

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 3 OF 10

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1 THE COURT: Well, I'm getting there.

2 MR. THOMAS: Just for the record, Your Honor, the
3 United States Government Accountability Office,
4 this isn't ...

5 THE COURT: You're going after 803(8); is that what
6 you're -- public records and reports?

7 MR. THOMAS: Well, that's one. I mean, I'm going to
8 also -- just, I mean, forget about the hearsay
9 documents ---

10 THE COURT: And then the other that he relied on?

11 MR. THOMAS: Yeah. This is the type of report that
12 an expert in healthcare finance ---

13 THE COURT: Well, you've got to lay the foundation
14 for that.

15 MR. THOMAS: Right. Well, I do. I haven't had an
16 opportunity to do that.

17 THE COURT: All right.

18 MR. LONG: Your Honor, I am just concerned about the
19 conversations with regards to, at the moment,
20 about admissibility. I want to make sure that
21 the document is not coming into -- hasn't come
22 into evidence yet. I'm not sure how he's
23 planning to -- what he's trying to do with it,
24 but I don't think this document is going to
25 come into evidence as an exhibit.

1 THE COURT: As I remember -- yeah, you're correct
2 that simply because a report is relied on, and
3 I don't have a case in front of me, but I think
4 current case law is that he can rely on it, but
5 the substantive aspect of the document doesn't
6 come in.

7 MR. THOMAS: I think you're right, Your Honor.

8 THE COURT: All right.

9 MR. LONG: So the article would be not admitted as
10 evidence but he can ask you questions about it.

11 MR. THOMAS: And he can actually read portions of
12 the article into the record, Your Honor. And
13 that is -- that is completely fair game.

14 THE COURT: I have to go look that up. If you can
15 give me the case on that.

16 MR. THOMAS: Yeah, I think that -- I can read
17 learned treatises and this -- let me just read
18 the rule, Your Honor. It says, "To the extent
19 called to the attention of ---"

20 THE COURT: Give me the rule so I can ---

21 MR. THOMAS: 803(18).

22 THE COURT: All right. Go ahead.

23 Q: To the extent's relied -- to extent called to
24 the attention of an expert witness upon cross-
25 examination and relied upon by the expert in

1 direct examination, statements contained in
2 public treatises, periodicals, or pamphlets on
3 subject of history, medicine or other science
4 or art established as a reliable authority by
5 the testimony or admission of the witness or by
6 other expert testimony or by judicial notice.
7 If admitted, the statements may be read into
8 evidence ---

9 THE COURT: But not received as exhibits.

10 MR. THOMAS: --- but may not be received as
11 exhibits. This rule is in addition to any
12 statutory provisions on the subject.

13 THE COURT: Yeah. All right.

14 Q: All right. Mr. Sullivan, what is this document
15 here? Could you just describe what it is
16 before you get into saying anything about it.

17 A: Sure. You mentioned it's the General
18 Accountability Office, and that's an
19 independent arm associated with the US Congress
20 that undertakes investigation into various
21 subject matters, not just healthcare, but you
22 know, a whole range of subject matters. In
23 this case, the study was, there were questions
24 -- a set of questions were raised about self-
25 referral's role in Medicare Part B expenditures

1 rapid growth. And so that's what they were
2 investigating, is specifically in this case,
3 whether there was a significant increase in the
4 use of IMRT for prostate treatment.

5 Q: Okay. Let me stop you there. What's the date
6 of this document?

7 A: It is -- it's 2013. Let me find the actual
8 date; it's on the front page. July 2013.

9 Q: Okay. And is a report from the GAO regarding
10 Medicare something you as an expert in
11 healthcare planning and finance would rely
12 upon?

13 A: Sure.

14 Q: Why would you rely upon something like this?

15 A: Well, this is an independent organization. I
16 think they've got a pretty good track record
17 from my experience in the past in terms of
18 doing in-depth research, and they also have
19 access to all of the Medicare data to a greater
20 extent a lot of times than an independent
21 consultant like I would have in terms of being
22 able to analysis different trends.

23 Q: And is it your understanding that they set the
24 findings out of the study on Grand Strand 5689?

25 A: They do.

1 Q: Okay. I want you to basically read the
2 findings into the record, first page there
3 because it is a long study.

4 A: What GAO found?

5 Q: Yes.

6 A: The number of Medicare prostate cancer related
7 intensity modulated radiation therapy (IMRT)
8 services performed by self-referring groups
9 increased rapidly while declining for non self-
10 referring groups from 2006 to 2010. Over this
11 period, the number of prostate cancer related
12 IMRT services performed by self-referring
13 groups increased from about 80,000 to two
14 hundred and -- I'm sorry, 366,000. Consistent
15 with that growth, expenditures associated with
16 these services and the number of self-referring
17 groups also increased. The growth and services
18 performed by self-referring groups was due
19 entirely to limited specialty groups, groups
20 comprised of urologists and a small number of
21 other specialties rather than multi-specialty
22 groups. Providers substantially increased the
23 percentage of their prostate cancer patients
24 they referred for IMRT after they began to
25 self-refer. Providers that began self-

1 referring in 2008 or 2009, referred to as
2 switchers, referred 54 percent of their
3 patients who were diagnosed with prostate
4 cancer in 2009 for IMRT compared to 37 percent
5 of their patients diagnosed in 2007. In
6 contrast, providers who did not begin to self-
7 refer, that is non self-referrers and providers
8 who self-referred the entire period,
9 experienced much smaller changes over the same
10 period. Among all providers who referred to a
11 Medicare -- referred a Medicare beneficiary
12 diagnosed with prostate cancer in 2009, those
13 that self-referred were 53 percent more likely
14 to refer their patients for IMRT and less
15 likely to refer them for other treatments,
16 especially radical prostatectomy or
17 brachytherapy. Compared to IMRT, those
18 treatments are less costly and often considered
19 equally appropriate but have different risks
20 and side effects. Factors such as age,
21 geographical location, and patient health did
22 not explain the large differences between
23 referring and non self-referring providers.
24 These analyses suggest that financial
25 incentives for self-referring providers,

1 specifically those in limited specialty groups,
2 were likely a major factor driving the increase
3 in the percentage of prostate cancer patients
4 referred for IMRT. Medicare providers are
5 generally not required to disclose that they
6 self-referred IMRT services, and the Department
7 of Health and Human Services lacks the
8 authority to establish such a requirement.

9 Thus, beneficiaries may not be aware that their
10 provider has a financial interest in
11 recommending IMRT over alternative treatments
12 that may be less -- may be equally effective,
13 have different risks and side effects, and are
14 less expensive for Medicare and beneficiaries.

15 Q: Can you put that into layman's terms, Mr.
16 Sullivan?

17 A: Sure. Essentially, the study found that
18 limited specialty groups, they said primarily
19 urologists, who began to self-refer in 2008 or
20 2009, there was a dramatic increase in the use
21 of IMRT over alternative treatments. And so
22 rather than -- they talk about radical
23 prostatectomy, the removal of the prostate, or
24 brachytherapy, which is -- well, some people
25 describe that as seed implants into the

1 prostate, radioactive seeds. Those treatments,
2 which don't cost as much and there's
3 information in the document that sort of
4 compares the costs, the costs of the IMRT could
5 be well more than double the cost of some of
6 these alternative treatments, that they are
7 using IMRT to a much greater extent than they
8 did before they had the financial incentive to
9 self-refer.

10 Q: Okay. And turn quickly within that same
11 document to Grand Strand 5701 for me. Is there
12 a reference there to kind of the costs that you
13 were just discussing?

14 A: It does. It says on page -- towards the end of
15 that narrative, One recent study found that
16 among men diagnosed with prostate cancer in
17 2005, the cost of Medicare per course of
18 treatment -- per course of treatment was
19 approximately 14,000 to \$15,000 higher for men
20 receiving IMRT (\$31,574) than for men who
21 received brachytherapy (\$17,076) or
22 prostatectomy, 16,469 or 16,762 depending on
23 the type of prostatectomy. Despite the 2013
24 reduction in the Medicare reimbursement rate
25 for IMRT delivery services performed in

1 physician's offices, we found that IMRT remains
2 substantially more expensive than other
3 treatments for prostate cancer with the
4 exception of proton therapy.

5 Q: Okay. In terms of cost containment, and
6 understand the Department did not have the, I
7 guess, the benefit of this document at this
8 time, what opinions, if any, do you have about
9 the cost containment decision portion of the
10 letter on 944 in Joint Exhibit 2?

11 A: You know, I think that it's -- it sort of
12 misses the mark in that it doesn't recognize
13 that the financial incentives that are in place
14 might results in patients getting more
15 expensive treatment than if CRCC is granted
16 additional capacity as opposed to another
17 provider where those same financial incentives
18 wouldn't be in place.

19 Q: Look at the bottom of page 944 for me.

20 A: Okay.

21 Q: In Joint 2. There's some conclusions there
22 where I guess Ms. Brandt concluded that --
23 something about the approval of more would have
24 an adverse impact on other providers, more
25 than one would have an adverse impact on other

1 providers in the service area. Do you agree
2 with that conclusion?

3 A: I do not.

4 Q: Okay. And if you turn the page there. Again,
5 if you look down on the third full paragraph
6 where it says, staff recognizes the strong
7 support received by Grand Strand.

8 A: Okay.

9 Q: What, if any, opinions do you have about, you
10 know, DHEC kind of glazing over the
11 comprehensive care significance of the project?

12 A: I mean, again, I think that DHEC missed the
13 mark in the way they evaluated these projects.
14 They seemed to be most concerned about the
15 impact that Grand Strand would have on CRCC
16 rather than the benefits that would accrue to
17 the community associated with the development
18 of a comprehensive center and a hospital-based
19 center. And, you know, when I might look at
20 CRCC's scope of operations, they are so large
21 relative to other providers in the state and
22 their profitability is so strong that I don't
23 think that any adverse impact associated with
24 this project would rise to the level of being
25 concerned about the ability of CRCC to provide

1 quality or to maintain financial viability.

2 Q: Okay.

3 MR. THOMAS: Your Honor, could we take a quick
4 break?

5 THE COURT: Yes.

6 (Break from 3:50 p.m. until 4:02 p.m.)

7 THE COURT: All right. Mr. Thomas.

8 BY MR. THOMAS:

9 Q: Mr. Sullivan, quick question to you. In terms
10 of Grand Strand standing alone, I want you to
11 assume that no affected persons, no CRCC-
12 Conway, CON competing or not, in your opinion,
13 you believe that if Grand Strand and this
14 project standing alone were the only project at
15 issue, is it approvable under the State Health
16 Plan and the project review criteria?

17 A: In my opinion, it would be. I believe it meets
18 the State Health Plan; I believe it meets each
19 of the applicable review criteria.

20 Q: How about the CRCC-Conway CON app?

21 A: I believe that standing alone, it's approvable.

22 Q: Well, what I want to do is I want to go through
23 a comparative analysis. What I'm going to do
24 is because it's set out here is provide you
25 with a copy of the project review criteria the

1 way they're set out in the regs and go through
2 what the ... what the Department touched on as
3 well. And what I'd like you to do is discuss
4 the CRCC application and the Grand Strand
5 application and which one, in your opinion, you
6 think is superior on the particular project
7 review criteria.

8 A: Okay.

9 Q: Okay. So let's just start. Obviously, number
10 one criteria is need and the proposal shall not
11 be approved unless it is in compliance with the
12 South Carolina Health Plan. In terms of CRCC's
13 Conway project and Grand Strand, what opinions
14 do you have on that particular project review
15 criteria?

16 THE COURT: Are you at Regulation 304?

17 MR. THOMAS: I'm sorry, Your Honor, yeah, I'm at
18 Regulation 61-15, I believe it's 802(1).

19 THE COURT: Oh, project review criteria.

20 A: I believe that both projects satisfy the State
21 Health Plan. I believe that if you had to
22 weigh one versus the other, the Grand Strand
23 project would be better conforming to the State
24 Health Plan because it's providing a more
25 comprehensive range of services.

1 Q: Okay. And I think we'll get into that as we
2 get into some of the other project review
3 criteria. So, if you would, on community need
4 documentation 2a what, if any, opinions do you
5 have the superiority of the projects in 2A?

6 A: You know, again, without repeating everything
7 I've said before, with respect to location,
8 distribution, the Grand Strand project offers
9 something not present in Horry County
10 currently, and as a consequence, I believe it
11 better meets the criterion 2a.

12 Q: Okay. And how about 2b?

13 A: I believe that both projects have reasonably
14 projected utilization based on accepted
15 methodology.

16 Q: Okay. And 2c under the community need
17 documentation, the proposed project should
18 provide services that meet an identified
19 documented need of the targeted population?

20 A: Again, this one I would think that Grand Strand
21 would better meet the criterion because I think
22 that they're meeting an identified need for an
23 alternative to the existing model of cancer
24 care delivery in Horry County.

25 Q: Okay. And then if you look at 2e, it's my

1 understanding that the -- that the letter, the
2 DHEC letter did not include e. In terms of 2e,
3 what is your opinion regards the two projects?

4 A: I believe that they both have -- well, current
5 -- obviously currently utilization doesn't
6 apply to Grand Strand. Certainly utilization
7 at CRCC is by currently and both applicants, I
8 think, have projected utilization that would
9 justify the expansion or limitation of the new
10 project.

11 Q: Okay. Would you go to 3, project review
12 criteria 3, Distribtuion (Accessability) and
13 3a. What is your opinion with respect to
14 duplication, modernization of services must be
15 justified?

16 A: Well, in the case of -- any time you add an
17 additional unit to an area that has such
18 services there's going to be duplication. So
19 the question is whether it's unnecessary
20 duplication or not. In this case, I believe
21 that both the projects propose to add needed
22 capacity to the system, so in that respect,
23 they both meet the standard. But again, the
24 Grand Strand project least duplicates the
25 existing services by providing a different

1 approach to the delivery of cancer treatment.

2 Q: Okay. Let's look at 3b if we could. Proposed
3 service should be located so that it may serve
4 medically underserved areas or underserved
5 population segment, and should not, again,
6 unnecessarily duplicate existing services.
7 What, if any, opinions do you have on that?

8 A: I believe both projects can satisfy 3b. I
9 believe both are located in areas where
10 medically underserved can reach them. And my
11 same comments would be true about unnecessary
12 duplication. I think Grand Strand would have
13 a less -- with less duplicate existing services
14 but providing a different model.

15 Q: Okay. And then go to 3c for me. Location of
16 proposed service should allow for the delivery
17 of necessary support services in an acceptable
18 period of time and at a reasonable cost. First
19 of all, what is it your understanding of what
20 the support services they're talking there
21 might be?

22 A: My understanding would be that the services
23 necessary to implement the radiation therapy
24 unit, so that would include necessary staff and
25 other ancillary services that would be needed

1 to operate.

2 Q: And what, if any, opinions do you have
3 regarding the superiority of this particular
4 project review criteria at 3c?

5 A: I believe that the Grand Strand project would
6 be superior. Within the hospital itself,
7 there's a much wider array of support services
8 available immediately to patients. CRCC can
9 access those services, but they have to be
10 accessed at different sites; for example,
11 radiology, surgical services, physical therapy
12 services, all of those things are located
13 within Grand Strand Medical Center, so I
14 believe that they would better meet 3c.

15 Q: Is it your opinion that 3c references back-up
16 services?

17 A: My opinion it does not. That's not a support
18 service.

19 Q: Got to 3e for me, if you would. The applicant
20 must document the means by which a person will
21 have access to its facilities. Any opinions on
22 that particular project review criteria?

23 A: I believe both applicants met the criterion.
24 I believe that Grand Strand better meets the
25 criterion because it has the added dimension of

1 patients who are inpatients being able to
2 access care within the same facility without
3 having to experience transfer.

4 Q: Okay. And 3f, The applicants should address
5 the extent to which all residences of the area
6 and particularly low income persons, racial and
7 ethnic minorities, women, and the elderly,
8 handicapped persons and other medically
9 underserved groups are likely to have access to
10 those services being proposed. What opinion do
11 you have on that?

12 A: I think that's one where both applicants have
13 met the standard. Both proposed to serve all
14 categories of patients. Grand Strand
15 historically had provided a significant level
16 of uncompensated care to patients and a
17 relatively high level of Medicaid services as
18 a -- so when you look at the projected payer
19 mix for the two facilities, I think they both
20 provide that level of access, and I believe
21 both have stated that they wouldn't
22 discriminate based on race or ethnicity or
23 handicap or anything else.

24 Q: Okay. Flip over to project review 13, because
25 I believe it kind of falls -- it's how the

1 Department grouped it on the record of the
2 applicant.

3 A: Okay.

4 Q: And on 13a, The applicant's record should be
5 one of successful operation with adequate
6 management experience. What, if any, opinion
7 do you have about that?

8 A: I believe that both applicants meet this
9 criterion. Obviously, CRCC has specific
10 experience in Horry County in providing
11 radiation therapy services. Grand Strand
12 certainly has a record of successful operations
13 of an acute care hospital and other types of
14 services, and it has the resources, I think, to
15 demonstrate that it would be able to
16 effectively operate the facility being proposed
17 in the application.

18 Q: How about 13b?

19 A: The ability to obtain financing, I believe both
20 applicants have demonstrated that.

21 Q: All right. If you would, go back to 4, project
22 review 4 on the acceptability.

23 A: Okay.

24 Q: 4a. What, if any, opinions do you have
25 regarding acceptability of the project?

1 A: I believe both applicants have documented the
2 support for the -- for their respected
3 projects. So I believe they both meet this
4 criteria.

5 Q: How about 4b?

6 A: This one's a little difficult to apply, you
7 know, on a comparative basis. Both applicants
8 are obviously facing opposition from each other
9 as it relates to this project, but as it
10 relates to the community, I think the level of
11 documentation that Grand Strand presented was
12 superior to that presented by CRCC.

13 Q: Okay. Now, again, at the way they've been
14 grouped, if you'd jump over to 22, project
15 review 22 for me.

16 A: Okay.

17 Q: And that is distribution. Existing
18 distribution of health services should be
19 identified and the effect of the proposed
20 project upon that distribution should be
21 carefully considered to functionally balance
22 the distribution to the target population.
23 What, if any, opinions do you have regarding
24 which project is superior on this project
25 review criteria?

1 A: I think this is the one where Grand Strand is
2 clearly superior. I'm being somewhat
3 repetitive, they're proposing to add something
4 to the area that doesn't exist in terms of a
5 comprehensive hospital-based service, whereas
6 what CRCC proposes would be more of the same.

7 Q: Okay. I ask you to go to 23a.

8 A: Okay.

9 Q: And this is the adverse effects on other
10 facilities. Could you provide your opinion
11 here with respect to the two projects?

12 A: Sure. Well, obviously, CRCC can't adversely
13 impact Grand Strand because it doesn't offer
14 the services currently. In terms of
15 projections, I believe that Grand Strand's
16 impact on CRCC and other providers in the
17 service area will be minimal, and so I believe
18 from this particularly criterion, I'd say both
19 applicants satisfy the criterion.

20 Q: In terms of just Grand Strand being approved,
21 and I know we're going to get into your
22 opinions about whether two should be approved,
23 but in terms of the 80 percent threshold, what,
24 if any, opinion do you have about Grand
25 Strand's approval bringing the existing

1 facilities under 80 percent, and I guess those
2 would be CRCC and Georgetown?

3 A: Right. Given the high level of utilization
4 that exists today, I can't envision any
5 scenario in which Grand Strand could drop
6 utilization of existing providers below 80
7 percent.

8 Q: And have you seen any analysis from CRCC
9 regarding what would happen if just one
10 hospital -- I mean, if just Grand Strand's
11 project would be approved in terms of the 80
12 percent threshold?

13 A: I have not.

14 Q: Have you seen one if two are approved?

15 A: I haven't.

16 Q: Let's go to project review criteria 15, which
17 is financial feasibility.

18 A: Okay.

19 Q: What, if any, opinions do you have regarding
20 that particular project review criteria with
21 respect to both applications?

22 A: I believe that both applicants have adequately
23 demonstrated immediate and long-term financial
24 feasibility.

25 Q: And let's go to cost containment, which is 16a

1 through 16c.

2 A: Okay.

3 Q: On 16a, do you have any opinions about the
4 applicants and the funding?

5 A: I do not. I think both applicants satisfy 16a
6 in terms of having reasonable sources of
7 funding for their project.

8 Q: Okay. And how about 16c what, if any, opinions
9 do you have on that?

10 A: I guess this goes back to the discussion we
11 were having a little while ago. I believe that
12 -- I mean, first of all, as it relates to Grand
13 Strand having any impact on its current charges
14 or projected charges, I don't think the project
15 will because it stands on it's own two feet
16 financially, so I don't see any reason why that
17 should adversely affect the charges of Grand
18 Strand prospectively. But as it relates to the
19 costs and charges of other providers with
20 similar services, I think the approval of Grand
21 Strand would actually potentially have a
22 beneficial effect by -- because of the
23 financial incentives that are in place for the
24 urologists today to utilize radiation therapy,
25 Grand Strand providing an alternative setting

1 could result in lower costs for patients who
2 are getting certain types of treatment.

3 Q: Okay. Let's go to projected reviews, projected
4 expenses, that's 6a and 7. What, if any,
5 opinions do you have regarding 6a with respect
6 to the two applications?

7 A: I think both applicants meet 6a in terms of
8 proposed charges. Grand Strand, the testimony
9 I heard from Mr. Grace was he based it on the
10 charges at Trident, and that would seem to be
11 reasonable. CRCC is obviously basing theirs on
12 the existing charges.

13 Q: Okay. And how about 6 -- excuse me, project
14 review criteria 7 on projected expenses with
15 respect to start-up costs and construction
16 costs?

17 A: As I mentioned earlier, the costs are less for
18 the CRCC project because it's really proposing
19 to create a different kind of facility. It's
20 going to be just a standalone radiation
21 treatment facility in an older building,
22 whereas Grand Strand is proposing to develop a
23 radiation treatment center. It's going to be
24 much larger and have more capacity to
25 accommodate other types of services in the

1 center. So I think that in terms of the
2 comparison, I mean, both applicants had
3 proposed reasonable costs, construction costs
4 and start-up expenses relative to the services
5 that they're proposing, but I think what Grand
6 Strand is proposing is a different character
7 than what CRCC is proposing and I think is
8 superior in that regard.

9 Q: In terms of completion date, and I know there's
10 been some submissions to the Department by CRCC
11 with respect to the fact that they can get
12 their project done about a year or earlier,
13 what if any, opinions do you have about that?

14 A: Again, I don't think that should be a factor
15 that was given much weight in this evaluation.
16 Obviously, to build a brand new facility is
17 going to take longer than to simply rehab an
18 older building that's already in place, but you
19 get a much different service in the new
20 facility than you will in an older modular
21 building, so I think the more important thing
22 is to provide the access to the type of service
23 that Grand Strand is proposing.

24 Q: Okay. What about in terms of there's also been
25 some testimony about the idea of being a multi-

1 unit versus a single operator. What, if any,
2 opinions do you have about that?

3 A: Most radiation therapy programs start with a
4 single unit. If the only way that you could be
5 approved would be a multiple unit operator,
6 then there would be very few new radiation
7 therapy providers in South Carolina in the
8 future. Secondly, there's a significant number
9 of single unit providers, not only in South
10 Carolina but throughout the country, who
11 operate very successful operations. There are
12 contingencies that can be put into place, and
13 during those rare times when the equipment goes
14 down, there's some need for maintenance or what
15 have you, other providers deal with that all
16 the time. Again, if that were a bar to a
17 provider being able to offer a service, then
18 you would never have a new competitor in Horry
19 County.

20 Q: Are there any other single unit providers in
21 the service area?

22 A: There are. Georgetown has operated a
23 successful program with a single unit, and the
24 closest "backup unit" would be at the Medical
25 University, which is 60 miles away from them.

1 Q: Other than CRCC?

2 A: Other than CRCC.

3 Q: Okay. And is that an ARC accredited facility?

4 A: It is.

5 Q: What does that mean, Mr. Sullivan?

6 A: It just means that the center has undergone a
7 review by the American College of Radiology and
8 they've met certain criteria and have certain
9 services, staff and protocols in place that
10 indicate that it's providing a level of quality
11 that merits that accreditation.

12 Q: Okay. In terms of comprehensive cancer
13 treatment, there's been some discussion on
14 that, in terms of the setting and having
15 radiation therapy mode at the hospital, what,
16 if anything, can that lead to in your opinion,
17 down the line?

18 A: Well, you know, it's the first step in the
19 development of a comprehensive center. You
20 can't do everything on day one, but if you have
21 radiation therapy and you begin to see more
22 cancer patients in your hospital and they come
23 in for other types of services, whereas before
24 they might not have, they might have gone to
25 the Medical University in Charleston, for

1 example, or some other center. And also,
2 there's a greater need for other types of
3 specialists, such as specialized cancer
4 surgeons, general surgeons, breast surgeons,
5 GYN, the whole range of things where there's
6 super specialized, there's been the potential
7 to be able to expand those offerings in the
8 community and patients won't have to leave the
9 area to get those services in Charleston or
10 Wilmington or Duke or, you know, wherever they
11 might go to get that treatment. And so without
12 the radiation program, Grand Strand's going to
13 be missing a fundamental piece of cancer
14 treatment, and it's unlikely they're going to
15 be able to develop those other related
16 services.

17 Q: There was a discussion this morning, I think
18 Mr. Mullins was cross-examining Dr. Collins
19 about the number of inpatients. Would you turn
20 in your, I think it's the Respondent notebook
21 to Respondent's 23.

22 A: Okay.

23 Q: Have you seen these documents before?

24 A: Yes.

25 Q: And what do they purport to be?

1 A: Respondent's 23 is showing the oncology product
2 line inpatient discharges for 2009, then it has
3 2010, '11, '12, and then the first quarter,
4 first big quarter of 2013.

5 Q: Oh, I think you're looking at Petitioner's 23.

6 A: I'm sorry. You said Respondent?

7 Q: Yeah.

8 A: I'm sorry.

9 Q: No, that's all right. That's all right.

10 THE COURT: I thought I was having an aneurysm or
11 something.

12 MR. THOMAS: Oh, no, you and me both.

13 A: It's just me, I guess. Yeah, these are --
14 sorry, these are the Exhibit 23 and
15 respondent's number of Grand Strand inpatient
16 referrals for 2010, '11 and '12 indicating the
17 diagnosis and the payer.

18 Q: What, if any, opinions do you have about the
19 number of inpatients that would be served? And
20 I think this morning we heard anywhere from two
21 to five treatments per inpatient transfer.

22 A: Yeah, I mean, the number of treatments I don't
23 think would be that great, but the number of
24 patients, I believe this data shows that over
25 those -- that three year period it's somewhere

1 between 25 and 30 inpatients who were
2 transferred and ---

3 Q: Per year?

4 A: Per year.

5 Q: Okay.

6 A: And so, as Dr. Collins said, I would think that
7 number would go up some, and so with the
8 presence of a radiation therapy unit there
9 because there would be a greater interest in
10 the patient being hospitalized there. And so
11 there would -- I think that, you know, while
12 it's not a huge number, certainly a material
13 number in terms of providing better access to
14 those patients.

15 Q: With the data, Mr. Sullivan, that you've looked
16 at, do you believe that these applications
17 should be considered competing applications?

18 A: In my view, they should not.

19 Q: Okay. Why not?

20 A: I believe there is ample utilization in the
21 area to support the approval of two different
22 linear accelerators.

23 Q: Can you say generally why you believe that?

24 A: Sure. Well, first of all, the 2010-2011 State
25 Health Plan identified a need for one. When

1 the 2011 data became available; it was obvious
2 that the numbers at CRCC had increased pretty
3 significantly in 2011 over 2010, and so there
4 was even an bigger pool of patients and
5 treatments out there to be served. The 2012-
6 2013 State Health Plan identifies a need for
7 yet another unit. And so, that's assuming that
8 one is already approved, there'd still be a
9 need for a sixth unit in the area. So based on
10 the State Health Plan's own methodology, there
11 could be a sixth unit approved in the area,
12 which would allow the approval of two in this
13 case.

14 Q: Okay. Now, I ask you to turn to -- I want you
15 to look at Respondent's 39 for me and I'll ask
16 you a couple of some general questions about
17 it.

18 THE COURT: Respondent's?

19 MR. THOMAS: Respondent's, yes, sir.

20 THE COURT: Y'all threw me off; y'all went to
21 Petitioner's then.

22 MR. THOMAS: I apologize.

23 MR. LONG: Your Honor, this will be the same
24 objection I made earlier with regards to 13.
25 I understand the Court's ruling, but this is

1 another exhibit prepared by Mr. Tolbert.

2 MR. THOMAS: I'm going to ask him general questions
3 about it, Your Honor. I'm not going to get him

4 ---

5 THE COURT: Sustained.

6 MR. THOMAS: --- to critique it.

7 THE COURT: Oh, okay.

8 MR. THOMAS: Yeah, just to kind of set -- lay some
9 foundation.

10 THE COURT: Any objection in that regard then?

11 MR. LONG: No, Your Honor. I just would assume ---

12 THE COURT: Okay.

13 MR. LONG: --- the same rules apply for this exhibit
14 that applied for the other one.

15 THE COURT: They do.

16 MR. LONG: Okay.

17 Q: Now, Mr. Sullivan, did you have opportunity
18 just to review and listen to testimony of Mr.
19 Tolbert during his deposition with respect to
20 Exhibit 39?

21 A: I did.

22 Q: Okay. And Mr. Tolbert on Exhibit 39 ---

23 MR. THOMAS: Judge, I'm referring specifically to
24 page, it's Tolbert 12735.

25 Q: Now you understand that he did an adverse

1 impact analysis based on, I guess, different
2 market shares, Mr. Sullivan?

3 A: He did. I think he looked at it appears using
4 five different market share assumptions.

5 Q: There's a column there that's, I guess, listed
6 more likely GS market share.

7 A: Yes.

8 Q: And I just want you to without -- I don't want
9 you critiquing this document -- later, but what
10 did he find for Grand Strand's number of
11 treatments in 2017, I guess a 25 percent market
12 share?

13 A: He found 7,951 projected treatments.

14 Q: Okay. Now, did you -- sorry to make you do
15 this -- I'm going to ask you to jump to
16 Petitioner's Number 2 for me.

17 A: Okay.

18 Q: And can you tell me what that particular
19 exhibit shows?

20 A: Sure. This is an exhibit that I prepared, and
21 what it looks at, couple of different
22 historical figures. First line shows the
23 average number of treatments per linear
24 accelerator for the top five radiation therapy
25 centers in the state, and they average about

1 5,100 -- exactly 5,182. If we look at the
2 average volume for providers in South Carolina
3 that operated only one linear accelerator, that
4 average was 4,819, so the projection we just
5 saw on Exhibit 39 of 7,951 would mean that
6 Grand Strand would be operating at 165 percent
7 of the average utilization of the five largest
8 -- I'm sorry, of the single operators and 153
9 percent of the top five radiation therapy
10 providers in the state. So at a start-up
11 program in an area where there's a much larger
12 provider that's been in the marketplace for a
13 long time, Grand Strand, within three years,
14 would have utilization well above the
15 experience of all the other providers in South
16 Carolina.

17 Q: Now, did you do any ---

18 THE COURT: What exhibit number is that?

19 MR. THOMAS: Oh, I'm sorry, Your Honor, Number 2,
20 Petitioner's 2.

21 THE COURT: All right.

22 Q: But generally, do you agree with Mr. Tolbert's
23 kind of use of, I guess, oncology and inpatient
24 market share in his adverse impact analysis in
25 terms of showing two that could be approved?

1 A: I don't agree with that.

2 Q: Now, I'd ask you to turn to Petitioner's 39 for
3 me.

4 A: Okay.

5 Q: And could you explain to the Court, first of
6 all, what this document is and what it's based
7 on?

8 A: Sure. The service area treatments for 2012
9 come from the Joint Annual Reports, and the
10 CRCC treatments come from the Joint Annual
11 Reports then GMH as well. We also had internal
12 information from the CRCC operations, and we
13 found that in 2012, AUC, the urology group,
14 represented 263 patients in terms of referrals.
15 We assumed in order to calculate the number of
16 treatments that it would be 40 treatments per
17 patient times the 263 patients.

18 Q: Why did you assume 40?

19 A: That was testimony that I read in deposition,
20 I believe of Rich Lewis and I can't remember,
21 Dr. Mantz maybe, and also that's consistent
22 with what Dr. Collins testified to this morning
23 as well, but -- and so what that says is that
24 AUC treatments represented 46 percent of all of
25 CRCC's treatments and 37 percent of the service

1 area treatments.

2 Q: Just for the record, on the source CRCC 2134 to
3 2151 is Respondent's 25 and Tolbert 12734-12735
4 is Respondent's 39 and CRCC 2012 JARS is Joint
5 Exhibit 9. Okay. So would you turn to
6 Petitioner's 40 in the same notebook, Mr.
7 Sullivan.

8 A: I'll just look at it on the screen.

9 Q: Oh, okay, yeah, you can just look at it on the
10 screen. Explain what this exhibit is and why
11 you did it?

12 A: Sure. If we look at CRCC's total treatments in
13 2012 and then using the same projection numbers
14 that Mr. Tolbert used, what the projected
15 number was in 2017, we can estimate how many
16 total patients were treated at CRCC or will be
17 treated in the future. We can see the 263
18 number that I just mentioned historically, that
19 would grow to 284 based on his growth
20 assumptions, and then the number of non-AUC
21 patients would be the number that's remaining,
22 the 621 in 2012 and the 669. And so when you
23 look at the AUC treatments and subtract those
24 from both the historical numbers and the
25 projected number, what's left over is really

1 the treatments that would be available to Grand
2 Strand. It would not be the entirety of CRCC's
3 treatments, the roughly 23,000 in 2012 or
4 25,000 in 2017; it would only be about 12,300
5 in 2012 and 13,200 in 2017. So in terms of any
6 impact on CRCC, almost half of their volume is
7 not at risk. And so Grand Strand would be
8 competing for the piece that remained, and they
9 would be competing against an existing provider
10 with more capacity and potentially more
11 locations.

12 Q: So the 13,205 treatments on Petitioner's 40,
13 the projected 2017 number, is that the number
14 that's kind of up for grabs?

15 A: In reality, yes.

16 Q: Okay. If you'd turn to Petitioner's 41 for me.
17 All right. Tell the Court what this document
18 is. First of all, did you create this
19 document?

20 A: I did.

21 Q: Tell the Court what it is and why you did it.

22 A: Okay. Again, this is using Mr. Tolbert's
23 projections of utilization. And what we did is
24 we assumed that none of the AUC referrals would
25 be available to Grand Strand, and if we took

1 his 25 percent market share assumption from
2 Respondent's Exhibit 39, and then also assumed
3 a very small impact on Georgetown of one
4 percent, since there was some questions about
5 whether or not there would be any impact on
6 Georgetown, and then calculate what the overall
7 utilization of capacity would be in the area,
8 under this scenario, Grand Strand would have
9 3,380 treatments in 2017 and the existing
10 providers in the area would be operating at 88
11 percent. So under this approach where we're
12 taking the urological referrals off the table
13 and then applying the market shares that Mr.
14 Tolbert came up with, the impact on existing
15 providers would clearly be far less than would
16 be needed to drop them below 80 percent.

17 Q: Did you only look at what it would be at 25
18 percent?

19 A: No, I looked at it other market shares as well.

20 Q: What was it at, for the record, turn the page,
21 what market share did you look at on the second
22 page of Petitioner's 41?

23 A: We looked at 30 percent, and that comes up with
24 4,041 projected treatments for Grand Strand,
25 which is about what the year two projection was

1 in the Grand Strand application. And then, you
2 know, making the same assumption about the
3 urological referrals not being in play, that
4 would result in the existing providers in the
5 area dropping to 86 percent utilization, but
6 again, still well above the 80 percent
7 threshold.

8 Q: Okay. And turn to page three. What did you do
9 on page three?

10 A: Just sort of following the assumptions that
11 were in Respondent's Exhibit 39, we applied a
12 35 percent market share, and that gets us up to
13 4,703, which is very close to the number
14 projected in the application of 4,690. So this
15 is probably the one that's -- ties most closely
16 to the application that Grand Strand filed.
17 And that shows that the existing providers
18 would still be at 83 percent. That would be
19 with the approval of the Conway facility and
20 with the approval of the Grand Strand facility.

21 Q: Okay. So in your opinion -- well, what, if
22 any, opinion then do you have based on the
23 analysis you did using Mr. Tolbert's market
24 share with the urologists carved out whether or
25 not two can be approved.

1 A: In my view, what this analysis shows is even
2 using his approach and his market shares that
3 the approval of the Grand Strand application,
4 along with the approval of the Conway
5 application, would not result in the existing
6 providers dropping below 80 percent and both
7 can be approved.

8 Q: Okay. Let's focus on that last page there in
9 terms of what would CRCC's -- I mean, in terms
10 of the Conway treatments and the existing
11 treatments, CRCC existing treatments and CRCC
12 Conway treatments, what would that total be?

13 A: Those two categories would total 21,620.

14 Q: And what, if any, kind of opinion do you have
15 regarding what kind of financial impact that
16 would cause CRCC if they were operating at
17 those levels?

18 A: I believe that, you know, the loss of volume
19 would result in some financial loss to CRCC,
20 but given the level of profitability that CRCC
21 has enjoyed historically, it's not going to
22 take them down to any level that would impair
23 their ability to operate any of these
24 facilities. So the financial impact, which
25 should not, I think, rise to the level of

1 concern that would warrant not approving the
2 Grand Strand project.

3 Q: At the levels here in 2017, I guess at 21620 or
4 something along those lines?

5 A: Correct.

6 Q: Well, let me ask you this. I think -- I think
7 the 21620 may be the Ford Cancer Center versus
8 the ---

9 A: I'm sorry, you're right. It's the ---

10 Q: Yeah, let's get that straight for the record.
11 In terms of CRCC-Conway treatments and CRCC
12 existing treatments, what would that number be?

13 A: That would be, give me one second, 14,455 plus
14 5,479, which would equal to 19,934.

15 Q: Would you expect any problems with
16 profitability at those levels?

17 A: No, that would be, you know, well above the
18 level that CRCC operated in 2009 when they were
19 very profitable and very close to the level
20 they operated at in 2010 when, again, they were
21 very profitable.

22 Q: Okay.

23 THE COURT: So where I can be clear, the total
24 existing, what is TX?

25 MR. THOMAS: Yeah, treatments, I'm sorry, it's a --

1 that's an abbreviation there.

2 THE COURT: Treatments, that included both Georgetown
3 on it?

4 MR. SULLIVAN: Right, and the CRCC existing.

5 THE COURT: So the correct figure is for this case
6 with CRCC is ...

7 MR. SULLIVAN: 19,934. That number's not shown on
8 the chart, that's just ---

9 THE COURT: That's fine.

10 MR. SULLIVAN: --- the sum of those two numbers.

11 THE COURT: That's why I want to get it down. Thank
12 you.

13 Q: I believe that at your deposition you made a
14 comment about potentially doing a referral
15 analysis; do you recall that testimony?

16 A: I do.

17 Q: Did you ever undertake a referral analysis?

18 A: I began down that path.

19 Q: And did you continue down that path?

20 A: I didn't. I mean, after -- maybe just explain
21 a little bit. We had received information from
22 CRCC that showed for each individual doctor how
23 many referrals they made to CRCC. We got it
24 for multiple years, I was looking at 2012 as a
25 starting point. And I began to compare the

1 names on that list to the medical staff rosters
2 that we looked at earlier today to see which
3 medical staffs those doctors might have
4 privileges at, and I discovered that a
5 significant number of the doctors had
6 privileges at multiple hospitals. For example,
7 I mentioned earlier that the medical
8 oncologists at Coastal had privileges at three
9 or four hospitals typically. Several of the
10 other doctors who were referral sources had
11 privileges in some cases at two, three, or four
12 hospitals. And so as I began to work through
13 it, I realized that the only two groups I could
14 be reasonably certain about was the urologists
15 were going to send their referrals to CRCC and
16 the employee doctors at Grand Strand were
17 likely to send their referrals to Grand Strand.
18 But all the other physicians, it would be
19 speculation on my part as to how many referrals
20 they would send in one direction or the other
21 without talking to those doctors, and even
22 then, we'd be talking about something that was
23 going to occur two or three years down the
24 path. And so, you know, I finally determined
25 it was just not a, not a worthwhile endeavor.

1 It's a lot easier to project things on a level
2 of a service area or a county than it is to try
3 to project what an individual physician is
4 going to do without knowing, you know,
5 significantly more about that physician and his
6 referral patterns and their relationships with
7 the different organizations.

8 Q: So you decided to go through with it?

9 A: I basically abandoned the analysis once I got
10 to the point of looking at the medical staff
11 affiliations and realized that there was just
12 no effective way to be able to do that.

13 Q: Turn to Petitioner's 17. I meant to bring this
14 one up with you, Mr. Sullivan.

15 A: Okay.

16 Q: All right. For the record, CRCC 59 to 73, it's
17 Bates labels, it's actually Petitioner's 52.
18 What does this chart show?

19 A: This is, again, information provided in
20 discovery in terms of the financial performance
21 of CRCC in 2010, '11 and '12 and shows the net
22 revenue, the EBITDA earnings before interest,
23 taxes, depreciation and amortization, total
24 treatments, and then the revenue per treatment.
25 And it shows that profitability after CRCC was

1 acquired by 21st Century increased
2 dramatically. It basically doubled between
3 2010 and 2011, went down a little bit in -- by
4 three million in 2012, but still remains very
5 profitable in terms of EBITDA. When you look
6 at the revenue per treatment, 21st Century
7 coming in, the revenue per treatment went up by
8 about 50 percent between 2010 and 2011 and went
9 down slightly in 2012. So CRCC has been very
10 successful since the acquisition by 21st
11 Century in increasing its profitability,
12 increasing its volume and increasing its
13 revenue per treatment. So they're in a very
14 enviable financial position. If you look at
15 their EBITDA as a percentage of their net
16 revenue, many organizations would like to have
17 that relationship where in 2011, for example,
18 they had \$13 million in EBITDA over a \$22
19 million revenue base.

20 Q: What's that percentage of EBITDA over revenue
21 on that one? Do you have a calculator?

22 A: I do. It's 60 percent.

23 Q: Okay. And as based on the other applications,
24 CON applications you've worked on throughout
25 the country in linear accelerator projects, is

1 that a healthy margin comparatively?

2 A: Yeah, I mean that's on the higher end of the
3 spectrum of profitability that I've seen in
4 linear accelerator projects.

5 Q: And based on Grand Strand operating as a single
6 operator, taking some of the incremental volume
7 we were talking about, what, if any, financial
8 impact do you think that would have on CRCC?

9 A: Well, you know, the -- as I said before,
10 because of the incremental growth in the area
11 that, in terms of net reduction in number of
12 treatment, I think the net reduction would be
13 relatively small, six or seven hundred
14 treatments, so that would have a relatively
15 modest effect on CRCC's overall profit.

16 Q: What about if two projects were approved?

17 A: That obviously would add some fixed costs to
18 the operations for CRCC because they would then
19 have to sort depreciation as well as the
20 additional operating costs associated with
21 that. But still, they have -- with these kind
22 of profit margins should not be any threat of
23 them facing any kind of financial difficulties.

24 Q: I believe you heard testimony on Friday from
25 Mr. Grace regarding kind of his initial

1 analysis or initial need projection or demand
2 projection, the Request for Capital?

3 A: Yes.

4 Q: And then -- first of all, what, if any,
5 opinions do you have about that?

6 A: I mean, from my discussions with him
7 independently and his testimony, I don't
8 believe there was any basis for his initial
9 utilization projections. I think it was
10 something he just sort of had to do quickly and
11 came up with his best estimate without a whole
12 lot of analysis behind it.

13 Q: And you heard his testimony regarding the "what
14 if" analysis; do you recall that?

15 A: I do.

16 Q: What, if any, opinions do you have with respect
17 to Grand Strand's ability to achieve those
18 volumes that Mr. Grace -- well, first of all,
19 how do you -- what's your understanding of how
20 he calculated the "what if" analysis?

21 A: Essentially, he more or less doubled the
22 volumes that I had projected and given to him
23 and ---

24 Q: What was the basis for that number?

25 A: As far as I know, he has no basis other than

1 the fact he just wanted to present a more
2 aggressive scenario. So I don't believe that
3 that has any more foundation than his original
4 analysis was based on, you know, just very
5 preliminary estimates.

6 Q: Okay. And so what, if any, opinion do you have
7 regarding Grand Strand's ability to achieve the
8 levels of utilization that Mr. Grace came up
9 with?

10 A: It would be very, very difficult to operate a
11 linear accelerator at those volumes. You would
12 have to be operating very long hours each day
13 to be able to do 8,000 treatments annually on
14 a single linear accelerator, and based on the
15 market conditions that I've already talked
16 about in some length here, I don't think that's
17 achievable given the presence of CRCC.

18 Q: Okay. Well, let's conclude like this, Mr.
19 Sullivan. What is your opinion if the Court
20 finds only the -- that only one CON application
21 can be approved in this case?

22 A: My opinion is that clearly Grand Strand should
23 be the approved applicant. It offers
24 competition. It offers a different model of
25 care delivery, and it provides the potential

1 for, I think, growth in the overall level of
2 cancer services in the community long term. So
3 I think that they provide the superior
4 alternative.

5 Q: And again, do you believe the applications, in
6 your opinion, are competing?

7 A: I do not.

8 Q: Okay. So what is your opinion with respect to
9 whether or not the Court can approve both
10 applications without exceeding the need in the
11 service area?

12 A: I believe that the Court could do that. I
13 believe that there's sufficient volume
14 currently and the projections of future volume
15 would support the approval of two and still
16 would be within the guidelines set forth in the
17 State Health Plan.

18 Q: Okay. And in your opinion what, if any,
19 adverse impact do you expect Grand Strand's
20 radiation therapy center to have, first of all,
21 on Georgetown?

22 A: I believe that it would be minimal, virtually
23 none.

24 Q: What about on CRCC?

25 A: I believe that it will have an impact on CRCC,

1 the growth and volume in the area that CRCC
2 would have enjoyed would go to Grand Strand
3 instead, but in terms of absolute terms in
4 terms of where they are today versus where
5 they're going to be in the future, I don't
6 think it's going to be a very significant
7 impact at all, certainly not enough to warrant
8 disapproval of the project.

9 Q: And just for the record, turn -- just for the
10 record, Mr. Sullivan, go to Petitioner's 1 for
11 me.

12 A: All right.

13 Q: What does this chart show? Well, first of all,
14 did you create this chart?

15 A: I did.

16 Q: What does the chart show?

17 A: This looks at -- it takes the information that
18 was in the 2012-2013 State Health Plan and
19 updates it based on -- that State Health Plan
20 had 2011 utilization data, and this updates it
21 to 2012. And it shows that, even if you
22 substituted 2012 utilization data into the
23 calculations, there would still be a need for
24 one additional linear accelerator above the
25 four existing and one approved.

1 Q: I'm sorry, Petitioner's 1. Is that
2 Petitioner's 1? Oh, you know what ---

3 MR. THOMAS: Hold on, I'm sorry, Your Honor. It's
4 my bad. Bear with me, Your Honor.

5 Q: What's your understanding, Mr. Sullivan, I'll
6 do it like this because I've having some
7 technical difficulties, Your Honor. In terms
8 of ranking by volume in South Carolina, are you
9 aware of what the highest volume provider of
10 radiation therapy services is in the state
11 based on the 2011 volumes?

12 A: Yeah, based on 2011 volumes, I believe that
13 that would be CRCC. They would have the, and
14 I'll open the 2012-2013 State Health Plan,
15 which has the volume by individual provider,
16 and it shows that CRCC had 25,709, and that is
17 the highest among all providers.

18 Q: So they're ranked number one then out of all
19 the providers in South Carolina?

20 A: They are.

21 Q: Okay.

22 MR. THOMAS: That's all the questions I have for
23 this witness, Your Honor.

24 MR. LONG: It's five o'clock, Your Honor, I mean
25 obviously I would just ask him a few questions

1 and I would probably prefer to start in the
2 morning if it's okay with Your Honor.

3 THE COURT: Well, I can go for an hour, but how much
4 are we going to mess up our schedule if we ...

5 MR. LONG: I'm not sure we will. I still think
6 we'll do the cross of Ms. Brandt tomorrow and
7 we might even start Mr. Lewis. Since Dr. Mantz
8 is no longer a witness, we would have then even
9 if we did ---

10 THE COURT: Oh, okay.

11 MR. LONG: We would have four CRCC witnesses to do
12 over two days. Mr. Tolbert has to be Friday
13 because of his teaching schedule, so it's ...

14 THE COURT: Okay.

15 MR. LONG: I mean, we can't really finish earlier
16 than Friday. He has to start Friday morning.

17 THE COURT: Well, then it's now your choice. Do you
18 want to start tomorrow morning? Is that what
19 you're suggesting? That's fine with me.

20 MR. LONG: I think so Your Honor.

21 MR. THOMAS: I'm fine with that, Your Honor.

22 THE COURT: All right.

23 MR. THOMAS: I've got to do some work to get
24 prepared myself for tomorrow myself.

25 THE COURT: All right. With that said we'll ---

1 MR. THOMAS: And just for the schedule, Your Honor,
2 I may need to bring Mr. Sullivan in on Monday.
3 My goal is if we're going to do rebuttal, it
4 would be on Monday.

5 THE COURT: All right.

6 MR. THOMAS: If that's okay.

7 MR. LONG: That's what I figured.

8 THE COURT: We'll cross that bridge when we come to
9 it.

10 MR. THOMAS: Okay. Thank you, sir.

11 (There being nothing further, the hearing recessed
12 for the day at 5:00 p.m.)

13 DAY 4 - TUESDAY, SEPTEMBER 17, 2013:

14 MR. LONG: May it please the Court.

15 MR. SULLIVAN - CROSS-EXAMINATION BY MR. LONG:

16 Q: Mr. Sullivan, good morning.

17 A: Good morning.

18 Q: It's good to see you today. I'd like to talk
19 to you a little bit about your testimony
20 yesterday. First I want to talk to you about
21 single unit providers. If we could, let's pull
22 up Joint Exhibit Number 5, page IX-9. Now,
23 this is the 2000 -- this is the most recent
24 Health Plan. I have it on the screen here.

25 A: Okay.

1 THE COURT: What page are we going to?

2 MR. LONG: IX-9.

3 Q: It gives the data from the different providers.

4 Are you there?

5 A: I am.

6 Q: Okay. And of course you had an exhibit that
7 you talked about yesterday that talks about the
8 average number of treatments for single unit
9 providers?

10 A: Right.

11 Q: Okay. Let's look at a couple of them actually
12 on the chart. First let's look at Eastside
13 which is in the top group there for
14 Greenville.

15 A: Okay.

16 Q: Okay. That's a single unit provider in
17 Greenville, right?

18 A: It is.

19 Q: 6,875 treatments in 2011, right?

20 A: That's true.

21 Q: And actually two years earlier they had 9,487
22 treatments at Eastside?

23 A: That's what it says.

24 Q: All right. And that's a highly populated
25 county with a number of different machines in

1 the county, right?

2 A: True. That's true.

3 Q: All right. Let's take a look at Oconee. All

4 right.

5 A: Okay.

6 Q: Do you know the biggest city in Oconee County?

7 I won't trick you, it's Seneca. Okay?

8 A: I didn't know that.

9 Q: Seneca, South Carolina. All right. And Oconee

10 has one machine in 2011, 6,173 treatments?

11 A: Correct.

12 Q: And in 2009, 6,279. Let's go to CRCC Exhibit

13 42. Go to the book. This is population data,

14 of course you're familiar with that.

15 A: I am.

16 Q: If you want to look at it in the book, it will

17 be Exhibit 42.

18 A: Okay.

19 Q: So Oconee, which we just saw has over 6,173

20 treatments in 2011 has a -- could you tell the

21 Court the population for Oconee County in the

22 2010 census?

23 A: 92,501.

24 Q: Oh, that's not what I ---

25 A: I'm sorry, did I look at the wrong one? I'm

1 sorry. 74,273.

2 Q: Yeah, that's right. 74,000. All right. Let's
3 look at the same sheet, Horry, so Oconee is a
4 little less than 75,000, Horry County 269,000,
5 right?

6 A: Right.

7 Q: Okay. So a single unit machine in Oconee
8 County is doing over 6,000 treatments with a
9 population of 75,000, and you're projecting
10 less than 5,000 for a single unit machine in
11 Horry County, right?

12 A: Right.

13 Q: All right. Now, let's look at Hilton Head. Go
14 back, if we could, to Joint Exhibit -- well
15 first, before we leave that, look at Beaufort's
16 population. We'll look at two more counties on
17 here because we're going to look at their
18 machines too. Beaufort's population, 162,000?

19 A: Right.

20 Q: So that's still significantly less than Horry,
21 right?

22 A: Yes.

23 Q: And let's look at Georgetown. 60,000, right?

24 A: Correct.

25 Q: Okay. Let's go back to Joint Exhibit 5, IX-9.

1 Towards the bottom of the sheet you'll see
2 Hilton Head. SJC Oncology Services, that's in
3 Hilton Head, right?

4 A: Right.

5 Q: Over 6,000 treatments?

6 A: Correct.

7 Q: 6,182 in 2009?

8 A: Correct.

9 Q: And even Georgetown is over 6,000 treatments,
10 right, with a population of 60,000, correct?

11 A: It is in 2011.

12 Q: In 2011, correct. But you're projecting less
13 than 5,000 treatments for Grand Strand, right?

14 A: That's true.

15 Q: An applicant that's intending to build a world
16 class cancer center at their hospital?

17 A: It won't be that the first three years, and you
18 also have the sort of unusual situation of the
19 oncology relationship in Horry County.

20 Q: Let's take a look at that. Let's look at your
21 exhibits in regards to the, I think you meant
22 to be saying urology, right, not oncology?

23 A: If I said oncology, I mean urology.

24 Q: Maybe you said urology. I thought you said
25 oncology but you meant urology, right?

1 A: I did.

2 Q: Let's take a look at your Exhibit Number 40
3 that you talked about at the end of the day
4 yesterday.

5 A: Okay. Let me grab that notebook. All right.
6 That's up here, I'll find it. Okay.

7 Q: This is where you tried to calculate yesterday
8 the treatments -- you tried to divide the
9 treatments at CRCC based on the urologists and
10 the other physicians who are not urologists,
11 right?

12 A: Correct.

13 Q: Referrals. Now, just to clarify, you have no
14 data to back this up, right; this is totally
15 based on assumptions on your part, right?

16 A: The 263 I believe is real, but that came from
17 your discovery information in terms of the
18 number of AUC patients. So the assumption is
19 on the number of treatments per patient.

20 Q: Right. And I should have been clearer in my
21 question. That's exactly right. The numbers
22 are 263 referrals from Atlantic Urology and 621
23 from everybody else are actually hard numbers
24 from discovery at CRCC?

25 A: Right.

1 Q: Okay. But then your assumptions under that in
2 regards to these projected treatments for each,
3 the projected treatments for each group are
4 based on assumptions, right?

5 A: Right.

6 Q: Let's look at -- and you took 40 treatments for
7 the urology group, and that's how you get the
8 10,520 number?

9 A: Yeah.

10 Q: All right. Let's take a look at -- let me use
11 this calculator for a second. Thanks. Let's
12 go to the next page if we could.

13 THE COURT: Next page?

14 MR. LONG: Yes. It's multi page, I'm sorry, maybe
15 it's the next exhibit.

16 Q: Is that a one-page exhibit? Okay. Sorry.
17 Let's go to Exhibit 41, which is the next
18 exhibit, right?

19 A: Okay.

20 Q: You were here yesterday and heard the testimony
21 of Dr. Collins, right?

22 A: I did.

23 Q: All right. So if you're correct in your
24 assumption, take the number of treatments for
25 the other providers, which is -- I'm sorry, I'm

1 getting -- let's go back to 40. It will be
2 easier to see on 40. Let's do the calculation
3 on 40. All right. Let's take the number of
4 treatments from the other providers, which is
5 12,278 and divide that by 621. Tell me what
6 you get.

7 A: Let me just clarify, that's not for Georgetown,
8 this is just CRCC data on this chart.

9 Q: Yeah. I'm talking about for the other patients
10 at CRCC.

11 A: That would 19.8, so roughly 20.

12 Q: So a little less than 20. So you're projecting
13 that the average number of treatments for the
14 non-AUC patients is less than 20?

15 A: Yes.

16 Q: You heard the testimony of Dr. Collins
17 yesterday, right?

18 A: I did.

19 Q: Okay. He listed out the following cancers and
20 said that the average number of treatments for
21 those cancers was 30 or more. Brain, remember
22 that?

23 A: I do.

24 Q: Bladder?

25 A: Yes.

1 Q: GYN?

2 A: Yes.

3 Q: Lung?

4 A: Yes.

5 Q: Breast?

6 A: Yes.

7 Q: Head and neck?

8 A: Yes.

9 Q: So all of those cancers are more than 30
10 treatments?

11 A: On the standard course.

12 Q: And colon was 25, right?

13 A: Right.

14 Q: Skin was 15 to 30?

15 A: Right.

16 Q: And lymphoma was 20?

17 A: Right.

18 Q: So except for the metastatic cancers, the
19 palliative patients, nobody was below 20 on any
20 cancer that he listed yesterday?

21 A: Right. If I could explain why I think that's
22 still a reasonable assumption.

23 Q: Well, let me do a couple more mathematical
24 calculations.

25 MR. THOMAS: Your Honor, he just asked if he could

1 explain his reasoning.

2 MR. LONG: I wasn't asking him a question, I was
3 just giving him math. But if Your Honor thinks
4 it's appropriate.

5 THE COURT: Normally I let witnesses explain. That
6 one I think I'll let you handle that on
7 redirect because we just didn't get far enough
8 into the answer, I mean he's right, he was just
9 asking math.

10 MR. LONG: Well, and if I get an opportunity here.

11 Q: So if you take, all right, probably the two
12 biggest cancers that you would see in the
13 radiation therapy center, it would be prostate
14 and breast, right?

15 A: And maybe lung.

16 Q: And maybe lung?

17 A: Yeah. Those are the big three usually in
18 cancer treatment.

19 Q: And certainly the breast and the lung together
20 would be as much as the prostate, right? It
21 would be a third of that number that you just
22 stated, right? Let's just assume for a second,
23 let's just do the question this way. Just
24 assume for me for a second that you're going to
25 have 250 lung and breast cases on that list,

1 and multiply 250 times 30.

2 A: 250? It's 7,500.

3 Q: So just those two cancers right there would
4 account for 7,500 of your 12,278 treatments?

5 A: Right. If that would ---

6 Q: According to your analysis.

7 A: If indeed that was the average.

8 Q: Well, are you assuming that Dr. Collins was
9 incorrect yesterday when he talks about how
10 many treatments that he does on patients that
11 he actually treats for cancer?

12 A: No. He was talking about what a standard
13 course would be, and my understanding is that
14 not every patient makes it through a standard
15 course. Sometimes patients drop out of
16 treatment, sometimes patients die, sometimes
17 patients, for whatever reason, interrupt
18 treatment. So, you know, I guess I would like
19 to see the actual data. I assume that CRCC has
20 the data.

21 Q: Well, you assumed no interruption. You assumed
22 a full standard course of 40 on every urology
23 patient, right?

24 A: Well, the assumption was 40 to 45 I think from
25 the deposition testimony of the CRCC witnesses.

1 So I assumed the lower end of that scale to
2 give some effect anyway to patients who maybe
3 don't complete their treatment.

4 Q: Well, let's just finish doing a little bit of
5 calculations. If you're at 30 on breast and
6 lung and that's 7,500 treatments, you do
7 12,278, which is the total number of treatments
8 minus 7,500; how much does that leave?

9 A: 4,778.

10 Q: 4,778. And we've just taken 250 patients and
11 263, and I can tell you or you can check me on
12 the math, it's 371 patients remaining.

13 A: 371, okay.

14 Q: That would not be prostate, lung, or breast.

15 A: Okay.

16 Q: So let's divide 4,778 divided by 371 and see
17 how many treatments you get per patient for the
18 remaining 371 patients at the center.

19 A: 12.9.

20 Q: 12.9, so everybody else that doesn't have
21 breast, lung, or prostate cancer, according to
22 your analysis, gives a grand total of 12.9
23 treatments, right?

24 A: Right.

25 Q: And you heard that every cancer he listed

1 yesterday had 20 or more? Or 25 or more,
2 right?

3 A: Except for palliative.

4 Q: Right. So you still think you might not have
5 a flaw in your number, in your assumptions?

6 A: I don't. As I recall from the CRCC data that
7 we had, the one, the largest categories of
8 disease was metastatic, and so, therefore, the
9 -- I don't remember the exact percentage, but
10 they have a relatively high percentage of
11 metastatic cancer, and in some cases that might
12 only be, you know, in the range of ten
13 treatments. You also have inpatients who were
14 served.

15 Q: Well, let's talk about the inpatients.

16 A: Okay.

17 Q: Because at Trident the percentage of patients
18 or treatments for inpatients is one percent of
19 the total. You saw that calculation yesterday,
20 didn't you, from Dr. Collins?

21 A: I thought that he testified that it was four
22 and a half percent.

23 Q: Of patients. But when Mr. Mullins ran him
24 through the calculation on the treatments, it
25 was one percent of the total treatment for

1 inpatient treatments.

2 A: Yeah, based on some assumptions. But the
3 numbers that we have from Grand Strand would
4 indicate that the percentage of inpatients
5 would be higher at Grand Strand if we look at
6 the historical trend, which was 25 to 30. If
7 we assumed that we were doing over 200 patients
8 at Grand -- and I projected about 223, that
9 would mean that we'd be looking at inpatients
10 as a total, in terms of total patients of being
11 maybe double what Trident has right now.

12 Q: You could have done the analysis on this
13 application, on this thing right here, you had
14 the data to try to calculate this by specific
15 disease other than urology, right, but you
16 didn't do it?

17 A: I didn't have, I mean, what I would have liked
18 to have had was CRCC's actual treatment counts
19 by disease category. I didn't see that in the
20 discovery.

21 Q: Yeah, but you didn't ask for it either, right?
22 We didn't refuse to give it to you, right?

23 A: I don't recall.

24 Q: Now, let's look at Exhibit 41 now. So under
25 your new projection in Exhibit 41, are you now

1 projecting that you're going to only, that
2 Grand Strand is only going to get 3,380
3 treatments in 2017?

4 A: No. This really isn't my projection. This was
5 really just a variation on a theme that Mr.
6 Tolbert had developed, and we were -- I think
7 the point that I was trying to make with this
8 exhibit was that if you adjust for the urology
9 presence in the CRCC numbers, that the
10 potential impact on CRCC is going to be
11 significantly less than it would appear to be
12 with Mr. Tolbert.

13 Q: Well, this is calculated on a market share of
14 25 percent, right?

15 A: It is.

16 Q: And it's 3,380 treatments is what you
17 calculated, right? So is that what you stand
18 by now on a market share of 25 percent or not?

19 A: No. This is just showing that had Mr. Tolbert
20 taken into account the urology effect, that he
21 would have come up with a significantly lower
22 number than what he did.

23 Q: Okay. And did he take into -- so is there
24 anything on Exhibit 41 that you contend will
25 actually happen in the market?

1 A: No. I think that the projections that were set
2 forth in the application are the reasonable
3 ones. I wouldn't have approached developing
4 projections in this fashion. This was Mr.
5 Tolbert's approach and I was just taking a
6 variation on his approach.

7 Q: Well, Mr. Tolbert doesn't project that the
8 treatments are going to be 3,380 in 2017 or
9 anything even remotely close to that.

10 A: That's exactly the point. I was trying to
11 demonstrate that he had overstated what the
12 potential impact would be on CRCC.

13 Q: You made no calculation about the urology
14 patients in your calculation of market share or
15 treatments, did you?

16 A: You mean in the application?

17 Q: Right.

18 A: No. Only in the sense that I knew that that
19 relationship existed and I knew that that, in
20 effect, capped the potential market share that
21 Grand Strand could hope to enjoy because
22 urologists are significant referrers, and I
23 knew that all of that business was not really
24 available to Grand Strand.

25 Q: Because if Grand Strand actually had a world

1 class cancer facility that had only 3,380
2 treatments a year, will you do the math for me
3 on what that is per day, being open 250 days a
4 year?

5 A: Sure. That would be 13 and a half treatments
6 a day.

7 Q: Thirteen a day. And you heard the testimony
8 that a treatment is like 15 to 20 minutes, so
9 probably three to three and a half patients an
10 hour, right?

11 A: Yeah, I mean, I've seen different standards but
12 yeah, somewhere about three an hour is pretty
13 typical.

14 Q: Okay. And so based on your calculation, the
15 center would only need to be open four hours a
16 day, right?

17 MR. THOMAS: Objection, Your Honor. That's not the
18 testimony of the witness. He's
19 mischaracterizing what he's saying.

20 THE COURT: I overrule that.

21 A: Sure, if that were the volume. That's not what
22 I think the volume is going to be, but if that
23 were the volume, you would only need to be
24 operational for a portion of the day.

25 Q: All right. Look at the next page on your

1 Exhibit 41.

2 A: Okay.

3 Q: So you also don't think the 30 percent market
4 share number that you've got on here is valid
5 either, 4,041?

6 A: It's not so much the market share, it's the
7 approach. I mean I just don't think that this
8 approach that Mr. Tolbert took is the way to go
9 about doing this. You know, I build up my
10 projections ground up, you know, from
11 population use rates and so forth. What he's
12 doing here is basically trying to substitute
13 acute care market shares or inpatient cancer
14 market shares with what's going to happen in an
15 outpatient service. And so what I was trying
16 to do was just show that if you took out
17 urology treatments that you would come up with
18 a much different number than Mr. Tolbert came
19 up with.

20 Q: Are you aware that this Court, actually this
21 Administrative Law Court has held that an
22 inpatient hospital market share is the closest
23 available proxy to the radiation therapy market
24 when there are no operating linear
25 accelerators, when the applicant is not already

1 operating a linear accelerator program; did you
2 know that?

3 A: I did not.

4 Q: Do you disagree with that?

5 A: I do.

6 Q: Let's look at the third sheet on Exhibit 41.

7 THE COURT: Wait, I want to make sure my note's
8 correct. You said Mr. Tolbert was trying to
9 substitute the inpatient, and what was the rest
10 of that?

11 MR. SULLIVAN: The inpatient market share, and also
12 he was looking at the oncology inpatient market
13 share in the primary service area. And just
14 one step further, he was applying the market
15 share for Grand Strand's service area to the
16 entire three-county area.

17 THE COURT: All right.

18 Q: On the third page in here you've got a
19 calculation of 4,703, right?

20 A: I do.

21 Q: Okay. And that's actually a little higher than
22 what you project in the application, isn't it?

23 A: I think it's about 13 higher if I recall
24 correctly.

25 Q: Okay. Well let's do -- and you're basing that

on -- okay, let's do the math on that on
treatments per day, 4,000, you can take your
number from the application, if you want to,
which is what? 4,690?

A: 4,690.

Q: What's 4,690 divided by 250?

A: It's about 19.

Q: It's 19 patients per day?

A: Right.

Q: And if you're doing 3.5 an hour, can you divide
that and see how many hours you're going to be
open?

A: Let's use three. 6.3 hours.

Q: 6.3 hours. So a world class cancer center and
tied to a hospital-based program is going to be
open from 9:00 to 3:00, right?

A: Well, no. Obviously you're going to spread out
your treatments based on the scheduling needs
of your patients.

Q: But they would only need to be open from 9:00
to 3:00, right? Six hours?

A: That's true. As you build volume, that's true.
The State Health Plan only requires you to be
50 percent occupied.

Q: All right. Let's look at your market share

1 calculations. Now, you could have looked at
2 inpatient discharges for Grand Strand to
3 determine your market share, right?

4 A: I could have.

5 Q: And you could have looked at outpatient for
6 Grand Strand but -- to determine your market
7 share but you didn't, right?

8 A: I don't have a good outpatient market share
9 number.

10 Q: Right. And you certainly could have looked at
11 Grand Strand's internal market share
12 calculations, what they considered to be
13 important, what they track in regards to market
14 share, right?

15 A: I'm not sure exactly what you're referring to.

16 Q: Well, let's look at a couple of documents. All
17 right. Let's look at Grand Strand, Grand
18 Strand Petitioner Exhibit Number 13. This is
19 the actual number that you based your draw rate
20 off of, right? Look at the bottom total
21 number.

22 A: I believe I did.

23 Q: Right at the top of it. First let's look at
24 the top and see what the document shows.

25 A: All counties, inpatients by DRG, All counties,

1 oncology ABSL. I think that's service line.

2 I don't know what the AB stands for. But I
3 mean, this isn't the actual document I based it
4 on because this has 2012 data and I did this
5 back in 2011.

6 Q: I think you were using 2010, weren't you?

7 A: I was using 2010.

8 Q: Yeah. So this has the 2010 also on it.

9 A: Right.

10 Q: But that's the -- that's the info -- you were
11 doing inpatient, you were doing cancer
12 diagnosis inpatients only, right?

13 A: Right.

14 Q: And let's look at the total number of patients
15 that fall under that category of Grand Strand
16 in 2010, '11, and '12. So in 2010, it's 464
17 patients, right?

18 A: Right.

19 Q: All right. And of course, this is for a
20 hospital that doesn't do -- that doesn't really
21 do chemo, right?

22 A: No.

23 Q: They don't do radiation, right?

24 A: Right.

25 Q: And so most of the patients were probably

1 surgery, right?

2 A: That would be my ---

3 Q: Wouldn't you expect?

4 A: That would be my guess, and maybe some who had

5 medical complications related to cancer that,

6 you know, maybe needed hospitalization to deal

7 with low blood counts and things of that sort.

8 Q: Now, Grand Strand, let's look at CRCC Exhibit

9 77. These are discharge -- all inpatients by

10 zip code for Grand Strand, right?

11 A: Right.

12 Q: Look at the bottom for 2010, 20 -- you're going

13 to have to go to the last page to get the

14 total, sorry.

15 A: A lot of zip codes.

16 Q: Yeah, a lot of zip codes. All right. 2010

17 they had 14,245 inpatient discharges, right?

18 A: Correct.

19 Q: And in 2012, it was 16,006, right?

20 A: Right.

21 Q: So your number, 464, is a pretty small subset

22 of the total number of inpatients, right?

23 A: It is.

24 Q: And you also had access to another number at

25 Grand Strand Exhibit Number 22 on page 5435,

1 which his all cancer diagnoses at Grand Strand
2 both inpatient and outpatient by zip code,
3 right?

4 A: Right.

5 Q: And that number is in 2010, 4,860, right?

6 A: That's true.

7 Q: And you actually referred to this number in
8 your PowerPoint at the project review, right?

9 A: I did.

10 Q: But you told me in your deposition that you
11 thought it was basically a useless number for
12 our purposes here today?

13 A: For purposes of projecting, yes.

14 Q: And the reason is is because you don't know how
15 many patients it is because many cancer
16 patients could have multiple outpatient events,
17 right?

18 A: Sure. I mean they could have come into the ED
19 with a cut foot but still had a cancer
20 diagnosis and they would have been counted in
21 this.

22 Q: Hospitals closely track their inpatient
23 discharges or admissions, don't they?

24 A: Sure.

25 Q: And as a matter of fact that's a very important

1 market share number to them, isn't it?

2 A: That's their primary business.

3 Q: And let's look at CRCC Exhibit 97, which is the
4 Eastern Group Visit PowerPoint. We heard some
5 testimony on that last week. Let's go to page
6 3081. The number one number at the top,
7 overall market share, right?

8 A: Right.

9 Q: And their overall market share in 2009 is 35
10 percent of the market for all inpatients,
11 right?

12 A: That's true.

13 Q: All right. And then they also track their
14 oncology market share which is right at 30
15 percent, right?

16 A: Twenty-nine.

17 Q: Twenty-nine, sorry.

18 A: Twenty-nine.

19 Q: Twenty-nine percent. And there's no doubt that
20 you could have had this information to do your
21 application because this PowerPoint was
22 actually given in March and that's when you
23 were working on the CON, right?

24 A: Yeah. I think I was aware of these numbers at
25 the time I was doing the application.

1 Q: But they weren't in your file though?

2 A: No, they weren't. But I remember talking with
3 Mr. Rudd and just generally about what their
4 market share was and the conversation was that
5 their oncology market share was somewhat below
6 their regular inpatient market share.

7 Q: Well, in your deposition when I asked you about
8 your conversation with Mr. Rudd about market
9 share you told me he didn't know what the
10 market share was in the conversation?

11 A: He didn't. He just said that it was low.

12 Q: All right. Now, let's look at a couple of our
13 maps if we could. We did first -- let me get
14 these up on the board here so you can get them
15 close enough for you to see. One of the first
16 things you would look at that's important in
17 doing a need analysis is population, right?

18 A: Sure.

19 Q: You agree with that? Okay.

20 A: That's a start. Yeah.

21 Q: That's a good starting point. And here's our
22 map of the population of the service area. Can
23 you see it from there or do I need to move it
24 a little bit closer to you?

25 A: I can see it.

1 Q: Can you read these zip codes?

2 A: I can.

3 Q: Yeah, this is CRCC Exhibit Number 1. Okay.

4 All right. And we broke the zip codes down
5 into three categories just to try to look at
6 different breaks or whatever, but obviously
7 there's certain zip codes that have higher
8 population in the three county service area,
9 right?

10 A: Right.

11 Q: And those are Conway, to the south of Conway,
12 29588, and Myrtle Beach. Those are the three
13 biggest ones in Horry County, right?

14 A: That's true.

15 Q: But also some of these population centers, like
16 Little River is over 20,000, right, per zip
17 code, North Myrtle Beach?

18 A: Yes.

19 Q: And of course Murrells Inlet is 22,000, that
20 zip code there, right?

21 A: Right.

22 Q: And a significant population to the west of
23 Conway, 22,000 in 29527, right?

24 A: Correct.

25 Q: All right. So did you look at this data, did

1 you look at these zip codes to determine where
2 the people live?

3 A: I did. I had population by zip code.

4 Q: And generally it's pretty safe to assume that
5 if you have more people living in a zip code,
6 you're more likely to have more patients,
7 right?

8 A: I think that's a fair assumption.

9 Q: All right. Let's look at CRCC Exhibit Number
10 3, this map. Now, these are Grand Strand's
11 inpatient discharges for the hospital, okay,
12 which show where they get their patients at
13 their hospital for inpatient, right, by zip
14 code. And it's pretty obvious that the vast
15 majority of their patients are right in this
16 highly populated area in Myrtle Beach and
17 Conway and North Myrtle Beach, right?

18 A: Sure.

19 Q: The purple is more than 1,000 in discharges,
20 and the zip codes that are in purple are North
21 Myrtle Beach, and Myrtle Beach is the highest,
22 29577, and North Myrtle Beach, Conway, the two
23 zip codes between Conway and Myrtle Beach,
24 right?

25 A: Those are the highest. Those are some of the

1 largest populations it appears.

2 Q: That's not surprising, more people living
3 there, more people using the hospital, it's
4 close to the hospital, right?

5 A: Relatively.

6 Q: Okay. Now, CRCC Exhibit 5, we also took the --
7 you had the patients by zip code numbers for
8 CRCC, right?

9 A: I did.

10 Q: And that map looks very similar to the Grand
11 Strand map, doesn't it?

12 A: It does.

13 Q: CRCC's patients are coming from the same
14 general area that Grand Strand's patients are
15 coming from, right?

16 A: That's true.

17 Q: All right. Now, let's look at what you did
18 with CRCC Exhibit Number 4, and I've got two
19 maps here. The first is you did in a CON
20 application, you projected the total number of
21 patients by zip code that would need radiation
22 therapy, right?

23 A: Sure.

24 Q: You went through every zip and you said, you
25 calculated out the exact number ---

1 THE COURT: Excuse me. What exhibit is that?

2 MR. LONG: I'm sorry, what?

3 THE COURT: What exhibit is that?

4 MR. LONG: This is CRCC Exhibit 4 and it's a two map
5 exhibit, Judge.

6 Q: The first map is this one, which is the total?
7 population that Grand Strand projected. So,
8 for example, you projected in Conway there
9 would be 127 actual patients in 2015 that would
10 need radiation therapy?

11 A: That's true.

12 Q: Okay. And in Myrtle Beach, 29577, you
13 projected 103, right?

14 A: Right.

15 Q: And 95 in 29582, which is North Myrtle Beach.
16 So these are actual numbers of people. All
17 right. And as you can see the ones in purple
18 are more than 90 cases. Okay?

19 A: Right.

20 Q: Now, let's put this one down and look at what
21 you projected that they would actually do in
22 the application. A lot less purple, right?

23 A: True.

24 Q: Okay.

25 A: Well you could change your scale and get more

1 purple if you wanted to but, I mean, I
2 projected that most of our business would come
3 along the coast.

4 Q: Right. Let's look at a couple of actual
5 counties where you made specific projections
6 with your draw rate as to what would happen.
7 Let's start first with 29 -- and of course when
8 you made your projections you weren't
9 projecting, you were projecting that Grand
10 Strand would be approved, right?

11 A: I was.

12 Q: Okay. And that would -- it wouldn't be -- that
13 would be the applicant that would be chosen.
14 All right. 29526, you projected 127 patients
15 in 2015, you projected that Grand Strand would
16 get four?

17 A: Right.

18 Q: 29527, just to the west of Conway, you
19 projected 68 actual patients that would need
20 radiation therapy and you projected that Grand
21 Strand would only get two?

22 A: Correct.

23 Q: Loris, 29569, 49 actual patients that would
24 need radiation therapy and you projected they
25 would get one?

1 A: Correct.

2 Q: Okay. So out of just those three zip codes
3 right there you projected a total of seven
4 patients out of 200 actual, more than 200, 220
5 something actual cancer patients and you said
6 that they would get seven, right?

7 A: That's true.

8 Q: Okay. Other zip codes you projected 95. You
9 have no single zip code on here where the
10 percentage is higher than 25 percent?

11 A: That's true because that was the maximum market
12 share that I projected that Grand Strand would
13 achieve.

14 Q: For any zip code?

15 A: That's true.

16 Q: Even the zip code where the hospital is
17 located?

18 A: That's true.

19 Q: Even the zip code right to the south where they
20 get 3,200 inpatients every year from one zip
21 code and you said they would get 26 out of 103
22 radiation therapy treatments?

23 A: That's correct.

24 Q: Does this look like what a world class cancer
25 center would project, would attract?

1 A: It looks like what a startup radiation therapy
2 provider would attract.

3 Q: At a hospital?

4 A: At a hospital facing entrenched competition
5 that had an employed urology group.

6 Q: Well also, it's also a hospital that's got a
7 pretty good lead on the number one referral
8 source in the county, Dr. Holt's group, right?

9 A: I don't believe they're number one as it
10 relates to treatments; they are perhaps in
11 terms of patients.

12 Q: Okay. You don't know that? You don't know
13 that, do you? You're making an assumption on
14 that and that was based on your -- on your
15 exhibit before, but you do not know that, do
16 you?

17 A: It's an informed assumption, if I could
18 explain.

19 Q: Well, isn't it based on the 40 treatments?

20 MR. THOMAS: Your Honor, I think he'd like to
21 explain himself. He said it was an informed
22 assumption.

23 THE COURT: Go ahead.

24 A: If we look at what the actual number of
25 treatments were in the service area at the time

1 I was doing the application, I had data for
2 basically 2008 and 2009. The number of
3 treatments per patient was a little bit, right
4 around 21, slightly over 21 treatments per
5 patient. That was during the time when the
6 urologists were somewhat disaffected with CRCC,
7 based on my understanding, and weren't making
8 significant numbers of referrals to CRCC.
9 CRCC's numbers jumped in 2010 and then again in
10 2011 after urologists became employed, and the
11 number of treatments at CRCC went up
12 proportionately. So I believe that the
13 assumption that the urologists have a higher
14 number of treatments per patient than all the
15 other categories put together I think is
16 reasonable in light of that historical data.

17 THE COURT: I've got to step out one moment and
18 handle another matter with the courts. I'll be
19 right back.

20 (Break from 10:06 a.m. until 10:12 a.m.)

21 THE COURT: I may have to take one other call today,
22 I don't know.

23 BY MR. LONG:

24 Q: Let's move to Grand Strand Exhibit Number 26.

25 Now, you obtained this document, Grand Strand

1 Exhibit Number 26 and produced it, correct?

2 During the discovery process, right?

3 A: I may have. I've seen this document before.

4 It may have been ---

5 Q: And this is similar to what you actually base
6 your decision on in regards to the market share
7 numbers because this is oncology inpatient at
8 the hospital, right? Oncology inpatient.

9 A: It's similar. It's not the exact same data but
10 it's similar to the data I used.

11 Q: Well it's just different because it -- it's not
12 dramatically different, right?

13 A: I mean the numbers are lower in that I was
14 looking at numbers that were closer to 500 and
15 this shows 243. So I think it's a different
16 cut at oncology than what I based my numbers
17 on.

18 Q: But it does list the other hospitals that would
19 have inpatient market shares. So this,
20 obviously, CRCC would not be on this because
21 they don't have inpatient, right?

22 A: That's true.

23 Q: This is just hospital's oncology?

24 A: True.

25 Q: All right. And you see on this list that I

1 found to be -- I wanted to ask you about is
2 Waccamaw and Conway have higher inpatient
3 cancer market share than Georgetown, which has
4 a linear accelerator, right?

5 A: Right.

6 Q: What do you attribute that to?

7 THE COURT: Waccamaw and where?

8 MR. LONG: And Conway hospitals.

9 THE COURT: Okay.

10 MR. LONG: Are three and four on the list.

11 A: I think it's the same logic by which Waccamaw
12 or Georgetown is seeking to relocate its cancer
13 center that sort of the balance of population
14 in its service area shifted to the northern part
15 of Georgetown County, and Georgetown itself is
16 not in a growth area and a lot of the patients
17 I believe in Georgetown proper may be migrating
18 south into Charleston. So I think that this is
19 sort of a reflection that Georgetown Hospital,
20 Georgetown Memorial Hospital is sort of in
21 somewhat of a decline.

22 Q: Well, you certainly would agree with me that no
23 one who has inpatient cancer care at Waccamaw
24 or Conway is going to get their radiation
25 therapy done at either one of those hospitals,

1 right, because they don't do it?

2 A: That's true. They'd have to go elsewhere.

3 Q: You'd have to go elsewhere. So both those
4 hospitals would be a natural source for Grand
5 Strand to draw patients to, right?

6 A: Not really. Grand Strand is competitive with
7 both of those hospitals and with the medical
8 staff members on those two hospital's medical
9 staffs, so I would think -- that's one of the
10 reasons we were talking about why I drew my
11 service area the way I did. I didn't expect
12 Loris, who's aligned with McLeod in Florence
13 which has its own cancer program, Conway has
14 been a long time competitor of Grand Strand's,
15 and then Waccamaw and Georgetown have their own
16 system and their own cancer program. So to a
17 certain extent, the ability to get referrals
18 from medical staff members of these competing
19 hospitals I think is going to be limited,
20 particularly in the early years. Over time, if
21 truly Grand Strand develops into a world class
22 center, I think some of those barriers will
23 come down. But for the first three years, I
24 certainly didn't see that there was going to be
25 any significant number of referrals coming out

1 of these competing hospital markets.

2 Q: Well, who makes the choice on the referrals;
3 the physician and the patient or the hospital
4 administrator?

5 A: The doctors.

6 Q: Okay. And you just testified yesterday that
7 most of these doctors are on multiple medical
8 staffs?

9 A: Well, I think I said that Conway's medical
10 staff overlaps very little with Grand Strand
11 and that Georgetown's medical staff overlaps
12 little with Grand Strand. What I was talking
13 about was the patients who were referred to
14 CRCC, the medical oncologists for example are
15 on three or four medical staffs. Some of the
16 surgeons are on multiple medical staffs. But
17 by and large, I wouldn't think that there would
18 be an outpouring of referrals from Waccamaw,
19 for example, when they're aligned with
20 Georgetown and Georgetown has its own cancer
21 center.

22 Q: Well, these patients right now are probably
23 already getting radiation therapy in either
24 Georgetown or Horry County, aren't they?

25 A: I would hope so.

1 Q: As a matter of fact, the MUSC number, those
2 patients are probably getting their radiation
3 therapy in either Horry or Georgetown County,
4 right?

5 A: They could be and some of them may be going to
6 Charleston. I think that still happens because
7 I've just heard anecdotal stories of people
8 from that area who wanted to be treated in
9 Charleston.

10 Q: But the general rule for radiation therapy is
11 that people tend to get the service close to
12 their home, right?

13 A: That's the idea.

14 Q: Okay. Let's look at CRCC Exhibit Number 122.
15 If you will turn over to the second page GSRMC
16 644. This is an email that we had some
17 testimony about last week in regards to -- and
18 the date on this conversation is June 16th of
19 2011, and this is right about - this is during
20 the time that the application was approved,
21 right? You saw -- by the folks in Nashville?

22 A: Right. The application I think was filed July
23 the 11th.

24 Q: Right. So the approval comes in mid June and
25 y'all get finalized and filed a few weeks

1 later. Okay. This is Jerry Rooker, who's the
2 controller for the whole Eastern Group in
3 Nashville, and he has this sentence here at the
4 end of this email that says, The current NPV is
5 1.4. Okay, what does NPV mean?

6 A: Net present value.

7 Q: All right. Can you kind of explain that; what
8 you're looking for as a financial person in
9 regards to that number?

10 A: Basically you look at the projected cash flow
11 stream that comes from a particular service.
12 You apply a discount factor to that cash flow
13 stream. And different people use different
14 periods of time in terms of how far out they
15 project those cash flows, but then you
16 basically discount the present value of the
17 cash flow stream back to the present.

18 Q: And you want that number to be positive, right?

19 A: Yeah. You wouldn't want to make -- I mean, in
20 theory you wouldn't want to make an investment
21 where there's a negative net present value.

22 Q: Right. And the higher the number the better,
23 right?

24 A: Sure.

25 Q: All right. Let's look at the return on

1 investment. And it says here the return on
2 investment is 32.8 percent. What is return on
3 investment?

4 A: That looks at the total capital funds invested
5 in a project. That's the denominator and then
6 the numerator would be the annual return. It's
7 calculated a lot of different ways. I don't
8 know how they did it here, but one way to
9 calculate it is to look at the annual return on
10 the capital funds invested.

11 Q: And that number is the number you want to be
12 positive, right?

13 A: Sure.

14 Q: And you want it to be, the higher the better,
15 right?

16 A: If you're an operator, yes.

17 Q: Or a hospital administrator or whatever, you
18 want that number to be the higher the better?

19 A: Sure.

20 Q: And the third number is the payback of 6.3
21 years. Can you explain what the payback means?

22 A: Sure. That's a fairly simple calculation where
23 you look at the total amount of investment and
24 then you look at how many years of income does
25 it take you to earn back that investment. So

1 in this case, 6.3 years would mean if you had
2 a nine and a half million dollar investment, it
3 would take 6.3 years in order to generate \$9.5
4 million.

5 Q: Okay. Let's look at CRCC Exhibit 115 page
6 1630. This is an email that we looked at the
7 other day from Mr. Bryant, has an attachment to
8 it. I'm sorry, 1639. Okay. Go to the bottom
9 if you would. Just pull up the bottom part.
10 This is the financial analysis summary. Let's
11 do the financial analysis summary first, little
12 block there at the bottom. Okay. The
13 financial analysis summary for this document,
14 this internal document matches Mr. Rooker's
15 email, doesn't it?

16 A: It does.

17 Q: NPV is 1.54 just like the email. The EBITDA
18 return on investment is 32.6, right?

19 A: 32.8.

20 Q: 32.8, I'm sorry. I can't see from here. And
21 the cash payback is 6.3 years. And also, what
22 would the internal rate of return be?

23 A: It's sort of a different way of looking at some
24 of these same numbers. It would be, if you
25 look at the cash flow stream that was generated

1 from a particular service and what would be --
2 I'm trying to think of the easiest way to say
3 this. If you invested the same, if you
4 invested that money the cost of capital cost to
5 the project, and you got a certain income
6 stream over a period of time, what would be the
7 rate of return on that money. It's just like
8 if you deposited money in the bank and at the
9 end of ten years you had X number of dollars
10 then you would calculate what the rate of
11 return was on that investment based on the cash
12 flow or stream that you received.

13 Q: Okay. So 19.4 percent, that's a pretty good
14 internal rate on return, internal rate of
15 return, isn't it?

16 A: It's not bad.

17 Q: Yeah. I mean most people don't get that on
18 their personal investments.

19 A: Not on your CD, no.

20 Q: All right. Now, let's take a look at the
21 bottom part of this page, the tag line on this.
22 This is what we called last week the "what if"
23 file. Do you see that?

24 A: I do.

25 Q: The "what if" CAMS?

1 A: Right.

2 Q: If you turn over to page 1635, same document,
3 the what if CAMS. All right. Let's go to the
4 top and look at the number of treatments. I
5 think it's this document that had the number of
6 treatments on it.

7 A: I don't see the number of treatments on there.

8 Q: Let's look at -- well, we'll look at the income
9 payments on this one. Okay. On 1635. The net
10 revenue projected in the treatment for 2015; do
11 you see that at the top of the page?

12 A: Yeah.

13 Q: It's 6.4 million dollars, right?

14 A: Maybe I'm not seeing what you're ---

15 Q: The net revenue.

16 A: In 2015?

17 Q: Yeah. The 2015.

18 A: I'm sorry. Yeah, sure.

19 Q: Over here it's 6.4 million dollars, right?

20 A: 6.4.

21 Q: And the EBITDA is 3.3 million?

22 A: That's down at the bottom if you could pull it
23 up. That's right.

24 Q: And then net income is 1.783 million, right?

25 A: I think that's correct.

1 Q: And that's all substantially higher than the
2 pro formas in the application?

3 A: Not surprising since the numbers were doubled.

4 Q: Right. So is there any doubt in your mind that
5 the folks in Nashville approved this
6 application based on the what if file numbers?

7 MR. THOMAS: Objection, Your Honor. That's asking
8 the witness to speculate.

9 THE COURT: I'll sustain that one unless you've got
10 a better explanation.

11 MR. LONG: Let me ask it a different way. I'll ask
12 a few other questions.

13 Q: Did you ever communicate with anybody in
14 Nashville about this project?

15 A: No.

16 Q: Jamie Thomas is actually a friend of yours,
17 isn't he?

18 A: He is.

19 Q: And he's the district, he's the division head,
20 right?

21 A: He is.

22 Q: Have you ever told any of the people, now that
23 you've looked at all this discovery have you
24 told anybody at HCA that they've over projected
25 this project?

1 A: No, because it's never come to my attention
2 that they believe that this "what if" scenario
3 is the actual outcome that's expected.

4 Q: It hasn't ever come to your attention?

5 A: No.

6 Q: Okay. You've worked with HCA for 25 years,
7 right?

8 A: I have.

9 Q: It's a highly successful company, isn't it?

10 A: It is.

11 Q: And as a matter of fact it's one of the top, I
12 guess one of the top healthcare providers in
13 the United States, right?

14 A: It's the largest hospital provider.

15 Q: Largest hospital, has the largest number of
16 hospitals in the United States. And you've
17 done pro formas for them in the past, right?

18 A: I have.

19 Q: And do you think that they routinely make
20 decisions based on numbers that are faulty or
21 false?

22 A: I don't think they routinely do that. Do they
23 ever? Yes.

24 Q: Do you think they've done that in this case?

25 A: Well, I think, as I understand it, the numbers

1 that were first presented to them were the
2 numbers based on my projections, which I think
3 are realistic. I don't believe that this what
4 if scenario is realistic in light of the market
5 in which this project will be implemented.

6 Q: Okay. Let's look at the -- any financial
7 projection based on your projections, right,
8 would have substantially lower financial
9 numbers than what we just looked at, right?

10 A: Sure.

11 Q: As a matter of fact if we could look at Grand
12 Strand Exhibit 6, this is the document that Mr.
13 Grace brought to the deposition and told me
14 that I needed to look at this, this was
15 important. Do you recall the testimony on
16 that?

17 A: I do.

18 Q: And it had not been produced in discovery, but
19 he brought it to the deposition and of course
20 this is the one at the bottom that says For
21 Will Thomas, right?

22 A: Yes.

23 Q: All right. Now, look at page, we'll have to do
24 this kind of -- we don't have Bates on these,
25 page four of the document. About the middle of

1 the page it gives the treatments. Is that page
2 four with the treatments?

3 A: Yeah, I see that.

4 Q: Do you see that?

5 A: I do.

6 Q: Those treatments that are listed there in the
7 three years, the first three years are 3,234,
8 4,011, and 4,620, those are your projections,
9 right?

10 A: Yeah. Those are my three county projections.
11 My zip code analysis was slightly different but
12 very close to it.

13 Q: This was actually the first one that you did
14 and you revised it later, right?

15 A: Right.

16 Q: So they didn't use the -- but you had already
17 revised it by the time that -- no, that was
18 later on. Okay, sorry about that. Let's go
19 back to the page before, page three, they've
20 got a financial analysis at the bottom of this
21 page. So based on your projections, the net
22 present value is the NPV discount -- sorry I'll
23 do it again, the NPV index is .85, right?

24 A: Yes.

25 Q: Okay. Substantially lower than the other

1 projection, right?

2 A: It is.

3 Q: The EBITDA return on investment is 16 percent
4 instead of 32.8, right?

5 A: Right.

6 Q: The internal rate of return is 6.9 instead of,
7 I think was it 19 was the number?

8 A: I think it was 19.

9 Q: 19.4. And then here's my favorite, the
10 discounted cash payback is never?

11 A: Right. I believe that Mr. Grace explained that
12 the model only goes out I think he said five
13 years. And so if it's not paid back within --
14 I don't know how this model works, but I know
15 he testified that it's a limited amount of time
16 that they look at in terms of calculating,
17 maybe it was seven years.

18 Q: Okay. Now, let's go look at your -- your role
19 in this CON was very specific, right?

20 A: It was.

21 Q: During the preparation of the Certificate of
22 Need, you never had an in-person meeting at
23 Grand Strand with anybody, did you?

24 A: I did not.

25 Q: You did not actually go to the facility or sit

1 down with anybody who works at Grand Strand or
2 HCA about this project?

3 A: Not in person.

4 Q: There were no regularly scheduled conference
5 calls, right?

6 A: That's true.

7 Q: There were no -- we had no emails between you
8 and the folks at Grand Strand directly?

9 A: That's true.

10 Q: All right. Now, you actually started work in
11 late January, right?

12 A: That's was when I was contacted.

13 Q: Okay. And then the first thing that you
14 remember is that you had a conference call with
15 Dr. Holt, Doug White, Adam Rudd, Will Thomas,
16 and yourself, right?

17 A: Right.

18 Q: And that was the only conference call or time
19 that you ever spoke to Doug White about the
20 project, right?

21 A: To my knowledge.

22 Q: And Dr. Holt was on the phone, right?

23 A: Yes.

24 Q: And you testified yesterday about that
25 conversation somewhat, right?

1 A: I did.

2 Q: All right. I want to contrast yesterday with
3 some of the statements that you made in your
4 deposition. So let's pull out pages 34, I
5 think this is the regular part of the
6 deposition. Here's the deposition I'd like to
7 read a little bit from.

8 A: Okay.

9 Q: All right. If you would, turn to page 34.

10 A: Okay. All right.

11 Q: Oh, wait a minute, I'm sorry. Let's back up
12 some, 31. If you'll turn back to page 31.

13 A: Okay. I'm there.

14 Q: All right. Now, I'll read the questions and if
15 you could read the answers, okay?

16 A: Okay.

17 Q: All right. Question, line 13, "Why was Dr.
18 Holt on the phone?"

19 A: "I think because at that time there was some
20 discussion about building a facility on his
21 property and then also I think I was, I can't
22 remember whether I expressed an interest for
23 him to be there or if he was just on there, but
24 I had some questions from him" and I think that
25 should be for him.

1 Q: Okay.

2 A: "Just general about the level of support among
3 the medical oncologists in the community for a
4 program at Grand Strand."

5 Q: And my question is, "What did he say?"

6 A: "I'm not sure I can remember verbatim but, I
7 mean, generally he thought that the medical
8 oncologists would be supportive, that they
9 would like to have a hospital based option and
10 if the facility was located on the Grand Strand
11 campus or on his property that, you know, he
12 was likely to refer at least some of his
13 patients to that facility."

14 Q: Okay. If we could skip down to line 21 on page
15 32. My question, "Okay. Was most of the call
16 a conversation between you and Dr. Holt?"

17 A: "No, I mean, I probably talked to him for five
18 minutes. It was just, it was a group call and,
19 I mean, I wasn't the only one talking the whole
20 time. I just jumped in with questions every
21 now and then. It was just talking about the
22 project, what it was going to entail, and I
23 don't know all the details about, you know,
24 where people were located, where medical
25 oncologists were located in the community and

1 so forth. It was just somewhat for my benefit,
2 you know, an educational process to kind of lay
3 out those landscapes for me."

4 Q: Okay. And then on page 34, line six. My
5 question, "Was there any discussion about
6 location other than Dr. Holt's property?"

7 A: "Not on that call."

8 Q: Okay. So this is your first call with Grand
9 Strand about the project, right? First time
10 you ever spoke to anybody at the hospital about
11 the project, right?

12 A: To my recollection.

13 Q: Okay. And when you get on the phone Dr. Holt
14 is a physician on there who's not employed with
15 the hospital, right?

16 A: He's not.

17 Q: Okay. That's a pretty good sign for a planner
18 that that doctor is committed to that project,
19 isn't it? I mean he's on the phone with you
20 before you even started work?

21 A: Well, I knew that he was trying to sell his
22 property at Grand Strand, so I assumed that he
23 had some incentive to be on the call.

24 Q: Well, during the conversation that you had with
25 him that's where it was going to be, right?

1 Dr. Holt's property, they were talking to you
2 about how it was going to be on the property,
3 connected to his building, and all that, right?

4 A: That was -- that was what was presented at the
5 time of the conversation. I knew that it
6 wasn't a done deal, but that was what we
7 discussed on the call.

8 Q: And of course, that would have been a
9 freestanding center on Dr. Holt's land, right?

10 A: Yes.

11 Q: And nobody during that call said well, we
12 really need to have it at the hospital because
13 we want to have a hospital-based center, did
14 they?

15 A: Well, that really wasn't the focus of the call,
16 but no, nobody said that.

17 Q: Well, you've said part of the main focus of the
18 call was that he was -- it was going to be on
19 his land. That's what you said in the
20 deposition.

21 A: Well, the main focus of the call was for me to
22 be able to get at least some information from
23 Dr. Holt about his medical oncologist brethren
24 and their support for the project.

25 Q: Okay. After that phone call, you had two more

1 phone calls with Adam Rudd before the
2 application was filed, right?

3 A: That's my -- it could have been three, but
4 that's my recollection.

5 Q: All right. And in the first phone call you
6 asked him for some market share data, mostly
7 about oncology, right?

8 A: Right.

9 Q: And he didn't know the information off the top
10 of his head, did he?

11 A: Not to my recollection.

12 Q: All right. Again, there were no emails from
13 Adam Rudd to you or anybody at Grand Strand
14 sending you any information?

15 A: Right. I mean, we've got a standing sort of
16 way of operating. Basically, I make all my
17 requests to Mr. Thomas and Mr. Thomas makes the
18 request of the hospital.

19 Q: Okay. But then you've got to get the documents
20 somehow?

21 A: Mr. Thomas sends them back to me.

22 Q: Okay. And all of those documents that you went
23 over yesterday, or the work papers that you
24 presented yesterday, that's basically your
25 file, right?

1 A: It is.

2 Q: Okay. And then you had one other conversation
3 with Mr. Rudd right before the application was
4 filed because you were looking for something
5 that you don't really recall what it was,
6 right?

7 A: Right.

8 Q: All right. And then you wrote the need
9 analysis and presented it and then that was it,
10 right?

11 A: Yeah. I sent a draft to Mr. Thomas, and I
12 don't remember exactly, maybe a week or two
13 before the application was filed, I believe Mr.
14 Thomas called me with a few editorial changes
15 to the document, and then we filed the
16 application.

17 Q: Okay. So you never spoke to anybody at Grand
18 Strand about any edits to the document, right?

19 A: I did not.

20 Q: Okay. And as far as you know nobody at Grand
21 Strand ever looked at it before it went in, the
22 application? As far as you know.

23 A: I don't know one way or the other.

24 Q: Okay. All right. Now, your work with -- in
25 your working as a consultant, you keep up with

1 the State Health Plan for South Carolina,
2 right?

3 A: I do.

4 Q: And the process for the State Health Plan is
5 such that the providers see a draft of the
6 State Health Plan usually in the spring of the
7 year that it's issued, right?

8 A: Sometimes that slips, but yes.

9 Q: Right. Well usually, that's true, but it
10 usually is in the spring because usually there
11 are public comments in the summer. It always
12 seems like it's in July when it's hot, right?
13 Okay?

14 A: That's true.

15 Q: All right. And so when those public comments
16 are looked at by the providers and other people
17 who work in this area, it has the data in it,
18 doesn't it?

19 A: The draft plan?

20 Q: The draft plan.

21 A: It does.

22 Q: It does. All right. And so of course you work
23 with Grand Strand on a regular basis, right?

24 A: I do.

25 Q: So there was nothing to prevent Grand Strand

1 from starting to apply for a linear accelerator
2 in the spring of 2010, right? I mean they knew
3 this plan coming out was going to have -- was
4 going to show that the 80 percent threshold had
5 been satisfied, right?

6 A: I would assume that's true.

7 Q: Okay. And let's talk about -- and so you
8 weren't even contacted until January of the
9 next year, really late January, almost
10 February, about getting involved in the
11 project, right?

12 A: That's true.

13 Q: And then they didn't actually file until July
14 of that next year, right?

15 A: Correct.

16 Q: So Grand Strand knew for a whole year before
17 they filed that there might -- that the 80
18 percent threshold had been satisfied where they
19 could apply for the accelerator, right?

20 A: I assume that's true.

21 Q: And in the past there certainly have been other
22 opportunities where applicants could applied
23 where the threshold had been satisfied and
24 applicants could apply for a linear
25 accelerator, right?

1 A: Yeah. I believe the time before this was about
2 2006.

3 Q: Right. And then there was one I think before
4 that, too, right? And of course you had worked
5 on the Georgetown one years ago, right?

6 A: Right. That was in the early 2000s.

7 Q: In the early 2000s. And so, and this is the
8 first time that Grand Strand had ever applied
9 for a linear accelerator, right?

10 A: To my knowledge.

11 Q: Okay. Now, in regards to the State Health
12 Plan, when the State Health Plan says -- let's
13 pull up Joint Exhibit 4, page IX. Joint
14 Exhibit 4, which is the 2010-2011 State Health
15 Plan and let's look at page IX.

16 A: Okay.

17 Q: To meet the standard of need in the State
18 Health Plan, it's a three-step process, isn't
19 it?

20 A: It is.

21 Q: Okay. And the first step is you have to -- the
22 existing providers have to meet the threshold
23 of 80 percent, right?

24 A: That's correct.

25 Q: Okay. And so when the existing providers meet

1 the 80 percent threshold, that does not mean
2 that there is a need for a linear accelerator,
3 does it?

4 A: Not in and of itself.

5 Q: Sometimes people talk about that in a very kind
6 of casual way, but the reality is is that all
7 three of the criteria have to be satisfied
8 before there is a need for a linear
9 accelerator, correct?

10 A: That's true.

11 Q: And the first criteria is 80 percent, to
12 satisfy the 80 percent threshold, right?

13 A: Correct.

14 Q: The second criteria is that the new provider
15 has to project that they will be at least 50
16 percent capacity by year three?

17 A: Correct.

18 Q: And then the third is that the new provider
19 cannot drive the existing providers below the
20 80 percent threshold, right?

21 A: That's true as well.

22 Q: And if the new provider drives the existing
23 providers below the 80 percent threshold, there
24 is no need for the linear accelerator, right
25 under the State Health Plan?

1 A: For that particular applicant, yes.

2 Q: And likewise, if two applications were approved
3 at the same time and it drove the existing
4 providers below the 80 percent threshold, there
5 would not be a need for two linear
6 accelerators, would there?

7 A: That's true.

8 Q: And under no circumstances have you seen any
9 data or have an opinion that this service area
10 needs three new linear accelerators, right?

11 A: I've not seen any data that says it needs
12 three.

13 Q: Right. And so if the Court were to give the
14 '05 -- the most recent linear accelerator
15 that's discussed in the new Health Plan, Joint
16 Exhibit 5, to Grand Strand or to award two in
17 this hearing, it would foreclose other
18 providers from applying and being able to
19 satisfy the needs standard in the current State
20 Health Plan, right?

21 MR. THOMAS: Your Honor, I object. I think he's
22 calling for a legal conclusion in a back door
23 kind of way. We've dealt with this issue. We
24 all know what it is. I briefed it on summary
25 judgment, you denied it, partial summary

1 judgment, Your Honor, about whether or not you
2 can approve the one that's in the 2012-2013
3 State Health Plan.

4 MR. LONG: I didn't ask him that, Your Honor. I
5 asked him if there was a need for three, and
6 since he said there's not, if the court awarded
7 two, then there would not be -- it would not
8 satisfy the need standard of the most recent
9 Health Plan. I asked him to agree with me on
10 that.

11 MR. THOMAS: I think that calls for ---

12 MR. LONG: There was no way to satisfy it as a
13 health planner. It's three steps, 80 percent
14 threshold ---

15 THE COURT: I'm going to ---

16 MR. THOMAS: There's a statute. Okay.

17 THE COURT: He's asking about the statute but he's
18 asking a factual, well, he's asking about the
19 State Health Plan but you're asking a factual
20 rendition ---

21 MR. LONG: Right.

22 THE COURT: --- of the State Health Plan.

23 MR. THOMAS: Can I put my ---

24 THE COURT: Yeah.

25 MR. THOMAS: --- argument on the record, Your Honor?

1 There's a statute that allows you to consider
2 subsequent State Health Plans, Your Honor.
3 Okay? And that's the motion that we briefed
4 back in May or June. But you denied that
5 within that motion and said you were well
6 within your rights to approve it too.

7 THE COURT: Yeah.

8 MR. THOMAS: So I think what he's trying to do is
9 trying make a back door argument, through my
10 expert, make a legal conclusion that for some
11 reason you can't do that. You've already ruled
12 on that.

13 THE COURT: Well, I've ruled that legally I can.
14 But then there's the factual dispute about
15 whether I can. And that's what I'm
16 interpreting him to be asking about is the
17 factual analysis, which I certainly think is
18 open for game. If it wasn't, this hearing
19 could be quickly concluded. Go ahead.

20 MR. LONG: Thank you, Your Honor.

21 Q: Do you recall the question, Mr. Sullivan?

22 A: I do.

23 Q: Can you answer it?

24 A: I think as a practical matter that would
25 eliminate the need for another linear

1 accelerator under the 2012-2013 State Health
2 Plan.

3 Q: Okay. Let's take a look at the Grand Strand
4 pro forma, which is Joint Exhibit 2, page 306.
5 Do you have it in front of you?

6 A: She's going to pull it up?

7 Q: If you look at the couple pages before, do you
8 recognize the back -- this is actually from the
9 application itself, but that document is also
10 an exhibit. This is from the pro forma, right?

11 A: It is.

12 Q: And you testified about that yesterday a little
13 bit. Let's look at some of the assumptions in
14 the Grand Strand pro forma in regards to the
15 reimbursement. First, just to kind of quickly
16 review, categorizing the payers, the people who
17 actually pay for healthcare into these five
18 categories is appropriate, right?

19 A: It is.

20 Q: It's often done by health planning and other
21 financial people like yourself, right?

22 A: This is the most common way to summarize.

23 Q: Okay. And you're aware that IMR -- that
24 reimbursement by Medicare for radiation therapy
25 treatments, or IMRT, is substantially greater

1 than \$324 per treatment, isn't it?

2 A: It is.

3 Q: It's at least probably three times greater?

4 A: My recollection is it's somewhere in the high
5 800s, low 900s, if I can recall correctly.

6 Q: Per treatment?

7 A: Per treatment.

8 Q: Okay. And there's no doubt also that hospital
9 reimbursement is higher than a freestanding,
10 right? Medicare reimburses higher for the same
11 treatment, same machine to a hospital, they pay
12 more to a hospital than they do a freestanding,
13 right?

14 A: Right, they're reimbursed under two different
15 reimbursement systems.

16 Q: Looking also at this page 306, there's no doubt
17 that Medicaid is lower than Medicare for
18 radiation therapy reimbursement for a hospital,
19 right?

20 MR. THOMAS: Object, Your Honor. Assumes facts not
21 in evidence.

22 MR. LONG: Well, he's an expert, Your Honor, he also
23 does a lot of these financial pro formas. He
24 knows the Medicaid stats.

25 THE COURT: Well, I presume that when he asks you

1 that question, he's asking if you know of your
2 own knowledge.

3 MR. SULLIVAN: Yes.

4 THE COURT: All right.

5 A: My understanding is that Medicaid pays less
6 than Medicare for most services. There are a
7 few where they are roughly equivalent, but
8 rarely do you would you see Medicaid pay more.

9 Q: You've done financial pro formas before for a
10 radiation therapy center, right?

11 A: I have.

12 Q: Okay. Have you ever done one where you've had
13 the Medicaid reimbursement higher than the
14 Medicare?

15 A: No.

16 Q: All right. Now HMO/PPO, that's the commercial
17 payer, right? That's the private insurance
18 companies, right?

19 A: That's true.

20 Q: And that number is five times the Medicare
21 number on this pro forma, right?

22 A: Yeah, I mean typically the private payers pay
23 substantially more than Medicare.

24 Q: But if that number is solely based on
25 conventional treatments, like the Medicare

1 number apparently is, then you would expect
2 that number to be higher too, wouldn't you?

3 A: I don't know the answer to that because I don't
4 know what kind of contracts are in place in
5 that particular market.

6 Q: Okay. If you go to the page before, 304, two
7 pages before at the top.

8 A: Yes.

9 Q: Under different revenue sources. Now, Mr.
10 Sullivan, when you do a financial pro forma for
11 a hospital-based service, you do -- you
12 personally do include some revenue for
13 inpatients, don't you?

14 A: You could include a very small amount. It
15 really depends on the payer contracts you have.
16 If they're all DRG based, then you would not
17 probably include any. If you had some that
18 were not DRG based where they paid as a
19 percentage of charges, for example, those are
20 pretty rare these days, that insurers reimburse
21 hospitals as a percentage of charges, then you
22 would get some return for providing radiation
23 therapy for inpatients.

24 Q: Now, I understand, I appreciate that but I
25 talking about you personally. Don't you

1 personally include some inpatient revenue when
2 you do a financial pro forma for a hospital-
3 based radiation therapy project?

4 A: It's been a long time since I can recall. I've
5 done some freestanding ones recently, I just
6 can't recall doing one for a hospital in a
7 while.

8 Q: And do you know -- and you're aware, too, that
9 the CT scans that are done for a hospital for
10 a radiation therapy patient is usually the PET
11 scan that's done before they even start
12 service, right?

13 A: Sometimes, sometimes after, you know, or during
14 the course of the treatment. I mean always
15 there's a CT in order to load in the
16 information into the treatment planning system.
17 I'm not sure there's always a PET scan.

18 Q: Okay. But there's always a CT before you
19 start? You've got to do the CT before you can
20 do the treatment plan and you have to do the
21 treatment plan before you can start, right?

22 A: That's true.

23 Q: Okay. And so, and oftentimes the CT scan is
24 done at the medical oncologist's office, right?
25 Especially in Myrtle Beach.

1 A: Typically the doctors do as much in their
2 office as they can.

3 Q: Did you ever have any conversations with Mr.
4 Grace about the outpatient diagnostic tests?

5 A: Not specifically. You know ,I was not involved
6 in the preparation of the financial projections
7 for the application, so I didn't have any
8 conversations with Mr. Grace about his
9 assumptions prior to the time it was filed.

10 Q: No one ever asked you or anybody asked you to
11 look at it or do anything about the pro forma
12 before the application was filed, did they?

13 A: They did not.

14 Q: Okay. Looking at the information we just
15 talked about on the revenue in regards to the
16 failure -- because you anticipate there are
17 going to be at least 60 percent or 50, 60
18 percent of the patients will have IMRT
19 treatments, right?

20 A: I do.

21 Q: So there's no doubt that the revenue number on
22 the pro forma is incorrect, right?

23 A: I think it's probably too low.

24 THE COURT: You think it's probably too low?

25 MR. SULLIVAN: Too low, yes.

1 THE COURT: Too low. Okay.

2 Q: All right. Also look at the expenses if you
3 could, go back to page 306, I'm sorry, 307 and
4 308, all of these expenses on the pro forma are
5 tied to the net revenue number, right? Let's
6 look at a few of them. Contract services,
7 number five, tied to the net revenue number,
8 right?

9 A: Yes.

10 Q: Go to the next page, six, repairs and
11 maintenance, tied to the net revenue number?

12 A: Correct.

13 Q: Rents and leases, tied to the net revenue
14 number?

15 A: It is.

16 Q: Utilities, tied to the net revenue number?

17 A: Right. And these are very small percentages of
18 the net revenue number.

19 Q: Yeah, but the amount of the expense on the pro
20 forma is determined by the net revenue, right?

21 A: Sure. Yeah, I mean, if you increase the net
22 revenue as you were suggesting to include the
23 IMRT, I don't think that there's any question
24 that the expenses would go up a little bit but
25 the net revenue would go up substantially more.

1 Q: Okay. But that's not -- I'm just asking you
2 about the expense calculations.

3 A: Okay.

4 Q: The insurance is also tied to it and so is the
5 bad debt, right?

6 A: Correct.

7 Q: And the income taxes would be different too,
8 right?

9 A: Sure, I mean, if they made more money, the
10 income taxes would be higher.

11 Q: So the pro forma is just incorrect, isn't it?

12 A: It's understated.

13 Q: Do you think it's correct?

14 A: It's a projection. I think that the revenues
15 are understated and the expenses may be
16 slightly understated. I don't think there's
17 any question that if you make the adjustments
18 that we just discussed that the project would
19 still show a substantial bottom line and it
20 would be financially feasible.

21 Q: How do you know that? Because you haven't
22 looked at the numbers.

23 A: Well, I mean, I can do this math in my head.
24 If you substantially increase the net revenue,
25 the rate of reimbursement per treatment, you

1 would be talking about substantially increasing
2 the net revenue on the financial projection.

3 If we add up all of those different percentages
4 that you just talked about for all those
5 individual categories, they're far less than
6 100 percent of the net revenue. So we know
7 that if we increase the net revenue, the
8 expenses are going to go up less than the net
9 revenue's going to go up, so the bottom line is
10 going to increase.

11 Q: Mr. Sullivan, isn't the underlying data which
12 the pro forma is based on fundamentally flawed?
13 I mean, how do you even -- how could you today,
14 on the witness stand, even assume what the
15 revenue number would be based on these numbers
16 on this pro forma?

17 A: Well, we know that the number would be higher.
18 I think that's a pretty good assumption. I
19 mean, I'm never concerned when somebody gives
20 me a financial projection and they've
21 understated revenue. I get much more concerned
22 when they've overstated revenue because that
23 really goes to the underlying feasibility of
24 the project. So if anything, this is probably
25 a very conservative picture of what the

1 financial performance would be.

2 Q: Albeit incorrect?

3 A: There are assumptions that could be corrected.

4 Q: Now, in regards to the treatment reimbursements

5 by the government, Medicare and Medicaid,

6 neither CRCC, 21st Century Oncology, HCA, or

7 Grand Strand have the capability to change or

8 negotiate the reimbursement for Medicare and

9 Medicaid, right?

10 A: Not to my knowledge.

11 Q: Okay. They would be a pretty powerful person

12 if they could do that, wouldn't they?

13 A: I think they would be wasting their time in

14 Myrtle Beach if they could.

15 Q: And so those numbers are just given to them,

16 right? And there's no doubt that -- I mean,

17 that's at least half the patients, right?

18 A: It is.

19 Q: More than half actually?

20 A: It's about 60 percent.

21 Q: Okay. And there's no doubt that for the same

22 treatment, that same cancer, same treatment,

23 that the hospital is going to be paid more

24 than the freestanding center at CRCC, right?

25 A: That's true.

1 Q: So there's more cost to the healthcare system
2 to have the treatments done at Grand Strand
3 than it is to be at CRCC, correct?

4 A: Not necessarily, for the reasons that I talked
5 about yesterday with the concerns I have about
6 the urologists and the potential overuse of
7 radiation. And then also I think that, you
8 know, there's sort of a policy issue here, a
9 health planning policy issue here that
10 hospitals are reimbursed under the hospital
11 outpatient payment system. And that's based on
12 Medicare cost report data. It takes into
13 account the higher overhead that hospitals
14 have. The logic that you're suggesting is that
15 all of the services, all the profitable
16 services could be stripped out of the hospital.
17 For example, ambulatory surgery centers get
18 reimbursed at a lower rate than hospital
19 surgery. Diagnostic services get reimbursed in
20 a hospital at a higher rate than they do at a
21 freestanding setting. But hospitals have to be
22 able to generate revenues from certain services
23 in order to compensate for the other services
24 for which they're not well compensated. So
25 there's a health policy reason why Medicare and

1 Medicaid pay hospitals more than they do
2 freestanding centers.

3 Q: Mr. Sullivan, I haven't suggested anything.
4 What I said, what I asked you was is it more
5 costly to the system for -- to pay, for the
6 system to have to pay for treatments at a
7 hospital than they do in a freestanding center?

8 A: On an apple, I mean, looking at one treatment
9 side-by-side, sure, the reimbursement is higher
10 for a hospital than for a freestanding.

11 Q: Okay. And by no means does Grand Strand need
12 to do this project to maintain its financial
13 viability, does it?

14 A: Yeah. This is not critical to the financial
15 viability of the hospital, but it certainly
16 would contribute to it.

17 Q: Yeah, they're going to make a lot of money off
18 the project you think, but they don't need to
19 do it for financial reasons, do they?

20 A: They're not on -- they're not on the edge of
21 collapse, no.

22 Q: No. Okay. All right. Let's talk about a
23 little bit about you raised the issue with the
24 urologists.. Let's go to the GAO report, which
25 Grand Strand Exhibit Number 24, page, GSRMC

1 page is 5689.

2 A: I'd like to get the original. I'm having a
3 hard time reading that.

4 Q: Yeah, you will.

5 A: What's the number again?

6 Q: It's Petitioner's Exhibit 24, Grand Strand's
7 Exhibit 24.

8 MR. LONG: Your Honor, I'd like to remind the Court
9 that this document is not in evidence. It was
10 discussed yesterday under the learned treatise
11 exception.

12 A: Okay. I'm there.

13 Q: I was going to ask you to re-comment on a
14 couple of things. Okay. First, the -- let's
15 look down. See where it says what GAO
16 recommends?

17 A: Are we on, I'm sorry?

18 Q: I'm sorry, first page, 5689, right there to the
19 left. See, what GAO recommends. Okay? Could
20 you read ---

21 THE COURT: I'm sorry. This is Petitioner's 24?

22 MR. LONG: This is Petitioner's 24 and this is the
23 GAO report that Mr. Thomas had Mr. Sullivan
24 read yesterday.

25 THE COURT: Okay. You said the first page?

1 MR. LONG: The first page of the document. I'm

2 sorry, it's not the first page of the exhibit.

3 THE COURT: Yeah, there you go.

4 MR. LONG: It's GSRMC5689 at the bottom right here.

5 THE COURT: Okay. That's where I need to be.

6 MR. LONG: Thank you for clearing that up, Your

7 Honor. It's the first page of the document.

8 Q: Mr. Sullivan, why don't you go ahead and read

9 that where it says, What GAO recommends, and

10 then read that at least down to the -- I'm

11 really interested in this sentence about HHS.

12 A: Okay. "Congress should consider directing the

13 Secretary of Health and Human Services, whose

14 agency oversees CMS, to require providers to

15 disclose their financial interest in IMRT to

16 their patients. GAO also recommends that CMS

17 identify and monitor self-referral of IMRT

18 services. HHS disagreed with the GAO's

19 recommendation."

20 Q: Okay. Let's stop for a minute. That's what

21 this is all about, isn't it? It's about

22 disclosure, right? That's the GAO

23 recommendation is that there should be

24 disclosure to patients and HHS disagrees with

25 the recommendation, right?

1 A: That's what this says.

2 Q: Okay. And so this is actually a debate between
3 Health and Human Services at the federal
4 government level, it's a large governmental
5 agency, and GAO as to this disclosure issue,
6 right?

7 A: That's part of it. But this issue about self-
8 referral for radiation therapy has permeated
9 the industry for a number of years, and I think
10 I talked about that in my deposition, that I've
11 been involved in other cases where this was a
12 central issue in the case about whether
13 urologists should allow -- be allowed to have
14 ownership interests in radiation therapy
15 centers.

16 Q: And the case that you were involved in in
17 Mississippi that you testified to me about in
18 your deposition involved a situation where the
19 urologist would have actually owned the
20 machine, the urologist physicians themselves
21 would have owned the machine and employed the
22 radiation oncologist at the machine, right?

23 A: Yes.

24 Q: So they would have been actually his boss, the
25 radiation oncologist, right?

1 A: Right.

2 Q: And people, and there are people who criticize
3 that, right?

4 A: Not just that part of it. They criticize the
5 ownership of urologists in the radiation
6 therapy business.

7 Q: But actually, that situation that I just
8 described is legal, right?

9 A: It is.

10 Q: But that's not what's going on in South
11 Carolina, is it?

12 A: That particular structure isn't in place at
13 CRCC.

14 Q: Right. Because the urologist physicians in
15 Myrtle Beach do not own the machine, right?

16 A: No, my understanding is they have a financial
17 interest in the profits from the machine.

18 Q: And they do not employ the radiation
19 oncologist?

20 A: To my knowledge, they do not.

21 Q: And so he doesn't have to do what they say,
22 right?

23 A: He doesn't.

24 Q: He doesn't. Now, let's turn over to page 5694.
25 I'd like you to read this sentence here in the

1 first paragraph after footnote four. It says,
2 Proponents of self-referral arrangements.

3 A: I'm sorry, I'm not seeing where you're at.

4 Q: It's at the top. Are you on 5694?

5 A: 5694.

6 Q: At the top of the page right after footnote
7 four.

8 A: Oh, I'm sorry. I was looking down at the
9 footnote.

10 Q: I'm sorry, not the footnote itself but the
11 little footnote number here, proponents of.

12 A: "Proponents of self-referral arrangements
13 contend that the self-referral of IMRT services
14 does not affect clinical decision making and
15 that patients benefit from self-referral
16 through, for example, improved coordination
17 among the providers who diagnose and treat
18 patients."

19 Q: Okay. Well, you certainly testified on your
20 last day that coordination among providers is
21 a good thing for patients, right?

22 A: It is.

23 Q: And let's look down at the bottom at footnote
24 five. This report, this GAO report is
25 controversial, isn't it? You're aware of that,

1 right?

2 A: Sure. I mean this debate has been ongoing for
3 a long time between what I'll call the
4 radiation therapy professionals and urologists
5 and other specialists who want to get into the
6 radiation therapy business.

7 Q: And one of the criticisms with this report is
8 the way they limited this study, right?
9 Because they said in here, "Our analysis of
10 self-referred prostate cancer related IMRT
11 services is limited to those services performed
12 in physician offices." Okay? So they limited
13 the scope of what they were looking at, right?

14 A: Yeah. I mean, based on the available data is
15 my understanding.

16 Q: And they also looked at a number of different
17 factors like geography and age and some things,
18 and other factors, right?

19 A: They did.

20 Q: But there's nothing in this report about
21 patient choice, is there?

22 A: I don't recall that discussion.

23 Q: Okay. And there's no doubt that IMRT ---

24 MR. THOMAS: Your Honor, I want to object real
25 quickly. Mr. Long's asking nothing in the

1 entire report about that. If we want to, we
2 can bring the whole report into evidence. I
3 think we can actually do that because it is a
4 governmental document that's, you know, got a
5 seal I think at the back. But, you know, he's
6 asking him specifically. I asked Mr. Sullivan
7 about specific passages. I'm fine if Mr. Long
8 wants to get it to read in certain passages,
9 but this is a long document, Your Honor. I
10 mean many, many pages long. So I think to ask
11 him, well, this doesn't mention anything about
12 this or that, I mean, I think that's a little
13 bit out of bounds.

14 MR. LONG: Do I even have to comment on that?

15 THE COURT: Yes.

16 MR. LONG: Okay. I asked him if there was anything
17 in there about patient choice. He's read the
18 report. He testified about it, and he's read
19 parts of it. I mean, that is entirely
20 appropriate for cross. And I actually think
21 what Mr. Thomas is doing, he's already done it
22 a couple of times, is he objects, makes these
23 long speaking objections, and then tries to
24 disrupt the flow of the cross and educate the
25 witness, and it's inappropriate.

1 THE COURT: I overrule his objection.

2 MR. THOMAS: Your Honor, if you'd like me to
3 approach the bench every time I need to object,
4 just let me know.

5 THE COURT: No, I'm fine.

6 MR. LONG: Well, actually, maybe we should, Your
7 Honor, if he's going to continue to make these
8 long speaking objections in front of the
9 witness.

10 MR. THOMAS: Last time I checked you could make a
11 speaking objection in court.

12 THE COURT: Well, now, I don't want the witness to
13 be educated.

14 MR. THOMAS: I understand that. I'm not trying to
15 do that, Your Honor.

16 THE COURT: So, I know you can make one, but if it
17 gets to be problematic from my view, I'll let
18 you know. I'll let both of you know.

19 MR. LONG: I appreciate that, Your Honor. And I'm
20 just stating for the record from my point of
21 view, it's problematic.

22 THE COURT: Okay.

23 MR. LONG: I'd like that to be on the record because
24 that's exactly what I think he's doing.

25 THE COURT: All right.

1 Q: My question, Mr. Sullivan, there's nothing in
2 here about patient choice, is there?

3 A: I don't recall any reference to it.

4 Q: And there's no dispute that IMRT treatments for
5 prostate cancer patients are a very effective
6 way to treat the patient, treat the disease,
7 right?

8 A: Yeah, for patients who need that type of
9 treatment.

10 Q: There's no dispute about the clinical option,
11 right?

12 A: Right. I think it's just a question of whether
13 it's being applied in certain situations that
14 are inappropriate.

15 Q: Well have you -- and mostly the choice or
16 oftentimes the choice for the patient is
17 whether to have IMRT treatment or to have
18 surgery, what they call radical prostatectomy;
19 am I saying that right?

20 A: You did.

21 Q: All right. Thanks. I notice you said it
22 correctly yesterday too. Which is the removal
23 of the prostate, right?

24 A: Or the, I guess the third option is what they
25 call a watchful wait.

1 Q: Right, and just leave the cancer there?

2 A: Right.

3 Q: But the radical prostatectomy is the removal of
4 the prostate?

5 A: It is.

6 Q: Okay. Don't you think that most men would like
7 to keep their prostate?

8 MR. THOMAS: Objection, Your Honor, again, calling -

9 --

10 THE COURT: I sustain that one.

11 MR. THOMAS: --- for rank speculation.

12 THE COURT: I don't know if it calls for, what did
13 you call it?

14 MR. THOMAS: Rank speculation. Every now and then
15 you don't know what the different ---

16 THE COURT: Well, he said most men. I don't know if
17 it's rank speculation, but it's speculation.

18 Q: All right. I want to talk to you a minute
19 about Petitioner's Exhibit Number 38.

20 A: Okay.

21 Q: This was an exhibit that you prepared, right,
22 Grand Strand Exhibit 38?

23 A: Trying to summarize the data that we got from
24 CRCC.

25 Q: Now, you understand that, or do you understand

1 the difference between what we refer to in the
2 discovery as consults versus treatment plans?

3 A: I do. A consult means the patient comes in and
4 is evaluated for radiation therapy. Not every
5 patient who receives a consult actually
6 receives radiation therapy.

7 Q: As a matter of fact, there's a pretty good
8 percentage of patients that are determined not
9 to be appropriate candidates, right?

10 A: Yeah. I mean, if for example, in 2012, I
11 believe the number of treatment plans was 263
12 and there were 303 consults.

13 Q: And of course some of that is just physician
14 choice, I mean some doctors probably send
15 patients, if you have cancer they send you over
16 to talk to a radiation oncologist to get an
17 opinion while other doctors would be not as
18 likely to send the patients, right?

19 A: I'm sure that's true. Some doctors are more
20 likely to choose radiation as an option.

21 Q: Okay. So this number, these numbers on 38 do
22 not reflect actual patients that received
23 treatment at the center, do they?

24 A: They don't. This is just looking at the volume
25 of activity that was going on at CRCC.

1 Q: All right. If the Court were to conclude that
2 these applications are competing, then only one
3 can be selected, right?

4 A: Yes.

5 Q: All right. And so if the -- and if that is the
6 situation, then it is the role of the
7 Department to compare the applications and
8 select the one that best satisfies the project
9 review, State Health Plan project review
10 criteria and regulations, correct?

11 A: I would agree.

12 Q: And the purposes of the Act, right?

13 A: I would agree.

14 Q: Okay. Now, you agree that this is the same
15 service, right?

16 A: I will.

17 Q: Radiation therapy services. And it's provided
18 by radiation oncologists, right?

19 A: Yes.

20 Q: With a linear accelerator?

21 A: Yes.

22 Q: And your client's position is is that the
23 machines in these applications are similar,
24 right?

25 A: Yes.

1 Q: All right. Now, apparently, Grand Strand for
2 at least half of the period of time that y'all
3 were doing the application did not think that
4 there was much difference between a
5 freestanding facility and a hospital-based
6 facilities since they planned to build the
7 facility at Dr. Holt's office, right?

8 A: Well, I think -- I mean at least the
9 discussions that I was involved in, I believed
10 that there was a difference. I can't say what
11 Grand Strand believed, but I expressed my
12 preference that it be done in the hospital.

13 Q: How did you express it to them?

14 A: There was a call with Mr. Rudd and Mr. Thomas
15 where we were talking about the options, and I
16 said I thought that it would be better placed
17 in the hospital. But I mean, obviously, I'm
18 not the ultimate decision maker.

19 Q: Well, that conversation occurred very late in
20 the process. Mr. Rudd was actually -- that was
21 during the same, right before the application
22 was filed, right?

23 A: I don't recall exactly when, maybe it was -- I
24 think that there was still some question about
25 whether they were going to go with the option

1 of Dr. Holt's property or not.

2 Q: Don't you remember it was late in the late
3 spring or early summer?

4 A: It was certainly in April or May.

5 Q: Or even June?

6 A: It could have been.

7 Q: And part of that conversation was about whether
8 to go with South Strand, the freestanding ED
9 that Grand Strand owns?

10 A: Yeah, I never saw that as an option. That was
11 raised very briefly and I just said I don't
12 think that's a realistic option.

13 Q: That's the conversation that you had with Mr.
14 Rudd?

15 A: Yeah.

16 Q: He asked you about going to South Strand
17 because Mr. Hall wanted to go to South Strand
18 and you told him you didn't think that was a
19 very good option, right?

20 A: I did.

21 Q: Because you thought that it would not be a very
22 attractive option for the Department?

23 A: It just didn't make any sense from a health
24 planning perspective.

25 Q: Okay. But you didn't tell them over the call

1 with Dr. Holt that they shouldn't build a
2 center in Dr. Holt's parking lot?

3 A: Well, that would probably not be the
4 appropriate time to have that conversation.

5 Q: Well, you didn't call them afterwards and tell
6 them that either, did you?

7 A: No.

8 Q: Because I don't think you ever called them.
9 They called you three times, right?

10 A: I had that discussion with Mr. Thomas.

11 Q: Okay. Let's look at Grand Strand Exhibit 14.
12 This is the exhibit that had the error on it
13 that you're going to correct.

14 A: Yes.

15 Q: So there are freestanding facilities in
16 Charleston, right?

17 A: There are.

18 Q: Okay. Are you on -- I want to talk to you
19 about Spartanburg. You're aware that the
20 hospital-based linear accelerators in
21 Spartanburg are not connected to the hospital,
22 right?

23 A: I'm trying to remember. We did some work with
24 them.

25 Q: The Gibbs Cancer Center is a freestanding

1 building.

2 A: It may be. I have a recollection that's true,
3 that it's a separate building near the
4 hospital.

5 Q: Well, it's a couple miles, isn't it?

6 A: I don't know exactly how far. .

7 Q: And that's a beautiful facility that that
8 hospital built, right?

9 A: I've seen it online. I've not seen it in
10 person.

11 Q: Mr. Gibbs gave a lot of money to the hospital,
12 they built it, that's why they call it the
13 Gibbs Cancer Center, right?

14 A: That's usually the way it works.

15 Q: Okay. And of course that's not connected to
16 the hospital, so at Spartanburg Regional, okay,
17 they put the patients in an ambulance and they
18 drive them over to the linear accelerator to
19 have their treatment if they have an inpatient
20 that needs treatment, right?

21 A: Apparently they do.

22 Q: And in Richland they do have two linear
23 accelerators at Palmetto Richland, but anybody
24 who knows about Columbia knows that the vast
25 majority of linear accelerator treatments are

1 done at Greystone at the SCOA office out there,
2 right?

3 A: Yes.

4 Q: Okay. And that's also freestanding, correct?

5 A: It is.

6 Q: Now, yesterday when we went through the project
7 review criteria, it seemed like to me that, and
8 in your deposition, that when you were asked a
9 good reason as to why Grand Strand was superior
10 to CRCC in regards to the different project
11 review criteria, that your answers could really
12 be categorized as one of two things. One, it's
13 a hospital-based service; it's superior. So
14 having it at a hospital was superior than
15 freestanding, or the competition would be
16 healthy. Would you agree with me; that's the
17 main focus of your reasons as to why Grand
18 Strand should be approved over CRCC?

19 A: Sure.

20 Q: Okay. Now, there's nothing in the statute, the
21 regs, the State Health Plan, the purposes of
22 the Act that says that hospitals get favored
23 treatment over physicians, right?

24 A: No. I wasn't trying to imply that in my
25 response.

1 Q: And there's nothing in the purposes of the Act,
2 State Health Plan, the regs, the statute that
3 says that competition is something that
4 basically should be a big focus of the CON Act,
5 right?

6 A: No, I agree with you, but I think that when you
7 look at some of the criteria related to
8 distribution and I think that's where you bring
9 the competition aspect in.

10 Q: Well, the purposes of the Act talk about
11 quality and cost, right?

12 A: Yes.

13 Q: They don't talk about improving competition or
14 allowing competition or encouraging
15 competition, right?

16 A: Right, but competition has an impact both on
17 the quality and cost.

18 Q: Right. Because generally if you have an
19 overgrowth or proliferation of services,
20 quality will drop and costs will go up, right?
21 That's the theory, right?

22 A: If you have too many of something, yes.

23 Q: And that's basically unnecessary duplication?

24 A: Right. If there's not a need for something,
25 then that's considered unnecessary duplication.

1 Q: And so the statute requires, that's one of the
2 reasons that if these applications are
3 competing, only one can be chosen because it
4 would lead to an over -- because there's not a
5 need for both, right?

6 A: If that were the determination. I happen to
7 believe that there is a need for two.

8 Q: So in your opinion, the Department, during its
9 review process, should have either given very
10 little weight or ignored the fact that the
11 TrueBeam linear accelerator proposed by CRCC is
12 superior to the Clinac IX, right?

13 A: Yes.

14 Q: And there's no doubt that it's superior, right,
15 based on the testimony you've heard today,
16 right?

17 A: Sure. It has capabilities that the Clinac iX
18 does not have. I mean, my experience with
19 equipment is that most equipment ultimately is
20 upgradable and that over time differences
21 between different manufacturer models from the
22 same company, you can often times bridge that
23 gap as was discussed by Dr. Collins yesterday
24 with 2100 versus the Clinac iX.

25 Q: So again, the Department should either ignore

1 or give very little weight to the fact that
2 TrueBeam is superior to the Clinac IX, right?

3 A: I think in the grand weighting of all of the
4 factors, I don't think that should be the
5 determining thing.

6 Q: Okay. You also the Department should either
7 ignore or give very little weight to the fact
8 that CRCC's project is significantly less, has
9 required significantly less capital investment
10 ---

11 A: Right.

12 Q: --- than Grand Strand's?

13 A: That's true because they were provide --
14 offering a project that was substantially
15 different from what Grand Strand was offering.

16 Q: Well, it's really not substantially different
17 to the patient because it's the same machine,
18 the same doctor, the same cancer, the same
19 service, right?

20 A: Well, it's different in the sense that it's
21 located in an older facility, it's not located
22 in a hospital where there would be a
23 comprehensive array of services.

24 Q: This hospital-based service has really just
25 been building a building next to the hospital,

1 right? That's what they're doing, they're just
2 adding on into the parking lot, right?

3 A: It's an addition to the building.

4 Q: Okay. You think that DHEC should ignore or pay
5 very little attention to the fact that we will
6 complete our project nearly a year faster,
7 therefore bringing the services closer to --
8 bringing the services to the patients faster,
9 right?

10 A: Sure. Because, again, it's a question of
11 what's the end result, what do you end up with,
12 not -- you know, if speed was always the option
13 that you chose, you would be building a lot of
14 projects that would be substandard.

15 Q: You also think that the Department should not
16 give great weight to the fact that the CRCC
17 project increases geographic access?

18 A: I think that's a factor, but again, in the
19 weighing and balancing of these criteria, I
20 think that that's not as important as the
21 introduction of a different model of care
22 delivery and competition to the existing
23 provider.

24 Q: And one of the advantages to the Georgetown
25 application that you worked on ten years ago

1 was because that project was going to increase
2 geographic access to patients in the service
3 area, right?

4 A: That's true. And you're talking about a 40
5 mile difference as opposed to, you know, a ten
6 minute driving time difference in Conway.

7 Q: Let's talk about the ten minutes. You haven't
8 done any drive time studies, right?

9 A: I have not.

10 Q: And you haven't been to the beach in a while
11 because you haven't been to Grand Strand since
12 before the project started, right?

13 A: Right.

14 Q: Okay. But you are familiar enough with Horry
15 County to know that it can be tough to get
16 around sometimes, right?

17 A: It can, particularly in the summer.

18 Q: Okay. And there's no doubt in regards to
19 access that was added that the people who live
20 there, there's a significant number of people
21 who live in Horry County and that zip code --
22 sorry, it's this one, and that this zip code,
23 29526, actually has the largest population of
24 any zip code I think in the entire service
25 area?

1 A: Yeah. Of course it's a very large geographic
2 zip code.

3 Q: Uh-huh (affirmative response).

4 A: Eventually it will be split. But yeah, I agree
5 with you.

6 Q: Which is also one of the reasons that you might
7 want to move the linear accelerator there
8 because it's in the middle of not only a large
9 geographic area but the largest population
10 area?

11 A: I mean, I think the population concentration is
12 greater along the coast, but, yeah, in terms of
13 individual zip codes I would agree with you,
14 that's the largest of them.

15 Q: And there's no doubt that our project at CRCC
16 increases geographic access, right?

17 A: It does.

18 Q: And you also think that the Department should
19 have not given very much weight or ignored the
20 fact that the Grand Strand project will have a
21 greater adverse impact on the existing
22 providers than the Conway or North Strand
23 projects, right?

24 A: Well, I don't think that the impact will be
25 greater from Grand Strand. In fact, I believe

1 that the projections that CRCC makes for its
2 Conway center is projecting a higher volume of
3 patients that will be taken out of the existing
4 volume of CRCC than what Grand Strand is
5 projecting.

6 Q: Well that's -- let's get to that. I'll point
7 that out to you. You project that -- you're
8 very comfortable with Conway's projection of
9 patients over 5,000 treatments in year three
10 and you projected Grand Strand would be at 40,
11 what's the number again, 4,690?

12 A: 4,690. Yeah.

13 Q: So you're very comfortable with the idea that
14 the Grand Strand single unit, I'm sorry, the
15 CRCC single unit in Conway will be more, 20
16 percent more successful than Grand Strand,
17 right? That's your projection?

18 A: Well, I mean, it's apples and oranges because
19 CRCC already has the patient volume. They have
20 the control to shift those referrals from one
21 center to the other. Grand Strand doesn't have
22 that luxury. They don't have an existing base
23 of referrals.

24 Q: But they have Dr. Holt, the man you talked to
25 in the first phone call. And if his referrals

1 move, then they'll have a big space of
2 referrals, won't they?

3 A: Well, I mean, Dr. Holt never indicated to me
4 that he was moving all of his referrals. But
5 to the extent that the medical oncologists
6 refer patients, sure, there's going to be that
7 number of patients served at Grand Strand
8 rather than CRCC.

9 Q: Okay. And the employee physicians at Grand
10 Strand, the neurosurgeons, they refer for
11 radiation therapy, right?

12 A: They do.

13 Q: They'll certainly refer to Grand Strand?

14 A: Sure.

15 Q: Right?

16 A: Sure.

17 Q: And there are surgeons in Myrtle Beach who do
18 their surgery every day in Grand Strand's
19 operating rooms, right?

20 A: I believe including the urologists.

21 Q: And they'll be doing their cancer related
22 surgeries in Grand Strand's operating rooms,
23 right?

24 A: Sure.

25 Q: And there will be pressure from the hospital

1 for them to use their linear accelerator,
2 right?

3 MR. THOMAS: Object to form, Your Honor. That
4 assumes facts in evidence, the pressure
5 question.

6 MR. LONG: He did it again, Your Honor. That's
7 another one.

8 THE COURT: Actually I think I should sustain that
9 objection because you said there will be
10 pressure.

11 MR. LONG: Okay. I'll rephrase the question.

12 Q: There will be heavy encouragement from the
13 hospital to use their linear accelerator,
14 right?

15 A: The hospital will market its services to its
16 medical staff. I mean, I don't think that's
17 any question. Now, whether the doctors will
18 choose to use the hospital service, I mean,
19 that's the big issue. And doctors tend to do
20 what they're comfortable with and if they've
21 been referring to CRCC for a number of years,
22 I think it's going to take some convincing on
23 Grand Strand's part to get them to change their
24 referral pattern.

25 Q: Okay. That's your opinion, right?

1 A: It is.

2 Q: Now, if the project at Grand Strand is an
3 unnecessary duplication, it should be denied,
4 right?

5 A: Sure.

6 Q: Okay. And looking at this map here, which is
7 CRCC's Exhibit Number 2, this shows the
8 distribution of the linear accelerators based
9 on the current applications?

10 A: Right.

11 Q: Okay. And you can see Conway, Murrells Inlet,
12 Georgetown are geographically distributed and
13 then Grand Strand will be right on top of CRCC,
14 right?

15 MR. THOMAS: Can I make one objection, Your Honor?

16 THE COURT: You may.

17 MR. THOMAS: And it may just be Mr. Long. It's
18 interesting that the approved CRCC office on
19 this exhibit from Murrells Inlet is actually on
20 here but Ford Cancer Center has also been
21 approved and yet it's not reflective of the
22 same situation. So both have been approved,
23 but for some reason they keep this one down
24 here. Just wanted to note that for the record.

25 MR. LONG: It says right there, Your Honor, it says

1 right there that it's been relocated to
2 Murrells Inlet. All right?

3 MR. THOMAS: Then why do they ---

4 MR. LONG: Your Honor, this is just exactly what I'm
5 talking about. This is so incredibly improper.

6 MR. THOMAS: It's just a standard objection, Your
7 Honor.

8 MR. LONG: What is the objection? I haven't heard
9 the objection.

10 THE COURT: The objection is that the exhibit
11 doesn't actually, the markings on the exhibit
12 don't accurately reflect the actuality, I mean,
13 you've got a factual statement, but ---

14 MR. LONG: And all I'd say, Your Honor, as far as
15 it's a admissibility, it says on here Ford
16 Cancer Center, this is where it's currently
17 located and it's approved to relocate. This
18 says approved CRCC office in Murrells Inlet.
19 Approved. This says Conway, approved CRCC
20 office in Conway. Grand Strand proposed
21 location. They haven't been approved. CRCC
22 office on Oleander Drive. So absolutely, it's
23 accurate.

24 THE COURT: Well I'm going to -- I'm going to allow
25 it in because I think it's sufficiently

1 accurate. I don't think the objection is
2 improper, and I will tell you from what I've
3 been hearing on this witness, and I've been
4 listening to your concerns, I don't think he's
5 getting educated by any of these objections
6 because I think this man pretty well has got
7 the facts down already anyway on what you're
8 going to ask him, so from what I'm observing.

9 If I start feeling that it's going another
10 way, I certainly will take measures to ensure
11 that an improper education of the witness
12 doesn't occur.

13 MR. LONG: Thank you, Your Honor.

14 Q: Back to this chart here. And so looking at
15 Grand Strand's location compared to Oleander
16 Drive, they're basically on top of each other,
17 aren't they?

18 A: Well, they're three point something miles
19 apart.

20 Q: Three miles. And there was testimony about the
21 drive and how Dr. Holt's office is so close to
22 the hospital it takes about three minutes to
23 drive there, right?

24 A: Correct.

25 Q: Okay. But it takes about five minutes to drive

1 from Dr. Holt's office to Oleander Drive,
2 right?

3 A: I saw a MapQuest number that indicated it was
4 like ten or 11 minutes.

5 Q: Well it's only five miles, it's three miles
6 from the hospital, right?

7 A: Right.

8 Q: And of course you've seen the pictures of how
9 on Mr. Holt's property even though he's next to
10 the hospital, he's not next to it by car,
11 you've got to drive all around ---

12 A: Right.

13 Q: --- different streets and stop lights.

14 MR. THOMAS: Object to the form, Your Honor. Excuse
15 me, objection, assumes facts not in evidence.
16 I've done the drive and there are no stop
17 lights.

18 MR. LONG: Whoa, see what he's doing now? See how
19 he's done it.

20 THE COURT: You can't make statements yourself about
21 the evidence.

22 MR. THOMAS: All right, Your Honor.

23 MR. LONG: Your Honor, we really should just do the
24 objections at the bench. I really do think
25 that's the best way to handle it now. I mean

1 it's just been going on and on and on for days.
2 Your Honor, if I could ask the Court's
3 indulgence to take maybe a five minute or ten
4 minute break, I might be pretty close to being
5 finished. I need a minute.

6 THE COURT: If it would expedite you getting
7 through, then I'll gladly do that.

8 MR. LONG: Okay. Thank you.

9 (Break from 11:29 a.m. until 11:36 a.m.)

10 THE COURT: Was that long enough?

11 MR. LONG: It was. Thank you, Your Honor. And
12 actually I'm going to be very short. Whenever
13 you're ready, Your Honor.

14 THE COURT: I'm ready.

15 MR. LONG: Thank you.

16 BY MR. LONG:

17 Q: As a final issue, Mr. Sullivan, you -- in
18 regards to calculating adverse impact against
19 exhibit providers, right?

20 A: Right.

21 Q: That's been an issue? All right. You have
22 basically in the application allocated almost
23 all, if not all of the growth in the market to
24 Grand Strand, right?

25 A: Not exactly. What I was -- the point I was

1 trying to make is that there's going to be
2 growth in the market and absent the approval of
3 Grand Strand that growth will go to the two
4 existing providers. Grand Strand's going to
5 come in and it's going to serve, I projected,
6 220 patients, I think, or whatever the number
7 was from the service area. And so those 220
8 patients are coming out of the volumes that the
9 existing providers would have at some date in
10 the future. In this case 2015. So what I'm
11 saying is in measuring the impact, look at the
12 overall growth in the market, take Grand
13 Strand's volume out and that tells you the net
14 effect on the existing providers.

15 Q: Well, you'd agree with me, wouldn't you, that
16 the existing providers, you certainly opined in
17 other cases that existing providers are
18 entitled to the growth that occurs in the
19 market, right?

20 A: Yeah. If you're asking me about financial
21 impact, then I would agree that the incremental
22 financial impact would include the growth. But
23 I was looking at impact in the sense of
24 dropping the existing providers below the 80
25 percent. That's a different approach to impact

1 than what I normally do. If I'm doing
2 financial impact, I would agree with you that
3 growth ought to be allocated to the existing
4 providers.

5 Q: Well and just looking at the adverse impact on
6 Grand Strand, on CRCC themselves, if those
7 patients that you projected that Grand Strand
8 would take would otherwise go mostly to CRCC,
9 right?

10 A: That's true.

11 Q: Okay. And if Grand Strand is approved by the
12 Court, then those patients will go to Grand
13 Strand and that would be an adverse impact on
14 CRCC, won't it?

15 A: It would.

16 Q: Okay.

17 MR. LONG: That's all the questions I have, Your
18 Honor.

19 MS. BIGGERS: No questions, Your Honor.

20 MR. THOMAS: I'll have a few.

21 MR. SULLIVAN - REDIRECT EXAMINATION BY MR. THOMAS:

22 Q: As Ms. Tuska is getting us ready on the
23 computer, Mr. Sullivan, you were shown
24 Respondent's 2. All right. And so we can
25 clarify the record, you were -- you're familiar

1 with the CON applications and the relocation
2 projects in Murrells Inlet that we discussed,
3 correct?

4 A: I am.

5 Q: What's your understanding of how close they
6 are?

7 A: The two -- Georgetown, the Ford Cancer Center,
8 and the CRCC Murrells Inlet are about half a
9 mile from each other.

10 Q: From the proposed locations. So if this is the
11 scale that's been offered here where I guess
12 that's five miles, where would this circle need
13 to be placed in terms -- Georgetown's circle
14 need to be placed in terms of the approved CRCC
15 office in Murrells Inlet?

16 A: Right on top of it.

17 Q: Actually closer, closer than what these two
18 are; Grand Strand's proposed location and
19 CRCC's location?

20 A: That's true.

21 Q: Mr. Long asked you a little bit about some of
22 the travel times and whether or not you did a
23 travel time study, correct?

24 A: Yeah.

25 Q: Okay. Turn to Joint Exhibit 1 for me. That's

1 going to be the little bit bigger book since
2 it's the CRCC application. And go to CRCC DHEC
3 record page 19.

4 A: Okay.

5 Q: Where were you getting the data? First of all,
6 if you look here on page -- the second
7 paragraph, could you read that into the record,
8 please?

9 THE COURT: Hold on a second while I get there.

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

11 THE COURT: You said 19?

12 MR. THOMAS: Yes, sir. Joint 1, Bates 19.

13 THE COURT: All right.

14 Q: And read into there into the record that
15 paragraph if you would, just down to I guess
16 after the first word "patients."

17 A: Okay. "Currently patients from the Conway and
18 Loris areas drive an average of 45 minutes to
19 the closest of the two cancer centers with
20 linear accelerators. However, the proposed
21 project would reduce their drive time by more
22 than 21 percent to 35 minutes. A patient from
23 the Conway/Loris area would save an average of
24 20 minutes on each round trip to receive
25 treatment."

1 Q: Okay. So the ten minute one-way travel time
2 savings, that comes from where?

3 A: That comes from an analysis in the CRCC
4 application.

5 Q: Okay. Now, if you look, open up Joint Exhibit
6 4 for me. Mr. Long asked you some questions
7 about single operators.

8 A: Yes.

9 Q: I'm sorry, go to Joint Exhibit 5 first. I
10 think that's where it started.

11 A: Okay.

12 Q: And the page IX-9 maybe.

13 A: Okay.

14 Q: Okay. IX-9, and let's start with Eastside. Do
15 you know how long Eastside Cancer Centers of
16 the Carolinas has been around as a provider?

17 A: It's been a long time. I've done some work in
18 Greenville and they've been there for many,
19 many years.

20 Q: Do you agree that this is not a startup
21 facility, is it?

22 A: It's not.

23 Q: Okay. And I think Mr. Long also referenced
24 Ocone?

25 A: He did.

1 Q: Okay. Let me find it on the page here. It's
2 GMH, it says GMH Cancer Centers Carolinas
3 Oconee, and again, is that a startup provider?

4 A: It's not. It's been around for several years.

5 Q: But do you find that either of those two
6 comparisons merits comparison to the instant
7 situation?

8 A: I don't. Again, long term, Grand Strand might
9 be able to achieve volumes equivalent to what
10 these facilities are doing, but I don't think
11 it's going to happen in the first three years
12 given the dynamics of the market in which
13 they're operating.

14 Q: Okay. Let's call up Petitioner's 40 if we
15 could. Mr. Long asked you a few questions
16 about these three exhibits here. I'm going to
17 break open -- did you have an opportunity to
18 read Dr. Constantine Mantz's deposition?

19 A: I did.

20 MR. LONG: This is not a proper use of a deposition.

21 MR. THOMAS: It absolutely is. He's an expert and
22 I'm talking about -- Mr. Long asked him
23 questions about treatments. You remember, he
24 went down all the different cancer treatments
25 and what Dr. Collins had said. We just want to

1 get, for the record, where the number of
2 treatments came from that Mr. Sullivan relied
3 on for this exhibit as an expert.

4 MR. LONG: It's just not proper use of a deposition.

5 I mean he's not -- he's going to hand him a
6 deposition because he's going to have him read
7 it.

8 THE COURT: I think he can use depositions to
9 impeach but there are narrower rules about
10 allowing it to be used as your case-in-chief.
11 So I certainly think you can ask ---

12 MR. THOMAS: Okay. Go ahead.

13 THE COURT: I think you can ask him about where he
14 obtained the information, but publishing the
15 exhibit, do you have a rule of evidence ---

16 MR. THOMAS: I don't have a rule of evidence, Your
17 Honor, on that because, I mean, he's an expert.
18 He relied on this deposition transcript which
19 he put in the exhibit.

20 THE COURT: Oh, well, then you need to lay the
21 foundation on that then.

22 MR. THOMAS: Okay. Thank you.

23 Q: Now, Mr. Sullivan, on Petitioner's 40, where
24 did you get the number of treatments, or how
25 did you come up with 10,520 as the expected

1 estimated number of AUC referrals and
2 treatments?

3 A: Well, Dr. Mantz in his deposition discussed a
4 range of 40 to 45 treatments for prostate
5 cancer patients.

6 Q: Okay.

7 A: And so that was my starting point. I believe
8 that Mr. Lewis might have said something about
9 that as well, but I know Dr. Mantz for sure
10 did, and that was the starting point. And
11 that's also consistent with work I've done with
12 other cancer centers where urologists projected
13 a number of treatments.

14 MR. THOMAS: And, Your Honor, just for the record,
15 here's the rule. Going back to Mr. Long's
16 deposition. Use of depositions in court
17 proceedings, Rule 32.2, the deposition of a
18 party or of anyone who at the time of taking
19 deposition was officer, director, or managing
20 agent or person a designated ---

21 THE COURT: 30(b)(6).

22 MR. THOMAS: --- 30(b)(6) or 31(a) to testify on
23 behalf of a public or private corporation,
24 partnership, or association or government or
25 agency party may be ...

1 THE COURT: Well, was this such a deposition?

2 MR. THOMAS: Hold on, Your Honor, I'm sorry. I'm
3 sorry, I assumed since Dr. Mantz was an officer
4 of the company, that's why.

5 THE COURT: Okay.

6 MR. THOMAS: Your Honor, wait a second. A
7 deposition of a witness, whether or not a
8 party, may be used by any party for any purpose
9 that the court finds that the witness is at a
10 greater distance more than 100 miles from the
11 place of trial or is out of the state unless it
12 appears that the absence of the witness were
13 procured by the party offering the deposition.
14 I believe Mr. Mantz resides in Florida, Your
15 Honor, he's out of the state. He's actually
16 been withdrawn as a witness. So I think under
17 32(3)(b), I can use this transcript.

18 MR. LONG: He has to give me notice, Your Honor,
19 which he's failed to do.

20 THE COURT: I think it does require that. I can
21 withhold a ruling or I can look it up. Do you
22 have the rule in front of you?

23 MR. THOMAS: Yes, sir.

24 MR. LONG: Your Honor, I think there are two
25 purposes of the deposition, it's the Civil

1 Procedures Rule 32, use of a deposition in
2 court proceedings, you can impeach somebody
3 with it, you can't do that with this witness
4 since he's not, it's a different deposition ---

5 THE COURT: Yeah, hold on one moment ---

6 MR. LONG: --- there's nothing to impeach or publish

7 ---

8 THE COURT: Hold on one moment before you go there.

9 I just want to pull the rule up while I ---

10 MR. THOMAS: Your Honor, just for the practical --

11 you know, Mr. Sullivan is an expert and can
12 rely on many things. He can rely on hearsay.

13 This is sworn deposition testimony by the chief
14 medical officer of 21st Century, Your Honor.

15 So I'm kind of at a loss, especially with
16 32(a)(3)(B). Now, if they want to represent
17 that Mr. Mantz is in the state of South
18 Carolina and within 100 miles, then that's
19 fine.

20 THE COURT: Any response ---

21 MR. LONG: Yeah, Your Honor ---

22 THE COURT: --- because I see 32(b)(6), I'm familiar
23 with that one, but that one's under two, this
24 one is under three. So ---

25 MR. LONG: Well, under Mr. Thomas' interpretation of

1 the rule you would never have to give anybody
2 notice that you were going to use a deposition
3 of any witness or party if they were more than
4 100 miles away. You could just come in at the
5 trial and just start publishing their testimony
6 and turn them into a witness. That's the
7 problem of what he's doing here, Your Honor.
8 By publishing this, Dr. Mantz's deposition,
9 he's turning him into a witness in a lawsuit,
10 that's the problem. Here's the thing, Your
11 Honor. This is all much to do about nothing,
12 Your Honor. He already testified.

13 THE COURT: Yeah, that's the thing.

14 MR. LONG: There's nothing to impeach. There's
15 nothing that he said, what he heard, and he
16 testified to it without objection because so
17 ...

18 THE COURT: I do agree with that.

19 MR. THOMAS: If you want to rely, Judge, on his
20 testimony, I mean that's fine. But I mean
21 here's the notice. The deposition of
22 Constantine Mantz. That notice was given two
23 weeks ago that we would be relying on that for
24 that exhibit, and they just made a very big
25 deal about the number of treatments. This is

1 the chief medical officer of a billion dollar
2 company saying that 40 to 45 treatments ---

3 THE COURT: By the way, just for -- I'm going to,
4 since he's already testified to it ---

5 MR. THOMAS: Okay.

6 THE COURT: --- if Mr. Long offers testimony where
7 he attempts to dispute the accuracy of that,
8 then you can come back with the deposition.
9 But I'll also tell you I've looked at --
10 because Mr. Long referenced notice and I try to
11 keep up with the rules. 32 Section 5, 32(a)(5)
12 is the one that I'll -- I guess 32(b)
13 references -- (a)(5) is the one that references
14 notice. Under the circumstances, I'm just
15 going to deny it at this point.

16 MR. THOMAS: Well, it's a little late for me to
17 offer it in my case-in-chief, Your Honor,
18 that's the problem, and I found out yesterday
19 that they weren't going to be calling that
20 witness.

21 THE COURT: What was that?

22 MR. THOMAS: I mean I was told that this witness
23 would be coming up and informed yesterday that
24 they were withdrawing him.

25 THE COURT: That's a good point.

1 MR. LONG: Your Honor, we have a witness, Mr. Jamie
2 Thomas, and we're submitting deposition
3 designations for him, we complied with the rule
4 on that, and I don't know whether he was going
5 to bring him or not, he said he was, then he
6 wasn't sure, then he said he wasn't. I mean we
7 would have -- if I had ---

8 THE COURT: At this point in time I don't see any
9 prejudice to you. I'm going to allow you to
10 use it if, indeed, it's challenged.

11 MR. THOMAS: Okay. Thank you, Your Honor.

12 Q: Okay. And so was there a range provided by Dr.
13 Mantz?

14 A: Forty to 45.

15 Q: Okay. And which portion of that range did you
16 choose?

17 A: The lower end.

18 Q: Okay. Now, let's go to Petitioner's 40. Would
19 you go to Petitioner's 41 in there for me?

20 MR. THOMAS: I'm sorry, Your Honor.

21 Q: Actually, let's go to Respondent's 21. Mr.
22 Long asked you about various treatment types,
23 patients treated by diagnosis. Have you seen
24 this chart before?

25 A: I have.

1 Q: Okay. What is ---

2 MR. LONG: Your Honor, this exhibit wasn't
3 introduced in the cross; it's not been
4 introduced in the trial. I'm being told by my
5 staff this ---

6 THE COURT: Well, you are correct on that.

7 MR. LONG: Okay. It's not been admitted yet, so I
8 object to him, I object to it coming in at this
9 stage of the proceeding with this witness and
10 this place in redirect.

11 MR. THOMAS: Your Honor, he asked him about all of
12 these different treatment types, the number of
13 treatments, you know, did he have the
14 information available, did he not have the
15 information available at the time. Well, the
16 information is available now after discovery.
17 So that's what I'm asking about. So the topic
18 was brought up, I'm certainly allowed to ask
19 him about CRCC's own document referencing the
20 patients treated by diagnosis.

21 THE COURT: I overrule the objection.

22 MR. THOMAS: Thank you.

23 Q: Mr. Sullivan, what does this document show you?

24 A: This is a breakdown for 2010, '11, and '12 of
25 the patients treated by diagnosis at CRCC.

1 Q: Okay. And you remember Mr. Long was asking you
2 questions about, hypotheticals what if the
3 breast counts plus the lung counts equal 250.
4 Well, what do they actually equal?

5 A: The breast counts plus the lung counts equals
6 186.

7 Q: Okay. Well, first of all, what's the largest
8 category for 2012, let's just look at 2012, the
9 most recent data, the largest category of
10 patients treated by diagnosis at CRCC?

11 A: Prostate, 304.

12 Q: Okay. That's prostate, 304. Do you remember
13 how many referrals there were by the urologists
14 in 2012? Do you recall that number?

15 A: 304.

16 Q: No, the number of referrals by the urologists.

17 A: Oh, I'm sorry. I don't recall that number.

18 Q: Okay. Let me refresh your recollection. Go to
19 Petitioner's 40, excuse me, is it 39? No, 40
20 please.

21 A: Okay.

22 Q: Well, how many treatment plans were there by
23 the urologists in 2012?

24 A: I do remember that number, 263.

25 Q: Okay. And does the treatment plan normally

1 equal patient?

2 A: It can. Sometimes patients come back twice, so
3 sometimes you count treatment plans and
4 patients differently. But I don't know exactly
5 how they do it.

6 Q: Okay. And so what's the second largest count
7 on this page for patients treated by diagnosis
8 at CRCC in 2012?

9 A: Metastatic.

10 Q: Okay. And what did Dr. Collins testify in
11 terms of the number of treatments for
12 metastatic cancer?

13 A: I believe he said ten to 15.

14 Q: Okay. So if you took the low end of that, ten
15 treatments, and you multiplied that by 138, how
16 many treatments would that be for that
17 proportion of patients?

18 A: 1,380.

19 Q: Do you feel confident about the AUC, or excuse
20 me, the number of treatments for what
21 urologists do?

22 A: I do, and based on all available data, I mean
23 if we -- we sort of approached that same
24 calculation in a different fashion, if we
25 looked at what the average treatments were in

1 the areas say in 2009 when urologists weren't
2 significant referrers at 21, I think I
3 calculated my assumption was 19.8 for the non-
4 urology treatments. So that 19.8 is pretty
5 close to the 21 that we saw in the area, you
6 know, prior to the time that urologists really
7 ramped up their referrals for radiation
8 therapy.

9 Q: Okay. And at the time you did your projections
10 in this case, were you aware -- what if any
11 awareness did you have for the number of
12 treatments done by the urologists?

13 A: I didn't. I didn't know what their profile
14 was. I just, you know, I knew that they had a
15 relationship, but I knew that that was a
16 material portion of the total population of
17 radiation therapy patients, I just didn't know
18 what the treatments were.

19 Q: And so what is your opinion based on your
20 informed assumption that the number of
21 treatments they did -- did at least in 2012
22 using the low end of the treatment scale?

23 A: That they represent nearly half of the total
24 treatments available in the market. And then
25 that's the portion that would not be available

1 to Grand Strand.

2 Q: Did you recall in any testimony or anything
3 you've read Grand Strand indicated it would
4 become a world class cancer treatment center by
5 the third year of operations?

6 A: No.

7 Q: Would you expect it as a health planner to
8 become that in the third year of operations?

9 A: No, I mean developing a cancer center is much
10 the same as Mr. White described for a cardiac
11 center. It takes a long time. You have to
12 develop the infrastructure, you have to recruit
13 all of the specialty staff, you have to be
14 trained, you have to develop your reputation.
15 That takes quite some time, particularly when
16 you're in a market where there's other
17 providers that have these established
18 reputations.

19 Q: How many startup linear accelerator providers
20 have you worked with?

21 A: Probably 15 or 20.

22 Q: Are you aware of any that have achieved 8,000
23 treatments by the third year of operation?

24 A: Only one.

25 Q: What was that situation?

1 A: It was a very unusual situation on Raleigh,
2 North Carolina. This happened about six years
3 ago I guess. There's a large hospital system
4 there, UNC Hospitals owns a hospital called Rex
5 Hospital in Raleigh. Their medical oncologists
6 decided to go off and do their own radiation
7 therapy center, and they joined with a group of
8 radiation oncologists in a county with a
9 population of about a million people. And they
10 were able -- I can't remember the exact number
11 of medical oncologists, I think it was eight,
12 it might have been slightly more or less than
13 that, but they were able over the course of
14 about three years to get up over 8,000. But
15 that was a very unique situation where you had
16 virtually all of the significant medical
17 oncologists in the area aligned and providing
18 all of their treatments to that one center.

19 Q: Is that the situation with Grand Strand?

20 A: It is not.

21 Q: In terms of inpatient market share and
22 inpatient oncology market share, can you
23 explain to the Court why you do not feel that
24 that is an appropriate metric to use in this
25 case when determining Grand Strand's projected

1 utilization?

2 A: Okay. As it relates to inpatient total or
3 inpatient oncology only, the dynamic associated
4 with the urologists isn't in play. You know,
5 on the outpatient radiation therapy side, the
6 urologists control a substantial share of the
7 market. On the inpatient oncology side, that's
8 not attributable. Even urologists who do
9 inpatient cases have to go to a hospital to do
10 those. They can't send those to CRCC. So the
11 sort of market barrier, if you will, is not in
12 place on the inpatient side. So whereas Grand
13 Strand might have had a 29 percent market share
14 of the inpatient oncology market, I would not
15 expect them to have a 29 percent market share
16 of the outpatient radiation therapy market
17 because of that anomaly with the urologists.

18 Q: Okay. Now, I just want to use Respondent's 4
19 here. What's your understanding of how long
20 CRCC has been in this market? You keep using
21 the term entrenched provider. I don't know if
22 we've ever said how long that is.

23 A: My understanding is it's been over 30 years.

24 Q: So for the last 30 years, where have the
25 residents of 29526 been going for radiation

1 therapy?

2 A: My understanding is by and large to CRCC.

3 Q: How about 29527?

4 A: CRCC.

5 Q: 29579?

6 A: CRCC.

7 Q: In fact, all of these zip codes, every one,
8 29569 that Mr. Long mentioned, 295 -- the only
9 history these people have is with what linear
10 accelerator service for the last 30 years in
11 Horry County?

12 A: CRCC.

13 Q: Would you agree with me as an expert in health
14 planning what you do is you make informed
15 assumptions, correct?

16 A: Yes.

17 Q: That's all you can do in order to make a
18 projection, right?

19 A: You rarely have perfect information. You
20 certainly don't know what's going to happen in
21 the future exactly.

22 Q: In terms of the financial statements that Mr.
23 Long showed you, I believe it's Respondent's,
24 excuse me, let's see, excuse me Petitioner's 6
25 and I guess the "what if" analysis. Yeah, I'm

1 sorry, it's Respondent's 115. And he asked you
2 questions about the payback and the net present
3 value and the internal rate of return. That
4 information was based on what volumes?

5 A: The essentially doubling of the volumes that I
6 projected.

7 Q: Okay. And the person who testified under oath
8 about what he did in your volumes stated what
9 in terms of the basis for that doubling?

10 A: That he had no basis. It was just an attempt
11 to be more aggressive.

12 Q: And to satisfy the leadership at HCA, correct?

13 A: Correct.

14 Q: Now, Mr. Long seems -- was very interested in
15 the fact that you didn't have any in-person
16 meetings with anybody at the hospital. As a
17 health planner, again, what's your experience
18 in Grand Strand in this service area?

19 A: I've worked with them on several projects over
20 the last five or six years, and with many of my
21 established clients I don't have very many
22 face-to-face meetings. Much of what we do is
23 via the telephone. You know, you sort of know
24 your organization, you know the market that
25 they're serving. You know, it's not the same

1 as if you have a new client or you need to go
2 and sort of drive around the area and talk to
3 them, get a sense for who they are and what
4 kind of services they provide and so forth.

5 Q: Well, and in terms of the lack of in-person
6 meetings, do you feel like that was any
7 disadvantage to you in your analysis?

8 A: No. No. I mean I had the data I needed to
9 conduct the analysis. I was familiar with the
10 area and I knew the players. I don't see that
11 as a disadvantage.

12 Q: And the discussion you had with Dr. Holt with
13 respect to his support, other than Dr. Holt,
14 were any of the Coastal Cancer physicians on
15 that phone call?

16 A: They were not.

17 Q: And in terms of -- the deal fell through,
18 correct? I mean, Dr. Holt's land was never
19 purchased for \$1.4 million, was it?

20 A: That's true.

21 Q: Do you have any knowledge as to whether Dr.
22 Holt was upset about that?

23 A: I don't know one way or the other.

24 Q: If his expectation was to get \$1.4 million for
25 land that he never received, would you agree

1 with me ---

2 MR. LONG: Objection.

3 MR. THOMAS: I'll withdraw the question, Your Honor.

4 THE COURT: I didn't let you finish it, but I don't
5 see how you could have made it.

6 Q: Mr. Long asked you some questions about the
7 State Health Plan, what you require to get --
8 have a need, right?

9 A: Right.

10 Q: Do you recall that?

11 A: I do.

12 Q: Look at Joint Exhibit 5 for me, if you would.

13 A: Okay.

14 Q: And turn to Roman Numeral IX-8. IX-8.

15 A: Okay.

16 Q: Okay. And of course this is the -- this is the
17 State Health Plan that already shows CRCC's
18 Conway unit approved, correct?

19 A: Yes.

20 Q: What is that word there on the second to last
21 column under the heading "unmet need"?

22 A: It says need.

23 Q: Okay. And this is the starting point, correct?

24 A: It is.

25 Q: And that's the State's very own document that

1 it publishes, correct?

2 A: Yes.

3 Q: In terms of Grand Strand, Mr. Long took you
4 through some exercise where regarding
5 publishing of the State Health Plan and Grand
6 Strand knew for so much time that I guess they
7 could have applied for a CON for a linear
8 accelerator?

9 A: Yeah.

10 Q: Would that apply equally to any of the other
11 providers in the service area?

12 A: It did.

13 Q: Including CRCC?

14 A: Yes.

15 Q: What's your understanding -- Mr. Long asked you
16 several questions about reimbursement and why
17 private payers get reimbursed more than
18 Medicare, than CMS reimburses, correct?

19 A: Yes.

20 Q: Okay. What is your understanding of why that
21 occurs? Why is the private pay, the commercial
22 payers charged so much more?

23 A: Well, the system we have, unfortunately, is
24 that Medicare and Medicaid dictate and to a
25 certain extent Champus and other governmental

1 payers dictate what they're going to pay. And
2 oftentimes what they pay is either at or below
3 the cost of the services actually rendered. So
4 typically, what's often been referred to as
5 cost shifting in the industry, rates paid by
6 HMOs, PPOs, commercial insurance plans are
7 substantially higher than what Medicare -- and
8 that's how hospitals make their margins is
9 through the non-governmental payers.

10 Q: In terms of the chargemasters, how many private
11 payers are you aware of that actually pay a
12 percentage of the chargemaster?

13 A: In my experience with the clients I work with
14 now, I mean, that's usually less than five
15 percent.

16 Q: So did it surprise you that there were no
17 revenues on the inpatient line item on the
18 Grand Strand pro forma?

19 A: It doesn't. I mean, you could have put a small
20 amount there, but it would have been immaterial
21 to the feasibility of the project.

22 Q: I got a little confused, I'll admit, when Mr.
23 Long was asking you about the number of CT
24 scans. So for the record, I'm not saying that
25 when I get confused everybody else does, but

1 I'm going to make an assumption that maybe it
2 wasn't clear. On page 304 of Joint Exhibit 2,
3 all right.

4 A: Okay.

5 Q: Look at that for me. Just let me know when you
6 get there.

7 A: I am there.

8 Q: Okay. And there's a number, the number of CT
9 scans there, 154, 191, and 220, what does that
10 number represent?

11 A: That's roughly the number of patients that I
12 projected.

13 Q: Okay. Well, let's look on page 34 of the DHEC
14 record for Grand Strand. And that was the
15 number of patients for the service area,
16 correct?

17 A: Right. Right. So, you know, it may be
18 slightly understated if you added in the in-
19 migration. Maybe that number should be 232 in
20 the third year instead of 220, but it's pretty
21 close.

22 Q: And what does the CT scan there represent?

23 A: My assumption was that it represents the
24 initial CT scan used in the treatment planning
25 part of it.

1 Q: A PET scan, PET/CT is something different,
2 correct?

3 A: It is. I've actually had a couple of those.

4 Q: I don't want to make you talk about that, HIPAA
5 and all. All right. Mr. Long asked you some
6 questions about the GAO report. That's
7 Petitioner's 24. And he asked you ---

8 MR. LONG: Just to clarify, Your Honor, it's not in
9 evidence.

10 MR. THOMAS: It's not in evidence, Your Honor.

11 THE COURT: I guess, if that's what y'all say.

12 Q: Just turn there to page 5689 because I think
13 that's what -- what Mr. Long started with.

14 A: One second.

15 Q: Okay.

16 THE COURT: Is this Respondent's or Petitioner?

17 MR. THOMAS: This is Petitioner's, Your Honor.

18 THE COURT: Okay.

19 Q: Okay. Are you there?

20 A: I am.

21 Q: And then I guess Mr. Long had you read in what
22 the GAO recommends?

23 A: Yes. Correct.

24 Q: And he said that this was all about just
25 notification, this whole project, or excuse me,

1 this whole report was about notification; do
2 you recall that?

3 A: I do.

4 Q: Okay. Turn over, if you would, to Grand Strand
5 5714. You said there was a disagreement,
6 that's what it says on 5689, that HHS disagreed
7 with the GAO's recommendation, correct?

8 A: Yes.

9 Q: Okay. Well, under five, if you look at page
10 5714 and the second paragraph under HHS
11 comments, and look down at the beginning of the
12 second sentence where it says, HHS stated.

13 A: Okay.

14 Q: And I'd like you to read that into the record,
15 please.

16 A: "HHS stated that flagging self-referred
17 services and tracking their effects would not
18 address overutilization that occurs as a result
19 of self-referral. It would be complex to
20 administer and may have unintended consequences
21 which HHS did not delineate." Do you want me
22 to keep going?

23 Q: No, that's fine, that's what I wanted you to
24 read. So HHS didn't deny that overutilization
25 was taking place, correct?

1 A: That's correct. They just wondered whether the
2 solution the GAO recommendation would be
3 sufficient to address the problem.

4 Q: And they thought it would be complex to
5 administer too, right?

6 A: Right.

7 Q: And this GAO report, just for the record,
8 doesn't mention anything about urologists
9 needing to own the center, correct? It's about
10 self-referral and financial incentive
11 relationships?

12 A: That's true.

13 Q: And in terms of the urologists sharing in the
14 revenue, do the urologists have anything to do
15 with the radiation therapy portion of the
16 treatment?

17 A: They're not directly involved in the radiation
18 therapy.

19 Q: They don't go over to the radiation therapy
20 center and sit there and stay with their
21 patient and operate the machine, do they?

22 A: They do not. I mean, they probably consult
23 with the patients from time to time during the
24 course of treatment, but they're not involved
25 in the treatment itself.

1 MR. THOMAS: Sorry, Your Honor. Thank you, Your
2 Honor. Sorry.

3 Q: Do you recall how many neurosurgeons that Grand
4 Strand employs?

5 A: I want to say two.

6 Q: Do you recall how many treatments that referred
7 to CRCC?

8 A: It was a very small number. I don't recall the
9 number, but it was a very insignificant part of
10 their total.

11 Q: Grand Strand doesn't employ, or does Grand
12 Strand employ medical oncologists?

13 A: They do not.

14 Q: Or urologists?

15 A: No.

16 Q: How about GYN oncologists?

17 A: No.

18 Q: And Grand Strand Medical staff that aren't
19 employed, who have they been using for
20 radiation therapy for the last 30 years?

21 A: CRCC.

22 MR. THOMAS: One second, Your Honor. Your Honor,
23 one thing that my co-counsel has brought to my
24 attention, we had a little technical difficulty
25 as you recall yesterday at the end when I was

1 trying to look for an exhibit. Our exhibit
2 list had a ranking of South Carolina radiation
3 therapy treatment centers by volume. For some
4 reason what we had in the notebooks themselves
5 was a different document, and what I'd like to
6 do is at least get this document in through
7 this witness at this time. It's Petitioner's
8 1, unless there's an objection. Yeah, let me
9 show you. This is the document, our exhibit
10 list has a different number.

11 MR. CARTIN: Yeah. There's a wrong Exhibit 1 in the
12 notebooks.

13 MS. HOLLINGSWORTH: I think it was only wrong in
14 their notebook. It was right in what we saw.

15 THE COURT: Is this Petitioner's Exhibit 1?

16 MR. THOMAS: Yes. It would be Petitioner's Exhibit
17 1. It's right from the State Health Plan.

18 MR. LONG: This doesn't look familiar to us, Judge.

19 I don't know.

20 MR. CARTIN: It was produced on August 30th.

21 MR. THOMAS: Yeah.

22 MR. LONG: I don't know. I don't ---

23 MR. THOMAS: We produced it.

24 THE COURT: Does it start with 2012 radiotherapy
25 need?

1 MR. THOMAS: Yeah, Ranking of South Carolina radiation
2 therapy treatment by volume.

3 MR. LONG: Your Honor, I don't think it was produced
4 on the 30th. I'm not sure ---

5 MR. CARTIN: It absolutely was. On page 4 of the
6 PDF. I apologize.

7 MR. LONG: I don't think I've ever seen it. And
8 nobody over here has ever seen it, not a single
9 lawyer or person that's over here recognizes
10 the document. Now it's different to be handed
11 something in the middle of the trial ---

12 MR. THOMAS: We'll withdraw it.

13 MR. LONG: Well, I'm just saying, I just don't ---

14 THE COURT: He just withdrew it.

15 MR. THOMAS: It's based on the State Health Plan.

16 Q: All right. Mr. Sullivan, in terms of the
17 purposes of the State Health Plan, Mr. Long
18 asked you, he referenced the State Health Plan
19 and he asked you about competition and whether
20 or not that's mentioned anywhere and the
21 purposes of the project review criteria. But
22 in a similar vein, is there anything in the
23 State Health Plan, project review criteria, the
24 CON Act that denigrates competition?

25 A: No. No, I think it's just assumed then there's

1 some in the other criterion.

2 Q: Okay. And in terms of cost containment, which
3 is the first purpose of the State Health Plan,
4 how does competition affect that?

5 A: Well, I mean I think in a couple of different
6 ways. I mean, one, when you have a competitor
7 that typically requires you to be more
8 efficient in the way you provide services; and
9 two, from the standpoint of payers who
10 negotiate for rates, it gives them more
11 leverage in terms of negotiating prices.

12 Q: Okay. In terms of -- I think you've already
13 testified you do not believe this project is
14 unnecessary duplication services. But in terms
15 of number three, the purpose of the State
16 Health Plan in guiding the establishment of
17 health facilities and services which best serve
18 the public needs, how can competition help that
19 or promote that?

20 A: Well, if there's only form of a service being
21 offered and there's an alternative way of
22 providing that service, then having competition
23 then enhances the choices and the quality that
24 may be available for the residents of South
25 Carolina.

1 Q: Okay. And of course the fourth is ensuring
2 high quality services.

3 A: Right.

4 Q: And you believe that competition can help
5 promote that?

6 A: Absolutely.

7 MR. THOMAS: One second, Your Honor, I may be able
8 to finish up. Your Honor, at this time we'd
9 like to dismiss Mr. Sullivan.

10 THE COURT: Well, let me see.

11 MR. LONG: Yeah, I've got a question.

12 THE COURT: Okay.

13 MR. THOMAS: I didn't raise any new issues.

14 THE COURT: Well, we'll find out.

15 MR. THOMAS: Okay.

16 MR. SULLIVAN - RECROSS-EXAMINATION BY MR. LONG:

17 Q: Mr. Thomas asked you about the patients that
18 live in these counties in these zip codes and
19 that they've been referring -- I mean, that
20 they've been -- that patients in these zip
21 codes have been going to CRCC for 30 years.

22 A: Right.

23 Q: Didn't he ask you about that?

24 A: Right.

25 Q: But the patients that will be going to Grand

1 Strand and CRCC in the future years we've
2 talked about are new patients, aren't they?

3 A: New cancer cases.

4 Q: They're not patients who currently have had
5 cancer typically in the past, right, have used
6 the service in the past, right?

7 A: Right. But I mean the physicians who were
8 referring them are the same physicians.

9 Q: Right. And if physicians change their referral
10 patterns, then utilization will change at the
11 centers, right?

12 A: That's true.

13 Q: Okay. And no patients carry cards or have any
14 grand loyalty to radiation therapy centers,
15 right?

16 A: Probably not.

17 Q: Okay. That's all.

18 MR. LONG: Thank you Your Honor.

19 THE COURT: All right. You may step down. Any
20 objection to him being -- you said you wish him
21 to be dismissed?

22 MR. THOMAS: Yes, dismiss the witness who may come
23 back on rebuttal, Your Honor.

24 THE COURT: All right. Dismissed in part.

25 MR. LONG: We don't plan to call him in our case,

1 Your Honor.

2 THE COURT: All right. Well, we're going to break
3 for lunch. When are we going to be back?

4 MR. LONG: 12:30, Your Honor.

5 MR. THOMAS: Your Honor, before I rest, I did want
6 to make a motion for a directed verdict as
7 well.

8 THE COURT: There's not such a thing as a directed
9 verdict.

10 MR. THOMAS: Well, under Rule 50.

11 THE COURT: Voluntary non-suit.

12 MR. THOMAS: Rule 50, judgment as a matter of law.

13 THE COURT: Yeah.

14 MR. THOMAS: Can I make that now or would like me to
15 make it ---

16 THE COURT: I'd like you to make it when we come
17 back.

18 MR. THOMAS: Okay. Thank you Your Honor. It's not
19 something -- it's going to be brief.

20 THE COURT: All right. We're going to be back at
21 1:45. Mr. Long?

22 MR. LONG: Yes, Your Honor. Thank you.

23 THE COURT: No, did you ---

24 MR. LONG: 1:45 is fine.

25 (Lunch break from 12:25 p.m. until 1:43 p.m.)

1 THE COURT: All right. Mr. Thomas, apparently you
2 have a motion for me?

3 MR. THOMAS: Yes, sir. Just pursuant to South
4 Carolina Rule of Civil Procedure 50, motion for
5 directed verdict, Your Honor, you've now heard
6 Grand Strand's case and Grand Strand would
7 assert that no reasonable inference can be
8 drawn that there is not a need for two linear
9 accelerators in the service area. First of
10 all, we do have a 2012-2013 State Health Plan,
11 Your Honor, that actually says the word need,
12 we established that this afternoon, for an
13 additional linear accelerator. The evidence
14 shows that CRCC and you've heard -- well we
15 think it's incontrovertible evidence that CRCC
16 has nearly 50 percent of its linear accelerator
17 treatments guaranteed through their employed
18 urologists and that it would be impossible to
19 adversely impact CRCC in any material manner,
20 for a few things. They're the largest
21 radiation therapy center in the state by
22 volume. Their financials are extremely
23 healthy; you saw evidence that showed that.
24 They're an entrenched provider in this market;
25 they've been there for 30 years. And they've,

1 you know, greatly improved provider relations.
2 Both of these projects, Your Honor, can be
3 easily approved on their own merits. So I
4 don't think you'd have any problem with that,
5 heard that evidence. And I think you've also
6 seen the evidence through Mr. Sullivan's slides
7 that indicate that even using Mr. Tolbert's
8 market share numbers, which he doesn't
9 necessarily agree is the right way to do it,
10 but even using those and accounting for, which
11 you have to, the urologists who make up the
12 nearly 50 percent of the treatment volumes, it
13 was 46 percent at CRCC, there's no way that the
14 existing providers in the service area will be
15 brought below the 80 percent threshold. So we
16 believe that you can right now, based on the
17 evidence already provided, that you can approve
18 two linear accelerators in the service area.
19 Now, if for some reason the evidence didn't
20 convince you, we think that the evidence is
21 pretty overwhelming, Your Honor, that Grand
22 Strand's project should have been approved by
23 DHEC over the other two applications because,
24 first of all, there are no comprehensive cancer
25 centers in the area; there are no hospital-

1 based linear accelerators in the area. CRCC's
2 own application basically shows it's going to
3 save the average patient ten minutes one way
4 travel time when we know that the nearest
5 comprehensive care for -- cancer care is either
6 -- you've got a couple of options. You've got
7 80 miles to Florence or 100 plus miles to MUSC
8 from the Myrtle Beach area.

9 THE COURT: Oh, comprehensive?

10 MR. THOMAS: Yes, sir. So under no scenario -- also
11 Your Honor, under no scenario -- and there
12 hasn't been anything entered into the record at
13 this point that shows that if only Grand Strand
14 is approved that the existing providers would
15 -- you know, come under 80 percent, the under
16 80 percent threshold. And also, Your Honor,
17 you've heard from the technology, Grand
18 Strand's witnesses have already testified that
19 because prices come way down on the technology,
20 the TrueBeam, that they're going to ask the
21 State if they can replace it with that. From
22 a public policy perspective, there would be no
23 reason for the State to deny them to replace a
24 TrueBeam. Excuse me, replace the Clinac iX
25 with the TrueBeam. But even if they, even if

1 the Department wouldn't allow that, Dr. Collins
2 testified that the Clinac iX was basically a
3 work horse and could do just about everything
4 the TrueBeam could do. So Your Honor, for
5 those reasons we'd ask that you cut the trial
6 short and you approve two, or in the case for
7 some reason the evidence didn't convince you
8 that we put on our case that there's not a need
9 for two then that you approve Grand Strand.
10 Thank you.

11 MR. LONG: Your Honor, I'm going to be brief. Rule
12 50 does not -- Mr. Thomas' motion is
13 inappropriate. Rule 50 doesn't apply to non-
14 jury actions; it only applies to jury trials.
15 The only way to end the trial before the
16 conclusion of all of the evidence in a non-jury
17 case is under Rule 41(b), South Carolina
18 Jurisprudence -- I've got a South Carolina
19 Jurisprudence article on this issue, and I
20 quote, it says, "In non-jury civil cases, the
21 only motions specifically authorized by Civil
22 Procedure Rule is a motion for involuntary non-
23 suit by the defendant at the close of the
24 plaintiff's case." All right. So, and of
25 course, that's appropriate because Mr. Thomas

1 just asked you to make all these findings and
2 determinations about the project and about
3 their evidence without the court even having
4 the opportunity to hear any witnesses from the
5 respondent defendants in the case, and that's
6 patently unfair and not permitted under rules.

7 There will be plenty of evidence that we ---

8 THE COURT: Tell you what, I agree with you the
9 proper motion is involuntary non-suit, but even
10 if I treat it as that, which I will, it's
11 denied.

12 MR. LONG: Thank you.

13 THE COURT: Although I would love to bring it to an
14 end. Who's up?

15 MR. MULLINS: I think Ms. Biggers, the Department is
16 putting up their case.

17 MS. BIGGERS: Yes, Your Honor. We call Beverly
18 Brandt to the stand.

19 BEVERLY A. BRANDT, having been duly sworn, testifies
20 as follows:

21 MS. BIGGERS: And, Your Honor, if you'll indulge me
22 for a moment, I'd like to make a statement on
23 the record. Since there is a Supreme Court
24 petition pending right now, I just wanted to be
25 clear on the record in this case that that

1 actually does not affect this matter, that this
2 matter is about a decision that was made before
3 July 1, 2013.

4 THE COURT: Okay.

5 MS. BIGGERS: Thank you.

6 MS. BRANDT - DIRECT EXAMINATION BY MS. BIGGERS:

7 Q: Ms. Brandt, could you give us some of your
8 background please?

9 A: Yes. I have been -- well, I was with DHEC for
10 32 years. My first job with DHEC for over 22
11 years was in the Bureau of Radiological Health.
12 And I was a health physicist and I inspected
13 sources of radiation, and I wrote regulations
14 and procedures and developed forms. And some
15 of the sources of radiation included
16 electronically produced radiation, such as x-
17 ray equipment and particle accelerators and
18 linear accelerators. And I worked in that
19 program for over 22 years. And then I worked
20 with public health preparedness for five years
21 in which I worked with hospitals on planning
22 for disasters and mass casualty incidents and
23 terrorism incidents, and I helped the hospitals
24 buy equipment, safety equipment, portable
25 hospitals, respirators and so forth. And we

1 did joint planning for mass casualty incidents.
2 Then after that, in 2008, I was hired as the
3 Bureau Chief for the Bureau of Health
4 Facilities Services Development, or Certificate
5 of Need, and I served in that capacity for five
6 years.

7 Q: And can you go back and give us some of your
8 educational background as well, please?

9 A: Yes. I have a masters in public health, and my
10 practicum project dealt with mammography x-ray
11 equipment, and I've taken, you know, classes
12 here and there. Primarily I've done an online
13 class and I've lectured at the university and,
14 you know, I've gotten some help in some
15 textbooks upon their recommendations. So a lot
16 of it is just on-the-job training as well as my
17 master's degree.

18 Q: And when you were in the position of head of
19 the Certificate of Need program at DHEC, what
20 were your job duties?

21 A: I was responsible for serval programs, for
22 certainly making decisions on Certificate of
23 Need projects. I oversaw the development of the
24 State Health Plan and the Certificate of Public
25 Advantage and also the Joint Annual Report

1 program. But most of my time was spent
2 analyzing certificate of need applications and
3 supervising the analysis and making the
4 decisions.

5 Q: What do you typically do, or did you typically
6 do when reviewing a CON application?

7 A: We looked at how they measured up, if you will,
8 with the standards in the Health Plan and also
9 with the regulations. There are approximately
10 40 items that we must review in the regulations
11 as far as comparative review with the
12 regulations and the application.

13 Q: Did you make the decision in this matter that
14 we're here about today?

15 A: Yes, I did.

16 Q: And what was that decision?

17 A: My decision was to find for CRCC to add a
18 linear accelerator and expand in the Conway
19 area.

20 Q: And with respect to Grand Strand?

21 A: I denied their application.

22 Q: In the course of making that determination, did
23 you look at the definition of competing
24 applicants?

25 A: Yes, I did, and that's certainly reflected in

1 my letter and in my analysis.

2 Q: And what did you ultimately find with respect
3 to competing applicants?

4 A: I found that they were competing and that the
5 need would be exceeded if more than one linear
6 accelerator was approved.

7 Q: I'd like to turn now to your decision, and if
8 you'd pull out Joint Exhibit 1, and if you'll
9 turn towards the very back to page 655 of Joint
10 1.

11 A: Okay.

12 Q: Is this your decision letter?

13 A: Yes, it is.

14 Q: Looking on page 655, if you'll go down to the
15 last paragraph and about four lines in, do you
16 see the sentence beginning staff concludes?

17 A: Yes.

18 Q: Could you please read that and the rest of that
19 paragraph into the record for us, please.

20 THE COURT: Can you give me the page number again?

21 MS. BIGGERS: 655.

22 A: Okay. Staff concludes CRCC-Conway would better
23 comply with the purpose of CON, with its
24 finding from cash balances, lowest private
25 cost, to include an linear accelerator cost,

1 cost containment, rapid ramp up time with
2 advanced equipment in a more economically
3 disadvantages area, guide the establishment of
4 health facilities and services which will best
5 serve the public's needs, location in Conway,
6 prevent unnecessary duplication, and extensive
7 experience, ensure quality services. Would you
8 like for me to continue?

9 Q: Yeah, until the end of that paragraph, please.

10 A: The South Carolina Health Plan and project
11 review criteria are addressed in the attached
12 analysis. Adverse impact of GSRMC, or Grand
13 Strand Regional Medical Center, was considered.
14 Staff determined approval of the GSRMC
15 application could have substantial negative
16 impact upon the approved, but appealed,
17 relocated Francis B. Ford Cancer Center as well
18 the existing CRCC-Myrtle Beach.

19 Q: Now, in that paragraph there were -- on page
20 655, there were certain phrases that are in
21 parentheses?

22 A: Yes.

23 Q: What's the significance of the phrases in
24 parentheses?

25 A: Those identify the purposes of the Certificate

1 of Need program.

2 Q: Okay. And going back to page 656. Can you
3 please read for us the four findings that you
4 have in numbered paragraphs.

5 A: Yes. It states, The decision is based upon
6 written findings contained in the attached
7 analysis and upon the following conclusions.
8 One, the applicant has documented the need for
9 the proposed project within the application and
10 the project will increase accessibility and
11 availability of oncology services for residents
12 of Horry County and surrounding areas. Two,
13 the applicant's record is one of successful
14 operation with adequate management experience.
15 Three, support, documented opposition and
16 adverse effects on other facilities were
17 considered. And four, the project appears to
18 be financially feasible and cost effective
19 based on the information available.

20 Q: The paragraph that you read and then these four
21 bullet points, is that your -- do those
22 represent your main findings in making your
23 decision in this matter?

24 A: Yes, they do.

25 Q: And then if you'll turn to page 658.

1 A: Okay.

2 Q: And can you tell us what this document is that
3 starts on 658 and goes through 675?

4 A: This is the analysis that I developed for this
5 project.

6 Q: Okay. I'm just going to walk you through a few
7 particular pieces of this analysis. Let's look
8 first at page 668.

9 A: Okay.

10 Q: And going a little more than halfway down,
11 distribution accessibility. Can you just tell
12 us in general what distribution accessibility
13 is, that project review criterion?

14 A: We looked at geographic access as well as
15 financial access, as far as the accessibility
16 goes.

17 Q: And what were your findings with regard to
18 distribution accessibility criterion in this
19 case?

20 A: I felt that this project will increase the
21 geographic accessibility because of the Conway
22 location as far as -- well, this is
23 specifically here talking about Grand Strand.
24 But I felt that CRCC would increase
25 accessibility and that due to the close

1 proximity of Grand Strand to the current CRCC
2 location that their project would not increase
3 accessibility. And then we also -- well, I
4 concluded that all the applicants demonstrated
5 financial accessibility, but my findings, you
6 know, were very specific about the location, as
7 I had previously stated.

8 Q: And flipping over to page 671, towards the
9 bottom there's another heading distribution
10 accessibility.

11 A: Yes.

12 Q: And can you tell us what your findings were
13 here?

14 A: This finding discussed the implementation time.
15 And CRCC, their project projected the quickest
16 implementation time with six months as opposed
17 to around a year and a half for Grand Strand,
18 and the quick ramp up was due to existing
19 vault, which would necessitate and facilitate
20 accessibility.

21 Q: And did you also address socioeconomic status?

22 A: Yes, I had noted that Conway was an area that
23 had the lower socioeconomic status in that that
24 fact, the accessibility to that population was
25 increased by the CRCC project.

1 Q: Comparing the CRCC project and the Grand Strand
2 project, which if any, did you find best met
3 the project review criterion of distribution
4 accessibility?

5 A: I felt due to the ramp up time that CRCC better
6 met or best met since they were -- that project
7 review criteria.

8 Q: And did geographic location have any bearing on
9 that as well?

10 A: Yeah. Certainly, you know, the Conway location
11 there's currently not a site in Conway and
12 there is currently a site in Myrtle Beach.

13 Q: Okay. Now I'm going to turn your attention to
14 page 672. When you read out the bullet points
15 from your letter, one of them was the
16 applicant's successful operation and management
17 experience. If you'll look on page 672, can
18 you tel us with your findings were with respect
19 to that factor?

20 A: I had ---

21 THE COURT: What is the paragraph again that you're
22 referring to?

23 MS. BIGGERS: Specifically on 672, looking down at
24 the bottom paragraph "Record of the Applicant."

25 THE COURT: Okay.

1 A: I stated that CRCC had provided services for
2 three decades and that they were accredited by
3 the ACR, which has very high standards, and
4 that the equipment was state of the art that
5 they had chosen.

6 Q: And looking back up towards the top of the
7 page, the second full paragraph, can you tell
8 us what your findings were with respect to the
9 equipment that each applicant proposed to
10 acquire?

11 A: My findings stated that the proposed Varian
12 Trilogy TrueBeam was more advanced than the iX
13 system and that specifications for the unit
14 include a higher dose rate, image guidance
15 during treatment and is faster and more precise
16 and that the TrueBeam was a more advanced
17 system.

18 Q: And as to the CON goal of providing quality
19 services, high quality services to the public,
20 which if any, of the applicants did you
21 determine best met that goal?

22 A: CRCC-Conway.

23 Q: Okay. Now let's talk about adverse effects.
24 And I'll turn your attention to page 668, the
25 third paragraph. And can you describe for us

1 your findings with respect to adverse impacts?

2 A: Page 668, Ms. Biggers?

3 Q: Yes.

4 A: The one, the paragraph that states, Grand
5 Strand projects?

6 Q: Correct.

7 A: Okay. I felt that the claims by Grand Strand
8 that they would only be taking 26 patients from
9 CRCC, those claims were understated. And I
10 looked at the number of projected additional
11 patients per year, and the only way it appeared
12 that they could meet their projects was to take
13 all of the new patients away, plus more than
14 they had projected from CRCC. It just, it
15 didn't seem -- it seemed to me that there would
16 be numerous impact on CRCC, and I did draw that
17 conclusion.

18 Q: And if you'll turn to the next page 669 and
19 look at the last paragraph.

20 A: Okay.

21 Q: And can you describe further your findings on
22 adverse effects?

23 A: I quoted a statement from Mr. Sullivan. And it
24 stated that the -- and this was regarding the
25 Coastal Cancer Center, that the physicians

1 serve a high percentage of the cancer patients
2 in Horry County because Coastal's main office
3 is next to the GSRMC campus and many of its
4 patients receive chemotherapy at the main
5 office, and it is reasonable to conclude that
6 a significant percentage of Coastal's patients
7 from the service area will choose GSRMC for
8 radiation treatment. So I took the significant
9 percentage statement to heart as far as the
10 impact upon CRCC.

11 Q: In comparing the two applications, which, if
12 either, did you find most fully complied with
13 adverse effects criterion?

14 A: Well, I felt that CRCC-Conway would certain
15 comply better with not exhibiting the adverse
16 effects.

17 Q: And then regarding cost effectiveness -- I'm
18 sorry cost containment. Let's look at page
19 674, the top paragraph.

20 A: Okay.

21 Q: And I'm sorry, the paragraph directly under
22 cost containment. Can you describe for us your
23 findings with respect to cost containment?

24 A: I felt that CRCC-Conway, you know, best
25 demonstrated cost containment because they're

1 using an existing building with some remodeling
2 there -- so their total project cost was lower,
3 and that was also due to the lower price of the
4 equipment as well. And certainly they're not
5 financing the project as well.

6 Q: With respect to cost containment, which, if
7 either, of those applicants did you find best
8 met that goal in that project review criterion?

9 A: I found it was CRCC.

10 Q: And can you explain for the Court why you found
11 that these applications were competing
12 applicants?

13 A: Well, I looked at the definition and the --
14 they were a common thread certainly as opposed
15 to the definition. And the issue -- I'm going
16 to the definition, if it's okay.

17 THE COURT: What regulation are you going to?

18 MS. BIGGERS: I believe she quoted that in this
19 analysis, Your Honor, on page 658.

20 A: Yes.

21 Q: About the middle of the page.

22 A: I was going back to that where the regulations
23 define competing applicants, and that's two or
24 more persons enter healthcare facilities who
25 apply for a CON to provide similar services

1 and/or facilities, which they did, in the same
2 service area, which they did, and whose
3 applications, if approved, would exceed the
4 need for this facility or service. And I
5 concluded that approval of any two of the
6 applicants would exceed the need in the service
7 area.

8 Q: And finally, can you just sum up for us the
9 major reasons why you determined to approve
10 CRCC over Grand Strand?

11 A: Well, again, I looked at -- closely at the
12 merits of both applications, and I looked at
13 how they -- they measured up, if you will, to
14 the goals and purposes of CON. And I felt the
15 CRCC-Conway application best embodied the goals
16 and purposes through the items that are
17 enumerated in my approval letter, as well as
18 the analysis. And I certainly felt that they
19 were competing. And I also expressed concern
20 upon the impact of the Murrells Inlet project
21 as well and that it wasn't good health planning
22 to add another facility in the mix. And I
23 felt, again, that they were competing and
24 approval of more than one would exceed the
25 need.

1 Q: Thank you very much. If you'll just answer any
2 questions other counsel have.

3 MS. BRANDT - CROSS-EXAMINATION BY MR. MULLINS:

4 Q: Good after Mr. Brandt, how are you?

5 A: Fine. Good afternoon.

6 Q: I'm going to go ahead and hand you a copy,
7 although you're going to keep that in front of
8 you; you're going to need that. But I'm just
9 going to hand you a copy of the Regulations,
10 61-15.

11 A: Okay. Mr. Mullins, if you don't mind, may I
12 get my reading glasses?

13 Q: Sure. Well if the judge ---

14 A: If Your Honor doesn't mind.

15 THE COURT: I have no problem with that.

16 MS. BIGGERS: Thank you.

17 Q: All right. Ms. Brandt, I just want to make
18 sure that the record is clear. At the time
19 that you made this decision, you were the
20 bureau chief for the Bureau of Health
21 Facilities and Services Development; is that
22 correct?

23 A: Yes, I was.

24 Q: Okay. And in connection with your role as the
25 bureau chief, you oversaw the entirety of the

1 CON program; is that correct?

2 A: Yes, I did.

3 Q: And you had, in the functions of the CON
4 department there are reviewers, staff reviewers
5 that review CON applications. You ultimately
6 are the one that made the decision on all the
7 CON applications; is that a fair statement?

8 A: Yes, I am.

9 Q: And in this particular case, you were actually
10 the reviewer?

11 A: Yes, I was.

12 Q: Okay. And so this was not assigned to any
13 other reviewer; you were the one that handled
14 these applicants -- the three applications and
15 the review process, and ultimately, the
16 decision in this case?

17 A: Yes, I chose to assign them to myself.

18 Q: Okay. Can you briefly for the Court just
19 describe what are the duties or what the
20 functions of a CON staff reviewer -- what is a
21 staff reviewer doing upon assignment of a CON
22 application?

23 A: Well, in a nutshell as far as the review
24 process, there's certainly paperwork. We
25 review the application, again, for compliance

1 with the standards in the plan and for the
2 items that are enumerated in the regulations.
3 And if we don't feel that the information is
4 sufficient, then we're allowed to ask two
5 rounds of questions. Does that -- do you want
6 me to ---

7 Q: Right, that's it. Yes, you get the idea.

8 A: Yes. So, you know, once we get to that point
9 and we're satisfied that we have all of the
10 information that we need, then we deem the
11 applications complete. And it gets published
12 in the State Register under Notification of
13 Affected Persons, so that opens the door for
14 somebody that may be determined to be competing
15 at some point to apply, which is what happened
16 in this case. And we, of course, review those
17 applications and we get to a certain point to
18 where we have project review typically, and
19 then we set a deadline to make a decision, and
20 also to receive post project review comments
21 and so forth.

22 Q: All right. Tell the Court, if you will, what
23 information are you considering while you're
24 making this determination, the CON applications
25 themselves, and then I think you discussed

1 there was a process by which you could ask for
2 additional information?

3 A: Yes.

4 Q: From the applicant?

5 A: Yes.

6 Q: All right. And the CON Act, is that something
7 you consider in your review?

8 A: Well, yes, we certainly do, but we look more so
9 at the regulations. But the Act is the
10 legislative authority that give us the
11 authority to have the regulations.

12 Q: Okay. The regulations are 61-15 that I handed
13 you ---

14 A: Yes.

15 Q: --- a copy, correct?

16 A: Yes.

17 Q: And the State Health Plan, that's something you
18 consider?

19 A: Oh, absolutely, yes.

20 Q: And any other information that you might
21 consider during the review process?

22 A: I mean, we consider anything that's submitted
23 to us by the applicants or affected parties or
24 certainly supporters.

25 Q: All right. And also maybe your experience in

1 reviewing applications or the staff's
2 experience in reviewing applications, other
3 applications?

4 A: Well, certainly, yes.

5 Q: All right. I handed you the regulation I want
6 to ask you about. And Ms. Biggers asked you,
7 I think, some questions relating to the purpose
8 of the CON Act.

9 A: Yes.

10 Q: And if you look at Section 101 of the
11 regulation.

12 A: Okay.

13 Q: Is that the bases -- I think this is actually
14 in the statute too but ---

15 A: Yes.

16 Q: --- purpose as set forth in Section 101, is
17 that what you were referring to?

18 A: Yes, I was.

19 Q: Okay. And they're -- essentially, there are
20 four categories that are defined as the purpose
21 of the regulations, right?

22 A: Yes.

23 Q: Can you read those?

24 A: One is cost containment. The second is prevent
25 unnecessary duplication of healthcare

1 facilities and services. The third one is
2 guide the establishment of healthcare
3 facilities and services which will best serve
4 the public needs. And four, ensure that high
5 quality services are provided in health
6 facilities in the state.

7 Q: And you use the State Health Plan and the
8 Regulation 61-15, the review criteria I think
9 you mentioned, the 40 review criteria?

10 A: Well, there's project review criteria and then
11 there's items that have to be covered in the
12 application.

13 Q: Right.

14 A: It's two separate lists.

15 Q: Okay. But you use the Health Plan and the
16 regulations to -- as a guide, if you will, for
17 achieving the purposes and the goals of the
18 Act, correct?

19 A: Yes, I did.

20 Q: All right. Now, in this case, we had multiple
21 applications, right?

22 A: Yes.

23 Q: Okay. And with Ms. Biggers, you just walked
24 through, I think, the definition of competing
25 applications. And I think that -- well, I tell

1 you what. Let's go to your decision letter,
2 that might be the easiest thing to refer to.
3 655, that's Joint Exhibit -- Joint Exhibit 1,
4 655.

5 A: Okay.

6 Q: You were just -- you were there.

7 A: Yes.

8 Q: All right. You there?

9 A: Yes.

10 Q: Okay. And under the definition of competing
11 applications -- well, I won't have you walk
12 through that definition again. But you don't
13 -- and I don't think there's any issue in this
14 case that, essentially, the first three
15 components of the competing applications you
16 knew were met at the time those applications
17 were filed, two or more facilities who were
18 applying for a Certificate of Need to provide
19 similar services in the same service area; you
20 knew that, right?

21 A: Yes. Yes.

22 Q: And the last component in terms of the
23 definition of competing is whose application,
24 if approved, would exceed the need for this
25 service. When did you make that decision

1 during this process?

2 A: Well, it would've been in between the time that
3 we received all the information post project
4 review and the date of this letter. I couldn't
5 tell you the exact date.

6 Q: Okay. But you get three applications, they're
7 -- they meet the first three definitions of the
8 definition of competing applications, you think
9 there's a possibility they may be competing,
10 but you don't make that decision until the end
11 of the review process; is that a fair
12 statement?

13 A: Yes, that's correct.

14 Q: All right. Let's talk about, I think you had
15 mentioned -- I just want to talk a little bit
16 about the review process that you undertook in
17 this case. And let's look at the CRCC record
18 first. You mentioned that you have an
19 opportunity to ask for additional information;
20 that's authority provided you under the
21 regulations, right?

22 A: Yes.

23 Q: And you did that in this case, correct?

24 A: Yes.

25 Q: You did that for both applications, correct?

1 A: Yes, as I recall. Yes.

2 Q: And let's look at Joint Exhibit 2, Bates 513.

3 A: Okay.

4 Q: Do you recall that being your first request for
5 additional information that you submitted to
6 Mr. Tolbert?

7 A: I recall it being results of a request, I
8 believe. But certainly it's submitted to us by
9 the applicant. Again, I don't quite quote --
10 remember exactly when we got it without really
11 going through the file, but it was certainly
12 information was provided.

13 Q: Oh I'm sorry. I said ---

14 A: Yeah, this is the quote for Grand Strand.

15 Q: Yeah. I'm in the wrong book. Sorry. Joint
16 Exhibit 1. We're talking about CRCC.

17 A: Okay.

18 Q: I should be like Mr. Long and just not refer to
19 the Joint Exhibit.

20 A: Okay. _I'm back to 1.

21 THE COURT: All right. So what page are we on
22 again?

23 MR. MULLINS: 513 of the CRCC record, which is Joint
24 Exhibit 1. I apologize.

25 A: Okay. I'm on 513.

1 Q: Okay. Does that look like the first request
2 for additional information that you submitted
3 to Mr. Tolbert, who is the consultant for CRCC?

4 A: Yes, it is.

5 Q: Okay. And then 519. Look over to 519.

6 A: Okay.

7 Q: Does that look like the response provided by
8 Mr. Tolbert?

9 A: Yes, it does.

10 Q: Or provided by CRCC?

11 A: Yes.

12 Q: Response from Sissy Price on behalf of CRCC?

13 A: Yes.

14 Q: Okay. And this letter, I'm going to this
15 letter because it actually quotes your
16 questions and then it has a response; is that
17 right?

18 A: Yes, it does.

19 Q: All right. I just want to look at a couple of
20 these. These are items that you had identified
21 as wanting additional information. Number 1,
22 you asked a question about cross coverage; is
23 that right? Cross coverage of the staff of
24 CRCC? How CRCC was going to staff its
25 facilities with a new one opening in Conway?

1 A: Yes.

2 Q: Okay. And 2 through 5 basically deal with
3 physical aspect of the facility. You were
4 asking some more questions about the actual
5 facility that CRCC proposed to be located in
6 Conway?

7 A: Yes.

8 Q: All right. And then 6, you're asking for
9 backup population statistics on some of the
10 representations that were made in the
11 application?

12 A: Yes.

13 Q: Relating to the Conway -- Conway and Loris
14 populations?

15 A: Yes.

16 Q: Okay. There had been some representations made
17 by CRCC in terms of the support of its decision
18 to go locate in Conway, that Conway and Loris
19 had a high population area and a high patient
20 population area; is Is that -- do you recall
21 that?

22 A: Yes.

23 Q: Okay. So you were asking for additional
24 information to support that, correct?

25 A: Yes.

1 Q: All right. And then 7 through 9, I think you
2 had some -- just some questions relating to the
3 standards in the State Health Plan, right?

4 A: Yes.

5 Q: Okay. And actually question 9, you're asking
6 about letters of support and referral numbers,
7 right?

8 A: Yes, because that's what Standard 8 indicated
9 that was needed.

10 Q: That's Standard 8 in the State Health Plan that
11 addresses requirements that applicants are
12 supposed to fulfill in connection with their
13 application, correct?

14 A: Yes.

15 Q: All right. And CRCC's response, what was
16 CRCC's response to that specific question?

17 A: Would you like for me to read it into the
18 record?

19 Q: Well, you can read it. Why don't you review it
20 and I'll ask you a question. I just want to
21 make sure you recall this response. And
22 actually, the main question relates, is
23 addressed in the first sentence. Their
24 justification for Conway was built on their
25 existing volume, is that correct, their

1 existing referrals?

2 A: Yes, it does state that.

3 Q: All right. And in essence, what CRCC was doing
4 was moving a machine closer to a portion of
5 their patient base, correct?

6 A: They were going to put in new machines.

7 Q: Right.

8 A: But yes it was ---

9 Q: I'm sorry, installing a new machine closer to
10 their patient base?

11 A: Yes, in the Conway area.

12 Q: Okay. And then you asked, 10 and 11 you asked
13 some questions, some financial-related
14 questions, and I think 12 and 13 you were
15 asking some staff questions; Does that look
16 right?

17 A: Yes.

18 Q: All right. And then 442.

19 A: Excuse me?

20 Q: Bates 442. I'm sorry. __ Flip over to 442.

21 A: 442?

22 Q: I'm sorry. 542. Sorry.

23 A: Okay.

24 Q: That's the -- you asked as authorized under the
25 regulations, a second request for additional

1 information?

2 A: Yes.

3 Q: To CRCC?

4 A: Yes, I did.

5 Q: Okay. And 544 was a response from Mr. Tolbert
6 relating to that, and again, the questions are
7 quoted?

8 A: Yes.

9 Q: Your questions are quoted and then there's a
10 response?

11 A: Yes.

12 Q: Okay. And the first question relates to the
13 TrueBeam and some questions about capacity,
14 correct?

15 A: Yes.

16 Q: All right. And what is the first sentence --
17 first sentence in response to that essentially
18 reflects that the capacity was 7,000?

19 A: Yes, that's what they had indicated.

20 Q: Okay. Number 2 -- I'm sorry. Number 3 on your
21 request asks for any overlap of referral
22 sources with existing and proposed facilities
23 in the area.

24 A: Yes.

25 Q: Right? Okay. The date of this June 28, 2011;

1 correct?

2 A: Yes.

3 Q: And actually your initial request would have
4 been prior to that. That was before Grand
5 Strand filed their application, correct?

6 A: Yes, I believe you're right.

7 Q: Okay.

8 A: I believe they filed in July.

9 Q: Okay. All right. But you are, this question
10 I guess reflects you've got a concern about the
11 overlap in referral sources, potential overlap
12 in referral services, correct?

13 A: Yes, I did.

14 Q: And that, in essence, you're trying to dig
15 into, if you will, the potential for adverse
16 impact; is that a fair statement?

17 A: Yes, that is a fair statement.

18 Q: Okay. Number 4, and let me just back up to
19 that. CRCC indicated that the Georgetown
20 facility was the only facility in the service
21 area, correct? But you knew that anyway, but
22 that was the response, correct?

23 A: Yes. They indicated they were the only
24 provider.

25 Q: All right. And CRCC indicated that their

1 projections, their volume projections did not
2 assume any change in the existing referral
3 patterns and did not anticipate that there will
4 be any impact on Georgetown, correct?

5 A: Yes, that's what it states.

6 Q: In other words, like we talked about a minute
7 ago, their need projections were based on their
8 historical volumes, CRCC's historical volumes,
9 and they were proposing to add a machine in an
10 area that they already served, correct?

11 A: Yes. Yes.

12 Q: Okay.

13 A: And they were definitely over capacity, yes.

14 Q: Okay. All right. Number 4 in your -- this
15 request here, you have asked for a breakdown of
16 patients by zip code, the projected patients by
17 zip code?

18 A: Yes.

19 Q: All right. And the purpose of that is to
20 analyze the need projections and potential
21 adverse impact; is that a fair statement?

22 A: Yes, and see where the patients are coming
23 from.

24 Q: Okay.

25 A: Proposed patients.

1 Q: All right. And number 5, you recall CRCC in
2 its original application had identified an
3 accessibility problem in the Conway-Loris area,
4 and you had asked for additional information
5 relating to that and how that would be
6 addressed; is that a fair statement?

7 A: Yes, it's certainly about travel time.

8 Q: Okay. And Mr. Tolbert provided a response
9 there for you that you considered, correct?

10 A: Yes.

11 Q: All right. I want to look real quickly at the
12 Grand Strand record, which is going to be Joint
13 Exhibit 2. And actually if you'll go to page
14 7.

15 A: Okay.

16 Q: All right. Read the -- under the number 2 for
17 the additional information, that's kind of
18 known as the project description, project
19 summary; is that right?

20 A: Yes.

21 Q: Read the second sentence that is set forth in
22 Grand Strand's application.

23 A: "Grand Strand proposes to install a state-of-
24 the-art Varian Clinac iX linear accelerator
25 along with a CT simulator and will provide

1 conventional radiotherapy services, as well as
2 IMRT and IGRT services to residents of and
3 visitors to the state-defined service area of
4 Horry, Georgetown, and Williamsburg counties."

5 Q: Okay. It didn't say that we're providing the
6 Clinac iX or some other type piece of equipment
7 that they may determine in the future. You
8 analyzed this application in terms of a Varian
9 Clinac iX being offered in the application. Is
10 that a fair statement?

11 A: Yes, that was the equipment that they proposed.

12 Q: Okay. All right. Flip to 483. And that's the
13 request for additional information that you
14 made?

15 A: Yes, it was.

16 Q: And if you flip over to 485, Mr. Thomas,
17 likewise, has quoted your request and provided
18 a response on behalf of Grand Strand, correct?

19 A: Yes.

20 Q: Okay. And the second question there you're
21 asking for a better copy of the Varian quote,
22 correct?

23 A: Yes, that's because the regulations require one
24 side only.

25 Q: Okay. And why is it important for you to have

1 a quote, an equipment quote?

2 A: Because we can see what the price is and what
3 the specifications are on the equipment.

4 Q: All right. So you can see that they're getting
5 what they say they're going to get, correct?

6 A: Yes.

7 Q: And with regards to linear accelerators, does
8 the type of equipment, could that have an
9 impact on utilization or capacity?

10 A: Well, with some pieces of equipment they can
11 see -- there can be faster patient through put,
12 and then there can also be better, I guess,
13 focus upon the tumor and the ability to move
14 with the tumor and to be more precise as far as
15 the treatment.

16 Q: And that may relate to quality of care as well,
17 right?

18 A: Well, yes, it certainly could.

19 Q: Right. And I think you mentioned the project
20 cost, knowing -- having the equipment quote and
21 knowing what it is relates to your analysis of
22 the total project costs and the criteria that
23 relate to that, correct?

24 A: Yes. And we certainly reconcile the cost on
25 the quote with what they put in the

1 application.

2 Q: Okay. Look at number 5 in your request for
3 additional information. You've asked -- you
4 asked Grand Strand to indicate how many
5 patients and treatments they're projected to be
6 redirected from CRCC to Grand Strand. You see
7 that?

8 A: Yes.

9 Q: So you've got some concern about the impact of
10 Grand Strand's facility to -- on CRCC's
11 existing facility, correct?

12 A: Yes.

13 Q: All right. Number 6, you're asking for patient
14 volumes by zip code.

15 A: Yes.

16 Q: Again, why are you asking for that information?

17 A: Again, we want to see where the patients are
18 projected to come from and also look at the
19 volumes.

20 Q: And those efforts are in attempt to verify
21 representations that have been made in the
22 application also allow you to make your own
23 analysis, correct?

24 A: Yes, that's correct.

25 Q: Let's flip over, if you will, I don't know if

1 you mentioned this, so I'll ask you. In a case
2 like this, you customarily conduct what's
3 called a project review committee meeting?

4 A: Yes, we do.

5 Q: And explain for the Court what that is.

6 A: Well, the purpose of the project review meeting
7 is to gather information that's used to make
8 the best decision possible. And typically,
9 it's an opportunity for the applicants to
10 really voice their strengths and what they feel
11 are the strong points of their applications and
12 give us a real concise summary of the strong
13 points of their application.

14 Q: All right. I've heard some describe it as the
15 dog and pony show. In a normal situation,
16 applicants will come in and they have
17 PowerPoint presentations and they submit any
18 information they believe is going to be
19 pertinent to the review?

20 A: Yes. They're just basically trying to support
21 their application.

22 Q: All right. And who's there on behalf of the
23 Department?

24 A: Well, the project review committee for the
25 Department consists of all the staff of the

Bureau of Health Facilities and Services

Development. We also always invite the other staff in the building, such as the staff from health facilities and licensing certification and so forth.

Q: And that was conducted in this case, correct?

A: Yes.

Q: In 822 in Grand Strand's record, there's a copy of their PowerPoint presentation that they made to the committee, correct?

A: Yes.

Q: All right. I think that runs through 861, correct?

A: Yes.

Q: You consider this, all of the information that Grand Strand presented at the project review meeting, right?

A: Yes.

Q: Let me ask you this. Turn to Bates 860. You recall who presented on behalf of Grand Strand? Mr. White made some comments on behalf of the hospital?

A: Yes, I believe he did.

Q: Okay. And then Mr. Sullivan made a presentation and finished out the presentation;

1 do you recall that?

2 A: I do recall that Mr. Sullivan spoke.

3 Q: All right. And then the conclusion, the last
4 slide here, I just wanted you to look at that.
5 What does the last bullet point here say?

6 A: On page 860?

7 Q: 860.

8 A: The last bullet states, The superior
9 alternative among the competing applications.

10 Q: Okay. So they, at this point, were referring
11 to these applications as competing
12 applications, correct?

13 A: Yes, they were.

14 Q: And at the conclusion of the project review, I
15 think you said you -- you set a time limit and
16 you allow all the parties to make one final
17 submission of information; is that correct?

18 A: Yes. We establish a deadline for them to
19 submit additional information.

20 Q: And after that deadline comes and goes and you
21 get all of the information, that's when you
22 begin to make your -- begin the process of
23 making your decision; is that a fair statement?

24 A: Well, yes, sometimes people continue to give us
25 information.

1 Q: Okay.

2 A: In addition to the established deadline, I
3 guess.

4 Q: All right. Back to the question relating to
5 the competing applications, was it -- with this
6 particular review process, and I think you set
7 -- we'll look at this in a minute, November
8 28th as the deadline for submissions. Was it
9 after that date that you began making the
10 determination on whether these were competing
11 applications?

12 A: Yes, I would say primarily so. Certainly I'd
13 gathered a lot of information prior to that,
14 but that was when I really got down to
15 business, so to speak with the decision.

16 Q: In fact, I think it was you had requested at
17 the project review, you had requested that the
18 parties address in their post-project review
19 whether there was a need for one or two
20 machines.

21 A: Yes. I seem to recall at some point, it may
22 have even been during the project review, that
23 they address the applications in both manners,
24 competing and non-competing. It's been a long
25 time since I've looked at this, so I might not

1 be remembering correctly.

2 Q: All right. Well, we'll look at some of the
3 post-project review submissions and discuss
4 what was presented to you as far as the party's
5 positions on one versus two machines.

6 A: Okay.

7 Q: Let's look at the -- I'm going to refer you
8 back to the decision letter, which is in CRCC
9 Joint Exhibit 1, 655.

10 A: I'm sorry. What page, please?

11 Q: 655.

12 A: Okay.

13 THE COURT: Are we still in 1?

14 MR. MULLINS: Yeah. Well we moved to -- yeah.

15 CRCC, which is Joint Exhibit 1.

16 THE COURT: Okay.

17 Q: All right?

18 A: Yes, I'm there.

19 Q: Second paragraph there you, in essence, provide
20 a summary of what's before you. And what I
21 want to make sure that we are all on the same
22 page about and you've stated here, CRCC is
23 proposing to expand their services, correct?

24 A: Yes.

25 Q: And Grand Strand is proposing to add a new

1 service?

2 A: Yes.

3 Q: Correct?

4 A: Yes.

5 Q: Okay. And then you actually at the end of this

6 paragraph you discuss what's happening and

7 there's a reference here to a determination

8 that there are issues with exceeding the

9 service area need, right?

10 A: Yes.

11 Q: Okay. All right. And I want to talk a little

12 bit about competing applications. But before

13 we do that, let's -- I want to look at

14 something in your analysis. Let's go to -- all

15 right. 658 is the beginning of your analysis

16 of the applications, correct?

17 A: Yes.

18 Q: And if you turn over to 659, you quoted that

19 the excerpts from the standards, these are

20 pertinent standards out of the State Health

21 Plan?

22 A: Yes, they are.

23 Q: And you've got 1, 2, 6, 7, and 8, correct?

24 A: Yes.

25 Q: All right. And number 6, I want to talk about

1 this distinction between adding a new service
2 and expanding a service.

3 A: Okay.

4 Q: Number 6 is a standard that applies to new
5 radiotherapy services, correct?

6 A: Yes, it is.

7 Q: Okay. 6a and 6b, and that would have applied
8 to Grand Strand in this case, correct?

9 A: Yes.

10 Q: That would not apply to CRCC, right?

11 A: No, they were expanding.

12 Q: They're expanding. Okay. And the standard
13 that applies to the expansion of a service is
14 Standard 7, correct?

15 A: Yes, it is.

16 Q: Okay. Now, Standard 6A, what does Standard 6A
17 say?

18 A: 6A states that all existing units in the
19 service area have performed at a combined use
20 rate of 80 percent of capacity for the year
21 immediately proceeding the filing of the
22 applicant's CON application.

23 Q: All right. So the trigger point, if you will,
24 about -- in terms of the ability to file an
25 application is that if all of the units in a

1 service area have been performing at a combined
2 use rate in excess of 80 percent, that's ---
3 A: Yes, for the ---
4 Q: That opens the door?
5 A: Yes.
6 Q: Correct?
7 A: Yes.
8 Q: Now let's look at the expansion. Well let's --
9 hold on. Let's turn the page to 660. All
10 right. At the top of that page you've provided
11 that the historical utilization for the region
12 and for the individual providers, correct?
13 A: Yes.
14 Q: All right. And keep that highlighted on the
15 screen. But below that you've indicated that
16 the treatment capacity for CRCC's three units
17 that existed at the time was 19,000.
18 A: Yes.
19 Q: Correct?
20 A: Yes.
21 Q: Okay. And the plan provided that capacity for
22 Georgetown's linear accelerator was 7,000,
23 correct?
24 A: Yes.
25 Q: So the total capacity for the service area was

1 26,000, and that's what you've, you make that
2 statement in the paragraph, correct?

3 A: Yes.

4 Q: All right. And if you look at 2009, which you
5 did, you make a statement that the service area
6 utilization in 2009 was 80.5 percent of
7 capacity.

8 A: Yes.

9 Q: Correct?

10 A: Yes.

11 Q: All right. So based on Standard 6A, Grand
12 Stand could have applied for a linear
13 accelerator in 2010; is that correct?

14 A: Yes, that's correct.

15 Q: All right. In fact, you make a note of that
16 the next paragraph down, based on this data;
17 you see that?

18 A: Yes. Yes, I do.

19 Q: All right. Read the first two sentences.

20 A: Based on this data, the above Criteria 6A and
21 7 have been met. In fact, based upon the data
22 under Criterion 6A, both Grand Strand and North
23 Strand could have applied as a need facility in
24 2010, but did not.

25 Q: Okay. So you noted that they could have

1 applied earlier, but they did not?

2 A: Yes.

3 Q: Now, the fact that the service was above 80
4 percent for 2009 does not mean that anybody can
5 apply in 2010, does it?

6 A: No.

7 Q: Let's look at -- let's look at Standard 7.
8 CRCC, who is an existing provider that would be
9 expanding, what did they have to show before
10 they can file for an expansion?

11 A: The 80 percent capacity has to be achieved for
12 the past two years.

13 Q: For the past two years?

14 A: Yes.

15 Q: So their machines -- now this, it's for their
16 service, right?

17 A: Yes, their proposed expansion.

18 Q: But they have to be doing 80 percent?

19 A: Yes.

20 Q: For the two years prior before they can file an
21 application, correct?

22 A: Yes.

23 Q: All right. And I don't know if you need a
24 calculator. Do you want run the numbers? Do
25 you recall running the numbers and determining

1 whether CRCC could have applied in 2010?

2 A: CRCC?

3 Q: Yes.

4 A: Well, certainly the data was in the Health
5 Plan, and I have no doubt that I looked at it.

6 Q: Do you know whether 2008 if you take 14,000,
7 we've already established their capacity is
8 19,000, correct? CRCC?

9 A: Yes.

10 Q: All right. In 2008, you see they did 14,385?

11 A: Yes.

12 Q: You want to run that calculation and see what
13 that percentage is?

14 A: That would 75.4 percent.

15 Q: Which is less than 80 percent, correct?

16 A: Yes.

17 Q: So CRCC could not have filed an application in
18 2010, could they?

19 A: No.

20 Q: Now, when their 2010 data came in, it was above
21 80 percent, wasn't it?

22 A: Yes, it was.

23 Q: All right. And they filed their application in
24 the spring of 2011 after their data came in,
25 after the JARS were submitted, correct?

1 A: Yes.

2 Q: Let's talk about your determination relating to
3 whether approval of more than one would exceed
4 the need.

5 A: Okay.

6 Q: When you made the determination about whether
7 approval of two would exceed the need, you were
8 considering everything in the record,
9 everything that you had, correct?

10 A: Yes.

11 Q: Considered everything that's set forth in the
12 Grand Strand DHEC record and everything that's
13 contained in the CRCC DHEC record, Joint
14 Exhibit 1 and 2, as well as the North Strand
15 information, correct?

16 A: Yes.

17 Q: All right. And when you're making this
18 determination, you're also considering the
19 totality of the circumstances in the service
20 area; is that a fair statement?

21 A: Yes, I'm considering everything.

22 Q: And Standard 6 and 7 that we were just looking
23 at, those would be a factor that you would
24 consider in determining whether it exceeds
25 need, correct?

1 A: Yes. I mean we're certainly required to look
2 at the standards in the plan.

3 Q: Okay. And 6 -- or 6 which talks about new
4 services, 6B discusses that the applicant must
5 obtain 50 percent utilization within year three
6 without reducing the existing machines below 80
7 percent, correct?

8 A: Yes.

9 Q: And that's something that you would consider,
10 right?

11 A: Yes.

12 Q: And you considered that in this case?

13 A: Yes, I did.

14 Q: And let me ask you this. You've still got the
15 regulation up there in front of you?

16 A: Yes.

17 Q: Okay. Section 504.

18 A: Okay.

19 Q: That requires you to consider the State Health
20 Plan in effect at the time the application was
21 filed?

22 A: Yes.

23 Q: Okay. And that's what you did in this case,
24 you considered the 2010 and '11 State Health
25 Plan; correct?

1 A: Yes, that was the current plan at the time.

2 Q: Okay. All right. And Standard 8, I think you
3 said you considered the standards in
4 determining whether it exceeds the needs.
5 Standard 8 is another standard that requires
6 you to project utilization, correct?

7 A: Well, it requires the applicant to, yes.

8 Q: Right. I'm sorry. Requires the applicant.
9 All right. It also requires the applicant to
10 document referral sources and letters of
11 support indicating a willingness to refer
12 patients?

13 A: Yes.

14 Q: Including expected annual referral volumes,
15 correct?

16 A: Yes.

17 Q: All right. You considered that in terms of the
18 need analysis in determining whether they would
19 exceed the need, correct?

20 A: Yes, I looked closely at the referrals.

21 Q: Okay. And then there are other criteria that
22 we may look at in a minute within the
23 regulation that refer to need, correct?

24 A: Yes.

25 Q: In the -- in 61-15, Section 803.

1 A: Yes.

2 Q: Correct?

3 A: Section 803?

4 Q: Well, the section that the review -- there are
5 other review criteria that relate to need,
6 correct? Community need being one of them?

7 A: Yeah, Section 802.

8 Q: 802, I'm sorry. Community need, unnecessary
9 duplication of services, you heard Mr. Sullivan
10 say that that was a reflection of no need.
11 There are review criteria that relate to need,
12 correct?

13 A: Yes.

14 Q: All right. And you would consider that in
15 your review and determination as to whether
16 approval of two applications would exceed the
17 need, correct?

18 A: Yes. The criteria we chose were certainly
19 outlined in the complete letter.

20 Q: Okay.

21 A: Which is reflected in my analysis.

22 Q: All right. And you would also consider
23 peculiar or unique circumstances that may
24 factor into your analysis that may relate to a
25 specific service area in determining the impact

1 on the need?

2 MR. THOMAS: Your Honor, I object. I've given Mr.

3 Mullins a lot of latitude, but that's about as

4 leading question as you can get. And I think

5 he can ask open-ended questions. This is his

6 witness; it's not a cross.

7 MR. MULLINS: It's not my witness, but I'll ...

8 MR. THOMAS: Well, it's not a hostile witness. and I

9 think he knows he has to direct this witness.

10 THE COURT: I normally let individuals lead when

11 it's not their witness.

12 MR. THOMAS: Mr. Long and I battled this out before

13 Judge McLeod in the last case, Your Honor, and

14 ---

15 MR. MULLINS: Well, I wasn't a part of that, so.

16 MR. THOMAS: That's fine. But what I'm saying is

17 Your Honor ---

18 THE COURT: If you want to cite me a rule that

19 requires that but ---

20 MR. THOMAS: Well I can cite you a case if I had

21 some time. But Mr. Mullins is not allowed to

22 lead this witness unless it's more of hostile

23 witness. And this is not. This is a favorable

24 witness and a favorable ruling for their

25 client. He cannot lead this witness, Your

1 Honor.

2 THE COURT: Do you want to speak?

3 MR. MULLINS: Well, I don't know what her testimony
4 is going to be. It's not my witness. I'm
5 trying to question the witness.

6 MR. THOMAS: Your Honor, they prepared this witness.
7 They met with this witness. They talked with
8 this witness. They defended her deposition. I
9 mean they were at her deposition, Your Honor,
10 and they met with her.

11 THE COURT: Mr. Mullins?

12 MR. MULLINS: We did not defend her deposition. Her
13 attorney is over there. We represent CRCC.

14 MR. THOMAS: They met with the witness.

15 THE COURT: Unless you show me that case, I'm not
16 familiar with it. I've researched this a
17 little bit myself.

18 MR. THOMAS: All right.

19 THE COURT: Proceed.

20 Q: Okay. Ms. Brandt ---

21 THE COURT: If I could just add further, the rules
22 of evidence regarding hostile witnesses are
23 when an individual is permitted to cross-
24 examine their own witness. That rule doesn't
25 address the provisions of cross-examination.

1 All right.

2 MR. MULLINS: Thank you, Your Honor.

3 Q: Ms. Brandt, you recall in this particular
4 instance that there were applications that you
5 had considered and made a decision on relating
6 to relocation of two machines in the service
7 area; you recall that?

8 A: Yes, I do. I had made the decision for the
9 relocation of CRCC and the Francis B. Ford
10 Center. It was affiliated with Georgetown
11 Memorial.

12 Q: Okay. And that was to move, both of those
13 relocations were to relocate machines to the
14 Murrells Inlet area?

15 A: Yes.

16 Q: All right. And I think we've outlined it, and
17 I'll just ask you, during your review process,
18 were you concerned about how that would impact
19 the referral patterns within the service area?
20 I mean, you asked questions about and you've
21 looked at zip codes and specific utilization
22 from -- you asked for zip code analysis from
23 the existing providers, and that was one of the
24 reasons you did that, correct?

25 A: Yes, I was concerned and I did ask questions.

1 Q: Okay. All right. Let's look at Joint Exhibit
2 1, 626. I'm sorry. 623.

3 A: Okay.

4 Q: You read the first sentence there. And do you
5 recall what this letter is?

6 A: This letter, which is dated November 28, 2011,
7 is from Mr. Tolbert, and it states that it's a
8 follow up to the project review meeting.

9 Q: Okay. Is this one of the -- is this the post-
10 project review submissions that you were
11 referring to?

12 A: Yes, it appears to be. Yes.

13 Q: All right. And if you turn to Bates 626.

14 A: Okay.

15 Q: All right. You see section C?

16 A: Yes.

17 Q: Regarding the question of approving two linear
18 accelerators?

19 A: Yes.

20 Q: All right. What does it say there?

21 A: Well, it addresses the fact that they were
22 asked about potential to approve two linear
23 accelerators. and he enumerates his position on
24 that.

25 Q: Okay. All right. And number one, let's just

1 go through a couple of these enumerations.

2 Number one, he sets forth the position that
3 only one linear accelerator should be approved,
4 correct?

5 A: Yes.

6 Q: All right. Two is in essence referring to the
7 -- to the standard that we were talking about,
8 right?

9 A: Yes.

10 Q: All right. Number three, what is -- read the
11 first sentence of number 3.

12 A: Exhibit A presents the analysis if any two of
13 the applications are approved and shows that in
14 every case the utilization of the existing
15 units is below the 80 percent threshold.

16 Q: All right. And flip if you will, hold your
17 finger there, but flip if you will to 630. The
18 cover page of Exhibit A, 631 is actually where
19 I'm ...

20 A: Okay.

21 Q: All right. And I think if you flip back; but
22 I'll just represent to you that Mr. Tolbert
23 states that the first page represents the
24 backup for his analysis. Flip over to page
25 632.

1 A: Okay.

2 Q: Is this an analysis which looks at if CRCC and
3 North Strand are approved, what the impact
4 would be?

5 A: Yes, it is.

6 Q: All right. And you see the block that says
7 existing units below?

8 A: Yes.

9 Q: All right. Percent capacity, you see that
10 line?

11 A: Yes.

12 Q: All right. And go to year three, 2015, what
13 would the percent capacity of the existing
14 units be?

15 A: This states 70 percent.

16 Q: Okay.

17 A: Is his projection.

18 Q: Which would not meet the threshold of the
19 standard, correct?

20 A: Correct.

21 Q: All right. Flip over the page, 633.

22 A: Yes.

23 Q: Is that a scenario if CRCC and Grand Strand are
24 approved?

25 A: Yes, it is.

1 Q: And same thing if you look at the existing
2 units and you go over to the percent capacity
3 for the third year, what does that say?

4 A: For existing units it says 77 percent.

5 Q: That would not meet the Standard 6, would it,
6 the threshold?

7 A: No.

8 Q: And then the last page is a scenario if North
9 Strand and Grand Strand are approved; you see
10 that?

11 A: I'm sorry. What page would that be?

12 Q: 634, sorry.

13 A: I don't have page 634.

14 Q: Oh, you don't?

15 A: No.

16 Q: All right. That was an analysis with North
17 Strand, so instead of taking the court's time,
18 I'm going to move on. This was an analysis
19 that was submitted by Mr. Tolbert as part of
20 the post-project review submission, correct?

21 A: Yes, I recall. He did a lot of comparisons.

22 Q: Did you consider this information in terms of
23 your analysis?

24 A: Yes.

25 Q: All right. Flip back to the narrative of his

1 submission, which is 626.

2 A: Okay.

3 Q: All right. And the enumeration, the number

4 four, the fourth rationale for the issue of

5 approval of one linear accelerator; you see

6 that?

7 A: Yes. He discusses the Murrells Inlet

8 situation.

9 Q: Okay. And he says in this first sentence, he

10 states that it will naturally cause a shift in

11 the patient volume among the existing

12 providers?

13 A: Yes, he states that.

14 Q: All right. And then he goes on to discuss the

15 impact of approving two new machines without

16 historical data to address the shifts, correct?

17 A: Yes.

18 Q: All right. And he states that that would not

19 account for a true indication of the need in

20 the service area, correct?

21 A: Yes, that's what it states.

22 Q: And number five.

23 A: Yes.

24 Q: What is Mr. Tolbert telling you in number five?

25 A: He's talking about cost containment and that

1 CRCC's total project cost is significantly
2 less.

3 Q: What does he say on the next -- turn to the
4 next page.

5 A: He also states that the project can be brought
6 online in six months as opposed to 17 or 18
7 months, and he talks about that as far as the
8 health planning aspects of it and the
9 compliance with the CON Act.

10 Q: Okay. All right. And then he in number six,
11 just skip down. There's a reference to Mr.
12 Bailey; you see that?

13 A: Yes.

14 Q: All right. Who is Mr. Bailey and what is ...
15 what does this reference relate to?

16 A: Mr. Bailey is Bruce Bailey. He's the CEO of
17 the Georgetown Hospital -- probably the System.
18 I'm not sure if it's a hospital or if it's a
19 hospital system. But he is involved in
20 Georgetown. And he does raise the issue about
21 the impact upon his facilities with these
22 projects and the cost.

23 Q: All right. What did he say? Specifically,
24 read what he, what Mr. Tolbert is referencing
25 that he said in the project review meeting.

1 A: It says that he noted if the previously
2 approved linear accelerator projects in
3 Murrells Inlet are initiated and two additional
4 linear accelerators are approved for Horry
5 County, the total cost for additional
6 accelerators will exceed \$40 million. This
7 will represent an unreasonable cost and
8 unnecessary duplication of services.

9 Q: All right. Did you consider all of these
10 enumerated reasons in your consideration as to
11 whether approving two would exceed the need?

12 A: Yes. I consider any and everything that is
13 presented to me.

14 Q: Okay. All right.. Turn to 667 in the CRCC
15 Joint Exhibit 1.

16 A: Okay.

17 Q: All right. We were talking about Standard, I
18 think we were talking about Standard 9 earlier
19 about the documentation of referrals; do you
20 recall that?

21 A: Yes.

22 Q: All right. And if you look under -- this is
23 the Grand Strand section of your analysis in
24 your decision, correct?

25 A: Yes.

1 Q: All right. Read the third sentence in that
2 first section, many letters.

3 A: Many letters expressed a willingness to refer
4 but did not ---

5 THE COURT: Hold on a second. You're on page 667?

6 MR. MULLINS: Correct.

7 THE COURT: Oh, on Grand Strand. Okay. Go ahead.

8 A: Okay.

9 Q: All right.

10 A: Many letters expressed a willingness to refer
11 but did not quantify referral volumes. Mr.
12 Sullivan stated in most physician specialties
13 do not refer patients directly to radiation
14 therapy centers but typically a primary care
15 physician or a general surgeon upon diagnosing
16 cancer in a patient would refer the patient to
17 a medical oncologist to determine the most
18 appropriate type of treatment.

19 Q: All right. That's good. We talked about the
20 fact that the standard, Standard 8 required --
21 was a requirement that you quantify the
22 referral volumes, correct?

23 A: Yes.

24 Q: And you can look at it if you need to. And you
25 noted that they did not quantify their referral

1 volumes, correct?

2 A: Yes, I did.

3 Q: All right. And was that a concerning issue
4 with you because of the relationship with the
5 medical oncologists that you might be concerned
6 about what volumes would be redirected from
7 CRCC?

8 MR. THOMAS: Your Honor, before she answers, I've
9 kind of got at least a chance to read the rule
10 on the leading question. Again, this is a
11 direct examination, not a cross, and if you
12 look at Rule 611, mode and order of
13 interrogation presentation.

14 THE COURT: Let me go there.

15 MR. THOMAS: Yeah.

16 THE COURT: I don't -- when you say that this is a
17 direct examination, only one person calls a
18 witness. He didn't call the witness.

19 MR. THOMAS: I understand that. But because it's
20 not a witness in an adverse position to him, I
21 think the rule makes that clear that ---

22 THE COURT: And where do ---

23 MR. THOMAS: Okay. All right. 611(b), the scope of
24 cross. A witness may be crossed-examined on any
25 matter relevant to an issue, including

1 credibility. And then (c) leading questions
2 shall not be used on a direct examine except as
3 may be necessary to develop a witness'
4 testimony. Ordinarily, leading questions
5 should be permitted on cross. When a party
6 calls a hostile witness, an adverse party or a
7 witness identified with an adverse party,
8 interrogation may be by leading question.. I
9 think that -- this is not a hostile party to
10 them, and it's not an adverse party.

11 THE COURT: Well, my understanding of that rule is
12 when a party in direct examination calls a
13 hostile witness, and that's what I was
14 referring to earlier, you can ask leading
15 questions.

16 MR. THOMAS: I'm going to read State v. Hoffman,
17 Your Honor.

18 THE COURT: Well, give me the ...

19 MR. THOMAS: Let's look at ---

20 MR. CARTIN: It is 257 SC 461, pages 469 to 70.

21 THE COURT: Wait a minute. 461?

22 MR. CARTIN: Yes, sir.

23 THE COURT: All right. What page?

24 MR. CARTIN: It should be 469 to 470.

25 THE COURT: All right.

1 MR. THOMAS: All right. Your Honor, I believe it
2 says the reason for the rule permitting leading
3 questions to an adverse party, adverse witness
4 on cross is the assumed hostility of such
5 witness to the cross-examiner's cause, and
6 where an adverse witness is shown to be
7 friendly toward or biased in favor of the
8 cross-examiner, the reason for the rule ceases
9 to exist and leading questions may not be used
10 to examine such witnesses. State v. Hoffman.

11 THE COURT: All right. Any response to that?

12 MR. MULLINS: Well, I don't have the benefit of the
13 case, Your Honor. This is the decision maker
14 in this case.

15 THE COURT: Well, let me read it to you one more
16 time. The reason for the rule permitting
17 leading questions to an adverse witness on
18 cross-examination is the assumed hostility of
19 such witness to the cross-examiner's cause, and
20 where an adverse witness is shown to be
21 friendly toward or biased in favor of the
22 cross-examiner, the reason for the rule ceases
23 to exist and leading questions may not be used
24 in examining such witnesses. So the issue is
25 here is the witness friendly towards or biased

1 in favor of your position.

2 MR. MULLINS: Right. I think that there needs to be

3 -- I mean, she's testifying as a fact witness
4 as to the decisions that she's making. I don't
5 think there's any evidence that she is friendly
6 towards my client or biased towards my client.
7 She's testifying as to the facts as they
8 occurred.

9 THE COURT: I don't believe she's biased, I'll start
10 off with that. I don't think you made that
11 assertion. But since she has ruled in your
12 favor, I would think she would be friendly
13 towards your position because friendly doesn't
14 -- that doesn't go the ---

15 MR. MULLINS: Well, she's friendly towards the
16 Department. There's no question about that.

17 MR. THOMAS: Your Honor, I think the case speaks for
18 itself. She's up there. She's advocating the
19 position that is friendly. I think she's
20 friendly towards CRCC in this case. And as a
21 fact finder I think you'd want to probably find
22 out what she knows on kind of a direct kind of
23 scope, which is open-ended questions so we can
24 get to really how she made the decision and not
25 have the questions be leading her to ---

1 THE COURT: At this point in time, I'm going to
2 follow the reasoning of State v. Hoffman. I
3 haven't thought through -- you know, I did look
4 up South Carolina Am. Jur. and Wharton's on
5 leading questions, and I didn't find this
6 theory. But I don't believe it would be
7 prejudicial to require you to ask the direct
8 questions. So under the circumstances, I'm
9 going to require at this point in time from now
10 on that you not ask leading questions.

11 MR. MULLINS: All right, Your Honor. Your Honor,
12 given we're kind of at a stopping point, would
13 it be appropriate to take a five minute break
14 right now?

15 THE COURT: Yes, it would.

16 (Break from 3:16 p.m. until 3:26 p.m.)

17 THE COURT: Mr. Mullins?

18 MR. MULLINS: Thank you Your Honor.

19 BY MR. MULLINS:

20 Q: Ms. Brandt, if you would turn to Joint Exhibit
21 2, Grand Strand record 866.

22 A: Okay.

23 Q: You're there?

24 A: Yes.

25 Q: All right. What is this document?

1 A: This is a response from Mr. Sullivan dated
2 November 16, 2011. And it was responding to an
3 email requesting for a current index of support
4 letters and also categorizing the referral
5 information.

6 Q: This was something that was requested after
7 project review?

8 A: I'll have to check ---

9 Q: Or close enough?

10 A: --- check the date of project review, but yes,
11 this appears to be, yes.

12 Q: Okay. Read the third paragraph there, if you
13 will, for me.

14 A: GSRMC has the strong support of Coastal Cancer
15 Center, Coastal, the service area's largest
16 medical oncology practice as evidenced by
17 letters of support from six of its oncologists.
18 Prior to filing its application, GSRMC
19 discussed its plans with Coastal and they
20 indicated that they anticipated referring a
21 significant number of patients to its radiation
22 therapy program, if approved. The Coastal
23 letters do not quantify a specific number of
24 referrals. These physicians, however, serve
25 100 percentage of the cancer patients in Horry

1 County, and because Coastal's main office is
2 next to the GSRMC campus and many of its
3 patients receive chemotherapy treatment at the
4 main office, it is reasonable to conclude that
5 a significant percentage of Coastal's patients
6 from the service area will choose GSRMC for
7 radiation treatment.

8 Q: All right. Is that the information that was
9 provided to you that was reported in your
10 analysis, and I think you stated on direct that
11 you had taken to heart; is that the
12 information?

13 A: Yes. Yes, I had actually quoted some of this
14 response in my analysis.

15 Q: Okay. All right. And the second -- okay.
16 Second letter you received, turn to page 875.

17 A: Okay.

18 Q: Let me ask you this. The information that you
19 -- that you just read relating to the strong
20 support from the medical oncologists, what
21 impact did that have on your analysis and your
22 consideration?

23 A: I felt that that was huge because he stated
24 significant percentage. And, you know, Coastal
25 was the only game in town as far as

1 oncologists, and certainly they're currently
2 doing all their referrals to CRCC. So I was
3 very concerned about the shift in patients and
4 the adverse impact upon CRCC.

5 Q: All right. And that would necessarily -- would
6 that relate to the Standard 6 and the 80
7 percent threshold as well?

8 A: Well, it would certainly affect Grand Stand
9 proposing the new radiotherapy services. And
10 certainly, I was concerned with the impact upon
11 the reduction of the volumes at CRCC.

12 Q: All right. And whether CRCC would be doing in
13 excess of 80 percent after year three; is that
14 what you're referring to?

15 A: Yes.

16 Q: All right. Turn to page 875 if you will.

17 A: Okay.

18 Q: Is that the post-project review submission from
19 Mr. Sullivan?

20 A: Yes, it is.

21 Q: Let me ask you this. In Mr. Sullivan's
22 analysis or his submission, did he do any
23 analysis similar to Mr. Tolbert that showed
24 what the impact on the utilization of the
25 existing machines would be in year three?

1 A: I believe he probably addressed everything. I'm
2 flipping through it right now. He does have --
3 -

4 Q: There's a narrative. But is there any type of
5 analysis that was done similar to the -- to the
6 analysis that Mr. Tolbert did in his Exhibit A
7 that we went through?

8 A: I don't see that there were any similar tables
9 to what Mr. Tolbert did.

10 Q: All right. Let me ask you to turn -- all
11 right. Let me ask you to turn to page 878
12 within Mr. Sullivan's submission.

13 A: I'm sorry. 878?

14 Q: Yes.

15 A: Okay.

16 Q: Read the -- look at the -- you see the section
17 that deals with geographic location in the
18 paragraph underneath the bullet points there,
19 the last sentence in that paragraph.

20 THE COURT: That paragraph has already entirely --
21 well, that entire paragraph has already been
22 published in the record. I don't know if y'all
23 want to keep republishing it.

24 MR. MULLINS: All right. We'll move on, Your Honor.

25 THE COURT: And I can read.

1 MR. MULLINS: All right. Well, Your Honor, Mr.

2 Sullivan had some contrary testimony.

3 THE COURT: Well if you want to ask about it. I'm
4 just telling you it's already been published.

5 MR. MULLINS: Right.

6 Q: All right. Ms. Brandt, we've gone through a
7 number of factors and issues that relate to
8 need and the information that was submitted to
9 you during the review process, correct?

10 A: Yes.

11 Q: In terms of your consideration of whether
12 approval of two would exceed the need, if you
13 -- do you consider more than just Standard 6 in
14 your analysis as to whether they would exceed
15 the need?

16 A: I mean that was certainly of primary
17 consideration, you know, the standards in the
18 plan. But as my analysis and my letter says,
19 I mean, I can certainly quote that, I looked at
20 other things, such as the impact upon the
21 Murrells Inlet projects. I believe I used the
22 term collectively. I had said collectively
23 there are issues with exceeding the service
24 area need. But that was certainly, you know,
25 first and foremost was to consider the

1 standards in the plan.

2 Q: All right. But there were other factors,
3 including your referencing the conclusion
4 section in your analysis where you reference
5 the Murrells Inlet situation as an impact on
6 your decision?

7 A: Yes. I believe -- I know it's mentioned in the
8 conclusions. I'm not sure if it's mentioned in
9 other places. But yes, I certainly did mention
10 that in the conclusions.

11 Q: And if you -- if a -- if an applicant is, in
12 this situation, if you determine that an
13 applicant, the impact on the existing providers
14 reduces the existing providers below 80
15 percent, can there be need in that situation?

16 A: There would only be need for the one provider,
17 not for both.

18 Q: Okay. All right. Look at your decision
19 letter. I'm sorry. Why don't we go -- go to
20 the conclusion section of your analysis.

21 A: Okay.

22 THE COURT: What page?

23 MR. MULLINS: 675.

24 THE COURT: We're back on Exhibit 1?

25 MR. MULLINS: Yes.

1 Q: All right.. And I'm looking at the last
2 sentence of your analysis, staff concludes.

3 A: Yes.

4 Q: All right. And the first section there relates
5 to what we were just talking about, the
6 approval of one project. And Ms. Biggers had
7 asked you what the terms were that were in
8 parentheses, and I think that you stated those
9 were the references to the goals and purposes
10 of the CON Act, correct?

11 A: Yes.

12 Q: And I just want to make sure. Each of these
13 factors that you identify prior to the
14 parenthetical, you've made a determination that
15 the CR -- that that, those factors apply to
16 that parenthetical?

17 A: Yes. And they support how those items were
18 met.

19 Q: So those are specific findings as to how those
20 items would be met, those purposes and goals
21 would be met?

22 A: Yes.

23 Q: All right. Ms. Biggers had walked you through
24 some of the review criteria, and let me clarify
25 for the record, Ms. Brandt. If you'd go to

1 Bates 660 in Joint Exhibit 1 in your decision
2 analysis.

3 A: Okay.

4 Q: 660 and 661 you have outlined all of the
5 applicable review criteria; is that correct?

6 A: Well, these were the ones that were identified
7 in the complete letter as what we were going to
8 review the applications against.

9 Q: And that runs over to the top of page 662?

10 A: Yes.

11 Q: All right. And then with each of the
12 applications you've gone through and addressed
13 the review criteria; correct?

14 A: Yes.

15 Q: And with Ms. Biggers you indicated that with
16 regards to distribution and accessibility with
17 regards to Grand Strand and CRCC, which
18 applicant more fully complies with that review
19 criteria?

20 A: That would be CRCC.

21 Q: All right. And with regards to adverse effects
22 on other facilities, criteria 23a, which
23 applicant CRCC or Grand Strand more fully
24 complies?

25 A: CRCC.

1 Q: And cost containment, and you discuss some of
2 the -- why don't we look at Bates 674.

3 A: Okay.

4 Q: The second paragraph under cost containment.

5 A: Yes.

6 Q: Can you describe, I think you ran through a
7 couple of these, but can you describe each of
8 these and explain the significance as to how
9 that impacts cost containment?

10 A: While these all kind of speak to the lowest
11 total project cost, in other words, they're
12 using an existing building instead of building
13 from ground up, all things considered they have
14 the least total project cost, which is
15 substantially lower than the other projects,
16 around half the cost. It's only taking six
17 months to bring the new linac online, which is
18 a shorter time frame which would allow them to
19 serve patients quicker.

20 Q: Why is that important in this case?

21 A: Because CRCC is currently operating in excess
22 of capacity and they actually expanded their
23 working hours, I think somewhere it said maybe
24 12 hours to try to accommodate the need. So
25 that would help them, you know, offload to --

1 by having an additional linear accelerator and
2 offload some of the burden. They talked about
3 having discounts because of their company being
4 large and certainly a huge provider of services
5 and that supported them a lot of discounts. So
6 they did have quite a good deal it appeared on
7 the linear accelerator and other equipment.
8 They talked about sharing administrative
9 support and computer systems, which could speak
10 to economies of scale. And then they certainly
11 had a state of the art TrueBeam system. And
12 then they ---

13 THE COURT: A state of the art what?

14 A: TrueBeam, Varian TrueBeam system.

15 THE COURT: Oh, a TrueBeam.

16 A: And I also mentioned just the resources that
17 were available at the management of 21st
18 Century Oncology to help be, you know, more, I
19 guess, economical because they had
20 organizational support and clinical support and
21 financial support.

22 Q: And so with regards to the cost containment,
23 which applicant more fully complied?

24 A: CRCC.

25 Q: All right. Let me just direct you to your --

1 we'll finish with this. Let me direct you to,
2 back to your conclusionary paragraph, Bates
3 675. And the first sentence there, the last
4 paragraph is a reference to the fact that Grand
5 Strand is a hospital that doesn't have a
6 radiation therapy program. Did you consider
7 that in your review of the applications?

8 A: Yes, I did.

9 Q: All right. And was it -- did you consider the
10 representations made by Grand Strand that they
11 intended to develop a comprehensive cancer
12 program?

13 A: Yes, I did consider that.

14 Q: How did those two factors impact or relate to
15 your decision?

16 A: Well, I talked about those, and I also, as far
17 as accessibility, that I felt that this does
18 not improve the accessibility because they --
19 the CRCC project was in Conway, and that
20 improved accessibility to the different area
21 and to underserved populations. So I certainly
22 considered it but didn't feel that that was,
23 you know, overwhelming enough to make a
24 decision in their favor.

25 Q: Okay. Did you review this matter in the manner

1 in which customary procedures that DHEC has for
2 reviewing all CON applications?

3 A: Yes, I did.

4 Q: And your conclusion was that granting the CRCC
5 application would more fully comply with the
6 goals and purposes of the CON Act?

7 A: Yes, that was my conclusion.

8 Q: All right. Thank you.

9 MS. BRANDT - CROSS-EXAMINATION BY MR. THOMAS:

10 Q: Good afternoon, Ms. Brandt.

11 A: Hey, Mr. Thomas. Good afternoon.

12 Q: Let's see if we can get you out of here today.

13 A: Thank you.

14 Q: You would agree with me you're here today to
15 defend a decision that you made nearly three
16 years ago, correct?

17 A: I believe it's two years ago.

18 Q: I said nearly three years. It was in December
19 of 2010, or excuse me 2011. Very good, two
20 years ago. All right. And you would agree
21 with me that a lot can change in a two year
22 period, correct?

23 A: Certainly. Yes, it may.

24 Q: You're no longer the bureau chief of the CON
25 program or the division of Health Services; is

1 that right?

2 A: No. No, I'm not. And certainly there's, as
3 far as I've heard, not a CON program in
4 existence.

5 Q: Now, just a few things I want to get out of the
6 way. You've never been qualified as an expert
7 in healthcare planning or finance, have you?

8 A: No, no. We covered this in my deposition.

9 Q: Right. But unfortunately, I've got to get it
10 on the record here today.

11 A: Okay.

12 Q: So that's why I'm going to try to roll through
13 it. And you just admitted that you were the
14 reviewer on this case, right?

15 A: Yes.

16 Q: Okay. And you're not an accountant, right?

17 A: No.

18 Q: You've never been an employee or employed at a
19 hospital, have you?

20 A: No.

21 Q: Okay. And I think you testified that you'd
22 never been employed in a healthcare
23 organization other than DHEC, right?

24 A: That's correct.

25 Q: And prior to your role as the director of the

1 CON program, you had never drafted a CON
2 application, you'd never developed or drafted a
3 need analysis associated with a CON
4 application, correct?

5 A: No, I had not. But when I was hired into this
6 position, I certainly had a lot of skills that
7 transferred to running the program, and I had
8 done a lot of other analyses and had been very
9 heavily involved in regulatory areas,
10 development and implementation.

11 Q: But just so we're clear, you hadn't done a need
12 analysis, correct?

13 A: No.

14 Q: Okay. And you're aware -- you're aware just
15 from a big picture that Varian -- Varian sells
16 a lot of Clinac iX's, correct?

17 A: Yes, I believe they do.

18 Q: Okay. And a lot of Clinac iXs, for the record,
19 a Clinac iX is a linear accelerator unit,
20 correct?

21 A: Yes.

22 Q: That's the one that Grand Strand proposed to
23 get in the application, correct?

24 A: Yes.

25 Q: And you're aware that when CRCC replaced its

1 older linear accelerator in its Myrtle Beach
2 facility, I think in the earlier part of 2011,
3 they had actually replaced it with a Clinac iX
4 machine, correct?

5 A: Yes, I believe you're right.

6 Q: Even though at that time a TrueBeam was an
7 option, correct?

8 A: I would assume so.

9 Q: And you would agree that CRCC is not going to
10 place an inferior piece of equipment in one of
11 its locations, correct?

12 A: I believe they would very strategically analyze
13 what's the best equipment for that particular
14 area.

15 Q: Okay. And I think you're familiar with the
16 term comprehensive cancer treatment center,
17 correct?

18 A: Yes.

19 Q: And, in fact, you just admitted to Mr. Mullins
20 on the record that you considered Grant
21 Strand's verbiage in its application regarding
22 the comprehensive cancer center, right?

23 A: Yes, I certainly considered everything in every
24 application.

25 Q: I understand. And you're familiar with the

1 concept of a multidisciplinary team approach to
2 cancer treatment, aren't you?

3 A: Yes.

4 Q: Okay. And you would agree that that has --
5 that there is a value in delivering cancer
6 treatment in a comprehensive cancer setting in
7 a multidisciplinary team approach, right?

8 A: I believe that -- I think my letter says that
9 it can, yes.

10 Q: Okay. And I think you mentioned in your
11 deposition that there's a variety of cancer
12 care approaches in South Carolina, correct?
13 There's some linear accelerators that are in a
14 freestanding center and there's some are in
15 hospital based, correct?

16 A: Yes.

17 Q: Okay. Now, you would agree with me that, at
18 least with respect to the service area at issue
19 here, Georgetown, Williamsburg, and Horry
20 County, there's only one type of linear
21 accelerator type facility available, right, and
22 that's freestanding, correct?

23 A: Well, I know -- I don't believe Francis B. Ford
24 is attached, but it's certainly a part of that
25 system.

1 Q: It's a freestanding center, isn't it?

2 A: Yes.

3 Q: Okay. So if a patient or a physician desires
4 to have their cancer care, which may include
5 radiation therapy, in a hospital setting, that
6 currently does not exist in the service area
7 today, correct?

8 A: It would not exist in a hospital. There would
9 not be that capability physically in a
10 hospital.

11 Q: Now, I think you've got Joint 3, Joint Exhibit
12 3 over there in a cart. If you would grab that
13 for me. Make sure you've got that, Ms. Brandt.
14 And if you'd just turn into page II-67 for me
15 with that exhibit. Let me know when you get
16 there. Kind of an abridged bridge version.

17 A: Okay. Under tab three?

18 Q: Yes.

19 A: Okay.

20 Q: All right. And let's look at the -- at what
21 we've got there in terms of utilization for
22 Georgetown County and Horry County. All right.
23 Now, Georgetown Memorial Hospital, that's
24 Francis B. Ford, correct?

25 A: Yes.

1 Q: In 2004, there was what, 1,889 treatments?

2 A: Yes.

3 Q: And then it ramped up to 5,416 by 2006,
4 correct?

5 A: Yes.

6 Q: And do you understand Georgetown, that Francis
7 B. Ford is ACR accredited? Do you understand?
8 Did you know that?

9 A: I don't dispute it.

10 Q: And Horry County, that's where Carolina
11 Regional, it says radiation center, but that's
12 Carolina Regional Cancer Care, correct?

13 A: Yes.

14 Q: And what we see there is that even though it
15 says three units, they were doing 15,422, I
16 guess 15,770 and 14,032 actually dipped in
17 fiscal year 2006, correct?

18 A: Yes, and it states that they had added a
19 TomoTherapy unit.

20 Q: Well, they were approved for it, but it was
21 appealed and the CON was actually issued on
22 July 18, 2007, correct?

23 A: Yes.

24 Q: So these numbers here, 14,032, that reflects
25 utilization on two units, correct?

1 A: I believe you're right.

2 Q: Okay. Now, in the same book I think you've got
3 there, Ms. Brandt, if you'd turn to Joint
4 Exhibit 4 for me.

5 A: Okay.

6 Q: Let's go to IX -- go to IX-9.

7 A: Okay.

8 THE COURT: You've got to give me a second.

9 MR. THOMAS: No problem, Your Honor.

10 THE COURT: Joint 4?

11 MR. THOMAS: Yes, sir. Joint Exhibit 4.

12 THE COURT: I'm trying to highlight and you go so
13 fast I can't do my highlighting. All right.

14 MR. THOMAS: Okay.

15 THE COURT: What page again?

16 MR. THOMAS: Roman numeral IX-9.

17 THE COURT: Go ahead.

18 Q: And on that page if you kind of look at the
19 bottom, Georgetown in fiscal year 2007, 2008,
20 2009, they're all -- they're operating in about
21 5,400, you know, they spike up a little bit and
22 then they go back down to 5,305, correct?

23 A: Yes.

24 Q: And if you turn the page, Carolina Regional
25 Cancer Center, they go from 13,000 to 14,000 to

1 15,000, correct?

2 A: Yes.

3 Q: From basically 2007 to 2009. And if we flip
4 back to IX-8, because there's an 80.5 percent
5 need -- or excuse me, capacity in that service
6 area, that's an invitation for somebody to
7 apply for a CON, correct?

8 A: Yes.

9 Q: Okay. In the same book, if you'd flip over to
10 Joint Exhibit 5 for me, page IX-9. And this is,
11 for the record, the 2012-2013 State Health
12 Plan.

13 A: Okay.

14 Q: All right. And again, let's start with
15 Carolina Regional Cancer -- let's do Ford.
16 Ford is 5305 in 2009.

17 A: I'm sorry, Mr. Thomas, what page?

18 Q: I'm sorry. IX-9.

19 A: Okay.

20 Q: All right. And we have there again 20 --
21 excuse me. If I can find my place. Yeah,
22 Region 3, Carolina Regional Cancer Center is
23 15,613 in the fiscal year 2010 is 20,946 and
24 that's the last year of data you had, correct?

25 A: Yeah. Yes, my decision was not based on this

1 particular Health Plan.

2 Q: But then in fiscal year 2011, what happened at
3 Carolina Regional Cancer Center?

4 A: The volume increased.

5 Q: By up to 25,709, correct?

6 A: Yes.

7 Q: And you would agree with me that on this page
8 here, that makes CRCC the highest volume
9 provider of radiation therapy in the state of
10 South Carolina, correct?

11 A: It's certainly the greatest number on this
12 page, yes.

13 Q: And that's more than -- that's more than MUSC
14 Medical Center, the state's premiere academic
15 medical school, correct?

16 A: Yes, and certainly they have different types of
17 equipment there.

18 Q: MUSC has five linear accelerators and CRCC has
19 three, right?

20 A: Yes, but they don't have necessarily the same
21 type of equipment.

22 Q: CRCC is higher than MUSC, you don't -- you
23 don't deny that, correct ---

24 A: No.

25 Q: --- in terms of volume? All right. Now, and

1 Ms. Brandt, at the time that you made your
2 decision, you made your decision on, was it the
3 last business day of the year, December 28,
4 2011?

5 A: I know it was -- that's certainly quite
6 possible. I don't really recall what day of
7 the week that was.

8 Q: Okay. But you didn't have the benefit of the
9 volumes that are in the State Health Plan,
10 right? The 2012-2013 State Health Plan,
11 correct?

12 A: No, it was not in effect.

13 Q: You had no projections based on ten months of
14 data from CRCC, did you, from 2011?

15 A: No, they wouldn't have been required to do
16 that.

17 Q: They weren't required to but they could have,
18 correct?

19 A: They could have done any -- I really can't
20 answer. They could submit anything they want
21 to.

22 Q: They didn't -- the volumes that you got as late
23 as November 2011 were the volumes they
24 projected back in February, correct?

25 A: I'm sorry.

1 Q: The volumes that you were being led to believe
2 that were being done -- would be done for 2011
3 were the same volumes you had back in February
4 when they applied, correct, 22 and change for
5 2011? We can look at it if you want.

6 A: I just don't recall having 2011 projections.
7 I recall having the 2010.

8 Q: Okay. Well, let's go to CRCC, you'll need to
9 go to Joint 1, and go to page DHEC record 23
10 for me. And there's a page, Table 13, and it
11 states, CRCC Myrtle Beach 2011. What was the
12 treatment volume CRCC provided you?

13 A: If you could give me a minute ---

14 Q: Sure.

15 A: --- to see if these are projections or actual.

16 Q: Well, we know they submitted the application in
17 March of 2011, correct?

18 THE COURT: Are you at the top or the bottom of that
19 page?

20 MR. THOMAS: The top, Table 13, Your Honor.

21 THE COURT: I see.

22 A: It appears to be these are estimates.

23 Q: Right, projections, the 2011 projection that
24 you got.

25 A: Yes.

1 Q: Was 22,419, correct?

2 A: Yes.

3 Q: And I'll tell you, turn with me in the same
4 DHEC record, Joint 1, page 623.

5 A: Okay.

6 Q: That's a letter from Mr. Tolbert, who's in the
7 room right now. Strategic Directions, November
8 28, 2011. Basically that's 11 months of the
9 year that's been completed. And go to Exhibit
10 A for me on page 631.

11 A: Okay.

12 Q: Okay. And then down at the bottom of the page,
13 one, two, three, four, it says CRCC projections
14 in its CON application, right?

15 A: Yes.

16 Q: 2011, hat's the same exact number, correct?

17 A: Yes, it is.

18 Q: Okay. So Mr. Tolbert still relied on a
19 projection that was made back in February of
20 2011, right?

21 A: Yes.

22 Q: Even though we now know looking at the State
23 Health Plan, the 2012-2013 State Health Plan,
24 CRCC did well over 25,000 treatments in 2012 --
25 I mean, 2011 correct? And we know that; that's

1 what they reported?

2 A: Yes, I'm not disputing that. That, again, they
3 were making projections and that was not the
4 plan that I had to make the decision under.

5 Q: I understand that. I'm not accusing you of
6 anything. I'm just saying that's what they
7 did, they represented those were still the
8 numbers from 2011, correct?

9 A: Yes.

10 Q: Let's go to Joint Exhibit 13 if we could. And
11 that's going to be the Murrells Inlet
12 application.

13 A: I don't believe I have that. Could you direct
14 me to it.

15 Q: Here you go, that's it.

16 A: Oh, I thought you said 13. I'm sorry.

17 Q: Yeah, it is, it's Joint Exhibit 13, but it's in
18 Exhibit Notebook 5.

19 A: Okay. Thank you. Okay.

20 Q: And we may not even have to open this, but just
21 in case we do, back in 2011, do you recall
22 evaluating the CON application that was filed
23 by Georgetown to relocate one of its
24 radiotherapy unit or its only radiotherapy unit
25 from Georgetown up to Murrells Inlet?

1 A: Yes.

2 Q: Basically near its Waccamaw campus, right?

3 A: Yes.

4 Q: And you also evaluated a CON application that
5 was filed after Georgetown's CON application,
6 that was CRCC's, correct, to relocate one of
7 its CONs from its Myrtle Beach facility down
8 into Georgetown County, right?

9 A: Yes, their -- yes, linear accelerator, yes.

10 Q: About a half a mile away from the Georgetown
11 relocation?

12 A: Yes.

13 Q: Okay. And at that time when you did that, when
14 you approved those two relocations, did you
15 realize that the proposed relocations were
16 actually going to be in the very same zip code?

17 A: Yes, I did.

18 Q: Okay. And you would agree with me that those
19 two facilities have overlapping service areas,
20 right? Because they're right -- they're both
21 going to be right in here right, 29576? And
22 they're going to be about a half a mile from
23 each other, right?

24 A: Yes.

25 Q: Okay. You would agree that their service areas

1 are overlapping; is that a fair statement?

2 A: Yes, but certainly I concluded when I made my
3 decision that the -- I looked at the referral
4 patterns and that was a distinction as well.

5 Q: Okay. Well, we're going to talk about that.
6 Now, you would agree with me, Ms. Brandt, that
7 with respect to the State Health Plan and the
8 determination of need for a linear accelerator,
9 kind of first and foremost, but this
10 mathematical formula in the health plan that
11 Les does, that is what determines a need for a
12 new unit, correct?

13 A: Yes, I mean it's based upon very specific
14 information from the Joint Annual Report and
15 population data.

16 Q: Okay. And at the end of the day, would you
17 agree that the 2012-2013 State Health Plan, no
18 matter how you cut it up, there's a big --
19 there's a big bold need under the column un-met
20 need for Georgetown, Horry, and Williamsburg
21 County in the 2012-2013 State Health Plan; you
22 would agree with that?

23 A: Yes.

24 Q: Okay. Now, when you were evaluating the CON
25 applications in this case, you knew that in

1 2010 that the utilization in the service area
2 was all the way up to about 26,460 treatments
3 or so; is that fair?

4 A: Yes.

5 Q: And that was based on four units operating in
6 the service area, right? So there's at CRCC,
7 the tomo plus I guess the other two, and the
8 one at Georgetown, correct?

9 A: Yes. And I certainly asked CRCC about the
10 increase in volume.

11 Q: Okay. And so if -- and so the capacity of
12 those four units was 26,000 treatments because
13 I think the tomo was going to be operating at
14 5,000 and the other three were at seven, right?
15 So that gets us 26,000?

16 A: Yeah, I think that's right.

17 Q: Okay. So based on the math we just did, in
18 2010 you've got the four units you're going to
19 be operating at 102 percent, correct?
20 Thereabouts meaning you've got 26 -- 26,461
21 treatments divided by 26,000, right? It's more
22 than 100 percent, isn't it?

23 A: That sounds correct.

24 Q: Now would you -- would you agree with me that
25 if no one would have applied under the 2011-

1 2012 State Health Plan, that there could have
2 been a need for two linear accelerators in the
3 2012-2013 State Health Plan based on the
4 utilization as set forth in the plan? Meaning
5 that 31,902 treatments were going to be done,
6 correct, were actually done in that service
7 area?

8 A: Yeah, I mean I -- I agree. I mean that's a
9 hypothetical, and I really didn't have that
10 scenario to deal with.

11 Q: Okay. Well, you know what we'll see if we --
12 we've got this whiteboard over here. And let's
13 see here. And so let's do -- I just want to
14 do a little math. Would you pull out Joint 5
15 for me.

16 A: Okay.

17 Q: Okay. And the total area treatments ...

18 THE COURT: Page number?

19 MR. THOMAS: IX-8, Your Honor.

20 Q: Total treatments 31,902, correct?

21 A: Hang on a second, Mr. Thomas, what page are you
22 on? In Exhibit 13 you said?

23 Q: IX-8.

24 MR. CARTIN: Exhibit 5.

25 Q: Oh, Exhibit 5. I'm sorry. The page in Exhibit

1 5 is IX-8.

2 A: Okay.

3 Q: Okay. So we're there. So did I write down
4 correctly for the Georgetown, Horry,
5 Williamsburg County area 31,902 total
6 treatments? I'm going to use TX for treatments
7 there.

8 A: Yes.

9 Q: Okay. And so at 26,000 -- well, let's talk
10 about this. It says number of linacs there are
11 five, right?

12 A: Yes.

13 Q: Four. Okay. But we know there's only four in
14 operation, correct?

15 A: Yes.

16 Q: Okay. So of the four that are in operation,
17 would you agree with me three have capacity of
18 7,000 and one has five, so the capacity there
19 is going to be 26,000; is that fair?

20 A: Yes.

21 Q: I'm just going to say cap. All right. So if
22 we do 31,902 divided by 26,000, we get what?
23 I've got 122.7 percent; does that sound about
24 right?

25 A: Yeah, sounds about right.

1 Q: Okay. We know that's the capacity based on
2 these numbers in 2011. All right. Now, let's
3 add two brand new units operating at full
4 capacity in year one. All right. So we talked
5 about the Grand Strand unit. Let's talk about
6 the unit in CRCC-Conway. So we're going to say
7 -- Grand Strand said 5,000 for its unit and
8 CRCC believes it can run at a higher level,
9 7,000, correct?

10 A: Yes.

11 Q: So that's 12,000, right? That's 12,000
12 treatments if both of those are operating at
13 capacity. Is that a fair statement?

14 A: Yes.

15 Q: Okay. So we know that the new capacity number
16 has to be what, 38,000, correct? At 12,000
17 operating at full capacity, plus you've got the
18 other four, and we're talking about six linacs,
19 12,000 treatments, right?

20 A: Yes.

21 Q: So the capacity in the service area if you had
22 to prove the other one and they work at the
23 same time in 2012, we're talking about 31,902
24 divided by 38,000, correct? And that's 84
25 percent, right? Based on the 2011 numbers you

1 had two operating at full capacity in the very
2 first year. That service area is operating at
3 84 percent, isn't it?

4 A: I mean, I see what you're trying to
5 demonstrate, but I mean, you're using the
6 capacity and not the projections or not the
7 actual data.

8 Q: Yeah. In fact, the number of treatments would
9 probably be less, wouldn't it?

10 MR. MULLINS: Your Honor, I'm going to object. You
11 know, Ms. Brandt has not been qualified as an
12 expert. He's run her through a pretty technical
13 hypothetical and asking her opinion ---

14 THE COURT: Well ---

15 MR. MULLINS: --- with regards to something that has
16 not occurred, and it's futuristic in terms of
17 what she did in terms of ---

18 THE COURT: I agree with you and I disagree with
19 you. I agree with you she's not an expert.
20 She can't give an opinion. And I'd have to go
21 back and read his questions. He can ask about
22 what the Department would do. And I thought
23 that's why he was asking it from that
24 perspective, but he can't ask her as an expert.

25 MR. THOMAS: I'm not asking her as an expert. I'm

1 just asking her based on the numbers in the
2 2012-2013 State Health Plan there would show a
3 need for two if one hadn't been approved. And
4 clearly, even if they're both operating at full
5 capacity, at 84 percent there will still be
6 need. That's all I'm asking. She made a
7 decision on ---

8 THE COURT: You can only ask it from the Department's
9 perspective of what their analysis and how
10 they're going to analyze it in terms of what
11 you ---

12 MR. THOMAS: Okay. Fair enough. I can do that.

13 Q: So, Ms. Brandt, from the Department's analysis,
14 it would be a need and technically even if both
15 units were operating at full capacity, and you
16 had the total capacity at 26,000, even with two
17 operating at full capacity, you'd still be 84
18 percent ---

19 A: Well, I don't believe that's the Department's
20 analysis. I believe it's yours. But, I mean,
21 again that's not how things were done in the
22 health plan.

23 Q: Well, I understand that. But you don't
24 disagree that's the percentage there, do you?

25 A: I don't disagree with the math.

1 Q: Okay. Thank you. Now I'm going to hand you --
2 I've got some interrogatory responses from the
3 Department, and I'm just going to ask you about
4 some of this, sworn statements, some of these
5 answers. Now, I want to talk about the very
6 response to the interrogatory where Grand
7 Strand asks the Department, Is CRCC's project
8 superior to Grand Strand's proposed project for
9 the following project review criteria, and if
10 so, how is it superior for each project review
11 criteria. And as compliant with the need
12 outlined in the plan, community need
13 documentation, accessibility, all of the
14 different project review criteria, correct?

15 A: Yes. And Mr. Thomas, I also want to point out,
16 and this is reflected in my deposition, that
17 the day of this document was after I left DHEC,
18 and I didn't necessarily recall drafting some
19 of these answers.

20 Q: All right. Well, I mean this is the
21 Department's statement that I have to go on.

22 A: Yes. Yes, it is.

23 Q: Thank you. And you would agree with me if you
24 read the first answer there that CRCC's project
25 was superior to Grand Strand's with regard to

1 accessibility, correct?

2 A: Yes.

3 Q: And there was an implementation time of
4 approximately six months was the quickest of
5 all applications, so you mentioned that. And
6 that was mentioned by the Department, correct?

7 A: Yes.

8 Q: And then it says, Further, CRCC's proposed
9 Conway location, which is centrally located
10 within the service area, improves geographic
11 accessibility, correct?

12 A: Yes.

13 Q: Accessibility, project implementation time,
14 accessibility again and then there's a
15 reference to improved access to residents of
16 Conway and Loris, correct?

17 A: Yes.

18 Q: Or lower socioeconomic. So accessibility was
19 definitely a focus of the Department; you would
20 agree with that in terms of the decision?

21 A: Yes. It was one of many, but yes, it was.

22 Q: Okay. And in terms of the approving access to
23 lower socioeconomic status residents, you would
24 agree that based on CRCC's CON application that
25 the improvement to access on average for those

1 lower socioeconomic patients was about ten
2 minutes one way travel time, correct? And
3 that's what was listed in the application,
4 right?

5 A: I believe you're right.

6 Q: Okay. And you would agree with me that in
7 terms of access for those lower socioeconomic
8 patients that even with the establishment of
9 CRCC-Conway that those same patients would not
10 have any access or any improved access to a
11 hospital-based linear accelerator, correct?

12 A: Well, there would not be one in existence.

13 Q: And they would have no improvement in access to
14 a comprehensive cancer treatment program, would
15 they?

16 A: No, but they would certainly have improved
17 access to radiation therapy services.

18 Q: To a freestanding radiation therapy center that
19 will save them on average ten minutes of travel
20 time one way, correct?

21 A: Yes.

22 Q: Okay. And you would agree with me that CRCC in
23 its CON application mentions nothing about the
24 provision of comprehensive cancer treatment,
25 correct?

1 A: No, that's not part of their proposal.

2 Q: And that's not what they do, is it? They do
3 one service line, which is linear accelerators,
4 correct?

5 A: Yes, to my knowledge. Yes.

6 Q: Okay. Now let's look at INT, interrogatory
7 number 2. Can two linear accelerators be added
8 to the applicable service area given the
9 current and projected utilization of
10 treatments? If not, explain why not. You see
11 that?

12 A: Yes.

13 Q: And you would agree with me that -- I think I
14 asked you at your deposition about this
15 question, and you said well, there was a
16 potential as stated here in the answer while
17 the potential exists for two to be added, the
18 Department determined that the State Health
19 Plan only allowed for one, right?

20 A: Yes.

21 Q: That's what you said. So you recognize there
22 was a potential, but at your deposition you
23 stated well, you know, I made the decision
24 based on the information I had at the time,
25 correct?

1 A: Yes.

2 Q: And at least when this interrogatory had been
3 drafted, you were aware at that time that I
4 think the record -- the date on the record
5 February 4, 2013, that at that time, the new
6 State Health Plan came out and said there's a
7 need for another one in the service area,
8 another linear accelerator in the service area,
9 right?

10 A: Yes.

11 Q: Okay.

12 A: But as I stated several times, that wasn't the
13 plan that I had to use to make my decision and
14 that data was not out.

15 Q: Well, the data hadn't been published in a JAR
16 report, correct?

17 A: Correct.

18 Q: Let's go to interrogatory number three.

19 A: Okay.

20 Q: All right. And this one asks beyond mentioning
21 the fact that there are overlapping service
22 areas in the Department's December 28, 2011,
23 letter denying Grand Strand's CON application,
24 we asked, Explain in detail how Grand Strand's
25 linear accelerator would have a substantial

1 negative impact upon the approved but appeal
2 relocated Francis B. Ford Cancer Center; do you
3 see that?

4 A: Yes.

5 Q: As well as CRCC Myrtle Beach. Okay. You see
6 that?

7 A: Yes.

8 Q: Okay. Now, you would agree with me that the
9 Department actually never actually determined
10 that Grand Strand would have an adverse impact
11 on Georgetown's relocated linear accelerator,
12 correct? You only said here in the application
13 that you determined, look in the second
14 paragraph, that it was plausible that Grand
15 Strand's proposed project could in -- I mean in
16 quotes, have a substantial negative impact on
17 the relocation -- relocated Francis B. Ford
18 Center; is that right?

19 A: I looked at the overlapping zip codes. There
20 was information supplied to support that there
21 could be an effect upon these linear
22 accelerators, and I did look at the overlapping
23 zip codes. I don't recall all the detailed
24 numerical values, but it was something that
25 certainly got my attention.

1 Q: Overlapping zip codes, correct?

2 A: Yes.

3 Q: Okay. But here, I mean, I didn't misrepresent
4 anything from the response from DHEC in the
5 interrogatory, did I? It said that after
6 reviewing the application, the Department
7 determined that it was plausible that Grand
8 Strand's proposed project could, and that's in
9 quotes, have a substantial negative impact,
10 correct?

11 A: That's what this response states. Again, I was
12 very concerned about it, plus the fact that
13 Grand Strand was a new provider in the market.

14 Q: You thought it was a possibility, right?
15 That's what you thought? That's what you're
16 saying?

17 A: Well, it was not that I looked at the zip codes
18 and I was concerned enough to have it in my
19 analysis.

20 Q: Well, in terms of the zip codes, you saw Dan
21 Sullivan's analysis. I mean, he made a
22 projection of how many treatments Grand Strand
23 would do by year three of the application,
24 correct? I mean, you saw that?

25 A: Yes.

1 Q: Okay. And Mr. Sullivan stated that most of the
2 utilization would be new, correct?

3 A: Yes.

4 Q: Okay. Incremental, right?

5 A: Yes.

6 Q: All right. And you would agree with me that
7 there's no way around it? I mean, CRCC is the
8 only game in town in all of Horry County,
9 correct?

10 A: Yes, but not in the service area.

11 Q: Okay. I understand that. But it's the only
12 game in town in Horry County and it by far does
13 more treatments than Georgetown, correct?

14 A: Yes.

15 Q: Okay. And Georgetown is located way down here
16 40 miles to the south from Grand Strand,
17 correct, currently?

18 A: Yes, but the CON application I approved was the
19 relocation to Murrells Inlet.

20 Q: Okay. And you know that's still mired in
21 litigation, right? I mean that case isn't even
22 set to try until 2014, right?

23 A: I know. But I made the decision to allow the
24 relocation is my point.

25 Q: Okay. And you would agree with me, Ms. Brandt,

1 that no matter what Grand Strand's analysis
2 said, I mean most of the patients that it's
3 going to get would had otherwise gone to CRCC,
4 right?

5 A: Yes, yeah, I would say most. Certainly there's
6 provisions for in-migration.

7 Q: Correct. But that's a small number compared to
8 the overall amount; would you agree with that?

9 A: Yes, but it's certainly something.

10 Q: Would you agree with me it doesn't make much of
11 a difference where the patients would have gone
12 if they're incremental? I mean, if they're
13 incremental patients, like Mr. Long said
14 earlier today, they're not anybody's patients,
15 right?

16 A: Right, but certainly Coastal Cancer Center is
17 the only oncology group. So at some point they
18 would more than likely end up there seeking a
19 referral onto another, -- to you know, a
20 certain amount would need to have some type of
21 radiation therapy.

22 Q: And just for the record so we get this in, you
23 never spoke to any physician at Coastal Cancer
24 Center, correct, when you were reviewing these
25 applications, right?

1 A: No, I relied upon what was submitted to me by

2 ---

3 Q: Right. You got letters of support from Coastal
4 Cancer Center for not only Grand Strand's
5 project, but for CRCC's project and North Grand
6 Strand's project, correct?

7 A: Yes, I did.

8 Q: Because those physicians have medical staff
9 privileges at Loris, Conway, Georgetown, and
10 Grand Strand, correct?

11 A: I believe you're right.

12 Q: Now, you would agree with me that you didn't
13 have a specific total treatment number in mind
14 in terms of what CRCC could withstand to lose
15 when you made the decision that it was
16 plausible that Grand Strand could have an
17 adverse impact on CRCC, correct?

18 A: I looked at the projections. I looked at how
19 many patients there were -- there was estimated
20 to, you know, the incremental patients, and I
21 looked at a lot of different things, and from
22 what Grand Strand proposed, they said they
23 would only take away 26 patients, I believe was
24 the number. And I just didn't buy that number.

25 Q: Okay. Did you do a specific calculation to

1 determine what the number would be that they
2 would take away?

3 A: I looked at what was proposed to me. But I
4 personally didn't do a specific calculation.

5 Q: You would agree with me that CRCC never
6 presented you with an adverse impact analysis
7 during the entire review process showing what
8 Grand Strand's adverse impact, specific adverse
9 impact would be if CRCC were not approved and
10 Grand Strand was approved, correct? You never
11 presented that analysis?

12 A: I believe you're correct. I believe Mr.
13 Tolbert looked at pairs of applicants.

14 Q: He only looked at what the adverse impact would
15 be if two were approved, correct?

16 A: Correct.

17 Q: Okay. And even then he didn't call it adverse
18 -- well, he may have called it adverse impact,
19 but what he was looking at as the 80 percent
20 threshold to see if two new providers would
21 bring the existing providers under an 80
22 percent threshold; is that a fair statement?

23 A: Yes. I mean that's certainly adverse impact.

24 Q: But never quantified, you never saw anything
25 from CRCC that showed anything quantified from

1 a financial perspective of what the adverse
2 impact would be to CRCC if Grand Strand were
3 approved, did you? You never saw it?

4 A: No, there wasn't a financial quantification by
5 any of the applicants.

6 Q: And CRCC, even though Grand Strand made no
7 secret in its application that it was relying
8 on referrals from the medical oncologists,
9 correct, because the urologists are bought and
10 paid for, correct? They're not getting any
11 from the urologists?

12 A: I'm not going to agree with that
13 characterization.

14 Q: Okay. Well, you would agree with me the
15 urologists are employed by AUC, correct?

16 A: Yes.

17 Q: And AUC owns Carolina Regional Cancer Center,
18 correct?

19 A: Yes.

20 Q: Okay. And you would agree with me that CRCC
21 never presented the Department with any
22 analysis at all indicating how many referrals
23 CRCC would lose from Coastal Cancer Center if
24 Grand Strand was approved? You never saw that,
25 did you?

1 A: No, but I did see where they had indicated
2 specifically by each doctor, I believe it was
3 a history of patient referrals. So I was able
4 to look at that listing and see how many were
5 Coastal Carolina Cancer Center doctors.

6 Q: Coastal Cancer Center. Coastal Cancer Center.

7 A: Coastal Cancer Center doctors.

8 Q: They just showed you the number of referrals
9 they got in 2011, correct?

10 A: I believe it probably was 2011. I'm not sure
11 about the year.

12 Q: Okay. Well, it was a 12 month period starting
13 in I believe November 1st, 2010, through
14 October 31st, 2011, correct?

15 A: Probably so. I know, too, that Mr. Sullivan
16 was very clear about the -- that there would be
17 a substantial effect as far as those doctors.
18 Significant I think was his word, and that's in
19 my analysis.

20 Q: But he never said there would be a substantial
21 effect on CRCC, did he, or Georgetown's
22 existing operation, did he? He just said that
23 out of the 4,620 treatments, a good number of
24 those were going to come from medical
25 oncologists, correct?

1 A: Yes, but they were the only other providers.

2 So we had to assume that's where they would
3 come.

4 Q: Well, but he also told you that he assumed that
5 100 percent of the urology referrals were going
6 somewhere else, correct?

7 A: I'm not sure if he said that or not.

8 Q: Okay. Well ---

9 A: He probably did. I just don't recall.

10 Q: No, that's all right. That's why we do that.
11 Mr. Mullins I think referenced in a letter that
12 Mr. Sullivan wrote. I'm looking in Joint 2.
13 And I don't have the page number here. One
14 second. Go to Joint 2, page 866 for me.

15 A: Okay.

16 Q: All right. Are you there?

17 A: Yes.

18 Q: Okay. Now, this is the letter I believe that
19 Mr. Mullins directed you to. And if you look
20 on page 867 ---

21 A: Yes.

22 Q: --- that last paragraph, read what Mr. Sullivan
23 wrote there.

24 A: Okay. I see where he does mentions, I expect
25 that nearly 100 percent of urological referrals

1 are now going and would be expected in the
2 future to go to CRCC.

3 Q: Okay. And ---

4 THE COURT: Just for the record, that's the next to
5 the last paragraph, I think.

6 MR. THOMAS: You're correct, Your Honor. Thank you.

7 THE COURT: One sentence paragraph.

8 MR. THOMAS: Yes, sir.

9 Q: And you would agree, Ms. Brandt, that based on
10 the referral data that you received from CRCC
11 that the urologists had something like 360
12 referrals out of 1,000, correct?

13 A: That's sounds right.

14 Q: Okay. So about 36 percent of the patient
15 referrals, right?

16 A: Yes, that sounds right.

17 Q: And the medical oncologists were actually less
18 that year, correct?

19 A: I don't remember what their figures were.

20 Q: I think we went over this in your deposition,
21 but you realize that Coastal Cancer Center has
22 an office in Loris, an office in Conway, an
23 office in Myrtle Beach, an office in Murrells
24 Inlet and wherever Supply, North Carolina is,
25 correct? There are five offices in the service

1 area. Is that your understanding?

2 A: I believe you're right. I mean, I recall them
3 mentioning putting an office near the proposed
4 North Strand location. But if -- I mean, I'm
5 not disputing that.

6 Q: Okay. And you would agree with me, Ms. Brandt,
7 that again, Grand Strand never tried to hide
8 the fact that it was going to try to -- try to
9 get referrals from Coastal Cancer Center,
10 right? I mean, it mentioned Coastal Cancer
11 Center by name not only in the application but
12 in submissions to the Department following the
13 application, correct?

14 A: Yes.

15 Q: And you would agree with me, Ms. Brandt -- if
16 you want to flip to the project review meeting
17 slides for CRCC-Conway and basically start on
18 page 578 of Joint Exhibit 1. Okay.

19 A: Okay.

20 Q: You were at project review, correct?

21 A: Yes.

22 Q: Okay. And if you would go down to page -- I
23 believe it's 586 of Joint 1. It's in those
24 slides.

25 A: Okay.

1 Q: Okay. One thing, kind of a major point that
2 CRCC made at the project review meeting was
3 that they -- right here, greatly improved
4 provider relations and reversed historic
5 patient outmigration, right?

6 A: Yes.

7 Q: That was a big point of that. And then if you
8 go to project review, those same slides within
9 the same exhibit, page 613, I'd ask you to do
10 that for me if you would.

11 A: Okay.

12 Q: The slide said, Would the approval of a new
13 provider unfairly and adversely impact CRCC;
14 you see that?

15 A: Yes.

16 Q: And what CRCC said in terms of how the adverse
17 impact was going to come about was that Grand
18 Strand and North Strand methodologies, they
19 accuse those two applicants of overstating the
20 growth to minimize the adverse impact on CRCC,
21 correct?

22 A: That's what this states, yes.

23 Q: Okay. And if you turn the page and see the
24 next page 614 and 615, you don't see any
25 mention on either of those pages that CRCC is

1 worried about losing all the medical oncology
2 referrals, do you?

3 A: It's not on these pages.

4 Q: It's not on any submissions from CRCC, right?

5 A: I don't recall that it is.

6 Q: In fact, if you look on page 615 of the DHEC,
7 CRCC DHEC record, this is what kind of
8 interested me. It says, To allow a new
9 inexperienced provider to meet that need would
10 adversely impact CRCC. That's CRCC basically
11 saying some inexperienced provider can come in
12 and just take patients from them, right? And
13 that's what they're saying, isn't it?

14 A: That's what it implies.

15 Q: Yeah. Go to page 630 in this same DHEC record,
16 because Mr. Mullins asked you a few questions
17 about Mr. Tolbert's adverse, I think he calls
18 it, analysis of impact of approval of two new
19 linear accelerators, right?

20 A: Yes.

21 Q: I want to bring something to your attention
22 there if I could. I think at your deposition
23 you told me that you looked at this analysis
24 and you relied on it to some extent, correct?

25 A: Yes.

1 Q: Okay. So on page 631, 2015, let's go to 2015,
2 that's the third year of operations, correct?
3 That's what Mr. Tolbert's representing here,
4 isn't it, the proposed third year of
5 operations?

6 A: Yes.

7 Q: Okay. What he said here, he says CRCC's total
8 is 24,892, right?

9 A: Yes.

10 Q: Okay. Let's do that, total treatments.
11 Treatments. That's CRCC.

12 THE COURT: You said 24?

13 MR. THOMAS: Twenty-four thousand ---

14 THE COURT: You said 892. That's two thousand ...

15 MR. THOMAS: Yes, sir. 24,892. Okay.

16 THE COURT: Is that 2015?

17 MR. THOMAS: 2015, yes, sir. In fact, let me put
18 that up here.

19 Q: Okay. Look at 2015, 24,892 and we've got --
20 and I want you to drop down just a line there
21 to next grid, and it's got 6904 for Francis
22 Ford Cancer Center, correct?

23 A: Yes.

24 Q: Okay. 6904. You've got a big calculator
25 there. You can use that one or you can take my

1 word for it, but what I come up with is 31,796.

2 Okay?

3 A: Yes.

4 Q: All right.

5 MR. THOMAS: Sorry, Your Honor.

6 Q: And that's for four linear accelerator
7 treatments, correct -- I mean, linear
8 accelerator units, correct? That's 122 percent
9 capacity. Let's write that down here. Capacity
10 there for those four is 26,000, right? Am I
11 right?

12 A: Yes.

13 Q: Three at seven, one at five. So let's go to
14 Grand Strand's -- let's look at this right
15 here. Grand Strand, same page on 631. Let's
16 see what Grand Strand does. 4,690, correct?
17 That's Grand Strand, right?

18 A: Yes.

19 Q: Okay. 4,690. I'm going to subtract that.
20 31,796 minus 4,690. I get 27,106. All right.
21 Okay. But we know CRCC is going to be coming
22 in, right, with their Conway unit; is that
23 right?

24 A: Yes.

25 Q: I believe Mr. Tolbert said he was going to do

1 5,22, that was his projection. And for 2015,
2 correct?

3 A: Yes.

4 Q: Okay. All right. I get 21,879, all right.
5 That's what I get that the existing units would
6 still be doing in 2015. If I divide that by
7 those same existing units -- same existing
8 units capacity 26,000. Okay. Can you do that
9 for me?

10 A: I'm sorry, Mr. Thomas?

11 Q: I'm sorry. The 21,879 that's what's left over
12 after you take out from 31,796 to be the total
13 number of treatments in 2015.

14 A: Uh-huh (affirmative response).

15 Q: Take out Grand Strand.'s You subtract
16 Conway's, you got 21,879, correct?

17 A: Uh-huh (affirmative response).

18 Q: Divide that number 21,879 ---

19 A: Okay.

20 Q: --- by 26,000 which is the capacity of the
21 existing units in 2015.

22 A: Okay.

23 Q: What do you get?

24 A: Oh, I just -- I think it was 84 point
25 something.

1 Q: 84.5 percent. And Mr. Tolbert on 633, he came
2 up with a different number, didn't he?

3 A: 633?

4 Q: Yeah.

5 A: His conclusion was, I think it was 77 percent.

6 Q: Seventy-seven percent. Because somehow about
7 1,700 treatments disappeared from his 2015
8 number, didn't it? And you remember Les
9 Shelton brought that to your attention,
10 correct?

11 A: Yeah. Yeah. And I know this assumes that
12 everybody will meet the capacity that they
13 proposed and there won't be any taking away
14 from the other.

15 Q: Well, we did. We did take away. I mean, we
16 took Grand Strand's right off the top, 31,796,
17 and we even took CRCC-Conway 5,227 out of --
18 right off the stop. So we took theirs just
19 out.

20 A: Right. But I'm saying assuming they're going
21 to reach the capacities that they proposed.

22 Q: Ms. Brandt, at the end of the day the number is
23 84.5 percent and it's not 77 percent, is it?
24 That's the math?

25 A: That's your math. I can't sit here and really

1 analyze his math. But that's ---

2 Q: Did you ever -- Les Shelton analyzed the math
3 and he found the same thing I did, didn't he?
4 And those were in your notes.

5 A: Yes, he did. And I ---

6 Q: Did you disregard it?

7 A: I didn't necessarily agree, I would assume. I
8 can't remember that far back. But I know that
9 there were other considerations too. I know
10 that Mr. Tolbert's math was different, and I
11 know that -- I'm trying to think of some of the
12 other things in my analysis. But I can't
13 really go back right now and reconstruct what
14 Les ---

15 Q: Well, I just did it for you, didn't I?

16 A: Well, you did your version of it, yes.

17 Q: All right. Now, I want you to look at within
18 that same letter, there's I think an Exhibit D
19 on page 642.

20 A: Okay.

21 Q: And this was what we were talking about
22 earlier, right?

23 A: Yes.

24 Q: Excuse me. If you look at 646 in Joint 1, in
25 that one year period, CRCC did one, it says

1 unique count of patients treated, correct?

2 A: Yes.

3 Q: And it's 1,000, right?

4 A: Yes.

5 Q: Okay. Did that number seem high, low to you,
6 or was there not really much significance with
7 it?

8 A: Well, I assumed it was factual. I don't think
9 I really thought about it.

10 Q: And throughout this litigation, were you here
11 when we were talking about what the average
12 number of treatments are for a patient on
13 linear accelerator overall 20 -- it's about 25?

14 A: I'm not sure if I recall 25. I think for the
15 purposes of this they may be 21.

16 Q: Okay. Who used 21?

17 A: I'm not -- it seemed like I recall seeing an
18 average of 21 somewhere.

19 Q: Mr. Sullivan used an average of 21, didn't he?

20 A: Oh, oh, okay. Maybe so. I just don't recall
21 the details.

22 Q: But if the average number of treatments when
23 you add urologists in is actually 25, 25 times
24 1,000 is what?

25 A: Twenty-five thousand.

1 Q: Twenty-five thousand treatments, correct?

2 A: Yes.

3 Q: So if that is a number you would have been
4 aware of at the time, and there's no reason --
5 I mean, they gave you the number of referring
6 physicians, but they never gave you the number
7 of treatments through October 2011, did they?
8 Did CRCC do that?

9 A: No, I don't recall that I asked for that. We
10 were looking for patient referral information.

11 Q: But you understand that the number of patients
12 that -- that the number of treatments per
13 patients differs by diagnosis type, correct?

14 A: Yes.

15 Q: Okay. And were you aware that the highest
16 number of treatments by diagnosis type is for
17 prostate cancer?

18 A: I don't believe I was aware of that until
19 today.

20 Q: Okay. I want to go back to answer number three
21 in the interrogatory that I gave you earlier,
22 if you've still got it up there.

23 A: I'll have to find it.

24 Q: Okay.

25 A: Again.

1 Q: That's all right, take your time.

2 A: Okay.

3 Q: Are you there?

4 A: Yes.

5 Q: Okay. Good. And I just want to get this

6 straight. So that third paragraph there under

7 answer, for the Francis B. Ford Cancer Center,

8 Grand Strand's proposed linear accelerator had

9 six overlapping zip codes, right?

10 A: Yes.

11 Q: You see that?

12 A: Yes.

13 Q: The six zip codes accounted for 36.6 percent of

14 the 2009 Francis B. Ford Cancer patient origin

15 and 48.2 percent of Grand Strand's 2010 patient

16 discharges, correct?

17 A: Yes.

18 Q: Okay. So you're comparing 2009 to 2010 numbers

19 first. That's one thing you're doing, correct?

20 A: Yes.

21 Q: Okay. And you would agree with me that the

22 Francis B. Ford Cancer patient origin, those

23 are primarily, if not mostly, say 90 percent

24 out patient, correct?

25 A: I don't know what the percent is, but I know

1 the vast majority is outpatient.

2 Q: Fair enough. And so you then, what you decided
3 to do is compare the zip codes and outpatient
4 utilization to inpatient, correct?

5 A: Yes.

6 Q: Okay. And you never did any analysis to
7 determine the number of patients that Francis
8 B. Ford Cancer Center could lose to Grand
9 Strand if and when Francis B. Ford moves up to
10 Murrells Inlet, correct? Is that a fair
11 statement?

12 A: I don't believe that was quantified.

13 Q: So the answer to my question is that you
14 didn't, right?

15 A: No. I just looked at the zip codes and the
16 patient origin.

17 Q: Okay. And let me ask you a question. If
18 Murrells Inlet is here, I think Grand Strand's
19 -- here's a b better one. Here's Murrells
20 Inlet and this is Grand Strand. Do you
21 understand that to be about 20 miles from
22 Murrells Inlet to where Grand Strand's proposed
23 location is going to be?

24 A: You're probably right. I'm not sure.

25 Q: We could -- we could get the key out here.

1 It's 15. We're getting close. Murrells Inlet
2 at five -- about 20?
3 A: Yes.
4 Q: Are you familiar with the traffic on Highway 17
5 from Murrells Inlet up to North Myrtle Beach?
6 A: Yes.
7 Q: And it's pretty heavy, isn't it?
8 A: Yes.
9 Q: Okay. I want you to look in a notebook over
10 here, Petitioner's 28. Let me know when you
11 get to it.
12 A: Petitioner's 28?
13 Q: Correct.
14 A: Yes, I'm there.
15 Q: Okay. Now this is an approval letter for the
16 Carolina Regional Cancer, LLC, Murrells Inlet
17 CON relocation application, correct?
18 A: Yes.
19 Q: Okay. And this is a letter that you signed on
20 behalf of the Department, correct?
21 A: Yes.
22 Q: And the date on this was September 26, 2011?
23 A: Yes.
24 Q: Okay. I want you to go to page 5940 for me.
25 And just on that second paragraph, just so the

1 judge has an appreciation for kind of the
2 context, you noted here that the applicant's
3 propose to transfer a linac, a linear
4 accelerator to an area to within close
5 proximity of each other, less than one mile,
6 and that's they're proposing to establish
7 services in the Murrells Inlet area, correct?

8 A: Yes.

9 Q: Okay. Now go to 5941 for me. And under the
10 heading "Project Review Criteria Analysis"
11 there are two paragraphs, and I'd like you to
12 read the second paragraph for me into the
13 record.

14 A: Starting with the Department?

15 Q: Yes, ma'am.

16 A: Okay. "The Department also considered adverse
17 impact. Both projects reflect a shift in
18 current patients, that is, redirection of
19 existing patients based on current patient
20 distribution. Population shifts were
21 considered. It is noted that in its August 26,
22 2011, response, CRCC made this comment
23 regarding the Ford Cancer Center, the patients
24 in the Murrells Inlet area are being referred
25 by physicians employed by or with very high

loyalty to Georgetown Hospital System. It is not likely that CRCC's presence in Murrells Inlet will change those with referral patterns which are due to existing economic and professional relationships."

Q: Okay. And you agreed with CRCC, didn't you, their comment that they made?

A: Yes, I did.

Q: Okay. So the basis of the decision here to find that there was an adverse impact was that patients in Murrells Inlet are being by physicians employed by or with very highly loyalty to GHS; is that a fair statement?

A: Yes.

Q: Okay. GHS is Georgetown Hospital Systems, correct?

A: Yes.

Q: Now I want you to look in Joint 2, if you would.

A: Do you want me to hold this place?

Q: Yeah, if you don't mind, that'd be great.

A: Okay. What particular page?

Q: And go to page 35 for me.

A: Okay.

Q: All right. And actually look on 34, I'm sorry,

1 because it goes on to the next page. Now, in
2 terms of impact on existing providers, Mr.
3 Sullivan, who stated that he wrote this
4 analysis, would you read what he wrote there on
5 the bottom part of that page going on to the
6 top of the Joint 2, 35.

7 A: Impact on existing providers, below that?

8 Q: Correct.

9 A: The approval of Grand Strand's radiation --
10 radiotherapy center will not result in either
11 of the existing radiotherapy programs in the
12 service area falling below a utilization rate
13 of 80 percent. Grand Strand's program should
14 have a de minimis effect on Georgetown Memorial
15 Hospital's program since each program will get
16 its largest number of patients from different
17 counties and will have different referral
18 sources.

19 Q: Okay. Ms. Brandt, I guess my question is that
20 CRCC made a very similar comment that you
21 relied upon to find that there would be no
22 adverse impact for its relocation to the same
23 zip code within a half a mile of the Georgetown
24 relocated project in Murrells Inlet. But Mr.
25 Sullivan made a very similar statement here

1 about de minimis effect, he actually said there
2 may be a de minimis, which is a small effect,
3 but that they will have different referral
4 sources, and Grand Strand is going to be 20
5 miles away ---

6 A: Yes. And I know ---

7 Q: --- from Georgetown.

8 A: --- you made this point in my deposition. And
9 I had stated that in the Murrells Inlet case
10 these were existing providers just shifting
11 locations. In the Grand Strand case, this is
12 a new provider on the market and they've got to
13 get their clients from somewhere.

14 Q: Ms. Brandt, you realize that Georgetown
15 actually employs, Georgetown Hospital Systems
16 employs a medical oncology group; did you know
17 that?

18 A: Yes.

19 Q: Okay. And oncologists are one of the primary
20 referral sources, along with urologists and
21 surgeons to radiation therapy centers, correct?

22 A: Yes.

23 Q: And generally if a physician is employed by a
24 healthcare facility, they're going to generally
25 refer their patients to their employer absent

1 a pretty serious reason not to, correct?

2 A: Yes, but I know that Grand Strand certainly
3 mentioned those zip codes as far as their
4 application.

5 Q: Okay. Well, if they just say they're going to
6 draw from those zip codes, how is that going to
7 affect Georgetown -- the loyalty of
8 Georgetown's medical staff or the employed
9 physicians on Georgetown's medical staff?

10 A: It my not affect the physicians, but certainly
11 there's patient choice.

12 Q: And Ms. Brandt, you agree with me that if a
13 linear accelerator facility less than a mile
14 away is not going to have an adverse impact on
15 Francis Ford, Grand Strand 20 miles away
16 through all that traffic is going to have even
17 less; isn't that a fair statement?

18 A: Again, my point is there's going to be new
19 patients, they're going to have as choice as to
20 where they go, and certainly, the application
21 mentioned those zip codes as far as the Grand
22 Strand application.

23 Q: It mentions the zip codes and CRCC got the same
24 zip codes, correct?

25 A: Yeah, certainly I -- well, I don't really

1 recall the details of it but I ---

2 Q: Well, CRCC is going to be located in the same
3 zip code as Murrells Inlet, right?

4 A: Okay. I thought you were referring to the
5 Conway application.

6 Q: No.

7 A: But I know that certainly Grand Strand made a
8 good point with the Coastal Carolina oncology
9 group that they plan to get a significant
10 number of referrals from them.

11 Q: Well, how many -- do you know how many
12 referrals to Georgetown Memorial Hospital that
13 Coastal Cancer Center does?

14 A: I don't know.

15 Q: And basically, to find adverse impact, Ms.
16 Brandt, you would have to include the Grand
17 Strand would have to receive referrals from
18 physicians employed by or with very high
19 loyalty to Georgetown Hospital Systems,
20 correct? That would have to be your conclusion
21 in order to be consistent with what you wrote
22 in CRCC's letter; that's fair, isn't it?

23 A: And when you're saying CRCC's letter?

24 Q: Yeah, the approval letter for the Murrells
25 Inlet relocation.

1 A: Again, these are two existing providers, and I
2 tried to make the point that Grand Strand would
3 be a provider.

4 Q: A new provider with outpatient service,
5 correct?

6 A: Well, I think they said primarily outpatient.

7 Q: Right. You would agree with me that it would
8 be difficult for Grand Strand, and you
9 testified to this fact in your deposition, to
10 change the referral patterns of Georgetown
11 hospital's employed physicians and physicians
12 on their medical staff for radiation therapy,
13 that would be a difficult thing for Grand
14 Strand to do, wouldn't it?

15 A: Yes, I'm not disputing that.

16 Q: Okay.

17 THE COURT: Mr. Thomas, how much longer are you
18 going to be?

19 MR. THOMAS: I don't think that much longer Your
20 Honor. I'm not sure what time it is.

21 THE COURT: The reason I ask is you ran my pen out
22 of ink.

23 MR. THOMAS: I did? I would love to finish this
24 witness today if I could.

25 THE COURT: Okay. Well, let's just take a break and

1 I'll go get another pen.

2 MR. THOMAS: Okay.

3 (Break from 4:54 p.m. until 5:00 p.m.)

4 Q: All right. Ms. Brandt, real quickly for the
5 record, would you turn to page, Petitioner's
6 29. It should be right next to Petitioner's 28
7 that you were just looking at in the big
8 notebook. And just for the record, that's the
9 decision letter that you wrote for the Francis
10 B. Ford treatment center, correct, to relocate;
11 is that right?

12 A: Yes.

13 Q: Okay. Now back to the interrogatory response
14 for number five. Grand Strand asked the
15 Department, Does DHEC believe there's any
16 possibility that CRCC's monopoly of linear
17 accelerator services in Horry County could give
18 CRCC an advantage when setting its rates with
19 third-party payers for such services, and if
20 so, did it consider this possibility when
21 approving CRCC's CON application. You would
22 agree with me that the Department did not
23 consider that matter when making its decision
24 in this case?

25 A: Yes, I would agree with that in that that was

1 not raised as an issue.

2 Q: Well, cost containment is raised as an issue,
3 correct?

4 A: Yes.

5 Q: And Mr. Sullivan raised in one of his letters
6 about the leverage in terms of payers, correct?

7 A: I'm not disputing that. I just don't recall.

8 Q: And you would agree with me, I think you agreed
9 at your deposition, that if a provider has a
10 monopoly on services and can set a very high
11 rate, that could potentially offset whatever
12 value is there is to a less expensive project,
13 correct?

14 A: I honestly don't recall that in my deposition.
15 It may very well be there.

16 Q: Just to refresh your recollection, Ms. Brandt.

17 A: Okay. Thank you.

18 Q: Okay. I'm going to hand you a copy of your
19 original deposition. If you would go in that
20 book to page 49 for me in your transcript.

21 A: Okay.

22 Q: All right. And on question line -- page 49
23 line 23, I asked and you can answer, I said,
24 "Okay. And that's the type of thing that goes
25 to cost containment though, right? I mean if

1 somebody's got a monopoly and can set a very
2 high rate for services, that could offset
3 whatever value there is to a less expensive
4 project, couldn't it?" And what did you
5 answer?

6 A: "I believe it can, but I can't tell you. We've
7 never in my history that I can recall ever
8 really considered rates from third-party payers
9 in making a decision."

10 Q: Okay. So it's just not something that you
11 really considered, right?

12 A: Right.

13 Q: Okay. And if we could go over to interrogatory
14 response number seven from the Department.

15 A: Okay.

16 Q: And I believe the question was asked, "In the
17 Department's analysis, it states that CRCC
18 maintains that Conway Regional Medical Center
19 and Loris Community Hospital will not refer
20 patients for radiation therapy to Grand Strand.
21 This is a regional concern and could limit
22 accessibility." And it states, "Given that
23 physicians, not hospitals refer patients to
24 radiation therapy centers then it's ultimately
25 the patient's choice where he or she receives

1 such services, please explain how accessibility
2 could be limited?" And what was the response
3 there?

4 A: Well, the response quotes Standard 8 because we
5 had to work within the constraints of the
6 wording in the Health Plan. So it quotes that.
7 And then there's a paragraph acknowledging that
8 physicians, not hospitals refer patients.

9 Q: And you stated, "Thus, hospital employed
10 physicians could not and would not refer
11 patients to rival hospitals." That's the
12 Department's response, or a portion of it,
13 correct?

14 A: Yes.

15 Q: And so you would agree with me, Ms. Brandt, if
16 these -- if an inpatient at one of these
17 hospitals needed linear accelerator services,
18 you would agree with me that CRCC is likely
19 going to be the beneficiary of those inpatient
20 transfers, correct?

21 A: Yes.

22 Q: Okay. Now, you would agree with me, Ms.
23 Brandt, that in terms of the service area
24 population, Grand Strand is located in the most
25 heavily populated county in the service area,

1 which is Horry, correct?

2 A: Yes.

3 Q: Okay. And when you made the decision to
4 approve the new linear accelerator in this
5 case, you'd already decided to allow CRCC to
6 move one of its linear accelerators to
7 Georgetown County, correct?

8 A: Yes.

9 Q: Okay. Would you pull out -- I won't make you
10 get up. Let's go to Respondent's 42 if we
11 could. I'll take that. Yeah, let me take that
12 away from you. Look at Respondent's 42 for me
13 if you would.

14 A: Okay.

15 Q: Okay. And I believe what we have here, we've
16 got some population counts and some
17 projections. I don't know if you can read
18 those on the screen. But can you tell me what
19 the projections are for Horry County in 2015?

20 A: The projection is 294,600.

21 Q: Okay. And what's the -- and I've wrote, I've
22 written that down here, 294,600. And what's
23 the -- what's the population Georgetown County
24 will have in 2015?

25 A: 20 -- excuse me. 61,300.

1 Q: Okay. And there's already one linear
2 accelerator in Georgetown County, correct, and
3 you approved another to go down there, right?

4 A: Yes.

5 Q: So I'm going to put in this column linacs.
6 We've got Georgetown County is going to have
7 two, and if Grand Strand isn't approved, how
8 many would that leave for Horry County?

9 A: I guess that would be three.

10 Q: All right. So we can kind of do the rough math
11 here, but in terms of kind of the distribution
12 of these per population and county, Georgetown
13 is 61,300, you're going to have two. So that's
14 going to be about one per every third -- per
15 every, you know, 30,000 people and some change;
16 is that a fair statement?

17 A: Well, yes. I mean, I see your math. However,
18 the reason that those linear accelerators were
19 to be located where they were were population
20 centers because the population had shifted to
21 the Murrells Inlet area, which is right on the
22 border of Georgetown and Horry County. There
23 was a lot of -- some patients served in Horry
24 County.

25 Q: Fair enough. But I'm just saying by county

1 right now, what you'll have in 2015 if Grand
2 Strand is not approved is you'll have two in
3 Georgetown. So that's one per every 30,000
4 patients, because now you've got a bunch of
5 people down here that got to get up here,
6 right? You've got to go over the Winyah Bay
7 bridge, right?

8 A: I don't know about the bridge. But I know
9 where the population density is and that we had
10 considered the population of that county when
11 I made that decision.

12 Q: Okay. Well, let's look at Horry with 294,600.
13 If I divide that by three, they're at one for
14 every 98,000 people, correct?

15 A: Well, that's assuming every single person in
16 the county would be receiving radiation
17 therapy, which is not how it is.

18 Q: All right. I understand. I'm just doing the
19 math linacs per county and population, all
20 right. But if we're at 294,600 in 2015, if
21 there are four, that's going to be 73,650
22 people per every linac, correct? That's the
23 way the math shapes out?

24 A: Your math is correct, but again, that's not
25 real life.

1 Q: Well, I mean that's where the county lines are.
2 That's the population of the county. That's
3 the number of linacs in the county, correct?

4 A: Yes, but that's not the population necessarily
5 to be served.

6 Q: That's your opinion, correct?

7 A: Well, I think that the statistical information
8 supports that not everybody that has -- that's
9 alive is going to have cancer and not everybody
10 that has cancer is going to be the method of
11 treatment is going to be radiation therapy.

12 Q: Okay. You would agree with me that most of
13 Georgetown's linear accelerator treatments
14 comes from Georgetown and most of the linear
15 accelerator treatments at CRCC come from Horry
16 County, correct?

17 A: Yes.

18 Q: You do know that? All right. Now in terms of
19 CRCC's facility that's being proposed for
20 Conway, you would agree with me that compared
21 with other radiation facilities in this state,
22 CRCC's Conway facility is going to be amongst
23 the smallest, if not the smallest facility in
24 the state of South Carolina, correct?

25 A: Well, we went through this in my deposition and

1 I testified that I had not been in every single
2 linear accelerator facility in the state. And
3 then some are actually within hospitals so it
4 was to find the square footage.

5 Q: But you agreed with me that you thought it was
6 on the small side, correct?

7 A: Yes, but I also testified and it's written in
8 my analysis that they possess the expertise to
9 and experience to know how to utilize that
10 space.

11 Q: Okay. But you, and I can turn you to your
12 deposition, but you would agree that it's small
13 comparative to the other freestanding
14 applications that you've reviewed while in your
15 job, correct?

16 A: Yes, I will agree with that.

17 Q: Okay. Now if you turn to -- go to your
18 decision letter if we could. You go to Joint
19 1, Mr. Mullins used that one, 655 I think it was
20 on.

21 A: Okay.

22 Q: Okay. In the third paragraph there on that
23 page, last sentence, Staff have determined the
24 approval of more than one linear accelerator
25 would exceed the need projected for this

1 service area in the South Carolina Health Plan,
2 correct?

3 A: Yes.

4 Q: Okay. But you did -- you agree with me the
5 math that we did earlier under Mr. Tolbert's
6 analysis, if we've done the addition correctly,
7 it would have showed an actual -- that all the
8 existing linear accelerators would be operating
9 at above the 80 percent threshold by the third
10 year of operations, correct?

11 A: Well, I'm not really -- your math is correct,
12 but I'm not really prepared to draw the
13 conclusion that Mr. Tolbert's calculations are
14 wrong.

15 Q: But Mr. Shelton also came to that same
16 conclusion as well, correct?

17 A: I believe he couldn't reproduce the results.

18 Q: Because ---

19 A: I'm not sure that he concluded Mr. Tolbert was
20 wrong.

21 Q: Well, he couldn't reproduce Mr. Tolbert's math
22 because 1,700 treatments disappeared, correct?

23 A: I believe that was -- Mr. Shelton said he
24 couldn't -- he couldn't account for that.

25 Q: Okay. Now, if you go to page 656 in your

1 decision letter, you came to the conclusion
2 that CRCC, or excuse me, that CRCC could be
3 adversely impacted by Grand Strand's project,
4 correct?

5 A: Yes.

6 Q: Okay. And again, this wasn't a definite; this
7 was a it could have an impact, correct?

8 A: Yes.

9 Q: Okay. Turn over to page 668 for me, Ms.

10 Brandt. And this is -- I'm sorry. 667, I
11 believe this is where Grand Strand's portion
12 starts.

13 A: Okay.

14 Q: Okay. On page 667 -- I'm sorry. Go to 668.

15 A: Okay.

16 Q: And go to the third paragraph for me.

17 A: Yes.

18 Q: And if you look at the last sentence there, the
19 conclusion is, Even at the higher number of
20 patients taken from CRCC, it does not appear to
21 decrease CRCC below 80 percent capacity.

22 A: I agree that's what it says. And I believe in
23 my deposition, and I can't exactly remember
24 what I testified, that I wasn't quite sure why
25 this was in here. But clearly, the letter and

1 the analysis repeatedly says that there would
2 be an issue. So I honestly don't recall why
3 this is in here. If it's a typo, an error on
4 my part, I don't recall.

5 Q: Well, because that's what Les told you, right?
6 Because even when Les told you about the math
7 error, he showed that all the existing
8 providers would be operating above 80 percent,
9 correct, in year three?

10 A: I believe that's what he's concluded.

11 Q: Okay.

12 A: But again, I don't -- I can't recall why that's
13 in there. All I know is that I repeatedly say
14 otherwise in my analysis in my letter.

15 Q: I understand. I understand. But you also
16 relied, you said in your deposition you relied
17 on Mr. Tolbert's analysis that he did in his
18 letter, correct?

19 A: Yes.

20 Q: Okay.

21 A: That was certainly one of several things, but
22 yes, I did.

23 Q: Okay. And if you go down to paragraph five of
24 your decision letter if you would. I'm sorry.
25 It's on page 668. Same page. Just paragraph --

1 it's the first paragraph under distribution
2 slash -- or in paren, accessibility.

3 A: I need to go back there. And I'm sorry, which
4 paragraph?

5 Q: Paragraph, first paragraph right under
6 distribution accessibility.

7 A: Okay.

8 Q: All right. Now, you say here in the second
9 sentence, you say, However, Grand Strand does
10 not propose any inpatient treatments according
11 to their pro forma. That's what you stated,
12 correct?

13 A: Yes.

14 Q: Now, you realize that -- I guess, were you not
15 aware that there would be not be separate
16 inpatient revenues for those inpatients because
17 of DRG payment methods?

18 A: I was not and I believe my -- my deposition
19 mentioned that that was not ever -- that issue
20 was never raised when I asked the question to
21 Grand Strand. And also, and when I reviewed
22 other linear accelerator applications there --
23 there were either figures or money attributed
24 to outpatient. And so that was something that
25 I had seen in the past. But I'd never been

1 given that explanation, and I was not given
2 that explanation by Grand Strand.

3 Q: Do you think maybe Grand Strand would have
4 assumed as the bureau chief for CON that you
5 may have known that?

6 A: I don't know what Grand Strand would have
7 assumed.

8 Q: Okay. But you then conclude that it's
9 advantageous to have the radiation oncologists
10 and medical oncologists practicing in close
11 proximity, correct?

12 A: Yes.

13 Q: All right. And then you stated that Grand
14 Strand and CRCC are both close to Coastal
15 Cancer Center's Myrtle Beach office, right?

16 A: Yes.

17 Q: Okay. You would agree with me that the Coastal
18 Cancer physicians don't have occasion or
19 reasons to go to CRCC, right? They don't round
20 on their patients at CRCC, do they?

21 A: They don't. I can't say that they don't visit
22 it for other reasons.

23 Q: And these type of medical oncologists are
24 frequently in the hospital rounding on their
25 very sick medical oncology patients, correct?

1 A: I'm sure they would.

2 Q: Okay. And look at the next paragraph, CRCC
3 maintains that Conway Medical Center and Loris
4 will not refer patients for radiation therapy
5 center to Grand Strand. We covered that,
6 correct? And they're most likely going to go
7 to CRCC, correct?

8 A: Yes. They did not submit letters of support.

9 Q: Okay. Well, I just wanted to get this
10 straight, because basically what you're saying
11 is these hospitals are going to transfer their
12 patients over to CRCC, right?

13 A: Well usually ---

14 Q: And that's the assumption?

15 A: -- they could go other places. But the
16 assumption was that they would not refer them to
17 Grand Strand.

18 Q: So you assume that Conway and Loris, what you
19 would agree with me are both smaller community
20 hospitals compared to Grand Strand, right?

21 A: Well, Loris in particular is.

22 Q: Yeah. And Conway is smaller than Grand Strand
23 too, correct?

24 A: Well, it is.

25 Q: Yeah.

1 A: It would be more of a medium hospital. But
2 yes, it's smaller.

3 Q: So you assume that those two hospitals, which
4 are smaller than Grand Strand, which is a
5 tertiary hospital, are going to have inpatients
6 of need -- in need of radiation therapy,
7 correct?

8 A: Yeah, I can't quantify it but I would -- I
9 would see that that would be possible.

10 Q: Okay. Well, don't you think if those small
11 community hospitals, that Conway and Loris are
12 going to have inpatient, that the larger
13 tertiary care center, that Grand Strand in the
14 service area is also going to have inpatients?

15 A: Inpatients that are radiation therapy patients?

16 Q: Yes.

17 A: Well, they were given that opportunity to give
18 me that information. I ---

19 Q: Okay. When you wrote that paragraph that
20 didn't kind of set some wheels in motion?

21 A: Well, I had asked them in additional
22 information about inpatients.

23 Q: Well, they just said that there were rare cases
24 where they would treat inpatients, correct?

25 A: Yes.

1 Q: Okay. But you say in here that they don't
2 propose any inpatient treatments, right?
3 That's what you say.

4 A: I'm sorry. You'll ... you'll have to repeat
5 that.

6 Q: Look at the paragraph. You say however --
7 first paragraph after the distribution heading.

8 A: Oh, I'm sorry.

9 Q: Grand Strand does not propose any inpatient
10 treatments, right?

11 A: According to their pro forma.

12 Q: Okay. All right. The next paragraph, The
13 project will not increase geographic access
14 since CRCC is currently located in Myrtle
15 Beach, correct?

16 A: Yes.

17 Q: And you admitted earlier that you were -- that
18 you had not been qualified as an expert in
19 healthcare finance, correct?

20 A: Yes.

21 Q: All right. And you agree with me that a
22 comprehensive cancer treatment center is going
23 to treat primarily outpatients, right?

24 A: Yes.

25 Q: Now, if you turn over to page 670 in Joint 1.

1 A: Yes.

2 Q: Okay. Here on -- under the first paragraph,
3 compliance with South Carolina Health Plan. It
4 says, For a total unique patient count of 1,000
5 patients, 360 patients or 36 percent of the
6 total were from Atlantic Urology. Coastal
7 Cancer Center physicians accounted for 26 or
8 263 or 26.3 of referred patients, correct?

9 A: Yes.

10 Q: Okay. So you would agree with me that Grand
11 Strand is getting the lesser of the two
12 significant referral sources in the service
13 area, correct?

14 A: Yes.

15 Q: Is that where ---

16 A: I mean, I didn't analysis the other -- you
17 know, I have the names of the doctors; I don't
18 know where they practice. But I agree that
19 it's -- that certainly Coastal Cancer Center is
20 less as far as unique patients than Atlantic
21 Urology.

22 Q: Would you go to page 672 in that same letter
23 for me.

24 A: Okay.

25 Q: Okay. And I believe that there's a notation

1 there that CRCC, it's the fourth -- well, third
2 full paragraph down. CRCC stated they will
3 offer access to support services to accommodate
4 the needs of their patients, correct?

5 A: Yes.

6 Q: I mean, you would agree with me that CRCC
7 doesn't have PET/CT capabilities, correct?

8 A: No, not to my knowledge.

9 Q: Other than CT, CRCC doesn't have any imaging
10 capabilities, do they?

11 A: No. That doesn't mean that they can't refer
12 patients for PET/CTs.

13 Q: Understood. But they would have to refer those
14 to other providers, correct?

15 A: Yes.

16 Q: And they don't offer surgical cancer services,
17 do they?

18 A: No.

19 Q: They don't have provisions for chemotherapy
20 services in their facility, do they?

21 A: No. I believe Coastal Cancer Center does all
22 that.

23 Q: Well, you saw in Grand Strand's application
24 that they have chemo days in their radiation
25 therapy center, correct?

1 A: I don't recall.

2 Q: Okay.

3 A: I know that there was mention of the chemo at
4 Coastal.

5 Q: But you would agree with me that Grand Strand
6 has an incredible amount of support services
7 for cancer patients, correct?

8 A: Well, you'd really have to delineate all those.
9 I agree that they do have resources.

10 Q: I mean, they are accredited by the American
11 College of Surgeons as a community cancer
12 center, aren't they? I mean, that's in their
13 application.

14 A: I don't recall.

15 Q: You don't recall that?

16 A: No.

17 Q: Go to 674 for me and I want to talk a little
18 bit about your conclusion.

19 A: Okay.

20 Q: All right. Again, under your conclusion you
21 say, Staff believes the approval of more than
22 one of these CON applications is going to have
23 adverse impact and that this negative impact
24 exceeds the benefits of improved accessibility,
25 correct?

1 A: Yes.

2 Q: What you know now is that there -- what Grand
3 Strand was saying all along in its letters and
4 this letter from Mr. Sullivan that two could be
5 approved, and Mr. Sullivan said at the project
6 review meeting that two could be approved that
7 they were right, correct? Because the 2012-
8 2013 State Health Plan that based its needs
9 analysis on the 2011 numbers showed a need for
10 linear -- for another linear accelerator,
11 correct?

12 A: I agree that the current Plan shows a need, but
13 also, that was not the Plan under which I was
14 required to review these applications.

15 Q: I understand that. But you would agree with me
16 that that 2012-2013 State Health Plan
17 vindicates Grand Strand's position all along,
18 correct?

19 A: Not necessarily. I mean, I would have to have
20 an application to review.

21 Q: It shows a need for an additional one in
22 addition to the one, the fifth one that you
23 approved, correct?

24 A: Yes.

25 Q: Okay. Now, Ms. Brandt, with respect to cost

1 containment, I think you testified in your
2 deposition that nobody on your staff did kind
3 of any research with respect to what happens
4 with linear accelerator utilization when
5 urologists come to have financial interest in
6 that linear accelerator. Would you agree you
7 did not do any research on that, correct?

8 A: No, I did not.

9 Q: And you would agree with me that the
10 utilization from 2010 to 2011 went up
11 substantially at CRCC, correct? Went up from
12 15,000 treatments up to 20,000 treatments?

13 A: From 2009 to 2010?

14 Q: 2010 to 2011.

15 A: Yes.

16 Q: Well, yeah, from 2009 to 2010 from 15 to 20?

17 A: Right.

18 Q: And then from 2010 to 2011 from 20 to 25,000,
19 correct?

20 A: Yes.

21 Q: Okay. Ms. Brandt, you would agree with me that
22 you cannot duplicate something that doesn't
23 already exist, correct?

24 A: Not in the plain language of the word.

25 Q: And you would agree with me from a cost

1 containment perspective there are no other
2 providers in Horry County for a non-
3 governmental insurance company to negotiate
4 with at this time in terms of negotiating rates
5 for linear accelerator services, correct?

6 A: Yes.

7 Q: Okay. Do you have any doubts under the record
8 of the applicant that Grand Strand would have
9 any problems setting up and administering a
10 linear accelerator program at Grand Strand, a
11 high quality linear accelerator program?

12 A: I would have to go back and review that, but I
13 know that, you know, I concluded that certainly
14 CRCC had extensive experience. I don't recall
15 without looking at my analysis what I said
16 about Grand Strand.

17 Q: Well, let me ask you this, of what you know
18 about Grand Strand and all the tertiary care
19 services that they provide, their open heart
20 program, which is very well respected in the
21 state, do you have any reservations that they
22 may have difficulty establishing that program?

23 A: I think it's certainly plausible that they can.

24 Q: Aren't you assuming that they have to if
25 they're going to have such an adverse impact on

1 CRCC in the third year of operations?

2 A: Well, I see your point.

3 Q: I mean, don't have to kind of assume that
4 they're going to do a good job?

5 A: Well, I would assume they would reach the
6 projections.

7 Q: Would you agree with me that because of the
8 passage of time, technology costs can come down
9 and that can enable CON applications to upgrade
10 their equipment?

11 A: Well, I would agree through time that the cost
12 have come down. I mean, it could certainly
13 affect the decision about what equipment to
14 purchase.

15 Q: Well, if there's a long passage of time, Ms.
16 Brandt, between when an applicant applies and
17 say four or five years later when litigation
18 could actually resolve, you're not going to --
19 as the Department, you're not going to make
20 that applicant stick to the same unit or the
21 same machine from five years before after half
22 a decade has passed when they can probably get
23 a better unit for a lesser cost, are you?

24 A: Well ---

25 Q: That's not something the Department would do as

1 a matter of public policy, would it?

2 A: Well, what we've done in the past is require
3 them to submit a substantial change
4 determination ---

5 Q: Correct.

6 A: --- request.

7 Q: Right. And what I'm asking you is do you
8 recall ever denying one for a faster piece of
9 equipment that's at a -- the same or lesser
10 cost because of the passage of time?

11 A: Well, I recall -- I'm not sure if that
12 situation has arised (sic), but I know in the
13 case I've just represented there wasn't -- the
14 issue was resolved, you know, the appeal was
15 resolved. So after that was resolved was when
16 the facility came back to us with the request.

17 Q: Okay. But you're not going to fault an
18 applicant who comes back for a better piece of
19 equipment at the same lower price as the
20 original piece of equipment they applied for if
21 they want to upgrade, are you? Is that
22 something the Department of Health and
23 Environmental Control in the state South
24 Carolina is going to do?

25 A: All I know is ---

1 MR. MULLINS: Your Honor, objection. It calls for
2 speculation. There's nothing -- there's no
3 evidence in the record as to exactly what kind
4 of equipment, what quote, what was being
5 presented to Department and what they would do.
6 He can ask her about what, you know, her
7 position as a director of the program ---

8 MR. THOMAS: I'll withdraw the question, Your Honor.

9 THE COURT: Okay.

10 MR. THOMAS: It's getting late.

11 THE COURT: He withdrew. You beat him down.

12 MR. MULLINS: He's beating himself down.

13 MR. THOMAS: I'll take that as a compliment.

14 Q: Ms. Brandt, do you have any doubts that Grand
15 Strand can staff their linear accelerator
16 project?

17 A: I don't believe I raised that as an issue.

18 Q: Well, I was just bringing it up because I felt
19 like Mr. Mullins may have raised it as an
20 issue.

21 A: Oh, I don't recall that as being an issue with
22 me.

23 Q: Okay. All right. Let me just check over some
24 notes. In terms of, I think -- did you give
25 much weight to Mr. Bailey's -- I think Mr.

1 Mullins brought it up, the fact that there
2 would be \$40 million worth of linear
3 accelerator facilities being approved at the
4 same time; did that play into your decision at
5 all?

6 A: I know that I considered that and certainly
7 cost was a factor, but the big issue with me
8 was the fact that these facilities had not, due
9 to the appeal, had not been allowed to come to
10 fruition, so we didn't know what type of
11 workflow they would have.

12 Q: All right. But you would agree with me that we
13 shouldn't have to wait around while there's a
14 need in the State Health Plan for two different
15 linear accelerators to see what's going to
16 happen down in Murrells Inlet, South Carolina,
17 on two relocated linear accelerators, do you?
18 I mean, that could take years. Is everybody on
19 hold in Horry County until this is resolved?

20 A: No. The Health Plan speaks for itself as far
21 as what's -- what can be done.

22 Q: Okay. Thank you. That's all the questions I
23 have, Ms. Brandt. Thank you for your time and
24 your patience.

25 A: Thank you.

1 THE COURT: Ms. Biggers?

2 MS. BIGGERS: I don't have any redirect, Your Honor.

3 MR. MULLINS: Just a couple.

4 THE COURT: All right.

5 MS. BRANDT - RECROSS-EXAMINATION BY MR. MULLINS:

6 Q: Ms. Brandt, Mr. Thomas had you take a look at
7 some interrogatories.

8 A: Yes.

9 Q: And answers that were served by the Department.
10 And I think you stated, I just want to make
11 sure this is clear, you were not involved in
12 the drafting. I know Mr. Thomas used the term
13 "you" a couple of times. But you weren't
14 involved in the drafting of these answers?

15 A: No, I don't recall being involved.

16 Q: Okay. And Mr. Thomas asked you a couple of
17 questions about advantages that CRCC may have
18 in terms of setting rates with third-party
19 payers or the impact of the negotiated rates
20 with third-party payers if there was
21 competition in the market; do you remember him
22 asking you about that?

23 A: Yes.

24 Q: And you agree with me that a large portion of
25 the third-party payer rates are set, Medicare

1 and Medicaid, government rates, those are set
2 by the government, correct?

3 A: Yes, that is.

4 Q: Okay. So the negotiated rate that he was
5 referring to, I just want to make sure you were
6 understanding, where the negotiated rates with
7 private payers?

8 A: Yes.

9 Q: Okay. And I think you said that, to your
10 knowledge, the Department had never considered
11 the negotiated rates or that issue in terms of
12 its review of the CON applications?

13 A: Correct. I've never -- I mean, I've probably
14 reviewed 150 applications. I've never seen
15 that raised as an issue.

16 Q: Okay. All right.

17 THE COURT: I mean, your two questions are moving
18 into the great grandchildren now. You started,
19 you said just a couple, that's why ---

20 MR. MULLINS: Well, I'm sorry. Two issues I guess.
21 That was an unfair characterization.

22 Q: All right. I'm going to have you look at one
23 thing and maybe ask you one question with that,
24 okay?

25 A: Okay.

1 Q: The regulations are still up there?

2 A: Yes.

3 THE COURT: Oh, that's the question.

4 Q: Section 504 I think you were looking at.

5 A: Yes.

6 Q: I guess this counts as a question. Mr. Thomas
7 you recall was asking you some questions about
8 the impact of the 2012-2013 State Health Plan,
9 right?

10 A: Yes.

11 Q: Okay. What options -- let me ask you to look
12 at the -- I had you read the first sentence,
13 but what options does an applicant have, let me
14 have you take a look at the second sentence
15 there, in terms of a new plan being approved?

16 A: It states that if a new plan is adopted during
17 any phase of the review or appeals process, the
18 applicant shall have the option of withdrawing
19 and resubmitting under the newly adopted plan
20 or continuing the review or appeal process
21 under the plan in use when the application was
22 submitted.

23 Q: And that certainly could have been done in this
24 case, correct?

25 A: Yes. According to this, yes.

1 Q: All right. Just want to confirm one last
2 thing, Ms. Brandt. You cannot approve two, or
3 a linear accelerator in your review, you cannot
4 approve a linear accelerator, a new service, a
5 new linear accelerator if it reduces the
6 existing providers below 80 percent; is that
7 correct?

8 A: Yes, according to the Health Plan, that's
9 correct.

10 Q: Thank you.

11 THE COURT: All right. You're through.

12 MS. BRANDT: Thank you.

13 THE COURT: You may step down. We're done for the
14 day, right?

15 MR. MULLINS: I believe so.

16 MR. THOMAS: Thank you, Your Honor.

17 (There being nothing further, the hearing recessed
18 for the day at 5:38 p.m.)

19 DAY 5 - WEDNESDAY, SEPTEMBER 18, 2013:

20 THE COURT: All right.

21 MR. LONG: Good morning, Your Honor. I thought I
22 might as well go ahead and bring this up now as
23 far as the scheduling. We've got up to three
24 fact witnesses today that we would hope to get
25 up and maybe all three of them will be able to

1 testify. Tomorrow we have a physician who will
2 be here in the morning ---

3 THE COURT: I assume that there was a period before
4 you got to tomorrow?

5 MR. LONG: I'm sorry, Your Honor?

6 THE COURT: You said there would be up to three
7 witnesses tomorrow?

8 MR. LONG: No, for today.

9 THE COURT: Yeah, that's what ---

10 MR. LONG: Today, sorry about that. Yeah, there's
11 up to three today, and we may get finished with
12 all three of them today, or at least certainly
13 I would think get at least two of them done.
14 And tomorrow we would have a physician who's
15 here. Mr. Tolbert, of course, is unavailable
16 on Thursday as I said at the beginning of the
17 trial. We propose to start on Friday at 9:00
18 a.m. instead of 9:30, if that's okay with Your
19 Honor, the lawyers have talked, because we
20 really obviously want to try to get Mr. Tolbert
21 in on Friday.

22 THE COURT: Okay. So 9:00 on Friday?

23 MR. LONG: Yes, sir.

24 THE COURT: All right.

25 MR. LONG: Your Honor, CRCC calls our first witness

1 to the stand. We would call Rich Lewis.

2 RICHARD R. LEWIS, being duly sworn, testifies as
3 follows:

4 MR. LEWIS - DIRECT EXAMINATION BY MR. LONG:

5 Q: Mr. Lewis, can you state your full name for the
6 Court, please?

7 A: Yeah, it's Richard R. Lewis, L-E-W-I-S.

8 Q: And where do you reside?

9 A: Fort Myers, Florida.

10 Q: And who do you work for?

11 A: 21st Century Oncology Management Services.

12 Q: And can you tell the Court a little bit about
13 21st Century and a little bit about that
14 company you work for.

15 A: Yeah. It's an integrated cancer care company.
16 We employ in excess of 125 radiation
17 oncologists, more than double that of other
18 oncology-related physicians. We operate
19 approximately 100 radiation therapy centers
20 throughout the United States. We have a
21 division in South America that's related with
22 where our CEO is from, he's from Argentina,
23 that has an additional 30 centers.

24 Q: Okay. And where did 21st Century kind of
25 start?

1 A: In Fort Myers, Florida.

2 Q: All right. And how many different states did
3 you say you were in?

4 A: Sixteen.

5 Q: Does 21st Century employ radiation oncologists?

6 A: Yes.

7 Q: Does it employ other physicians?

8 A: Yes.

9 Q: What kind of other physicians?

10 A: Urologists, surgeons, medical oncologists. We
11 have a few primary care physicians. The
12 surgeons are multiple specialities, some are
13 general, gyn/onc. We employ pulmonologists.

14 Q: You said your CEO was from Argentina. Who is
15 your CEO?

16 A: Daniel Dosoretz.

17 Q: Is he a physician?

18 A: Yes.

19 Q: All right.. Is he kind of the founder of 21st
20 Century?

21 A: Yes.

22 Q: And where does he reside now?

23 A: Fort Myers.

24 Q: And what is your current occupation with 21st
25 Century?

1 A: I'm the vice president of operations finance.

2 Q: And what are your responsibilities?

3 A: They're varied. But, you know, I handle our
4 physician compensation, both contracting and
5 administration. I am very involved in our
6 business development, which includes our
7 certificate of need, overseeing our cert of
8 need in the various states where we have
9 certificate of need.

10 Q: Do you have special responsibilities for
11 certain centers throughout the company?

12 A: I do a lot of financial analysis, analytics of
13 the centers. I don't have -- in a former role
14 I was a regional director directly managing
15 centers over -- but currently I do, you know,
16 analytics of all the centers as needed.

17 Q: Okay. When you started with the company, was
18 there a project that you worked on that was
19 very important early in your career in regards
20 to the company?

21 A: Yes, I was -- my regional project, the reason
22 I was hired into the company was to develop a
23 financial analytics framework for the company.
24 The company had very -- had a lot of data, but
25 very limited analytics in looking into it. And

1 over the years, that evolved into our
2 developing and implementing an IBM Cognos
3 database where we can, you know, on a daily
4 basis retrieve our financial and operational
5 metric data.

6 Q: So you had a lot -- when you said you had a lot
7 of data, but you didn't have an ability to
8 access it?

9 A: Right. No ability to access it and very few
10 people were even looking at it.

11 Q: Okay. And so what did that involve you doing
12 to create that?

13 A: Well, first, organizing it into key metrics,
14 you know, we have a lot of metrics we look at.
15 And then looking at it, you know, at a region
16 market location and by line of business, so
17 radiation versus urology versus surgery versus
18 medical oncology.

19 Q: So are you kind of an important data person in
20 the company?

21 A: Yes.

22 Q: Other people come to you to get information
23 about ---

24 A: Yes.

25 Q: --- different centers and what's going on in

1 the company?

2 A: Yes.

3 Q: And were you involved in the collection of data
4 for this particular lawsuit?

5 A: Yes.

6 Q: All right. Tell the Court what advantages
7 there are in resources for a company like 21st
8 Century compared to other providers of
9 radiation therapy services?

10 A: I mean, we have a huge -- well, like I said, we
11 employ over 125 radiation oncologists. We have
12 a very large network of radiation oncologists
13 that do collaborate. We have, by far, the best
14 physics capabilities in the country. We have
15 proprietary technology that we have developed
16 that nobody else has. With a company our size
17 and, you know, a focus in radiation, we're the
18 leading company in the field.

19 Q: What about in regards to clinical protocol?

20 A: Well, that would be included. We have
21 protocols for all the cancer specialties,
22 different modalities of treating them. They
23 follow the international guidelines, and we are
24 a leader in that area as well.

25 Q: Does your company have special advantages in

1 regards to the purchasing of equipment?

2 A: Yes. We are the largest provider of radiation
3 therapy services, and we have favorable
4 pricing.

5 Q: All right. As a little background, will you
6 give the Court your educational background?

7 A: Yeah, I have a -- my undergraduate's a bachelor
8 of science in business administration from The
9 Ohio State University. It's major of
10 accounting. I have an MBA from the University
11 of Pittsburgh with an accounting and finance
12 concentration. I'm a inactive -- I hold my CPA
13 license in the State of Ohio, but it is an
14 inactive license.

15 Q: Okay. And tell the Court a little bit about
16 your work history, particularly in the
17 healthcare industry.

18 A: Healthcare, I worked just shy of ten years at
19 Anthem Blue Cross Blue Shield where I was in
20 the national account division. That was from
21 1996 until January of 2006, approximately. And
22 in that, like I said, I worked in the national
23 account division. We worked primarily with the
24 employer groups who were purchasing their
25 healthcare through the Anthem Blue Cross Blue

1 Shield. For the last almost eight years I've
2 been at 21st Century Oncology, I've had various
3 roles. The first one, as I mentioned, was
4 brought in to build the financial analytic
5 framework. I moved from that into a regional
6 director of operations where I oversaw what, at
7 that time, was the central region. It was
8 Michigan, Kentucky, West Virginia, North
9 Carolina, and the east coast Broward, Ft.
10 Lauderdale area of Florida. And then from that
11 role, I actually relocated from Ohio, where I
12 was living, to Fort Myers with the company into
13 what's evolved into my current role.

14 Q: Now, you said you were involved in the
15 certificate of need aspects of the company,
16 right?

17 A: Yes. I've really handled that from the first
18 day on the job.

19 Q: Tell us some of the things that you do in
20 regards to the certificate of need program or
21 certificate of need for 21st Century.

22 A: Initially, it was just on existing markets
23 where certificate -- I would handle all the
24 applications to relocate a service, expand a
25 service, replace the equipment, and then the

1 annual reporting that's required with that.

2 Since then, I've gotten more into, not in South
3 Carolina at the time, but onto the -- when
4 we're doing an acquisition, actually getting
5 into the certificate of need applications when
6 we're doing the acquisition.

7 Q: Certain acquisitions require certificate of
8 need in some states?

9 A: Yes. Yes, you generally have to have approval
10 to acquire a center that has a certificate of
11 need.

12 Q: All right. Now, how quickly -- well, is 21st
13 Century in South Carolina?

14 A: Yes.

15 Q: And where in South Carolina?

16 A: The Horry County, Myrtle Beach area.

17 Q: CRCC, what we've called it during the trial?

18 A: Yes.

19 Q: CRCC?

20 A: Uh-huh (affirmative response).

21 Q: Do you have any other centers in South
22 Carolina?

23 A: No other radiation centers.

24 Q: Do you have any in North Carolina?

25 A: Yes.

1 Q: All right. Now, how quickly after 21st Century
2 acquired CRCC did you become involved with
3 CRCC?

4 A: Pretty much immediately upon the acquisition, I
5 became involved.

6 Q: All right. And what were some of the areas
7 that you were asked to focus on with CRCC?

8 A: I mean, immediately we looked to upgrade the
9 equipment. The equipment was dated and needed
10 improvement to provide, you know, the best care
11 to the patients.

12 Q: What other things did 21st Century plan to do
13 or wanted to do with CRCC?

14 A: We also wanted to improve the physician
15 relationships. We do that in all of our
16 acquisitions. And what was different in Myrtle
17 Beach versus how we would normally operate is
18 we wanted to distribute the assets, the linear
19 accelerators throughout the market, the service
20 area. Rather than have, you know, three linear
21 accelerators in one location, it would make
22 more sense to get the linear accelerators out
23 to where the population, where the patients
24 live.

25 Q: You said that's a little different from what

1 you normally do. Can you explain that?

2 A: What we would normally do is have the linear
3 accelerators disbursed in multiple locations
4 within a market, what I'll call a market or a
5 service area. When we acquired the Myrtle
6 Beach location, it had three linear
7 accelerators all under one roof.

8 Q: And no other linear accelerators?

9 A: And no other linear accelerators, right. So
10 the patients have to drive a long distance to
11 get there.

12 Q: All right. Let's first look at the equipment
13 issue. First, I want to direct your attention
14 to, just a little background to refresh your
15 memory a little bit. One of the machines in
16 Myrtle Beach is a TomoTherapy unit, right?

17 A: Correct.

18 Q: And let's look at Joint Exhibit 3, pages II-67.
19 We're just going to use this for a real quick
20 matter to try to date something. Okay?

21 A: What page again?

22 Q: It's two, Chapter II-67.

23 A: Joint Exhibit 3. Okay.

24 Q: All right. I know this predates you, but this
25 is the Health Plan. I'm going to direct your

attention to footnote 5.

A: Right.

Q: And well, actually I'm sorry. Let's go back up and look at where the footnote is. Look at the Carolina Radiation Therapy Center line about midway down.

A: Correct.

Q: And you see there's a little footnote right there?

A: Right.

Q: Footnote 5. All right. Let's go down and see what Footnote 5 says.

A: It says, CON approved for a TomoTherapy unit as a third linac, appealed, CON issued July 18th, 2007.

Q: So the TomoTherapy CON was issued in July of 2007. All right. And when you get a CON for a linear accelerator, can you put it in the building like the next day?

A: No.

Q: Is it like driving a -- buying a car, you just drive it off the lot?

A: No.

Q: So it takes a little while?

A: Correct.

1 Q: All right. So the TomoTherapy unit then was --
2 certainly didn't come online until '08 or
3 something like that, right?

4 A: I'm sure many months or a year later.

5 Q: Okay. Let's go look at CRCC Exhibit Number 22.
6 Particularly, the bottom of the page.

7 A: Correct.

8 Q: That's what I really want to focus on. First,
9 is this a document that you prepared or
10 produced?

11 A: Yes.

12 Q: In the discovery process?

13 A: Yes.

14 Q: All right. Let's look at the bottom of the
15 page here. This lists the linear accelerators
16 in Myrtle Beach; is that right?

17 A: Yes.

18 Q: Okay. And then each year. Now, these are the
19 utilization by machine, right?

20 A: Correct.

21 Q: Is the 2010 numbers for a full year or a
22 partial year?

23 A: I believe it's a partial year, post-
24 acquisition. We acquired it May 4th, I
25 believe.

1 Q: Okay. Now, let's talk about each one of these
2 units. Start from the bottom going to the top,
3 the TomoTherapy unit, that's the unit that we
4 just saw?

5 A: Correct.

6 Q: So it was acquired, installed probably '08?

7 A: That would seem reasonable, yes.

8 Q: Okay. Tell me a little bit -- tell the Court
9 a little bit about that unit. What makes it
10 unique?

11 A: The TomoTherapy unit is rather unique in that
12 it was one of the original, if not first,
13 linear accelerators to do 3D imaging. And
14 what's unique about the TomoTherapy, it's 100
15 percent IMRT, 100 percent IGRT. It looks more
16 like a CT, a CAT scan, than a traditional
17 linear accelerator. But it is a linear
18 accelerator, always producing a IMRT/IGRT
19 treatment.

20 Q: Okay. So a TomoTherapy you said is 100 percent
21 IMRT?

22 A: Yes.

23 Q: So every treatment done on a Tomo unit is an
24 IMRT treatment?

25 A: Yes.

1 Q: Okay. And I noticed that you have -- in 2011,
2 you did 10,384 treatments on a Tomo unit?

3 A: Yes.

4 Q: So does that machine have a real world capacity
5 greater than 5,000?

6 A: Yes.

7 Q: Okay.

8 THE COURT: Let me make sure I'm at -- I see the
9 exhibit y'all have got. This is Respondent's
10 22?

11 MR. LONG: Yes, Your Honor, CRCC, yes, Exhibit I
12 think it -- no, is it 22? CRCC Respondent's
13 Exhibit 22.

14 THE COURT: Okay.

15 MR. LONG: We're at the bottom of the page.

16 THE COURT: Yeah, I gathered that.

17 MR. LONG: Okay.

18 Q: All right. Let's talk about the -- are there
19 any plans with 21st Century in regards to the
20 TomoTherapy unit?

21 A: No.

22 Q: Is that a unit that's commonly in the company?

23 A: Yes.

24 Q: Do you have centers that really rely on that
25 kind of unit?

1 A: Yes. We have several centers that it's the
2 only unit.

3 Q: All right. Let's look at the next one, which
4 is the 6EX. Can you tell the Court a little
5 bit about the 6EX.

6 A: The 6EX, I believe it's right now about 11
7 years old. I think it's a 2002 model. It was
8 -- when we acquired the center, it did not have
9 very good imaging capabilities, so we actually
10 applied to replace it, but that application was
11 denied because what we wanted to replace it
12 with ---

13 Q: Well, let's slow down a second. So you
14 applied, who did you apply with?

15 A: DHEC.

16 Q: All right. To replace it?

17 A: Correct.

18 Q: All right. So did you file a CON for that?

19 A: We filed an exemption request, I believe is
20 what it's called.

21 Q: Okay. Exemption request. And was that
22 accepted or denied by the Department?

23 A: It was denied.

24 Q: Okay. Why was the exemption denied by the
25 Department to replace the EX?

1 A: Because the unit we proposed had different
2 energy levels.

3 Q: Explain that to the Court.

4 A: Linear accelerators, the 6EX, the six means the
5 energy, so it's a six megavolt, six million
6 volts. And it's a single energy. It only
7 produces a six megavolt energy. Most linear
8 accelerators will have dual energies, so it
9 might be, you know, 23 and 12 or 23 and six,
10 you know, different combinations. So the unit
11 we proposed to replace it with was dual energy,
12 so they basically said it wasn't similar,
13 therefore, denied the exemption.

14 Q: Okay. So what did you do with that machine
15 when you weren't able to replace it?

16 A: We did do the upgrade on the imaging.

17 Q: Okay. And if you had replaced it, you would
18 have purchased a new one to replace it with?

19 A: Yes, we would have -- yes.

20 Q: And that would have cost the company millions
21 of dollars?

22 A: Yeah, millions, yes.

23 Q: All right. So you replaced the imaging. What
24 are your current plans for the 6EX?

25 A: It is the unit that is approved to relocate and

1 replace when we move it to Murrells Inlet with
2 the TrueBeam.

3 Q: Okay. So the 6EX will become a TrueBeam?

4 A: At Murrells Inlet.

5 Q: At Murrells Inlet?

6 A: Yes.

7 Q: Is it still operational today?

8 A: Yes.

9 Q: Do you use it on patients in the Myrtle Beach
10 center?

11 A: Yes.

12 Q: All right. Let's look at the top unit at the
13 top there, it's listed as 2100C/2300iX. Let's
14 talk about what you had when you got there in
15 2010.

16 A: When we acquired the center, it had a 2100C.
17 I believe it's a late 1990s vintage linear
18 accelerator. It also had very limited imaging
19 capabilities. It did have dual energy and
20 electrons and other things the 6EX did not
21 have.

22 Q: And so what did you do? What did you decide to
23 do then?

24 A: Well, we needed more throughput in the center
25 to get rid of some of the older technology, so

1 we applied for an exemption to replace the
2 2100C, and that exemption was approved and we
3 installed the 2300iX.

4 Q: Okay. And is this very similar to the machine
5 that Grand Strand proposes to use?

6 A: Yeah, I believe it is.

7 Q: Okay. And I noticed that in your 2011 -- when
8 you're looking at the three -- well, let me ask
9 you this. Why didn't you replace it with a
10 TrueBeam?

11 A: They weren't available at the time.

12 Q: When did a TrueBeam become available?

13 A: I think -- I don't know the exact date, but
14 they weren't even available when we went
15 through this process. They became available
16 sometime after this linear accelerator was
17 purchased and installed.

18 Q: Okay. Now, well, certainly it was after the
19 exemption request was granted, right?

20 A: Correct. Correct.

21 Q: When the TrueBeam first came out, was anybody
22 able to buy those?

23 A: No, when a new model comes out they generally
24 take, you know, you place an order and you'll
25 get it months down the road because it's not

1 like Varian has some sitting around just
2 waiting for people to buy them. They generally
3 build them when they get a purchase order. And
4 you can't just, you know, go buy one and get it
5 tomorrow.

6 Q: Can you explain to the Court why the treatments
7 for these machines, at least the 6EX and the
8 Tomo unit, increased in 2011 and then decreased
9 in 2012, while the 2100/2300 increases from
10 2011-2012. Can you explain that?

11 A: Yeah, well, when we -- when you replace a
12 linear accelerator, you know, on a very quick
13 aggressive schedule you can replace it in eight
14 weeks. A normal replacement time frame is
15 about 12 weeks. And it can even take longer
16 than that. So when we were replacing the
17 2100C, we had to put all of our patient volume
18 on the Tomo and the 6EX. So their volumes went
19 up during that time frame.

20 Q: Were they able to handle the extra capacity?

21 A: Yes.

22 Q: So there was a period of time there where you
23 had two machines, in a sense?

24 A: Right, two machines. We did extended hours to
25 accommodate the patients.

1 Q: Okay. All right. Let's take a look at dates
2 the -- I want to date this exemption with what
3 I -- if you would turn, you have the CRCC
4 exhibits there in front of you?
5 A: Yes.
6 Q: Take a look at Exhibit 28.
7 A: Okay.
8 Q: CRCC Exhibit 28.
9 A: Right. Well, wait, that's not what -- CRCCs
10 ...
11 Q: Respondent's 28.
12 A: Am I in the wrong book, because that's not
13 what's on the screen.
14 Q: Sorry, that's not on the screen, but that's the
15 right exhibit.
16 A: Okay.
17 MR. LONG: Are you having problems with that? Okay.
18 We may not have 28 on the screen, Your
19 Honor. Do you have it? In front of you is
20 the letter from ---
21 THE COURT: I've got it.
22 MR. LONG: You have it? Okay.
23 Q: I know you're not on this letter, it's
24 addressed to Ms. Price ---
25 A: right.

1 Q: --- but do you know what this letter is?

2 A: Let me look at it real quick. Replacement of
3 one exhibit conventional linear accelerators
4 with like equipment -- this is the approval
5 letter to replace the 21C with the 23iX.

6 Q: And what's the date of that?

7 A: It is dated November 3rd, 2010.

8 Q: All right. And so that would have been six
9 months after you acquired the center, right?

10 A: Yes.

11 Q: And then you see in there that the applications
12 were made in October?

13 A: Correct.

14 Q: Okay. And you've made already the application
15 for the -- to replace the 6EX was done earlier,
16 right?

17 A: Right.

18 Q: So that was done almost immediately after you
19 acquired the center?

20 A: Correct.

21 Q: Okay. Would the upgrade of the equipment of
22 the 23 to the 2300 have cost the company
23 millions of dollars in capital?

24 A: Yes.

25 Q: The acquisition of the 2300, what are the

1 benefits to upgrading the equipment?

2 A: Generally every time a new linear accelerator
3 is released it has better imaging and faster
4 throughput. You can treat more patients on
5 each newer generation you acquire.

6 Q: So, and what about the quality?

7 A: Well, with better imaging comes better quality.
8 I mean, I think that is a given, in my opinion.

9 Q: But you're not reimbursed based on the machine,
10 right?

11 A: No, the reimbursements are the same regardless
12 of the machine.

13 Q: So you're paid the same -- are you paid the
14 same amount for a treatment whether it's done
15 on a 6EX or whether it's done on a TrueBeam?

16 A: Yes.

17 Q: So there's no increase in revenue. Is there
18 any increase in revenue, basically, by getting
19 a new machine?

20 A: No.

21 Q: All right. Let's take a look at -- and you
22 said the other issue that you wanted to work on
23 when you first came here was distributing the
24 assets, right?

25 A: Correct.

1 Q: Tell the Court about what you mean by that or
2 what your plan was on that.

3 A: Well, we very quickly started looking at the
4 service area, the three-county area where our
5 patients were coming from and wanted to get the
6 linear accelerators out to where those patient
7 populations are.

8 Q: Let's take a look at CRCC Exhibit Number 27.
9 I actually want to turn over to the third page
10 of that email on 1682.

11 A: Okay.

12 THE COURT: Are you having computer problems?

13 MR. LONG: I'm not sure, we might be. It's Exhibit
14 Number 27, third page.

15 Q: I particularly want to direct your attention to
16 this email. All right. About the middle of
17 the page, can you tell the Court what this is,
18 this email right here?

19 A: Yeah, it's an email I sent to a consultant I
20 was introduced to. And, you know, the first
21 bullet point ---

22 Q: Let me walk you through.

23 A: Okay.

24 Q: First let's do, what date is it?

25 A: It is September 29th, 2010.

1 Q: Okay. 7:30 in the morning?

2 A: 7:31 a.m.

3 Q: Okay. Tell me what you're telling -- what
4 you're saying in this email in these three
5 bullet points.

6 A: I'm asking to set some time to discuss with
7 Doug, the first bullet point is that we -- it
8 was our attempt to replace the 6EX that was
9 denied. The second bullet point ---

10 Q: So is that the first -- the first bullet point
11 here is about what we just talked about?

12 A: Right, what we just talked about, yeah.

13 Q: Upgrading the equipment?

14 A: Yes.

15 Q: And I guess a couple weeks after that is when
16 you made the application and it got approved in
17 November, right?

18 A: Correct.

19 Q: To replace -- to go to the 2300?

20 A: Right.

21 Q: All right. What about the second bullet?

22 A: We wanted to -- we were -- wanted to talk about
23 preparing and submitting a CON application to
24 expand our current radiation therapy service at
25 an alternate location within the service area.

1 So expand to a fourth linear accelerator, but
2 at a different location than the current
3 location.

4 Q: Okay. So the decision had already been made
5 that you were going to do that on September
6 29th?

7 A: Yes.

8 Q: Okay. And then this third bullet, does it have
9 anything to do with anything?

10 A: No.

11 Q: Okay. It was about something that you had
12 received that you weren't ---

13 A: Right, I -- correct.

14 Q: Okay. All right. Now, I want to get you to
15 look at -- all right. We look up a little bit,
16 you'll see in his response he mentions and
17 copies a man named Sam Tolbert?

18 A: Correct.

19 Q: Okay. Who is he?

20 A: Sam is a consultant, he's here, that we use to
21 develop the CON applications.

22 Q: And when you do CON applications in states, is
23 that typical that you bring in some consultant?

24 A: Yeah, always. We have consultants in every
25 state.

1 Q: Okay. All right. Now, I'm going to jump you
2 over to Grand Strand Exhibit Number 46.

3 A: 46?

4 Q: 46. I'm really just mostly interested in the
5 date. We're going to talk about this email
6 for a second. Can you turn over to the -- this
7 is an email string.

8 A: Correct.

9 Q: I'm really focused on the very first email that
10 started the string.

11 A: Okay.

12 Q: Who is Rosa Maynor?

13 A: Rosa Maynor is the regional director for our
14 Region Three, which includes North and South
15 Carolina, the Panhandle of Florida, Alabama.

16 Q: She's here today, right?

17 A: She's here today.

18 Q: She's been here for the whole trial?

19 A: Yes, she's been here the whole trial.

20 Q: Okay. And you are on this group getting this
21 email, right?

22 A: Correct.

23 Q: Okay. And so what does she tell you? What's
24 the date of this?

25 A: September 30th.

1 Q: At 8:00 in the morning?

2 A: Eight.

3 Q: Or eight at night? In any event, it's

4 September 30th right?

5 A: Yes, right.

6 Q: Now, the email from you to Mr. Bryant was

7 September 29th, right?

8 A: Correct.

9 Q: This is the September 30th?

10 A: Correct.

11 Q: Next day, right?

12 A: Correct.

13 Q: What does she say to you?

14 A: In today's paper Georgetown has placed their

15 public notice to move their center from

16 Georgetown to Murrells Inlet. If they are

17 allowed to do this, it will take patients from

18 the Myrtle Beach radiation site. The public

19 notice is attached.

20 Q: Okay. Had you already decided on September

21 30th that you were going to add a new center in

22 another location?

23 A: Yes, because actually even prior to my note

24 contacting Doug, I generally, in a new CON

25 state I will research the CON regulations

1 myself, so I have a pretty good understanding
2 of them. So we had been working on that for
3 quite some time before even that email.

4 Q: Okay. And did you have any idea that
5 Georgetown might be moving to Murrells Inlet
6 prior to the morning of September 30th when it
7 was in the newspaper?

8 A: No, not until reading this email.

9 Q: And if someone in the company knew that
10 Georgetown was going to move a linear
11 accelerator to Murrells Inlet, would you be
12 told?

13 A: Yes.

14 Q: All right. Now, let's go back and ask, did
15 CRCC ultimately apply for a CON to go to
16 Murrells Inlet?

17 A: Yes.

18 Q: And Georgetown, did they go forward with theirs
19 too?

20 A: Yes.

21 Q: So what happened with those two applications?

22 A: They were both approved.

23 Q: Are they for new machines or for relocations?

24 A: Relocation of existing machines.

25 Q: So you made the decision that you would

1 relocate and replace to Murrells Inlet, right?

2 A: Correct.

3 Q: Is 21st Century opposing Georgetown's
4 relocation?

5 A: Yes.

6 Q: Is Georgetown opposing 21st Century's
7 relocation?

8 A: Yes.

9 Q: Why are you just generally opposing the
10 Georgetown relocation?

11 A: We are wanting to put our center where we get
12 a significant portion of our treatments, our
13 population from today. I believe it's, you
14 know, 20 percent plus or minus, so that's why
15 we want to put our center there. And we don't
16 believe Georgetown should abandon the service
17 area that they're currently servicing.

18 Q: And do you think there ought to be two linear
19 accelerators a half a mile from each other?

20 A: No.

21 Q: Do you think Murrells Inlet can support a
22 linear accelerator?

23 A: A, yes.

24 Q: You think it can support two?

25 A: That wouldn't make sense to me.

1 Q: Now, what are some of the benefits to -- I tell
2 you what, we'll wait on that. When you decided
3 to apply for the certificate of need, what did
4 -- tell me a little bit about what you looked
5 at in regards to potential locations.

6 A: This is where we worked very closely with Sam
7 Tolbert. We analyzed where are our patients
8 coming from, so the data we had, and then we
9 used his demographic population, and it -- you
10 know, it turned out that, you know, we get very
11 significant portions of our population outside
12 of Myrtle Beach from Murrells Inlet and from
13 Conway.

14 Q: Let's take a look at two exhibits. We're going
15 to look at Exhibits 1 and 5.

16 A: CRCCs?

17 Q: CRCC 1 and 5, and this will be these maps. You
18 can see them on the screen or you can ---

19 A: Okay.

20 Q: Let's look first at -- okay. Is one of the
21 things that you look at is population?

22 A: Correct.

23 Q: All right. This is a population map of what's
24 prepared based on the 2010 Census by zip code.
25 Is this the kind of information you would look

1 at to decide where you wanted to relocate?

2 A: Yes.

3 Q: And just looking at the population on here,
4 what do you see that's important to you?

5 A: Well, it's the Myrtle Beach, Conway, and then
6 the southern part of Horry County, which is
7 down towards the Murrells Inlet are where the
8 population, the big population centers are.

9 Q: Okay. And even in the zip codes, even Murrells
10 Inlet being orange, the key zip code is 22,000,
11 right?

12 A: Yes.

13 Q: See, I don't know if you can see that number
14 from here. So that's a significant population,
15 right?

16 A: Right.

17 Q: And then even in the north at North Myrtle
18 Beach, 29582, over 20,000?

19 A: Correct.

20 Q: It's 20,345. Is that a significant population
21 to you for a zip code?

22 A: Yes.

23 Q: Okay. All right. So you looked at this
24 information, right?

25 A: Correct.

1 Q: And why is the population important, population
2 density, where people are living?

3 A: That's going to tell you where the majority of
4 the patients are going to be coming from. Your
5 population centers are where the patients are
6 going to be, where they live.

7 Q: Is that the goal of what we're doing?

8 A: Right. We want to get care out to the
9 patients.

10 Q: Okay. Now, this is Exhibit 5. Now this is
11 CRCC patient origin by zip code.

12 A: Right.

13 Q: Now, this is based on the 2012 numbers, this
14 particular map.

15 A: Right.

16 Q: Have you had in the two years -- well, since
17 2010, since you acquired the center, has there
18 been any sort of significant shift in where
19 your patients come from?

20 A: Not that I'm aware of, no.

21 Q: So in 2010, would this map have looked very
22 similar to this?

23 A: Very similar.

24 Q: Okay. When you look at this particular map,
25 CRCC Exhibit Number 5, what is significant to

1 you about this map?

2 A: I mean, some of the colors have changed from
3 orange to purple, but it mirrors the patients
4 are in Myrtle Beach, down around Murrells
5 Inlet, in Conway and to the north.

6 Q: So you see on here four major geographic?

7 A: Correct.

8 Q: I mean, four major population centers?

9 A: Right.

10 Q: Okay. Now, in your -- was there analysis or
11 discussion among the group as to where you
12 should go?

13 A: Yes.

14 Q: Well, who were some of the people that would
15 have participated in that?

16 A: Well, myself, Sam, Doug, you know, local
17 management, Rosa, Sissy, Dr. Francke. You
18 know, from a corporate perspective, we had our
19 legal department. We had outside legal
20 counsel.

21 Q: So was it a fairly -- was it a decision made
22 solely by you?

23 A: No.

24 Q: Is it a decision solely made by Mr. Tolbert?

25 A: No.

1 Q: So was it a number of people trying to reach
2 consensus?

3 A: Yes, a very collaborative process.

4 Q: Did people express their opinion?

5 A: Yes.

6 Q: Did some of their opinions differ?

7 A: Yes.

8 Q: Tell us what you ultimately decided in regards
9 to kind of the order in which you would
10 proceed?

11 A: Well, our largest unserved population area was
12 Murrells Inlet, and we decided to relocate one
13 of the centers to Murrells Inlet. The next
14 largest population unserved was in Conway, so
15 that's why we chose to expand to Conway as
16 opposed to the north. That still has a
17 significant population, but not as big as
18 Conway.

19 Q: Okay. I want to ask about a couple of things
20 when you were looking at this. This Conway zip
21 code right here, 29526, would you say that
22 that's a fairly large zip code?

23 A: Yes.

24 Q: That's a fairly large geographic area?

25 A: Right.

1 Q: This Murrells Inlet zip code, 29576, is it
2 larger or smaller than the Conway?

3 A: Smaller geographic.

4 Q: Okay. So when you were looking at Murrells
5 Inlet as an area of drawing patients, were you
6 looking at more than just 29576?

7 A: Yeah, I believe -- I believe it was more than
8 one zip code, yes.

9 Q: So would it have been this zip code to the
10 north, 29575?

11 A: Yes.

12 Q: And then also, how about part of 29588?

13 A: Correct.

14 Q: Okay. And then when you were looking at
15 Conway, it was mostly, I guess, 29526?

16 A: Correct.

17 Q: Maybe some to the left here?

18 A: Yes.

19 Q: Okay. Were there other people who advocated
20 for North Myrtle Beach?

21 A: Yes.

22 Q: Okay. But ultimately, was that accepted or
23 rejected at that time?

24 A: Rejected at that time. Until the analysis was
25 complete, you know, there was a lot of

1 speculation north, Conway, Murrells Inlet, and
2 others.

3 Q: Well, what was the driving factor in the choice
4 to choose these two locations at this time?

5 A: Well, where we were getting significant
6 portions of our patients from already and the
7 largest unserved areas in the county.

8 Q: Okay. Ultimately, is North Myrtle Beach an
9 attractive area?

10 A: Yes, it would be next in line.

11 Q: Were there also some other advantages to the
12 Conway location in regard -- compared, other
13 than just patient origin and population?

14 A: A significant advantage to Conway was the
15 existence of a already built center so that it
16 would be cheaper and faster to being put on
17 line.

18 Q: Okay. What do you mean an already built
19 center?

20 A: My understanding is, and I don't have the exact
21 time frame, but in the early to mid-2000s, a
22 different entity applied to get a CON and
23 actually built the center without having the
24 approval.

25 Q: Including the vault?

1 A: Including the vault, right. So it's been
2 sitting dormant for quite some time." We ended
3 up leasing the facility, have it under lease.
4 And that's the facility we're going to open
5 once we get approval.

6 Q: And the center, just remind the Court about in
7 a center, the vault. Why is that significant?

8 A: Well, the vault, you have to -- for a linear
9 accelerator treatment with, you know, millions
10 of volts of radiation therapy, you have to
11 shield the room; otherwise, that radiation
12 would sicken everybody, you know, in the
13 facility. So a vault is a very integral part
14 of radiation therapy. It can be built
15 different ways, concrete or lead. The cost is
16 typically anywhere from a million to two
17 million dollars to build one, depending on the
18 materials.

19 Q: A significant investment?

20 A: Very significant.

21 Q: And so you have a building in Conway that
22 already has a vault?

23 A: Already has the vault. A very large vault,
24 actually.

25 Q: Okay. Once the decision was made to go forward

1 with the CON for Conway, who was the
2 quarterback of the CON?

3 A: Well, I quarterbacked the data. Sam Tolbert
4 was the one that was, you know, preparing the
5 application.

6 Q: Who were some of the other people that worked
7 on it and what were their roles?

8 A: You know, Rosa and Sissy and Dr. Francke worked
9 on it locally. You know, a lot of that would
10 have been the local support for the project.
11 We had, you know, obviously outside counsel
12 that helped work on it. We have a facilities
13 department that, you know, went and visited the
14 center. We have an architect that they've
15 contracted that, you know, reviewed the center,
16 and we've made recommendations to improve it.
17 You know there --

18 Q: There are going to be some construction to the
19 building itself, right?

20 A: Yes, there is.

21 Q: As part of the project? And in regards to
22 working with Mr. Tolbert and yourself and the
23 other people in the group, did y'all work
24 collaboratively on that?

25 A: Yes.

1 Q: Did you have regularly scheduled phone calls?

2 A: We had several phone calls. We, you know,
3 reviewed drafts, updated the drafts. It was a
4 very collaborative process.

5 Q: Were there lots of emails exchanged between the
6 parties?

7 A: Yes.

8 Q: Lots of conversations?

9 A: Yes.

10 Q: And were those all collected and produced in
11 discovery?

12 A: Yes, I've seen many, many, many documents.

13 Q: I want to just give a couple of examples for
14 the Court. Let's take a look at CRCC Exhibit
15 Number 34.

16 A: Okay.

17 Q: You're on these emails, right?

18 A: Yeah. Yes.

19 Q: Can you kind of tell me what's going on here?

20 A: I think this is where we're working with Sam.
21 So Sam was needing information and I'm
22 responding back to him, giving it to him or
23 answering questions.

24 Q: So is this part of the effort of back and forth
25 and getting materials for the application?

1 A: Yes.

2 Q: All right. Let's take a look also at 30 -- are
3 we at 35 here or 34?

4 A: 34.

5 Q: Okay. Take a look at 35. I think 35 may
6 predate 34 actually. Is this similar? Can you
7 tell me about this email, 35?

8 A: Yeah, 35. Here again, I'm, you know, working
9 with Sam answering questions or giving input.

10 Q: All right. I want to look at this particular
11 email too where you're commenting about the
12 hours that it would be open, okay?

13 A: Right.

14 Q: And you say in here 9,000 treatments if
15 operating 12 hours a day, 7,000 if nine hours
16 a day. Can you explain that?

17 THE COURT: Where was that?

18 MR. LONG: I'm sorry, at the very top of Exhibit 35.

19 THE COURT: Oh, I see.

20 A: Yeah, I mean, if you take ---

21 Q: This is excessive framework, I'll lay some
22 foundation for this. This is part of the
23 conversation of preparing for the CON?

24 A: Right. But basically, you take the annual
25 treatments and divide it by the number of

1 treatment days and then divide that into the
2 number of days a center is open and you can,
3 therefore, project the capacity of a machine.
4 So depending on how many hours a day your
5 center is going to be open ---

6 Q: Well, let's walk through the math of that real
7 quick.

8 A: Okay.

9 Q: Let's do a -- I have to get a calculator.

10 A: A calculator, yeah. I've lost the ability to
11 do math in my head.

12 Q: That's okay. I bought a big calculator for
13 these cases, all right, we've got a lot numbers
14 on it.

15 A: Yeah. If you go ---

16 Q: Let's slow down a second.

17 A: Okay.

18 Q: Let's say -- are there a couple of different
19 ways to look at utilization in a center,
20 treatments per day?

21 A: Correct.

22 Q: Do y'all often do that when you talk among
23 yourselves?

24 A: Right, treatment per day is a very, very common
25 metric.

1 Q: Okay. Also do annual treatments, right?

2 A: Correct.

3 Q: I guess you can look at it monthly too, right?

4 A: Correct.

5 Q: Typically, are you more likely to track

6 treatments or patients?

7 A: Treatments per day.

8 Q: Okay. All right. If you were doing -- if you

9 were doing, let's say, 7,000 treatments you

10 said if operating nine hours, tell me what your

11 -- how your -- what your calculation is there?

12 A: Well, if you go with 7,000 treatments, okay,

13 7,000 treatments and if you use a 250 day

14 treatment ---

15 Q: And I did 250 yesterday, do you have a

16 different number you use?

17 A: I always use 255. But to be consistent so to

18 -- this is the way I would do it. I would take

19 7,000 divided by 255 treatment days, that's 27

20 and a half treatments per day. And then you

21 said a nine hour, so then divide that by nine

22 is three treatments per hours.

23 Q: Okay. Is three treatments per hour pretty

24 normal?

25 A: Very reasonable.

1 Q: Okay. So it's not very hard to hit 7,000
2 treatments ---

3 A: No.

4 Q: --- in a center, is it?

5 A: No, not at all.

6 Q: And nine hours would be typical, and actually,
7 the centers are often open more than nine
8 hours, right?

9 A: Right. We often have centers that offer early
10 evening hours because the patients work and
11 want to come in after work.

12 Q: Okay. How about early in the morning?

13 A: Very early, too, to go in before work.

14 Q: Doctors like to work early in the mornings,
15 which we don't have?

16 A: Right.

17 Q: Okay. And is that true even if you're doing a
18 heavy load of IMRT?

19 A: Yeah, with the advancement of technology your
20 IMRT treatments are much quicker than they
21 were, you know, when they initially came out;
22 hence, you know, the reason why we needed to
23 upgrade the equipment.

24 Q: All right. In regards to the CON, did you have
25 a special role in defining it?

1 A: Yes.

2 Q: Tell the Court about that.

3 A: I did the pro formas that were included.

4 Q: All right. Why don't we take a look at that

5 real quickly. Let's look at page 533. Do we

6 need to get into the CON application?

7 A: Which exhibit?

8 Q: Joint Exhibit 1. And the page is I think 533.

9 It looks like this.

10 A: Which number?

11 Q: It says CRCC on it.

12 A: Okay. I got it.

13 Q: There's actually two pro formas in the

14 application. There are two different times you

15 submitted documents to the Department?

16 A: Yes.

17 Q: Do you recall why that is?

18 A: Well, we supplied -- the original one was

19 Conway project. Then I believe they asked us

20 to supply one that showed with the Conway and

21 Murrells Inlet projects, and I believe they

22 even asked us at a different time to supply an

23 additional year.

24 Q: Okay. And so this is the one from, on page

25 533, if you want to turn to that and give the

1 Court the date.

2 A: 533, the date is April 29th of 2011.

3 Q: Okay. So this would have been after the

4 application was filed, right?

5 A: Right.

6 Q: And that was in March?

7 A: March.

8 Q: And you would have filed the pro forma. The

9 original pro forma would have been filed with

10 the application, right?

11 A: Correct.

12 Q: Are there any differences on the two pro

13 formas, except for this additional year? I

14 mean, as far as the revenue and expense

15 projections and all?

16 A: Well, I think -- yeah, the second one we

17 supplied they asked us to include both Murrells

18 Inlet and Conway both in the same pro forma.

19 Q: Yeah, but I'm just saying like the Conway pro

20 forma, did you change the revenue or expenses?

21 A: Oh, no. No, no, no, no.

22 Q: Let's look at page number 533 here in the

23 middle of the page.

24 A: Okay.

25 Q: Can you tell the Court what you're telling the

1 Department here?

2 A: Regarding the payor mix?

3 Q: Yes.

4 A: Yeah, the payor mix assumption was based off
5 2010 actuals. We had 53.6 percent Medicare,
6 3.3 percent Medicaid, 1.6 percent self-pay, 4.9
7 percent HMO, and then 28.5 percent PPO and then
8 8.1 percent commercial.

9 Q: Okay. So Medicare, of course, is the federal
10 government reimbursement, right?

11 A: Correct.

12 Q: So you're 53 and a half, 53.6 percent, right?

13 A: Correct.

14 Q: Medicaid, 3.3?

15 A: Yes.

16 Q: So those are government payors?

17 A: Correct.

18 Q: Then self-pay is pretty small. HMO, PPO and
19 commercial are all those ...

20 A: Those would be mostly private payors.

21 Q: Like insurance companies primarily?

22 A: Yes, Blue Cross Blue Shield, Aetna, United,
23 that type.

24 Q: Okay. And this is based off your actual
25 numbers in Myrtle Beach?

1 A: For 2010, yes.

2 Q: Are those fairly typical for your other centers
3 in the country?

4 A: Yeah. I think as a company we're just shy of
5 50 percent Medicare, so this is just above it,
6 and that will vary center to center.

7 Q: Okay. How did you do -- let's turn over to the
8 next page. And 530, well let's actually I
9 think go to the last page, 536. I think it's
10 the actual pro forma. It's a little tougher to
11 read. Do you want to just kind of briefly or
12 generally kind of explain to the Court what
13 this pro forma shows?

14 A: Yeah, this was where they had asked us to put
15 one pro forma with both Conway and Murrells
16 Inlet together, so you have 2012 where we're
17 showing, you know, at that time that the Conway
18 Center would be open, but Murrells Inlet
19 wouldn't be online yet. And then you go to
20 2013 where we have both centers open and it
21 continues 2014 and 2015.

22 Q: Okay. What is the basis of the pro forma;
23 where did you get the information?

24 A: We used the actual data we had pre-acquisition
25 and for 2010 with very minimal data at that

1 time on 2011. Because we had to file the
2 application in March, so it's really based off
3 2010 actual pre and post-acquisition and the
4 prior year actual P&Ls.

5 Q: Okay. Did you take into account that there
6 would be different types of treatment?

7 A: Yes.

8 Q: Like IMRT and non-IMRT?

9 A: Yes.

10 Q: Did you take into account different payors?

11 A: Yes.

12 Q: And the sdifferent reimbursement that those
13 payors would have?

14 A: Yes.

15 Q: And how about your expenses, where did those --
16 that information come from?

17 A: Well, the expenses we projected. Because you
18 start with actual, but then when you're
19 deploying, opening two new centers, you're
20 going to have two additional rents; you're
21 going to have two additional -- well, actually
22 in this case, one additional machine and one
23 relocated machine, albeit the new machine,
24 that's going to be more expensive than the
25 current machine. And then you have additional

1 staff and, you know, a whole slew of other
2 expenses that are all built into this
3 projection.

4 Q: Do you typically do the pro formas for the
5 certificate of need applications for the
6 company now?

7 A: Yes.

8 Q: How about if y'all do an acquisition, do you do
9 the pro formas for that?

10 A: Yes.

11 Q: So how many pro formas have you done?

12 A: Hundreds, probably ---

13 Q: Dozens? Hundreds?

14 A: Probably -- yeah, high hundreds. I mean, I'm
15 doing -- I was working on a pro forma last
16 night.

17 Q: All right. Let's take a look at -- are you
18 very familiar in your position with how much
19 these payors -- let's go back to the payor mix
20 page that we earlier looked at. Are you very
21 familiar with how much these payors reimburse
22 for radiation therapy services?

23 A: Yeah. What we do is generally benchmark
24 against Medicare because it's set and easy to
25 benchmark against.

1 Q: Why is it easier to benchmark against?

2 A: I mean, it's based off of, not to get into a
3 lot of technical, it's based off an RVU value.
4 So they give every procedure code a value.
5 They assign a dollar to that, so it's data that
6 you can easily benchmark to.

7 Q: It's available, right?

8 A: And available, correct.

9 Q: And it's available to payors too?

10 A: Yes.

11 Q: So a payor, like a commercial insurance
12 company, they know what you're getting
13 reimbursed for Medicare, right?

14 A: Correct.

15 Q: And so how much ability do you have to
16 negotiate with CMS to get a better Medicare
17 reimbursement than other centers in the United
18 States?

19 A: None. They set the rate.

20 Q: And they tell you what they're going to pay
21 you, right?

22 A: Right.

23 Q: All right. So let's take a look at Grand
24 Strand CON Joint Exhibit 2. This one. And
25 take a look at page number 306, okay.

1 A: Okay.

2 Q: And as part of your position at 21st Century,
3 are you also aware of reimbursement -- at least
4 certain governmental -- well, reimbursement for
5 hospital based ---

6 A: Yes, I'm very ---

7 Q: --- centers?

8 A: Yes.

9 Q: How is that?

10 A: Well, different ways. One, we partner with
11 many hospitals and have access to their
12 reimbursement information. And secondly, we're
13 part of what's called the Radiation Therapy
14 Alliance, and it's a group that analyzes the
15 annual Medicare reimbursements and compares
16 physician reimbursement to hospital-based
17 reimbursement.

18 Q: This is the portion of the Grand Strand CON
19 where they laid out their reimbursement for,
20 their expected reimbursement from their
21 different payors.

22 A: Correct.

23 Q: Okay. So I'd like you to kind of go through
24 these one at a time for me and let's talk about
25 them. The first one on the list, of course, is

1 Medicare.

2 A: Correct.

3 Q: And they estimated that their Medicare
4 reimbursement would be three -- in 2013 would
5 be \$324 per treatment?

6 A: Correct.

7 Q: Can you tell me your response to that?

8 A: It can't be correct. I mean, Medicare should
9 be, on a freestanding basis, probably closer to
10 900, and in a hospital, probably closer to
11 \$1,000 per treatment.

12 Q: Hospitals are reimbursed higher than
13 freestanding?

14 A: Yes, they are.

15 Q: Typically, by how much?

16 A: About ten percent.

17 Q: Based on what? What do you base that on?

18 A: That's based through the work with Radiation
19 Therapy Alliance. We have a consultant that
20 has direct access to the Medicare data, and
21 they actually compute that every year that the
22 reimbursement announcements are made.

23 Q: Okay. Let's switch over, we'll come back to
24 this screen in a second. Let's switch over ---

25 THE COURT: You said for freestanding it's about

1 900, for hospital it's about 1,000.

2 MR. LEWIS: Yeah, and that can vary, but that, I
3 think, is a pretty good estimate for ---

4 THE COURT: Okay. I just wanted to make sure I got
5 your testimony.

6 MR. LEWIS: Yeah.

7 Q: Let's take a look a CRCC 140. Just hold your
8 place there; we're going to come back to that.

9 A: Okay.

10 Q: But while we're on this Medicare reimbursement
11 issue, let's just look at -- that's Grand
12 Strand, I'm sorry. 140.

13 A: 140 is right there.

14 Q: Tell the Court what this document is.

15 A: Oh, okay. Yeah, this is what I was talking
16 about. This is the -- Avalere is a consultant
17 that the Radiation Therapy Alliance uses, and
18 they have direct access to the CMS actual
19 claims data. And this is the analysis of 2013
20 actual and 2014 proposed Medicare
21 reimbursements hospital outpatient versus
22 freestanding clinics.

23 Q: Okay. So when you were using the number 900,
24 you were actually talking -- is that a blended
25 number? Well, let me ask you this. Looking at

1 this chart here and your experience, is the
2 reimbursement different for different types of
3 treatment?

4 A: Yeah, different diagnoses, different -- I mean,
5 your reimbursement is going to vary based on
6 diagnosis, based on payor, based on the
7 technology you utilize.

8 Q: Well, let's just talk about Medicare.

9 A: Right.

10 Q: So if you -- explain why there are different
11 categories of numbers on there.

12 A: Yeah, well that -- this would be the technology
13 differential. IMRT is the most complex. Well,
14 not the most complex external beam, but it's a
15 more complex external beam treatment. It has
16 a higher reimbursement than what's listed as
17 the 3D-CRT, or commonly referred to as
18 conformal treatments. Those have a lower
19 reimbursement per treatment.

20 Q: Okay. And it shows here over in this, I guess
21 it's fourth column over, the percentage that
22 freestanding is reimbursed compared to
23 hospital, right?

24 A: Correct.

25 Q: So what does that 90 percent number mean?

1 A: It means that a freestanding center is getting
2 90 cents on the dollar compared to a hospital
3 for the exact same procedures performed.

4 Q: The hospital's getting a dollar for the exact
5 same thing; freestanding gets 90 cents?

6 A: Correct.

7 Q: What's the proposal for 2014?

8 A: It goes even worse. It's 80 cents on the
9 dollar.

10 Q: Okay. Now, let's go back to the CON
11 application, page 306.

12 A: Page 306, I've got it.

13 Q: Right. So you think the reimbursement per
14 treatment for a hospital is probably 1,000
15 average and for a freestanding 900?

16 A: Yes. I mean, yes.

17 Q: Significantly more than 324?

18 A: Correct.

19 Q: Okay. How about Medicaid? Does Medicaid
20 reimburse higher or lower than Medicare?

21 A: I've never seen it -- it's always lower than
22 Medicare. This just doesn't make any sense.
23 In the Myrtle Beach market, it should be
24 probably 75 to 80 percent of Medicare.

25 Q: All right. Now, HMO/PPO, that's your

1 commercial, right?

2 A: Correct.

3 Q: Okay. What is your -- okay. They projected
4 that their reimbursement from commercial payors
5 would be five times Medicare?

6 A: Five times, I'm a little surprised at that.
7 Generally, what I see with the hospitals we
8 work with, they get a 200 to 300, two times to
9 three times multiple Medicare. But HCA is, you
10 know, the largest healthcare or largest
11 hospital, so maybe they can achieve a five
12 times multiple. I mean, that's what their data
13 would show.

14 Q: So if they were doing a five times multiple in
15 their reimbursement for commercial, they would
16 be getting reimbursed ---

17 A: Five thousand per treatment.

18 Q: Five thousand per treatment, not 1,500?

19 A: Correct.

20 Q: What would you expect to see in a freestanding
21 center in Myrtle Beach that's an average per
22 treatment for commercial?

23 A: Commercial, you know, a good contract for us is
24 probably a 10 percent to 30 percent multiple.
25 So, you know, taken on the high end, 30 -- you

1 know, that would be, you know, \$1,100 on the
2 high end. Probably \$1,000 on the low end from
3 a commercial payor.

4 Q: Okay. Well, you heard the testimony earlier
5 from some of the witnesses that if Grand Strand
6 gets a linear accelerator that the payers, the
7 commercial payors will have leverage to
8 negotiate ---

9 A: Right.

10 Q: --- down your reimbursement at CRCC. What's
11 your response to that?

12 A: That doesn't make any sense.

13 Q: Okay. Why not?

14 A: It would make sense if it were two hospitals or
15 two freestanding centers because then that
16 payor could go to one of those entities and cut
17 an exclusive deal. But when you're comparing
18 a freestanding center that's getting a 10
19 percent, maybe 25, 30 percent markup versus a
20 hospital that's getting, you know, upwards of
21 500 percent markup, the payor's not going to
22 come to the freestanding to cut their rate.
23 The payor's going to try to funnel their
24 patients ---

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

1 THE COURT: Whoa, whoa. Okay.

2 MR. THOMAS: I'm sorry, he's -- he said 500 percent
3 markup. All right. There's been no evidence
4 entered to that. The only evidence that I've
5 seen so far is an exhibit that we got and was
6 actually showed to you just recently. And I
7 just don't want -- I mean, all that testimony
8 -- the question itself is assuming facts not in
9 evidence.

10 THE COURT: He's also speculating about what the
11 payor's going to do.

12 MR. LONG: Your Honor, it's his reaction to how the -
13 - they've testified from their witnesses how
14 this would impact it. He's just ---

15 THE COURT: Well, at least on the --

16 MR. LONG: I'm just giving ---

17 THE COURT: On the percentages, lay the foundation
18 because I haven't heard it.

19 MR. LONG: Okay. Your Honor, I would say I have
20 laid the foundation on the percentages ---

21 THE COURT: Okay.

22 MR. LONG: --- because we've just looked at their
23 application and he just answered several
24 questions about their application.

25 THE COURT: Well, he said it was five times.

1 MR. LONG: Yeah, that's what he said. When he says
2 500 percent, he means five times, not 500
3 times, five times. We can clarify, I'll ask
4 him to clarify that. But that's what he's
5 talking about.

6 THE COURT: Well, that's all I'm ---

7 MR. THOMAS: Well, no, because what he ---

8 MR. LONG: But that comes directly from their
9 application and he's already -- that's already
10 ---

11 THE COURT: I heard the five times.

12 MR. THOMAS: Yeah, but nowhere in our application
13 does it say five times. Now, let me tell you
14 what it says. It says HMO/PPO and it's still
15 on the screen, so you're up there, 1,400 Mr. --

16 -
17 THE COURT: Well, can I stop you so you ---

18 MR. THOMAS: Yeah.

19 THE COURT: From what I've heard, he got the five
20 times from the difference in Medicare,
21 Medicaid and going up to HMO ---

22 MR. THOMAS: But he just testified those Medicare
23 numbers were wrong, so now he's comparing. He
24 said it was wrong, then he's saying well,
25 HMO/PPO is five times the 305, which is wrong.

1 He didn't say the HMO/PPO was wrong.

2 THE COURT: I follow the theory of what he's saying.

3 So following the theory of what he's saying, I
4 think he can testify. You may come back and
5 present testimony that that theory is
6 incorrect, but following his analysis, just
7 give me the 500 percent, so I ---

8 MR. LONG: Yeah, let's clarify that if that's
9 confusing in the record.

10 Q: When you said the 500, you didn't mean 500
11 times, right?

12 A: Right, five times is 500 percent.

13 Q: Okay. So according to that page, the
14 commercial is five times the Medicare or a
15 little less than five times?

16 A: Yes, their data to me would present to me that
17 they are expecting to get five times Medicare
18 on their HMO/PPO product line.

19 Q: And is part of the reason you believe that from
20 that page is because Medicare is a benchmark?
21 You testified to that earlier.

22 A: Correct.

23 Q: Explain what that means.

24 A: Well, a benchmark is a data point that you use
25 to then compare other, in this case, payors to.

1 So on Medicaid you would expect to receive less
2 than Medicare, so you might -- your benchmark
3 might be .8 times or 80 percent of Medicare.
4 For us on a commercial payor, you know, the
5 benchmark might be 1.3 times or 130 percent of
6 Medicare.

7 Q: Okay. And Medicare, the Medicare benchmark is
8 a data point. Is that a data point that's used
9 in the negotiations of the payors?

10 A: Yeah. Often you negotiate your rate as a
11 percent of Medicare. So as Medicare fluctuates
12 its payment year to year to year, if your
13 contract says you're going to get reimbursed at
14 130 percent of Medicare, your reimbursement
15 will go up or down as Medicare goes up or down.

16 Q: Okay. Now, getting back to my question, which
17 is, you have a freestanding center and a
18 hospital center, okay why do you think that
19 your freestanding center is not likely to have
20 to negotiate lower rates because of a hospital-
21 based center.

22 A: The hospital or the payor will understand that
23 we're a much more economical solution for their
24 patients, but the payor cannot sign an
25 exclusive deal with us because the hospital

1 provides a much larger spectrum of services and
2 the payor doesn't have the clout to carve out
3 a line of business from the hospital. So they
4 have to provide both options to their patients
5 or the employers won't buy their insurance.

6 Q: And what about your potential to get -- what
7 about the potential that the hospital could get
8 an exclusive and patients could not come to
9 your center?

10 A: That's a possibility, but it would not make
11 sense from the payor perspective because they
12 would be paying the more expensive 100 percent
13 option.

14 Q: So they would be exclusively contracting to pay
15 more?

16 A: Correct.

17 Q: All right. Does your center in Myrtle Beach
18 provide PET/CT?

19 A: No.

20 Q: Where are the PET/CTs performed typically in
21 Myrtle Beach?

22 A: My understanding is at the medical oncologists.

23 Q: Coastal?

24 A: Coastal.

25 Q: Dr. Holt's group?

1 A: Yeah, Dr. Holt.

2 Q: They have a PET/CT?

3 A: I believe they have more than one, but I know

4 they have at least one.

5 Q: Okay. All right. Let's go and talk about --

6 now, do you -- let's turn to the CRCC

7 application if we could, which is Joint Exhibit

8 1, and ask you to turn, I'm sorry. It's Joint

9 Exhibit 2.

10 A: Joint Exhibit 1. All right, I got it.

11 Q: Oh, no, it's 1. I wrote this down wrong. I

12 actually did not; somebody else wrote it down

13 wrong. Do we have the CRCC application, Joint

14 Exhibit 1, page 246.

15 A: Okay.

16 Q: Did you help prepare or get the information to

17 do this chart for the application?

18 A: Yeah, actually I retrieved it from our legal

19 department. They handle these types of things.

20 Q: All right. And this will reflect the current

21 ownership of the center in South Carolina?

22 A: Correct.

23 Q: Okay. So Radiation Therapy Services, we've

24 been calling -- how does that relate to 21st

25 Century?

1 A: Radiation Therapy Services is our parent
2 company. All of our legal entities roll up to
3 that. How it relates to 21st Century Oncology,
4 it's really twofold. 21st Century Oncology,
5 LLC is our primary operating entity in Florida,
6 physician, you know, employing group. But we
7 also do business as across the company 21st
8 Century Oncology, so it's a d/b/a in South
9 Carolina.

10 Q: Okay. And is there an LLC for 21st Century in
11 South Carolina?

12 A: Yes. There's several, but the first, the
13 highest level entity in South Carolina is 21st
14 Century Oncology of South Carolina, LLC.

15 Q: Okay. And is that wholly owned by Radiation
16 Therapy Services?

17 A: One hundred percent.

18 Q: All right. And then does 21st Century Oncology
19 of South Carolina own Atlantic Urology?

20 A: Yes.

21 Q: Do they 100 percent own that?

22 A: Yes.

23 Q: Are there any South Carolina physicians that
24 are owners of Atlantic Urology?

25 A: No.

1 Q: Are there any South Carolina physicians that
2 are owners of 21st Century Oncology of South
3 Carolina?

4 A: No.

5 Q: Then Atlantic Urology owns Carolina Regional
6 Cancer Center?

7 A: Correct.

8 Q: Are there any South Carolina physicians that
9 are owners of Carolina Regional Cancer Center?

10 A: No.

11 Q: When 21st Century acquired Carolina Regional
12 Cancer Center, CRCC, did they also acquire
13 Atlantic Urology at about the same time?

14 A: Yeah. They were done simultaneously.

15 Q: Okay. What was Atlantic Urology?

16 A: Atlantic Urology Clinics, it wasn't an LLC, but
17 Atlantic Urology Clinics was the local urology
18 group that we acquired.

19 Q: So that's the urologists in Horry County, or at
20 least Horry?

21 A: Horry, parts of Georgetown, I believe, too.

22 Q: Okay. And what happened with those physicians
23 that were owners of or had ownership in
24 Atlantic Urology?

25 A: They became employees of Atlantic Urology

1 Clinics, LLC.

2 Q: So they're employees of 21st Century?

3 A: They are employed, yes.

4 Q: All right. Now, so do most physicians who are

5 employees, do they own Carolina Regional Cancer

6 Center?

7 A: No.

8 Q: Do the employees of Carolina Regional Cancer

9 Center work for those physicians?

10 A: No.

11 Q: All right. Now, Carolina Regional Cancer

12 Center, there's physicians that work there,

13 right?

14 A: Correct.

15 Q: I'm not looking for the names for the moment,

16 but just who works -- what types of physicians

17 work at CRCC?

18 A: Radiation oncologists.

19 Q: I think there are three, right?

20 A: Correct.

21 Q: Do those physicians work for those urologists?

22 A: No.

23 Q: If the urologist thinks it's in the patient's

24 best interest to do surgery, are they allowed

25 to do that?

1 A: Yes.

2 Q: Do the urologists themselves actually own
3 another entity?

4 A: Yeah, the urologists separate from 21st
5 Century, we have no ownership in it, they own
6 at least one surgery center. I don't -- it's
7 not involved at 21st Century Oncology, so I
8 really don't know much about it other than
9 that's not uncommon for urologist surgeons to
10 own a surgery center outside of their
11 employment with us.

12 Q: And so they own that themselves, right?

13 A: Correct.

14 Q: So if they do procedures there, they get the
15 revenue from that?

16 A: Yeah, their separate legal entity would do the
17 surgery center billing and collections.

18 Q: And are there any requirements that those
19 urologists only send their patients for IMRT
20 treatment?

21 A: No.

22 Q: Now, let's go look at CRCC Exhibit 21. Well,
23 actually before we get there -- well, let's
24 just talk about this and we don't have to go to
25 the page. I think in the CON application I

1 think there's been some documents that have
2 been produced that talk about consults.

3 A: Correct.

4 Q: Particularly consults for the urologists, okay?

5 A: Okay.

6 Q: What is the -- can you explain what a consult
7 is and why that's different from, say, a
8 treatment plan?

9 A: Right. A consult, I mean, it's a specific CPT
10 code that, you know, all physician types use.
11 It's when they do either an initial visit with
12 a new patient or, say, an annual follow-up
13 visit with an established patient. So the
14 consult is when, for example, a referring
15 physician, a neurologist, a medical oncologist,
16 a surgeon sends the patient for their initial
17 meeting with the radiation oncologist.

18 Q: And then is it -- or do those patients always
19 have radiation therapy?

20 A: No, they often do not.

21 Q: And is there a significant percentage of
22 patients who have a consult that don't have it?

23 A: Yes.

24 Q: And is that because they're not clinically,
25 it's not clinically appropriate for them?

1 A: Sometimes it's not clinical appropriateness.
2 Sometimes, you know, they have options. They
3 could have, you know, some other type of
4 therapy. You know, unfortunately, sometimes
5 the patient dies before they get to treatment.
6 There's many reasons a consult doesn't convert
7 to a treatment plan.

8 Q: Okay. But that would not -- so do consults
9 represent actual patients in the center who's
10 receiving treatments, that is a total number?

11 A: Patients in the center, but no, not receiving
12 treatment.

13 Q: Okay. Now, let's take a look then at Exhibit
14 Number -- let's look at 25 first. Mostly focus
15 on the top part of this exhibit here. All
16 right. First, on this Exhibit 25, you have it
17 in front of you?

18 A: Yes.

19 Q: You collected or who collected this data?

20 A: I did.

21 Q: Or people under your supervision did?

22 A: Yes.

23 Q: And did you produce this as part of the
24 discovery process?

25 A: Yes.

1 Q: All right. Now, is 2010 a full year or a
2 partial year?

3 A: No, it would be a partial year, because pre-
4 acquisition data would not be in that database
5 I mentioned.

6 Q: Okay. What are you showing on Exhibit 25?

7 A: This is the by financial year, so 2010, '11,
8 and I assume it goes through 2012. It's by
9 patient zip code, referring physician, and then
10 the referring physician group where the group
11 is broken into AUC, the urologists, Coastal,
12 the medical oncologists, and all others.

13 Q: Okay. And all others would include what kind
14 of physicians?

15 A: Surgeons of any type, ENTs, pulmonologists, you
16 know, any type of physician that would see a
17 patient with a cancer treatable with radiation.

18 Q: Now, the group of other is a fairly large
19 group, isn't it?

20 A: Yes.

21 Q: As in number of physicians?

22 A: Correct.

23 Q: On the chart? But do any of those physicians
24 have a very high number, or is it -- are their
25 numbers less than the urologists and the

1 medical oncologists?

2 A: You know, as a group, they're probably in total
3 somewhat comparable, I would think, but per
4 physician, much less.

5 Q: Okay. So those are calculated by -- what is
6 treatment plans need?

7 A: Treatment plans is where the patient not only
8 came in for the consult, the physician and
9 patient agreed that radiation therapy was
10 appropriate. So then the physician did the
11 treatment plan to order the radiation therapy
12 to be delivered to that patient.

13 Q: When you're saying physician, that the
14 physician met with the patient, what type of
15 physician are you talking about?

16 A: Radiation oncologist.

17 Q: Now, the treatment plan, so are we using the
18 treatment plans to represent patients?

19 A: Patients treated.

20 Q: Yeah. Because if a patient has a treatment
21 plan, they're probably going to get the
22 radiation treatment, right?

23 A: Correct.

24 Q: You wouldn't order a treatment plan unless you
25 decided that you were going to do it?

1 A: Right. There's a lot of work that goes
2 involved in creating the plan. You wouldn't do
3 that until the patient's already agreed that
4 they want to receive the radiation treatments.

5 Q: Okay. So this shows, this exhibit right here
6 shows the number of patients that each of these
7 physicians referred to CRCC?

8 A: Correct.

9 Q: By zip code?

10 A: By zip code.

11 Q: And also by year?

12 A: Correct.

13 Q: All right. Let's take a look at -- well,
14 that's through 2012. We'll go ahead and look
15 -- let's look at 2013. Let's go to Exhibit
16 Number 139. Well, I tell you what, let's go to
17 142 and then we'll go back to 139.

18 A: Okay.

19 Q: This is Exhibit 142.

20 A: Got to get 142. Okay.

21 Q: Did you pull this data?

22 A: Yes.

23 Q: All right. And can you tell me what this
24 exhibit represents?

25 A: It's the treatment plans by referring physician

1 name for the seven months, January to July of
2 2013.

3 Q: Okay. And were you asked to update this
4 information for the trial?

5 A: Yes.

6 Q: All right. And so this reflects the actual
7 physician referrals and the patients for the
8 first seven months of this year, right?

9 A: The treatment plans.

10 Q: Let's go back and look at -- well, let's tell
11 the Court -- if you would, tell the Court about
12 the utilization in Myrtle Beach since you
13 acquired the center.

14 A: Right. The utilization has actually been kind
15 of a roller coaster. 2011 was, you know, an
16 aberration, can't really explain why the volume
17 was so high. It was way higher than my
18 projection. 2012 actually was in line with my
19 projection per the CON application, which is a
20 significant decline from 2011.

21 Q: Okay. Let's talk about that. So in 2010, you
22 had a partial year in 2010, right?

23 A: Right.

24 Q: And utilization was higher in 2010 than in
25 2009, right?

1 A: Correct.

2 Q: And in 2011, it's higher again, right?

3 A: Was higher again.

4 Q: Okay. Did you see that throughout the company?

5 A: No.

6 Q: All right.

7 A: Not to the extent.

8 Q: That you saw in Myrtle Beach?

9 A: Right.

10 Q: All right. And then what happened in 2012?

11 A: 2012, well, 2012, the volumes in Myrtle Beach

12 declined significantly. But part of that is

13 something that hit the entire industry is ---

14 Q: Let me ask you something. I want to talk about

15 that, but I want to lay the foundation.

16 A: Okay.

17 Q: Did the company ask you to get involved kind of

18 in Myrtle Beach about the particular issue?

19 A: Yes.

20 Q: Why is that?

21 A: Per my, you know, I'm, as I mentioned, the data

22 guy. I get asked to really investigate any of

23 our locations, regardless of the specialty, if

24 there's, you know, a negative trend, especially

25 that is above and beyond explanation.

1 Q: So did Myrtle Beach fall into that category?

2 A: Yes.

3 Q: So have you been looking, not only for this
4 lawsuit, but just looking at Myrtle Beach
5 numbers?

6 A: Correct.

7 Q: All right. Well, tell the Court what happened
8 in 2012 and what your ...

9 A: Well, in 2012, we had a significant decline of
10 prostate patients, referrals, you know, from
11 urologists. But that was in large part due to
12 guidelines that were issued for the PSA exam.
13 Generally, your primary care physician will do
14 a PSA exam on a patient of, you know, following
15 the guidelines, and then based on that score
16 would then refer them to a urologist if there's
17 a potential issue. The urologist would then do
18 further tests, potentially diagnose the cancer,
19 and then give the patient their options for
20 treatment.

21 Q: What happened with the PSA guidelines?

22 A: They changed them. The PSAs aren't being given
23 in the same number, and/or based off the scores
24 of the PSAs, the patients are being delayed in
25 the referral to the urologist.

1 Q: And you think that's having an impact on
2 radiation therapy?

3 A: Yes. Well, it's having an impact on the
4 urologists too. And this is not a South
5 Carolina Myrtle Beach phenomenon, this is
6 company-wide, industry-wide. As we talked to,
7 you know, urology groups that aren't part of 21
8 C, they're experiencing the same reduced volume
9 of patients coming through their doors.

10 Q: Okay. What about let's take a look at Exhibit
11 CRCC 139.

12 A: Okay.

13 Q: What's happening in the first seven months of
14 2013?

15 A: We have about a ten percent decline in this is
16 treatment units. So first seven months of
17 2012, 14,391 treatment units. First seven
18 months 2013, 12,904, a decline of 1,487 or 10.3
19 percent.

20 Q: Okay. And when you say treatment units, that's
21 the same thing as treatments, right?

22 A: Correct.

23 Q: What we refer to as treatments in the trial.
24 So you're ten percent off of 2012?

25 A: Correct.

1 Q: For 2013?

2 A: Correct.

3 Q: Okay. Have you looked at those referral
4 numbers that we looked at in Exhibit 141 as
5 part of your investigation? Do you have any
6 explanation as to what is happening?

7 A: Yeah, the -- all of the decline, actually more
8 than 100 percent of the decline is from the
9 prostate patients. We actually have had an
10 increase in our volumes and revenues from the
11 all other bucket, medical oncologists and other
12 combined. So without that increase from the
13 non-urology referrals, our numbers would be
14 even further lower.

15 Q: So urology is declining more than ten percent?

16 A: A very significant decline, yes.

17 Q: Is it more than ten percent?

18 A: More than ten percent, yes.

19 Q: And it's being offset somewhat by other
20 physicians, particularly medical oncology?

21 A: Yes.

22 Q: So is 21st Century and -- I mean, is CRCC
23 becoming more dependent on the medical oncology
24 group in Myrtle Beach?

25 A: Very much so.

1 Q: Okay. And would a loss of those patients then
2 have a even greater impact than you would have
3 thought a year or two ago?

4 A: Yes, they would. We're trending right now to
5 be probably close to 5,000 treatments lower in
6 2013 than we were in 2011.

7 Q: So back down to 20,000?

8 A: Twenty, yeah.

9 Q: Let's take a look at CRCC Exhibit 21.

10 A: 21?

11 Q: Yes. Are we there?

12 A: Yes.

13 Q: All right. There was some testimony I think
14 about this exhibit yesterday. Did you actually
15 pull the data for this exhibit?

16 A: Yes.

17 Q: What does it show?

18 A: It shows by service year and by diagnosis the
19 number of patients treated by diagnosis.

20 Q: And let's take a look at 2011.

21 A: Okay.

22 Q: The 2011 count of patients on this chart is
23 1,013, right?

24 A: Correct.

25 Q: But that is more patients than you reported,

1 say, on your JAR, right?

2 A: Correct.

3 Q: Why is that?

4 A: This is breaking the patients out by diagnosis,
5 that you have a patient that gets more than one
6 site treated. They could have two different
7 diagnoses. If you have a patient that
8 metastasizes mid-treatment, they could have two
9 different diagnoses; one continuous treatment
10 course, but, you know, halfway through a 35
11 course of treatment, it changes from, say, lung
12 to metastasis.

13 Q: Okay. So there's a double count in here then
14 you're saying?

15 A: Right. This is not a unique count of patients.

16 Q: So there are patients that are on here that
17 could be on here twice, right?

18 A: Correct.

19 Q: All right. And, of course, that also helps
20 explain the metastasis number being 131?

21 A: Correct.

22 Q: Because what does that represent on the chart,
23 metastasis, is that two sites?

24 A: Yes. Metastasis is when a cancer from a
25 primary location spreads to a different

1 location. You know, the cancer has spread, it
2 has metastasized.

3 Q: Or let's say somebody -- let's do -- let's say
4 lung and brain, okay? Is that a common, or ---

5 A: Yeah.

6 Q: --- or prostate and bone, I guess, is common?

7 A: Right. Prostate can metastasize to the bones
8 near the prostate.

9 Q: So if somebody comes in and they're diagnosed
10 with prostate cancer, they go on the chart as
11 prostate, and during their treatment cancer is
12 found in their bone.

13 A: Correct.

14 Q: Okay, do they go also on there as metastasis?

15 A: They would switch. Yeah, that diagnosis would
16 switch to metastasis.

17 Q: Okay. So they'd be on there twice?

18 A: Correct.

19 Q: All right. And how does that affect -- so
20 there was some calculations yesterday about
21 using numbers like this to calculate treatments
22 and all. First, I want to ask you this
23 question. Why, if you know the answer to this,
24 why would a patient -- Dr. Collins, yesterday
25 listed all these cancers and every single one

1 of them, it seemed like, was over 30. There
2 were a couple of exceptions, but the regular
3 course of treatment is 30 or above?

4 A: Right.

5 Q: Then why would the average number of treatments
6 in the center be less than 30 if the regular
7 course of treatment is usually over that? If
8 you know the answer to that or do I need to ask
9 Dr. Francke?

10 A: Yeah, I would -- I mean, there's many reasons
11 a patient won't go through the full course of
12 treatment. That would probably be better for
13 Dr. Francke.

14 Q: Okay. That's fine. But as far as this
15 document goes here, if a patient had more than
16 one cancer site, they're on that chart in what
17 category?

18 A: More than one, they can be in there ---

19 Q: What category? If there are two sites ---

20 A: Well, if it's two primary sites, they could be
21 in brain and lung. But if it metastasized,
22 then they'd in, you know, prostate and
23 metastasis or lung and metastasis.

24 Q: Let's talk about capacity of machines in the
25 real world, okay, the actual world that you

1 work in in these centers, okay?

2 A: Right.

3 Q: The average number of treatments I think you
4 testified per hour is three?

5 A: Yeah. Well, that's what I used in that
6 example, yeah. It was three.

7 Q: Sometimes the number can be higher?

8 A: Can be.

9 Q: Four in an hour?

10 A: Could be, yes.

11 Q: All right. The TomoTherapy unit, which is 100
12 percent IMRT.

13 A: Right.

14 Q: What is the real world capacity of that
15 machine? What are the numbers that you see for
16 TomoTherapy units in the company for capacity
17 on a daily or annual basis?

18 A: Yeah. Well, on a daily basis, real world,
19 we're consistently capable of treating 30 or
20 more. But in a real world actual case in
21 Myrtle Beach, we were treating over 50 a day on
22 a Tomo.

23 Q: And was that causing problems for the machine?

24 A: It was capable of doing it. It's not ideal for
25 the machine to treat -- for a Tomo to treat 50

1 a day, but it did it.

2 Q: Can it easily treat 30 a day?

3 A: Yes, it can easily treat 30 a day.

4 Q: How about a Clinac iX?

5 A: A Clinac iX would probably be more in the 40 to
6 50 range ideal.

7 Q: So it can easily do 40 or 50 a day?

8 A: Yes.

9 Q: And how many would that be on an annual basis?

10 A: Well, if you take 50 times 255, would be
11 12,750.

12 Q: Okay. So you could do 12,000 -- so the Grand
13 Strand Center, you've seen a Clinac iX in
14 centers do 10,000 treatments in a year?

15 A: Yes.

16 Q: Okay. Does 21st Century have a lot of single
17 unit centers?

18 A: Yeah, of our -- I don't have a precise number,
19 but of our 100 centers, I would say 75 percent
20 of them are probably single unit.

21 Q: Okay. And is that part of the philosophy of
22 the company?

23 A: Yes. It gets back to the spread the centers
24 out to where the patients live within a market
25 area rather than have a mega-center that you

1 have to bring everybody to.

2 Q: With some of the changes in reimbursement in
3 the last couple of years, were you asked to do
4 a project for the company in regards to
5 calculating a breakeven point?

6 A: Yes.

7 Q: Can you tell the Court what you did in regards
8 to that project?

9 A: Yeah. It was related to the 2013 Medicare
10 proposed rate change. Through the Radiation
11 Therapy Alliance, we were able to obtain, you
12 know, the actual treatment volumes for over
13 1,000 freestanding radiation therapy centers
14 throughout the country.

15 MR. THOMAS: Your Honor, I need to object real
16 quickly. If this is going where I think it's
17 going, I've asked for any kind of financial
18 adverse impact documents to CRCC and never
19 received any. So if this is some kind of way
20 to say what, you know, they've got a breakeven
21 point and they, because of Grand Strand's
22 project it's somehow going to bring them below
23 that breakeven point, I don't think that's
24 proper testimony here, Your Honor, because I've
25 asked in discovery any adverse impact analyses

1 that were related to this case and in
2 interrogatories, I got nothing.

3 MR. LONG: I don't think that's where it's going.

4 THE COURT: Well, you're in control. You open the
5 door, you open the door.

6 MR. LONG: Thank you.

7 Q: Were you asked of the company to do an analysis
8 of the breakeven point?

9 A: Yes.

10 Q: Tell that again for us ---

11 A: Right.

12 Q: --- since we had an objection. I'd like for
13 you to inform the Court and us exactly what all
14 you did as part of that project.

15 A: Right. Yeah, I mean, one of my data sources
16 was through the Radiation Therapy Alliance. I
17 received a listing of all the freestanding
18 radiation therapy centers throughout the
19 country and their average treatments per day.
20 Then utilizing, you know, financial data at my
21 disposition, our own centers, data from other
22 centers, data we've acquired through due
23 diligence where we've, you know, looked at
24 acquiring centers, I was able to build a high,
25 medium, low technology utilization and a high,

1 medium, low volume metric -- matrix. And then
2 taking revenues based off those different
3 technology levels, the expenses that you would
4 incur in the centers, the cost of capital
5 because, you know, there's on a freestanding
6 center we assumed about a five million dollar
7 investment, income taxes, a full-loaded P&L.
8 I then applied the proposed Medicare
9 reimbursement rates for 2013, which is what
10 we're currently experiencing, and through all
11 that work, the breakeven point for a
12 freestanding center was about 18 treatments per
13 day.

14 Q: Eighteen treatments per day. And how many
15 would that be on an annual basis?

16 A: It would be about 4,500.

17 Q: To about 4,500 treatments annual?

18 A: Right.

19 Q: Is kind of a breakeven?

20 A: Right.

21 Q: If you're consistently below 18, I guess you
22 could have day it'd be low.

23 A: Right.

24 Q: If you were consistently below 18, what would
25 that mean for the center?

1 A: Well, what it would mean is for any center
2 below 18 treatments per day, they would not be
3 able to afford to upgrade their equipment in
4 the future and eventually would, you know, go
5 out of business because they wouldn't be able
6 to deliver, you know, down the road, radiation
7 therapies quickly advancing, a competitive
8 product. So ultimately, it would mean those
9 centers would shut their doors.

10 Q: Would it be a cash flow issue too with those
11 centers if their numbers were lower than that?

12 A: Yes.

13 Q: Okay. Hospital-based center, what did you
14 think the breakeven on that would be, 18? Did
15 you look at that?

16 A: No, I didn't look at the hospital center, but
17 we already know their revenues are higher.

18 Q: They have additional cost though, right?

19 A: Right. But they would have additional cost.
20 Yeah, hospitals generally bill much larger,
21 elaborate buildings. And we often find that,
22 you know, especially when we deal with
23 hospitals, when we partner with them, manage
24 them by the center from the hospital, they're
25 often overstaffed, you know, a lot of excess

1 expense.

2 Q: And which would then cause their breakeven
3 point to be higher, right?

4 A: Yeah.

5 Q: If you have higher expenses, you're going to
6 have a higher breakeven point, right?

7 A: Right.

8 Q: In Conway, I think we've estimated
9 approximately 5,500 treatments per year, right?

10 A: Uh-huh (affirmative response).

11 Q: Okay. So how many is that per day?

12 A: It's about 21 and a half.

13 Q: Okay. So that, as in the project as set forth,
14 is that above your viability numbers?

15 A: Right, that's above the viability. And
16 important to note in Conway is we'll have
17 economies of scale because we'll have a cluster
18 of centers with some common expense servicing
19 all of them. So we'll be fine at that volume.

20 Q: Okay. I want to ask you to look at Grand
21 Strand Exhibit Number 6. And we're going to
22 have to find the page because this one doesn't
23 have page numbers on it. Page six. At the
24 bottom, I want to look at this little chart
25 right here. This is internal documents for

1 Grand Strand regarding their particular
2 project.

3 A: Okay.

4 Q: This is Number 6. Well, we call it the For
5 Will Thomas CAM, at the bottom of the page.

6 A: Right.

7 Q: You see that on the tag line?

8 A: Correct.

9 Q: Are these financial indicators numbers that you
10 would look at when you do acquisitions or
11 projects for the company?

12 A: Yeah, I would look at investment amount, cost
13 of capital, the present value, the EBITDA and
14 the payback period, yes.

15 Q: Net present value, is that one? I mean, I'm
16 sorry. Net present value index, is that one
17 that you would look at?

18 A: Yes.

19 Q: Okay. What does .85 on an NPV index mean?

20 A: It means they're getting 85 cent return on
21 every dollar they invest.

22 Q: So they're investing a dollar, but they're
23 getting less than a dollar back?

24 A: Right, and that's what you're -- they have a
25 negative net present value. That's what that

1 would imply.

2 Q: Because the breakeven on that is not zero, it's

3 one?

4 A: 1.0.

5 Q: 1.0?

6 A: Right.

7 Q: So the net present value should always be above

8 1.0, right?

9 A: The index, yes.

10 Q: The index, I mean. If it's below one, it's

11 negative?

12 A: It's negative.

13 Q: Okay. How about a five year EBITDA return on

14 investment of 16 percent, what do you think

15 about that?

16 A: That's not a good percent.

17 Q: Okay. How about a discounted cash payback

18 period of never?

19 A: That's not a good sign.

20 Q: If you were presented this analysis to acquire

21 a center investing 21st Century's capital in a

22 center with these financial metrics, would you

23 do the deal?

24 A: No, definitely not.

25 Q: Any consideration of it?

1 A: No, this is definitely a losing proposition.

2 Q: Okay.

3 MR. LONG: Your Honor, at this time I'd like to ask
4 the Court if I could take a break, short break
5 just to kind of gather my thoughts and make
6 sure I haven't forgotten anything.

7 THE COURT: All right.

8 (Break from 11:16 a.m. until 11:27 a.m.)

9 THE COURT: All right.

10 MR. LONG: Okay. Just a few more questions, Your
11 Honor.

12 BY MR. LONG:

13 Q: Mr. Lewis, in your role of handling the CONs
14 and all, and CONs for the company, if the
15 company constructs a new center like it's
16 proposed for Murrells Inlet or purchases one,
17 or purchases a building and does a new center
18 like for Conway, does -- do you work with --
19 are there accountants and other construction
20 people that the company routinely uses for
21 those projects?

22 A: Yes.

23 Q: Who are they, or how do y'all do that?

24 A: Well, for all of our CON filings, you generally
25 have to list, especially any quotes on

1 equipment or related to the equipment,
2 construction, and we have an architect we use
3 in both North and South Carolina named Bowers,
4 Ellis.

5 Q: Apparently, I said accountant when I actually
6 meant architect.

7 A: Right.

8 Q: So have you had architects rather than
9 construction people that you use for these
10 projects?

11 A: Right. Yes.

12 Q: And do you rely on their advice in regards to
13 how to put the center together?

14 A: Yes.

15 Q: And what kind of decisions will be made in
16 regards to construction?

17 THE COURT: Hold on one moment. I want to be able
18 to hear you and I've got to deal with a matter.

19 (Pause)

20 THE COURT: Go on, proceed.

21 Q: So do you rely on their advice?

22 A: Yes.

23 Q: Construction people and the architects?

24 A: Yes.

25 Q: And you try to have some consistency in your

1 centers?

2 A: Yeah.

3 Q: To the extent you can?

4 A: Yes.

5 Q: Are they different sizes?

6 A: Yes.

7 Q: Is it important for the centers to comply with

8 all fire and safety codes?

9 A: Yes.

10 Q: And do you do that in your centers?

11 A: Yes.

12 Q: All right. I meant to reference you earlier in

13 your testimony to exhibit, CRCC Exhibit 17. I

14 don't think you need to pull it out.

15 A: Okay.

16 Q: Just look at it on the screen.

17 A: Okay.

18 Q: Can you tell me what this document is?

19 A: Yeah, it's my CV.

20 Q: Does it reflect your prior employment history

21 and your educational background?

22 A: Yes.

23 Q: All right. My final issue getting back to this

24 breakeven issue. Grand Strand has projected in

25 their CON application that they're going to do,

1 I think, 4,690 treatments in year three at the
2 hospital. How many treatments is that per day?

3 A: About 18.4.

4 Q: 18.4. And your calculation for the breakeven
5 of a freestanding center was how much per day?

6 A: Eighteen.

7 Q: Eighteen. So barely above it, right?

8 A: Correct.

9 Q: And if ---

10 MR. THOMAS: Your Honor, I need to object. I mean,
11 he's making an improper characterization. He's
12 comparing freestanding and hospital based.
13 Well, he just did it.

14 THE COURT: Inferentially, he did, yeah, yeah. He
15 talked about Grand Strand, then he went to
16 talking about freestanding. He never made the
17 inference about it exactly. He danced on it
18 though.

19 MR. THOMAS: Yeah. So I can get it on cross.

20 THE COURT: All right. Yeah.

21 Q: That's all I have. Answer any questions Mr.
22 Thomas has for you.

23 A: Okay. Thank you.

24 MR. LEWIS - CROSS-EXAMINATION BY MR. THOMAS:

25 Q: When did you do your breakeven analysis, Mr.

1 Lewis?

2 A: It would have been during the third and fourth
3 quarter of last year.

4 Q: Of last year?

5 A: Correct.

6 Q: Okay. And that's nothing that you ever
7 produced to us in response to any kind of
8 adverse impact the project would have on CRCC,
9 correct?

10 A: I have not produced it, no.

11 Q: Okay. And you would agree with me you just
12 stated that your adverse impact, or excuse me,
13 your breakeven analysis was for freestanding
14 centers, correct?

15 A: Correct.

16 Q: All right. You didn't look at hospital based,
17 right?

18 A: Not in that analysis, no.

19 Q: Did you look at it in a separate analysis?

20 A: No.

21 Q: And you stated that when you looked at, I
22 believe it was the Grand Strand's Exhibit
23 Number 6 that had some ROI numbers, net present
24 value -- you can get it out if you want, I
25 think you'll remember -- but you looked at

1 those numbers, correct, and stated what, that
2 you wouldn't do that deal, right?

3 A: Which page are you looking at, please?

4 Q: Let's go to Grand Strand Exhibit 6. Yeah, go
5 to the third, one, two, it looks like the third
6 page there for me.

7 A: Okay.

8 Q: This is what you were just talking about with
9 Mr. Long, right?

10 A: Correct.

11 Q: And you let me know if I've got it wrong. You
12 said based on these numbers, you wouldn't do
13 the deal, right?

14 A: No, we would not.

15 Q: And you wouldn't do that deal because what CRCC
16 and 21st Century does, I mean, they do linear
17 accelerator projects, correct?

18 A: We're an integrated cancer company.

19 Q: You do mainly radiation therapy projects,
20 correct?

21 A: We do a lot of different types of projects.

22 Q: Okay. Well, when you're talking about
23 comparing you wouldn't do this deal, this deal
24 is for radiation therapy center, right?

25 A: Right, if specific to -- yeah, if all of the

1 financial indexes three years out are negative,
2 that deal's not worth doing.

3 Q: Okay. But you do see though that the five year
4 average EBITDA is 16 percent, correct?

5 A: Which is very, very low.

6 Q: Okay. Well, Grand Strand might choose to do
7 this deal because it wants to create a
8 comprehensive cancer center, correct?

9 A: I don't know what Grand Strand wants to do.

10 Q: Okay. But they might choose to do it for that
11 reason, correct?

12 A: They could.

13 Q: Okay. And you would agree with me that
14 hospitals have to have loss leaders, because
15 they're hospitals, correct?

16 A: I don't know that.

17 Q: You don't know that. So you don't know that
18 most emergency rooms are loss leaders for
19 hospitals?

20 A: Right.

21 Q: You don't know that because you never worked in
22 a hospital, right?

23 A: No, I have not.

24 Q: Okay. And so you would agree with me that if
25 your numbers at a 21st Century facility looked

1 like what they do on the Exhibit 6, that's not
2 a project 21st Century's going to do, right?

3 A: No. And this case is about a radiation therapy
4 center and, you know, that's not a viable
5 radiation therapy center based on those
6 numbers.

7 Q: Freestanding, correct?

8 A: No, the hospital numbers are not viable.

9 Q: Okay. Well, the hospital makes \$60 million a
10 year, Mr. Lewis, do you realize that? And you
11 saw those financials that Mr. Long put up,
12 didn't you?

13 A: I don't believe I've seen them.

14 Q: Okay. So you haven't seen the numbers that are
15 in evidence, correct, that Mr. Long asked Mr.
16 Grace about?

17 A: I wasn't here for that.

18 Q: Okay. But there are other reasons the hospital
19 might have than just to make money on this
20 project, correct?

21 A: I don't know what their reasons are.

22 Q: Well, you heard some testimony that they want
23 to create a comprehensive cancer center, right?
24 You heard that testimony, didn't you?

25 A: Yes.

1 Q: Okay. Now, in terms of the numbers on this
2 page, you admitted, I mean, you admitted under
3 oath that Grand Strand got their revenues
4 wrong, correct, in terms of Medicare and
5 Medicaid? I mean, you testified to that.

6 A: Well, I would assume they're all wrong. If
7 one's wrong, they're all wrong, but the ratio
8 could be correct. My understanding from the
9 testimony is they only included conformal
10 reimbursements. So if all these are conformal,
11 you make those all appropriate, the five times
12 would still hold true.

13 Q: So do you think that Grand Strand gets \$5,000
14 per treatment on its IMRT; is that what you're
15 testifying to today?

16 A: I don't know what they get. But I do know
17 through my work with hospitals that they often
18 -- I did testify that normal to me would be two
19 to three times.

20 Q: Okay. Well, I'm asking you five times, have
21 you seen that before?

22 A: That would be out of the norm.

23 Q: Yeah, that would be for an IMRT course of
24 treatment, 150, 160 thousand dollars, wouldn't
25 it?

1 A: It would be a lot.

2 Q: You think the Blues in this state pay that?

3 A: I don't know what the arrangement with BCA is.

4 Q: All right. You work for and are employed by

5 21st Century Oncology, correct?

6 A: Right.

7 Q: And the CEO of the company, that's Daniel

8 Dosoretz, right?

9 A: Correct.

10 Q: And the CFO of the company, that's a guy named

11 Bryan Carey, right?

12 A: Correct.

13 Q: And you report directly to him, don't you?

14 A: Correct.

15 Q: The general counsel of the company is who?

16 A: Norton Travis.

17 Q: All right. And he was very involved in this

18 project, wasn't he?

19 A: Yes.

20 Q: Okay. And who is Michael Asbill; do you know

21 who that is?

22 A: Yes, he is the practice administrator for the

23 Atlantic Urology group.

24 Q: And who is Doug Bryant? We all know -- I mean,

25 most people in this room know that he is the

1 former commissioner of DHEC.

2 A: Right.

3 Q: But what did he do for y'all?

4 A: He's a consultant that guides us through our
5 CON and legislative dealings in South Carolina.

6 Q: You have him on the payroll, correct?

7 A: He ---

8 Q: Is he doing it for free?

9 A: No. I mean, he's not an employee on payroll,
10 no.

11 Q: But he is being paid by CRCC?

12 A: Yes, he is a paid consultant.

13 Q: Okay. And do you know how long ago he was
14 hired?

15 A: I'm sure back -- no, I don't know when he was
16 hired, but I know back as early as 2010.

17 Q: And he was hired to advise CRCC and 21st
18 Century on CON issues in the state of South
19 Carolina, correct?

20 A: That and other legislative.

21 Q: And did you rely on his advice?

22 A: Yes.

23 Q: And would you agree with me that Radiation
24 Therapy Service Holding, Inc., that's the
25 parent, what, RTSI; is that right?

1 A: Right. It's a holding company.

2 Q: Everything kind of rolls up into that?

3 A: Yes.

4 Q: All right. And Radiation Therapy Service
5 Holding, Inc. actually has to file something
6 called a 10-K with the Securities and Exchange
7 Commission, right?

8 A: Yeah, we file a 10-K. I don't know if it's
9 that legal entity exactly. But yes, we file a
10 10-K.

11 Q: It's easy to find out because it says right on
12 the front of the 10-K, right?

13 A: Right. I don't read the document.

14 Q: Okay. But you know, because CRCC, or excuse
15 me, 21st Century actually issues public debt,
16 correct?

17 A: Right.

18 Q: In the form of indentured bonds?

19 A: We're an SEC registrant because of our debt.

20 Q: Okay. So what that means is that the company's
21 got to let the world kind of know what their
22 strategies are and what their business model is

23 ---

24 A: Right.

25 Q: --- where they operate and what their

1 financials are, correct?

2 A: Right.

3 Q: Okay. And on your CV, which I believe is
4 Respondent's 17, if we could go there. All
5 right. And I'm not going to ask you much about
6 this, but in terms of under the 21st Century
7 Oncology, how do you describe it? Read it into
8 the record for me.

9 A: A \$700 million dollar integrated cancer care
10 company providing radiation oncology, medical
11 oncology, urology, surgery and other medical
12 services primarily in North and South America.

13 Q: Okay. So \$700 million, is that what the
14 revenues are per year?

15 A: Right.

16 Q: Okay. An integrated cancer care company.
17 That's an important concept for 21st Century,
18 isn't it?

19 A: Yes.

20 Q: Okay. And so you say provides radiation
21 oncology, medical oncology, urology and
22 surgery. Those are the very specialties that
23 21st Century would employ in various affiliates
24 around the country?

25 A: Amongst others.

1 Q: Okay. And the others are what? I think you
2 said primary care, pulmonologists?

3 A: Right. Correct.

4 Q: Okay. And you would agree that creating a
5 continuum of care can be beneficial to patients
6 because you can provide them with more
7 comprehensive treatment to better treat their
8 cancer, correct?

9 A: Correct.

10 Q: Now, you would agree with me that 21st Century
11 Oncology actually outbid Grand Strand for CRCC
12 back in 2010?

13 A: I wasn't directly involved, so I don't know who
14 was bidding.

15 Q: You have no idea that Grand Strand made a play
16 for that business?

17 A: No, I don't.

18 Q: None at all? You never heard that?

19 A: It may have been mentioned in this trial, but
20 before that, no.

21 Q: The vice president of finance for 21st Century
22 Oncology, no clue?

23 A: I was not involved in the acquisition of this
24 one.

25 Q: When I deposed you back in June, you hadn't

1 really reviewed Grand Stand's CON application,
2 had you?

3 A: No, I think I said I had looked at it, but I
4 hadn't reviewed it since it was issued.

5 Q: You didn't even know that Grand Strand was
6 going to put the linear accelerator within the
7 four walls of the hospital, did you? You
8 didn't know that when I ---

9 A: Yeah, I may not have.

10 Q: And your job is to work -- a big part of your
11 job is doing business development for 21st
12 Century Oncology, isn't it?

13 A: Yes, I'm involved at different levels on
14 different projects.

15 Q: And I think I heard you just testify you work
16 on CON applications throughout the company,
17 which is 21st Century, right?

18 A: Correct.

19 Q: And you're generally expected to be aware of
20 CON regulations throughout the United States,
21 aren't you?

22 A: Yeah, I work with consultants and when there's
23 changes, review those.

24 Q: Okay. And 21st Century operates in a lot of
25 non-CON states too, correct?

1 A: We do.

2 Q: You actually operate in more non-CON states
3 than CON states, correct?

4 A: That would sound reasonable.

5 Q: Now, I'm just going to ask you a question, if
6 you don't know, we can open up the exhibit.
7 But you realize that in 2011, CRCC was the
8 largest volume operator of radiation therapy in
9 the state of South Carolina, correct?

10 A: Yeah, that's what the annual report showed.

11 Q: And did you know what the second highest
12 treatment volume provider was?

13 A: No.

14 Q: Did you review closely the CON application that
15 CRCC actually submitted? I mean, did you go
16 through it and read what Mr. Tolbert had
17 drafted?

18 A: Many times.

19 Q: And you agreed with everything in it?

20 A: Yes. Like I mentioned, it was a collaborative
21 process amongst many different people, several
22 reviews and updates to get the finished
23 product.

24 Q: But you would agree with me that CRCC as a kind
25 of going concern is a successful and profitable

1 enterprise, correct?

2 A: It is.

3 Q: Let me ask you this. Do most of 21st Century
4 Oncology's affiliates around, and when I say
5 affiliates, they're the parents of their
6 subsidiary ---

7 A: Right.

8 Q: --- of Radiation Therapy, do most of them
9 operate with EBIDTA margins over 50 percent?

10 A: You know, that's not uncommon, but the EBIDTA
11 margin is really misleading because that's
12 really just the revenues and expenses that
13 happen within the four walls of that center.
14 There's no corporate overhead. There's no cost
15 of capital allocation. There's, you know,
16 there's no accounting, HR, my costs aren't
17 allocated. So that's really just what happened
18 in the four walls of that facility.

19 Q: I understand that. But that gives you a good,
20 at least decent idea of how the facility is
21 operating on its own, correct?

22 A: Right. That's an internal, you know, view.

23 Q: Sure. And CRCC's IMRT treatments, I think we
24 talked about this, they're on the lines of 75
25 percent of the total, correct?

1 A: Correct. And that's largely influenced by the
2 TomoTherapy, which I testified is 100 percent
3 IMRT.

4 Q: Understood. And relative to conventional
5 treatments ---

6 THE COURT: Will you repeat that ---

7 MR. THOMAS: Go ahead.

8 THE COURT: The CRCC, excuse me, IMRT totals are
9 what percentage?

10 MR. LEWIS: He said 75 percent. And I just said
11 that's largely influenced by the TomoTherapy
12 unit, which only performs IMRT. So when you
13 have a TomoTherapy single unit center, it'll be
14 100 percent. When you have a center that has
15 two or three units, one of them being a Tomo,
16 its IMRT percentage is going to be high because
17 of that influence. That's how that machine was
18 developed.

19 Q: Well, we can look at the 10-K if we have to,
20 but company-wide, CRCC operates -- I mean,
21 excuse me, 21st Century operates at about 70
22 percent IMRT, correct?

23 A: That sounds reasonable.

24 Q: Okay. So CRCC's not that much outside the norm
25 because of the Tomo. It's about five percent

1 outside the norm, right? Correct?

2 A: Correct.

3 Q: All right. Go to Petitioner's 52 for me, Mr.
4 Lewis.

5 A: Which? Grand Strand 52?

6 Q: Yes.

7 A: Okay.

8 Q: First of all, we can do the calculation if you
9 want, but I think you testified that one of the
10 things CRCC was able to do pretty quickly when
11 it acquired -- when it was acquired by 21st
12 Century, 21st Century was able to get those
13 revenues per treatments up at CRCC, correct?
14 I mean, I think in 2010 it was in the 500 range
15 and then by 2012, it was in the 800 range; does
16 that sound about right?

17 A: I'd say let's compute it, the 500 sounds way
18 low.

19 Q: All right. Well, let's try, let's do 2010 and
20 the P&L there on CRCC 59 and kind of take the
21 court what you're doing.

22 A: CRCC 59?

23 Q: Yeah, it's the very first page of the document.
24 Oh, I'm sorry, it's the Bates number.

25 A: Oh.

1 Q: Petitioner -- yeah, you need to be in
2 Petitioner 52.

3 A: Right here.

4 Q: Yeah. And then on the lower right-hand corner
5 you'll see the Bates number there.

6 A: Oh, all right.

7 Q: Sorry about that.

8 THE COURT: Wait a second, y'all ...

9 MR. THOMAS: We've got some technical difficulties.

10 THE COURT: Okay. Do y'all want to take a five
11 minute break?

12 MR. THOMAS: Well, I mean, if you've got it on your
13 screen.

14 THE COURT: I've got it on mine.

15 MR. THOMAS: Everybody here's got it. I think we can
16 continue on, if that's all right.

17 THE COURT: Okay.

18 Q: Okay. So you see on the first page there, CRCC
19 59, correct, see that -- what's the net
20 revenue? Is it \$12.374 million?

21 A: Right.

22 Q: Okay. And then the number of treatments done
23 that year is 15,565? If you turn the page over
24 to CRCC 60 and look at total treatments.

25 A: Yeah, that's a much higher number than what you

1 said.

2 Q: Okay. But why don't you compute it for me.

3 A: It's 12,374,603 divided by 15 by 65.

4 Q: Yeah.

5 A: Is \$795.

6 Q: Okay. So is that how you do it then?

7 A: Yes.

8 Q: So it's 795?

9 A: Right. You said 500, which wasn't close at
10 all.

11 Q: I apologize for that. And let's go to the last
12 couple of pages there in the same document.

13 Excuse me, I want to go to 2011 now.

14 THE COURT: You want to go to 2011?

15 MR. THOMAS: Yeah, to 2011, the year 2011, CRCC 64.

16 Q: What was the net revenue in that year?

17 A: 21,930,979.

18 Q: Okay. So, first of all, we know that CRCC was
19 able to get that, and I understand it was a
20 four months of revenue not in 2010, correct?

21 A: Correct.

22 Q: Okay. So we're up to 21930, and the number of
23 treatments for that year was?

24 A: 25,997. That's \$843 per treatment.

25 Q: Okay. \$843 per treatment?

1 A: And that is influenced by many, many different
2 factors, technology used, diagnosis treated.
3 You know, it's not something that can be
4 explained in the time here in this courtroom.
5 But there's just many factors that go into that
6 revenue per treatment computation.

7 Q: Okay. Well, go into CRCC's DHEC record for me,
8 if you would, and go to page 300.

9 MR. THOMAS: That would be Joint 1, Your Honor.

10 THE COURT: Hold on just a second.

11 A: Okay.

12 MR. THOMAS: Let's wait for the judge.

13 THE COURT: Proceed.

14 Q: Okay. Are you on page 300?

15 A: Yes.

16 Q: Okay. You see the net fees collected there for
17 2009?

18 THE COURT: What exhibit is this?

19 MR. THOMAS: Oh, I'm sorry. We're in Joint 1, Your
20 Honor, page 300.

21 THE COURT: Okay.

22 Q: And what's the revenue for treatment when 21st
23 Century didn't own CRCC?

24 A: Do you mean for 2009?

25 Q: 2009.

1 A: 50,022,597.

2 Q: Okay. And look at the bottom there. It says

3 treatment volume 15,613.

4 A: Correct.

5 Q: Do that calculation for me, please.

6 A: It's \$962 per treatment.

7 Q: Okay. So why did it fall?

8 A: I'm sure in large part it would be we're

9 dependent, you know, well over 50 percent of

10 our revenue on Medicare, and Medicare has cut

11 freestanding centers, especially drastically

12 year over year.

13 Q: Did it do it from 2009 to 2010?

14 A: Yes. We've had successive cuts numerous times.

15 Q: How much was it in 2009?

16 A: I don't know that off the top of my head.

17 We've been facing double digit cuts year after

18 year.

19 Q: Why is Medicare cutting the revenue?

20 A: They've been cutting everybody's revenue.

21 They've devastated many of the physician fee

22 schedule lines of business.

23 Q: But even with those cuts, you're still making

24 on an EBIDTA margin over 50 percent, correct?

25 A: Like I said, that's just the expenses and

1 revenues inside the four walls of the center.

2 Q: But this is what you gave me when I asked for
3 financials, this is what I received.

4 A: Right.

5 Q: So you're making -- well, in 2011, you made
6 almost 60 percent EBIDTA margin, correct?

7 A: Right. And 2011, as I've testified, was a
8 aberration.

9 Q: That was an aberration because?

10 A: The volumes were way higher than projected and
11 they've come down 20 percent since.

12 Q: And your only explanation is the PSA tests have
13 changed, correct?

14 A: The decline is more than 100 percent from
15 prostate patients, offset partially by all
16 other referrals.

17 Q: Okay. Let me ask you this. Is that your
18 testimony today that if I go back and I do an
19 analysis of the 2012 physicians and what
20 they've referred and the 2013 physicians, what
21 they referred, that there's going to be an
22 offset by the medical oncologists?

23 A: I didn't say medical oncologists. I said all
24 other physicians, which would include the
25 medical oncologists.

1 Q: Actually, have you looked at that and really
2 analyzed it? I know you said you analyze a lot
3 of metrics.

4 A: Yes. I ---

5 Q: Because I did too.

6 A: Right. I analyzed it at the revenue level.

7 Q: Did you actually look at the operational level?

8 A: But there again, treatment plans can be
9 misleading. You have to look at it at the
10 revenue level. And I know from my analysis
11 recently that the revenue decline we're
12 experience is partially offset by revenue
13 increase from the all other bucket.

14 Q: Actually, the number of medical oncology
15 referrals or treatment plans didn't change from
16 2012 to 2013, did it?

17 A: I don't know.

18 Q: The only thing that changed was the urologists,
19 correct?

20 A: Plans could be, but there again ...

21 Q: Mr. Lewis, did you look closely at the data to
22 see really what happened in terms of the
23 treatment plans?

24 A: Yes, the treatment plans are down from the
25 urologists year over year.

1 Q: It's one urologist mainly, isn't it? It's one
2 urologist?

3 A: No, I don't think so.

4 Q: A guy named Dr. Gangi?

5 A: Gangi is one of them.

6 Q: He is significantly down?

7 A: Right.

8 Q: Did you ask him why he was so down?

9 A: I've not asked him. I've talked with the
10 practice administrator, Michael Asbill, and
11 it's the same story there as all urology
12 practices, and it goes back to the point in
13 time when the PSA guidelines changed. It's a
14 nationwide trend, all urology, all radiation
15 providers.

16 Q: Just for the record, you did not talk to Dr.
17 Gangi about ---

18 A: No, I did not.

19 Q: --- this precipitous decline from 2012 to 2013,
20 did you?

21 A: No.

22 Q: All right. Same Petitioner's 52. I want you
23 to look at 2012 because that's the most recent
24 data I've got. And I think that's going to be
25 on CRCC 60 -- make sure I get it right, 72.

1 Turn to that one for me, if you would. Let me
2 know when you get there.

3 A: Okay.

4 Q: All right. So at the top of the page, we've
5 got something called the diagnosis mix. Can
6 you explain to the Court what that is?

7 A: Yeah. That would be the percent of revenue
8 based off the diagnosis being treated.

9 Q: And so we've got the numbers. We look on the
10 far right-hand side, one thing we've got is
11 28.4 percent for prostate, correct?

12 A: Correct.

13 Q: All right. And treatment diagnosis percentage,
14 that's different for the prostate treatments,
15 correct?

16 A: Right. It's the number of treatments
17 delivered, the percent of treatments delivered
18 by diagnosis. One's revenue, the other one's
19 treatments.

20 Q: Got you. All right. That's what I was
21 wondering. And the reason that the 28.4
22 percent on the diagnosis mix is lower than what
23 is on the treatment mix is because prostate
24 cancer is a much higher treatment count,
25 somewhere around 40, right?

1 A: Well, the protocol's 40, 40 to 45. But they
2 don't necessarily get -- always get treated to
3 the protocol.

4 Q: Okay. But using this we can kind of figure
5 out, you just said the treatment -- that the
6 treatment diagnosis percentage, if we know the
7 number of treatments and we got the treatment
8 diagnosis percentage, we can figure out roughly
9 how many prostate cancer treatments there were,
10 correct? That's exactly what you just said.

11 A: Right, there's enough data in this report to do
12 that. I don't know that you can do it just
13 from those two metrics though.

14 Q: You're telling me I can't now get the prostate
15 percentage treatments ---

16 A: Tell me how you're trying to get to that and
17 I'll tell you if that's correct.

18 Q: Well, you tell me. I heard you just testify
19 that that number there will tell me out of the
20 total number of treatments what the percentage
21 of prostate treatments would be.

22 A: Oh, yeah, that is the percent of total
23 treatments, you would multiply that -- I
24 thought you were ---

25 Q: No, that's what ---

1 A: I though you were asking something -- okay,
2 sorry.

3 Q: On that same page, if you go down to REV per
4 RVU by payor for me.

5 A: Correct.

6 Q: Okay. Can you explain to the judge what REV
7 per RVU by payor means?

8 A: It's revenue per RVU. RVUs, you know, the
9 value, not the numeric, not the dollar value,
10 but it's the work effort value that Medicare
11 assigns to a procedure. So this report would
12 show what the average revenue received per RVU
13 is.

14 Q: Okay. And so for, I know you said we can go
15 back and look at the numbers, but CRCC is about
16 50, 51 percent Medicare; is that about right
17 for the payor mix?

18 A: I think the one report we looked at was 53.

19 Q: Make sure I did that right.

20 A: It's right here. Yeah, it's 52.6 on this same
21 page.

22 Q: Okay. CRCC, I'm sorry I was looking at the CON
23 record. But, yeah, what is it here for 2012?
24 What does it say that your payor mix was for
25 Medicare?

1 A: 52.6.

2 Q: Okay. 52.6. And so the REV per RVU by payor
3 for Medicare is how much?

4 A: 30.73.

5 Q: And then like you said, like you testified, and
6 I believe Mr. Grace actually admitted that
7 Medicaid is going to be lower there, so it's
8 about what, seven dollars lower?

9 A: Right.

10 Q: All right. Self-pay, you're not going to get
11 much from that, right?

12 A: Correct.

13 Q: All right. And then the REV by HMO is what?

14 A: 29.82.

15 Q: Okay. So that's actually lower than Medicare,
16 isn't it?

17 A: Right. That could be the Medicare HMOs though
18 too.

19 Q: Okay. Fair enough. So you think that could
20 be in there and it could be Medicaid HMOs as
21 well, right?

22 A: Could be. Right.

23 Q: All right. What is the REV per RVU for PPO?

24 A: 52.62.

25 Q: And that's 170 percent of Medicare, correct?

1 Do the math.

2 A: About 150 percent. Medicare allowable is about
3 34, so it's about 150 percent of Medicare.

4 Q: Well, I'm just talking about right here, you
5 said you -- you actually had the number for
6 Medicare ---

7 A: But this is ---

8 Q: --- of 30.73?

9 A: Yeah, but we're not in this market collecting
10 on the Medicare line the full amount. Medicare
11 pays 80 percent and you have to collect 20
12 percent from the patient. So we're collecting
13 less than the full Medicare allowable amount.

14 Q: Okay. What about PPO, don't you have to
15 collect something from the patient there too?

16 A: Depends on the contract, but likely.

17 Q: But for these numbers, if you get the full
18 collections, the PPO is 170 percent of
19 Medicare, correct?

20 A: No, I would -- well, on a collections basis,
21 yes. But not on a Medicare allowable benchmark
22 basis, no.

23 Q: It's 171 percent of this -- of these numbers,
24 PPO is 171 percent of the Medicare, correct?

25 A: Yeah, and ---

1 Q: On RVU?

2 A: What I would say is if you take the bottom line
3 blended average everything, we're collecting
4 about 101-102 percent of Medicare for the
5 entire location.

6 Q: I understand that, but your PPO percentage is
7 how much?

8 A: I would say it's 150 percent on that particular
9 line.

10 Q: On your payor mix though, it's 32.1 percent,
11 correct?

12 A: It's 32 percent of the revenue.

13 Q: Okay. That's fairly significant. The PPO
14 portion of the revenue collections is a fairly
15 significant portion of the overall, isn't it?

16 A: It's 30 percent, yes.

17 Q: Okay. I believe you testified that 21st
18 Century operates approximately 100 freestanding
19 radiation therapy centers across the United
20 States?

21 A: Correct.

22 Q: Okay. And I think you said that 21st Century
23 was developing a new radiation therapy center
24 in a place called Riverhead, New York, correct?

25 A: Correct.

1 Q: And that's what you called a single?

2 A: It's a de novo, it's -- well, no. Yeah, it's
3 a single vault center located near where we
4 have two other freestanding centers and a
5 hospital-based facility we provide services at.

6 Q: So you said located near, because when it's --
7 to be located nearby, that's good for what I
8 think is support in case something happens at,
9 say the Riverhead, if the machine breaks down,
10 you can send a patient to your nearby support
11 center?

12 A: That would be an option, yes.

13 Q: Now, have you been -- do you know where
14 Riverhead, New York is?

15 A: It's on Long Island.

16 Q: Do you know where on Long Island?

17 A: It's on the far east end, I believe.

18 Q: Yeah. And you've stated it's important, CRCC
19 throughout this case has stated it's important
20 for the applicant to have some kind of backup,
21 right?

22 A: Right. I would say more so the backup's
23 physician and staff, less so much the
24 equipment. If the equipment breaks down,
25 typically it's resolved same day and treatments

1 continue on.

2 Q: Okay. And that would be ---

3 A: It would be very uncommon, and actually --
4 yeah, it would be very uncommon for -- anyway.

5 Q: So the two centers that are backing up
6 Riverhead, New York, that's Yonkers and the
7 Bronx, right?

8 A: Correct.

9 Q: And those are about 80 miles away from
10 Riverhead, New York, right?

11 A: I don't know.

12 Q: You don't know?

13 A: No.

14 Q: You've never looked at that before?

15 A: I've not looked at that distance.

16 Q: Okay. Well, I did. This is just a
17 demonstrative of a Google map that I'd like the
18 Court to take judicial notice of.

19 MR. LONG: Your Honor, I object to the judicial
20 notice of the Google map.

21 THE COURT: I don't take judicial notice of Google
22 maps.

23 MR. THOMAS: All right. Well, I'm still going to
24 try to use if I can as a demonstrative, Judge.
25 I don't think -- I think it's self

1 authenticating and Mr. Tolbert based his entire
2 drive time analysis on Google maps, so if this
3 can't come in for a demonstrative, I'd like to
4 move to exclude Mr. Tolbert's drive time
5 analysis.

6 THE COURT: We're not even there yet, but ...

7 MR. LONG: We're not there. And secondly, the
8 reason it can't come in is because I've never
9 seen it before, Your Honor. And that's the
10 problem with the document.

11 THE COURT: Yeah.

12 MR. LONG: And he's using it solely for impeachment.

13 So if he wants to ask him to look at it, he
14 can, but it would not come in as an exhibit.

15 MR. THOMAS: Otherwise, I'm not asking ---

16 THE COURT: He's already said ---

17 MR. LONG: And he keeps saying the word
18 demonstrative, which I'm not really sure what
19 he means when he says that. But the reality is
20 I think it was never shown to us, never seen it
21 before right now. The witness obviously had no
22 time to prepare for it or see it or anything
23 like that. But if he wants to ask him a
24 question or two about it ---

25 THE COURT: Well, he can use anything to refresh his

1 recollection.

2 MR. LONG: Right.

3 THE COURT: I mean, the case law says you can ...

4 Q: You know Yonkers, the Town of Yonkers is not on
5 Long Island, correct?

6 A: I don't know my New York geography that well,
7 but I can see from your map it's not.

8 Q: And ---

9 MR. LONG: Your Honor, I just ---

10 Q: --- you know where the Bronx is, don't you?

11 THE COURT: Whoa, whoa.

12 Q: That's where the Yankees play.

13 THE COURT: You had a ---

14 MR. THOMAS: I didn't hear an objection.

15 MR. LONG: You can try -- we got off on the
16 refreshing tangent, he's testified he doesn't
17 know. There's really nothing to refresh.

18 MR. THOMAS: Well, I'm going to ask him some more
19 questions.

20 THE COURT: All right.

21 Q: Is it your understanding Yonkers is on Long
22 Island? You're the vice president of finance
23 for 21st Century, right?

24 A: I know it's part of what I would consider New
25 York City.

1 Q: Okay. And you know where the Bronx is, don't
2 you?

3 A: There again, I'm not familiar with my New York
4 geography.

5 Q: Have you ever been to New York City?

6 A: Yeah, back in 1988.

7 Q: Do you know where -- have you ever the phrase
8 The Bronx Bombers?

9 A: Sure.

10 Q: Yeah, that's where the Yankees play, right?

11 A: Right.

12 Q: Okay. They don't play on Long Island, do they?
13 Do you know that?

14 A: I don't know my New York geography.

15 Q: Okay. Let me ask you this. Do you think that
16 centers 70, 80 miles away in one of the most
17 heavily populated areas of the United States,
18 that provides ample backup for ---

19 A: For I don't --

20 Q: Let me get my question out.

21 A: Okay.

22 Q: That that provides ample backup for Riverhead,
23 New York single operator?

24 A: Sure, when you're talking about staff and
25 physicians in the area. But I don't know that

1 you even have all the centers located in here
2 because you don't have the Westchester facility
3 listed, and where is that and ---

4 Q: Well, Westchester is near Connecticut ---

5 A: I don't know.

6 Q: --- isn't it? I know that.

7 A: I don't know.

8 Q: You don't know? So you would agree with me
9 that, Mr. Lewis, in terms of backup in a not so
10 heavily populated portion of the United States,
11 which is South Carolina, that Trident Medical
12 Center could back up Grand Strand Medical
13 Center about 100 miles away, correct?

14 A: That would be a longer distance. .

15 Q: A longer distance in a much different
16 metropolitan area, correct? I mean, are you
17 familiar with the landscape between Charleston,
18 South Carolina, and Myrtle Beach, South
19 Carolina?

20 A: No.

21 Q: Now, you would agree with me that 21st Century
22 Oncology operates in Nevada, correct?

23 A: Yes.

24 Q: That's not a CON state, is it?

25 A: No.

1 Q: And you testified that your locations in Nevada
2 are all very successful and profitable
3 facilities, didn't you?

4 A: Yes.

5 Q: And CRCC operates facilities in California,
6 which is not a CON state, correct?

7 A: Correct.

8 Q: They have competitors in that market as well,
9 don't they?

10 A: Correct.

11 Q: And New York, just for the record, that's not
12 a CON state either, is it?

13 A: It is applicable to hospitals, not to provider
14 org -- or physician organizations.

15 Q: You would agree with me that as a company, 21st
16 Century Oncology also competes with national
17 companies that are not unlike 21st Century,
18 right? Like, I think you mentioned Oncure.
19 What were some of the other ones?

20 A: Oncure, Vantage, US oncology.

21 Q: And those are also operators of radiation
22 therapy facilities?

23 A: Correct.

24 Q: And in some markets you actually go, 21st
25 Century affiliates go head to head against

1 those affiliates, correct?

2 A: Correct.

3 Q: And then where does 21st Century have its most
4 sizable operation in terms of states?

5 A: Florida.

6 Q: And you operate over 30 centers in Florida,
7 correct?

8 A: That's sounds reasonable, yes.

9 Q: And there's market-based competition in Florida
10 against 21st Century facilities, correct?

11 A: In some of the markets, yes.

12 Q: And you would agree with me, I think I asked
13 you as well, at many of the Florida locations
14 21st Century operates what's known as the
15 Clinac iX platform, correct?

16 A: Yes.

17 Q: Now, I think when I had deposed you, you hadn't
18 been to the CRCC-Conway site and actually
19 looked at it. Have you been there since I
20 deposed you?

21 A: I have not been in our CRCC site, no.

22 Q: You haven't been inside of it. Did you visit
23 it and see the outside of it?

24 A: No, I have not been to our CRCC -- oh, Con --

25 Q: Conway.

1 A: Conway, no, I've never been -- no, I've never
2 been to -- no, I've never been to Conway.

3 Q: Have you ever been to the CRCC-Myrtle Beach
4 facility?

5 A: No, I have not been in that facility.

6 Q: Have you been to that market?

7 A: I've been to Myrtle Beach, yes.

8 Q: When did you go to Myrtle Beach last?

9 A: I've been -- I've gone since the deposition.

10 Q: Okay. And what was your purpose for going?

11 A: I met with our urology group and met with the
12 practice administrator from a group.

13 Q: Okay. But you didn't stop by CRCC's Myrtle
14 Beach facility to check in on it?

15 A: No, I did not go to our site.

16 Q: Okay. And when I deposed you, I showed you a
17 picture of what CRCC-Conway looks like,
18 correct?

19 A: Correct.

20 Q: And you described it as it looks like a nice
21 facility, right?

22 A: I believe that's what I said.

23 Q: Okay. Now, Mr. Long asked you a few questions
24 about the ownership model, and I want to ask
25 you a few questions about that as well. CRCC,

1 that's the actual operator of the linear
2 accelerators, right, the three in Myrtle Beach?

3 A: Correct.

4 Q: Okay. And they're all owned by Atlantic
5 Urology Clinics, correct?

6 A: That legal entity rolls up to Atlantic Urology
7 Clinics, yes.

8 Q: Okay. So 21st Century, I guess, Oncology of
9 South Carolina, that's the entity that actually
10 owns the practice that employs the urologists,
11 correct?

12 A: Yeah, AUC rolls up to 21 C of South Carolina.

13 Q: And but 21st Century Oncology doesn't
14 necessarily own the land and the building that
15 the urologists practice in, correct?

16 A: No, we generally don't own lands or buildings.
17 We generally lease the land and buildings.

18 Q: And you leased the land and buildings in this
19 case from the urologists, correct?

20 A: That would sound correct, yes.

21 Q: And what's your understanding of why the
22 urologists who owned their own practices sold
23 their practices to CRCC, or excuse me, to 21st
24 Century Oncology, but decided to maintain their
25 own surgery center?

1 A: You know, I don't know why that model is set up
2 exactly that way. We don't own and operate
3 surgery centers, that's not a business we get
4 into. So all of our urologists that own
5 surgery centers, they're separate and they're
6 often owned by multiple physicians that may not
7 necessarily be in the group that we employ.

8 Q: And it was important to employ the urologists
9 in this case because that would give -- that
10 would guarantee CRCC a very good referral
11 stream, correct?

12 A: No, there's no requirement they refer.

13 Q: Okay. But they do, right?

14 A: Yes, they do.

15 Q: They refer overwhelming numbers to CRCC, don't
16 they?

17 A: They refer I'm sure patients who have prostate
18 cancer, and they're given the option of being
19 treated with radiation along with all other,
20 you know, surgeries and other options that are
21 available to them.

22 Q: Well, we can get the data out, but you know
23 until 2012, the urologists referred 263
24 patients to CRCC for treatment, not consults,
25 treatments, correct?

1 A: (Nods head affirmatively.)
2 Q: You have to say yes.
3 A: Yes, sorry.
4 Q: And Mr. Tolbert, who's sitting right over
5 there, in his models, in all his adverse impact
6 models that he did, he assumed 100 percent
7 referrals from AUC to CRCC, correct?
8 A: I don't know.
9 Q: Oh, you haven't -- did you not talk with him
10 about his referral models?
11 A: I -- produced when?
12 Q: To me about three weeks ago?
13 A: No, I have not.
14 Q: So you didn't sit down and talk with him and
15 talk about that analysis, did you?
16 A: Not in the last three weeks, no.
17 Q: Well, did you talk about a referral analysis
18 that he would do before that?
19 A: No.
20 Q: Okay.
21 A: I mean, our urologists are not required to
22 refer to us, there's nothing in their contract,
23 and they do actually refer to Georgetown
24 Hospital. So we do not get and will not get
25 100 percent of their referrals.

1 Q: Okay. But you don't dispute the fact that the
2 urologists do have a financial relationship
3 with CRCC, do you? They share profits ---

4 A: Right.

5 Q: --- from CRCC, correct?

6 A: They are in an ancillary bonus pool.

7 Q: Okay. And let me ask you this. You would
8 agree with me that in other markets, 21st
9 Century facilities have employed not just
10 urologists, but medical oncologists, surgeons -
11 --

12 A: Right.

13 Q: --- and other type of physicians that refer to
14 linear accelerators, correct?

15 A: Correct.

16 Q: Okay. And you would agree with me that there's
17 nothing stopping CRCC if both of these
18 applications are approved from potentially
19 employing medical oncologists on their own,
20 correct?

21 A: Say that once more.

22 Q: Yeah. There's nothing stopping CRCC or the
23 group practice, AUC, from employing medical
24 oncologists ---

25 A: Right. We ---

1 Q: --- if both of these applications are approved,
2 right?

3 A: Right. We are looking to, always looking to
4 hire physicians that would complement our group
5 practice.

6 Q: And you would agree with me that CRCC or AUC,
7 whichever entity it is that met recently with
8 ---

9 THE COURT: Hold on a second. I've got to take a
10 break, so I'll ---

11 MR. THOMAS: Can we do lunch then maybe?

12 THE COURT: Let's just take our lunch break at this
13 point in time. We'll come back at 1:30.

14 MR. THOMAS: That sounds great.

15 (Lunch break from 12:15 p.m. until 1:33 p.m.)

16 BY MR. THOMAS:

17 Q: Good afternoon, Mr. Lewis. When we took a
18 break the question I asked, and I'm not sure if
19 you answered it, I apologize if I'm re-asking,
20 but I asked you if there was anything stopping
21 CRCC from either purchasing a local medical
22 oncology practice in Horry County or recruiting
23 its own medical oncologist as 21st Century
24 affiliates have done in other parts of the
25 country?