I don't know why DHEC would have, I
23 believe, three months earlier found having two
24 centers located in very close proximity would
25 be no adverse impact and yet a center that

1 would be located 20 miles away would somehow
2 have an adverse impact.

3 Q: And stay on the same page there, on the Joint
4 Exhibit, 940. Actually if you'd go to -- go to
5 page 941. This is the Carolina Regional
6 Center-Conway. This is the decision letter
7 portion about that project, correct?

8 A: It is.

9 Q: Okay. And there's a Table 10 there on page
10 941. What is the volume number that the
11 Department references for 2011 for CRCC Myrtle
12 Beach and the total treatments?

13 A: 22,419.

14 Q: Do you know what the actual number volume
15 number was for 2011 for CRCC's total
16 treatments?

17 A: It was 25,900, something in that range.

18 Q: And right underneath that, the Department
19 indicates that the contrast to the substantial
20 growth experienced in 2010, which is attributed
21 to the purchase of the facility by 21st
22 Century. What do you think the Department was
23 under the impression of in this decision letter
24 in this portion?

25 A: This reading ---

1 MR. LONG: Your Honor, I have to object to that.

2 He's going to have to lay a little better
3 foundation.

4 MR. THOMAS: Okay. That's fine. I'll withdraw that
5 question.

6 Q: In terms of the 2011 volumes -- we're going to
7 move on actually. In terms of the -- again, if
8 you'd go to page 943 for me, Joint 2.

9 A: Okay.

10 Q: What reason does the Department give in this
11 section that CRCC-Conway would not have an
12 adverse impact on Georgetown's relocated
13 project?

14 A: It says that GHS mentions lack of need and
15 significant adverse impact, but did not provide
16 any data to support these claims.

17 Q: What, if any, data are you aware of that
18 Georgetown provided with respect to Grand
19 Strand's project?

20 A: I'm not aware they presented any.

21 Q: And how far away is Georgetown's project from
22 the Murrells Inlet location for Georgetown?

23 A: Roughly 20 miles.

24 Q: So do you think that in your opinion, is this
25 a -- is this reason provided by the Department

1 under adverse effects on other facilities apply
2 also to Grand Strand, or should it apply to
3 Grand Strand?

4 A: I believe it should to be consistent.

5 Q: Go to page 941, I'm sorry, I'm going to ask you
6 to go back to 941. In terms of under this
7 heading distribution.

8 A: Yes.

9 Q: What is your understanding how much time, one
10 way travel time that Conway's, CRCC-Conway's
11 project were to save the average patient?

12 A: Based on the information that was presented, I
13 believe at the project review meeting, it
14 appears that there would be about an average of
15 about ten minutes one way travel time saved for
16 the location in Conway.

17 Q: What is your understanding of kind of what the
18 closest location is to get kind of
19 comprehensive cancer treatment to Horry County?

20 A: To really go to a comprehensive center, you
21 would either have to go to Charleston, which is
22 about 100 miles to the south or potentially to
23 Wilmington, which is close to 100 miles to the
24 north.

25 Q: So, in your opinion, does CRCC offer any

1 advantages in terms of distribution or
2 accessibility when compared to both projects?

3 A: They do offer that small improvement in travel
4 time for folks in Conway, but in terms of the
5 distribution of an alternative delivery model
6 for cancer care, the comprehensive model that
7 Grand Strand is talking about, they do not
8 offer that, and therefore, I believe that the
9 Grand Strand project would be superior.

10 Q: And if you look on page 944 for me.

11 A: Okay.

12 Q: I want to talk a little bit about cost
13 containment. I know you've referenced that
14 before. Look in your notebook, if you would,
15 to Petitioner's 38.

16 A: 38?

17 Q: Yes.

18 A: Okay.

19 Q: Let me just know when everybody's there. Okay.
20 And just for the record, these were, exhibits
21 were prepared before we had actual exhibit
22 numbers, but CRCC 175 is Petitioner's 45 and
23 CRCC 1948 is Petitioner's, or excuse me, let me
24 -- yes, Petitioner's 56.

25 MR. THOMAS: Would you change that for me? Hold on.

1 Beg the Court's indulgence, I want to make sure
2 that's right for the record, Your Honor. All
3 right. I had it right the first time, Your
4 Honor.

5 Q: Petitioner's 45 and 56 are the underlying
6 documents for the summary document. Mr.
7 Sullivan, what does this document show?

8 A: This is just complies the number of consults,
9 which I believe would be the number of
10 referrals for radiation therapy from Atlantic
11 Urology Clinic physicians for each of these
12 years, 2009 through 2012, based on internal
13 data at CRCC.

14 Q: What do you understand happened from 2009 to
15 2010?

16 A: There was a fairly dramatic increase. Almost
17 750 percent increase in the number of consults
18 referred to CRCC for radiation treatment.

19 Q: And what do you understand happened in terms of
20 the ownership of CRCC during that period of
21 time?

22 A: That in the early part of the year the
23 ownership changed from Dr. Bass to the 21st
24 Century.

25 Q: Is it your understanding that during this time

1 period of 2009-2010 that the urologists came to
2 have a financial relationship with CRCC?

3 A: Yes.

4 Q: All right. Let me ask you to turn to
5 Petitioner's 24, to a specific document in
6 Petitioner's 24, and the document is ---

7 MR. LONG: Your Honor, I need to make an objection
8 here. This is ---

9 MR. THOMAS: I haven't even gotten the document out,
10 Your Honor.

11 MR. LONG: Okay. Well ---

12 THE COURT: Let me get there too.

13 MR. THOMAS: And it's the document within -- here's
14 Grand Strand Regional Medical Center 5688. I'd
15 like to lay some foundation, Your Honor, with
16 my expert witness, who's qualified as an expert
17 in healthcare finance. .

18 THE COURT: Well, there's an outstanding objection.
19 Do you ---

20 MR. LONG: Yes, Your Honor. Let me just renew our
21 objection from Monday about this particular
22 Exhibit 24. I want to be clear on the record
23 that just because he's mentioned it and has
24 asked him questions about that we don't agree
25 to its admissibility. I do think that if the

1 document does become such that he can ask him
2 any questions about it, it's going to under a
3 learned treatise; it's not going to come into
4 evidence.

5 Q: Mr. Sullivan, what is the document ---

6 THE COURT: Wait ---

7 MR. THOMAS: Oh, I'm sorry. I don't get to lay

8 foundation and then, I mean ---

9 THE COURT: I was going to get you to respond to his
10 objection.

11 MR. THOMAS: Well, I mean, first of all, this is a
12 government report about Medicare costs and the
13 effect of costly prostate cancer treatment by
14 providers who self refer. And so, you know,
15 this is a report under number -- and it's a
16 hearsay exception, Your Honor, 803(8) public
17 records and reports. Also, this is a document
18 that an expert in healthcare finance would
19 typically rely.

20 THE COURT: Wait a second, let me get to it.

21 MR. THOMAS: And experts can rely on a hearsay
22 document; they do it all the time.

23 THE COURT: Yes, I'm aware of that. Any response to
24 that or are we going ---

25 MR. LONG: I think 803 ...