

VOLUME VII

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

Trident Medical Center, LLC, d/b/a
Berkeley Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control and Roper St. Francis
Hospital-Berkeley d/b/a Roper St. Francis Hospital,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

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

Trident Medical Center, LLC, d/b/a
Berkeley Regional Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control, and Roper St. Francis
Hospital-Berkeley, Inc. d/b/a Roper St. Francis
Hospital-Berkeley,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

RECORD ON APPEAL - VOLUME VII OF XVI

(caption continued from cover page):

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

CareAlliance Health Services and Roper
St. Francis Hospital-Berkeley, ... Respondents/Appellants,

v.

South Carolina Department of Health and
Environmental Control and Trident Medical
Center, LLC Respondents,

Of whom Trident Medical Center, LLC is the Appellant.

David B. Summer, Jr., SC Bar #7974
William R. Thomas, SC Bar #16348
Faye A. Flowers, SC Bar #2043
Parker Poe Adams & Bernstein LLP
1201 Main Street, Suite 1450 (29201)
Post Office Box 1509
Columbia, South Carolina 29202
Telephone: 803.255.8000
Facsimile: 803.255.8017
E-mail: davidsummer@parkerpoe.com
E-mail: willthomas@parkerpoe.com
E-mail: fayeflowers@parkerpoe.com
Attorneys for Appellant/Respondent
Trident Medical Center, LLC

James G. Long III, SC Bar #64103
Jennifer J. Hollingsworth, SC Bar #73535
Tanya A. Gee, SC Bar #70191
NEXSEN PRUET, LLC
1230 Main Street, Suite 700 (29201)
Post Office Drawer 2426
Columbia, South Carolina 29202
Telephone: 803.771.8900
Facsimile: 803.253.8277
E-mail: JLong@nexsenpruet.com
E-mail: JHollingsworth@nexsenpruet.com
E-mail: TGee@nexsenpruet.com
Attorneys for Respondents/Appellants
CareAlliance Health Services and
Roper St. Francis Hospital-Berkeley

W. Marshall Taylor, Jr., SC Bar #16646
Ashley C. Biggers, SC Bar #17225
Vito M. Wicevic, SC Bar #100265
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201
Telephone: 803.898.3350
Facsimile: 803.898.3367
E-mail: taylorwm@dhec.sc.gov
E-mail: biggerac@dhec.sc.gov
E-mail: vito.wicevic@dhec.sc.gov
Attorneys for Respondent
South Carolina Department of Health
and Environmental Control

INDEX

RECORD VOLUME I OF XVI

ORDERS

PAGE

Order of Judge McLeod, filed November 1, 2012.....	1
Final Order and Decision of Judge McLeod, filed September 26, 2012	3
Order of Judge McLeod, filed February 10, 2012	55
Order of Judge McLeod, filed January 28, 2011	59
Consent Order of Intervention and Consolidation of Judge McLeod, filed January 7, 2010	62

PLEADINGS

Trident Medical Center, LLC's Petition for Administrative Review and Request for Contested Case Hearing, Docket No. 09-ALJ-07-0332-CC, filed August 7, 2009.....	68
Trident Medical Center, LLC's Petition for Administrative Review and Request for Contested Case Hearing, Docket No. 09-ALJ-07-0333-CC, filed August 7, 2009.....	120
CareAlliance Health Services and Roper St. Francis Hospital-Berkeley's Request for Contested Case Hearing, Docket No. 09-ALJ-07-0336-CC, filed August 7, 2009.....	165
SCDHEC's Memorandum of Law in Opposition to Trident Medical Center's Motion for Summary Judgment, December 15, 2010.....	192
Joint Deposition Designation and Counter-Designation Master List (with all deposition designations, filed February 21, 2012	271

RECORD VOLUME II OF XVI

Trident Medical Center, LLC's Motion to Alter or Amend (Reconsider), filed October 5, 2012.....	501
CareAlliance Health Services and Roper St. Francis-Berkeley's Memorandum in Opposition to Motion to Alter or Amend, filed October 19, 2012	516

TRANSCRIPTS**PAGE**

Transcript of Administrative Hearing before The Honorable John D. McLeod, January 30, 2012 – February 16, 2012.....	527

(pp. 10-71 omitted)

JAMES P. RARDIN

Direct Examination by Mr. Thomas	537
Cross Examination by Mr. Long.....	628
Redirect Examination by Mr. Thomas.....	701

TODD GALLATI

Direct Examination by Mr. Summer.....	732
Cross Examination by Mr. Long.....	889

<u>RECORD VOLUME III OF XVI</u>	987

TODD GALLATI

Cross Examination by Ms. Biggers	987
Redirect Examination by Mr. Summer	992

MICHAEL RIDGEWAY

Direct Examination by Mr. Thomas	1039
Cross Examination by Ms. Hollingsworth.....	1063
Redirect Examination by Mr. Thomas.....	1081

BEVERLY BRANDT

Direct Examination by Mr. Summer.....	1087
Cross Examination by Ms. Biggers	1210
Cross Examination by Mr. Long.....	1288
Redirect Examination by Mr. Summer	1340

JOHN S. WEST

Direct Examination by Mr. Summer.....	1401
Cross Examination by Ms. Hollingsworth.....	1435

LESLEY WOODSON SHELTON, III

Direct Examination by Mr. Summer.....	1460

<u>RECORD VOLUME IV OF XVI</u>	1479

LESLEY WOODSON SHELTON, III

Cross Examination by Ms. Biggers	1574
Cross Examination by Mr. Long.....	1609
Redirect Examination by Mr. Summer	1633

TRANSCRIPTS (CONT'D)**PAGE****RICHARD BAEHR**

Direct Examination by Mr. Thomas 1660

RECORD VOLUME V OF XVI.....1971**RICHARD BAEHR**

Cross Examination by Mr. Long.....2001

Redirect Examination by Mr. Thomas.....2221

KARL GORRELL

Direct Examination by Mr. Long.....2319

Cross Examination by Mr. Thomas 2379

Redirect Examination by Mr. Long 2408

LOUIS F. CAPUTO

Direct Examination by Ms. Hollingsworth.....2417

RECORD VOLUME VI OF XVI.....2463**LOUIS F. CAPUTO**

Cross Examination by Mr. Summer.....2470

TERRY J. GUNN

Direct Examination by Ms. Hollingsworth.....2500

Cross Examination by Mr. Summer.....2582

Redirect Examination by Ms. Hollingsworth 2611

BRET D. JOHNSON

Direct Examination by Mr. Long.....2617

Cross Examination by Mr. Thomas 2704

Redirect Examination by Mr. Long 2872

DOUG BOWLING

Direct Examination by Mr. Long.....2907

RECORD VOLUME VII OF XVI 2955**DOUG BOWLING**

Cross Examination by Mr. Thomas 3084

Redirect Examination by Mr. Long 3230

MATTHEW J. SEVERANCE

Direct Examination by Mr. Long.....3255

Cross Examination by Mr. Summer.....3289

TRANSCRIPTS (CONT'D)

PAGE

RICK KNAPP

Direct Examination by Mr. Long.....	3364
Cross Examination by Mr. Thomas	3432

RECORD VOLUME VIII OF XVI.....3447

RICK KNAPP

Redirect Examination by Mr. Long	3525

MARK M. RICHARDSON

Direct Examination by Mr. Long.....	3545
Cross Examination by Mr. Summer.....	3716
Redirect Examination by Mr. Long	3879

RICHARD BAEHR

Direct Rebuttal Examination by Mr. Summer	3914

RECORD VOLUME IX OF XVI.....3939

RICHARD BAEHR

Cross Rebuttal Examination by Mr. Long	4062
Redirect Rebuttal Examination by Mr. Summer.....	4198

EXHIBITS

Petitioner Trident Medical Center, LLC

46.....	4260
112.....	4321
169.....	4322
221.....	4334

Respondent CareAlliance Health Services and Roper St. Francis Hospital-Berkeley

15.....	4335
25.....	4336
36.....	4343
38.....	4344
41.....	4345
45.....	4352
59.....	4353
70.....	4359
75.....	4366
76.....	4375
77.....	4381
82.....	4382

**RESPONDENT CARE ALLIANCE HEALTH SERVICES AND
ROPER ST. FRANCIS HOSPITAL-BERKELEY EXHIBITS (CONT'D)**

PAGE

138.....	4384
146.....	4385

RECORD VOLUME X OF XVI.....4386

158.....	4386
160.....	4458
163.....	4459

Joint Exhibits

1.....	4461

RECORD VOLUME XI OF XVI.....4878

RECORD VOLUME XII OF XVI.....5366

2.....	5379

RECORD VOLUME XIII OF XVI.....5857

RECORD VOLUME XIV OF XVI.....6347

3.....	6663

RECORD VOLUME XV OF XVI.....6838

4.....	6873
8.....	7052

RECORD VOLUME XVI OF XVI.....7330

9.....	7414
10.....	7450
16.....	7519

CERTIFICATE OF COUNSEL.....7527

1 Q: And so roughly what's the percentage of
2 transfers to visits?

3 A: In my head, I would think it's seven or eight
4 percent.

5 Q: Is that a surprising number to you?

6 A: No.

7 Q: And earlier you talked about 40 percent, I
8 think, or 35 percent of the ED patients. Kind
9 of explain to the judge what the --

10 A: Actually, 40 percent of the patients who are
11 inpatient in a hospital came through the
12 emergency department to be admitted. These
13 are, of all emergency visits, what percent end
14 up in an admission, and that's usually seven or
15 eight percent.

16 Q: All right. Looking at these two exhibits and
17 your knowledge of, you know, of the area, what
18 is the utilization patterns in Berkeley County
19 in regards to the people that live there?
20 Where do they -- how do they go to access
21 healthcare?

22 A: I think the people in the southern part of the
23 county stay in that part of the county or
24 travel to the south to receive healthcare.
25 Those patients that are in the northern part of

1 the county around the lake, you know, the
2 services that are there are in Moncks Corner
3 and they've gone there usually first for their
4 service.

5 Q: Okay. Now, let's look at Respondent's -- let's
6 look at Respondent's 36. These are the non-
7 tertiary -- now, the hospital in Carnes
8 Crossroads, is it a tertiary hospital; the
9 proposed hospital, is it a tertiary hospital or
10 a non-tertiary hospital?

11 A: It's a non-tertiary community hospital.

12 Q: And what does that mean?

13 A: It means that they will not take the cases that
14 are of the highest acuity. There's won't be
15 open hearts; there won't be open heads or
16 craniotomies; be very little, probably acute
17 spinal surgery, there may be some there; and
18 probably not as much stroke and other more
19 acute cases.

20 Q: Okay. Now, these are the admissions to Roper
21 Hospital and St. Francis for 2007, 2008, 2009.
22 Let's just look at the 2009 number because the
23 2010 number is not a complete number. So how
24 many patients from Berkeley County alone were
25 admitted in 2009 to Roper St. Francis?

1 A: 3,596.

2 Q: Okay. Now --

3 **THE COURT:** What does the DRG stand for?

4 A: Diagnostic related grouping, Your Honor. And
5 so with every admission that occurs into a
6 hospital, they go into a grouping and that
7 grouping is set by Medicare. And so when we
8 say non-tertiary DRG, it just means those
9 patients that were put into a grouping that
10 wasn't of the highest acuity. So this doesn't
11 include the heart cases, the cranial
12 neurosurgery cases and those types of cases.
13 It's only those cases that would be appropriate
14 in a community hospital.

15 **THE COURT:** And, again, what does it stand for?

16 A: Diagnostic related grouping.

17 Q: And is it basically a code? DRG, is it a code?

18 A: It's a code.

19 Q: So each patient that comes into the hospital,
20 are they given a DRG code and coded?

21 A: They are. And it's a means by which we're
22 reimbursed.

23 Q: So explain that, just briefly.

24 A: I'm not familiar with the codes themselves.
25 But if you come in for a heart procedure, say

1 an interventional catheterization, that has a
2 certain diagnostic related grouping code that
3 goes with it and based on that code is how
4 Medicare will reimburse you for that procedure.
5 Q: Okay. And are these codes a way that you can
6 tell the difference between whether a service
7 is tertiary or non-tertiary?
8 A: You can.
9 Q: Okay. And so is that -- so when we say non-
10 tertiary DRGs, what does that mean to you?
11 A: That means that the cases that are represented
12 here would only be cases that were appropriate
13 for a community hospital and would not go to --
14 need to go to a tertiary facility.
15 Q: Okay. And let me show you, if I can,
16 Respondent's 76. And this map, which is a
17 chart that we -- it's 4713. Do you have it in
18 front of you? Can you see it on the screen?
19 A: I do.
20 Q: All right. And this map, do you see it down
21 here at the bottom right-hand corner it shows
22 inpatient count, all right?
23 A: Yes.
24 Q: Can you kind of tell what this map is showing
25 here?

- 1 A: Yeah. What it's showing in raw numbers is from
2 which areas we received inpatients into Roper
3 St. Francis Healthcare from Berkeley County.
4 The pink areas are zip codes from which we
5 received 751 patients or more from that zip
6 code. The orange is 501 to 750, yellow 251 to
7 500. And the green, one to 250. And what I
8 think it shows here is that you can see in raw
9 numbers we received considerably more patients
10 from the southern half of Berkeley County than
11 we did from the northern half.
- 12 Q: Okay. And when you're talking about the
13 northern half, what are you talking about?
- 14 A: Those zip codes that are north and west around
15 the lake and then actually the zip codes that
16 are north going toward Georgetown County.
- 17 Q: Those -- which two are those?
- 18 A: That's 29453 and 29450.
- 19 Q: Okay. And where is the -- in regards to this
20 area that's in pink --
- 21 A: Yes.
- 22 Q: -- where is the proposed Roper St. Francis
23 Hospital located?
- 24 A: Just about in the middle of the pink area.
- 25 Q: Now, is this chart here a factor that you

1 considered in where to -- in where to locate
2 the proposed hospital?

3 A: It is. We looked at the population
4 distribution within the county and then we
5 looked at the population distribution of our
6 inpatients and where they were coming from
7 within the county.

8 Q: How far is it from Roper St. Francis for the
9 proposed site at Carnes Crossroad to the Roper
10 Downtown?

11 A: It's probably 20 to 22 miles, somewhere in that
12 area.

13 Q: And then how far is it from Roper St. Francis
14 at Carnes Crossroads to the proposed site or to
15 the ED in Moncks Corner?

16 A: 11.8, just shy of 12 miles.

17 Q: So it's over 30 miles then from downtown to the
18 Moncks Corner ED?

19 A: Right.

20 Q: All right. What would you have expected to
21 occur if Roper St. Francis had decided to
22 locate the hospital in Moncks Corner?

23 A: I think the majority of those patients that are
24 currently using Roper St. Francis Healthcare
25 would not feel that that had improved their

1 access to services. Most of them are in the
2 southern portion of the county and as I said
3 before, we rarely see patients drive upstream
4 for inpatient services.

5 Q: And where would you expect them to seek their
6 healthcare?

7 A: I think they would continue to come to St.
8 Francis or Roper Downtown.

9 Q: Do doctors get paid for being in their car?

10 A: No, they don't.

11 Q: What do they get paid for?

12 A: They get paid for performing evaluations and
13 treatment of patients.

14 Q: All right. So can you kind of explain the
15 concept of a critical mass of patients?

16 A: I can. It's really having enough patients at
17 a location to make it worthwhile for the
18 physician to travel there and spend their time
19 seeing them. It's -- you know, you don't want
20 to be in the car driving for an hour to be
21 somewhere and only see two or three patients
22 and drive back an hour, which makes these more
23 distant facilities somewhat problematic at
24 times.

25 Q: All right. Now, for a new hospital, though,

1 what's a -- does the critical mass create a
2 challenge?

3 A: It does. I think it's like anything in
4 business; you have to have so many patients to
5 support a physician being there to see them.
6 But if a physician's not there to see them,
7 you're not going to build up the patients. So
8 you do this kind of development dance where we
9 have physicians that are traveling out to Mount
10 Pleasant and they're satelliting in offices
11 there, seeing patients, and then that patient
12 base is continuing to grow. And as it grows
13 they're willing to spend more time there and
14 you get finally to a tipping point where
15 there's enough patient base that the physician
16 will move their practice in its entirety to the
17 site.

18 Q: In regards to the services that are offered at
19 a hospital, what services tend to come to the
20 new hospital first and which ones are last?

21 A: What tends to come first are the medical
22 admissions, those that can be admitted through
23 the hospitalist because those physicians are on
24 staff 24 hours a day, then you see general
25 surgery.

1 Q: I'm talking about all services, including
2 outpatient, diagnostic, everything that's
3 offered at a hospital.

4 A: Okay. Repeat the question.

5 Q: So what do you typically see at a new hospital;
6 what services tend to come to the new hospital
7 first?

8 A: Oh, as far as patient utilization of the
9 services?

10 Q: Patient utilization, right.

11 A: The ones that obviously are the easiest and you
12 see happen first are those evaluation and
13 treatments that don't require the physician to
14 be present at the time. So if a patient's
15 coming in to have an MRI or a CT scan, the
16 physician doesn't have to be located at that
17 device while the scan's being done, so it makes
18 it easier and patients want to go someplace
19 close for those kinds of tests. So early on
20 you see the diagnostic imaging, the lab tests
21 build up first and then you'll see outpatient
22 services and typically the last thing, because
23 of the complexity of resources that are
24 associated with it, the last thing that occurs
25 is the inpatient admission.

1 Q: Is 50 beds large enough to create a critical
2 mass in a hospital?

3 A: It is for community hospital-based services;
4 obstetrics, general surgery, orthopaedics.
5 It's certainly not enough to get a critical
6 mass for more complex and more acute cases.

7 Q: Do you see 50 bed hospitals around the country?

8 A: Yes.

9 Q: Can they be successful?

10 A: They can be very successful.

11 Q: Let's take a look at your decision to locate
12 the hospital project at Carnes Crossroads.
13 When did you start seriously looking at
14 Berkeley County for Roper St. Francis?

15 A: Our first discussions on Berkeley County
16 occurred as early as late 2004. We were in a
17 planning session literally between Christmas
18 and New Year's discussing what to do to address
19 some of the market share erosion and the out-
20 migration of physicians to the suburban areas.
21 And we decided at that time that we were going
22 to have to take services off of the peninsula
23 and go to the outlying areas. The two areas
24 that we discussed were Mount Pleasant and
25 Berkeley County, both because of our market

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1 share in those areas. We made the decision
2 that week that we would go to Mount Pleasant
3 first and that Berkeley would be the next area
4 that we would try to expand to.
5 Q: Okay. So when did you seriously return --
6 because you've gone to Mount Pleasant, correct?
7 A: Right.
8 Q: And Roper St. Francis has a hospital there?
9 A: We do.
10 Q: When did you start looking at Berkeley then?
11 A: As soon as the decision was issued in Mount
12 Pleasant and we knew what our time line there
13 was, we started looking immediately at Berkeley
14 County. So that would have been mid-2006, June
15 or July.
16 Q: Did you look at a --
17 A: Excuse me.
18 Q: Do you have some water there?
19 A: Yeah, let me grab some.
20 Q: Did you look at a number of different sites?
21 A: We did. We looked at sites up and down Highway
22 52. We looked in the Holly Hill Industrial
23 Development. We looked at other sites along
24 17-A. But ultimately decided on the Carnes
25 Crossroads site.

1 Q: Let's look at Petitioner's 18, I think Mr.
2 Thomas' map here that has the roads on it. I
3 think this might help kind of.

4 MR. LONG: If we can blow this up a little bit
5 maybe?

6 Q: Okay. Can you talk about some of these key
7 roads in Berkeley County and how that -- what
8 you were looking at in regards to these other?

9 A: Yes, I can. Number two on this map is the
10 Carnes Crossroads location. And as you'll see
11 there, there are two major roads that kind of
12 bisect the county in both directions, 17-A
13 clearly running from the southwest to the
14 northeast.

15 Q: It actually runs all the way through Dorchester
16 County too, doesn't it?

17 A: It does.

18 Q: And then all the way north up into --

19 A: Up into Georgetown County I believe.

20 Q: And above, okay. So that's -- so 17-A. And
21 then what's the other major --

22 A: The other one is the one that really is the
23 major artery in Goose Creek and that's State
24 Highway 176, and you can see that running from
25 down near Hanahan through Goose Creek and on

1 up into Orangeburg County. So those two
2 arteries we thought were very important. On
3 176 is where a lot of the development is
4 scheduled to be and a lot of the development
5 has occurred. That's where the new Cane Bay
6 High School is, is on 176. It's where the Dell
7 Web development, Sun City project is, is on
8 176. Parks of Berkeley will be on 176. So it
9 will be a major development artery for the
10 county.

11 Q: And is that also where Trident Health System
12 owns 20 acres of land?

13 A: It is.

14 Q: Is this at Cane Bay?

15 A: It is.

16 Q: And Cane Bay is on 176 too?

17 A: Yes, it is.

18 Q: Is it a little north or south of the --

19 A: It is a little north.

20 Q: North from the Carnes Crossroads location,
21 okay. Let's look at -- I want to ask you, if
22 I can, I want to discuss with you some of the
23 factors that you may or may not have considered
24 in regards to your decision to locate the
25 hospital at Carnes Crossroads instead of Moncks

1 Corner and, I guess, get you to comment on that
2 if I could.

3 A: Okay.

4 Q: Okay. How about the population growth in
5 Berkeley County?

6 A: We did look at the population growth in
7 Berkeley County as a reason for selecting
8 Carnes Crossroads. A lot of that was based on
9 a report that was done by the Berkeley Chamber
10 of Commerce. They actually did an analysis in
11 the county and they designated what they called
12 growth corridors and maintain rural corridors.
13 And when you look at Berkeley County, those
14 counties or those zip codes around the lake and
15 to the north and east of Moncks Corner were
16 designated to maintain rural status. They've
17 designated 176 and that corridor as the center
18 of the growth corridor for Berkeley County.
19 And we knew that decision had been made by the
20 council and you could see the push towards
21 business development along that corridor.

22 Q: Okay. What about these planned developments
23 that you just mentioned?

24 A: Significant planned developments. You know,
25 after the mortgage meltdown they've slowed

1 somewhat. But, as I said, the Dell Web Project
2 is on 176, Cane Bay, the Parks of Berkeley.
3 Mead Westvaco has a huge project on 17-A in
4 Berkeley County that they actually have
5 announced that they're going to begin
6 construction in the next 60 days, so.

7 Q: How about this seven mile population circle,
8 can you tell what that is and whether it was a
9 factor or not?

10 A: It is. In most counties in the state and
11 everywhere I've seen hospital development, you
12 know, hospitals tend to be put at the center of
13 the population of the county because that's
14 what has the greater access to the greatest
15 number of people. We use the seven mile,
16 which I've heard debated back and forth. But
17 from a planning perspective, it's used, I think
18 probably the best expression is the sniff test;
19 you know, how much population is closely
20 proximal to what you intend to build. And we
21 use the seven mile test to look at that.

22 Q: Okay. What about the population that is
23 outside of 30 minutes drive time to a hospital,
24 was that a major factor in your choice between
25 the two locations?

1 A: It was not.

2 Q: Can you tell why not?

3 A: You know, we looked at that. If you view that
4 guideline from the state, it's really an upper
5 limit. It's a goal that the population in
6 South Carolina is within 30 minutes of a
7 hospital, but it's certainly not a criteria.
8 And when you're looking at access, we look to
9 provide access to the greatest number of
10 people. And if you start trying to fit them
11 within, everybody within 30 minutes, you start
12 getting into very small populations that you're
13 serving.

14 Q: All right. How about the Roper St. Francis
15 total market share as a factor in regards to
16 your decision to go to Carnes Crossroads over
17 Moncks Corner?

18 A: Total market share in Berkeley County?

19 Q: In Berkeley County.

20 A: Yeah, I mean, it's a huge factor. You know, as
21 I said, the greatest raw number of patients
22 come to us from that portion of the county. We
23 do have some medical practices there. It was
24 something that we felt we were at risk of
25 losing as it's taking a greater amount of time

1 to get from Goose Creek and in that part of
2 Berkeley County to downtown because of traffic.
3 You have to start questioning how much longer
4 will people be willing to drive that kind of
5 distance to use your services. And so we felt
6 in order to maintain that market share, we
7 needed to get services in that area of the
8 county.

9 Q: How about the need to serve Roper St. Francis
10 patients in Berkeley County?

11 A: Clearly that location was picked for that
12 reason and that's why we want to go to Berkeley
13 County. You know, if you have a population
14 that has selected you for that long, you figure
15 you have an obligation to provide services to
16 them.

17 Q: Now, your -- this project is moving beds from
18 downtown to Carnes Crossroads, right?

19 A: Yes.

20 Q: So explain the concept of redirection and how
21 that factors into your decision making.

22 A: Well, redirection I think you have to
23 understand, you know, I can't redirect a
24 patient, Todd Gallati can't redirect a patient.
25 What we're hoping is that consumer patterns

1 will change to utilize the facilities that
2 we've provided. So that's a big point. We
3 feel that with a very consistent market share
4 that we've had there and selection of Roper St.
5 Francis, that we'll be very successful at
6 redirecting those patients, changing the
7 consumer pattern. You know, we think they're
8 still going to choose Roper St. Francis, we
9 just make the choice easier by having a
10 facility in Berkeley County.

11 Q: Now we're looking again at this map,
12 Respondent's 76, that shows where the
13 inpatients come from for Berkeley County.

14 A: Uh-huh.

15 Q: Talk about the challenges of having these
16 patients use the new facility if you had chosen
17 to locate in Moncks Corner instead of at Carnes
18 Crossroads.

19 A: I think it would be very challenging that, you
20 know, first of all, Goose Creek, I don't know
21 that they would feel like a Moncks Corner
22 hospital was their hospital. So you have some
23 of that, you know, community connection there.
24 It's also would be going 12 miles backwards in
25 terms of healthcare planning.

1 Q: Okay. And in regards to the distance, would it
2 be a whole lot closer to go to downtown than it
3 would be to go to Moncks Corner if you lived in
4 29445 --

5 A: Yes.

6 Q: -- which is the Goose Creek zip code?

7 A: Right. You'd definitely be closer to downtown
8 than going up to Moncks Corner.

9 Q: Okay. So would that affect your ability to
10 kind of redirect patients?

11 A: Well, it would because I think you'd, as we've
12 talked about, you'd see those patient just
13 decide to continue to come downtown because the
14 distance wouldn't be any greater and the level
15 of facility would be much superior downtown
16 than going back to Moncks Corner.

17 Q: You also look at -- is there another thing that
18 you look at where you like to locate your
19 hospitals in regards to education?

20 A: We have tended to kind of follow the high
21 schools. In Mount Pleasant, the location that
22 we selected there was very close, less than a
23 quarter of a mile from the new Wando High
24 School. And Carnes Crossroads we gave a great
25 deal of consideration to that site because of

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1 it being located near the new Cane Bay High
2 School. Being close to high schools, there's
3 no magic to that, it just demonstrates that the
4 community is familiar with the location, they
5 develop a traffic pattern around the high
6 school. So it's just a good way to jump onto
7 existing consumer patterns.

8 Q: Okay. How about the payer mix between Moncks
9 Corner and Goose Creek? And you need to
10 probably explain what the payer mix is before
11 you comment on that.

12 A: Payer mix is the distribution of patients by
13 the source of payment they have. So we have
14 Medicare, Medicaid and Tri-Care are the
15 government payers. You have the commercial
16 payers; Blue Cross, Cigna, United Healthcare
17 and others. And then we have indigent care or
18 those people that are -- make less than 300
19 percent of the federal poverty limit, which in
20 our case qualify for charity care, which means
21 we do not seek payment from them. Those are
22 the major payers.

23 Q: Okay. Did you look at that payer mix between
24 Moncks Corner and Carnes Crossroads in making
25 your decision about where to locate?

1 A: Payer mix wasn't a big issue. We did look at
2 the payer mix in each area. There's actually
3 a greater number of indigent patients in the
4 Carnes Crossroads area than there were around
5 the Moncks Corner area, so.

6 Q: And how about the affluence of the two
7 communities, Goose Creek compared to Moncks
8 Corner?

9 A: There may be a slight difference. I think, you
10 know, Goose Creek I've heard characterized in
11 here as an affluent community. I certainly
12 wouldn't characterize them as affluent. I
13 think they're pretty much bread and butter. I
14 think the median household income in Goose
15 Creek is just about exactly the median
16 household income of the Tri-county area. So
17 I'd consider it kind of right in the middle.

18 Q: And how about comparing that to Mount Pleasant?

19 A: Mount Pleasant definitely has a much higher
20 median income, or did when we built out there,
21 than Goose Creek. Those income statistics in
22 Mount Pleasant, I think, have been hurt
23 somewhat since 2008. But the Mount Pleasant
24 Hospital also serves a pretty good indigent
25 population. You know, we're -- I think

1 somebody in here said it's the Awendaw
2 Hospital. And we do serve a number of patients
3 from Awendaw, McClellanville and some of the
4 underserved areas up there at Mount Pleasant
5 Hospital.

6 Q: And those areas, are they affluent?

7 A: They are not.

8 Q: Awendaw and McClellanville?

9 A: No.

10 Q: How about Summerville compared to Goose Creek?

11 A: Summerville I believe has a higher median
12 household income than Goose Creek.

13 Q: Let's go back to the little time line if we
14 can. Let's talk about your decision -- let's
15 talk a little bit about Mount Pleasant.

16 A: Uh-huh.

17 Q: We'll come back to Carnes Crossroads, okay?
18 All right. Now, when exactly did Roper St.
19 Francis apply for a new hospital in Mount
20 Pleasant?

21 A: We applied for that hospital in 2005.

22 Q: And when did it open?

23 A: It opened November 1st of 2010.

24 Q: Okay. Now, is the population in Mount Pleasant
25 smaller or larger than the population in

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1 Berkeley County?

2 A: Smaller.

3 Q: Okay. So what factors led you to file in Mount
4 Pleasant before you filed in Berkeley?

5 A: The main factor that the reason we chose Mount
6 Pleasant over the Berkeley County project,
7 first was we'd already seen a significant
8 number of our physicians migrate from the
9 peninsula over into Mount Pleasant. We had a
10 number of specialists, probably 30 of them,
11 that had already set up satellite offices in
12 the Mount Pleasant market. There was a
13 significant primary care base of ours that
14 already existed in the Mount Pleasant market.
15 So we felt from a risk profile and from being
16 able to have a little more expectation of
17 redirection that Mount Pleasant was going to be
18 an easier site to develop initially than
19 Berkeley County.

20 Q: How about your market share in Mount Pleasant?

21 A: Market share in Mount Pleasant was about 36
22 percent compared to 23 percent in Berkeley
23 County. So we did have a higher market share.

24 Q: And how many hospitals were located in Mount
25 Pleasant before Roper St. Francis Mount

1 Pleasant opened?

2 A: There was one.

3 Q: All right. And what hospital was that?

4 A: East Cooper Medical Center.

5 Q: And did East Cooper -- what was their market
6 share at the time you applied?

7 A: Their market share was about 30 to 35 percent
8 also.

9 Q: In the Mount Pleasant area?

10 A: In the Mount Pleasant area.

11 Q: Now, when you applied for the CON in 2005, what
12 provision under the State Health Plan did you
13 apply under?

14 A: The bed transfer provision.

15 Q: So exactly what did Roper St. Francis do to
16 construct the hospital there?

17 A: We went to the state requesting to relocate 85
18 med-surg beds from Roper Hospital Downtown to
19 a new site in northern Mount Pleasant.

20 Q: And was that site a greenfield?

21 A: It was.

22 Q: And when we say greenfield, what does that
23 mean?

24 A: Nothing but trees and grass.

25 Q: Okay. And how far is it from the downtown

1 hospital to the new Mount Pleasant Hospital?

2 A: 14.2 miles.

3 Q: And how many acres is the Mount Pleasant site?

4 A: Seventy-eight.

5 Q: Okay. Now, at the same -- around this same
6 time in 2005, did East Cooper file a CON with
7 the Department?

8 A: They did. They filed a certificate of need to
9 build a replacement hospital virtually adjacent
10 to their existing facility and to use a bed
11 need they had of one to add 50 beds to that
12 facility.

13 Q: And did they add 50 or how many did they add?

14 A: They were approved to add 50. They ultimately
15 only added 40 to the hospital.

16 Q: Okay. Was that replacement hospital
17 constructed?

18 A: Yes, it was.

19 Q: And is it open today?

20 A: It is.

21 Q: Now, was it on the same site or was it a
22 greenfield site?

23 A: It's a greenfield site.

24 Q: Now, were those applications reviewed by the
25 Department together?

- 1 A: They were.
- 2 Q: Were the decision letters issued on the same
- 3 day?
- 4 A: They were.
- 5 Q: Were the project reviews conducted together?
- 6 A: They were.
- 7 Q: And did the Department determine that the
- 8 applications were competing?
- 9 A: They did not.
- 10 Q: And after that decision, was there an appeal?
- 11 A: There was not. There was a request for
- 12 reconsideration for the DHEC Board and the DHEC
- 13 Board denied that request to reconsider and
- 14 then ultimately the parties settled before it
- 15 went to litigation.
- 16 Q: So, and was there any money paid from one party
- 17 to the other?
- 18 A: There was not, no.
- 19 Q: Now, did East Cooper's hospital open before the
- 20 Mount Pleasant Hospital?
- 21 A: It did.
- 22 Q: All right. You saw the testimony I guess with
- 23 Mr. Baehr earlier about the -- do you follow
- 24 the utilization numbers for the other hospitals
- 25 somewhat?

1 A: To some degree. I don't know that I could
2 quote them, but I look at them.

3 Q: Do you have any insight as to why the East
4 Cooper utilization numbers declined from '03 to
5 2010?

6 A: I think everyone has a pretty good
7 understanding of why that happened. MUSC
8 became --

9 MR. THOMAS: Objection, Your Honor. I don't think
10 there's been enough foundation laid simply --
11 he just said he doesn't even review the numbers
12 that much.

13 MR. LONG: Let me ask the question again.

14 THE COURT: I'll sustain and let you ask the
15 question again.

16 Q: Are you familiar with changes that have
17 occurred out in the Mount Pleasant area in
18 regards to providing healthcare services?

19 A: I am.

20 Q: And what are some of the things that have
21 occurred in Mount Pleasant since these
22 applications were filed in 2005?

23 A: As I said, a number of our specialists have
24 migrated out into the Mount Pleasant market and
25 also MUSC placed a number of employed

1 physicians in the Mount Pleasant market and
2 actually on the campus of East Cooper Medical
3 Center. Also, at about that time --

4 Q: On the campus?

5 A: On the campus.

6 Q: Okay.

7 A: Also, at about that time, East Cooper actually
8 contracted with MUSC to provide their
9 hospitalist program. And many of us have
10 characterized that as letting the fox in the
11 hen house, because it did cause a pretty
12 significant diversion of patients to their
13 downtown facility.

14 Q: Have there been any other providers that have
15 entered in that area around East Cooper?

16 A: Not that I can think of.

17 **THE COURT:** Before you go on and get too far past
18 this, when you were questioning Mr. Bowling
19 about the East Cooper expansion, let's call it,
20 it was said I believe that it was a greenfield
21 expansion.

22 **MR. LONG:** Yes, sir.

23 **THE COURT:** The East Cooper facility, which I'll
24 take judicial notice of, has been there for
25 many years. How did that morph into a

1 greenfield? Was it an entirely new facility?

2 Explain that to me.

3 Q: Can you explain that to the judge?

4 A: Yes, Your Honor. What they applied for was to
5 build a replacement facility. So they, in
6 essence, closed the existing 100 bed hospital
7 that they had.

8 THE COURT: That answers my question. Thank you.

9 Q: And the new hospital is how far from the old
10 one?

11 A: A tenth of a mile maybe.

12 Q: But it is a separate parcel?

13 A: It is a separate parcel of land.

14 THE COURT: One further question. Then I assume
15 that they transferred all the old beds plus the
16 40 new ones, is that --

17 A: They did. And the facility is 140 beds today.

18 THE COURT: Thank you.

19 Q: Now, have you been by the Mount Pleasant
20 Hospital since it opened?

21 A: Right.

22 Q: When a hospital opens, brand new hospital like
23 Mount Pleasant, is it like a new Apple store
24 opening?

25 A: No.

1 Q: Tell us why it's different.

2 A: The consumer patterns and by patterns, the
3 patterns of the physicians and the patients,
4 they just take much longer to develop. You
5 know, we have physicians that they have their
6 office schedule, they have blocked time in the
7 ORs at other facilities, so you get to that
8 efficiency is how -- how quickly can they
9 afford to devote time at the new facility. And
10 so that transition does take a while to occur.

11 Q: Okay. What about in regards to reimbursement?

12 A: Any new hospital must first be certified by
13 Medicare as a participant of Medicare before
14 you can charge Medicare for patients that are
15 seen there. Medicare has up to six months to
16 survey you and provide that certification. So
17 what happens is when a hospital first opens, we
18 artificially hold the volume down at that
19 facility because everything we do is
20 essentially free care.

21 Q: So you actually have to open before you are
22 certified by Medicare?

23 A: You do. You have to be open, you have to have
24 seen a certain number of Medicare patients
25 before they will submit to coming in and

1 surveying your property or hospital and then in
2 granting you certification. Also, the other
3 payers, Blue Cross, Cigna, United Healthcare,
4 will not pay you during that time either until
5 you are certified by Medicare. The difference
6 being is those patients that you treat that are
7 Medicare patients in those first few months,
8 even once you're certified you cannot go back
9 and bill for them. So it is truly free care
10 for that period of time. The other insurers
11 will typically let you bill retro after
12 certification.

13 Q: But Medicare does not?

14 A: Medicare does not.

15 Q: And so do you know when you open the door --
16 when you opened the doors on November 1, 2010,
17 did you know when the certification was going
18 to occur?

19 A: We did not. We knew it could take as long as
20 six months.

21 Q: Now, when actually did the hospital get
22 certified?

23 A: I think its certification was mid-January when
24 it came through. It was just slightly over 60
25 days.

1 Q: Give the court, if you would, kind of an
2 overview of what has happened at the Mount
3 Pleasant Hospital since it opened in regards to
4 its utilization and care of patients?

5 A: The hospital, as we said, in typical fashion,
6 those outpatient services, diagnostic services,
7 they come first. We had a very good 2011. Our
8 emergency department performed better than
9 expected. We had I think almost three times as
10 many MRIs done as we expected. The diagnostic
11 imaging services performed very well. Most of
12 the outpatient, the lab and other services did
13 well. We did lag in inpatient services. We've
14 seen that taking a little longer than we had
15 hoped for, but a lot of it is just getting to
16 that critical mass. So we have -- still have
17 no doubt that that ultimately, that redirection
18 that we predicted by year three will occur.
19 But the first year ramp up was a little slow on
20 the inpatient side.

21 Q: And what did you -- did the specialists have
22 some impact on that?

23 A: They did. Just the ability to get out there in
24 a cost efficient manner and provide time. We
25 have certain areas that we still need to

1 recruit some specialists. One is cardiology.
2 We do have a cardiologist that goes out there
3 part-time on a consulting basis, but he's doing
4 no, what we call, longitudinal care at that
5 facility, which means --

6 Q: What's that?

7 A: -- he's not seeing patients in the office and
8 available full-time for consults. So just that
9 alone has hurt the redirection. And that -- we
10 have a cardiologist that will be starting there
11 in the next couple of months and we expect that
12 to improve.

13 Q: And how does that relate to this concept of the
14 tipping point?

15 A: It's very important. Those cardiology patients
16 which you hope to get there and they use other
17 services, whether its nephrology,
18 endocrinology, we don't have them at this point
19 and once the cardiologist is there, that group
20 of patients will start building.

21 Q: Is there any doubt in your mind that the
22 patients will come to the Roper St. Francis
23 Mount Pleasant Hospital?

24 A: No. No doubt whatsoever. I think it's
25 important. I mean the Department looks at a

1 three year horizon to get there. Actually in
2 healthcare planning, that's still considered
3 pretty quick. You know, we expect a facility
4 to continue to grow and looking at five and
5 seven years is not a long term to look for a
6 hospital getting to that point.

7 MR. LONG: Your Honor, this might be a good break
8 point. We've been going now for about two
9 hours. It's about ten after eleven. Maybe a
10 five minute break?

11 THE COURT: Let's say ten.

12 MR. LONG: Ten.

13 THE COURT: We'll be in recess for ten minutes.

14 (Off the Record from 11:10 a.m. until 11:20 a.m.)

15 THE COURT: Back on the record. Mr. Long.

16 MR. LONG: Thank you, Your Honor.

17 Q: Mr. Bowling, how did you come to -- let me ask
18 this. Were you approached by developers in
19 regards to this proposed hospital project?

20 A: We were. We had the commercial real estate
21 developer -- or agent rather that we used for
22 Mount Pleasant also helped us in looking at
23 sites in Berkeley County. He was approached by
24 the people that had the Daniel Island
25 Development and those are the developers of

1 Carnes Crossroads and they approached Chris
2 Fraser, who was our broker, about the site and
3 then Chris in turn led us to it.

4 Q: And were there other options available to you
5 in that area?

6 A: There were.

7 Q: What were some of those other options?

8 A: We talked to the people in Cane Bay also. We
9 talked with the folks at Mead Westvaco, which
10 is essentially across the street from Cane Bay
11 on 176. As I said earlier, we looked at the
12 Holly Hill Industrial Development, which is on
13 Highway 52 between Goose Creek and Moncks
14 Corner. And evaluated all of those and really
15 felt that Carnes Crossroads was the site that
16 suited us best.

17 Q: Let's look at Respondent's 5 if we could. This
18 document reflects some of those developments
19 and growth in Berkeley County that you looked
20 at at this time.

21 A: Yeah, I see the Mead Westvaco mentioned there
22 and the Parks at Berkeley, and then Crescent
23 Resources, I remember actually having some
24 discussions with that group. The home
25 developers --

1 MR. THOMAS: Could I quickly object to -- I don't
2 mind this document coming in, but it is
3 hearsay, so as long as it's understood that
4 they can't, you know -- this would be he his
5 understanding of what was going to happen, but
6 I don't want that there's information in this
7 document that projects home developments and
8 the number of homes that --

9 THE COURT: In other words, you object to it being
10 absolute. This is a projection.

11 MR. THOMAS: Yes, sir.

12 THE COURT: All right. Any problem, Mr. Long?

13 MR. LONG: No, Your Honor.

14 THE COURT: All right.

15 MR. THOMAS: Thanks, Your Honor.

16 Q: This article here is about which development?

17 A: This is Goose Creek. I think the beginning of
18 this article talks about the new Cane Bay High
19 School and the elementary school. It talks
20 about Ben Gramling and the Cane Bay
21 development.

22 Q: How big is that high school? I think we've got
23 one slide here. We'll talk about that in a
24 second. And then what community is this?

25 A: This is Carnes.

1 Q: This is Carnes, okay, is the next one.

2 A: Uh-huh.

3 Q: All right. And then what is happening in
4 regards to some of the economic development?

5 A: Well, Google chose that area between Moncks
6 Corner and Goose Creek for one of their server
7 centers, and that is open and operating and
8 employing a number of people.

9 Q: Okay. Carnes. And then what is that?

10 A: That's the new Cane Bay High School, which is
11 right on 176 probably two miles from our
12 Carnes Crossroads projected site.

13 Q: Is it open now and operating?

14 A: It is open. It's been open for a couple of
15 years. I think it actually may have been open
16 three years because they graduated their first
17 class.

18 Q: Okay. And then the company that is developing
19 Carnes Crossroads is?

20 A: Is the Daniel Island Company.

21 Q: All right. We'll come back to that document.

22 A: Respondent's 10?

23 Q: So you looked at these different developments,
24 but you settled on Carnes Crossroads, right?

25 A: Yes, we did.

1 Q: All right. Let's look at Respondent's 10. And
2 tell me what Respondent's 10 is.

3 A: Respondent's 10 is Chris Fraser receiving a
4 letter from, I believe, the Daniel Island
5 Development Company. I think this is from Matt
6 Sloan. Yes, it is. To really lay out, you
7 know, what Carnes Crossroads is --

8 MR. THOMAS: Your Honor, I think I need to object to
9 this one. Is this something that Mr. Bowling
10 received or wrote?

11 THE COURT: All right. This was the sort of thing,
12 Mr. Thomas, that I anticipated being taken care
13 of by my pretrial order. You know, you all
14 were supposed to agree on these things ahead of
15 time.

16 MR. THOMAS: Mr. Long and I have agreed that, you
17 know, the document itself, it depends on how it
18 would come into evidence. So, we said yeah,
19 this would be fine, it just depends on what
20 kind of witness it comes through. So, if
21 they're going to call Mr. Fraser, for instance,
22 or something along those lines, but I don't
23 think that Mr. Bowling had anything to do with
24 this letter. I could be wrong.

25 THE COURT: Well, let me say before Mr. Long speaks,

1 that wasn't what I anticipated. I want these
2 issues to be resolved ahead of time or put
3 before me ahead of time for resolution. You
4 understand that?

5 **MR. THOMAS:** Yes, sir. I thought we had come to
6 that agreement in pretrial conference.

7 **MR. LONG:** Your Honor, I think this document is
8 exactly what Your Honor was contemplating
9 because there's no way I can call Chris Fraser
10 to the trial. He's never been on a witness
11 list. He's not on the witness list of people
12 who are going to testify at the trial. If I
13 was to stand up and say we call Chris Fraser,
14 he'd be out of the chair in two seconds, okay.
15 Rightly so. I would object to him calling
16 Chris Fraser in the case today. That guy's
17 never been mentioned. This letter, you can
18 turn it over, I don't know if Mr. Bowling's on
19 the cc or not, but this is, you know, there's
20 no way that letter's coming in through a
21 witness that's scheduled to testify in the
22 trial because it's between, if he's going to
23 limit it to the two people that are involved
24 with the letter. In other words, it had to
25 come in through somebody else. That's why I

1 think this is the type of letter that should
2 have been raised at pretrial if there was going
3 to be an objection.

4 **MR. THOMAS:** Your Honor, a couple of things. What
5 Mr. Long just said is interesting because when
6 I tried to get in a broker document through
7 their CFO that mentioned financial issues, he
8 objected to being -- as that as being hearsay,
9 that the witness had no knowledge of it. This
10 is about the terms of the Carnes Crossroads
11 sale and purchase agreement, okay. That is an
12 actual exhibit into evidence. That's in
13 evidence. So, you know, I mean that's what I
14 understand this document to be. So why doesn't
15 he just ask Mr. Bowling who helped negotiate
16 the Carnes Crossroads purchase agreement about
17 that? But Mr. Bowling didn't write this and he
18 didn't receive it. He's not copied on the
19 letter.

20 **THE COURT:** Mr. Long.

21 **MR. LONG:** I mean, Your Honor, he's -- the
22 objection, he waived the objection, Your Honor.
23 If he was going to take it up, he should have
24 taken it up at the pretrial.

25 **MR. THOMAS:** That is not true.

1 MR. LONG: This is a clear document, it falls into a
2 different category. It falls in the category
3 of the other documents. And I think that, you
4 know, he's obviously the person who was
5 involved in it and Mr. Fraser is his agent. I
6 mean that's another fact that he's already
7 testified to that it's important to note about
8 this process. Mr. Fraser is his agent.

9 THE COURT: Overruled.

10 Q: So tell me --

11 MR. THOMAS: Your Honor, I'm sorry. I've got to put
12 something on the record here.

13 THE COURT: Very well.

14 MR. THOMAS: Because Mr. Long just said that that
15 was the agreement that we reached. That is not
16 the agreement we reached. And the agreement we
17 reached, and as I recall telling it to the
18 court, was that we didn't mind if certain
19 documents would come in or hearsay, kind of
20 like the articles that we just looked at. But
21 the whole thing depended on who was the
22 document going to come through. And so that
23 was the agreement that we made. And Mr. Summer
24 makes a good point. We reserved the objections
25 at that time. I just wanted to put that on the

1 record. But this is hearsay, as hearsay as it
2 gets, Your Honor.

3 MR. LONG: I don't remember seeing an agreement,
4 Your Honor. But if Your Honor's ruled, I'm
5 ready to move on.

6 THE COURT: Let's move on.

7 MR. LONG: Thank you, Your Honor.

8 Q: Okay. Who's Chris Fraser again?

9 A: He was our real estate broker on the Carnes
10 Crossroads transaction.

11 Q: Who's we?

12 A: Roper St. Francis Healthcare.

13 Q: Okay. And who's Matt Sloan?

14 A: Matt Sloan is the president of the Daniel
15 Island Development Company.

16 Q: Okay. And what's the date of this?

17 A: December of 2006.

18 Q: Okay. And what is this letter right here or
19 back and forth?

20 A: This is a letter that Matt Sloan sent to Chris
21 Fraser and Mr. Fraser shared with us, outlining
22 a proposal for purchasing the property at
23 Carnes Crossroads.

24 Q: Okay. Take a look at Respondent's 11. Now,
25 what is Respondent's 11?

1 A: Respondent's 11 is virtually identical to
2 Respondent's 10 except it is addressed to me
3 and in the form of a non-binding letter of
4 intent.

5 Q: And there's no date on this letter. How do you
6 send a letter without a date on it, but is the
7 time frame for this letter, Respondent's 11, in
8 the same general time frame as Respondent's 10?

9 A: It is. Chris reviewed the document
10 Respondent's 10 with Bret Johnson, myself and
11 then a couple of others I believe on senior
12 staff. Once we were comfortable with the deal
13 points in that, it was converted to this non-
14 binding letter of intent and sent to us
15 probably within a week or two of the other
16 document.

17 Q: Okay. And how many acres were you negotiating
18 to buy?

19 A: I believe it's about 68 acres is ultimately --
20 it's around 68, and the acreage is larger than
21 that, but the dry acreage is about 60 and
22 eight.

23 Q: Good. Let's take a look at Respondent's 16.
24 Do you recognize this document?

25 A: I do.

1 Q: What is it?

2 A: This is the purchase agreement for the
3 property.

4 Q: Okay. And what's the date on it? It would be
5 on the last page or the next to last page.

6 A: Let me get there. It looks like this was
7 executed in July of '07.

8 Q: Okay. And who executed it?

9 A: David Dunlap, the president of Roper St.
10 Francis Healthcare for us; Matt Sloan for
11 Carnes Crossroads; and Susan Smythe, looks like
12 she was the escrow agent.

13 Q: Okay. And what occurred between December of
14 '06 and July of '07 in regards to this property
15 at Carnes Crossroads?

16 A: From December of '06 and July of '07 we did our
17 customary -- well, we signed the purchase
18 agreement and did our customary due diligence
19 on the project, all the, you know,
20 environmental and research that needed to be
21 done, the tree-survey, access points, worked
22 with the Department of Transportation. Also,
23 before this agreement was signed we would have
24 met with the Roper St. Francis Healthcare Board
25 to get their final approval for the purchase of

1 the property. We had sought preliminary
2 approval from the board back in October of '06.
3 And then so we went back to them I'm sure
4 before this document was signed and got the
5 final motion for approval.

6 Q: What was the purpose of the purchase of this
7 property at Carnes Crossroads?

8 A: It was to build a hospital in Berkeley County.

9 Q: And did you buy 66 or 68 acres of land just to
10 build a medical office building?

11 A: No, we did not.

12 Q: All right. Let's take a look at this purchase
13 and sale agreement on Roper Berkeley 1196,
14 which is section eight of the document. It's
15 on page three.

16 A: Okay. The deed restrictions?

17 Q: Tell me, explain to me what the deed
18 restrictions are in regards to this property.

19 A: What we had discussed with the Daniel Island
20 Company is that we felt with this size of a
21 purchase, and being very early on in the
22 development of this, that we needed protections
23 with regard to the services that we provide.
24 So we wanted, with our purchase, to exclude the
25 development of any other acute care hospital in

1 that development, an ambulatory surgery center,
2 major diagnostics and linear accelerator.

3 Q: So you wanted an exclusive to Carnes
4 Crossroads?

5 A: Exclusive to the Carnes Crossroads development,
6 yes.

7 Q: And so Roper St. Francis would be the sole
8 healthcare provider in the development?

9 A: We would, right.

10 Q: Okay. Now, in exchange for that desire to have
11 that exclusive arrangement, what did the Daniel
12 Island folks request in return?

13 A: The Daniel Island folks wanted assurances that
14 we were going to move forward with the level of
15 medical services that we had committed to and
16 therefore there are requirements in here as to
17 when certain medical services and the hospital
18 would be built. You know, we tried to give
19 ourselves as much time as we could in that
20 negotiation. So for in exchange for those
21 exclusions, you know, we set some pretty outer
22 limits of when we thought we would be able to
23 get stuff built or constructed there.

24 Q: Okay. And so are those found here on the
25 second page?

1 A: They are.

2 Q: So what was your commitment to them in regards
3 to applying for a hospital?

4 A: That we would apply for a hospital certificate
5 of need no later than end of year 2015, or
6 shortly after they had 1,700 residential units
7 in the development.

8 Q: Okay. What was your intention in your
9 negotiating these dates with the Daniel Island
10 Company?

11 A: We wanted to give ourselves some leeway. I
12 mean, it was our intention to build a hospital
13 as soon as we practically could construct
14 there. But we wanted to give ourselves some
15 time to do that, so we felt that setting the
16 outer limit at the end of year 2015 was
17 reasonable.

18 Q: Okay. What was the original plan in regards to
19 the development of services at Carnes
20 Crossroads?

21 A: The original plan was to build a hospital and
22 to look as soon as possible at relocating
23 medical offices and the ambulatory surgery
24 center onto that site as an initial phase to
25 getting to that.

1 Q: Why would you want to add the ambulatory
2 surgery facility there before the hospital?

3 A: It would -- we could do it more rapidly. The
4 facility in Moncks Corner, and I think we've
5 talked about, was under performing. Some of it
6 had to do with that tipping point, getting a
7 critical mass of patients where physicians
8 could be economically, you know, viable to do
9 surgery there. We felt moving it to the Carnes
10 Crossroads location would make that more
11 convenient. And we did, we had physicians who
12 signed letters in favor of that and we knew
13 we'd have greater physician participation if it
14 was relocated to that area. But it's a way
15 that, much like we've heard in the Summerville
16 case, that staging of services to get to the
17 inpatient facility.

18 Q: Now, when you purchased -- let's look at
19 Respondent's 27.

20 A: Okay.

21 Q: Did you hide the purchase of this land?

22 A: No. We did a press release in the *Post and*
23 *Courier* and in the *Business Journal* and just
24 about everywhere.

25 Q: Okay. What's the date of this article about

1 Roper's buying the land in Berkeley County?

2 A: It's September 22nd of 2007.

3 Q: And is this article about the purchase of the
4 Carnes Crossroads tract?

5 A: It is.

6 Q: All right. Let me ask you about, what is the
7 Berkeley Advisory Board?

8 A: The Berkeley Advisory Board is a group of
9 community leaders who give us input,
10 recommendations and act as our liaisons to the
11 Moncks Corner community at our Berkeley Roper
12 facility.

13 Q: So it's kind of a -- are their residents of
14 both Moncks Corner and Goose Creek on the
15 advisory board or is mostly Moncks Corner?

16 A: It's mostly Moncks Corner.

17 Q: And does your advisory board support this CON
18 application?

19 A: They do.

20 Q: Now, did you have -- did you disclose with them
21 your plans to buy the land at Carnes
22 Crossroads?

23 A: We did.

24 Q: Did you also have community meetings in Moncks
25 Corner to explain your decision to buy the land

1 at Carnes Crossroads?

2 A: We did. We met not only with our advisory
3 board, but we had separate meetings with
4 community leaders and elected officials in that
5 area to disclose our plans.

6 Q: Let's look at Respondent's 28. Tell me what
7 Respondent's 28 is.

8 A: Looking at this, it's Brenda Myers who's the
9 administrator at Berkeley sent an email to
10 David Dunlap and myself and copied our
11 assistants just to give us an update on a
12 meeting that we were having up there on March
13 31st. And she's confirming the attendance of
14 those elected officials and others that will be
15 at that meeting at the Wampee Conference
16 Center. And we're going to discuss really our
17 entire strategy for Berkeley Count at that
18 time.

19 Q: And what is the date of that meeting? What
20 month?

21 A: That is March 31, 2008. I guess or March 26,
22 2008.

23 Q: So it would have been in March of '08 --

24 A: Yes.

25 Q: -- when that meeting occurred or shortly after?

1 A: Uh-huh.

2 Q: Now, did you have other meetings in the
3 community before and after this period of time?

4 A: We did. We had one other meeting at the Wampee
5 Conference Center with community leaders. We
6 had this meeting with elected officials. We
7 had a meeting, actually I think it was after
8 the CON filing, at Gilligan's. It was
9 community leaders, elected officials and
10 anybody from the community that wanted to come
11 hear about what we were doing.

12 Q: And did you prepare some PowerPoints to present
13 at those?

14 A: I did, yes.

15 Q: And what kind of things did you tell the
16 community leaders as in regards to your
17 decision?

18 A: We told them about our analysis of the county,
19 why we felt it was important to move forward
20 with a hospital project, why we felt the best
21 location was Carnes Crossroads, and what
22 services we intended to have remain at the
23 Moncks Corner facility.

24 Q: Now, let's look at Respondent's 1.

25 MR. THOMAS: Your Honor, I have a quick question.

1 It's not -- actually, not a question, an
2 objection. I'm sorry. Mr. Long's moving
3 through these exhibits pretty fast. But just
4 for the record on Respondent's 27, which is
5 again a newspaper article, I did not object to
6 this at the time and it actually has a quote
7 from Mr. Bowling in the article. Mr. Long
8 didn't ask Mr. Bowling about that, but I just
9 want for the record to be clear. There's other
10 quotes in this newspaper article from like the
11 Goose Creek mayor and some other folks like
12 that and I just want that to be recognized as
13 hearsay for the record so it's not included in
14 an order of findings of fact or something along
15 those lines.

16 **MR. LONG:** Your Honor, 27 was admitted during Mr.
17 Rardin's testimony. It's already in as an
18 exhibit.

19 **MR. THOMAS:** Well, I'm objecting now, Your Honor.
20 I'm sorry.

21 **MR. LONG:** Well, it's already in, Your Honor. I
22 mean the exhibit's in.

23 **MR. THOMAS:** I'm just objecting to the hearsay
24 portion.

25 **THE COURT:** I understand. I overrule.

- 1 Q: Let's look at Respondent's 1. . . Would you tell
2 the court what Respondent's Exhibit Number 1
3 is?
- 4 A: This is a press release that was issued --
- 5 Q: Actually, let me back up on that, I jumped
6 ahead of myself a little bit. Let's -- we'll
7 get to that one in a second. When did you
8 learn that Trident Health System was filing a
9 CON to build a hospital at Moncks Corner?
- 10 A: The Friday before they submitted their
11 application, so it would have been August 10th
12 maybe.
- 13 Q: Okay.
- 14 A: '08.
- 15 Q: Of '08?
- 16 A: Of '08.
- 17 Q: So it would have been after these community
18 meetings that we talked about in the spring?
- 19 A: Yes.
- 20 Q: All right. Were you surprised that they filed
21 an application for a -- this application for a
22 hospital?
- 23 A: Yes, we were.
- 24 Q: Why?
- 25 A: We'd had multiple discussions with community

1 leaders in the Moncks Corner area, everyone
2 from the mayor to the house representatives to
3 the business owners and no one had mentioned --

4 **MR. THOMAS:** Objection, Your Honor. He's about to
5 launch into hearsay testimony.

6 **MR. LONG:** I don't think so, Your Honor. I asked
7 him why they were surprised. He's not going to
8 answer what they told him. Okay. But he's
9 going to describe the basis of his
10 understanding as to why he was surprised. I
11 don't think it's hearsay.

12 **MR. THOMAS:** He's offering an out of court statement
13 for the truth of the matter asserted.

14 **MR. LONG:** He hasn't done that and I don't
15 anticipate him doing that.

16 **THE COURT:** You understand the objection?

17 **A:** I do, sir.

18 **THE COURT:** Well, proceed without violating the
19 objection. I sustain it if you're going to say
20 what somebody else said.

21 **A:** I will not, Your Honor. But I'm going to say
22 is we had not heard any discussion regarding a
23 Trident Hospital in Moncks Corner.

24 **Q:** When you saw that announcement that they were
25 going to build the hospital in Moncks Corner,

1 okay, how did Roper St. Francis -- how did you
2 and the senior management team address that
3 issue or that fact?

4 A: We quickly gathered to look at our timing for
5 the Carnes Crossroads project. As I said, it
6 was a surprise. Trident had shown no
7 indication in almost 40 years of having any
8 intention of building a hospital in Berkeley.
9 As we heard Mr. Gunn, their CEO testify, the
10 only reason they filed the application was to
11 keep us out. So we knew that we had to respond
12 to that and look at our options with regard to
13 what was already a very major capital
14 investment in Berkeley County.

15 Q: And did you look at a number of different
16 options as to what was available at Roper St.
17 Francis in regards to Berkeley County at that
18 time?

19 A: We did.

20 Q: Okay. And did you have discussions in your
21 senior management meetings?

22 A: We did. This is clearly an important decision
23 and we discussed it both in senior staff and in
24 some executive sessions with the senior
25 leaders.

1 Q: And in those conversations with the senior
2 staff, are those very scripted conversations or
3 are they more free will?

4 A: They're pretty free will.

5 Q: So tell me what you mean by that.

6 A: It means that David Dunlap has a group of vice
7 presidents, senior leaders around him and he's
8 interested in hearing their opinions. That's
9 what we're there for is to give input. And
10 you'll find that it's a pretty robust and
11 sometimes contentious discussion, but everybody
12 gives their point of view and tries to help
13 guide the direction of the healthcare system.

14 Q: Are there times that people give their opinion,
15 just kind of throw out ideas and then discuss
16 them?

17 A: Oh, absolutely.

18 Q: Okay. Now, who takes the minutes of those
19 meetings?

20 A: Senior staff minutes are usually taken by, we
21 typically have one or two residents in the last
22 year of their master's program, near the
23 completion of their master's program, and one
24 of the residents will take minutes in senior
25 staff. It's actually an educational thing for

1 them to see the workings of the healthcare
2 system.

3 Q: Okay. Now, were there times also that you had
4 meetings with the board and with other people
5 among yourselves at Roper St. Francis during
6 this period of time after they filed?

7 A: Yes, there were.

8 Q: Okay. Were there PowerPoints prepared?

9 A: There was. There was a PowerPoint presentation
10 that was done for the board to disclose what
11 Trident's intentions were and some of the
12 options that we were discussing at the
13 management level.

14 Q: Okay. And what were the options?

15 A: The first was just to do nothing, which when
16 you've just made a nine million dollar purchase
17 is probably not reasonable, but it was
18 certainly something we evaluated. The second
19 was to file as an affected party and oppose the
20 Moncks Corner Hospital construction. We
21 evaluated that and looked at our project and
22 really didn't feel that it was appropriate, nor
23 would affect our project at all, so we
24 dismissed the idea of just filing an appeal and
25 opposing the project. Or the third and the one

1 we elected was, you know, do we go ahead and
2 move our project forward and file a CON in the
3 same planning cycle so that it's considered in
4 parallel.

5 Q: Now, during the time that you're doing this
6 discussion, had the senior staff people in your
7 area, department or the hospital done a
8 detailed analysis of the Trident application?

9 A: No. We hadn't seen the application. Our
10 knowledge was really from the press release.
11 We knew the location of the facility and what
12 we thought would be the, you know, expected
13 patient base for that facility.

14 Q: And had Mr. Richardson been retained to do any
15 sort of analysis of the application or work --

16 A: Not at that point, no

17 Q: And now, in those PowerPoints do they use the
18 word competing?

19 A: They do.

20 Q: Okay. What's your position in regards to
21 whether these applications are competing?

22 A: We never felt they were competing simply
23 because of the bed need criteria. This doesn't
24 exceed the need for beds since ours is a
25 transfer and theirs was a bed need that existed

1 in the State Health Plan. We certainly knew
2 that they were going into the same service
3 area. We knew the facilities were very
4 similar. Most 50 bed hospitals are similar.
5 But we did not believe and don't today believe
6 that it exceeds the need in the service area.

7 Q: Does the population of communities in Berkeley
8 County, is that a factor that would affect your
9 belief as to whether these applications are
10 competing?

11 A: Not populations, per se. It really has nothing
12 to do with the legal determination or the
13 regulatory determination as to whether or not
14 they're competing.

15 Q: When you look at these two hospitals as a -- in
16 your position at Roper St. Francis, how much
17 overlap do you see between the two facilities?

18 A: I see very little, almost no overlap.

19 Q: What's the basis of that?

20 A: The basis of that is Moncks Corner is a
21 community center for that rural area around the
22 lake. And people in Bonneau and St. Stephen,
23 they come to Moncks Corner to shop. That's
24 clearly their community center. The people in
25 Goose Creek don't go to Moncks Corner to shop,

1 they don't go up there for their groceries or
2 their pharmacy or anything else. They tend to
3 shop and work within their community. So we
4 see very little overlap between the two.

5 Q: Who ultimately makes the decision as to whether
6 the applications are competing?

7 A: The Department.

8 Q: And do you believe that you as a applicant can
9 decide that?

10 A: No, I do not.

11 Q: Now, if Moncks Corner was not the right
12 location for Roper St. Francis to build a 50
13 bed hospital, how can it be the right location
14 for Trident Health System?

15 A: There are a couple of factors there. I think
16 the single largest factor in that is Trident's
17 market share in Berkeley County and in that
18 area already. You know, they have 54 percent
19 market share. Their ability to redirect
20 patients who have a relationship with Trident,
21 have a relation with Trident's physicians is
22 much greater than ours would be in the Moncks
23 Corner area. I think they'll be much better
24 around that lake than they projected. But they
25 certainly have an easier ability to redirect

1 patients.

2 Q: Okay. Is there a second fact?

3 A: Just their history in that area, how long
4 they've been there.

5 Q: What about the distance between Trident Medical
6 Center in Summerville and Moncks Corner and the
7 distance from Roper Downtown to Moncks Corner?

8 A: Well, they're definitely similar. You know,
9 Trident to Carnes Crossroads is 8.1 miles and
10 it's another 11.8 from Carnes to the proposed
11 facility, so they're just about 20 miles from
12 their proposed satellite hospital to their main
13 campus. Carnes Crossroads is just about 20 or
14 just a little more than 20 from Carnes
15 Crossroads down to the Roper campus.

16 Q: Okay. You also talked earlier about the
17 redirection issue. If I could get you to look
18 at a map of Respondent's 76, the projected
19 inpatient market share map.

20 A: Yes.

21 Q: And if you will recall from your earlier
22 testimony, this is from the Trident application
23 which you have reviewed the application some,
24 I guess, right?

25 A: I have.

1 Q: But you recall from your earlier testimony in
2 the trial that in the application Trident
3 projects that it will get 50 percent of the
4 Trident Health System market share in the zip
5 codes in pink, okay. So what would that be for
6 the total market share of the Moncks Corner
7 Hospital for the zip codes in pink?

8 A: If they're getting 50 percent redirection from
9 about a 50 percent market share, it's about 25
10 percent market share out of those zip codes is
11 what they would be calculating.

12 Q: What would you expect this region to do? What
13 would you expect the hospital for Trident at
14 Moncks Corner to do in regards to market share
15 for the zip codes around Lake Moultrie?

16 A: I think it will perform much higher than that.
17 I mean you have communities who have been very
18 vocal about their desire to have that facility
19 built in Moncks Corner, as we've heard. The
20 mayors are supporting it. The population's
21 supporting it. I can't imagine that only one
22 in four of those people would choose to go to
23 that facility. That seems like a very, very
24 low projection.

25 Q: Okay. And what about these two zip codes that

1 we mentioned earlier, 29450 and 29453, that are
2 located kind of to the east and a little bit to
3 the south of Georgetown?

4 A: Those go a little bit of every direction right
5 now. Some of them could go to the Moncks
6 Corner site by going up Highway 41, I believe.
7 And you could see that some of them are going
8 to go to the Mount Pleasant Hospital site by
9 going 41 the other direction. And then the
10 453, some of that population even goes up to
11 Georgetown Hospital.

12 Q: Okay. So are you confident that Trident Health
13 System can sustain a volume, a critical mass
14 volume at the hospital?

15 A: Absolutely. I mean, it's that, you know, these
16 -- we're talking about two 50 bed hospitals.
17 It's -- I think there's more than enough
18 patient base with their redirection to fill
19 theirs at Moncks Corner.

20 Q: Well, let's about that. How different is a 50
21 bed hospital from say a 296 bed tertiary
22 hospital like Trident Medical Center?

23 A: Vastly. Number One, just the service lines
24 that you treat within those hospitals, as we've
25 talked. With a 50 bed hospital you're going to

1 see an emphasis toward obstetrics. There will
2 be deliveries in those hospitals. You're going
3 to see general surgery; taking out
4 gallbladders, appendix, hernia surgeries, but,
5 you know, predominantly, the more routine
6 general surgeries. You'll see definitely an
7 emphasis an orthopaedics in both of those
8 hospitals, if nothing else because of the aging
9 population out there and joints. You'll see a
10 number of medicine patients; patients who have
11 diabetes who are out of, you know, they got
12 their blood sugar out of control. You'll see
13 some respiratory patients that are treated by
14 the pulmonologist. But you won't see the
15 intensive tertiary patients; the complicated
16 hearts, the congestive heart failures, the
17 neurosurgery. And with that, because of those
18 more complex cases, there's also a greater
19 breadth of diagnostic imaging, more complex
20 equipment that's required in a tertiary
21 hospital than there is in a community hospital.

22 Q: Okay. Now, you're aware that Trident Health
23 System has a proposed CON to add 30 beds to the
24 Summerville Medical Center, right?

25 A: We are.

1 Q: Okay. And when was that CON filed relative to
2 these hospital applications?

3 A: It was filed after the Department had approved
4 both hospital projects.

5 Q: Could it have been in 2010?

6 A: Yes.

7 Q: Or early -- now, is Roper St. Francis opposing
8 that certificate of need?

9 A: We are.

10 Q: Okay. Did you present at the project review in
11 opposition to that?

12 A: I did.

13 Q: And what's the basis of that opposition?

14 A: The basis of that opposition is Summerville
15 Medical Center defines its primary service area
16 such that it includes the same zip codes in
17 Berkeley County that -- especially the Carnes
18 Crossroads project identified as a primary
19 service area and even the Trident Moncks Corner
20 facility does. So we really feel they are
21 double counting both need and it goes contrary
22 to their argument that the county cannot
23 support a hundred beds.

24 Q: Well, let's talk about that. What's your --
25 how is that factoring into your decision to

1 oppose it?

2 A: Well, the inconsistencies in their argument
3 that Berkeley County cannot support a hundred
4 beds but Dorchester County can support 127 as
5 a much smaller county that's much closer to a
6 tertiary facility than either of these
7 facilities in Berkeley County, we just felt
8 that that bed need argument probably needs to
9 be decided by a judge.

10 Q: What is the distance between Summerville and
11 Trident Medical Center?

12 A: Six miles.

13 Q: So of the four hospitals that are -- the two
14 that exist, Summerville Medical Center in
15 Dorchester County, Trident Medical Center in
16 North Charleston, and then the two proposed
17 hospitals at Berkeley, which of the four -- of
18 the four facilities, which two are closest in
19 geography?

20 A: Trident Medical Center and Summerville Medical
21 Center.

22 Q: Let's talk about the -- let's move to the
23 Moncks Corner -- Roper St. Francis Moncks
24 Corner facility. We talked earlier about the
25 emergency department.

1 A: Right.

2 Q: There's also an ambulatory surgery facility
3 there?

4 A: There are three ambulatory surgery ORs.

5 Q: What is exactly an ambulatory surgery facility?

6 A: An ambulatory surgery facility is a facility
7 freestanding, which means not attached to a
8 hospital, that performs surgical procedures
9 that meet Medicare's description for outpatient
10 surgical procedures. So there is an actual
11 listing I believe by ICD-9 code of the types of
12 surgeries that can be performed in that
13 setting.

14 Q: Okay. Is an ICD-9 code, how is that similar to
15 a DRG code?

16 A: Same as a DRG code, it just more clearly
17 defines the procedure. DRG's can tend to be
18 broader. ICD-9 is a more restrictive code.

19 Q: Okay. And so how long has that ambulatory
20 surgery facility been in operation?

21 A: Just over ten years, I believe.

22 Q: All right. And has it been successful?

23 A: It has limped along. It certainly hasn't been
24 a cost burden or a loss burden to the
25 healthcare system, but it's really only

1 performed probably at about 20 percent of
2 capacity.

3 THE COURT: Excuse me, I was making notes and missed
4 that. Where is this ambulatory surgery center?

5 A: This is the ambulatory surgery center that's
6 located with the Roper Berkeley Emergency Room
7 in Moncks Corner.

8 THE COURT: Moncks Corner. Thank you.

9 Q: And are they in the same building?

10 A: They are.

11 Q: At the same location?

12 A: Same location.

13 Q: Let's take a look at Respondent's 37. These
14 are the actual types of procedures that are
15 done at the ambulatory surgery facility; is
16 that right?

17 A: It is.

18 Q: Okay. For each of the four years, '07 to 2010?

19 A: Uh-huh.

20 Q: Okay. Can you kind of explain to the judge
21 what these type cases are that are being done
22 in the ambulatory surgery center?

23 A: I can. The predominance of the cases, just
24 about half, are digestive cases done by
25 gastroenterologists, and typically those are

1 going to be screening or diagnostic
2 colonoscopies that require anesthesia
3 assistance. We do also have, probably the next
4 largest group is the musculoskeletal, so that's
5 going to be orthopaedic surgeries or podiatric
6 surgeries. And then I'm not sure what all
7 clusters into the other factors, but that would
8 be the third largest group.

9 Q: Okay. Now, did you file a certificate -- did
10 Roper St. Francis file a certificate of need to
11 relocate this ambulatory surgery facility to
12 Carnes Crossroads?

13 A: We did. One of the obligations in our
14 contract, in the purchase agreement at Carnes
15 Crossroads was to file for that certificate of
16 need within six months of purchasing the
17 property and we did that.

18 Q: Okay. And did that process ever get to project
19 review?

20 A: It did not. We withdrew that when we knew we
21 were going to move forward and file the
22 certificate of need for the hospital.

23 Q: And so that's been -- so what's the plan for
24 the ambulatory surgery facility in Moncks
25 Corner?

- 1 A: At this point, the plan is to leave it in
2 Moncks Corner and since we'll have four ORs on
3 that site at Carnes Crossroads with the
4 hospital.
- 5 Q: Let's go back. I think I forgot to ask you.
6 Let's go back to Respondent's 1. So during
7 this period of time in August and early
8 September, did Roper St. Francis make a
9 decision as to what to do in regards to the
10 property at Carnes Crossing?
- 11 A: Yes. We made the decision to move forward with
12 the hospital CON.
- 13 Q: And what size hospital are you proposing?
- 14 A: Fifty beds.
- 15 Q: Is this the press release to announce that?
- 16 A: It is. This is the press release that was
17 issued in early September, once the decision
18 was made.
- 19 Q: And the CON was filed shortly thereafter?
- 20 A: It was filed in December, yes.
- 21 Q: December, right.
- 22 A: Uh-huh.
- 23 Q: But you're making the announcement that you're
24 going to prepare it?
- 25 A: Right.

1 Q: All right. Let's shift gears some for a second
2 here and talk about physician employment. Now,
3 was there a time in the 1990s when physicians
4 were employed regularly by hospitals?

5 A: There was. As I testified at the very
6 beginning, my role at HCA in the mid-90s was
7 the development of an employed physician group
8 at our Oklahoma facilities.

9 Q: Okay. And what kind of happened in the
10 industry in regards to the employment of
11 physicians?

12 A: The industry was very immature at employing
13 physicians. I think there was a mind set that
14 we were big organizations and we could somehow
15 manage physician practices much more
16 efficiently than those people whose livelihood
17 depended on it, and that didn't work out. We
18 found out that employed physician networks
19 require a substantial investment. And
20 contracts have changed. Back in the mid-90s,
21 the contracts were usually more of income
22 guarantees and income guarantees for a long
23 period of time. That's certainly changed.
24 Right now I think predominantly you find the
25 employment contracts have -- compensation is

1 based on their personally performed
2 productivity.

3 Q: Let's get there. First, I want to lay a couple
4 of foundation questions first.

5 A: Okay.

6 Q: So what kind of happened in the industry in, I
7 guess, early 2000s, late 1990s?

8 A: In the late 1990s hospitals sold those
9 practices back to the physicians and many, many
10 healthcare systems got out of the physician
11 employment.

12 Q: Okay. All right. You said that previously the
13 contracts tended to be based on the doctor --
14 on a salary --

15 A: They were.

16 Q: -- a fixed salary? All right. Now, what's
17 happening now in regards to the industry in
18 regards to physician employment just generally,
19 and then let's talk about the specifics?

20 A: Physician employment is greater now than it's
21 ever been in the healthcare industry's history.
22 There are a lot of elements that are driving
23 that.

24 Q: Let's get to that in a second. Let me ask you
25 this. I want to ask you a few questions.

1 First, what's the compensation arrangement, a
2 typical compensation arrangement now for
3 physicians in say the 2010 area?

4 A: The most common -- you know, they still run the
5 gamut from guarantees to what we call margins
6 contracts, which is revenue after expenses
7 before you get to physician comp. But by far
8 the most common one now is to pay a physician
9 per unit of work that they do and that unit of
10 work is a work RVU.

11 Q: So how does that work exactly for a physician?

12 A: The way that works is we have benchmarks that
13 we can look at through surveys, one is called
14 the Medical Group Management Association
15 Survey, of physician compensation and cost and
16 they set up a by decile, you know, the median
17 value per work RVU. So --

18 Q: What are median value per work RVU; what do you
19 mean by median?

20 A: Median is the middle.

21 Q: Half above, half below?

22 A: So half above, half below.

23 Q: Okay.

24 A: And then it's by sub-speciality. So where a
25 neurosurgeon, I think the median value for a

1 neurosurgeon right now is about \$70.00 per work
2 RVU, the median value for a family practice
3 physician is about \$39.00 per work RVU.

4 **THE COURT:** What does RVU stand for?

5 A: An RVU, Your Honor, is a relative value unit
6 and it's what has been defined by Medicare or
7 the Centers for Medicare and Medicaid Services,
8 in their annual report they put a value on each
9 service that a physician might perform and it's
10 a relative value. So --

11 Q: Can you give an example?

12 A: Yeah.

13 Q: What's a service that a physician --

14 A: If I look at a routine office visit with no
15 diagnostics and lab is called a, it's 99213 by
16 code. And that 99213 is worth .92 work RVUs.
17 So you take that \$39.00 per work RVU times .92,
18 that's what the physician will receive in
19 salary for that visit. Not what the visit will
20 be reimbursed, but just the physician's piece
21 of that.

22 Q: Okay. So continue about the RVUs, how that
23 factors into their compensation.

24 A: Well, when you pay on a value per work RVU,
25 then you're paying them only for their

1 personally performed services. There are no
2 diagnostics or any other factors in that. And
3 the physician knows that they're going to
4 receive that amount for doing those things
5 which the physician does, which is make
6 themselves available to the patient, properly
7 evaluate the condition and then set a treatment
8 plan and code it correctly. So once they do
9 that, they're going to be getting paid for that
10 visit. And in most RVU programs, it's blind
11 payer.

12 Q: Now, what does that mean?

13 A: That means if one of our physicians, a family
14 practice physician, generates an RVU for Blue
15 Cross, they get \$39.00. If they generate an
16 RVU for a charity patient, they also receive
17 \$39.00. If they generate an RVU for a patient
18 that just doesn't pay, they still get \$39.00.

19 Q: Okay. So it makes no difference to them who
20 they see --

21 A: No, it doesn't.

22 Q: -- between the different --

23 A: And --

24 Q: Is that the way Roper St. Francis typically
25 does a contract?

- 1 A: It is. And that was actually set by our board
2 through their compensation committee that they
3 wanted to be a blind payer.
- 4 Q: Okay. Now, what are some of the -- or when did
5 Roper St. Francis begin to -- when you got
6 there, how many employed physicians did Roper
7 St. Francis have?
- 8 A: Five.
- 9 Q: And how many does it have today?
- 10 A: I think just right at 200, maybe a couple more.
- 11 Q: Does the Medical University have a large
12 employed physician group?
- 13 A: They do. I'm not sure exactly what the size
14 is, but I understand it's about twice the
15 number of employed physicians that we have.
- 16 Q: Okay. Now, how did Roper St. Francis come to
17 employ these physicians?
- 18 A: You know, I actually --
- 19 Q: Or some other -- let me ask the question
20 better. What are some of the reasons as to why
21 Roper St. Francis has decided to employ these
22 physicians?
- 23 A: There are a number. Certainly, as we talked
24 about to begin with, we were seeing our primary
25 care physicians migrate to the suburban

1 communities and it became a concern for us that
2 we needed to have a more formal relationship
3 with those primary care doctors in order to
4 serve the specialists at Roper Hospital. So
5 the first reason was to develop and secure that
6 primary care base in order to protect market
7 share. A second very important reason is all
8 that's going on with healthcare reform, and by
9 that I just don't mean the PPAC or the, you
10 know, the bill that's out there right now.
11 Medicare is changing the way that they
12 reimburse hospitals and what they're doing,
13 it's called value-based purchasing. And what
14 that means is Medicare is trying to increase
15 the value of those healthcare services that
16 they purchase and they're using their
17 incredible purchasing power to really push the
18 industry with regard to quality and outcomes
19 and to lower cost. One of the things they do
20 right now is called pay for performance, which
21 they withhold a portion of your Medicare
22 payment and depending on how you perform on a
23 number of quality criteria, everything from a
24 patient's perception of how well you perform to
25 actually the safety and quality within the

1 institution, then they will pay that payment to
2 you or they won't. So we're seeing a real
3 drive towards pay for performance. Why that
4 necessitates having an employed physician group
5 is when we're doing that and we're setting
6 these standards, say for instance in joint
7 replacements, so we're looking at all the knee
8 joints primarily and some hips, it takes a
9 great deal of physician time and input in order
10 to set up the clinical protocols that are
11 needed within that area, to monitor them, to
12 adhere to them. If you're a private practicing
13 physician in the community, there is no
14 incentive for you to spend that time and effort
15 helping a hospital hit what it needs to do to
16 get paid.

17 Q: Why not?

18 A: There's no payment for the physician with
19 regard to that. So it makes it necessary in a
20 lot of areas to employ physicians just to have
21 their participation in those programs.

22 Q: Okay. So as this push towards quality
23 continues, exactly -- so what else are you
24 seeing in regards to quality?

25 A: Well, there are a number of things the

1 government's set forth. Re-admissions, you
2 know, we are now looking at, I think as of next
3 year, the hospital will no longer be paid for
4 re-admissions and that means for any reason.
5 So if a patient comes in with pneumonia,
6 they're there three or four days and they come
7 back a week later because they got hit by a
8 truck, you don't get paid for that.

9 Q: Do you have to take them?

10 A: You do have to take them. You're required by
11 law to take them.

12 Q: How can Medicare have this kind of power over
13 the hospitals?

14 A: Because they are probably the largest payer in
15 healthcare. I can't think of anybody else that
16 even comes close.

17 Q: What would it do to any hospital or system to
18 not participate in the Medicare program?

19 A: You would go out of business. Medicare
20 participation, number one, as I said, is your
21 largest payer, but it's also a requirement by
22 all the commercial payers that, you know,
23 you're a Medicare participant.

24 Q: Now, are hospitals allowed to pay for or buy
25 referrals?

1 A: No.

2 Q: Can you explain that?

3 A: You can't set physician compensation, you can't
4 have any economic relationship with a physician
5 for the purpose of directing a referral to your
6 hospital or services.

7 Q: Well, since the physicians are referring to
8 your hospital, and you're employing them, how
9 do you go about that particular issue? What
10 have you done at Roper St. Francis and other
11 hospitals have done to make sure you're not
12 paying for referrals?

13 A: We have, I'm trying to think of a better term,
14 but really fire-walled off the individuals. I
15 am the one that is personally responsible for
16 negotiating physician compensation, physician
17 contracts. We do that based on looking at the
18 benchmarks in the industry, like I said, the
19 Medical Group Management Association data. We
20 also on our contracts send them out for a
21 third-party opinion. So they go out to experts
22 to opine on the fact that this contract is not
23 only at fair market value but meets commercial
24 reasonableness. And that's a requirement by
25 our board that these contracts are reviewed.

1 That being said, I do not participate in
2 meetings, nor do I look at the revenue by
3 physician generated in the hospital. So we
4 want to make sure that there's a clear
5 separation between anything that has to do with
6 negotiating a contract and ultimately the
7 business that they do within the facilities.

8 Q: You mentioned this survey that started with MG
9 --

10 A: MGMA.

11 Q: MGMA. All right. And how important is that in
12 determining how much you can pay an individual
13 physician?

14 A: It's very important, and we have a board policy
15 through our compensation committee that, you
16 know, we are not to pay above the median of
17 MGMA, except in unusual circumstances, and when
18 we do that, it has to go before the
19 compensation committee for review. An unusual
20 circumstance would be, and we've had some, if
21 the physician in their private practice was
22 already earning above the median per unit of
23 work, then that comes into consideration
24 because they have something unusual or special
25 or their practice pattern is such that that's

1 their historical earnings and we'll usually go
2 above the median in those cases, but it's an
3 exception.

4 Q: Okay. And again, when you're talking about the
5 median, you're not talking about the average,
6 you're talking about --

7 A: The middle for the country.

8 Q: The middle for the country. Okay. So can you
9 just pay the physician anything that he wants
10 to be paid?

11 A: No, absolutely not.

12 Q: Now, what if you buy or purchase a practice, I
13 assume there's some assets that may come with
14 that?

15 A: There are..

16 Q: How does that work?

17 A: When we purchase a practice, we do not purchase
18 goodwill or intangibles. It is purely a value
19 of the assets. We look at their exam tables,
20 their desks, their chairs, and a third party
21 comes in and does an analysis of what the value
22 of those assets are and that's the purchase
23 price of the practice.

24 Q: Okay. Now, let's look at what it from -- is
25 the approach that Roper St. Francis is using in

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1 regards to the employment of its physicians and
2 the network unique to Roper St. Francis?

3 A: It's not. I hope that I can talk about this.
4 The Healthcare Advisory Board, which is a large
5 national think-tank for healthcare providers,
6 they have an arm of that called the Southwind
7 Institute and it is their division of the
8 company that deals with physician practice
9 management and practice acquisitions. And I
10 attended a conference in Atlanta a few years
11 ago with the top 50 not-for-profit healthcare
12 systems and they polled the 50 and said how
13 many of you are now looking at physician
14 employment and acquisition as your number one
15 strategic initiative, and 47 of the 50 said
16 that that was their priority going forward.

17 Q: And is the approach that Roper St. Francis is
18 using in regards to actually how they are
19 paying and how the practices are compensated a
20 standard approach?

21 A: It's very common.

22 Q: All right. Looking at it, let's turn to the
23 physician side. Why would a physician want to
24 be employed by Roper St. Francis?

25 A: There are a number of reasons. Income

1 stability I think is certainly number one.

2 Q: Why is that? Why is that an issue for them?

3 A: Well, the physicians, they not only have seen
4 a decrease in reimbursement in the last decade,
5 but they have the threat hanging over their
6 head every year that physician reimbursement's
7 going to be cut by anywhere from 27 to 30
8 percent by Medicare if the house doesn't
9 override. So far they've done that, but
10 there's no indication that will continue. And
11 Medicare has announced additional cuts. So
12 they see their compensation eroding and they
13 also will tell you they're working harder than
14 they ever have in their lives. Running a
15 physician practice used to be a pretty simple
16 thing. You had two or three employees per
17 physician, you had maybe a half a dozen
18 insurance companies that you dealt with and
19 there was typically one person that prepared
20 the bill and sent it out and took the checks
21 in. Today the complexity of running a practice
22 is just immense. You have dozens of payers,
23 each of them have different requirements and
24 restrictions with regard to getting paid. They
25 each have different denial policies. Their

1 certification to get a patient approved for a
2 procedure has become very difficult. It's just
3 tough to keep up with. So physicians have --
4 you know, most of the physicians we hire
5 express to us that they're tired of doing the
6 business and want to get back to just
7 practicing medicine.

8 Q: What about technology, is that an issue for
9 them?

10 A: Technology is an issue both from an education
11 standpoint, but more importantly it's an
12 extremely expensive capital purchase. I'm not
13 exactly up to date on the latest meaningful use
14 criteria from the government, but I believe
15 it's 2014 now that all practices will have to
16 go to some form of electronic medical record.
17 That's a very expensive thing for most private
18 practices to take on. It's, you know, hundreds
19 of thousands of dollars at a minimum and it is
20 a requirement that, you know, every patient
21 record will have to be converted to that
22 electronic medical record or they won't receive
23 payment.

24 Q: Okay. And why is that going to be important or
25 beneficial to the patient, having an electronic

1 medical record?

2 A: It's important as we move forward. We talked

3 about the gatekeepers and managing the health

4 of a population, not just treating their

5 sickness. But in order to do that you have to

6 know how well are they to begin with, and you

7 have to be able to retrieve discreet data

8 points. Right now if we wanted to go ask even

9 our Roper St. Francis primary care doctors a

10 very simple question, which would be, of all

11 your diabetic patients, how many of them have

12 their blood sugar controlled to a hemoglobin

13 A1C of less than seven, which that's just kind

14 of the standard for making sure your diabetics

15 are well-controlled and healthy, we would have

16 to pull tens and tens of thousands of charts

17 and look at the last entry on each one, in the

18 absence of an electronic medical record. With

19 the electronic medical record you're able to go

20 in and sample your entire patient population

21 and pull those discreet data points and find

22 out how well controlled are our diabetics,

23 what's our rate of return on admission for a

24 congestive heart failure patient. And so it

25 gives you a basis by which to start managing

1 the health of that population.

2 Q: Okay. And is Roper St. Francis going to make
3 the commitment to have their physicians have
4 electronic medical records?

5 A: We are. One of the things that led to the now
6 very public investment for the Partners last
7 year, the \$40 million, is -- was we implemented
8 electronic medical records for 103 of our
9 physicians. And not only is it a huge expense,
10 just the implementation and the cost of the
11 equipment and everything, but when you roll out
12 an electronic medical record into a practice,
13 your production in that practice slows
14 dramatically for two months.

15 Q: Why is that?

16 A: Well, number one, you have the physician out
17 for a full week just to train on the software
18 because these programs are very complicated.
19 They have a very sophisticated decision
20 matrixes. You know, if you look at just all
21 the things that an internal medicine physician
22 may treat, they have to know where to find it,
23 where to record it in that medical record. So
24 they go out for a full week of training so
25 they're out of the office for that. The first

1 week that they come in to the office, not only
 2 do we cut their schedule to one patient per
 3 hour is all they can really see when they first
 4 start with the medical record, and that's one
 5 patient per hour with an IT person standing by
 6 their side every minute of the day showing them
 7 now you need to go here, you should hit this.
 8 And then we build that slowly back up and you
 9 hope by six to eight weeks they're back up to
 10 a full schedule. But when you take that kind
 11 of volume reduction over two months across over
 12 a hundred doctors, it's a very expensive
 13 proposition. That's the other reason we're
 14 seeing a lot of private practitioners seek
 15 employment because while that's a huge
 16 investment for us, to the private practice who
 17 knows they're going to have reduce their
 18 schedule for two months, be out of the office
 19 for training, it's a very detrimental financial
 20 hit to most private practices.

21 Q: Okay. Let's talk about young doctors and new
 22 doctors that are coming out of med school now.
 23 Tell the court about what you're seeing as far
 24 as kind of this new generation of doctors.

25 A: The new generation of doctors definitely have

1 a mind set that is more of a work/life balance.
2 It wasn't many years ago that the government
3 regulated that these, the residents and fellows
4 in medical school could only work a certain
5 number of hours a week because I think they
6 used to run them ragged. But now I believe
7 it's down to 80 and it's getting ready to be
8 reduced again from that. But they come out not
9 wanting to do what those ahead of them have
10 done and that's, you know, work long hours,
11 work weekends, work all night and in private
12 practice, that's just to make any kind of
13 income, you have to do that. So they come out
14 looking for, you know, an employer. And we saw
15 that, I believe, last year's graduating class
16 at Mayo-Jacksonville, they said not one single
17 physician went into private practice.

18 Q: What's Mayo-Jacksonville?

19 A: It's a training program in Jacksonville,
20 Florida for physicians.

21 Q: And you said what happened with the graduates
22 last year?

23 A: Not one of them went into private practice.
24 Every one of them sought employment.

25 Q: Let's talk about the actual Physician Partners

1 Network at Roper St. Francis, all right. Is
2 there -- how do you enter into negotiations or
3 how do you come about approaching or being
4 approached by these physicians when you were
5 negotiating with them to join the network?

6 A: You know, in most cases, I would say probably
7 in 80 percent of the physicians that are now
8 within the Partners Group, the physicians
9 approached us. They were seeking to be part of
10 the network. A lot of that was reimbursement
11 in Charleston was very very low for physicians
12 for private practicing physicians.

13 Q: Why is that?

14 A: Well, we're a city where most of the physician
15 groups are one and two, three people, so they
16 had no negotiating leverage with Blue Cross.
17 When Blue Cross would say here's what we're
18 going to pay you for our patients next year,
19 they just had to accept it. There was no
20 saying, no, we want to negotiate, because Blue
21 Cross wasn't about to. They would say here's,
22 they actually called it the default letter,
23 here's what you were going to get. And that
24 had created a situation where Charleston was
25 the lowest reimbursed metropolitan area for

1 physicians in the state, significantly lower
2 than the Greenville area or the Fort Mill, Rock
3 Hill area of the state, lower even -- quite a
4 bit lower even than Columbia. So physicians
5 were trying to figure out how they could get
6 around that.

7 Q: So you said they approached you about
8 employment?

9 A: They did.

10 Q: All right. Now, the physicians that approached
11 you, were those physicians that were already on
12 the medical staff?

13 A: They were.

14 Q: All right. So talk to me about their pattern
15 or their familiarity with Roper St. Francis.

16 A: The majority of the physician or a vast
17 majority were already on the medical staff at
18 Roper St. Francis and already practiced, at one
19 of our facilities virtually full-time. They
20 might have used, you know, other facilities to
21 a small degree, but most of them were already
22 on staff with us and using our facilities. And
23 I think all of them that were within the market
24 already were members of the Medical Society.
25 So they were extremely familiar with our

1 facilities.

2 Q: Now, was there one particular group that joined
3 the physician network that made a significant
4 impact on the number of physicians?

5 A: It was. Our growth, and as I've said, we
6 started in 2007. Our first group, I believe,
7 was the four cardiothoracic surgeons, the heart
8 surgeons, because they -- you know, they're
9 really hospital-based physicians, have very
10 little outpatient practice. We employed a hand
11 surgeon to help us out with hand call in our
12 emergency departments and a few primary care
13 physicians. And literally through 2007 to
14 early 2009 we'd gone from five physicians up to
15 about 50. And then in late 2008, we began
16 discussions with a group called Lowcountry
17 Medical Associates. It was a group of 62
18 primary care physicians and it was family
19 practice, internal medicine and pediatrics.
20 And they were 62 physicians in 24 locations
21 throughout the Tri-county, mostly in Mount
22 Pleasant, West Ashley and on James Island.
23 That group was originally formed as a group
24 that was employed by Roper Hospital in the
25 early 90s and that's how that group came

1 together to begin with. And then when Roper
2 Hospital decided to sell off their physician
3 practices, they went from Roper into their own
4 group called Lowcountry Medical Associates. So
5 all those physicians had a close relationship
6 with Roper Hospital, for better or worse, and
7 utilized our facilities. So they contacted us
8 in I think the fall of 2008, maybe even the
9 summer of 2008, and for the next ten to 11
10 months we were in negotiations and actually
11 purchased that group, closed on it May 10th of
12 2009.

13 Q: Okay. Let's talk about the primary care groups
14 in Berkeley County, all right?

15 A: Okay.

16 Q: Tell me a little bit about the market in
17 Berkeley County.

18 A: The largest primary care group in Berkeley
19 County is Palmetto Primary Care.

20 **MR. LONG:** Let's put up Respondent's 161 if we can.
21 Can we blow that up a little bit?

22 Q: This is the website for Palmetto Primary Care?

23 A: Yes, I believe it is.

24 Q: And what do they -- how many different
25 locations does Palmetto Primary Care have?

1 A: I think it's about -- oh, 25 locations.

2 Q: Now, tell me about what you know about this
3 group, Palmetto Primary Care.

4 A: They are a very successful primary care group,
5 well run. They are predominantly in, I think,
6 Dorchester and Berkeley Counties and some up in
7 the North Charleston area. Last I counted, I
8 believe there are 42 physicians and just about
9 an equal number of mid-level providers, nurse
10 practitioners and physician assistants. So
11 they're a dominant group in the Charleston
12 area.

13 Q: Are you familiar with where some of their
14 locations are?

15 A: Some, yeah.

16 Q: Are they on the campus at Summerville Medical
17 Center?

18 A: They are.

19 Q: How about Trident Medical Center?

20 A: I believe that they have locations at Trident
21 Medical Center.

22 Q: And what hospitals do they typically use as a
23 group?

24 A: I think they predominantly refer to specialists
25 at Trident and Summerville.

- 1 Q: Okay. Does some of their -- do they sometimes
2 use Roper St. Francis?
- 3 A: St. Francis sees a number of their patients
4 primarily in the gastroenterology and ear, nose
5 and throat. They use those two specialities at
6 St. Francis.
- 7 Q: Okay. Now, what's the next biggest group in
8 Berkeley County after Palmetto Primary Care?
- 9 A: Berkeley Family Practice.
- 10 Q: And how many primary care physicians does
11 Berkeley Family Practice have?
- 12 A: They now have five.
- 13 Q: And how many offices or locations do they have,
14 do you know?
- 15 A: They have one.
- 16 Q: Okay.
- 17 A: It's on Highway 52 about three or four miles
18 outside of Moncks Corner.
- 19 Q: And all of the other primary care physicians
20 practice in groups smaller than five?
- 21 A: Yes.
- 22 Q: Does Roper St. Francis need to employ Palmetto
23 Primary Care to be successful at Carnes
24 Crossroads?
- 25 A: No.

1 Q: Why not?

2 A: Because they are already in the area, as I say.
3 You know, we employ primary care because they
4 were becoming distant to our facilities.
5 Palmetto Primary Care has a very good presence
6 in that community, so I wouldn't see that we'd
7 need to employ them.

8 Q: Let's talk about staffing at the new hospital.
9 When the hospital was built at Mount Pleasant,
10 did -- how was the staffing handled?

11 A: It was -- we first posted positions internally.
12 You know, with the redirection there, you hope
13 that you're going to migrate staff from the
14 host facility to the newly created one. In
15 fact, at Mount Pleasant I think close to 50
16 percent, 46, 47 percent of the employees that
17 are now at Mount Pleasant came out of Roper St.
18 Francis Healthcare. They were already in
19 positions and relocated to the Mount Pleasant
20 Hospital. And then about 50 percent ended up
21 being new hires, people that were not working
22 for us.

23 Q: Do you have any concerns about Roper St.
24 Francis' ability to staff the new hospital in
25 Berkeley County?

1 A: Not at all.

2 Q: Let's turn our attention, if we can, to the
3 actual CON and application itself. Now, you
4 said the decision was made in September to
5 apply for the CON to purchase the hospital; is
6 that correct?

7 A: That's correct.

8 Q: All right. Who were the primary people who
9 worked on the Roper St. Francis, the Carnes
10 Crossroads CON application?

11 A: Shannon Cantwell would have been the organizer
12 of the certificate of need document and drafted
13 much of the narrative in there. Shannon
14 reports to me and I would have kind of
15 quarterbacked that activity and routinely
16 checked on it and been very involved in the
17 decision as to who the experts would be on the
18 case and what the process would be for filing.

19 Q: Who were some of the other people that were
20 involved in it?

21 A: From the facility side, Peter DiNicola is our
22 director of facilities management, he would
23 have been working with the architects, which
24 were FreemanWhite, on this project to look at
25 the scale and scope of the facility from an

1 architectural standpoint. Penny Peralta, who's
2 the chief nursing executive at St. Francis, was
3 heavily involved in the staffing of the nursing
4 and clinical positions in the hospital. Mike
5 Riccardonni, who's our director of imaging,
6 would have worked on the diagnostic imaging
7 components of the facility. And then we used
8 Richardson and Knapp, Mark Richardson and Rick
9 Knapp, as our experts for healthcare
10 utilization and service demand analysis and
11 financial planning.

12 Q: And had you used Mr. Richardson and Mr. Knapp
13 before?

14 A: We had.

15 Q: In what projects?

16 A: The Mount Pleasant Hospital project.

17 Q: Okay. Let's turn to Joint Exhibit 2, page 15.
18 This is the beginning of the, what we call the
19 B11 analysis.

20 A: Yes, B11.

21 Q: It's sometimes called the need analysis.
22 You're familiar with that term, right?

23 A: I am.

24 Q: Okay. What was your role in regards to the
25 actual drafting of the need analysis?

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1 A: Really just to review it. I think Mark
2 Richardson prepared most of the narrative and
3 the tables in the B11 analysis.

4 Q: Okay. Well, in the need analysis, what --
5 there's a discussion about redirection of
6 patients. I think you talked about that
7 earlier this morning. So tell me again what
8 you mean, what redirection of patients means.

9 A: Redirection means changing consumer patterns so
10 that of the historic market share that you had
11 in the past, you're able to capture a portion
12 of that market share at the new facility being
13 constructed.

14 Q: All right. Now, in this application what was
15 the redirection percentage proposed in the
16 application?

17 A: I believe it was 50 percent of the non-
18 tertiary, non-speciality cases that were seen
19 at Roper St. Francis.

20 Q: I guess that's because the tertiary patients --

21 A: Wouldn't be appropriate for that facility.

22 Q: All right. Now, in the Mount Pleasant
23 application you used a higher number, didn't
24 you?

25 A: We did.

1 Q: Why would you use a higher number for Mount
2 Pleasant than you would for Berkeley?

3 A: We talked about that. We had not only a higher
4 market share there, but we had a great deal
5 more physician development in the market place
6 already. A number of our specialists were
7 already in that market, and even prior to the
8 employment and acquisition, there were a
9 significant number of LMA physicians that
10 officed in the Mount Pleasant area, so we felt
11 that we had more of a physician component there
12 to work with on redirection.

13 THE COURT: May I ask a question, please?

14 MR. LONG: Yes, Your Honor.

15 THE COURT: Just to clarify. You consider patients
16 being redirected as coming from both the host
17 facility as well as other providers? The fact
18 that the new location gets them means they've
19 been redirected there; is that right?

20 A: Yeah, but in our definition of redirection,
21 Your Honor, it is just redirection of those
22 patients who historically had used us, used our
23 Roper St. Francis facility.

24 THE COURT: The original facility?

25 A: Yes, the original facility now being seen at

1 the new facility.

2 **THE COURT:** It does not include those that might --

3 A: Have been in a competitor facility? No, sir.

4 **THE COURT:** Thank you.

5 Q: Now, in the Trident application they use a 100
6 percent redirection, right?

7 A: They did.

8 Q: So why didn't you use 100 percent redirection?

9 A: I think Mr. Richardson was being very
10 conservative and it's difficult to believe that
11 100 percent of anything is going to happen, so
12 I know we wouldn't have used 100 percent. I
13 think that with the number of patients that we
14 saw that came out of southern Berkeley County
15 to a Roper St. Francis healthcare facility, I
16 think 50 percent is a conservative and very
17 achievable number.

18 Q: Do you consider this area of the state,
19 Berkeley County, to be growing in population?

20 A: It is growing, yes, sir.

21 Q: And is that supported by the data that you've
22 -- that's come out?

23 A: It is. It's been supported by the projections,
24 the numbers from the Chamber and it was
25 confirmed really in the 2010 census. Berkeley

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1 County grew by almost 8,000 population more
2 than had even been projected and what were
3 considered some pretty optimistic projections
4 at the time.

5 Q: So what impact is this growth going to have in
6 regards to the ability of the hospital in
7 Carnes Crossroads to serve patients?

8 A: I think it's well positioned for where the
9 growth in the county will occur, where it has
10 occurred historically, and as I've said, it's
11 been designated a growth corridor. So I know
12 there's going to be a lot of support from the
13 Berkeley Chamber to continue to see growth and
14 development in that corridor.

15 Q: All right. Let's look at the -- let's look at
16 your project review. Now, you went to project
17 review; is that right?

18 A: I did.

19 Q: And what is project review?

20 A: Projects review is where you make an oral
21 presentation to the DHEC staff with regard to
22 the project.

23 Q: Sorry, can you say that again?

24 A: It's where you go make an oral presentation to
25 the DHEC staff regarding your project.

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- 1 Q: Let's look at page 1176, in Joint 2.
- 2 A: In Joint 2, yes.
- 3 Q: Are you there?
- 4 A: I am.
- 5 Q: Let's look at -- all right. Is this the, you
- 6 did a PowerPoint at project review?
- 7 A: We did.
- 8 Q: And is this the first slide of the PowerPoint?
- 9 A: It is.
- 10 Q: Okay. Who actually did the introduction to the
- 11 project review?
- 12 A: David Dunlap, the president, chief executive
- 13 officer of Roper St. Francis.
- 14 Q: And then what -- did you participate?
- 15 A: I did. I think at the end of this slide he
- 16 turned it over to me for the presentation.
- 17 Q: Okay. Let's take a look at the next page,
- 18 1177. So what were you presenting to the
- 19 Department there?
- 20 A: Really talking about our history in Berkeley
- 21 County, the fact that we've been up there for
- 22 17 years, a description of the facility as it
- 23 existed in Moncks Corner.
- 24 Q: Now, the words that are on the page here,
- 25 that's not a transcript, right?

- 1 A: No.
- 2 Q: And what is that?
- 3 A: It was the script for the presentation.
- 4 Q: Okay. So you kind of wrote out what you wanted
- 5 to say?
- 6 A: Yes.
- 7 Q: Okay. But did you say it verbatim or do you
- 8 think --
- 9 A: Pretty close. I don't think I strayed much
- 10 from it.
- 11 Q: All right., Let's look at page 1178.
- 12 A: Okay.
- 13 Q: What are you presenting to the Department on
- 14 page 1178?
- 15 A: 1178 is really to outline our request that's
- 16 before the Department; that's to transfer the
- 17 50 existing beds from Roper Hospital in order
- 18 to construct a new hospital in Berkeley County.
- 19 And then we talked about the hospital campus,
- 20 where it's located, the size of the
- 21 development, and basically the decision as to
- 22 why we selected Goose Creek Carnes Crossroads
- 23 compared to other areas of the county.
- 24 Q: Let me ask you about this sentence right here.
- 25 It says, "The decision to place inpatient

1 services in Goose Creek rather than Moncks
2 Corner was based on both internal and external
3 market analysis." So is that accurate?

4 A: It is.

5 Q: And what are the internal and external market
6 analysis that you're referring to in that?

7 A: Internally we looked first at Moncks Corner to
8 see if we could do beds there. Based on the
9 population, use rate of the county and our
10 market share, we thought that was going to be
11 problematic, that we couldn't financially
12 support it. We actually engaged Mark
13 Richardson to do a very quick analysis in that
14 area and he came to a very similar decision
15 that he thought that Moncks Corner itself would
16 only support about 22 beds and we felt that was
17 too small. We actually also had David Leavitt
18 work on a piece that -- who is another expert
19 who did a further analysis for us. And he
20 looked at the eight zip codes around the lake,
21 and he determined that the eight zip codes
22 around the lake and Moncks Corner would support
23 I believe about 40 beds. And at that time we
24 still felt that that wasn't going to work for
25 two reasons. I had had a discussion with DHEC,

1 with Joel Grice who was the director of the
2 Department at that time, and Mr. Grice had
3 relayed to me that following the Mount Pleasant
4 Hospital project he had no intentions of
5 approving a hospital under 100 beds in size
6 again, because it was his belief at that time
7 that they weren't efficient plants. And he
8 stated to me and legal representation that was
9 there with me that it was unlikely he'd
10 approved a hospital of 100 beds or less going
11 forward. Secondly, when we first chose that
12 location, as I said, we had no idea that
13 Trident had any interest in building a hospital
14 in Berkeley County because there had been no
15 indication of it. So with those two factors,
16 the low number of beds that we felt the Moncks
17 Corner area would support for us, because we
18 didn't have the ability to redirect that
19 Trident does, that coupled with the
20 Department's comments was why we purchased the
21 land at Carnes Crossroads. And, of course,
22 that purchase occurred well before we got to
23 certificate of need filing or project review.
24 So we had already made our commitment to that
25 location.

1 Q: Did you also do some analysis as to whether
2 Berkeley County could support -- how many beds
3 the county could support on its own population?

4 A: We did. David Leavitt also did that analysis
5 for us.

6 Q: Let's look at Respondent's 2. Is this that
7 analysis?

8 A: I think this is page one of a two-page
9 analysis.

10 Q: Okay.

11 A: And he concludes that based on the population
12 projections that in 2014, I guess it's bed need
13 at 65 percent occupancy would be 331.

14 Q: So 331 beds, Berkeley County's population?

15 A: Right.

16 Q: Now, would that be consistent with other
17 similar kind of counties in South Carolina?

18 A: It would be.

19 Q: Can you explain what you mean by that?

20 A: If you look at, you know, the number of beds
21 that were in Lexington County, it very closely
22 approximates that. Lexington County is similar
23 in size. In some areas of the state, I think
24 in Florence they have many more beds than that
25 for populations at or below that size, so.

1 It's pretty consistent with what you'd see with
2 the 176,000 people, the number of beds it would
3 support.

4 Q: And do you see counties in South Carolina with
5 smaller populations that had more than 150
6 beds?

7 A: You do.

8 Q: Let's go back to the PowerPoint. Look at page
9 1179.

10 A: Okay.

11 Q: All right. What are you presenting here to the
12 Department?

13 A: These are the objectives that we hope our
14 project will achieve at Carnes Crossroads.

15 Q: And what is the number one objective?

16 A: The number one objective is to provide enhanced
17 access to care for existing Roper St. Francis
18 Healthcare patients who reside in Berkeley
19 County.

20 Q: And look at the next page, 1180.

21 A: Uh-huh.

22 Q: You're discussing some data here with the
23 Department?

24 A: What we're showing the Department is how that
25 inpatient utilization to Roper St. Francis has

1 increased from 2004 to 2008.

2 Q: So these are patients that live in Berkeley
3 County but travel to Roper Downtown or St.
4 Francis here -- or Mount Pleasant hasn't opened
5 by this time, right?

6 A: Right.

7 Q: And the trend line as to what's happening with
8 that?

9 A: It's growing pretty significantly over time.

10 Q: Okay. What do you attribute that growth to?

11 A: You know, I just think we provide a good
12 service model, a high level of care. I think
13 patients that use Roper St. Francis Healthcare
14 facilities are pleased with the service they
15 get and word of mouth helps that. So I think
16 we just have a natural growth trend occurring
17 there.

18 Q: Will you look at 1181? Presenting some more
19 data to the Department regarding surgery
20 volumes, right?

21 A: Yes.

22 Q: What are you showing here?

23 A: These are surgery volumes from Berkeley County,
24 surgeries that are being performed in Roper St.
25 Francis and maybe to some degree the Moncks

1 Corner facility. But you can see that that
2 number has grown significantly over that period
3 of time also.

4 Q: Why is surgery volume important or a factor in
5 regards to a community hospital?

6 A: Community hospitals perform a lot of surgery.
7 That's one of the things that drives the
8 revenue at that facility.

9 Q: Look at page 1182.

10 A: Uh-huh.

11 Q: Presenting some data to the Department here in
12 regards to Berkeley County, right?

13 A: Uh-huh.

14 Q: What is this about? What does this show?

15 A: This is growth trend is apparent from our
16 emergency department volumes originating from
17 Berkeley County. So these are not only the
18 visits that occurred in the Moncks Corner
19 facility but also Roper and St. Francis
20 Hospitals.

21 Q: So increased emergency department visits lead
22 to what?

23 A: Increased admissions.

24 Q: Okay. Now, if we look over at pages 1183 and
25 1184, can you tell me what this is?

- 1 A: On 1183 we had a video of Representative Joe
2 Danning from Berkeley County talking about why
3 he thought our project was important.
- 4 Q: Okay. How about 1185 and 86?
- 5 A: 1185 was a letter that we received Mr. and Mrs.
6 Barner who live up in the Carnes Crossroads
7 area and their support of the project. And
8 then Deborah Calcote is a long-established
9 community leader in Berkeley County, sitting on
10 a number of boards up there and it's a letter
11 of support from her.
- 12 Q: Does Roper St. Francis have support in the
13 community for this hospital in Carnes
14 Crossroads?
- 15 A: We have a lot of support.
- 16 Q: And how did you obtain or how do you know you
17 have support from them?
- 18 A: We solicited letters of support from the
19 community, letters of support from our
20 physicians and from elected officials and
21 physicians.
- 22 Q: Okay. Take a look at, speaking of physicians,
23 let's look at 1187 and 1188.
- 24 A: Chip Bounds is a physician in Berkeley Family
25 Practice, that group of five that we talked

1 about, and he talks about the importance of
2 that hospital at Carnes Crossroads.

3 Q: Look at 1189 and 1190, talks about, what is
4 that? You start here, "Our second objective,"
5 so what --

6 A: That's to respond -- the second objective is to
7 respond to the significant growth in Berkeley
8 County and we show that, you know, clearly
9 Berkeley and Dorchester are growing at a rate
10 much higher than Charleston County, like three
11 and four times higher than Charleston County
12 and at a rate greater than the state of South
13 Carolina.

14 Q: In your presentation on page 1189, you make a
15 forecast of the Berkeley County population in
16 2015, right?

17 A: Right.

18 Q: What do you forecast the population to be in
19 2015 in your presentation to the Department?

20 A: I say I forecast the growth at more than nine
21 percent by 2015.

22 Q: What's the number of people?

23 A: It is 172,940.

24 Q: What was the actual census number for 2010 in
25 Berkeley County, do you recall?

- 1 A: It's more than 177,000.
- 2 Q: So the census showed that there was more people
3 in 2010 in Berkeley County than what you
4 forecast for 2015?
- 5 A: Yes.
- 6 Q: Okay. Look at 1190.
- 7 A: Okay.
- 8 Q: What are you presenting to the Department here?
- 9 A: What we're presenting to the Department is a
10 number of the business expansions that are both
11 slated and are already in place up in Berkeley
12 County. We talk about Google and their new
13 data center, Trump Medical Systems which has
14 also moved to Berkeley County, the Mead
15 Westvaco properties, Hillwood Developments and
16 others.
- 17 Q: And 1191?
- 18 A: Uh-huh.
- 19 Q: You mention here the seven mile radius, right?
- 20 A: Yes.
- 21 Q: And we talked about that a little bit earlier,
22 but what are you presenting to the Department
23 in regards to this and why do you think this is
24 important?
- 25 A: What we're presenting there is just how much of

1 the population is proximal to this facility and
2 that's one of the reasons we think it's the
3 best location and a location that will be very
4 successful for Berkeley County. We also talk
5 about the growth rate within that area at this
6 point.

7 Q: The next page is 1192.

8 A: Uh-huh.

9 Q: Does that continue with what you were just
10 discussing?

11 A: It does. We look at the county as a whole here
12 and kind of where the population resides within
13 the county and the travel patterns.

14 Q: 1193?

15 A: Yeah, that's the Berkeley traffic counts by
16 major arteries and you'll see the 17-A and 176
17 numbers.

18 Q: All right. 1194, who's Dennis Harmon?

19 A: He's the city administrator for Goose Creek.

20 Q: Does he have a role with Roper St. Francis?

21 A: He used to be on the Roper Board. I don't
22 believe Roper Hospital Downtown. Not the big
23 board. Just the advisory board to Roper
24 Hospital. I don't believe he's any longer in
25 that position.

1 Q: 1196, what are you presenting there to the
2 Department?

3 A: These are the planned developments, residential
4 developments in the Goose Creek area.

5 Q: How about 1197, 98?

6 A: That's Mike Heitzler who is the mayor of Goose
7 Creek, who I would assure doesn't feel Goose
8 Creek has a hospital and would be very excited
9 to have one.

10 MR. THOMAS: Objection. Your Honor, I would object
11 to that last statement and ask that it be
12 stricken from the record. Basically he said
13 that he assured what the witness said that he
14 didn't think that Goose Creek had a hospital.
15 That is just hearsay, Your Honor.

16 THE COURT: First of all, go back to the document
17 that he was speaking about.

18 MR. LONG: 1197 and 1198.

19 THE COURT: 1197 was it, I think.

20 MR. THOMAS: Right, he said, I believe --

21 THE COURT: Enlarge that please, ma'am. Now, what's
22 your objection?

23 MR. THOMAS: He said --

24 THE COURT: Do you object to his testimony?

25 MR. THOMAS: Yeah, he said I assure you Mayor

1 Heitzler would testify that Goose Creek does
2 not have a hospital.

3 MR. LONG: I don't think he said testify. I think
4 he just said --

5 THE COURT: Well, I sustain the objection, but it
6 hardly seems surprising that he would do that.

7 MR. THOMAS: I just want it clear for the record,
8 Your Honor.

9 THE COURT: Thank you, sir.

10 MR. THOMAS: Thank you.

11 A: I might look at the last sentence of that then
12 and just say Mayor Heitzler said he thought it
13 was important to provide people working in
14 their community with a convenient choice of
15 healthcare providers.

16 Q: Now, you said objectives, on 1199 we have
17 objective three, right?

18 A: Yes. That's to construct a not-for-profit
19 community-based hospital in the county without
20 inpatient services.

21 Q: Does Berkeley County have a hospital?

22 A: They do not.

23 Q: Let's look at Dr. Chaney, 1200 and 1201. Did
24 he speak by video at that project review?

25 A: He did.

1 Q: Okay. Is he in support of the project?

2 A: He is. And he lives in Summerville and thinks
3 that it's very important that the Goose Creek
4 area of Berkeley County have a facility.

5 Q: Okay. Let's look at 1202. And tell me what
6 you're presenting to the Department here.

7 A: What we're talking about is that issue of how
8 far should hospitals be separated in
9 metropolitan areas and we just point out the
10 distances that -- with a -- if you look from
11 Roper to St. Francis, it's about seven miles.
12 Roper to East Cooper Medical Center, seven
13 miles. East Cooper Medical Center to the new
14 Mount Pleasant Hospital is about seven miles.
15 Trident selected six miles as a separation
16 distance between Trident Hospital and their
17 satellite hospital. So we felt the distance
18 that separated us from Trident and us from
19 their proposed Moncks Corner site was
20 appropriate and sufficient.

21 Q: Let's take a look at Joint Exhibit 2, pages
22 1115 through 1120. You testified earlier about
23 support from the community regarding the
24 project, right?

25 A: Yes.

1 Q: Those letters were submitted to the Department
2 for review?

3 A: They were.

4 Q: All right. Now, let me talk to you about a
5 couple of specific letters that came in. The
6 date on this letter, on 1115, is June 16, 2009,
7 right?

8 A: Yes.

9 Q: Okay. And it's a two page letter. Can you
10 tell me what this letter is in support of?

11 A: This is a letter from a number of the elected
12 officials and then they are in support of both
13 hospital projects moving forward in that
14 county. You can see the representatives that
15 signed it on 1116.

16 Q: All right. Look at 1117, dated June 15, 2009.
17 What is that a letter from?

18 A: That is a letter to the Commissioner, DHEC and
19 Ms. Brandt expressing the mayors in those towns
20 also saying that they think these projects that
21 are about 12 miles apart will bring 100 beds to
22 the hospital and it says we understand that
23 both Trident and Roper have raised concerns
24 about the other's proposed project; however,
25 both projects are approved. We will strongly

1 encourage both Roper and Trident to accept that
2 decision and to not enter into a long legal
3 fight. And then that is signed by the mayor of
4 Goose Creek; the mayor of St. Stephen; Mr.
5 Peagler, the mayor of Moncks Corner; Roy Pipkin
6 in Jamestown and Mr. Wrenn in Bonneau.

7 Q: And I think you said 100 beds to the facility
8 or whatever. You mean 100 beds to the county?

9 A: To the county, yes.

10 Q: And then 1119 and 1120, what is this letter?
11 June 16, 2009.

12 A: This is a letter from Dr. Swicord, he's a
13 family practice physician in that area, just to
14 Ms. Brandt talking about his support of the
15 project.

16 Q: Let's take a look at page 1236. Tell me what
17 1236 is.

18 A: This was a letter that was sent to the
19 Department to Ms. Brandt and Ms. Sanders
20 following our project review presentation to
21 answer some questions and provide further
22 clarification on the certificate of need
23 application.

24 Q: Let's look at a couple of these sections if we
25 can. Section one, Roper's ongoing commitment

1 to Moncks Corner and rural northern Berkeley
2 County. Can you tell me what -- can you
3 summarize for me this section of the letter?

4 A: You know, once again, we talk about the
5 services that we've had in Moncks Corner, the
6 types of services and the scale of those that
7 we began developing in 1991. And then we talk
8 about our reasons to locate at Carnes
9 Crossroads, some of the low utilization of the
10 surgery center, and the population center of
11 the county.

12 Q: And let's look, there's a footnote there. Now,
13 footnote number one, can you kind of read that
14 footnote?

15 A: It says, "Despite clear references in Roper's
16 CON application, Trident has indicated that
17 they are confused about the service area that
18 Roper Berkeley Hospital will cover. To confirm
19 the service area is all of Berkeley County, the
20 seven mile radius population analysis simply
21 illustrates for planning purposes the location
22 of a majority of the patient base for each
23 applicant."

24 Q: Okay. Let's look at section two. Carnes
25 Crossroads is the best location for a Berkeley

1 County Hospital. Can you summarize for me what
2 points you're trying to make to the Department
3 in section two?

4 A: We're just really trying to point out that
5 Carnes Crossroads is in the midst where the
6 population of Berkeley County resides and where
7 the growth will occur and that ultimately that
8 location will be more convenient to a much
9 greater percentage of the county than any other
10 we might choose.

11 Q: Now, did Roper St. Francis choose to reference
12 or compare the Trident application when you
13 filed the application?

14 A: No, we did not?

15 Q: Okay. And why not?

16 A: We really didn't feel that the Trident location
17 in Moncks Corner would affect our project in
18 Carnes Crossroads.

19 Q: Still believe that today?

20 A: Still believe that today. I think it's two
21 completely separate communities and service
22 areas.

23 Q: I do want to -- I need to clear up something
24 I'm afraid in your earlier testimony just real
25 quick while we're on that subject. And that's

- 1 going back to my Respondent's 76 map here of
2 the inpatient projections by Trident. And just
3 to clarify for the record, when you were
4 talking about Trident having 100 percent
5 redirection --
- 6 A: Right.
- 7 Q: -- okay, did that mean they were going to get
8 100 percent of these patients in pink?
- 9 A: No. No, no.
- 10 Q: Okay.
- 11 A: It meant that --
- 12 Q: Can you explain that?
- 13 A: The volume that they contemplate in their
14 facility is a redirection of what they believe
15 was their existing market share and growth that
16 they were projecting; that they would not be
17 looking for new patients from any other source.
- 18 Q: Now let's go back to section three. A Roper
19 Berkeley Hospital will not adversely impact
20 existing providers. Can you summarize there
21 what -- some of the points you're trying to
22 make in that letter?
- 23 A: We feel that we clearly have enough market
24 share up there and with the growth that has
25 occurred and will occur in that county we

1 didn't believe we'd have any adverse impact on
2 either Trident or Summerville Hospital. To the
3 degree, I mean, for us to get to a 35 or more
4 patients in our facility, we just couldn't see
5 that that would have any impact on existing
6 providers with the amount of business that we
7 already have in the county.

8 Q: Okay. And does the bed transfer portion --
9 does the bed transfer piece of the application
10 also affect the issue of whether there's going
11 to be adverse impact on existing providers?

12 A: I imagine it does because the beds are already
13 in service, they're already, you know,
14 demonstrated a need and they're already -- it's
15 taking that number of beds to service the
16 market share that we already have in Berkeley
17 County.

18 Q: Also, I want you to, if you would, to look at
19 footnote number two on page 1240 in your letter
20 to Ms. Brandt.

21 A: Yes.

22 Q: Okay. Can you read that for the court?

23 A: "Although our application references the bed
24 transfer language from pages two, three of the
25 2008-2009 South Carolina Health Plan, it is our

1 position that even if that provision does not
2 apply to this situation, the Health Plan and
3 Regulations otherwise allow for the transfer of
4 existing beds for the development of a new
5 hospital. There is nothing in the Health Plan
6 or Regulations that prohibit this. Further,
7 DHEC has made it clear through the approval of
8 many other CON applications that the transfer
9 of existing beds to build a new hospital is
10 permitted."

11 Q: You heard the testimony of Mr. Shelton --

12 A: Yes.

13 Q: -- the first week of the trial, right --

14 A: Uh-huh.

15 Q: -- as to the creation of Summerville Medical
16 Center?

17 A: Yes.

18 Q: Okay. Do you recall what he testified about?

19 A: That they transferred beds and bed need from
20 Trident to create Summerville.

21 Q: And did that pre-date the bed transfer
22 provision?

23 A: You know, I don't know.

24 Q: Okay. Well, the testimony should stand for it.
25 So you brought to the Department's attention in

1 the letter that you sent to Mr. Brandt that you
2 thought the application could be approved even
3 if the bed transfer provision was interpreted
4 differently than the way it's been interpreted?

5 **MR. THOMAS:** Your Honor.

6 **Q:** Is that what this says?

7 **MR. THOMAS:** I was just going to object as to that
8 being a leading question. I've kind of given
9 him some leeway.

10 **THE COURT:** Sustained.

11 **Q:** Can you summarize again what you're trying to
12 say here in this footnote three?

13 **A:** Well, we're saying is that even in the absence
14 of the bed transfer provision as it's
15 interpreted by staff and the DHEC Board, we
16 felt that there was no prohibition in the State
17 Health Plan that would prohibit us from
18 transferring beds to create a new hospital in
19 Berkeley County.

20 **Q:** Okay. Let's look at section four. Roper
21 Hospital Downtown Charleston will maintain
22 adequate capacity despite the proposed bed
23 transfer to Berkeley County. Can you summarize
24 the points that you're trying to make to the
25 Department in that section?

- 1 A: Yeah, what we're telling the Department is that
2 Roper Hospital will certainly have enough
3 capacity to serve the patients that it needs to
4 serve downtown even after this 50 bed transfer
5 to the beds in Carnes Crossroads, you know, and
6 as I look these projections and the historic
7 utilization of Roper, we had an average daily
8 census coming down from 2005 to 2008 to 228
9 days and that put it at 55 percent occupancy.
10 In 2011 we finished the year with Roper
11 Hospital having an average daily census of 216.
12 So that number's continued to fall. An
13 inpatient census in tertiary facilities has
14 done that not because there are fewer patients
15 necessarily using the facilities, but it's how
16 they're designated. Without going into --
17 Q: We'll let Mr. Severance go into more detail on
18 that.
19 A: I'll let Mr. Severance go into the arduous
20 detail on observation beds.
21 Q: Number five, the applications are not
22 competing.
23 A: Right.
24 Q: Is that the position that you took with the
25 Department?

1 A: It is.

2 Q: Okay. Can you summarize the basis or what it
3 says in regards to why you took that position
4 with the Department?

5 A: Because the three elements that have to be met
6 to be considered competing are that you're in
7 the same service area, and I think we all agree
8 that Charleston, Dorchester, Berkeley County
9 are the definition of a service area; that it's
10 substantially the same facility and we're both
11 building 50 bed hospitals, so we agree that
12 under those two criteria, those are met; but
13 then it says exceeds the need, and we don't
14 believe in an existing bed transfer that
15 anything we would do with regard to that would
16 exceed the need within the service area.

17 Q: What about Berkeley County's population and its
18 ability to support 100 beds?

19 A: Clearly it'll support 100 beds. You know, as
20 we saw in the David Leavitt document, I think
21 if we had gotten to the second page of that, he
22 actually projects it would support 362 beds and
23 that's with the growth that was projected and
24 not the actual growth that occurred in that
25 county. The county can easily support 100

1 beds.

2 Q: And are there other county -- did you bring to
3 the Department's attention other comparable
4 counties --

5 A: We did.

6 Q: -- on page 1244.

7 A: Yes, we listed out a number of the counties.
8 You can see Anderson County with a very similar
9 population, two hospitals and 495 beds.
10 Lexington County in the 2006 population had
11 164,000 and had 384 beds. York County almost
12 identical to where Berkeley County is today
13 supporting 332 beds. And I'd further say in
14 each of these examples, especially with
15 Lexington and York County, they are adjacent to
16 other large counties that have major healthcare
17 providers. So they're not just standalone
18 rural counties.

19 Q: Anderson too, right?

20 A: Anderson too.

21 Q: You heard Mr. Baehr testify that Trident Health
22 System will lose almost 1,500 admissions in the
23 third year after the Carnes Crossroads facility
24 is open and running, okay. What is your
25 reaction to his calculation of 1,500 lost

1 inpatients?

2 A: Honestly I can't imagine that. The reason
3 being if you look at we built ours on 50
4 percent redirection which gave us I think about
5 60 percent of the facility census would come
6 from redirection at that point. Then there
7 were another 1,188 is the total number of
8 discharges that come from growth and growth
9 within the county. And we already -- you know,
10 if you figure we're going to get 25 percent of
11 that from us, there's really not a great deal
12 of growth there that occurs that could be
13 coming out of Trident Medical Center. And then
14 the rest of it was from out of area. And what
15 we looked at was very specifically we had about
16 1,200 discharges out of Dorchester County and
17 Summerville.

18 Q: What do you mean by that?

19 A: There were 1,200 patients in the Summerville,
20 Dorchester area that went to Roper St. Francis
21 Healthcare. So they either went to St. Francis
22 or Roper. We feel there would be some
23 redirection of that. And plus we had patients
24 from Orangeburg coming down. So we think
25 easily that that last ten percent from out of

1 area will be entirely redirected patients, so
2 I can't imagine how they get to 1,500 patients
3 adverse impact in their calculation.

4 MR. LONG: Your Honor, if I could have one moment.

5 THE COURT: Yes, sir.

6 MR. LONG: Your Honor, that's all the questions I
7 have.

8 THE COURT: I think this would be a good time to
9 break for lunch. We'll come back at quarter of
10 three p.m. In recess till quarter of three.

11 (Off the Record from 1:15 p.m. until 2:45 p.m.)

12 THE COURT: Back on the record. Mr. Long.

13 MR. LONG: Your Honor, we have concluded our
14 questioning of Mr. Bowling.

15 THE COURT: Mr. Thomas.

16 MR. BOWLING - CROSS EXAMINATION BY MR. THOMAS:

17 Q: Good afternoon, Mr. Bowling. My name's Will
18 Thomas. I represent Trident and I depose you,
19 as you'll recall. I think we looked at some
20 salary information last week. You recall that,
21 correct?

22 A: I do.

23 Q: I think your compensation for 2010 was
24 \$580,000, maybe a little more?

25 A: That sounds close with benefits and everything.

- 1 Q: Let me show you the 990 for CareAlliance in
2 2009. I just want to confirm something here.
3 Was your compensation in 2009, total
4 compensation \$427,555?
- 5 A: According to the 990, it was, yes.
- 6 Q: Okay. Thank you. Mr. Bowling, when's the last
7 time you actually worked for HCA?
- 8 A: In February of 2000.
- 9 Q: So about 12 years ago?
- 10 A: Yes.
- 11 Q: And you've never worked for Trident Medical
12 Center; have you?
- 13 A: No, I haven't.
- 14 Q: When you worked at HCA, you didn't work in the
15 South Atlantic division, did you?
- 16 A: No.
- 17 Q: Now, I think you mentioned that you served on
18 the South Carolina State Health Planning
19 Committee at the time that Roper's project was
20 approved; is that right?
- 21 A: That's correct.
- 22 Q: And you're still technically a member of the
23 committee, aren't you?
- 24 A: I haven't been informed otherwise.
- 25 Q: Okay. Now, as part of that job, would you

1 agree that you needed to become familiar with
2 the principles of South Carolina healthcare
3 planning?

4 A: To some degree.

5 Q: Well, you're serving on a State Health Planning
6 Commission -- Committee, right?

7 A: Yes. As an advisor for the providers.

8 Q: All right. And did you become familiar at all
9 with the CON regulations and the project review
10 criteria?

11 A: I did.

12 Q: Okay. Now, in terms of accessability with
13 respect to state healthcare planning, would you
14 agree that an individual should be able to
15 reach a healthcare facility in a reasonable
16 amount of time and a safe amount of time?

17 A: I would.

18 Q: And you've actually heard that a safe time
19 period in terms of inpatient beds is about 30
20 minutes, right?

21 A: I've heard that is the goal of the state, yes.

22 Q: And you would agree that another purpose or
23 goal of the CON Act is to prevent the
24 unnecessary duplication of services, correct?

25 A: That's correct.

1 Q: And just to kind of backtrack, you'd agree,
2 based on your service on the State Health
3 Planning Committee, that the CON is an
4 important program in this state, would you?

5 A: Absolutely.

6 Q: And you support the CON program, right?

7 A: I do.

8 Q: Now, in terms of unnecessary duplications of
9 services, would you agree that what you want to
10 avoid is too many providers in a given area so
11 you don't run into the issue of having prices
12 increase as a result of not enough patients to
13 support the providers in the area? Is that a
14 fair statement?

15 A: I would say you don't want an oversupply in the
16 defined service areas.

17 Q: And why don't you want the oversupply?

18 A: Well, a few of the experts and I disagree on
19 it. I think healthcare demand is not elastic
20 as it relates to prices, or virtually anything
21 else. We're very good at predicting the number
22 of procedures and treatments and inpatient
23 admissions that will occur within a given
24 population in a given year. If there are too
25 many providers within a defined service area to

1 provide that service, then for the existing
2 providers to remain viable they'll have to
3 increase prices.

4 Q: Fair enough. That was better than the way I
5 put it. And I think you just said when you
6 were on the State Health Planning Committee you
7 were actually kind of a provider
8 representative, correct?

9 A: I am.

10 Q: And were there any other hospital
11 administrators serving on the State Health
12 Planning Committee?

13 A: Dick Tinsley from Florence is on that
14 committee, and there's a gentleman from
15 Lexington Medical Center, I don't recall his
16 name.

17 Q: Okay. And so would you agree that you were
18 kind of charged for looking out for the best
19 interest of hospital providers while serving on
20 the committee?

21 A: I would, yes, I would say so.

22 Q: And while serving on the State Health Planning
23 Committee, you were actually in favor of
24 separating the Charleston -- well, the Tri-
25 county service area, which was Charleston,

1 Berkeley and Dorchester Counties, you actually
2 were in favor of kind of making those each
3 three distinct service areas; is that a fair
4 statement?

5 A: I clearly thought it was unusual, and asked why
6 it was done, and was in favor of them being at
7 least treated in the same manner as Lexington
8 and Richland Counties.

9 Q: Were you here for the testimony of Les Shelton
10 or were you aware that at least with Lexington
11 and Richland, Mr. Shelton does some kind of
12 interesting population swap or --

13 A: They do a utilization ratio between the
14 counties, yes.

15 Q: And were you aware that they did that during
16 the --

17 A: Yes.

18 Q: -- when you were on the State Health Planning
19 Committee?

20 A: Uh-huh.

21 Q: While you were in favor of that service area
22 change, and you were on the State Health
23 Planning Committee, you did know that Roper had
24 just purchased a large piece of property in
25 Berkeley County in order to put a hospital on

1 it, correct?

2 A: This would've been -- I don't know if we had
3 purchased the property or not when that
4 planning committee met because that was for the
5 2008-2009 Plan, so it would've been sometime in
6 2007 when we first started meeting.

7 Q: Well, you were looking already.

8 A: We were looking at Berkeley County, there's no
9 doubt.

10 Q: Okay. And under that service area scenario
11 that I think you described where you break out
12 Berkeley and Dorchester and Charleston
13 Counties, Berkeley County, if you just allocate
14 it, and I think we saw maybe something from Mr.
15 Leavitt, would all of a sudden have this bed
16 need, correct?

17 A: Uh-huh.

18 Q: And, but there wouldn't have been any hospital
19 credited with the inventory; is that right?

20 A: That's correct.

21 Q: And that would've benefitted Roper
22 economically, wouldn't it have, especially
23 since it was about to or had just bought land
24 in Berkeley County?

25 A: Not necessarily. It would've made Berkeley

1 County wide open for anybody to go in, and also
2 it would've put us in a significant bed excess
3 in Charleston County.

4 Q: Well, couldn't you have just used that as more
5 justification to transfer your beds to Berkeley
6 County?

7 A: Possibly. But almost anyone could have at that
8 point.

9 Q: But at that time, I think you testified
10 earlier, that, you know, you hadn't heard
11 anything about Trident having plans to build in
12 Berkeley County, right?

13 A: Not at all.

14 Q: You said 40 years, right?

15 A: Uh-huh.

16 Q: And at that time you hadn't heard anything
17 about MUSC making plans to apply for a hospital
18 in Berkeley County either, had you?

19 A: Not exactly, no.

20 Q: Now, while you were on the committee, is it
21 fair to say that you were aware that Trident
22 Hospital was actually located in its area to
23 serve Dorchester and Berkeley Counties?

24 A: I don't know that I was aware that it was in
25 that area for that purpose. I clearly knew

1 that within -- the primary service area of
2 Trident included Berkeley and Dorchester
3 County.

4 **THE COURT:** I need you define that. And you're
5 talking about the initial location of Trident
6 by agreement with Berkeley County closing its
7 old hospital?

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

9 **THE COURT:** That's the time you were referencing; is
10 that right?

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

12 **Q:** So are you saying that back in 2007, I mean,
13 you were aware of that; that one of the reasons
14 the CON was issued to the original Trident
15 Medical Center was because so it could serve
16 both Berkeley and Dorchester Counties, weren't
17 you?

18 **A:** / I understood that the two hospitals in Berkeley
19 and Dorchester were contributed to create the
20 Trident Medical Center.

21 **Q:** Now, you would agree that Roper St. Francis
22 Berkeley is not simply transferring 50 beds
23 from an existing hospital downtown to an
24 existing hospital at Carnes Crossroads, right?
25 I think we've established that. Is that a fair

1 statement?

2 A: In using the term existing for Carnes
3 Crossroads, I would agree with that; it's not
4 there yet.

5 Q: And in terms of this project, there's going to
6 be a new emergency department at Carnes
7 Crossroads, won't there?

8 A: There will be.

9 Q: Okay. And just for the record, isn't Carnes
10 Crossroads that area where Roper St. Francis
11 Berkeley would be located, that's actually been
12 annexed into the City of Goose Creek, hasn't
13 it? Is that your understanding?

14 A: It is part of the City of Goose Creek. I don't
15 know when it was annexed.

16 Q: So by virtue of this project, there will be
17 four new ORs in Goose Creek, won't there?

18 A: There will be.

19 Q: Okay. And you would agree with me that, you
20 know, Roper St. Francis in Moncks Corner, their
21 surgery center up there, they're not closing
22 down those ORs, correct?

23 A: No.

24 Q: And you're not aware of any ORs in downtown
25 Charleston closing down either, right? You're

1 not going to close down four ORs down there or
2 get them de-licensed, are you?

3 A: We haven't had that discussion, no.

4 Q: There are going to be some new imaging services
5 that are going to be established in Goose
6 Creek, right?

7 A: That's right, yes.

8 Q: There'll be a new lab and new pharmacy services
9 established in Goose Creek?

10 A: Lab and pharmacy will be extensions of our
11 current lab and pharmacy services. We matrix
12 those across the organization, so I'm not sure
13 how much of it would be there versus provided
14 from St. Francis or one of the other
15 facilities.

16 Q: So you don't think --

17 A: But we will have lab and pharmacy services.

18 Q: On site?

19 A: On site.

20 THE COURT: You referenced Goose Creek. Did you
21 mean Carnes Crossroads?

22 MR. THOMAS: I did.

23 THE COURT: Please use that consistently so I'll be
24 able to understand you.

25 MR. THOMAS: Okay, that's fine, Your Honor.

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1 Q: Would you agree there's not going to be any new
2 health services in Carnes Crossroads that
3 aren't currently offered at Trident or
4 Summerville today?

5 A: Or any other hospital in the Tri-county area.

6 Q: Okay. So is that yes, you would agree?

7 A: I would agree.

8 Q: Okay. A lot of the services that we just went
9 over are presently offered in Moncks Corner at
10 either Trident or Roper's site up there,
11 correct?

12 A: Many of them are, but most of the services that
13 you mentioned are a requirement for providing
14 inpatient services.

15 Q: Fair enough. Well, even though Roper claims
16 it's going to serve many redirected patients at
17 its new facility, would you agree that Roper
18 St. Francis Berkeley Hospital is duplicative of
19 existing services well within a 30 minute
20 travel time of the population that Roper St.
21 Francis Berkeley intends to serve?

22 A: I would say there are similar services that are
23 within a 30 minute drive time. I don't know
24 that they'd be duplicative because it's a
25 different patient base.

1 Q: So, but if they're the same services, are there
2 -- are there similar services within that 30
3 minute drive time?

4 A: There are.

5 Q: Thank you. Now, Mr. Bowling, do you think MUSC
6 should be able to establish a 50 bed hospital
7 in West Ashley based on a bed transfer, its
8 market share and the revenue it derives from
9 that area?

10 A: I probably wouldn't like it, but I would agree
11 that they should be able to do so.

12 Q: So based on that basis, they should be issued
13 a CON?

14 A: Uh-huh.

15 Q: Should they also be able -- and they've got
16 about 600 beds downtown, don't they?

17 A: Right, they do.

18 Q: Should MUSC, which has a solid market share in
19 the East Cooper area, also be able to establish
20 a 50 bed hospital in the East Cooper area based
21 on its market share, its revenues and a bed
22 transfer?

23 A: I think they'd have difficulty proving a need
24 in the Mount Pleasant area at this time, but I
25 can certainly see their logic, because they

1 have about a 30 percent market share there.

2 Q: So you think they'd have difficulty justifying
3 the need based on the fact there's 225 beds
4 over there right now?

5 A: I do.

6 Q: Okay. Now, you would agree with me that about
7 the time that Roper decided to -- well, about
8 the time the hospital opened in Mount Pleasant,
9 the Roper Hospital, that the household income
10 for that area was about \$112,000 a year?

11 A: I think for the City of Mount Pleasant that's
12 correct, yes.

13 Q: You don't think it was the radius around Roper
14 St. Francis Mount Pleasant Hospital site? I
15 can pull up the --

16 A: I don't recall exactly. It depends on how much
17 into Awendaw you get there. Awendaw brings
18 that average down considerably.

19 Q: Well, let's just put up Petitioner's 93, page
20 eight, if we could. This is the annual update
21 with Moody's.

22 A: Uh-huh.

23 Q: We've looked at this one a couple of times. So
24 this says Mount Pleasant Hospital five mile
25 radius, correct?

- 1 A: Yes, it is.
- 2 Q: So it's within that -- the demographics within
- 3 that radius?
- 4 A: Within the five mile radius, the average
- 5 household income in 2008 was 112.
- 6 Q: And that's what was presented to the bond at
- 7 the rating agency, correct?
- 8 A: That's correct.
- 9 Q: And do you recall that Roper actually submitted
- 10 its application for Mount Pleasant, its Mount
- 11 Pleasant Hospital two months after East Cooper
- 12 applied for their replacement hospital? Do you
- 13 recall that, that timing?
- 14 A: It's going to be close to that. Again, we
- 15 purchased the property some time before East
- 16 Cooper filed for their replacement hospital.
- 17 We already owned the property up in that area
- 18 in Carolina Park.
- 19 Q: And just like in Carnes Crossroads, you bought
- 20 that property and then Trident applied and then
- 21 you applied about a couple of months after,
- 22 right, or four?
- 23 A: That's correct.
- 24 Q: And am I correct that the justification for the
- 25 Roper Mount Pleasant Hospital project was

1 booming population growth, patient redirection
2 of Roper, you know, Roper patients and then a
3 modest, or in this case about a 30 percent
4 market share pickup; does that sound about
5 right?

6 A: That sounds about right.

7 Q: So that's a pretty similar justification as in
8 Carnes except I think in Carnes Crossroads it
9 would be the justification was rather than a 30
10 percent market share increase, it was a ten
11 percent market share increase; is that right?

12 A: That's correct. And as I stated back as early
13 as 2004, we had that discussion. Both areas
14 were very similar. We had significant market
15 share in those areas even though they were
16 distant to downtown, and so it was a very
17 similar planning process on both of those.

18 Q: Let me ask you this. Do you think Roper has a
19 higher market share in the zip codes around the
20 lake or in the zip codes that kind of, you know
21 --

22 A: In the south?

23 Q: Yeah.

24 A: The market share is higher in the zip codes
25 around the lake. The raw number of patients

1 seen is significantly higher in the southern
2 zip codes.

3 Q: Now, I think you've told me, before that you
4 actually had a hand in the patient utilization
5 projections for the Mount Pleasant CON
6 application; is that right?

7 A: I did.

8 Q: And you would've worked with a health planner
9 to do the B11 section in that case?

10 A: Yes, Mark Richardson did the B11.

11 Q: Mark Richardson, he is who?

12 A: He is our expert in healthcare utilization from
13 Richardson Knapp.

14 Q: And he's actually going to testify in this
15 case, isn't he?

16 A: He is.

17 Q: Now, when you do a patient utilization
18 projection, you would agree with me that you
19 look at population, look at market share data,
20 and utilization, correct?

21 A: What we look at is population, the use rate of
22 inpatients per thousand, and then we further
23 decompose that into use rate by service line,
24 and make an assumption of which service lines
25 we will serve within that facility, look at the

1 use rate appropriate to that service line, and
2 then make a projection of the market that we'll
3 capture related to that.

4 Q: Is that what you did in the Mount Pleasant CON
5 application?

6 A: That was my initial analysis before we filed
7 the application, yes.

8 Q: Okay. But you'd agree with me, what you just
9 said, that doesn't appear anywhere in the
10 application or the Carnes Crossroad
11 application, correct?

12 A: Because what I did was a service demand
13 analysis compared to Mark's. Mark's analysis
14 was truly utilization of that facility based on
15 redirection and market growth. Two different
16 ways of looking at it.

17 Q: Go to Joint Exhibit 8 for me. I'm going to
18 show you a page from the Roper Mount Pleasant
19 CON application. Go to page 23, if you would.
20 Do you recall this? This is a service area
21 population growth for the Mount Pleasant CON.

22 A: I do.

23 Q: You'd agree with me that the service area
24 population was projected based on a, kind of a
25 zip code basis, correct?

- 1 A: It is.
- 2 Q: And that wasn't done in the Roper Carnes
- 3 Crossroads application, was it?
- 4 A: It wasn't.
- 5 Q: Now, at the time you made the projection, I
- 6 mean, this wasn't your first -- Roper St.
- 7 Francis Mount Pleasant CON wasn't your first
- 8 kind of greenfield hospital CON application,
- 9 was it?
- 10 A: It was the first CON application I had done for
- 11 a greenfield project. In Texas and Oklahoma,
- 12 we had no certificate of need process.
- 13 Q: Had you ever done a -- I think you told Mr.
- 14 Long that you had participated in the, I guess
- 15 a start up of some greenfield hospitals?
- 16 A: Uh-huh.
- 17 Q: Maybe on one or two occasions?
- 18 A: Actually, four occasions.
- 19 Q: Four occasions, okay. So you would've done
- 20 demand analyses for those, right?
- 21 A: I did.
- 22 Q: And so, and then did you actually see them to
- 23 fruition? I mean, did you see the hospital
- 24 actually come out of the ground and begin
- 25 operation?

- 1 A: I did.
- 2 Q: So at the time you did the Roper St. Francis
3 Mount Pleasant application, you were well aware
4 of the assumptions that would need to be made
5 for how long it takes a hospital to ramp up and
6 begin operations, correct?
- 7 A: I would.
- 8 Q: I think Mr. Long maybe said something that
9 hospitals aren't like Walmarts where people
10 just wait in a parking lot, isn't that right?
- 11 A: Uh-huh.
- 12 Q: They're not Apple stores, right?
- 13 A: Right.
- 14 Q: You have to answer audibly, I'm sorry.
- 15 A: I said right.
- 16 Q: Okay. And so you know that hospitals aren't
17 going to be full on day one or day 50 or day
18 365, right?
- 19 A: That's correct.
- 20 Q: That's why in these hospital utilization
21 forecasts you actually show what the ramp up
22 time's going to be, isn't it? So in year one
23 you're going to say maybe 28 patients, year two
24 -- on average --
- 25 A: Uh-huh.

1 Q: -- ADC. Year three -- or excuse me, year two
2 might be 45, and year three might be 56,
3 correct?
4 A: Those could be numbers, yes.
5 Q: But you're aware of the ramp up, right?
6 A: Yes.
7 Q: You're aware of the time it takes to get
8 Medicare certification, too, right?
9 A: We are.
10 Q: And you're aware of the time it takes to
11 develop a medical staff, right?
12 A: Not always, but we make estimates on that.
13 MR. THOMAS: Go to Joint 8 on page 217 for me. And
14 this will be Trident 9128 for the record. Just
15 do that top line for me.
16 Q: This is the venue projection for the Mount
17 Pleasant Hospital, correct?
18 A: That's correct.
19 Q: And so you've got the first three years. I
20 think you've got the patient days of 10,083 for
21 2009, correct?
22 A: Uh-huh.
23 Q: And then it ramps up to sixteen thousand, looks
24 like, one hundred and thirty-three in 2010,
25 correct?

- 1 A: Yeah. Yes.
- 2 Q: And then by year three, 20,168.
- 3 A: That's correct.
- 4 Q: Okay. And that's what you and Mr. Richardson
- 5 projected would be the ramp up, right?
- 6 A: That was our estimate of the ramp up, yes.
- 7 Q: But the actual, the actual year one for Roper
- 8 St. Francis Mount Pleasant was on the order of
- 9 nine or ten patients a day for an ADC?
- 10 A: Uh-huh. I think so.
- 11 Q: So it was a little less than 3,000; is that
- 12 right?
- 13 A: Right at 3,000 patient days, yes.
- 14 Q: So it's fair to say that you and Mr. Richardson
- 15 knowing all you know about health planning,
- 16 knowing how to do demand service forecast,
- 17 knowing what the ramp up times are, y'all
- 18 missed by 300 percent, didn't you?
- 19 A: We missed the mortgage meltdown, yes. We saw
- 20 the growth rate in that into Mount Pleasant
- 21 slow dramatically, and as a result there have
- 22 been fewer physician practices located into
- 23 that area. If the question is do I think that
- 24 that hospital will ramp up, it will, there's
- 25 nowhere else for the growth in Mount Pleasant

1 to go.

2 Q: How many physician practices did Roper close
3 down because of the mortgage meltdown?

4 A: I don't think we've closed any physician
5 practices. We certainly consolidated some.

6 Q: You've opened two -- you've actually acquired
7 about, or employed, 200 doctors, correct?

8 A: We employ 200 physicians, yes.

9 Q: As far as the mortgage meltdown goes, I mean,
10 you just said, if I heard you right, the
11 healthcare demand is inelastic, right?

12 A: As long as there is a population there for
13 which that demand to be derived from.

14 Q: And Mount Pleasant is a -- I mean, the
15 justification for the CON was a booming
16 population, correct?

17 A: It is.

18 **THE COURT:** Mr. Thomas, I understand the definition
19 of inelastic, but can you put it in different
20 words so that somebody looking at this record
21 will know immediately what you mean?

22 **MR. THOMAS:** Sure.

23 Q: Mr. Bowling, would you explain for the court
24 what inelastic demand is?

25 A: It means that the demand doesn't go up or down

1 as it relates to another economic factor, and
2 in this case it's related to supply and price.
3 You know, if -- very simplistic, if you have
4 the price of tennis shoes drops significantly,
5 the demand is going to go up, more people are
6 going to purchase tennis shoes. If we drop the
7 price on open heart surgery, I don't think
8 we'll get a single additional open heart
9 surgery within the Tri-county.

10 **MR. THOMAS:** Did that do it for you, judge? Put up
11 Petitioner's 128 for me, Ms. Tyer.

12 Q: This is an email from you to Mr. Dunlap,
13 correct, the bottom portion?

14 A: It is.

15 Q: Mr. Dunlap I think we've established he is the
16 CEO of the Roper St. Francis system, correct?

17 A: That is correct.

18 Q: And would go to the next page for me. So this
19 says Roper St. Francis Healthcare 2008 Business
20 Plan Summary; is that right?

21 A: That's correct.

22 **MR. THOMAS:** Now, would you go to page seven of this
23 document?

24 Q: Mr. Bowling, if something's not clear on the
25 screen, if you'd just tell me we can get you

1 the hard copy.

2 A: Okay.

3 Q: And this is Roper Berkeley 3252 for the record,

4 and this is the zip code for Goose Creek,

5 correct?

6 A: That is correct.

7 Q: And there's some demographic information on

8 this page?

9 A: Uh-huh.

10 Q: And so you've got the population, you've got

11 the, looks like a population projection, and

12 then you've got the average household income

13 for Goose Creek, correct?

14 A: That's correct.

15 Q: And that's for 2007, isn't it?

16 A: It is.

17 Q: It's gone up since then, hasn't it?

18 A: I haven't seen since then to be honest.

19 Q: That's fair, fair enough. You've got here

20 Goose Creek has long been a fast growing town

21 with almost 30 percent population growth since

22 1990, right?

23 A: That's correct.

24 Q: And you would agree with me that Goose Creek in

25 southern Berkeley County has been kind of the

1 population center of Berkeley County for a long
2 time, hasn't it?

3 A: It has.

4 Q: Now, population's young, and then you've got
5 the 4.1 percent unemployment year. That was in
6 2007, right?

7 A: That's correct.

8 Q: Do you think that's changed at all in the last
9 four years?

10 A: I believe it's closer to nine percent right
11 now.

12 Q: And that nine percent number, just for the
13 record, that's probably more for Berkeley
14 County as a whole, isn't it?

15 A: It is.

16 Q: And then, you know, 28 percent have household
17 income of 25,000 to 50,000 and 26 percent have
18 household income of 50 to 75, right?

19 A: Yes.

20 Q: Now, the same document, there's a lot of
21 redacted pages in here, but if you'd go to page
22 38 for me.

23 THE COURT: What exhibit is this again, please?

24 MR. THOMAS: This is Petitioner's 128, Your Honor.

25 Q: This is hard to see, but let's see if we can

1 work through this one.

2 A: Okay.

3 Q: This is -- what that is is a satellite

4 photograph of Carnes Crossroads, correct?

5 A: It was. Yeah.

6 Q: And it's got some action steps there, and I

7 tried my best to discern these, and --

8 A: Okay.

9 Q: -- I believe the first one says file a CON to

10 relocate ORs from Moncks Corner.

11 A: That's correct, filing a CON to relocate.

12 These were, I'm sure, presented either early

13 2008 or late 2007 to the board, and it's

14 talking about what our next action steps will

15 be in Carnes Crossroads. So the first is the

16 filing of the CON to relocate the ORs from

17 Moncks Corner. Syndication of that ambulatory

18 surgery center from the physician support that

19 we were receiving for the move. That looks

20 like A and E --

21 Q: Construction begins?

22 A: Begins. And after that I can't help you.

23 Q: I think it says MOB physician development?

24 Does that look like --

25 A: Probably.

1 Q: And then the last one is determine scope of
2 diagnostics.

3 A: Scope of diagnostic imaging, yes.

4 Q: And just for the record, syndication, I believe
5 you told me earlier, was that that means that
6 the physicians were going to get 49 percent of
7 the ASC, and then --

8 A: Up to 49 percent. We were looking at
9 partnering with a number of surgeons on that
10 facility.

11 Q: And just for the record, on this slide here and
12 for the 2008 business plan, it doesn't say
13 anything about filing a CON application for a
14 new hospital, does it?

15 A: No, those were truly our very next steps after
16 purchasing the land.

17 Q: And you would agree with me that if Roper
18 doesn't protect its current business structure,
19 then it's a difficult -- it's difficult to
20 recapitalize existing assets and continue to
21 serve your patients, right?

22 A: Yes.

23 Q: If we go to Petitioner's 88, we talked a little
24 about this, but I just wanted to touch on this.
25 This is the purchase and sale agreement for

1 Carnes Crossroads, correct?

2 A: Yes.

3 Q: I think Mr. Long and you went through it a

4 little bit, but I just want to drill down in a

5 couple of areas here. And just for the record,

6 you actually helped negotiate the language in

7 this agreement, right?

8 A: I did.

9 Q: I think we said it was executed by Mr. Dunlap

10 sometime in July of 2010?

11 A: Early, middle of July, yes.

12 Q: Now, the timing of when Roper St. Francis was

13 going to actually build its hospital in

14 Berkeley County was pretty important because

15 right about 2008 you knew that Roper St.

16 Francis Mount Pleasant, that hospital was going

17 to start construction up about then, right?

18 A: We did, uh-huh.

19 Q: And that was about \$150 million project, right?

20 A: Yes, it was.

21 **MR. THOMAS:** If you'd go to page -- go back one.

22 I'm sorry. Yeah.

23 Q: All right. Let's see if we can maybe magnify

24 section B and all the points below. Is that

25 better, Mr. Bowling?

- 1 A: That is fine, yes.
- 2 Q: In terms of -- I believe the first thing you
- 3 had to do was that within six months you had to
- 4 do the -- submit a CON for the ambulatory
- 5 surgery center; is that right?
- 6 A: That's correct.
- 7 Q: And that's something y'all actually did,
- 8 correct?
- 9 A: We did.
- 10 Q: But then you decided not to because Trident had
- 11 applied for its CON, right?
- 12 A: When Trident announced they were going to build
- 13 a hospital in Moncks Corner and we wanted to
- 14 get in the same planning cycle, it no longer
- 15 made sense to phase into that development, but
- 16 just to go ahead and put a hospital there,
- 17 which we were planning on doing ultimately
- 18 anyway.
- 19 Q: Well, so I guess why didn't you just keep on
- 20 with the ASC plan to transfer the three ORs
- 21 down if you're going to build a hospital
- 22 anyway?
- 23 A: We looked at that, and didn't feel that having
- 24 seven operating rooms on that site was probably
- 25 good planning for us.

1 Q: Okay. But that's what was going to be the
2 result anyway if you --

3 A: Yeah, once we had -- if we had phased it and
4 had a syndicated ASC and built a medical staff
5 there and then had beds, by that time we
6 could've supported the seven ORs.

7 Q: Because that was the plan, right, was to phase
8 it?

9 A: It was.

10 Q: And the phasing is actually described right in
11 here, isn't it, on looks like part B, little in
12 parenthesis three here?

13 A: Yes.

14 Q: It says the purchaser shall file all of the
15 necessary documents to apply for the hospital
16 CON for the construction of an acute care
17 hospital by the earlier of December 31, 2015 or
18 the later of six months of the determination
19 that the residential benchmark as defined below
20 has been achieved and January 1, 2012, correct?

21 A: That's correct.

22 Q: And that's just a legal mumbo jumbo garbled way
23 of saying at the earliest January 2012, if
24 you've got a residential benchmark, and the
25 later of December 31, 2015, right?

- 1 A: And as I said, we negotiated and tried to get
2 those dates out to the point that we knew would
3 give us plenty of leeway. The developer really
4 pushed us to apply sooner than that.
- 5 Q: But this is the timeline you came up with,
6 correct?
- 7 A: It is.
- 8 Q: And this isn't -- this isn't begin construction
9 of a hospital by January of 2012, this is apply
10 --
- 11 A: That's correct.
- 12 Q: -- for a CON for a hospital, correct?
- 13 A: That's correct.
- 14 Q: The same with the 2015. It's not -- if the
15 residential benchmark hadn't been hit, it's you
16 would have to apply for a CON by December 31st?
- 17 A: That's correct.
- 18 Q: A residential benchmark, that's 1,700 homes,
19 correct?
- 20 A: Rooftops, yes.
- 21 Q: And today, you would agree with me, there are
22 no rooftops at that location?
- 23 A: That's correct.
- 24 Q: And so Roper would be under no obligation today
25 to actually file for a CON at that location

1 under this agreement?

2 A: Under that agreement we would be under no
3 obligation.

4 Q: And residential development was important to
5 Roper, because, obviously, you want to locate
6 in Carnes Crossroads because you want somebody
7 to be there, right, to actually to use the
8 facility?

9 A: Well, you know, Carnes Crossroads is the
10 development itself, and it only encompasses
11 about a half mile any direction from that
12 hospital site. There's already significant
13 population near Carnes Crossroads to support a
14 hospital.

15 Q: But not so much that you didn't keep that
16 residential benchmark threshold out of the
17 purchase or sale agreement, right?

18 A: No.

19 Q: And you'd agree with me that under this
20 agreement Roper has no obligation to apply for
21 or build a hospital in Carnes Crossroads with
22 the only penalty being that it would lose its
23 exclusive provider status, correct?

24 A: That's correct. Our desire to build there was
25 based on a nine million dollar purchase that

1 we'd already made and then didn't see any
2 reason to delay moving forward with that.

3 Q: Well, what you've got, you've got the timeline
4 here, right?

5 A: That's the contractual agreement with Carolina
6 Park, yes.

7 Q: Right.

8 A: I mean, sorry, Carnes Crossroads.

9 Q: Do you have an agreement with Carolina Park,
10 too?

11 A: We did.

12 Q: Well, what we do know is that Trident applied
13 and that caused Roper St. Francis to basically
14 announce in about three weeks time that it,
15 too, was going to go ahead and build in
16 Berkeley County as well; is that right?

17 A: That's correct.

18 Q: Now, we've heard a lot about the patients who,
19 I think you said, drive out of Berkeley County
20 to either Bon Secours St. Francis or Roper's
21 downtown hospital, correct?

22 A: That's correct.

23 Q: But you would agree with me that not enough
24 people drive out of the county to Bon Secours
25 or to Roper Downtown to give Roper an actual

1 bed need in the State Health Plan, would you?

2 A: Well, I don't know that people driving out of
3 Berkeley County has anything to do with the
4 facility bed need at Roper.

5 Q: Well, I mean, if there were so many more
6 patients driving out of Berkeley County to use
7 your facilities, that would increase your
8 utilization, correct?

9 A: If our utilization were higher, whether it came
10 from Berkeley County or Georgetown, then that
11 would help to eliminate any bed excess there.

12 Q: And you're actually trying to increase your
13 utilization from Georgetown, aren't you?

14 A: We are, yeah.

15 Q: You've got physician practices in Murrells
16 Inlet, don't you?

17 A: We do.

18 Q: You employ cardiologists up there, don't you?

19 A: We do.

20 Q: And those cardiologists, they send patients
21 down for interventional cardiology to Roper St.
22 Francis Downtown, don't they?

23 A: They split right now between Grand Strand and
24 Roper Downtown.

25 Q: So they split between a facility that's 83

1 miles away and one that's 20 miles away, right?

2 A: That's true.

3 Q: I think it's fair to say and you'd agree with
4 me that market share growth is very important
5 to Roper St. Francis, isn't it?

6 A: I think market share growth is important to any
7 healthcare system, and if it weren't, then Mr.
8 Rardin and I would not have positions.

9 Q: Well, that's something that you monitor very
10 closely though, correct?

11 A: It is.

12 Q: And in 2008 when Roper applied I guess in
13 December, after it found out about Trident's
14 application, and at that time Roper had an
15 aggressive, from a strategic standpoint, they
16 had an aggressive growth position, correct?

17 A: Yes, I mean, we call it aggressive growth
18 strategy or strong growth strategy. I think
19 it's pretty much semantics between Mr.
20 Gallati's definition of a strong growth
21 strategy and ours of an aggressive growth
22 strategy.

23 Q: And this is an email, I believe, from Elizabeth
24 Player and it's to Mr. Dunlap, you, Allen
25 Carroll and Mr. Severance, correct?

- 1 A: Yes.
- 2 Q: Just for the record, Mr. Severance is in the
- 3 room today, isn't he?
- 4 A: He is.
- 5 Q: If you go to -- well, go to the next page.
- 6 Just for the record, this is Petitioner's 136
- 7 and so we've got your Roper St. Francis'
- 8 strategic position right here, correct?
- 9 A: That is correct.
- 10 Q: And this was back in, looks like 2008, right?
- 11 Well, actually this is 2007, the end of 2007,
- 12 wasn't it?
- 13 A: It is.
- 14 Q: So back in 2007 Roper was the market leader in
- 15 the primary service area, right?
- 16 A: Roper St. Francis Healthcare was, yes.
- 17 Q: Thank you. And the primary service area, for
- 18 the record, for Roper, for Roper St. Francis
- 19 Healthcare, is Berkeley, Dorchester and
- 20 Charleston Counties, correct?
- 21 A: It is.
- 22 Q: If you'd go to the next page for me.
- 23 A: And just for clarification, Mr. Thomas.
- 24 Q: Yes?
- 25 A: In that slide we say primary service area, and

1 then there's a difference between that and the
2 service area. The primary service area for
3 Roper St. Francis Healthcare is about 18 zip
4 codes in the Tri-county. It does not include
5 all of the zip codes in the Tri-county.

6 Q: That's fair enough. And the last bullet here
7 just on the page, well the two last, you've got
8 the financial performance significantly above A
9 rated medians, and the last one is aggressive
10 growth strategy, correct?

11 A: That's correct.

12 MR. THOMAS: If you'd go to the next page for me,
13 Sara.

14 Q: Now, this is the 2008 SWOP analysis, right?

15 A: It is.

16 Q: And SWOP stands for strengths, weaknesses,
17 opportunities, and threats, correct?

18 A: It does.

19 Q: So the strengths, you've got financial
20 performance, geographic distribution, among
21 others; and weaknesses, the first bullet point
22 there is healthcare labor shortages, correct?

23 A: It is.

24 Q: And in your threats -- well, one of the
25 opportunities you have is secondary market

- 1 development, correct?
- 2 A: That's correct.
- 3 Q: Is that in those counties outside of the Tri-
- 4 county area?
- 5 A: It is.
- 6 Q: That's your secondary market, okay. Under
- 7 threats you have MUSC, right, competition and
- 8 expansion; is that correct?
- 9 A: That's correct.
- 10 Q: And you've got some declining reimbursement as
- 11 well; isn't that right?
- 12 A: That's correct.
- 13 Q: But Trident is not listed as a threat in here,
- 14 is it?
- 15 A: They're not in the 2008 analysis.
- 16 Q: Okay. Now, I think we pretty well established
- 17 Trident submitted its application on August 13,
- 18 2008. Does that sound right?
- 19 A: I thought it was the 12th, but I'll go with the
- 20 13th.
- 21 Q: I think it's stamped on the 13th.
- 22 **MR. THOMAS:** Could you go to Petitioner's 125 for
- 23 me, Sara?
- 24 Q: And I believe on August 12th, this is a memo
- 25 sent out from you to Mr. Dunlap, correct?

1 A: Yes.

2 Q: And it's sent to all the board members or all
3 the boards of directors that are kind of
4 affiliated with Roper St. Francis; is that
5 right?

6 A: It's sent to the members of each of our
7 different boards, yes.

8 MR. THOMAS: And, Sara, if you can enlarge this area
9 around underneath Trident announcement.

10 Q: So this indicates here that you just basically
11 tell them that Trident Regional Medical Center
12 announced late Friday, August 8th, of its
13 intent to submit a CON, correct?

14 A: Correct.

15 Q: And you say in the third paragraph Roper St.
16 Francis Healthcare has elected to reserve
17 comment on Trident's proposed project until
18 we've had the opportunity to review the
19 complete CON application; is that right?

20 A: That's it, correct.

21 Q: And it says determine its impact, if any, on
22 current Moncks Corner facility as well as our
23 future plans in Berkeley County, right?

24 A: Correct.

25 Q: I'd like you, if you would, would you read the

1 fourth paragraph for me?

2 A: "In the meantime, it's important to know that
3 the new State Health Plan, which goes to the
4 DHEC Board for approval Thursday, August 14th,
5 indicates a bed need for only two of seven Tri-
6 county hospitals; 56 beds for Trident Regional
7 Medical Center, and another 24 for Trident
8 Summerville Medical Center. Note, bed need is
9 determined based on current utilization at each
10 facility and offers additional beds to handle
11 existing patient volumes projected forward."

12 Q: So you thought that was important for these
13 boards to know, correct?

14 A: That's correct. It's so they know the basis of
15 where those beds were coming from.

16 Q: Well, you also knew that it was important for
17 the boards to know because you knew it was
18 going to be hard for Roper to justify its
19 project because it didn't have a bed need,
20 correct?

21 A: Our project's not based on bed need in any form
22 or fashion.

23 Q: Well, why did you think it was important for
24 your board to know that Trident had a bed need?

25 A: What we were telling the board is that the

- 1 Moncks Corner project related to the bed need
2 that existed at Trident and Summerville.
- 3 Q: Well, why would that make a difference?
- 4 A: It's by what means they were creating that
5 project.
- 6 Q: But why does that make a difference for your
7 board to know?
- 8 A: It was just to inform them.
- 9 Q: But you thought it was important for them to
10 know that, right?
- 11 A: We did.
- 12 MR. THOMAS: Sara, would you go to petitioner's 119
13 for me?
- 14 THE COURT: What was the last exhibit? Was that
15 still 136?
- 16 MR. THOMAS: 125, Your Honor.
- 17 THE COURT: This is?
- 18 MR. THOMAS: This is Petitioner's 119, Roper
19 Berkeley 2840.
- 20 Q: Okay. This is a new -- this is an email from
21 Tricia Crimminger to you, among others, that's
22 got the news release, right?
- 23 A: That's --
- 24 Q: I'm sorry.
- 25 A: Is that the attachments? Yes, they are.

1 Q: And this fourth paragraph there, it says,
2 "Currently Berkeley County is one of only five
3 counties in South Carolina without a hospital.
4 Roper St. Francis would like to change that and
5 address this very real need in a growing and
6 vibrant community, said Dunlap." Is that
7 correct?

8 A: That's correct.

9 Q: And the date of this for immediate release,
10 Thursday, September 4, 2008 --

11 A: Yes.

12 Q: -- is that right? Now, but you knew at this
13 time that Trident had applied for a 50 bed
14 hospital in Berkeley County, correct?

15 A: We did.

16 Q: Now, between I guess August 12th, that letter
17 that went out to the board of directors, you
18 know, announcing Trident's project, and this
19 day, September 4th -- yeah, September 4th,
20 there were probably a lot of meetings and
21 discussions about Trident's project, right?

22 A: Quite a few.

23 Q: And as far as this announcement goes, you would
24 agree with me by September 4th that there had
25 been no detailed financial analysis prepared of

1 what a hospital in Carnes Crossroads would look
2 like?

3 A: No, but we knew the book of business we had in
4 Berkeley County. We knew our history with the
5 market share there. So it didn't require a
6 significant analysis to figure out that it was
7 an important project for us.

8 Q: But no financial pro formas had been done at
9 this point, right?

10 A: Nothing with revenue and costs associated.

11 Q: No ROI or hurdle rate study or anything like
12 that; is that fair to say?

13 A: That's correct.

14 Q: Now, are you a member of what Mr. Dunlap refers
15 to as his senior staff?

16 A: I am.

17 Q: Who else is on the senior staff?

18 A: The CEOs of the three hospitals, Matt
19 Severance, Allen Carroll, John Sullivan; their
20 chief nurse executives, which Matt's is Lisa
21 Irvin, Allen's is Penny Peralta, John's is
22 Diana Topjian. Our general counsel is on
23 senior staff, myself, the chief medical
24 officer, the vice-president of admission, and
25 now the chief quality officer.

1 Q: So a pretty sophisticated group of people with
2 a lot of healthcare knowledge, correct; is that
3 fair to say?

4 A: I would say so.

5 MR. THOMAS: And put Petitioner's 143 up, if you
6 would.

7 Q: And this is an email I guess from Bryan Cox to
8 David Dunlap, and it attaches the minutes of
9 the August 12, 2008 senior staff meeting.

10 A: Uh-huh.

11 MR. THOMAS: And would you go to the next page,
12 Sara?

13 Q: And this has got present, David Dunlap, Mr.
14 Carroll, a bunch of those folks that you just
15 mentioned, including you, right?

16 A: Yes.

17 MR. THOMAS: Let's go to the next page. And if you
18 would blow that up a little bit for the court
19 and the witness. Thank you.

20 Q: And so there's a call to order about 8:32 in
21 the morning, correct?

22 A: Correct.

23 Q: And number three there, Trident issues, and it
24 says discussion about article in August 9, 2008
25 issue in the *Post and Courier* --

- 1 A: Uh-huh.
- 2 Q: -- about Trident's proposed new hospital in
3 Berkeley County. And the *Post and Courier* is
4 kind of the main paper down there in
5 Charleston, right?
- 6 A: It is.
- 7 MR. THOMAS: Sara, would you go to the next page?
8 And blow this up.
- 9 Q: These are action items. And so we've got four
10 --
- 11 A: These are discussion items, not action items.
- 12 Q: Okay. Fair enough. So the four bullets that
13 you have here are Roper St. Francis may
14 consider whether to contest the CON, correct?
- 15 A: Correct.
- 16 Q: Contesting new hospital may result in negative
17 community reaction. That's number two, right?
- 18 A: That's correct.
- 19 Q: Other affected parties may also appeal. That
20 would be someone like MUSC or East Cooper
21 Regional Medical Center?
- 22 A: Correct.
- 23 Q: And then read the fourth one for me.
- 24 A: RSFH could educate DHEC on lack of need for new
25 hospital in Moncks Corner without formally

1 opposing it.

2 Q: So RSFH for the record is Roper St. Francis --

3 A: Healthcare.

4 Q: -- Healthcare. Okay. So that means that
5 number four that you go up to Columbia or you
6 get on the phone with someone like Ms. Brandt
7 and you tell her, look, we don't want to oppose
8 this thing, but we don't think there's a need
9 for a hospital in Moncks Corner, right?

10 A: That was one of the things we talked about.

11 Q: So even though Roper is telling the state
12 publicly that there's enough need for two
13 applications in Berkeley County, here you are,
14 your senior staff at Roper St. Francis
15 Hospital, behind closed doors saying, well, one
16 of the things we could do is we could educate
17 DHEC that there's a lack of need in Moncks
18 Corner..

19 A: And I certainly don't know who that stream of
20 consciousness came from, but we throw a lot of
21 ideas up at senior staff. That's part of what
22 we're paid to do, and some of them are good and
23 some of them are not good.

24 Q: These are four bullets that came out of this
25 meeting --

- 1 A: Uh-huh.
- 2 Q: -- discussion items. First of all, there's
- 3 nothing on here about go ahead and file a
- 4 hospital in Berkeley County, is there? That's
- 5 not a discussion --
- 6 A: Not at this meeting, not in these notes, no.
- 7 Q: That's right. And that's because y'all, Roper
- 8 St. Francis, wasn't ready to file a -- to build
- 9 a hospital in Berkeley County, correct? I
- 10 mean, you were just coming out of ground in
- 11 Mount Pleasant, right?
- 12 A: On August 12th, no, we were not ready to start
- 13 construction.
- 14 Q: Well, I guess the question I have for you, Mr.
- 15 Bowling, is this. If there's not enough need
- 16 for a new hospital in Moncks Corner but there's
- 17 enough need for two hospitals in Berkeley
- 18 County, where do you think the second one
- 19 should go?
- 20 A: I don't know that I -- I certainly see no
- 21 evidence that there's not enough need for a new
- 22 hospital in Moncks Corner, other than a casual
- 23 comment that was made in senior staff.
- 24 Q: Other than --
- 25 A: There's no analysis that accompanies that.

1 Q: Other than this is the most sophisticated
2 healthcare administrators at Roper St. Francis
3 in a room discussing the reaction to Trident's
4 hospital in Berkeley County, correct?

5 A: That is correct. And somebody said could we
6 demonstrate there's not enough need up there in
7 Moncks Corner.

8 Q: Mr. Bowling, you hadn't actually reviewed
9 Trident's CON application prior to making -- to
10 Roper St. Francis making the decision to apply
11 for a new hospital in Moncks Corner, had you?

12 A: No, we hadn't.

13 Q: And you would say, I think you just admitted
14 this, but you would agree with Mr. Dunlap, who
15 is very well compensated, he is fairly
16 sophisticated in the healthcare world, isn't
17 he?

18 A: He's very sophisticated in the healthcare
19 world.

20 MR. THOMAS: Would you put up Petitioner's 137 for
21 me?

22 THE COURT: Who sent that email?

23 MR. THOMAS: Oh, let's go back. This is from, I
24 guess at the top, David Dunlap to Bryan Cox,
25 Your Honor. And then at the bottom it's from

1 Bryan Cox to David Dunlap.

2 Q: Do you recall this slide presentation? Because
3 I think you referenced it in your testimony
4 with Mr. Long. It would have been from August
5 25, 2008 board meeting.

6 A: Yes.

7 Q: And this says Berkeley County Trident
8 Healthcare CON, correct?

9 A: It does.

10 Q: And for the record, it's Roper Berkeley 3551 in
11 Petitioner's Exhibit 137. Go to the next page.

12 So this is a brief rundown. Let me ask
13 you this. Did you create this document?

14 A: I did. Yeah.

15 Q: So do a brief rundown on Trident's application
16 for a 50 bed acute care hospital on 21 acres,
17 and you've got the projections down there.

18 A: Uh-huh.

19 Q: Go to the next page. And you've got the
20 location, basically where the Moncks Corner --
21 that Trident's Moncks Corner facility is,
22 correct?

23 A: Yes.

24 Q: And you've also put Roper on there, right?

25 A: That's correct.

- 1 Q: The next one. And then I think this is just a
2 kind of a Google map. It's a satellite --
3 A: It's an ariel view of the same information.
4 Q: Let's go to the next one. And then you've got
5 possible responses to CON, correct?
6 A: Right.
7 Q: So says, first bullet, do nothing.
8 A: That's correct.
9 Q: Second one is file as an affected party in
10 opposition with the intent to appeal if
11 granted, correct?
12 A: That's correct.
13 Q: What would the basis of the opposition have
14 been?
15 A: You know, I don't know. I don't know that we
16 went that far into our thinking. It's just
17 these are the regulatory steps we could take at
18 this point.
19 Q: And then you've got the third one there. Would
20 you read that one?
21 A: File a competing application for a new 50 bed
22 hospital at Carnes Crossroads.
23 Q: And this was presented to the Roper St. Francis
24 Hospital Board, correct?
25 A: It was, at the end of August of 2008.

1 Q: And you were familiar with the CON regulations,
2 weren't you?

3 A: I am.

4 Q: Well, at the time you were on the State Health
5 Planning Committee, right?

6 A: That's correct.

7 Q: You still are on today, aren't you?

8 A: I am.

9 Q: You put this slide presentation together,
10 didn't you?

11 A: I did.

12 Q: And you said file a competing application for
13 a new 50 bed hospital in Carnes Crossroads,
14 didn't you?

15 A: I did.

16 Q: And you knew what competing application meant?

17 A: I did, but this was a presentation for the
18 board, and as we explained it to them, you
19 know, we would want to get in the same planning
20 cycle. We didn't know if they would be
21 competing or not, but we were going to
22 certainly compete for DHEC's attention within
23 that planning cycle.

24 Q: Mr. Bowling, you didn't do nothing, did you?

25 A: No, we didn't. We had already purchased a nine

1 million dollar piece of property.

2 Q: You didn't file as an affected party in
3 opposition with the intent to appeal if
4 granted.

5 A: That's correct.

6 Q: You filed what you thought was a competing
7 application for a new 50 bed hospital, correct?

8 A: We felt that if we applied, DHEC could deem
9 them competing. We didn't believe they were.

10 Q: Well, you knew DHEC could deem them competing
11 because as we just saw on the slide, you
12 didn't think there was a need for a hospital
13 in Moncks Corner, correct?

14 A: I don't know that you attributed that comment
15 to me.

16 Q: Okay. Well somebody on your senior staff said
17 that.

18 A: Somebody in senior staff when who knows how
19 much knowledge they had on it made that
20 suggestion.

21 Q: We'll let the document speak for itself. I
22 think Mr. Long showed you a slide, the Roper
23 St. Francis DHEC record, just the internal
24 analysis that Roper conducted showed that
25 utilization in Moncks Corner at this Moncks

1. Corner site would not justify the expense for
2 a hospital, correct?

3 A: For Roper St. Francis Healthcare, when we
4 looked at Moncks Corner itself, we couldn't
5 justify building a hundred bed hospital, and
6 that was the analysis that we did based on the
7 comments that were coming from DHEC. And it
8 was pretty clear in our presentation to the
9 Moncks Corner Advisory Board and the officials
10 that's exactly what we said, that we could not
11 support a hundred bed hospital.

12 MR. THOMAS: Okay. Put up the Roper St. Francis in
13 Joint 2, and I need you to go to the DHEC
14 record page 1178.

15 Q: Now, this doesn't say -- and the paragraph
16 below says in both cases -- well, the decision
17 to place inpatient services in Goose Creek
18 rather than Moncks Corner was based on both
19 internal and external market analyses, correct,
20 Mr. Bowling?

21 A: That's correct.

22 Q: It says in both cases Moncks Corner population
23 and growth would not support the invasion of
24 volume required to justify the expense,
25 correct?

1 A: That's correct.

2 Q: It doesn't say justify the expense of a hundred
3 bed hospital, it says justify the expense. And
4 in this case you were building a 50 bed
5 hospital, correct?

6 A: That's correct.

7 Q: Now, I think you've told me before that the
8 study basically found a hospital would not be
9 financially feasible in Moncks Corner because
10 it wouldn't have a profit margin; do you recall
11 that?

12 A: I don't recall saying it wouldn't have a profit
13 margin. I said I don't believe it would cover
14 the capital expense needed to construct it.

15 Q: Okay. Well, I'm going to show you your
16 original deposition, certified here. I'll hand
17 that to you. And I direct your attention to
18 page 18. All right. And I'll tell you what,
19 I'll read the question, you read the answer
20 starting on line seven, okay?

21 A: Okay.

22 Q: Page 18. "Okay. Well, tell me about the early
23 analysis on a Moncks Corner that Mark did."
24 And for the record, that would be Mr.
25 Richardson, correct?

- 1 A: Correct.
- 2 Q: And what did you say?
- 3 A: "We asked him -- what we asked him to do was --
- 4 there was look at the potential of adding beds
- 5 to our existing site in Moncks Corner."
- 6 Q: I said, "Okay."
- 7 A: "And based on the population and the
- 8 utilization in the area, it was determined it
- 9 would have to be a very small facility and we
- 10 didn't think it would be financially viable."
- 11 Q: I said, "What does financially viable mean to
- 12 Roper St. Francis?"
- 13 A: "Profitable in three to four years."
- 14 Q: And I said, "Okay. So profitability is
- 15 important to Roper St. Francis?"
- 16 A: "Margin is important, yes."
- 17 Q: I said, "Why did you change the word? I asked
- 18 is profitability important."
- 19 A: "Profitability is margin."
- 20 Q: You said "yes" after that, correct?
- 21 A: That's correct. I paraphrased your comment.
- 22 Q: Well, you can keep that there. I guess the
- 23 question I would ask is you've told me before
- 24 that the study found that a hospital would not
- 25 be financially feasible in Moncks Corner

1 because it wouldn't have a profit margin,
2 correct?

3 A: I said something similar to that. I said
4 profit was important.

5 Q: And that was because Roper concluded that there
6 wasn't a need for a 50 bed hospital at that
7 location, right?

8 A: What we concluded is that we couldn't build a
9 50 bed hospital with there a 24 percent market
10 share in the county.

11 Q: Now, you would agree, and I think you've
12 already said this, that there were not detailed
13 pro formas done for a proposed Moncks Corner
14 hospital, correct?

15 A: That's correct.

16 Q: In fact, no financial study was ever performed
17 for a proposed Roper Hospital on Moncks Corner,
18 was there?

19 A: No, what we looked at was where those -- the
20 admissions to Roper St. Francis were coming
21 from from the county, and in the raw numbers,
22 it was clear that they were coming from the
23 south part of Berkeley County and we weren't
24 going to be able to redirect to a Moncks Corner
25 location.

1 Q: Okay. But no financial study was ever
2 performed for a proposed Roper Hospital in
3 Moncks Corner?

4 A: That's correct. We looked at a volume analysis
5 was really the only -- where we stopped.

6 Q: And then you eyeballed what you thought the
7 financial result would be from that, correct?

8 A: That's correct.

9 Q: Okay. Now, you would agree with me the
10 internal analysis that looked -- looking at
11 adding beds was going to be to Roper's existing
12 operation in Moncks Corner, correct?

13 A: Correct.

14 Q: Okay. And when Roper St. Francis first built
15 the outpatient facility in '92, in 1992, I
16 believe you told me that you knew there was
17 consideration at the time that hospital beds
18 would be added to the Moncks Corner location
19 once the population dictated that?

20 A: That's what I had heard, yes.

21 Q: And you also heard Mr. West in this courtroom
22 a couple of weeks ago state that Roper promised
23 the Moncks Corner community a hospital,
24 correct? You heard him say that, right?

25 A: I'm sure I did.

1 Q: Adding beds at the existing location in Moncks
2 Corner, wouldn't you agree, would be a much
3 less expensive alternative to a new hospital
4 because you've got -- of all the services
5 you've already got there?

6 A: Those services would have to be dramatically
7 reconfigured. I can't say whether it would be
8 less expensive or not.

9 Q: Well, I mean, Judge McLeod has -- he's been
10 involved in these hospital cases before where
11 they're just adding a 50 bed wing. Are you
12 telling me that adding a 50 bed wing at Roper
13 St. Francis Moncks Corner would be anywhere
14 close to a hundred million dollars?

15 A: I don't know. You know, there are no dietary
16 services there. The plant operations and the
17 lab is really a draw station with very few
18 tests. It would take a significant
19 infrastructure improvement to add beds to that
20 site.

21 Q: But you have a 50,000 square foot facility
22 there, correct?

23 A: We do.

24 Q: Got an ED there, right?

25 A: We do.

- 1 Q: You've got imaging there, correct?
- 2 A: That's correct.
- 3 Q: You've got three -- well, you've got MRI and
- 4 CT, right?
- 5 A: CT, MRIs and a mobile unit that comes in and
- 6 out.
- 7 Q: And then you've got three ORs there, correct?
- 8 A: We do, ambulatory.
- 9 Q: Are they built to hospital scale?
- 10 A: They're not.
- 11 Q: But you've never actually looked at how much it
- 12 would cost if you --
- 13 A: We haven't, correct.
- 14 Q: Now, wouldn't it be important to know, Mr.
- 15 Bowling, the actual expense on what that would
- 16 be to adding 50 beds to the current Roper St.
- 17 Francis Moncks Corner operation before telling
- 18 DHEC that the utilization wouldn't justify the
- 19 expense?
- 20 A: I mean, when we looked at the percent of
- 21 patients coming from around the lake in the
- 22 northern part of the county as compared to the
- 23 number of patients, raw patients, we had in the
- 24 south, there was no question that Carnes
- 25 Crossroads was financially more viable than us

- 1 going to Moncks Corner.
- 2 Q: That means it would make a lot more money for.
- 3 you there, right?
- 4 A: It means it would have a chance of making a
- 5 profit, yes.
- 6 Q: Now, you went up in 2008 I think -- and you and
- 7 Mr. Long may have maybe talked about this --
- 8 but you went up to Moncks Corner to explain to
- 9 the Roper Advisory Board, I think some
- 10 community leaders, and maybe even the Chamber
- 11 of Commerce why Roper St. Francis wasn't going
- 12 to build a hospital in Moncks Corner, right?
- 13 A: That's correct.
- 14 Q: And you showed them some slide presentations
- 15 comparing what the utilization would be at the
- 16 two different sites, Carnes Crossroads and
- 17 Moncks Corner, correct?
- 18 A: Yes.
- 19 Q: Okay. And you would agree with me that most
- 20 patients who use Roper Moncks Corner's
- 21 emergency department actually live in Moncks
- 22 Corner in the communities around the lake,
- 23 correct?
- 24 A: About, yes, I would say 80 percent of our
- 25 emergency department business comes from those

1 eight zip codes.

2 Q: It's closer to 85 percent, isn't it?

3 A: Could be.

4 Q: Let's quickly just go to Petitioner's 243 for
5 me. It's a summary exhibit that we did. I
6 don't know if you've had a chance to look at
7 this. This shows the different zip codes of
8 eastern and northern Berkeley County for the
9 year 2010.

10 A: Right.

11 Q: And it shows just for those zip codes the total
12 visits to the Moncks Corner ED for Roper was
13 12,164, right?

14 A: Yeah, that's from the ten zip codes, and I had
15 referred to the eight zip code area, but.

16 Q: But this is -- these are all Berkeley County
17 zip codes, right?

18 A: Those are all Berkeley County zip codes.

19 Q: And so the total amount being 14,382 ED visits.
20 That gives you 85 -- or about 84.5 percent
21 utilization, doesn't it?

22 A: That's correct.

23 Q: I think you and Mr. Long maybe put up an
24 exhibit that talked about Roper St. Francis
25 Moncks Corner transfers about 1,100 patients a

1 year from this ED down to either Roper St.
2 Francis Hospital Downtown or Bon Secours.

3 A: That's correct. So it's 1,100 out of about
4 3,600. And that's just the non-tertiary, non-
5 speciality. When we look at adding the
6 tertiary back into that number, that's even
7 greater coming from southern Berkeley County
8 than the north.

9 Q: Okay. Now, did Roper ever do a zip code
10 analysis to determine the number of patients
11 Roper Moncks Corner Hospital would capture from
12 Moncks Corner in the communities in northern
13 and eastern Berkeley County?

14 A: We did it more on a service demand analysis.
15 We looked at the population in those areas, the
16 use rate for inpatient services, and projected
17 a market share capture.

18 Q: Let's look at Petitioner's 104 then if we
19 could. I think this may be the internal
20 analysis. So this is Roper St. Francis
21 Healthcare in Berkeley County. Do you
22 recognize this slide set?

23 A: I do.

24 Q: Okay. Is this what was shown to the Chamber
25 and the community leaders in Berkeley County?

- 1 A: I believe so. I'd have to see more of the
2 document.
- 3 Q: All right. So you start with giving a brief
4 history of Roper in Berkeley County; is that
5 right?
- 6 A: That's correct.
- 7 Q: Next page. And then these are the seven mile
8 radius, correct, for --
- 9 A: Yes.
- 10 Q: -- this area around Moncks Corner and Carnes
11 Crossroads?
- 12 A: That's correct.
- 13 Q: Next one. Now, let's stop here real quickly.
14 This is the surgery center annual performance,
15 too, right? So the surgery center opened in
16 2002, and then in 2007, I guess, that was the
17 last full year of data you had before this was
18 presented?
- 19 A: That's correct.
- 20 Q: And so first year there was a direct -- a
21 surgery direct margin loss of \$766,000, right?
- 22 A: Yes.
- 23 Q: And could you quickly explain to the court what
24 surgery direct margin means?
- 25 A: That meant truly the profit margin related to

- 1 those cases done in the ambulatory surgery
2 center, and the associated costs related to the
3 ambulatory surgery center.
- 4 Q: But it's got a trend, at least from 2002 to
5 2007, it's going at least in the right
6 direction, isn't it?
- 7 A: Slowly, but yes.
- 8 Q: In 2007 we're looking at about \$169,000 loss on
9 the ASC; is that right?
- 10 A: It is. And that actually had to do with a
11 significant lowering of volume that year, and
12 we had to cut staff and services to match that.
- 13 Q: You lost some physicians. I think you told me
14 that in your deposition.
- 15 A: That's correct.
- 16 Q: Let's go to the next page. And that's just a
17 graphical representation, right?
- 18 A: Correct.
- 19 Q: Now, on this page, though, there's service
20 growth between 2000 and 2007, correct?
- 21 A: That's correct.
- 22 Q: Looks like there's pretty good growth in all
23 areas, correct?
- 24 A: There is.
- 25 MR. THOMAS: Go to the next page for me, please.

1 Q: And then you've got on Petitioner 104 here,
2 Roper Berkeley 2316, a plan for Berkeley
3 County, right?

4 A: Yes.

5 Q: And at least on this particular slide there's
6 no mention of construction of a new hospital
7 yet, is there?

8 A: Not on this slide.

9 MR. THOMAS: Go to the next one, please.

10 Q: And this is -- this slide on Berkeley -- Roper
11 Berkeley 2317, this shows what's going to be
12 left behind at Roper St. Francis Moncks Corner,
13 you know, in the event that a hospital's not
14 built up there; is that right?

15 A: That's correct.

16 Q: This is what they'll have --

17 A: That's what will be left in Moncks Corner after
18 we build a hospital in Carnes Crossroads and
19 despite anything else. But at this time it
20 just contemplates moving the surgery center and
21 those services remaining in Moncks Corner.

22 Q: Next page. All right. And this is the
23 continued commitment, right?

24 A: Correct.

25 Q: Next page. And then there's the Moncks Corner

1 bed need analysis, right?

2 A: That's correct.

3 MR. THOMAS: And go to the next one.

4 Q: And this was prepared by Mark Richardson,
5 correct?

6 A: Yes.

7 Q: Is that right?

8 A: That is correct.

9 Q: And he's in the room with us today?

10 A: He is, indeed.

11 MR. THOMAS: Go to the next page.

12 Q: And this slide here, this is the actual bed
13 need analysis or the bed need compare and
14 contrast for the Carnes Crossroads site and the
15 Moncks Corner site; is that right?

16 A: That's correct.

17 Q: And when you got this and you looked at it, did
18 you think it was reasonable?

19 A: I did.

20 Q: And you would've checked it and looked at it
21 before going up to Moncks Corner and presented
22 it to community leaders and folks like that,
23 right?

24 A: It's a pretty simple analysis based on
25 population and use rate, which at that time was

1 111 admits per thousand. And then we, I think,
2 forecast it at 65 percent capture.

3 Q: Well, so the population there in Moncks Corner
4 is about 19,855 and Carnes Crossroads was just
5 shy of 90,000; is that right?

6 A: That's correct.

7 Q: And you'd agree with me that in terms of that
8 Moncks Corner circle, I mean there's no wall
9 that's going to keep anybody outside of that
10 circle from using a hospital in Moncks Corner;
11 is there?

12 A: Of course not.

13 Q: And one of the assumptions that was made here
14 is that in the -- in the seven mile radius
15 circle that we looked at just a minute ago,
16 that there would be 65 percent market share
17 capture, correct?

18 A: That's correct.

19 Q: And you thought that was reasonable, right?

20 A: I thought for the purposes of demonstration,
21 that was reasonable, yes.

22 Q: And you would agree this analysis doesn't
23 mention anything about a ten percent market
24 share capture or redirection like the Roper St.
25 Francis Berkeley hospital does, does it?

1 A: No, this wasn't done for that purpose. This
2 was not for the purpose of determining volume
3 and then applying a financial pro forma. It
4 was looking at what we felt was a very
5 optimistic scenario for each market, which is
6 why we projected a very high market share
7 within each of those seven mile radiuses and
8 what kind of facility it would support.

9 Q: This was done to prove to the folks up in
10 Moncks Corner that Roper shouldn't have to
11 build a hospital there because it only comes up
12 with 22 beds, right?

13 A: It was to show that Carnes Crossroads was a
14 better financial decision, yes.

15 Q: And you wouldn't have done anything to mislead
16 the folks up in Moncks Corner or Berkeley
17 County, would you?

18 A: No, we wouldn't have.

19 Q: Okay. So you assumed 65 percent market share,
20 correct? That's what you did?

21 A: We did. And the narrative that went with that
22 was that would be a -- that would be a very
23 high optimal market share to get in either of
24 those areas. What we were trying to prove was
25 where the upper limit would be for beds.

1 Because if you take that market share back down
2 to 30 or 40 percent, you're down to ten or 11
3 beds. So we were saying at the upper limit,
4 best performance, this is what we felt the
5 facilities could support.

6 Q: At least on this slide, it doesn't mention
7 anything about upper limits, does it?

8 A: No, but there was a significant amount of
9 narrative that went with this. I didn't just
10 put the slide up.

11 Q: Well, if this is true, you would agree with me
12 that Carnes Crossroads, if the market share
13 capture rate is 65 percent, that's going to
14 have a pretty big effect on Trident, isn't it?

15 A: It would have.

16 Q: Because Trident actually has only about a 55
17 percent market share in that area, correct?

18 A: They do. So, like I said, this was not for the
19 purpose of filing the CON or determining
20 financial performance.

21 Q: I understand this. This is for the purpose of
22 showing the folks in Moncks Corner that Roper
23 shouldn't have to build a hospital there,
24 right?

25 A: If you say shouldn't have to build a hospital

1 there, that's your testimony, not mine.

2 Q: Well, is that -- is that wrong? I mean, that's
3 what you --

4 A: What we're showing is that we're -- it's
5 comparing and contrasting the two areas and
6 showing what kind of facility we think could be
7 supported in each of those areas.

8 Q: I mean, you'd agree with me if Carnes
9 Crossroads -- if Roper and Carnes Crossroads is
10 going to pick up a 65 percent market share,
11 that would leave 35 percent to the other
12 providers, correct?

13 A: That it would.

14 Q: And if Trident has a 55 percent market share
15 now, the best it could do would be 35 percent
16 and that's if it somehow managed to completely
17 take every case and MUSC got nothing, correct?

18 A: Mr. Thomas, I don't know where you're trying to
19 go with this. This isn't projecting a 65
20 percent market share. It is showing the
21 maximum size a facility could be within that
22 area if it went all the way to achieve a 65
23 percent market share.

24 Q: Right. It's saying that in the seven mile
25 radius --

1 A: Right.

2 Q: -- Roper would get 65 percent market share. So
3 if there's 990 admits in there, it says Roper's
4 going to get 6,435, right?

5 A: That would be correct. And that would be a 100
6 bed facility. So if we take that down to about
7 25 or 30 percent, it works out just about right
8 for a 50 bed facility.

9 Q: Well, let's go back to 6,435 admits that Carnes
10 Crossroads would get. That would leave how
11 many for Trident? That would be less than
12 3,000, right? Or about 3,000?

13 A: Yeah.

14 Q: And that's if they got every last one of them,
15 right?

16 A: That's correct.

17 Q: Go to Petitioner's 150 for me real quickly.
18 We're going to come back to this one. And this
19 email from Bret Johnson to you -- or really I
20 guess from you to Mr. Dunlap and Bret Johnson
21 back in 2008, based on the market share numbers
22 you saw for 2006 --

23 A: Uh-huh.

24 Q: -- you were concerned. You said it wasn't good
25 news across the board because MUSC had gained

1 a market share across all service lines in all
2 three counties, correct?

3 A: That's correct.

4 Q: And that's something to do in your mind with
5 their aggressiveness and employing physicians,
6 correct?

7 A: It was.

8 Q: Okay. And do you recall what that market share
9 loss was, Mr. Bowling?

10 A: I don't, but I think it was about a half of
11 percent.

12 Q: About a half to one percent, wasn't it?

13 A: Less than one percent.

14 Q: Now, if you would go back to Exhibit 104, the
15 same page. Okay. Now, in this one, in this
16 bed need compare and contrast, it says assumes
17 a use rate of 1,100 -- or excuse me, 111 admits
18 per thousand, correct?

19 A: That's correct.

20 Q: And a 3.7 average length of stay, right?

21 A: That's correct.

22 Q: And you would agree with me that the lower the
23 length of stay, the less patient days the
24 overall facility would have in a given year,
25 assuming the number of admissions stays

- 1 constant?
- 2 A: Constant, yes.
- 3 Q: Okay. Now, let's go to Petitioner's 102. This
- 4 one is going to be hard to read, but I believe
- 5 this is the -- the slide said, Mr. Bowling,
- 6 that was -- was this the one shown to the Roper
- 7 Berkeley Advisory Council on May 19, 2008?
- 8 A: That looks like that could be 2008 or 2006 or
- 9 --
- 10 MR. THOMAS: See if you can't blow up that a little
- 11 bit, Sara.
- 12 A: Okay.
- 13 Q: Does that look like 2008?
- 14 A: It does.
- 15 Q: Okay, good. Let's go to the next page if we
- 16 could. And then this slide set here is very
- 17 similar to the one we just looked at, correct?
- 18 A: Yes, it is.
- 19 Q: So it kind of goes over to the next page.
- 20 A: I think that is the same slide set we just
- 21 looked at.
- 22 Q: Okay. Go one more over. And, you know, we've
- 23 got Moncks Corner bed need analysis, correct?
- 24 And right here down at the bottom it says
- 25 independent analysis conducted by Mark

1 Richardson, partner Rick Knapp and Associates,
2 right?

3 A: Correct.

4 Q: Okay, go to the next one. Now, this is Roper
5 Berkeley 2252, and it's going to be hard to
6 read, but it will help us out in a minute.
7 First of all, on the bed need compare and
8 contrast on the fifth slide, which is basically
9 the second one in the right column --

10 A: Yes.

11 Q: -- who prepared that slide?

12 A: You know, I don't honestly remember. At one
13 time I know David Leavitt actually had looked
14 at that eight zip code area for us and redid
15 this analysis based on the eight or nine zip
16 codes around the lake.

17 Q: Yeah.

18 A: This could be his work. Or it could be Mark
19 looking at those population estimates and
20 recreating his work for that same area. But
21 that's -- what we have here and the
22 compare/contrast shows that if you look at all
23 eight zip codes around the lake and you apply
24 a market share forecast, that it would support
25 41 beds.

1 Q: And so just for the record, this is the summary
2 -- you've got the summary highlight, primary
3 service area population protocol, right? And
4 that's the towns there and the zip codes of the
5 areas of Bonneau, Cordesville, Cross,
6 Jamestown, Moncks Corner, Pineville, Pinopolis
7 and St. Stephen, right?

8 A: That's correct.

9 MR. THOMAS: And then, Sara, if you'd put up 242 for
10 me.

11 Q: What I did, Mr. Bowling, is I took that one
12 slide, the second one on the right page, and I
13 just put all the information in it so we could
14 actually look at it here today.

15 A: Okay.

16 Q: And so in this one it says stats based on eight
17 zip code service area and a 50 percent market
18 share, right?

19 A: That's correct.

20 Q: And so the projected five year population is
21 about 47,500 people, right?

22 A: Correct.

23 Q: And then the number of admits was applied to
24 that using the use rate of 111, right?

25 A: Yes.

- 1 Q: Okay. And the 50 percent market share capture
2 for around the lake and Moncks Corner, right?
- 3 A: Uh-huh. Yes, that's correct.
- 4 Q: And then so the forecasted average daily census
5 was 26.7, correct?
- 6 A: Correct.
- 7 Q: If you divide that number by .65, you come up
8 with 41.
- 9 A: That's correct.
- 10 Q: All right. Now, let me ask you this. What was
11 the average length of stay that was actually
12 used in the Roper St. Francis CON application?
- 13 A: Without looking, I think it was 4.2.
- 14 Q: 4.25, wasn't it?
- 15 A: Okay.
- 16 Q: Okay. Now, are the patients who live in Moncks
17 Corner around the lake necessarily healthier
18 than the patients in and around Carnes
19 Crossroads to the extent their hospital stays
20 would be 14 percent shorter than the folks at
21 Carnes Crossroads?
- 22 A: No, not necessarily. I think that it's, you
23 know, 3.7 to 4.4, they're going to be the
24 typical length of stays that were used at that
25 time on a community hospital, and we had two

1 experts come to independent determinations, one
2 versus another.

3 Q: And, well, the 3.7 average length of stay, that
4 was used in Mr. Richardson's bed need compare
5 and contrast that we just looked at in
6 Petitioner's 104, wasn't it?

7 A: I didn't notice, but it probably was.

8 Q: Okay. So 3.7 was used by both experts,
9 correct?

10 A: Uh-huh.

11 Q: All right. I'm going to give you the
12 calculator here, and just ask you to do
13 something real quick for me. If we take the
14 number of forecasted admissions of 2,636 that
15 appears here on Petitioner's 242, and multiply
16 that by 4.25, what do you get?

17 A: That's an average daily census of 30.7

18 Q: That's 30.7. Now divide that number by the .65
19 for me.

20 A: Forty-seven.

21 Q: Is there a decimal point there?

22 A: Point two.

23 Q: Okay. So if you used the average length of
24 stay that Roper uses the average length of stay
25 that they use in their CON application, now

1 we've got a 47 bed hospital, right?

2 A: That's correct.

3 Q: And that's just for these zip codes, right?

4 A: Uh-huh.

5 Q: In the Moncks Corner area, correct?

6 A: Yes, that's correct.

7 Q: That's no in-migration from anywhere else.

8 A: Huh-uh.

9 Q: Now, you would agree with me that DHEC was

10 never shown this analysis with the actual

11 average length of stay of 4.25 applied,

12 correct?

13 A: No, they were not.

14 Q: And this analysis and the other analysis that

15 Mr. Richardson did, those were the analyses

16 that the -- were the internal and external

17 analyses referenced in the project review

18 meeting, right?

19 A: That along with the work that David Leavitt

20 did, yes.

21 Q: Okay. I want to talk a little bit about the

22 ambulatory surgery center relocation. I think

23 you and Mr. Long got into that a little bit.

24 And you were -- you were intimately involved in

25 that decision to move the surgery center from

- 1 Moncks Corner to Goose Creek, right?
- 2 A: To Carnes Crossroads, yes.
- 3 Q: Yeah. And for the record, Carnes Crossroads is
- 4 in?
- 5 A: Goose Creek.
- 6 Q: Thank you. All right. And that center, the
- 7 surgery center, actually opened its doors and
- 8 started seeing patients and having surgeries
- 9 done there in February of 2002; is that right?
- 10 A: I believe that's correct. I wasn't here.
- 11 Q: And the reason Roper wanted to move that
- 12 surgery center is that it wasn't profitable,
- 13 right?
- 14 A: Yes, that's correct.
- 15 Q: And the surgery center in Moncks Corner served
- 16 patients primarily from Berkeley County; is
- 17 that right?
- 18 A: The surgery center, yes. Yeah, entirely from
- 19 Berkeley County I believe.
- 20 MR. THOMAS: Would you put up Petitioner's 241 for
- 21 me?
- 22 Q: I'm going to show you a summary document. This
- 23 is Roper St. Francis Moncks Corner Surgery
- 24 Center utilization from selected zip codes,
- 25 Petitioner's 241.

- 1 A: Okay.
- 2 Q: All right. And on the left-hand side you've
- 3 got the surgeries that were done in November --
- 4 through November of 2010, correct?
- 5 A: Yes.
- 6 Q: And those are all the folks that literally
- 7 would have to come up from the south to use the
- 8 surgery center, right?
- 9 A: That's correct.
- 10 Q: And on the right-hand side you've got the folks
- 11 in Moncks Corner and kind of the folks in
- 12 northern and eastern Berkeley County, right?
- 13 A: That's correct.
- 14 Q: So you have 559 folks in the Berkeley County
- 15 central northern eastern area and then about
- 16 243 that are coming from North Charleston,
- 17 Hanahan, Goose Creek and Summerville and
- 18 Ladson, right?
- 19 A: That's correct.
- 20 Q: So the folks that come from around the lake,
- 21 559, if you divide that by 898, the percent in
- 22 Berkeley County is about 62 percent, isn't it?
- 23 A: That's correct.
- 24 Q: And the other folks, they're about 27 percent;
- 25 is that right?

- 1 A: They are, but you've got 29483 here, and so I
2 don't know how many of those were Berkeley
3 County versus Dorchester County.
- 4 Q: Okay, fair point. But those people would still
5 have to come up from the south to Moncks
6 Corner, right?
- 7 A: They would. And the Goose Creek obviously is
8 in Berkeley County, that's another 87. They
9 would travel --
- 10 Q: And they would travel up from the south, right?
- 11 A: They would.
- 12 Q: Okay. Go to Petitioner's 164 for me, please.
13 Do you recognize this document, the DHEC
14 Project Review Committee Meeting on November
15 10, 2008?
- 16 A: I do.
- 17 Q: It's entitled, Relocation of Roper Berkeley
18 Ambulatory Surgery Center for Moncks Corner and
19 Goose Creek, right?
- 20 A: That's correct.
- 21 Q: Okay. It's Exhibit 164. Would you go to the
22 third page of that exhibit? Okay. So this is
23 -- these are some statements here, some
24 bullets. It says DHEC issued a CON which
25 opened in February of 2002, right?

- 1 A: Correct.
- 2 Q: The only licensed surgery facility in Berkeley
3 County?
- 4 A: That's correct.
- 5 Q: And you say the current site does not support
6 adequate utilization; therefore, the facility,
7 the ASF, must either be closed or relocated,
8 right?
- 9 A: That's correct.
- 10 Q: And how much was that relocation going to cost;
11 do you recall?
- 12 A: I don't. I think that the total relocating the
13 ACS and the medical office building and the
14 other services we were looking at was about a
15 \$10 million project.
- 16 Q: \$10 million project. And we just saw when we
17 looked at Petitioner's 104, we saw the Advisory
18 Council slide where it looked like there was a
19 margin loss, a surgery direct margin loss of
20 \$169,281 for 2007, correct?
- 21 A: That's correct. That was the best year. And
22 on the average I think that facility was losing
23 close to a half a million a year.
- 24 Q: Well, the facility is still operating, correct?
- 25 A: It is.

- 1 Q: Is it still losing one or is it making money?
- 2 A: It's performing a little better. We have a
- 3 couple of new surgeons that are using it, and
- 4 so we're seeing some more caseload there.
- 5 Q: Right, it turned the corner, didn't it? I
- 6 mean, it's in the positive, right?
- 7 A: Yes. It's close to positive.
- 8 Q: Okay. But you would agree with me that Roper,
- 9 based on the numbers from 2007, didn't think
- 10 the facility was financially feasible, correct?
- 11 A: We didn't.
- 12 Q: Now, you were in the room for Mr. Johnson's
- 13 testimony when I asked him to calculate the net
- 14 revenue and the EBITDA for Roper St. Francis
- 15 for 2007 and 2008, right?
- 16 A: I was.
- 17 Q: Okay. And he calculated that over that two
- 18 year period Roper St. Francis had more than a
- 19 billion dollars in net revenue, correct?
- 20 A: I believe that's correct.
- 21 Q: Okay. And it had over 120 million in EBITDA
- 22 during that time period?
- 23 A: Right.
- 24 Q: So you would agree with me that despite the
- 25 impressive performance of Roper financially in

1 those two years, it felt its only option, this
2 ACS that's losing \$170,000, was to either close
3 it down or move it, correct?

4 A: That's correct.

5 Q: Now, there's another justification, right? Go
6 to the next page. The surgeons didn't like to
7 drive all the way to Moncks Corner, correct?

8 A: That is correct.

9 Q: And then --

10 A: And I'll even clarify that. The surgeons were
11 willing to drive to Moncks Corner for pre-
12 operative visits, to get patients scheduled,
13 but they were not willing to drive the hour
14 back just to do one or two surgeries. It was
15 easier to ask the patient to come downtown
16 where they could put that with another six to
17 eight surgeries that were scheduled on that
18 same day.

19 Q: So it was easier to inconvenience the patient
20 rather than the physician, correct?

21 A: That's correct.

22 Q: Now, if you'd go to the next page for me. And
23 then, again, we've got these circles, right?
24 These are five mile radii circles, right?

25 A: I believe they are.

1 Q: But you would agree with me again, the folks
2 that live on the northern side and the eastern
3 side of that circle that's kind of radiating
4 from Moncks Corner, you know, that line doesn't
5 mean anything to them, does it?

6 A: No.

7 Q: That five mile line?

8 A: As I said, the circles are a sniff test.

9 Q: Kind of a sniff test for money, right?

10 A: No, just for utilization, where you have
11 highest probability of utilization.

12 MR. THOMAS: Go to Petitioner's 1, same name as page
13 24 on the document, please, Sara.

14 Q: And this is the conclusion. The ASC will
15 provide better accessibility, right?

16 A: It will.

17 Q: But you would agree with me that it's not going
18 to provide better accessibility to the 62
19 percent of those people that live in Moncks
20 Corner and around the lake, right? It's going
21 to be less accessible to those people that used
22 your facility in 2010, right?

23 A: I guess it could be more distant to them, yes.
24 If there are more surgeons operating there,
25 it's going to improve accessibility for all of

1 them.

2 Q: Well, they're going to have to drive further,
3 correct?

4 A: They're going to have to drive further, yes.

5 Q: And then there it is. You already said that
6 you wanted to ensure the necessary volumes to
7 make the center financially feasible, right?

8 A: That's correct.

9 Q: It was losing about \$170,000.

10 A: In that single year it lost \$170,000. That was
11 not its average loss.

12 Q: Okay. Well, its average loss was a few hundred
13 thousand dollars, but it was trending up,
14 right?

15 A: Yes.

16 Q: And then the last one here, offers surgical
17 service convenience and choice to patients and
18 physicians, right?

19 A: That's true.

20 Q: Let's go to Joint 2, Roper's CON application,
21 if we could. Let's go to page 17 of the Roper
22 DHEC record. Now, I think you said you
23 testified that you reviewed the CON
24 application that was put together by your staff
25 and Mr. Richardson, correct?

1 A: I did.

2 Q: And let me ask you this. Did you ask after you
3 got the final documents, did you ask for
4 anything to be changed in the need section of
5 the CON application?

6 A: I did not.

7 Q: You accepted Mr. Richardson's assumptions as
8 they were?

9 A: I did.

10 Q: On page 17 here, down at the bottom of the
11 page, it states that the strategic
12 justification of the project is based on
13 providing the first local access to inpatient
14 care within the Berkeley County area, doesn't
15 it?

16 A: It does.

17 Q: Okay. But you couldn't have known that to be
18 true, correct, because Trident had actually
19 applied, too, right?

20 A: They had.

21 Q: Why was this -- why was this said?

22 A: I'm not exactly sure why it said the first
23 local access. It just should be providing
24 inpatient care in the Berkeley County area.

25 Q: Doesn't this assume that the applications are

1 going to be competing because only one's going
2 to be selected, and the one that's selected is
3 going to get to provide the first local access
4 to inpatient care within Berkeley County? I
5 mean, isn't that why that's there?

6 A: No, I can't say that that's why that's there.
7 It wasn't my language, but then again, it
8 really doesn't matter whether we thought they
9 were competing or don't think they're
10 competing. It's the Department's decision.

11 Q: But you didn't ask for that to be removed, did
12 you?

13 A: I did not.

14 Q: And you would agree with me that there was no
15 zip code analysis done in terms of utilization
16 for this project, right?

17 A: There was not. It was a county analysis.

18 Q: And in terms of the -- turn the page for me.
19 Go to the next page, be on 18. And another
20 bullet here, the third one, maximize the usage
21 of acute care beds at Roper's downtown
22 facility, right?

23 A: Yes.

24 Q: But in your letter you recall that you sent I
25 guess after the project review meeting --

- 1 A: Yes.
- 2 Q: -- you actually projected the utilization for
- 3 Roper St. Francis Downtown in the year 2015 to
- 4 be about 78 percent, didn't you?
- 5 A: We did.
- 6 Q: And so by my math, that means you would have a
- 7 bed need of about -- Roper Downtown would have
- 8 a bed need of about 296 beds, right?
- 9 A: At the 75 percent utilization?
- 10 Q: Seventy percent.
- 11 A: Seventy percent, yes.
- 12 Q: Okay. But you'd only have 266 beds in Carnes
- 13 -- downtown if you were allowed to build at
- 14 Carnes Crossroads, correct?
- 15 A: That's correct.
- 16 Q: So that would be a bed need showing there of
- 17 about 30 beds, right?
- 18 A: Would have been. There wouldn't be today.
- 19 Q: And why is that?
- 20 A: Because the length of stay at Roper Hospital
- 21 has come down substantially in the last five
- 22 years, and with the conversion of one-day
- 23 length of stay going over to observation. Our
- 24 average daily census, as I said, in 2011 was
- 25 216.

1 Q: And the utilization for non-tertiary out of
2 Berkeley County for Roper St. Francis has also
3 decreased, hasn't it?

4 A: The utilization rate for the county has
5 decreased per thousand population.

6 Q: Okay. And not just per thousand population,
7 but the actual number of patients coming out of
8 Berkeley County, non-tertiary patients coming
9 out of Berkeley County, as well as tertiary,
10 has been declining for Roper, correct, and as
11 well as for all hospitals, hasn't it?

12 A: I think it has some in total.

13 Q: Now, on this page here, page 18, proposed
14 service area, it states plainly, correct, that
15 it's anticipated to primarily serve the
16 residents of Berkeley County, right?

17 A: That's true.

18 Q: And will get some additional patients from the
19 adjacent areas within Charleston and
20 Dorchester, right?

21 A: Correct.

22 Q: Okay. And that makes sense, right, because
23 Dorchester County is what, about four miles
24 away from the site of Carnes Crossroads?

25 A: A little more than that, but just about.

1 Q: And Roper St. Francis is expecting people to
2 drive from the south, correct, to go up to
3 Roper St. Francis and Carnes Crossroads from
4 North Charleston, Ladson, Goose Creek and
5 Summerville, right?

6 A: Some from those areas, yes. '

7 Q: I think on page 22, I think you state on page
8 22 in the middle of the page --

9 MR. THOMAS: Sara, blow up that paragraph.

10 Q: I think it's the second sentence you state,
11 "Unlike the Moncks Corner area, there are
12 currently no comprehensive ambulatory service
13 providers located within the area." And that,
14 you mean Goose Creek, right?

15 A: I do.

16 Q: But you would agree with me that Trident
17 Medical Center, which is what, a mile and a
18 half away from the city limits of Goose Creek,
19 has a lot of ambulatory services on its campus,
20 correct?

21 A: They do.

22 Q: Now, if you'd look at page 23 for me, Mr.
23 Bowling, at the top. Let's see if we can blow
24 up that paragraph. Now, this is a paragraph
25 that references that seven mile radius and 15

1 mile travel time, correct?

2 A: Yes.

3 Q: And I think you told me before that with
4 respect to the seven mile radius, planning
5 radius around Roper St. Francis Berkeley, that
6 proposed site, you would agree with me that the
7 104,000 people that are, you know, I guess
8 lived in the radius back in 2008, they all have
9 access to a hospital within 30 minutes, right?

10 A: While I couldn't testify to that, it seems
11 reasonable that they would.

12 Q: Well, go to page 137 for me in your deposition.

13 THE COURT: Mr. Thomas?

14 MR. THOMAS: Yes, sir?

15 THE COURT: Let's take about a ten minute break now
16 if that suits everybody.

17 MR. THOMAS: Yes, sir.

18 (Off the Record from 4:25 p.m. until 4:35 p.m.)

19 Q: Mr. Bowling, before we took a break, I think I
20 asked you a question with respect to the seven
21 mile planning radius that shows up on page 23
22 of Joint 2, Roper's CON application, and
23 there's I guess it was estimated 104,000 people
24 living in that area. I asked you if you would
25 agree with me that the 104,000 people in that

1 radius all have access to a hospital within 30
2 minutes.

3 A: And I said that I couldn't to testify that, but
4 I believe they did.

5 Q: If you look on page 137 of your deposition.

6 A: Okay.

7 Q: Okay. And on this page I'm asking you about --
8 about the seven minutes -- or excuse me, the
9 seven mile travel radius. And on line five I
10 ask you, "In looking at this map, Mr. Bowling,
11 would you agree with me that all the residents
12 that Roper -- should I say that Trident -- or
13 excuse me, that Roper intends to serve within
14 the seven mile radius approximately is about
15 400 -- no, 104,000 people currently have access
16 to a hospital within 30 minutes?" And what's
17 your answer?

18 A: I said, "I would agree with you."

19 Q: Thank you. Now, you're not aware of any state
20 health planning standards or criteria that
21 defines seven miles as the distance that one
22 hospital should be from another, correct?

23 A: There isn't.

24 Q: Okay. And you're aware that in terms of
25 Berkeley County, the highest concentration of

1 residents live in Goose Creek, right?

2 A: That's correct.

3 Q: And you'd agree with me that Roper would have
4 a higher probability of attracting patients
5 from the seven mile radius around Carnes
6 Crossroads than the other areas, wouldn't you?

7 A: Restate the question.

8 Q: Yeah. Would you agree with me that Roper would
9 have a better likelihood or a higher
10 probability of attracting patients from the
11 seven mile radius around Carnes Crossroads than
12 from other areas?

13 A: A greater ability, no. Possibly a greater raw
14 number. I think if you draw any seven mile
15 circle, your probability of attracting patients
16 within that seven miles is pretty equal.
17 That's why we used it as a test, because of the
18 close proximity to the hospital, 15 minutes
19 away within seven miles. So our probability of
20 attracting patients within any seven mile
21 circle is essentially the same. How many
22 patients out of the seven mile circle I think
23 is what you're asking.

24 Q: And you have a higher probability of
25 utilization than if they were eight or ten

1 miles outside, correct?

2 A: Yes.

3 Q: Now, if you'll look at the bottom of page 23
4 for me, that paragraph starting with the
5 implication.

6 A: And this is in the deposition?

7 Q: Joint 2. I'm sorry.

8 A: Okay. Joint 2.

9 Q: Yes, sir.

10 A: And what was the page again?

11 Q: Page 23. It's the Roper CON application.

12 A: Okay.

13 Q: And would you read that sentence starting with
14 the implication?

15 A: "The implication of this Goose Creek Moncks
16 Corner comparison is that if a new hospital is
17 to be built in Berkeley County, it is clear
18 that the new hospital should be developed in
19 the Goose Creek area to provide the best care
20 possible to the large and rapidly growing
21 Goose Creek area, as well as Berkeley County as
22 a whole."

23 Q: Okay. And so you're actually advocating that
24 if a hospital is to be chosen and be built in
25 Berkeley County, it should be your hospital,

1 correct?

2 A: Yes.

3 Q: That's what you say here. Now, if you look at
4 the top of page 24, you state, or Roper states,
5 "Finally, the proposed Goose Creek development
6 by Roper St. Francis will ensure that all
7 Berkeley County residents, wherever they may be
8 located within the county, have adequate access
9 to competitive community-based not-for-profit
10 healthcare services," correct?

11 A: That is correct.

12 Q: So you're stating that your service area's all
13 of Berkeley County; is that right?

14 A: Yes.

15 Q: And the hospital is intending to serve all of
16 the communities, correct?

17 A: It is. As we said, it's to serve the Roper St.
18 Francis patients living in Berkeley County.

19 Q: And the 1,188 patients that you get from the
20 market share pickup, correct?

21 A: Growth in the community, yes.

22 Q: And 329 patients from Dorchester and Charleston
23 Counties, correct?

24 A: Which are redirected Roper St. Francis patients
25 also.

- 1 Q: All of them are redirected?
- 2 A: We assume they would be, yes.
- 3 Q: Okay. And you think that assumption was in the
- 4 CON application?
- 5 A: I don't know if we stated it as much as we just
- 6 said a ten percent from out of area, but we
- 7 clearly knew who we were referring to.
- 8 Q: So those ten percent from out of area, those
- 9 are going to be coming redirected as well?
- 10 A: Correct.
- 11 Q: So let's look at page 24 of the Joint 2 here,
- 12 and we have projected market share volume,
- 13 correct?
- 14 A: Page 24, yes.
- 15 Q: Yeah, projected market base volume forecast.
- 16 And it's -- if I recall correctly, you didn't
- 17 have any input with respect to Mr. Richardson's
- 18 assumptions on this page; is that right?
- 19 A: I did not.
- 20 Q: And you have no idea why Mr. Richardson chose
- 21 a ten percent market share capture rate for
- 22 Berkeley County, correct?
- 23 A: No, I don't.
- 24 Q: Okay. You never asked Mr. Richardson why he
- 25 chose the ten percent market capture number,

1 did you?

2 A: Yeah, I think we did, and we discussed that it
3 was reasonable if we had a Roper St. Francis
4 facility there with our historic, you know,
5 almost one in four patients out of that county
6 choosing us without an inpatient facility, we
7 considered that a very reasonable assumption.

8 Q: When did you have that conversation with him?

9 A: Honestly, Mr. Thomas, I don't know if it was
10 before or during project review or shortly
11 after when we were reviewing things.

12 Q: Go to page 145 of your deposition for me. And
13 at the top of the page here, asked you a
14 question. "Okay. But do you know how he
15 arrived at that number?" What did you say?

16 A: "I do not."

17 Q: I said, "Did you suggest to him or ask him
18 well, why is it ten percent?"

19 A: "No."

20 Q: And you said no, correct?

21 A: Correct.

22 Q: So does that refresh your recollection?

23 A: That does.

24 Q: Now, if the ten percent market capture number
25 is something along the order of 20 or 30

1 percent -- I believe 30 percent was the market
2 capture number for Mount Pleasant, correct?

3 A: That's correct.

4 Q: For the Mount Pleasant CON. That would
5 increase adverse impact to existing providers,
6 correct?

7 A: That's correct. And if it were 50 or 60
8 percent, it would create even more.

9 Q: Okay. And you would agree with me that because
10 Trident Medical Center and Summerville Medical
11 Center have the highest market shares in the
12 area that Roper St. Francis is projecting to
13 serve, they would be hit the hardest, correct?

14 A: If adverse impact were to occur, they would be
15 the ones that would be most at risk.

16 Q: And you would agree with me that Roper never
17 calculated what the increase to its tertiary
18 care market would be, correct?

19 A: We did not.

20 Q: But based on your experience in healthcare
21 planning, you would agree with me that if you
22 locate a new hospital in Goose Creek in the
23 Carnes Crossroad area and it has a hospital
24 based emergency department, you would expect
25 that your tertiary care market share is also

- 1 going to increase in that area, too, right?
- 2 A: It could.
- 3 Q: Okay. And you would agree with me that
- 4 tertiary care services are generally reimbursed
- 5 at a higher level than non-tertiary care
- 6 services; is that a fair statement?
- 7 A: Not entirely. Also there's a great deal more
- 8 cost and resources that go with tertiary
- 9 services, so from a profitability standpoint I
- 10 don't know that I would agree with that.
- 11 Q: Well, Roper Downtown offers a lot of tertiary
- 12 care services, correct?
- 13 A: It does.
- 14 Q: And open heart, neurosurgery and that type of
- 15 thing?
- 16 A: Yes.
- 17 Q: And in terms of reimbursement, are those
- 18 reimbursed at higher levels from Medicare than
- 19 say just an average run of the mill medical
- 20 stay?
- 21 A: Yeah, they'll have a higher case mix index and
- 22 therefore be reimbursed at a higher rate.
- 23 Q: If you'd go to page 25 for me. In the third
- 24 bullet point there -- and again, this is Mr.
- 25 Richardson's -- is this Mr. Richardson's

1 assumption?

2 A: It is.

3 Q: But you've read it and agree with it, correct?

4 A: I did.

5 Q: It says, with HCA Trident currently capturing
6 54 percent market share of the local inpatient
7 market, and there's some stuff in parenthesis
8 there, that ten percent of non-Roper St.
9 Francis market share level, less than one-fifth
10 of Trident's market share, is reasonable and
11 achievable; is that what it says?

12 A: It does.

13 Q: Why isn't 25 percent reasonable and achievable?

14 A: You'll have to ask Mr. Richardson on that.

15 Q: So you're not sure, right?

16 A: No.

17 **THE COURT:** What was the witness' response?

18 A: I said that no, I was not sure why he selected
19 that number.

20 **THE COURT:** Thank you.

21 Q: Now, you would agree with me, sir, that in both
22 the Roper St. Francis Mount Pleasant CON
23 application and both the Roper St. Francis
24 Berkeley CON application, Roper is relying on
25 market share increases, correct?

1 A: In both of those applications there was some
2 degree of market share increase that would
3 occur, yes.

4 Q: Okay. So you would agree with me that the bed
5 transfer section that we've all talked a lot
6 about in this trial is being used by Roper St.
7 Francis to some degree in an effort to gain
8 market share in the Tri-county area, correct?

9 A: I think that is an effect of transferring beds
10 to an area where population is growing, yes.

11 Q: But it is -- it's more than just a bed transfer
12 and then same utilization. It's a bed transfer
13 and in both cases, both Mount Pleasant and both
14 Berkeley, getting market share increases,
15 correct?

16 A: That's correct.

17 Q: Okay. Now, based on your understanding of the
18 bed transfer provision, I think Mr. Long asked
19 you some questions about it, is there a limit
20 to how many beds a hospital can move from one
21 location to another so long as the total bed
22 supply in the service area does not increase?

23 A: There is no limit that I'm aware of.

24 Q: Mr. Bowling, you would agree with me that
25 material adverse impact is one that would

1 change the financial condition of an existing
2 provider, correct?

3 A: Yeah, I think material changes, financial
4 condition and adverse impact means it would put
5 the entity in jeopardy.

6 Q: Would you agree with me that adverse impact,
7 according to the State Health Plan, is a
8 function of the impact on a current and
9 projected growth of existing providers weighed
10 against an accessibility standard?

11 A: No, I don't think growth has anything to do
12 with the adverse impact. I think it's from
13 your current state of patients.

14 Q: Sir, are you not familiar with the adverse
15 impact definition in Reg 61-15?

16 A: I may not be able to quote it exactly, no.

17 Q: Give you a copy of that. This is project
18 review criteria 23, Adverse Effects on Other
19 Facilities, and if you'd read 23(a) for me into
20 the record.

21 A: Adverse impacts on other facilities. The
22 impact on the current and projected occupancy
23 rates or use rates of existing facilities and
24 services should be weighed against the
25 increased accessibility offered by the proposed

1 service.

2 Q: So , there's a projected element to that,
3 correct?

4 A: Projected occupancy, yes.

5 **THE COURT:** What point are you trying to make, Mr.
6 Thomas? What existing facility do you have in
7 mind?

8 **MR. THOMAS:** Trident Medical Center and Summerville
9 Medical Summer, Your Honor, which are both
10 pretty close to where --

11 **THE COURT:** I'm with you.

12 **MR. THOMAS:** Okay.

13 Q: Now, if we look at page 31 in Joint 2, Roper
14 CON application, would you read the second
15 sentence in that paragraph? Page 31. Let me
16 see if I can get you there. Under adverse
17 impact on existing providers, and what do you
18 say here in the second sentence?

19 A: In fact, no material adverse impact is expected
20 on other local providers as population growth
21 alone and a resulting increase in market size
22 is anticipated to offset any possible patient
23 volume reductions.

24 Q: Now, we know that Roper appealed the
25 Summerville Medical CON application that was

1 awarded by -- or the CON decision awarded by
2 DHEC, correct?

3 A: That's correct.

4 Q: Okay. And Summerville Medical Center, just for
5 the record, they applied at the end of 2010,
6 right?

7 A: Correct.

8 Q: And they applied to add 30 beds on their campus
9 based on a 24 bed need in the State Health
10 Plan, correct?

11 A: That's correct.

12 Q: And you were aware of that bed need because you
13 actually served on the State Health Planning
14 Committee, correct?

15 A: Correct.

16 Q: And you knew that that bed need was projected
17 to 2013 by virtue of it being in the 2008-2009
18 Plan, correct?

19 A: Yes.

20 Q: Now, Mr. Bowling, at project review do you
21 recall stating that allowing additional beds at
22 Summerville Medical Center without giving
23 consideration to the volume of the two approved
24 but not yet operational hospitals in the same
25 service area does not constitute orderly health

1 planning?

2 A: I do.

3 Q: You'd said that, correct?

4 A: I did say that.

5 Q: Essentially --

6 A: I still believe it.

7 Q: You say you still believe it, right?

8 A: Yes.

9 Q: So what you're asking DHEC to do in the project

10 review meeting was you were telling them,

11 please delay Summerville Medical Center's

12 project until Roper's new hospital is open for

13 business to see what effect that new hospital

14 would have on the utilization of Summerville,

15 correct?

16 A: On the utilization of those zip codes in

17 Berkeley County that are in the Summerville

18 application, yes.

19 Q: And you'd asked -- and you said that on the

20 basis that you thought that Roper St. Francis

21 might have an impact on the utilization to

22 Summerville Medical Center in those zip codes,

23 right? And that's just what you say, correct?

24 A: No. The opposite of that. We thought

25 Summerville would have an impact on the

1 utilization at our facility in those zip codes
2 that are in Berkeley County.

3 Q: You say allowing additional beds at Summerville
4 Medical Center, without giving consideration to
5 the volume of the two approved but not yet
6 operational hospitals in the same service area,
7 does not constitute orderly health planning?

8 A: Yeah. We thought it might have adverse impact
9 on our project.

10 Q: You thought Summerville Medical Center --

11 A: If they expanded after we'd been approved but
12 held up, if they were allowed to go forward, it
13 could definitely impact our project.

14 Q: Okay. And Summerville Medical Center is about
15 a ten mile drive away from Carnes Crossroads,
16 correct?

17 A: Yes.

18 Q: And Carnes Crossroads from Roper St. Francis
19 Berkeley Hospital is going to be about seven
20 miles away from Trident Medical Center, eight
21 mile drive?

22 A: 8.1, yes.

23 Q: Okay. Now, regarding the pro formas in the CON
24 application, you never really looked over
25 those, correct?

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1 A: No, not in great detail. I looked at the
2 volume assumptions, probably top line revenue,
3 but beyond that I didn't go into it.

4 Q: And like the Roper St. Francis Mount Pleasant
5 CON application, when you looked over the
6 volumes in that application, you were fine with
7 the ones that you saw on the Roper St. Francis
8 Berkeley application, correct?

9 A: I am, yes.

10 MR. THOMAS: Put up Respondent's 2 for me, Ms. Tyer.

11 Q: Okay. I believe Mr. Long asked you a couple of
12 questions about this exhibit. This is what
13 I'll call the Leavitt bed need analysis.

14 A: Yes.

15 Q: Okay. Now, you would agree with me that bed
16 need analysis, that doesn't take into
17 consideration the 296 Trident beds that are
18 right across the border from Berkeley County,
19 right?

20 A: It does not, no. They're not in Berkeley
21 County.

22 Q: And it uses a 65 percent occupancy standard,
23 too, correct?

24 A: It does.

25 Q: Is that what the occupancy standard would be

1 for a 300 bed plus hospital?

2 A: No, I believe it would be 70 percent.

3 Q: You testified earlier that DHEC, and especially
4 in Lexington and Richland Counties, does a what
5 did you call it, in a bed need situation? They
6 do a ratio --

7 A: They do a utilization ratio between the
8 counties.

9 Q: But there's no utilization ratio applied here,
10 is there?

11 A: There's not.

12 Q: And Mr. Shelton or nobody at DHEC has ever
13 signed off on this bed need analysis, have
14 they?

15 A: No. This was an internal document for us.

16 Q: And this would be all tertiary beds. This
17 wouldn't just be non-tertiary beds, right?

18 A: This would be both community and tertiary
19 services.

20 Q: And you would agree with me that when Roper St.
21 Francis looks for a healthcare planning
22 consultant outside of its organization, it
23 typically is looking for someone recognized as
24 an expert, right?

25 A: That's correct.

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1 Q: It wants someone who has actually worked on
2 similar projects in the past, correct?

3 A: Correct.

4 Q: It wants somebody with experience and education
5 and a number of years with healthcare planning
6 experience, correct?

7 A: Correct.

8 Q: I think when we talked earlier I asked you
9 about the residents of Berkeley County who
10 don't presently have good access according to
11 the 30 minute drive time standard in the State
12 Health Plan, and you said the ones that
13 wouldn't would be the residents living in the
14 more rural region around the north side of the
15 lake, right?

16 A: That's correct.

17 Q: And based on the travel time studies that we've
18 seen in this case, if Carnes Crossroads
19 hospital is built, towns like St. Stephen and
20 Pineville still aren't going to be within a 30
21 minute drive time, are they?

22 A: I was not present in court the day the traffic
23 study analysis was done, but I'll grant that.

24 Q: But you're kind of aware of generally where
25 those towns are, aren't you?

1 A: I am.

2 Q: Mr. Bowling, you know based on your service on
3 the State Health Planning Committee and your
4 knowledge of 61-15 and the CON regs, the State
5 Health Plan, that there aren't any standards in
6 the State Health Plan for the establishment of
7 a new hospital, correct?

8 A: The bed transfer provision has always been used
9 for that since a bed is the unit of service to
10 define an inpatient general hospital, and there
11 are no prohibitions against it either.

12 Q: Well, turn to page 96 in your deposition for me
13 if you would.

14 A: Yes.

15 Q: You there?

16 A: I am.

17 Q: What's the date of this deposition, do you
18 recall?

19 A: October 4th of last year.

20 Q: Now, if you look on page 96, go down to line
21 23, and I ask you, "Are you aware of any
22 standards --"

23 MR. LONG: Your Honor, I object. He's got to ask
24 the whole question.

25 MR. THOMAS: Okay. I can do that, Your Honor. Just

1 trying to save time.

2 Q: 96, let's look at line 17. Said, "And you may
3 still be on it. We don't even know." That's
4 in reference to the State Health Planning
5 Committee, correct?

6 A: Correct.

7 Q: Then I said, "Are you aware of any standards --
8 I've got a copy of the 2008 Plan because I
9 think that refers to yours, don't have my copy
10 right now, but it doesn't really matter. Are
11 you aware of any standards in the 2008-2009
12 State Health Plan that actually speak to the
13 actual establishment of a new hospital in a
14 given area?" And what was your answer?

15 A: "No, not specifically." And it was because
16 your question asked the establishment of a new
17 hospital in a given area without regard to
18 transferring beds or transferring bed need,
19 just start from scratch is what I took by the
20 word actual establishment.

21 Q: Well, the question I asked you before we went
22 to your deposition was this. Based on your
23 service on the State Health Planning Committee,
24 you're aware that there are no standards in the
25 State Health Plan for the establishment of the

1 new hospital, correct?

2 A: Correct.

3 MR. LONG: Your Honor, I'd ask that he read the next
4 two lines.

5 THE COURT: I don't think he was reading from the
6 deposition then. He was going back to his
7 prior question.

8 MR. THOMAS: I was reading from my notes. He's
9 welcome to do that on cross, Your Honor.

10 MR. LONG: Your Honor, what I was asking is, I mean,
11 he just tried to talk to him about the
12 deposition and he stopped. I think the next
13 two lines are very relevant to what his
14 testimony has been, so.

15 THE COURT: Go ahead and read the next two lines.
16 Let's see what it says.

17 Q: As long as I get the -- go ahead and read the
18 next two lines.

19 MR. LONG: Don't you want to read the question?

20 MR. THOMAS: I don't have my place anymore.

21 MR. LONG: I can read the question, Your Honor, if
22 you want.

23 MR. THOMAS: No, hold on. I can find it. Give me a
24 second, please.

25 MR. LONG: It's 97, line two and three.

- 1 Q: All right. And I said, "Okay. There are
2 standards for beds, correct?"
- 3 A: And I say there are. And actually my answer to
4 the other one was, "Not specifically." And
5 then you said, "There are standards for beds,
6 correct?" And I said, "There are."
- 7 Q: Okay. And you had actually just testified to
8 that prior to us going to this page in the
9 deposition, correct?
- 10 A: Correct.
- 11 Q: Now, I think you testified when we were looking
12 at the slide that said final competing
13 application, you thought it was important to
14 apply when Trident applied so the CON
15 application could be in the same planning
16 cycle; do you recall that?
- 17 A: I do.
- 18 Q: And you were on the State Health Planning
19 Committee when Roper made the decision to apply
20 for the CON, right?
- 21 A: I was.
- 22 Q: And you thought that if Trident was approved,
23 it would be a couple of years before Roper
24 could apply because DHEC wouldn't even consider
25 approving another facility until it had

1 utilization data on Trident's new hospital; is
2 that right?

3 A: Actually, we thought it would be more like five
4 or six years because you'd have the
5 architectural and engineering time, then about
6 close to two years for construction. You'd
7 have to have a full calendar year of
8 operations, and then HR's report filed before
9 there could be given any consideration to
10 another facility, or before I believe the staff
11 would give consideration to another facility.

12 Q: Well, now, I'm aware that DHEC won't consider
13 a new CON for an ambulatory surgery center for
14 about a year after one is built, right?

15 A: That's correct.

16 Q: Are you aware of that rule?

17 A: It's -- yeah, they have to have a full year and
18 a JARS report.

19 Q: Are you aware of any similar rule in the State
20 Health Plan or the CON regulations for
21 hospitals?

22 A: I'm not familiar with a written rule. I think
23 that would be prudent on the Department's part
24 to act that way.

25 Q: But there's no rule that says what you think,

1 correct, in terms of --

2 A: That's correct.

3 Q: Now, Mr. Bowling, I think I asked you some --
4 I want to ask you a couple of questions about
5 Cane Bay. Now, first of all, you think it's
6 important for a health system to protect its
7 capital assets because of all the money that
8 goes into those investments, correct?

9 A: Correct.

10 Q: And I think you testified you learned at some
11 point in time that Trident Medical Center
12 bought some land in Cane Bay, right?

13 A: We did.

14 Q: About 20 acres or so, maybe 21; does that sound
15 about right?

16 A: That's sound close.

17 Q: And that was about three miles north of the
18 Carnes Crossroads area?

19 A: I believe so.

20 Q: Okay. And you would agree with me that had
21 Trident tried to apply for a hospital in that
22 location, Roper St. Francis would have opposed
23 that project, correct?

24 A: We likely would have, yes.

25 Q: And the basis for that opposition for Trident

1 Hospital on Cane Bay would've been that such a
2 hospital would've served the same population as
3 Roper St. Francis Berkeley's proposed hospital,
4 correct?

5 A: No, not necessarily. And we're -- in our
6 application the majority, 60 percent of our
7 patient base, is redirected, plus the
8 additional ten percent from out of area, so I
9 don't know that we'd serve the same patient
10 base. It certainly would put us very close to
11 each other.

12 Q: Talking about Cane Bay and Carnes Crossroads?

13 A: I am.

14 Q: Go to page 201 of your deposition, if you
15 would. That may be -- yeah, I think, yeah, 201
16 if you would. Let me know if you're there.

17 A: Uh-huh.

18 Q: Okay. Now, I ask you here on page 201 and I
19 say, "Okay. Well, let me ask you this.
20 Instead of Moncks Corner, HCA had chosen this
21 site that's noted on -- that's Roper Berkeley
22 3295 and it's the Cane Bay site -- do you know
23 if that's the site, Roper would have opposed --
24 would it have opposed that CON?" What did you
25 say?

1 A: I'm lost. What line are you on?
2 Q: Page 202.
3 A: Oh, 202.
4 Q: Line two.
5 A: "We probably would have."
6 Q: And I said, "Okay. Why?"
7 A: "That's clearly going to serve the same
8 population as Carnes Crossroads."
9 Q: So that -- does that refresh your recollection?
10 A: It does.
11 Q: Okay. Thank you, sir. And you'd agree with me
12 that Roper St. Francis Berkeley is proposing to
13 serve the same population that Trident and
14 Summerville already serve by virtue of that
15 seven mile radius where Roper St. Francis
16 intends to capture some market share, correct?
17 A: I would say that there is some overlap of the
18 service areas, yes.
19 Q: So it doesn't surprise you that just as if
20 Roper St. Francis Berkeley would oppose a
21 hospital in Cane Bay, Trident would also oppose
22 Roper St. Francis Berkeley's project, correct?
23 A: No, it doesn't now. I early on did not feel
24 that they would oppose us in the courts.
25 Q: Now, you testified earlier today that if Roper

1 St. Francis isn't allowed to build this
2 hospital on Carnes Crossroads, somehow the
3 system's going to be financially harmed,
4 correct?

5 A: I'm not sure that's exactly what I said. I
6 said there would be about a \$100 million net
7 revenue book of business there that we're very
8 concerned will erode as it becomes more and
9 more difficult to get downtown to the peninsula
10 and get to St. Francis.

11 Q: And you would agree with me, wouldn't you, Mr.
12 Bowling, that justification is nowhere
13 mentioned in the CON application, correct; that
14 if you don't get to build here, your market
15 share or your financial ability for the system
16 is going to erode, right?

17 A: Well, I do. I think we say in the application
18 that we need to relocate there to better serve
19 Roper St. Francis aligned patients. That's
20 clearly what we said.

21 Q: But you don't say that if this hospital's not
22 approved Roper's going to be in some kind of
23 financial distress, do you?

24 A: No.

25 Q: And you've never shared, and I think by this

1 time we've looked at 2007, 2008, 2009, and 2010
2 Roper presentations to the bond rating
3 agencies, you've never told them that if you
4 don't get to build a hospital in Carnes
5 Crossroads that Roper's going to be in some
6 kind of financial distress, correct?

7 A: We did not.

8 Q: In fact, the only thing we have seen is a
9 projection in your CON application, by you I
10 mean Roper, that shows that net income
11 continues to go up, all the way to 2017 to
12 where it reaches \$92 million, and that over
13 that period of time Roper's going to have
14 somewhere north of eight billion dollars in net
15 revenues, correct?

16 A: Over that combined period of time?

17 Q: Yes.

18 A: Yes.

19 Q: Okay. Now, do you recall Judge Kittrell's
20 ruling that Palmetto Health couldn't transfer
21 its hospital beds to Parkridge using the bed
22 transfer section?

23 A: As I recall, and I did not read his ruling, I
24 only read a synopsis of it that I was emailed,
25 that in his initial ruling he said you couldn't

1 use the bed transfer provision for transferring
2 beds and then he reversed himself later.

3 Q: Well, he remanded it back to DHEC for the DHEC
4 Board, right?

5 A: Right, he did.

6 Q: So you're at least aware of one judge that
7 actually thought that the bed transfer
8 provision language didn't say what Roper thinks
9 it says, right?

10 A: Yes. And then he, clearly I think he changed
11 his mind or he wouldn't have remanded it back
12 to the Department.

13 Q: We talked a little bit about Physician
14 Partners, right?

15 A: Yes.

16 Q: And said I think Roper has kind of gone from
17 employing about a handful of physicians in '07
18 to nearly 200 today, correct?

19 A: That's correct.

20 Q: And those physician offices are spread pretty
21 well throughout the Tri-county area, aren't
22 they?

23 A: They're predominantly in Mount Pleasant, James
24 Island, and West Ashley.

25 Q: But you've got some in Berkeley County,

- 1 correct?
- 2 A: We do have a few.
- 3 Q: You've got specialists up in Berkeley County,
- 4 right?
- 5 A: We have specialists who travel to Berkeley
- 6 County and use what are called our med-shares,
- 7 which is a timeshare suite, so they're up there
- 8 maybe a half a day a week or a half a day every
- 9 other week.
- 10 Q: And that's just more efficient for them, right?
- 11 A: It is.
- 12 Q: Now, I think we've established that in Roper's
- 13 physician employment agreement there is a
- 14 contractual obligation that the employee refer
- 15 to Roper facilities, correct?
- 16 A: Yeah, the contractual obligation says that the
- 17 physician agrees to use a Roper St. Francis
- 18 Healthcare facility, except for the case where
- 19 the patient selects to go elsewhere, if they do
- 20 not feel that we offer the service to the
- 21 degree necessary, or if the payer doesn't pay
- 22 for Roper St. Francis Healthcare.
- 23 Q: Because if a payer doesn't pay, then that means
- 24 the patient would be on the hook, correct?
- 25 A: That would be a burden on the patient, yes.

1 Q: Okay. Now, you would agree with me the
2 physician employment agreements don't have any
3 kind of contractual provision that requires the
4 physician to notify the patient of a closer,
5 more convenient facility that may be able to
6 take care of their healthcare needs, right?

7 A: They don't have that contractual obligation to
8 do that, no.

9 Q: Okay. And you would agree with me that
10 patients generally go where their physicians
11 refer them, right?

12 A: They do. That's becoming less common. And in
13 many cases we see insurance companies directing
14 patients, especially for diagnostic imaging and
15 lab work. The insurers have picked preferred
16 providers and so in those cases the patient
17 will go where the insurance company dictates.

18 Q: Has that just occurred in the last three or
19 four months?

20 A: No.

21 Q: Okay.

22 A: That's probably the last five years.

23 Q: Well, let's go to page 55 of your deposition
24 for me, if you would.

25 A: Okay.

- 1 Q: And down at the bottom of page 55, line 24,
2 I'll read the question. "What are your
3 feelings, just your general understanding, do
4 patients generally object to where their
5 physicians refer them to outpatient services,
6 inpatient services?" And what's your answer?
- 7 A: Okay. I lost the line number on that again,
8 I'm sorry.
- 9 Q: Yeah, go over to page 56.
- 10 A: Oh, 56.
- 11 Q: Yeah, line three is where your answer starts.
- 12 A: "No. I think the patient feels the physician
13 has much more knowledge of where, you know,
14 where it's best to have the procedure done than
15 the patient possibly could so they depend a
16 great deal on the physician's judgment."
- 17 Q: So that's what you told me back in October,
18 correct?
- 19 A: Yes. And I still agree with that. That has
20 nothing to do with the patient being directed
21 by insurance.
- 22 Q: But you didn't mention anything about patient
23 directed insurance when I asked you a very
24 similar question back in October, did you?
- 25 A: No.

1 Q: Now, I think we've already established this,
2 but Roper, in addition to employing
3 cardiologists in the Murrells Inlet area, also
4 employs cardiologists in the Beaufort area,
5 too, right?

6 A: It does.

7 Q: And it refers patients for interventional work
8 back to Roper, which is what, about sixty
9 something miles away?

10 A: We do, yes.

11 Q: And they refer them to Roper I guess that's
12 actually 70 miles away rather than maybe
13 referring them to Hilton Head Medical Center,
14 which would be 38 miles away, right?

15 A: And that arrangement with cardiologists in
16 Beaufort was at the request of the Beaufort
17 Memorial Hospital asking us if we would
18 increase our cardiology presence in Beaufort,
19 and they are actually the ones that requested
20 we employ two cardiologists, put them in the
21 market, they do all their diagnostic and
22 invasive work at Beaufort, and then only in the
23 case of an intervention does it come to Roper
24 St. Francis.

25 Q: And an intervention is a pretty lucrative

1 procedure from a reimbursement standpoint,
2 correct?

3 A: It does pay well, yes.

4 Q: And you would agree with me that Roper looks to
5 employ primary care physicians so Roper can
6 capture the speciality referrals, correct?

7 A: Yes.

8 Q: Now, I think Mr. Long mentioned the Lowcountry
9 Medical Associates practice acquisition back in
10 2009. And that was about a -- that was a group
11 of about 62 physicians at the time, right?

12 A: Sixty-two physicians, yes.

13 Q: Okay. And, you know, when Roper St. Francis
14 acquired LMA, it was about the same size in
15 terms of physicians as Palmetto Primary Care
16 Physicians that operates heavily in Dorchester
17 and Berkeley Counties, correct?

18 A: That's correct.

19 Q: Now, Roper, you're not willing to state on
20 Roper's behalf that your -- that Roper will
21 refrain from ever acquiring Palmetto Primary
22 Care Physicians, right?

23 A: We would never hire Palmetto Primary Care
24 unless they wanted to be.

25 Q: That's not my question. You're not going to go

1 on the record and say, look Palmetto Primary
2 Care is out there, they have loyalty to
3 Trident, we're simply not going to try to
4 acquire them or accept their employment should
5 they ask us, correct?

6 A: Won't say that. It's certainly not the plan at
7 the time being nor do we think it would be a
8 good idea.

9 Q: Well, the plan wasn't to acquire Lowcountry
10 Medical Associates back in 2009, was it? I
11 mean, you said they approached you, right?

12 A: They did.

13 Q: And you paid \$11 million for that practice,
14 correct?

15 A: No, that's not entirely true. We paid \$11
16 million for the total transaction, but that
17 transaction included two freestanding
18 diagnostic imaging centers.

19 Q: Fair enough. So you've got some hardware in
20 the transaction, correct?

21 A: Yeah, we had two ongoing business enterprises
22 that were outside of the practice acquisition.

23 Q: And you employed them and spent \$11 million on
24 the practices and some facilities that they
25 have, even though they were loyal to Roper,

1 correct?

2 A: That's correct.

3 Q: Now, you would agree with me that Roper
4 actively monitors the productivity of its
5 physicians, wouldn't you?

6 A: The financial guys do look at the physician
7 performance within the organization.

8 Q: So even though they're reimbursed on a RVU
9 basis, I mean, you know, you still want a
10 productive physician, don't you, because you've
11 got to subsidize those practices, right?

12 A: Well, from my standpoint, what I look at is
13 their personally performed services, so their
14 contract or discussions are really based on how
15 many work RVUs they produce.

16 Q: Right. But you monitor that production and
17 that productivity of their personally performed
18 services, correct?

19 A: We do.

20 Q: And that's because if you have someone who --
21 a physician that just decides well, I'm only
22 going to work a couple of days a week, I mean,
23 there's a heavy subsidy that goes along with
24 employing each physician, isn't there?

25 A: There is. That being said, on a work RVU

1 model, a physician who decides they only want
2 to work two days a week is only going to be
3 compensated for two days a week worth of work.

4 Q: Right. But Roper still has to pay \$150,000
5 subsidy per physician, correct?

6 A: Correct. Now, that subsidy per physician, as
7 I talked about, there is an incredible amount
8 of IT costs that went into that in that year.

9 Q: But that was just for that year, right?

10 A: And this year, because we have another hundred
11 to roll out in the first six months of this
12 year.

13 Q: So what do you think that the subsidy will be
14 after the IT costs?

15 A: I think we'll be able to get it down below
16 national standards. MGMA, I think, has the
17 median at 159 and that's for a blend between
18 specialty and primary care. Our objective is
19 to get primary care down at or below \$80,000 a
20 year in subsidy.

21 Q: So still a heavy subsidy for those physicians,
22 even after the IT costs, correct?

23 A: It is.

24 Q: Now, Roper has actually approached physician
25 practices in Berkeley County about acquiring

1 them, correct?

2 A: We've had a couple of meetings, one with an
3 internal medicine group that called us that's
4 not in Berkeley County. It was actually in
5 North Charleston. I'm trying to think if
6 there's anybody in Berkeley County itself that
7 we've talked to.

8 Q: Well, let me ask you this. Have you ever
9 contacted anyone in North Charleston close to
10 the Trident campus about trying to acquire
11 them?

12 A: Yes, I have. I've received calls from probably
13 three or four groups up there that have asked
14 us to come up and talk to them about
15 employment.

16 Q: Let me ask you this. You know, this is a
17 serious question. Have you ever approached a
18 physician without being contacted first by the
19 physician about acquiring their practice or
20 otherwise employing them?

21 A: Yes, we have.

22 Q: And you've done that often, haven't you?

23 A: No, not often. I would say 80 percent of the
24 physicians we employ initially contacted us.

25 Q: So 20 percent or 40 --

1 A: Forty.

2 Q: -- would have come -- you would have gone
3 directly to, correct?

4 A: Yes.

5 Q: And then you've probably done --

6 A: And actually, that's not all together true,
7 because out of that 40, probably 20 to 25 of
8 those are recruited out of their training
9 programs or relocated from other states.

10 Q: And then there are the ones that you contact
11 but they decline, right?

12 A: That's true. They're ones that have either
13 contacted us or we've contacted them, and
14 ultimately the decision was made that it wasn't
15 in the best interest for them to become part of
16 the Partners.

17 MR. THOMAS: Put up Petitioners 109 for me, if you
18 would.

19 Q: This is an email, Mr. Bowling, dated April 27,
20 2009, correct?

21 A: Yes.

22 Q: And that was before the project review meeting
23 for the Trident Medical Center or for the
24 Moncks Corner Hospital application and the
25 Roper St. Francis Berkeley Hospital

1 application, correct?

2 A: You're saying this followed the two
3 applications being submitted?

4 Q: Yeah. Well, it was before the project review
5 meeting on the two applications, wasn't it?

6 A: Yes, it was.

7 Q: It was April 2009 the email is dated. And who
8 is Christy Farrell?

9 A: Christy Farrell is one of our physician
10 liaisons.

11 Q: She works for you, right?

12 A: She does.

13 Q: And Dawson Cherry, if that is her real name, it
14 states, "Christy, thanks for the invite. Let's
15 shoot for 5/27, Wednesday, to meet with John
16 Sullivan and yourself. We will look forward to
17 seeing you then. Call me if something
18 changes." All right. And John Sullivan, he's
19 the CEO of Roper St. Francis Mount Pleasant,
20 right?

21 A: He is.

22 Q: And then above that -- but at this time Roper
23 St. Francis Mount Pleasant wasn't open for
24 business, was it?

25 A: Right. John is also, as assistant vice-

- 1 president, the Roper Moncks Corner facility
2 reports to Mr. Sullivan.
- 3 Q: Gotcha. Now, this practice administrator,
4 Dawson Cherry --
- 5 A: I think it's Cherry Dawson.
- 6 Q: All right, Cherry Dawson. We'll go with that.
7 But the address there is 9100 Medcom Street,
8 correct?
- 9 A: Yes.
- 10 Q: And that's for South Carolina Sports Medicine.
11 That's an orthopaedic group, right?
- 12 A: It is.
- 13 Q: And that's a group of surgeons up there, right?
- 14 A: They are.
- 15 Q: But where's 9100 Medcom Street?
- 16 A: It's up near the Trident campus.
- 17 Q: It's 100 yards from the hospital, isn't it?
- 18 A: If you say so.
- 19 Q: Well, so Christy Farrell, your employee, writes
20 back, "Regarding meeting with South Carolina
21 Sports Medicine Dr. Kupferman's ortho group at
22 Trident, May 27th." So that's basically saying
23 right there at Trident, correct?
- 24 A: Uh-huh.
- 25 Q: "Do you want to come with and talk about Roper

1 Berkeley Hospital? Or I could just give the
2 latest update. That will be just after project
3 review, correct?" And you say, "Christy, you
4 and John can handle," right?

5 A: That's correct.

6 Q: So this email says thanks for the invite, so
7 this is your employee inviting this group to
8 talk about the Roper St. Francis Mount Pleasant
9 -- or, excuse me, Roper St. Francis Berkeley
10 Hospital before the applications are even --
11 are even approved --

12 A: I think you've made quite a leap there, Mr.
13 Thomas. Christy Farrell calls on physician
14 practices all over the Tri-county with partners
15 and not with partners. Hers is a marketing
16 role. She hands out data on our new services,
17 diagnostic tests, and what she's doing is to go
18 out and do an update to this sports medicine
19 group. And she asked if I would like to come
20 give an update on the project.

21 Q: On what project?

22 A: The Berkeley Hospital project.

23 Q: Right.

24 A: Or she says or I can just give the latest
25 update. So it's clearly just a portion of what

1 they were meeting about.

2 Q: And Dr. Kupferman, he's got privileges at
3 Trident, correct?

4 A: He does.

5 Q: Is he one of those dual doctors that has
6 privileges at Roper?

7 A: I don't believe he is. I think he's pretty
8 much a Trident-only physician. But we call on
9 physicians throughout the Tri-county.

10 Q: Because you want to keep them informed and
11 perhaps acquire and employ them one day,
12 correct?

13 A: Or just to interest them in utilizing our
14 services, more appropriately.

15 Q: You would agree with me that if Roper St.
16 Francis employs enough physicians, I think this
17 has already been admitted, but that it can
18 demand much higher rates from insurance
19 companies, correct?

20 A: I think it allows us to better negotiate for
21 insurance rates, yes.

22 **MR. THOMAS:** And put up Respondent's 168 for me, if
23 you would, the 990 that was produced by Roper.
24 And if you go to page nine. This is Roper
25 Berkeley 4871. Let's see here, go back one.

- 1 Bear with me, Mr. Bowling. All right, yeah.
2 This is what I'm looking for. If you'd blow
3 this up for me.
- 4 Q: Now, these are some of the salaries of the
5 physicians that are employed by Roper St.
6 Francis Physician Partners, correct? That
7 would be Mr. Steichen, Dr. Khoury, Dr. Rawl,
8 Dr. Cuddy and Dr. Lowery, correct?
- 9 A: That's correct.
- 10 Q: And their salaries range here from \$1,064,000,
11 I guess the lowest one on this chart is about
12 \$783,283?
- 13 A: That's correct.
- 14 Q: And I guess back, was it in 2009 or 2010 Roper
15 got some pretty good -- pretty nice increases
16 from Blue Cross Blue Shield on the professional
17 side, right?
- 18 A: We did. We finally got off of the default rate
19 that was being offered to the doctors in
20 Charleston.
- 21 Q: But you got increases much higher than the
22 professional services CPI, didn't you?
- 23 A: Yes, because we were trailing the median
24 reimbursement for physicians by a considerable
25 amount.

1 Q: Well, I still haven't seen too many starving
2 physicians out there, Mr. Bowling, but I'll
3 take your word for it.

4 A: And even fewer starving insurance companies.

5 Q: Now, prior to Roper St. Francis breaking ground
6 in Mount Pleasant on its \$150 million, 85 bed
7 hospital, Roper hardly employed any physicians
8 in Mount Pleasant, right; is that a fair
9 statement?

10 A: That's true --

11 Q: Okay.

12 A: -- to some degree. We did have orthopaedic
13 surgery out there. I think we'd already
14 employed some general surgery. We had a couple
15 of OB's that were going into the market. So we
16 did have some physicians in there, but nothing
17 to the degree that we had later.

18 Q: Well, yeah, I think at the time I deposed you,
19 you told me that Roper St. Francis currently
20 has 22 primary care physicians, five OB
21 physicians, six to ten specialists, some of
22 whom have satellite offices in Mount Pleasant,
23 correct?

24 A: That's correct.

25 Q: So back in 2007 when there were just a few,

1 there are over 40 now who practice in Mount
2 Pleasant, correct?

3 A: That's correct.

4 Q: Now, in 2010, in the summer of 2010, Roper St.
5 Francis acquired Mount Pleasant OB/GYN, didn't
6 it?

7 A: We did.

8 Q: And where was Mount Pleasant OB/GYN located
9 prior to the acquisition?

10 A: They were at 1400 Hospital Drive, which is
11 about two blocks from the East Cooper Hospital.

12 Q: And you'd agree with me that all the babies
13 that were delivered out of that practice pretty
14 much delivered at East Cooper Regional Medical
15 Center, weren't they?

16 A: That's correct.

17 Q: And that was about 30 or 40 babies a month,
18 wasn't it?

19 A: That's correct.

20 Q: And now all those babies, they're delivered at
21 Mount Pleasant Hospital, at Roper's campus,
22 correct?

23 A: Not all of them. There's still probably about
24 ten percent of that practice or more goes to
25 East Cooper still.

1 Q: So maybe four or five will still go over to
2 East Cooper?
3 A: That's correct.
4 Q: And now -- that practice now has an office on
5 Roper's campus, correct?
6 A: They do.
7 Q: And their practice on Hospital Drive, do you
8 remember what you called it? That's their
9 satellite office, right?
10 A: Yes.
11 Q: Now, if you go to Petitioner 5 for me. Do you
12 recognize this document?
13 A: I do.
14 Q: The Business of Medicine. And can you -- you
15 authored this, correct?
16 A: I did.
17 Q: And the subtitle is, The Trend for Physician
18 Employment, correct?
19 A: That is correct.
20 Q: And maybe you've referenced this in earlier
21 testimony today, but in the second paragraph,
22 it's the second full paragraph on this page,
23 you state, "At a recent business development
24 conference of the top 50 not-for-profit
25 healthcare systems in the nation, members were

1 asked who of you are actively employing
2 physicians as part of your strategy,"

3 A: Growth strategy, yes.

4 Q: Growth strategy, thank you. "Forty-seven of
5 the 50 systems indicated physician employment
6 was a priority," correct?

7 A: That's correct.

8 Q: Now, you would agree with me that what Roper's
9 kind of trying to do here is they're trying to
10 do, kind of mimic the model that -- bear with
11 me for a second here -- that Carolinas
12 Healthcare System in Charlotte is doing, right?

13 A: No, Carolinas Healthcare System in Charlotte,
14 first, they never got out of the physician
15 employment business and have been in it since
16 the mid '80s. They employ, actually I think
17 they're now up to about 1,400 physicians, but
18 it's a mix between a private practice model and
19 an academic model.

20 Q: Well, don't you state here in the article on
21 the second column --

22 A: Yeah.

23 Q: -- the most notable --

24 A: Notable in our region --

25 Q: Right. Why don't you read that into the record

1 for us.

2 A: Okay. Could you blow that up?

3 Q: Yeah, sure.

4 A: Because it's really small on the screen -- it's
5 on down.

6 MR. THOMAS: Do the second half down, Sara.

7 Q: All right. Can you read that, Mr. Bowling?

8 A: Yeah. "The most notable in our region is
9 Carolinas Health System based in Charlotte. As
10 a managing founding member of Roper St. Francis
11 Healthcare, CHS now employs more than 1,200
12 physicians in North and South Carolina. It has
13 helped gain them and maintain position as a
14 market leader in their area."

15 Q: Then it says, "For protection of market shares,
16 one of two main reasons healthcare systems are
17 trying to better align with physicians through
18 employment," correct?

19 A: That's correct. The other reason is quality,
20 improving quality.

21 Q: Now, did I hear you correctly; you said that
22 Roper St. Francis Physician Partners was
23 structured from a corporate perspective so it
24 can avoid requirements of Joint Commission and
25 to avoid the 72 hour rule?

1 A: Yeah, I said that we wanted to avoid being
2 under Joint Commission review because of the
3 expense related to that, and most of our
4 physicians don't feel that the Joint Commission
5 standards accurately portray a safe environment
6 in the physician practice, and there was
7 concern with the 72 hour rule, not to avoid it,
8 just not to get crosswise with it, because it's
9 very difficult to keep track if a patient was
10 in a primary care office on Tuesday, and all of
11 a sudden they're in the emergency room on a
12 Thursday night and get admitted, it's very
13 difficult, especially without a common
14 electronic medical record and patient number to
15 make sure that you don't miss that. And
16 missing it is much more detrimental than trying
17 to avoid the rule.

18 Q: But it also allows the physician to bill for
19 the service if the service is within, to the
20 patient, is within 72 hours of the hospital
21 stay, correct?

22 A: That's correct.

23 Q: Go to Petitioner's 93, page 81 for me, if you
24 would. I'm going to show you a page out of the
25 annual update for Moody's, March 1, 2010. And

1 you participate in these, correct, Mr. Bowling?

2 A: I do.

3 **THE COURT:** This is Petitioner's what?

4 **MR. THOMAS:** 93, Your Honor, it's Roper Berkeley
5 1399.

6 **THE COURT:** Thank you.

7 Q: Okay. So, this, what this shows is for kind of
8 a market share in the Tri-county area from 2003
9 to 2008, correct?

10 A: That's correct.

11 Q: And it shows that Roper kind of went from 23
12 point, I think that's maybe nine percent.

13 A: It is.

14 Q: Down to 22 percent in 2008, right?

15 A: That's correct.

16 Q: But Bon Secours kind of, it kind of stayed the
17 same, maybe lost a tenth of a percent over a
18 five year period, six year period?

19 A: Yeah, and you can see that -- which we referred
20 to earlier with the 2006 market share, you can
21 see going from 2005 to 2006 St. Francis remains
22 very static.

23 Q: Right.

24 A: And Roper lost nine-tenths of a point.

25 Q: Right.

- 1 A: And that was the reference that we --
- 2 Q: Okay. And so that's a concern. I mean, the
- 3 graph in the middle, Roper St. Francis
- 4 Hospital, basically the system, it's gone from
- 5 about 35.9 percent to -- and it's lost 2.1
- 6 percent over that five year period, correct?
- 7 A: That's correct.
- 8 Q: Okay. And in about 2007 is kind of when we've
- 9 seen the documents referencing the aggressive
- 10 growth strategy, correct?
- 11 A: That's correct.
- 12 Q: Now, MUSC has been doing something from 2003 to
- 13 2008, correct?
- 14 A: Yes, they have.
- 15 Q: They've gone 24.8 percent to about 29.9
- 16 percent, right?
- 17 A: That's correct.
- 18 Q: And they've done that, would you agree with me,
- 19 they've done that with only one hospital in the
- 20 Tri-county area, right?
- 21 A: They have. They've created multiple medical
- 22 office and destination centers and increased
- 23 their employed group significantly during that
- 24 time.
- 25 Q: And I don't argue with you there, but they've

1 only got one hospital, and where is that
2 hospital located?

3 A: Downtown on the peninsula.

4 Q: Right across the street from Roper, isn't it?

5 A: It is.

6 Q: Your Honor, if you'll bear with me.

7 **THE COURT:** Okay.

8 Q: That's all the questions I have for you today,
9 Mr. Bowling.

10 A: Thank you, Mr. Thomas.

11 **MR. LONG:** Your Honor, it's 5:35. I would ask that
12 we recess until tomorrow to finish his
13 redirect, if that's okay. I would need a few
14 minutes to kind of get organized, but I think
15 we'd go well past six.

16 **MR. SUMMER:** Your Honor, it's going to be a long
17 week.

18 **MR. LONG:** I don't anticipate after I do that --
19 he's obviously tired. He's been on the stand
20 since 9:30 this morning. I think my redirect
21 will be less than an hour and then, of course,
22 he will be down.

23 **THE COURT:** Be assured, Mr. Summer, that I would
24 stay, but I think that out of consideration for
25 the witness and Mr. Long's request that we will

1 break.

2 MR. SUMMER: I understand, Your Honor.

3 THE COURT: Be in recess until 9:30 in the morning.

4 (There being nothing further, the hearing recessed at
5 5:35 p.m.)

6 DAY 12 - TUESDAY, FEBRUARY 14, 2012

7 THE COURT: Back on the record please, ma'am. Long,
8 redirect.

9 MR. LONG: Thank you, your Honor.

10 MR. BOWLING - REDIRECT EXAMINATION BY MR. LONG:

11 Q: Mr. Bowling, just a few questions for you this
12 morning.

13 A: Okay.

14 Q: Yesterday, you testified that if Berkeley
15 County were its own service area, that that
16 would make the county, I think you -- the word
17 you used was wide open. What did you mean when
18 you said, wide open?

19 A: I -- I just meant there -- there are no
20 inpatient facilities in that county, so by the
21 new State Health Plan and the bed needed in
22 county, other providers could apply for -- for
23 beds in that county.

24 Q: Would that include providers from where, all
25 over or just --

- 1 A: All over.
- 2 Q: Let's look at Petitioner's 136. And just
- 3 before we do that, just going back to what you
- 4 were saying. So if providers from all over
- 5 could apply, that would mean that providers
- 6 could apply that didn't have beds to transfer,
- 7 or beds -- facility bed need, right?
- 8 A: That's correct.
- 9 Q: All right. Let's look at Petitioner's 136.
- 10 This was an email. It had some slides on it.
- 11 You can turn to the next page so you can see,
- 12 remind you which one this is.
- 13 A: Uh-huh (affirmative response).
- 14 Q: Do you --
- 15 A: Yes.
- 16 Q: -- recall this?
- 17 A: I got --
- 18 Q: You had some questions on this?
- 19 A: Yes, sir.
- 20 Q: All right. Let's go back to page, first page.
- 21 I just wanted to ask you a little about the
- 22 timing on this. When was -- what does it mean
- 23 when it says strategic slides for BSHSI
- 24 PowerPoint?
- 25 A: BSHSI is the acronym for Bon Secours Health

1 Systems Incorporated. So Bon Secours is one of
2 our founding members with 23 percent ownership
3 in Roper St. Francis Healthcare. With that
4 ownership, it appears to me in this that they
5 are preparing a presentation for their bond
6 ratings for BSHSI Incorporated, and are wanting
7 some information with regard to our strategic
8 planning to incorporate in their bond
9 presentation.

10 Q: Okay. And the date on this exhibit is what?

11 A: It's November 19, 2007 and November 20, 2007.

12 Q: So where would that have been in relation to
13 the actual filing of the Carnes Crossroads CON?

14 A: About a little more than a year before the
15 filing of the CON.

16 Q: Okay. All right. Let's take a look at
17 Petitioner's 125. You were asked about this
18 yesterday. This is a memo that you had sent
19 out --

20 A: Yes.

21 Q: -- you said? Who did you say you sent the memo
22 to?

23 A: I sent to the members of each of our different
24 boards within the Roper St. Francis Healthcare
25 System. So it's sent not only to the big board

1 but the Bon Secours Board, the Roper Hospital
2 Board, the board of the Medical Society, the
3 board of our foundation, and looks like to the
4 Berkeley Advisory Board also.

5 Q: Okay. And look at -- and what is the date of
6 that?

7 A: That is April -- or I mean, sorry, August 12,
8 2008. So it's the day that the Trident CON was
9 filed.

10 Q: Okay. The day it was filed, right?

11 A: Yes.

12 Q: Okay. Read the third -- read the first
13 sentence of the third paragraph.

14 A: "Roper St. Francis Healthcare has elected to
15 reserve comment on Trident's proposed project
16 until we've had the opportunity to review the
17 complete CON application and are better able to
18 determine its impact, if any, on our Moncks
19 Corner facility as well as our future plans in
20 Berkeley County."

21 Q: So had you read the application when that memo
22 went out?

23 A: We had not.

24 Q: Okay. And that's August 12, '08, right?

25 A: Yes, sir.

1 Q: Okay. Let's take a look at Petitioner's 143.
2 Okay. Turn to the next page if you would.
3 Okay. These are the senior staff minutes,
4 right? You were asked about those.
5 A: Yes.
6 Q: And what is the date of the senior staff
7 meeting that day?
8 A: That is August 12th of 2008.
9 Q: And when do y'all typically meet on senior
10 staff?
11 A: Tuesday mornings at 8:30.
12 Q: In the morning?
13 A: Uh-huh (affirmative response).
14 Q: And so that would have been the same day as the
15 memo?
16 A: Yes.
17 Q: Okay. Turn over to the next page where there's
18 discussion of the -- and the next page, I
19 guess, in regards to the discussion of it. So
20 at the time that this discussion occurred at
21 senior staff, had anyone read the CON
22 application?
23 A: No. The only information that anyone had seen
24 by this time was Trident's press release that
25 was issued on the previous Friday.

1 Q: Okay. And so you had just seen the press for
2 the newspaper article --

3 A: Yes.

4 Q: -- basically? And are there other options
5 besides these that were available to Roper St.
6 Francis?

7 A: There were a laundry list of options that we
8 discussed over the next couple of weeks.

9 Q: Is there any way for anybody to know today
10 whether these minutes encompass the -- all of
11 the options that would have been discussed?

12 A: They do not.

13 Q: All right. Let's take a look at Petitioner's
14 104. This is the PowerPoint that you -- one of
15 the PowerPoint's that you were asked about?

16 A: Yes, sir.

17 Q: Now, this particular PowerPoint here,
18 Petitioner's 104, did you actually draft the
19 PowerPoint?

20 A: I would have been very involved in drafting
21 this PowerPoint and actually created some of
22 the slides.

23 Q: Okay. And who would have helped you? I'm just
24 talking about who would have helped you
25 actually write the slides.

- 1 A: Mike Cassells with decision support and likely
2 Elizabeth Player who worked for him in decision
3 support and my assistant Shannon Stefenson may
4 have actually put some of it together.
- 5 Q: Okay. But it was internal to Roper St.
6 Francis?
- 7 A: Yes.
- 8 Q: So this is an internally created PowerPoint,
9 right?
- 10 A: Yes, it is.
- 11 Q: All right. Let's go over and look at page four
12 of the PowerPoint. You were asked about this
13 slide particularly. This is discussing the
14 ambulatory surgery facility; is that correct?
- 15 A: It is.
- 16 Q: All right. Now, again, explain to the court
17 what the surgery direct margin numbers mean --
- 18 A: That is --
- 19 Q: -- for each year.
- 20 A: Yeah. That is revenue minus expenses. And so
21 actually how much the center made or lost in
22 each year from 2002 to 2007.
- 23 Q: And for each year in 2002, is the revenue
24 greater than the expenses or are the expenses
25 greater than the revenue?

- 1 A: Expenses are greater than the revenue.
- 2 Q: Okay. Now, so did it ever show a profit in any
- 3 of those years between '02 and '07?
- 4 A: It did not.
- 5 Q: All right. Now --
- 6 A: It's average -- we looked at the average loss
- 7 as about a half a million a year.
- 8 Q: Okay. And even with the utilization increasing
- 9 from '02 to '06, right?
- 10 A: That's correct.
- 11 Q: Okay. Yesterday Mr. Thomas asked you about
- 12 options when the service was not -- was not
- 13 showing a profit in regards to the relocation
- 14 of a surgery center.
- 15 A: Right.
- 16 Q: Is this surgery center still open today?
- 17 A: It is.
- 18 Q: Okay. Has it been relocated?
- 19 A: It has not.
- 20 Q: Has it been closed?
- 21 A: No. It has not.
- 22 Q: Okay. Are there -- does every service or
- 23 facility at Roper St. Francis have to show a
- 24 profit to stay open?
- 25 A: No.

1 Q: Okay.

2 A: No.

3 Q: Can you explain that to the court?

4 A: We have a number of services and hospitals that
5 are just not profitable. The -- they -- they
6 cost more, they utilize more resources than we
7 can possibly be reimbursed for and hospital
8 business that's offset with other procedures
9 that are more profitable. But those
10 unprofitable services have to be offered for
11 patient care.

12 Q: Well, what are some of the reasons that you
13 would offer a service at a hospital like Roper
14 St. Francis that's not profitable?

15 A: Well, as I said, for -- for the full continuum
16 of healthcare, many of those services have to
17 be offered. Nephrology is often not a
18 profitable service, but it is critically
19 important to an open heart program that -- that
20 you offer nephrology and dialysis. So those
21 components which by themselves are not
22 profitable are very important to the care of
23 the patients.

24 Q: And so is there a third option in regards to --
25 did Roper St. Francis actually choose an option

1 other than relocation or close the surgery
2 center facility?

3 A: No. We chose to keep it open.

4 Q: Okay. And has that always been an option for
5 Roper St. Francis?

6 A: It has.

7 Q: Is that true of every service or facility that
8 the hospital operates that is not profitable?

9 A: That's true.

10 Q: All right. Let's turn to page 12 of the
11 PowerPoint. All right. These are the compare
12 and contrast slides, right?

13 A: They are.

14 Q: And first I wanted to ask you, you testified
15 about the 65 percent market share on this
16 slide?

17 A: Yes.

18 Q: And I think -- how did you describe that? Do
19 you recall yesterday?

20 A: We felt that that -- when we were looking at
21 the maximum number of beds that we felt the
22 facility could support, we chose what we
23 thought would be upper possible limit of market
24 share achievement for that purpose. So you
25 wouldn't pick a low market share to determine

1 the maximum size of the facility. So we picked
2 a market share that we thought would be upper
3 limit and that was 65 percent. And by choosing
4 that, and that's what produced the bed need of
5 22 beds or 100 beds.

6 Q: Okay. Let's talk about what you -- how you did
7 the calculation too. Now, you got some of the
8 information to do this calculation from Mr.
9 Richardson; is that your testimony?

10 A: We did.

11 Q: Now, the population -- I'm going to give you a
12 calculator to help you, okay? You didn't use
13 the whole county to calculate this calculation,
14 did you?

15 A: No, we didn't. It's based on the seven mile
16 planning radius that we had used for multiple
17 analysis.

18 Q: Okay. Total the population for the two
19 communities, Moncks Corner and Carnes
20 Crossroads, and give me the total population,
21 if you would.

22 A: That's 109,042.

23 Q: Okay. And what's the population in Berkeley
24 County?

25 A: Over 177,000.

- 1 Q: On the 2010 census --
- 2 A: On the 2010 census --
- 3 Q: -- right?
- 4 A: -- yes.
- 5 Q: So you're capturing how much of the total
- 6 population with these two seven mile circles?
- 7 A: Okay. Sixty-one percent.
- 8 Q: Okay. So you're capturing a little less than
- 9 two-thirds of the population with these two
- 10 circles?
- 11 A: That's correct.
- 12 Q: And your market share is 65 percent, so are you
- 13 capturing 100 percent of the patients in that
- 14 area or are you capturing a percentage of the
- 15 patients?
- 16 A: Capturing a percentage of the patients.
- 17 Q: And so the percentage is the 65 percent market
- 18 share?
- 19 A: It is.
- 20 Q: Okay. What's the total number of beds that you
- 21 show needed for the two communities?
- 22 A: One hundred and twenty-two.
- 23 Q: Okay. And that is more or less than the 100
- 24 beds that have been applied for in this -- in
- 25 this case?

1 A: That is more than the 100 beds that have been
2 applied for.

3 Q: Okay. Let's look at Petitioner's 242. This is
4 Mr. Thomas' summary from yesterday, but it
5 reflects the PowerPoint that has the little --
6 that has the small boxes --

7 A: Yes.

8 Q: -- on it, the way it was printed. Do you
9 recall that?

10 A: I do recall it.

11 Q: Okay. And is that a similar PowerPoint to the
12 one we just looked at in Petitioner's 104?

13 A: Yes.

14 Q: Did you actually use some of the slides from
15 104 to create this PowerPoint that goes with
16 this? Do you want to look at that PowerPoint?
17 I think it's 102. Let me show it to you real
18 --

19 A: Okay.

20 Q: -- quick, and then we'll go back to 242 because
21 that -- I think it's 102.

22 A: Yeah.

23 Q: Okay.

24 A: Yes.

25 Q: So does this PowerPoint here use some of the

- 1 same slides of the PowerPoint that you had
2 before?
- 3 A: Yes, it does.
- 4 Q: Okay. And so which one do you think was
5 created first, if you know?
- 6 A: I don't know. I --
- 7 Q: Okay. That's fine. So let's go back to Mr.
8 Thomas' Petitioner's 242, the summary. There
9 we go. Okay. Now, this projection is based --
10 is a little bit different. It's based on, I
11 think, eight zip codes?
- 12 A: It is, eight zip codes. The eight zip codes
13 that we've seen around the lake.
- 14 Q: Lake Moultrie, right?
- 15 A: Yes, sir.
- 16 Q: Eight zip codes around Lake Moultrie?
- 17 A: Yes.
- 18 Q: All right. So is the population smaller or
19 larger than the slide that we just looked at in
20 Petitioner's 102?
- 21 A: As it relates to Moncks Corner, this is just a
22 little more than twice the population that we
23 discussed in the other one.
- 24 Q: Okay. So it's about 47,500 people, right?
- 25 A: Correct.

1 Q: Okay. And so the calculation of the admissions
2 -- now, what market share are you using in this
3 calculation?

4 A: In this calculation a 50 percent market share
5 was used.

6 Q: Okay. Now, what is Trident Health System's
7 market share in Berkeley County?

8 A: Fifty-four percent.

9 Q: Okay. How hard do you think -- would it be
10 harder for Trident to obtain a 50 percent
11 market share or Roper St. Francis to obtain a
12 50 percent market share in this area?

13 A: It's going to be more difficult for Roper St.
14 Francis because we have just less than 24
15 percent market share there. So we'd
16 essentially have to double ours, where this is
17 slightly less than there's.

18 Q: Okay. And would you hope that if you opened a
19 new hospital, like the hospital you had in
20 Carnes Crossroads, that you would at least be
21 able to maintain the market share for the eight
22 zip codes right around your hospital?

23 A: Yes.

24 Q: Okay. So if you had a 50 percent market share
25 at Moncks Corner, according to your

1 calculation, how big a hospital could that area
2 right there support?

3 A: Right there, it says a bed need of 41 beds, and
4 it's using the 3.7 average length of stay.

5 Q: Okay. And so if the average length of stay was
6 higher with that, what would that do to the bed
7 need calculation?

8 A: I think yesterday our calculation at 4.25
9 average length of stay took it to 47 beds.

10 Q: Okay. And what size is the hospital that's
11 proposed for Moncks Corner?

12 A: Fifty beds.

13 Q: All right. Let's look at Petitioner's 164.
14 Okay. This is the PowerPoint about the
15 ambulatory surgery center; is that correct?

16 A: That's correct.

17 Q: You were asked about this --

18 **THE COURT:** Excuse me. You said the bed -- the
19 hospital proposed for Moncks Corner. Did you
20 mean Carnes Crossroads?

21 **MR. LONG:** No, your Honor. I meant --

22 **THE COURT:** You meant Trident.

23 **MR. LONG:** -- Moncks Corner. I meant the --

24 **THE COURT:** The Trident Hospital?

25 **MR. LONG:** -- the Trident Hospital.

1 THE COURT: Okay.

2 MR. LONG: Because that was the Moncks Corner
3 population.

4 Q: Looking at Petitioner's 164, this is a
5 PowerPoint you were asked about yesterday,
6 right?

7 A: Yes.

8 Q: Okay. Now, what was this PowerPoint prepared
9 for?

10 A: This PowerPoint was prepared for a project
11 review on -- that was coming up regarding the
12 relocation of the ambulatory surgery center
13 from Moncks Corner to Carnes Crossroads.

14 Q: Okay. And was this PowerPoint ever presented?

15 A: It was not.

16 Q: Okay. Why not?

17 A: Because prior to the project review date, we
18 notified DHEC that we were going to withdraw
19 that CON application and submit the application
20 for the 50 bed hospital.

21 Q: Is it -- is this a final document or a draft?

22 A: This is a draft document.

23 Q: Okay. And you were asked some questions about
24 the impact of a shift in market share from the
25 construction of the hospital in Carnes

1 Crossroads towards the end of the day
2 yesterday; do you recall that?
3 A: I think so.
4 Q: Yeah. Well, and I believe your testimony was
5 something if the adverse impact were to occur,
6 that Trident would be at risk for losing market
7 share or --
8 A: If it were to occur, yes.
9 Q: All right. Now, isn't there another major
10 provider in this market in Berkeley County?
11 A: Yes --
12 Q: And who --
13 A: -- MUSC.
14 Q: Okay. Who is that?
15 A: Medical University of South Carolina.
16 Q: All right. And if there was a shift in market
17 share from the construction of the Carnes
18 Crossroads hospital, could there also be a
19 shift in market share from MUSC?
20 A: There could be.
21 Q: And are there some reasons that the market
22 share shift from MUSC might be greater than the
23 market share shift from Trident?
24 A: Absolutely. They -- they don't have a facility
25 in the area. They don't have physicians in the

1 area. And as we've talked about, it's getting
2 more and more difficult to get downtown. So to
3 get to MUSC is more difficult, so I think they
4 would be at greater risk of losing some market
5 share there than Trident.

6 Q: And is MUSC, with their market share, are they
7 a serious player in the market?

8 A: Absolutely.

9 Q: In the whole Tri-county market?

10 A: They are.

11 Q: What is their strategy in regards to at least
12 the Mount Pleasant area of Charleston County in
13 regards to their plans for market share? What
14 are you seeing their strategy is?

15 A: They have elected a strategy to put very
16 sizable outpatient services within a market,
17 large medical office buildings, a large number
18 of employed physicians and specialists in the
19 community to see the patient in the outpatient
20 setting. And then for any inpatient
21 procedures, the physicians take those patients
22 back downtown.

23 Q: Okay.

24 A: In Mount Pleasant they are just finishing
25 construction on a 70,000 square foot medical

1 office building and diagnostic center that will
2 be right in the heart of Mount Pleasant.

3 Q: And the question you were asked about yesterday
4 in regards to the market share email that you
5 sent, I think you were asked about it on direct
6 --

7 A: Yes.

8 Q: -- and in cross. And you said you thought MUSC
9 was a winner on the market share for 2006.

10 A: That's correct.

11 Q: Okay. What do you -- do you think the strategy
12 is related to that?

13 A: I think it is, and as we saw at that time,
14 that's when they became more aggressive at
15 practice acquisition and started moving
16 specialists out into the community.

17 Q: Okay. Now, you were asked about this subsidy
18 that is paid by Roper St. Francis to the
19 employed physicians. Do you recall that
20 testimony?

21 A: Yes, I do.

22 Q: Okay. Well, explain to the judge what you mean
23 when you -- when you're talking about a subsidy
24 being paid to physicians.

25 A: The revenue that is generated from the billings

1 for those physicians does not cover the overall
2 cost of employing physicians and their staffs
3 and paying for their real estate and the
4 physician compensation, so when we got to
5 revenue over expenses, expenses are outpacing
6 revenue right now. Great deal of it is -- is
7 related to the incredible amount of information
8 technology that we're having to put into these
9 practices as we bring them on board.

10 Q: Is the staffing, is the cost of staffing in
11 those physician offices also an impact?

12 A: It is.

13 Q: How does that impact the --

14 A: Well, when staff comes over to Roper St.
15 Francis Healthcare as a large employer, they go
16 onto our pay scales and benefits and typically
17 the benefits that we pay are much greater than
18 the physicians pay their employees in private
19 practice.

20 Q: You also mentioned a -- you mentioned something
21 yesterday called the MGMA?

22 A: Yes.

23 Q: Okay. What is the MGMA?

24 A: The Medical Group Management Association is a
25 national firm representing physician practices

1 across the country. They gather data on
2 physician compensation, cost, most of the
3 financial metrics with regards to physicians
4 across the country. They do have the largest
5 comparative database. And so as we look at
6 fair market value, and I think most of the
7 consultants across the country look at fair
8 market value, they use MGMA as the benchmark
9 for those numbers.

10 Q: And I think you also talked about the median
11 subsidy --

12 A: Yes.

13 Q: -- per physician. Kind of explain to me what
14 you were talking about in regards to that.

15 A: MGMA does track with both private practice and
16 healthcare system employed physicians what the
17 average subsidy across the nation is, and they
18 report that in what's called the annual cost
19 report. This last cost report, which came out
20 in 2011 based on 2010 data, showed the median
21 subsidy of healthcare system employed
22 physicians at about \$159,000 per physician.

23 Q: Okay. So that means -- what does that mean,
24 \$159,000 per physician?

25 A: That means for each physician that a healthcare

- 1 system employees they're having to invest about
2 \$159,000 beyond what's brought in by that
3 practice in order to fund it.
- 4 Q: And that's the median number?
- 5 A: That is the median.
- 6 Q: So that's like half above, half below?
- 7 A: Half above, half below.
- 8 Q: Okay. And where does Roper St. Francis fall in
9 that range? Are they above or below median per
10 physician?
- 11 A: With our primary care, we're well below median.
12 With our specialty care, we're slightly above
13 median.
- 14 Q: Okay. Do you know of any reason why Trident
15 could not employ physician or in -- in the
16 area?
- 17 A: No. They do. And they recently hired one of
18 my best practice managers to take that role at
19 their region office.
- 20 Q: And is there anything that, reason that Trident
21 could not employ Palmetto Primary Care other
22 than physician -- the physicians' choice?
- 23 A: Oh, absolutely not.
- 24 Q: Okay. All right. Let's look at Petitioner's
25 5. Let's look at page three. Now, what is

1 Petitioner's 5?

2 A: This is an article that I wrote for an internal
3 publication called *Consult*. It's a magazine
4 that goes to physicians primarily in the
5 Medical Society. And there are -- they wanted
6 an article from both sides, one on physician
7 employment and the other side of that article
8 was written by an independent physician on why
9 he felt it was best for some practices to
10 remain independent private practices.

11 Q: Okay. Let's look at page three of the article
12 if we can. Mr. Thomas quoted to you a portion
13 of the -- a portion of the article yesterday,
14 or had you read it. I want to get you to read
15 another part real quickly --

16 A: Okay.

17 Q: -- on page three, and I need to figure out --
18 tell her where to plug up.

19 MR. LONG: I'm sorry, your Honor. I'm sorry I'm
20 having this hard a time. All right. Let's go,
21 yeah, right at the top.

22 Q: Okay. Let's look at that. All right.

23 A: This?

24 Q: Can you -- can you publish this first paragraph
25 here?

1 A: You want me to read that?

2 Q: Yes, if you would.

3 A: "The business side of practicing medicine has
4 become incredibly complex and fraught with
5 legal pitfalls and risks. Further concern --"

6 Q: I'm sorry. I'm sorry. I apologize. We're on
7 page two instead of page three.

8 A: Okay.

9 Q: Okay.

10 A: "The healthcare system's desire to hard wire
11 quality improvement also drives the employment
12 model. It is difficult to ask private
13 practicing physicians to participate in
14 difficult and time-consuming quality
15 improvement initiatives that take them out of
16 the office or the operating room. Under an
17 employment model, a doctor can be compensated
18 not only for productivity, but also for
19 participation and achievement in quality
20 measures." Do you want me to go on?

21 Q: No, that's fine. Thank you. Does the
22 employment of physicians improve quality in
23 your facilities?

24 A: It does.

25 Q: That's all we have. Thank you, Mr. Bowling.

1 Thank you, your Honor.

2 THE COURT: Thank you, sir. You may step down.

3 THE WITNESS: Thank you, sir.

4 THE COURT: Next witness, Mr. Long.

5 THE COURT: Thank you, your Honor. We call Matt
6 Severance to the stand.

7 MATTHEW J. SEVERANCE, being duly sworn, testifies as
8 follows:

9 MR. LONG: Excuse me, your Honor. I want to make
10 sure the book is up there for him. That's it,
11 you need that one. May it please the Court?

12 THE COURT: Proceed.

13 MR. SEVERANCE - DIRECT EXAMINATION BY MR. LONG:

14 Q: Can you state your full name for me, please?

15 A: Matthew James Severance.

16 Q: And what is your address?

17 A: 54 Legree Street, Charleston, South Carolina.

18 Q: And Mr. Severance, where are you employed?

19 A: Roper St. Francis Healthcare.

20 Q: And what is your occupation at Roper St.
21 Francis?

22 A: I am the CEO at Roper Hospital.

23 Q: Okay. And is Roper Hospital the same thing as
24 Roper Downtown?

25 A: It is.

1 Q: Okay. And we've been referring to it as some
2 of the case. So where is the hospital located?

3 A: It's located on the peninsula of Charleston on
4 Calhoun Street, 316 Calhoun Street.

5 Q: All right. Let's before we start talking about
6 your hospital, the hospital where you're CEO,
7 let's -- can you give the court your kind of
8 educational and employment background since
9 college?

10 A: Sure. I attended Wake Forest University as an
11 undergraduate. I received a business degree
12 there. I followed that with graduate school at
13 the University of Florida where I received a
14 master's in hospital administration and a
15 master's in business administration. And part
16 of the master's in hospital administration was
17 to engage in a year long residency post. After
18 the didactic portion of the program, I did that
19 at Roper Hospital in 1990.

20 Q: Okay. And then after you completed your
21 residency program at Roper, what happened?

22 A: I worked at Roper Hospital from 1990 to 2001 in
23 a number of different capacities. Early on I
24 would characterize those jobs as operational in
25 nature. I had responsibility for multiple and

1 varying departments and was fortunate enough to
2 have those duties changed probably every 18
3 months or so, so that I got wide exposure to
4 many departments within the hospital. Later I
5 had some -- was employed as a strategic planner
6 for the health system, and got some experience
7 in planning and in development. It was a time
8 when the health system was growing; our
9 outpatient network, diagnostic centers, free-
10 standing surgery centers, things of that
11 nature. So I got some experience in that. And
12 then in I guess 1999 the CEO at Roper Hospital
13 left and I was asked to function in that
14 capacity on an interim basis, and did that for
15 about 14 months. And then in 2001 I had the
16 opportunity to take a job as the chief
17 operating officer, the number two guy at a
18 hospital, in Westchester County, New York. I
19 thought it was a good opportunity. It would be
20 good experience for me personally to, you know,
21 experience a different environment at a
22 different facility, so I took that opportunity.

23 Q: Okay. Let me ask you to speak up just a little
24 bit --

25 A: Sure.

1 Q: -- if you can. All right. Well, then did you
2 have the opportunity to come back to
3 Charleston?

4 A: I did. So I was in New York for three years,
5 and in 2004 the position of CEO at Roper
6 Hospital opened. I applied for that position
7 and was ultimately hired for that role.

8 Q: And how long have you been the CEO at Roper
9 Hospital?

10 A: Since May of 2004, so --

11 Q: Okay.

12 A: -- seven years.

13 Q: And what are your responsibilities as the chief
14 executive officer at Roper Hospital?

15 A: I am the individual that is ultimately
16 responsible for the operation of Roper Hospital
17 along a number of fronts; from a quality
18 standpoint, from a service standpoint, as an
19 employer to our employees, physician relations,
20 financial performance. So I'm the guy that at
21 the end of the day the people look to for Roper
22 Hospital's performance.

23 Q: Okay. And how many employees work at Roper
24 Hospital Downtown?

25 A: It's about 2,500.

- 1 Q: Just in that facility --
- 2 A: In the facility.
- 3 Q: -- on the peninsula?
- 4 A: That's correct.
- 5 Q: All right. And who do you report to?
- 6 A: I report to David Dunlap, who's the president
- 7 of the health system.
- 8 Q: Okay. And is there another hospital on the
- 9 peninsula in Charleston?
- 10 A: There are two hospitals; the Medical University
- 11 of South Carolina is across the street from
- 12 Roper Hospital, and the V.A. Hospital is also
- 13 within a block of Roper Hospital.
- 14 Q: Okay. What was your role in regards to the
- 15 Carnes Crossroads hospital's CON application?
- 16 A: My role was limited to opining on the -- on the
- 17 matter of whether or not we could give 50 beds,
- 18 we could relocate 50 beds from Roper Hospital
- 19 to service that community without impairing the
- 20 needs at Roper Hospital Downtown.
- 21 Q: Okay. Let me show you Respondent's 25. It's
- 22 also in your book there if you'd rather look at
- 23 the pages.
- 24 A: Twenty-five?
- 25 Q: Twenty-five. Okay. This is the second page of

- 1 the -- of the document. Let's see, do you have
2 it?
- 3 A: I do.
- 4 Q: Okay. So tell me what Respondent's 25 is.
- 5 A: So this was an analysis that we performed. And
6 we performed this in September of 2008 to look
7 at the ability of Roper Hospital to move beds
8 away from the downtown campus. And my main
9 concern was would that impair our ability to
10 continue our mission downtown on the peninsula.
- 11 Q: Okay. Now, who helped you with this analysis?
- 12 A: Our planning department.
- 13 Q: Okay.
- 14 A: My memory is it was Mike Cassells.
- 15 Q: All right. Can you kind of walk me through
16 this -- and so was it, your analysis, put into
17 the form of a PowerPoint?
- 18 A: It was.
- 19 Q: Okay. And that's what -- that's what this
20 document is?
- 21 A: And that's what this document is.
- 22 Q: Okay. And of course you -- was this PowerPoint
23 presented to others besides yourself?
- 24 A: I don't recall it being presented. I certainly
25 used this to be able to articulate that we

1 could move the beds.

2 Q: Okay.

3 A: It certainly could have been presented.

4 Q: Let's take a look at, let's walk through the
5 PowerPoint and look at each of the slides, and
6 you can kind of -- if you could, walk us
7 through the -- walk the court through what
8 these slides show. So let's start with Roper
9 Berkeley 2677, this page right here.

10 A: Sure.

11 Q: If you could kind of walk the -- well, walk
12 Your Honor through what this PowerPoint shows.

13 A: Sure. Your Honor, at the top is our current
14 licensed beds. This was as of September 2008.
15 And this is acute care only. So the fact is
16 that Roper Hospital has licensed acute care
17 beds and also licensed rehab beds.

18 Q: And let's stop for a second, because it does
19 say excluding rehab there. Explain what the
20 difference is between an acute care bed and a
21 rehab bed.

22 A: So an acute care bed is a bed for what you
23 would typically think of someone going to the
24 hospital for or length of stay. An acute care
25 bed is currently approximately five. At the

1 time of this analysis it was higher. Rehab are
2 folks that have suffered a stroke or a major
3 traumatic injury and they need extensive
4 rehabilitative services. Those being defined
5 as physical therapy, occupational therapy,
6 speech therapy. And typically those patients
7 will -- to meet the criteria for rehab, they
8 have to be -- be able to tolerate three hours
9 of therapy per day. And this population of
10 folks typically have lengths of stay that are
11 around 14 days. And so it's a -- it's a
12 separate type of bed as licensed through DHEC
13 and paid separately and distinctly from acute
14 care.

15 Q: Okay. And Roper Downtown has rehab beds?

16 A: We do. At the time of this analysis, we had 39
17 rehab beds. Since then, we've added 13, and we
18 currently have 52 rehab beds.

19 Q: All right. But the 414 acute care -- when you
20 say current licensed beds, does the rehab beds,
21 are they included in the 414, or are they in
22 addition?

23 A: They are not. Rehab would be in addition to
24 the 414.

25 Q: Okay. So you had current licensed beds at 414

- 1 and again walk me through --
- 2 A: Sure.
- 3 Q: -- these different --
- 4 A: So we were transferring 13 beds to the Bon
5 Secours St. Francis Hospital in Mount Pleasant.
6 They were --
- 7 Q: In Mount Pleasant?
- 8 A: In West Ashley. And so the St. Francis
9 Hospital in West Ashley was going through a bed
10 addition, and 13 of those beds were coming from
11 Roper Hospital. And so we back that out, and
12 that took us to a licensed beds of 401. And
13 then we contemplated the 85 beds that would be
14 going to the Mount Pleasant Hospital, which --
- 15 Q: All right. Stop there for a second. This was
16 done in 2008, correct?
- 17 A: That's correct.
- 18 Q: And when did the Mount Pleasant hospital open?
- 19 A: November 2010.
- 20 Q: So that facility was under construction, so the
21 beds had not been transferred yet, right?
- 22 A: The beds had not been transferred.
- 23 Q: All right. But they were going to be?
- 24 A: They were going to be.
- 25 Q: All right. What happened after that?

- 1 A: So the 85 beds reduction resulted in 316
2 licensed beds at Roper Hospital. And then we
3 contemplated 50 beds that would ultimately be
4 transferred to a Carnes Crossroad hospital.
5 And that left us with 266 licensed beds that we
6 would be -- that would remain at Roper Hospital
7 Downtown.
- 8 Q: Okay. And so if the hospital -- after the
9 hospital is constructed at Carnes Crossroads
10 and the beds are transferred, Roper Downtown
11 would have how many beds?
- 12 A: Two hundred sixty-six.
- 13 Q: Okay. Let's look at the next slide Roper
14 Berkeley 2678. Can you explain to the court
15 what this slide shows?
- 16 A: Sure. So, again, at the time of the analysis,
17 Roper Hospital was licensed for 414 beds. What
18 this shows is it shows the census on every day
19 of the year, and it shows that our peak census
20 was 284, which never approached the 414 beds
21 that we were licensed for. So --
- 22 Q: And let's slow down a second. What's the
23 census?
- 24 A: The census are the number of heads that are on
25 -- number of inpatient heads that are on

- 1 pillows at midnight.
- 2 Q: Okay. And what year is this data?
- 3 A: This is 2007.
- 4 Q: Each day of the year?
- 5 A: Each day of the year.
- 6 Q: Okay. I noticed that your census -- you said
- 7 your peak census day was 284?
- 8 A: That's correct.
- 9 Q: And let's turn to the actual next slide too.
- 10 So what was the next slide on Roper Berkeley
- 11 2679?
- 12 A: So we also looked -- this was a frequency
- 13 distribution of our census. And what we were
- 14 trying to look is, you know, so what is our
- 15 most frequent census. And that was determined
- 16 to be 231, which occurred 13 times in 2007.
- 17 Q: Okay. And of course, when you say 13 times,
- 18 does that mean a day, 13 nights?
- 19 A: Thirteen nights --
- 20 Q: Okay.
- 21 A: -- within the year.
- 22 Q: All right. Let's talk about your census at a
- 23 hospital like Roper Downtown. Does it -- does
- 24 your census fluctuate, or is it steady?
- 25 A: Our census fluctuates significantly. It

1 fluctuates by day of the week, by -- when I say
2 that, so --

3 Q: Can you explain why it would fluctuate by day
4 of the week?

5 A: Sure. The weekend tends to be a lower census.
6 If we looked at our delta in census from
7 Saturday to Tuesday, our census swings from 80
8 to 100 patients would not be unusual for a
9 typical week at the hospital.

10 Q: So what exactly does that mean? You're
11 comparing Saturday to Tuesday?

12 A: So generally what happens are patients --
13 physicians like to -- patients don't like to be
14 in the hospital on the weekend. They don't
15 like to be in the hospital on a holidays.
16 Physicians also don't like their patients to be
17 in the hospital on weekends and holidays, and
18 so they try to manage the schedules to
19 accommodate that. So what we end up with is a
20 bolus of business during the week. One of the
21 things that we happen to do a lot of at Roper
22 Hospital is what we call total joints. These
23 are hip and knee replacements. We do more of
24 those than I believe anyone in the state. And
25 the schedule for that is those surgeries are

1 done on Monday and/or Tuesday, patients recover
2 and are discharged Thursday and Friday. So
3 that unit, nursing unit, typically we are
4 closing down on the weekend because the
5 patients have been cared for and discharged
6 prior to the weekend. Same thing happens
7 around holidays. Seasonally, certainly the
8 colder months of the year are typically busier
9 as folks are suffering from respiratory
10 illnesses, so there's a seasonal dynamic. In
11 the summer, patients are on vacation,
12 physicians are on vacation. Spring break is
13 usually a low census period because physicians
14 take their families on vacation. If they're on
15 vacation, they're not bringing surgeries to the
16 hospital. So there's -- a hospital census is
17 a dynamic thing. It's certainly not a stable
18 phenomena.

19 Q: Okay. And so the most frequent census is 231
20 in 2007?

21 A: That's correct.

22 Q: Okay. All right. Let's look over to Roper
23 Berkeley 2680, and see if you can kind of
24 explain that slide to --

25 A: Okay.

1 Q: -- the court.

2 A: So this is again a frequency distribution, and
3 this is -- this is the Roper census extracting
4 patients from the Mount Pleasant zip code. And
5 so what we've done here is we -- we've removed
6 the 85 beds that would be relocated to Mount
7 Pleasant, so we would have gone down from 414
8 licensed beds to 316, assuming that the Mount
9 Pleasant hospital would be built and become
10 operational. And we removed the patient census
11 for patients that live in the Mount Pleasant
12 zip codes, and what that shows is that the peak
13 census after doing that analysis was 269, which
14 was well short of the 316 licensed beds that
15 would remain downtown at Roper. And that we
16 only get 80 percent or more occupancy on 14
17 days. And then the note at the bottom, I
18 think, is a critical note because it
19 underscores the conservative nature of this
20 analysis. And that is, it assumes that length
21 of stay would remain constant. And what we
22 knew was that our length of stay at Roper
23 Hospital was above the industry norm, and what
24 we knew is that we were actively seeking to
25 drive that length of stay down toward the

1 industry norm, and that by driving the length
2 of stay down, it would reduce our census on any
3 given night.

4 Q: Okay. Let's finish that. I want to come back
5 and ask you a few more questions about that
6 also. Let's look at the next page, Roper
7 Berkeley 2681. Tell me what -- this is the
8 last page of the PowerPoint.

9 A: Right.

10 Q: What does it show?

11 A: So this takes the next step, and it assumes
12 that 50 beds are relocated to the Carnes
13 Crossroads site, and it, in addition to
14 extracting the Mount Pleasant patients, it also
15 extracts the patients that were in the hospital
16 that had zip codes for the Carnes Crossroad
17 service area. And when we did that, what we
18 found was that our peak census was 245, which
19 again was below the new and reduced hospital
20 license, it would be 266. And we found that
21 the occupancy would be greater than 80 percent
22 one-third of the time. And again, we noted
23 that the assumption was that length of stay
24 would remain constant and conservative nature
25 of that.

1 Q: Okay. Look at this. Why did you select the 80
2 percent occupancy number in this analysis?

3 A: You know, that is at least a benchmark for me
4 as to a zone that we would like to operate the
5 hospital. The occupancy, you don't want to
6 operate a hospital at 100 percent occupancy
7 because that tends to create operational
8 problems. If you don't have beds available to
9 move people out of the emergency room into
10 beds, then they stack up in the emergency room
11 and end up spending the night in emergency
12 room, and it just it becomes very chaotic and
13 inefficient. And so you need some capacity in
14 order to allow the machine to move and
15 function. You know, I think 80 percent is a
16 reasonable number. I personally think the
17 hospital runs better when the occupancy is high
18 because everyone is on the ball, they know
19 we're busy and they're moving processes
20 through. But 80 percent is a good number to
21 look at.

22 Q: And, you know, planners would -- might
23 disagree with you about the 80 percent, right?
24 Would you -- in other words, you're aware of
25 that Health Plan percentages and all, correct?

1 A: I know the Health Plan percentages start, you
2 know, a smaller hospital needs a larger range
3 to flex. And so I think the occupancy
4 percentage on a smaller hospital would be
5 lower. The larger the hospital, obviously the
6 more space and more beds you'd have to
7 accommodate, I guess, the need for movement,
8 so.

9 Q: Can you kind of explain or expand on that? Why
10 would a smaller hospital need more of a range
11 to flex, in your words?

12 A: Sure. Well, if you have a 50 bed hospital and
13 let's say you apply the 80 percent to a 50 bed
14 hospital, so 20 percent of 50 would be ten. So
15 you would only have ten beds in play. And if
16 you've, you know, if you got a rush in your
17 emergency room, it wouldn't be unusual to get
18 ten, 12, 15 patients in a couple hours, it
19 could overcome the number of beds that you have
20 available. A larger facility, 20 percent of a
21 bigger number is just a bigger raw number, and
22 so you can accommodate that same phenomenon in
23 your ER with greater ease, so --

24 Q: Okay.

25 A: -- it's just math.

1 Q: After you did this analysis, what did you
2 conclude in regards to the ability of Roper
3 Downtown to transfer the beds to Carnes
4 Crossroads?

5 A: My conclusion was that we could accommodate it.
6 I was paying great attention to the fact that
7 we were actively working on length of stay, and
8 I -- and I knew that our efforts there were
9 beginning to pay off. And I knew that the
10 industry norm was well below where we were.
11 And I knew if we got to industry norm, it would
12 not be a hardship for Roper Hospital to
13 function at the 266 beds.

14 Q: Okay. And did you relay that conclusion to
15 other executives in management?

16 A: I did, yeah.

17 Q: Did you support the transfer of these beds as
18 the CEO of Roper Downtown to the hospital at
19 Carnes Crossroads?

20 A: I do.

21 Q: And let's pick up on a couple of issues you
22 raised in your testimony to follow up on, all
23 right? You talked -- mentioned a few times
24 this idea of average length of stay, or -- all
25 right. Can you explain why reducing average

1 length of stay would have an impact on the
2 census of the hospital?

3 A: Sure. So if you reduce length of stay across
4 time, that reduces your census. Since 2005 --
5 in 2005, which was shortly after I arrived at
6 Roper Hospital, a length of stay was, I
7 believe, 5.8 days on average.

8 Q: So what does that mean exactly?

9 A: So your average patient stayed 5.8 days. You
10 take your total patient days, divide by your
11 total discharges, you get an average length of
12 stay. And on average, patients were staying at
13 Roper Hospital 5.8 days.

14 Q: And does that include those rehab beds that you
15 mentioned earlier?

16 A: That did not include rehab. So rehab is about
17 a 14 day length of stay. That's a separate
18 population. But our acute care population was
19 5.8 beds.

20 Q: What's the industry norm?

21 A: The industry norm is a lot closer, and it
22 depends on your acuity. So if patients are
23 sicker, a hospital that takes care of sicker
24 patients has a longer length of stay than a
25 hospital that takes care of less acute patients

1 that, you know -- so if you had a -- you've got
2 a hospital that largely was non, what I call
3 non-tertiary services, so not -- maybe they
4 don't have a heart program, maybe they don't
5 have a transplant program, but their bread and
6 butter surgery, they have a large obstetric
7 population, then that would be a lower acute
8 population and their length of stay would be
9 lower.

10 Q: Would that be a Carnes Crossroads?

11 A: That would be a Carnes Crossroads. It would be
12 -- so their average length of stay would be
13 lower than a more tertiary facility. For a
14 facility like Roper --

15 Q: Right.

16 A: -- we would expect it to be, you know, in the
17 neighborhood of the, you know, five, a little
18 bit less than five days length of stay.

19 Q: So when you arrived in '04, in '05 the average
20 length of stay was almost six?

21 A: Close to six.

22 Q: Okay. Where is it today?

23 A: We finished 2011 at 4.8 days length of stay, so
24 we have reduced our acute care length of stay
25 by about a day since 2005. And just to tie

1 that to census, that equates to a reduction in
2 census on any given night on average of about
3 40 patients.

4 Q: Now, do you anticipate the average length of
5 stay to be continuing to decrease at Roper
6 Downtown?

7 A: We have some opportunity to continue to
8 decrease length of stay, but we're beginning to
9 approach the industry norm. So I would say the
10 -- that the low-hanging fruit has been picked.
11 We still have opportunity on certain, what I
12 would call diagnoses. Heart failure is one,
13 where we've got some opportunity. And we'll
14 continue to work on that. So I do anticipate
15 it will continue to come down. I think the
16 rate of decrease will slow.

17 Q: Okay.

18 **THE COURT:** Mr. Long?

19 **MR. LONG:** Yes, sir?

20 **THE COURT:** So I will better understand, what point
21 is it that you wish to make with his testimony;
22 that the relinquishment of the beds was
23 reasonable?

24 **MR. LONG:** Yes, sir.

25 **THE COURT:** Thank you.

1 Q: Is there also a phenomenon going on in
2 hospitals today regarding observation beds?

3 A: There is.

4 Q: Can you explain that?

5 A: Yes. So over the last let's say five years
6 there has been two things that have impacted
7 our traditional, what I would call our
8 traditional inpatient volume. One is that
9 procedures that historically have been
10 inpatient are now outpatient because technology
11 has advanced. A great example of that is when
12 I had my ACL repaired, I was in the hospital
13 for two nights.

14 Q: And when was that?

15 A: This was in the '90s, late '90s. Today if you
16 had an ACL repaired, it would be an outpatient
17 visit at an outpatient surgery center. You
18 would never step foot in a hospital. So
19 technology on many things is moving what has
20 traditionally been inpatient surgery, inpatient
21 care, to an outpatient setting. So that's one
22 thing that's driving down inpatient volume.
23 The other is more complicated, and it's a
24 movement of patients from what we called
25 inpatient status to what we all -- what we now

1 call observation status. And that change has
2 been driven largely by payers. And what payers
3 have said is in order to be an inpatient and to
4 be classified as an inpatient and be paid as an
5 inpatient, a patient has to, one, be very sick
6 and, two, be aggressively treated in a manner
7 that requires hospitalization. And so the
8 historical phenomenon of, you know, an elder
9 patient that is very sick that gets admitted to
10 the hospital for observation, that scenario
11 still occurs. We still take care of that
12 patient in the hospital. But that patient is
13 not classified as an inpatient. That patient
14 is classified as an observation patient. So
15 the patient might be in the hospital for two,
16 three days, be cared for by nurses, receive
17 drugs, receive food. You know, the volume of
18 work hasn't left the hospital. We're still
19 taking care of that patient. But from
20 Medicare's standpoint and other payers have
21 jumped on with Medicare, that patient is
22 classified as an observation patient and would
23 not today be considered an inpatient as we're
24 relating it to inpatient licensed beds.

25 Q: So those observation people would not be

1 included in the census numbers that we looked
2 at on your --

3 A: That's correct. And that's a -- so you had two
4 things going on that would bring, you know --
5 as we look at this last page and we say peak
6 census of 245, my point is, you know, since
7 that time our average census is, due to length
8 of stay, is down about 40. And in addition to
9 that, we've got this observation phenomena
10 which pulls it down more so that patients that,
11 you know, in 2007 might have been considered
12 inpatients. Today they're still there, they're
13 still consuming resources, but technically
14 they're not inpatients and they're not in an
15 inpatient licensed bed.

16 Q: Well, let's talk about the difference between
17 licensed beds and just regular beds. Are those
18 -- are those patients that are in the hospital
19 in an observation bed, they're still -- they
20 got their head on a pillow at night, right?

21 A: That's correct.

22 Q: Okay. Are they counted in the 266 licensed
23 beds?

24 A: No.

25 Q: Okay. So if you had 266 acute care inpatients,

1 you had a patient on every bed, and you had 20
2 observation patients, are you -- is that 286
3 beds being used at the hospital?
4 A: That's correct.
5 Q: Okay. And do you have the beds to do that --
6 A: I do.
7 Q: -- in your facility?
8 A: I do.
9 Q: All right.
10 A: So the work -- as it relates to observation,
11 the work has not changed; what we call it has
12 changed --
13 Q: Okay.
14 A: -- if you get my main point.
15 Q: But do you have the capacity to deal with these
16 observation beds --
17 A: I do --
18 Q: -- and still --
19 A: I do have the capacity because they're not
20 impaired by the licensed count.
21 Q: Okay. Now, the Mount Pleasant Hospital opened
22 in 2010, correct?
23 A: That's correct.
24 Q: All right. And have the 85 beds been
25 transferred out to Mount Pleasant from your

1 facility?

2 A: Yes, they have.

3 Q: All right. What did you see in the first year
4 at -- were you able to see changes in your
5 facility from the opening of the Mount Pleasant
6 Hospital?

7 A: We have. I guess I would say we just finished
8 the first year, and the -- I guess, as Mr.
9 Bowling testified, the early months were slow
10 because of the Medicare certification. But
11 looking back at the first year, we've seen a
12 shift of some volume. Predominately that
13 volume has been outpatient volume. About a
14 third of the volume that used to come to Roper
15 Hospital that was outpatient in nature shifted
16 to Mount Pleasant. On the inpatient side, we
17 saw about a five percent shift.

18 Q: Okay. And what's your basis of that conclusion
19 there was a five percent shift?

20 A: Just year end census numbers at Roper Hospital
21 from the Mount Pleasant zip code.

22 Q: Did this first year of Mount Pleasant being
23 opened, did it create any sort of issues at
24 Roper Downtown in regards to your ability to
25 treat your patients and serve your capacity?

1 A: No, it did not.

2 Q: What was your average daily census at Roper
3 Downtown for 2011?

4 A: 2011, our average acute care census was 187
5 patients year end.

6 Q: All right.

7 A: For 12 months.

8 Q: Now, let's talk about the staffing issue.
9 Since you've been at Roper Downtown 2004, have
10 you seen a change in the availability of nurses
11 and other staff to be employed at the hospital?
12 Has it changed since 2004, the nursing
13 availability?

14 A: Yes. You know, I think the economy in general
15 has improved our ability to recruit and retain
16 staff. I would say in 2004, we didn't
17 particularly have big issues with recruitment
18 and retention of staff. We survey our
19 employees regularly and we have consistently
20 operated in the top decile in the country in
21 terms of a place to work in terms of employee
22 satisfaction and employee engagement. And so
23 we've never had huge problems with recruiting
24 and retaining staff. The downward economy has
25 certainly created a situation where more folks

1 have entered the ranks of those looking for
2 jobs, and it's just made it that much easier to
3 recruit staff. At the same time, it's made it
4 less likely that people would leave a position.
5 So our retention has also dropped. But
6 historically we have used very little temporary
7 staff in the way of traveling nurses or locum
8 tenens and stuff like that. We just, we've
9 been fortunate in that regard.

10 Q: When the hospital at Mount Pleasant opened, did
11 staff move from the downtown hospital out to
12 Mount Pleasant?

13 A: Yes, they did. So as we opened those
14 positions, I didn't know the exact number, but
15 I believe Mr. Bowling testified that 50 percent
16 of the positions were filled internally. You
17 know, the folks, our staff that live in the
18 Mount Pleasant area were thrilled to have an
19 opportunity to work in the Mount Pleasant area
20 and so we saw them apply for those positions.
21 And quite frankly we welcomed that because when
22 you open a new hospital, you want to put your
23 best foot forward, an the best way to do that
24 is to put your experienced staff in that -- in
25 that facility, folks that know what our

1 expectations are and understand our commitment
2 to patient care. And so that was a, I think it
3 was a good thing for the facility, for the
4 community and for all of us.

5 Q: Did you have any trouble at your facility
6 backfilling or filling those positions of the
7 -- of the nurses and other staff people who
8 transferred out to Mount -- moved to Mount
9 Pleasant?

10 A: We did not.

11 Q: Okay. Do you have any stress on your hospital
12 now in regards to your ability to retain,
13 recruit and retain nurses and staff?

14 A: We do not.

15 Q: In your position as a CEO, how much do you
16 interact with physicians?

17 A: Daily. A lot.

18 Q: Okay. And why is that?

19 A: You know, physicians are a part of our team.
20 We look at them as partners in the care
21 process. And so, you know, if you're going to
22 improve the care that you deliver, you need to
23 be engaging your physicians in that regard.
24 That's what I do on a regular basis. I attend
25 many meetings. Often those meetings are with

1 physicians to talk about patient care, patient
2 safety, outcomes, growth strategics, things of
3 that nature.

4 Q: What have you seen -- well, you've seen since
5 you've been there an increase in the number of
6 employed physicians, right?

7 A: We have.

8 Q: In the physician network?

9 A: That's correct.

10 Q: And as an administrator or CEO at the hospital,
11 what do you attribute this growth in physician
12 employment?

13 A: I think there are multiple trends in healthcare
14 today that are driving physicians toward
15 employment. As an operator of a hospital, I'm
16 quite honestly agnostic to whether or not a
17 physician is employed or unemployed in terms of
18 my operation in the hospital. The more
19 physicians we employ, the more they compete for
20 capital that I'd like to use in the hospital.
21 But I think the fact is that physicians, you
22 know, if we fast forward ten years, I think
23 you're going to be hard pressed to find a
24 physician that is not in an employment
25 relationship with a larger healthcare system.

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1 And the dynamics of healthcare are moving us
2 that way. If you're a -- you'd be hard pressed
3 to find a young physician coming out of
4 fellowship or residency that wants to go open
5 up a private practice and hang a shingle on the
6 door. They're interested in coming out and
7 being employed in a stable environment within
8 a health system. I think Mr. Bowling testified
9 to the fact that 100 percent of the Mayo
10 residents came out with an employee situation.
11 So I think that's true. I think if you're
12 currently in private practice, you've got a
13 number of factors bearing down upon you. One
14 is reimbursement is under downward pressure.
15 The regulatory requirements are increasingly
16 more difficult. And then there's this thing
17 called the electronic health record, which the
18 federal government has not made optional. If
19 you want to continue to be paid, you need to
20 become compliant with the electronic health
21 record requirements. And that requires a
22 capital investment ranging from \$50,000 to
23 \$100,000. And I think you just have a lot of
24 physicians out there that are saying, you know,
25 this is not what I went into medicine for; I

1 went into medicine to take care of patients.
2 And so they're approaching health systems and
3 saying, you know, we want to be employed. And
4 frankly, if you look at the federal healthcare
5 legislation, the federal healthcare legislation
6 is forcing hospitals and doctors to work in
7 closer alignment. You hear about things like
8 bundled payment and accountable care
9 organizations and, you know, a lot of those --
10 a lot of those structure require a much closer
11 alignment between hospitals and physicians.
12 And so we see physicians reacting to those
13 pressures.

14 Q: Do you attend the senior staff meetings?

15 A: I do.

16 Q: All right. And what is the purpose of those
17 meetings?

18 A: They are a weekly meeting to debrief on what's
19 going on across the organization. Each of the
20 CEOs provides a briefing on what's going on in
21 their respective shop. We have a section on
22 quality and patient safety. We have financial
23 updates. If we closed out a month recently,
24 we'll get the financial report from that month.
25 Mr. Bowling will give a report on Physician

1 Partners. So it's just a general discussion as
2 to what's going on with the health system.

3 Q: How would you -- how would you characterize the
4 discussion that occurs at the senior staff
5 meeting?

6 A: You know, it's an open discussion about topics
7 that are current. There's debate. People --
8 you know, I think we've got a good environment
9 in that you can challenge any other member of
10 the -- of the team and that's okay. And at the
11 end of the day, we try to reach consensus
12 around certain things.

13 Q: I mean, do the members of that meeting feel
14 free to speak on any and all topics, or is it
15 very kind of rigid as to who talks about what?

16 A: No. Everyone feels free to provide input on
17 other topics.

18 Q: Okay. And who takes the minutes of those
19 meetings?

20 A: We have an administrative resident. So I
21 mentioned that when I came out of graduate
22 school, I had to do a year residency, and I did
23 that at Roper Hospital. We typically employ a
24 resident coming out of a master's program, and
25 we typically assign them to take the minutes of

1 the meeting.

2 Q: And do you pay attention to those minutes

3 personally?

4 A: I personally do not regularly read those

5 minutes.

6 Q: Okay.

7 A: I attend the meeting.

8 Q: Okay. One last issue, Mr. Severance. Can we

9 turn to page 974? Is this a letter that you

10 sent to Ms. Brandt, Ms. Patterson back then, in

11 this CON application? Do you recognize this

12 letter?

13 A: Yes, I did.

14 Q: Is that your signature?

15 A: That is.

16 Q: Okay. Can you tell me what this letter is

17 about?

18 A: Sure. This letter articulates our intent to

19 construct 50 beds at the Carnes Crossroads

20 site, and it acknowledges in writing that the

21 exchange is permanent. And it confirms that we

22 will not use the loss of beds as a

23 justification for subsequent requests for the

24 approval of additional beds.

25 Q: Okay. And you understand you can't get the

1 beds back, right?

2 A: I do. I understand that

3 Q: Okay.

4 A: Yes.

5 MR. LONG: Your Honor, that's all the questions I
6 have for Mr. Severance.

7 THE COURT: All right.

8 MR. SUMMER: Can we take a quick restroom break?

9 THE COURT: We'll take five minutes this time.

10 (Off the Record from 10:42 a.m. until 10:49 a.m.)

11 THE COURT: Mr. Summer, we're back on the record.

12 MR. SUMMER: Thank you.

13 MR. SEVERANCE - CROSS EXAMINATION BY MR. SUMMER:

14 Q: Mr. Severance, my name is David Summer. We've
15 never met before, and all I know about you is
16 what you've testified to about today and what
17 I've read in your deposition. I was -- I was
18 pleased to see some things in your deposition
19 that I think we probably would agree with. One
20 was the phrase that the Catholic sister told me
21 a long time ago when I referred to her hospital
22 as not-for-profit, she said, "Young man, no
23 margin no mission." What do you mean by that
24 phrase?

25 A: You know, the reality, I think, for any

1 business, whether it be not-for-profit or for-
2 profit is you need to be able to make a margin
3 to perpetuate that business. That holds true
4 for nonprofits. And in the instance of
5 nonprofits, we take that margin and put it back
6 into the charitable purpose into the
7 organization as opposed to distributing it to
8 shareholders.

9 Q: Okay. Some other things I think that I found
10 very interesting is you're a proponent of the
11 certificate of need program, aren't you?

12 A: I am.

13 Q: Okay. And you understand that there are
14 various purposes to that CON Act, aren't there?

15 A: True.

16 Q: One of the things that I think you believe in
17 is the notion that CON programs should promote
18 cost containment, shouldn't it?

19 A: I think that's a part of what it seeks to do.

20 Q: Okay. Another thing that you believe is that
21 the CON program should avoid unnecessary
22 duplication of facilities and services,
23 shouldn't it?

24 A: I think that's the intent of the CON law is to
25 base new resources on need.

- 1 Q: And then another purpose of the law is to guide
2 the establishment of healthcare facilities that
3 best serve the public need, isn't it?
- 4 A: Sounds good.
- 5 Q: Okay. You're working in a heavily regulated
6 industry, aren't you?
- 7 A: That's correct.
- 8 Q: Okay. It's regulated not just by the state
9 from a CON and licensure perspective, but it is
10 heavily regulated by the federal government,
11 isn't it?
- 12 A: That's correct.
- 13 Q: Okay. It's also an industry that is unlike a
14 typical capitalistic market, isn't it?
- 15 A: Correct.
- 16 Q: Okay. I did read with interest a number of
17 your points that you made in your deposition.
18 And without attributing the source, there was
19 the debate about the difference between a
20 hamburger stand and a hospital. Do you
21 remember that?
- 22 A: That's correct.
- 23 Q: Okay. And one of the things that you talked
24 about was how fragmented the delivery -- the
25 sale of the delivery of services is. And let

1 me kind of try to explain what I'm talking
2 about. First of all, you indicated that unlike
3 the hamburger stand, a patient typically is not
4 the person who's making the initial decision of
5 where to go. Do you remember that discussion?

6 A: I think it had less to do with where to go as
7 to what to have done.

8 Q: Okay.

9 A: My point, I think, was the surgeon would
10 decide, you know, you need -- I think we used
11 a total joint, you need a knee replacement --

12 Q: Right.

13 A: -- as opposed to the patient deciding.

14 Q: So it's not like the patient going in to order
15 a double cheeseburger with fries. This is a
16 situation where someone else is telling that
17 patient what he or she needs, right?

18 A: To some degree.

19 Q: Right. And then that physician has some
20 influence on where he or she determines to
21 perform that surgery, right?

22 A: You know, again, my example would pertain more
23 to the physician would have a lot of influence
24 on which implant he chooses. So I'm differing
25 with you a little bit because I think the

- 1 patient has a lot to do as to where they go.
- 2 Q: Sure.
- 3 A: The physician as to what is done and, you know,
- 4 the physician may say, you know, we're going to
- 5 use XYZ implant. You know, he would drive that
- 6 decision.
- 7 Q: Right. But if that physician only has
- 8 privileges at the Medical University of South
- 9 Carolina, the patient has either got to go
- 10 there to get the surgery or choose another
- 11 physician, fair statement?
- 12 A: Fair statement.
- 13 Q: Okay. So once again, we have all of these
- 14 other forces at work about what's to be done
- 15 and where it's to be done, correct?
- 16 A: Again, I would say more so on what's to be done
- 17 than on where to be done. I think the patient
- 18 -- if a patient does not want -- in your
- 19 example, if the patient does not want to go to
- 20 the Medical University, the patient would
- 21 choose a different physician.
- 22 Q: Okay. Let's further complicate things, and
- 23 let's talk about the role of the payer --
- 24 A: Right.
- 25 Q: -- in this. Okay. You would agree with me

1 that certain carriers will have preferred
2 provider lists; will they not?

3 A: They will.

4 Q: Okay. And your hospital may or may not be in
5 network with a particular carrier, correct?

6 A: Correct. Generally, in Charleston, most
7 hospitals that I'm aware of are in most
8 networks that I'm aware of.

9 Q: But once again --

10 A: But in theory, you're right.

11 Q: Right. So once again, we have some other
12 entity now that's entering this equation, and
13 that would be the payer, fair statement?

14 A: That's correct.

15 Q: And that payer is going to have some influence
16 over who's approved, where it's approved for
17 payment, correct?

18 A: It can. That's correct.

19 Q: Okay. And sometimes, I mean, it's very
20 complicated, but sometimes those payers will
21 say we'll pay for 70 percent of the operation
22 if you have it at Roper, but if you were to
23 choose East Cooper, we'll only pay for 80
24 percent. They actually have policies that --
25 or programs that have in-network and out-of-

1 network providers, and they discriminate, if
2 you will, or differentiate the amount that
3 carrier is willing to pay and consequentially
4 the amount that the patient may ultimately be
5 responsible for, correct?

6 A: In theory they could do that. In practicality
7 I'm not aware of much of that happening.

8 Q: Okay. In your market?

9 A: In our market.

10 Q: Okay. And you would agree with me that there
11 are nuances in every market that could be
12 different from yours?

13 A: Correct.

14 Q: Okay. All right. So I think we can agree that
15 healthcare, the delivery of healthcare, is
16 very, very different from what we would refer
17 to as true unregulated capitalistic market,
18 fair statement?

19 A: I believe that. I think my belief is
20 different than what you just articulated.

21 Q: Okay. Tell me what your belief is.

22 A: My example had to do with a patient goes to see
23 a doctor. The doctor says you need a total
24 knee. So the doctor has defined what's going
25 to be done. The doctor then defines what

1 prosthesis that patient might need, and so the
2 individual receiving the treatment is not the
3 individual deciding what's going to be done in
4 terms of the procedure or the prosthesis. And
5 the guy that actually decides what's going to
6 be done is not the guy who is bearing the cost
7 of that because the insurance company is
8 bearing the cost of it. And, you know, the
9 patient has already paid his premium, so he
10 wants, you know, the patient wants the same
11 knee that Jack Nicholas got because all on T.V.
12 The doctors not paying for it, so he wants to
13 keep his patient happy. So he get's the Jack
14 Nicholas knee. The insurance company pays for
15 it. That drives up the cost of healthcare. So
16 my, you know, my -- my example was it's not
17 like the patient that goes to McDonald's who
18 chooses what he wants and then bears the cost
19 of paying for it. So it's a different dynamic.
20 The other dynamic that is different is there's
21 no federal law that requires the hamburger
22 stand to give away free hamburgers to the
23 unfunded folks that want hamburgers. And so
24 it's a different playing field that we operate
25 in in the typical market.

1 Q: Okay. And you believe that the CON program is
2 a positive for the healthcare industry,
3 correct?

4 A: I do.

5 Q: Okay. And you believe that it supports a
6 healthcare industry in effectively and
7 efficiently delivering services to the public,
8 don't you?

9 A: I think that it's important to -- because of
10 the difference in the market as we just
11 discussed, it's important to have a good
12 regulatory process to distribute resources
13 based on need. And I think in the absence of
14 that you will threaten providers that, like
15 your client, like our institution, that provide
16 the full array of healthcare services, because
17 people will enter the market and seek to only
18 do the things that are profitable as opposed to
19 things that need to be done from a mission
20 standpoint, from a patient care standpoint that
21 may not be profitable.

22 Q: One of the things that -- statements you made,
23 which I think is probably a pretty good
24 assessment. Let's take a look at your
25 deposition. I'm going to ask you to turn to

1 page 30 for me, please.

2 A: Which book? This one?

3 Q: In the red one. In your right -- in your left
4 hand, thank you. The other are your exhibits
5 from your deposition. If you'd keep them
6 together, please.

7 A: I'm sorry, 30?

8 Q: Yes, page 30.

9 A: Okay.

10 Q: At the bottom of page 29, Mr. Thomas asked you
11 a question at line 21. He said, "I think I
12 didn't ask the question very well. If we don't
13 have the CON or if the CON program were
14 obviated or simply essentially abolished, do
15 you think that would mean that prices or that
16 competition would be fostered among inpatient
17 facilities that act as somewhat of
18 competitors?" And what was your answer,
19 starting on page 30, line three?

20 A: I said, "Here's what I think would happen. I
21 think you would have -- you would have a
22 proliferation of highly profitable things like
23 surgery centers and imaging centers, and that
24 would extract profits from hospitals that are
25 taking care of unfunded patients and providing

1 services that are necessarily" -- probably
2 should have read that aren't necessarily
3 profitable -- "and that would hurt hospital
4 performance across the state, particularly in
5 rural hospitals. And you would have closings
6 of hospitals, elimination of jobs because the
7 profitable services would be targeted by
8 entrepreneurs, and the hospitals would be left
9 with unprofitable services and EMTALA
10 obligations."

11 Q: Okay. Do you still believe that today?

12 A: Yeah, I think I just articulated that point.

13 Q: Okay. Let's talk a little bit about EMTALA.
14 EMTALA is basically a federal act that says if
15 you participate in the Medicare and Medicaid
16 programs, which means you get Medicare and
17 Medicaid dollars, then you must stabilize
18 and/or treat patients who present in an
19 emergent condition, correct?

20 A: That's correct.

21 Q: Okay. So whoever --

22 **THE COURT:** What is an emergent condition?

23 Q: An emergent condition, what -- could you
24 explain to Your Honor, or His Honor, what an
25 emergent condition is and how you understand

1 that as a healthcare administrator?

2 A: The way that our health system operationalizes
3 that is when patients come into the emergency
4 room, regardless of whether they have insurance
5 or the ability to pay, we assess them and treat
6 any life-threatening injury that they may have.
7 I would say there's probably some health
8 systems that, you know, scrutinize what, you
9 know, what's emergent versus what's not
10 emergent. From our perspective, we just treat
11 whatever they have. Because the penalties of
12 violating EMTALA are significant and we
13 honestly think it's our mission to take care of
14 folks regardless of ability to pay.

15 THE COURT: Spell emergent for me.

16 A: E-M-E-R-G-E-N-T.

17 THE COURT: Well, to me, and I really don't know the
18 sense and understand the sense you're using it
19 yet. I know that emergent means to emerge.

20 A: Right. So I'm using it in the sense of if you
21 -- if you come into my emergency room, my
22 assumption is you think something bad is wrong
23 with you, and we will assess and treat that
24 regardless of your ability to pay us.

25 THE COURT: You still need to connect up with me. I

1 understand every word you're say, but proceed
2 Mr. Summer.

3 Q: I think we can help us out a little bit. Would
4 you agree with me that the goal of EMTALA is
5 that when people are faced with an emergency
6 that may be life-threatening, that your
7 hospital as a participant in the Medicare and
8 Medicaid plans has an obligation to assess the
9 condition of that patient in emergency to
10 determine what their condition is and to
11 stabilize and/or treat them?

12 A: I agree with that.

13 Q: Okay. And that's true of any provider that
14 participates in the Medicare or Medicare
15 program, isn't it?

16 A: Anyone that has an emergency room.

17 Q: Right.

18 A: Correct.

19 Q: Okay. And you would agree with me that
20 frequently your hospital is not going to be
21 paid for the delivery of a great deal of that
22 care in the emergency room?

23 A: That's correct.

24 Q: I think one of the things that you've
25 previously stated is that your only involvement

1 in this certificate of need application, which
2 is the Roper DHEC record which appears at Joint
3 Exhibit 2, that your only involvement was in
4 assessing the redeployment of assets, i.e., the
5 beds; is that correct?

6 A: That's correct.

7 Q: Okay.

8 A: Could we -- could we do that without negatively
9 impacting the downtown Roper facility.

10 Q: You frequently used, in your deposition, the
11 term redeployment. I look at that as kind of
12 a military term. When you're looking at
13 putting those beds elsewhere, one of your
14 concerns is is that if I take them away from my
15 main hospital, I need to be certain that I
16 don't jeopardize my core mission, correct?

17 A: Correct.

18 Q: Okay. And you would agree with me that your
19 hospital -- when I say your hospital, that is
20 Roper Downtown on Calhoun Street in Charleston
21 -- that is the central nervous system of
22 CareAlliance; wouldn't you say so?

23 A: I would say there's great debate about that.

24 Q: Okay. You would agree with me it's the
25 tertiary care center of the Alliance?

- 1 A: I would also say there's debate about that.
2 But I think, I personally think yes. I will
3 tell you that as St. Francis matures it is
4 becoming more and more tertiary.
5 Q: Okay. But you agree with me that you don't do
6 open hearts out there?
7 A: We don't.
8 Q: Right.
9 A: But we do --
10 Q: And when I say out there, I need to be careful,
11 because the record needs to reflect. At Bon
12 Secours St. Francis, which is west of the
13 Ashley, correct?
14 A: Correct.
15 Q: You do not do open heart, do you?
16 A: We do not. They do far more neurosurgery than
17 we do downtown.
18 Q: Okay. And you don't do interventional
19 catheterizations out there either, do you?
20 A: That's correct. The heart and vascular
21 services are located downtown.
22 Q: Okay. So the largest concentration of tertiary
23 care services in your system is on Calhoun
24 Street at Roper?
25 A: Today, yes. I would say that is evolving.

- 1 Q: Okay. Fair statement. You would agree with
2 me, though, that the part of your tertiary care
3 mission is to make sure that you have all of
4 the necessary resources to take care of all the
5 patients that present to your facility,
6 correct?
- 7 A: That's correct.
- 8 Q: Okay. And you would also agree that based upon
9 the level of tertiary care services that you
10 have at Roper Downtown, that the higher acuity
11 patients in your system, many of the higher
12 acuity patients in your system will be located
13 there as opposed to say Mount Pleasant?
- 14 A: Certainly the populations downtown would be
15 higher acuity than Mount Pleasant.
- 16 Q: Okay. I want to take a look at this exhibit
17 that you all were talking about earlier when
18 you were discussing what you utilized to
19 determine the redeployment. And that would be
20 -- do you -- do you by any chance have a copy
21 of Respondent's 25? I'm going to pull it up on
22 the screen. If you would, I'm going to take
23 you over to page 2679. Do you remember
24 testifying about this page?
- 25 A: I do.

1 Q: Okay. Now, this is, 2679 is actually real
2 historical data; is it not?

3 A: It is.

4 Q: Okay. And it's from 2007, and it refers to a
5 midnight census. Now, midnight census is that
6 point in time where you determine whether or
7 not someone is an inpatient or an outpatient,
8 correct?

9 A: No.

10 Q: All right. I'll rephrase it because I know
11 what you -- what you're saying. A midnight
12 census is a way you use to calculate what your
13 inpatient census is?

14 A: Correct. We take those patients that are
15 categorized as inpatients --

16 Q: Right.

17 A: -- and we count the number of people in a bed
18 at midnight that are categorized as inpatients,
19 and that's my census on that day.

20 Q: Let's take a look at -- now, you did make this
21 observation. The most frequent census was 231
22 occurring 13 times in 2007. But if you don't
23 mind taking a look and seeing if you can
24 determine, but by my count you had 22 nights
25 where you had 266 or more patients in the

1 hospital. See if you can determine if that's
2 not accurate. My number, I came up with 22
3 based on this bar graph.
4 A: Okay. Y want me -- you want me to add them up?
5 Q: Yeah. You can just add them up in your head.
6 A: Okay.
7 Q: But if you look at where 266 starts, there were
8 three nights for 266, and then just pull it
9 forward and see how many you see.
10 A: What did you say, 22?
11 Q: I had 22. What did you come up with?
12 A: Okay. I got 21.
13 Q: Okay. All right. I'll use the 21, that's
14 fine.
15 A: Okay.
16 Q: And that would be 266 or more. And the peak
17 census would be 277; would you agree with that?
18 A: That's correct.
19 Q: Okay. Now, you would agree with me that
20 healthcare is a life and death mission, isn't
21 it?
22 A: Correct.
23 Q: All right. And so we certainly want to be
24 conservative when we make our projections about
25 healthcare resources, don't we?

- 1 A: That's correct.
- 2 Q: Okay. We want to make sure that we've got the
- 3 resources necessary to take care of a crisis
- 4 should one emerge, right?
- 5 A: That's correct.
- 6 Q: Okay. Are you familiar with how DHEC
- 7 calculates bed need for a hospital of your
- 8 size?
- 9 A: No. No, I'm not.
- 10 Q: Okay. Just turn your attention to -- well, you
- 11 were here yesterday when Mr. Bowling testified,
- 12 weren't you?
- 13 A: I was.
- 14 Q: If you look at Joint Number 2. Do you have
- 15 that handy? It should be in front of you. I
- 16 want to turn your attention to a page Mr.
- 17 Bowling testified to about yesterday, which is
- 18 1242. And that would be in Roper's record,
- 19 Joint 2, page 1242. Okay. You would agree
- 20 with me that you are an experienced healthcare
- 21 administrator, aren't you?
- 22 A: I'm not sure I'm on the same page you are here.
- 23 Q: 1242?
- 24 A: Am I in the wrong book?
- 25 COURT REPORTER: I think you're in the wrong book.

1 Yes, sir. I think it might be that one under
2 your deposition right there.

3 Q: Let's try that one. Joint 2, page 1242.

4 A: 1242, okay.

5 Q: Okay. Going back to my kind of preliminary
6 question here, you would agree with me that you
7 are an experienced healthcare administrator,
8 aren't you?

9 A: That's correct.

10 Q: Okay. And you run one of the largest tertiary
11 care hospitals in South Carolina, don't you?

12 A: I would say I'm in the large category, sure.

13 Q: Okay. Mr. Bowling has a role as basically a
14 strategic officer in planning, correct?

15 A: Correct.

16 Q: Mr. Bowling provides planning expertise to the
17 system, and you're part of that system, right?

18 A: Correct.

19 Q: You don't hold yourself out as a planner, do
20 you?

21 A: I do not.

22 Q: And you don't hold yourself out as an expert in
23 planning, do you?

24 A: I do not.

25 Q: Okay. Is it fair to say that you rely on Mr.

1 Bowling and his staff, including Mr. Cassells,
2 to provide you with planning information and
3 planning expertise?

4 A: That's correct.

5 Q: Okay. This is the letter that Mr. Bowling
6 testified about yesterday that he sent to DHEC.
7 And if you look at the bottom chart, it says in
8 2015 he's projecting that Roper Downtown would
9 have an ADC of 207 and an occupancy rate of 78
10 percent. Do you see that?

11 A: I do.

12 Q: Okay. He then testified that utilizing DHEC's
13 .7 bed methodology, in other words, DHEC would
14 basically say that when you're at 70 percent
15 occupancy, it projects a need that using DHEC's
16 formula DHEC's projected bed need in 2015 for
17 that utilization, for that ADC, would be 296
18 beds. Do you recall that testimony?

19 A: Not specifically --

20 Q: Okay.

21 A: -- but 407 divided by .7 is 296.

22 Q: Right. Okay. Now, whether you agree with it
23 or not, my point in all of this is simply that
24 from a DHEC perspective, they think you'd need
25 296 beds. Your testimony is you don't think

1 so, right?

2 A: That's correct.

3 Q: Okay. And one of the reasons you don't think
4 so is that you're redirecting. And we've put
5 85 of our beds -- when I say our, I'm referring
6 to Roper. So you put 85 of your beds over in
7 Mount Pleasant. That's going to take the
8 pressure off of you downtown, right?

9 A: No. The reason I don't think so is because we
10 ran the numbers and looked at our length of
11 stay trend, you know, length of stay
12 opportunity and observation trend and
13 determined that we didn't need those beds. And
14 the reality is -- we thought our analysis was
15 conservative. The reality is my current census
16 is 187 average daily census last year for acute
17 licensed beds. And if you apply that, that
18 would be 70 percent occupancy at 266 beds,
19 which is what I'll be left with. So I think in
20 hindsight our analysis was correct. You know,
21 you're looking at numbers that were estimated
22 in 1977, and they were people's best guesses.
23 I think the -- you know, I think the reality is
24 our assessment that we could do this without
25 negatively impacted Roper was, in fact, correct

1 if we look at 2011, this recent past year's
2 average daily census.

3 Q: Okay. Let's talk about being correct on
4 projections.

5 A: Uh-huh (affirmative response).

6 Q: I'm going to hand you a calculator because you
7 may need it. Are you aware that Roper St.
8 Francis projected that the ADC for Mount
9 Pleasant in year one, they told DHEC we think
10 our ADC for year one is going to be 28. Do you
11 know that?

12 A: I don't, but I'll accept that.

13 Q: Okay. Were you here when Mr. Bowling testified
14 about the purchase of Mount Pleasant OB/GYN in
15 Mount Pleasant?

16 A: I was.

17 Q: Okay. And you heard him say that those
18 deliveries had primarily been performed at East
19 Cooper. And that now 90 percent of those
20 deliveries are being performed in the Roper
21 system. Do you remember that testimony?

22 A: I do.

23 Q: Okay. The purchase of that practice was about
24 40 deliveries per month was his testimony. And
25 if he's -- his testimony was 90 percent. You

1 would agree with me then that 90 percent
2 capture rate, if you will, would be those 36
3 deliveries per month for Mount Pleasant, right?

4 A: That's correct.

5 Q: Okay. Using your calculator, what I want you
6 to do is let's figure out how much of your ADC
7 would be attributable to those 36 deliveries.
8 So 36 deliveries per month, and let's just
9 assume two day stay for each of those, because
10 some are going to be C-sections, some are not.
11 Would you agree with me that two is probably a
12 fair estimate of nights in the hospital for
13 those 36 deliveries?

14 A: Sure.

15 Q: Okay. So two times 36 is how much?

16 A: Seventy-two.

17 Q: Okay. And multiply that times 12 so that we
18 can get total patient days for the year.

19 A: Okay. 864.

20 Q: Okay. Right now, you're -- let's hold that 864
21 number, but right now you're running an ADC --
22 or let's just put it this way. The years
23 reported to us, your first year numbers of ADC
24 is about nine at Mount Pleasant, isn't it?

25 MR. LONG: Your Honor, I want to object to just

1 clarify the record. He keeps saying your to
2 Mr. Severance. Mr. Severance works downtown.
3 I think he's talking about the Mount Pleasant
4 Hospital. I just want to be clear on the
5 record, he's not talking about downtown
6 hospital.

7 MR. SUMMER: That's a fair objection, Your Honor.
8 I'll restate it.

9 THE COURT: Thank you.

10 Q: Let's talk a little bit about Mount Pleasant.
11 Is it your understanding their ADC is running
12 about nine?

13 A: That's what I heard yesterday.

14 Q: Okay. So multiply nine times 365 for me so we
15 can get some total patient days, please, sir.

16 A: Nine times 365, 3285.

17 Q: Okay. Let's subtract those new deliveries and
18 the days that you got from East Cooper, which
19 is 864, and what does that give you?

20 A: 2,421.

21 Q: Divide that by 365 for me.

22 A: I did something wrong. 2,421 divided --

23 Q: Divided by 365.

24 A: -- by 365, 6.6.

25 Q: 6.6. Let's round it up, give you the benefit

1 of the doubt. Assuming, okay, that all 100
 2 percent of that seven ADC is a redirection from
 3 downtown, it's not very significant, is it?
 4 A: You know, my -- again, I focus on downtown
 5 Roper Hospital. I operate from Roper Hospital.
 6 My observation has been that we've had a
 7 significant shift of volume from Roper Hospital
 8 on the outpatient side and a small shift on the
 9 inpatient side. And my opinion is if that is
 10 not -- should not be surprising if it took that
 11 facility time to get certified by Medicare, and
 12 it's taken them time to establish specialists
 13 to work at the facility. And I think my
 14 observation has been that, you know, the
 15 average census might be nine, but that -- that
 16 inpatient census is slowly growing. And as
 17 they get these specialists in place, it will
 18 continue to grow. I -- you know, that's what
 19 I do, I operate hospitals. I expect that will
 20 be a successful hospital. And I don't think
 21 any of us sitting here judging at the end of 12
 22 months is going to change that trajectory for
 23 them.
 24 Q: All right. You spent \$150 million to build it?
 25 A: Sure. And it was not a one year investment.

1 Q: Right. So whatever it takes in terms of
2 physician recruitment, you're going to do it to
3 make that hospital a success, aren't you?

4 A: Well, any hospital has to have a medical staff,
5 right?

6 Q: Right.

7 A: And so that hospital needs specialists to
8 practice there in order to have a census, and
9 that's what that administrator is working on.

10 Q: Right. And Mount Pleasant OB/GYN is a great
11 example. If you don't have it, you'll take it.

12 A: I don't -- I can't speak to that. I was not
13 engaged in that transaction.

14 Q: Okay. Taking market share is an important part
15 of your job, isn't it?

16 A: Important -- you know, let me say I am not
17 evaluated on market share. I never have been
18 evaluated on market share. I'm evaluated on
19 the organization's performance across five
20 pillars, none of which are market share. I
21 think we've demonstrated that our market share
22 declined, and I probably wouldn't be here if
23 that was my primary performance measure.

24 Q: Let's take a look at your resumé. This is
25 Petitioner's 86.

1 A: All right.

2 Q: It was provided during your deposition. And I
3 think this goes back to when you were working
4 for Jim Rogers. I'm looking at 86, and I'm
5 looking at page three, which on the bottom of
6 the page says Roper Berkeley 982. This is your
7 resumé, isn't it?

8 A: Which -- which book are you in?

9 Q: Here, why don't I just give you a copy.

10 A: Okay.

11 Q: That will make it easy for you.

12 A: Thank you. That's my resume.

13 Q: Okay. And between 1994 and 1998 you were
14 director of ambulatory care and system
15 development, right?

16 A: That's '94 to 1998, that's correct.

17 Q: Correct. Look at that third bullet, planned
18 and implemented a free-standing -- nope, wrong
19 one. Look at the fourth bullet, established a
20 highly successful free-standing emergency room
21 in competitor's primary market. You see that
22 one?

23 A: I do.

24 Q: You're referring to the ED at Northwoods Mall;
25 aren't you?

1 A: I believe so.

2 Q: Okay. And that competitor's primary market is
3 Trident's primary market, right?

4 A: That's correct.

5 Q: Okay. And the purpose of putting that ED
6 there, among other things, was to take market
7 share away from Trident, wasn't it?

8 A: Partly. That emergency room was established at
9 the same time we were -- and this is a long
10 time ago -- at the same time we were closing a
11 hospital called Roper North.

12 Q: The old Baker Hospital?

13 A: The old Baker Hospital.

14 Q: Where I was born.

15 A: And the, you know, one of the arguments in
16 favor of building the Northwoods Emergency Room
17 was we were closing a facility in the North
18 Charleston area that would result in a
19 reduction of emergency services available for
20 that population. And we felt that the
21 Northwoods would help mitigate that closing.
22 So, you know, there were -- there were multiple
23 reasons. Certainly part of it was to extend
24 care to that population that had been in
25 Northwoods. The other part was to reach out to

- 1 a growing area of the community.
- 2 Q: You had a hundred bed hospital at Baker.
- 3 Couldn't you have just closed the hospital and
- 4 run the free-standing ED right there and take
- 5 care of that community?
- 6 A: Huge access problems there.
- 7 Q: Huge access problems?
- 8 A: Hard to get to.
- 9 Q: Right. That hospital operated there for 20
- 10 years before you bought it and decided to close
- 11 it, right?
- 12 A: I couldn't tell you.
- 13 Q: Okay. You would agree with me --
- 14 A: I can tell you it's very hard to get to.
- 15 Q: Okay. It's at the intersection of Cosgrove
- 16 Avenue and I-26, isn't it?
- 17 A: Yeah, but you had to go about a mile around
- 18 your elbow and your ear to get to it. It
- 19 wasn't like you got off the intersection and
- 20 you were there.
- 21 Q: There's been a psychiatric hospital there run
- 22 successfully since 1981. They haven't closed,
- 23 have they?
- 24 A: Define successfully.
- 25 Q: It's made a lot of money.

1 A: I don't know that. I don't know. Is that
2 true?

3 Q: Yeah.

4 A: Do you know that?

5 Q: I know it for a fact.

6 A: Okay. You know more than I do about it.

7 Q: Okay. It's run successfully there. It was
8 part of the Charter System; is now known as
9 Palmetto Behavioral Health, right?

10 A: Okay.

11 Q: Okay. I mean that's a resource in your
12 community. It's run 100 -- now it's up to
13 almost 120 beds. It's run successfully in that
14 location. It hasn't closed. Roper made a
15 decision to close that hospital because they
16 weren't making enough money off of it; isn't
17 that true?

18 A: I can't speak to that.

19 Q: And you moved it ten --

20 A: I don't know.

21 Q: -- and you moved the ED ten miles to get into
22 a competitor's territory ten miles up the
23 interstate where the demographics were better,
24 where you could make more money; isn't that
25 correct?

1 A: I will tell you the demographics for our
2 Northwoods Emergency Room are not what anyone
3 would articulate as good. So I very much view
4 Northwoods -- in fact, I regularly look at
5 Northwoods and make decisions to maintain
6 Northwoods more from a mission standpoint than
7 a margin standpoint. So if you're articulating
8 Northwoods as a -- as a cash cow or a margin
9 enhancer, I would disagree with you on that
10 statement.

11 Q: But you closed an entire hospital because you
12 weren't making money, right?

13 A: I had zero role in that decision or the
14 analysis for the closing of that hospital. I
15 was six years into my career in hospital
16 administration and I was -- my pay grade was
17 not at the level to make those types of
18 decisions.

19 Q: All you're willing to take credit for is that
20 putting that ED at Northwoods was establishing
21 a highly successful free-standing emergency
22 room in a competitor's primary market, correct?

23 A: My role was to build the bricks and mortar of
24 that facility. So I was, you know, the
25 facility developer of the facility.

1 Q: Okay. But you're telling people who read your
2 resume that that ED is a highly successful
3 free-standing emergency room in a competitor's
4 primary market. Isn't that what you're saying?

5 A: That's what my resumé says. If you want to
6 know the details of my resumé, so that section
7 of my resumé would have been written probably
8 in 1999, and has not been edited since 1999.
9 So that's what I said back in 1999 as I was
10 looking for a job.

11 Q: Okay. Well, we'll probably be talking about
12 more resumé's before this case is over with.

13 A: Good.

14 Q: Talk to you about a few other things while
15 we're here. You would agree with me that
16 Trident already provides the same services that
17 the Carnes Crossroad Hospital is proposing to
18 offer, correct?

19 A: Yes.

20 Q: Okay. You would also agree with me that one
21 reason to do the Carnes Crossroad project is to
22 increase market share, correct?

23 A: The CON articulates that we would grow market
24 share by ten percent.

25 Q: Okay. So you would agree with me?

- 1 A: By ten percent, yes.
- 2 Q: Okay. You also define adverse impact as that
- 3 impact that is going to significantly impact in
- 4 a negative fashion a facility that already
- 5 provides those services. Does that sound
- 6 familiar to you?
- 7 A: Okay. Is that in my -- in my deposition?
- 8 Q: Almost verbatim, yeah.
- 9 A: Okay.
- 10 Q: So you would agree with that?
- 11 A: Okay, sure.
- 12 Q: Okay. Now, one reason that you employ your
- 13 MD's is to get referrals, right?
- 14 A: No. That's --
- 15 Q: No?
- 16 A: That's not the reason we employ them.
- 17 Q: You don't? Are you telling me that you don't
- 18 try to capture referrals from your employed
- 19 MD's?
- 20 A: No, I didn't say that. I said that's not why
- 21 we employ them.
- 22 Q: Would you agree with me that an employed
- 23 physician is one that's going to be more likely
- 24 to refer patients to Roper St. Francis unless
- 25 otherwise directed by the patient?

- 1 A: You know, Mr. Bowling, I think, testified to
2 their contractual obligations to admit. I
3 quite honestly, it doesn't matter to me whether
4 somebody's employed or not. What I'm -- I've
5 got -- some of my best referrers are unemployed
6 physicians. So as an operator of a hospital,
7 I'm agnostic to that, whether they're employed
8 or not. What I do want is them to give us the
9 opportunity to take care of their patients.
- 10 Q: Okay. I'm going to ask you to turn your
11 attention to page 71 of your deposition for me,
12 please, sir.
- 13 A: Okay.
- 14 Q: So we can get a little closure on this point.
15 Page 71, if you would look at line 16. Mr.
16 Thomas asked you this question. "Would you
17 agree with me that an employed physician is one
18 that's going to be more likely to refer
19 patients to a Roper St. Francis facility --
- 20 A: This -- this is Mr. Bowling's testimony.
- 21 Q: Oh, goodness. I'm sorry. I apologize. You
22 got yours down there?
- 23 A: I got it. I got it. Seventy-one?
- 24 Q: Yes, sir. Seventy-one, page 16.
- 25 A: Okay. Okay.

1 Q: Okay. Mr. Thomas asked you the following:
2 "Would you agree with me that an employed
3 physician is one that's going to be more likely
4 to refer patients to a Roper St. Francis
5 facility unless otherwise directed by a
6 patient?" And what was your response?

7 A: I said, "I would."

8 Q: Okay. I want to also show you something I
9 found very interesting. It's called the, I
10 think you referred to it as a score card. Let
11 me see if I've got a copy of this. This would
12 be Petitioner's Exhibit 165. This corporate
13 score card measures a lot of financial
14 indicators, doesn't it?

15 A: It does. It measures quality, finance,
16 service, growth.

17 Q: What I want to do is turn your attention to
18 Petitioner's 165, and I want to go over to page
19 three, which is Roper Berkeley 4516. And if we
20 could go down to that section right here. It's
21 got the -- the bottom line there says,
22 "Percentage of employed physicians with
23 collections at MGMA mediums," do you see that?

24 A: I do.

25 Q: Okay. MGMA is basically a trade organization

1 that -- that is utilized by the healthcare
2 industry for all kinds of benchmarks and
3 measurements for physicians, correct?

4 A: That's correct.

5 Q: Okay. It looks like your goal, your year to
6 date target, was to be 51 percent, and you're
7 actually at 42 year to date actual on this
8 snapshot which was taken on June 30, 2011,
9 right?

10 A: That's correct.

11 Q: Okay. So you definitely want to make money off
12 of them, don't you?

13 A: I don't -- I don't think we anticipate making
14 money off our physicians. And I don't think
15 being at MGMA medium means you make money.

16 Q: Well, would you agree with me that that is a
17 financial goal?

18 A: It's a financial goal.

19 Q: And would you agree with me that you're trying
20 to improve the financial performance of your
21 physicians?

22 A: We're trying to hit the median collections with
23 50 -- at least 51 percent of our physicians.

24 Q: And would that be an improvement over what your
25 year to date experience was on June 30, 2011?

1 A: It would.

2 Q: And would you agree with me that at least one
3 of the reasons you're tracking this is you want
4 to improve the financial performance of your
5 physicians?

6 A: We want to improve it. That's correct.

7 Q: One of the things that I want to talk to you
8 about is the frustration that MUSC felt about
9 a relationship with Roper St. Francis and the
10 CareAlliance. MUSC declined to provide a
11 letter of support for the Carnes Crossroad
12 project, didn't it?

13 A: They did.

14 Q: Okay. And you testified that MUSC was
15 basically frustrated with the Alliance. Do you
16 remember that testimony?

17 A: I do.

18 Q: Okay. And that they felt that -- when I say
19 they, that MUSC believed that Roper St. Francis
20 should be participating more with grants and
21 collaborative projects than had been
22 experienced?

23 A: Correct.

24 Q: Okay. MUSC did provide a letter of support for
25 Trident though, didn't it?

- 1 A: They did.
- 2 Q: Okay.
- 3 A: They have a long-standing relationship.
- 4 Q: A positive relationship.
- 5 A: Medical University, I believe, has a family
- 6 practice residency program on the campus of
- 7 HCA. And they came close to leasing the entire
- 8 Medical University facility to HCA in the '90s,
- 9 so they have a relationship that goes back.
- 10 Q: Would you view MUSC as your primary competitor
- 11 on the peninsula?
- 12 A: We do.
- 13 Q: Okay. But would you agree with me that MUSC is
- 14 a significant healthcare asset the state of
- 15 South Carolina?
- 16 A: I would.
- 17 Q: Would you agree with me that MUSC's success is
- 18 important not just to the state of South
- 19 Carolina, it's important to Roper, isn't it?
- 20 A: It is.
- 21 Q: In fact, many of these doctors that you're
- 22 choosing to employ or that choose to be
- 23 employed by you are coming out of residency
- 24 programs across the street from you, aren't
- 25 they?

1 A: Correct.

2 Q: So the health and well-being of MUSC is
3 important to the entire healthcare delivery
4 system in this state, isn't it?

5 A: It is.

6 Q: Okay. Are y'all playing better together today
7 than you were back then?

8 A: We're doing a number of things together. We
9 are collaboratively working in the arena of
10 rehabilitation. In fact, all of their rehab is
11 provided at Roper Hospital. We executed a bed
12 agreement with them where we guaranteed certain
13 beds will be available for their patients
14 needing rehab, and we've been doing that for
15 about five years now. And that's, I think,
16 been successful. We recently established a
17 clinic for spinal cord injury that we house at
18 Roper Hospital and that we subsidize the loss
19 on Roper Hospital, but we've engaged their
20 faculty to assist with that. And we are
21 working collaboratively with them and with your
22 client to develop a electronic health exchange
23 system that will improve community care in the
24 emergency rooms. So, you know, I think -- I
25 said I think healthcare reform is going to

1 force hospitals and doctors to be more closely
2 aligned. I think it's going to force more
3 collaboration among providers in general.

4 Q: Good.

5 A: I think it's probably good.

6 Q: I do too. Let's talk a little bit about -- I
7 want to get back to this notion of bed
8 utilization downtown. You spoke a little bit
9 about that the continuing evolution, that more
10 and more things are done outpatient as opposed
11 to inpatient. Do you recall that testimony?

12 A: I do.

13 Q: You also talked about this notion of
14 observation beds. Now, observation beds and
15 the surge in utilization of observation beds is
16 directly related to Medicare's refusal to pay
17 for inpatient admissions without certifying
18 that patient, right?

19 A: Okay. I can go with that.

20 Q: Okay. And so what occurs is, let's say that we
21 have a 70 year old male who presents with some
22 chest pain. You triage him in the ED. You
23 don't have anything that looks untoward on the
24 EKG, so you want to stabilize him, and you're
25 going to watch him for a little while. That's

1 basically a patient who's being observed. Can
2 we agree on that?

3 A: That's correct.

4 Q: Okay. And depending upon what may happen or
5 what may develop in terms of, you know, blood
6 tests, blood gases, whatever, if a physician
7 makes a determination that I'm not comfortable
8 sending this 70 year old home, I want to admit
9 them, until that admission is basically blessed
10 off by DHEC, they're going to have to remain in
11 observation, aren't they?

12 A: I don't think it's blessed off by DHEC. I
13 think, until that admission meets -- in our
14 institution, we use a system called InterQual.

15 Q: Okay.

16 A: If they meet InterQual criteria, then they
17 would become an inpatient. If they don't, they
18 would remain an observation patient. And
19 that's purely driven by the physician's action,
20 not the hospital's action.

21 Q: And would you agree with me that the criteria
22 or the protocols that you're looking at about
23 whether or not that patient qualifies for that
24 inpatient admission, these are dictated by
25 CMSE, to some degree.

1 A: Yeah, I mean, I think ultimately, sure.

2 Q: And unless those are met, you run the risk that
3 Medicare's just not going to pay for that
4 inpatient admission, right?

5 A: Yeah. It would be fraudulent billing to bill
6 for an inpatient if they didn't meet criteria.

7 Q: Okay. And this process has been -- I say this
8 process -- this phenomenon has been increasing
9 in magnitude over the last, basically, 24
10 months; wouldn't you agree?

11 A: I'll give you our experience. Our experience
12 is that it, you know, in the last four or five
13 years it's been growing. This last year it
14 began to level off, so.

15 Q: Okay. You'd agree with me that it's much more
16 significant now than it was five years ago?

17 A: We certainly have more observation people today
18 than we had five years ago. And I'd say that
19 trended up for about three years and has begun
20 to level.

21 Q: Okay. Now, the benefit to Medicare is that
22 they pay less to you in terms of reimbursement
23 because they've kept this individual from being
24 admitted and then thereby qualifying for DRG
25 reimbursement for that admit, right?

1 A: That's correct.

2 Q: Okay. So it's -- I don't want to -- I don't
3 want this to sound as pejorative as I believe
4 it really is, but this is a cost saving measure
5 by Medicare, isn't it?

6 A: I believe it is, probably.

7 Q: Okay. And it creates some pretty significant
8 challenges for you and your organization,
9 doesn't it?

10 A: It creates downward pressure on margin, but,
11 you know, that quite honestly is the trend of
12 the day in terms of Medicare reimbursement, so.

13 Q: It's one more regulatory requirement that you
14 have to administrate through, isn't it?

15 A: It's a -- yeah, it's a regulatory requirement,
16 sure.

17 Q: Okay. How many patients on average do you have
18 in observation beds on a given day?

19 A: I would be guessing. I would guess it's 20.
20 I could be wrong.

21 Q: Okay. We'll take 20 as a rough estimate, okay?
22 Fair statement?

23 A: It's a guess.

24 Q: Okay. So if we say that on any given day you
25 have approximately 20 in observation, where do

1 you house your observation patients? Where do
2 you place them?

3 A: We have multiple places that they could be. We
4 have a area that is, we call it 2HVT. It's in
5 our heart and vascular tower, and it is an area
6 that houses both outpatient an observation
7 patients that are cardiac in nature. So it
8 might be just pain observation. Patients would
9 go there. It might be a patient that had a
10 cath that the -- that the physician wasn't
11 ready to send home but didn't meet inpatient
12 criteria. If they're surgical, they could be
13 up on our seventh floor, which is the surgical
14 unit. They could be in our pre-op holding
15 area. They could be in any of probably four
16 different places in the hospital.

17 Q: So they may or may not be in a licensed bed,
18 right?

19 A: That's correct.

20 Q: Okay. And it really just depends on the acuity
21 of the patient and the condition of the patient
22 and the diagnosis of the patient as to where
23 you place them within the facility?

24 A: And the availability of space in that spot.

25 Q: Okay. You remember the -- I'm going to go back

1 to His Honor's question where he was talking to
2 Mr. Long and you and the notion of what your
3 prior testimony was was to determine whether or
4 not it was reasonable to move those 50 beds off
5 your campus and put them at Carnes Crossroads.
6 Do you remember that question from His Honor?

7 A: I do.

8 Q: Okay. Let's go back to 25. Yeah, it's 25.
9 Let me go back to Respondent's 25, and if we go
10 back to that 2007 daily census. Now, would you
11 agree with me that the only constant in
12 healthcare is change?

13 A: I think that change is certainly part of what
14 we live with.

15 Q: All right. I'm going to look at -- page five
16 is where we were. Now, I understand your
17 testimony that there have been phenomenon, and
18 that is the continuing move from inpatient to
19 outpatient. There's this notion of observation
20 beds. Of course, there are 20 of those folks
21 in the hospital on any given day. There's been
22 a reduction in average length of stay by one
23 over the last five years, I think you
24 previously testified to. But you would agree
25 with me that you can have significant peaks in

1 census that are caused by things that are
2 completely beyond your control as a hospital
3 administrator, can't you?

4 A: Okay. You could.

5 Q: Okay. And one easy example of that is a really
6 bad respiratory infection hits a community.
7 You get a bad influenza in a community. You're
8 going to watch your census spike, aren't you?

9 A: That's correct.

10 Q: Okay. Because there are a lot of things that
11 are -- that complicate that. It's not just the
12 influenza. It's the pneumonia, it can be the
13 congestive heart failure, all kinds of things
14 can occur when you have that kind of February
15 infection, right?

16 A: Right.

17 Q: Okay. What are you going to do if you have any
18 day like you did those 21 days in 2007 where
19 you got more than 26 people to take care of in
20 downtown? Where are you going to send them?

21 A: More than 26? More than 266?

22 Q: More than 266. Where are you going to send
23 them?

24 A: Well, I mean, start by saying in 2011, my peak
25 census was 253. So in 2011, I never had a

1 census day that was in excess of the 266 that
2 we're talking about. So that's a known thing
3 for me. If I did, we would work within the
4 system to move patients to where we have
5 resources available. So if let's say I'm at
6 266, and the 267th patient comes in, you know,
7 my option is to hold them in the emergency room
8 until someone's discharged or to consider
9 moving them to St. Francis or to Mount
10 Pleasant.

11 Q: Maybe that's how you can redirect patients to
12 Mount Pleasant.

13 A: I have -- I --

14 Q: Nothing else seems to be working.

15 A: I have the ability to take advantage of the
16 system's resource, and I view that as an asset
17 to me and my operation and to the community.

18 Q: Okay. Don't you think that this is rather than
19 reasonable, don't you think moving these 50
20 beds is reckless?

21 A: I don't think it's close to reckless. I think
22 you're wanting to rely on something that was
23 2007, when we've got real data in 2011 that
24 suggests that my average daily census is 187,
25 which would be an occupancy of 70 percent which

1 is right in line with DHEC's requirement, and
2 my peak census was 253, which is well below the
3 266. And I have resources that I can redirect
4 patients to in Mount Pleasant and St. Francis.
5 So I don't think -- I don't think it's close to
6 reckless.

7 Q: All right. I want to come back to this notion
8 that you already had 253 last year.

9 A: Uh-huh (affirmative response).

10 Q: I want to come back to that, but first I want
11 to ask you this. ADC at 187, that puts me at
12 70 percent, correct?

13 A: That's my calculation.

14 Q: Okay. Do you realize that with that ADC you're
15 going to start showing a positive bed need in
16 the State Health Plan probably in the next
17 Health Plan?

18 A: I have no knowledge of that, no.

19 Q: While I've got you under oath --

20 A: Yes.

21 Q: -- is it your testimony here today that if you
22 do show a positive need in the next State
23 Health Plan that you will not apply for beds
24 downtown?

25 A: I have written a letter that says we will not

- 1 apply for beds as a function related to our
2 reduction in beds, and I will stick with that.
3 I mean, I'm not a health planner, I can't tell
4 you what the Health Plan says, what it's going
5 to say, you know. I know that I wrote that
6 letter, and I know we'll adhere to that letter.
7 And, you know, I'm not going to promise you
8 things that I haven't said in that letter.
- 9 Q: All right. Let's talk about your mission.
10 You've got a mission as a tertiary care health
11 center. You're going to have to take care of
12 some pretty critically ill patients, aren't
13 you?
- 14 A: We do take care of critically ill patients.
- 15 Q: Right. You've got open heart patients, you've
16 got neuro patients, you've got all these joint
17 replacement patients that you were previously
18 talking about. You've got to have adequate
19 resources to hospitalize these people. We can
20 agree on that, can't we?
- 21 A: Yes.
- 22 Q: Okay. If you're going to show a positive bed
23 need in the next State Health Plan, do you
24 believe that the letter you wrote will prevent
25 you in the future from seeking a certificate of

1 need for new beds, even if the Plan says you
2 have a need for one or two or 12?

3 A: I have no idea, number one, if the Plan will
4 show that I need beds. And two, if it does, I
5 honestly don't think it's my decision. This is
6 a, you know, it's a regulatory issue. I have
7 articulated that we will not seek beds as a
8 function of our reducing beds and we won't do
9 that. So I don't know -- I don't know how to
10 answer your question, other than refer you to
11 that letter.

12 Q: Okay.

13 MR. SUMMER: Beg the court's indulgence, Your
14 Honor,.

15 THE COURT: Yes, sir.

16 Q: I think it's on page 975, 975 of Joint 2.

17 A: Okay.

18 Q: All right. Let's just look at the language of
19 that letter. It says, "Roper St. Francis
20 Hospital Berkeley will send/submit a CON
21 application to construct a 50 bed hospital in
22 Goose Creek, i.e. Carnes Crossroads, via bed
23 transfer from Roper Hospital. As required by
24 the State Health Plan, this letter acknowledges
25 in writing that this exchange is permanent and

1 confirms that Roper Hospital will not use the
2 loss of these beds as justification for a
3 subsequent request for the approval of
4 additional beds." And you signed that, right?

5 A: That's correct.

6 Q: Okay. I'm trying to determine --

7 A: Right.

8 Q: -- what it means.

9 MR. LONG: Your Honor, I'm going to object. I think
10 it's asked and answered. I mean, he's asked
11 him -- this is the same question he just asked
12 before, and same question he asked before that.
13 Mr. Severance on the other two times that he
14 asked him gave exactly the same answer.

15 MR. SUMMER: I hadn't asked the question yet.

16 MR. LONG: He just asked it.

17 THE COURT: No. I thought you did, Mr. Summer, but
18 maybe try to rephrase it --

19 MR. SUMMER: I will rephrase it.

20 THE COURT: -- and I will hear it.

21 Q: Okay. What does permanent mean to you?

22 A: It means they're not coming back.

23 Q: Okay. Those beds that moved, they're not
24 coming back?

25 A: That's correct.

1 Q: What does the phrase, "Roper Hospital will not
2 use the loss of these beds as justification for
3 a subsequent request for the approval for
4 additional beds"?

5 MR. LONG: I'm going to object again. This is the
6 third or fourth time he's asked the question.

7 THE COURT: I agree. I'm going to sustain. You've
8 got -- you've got the letter in the evidence if
9 you want to rely on it down the road, which is
10 your obvious intent.

11 MR. SUMMER: Your Honor, my problem is is that once
12 again I have DHEC requiring people to do
13 something that means nothing. This witness has
14 acknowledged to me that he's already at the 70
15 percent threshold. What that means is that
16 that ADC goes up one, okay, from 187 to 188,
17 there will be a positive bed need in the Plan
18 for him. Okay? That means in one year he can
19 apply for new beds. I think I'm entitled to
20 ask him if -- does this letter act as an
21 estoppel, does it prevent him from going after
22 those beds. Because if in his mind it does
23 not, then the letter is superfluous. It means
24 nothing. But if I can't ask him those
25 questions, I can't put it in the record.

1 THE COURT: I think that's for another day and
2 another court, Mr. Summer. Sustained.

3 MR. LONG: Thank you, Your Honor.

4 MR. SUMMER: I would like to ask a couple of
5 questions on proffer if I might?

6 THE COURT: Yes, sir.

7 MR. SUMMER: This will be the beginning of the
8 proffer and I will let the court know when the
9 proffer is over.

10 PROFFERED TESTIMONY OF MR. SEVERANCE - CROSS

11 EXAMINATION BY MR. SUMMER:

12 Q: If the next State Health Plan shows a bed need
13 of one bed for Roper Hospital, do you believe
14 your letter that you wrote on September 9, 2009
15 and appears in Joint 2, 975, will prohibit you
16 from applying for new beds?

17 A: I believe it will prohibit me from applying for
18 beds based on the using justification that we
19 had recently reduced beds. I certainly
20 wouldn't anticipate applying for beds. And I'm
21 not sure that -- I mean, I guess I'd rely on
22 DHEC and our staff to determine if we even
23 could. But I mean, I think we probably
24 couldn't.

25 Q: So is it your testimony that your understanding

1 of this letter is you will not be able to apply
2 for new beds in the foreseeable future because
3 having transferred 50, at least until you have
4 more than a 50 bed need, you wouldn't qualify
5 for any new beds?

6 A: Can you -- can you restate that or --

7 Q: You would agree with me you're giving up a
8 license for 50 beds.

9 A: That's correct.

10 Q: One way to read DHEC's rule and your letter is,
11 is that until you show a bed need in excess of
12 50, you should not be able to add new beds
13 downtown. My question to you is: Is that your
14 interpretation?

15 MR. LONG: Your Honor, further objection to this
16 question. I understand it's a proffer. I
17 think he's asking for an opinion. He's already
18 said he's not a planner. He doesn't -- you
19 know, it's not his decision, and he's asking
20 him an opinion question, I think. So further
21 objection, even though I understand it's on
22 proffer.

23 MR. SUMMER: It's his signature. He's made a
24 commitment to the state of South Carolina. All
25 I'm trying to get on the record is what does it

1 mean.

2 **THE COURT:** Overruled. That's in the proffer.

3 **MR. SUMMER:** Thank you, your Honor.

4 **Q:** Would you like me to restate the question?

5 **A:** Sure. That would be great.

6 **Q:** Okay. Is it your understanding, having signed
7 a letter which appears at Joint 2, page 975,
8 that you will not be allowed to apply for new
9 beds until such time as the State Health Plan
10 shows a bed need in excess of the beds you gave
11 up, in this case 50 beds.

12 **A:** I think that would be a -- let me just say, I
13 think that would be a reasonable position for
14 DHEC to take. I certainly -- operating at 70
15 percent would not, if there was a bed need of
16 one, I would not be asking for beds. I'm very
17 comfortable operating up to 80 percent. So I,
18 as an operator, would not be inclined to seek
19 beds short of 80 percent for certain. And I
20 can't tell you what that means to DHEC, but I
21 can tell you as an operator it's -- a bed need
22 of one would not impress me to action.

23 **Q:** So your testimony is that it would be
24 reasonable for DHEC to take the position that
25 you would have to have a need in excess of 50

1 beds before you could add beds downtown,
2 correct?

3 A: If that is the only item at play. I mean, I
4 guess I'm just sitting here thinking there
5 could be lots of other things going on that
6 were not contemplated here today that could --
7 that could drive a bed need, which would be
8 extraordinary. You know, we could do lots of
9 what-ifs. You know, what if, you know, the
10 Medical University decided to close their
11 doors. All of a sudden there's a huge unmet
12 need in the community, and we ought to be
13 responsive to that. I mean, so, I guess, you
14 know, I wouldn't want to close the door in its
15 entirety. There's lots of things that we
16 wouldn't anticipate that might bear on it and
17 create need. I think DHEC, you know, has
18 rules. I think the intent of this letter is
19 relatively straightforward, and I think
20 exceptions to the intent would be made by DHEC,
21 not by me.

22 Q: You really hadn't thought about that when you
23 signed that letter, had you?

24 A: Hadn't thought about what?

25 Q: That you might not be able to get any more beds

1 until you showed a need for 50?

2 A: No. I thought about it. That doesn't bother
3 me. I think I just told you that.

4 MR. SUMMER: End of proffer, your Honor.

5 THE COURT: Thank you.

6 MR. SEVERANCE - CONTINUED CROSS EXAMINATION BY MR.

7 SUMMER:

8 Q: I'm going to ask you about an event that
9 occurred. I need to lay a little bit of
10 foundation for this because there are several
11 boards that are associated with your various
12 hospitals and the Alliance, correct?

13 A: That's correct.

14 Q: Okay. Do you mind, because what I'm trying to
15 do here is to understand a specific position
16 that you took in your deposition, explain to me
17 who all the various boards are. And let's
18 start with your hospital. Does your hospital
19 have a board?

20 A: My hospital has a board.

21 Q: And what's the name of your hospital board?

22 A: Roper Hospital Board.

23 Q: Okay. Does Bon Secours St. Francis have a
24 board?

25 A: They do.

- 1 Q: That would be the Roper St. Francis Board?
- 2 A: That would be the Bon Secours St. Francis
- 3 Board.
- 4 Q: Okay. Bon Secours is an Order of Catholic
- 5 Nuns, correct?
- 6 A: That's correct.
- 7 Q: All right. And they're based out of Maryland.
- 8 They have about 33 hospitals across the
- 9 country, don't they?
- 10 A: Bon Secours Health System is based out of
- 11 Maryland, owns 33 hospitals. The Order of Nuns
- 12 is I think based out of France.
- 13 Q: Okay. So Bon Secours St. Francis has its own
- 14 board. I guess Roper Mount Pleasant now has a
- 15 board, doesn't it?
- 16 A: That's correct.
- 17 Q: And is there a big board?
- 18 A: A health system has the Roper St. Francis
- 19 Healthcare Board.
- 20 Q: Okay. So the Roper St. Francis Healthcare
- 21 Board. Is that the Alliance board?
- 22 A: Our legal name is CareAlliance. We do business
- 23 as Roper St. Francis. So I guess from a
- 24 lawyer's standpoint, you'd call it the
- 25 CareAlliance Board.

1 THE COURT REPORTER: Could you speak up just a
2 little bit, please?

3 A: CareAlliance is our legal name. Our -- we do
4 business as Roper St. Francis Healthcare.

5 Q: Okay. Now --

6 A: Physician Partners has a board.

7 Q: Okay.

8 A: The Foundation has a board.

9 Q: At one point in time Allan Nussbaum was your
10 chairman?

11 A: That's correct.

12 Q: Of which board?

13 A: Roper Hospital Board.

14 Q: You were scheduled to run a tour of the
15 hospital with the Roper St. Francis -- with the
16 Roper Board in May of 2009, and it got
17 cancelled. Do you remember that testimony?

18 A: Yeah. The schedule was -- so another board
19 that is an advisory board is our Roper Berkeley
20 Center Advisory Board. And that board is made
21 up of folks that live and work in the Moncks
22 Corner area. And they serve as an advisory
23 board for that Moncks Corner facility. They
24 were coming, my memory is, they were coming to
25 Roper Hospital. One of their members sits on

1 the Roper Hospital Board and -- but the whole
2 board was coming to Roper Hospital and we were
3 going to give them a tour.

4 Q: Okay. If you've got Joint 2 in front of you,
5 do you have Joint 2 in front of you?

6 A: Yes, I do.

7 Q: Would you turn to page 1176? Do you see that?

8 A: I do.

9 Q: And it says DHEC project with new committee
10 meeting. And what day was that held?

11 A: The 21st of May, 2009.

12 Q: May 21, 2009. And on May 22, 2009, Dee
13 Mullison is sending an email out to all the
14 board members saying that we cancelled the
15 board -- the tour. Do you remember that?

16 A: She cancelled the tour for the Roper Berkeley
17 Advisory Board.

18 Q: Okay. And instead of having the tour, you
19 convened the Roper Berkeley Board and the
20 Advisory Board, didn't you?

21 A: It was the regular meeting of the Roper Board
22 --

23 Q: Right.

24 A: -- that night --

25 Q: Right.

1 A: -- is my memory.

2 Q: Right.

3 A: And we had invited the Berkeley Board to come
4 to that meeting. And before the meeting we
5 were going to give them a tour, I believe of
6 our CyberKnife facility.

7 Q: Okay. But you cancelled it and you told your
8 board members, told your board chairman -- and
9 remember, this is right after project review.

10 A: Right.

11 Q: "Developing and solidifying political support
12 for our effort is an immediate priority." Do
13 you remember saying that?

14 A: What are you looking at?

15 Q: Well, I don't -- let me just see if I can
16 refresh your recollection.

17 MR. LONG: What was that, your Honor? Is this an
18 exhibit?

19 MR. SUMMER: It's not an exhibit. I'm refreshing
20 his recollection.

21 MR. LONG: No. Your Honor, we already went through
22 that with Mr. Baehr.

23 MR. SUMMER: I'm asking --

24 MR. LONG: Your Honor, I object to even showing it
25 to him. I went through all that with Mr.

1 Baehr. Mr. Thomas made a big deal about that.
2 What's good for the goose is good for the
3 gander.

4 MR. SUMMER: I'm not seeking to introduce.

5 MR. LONG: Neither was I. I was merely refreshing
6 Mr. Baehr's recollection.

7 MR. SUMMER: All I'm trying to do is get him to --
8 to refresh his recollection on the issue the
9 night that the tour was cancelled. He asked me
10 if there was something he could look at, and
11 I'm now providing it to him. It is not to be
12 introduced into evidence. It's merely to
13 refresh his recollection.

14 MR. LONG: Fundamentally unfair, Your Honor. That's
15 exactly the same thing that I did with Mr.
16 Baehr when I asked him about his testimony in
17 the open heart case. I showed him his
18 transcript to refresh his recollection of what
19 he testified to. Mr. Thomas stood up, made a
20 passionate objection about it. I said I'm
21 refreshing his recollection, that's all I'm
22 doing. Your Honor sustained objection, and I
23 had to pull the paper back from Mr. Baehr.
24 It's exactly the same thing. I even said to
25 the court I'm not seeking to introduce it, I

1 merely want to refresh his recollection. It's
2 exactly the same thing that they complained to
3 me about over a week ago in the trial. It
4 doesn't matter what the rules say, Your Honor.
5 They made an objection. I thought it was
6 permissible for me to do it when I did it with
7 Mr. Baehr. They objected to it, and Your Honor
8 ruled it out based on the order that Your Honor
9 had issued earlier in the case.

10 MR. SUMMER: All right. Your Honor, I believe I'm
11 entitled to refresh his recollection on this
12 under the rules.

13 MR. LONG: Not based --

14 THE COURT: I'm going to sustain the objection based
15 on my prior ruling.

16 MR. SUMMER: Okay. And I hate to do this, but I may
17 have two or three questions for proffer,
18 please.

19 THE COURT: Yes, sir.

20 PROFFERED TESTIMONY OF MR. SEVERANCE - CROSS
21 EXAMINATION BY MR. SUMMER:

22 MR. SUMMER: And let's go ahead now and mark it for
23 proffer, please. Exhibit Number --

24 MR. LONG: Your Honor, I think it's unfair to
25 proffer it. I mean, at the time, he's asking

1 to refresh his recollection. So what he's
2 getting ready to do is refresh his
3 recollection, which is exactly what your order
4 contemplated wouldn't happen. And I wasn't
5 allowed to do that with Mr. Baehr's testimony.

6 **THE COURT:** Well, an appellate court has to have
7 something to look at. I don't recall you being
8 denied the right to make a proffer. Is that
9 right?

10 **MR. LONG:** I don't recall that either. But --

11 **COURT REPORTER:** This is going to be Exhibit 244 for
12 proffer.

13 **THE COURT:** And I am correct in understanding that
14 this was not exchanged. You had no knowledge
15 of this beforehand.

16 **MR. LONG:** This is not an exhibit. I think it -- it
17 was produced in discovery, Your Honor, but it
18 was not on the exhibit list. It's never been
19 on the exhibit list. I've been working off
20 these exhibit sheets.

21 **THE COURT:** That's what I'm talking about.

22 **MR. SUMMER:** He testified about it in his
23 deposition. He's seen it before and testified
24 about it. All I was going to do was get the
25 issue into the record. But when he said he

1 couldn't identify -- wanted something to look
2 at, I literally pulled this from his
3 deposition. That's where it came from.
4 There's no surprise here. Did we fail to mark
5 it ahead of time, yes. We were trying -- we're
6 up to 244 exhibits. What we were trying to be
7 as judicious as we could. I would have assumed
8 that he would have remembered it and could have
9 simply reiterated this position about politics.
10 He didn't. So I don't want to put it into
11 evidence. And all I want to do with the
12 proffer is basically put up, you know, to
13 refresh his recollection under Rule 612.

14 **THE COURT:** I'm going to allow the proffer, but I
15 will say that this is squarely within what I
16 perceived to be the requirement and prohibition
17 in my order.

18 **Q:** All right. If you're looking at what's now
19 been marked as Petitioner's 244.

20 **A:** Right.

21 **Q:** I see your email to Mr. Nussbaum, who is the
22 chairman of the Roper Board, correct?

23 **A:** Right.

24 **Q:** Okay. And if you would, just read into the
25 record what you said to him.

1 A: Sure. It says, "Alan, the tour was cancelled"
2 -- this is the tour for the Roper Berkeley
3 Advisory Board -- "was cancelled so that David
4 and our strategy team can use the time from
5 4:00 to 5:00 p.m. to meet with the Roper
6 Berkeley Board to discuss the status of our
7 Berkeley County hospital CON application
8 article in today's paper and discuss our DHEC
9 strategy going forward. Developing and
10 solidifying political support for our effort is
11 an immediate priority. Just wanted to let you
12 know why this change occurred. Please feel
13 free to contact me with any questions. Also,
14 if you'd like to attend the 4:00 p.m. meeting,
15 it will be in the board room on the Burton
16 Pavilion."

17 Q: And the David in here is David Dunlap; is that
18 correct?

19 A: It is.

20 Q: The CEO of the Alliance, correct?

21 A: That's correct.

22 MR. SUMMER: Okay. End of proffer, your Honor.

23 Thank you very much.

24 MR. SEVERANCE - CONTINUED CROSS EXAMINATION BY MR.

25 SUMMER:

1 Q: All right. So May 22nd was the day after
2 project review in this case; was it not?

3 A: May 22nd was the day after, That's correct.

4 Q: Okay. And the day after project review, your
5 institution's number one issue was political
6 support, correct?

7 A: What it looks to me like is that this letter
8 was --

9 MR. LONG: I object, your Honor. It's still -- he
10 really needs to take the document back from
11 him.

12 MR. SUMMER: I'm happy to take the document back.

13 MR. LONG: And he's still asking him questions about
14 it.

15 THE COURT: All right. Well, ask him under the
16 deposition then if you say it's in there.

17 MR. SUMMER: That's a good point. Thank you, Your
18 Honor.

19 A: It looks to me like the -- looks to me like
20 this was more about -- so the 21st of May was
21 the, I guess, the hearing. The 22nd I sent the
22 letter to Dr. Nussbaum. And it looks like the
23 25th was the actual day of the board meeting.
24 So it was four days later. But it looks to me
25 like it was in response not to the meeting on

1 the 21st, but in response to the article that
2 was in the paper on the 22nd which is
3 referenced in that email. So my assumption, my
4 recollection, my, you know, I guess, position
5 as a hospital operator that manages a board is
6 you want to keep your board informed and you
7 don't want your board to be surprised by
8 articles in the paper. So if there was an
9 article in the paper, chances are we said, you
10 know, we want -- we've got these folks coming
11 together for a tour, let's take that
12 opportunity, instead of showing our new
13 CyberKnife, which is pretty neat, to inform
14 them fully on the specifics of what was covered
15 in the article in the paper so that they're --
16 you know, these people are volunteers. They're
17 out in the community. People are asking them,
18 aren't you on the Roper Berkeley Board, what do
19 you think about this? And if they're
20 uninformed, they feel uninformed and stupid and
21 resentful toward our organization. So we're
22 trying to keep our board informed, and that, I
23 think, is good board management.

24 Q: Would you do me a favor and look at page 178 of
25 your deposition?

1 A: One seventy-eight. The other thing I would say
2 is that the CON process asked for letters of
3 community support and political support. So we
4 were probably trying to cover that base.

5 Q: Okay. So let me know when you get to page 178.

6 A: I'm there.

7 Q: All right. I'm going to start with Mr. Thomas'
8 question to you at line 16.

9 A: Okay.

10 Q: And it says, "So there's another reference to
11 the tour being cancelled so that David and our
12 strategy team can use the time from 4:00 to
13 5:00 to meet with the Roper Berkeley Board to
14 discuss the status of our Berkeley County CON
15 application, discuss our DHEC strategy going
16 forward." Then Mr. Thomas asked you, "What was
17 the DHEC strategy that you're articulating
18 here?" Your first -- just read me the first
19 sentence. I'm going to let you read the whole,
20 I'm going to let you read the whole, but would
21 you please read me the first sentence?

22 MR. LONG: Your Honor, I think that's -- that's
23 objectional. I mean, it's question and answer.
24 He can't dice up the answer on a deposition.
25 He --

1 MR. SUMMER: I'll withdraw the question. Fine.

2 Q: Read your answer in toto, please.

3 A: "Looks like it's developing, solidifying
4 support, political support for the effort. It
5 was an immediate priority even though -- what
6 you've got here is you've got an advisory board
7 in Moncks Corner at our facility, and they are,
8 you know, at a function. In that role, they
9 are ambassadors of Roper St. Francis and
10 specifically that facility, being Moncks
11 Corner, and they're being peppered in the
12 community with questions about, you know, why
13 -- why is -- why is--" It stops, dash, dash.
14 "You know, what's going on with these two
15 hospitals. You've seen the newspaper articles,
16 the billboards, etcetera. There's a lot of mud
17 being slung, and they've got questions, and so
18 this was to share with them, you know, what the
19 facts are and what our intentions were."

20 Q: Thank you. One of the other issues I wanted to
21 broach with you was the notion of semi-private
22 beds. You do not use semi-private beds
23 downtown anymore, do you?

24 A: We've got, I think, 11 semi-private beds within
25 the rehab hospital.

1 Q: Okay.

2 A: And those are the only semi-private beds that
3 I'm aware of.

4 Q: All right. Different population. Let's talk
5 about general acute care. Do you utilize any
6 semi-private rooms in general acute care?

7 A: I don't think we do.

8 Q: Okay. You would agree with me that in a
9 general acute care setting there are good
10 quality patient issues about why you shouldn't
11 be using semi-private rooms, agreed?

12 A: I don't agree with that.

13 Q: Okay. Do you agree with me that semi-private
14 rooms create a HIPAA challenge?

15 A: I think it can be managed. In the -- if I can
16 expand. I spent three years on New York, and
17 all of our beds were semi-private, and that was
18 the norm in New York was to have semi-private
19 beds. So, and I think if you looked at the
20 quality of care in New York versus here, you'd
21 be hard pressed to say that the quality of care
22 is worse as a function of semi-private beds.

23 Q: You would agree with me that Charleston doesn't
24 have nine million people living on one island?
25 Can you agree with me on that?

- 1 A: I was working in a small facility in a town
2 that was one square mile that, you know, wasn't
3 -- I was in Westchester County. I was not in
4 downtown New York.
- 5 Q: Okay.
- 6 A: But I do agree with you.
- 7 Q: Okay. Westchester is a nice address.
- 8 A: It's a very nice address.
- 9 Q: Okay. Let me talk to you and see if you agree
10 or disagree with this. Do you agree that semi-
11 private rooms pose a challenge for HIPAA
12 issues?
- 13 A: I think they can.
- 14 Q: Okay.
- 15 A: I think they can be overcome.
- 16 Q: All right. But you'd agree with me the only
17 thing between those two patients is a curtain?
- 18 A: That's correct.
- 19 Q: And depending on the acuity level of the
20 patient, rolling somebody out in the hallway to
21 tell them that they're HIV positive isn't
22 always an option.
- 23 A: I think the -- the bigger challenge with semi-
24 private is just the, you know, more of the
25 social issue than is the HIPAA issue to be

1 honest with you.

2 Q: You'd also agree with me that there's an
3 infection issue related to semi-private rooms;
4 is there not?

5 A: No, because when you have semi-private rooms
6 you manage -- you manage that infection
7 problem. You know, one of the -- one of the
8 reasons that -- if I had all semi-private
9 rooms, I might be less inclined to say 80
10 percent is not a -- not a tough number to hit
11 utilization wise because you do encounter
12 circumstances, male/female, infected/non-
13 infected where it creates some -- more capacity
14 issues with semi-private rooms than if you
15 don't have semi-private rooms. But they can be
16 managed. They're managed -- you know, we
17 managed them in New York, and many parts of the
18 country have semi-private rooms.

19 Q: Well, despite your personal affinity for semi-
20 private rooms, you would agree that Roper
21 doesn't utilize semi-private rooms for its
22 general acute care population, correct?

23 A: That's correct.

24 Q: Thank you.

25 MR. SUMMER: Beg the court's indulgence.

1 THE COURT: Yes, sir.

2 Q: One last question on these observation patients
3 that we've talked about, you said things have
4 plateaued now, and that currently you estimate
5 that you see on average -- you have 20
6 observation patients per day. If we go back to
7 2008, what was the observation phenomenon back
8 then? Was it as acute as it is today?

9 A: You know, I'm speculating. It was probably raw
10 number per day was a little bit less, but the
11 trajectory was up. And where we are now, you
12 know, the trajectory went up for three or four
13 years and then began to level and drop a little
14 bit. So raw number, I couldn't give you a
15 number. But the trajectory was increasing.

16 Q: Okay. Thank you very much. If you'd answer
17 any questions anyone else would have.

18 THE COURT: Mr. Long?

19 MR. LONG: No questions, your Honor.

20 THE COURT: Probably a good time to break for lunch.
21 Come back at 2:00.

22 (Off the Record from 12:25 p.m. until 2:00 p.m.)

23 THE COURT: Mr. Long, your next witness?

24 MR. LONG: Thank you, Your Honor. We call Rick
25 Knapp to the stand.

1 RICK KNAPP, being duly sworn, testifies as follows:

2 MR. KNAPP - DIRECT EXAMINATION BY MR. LONG:

3 Q: Mr. Knapp, can you state your full name,
4 please?

5 A: My name is Rick Dougherty Knapp.

6 Q: Okay. And where do you reside?

7 A: Blowing Rock, North Carolina.

8 Q: And what is your occupation?

9 A: I'm a management consultant responsible for the
10 financial portion of our healthcare consulting
11 practice.

12 Q: And what is your healthcare consulting
13 practice?

14 A: We basically --

15 Q: What's the name of it?

16 A: Oh. Richardson Knapp and Associates.

17 Q: Okay. And who are the partners or associates
18 in that?

19 A: Myself and Mr. Richardson.

20 Q: Okay. Mark Richardson?

21 A: That's correct.

22 Q: He's here in the courtroom today?

23 A: He is.

24 Q: All right. Before we talk about your company,
25 can you kind of give me your educational and

1 employment background?

2 A: Yes, sir. I got my bachelor's of business
3 administration from Ohio University in 1969
4 with a major in accounting. Went on to get my
5 MBA from Ohio U in 1970, with a concentration
6 area in quantitative methods or business
7 statistics.

8 Q: And can you give us your employment background?

9 A: Yes, sir. From 1970 to 1972, I was in the Air
10 Force in Del Rio, Texas as a management
11 analysis officer. In 1972, I joined the firm,
12 at that time it was called Ernest and Ernest,
13 currently Ernest and Young, in Cleveland, Ohio.

14 Was with Ernest for about five years.
15 Probably two-thirds of my consulting experience
16 up there related to healthcare, doing financial
17 forecast sometimes in conjunction with bond
18 issues.

19 Q: And after that?

20 A: In 1977 I went to, I moved to Atlanta and went
21 to the investor owned hospital, a company
22 called American Medical International or AMI,
23 which is currently called Tenet. While I was
24 there I was responsible for such activities as
25 reimbursement, budget and finance -- excuse me,

1 financial analysis.

2 Q: What was your title there?

3 A: I was director of financial analysis and then
4 director of reimbursement.

5 Q: Okay. And how long were you a Tenet?

6 A: I was there till --

7 Q: Or the predecessor to Tenet, sorry.

8 A: Yes. I was there until 1983, at which time I
9 joined the healthcare consulting firm of FLR
10 Health Resources in Atlanta. Once again
11 responsible for the financial portion of our
12 consulting practice. Was with FLR from 1983 to
13 1989, at which time I joined Arthur Anderson in
14 Atlanta, pretty much doing the same thing I was
15 doing at FLR in terms of healthcare consulting.

16 Q: What kind of consulting were you doing?

17 A: Lots of financial forecasting. Most of our
18 work involved either preparing certificate of
19 need applications or the litigation support
20 expert witness activities that came on the back
21 end of preparing the CON applications.

22 Q: Okay.

23 A: Did that until 1989. The firm basically blew
24 up. I went with Arthur Anderson in 1989. And
25 then Mr. Richardson and I came together, since

1 we had both been at FLR Health Resources, to
2 form Richardson Knapp and Associates in 1990.

3 Q: Okay. And y'all have practiced together since
4 1990?

5 A: We have.

6 Q: And how do you -- how do you and Mr. Richardson
7 divide your roles in the company?

8 A: Basically Mark is a health planner. He gets
9 involved with the strategic planning
10 activities, use rates, market sizing, things of
11 that nature. Basically my role in life is to
12 dollarize various things. I'll dollarize the
13 projected volume that Mr. Richardson will come
14 up with in terms of generating adverse impact
15 analyses, generating pro formas, forecasts,
16 profit and loss statements, things of that
17 nature.

18 Q: Okay. Have you -- as part of your practice, do
19 you testify in court?

20 A: Yes, sir, I do.

21 Q: And have you been qualified as an expert in --
22 or what states have you been qualified as an
23 expert in?

24 A: Most of my activity has been in Florida, South
25 Carolina, Georgia, North Carolina and New

1 Jersey, Alabama, and Texas when they still had
2 CON.

3 Q: And have you testified in the Administrative
4 Law Court here in South Carolina?

5 A: Yes, sir.

6 Q: And were you qualified as an expert when you
7 did so?

8 A: Yes, sir, I was.

9 MR. LONG: Your Honor, this time we would move to
10 designate Mr. Knapp as an expert in the field
11 of healthcare finance.

12 MR. THOMAS: Without objection, Your Honor.

13 THE COURT: Without objection the witness is so
14 qualified.

15 MR. LONG: Thank you.

16 Q: Now, Mr. Knapp, did you -- earlier in your
17 career did you pass the CPA; did you take and
18 pass the CPA exam?

19 A: I did.

20 Q: And where were you employed when you took and
21 passed?

22 A: It was with Ernest and Ernest in Cleveland.

23 Q: And that would have been, I guess, early '70s,
24 mid-'70s?

25 A: Correct.

- 1 Q: And that was in Ohio?
- 2 A: That's correct.
- 3 Q: All right. And then when you were in the state
- 4 of Georgia, did you practice as a CPA?
- 5 A: Well, Ohio and Georgia had a reciprocity. And
- 6 so I didn't practice as a CPA, per se, in
- 7 Georgia.
- 8 Q: Are you -- do you still hold that certificate
- 9 today as a CPA?
- 10 A: I do not.
- 11 Q: Okay. And why not?
- 12 A: I was remiss in updating my professional
- 13 development.
- 14 Q: Your continuing education?
- 15 A: Correct.
- 16 Q: And have there ever been times in your past
- 17 where you have testified that you were a CPA?
- 18 A: Yes, sir.
- 19 Q: At the time that you did that, did you believe
- 20 that you were a licensed CPA?
- 21 A: Yes, sir.
- 22 Q: But today do you know differently?
- 23 A: I do.
- 24 Q: Okay. Do you hold yourself out today as being
- 25 a licensed CPA?

- 1 A: I do not.
- 2 Q: All right. When did you become involved in
- 3 representing Roper St. Francis in regards to
- 4 this CON application in dispute in this case?
- 5 A: My recollection would have been in summer or
- 6 early fall of 2008.
- 7 Q: Okay. And do you recall how you became
- 8 involved in it?
- 9 A: I believe Mr. Richardson, my partner, had been
- 10 contacted either by your firm, Nexsen Pruet or
- 11 by Roper St. Francis, I'm not sure which.
- 12 Q: Okay. Had you worked for Roper St. Francis
- 13 before?
- 14 A: Yes, sir. We have.
- 15 Q: In what other capacities had you worked for
- 16 them?
- 17 A: We helped develop the Mount Pleasant, the Roper
- 18 Mount Pleasant certificate of need application
- 19 I believe in 2005.
- 20 Q: Okay. And you've worked for other healthcare
- 21 providers in South Carolina?
- 22 A: Yes, I have.
- 23 Q: Other than Roper St. Francis?
- 24 A: Yes, sir.
- 25 Q: All right. Let's look at Joint Exhibit 2.

- 1 A: Yes, sir.
- 2 Q: Do you have the book there in front of you?
- 3 A: I do.
- 4 Q: All right. Let's look at pages 461 and
5 thereafter.
- 6 A: Yes, sir, I'm there.
- 7 Q: Okay. Now, is this section of the certificate
8 of need application -- if you look at the page
9 before that, 460, it has the heading. Is this
10 the section of the certificate of need that was
11 your primary responsibility?
- 12 A: Yes, sir, it is.
- 13 Q: All right. And who did you work with in order
14 to do your work in regards to this section of
15 the CON?
- 16 A: Worked with some Roper folks. Also worked with
17 my partner, Mark Richardson.
- 18 Q: Okay. Looking at page 461, can you tell me
19 what this page is?
- 20 A: Yeah. Basically this is a representation to
21 DHEC that I'm an accountant and responsible for
22 the financial portion of our healthcare
23 consulting practice. And I have prepared the
24 accompanying pro forma to the best of the my
25 ability and believe it to be an accurate

1 forecast.

2 Q: Okay. Let's turn to the next page, 462.

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

4 Q: Can you tell the court what this page
5 represents in the certificate of need
6 application?

7 A: Yes, sir. This pro forma is an incremental pro
8 forma. In other words, this pro forma purports
9 to represent the financial implications of the
10 proposed project, and it focuses on the
11 incremental volume. And what I mean by -- I'm
12 going to -- I think these terms have been
13 defined earlier in the proceeding, but I think
14 it may be worthwhile for me to define two
15 terms. One is venue. One is incremental.
16 Venue volume, the way I will use the term, will
17 be the volume that takes place at the proposed
18 hospital, whether it's from redirected from
19 existing Roper or redirected from existing St.
20 Francis. Or if it's incremental, that is new
21 to the Roper St. Francis system.

22 Q: Is another word for venue or venue like a
23 standalone pro forma?

24 A: That would be a fair statement. Yes, I would
25 agree with that. Incremental, on the other

1 hand, represents the difference between the CON
2 applicant assuming the project goes forward and
3 assuming that the project does not go forward.

4 Q: Now, let me ask you a couple of questions about
5 that. Can you explain to the court the concept
6 of fixed expenses?

7 A: Certainly. Fixed expenses are those expenses
8 that tend not to vary with changes, either
9 upward or downward in volume.

10 Q: Can you give some examples of what would be
11 fixed expenses in regards to this hospital
12 project?

13 A: Certainly. There would be a component of
14 salaries and wages that would be fixed. For
15 example, you have to have a core staff whether
16 you have extremely minimal volume or a fairly
17 large amount of volume. So there's a component
18 of salaries and wages that are indeed fixed.

19 Q: In other words, if you had one patient, you
20 would still have a component?

21 A: That is correct. That's correct. Another
22 example of fixed expenses, and there might be
23 a slight variable component to this, would be
24 utilities expenses, which are relatively
25 insensitive to movements upward and downward in

1 terms of volume. Other examples, traditional
2 examples of fixed expenses, would be such
3 things as depreciation expense and interest
4 expense.

5 Q: Can you explain to the court the concept of
6 variable expenses?

7 A: Certainly. Variable expenses, on the other
8 hand, would be those expenses that, in fact,
9 are a function of volume. That is they move up
10 when volume moves up; they move down when
11 volume moves down.

12 Q: So when you're creating an incremental pro
13 forma like the one that is on page 462, how
14 does those concepts of fixed and variable
15 expenses work in the creation of the pro forma?

16 A: Well, basically what happens is that to the
17 extent that you have fixed expenses, again
18 they're not going to change as volume ramps up
19 during the first three years of operation. The
20 variable expenses will indeed ramp up. They
21 are, in fact, a function of both inflation and
22 increases in volume. So those two interplay in
23 such a fashion that they manifest themselves in
24 an incremental pro forma.

25 Q: Okay. Let's look at the patient days. Now,

- 1 who actually does, between you and Mr.
2 Richardson, the calculations to determine what
3 the patient days are on the pro forma?
4 A: That would be Mr. Richardson's purview.
5 Q: Okay. So does he -- so what does patient days
6 incremental mean?
7 A: Those are the patient days that, in fact, will
8 be seen at the proposed Carnes Crossing
9 Hospital that absent the proposed hospital,
10 Roper St. Francis would not have received those
11 patients.
12 Q: You've been here for almost all of the trial.
13 You've heard us use the term redirected?
14 A: Yes, sir.
15 Q: As in redirected patients?
16 A: Yes, sir.
17 Q: Okay. How does that factor in regards to your
18 calculation of incremental patient days?
19 A: Redirected patient days would indeed not be
20 reflected on an incremental pro forma because,
21 again, Roper St. Francis is already receiving
22 those patients.
23 Q: And what does adjusted patient days incremental
24 mean?
25 A: Yeah. I think Mr. Baehr did a very nice job

1 and I think Mr. Gallati, perhaps, in terms of
2 defining what the term adjusted means as it
3 relates to volume. Many healthcare statistics
4 really embrace both inpatient and outpatient
5 concepts. And there has to be a way, in fact,
6 to give an inpatient equivalent, if you will,
7 to outpatient activity. And the way typically
8 healthcare people do this is to take the ratio
9 of total gross revenues and divide that by
10 total inpatient gross revenues. For example,
11 in the incremental pro forma, the Roper St.
12 Francis CON pro forma, that ratio was 1.96,
13 which really implies that there's almost as
14 much outpatient gross revenue expected as
15 inpatient revenue expected. That 1.96, or
16 whatever that ratio happens to be in a
17 particular situation, is then multiplied times
18 patient days to give rise to adjusted patient
19 days. So then you have a statistic that, in
20 fact, embraces both inpatient and outpatient
21 notions, and you can utilize that when you're
22 dealing with statistics that also embrace
23 inpatient and outpatient notions.

24 **THE COURT:** May I ask, please, sir?

25 **THE WITNESS:** Yes, sir.

1 THE COURT: Would a good layman's definition of
2 that, of adjusted patient days, be total
3 inpatient days plus a distilled amount of
4 outpatient days?

5 THE WITNESS: I think your definition is probably a
6 bit superior to mine. So yeah, I would agree.
7 That's a fair statement.

8 THE COURT: Thank you.

9 Q: All right. You said Mr. Richardson helps you
10 with these numbers, correct, to determine that?

11 A: That's correct.

12 Q: All right. So what are you estimating in
13 regards to the number of admissions or
14 discharges in say 2015, the third year of
15 operations here, to create 6,388 patient days?

16 A: Your question was how many discharges?

17 Q: How many discharges is that?

18 A: I would direct your attention to the column
19 headed up by the year 2015. Patient days
20 incremental are 6,388. Divided through by the
21 4.25 average length of stay that was
22 contemplated by Mr. Richardson, that gives rise
23 to an incremental adjusted -- I'm sorry,
24 incremental admission number of 1,503.

25 Q: Okay. Is that kind of reflected over on page

1 463 in your financial assumptions? I don't see
2 the patient day number, but is it explained
3 here the concept of what you've been testifying
4 about on page 463?

5 A: Certainly the concept of adjusted days is
6 spoken to on 463. I don't see where admissions
7 are.

8 Q: Yeah, I'm just talking about the concept.

9 A: Yeah, the concept. Yes, sir.

10 Q: When you talk about cannibalized days on page
11 463, what does mean?

12 A: Cannibalized is my term that I -- that I
13 sometimes use interchangeably with the term
14 redirected. In other words, those days are
15 cannibalized out of existing providers. In
16 this case, Roper and St. Francis Hospital.

17 Q: After the certificate of need application was
18 -- been approved by the court, did you realize
19 that your calculation in regards to the
20 incremental patient days had a issue with it?

21 A: Yes, sir.

22 Q: Okay. Can you explain that to the court?

23 A: Yes, sir. This was a miscommunication between
24 myself and Mr. Richardson. I own the
25 miscommunication. In other words, no fault of

- 1 Mr. Richardson's. Basically Mark assumed that
2 50 percent of the service area patients that
3 Roper and St. Francis already were seeing
4 would, in fact, be redirected or would, in
5 fact, be cannibalized. I took him to mean that
6 50 percent of the venue admissions would indeed
7 be incremental, and therefore the other 50
8 percent would be redirected or cannibalized.
- 9 Q: And what was the -- how do those formulas
10 actually interact with each other?
- 11 A: My incremental admissions of 1,503 I believe is
12 greater than what Mark really intended, which
13 was just under 1,400 admissions.
- 14 Q: All right. Let's look at page -- let's also
15 look at if you were to increase your
16 incremental days on the pro forma.
- 17 A: Increase it?
- 18 Q: Increase it. Would the net income go up or the
19 revenue over expenses go up or go down?
- 20 A: It would go up.
- 21 Q: Okay. And explain that, explain why that would
22 be.
- 23 A: Well, if the days were to go up, the adjusted
24 days also would go up and the adjusted
25 admissions also would go up. And since there's

1 a positive contribution margin per adjusted
2 admission, that would be layered on top of the
3 pro forma as submitted within the four corners
4 of the CON application to give rise to a larger
5 net income number.

6 Q: Now, Mr. Baehr testified in his testimony that
7 a full venue approach was the more appropriate
8 way to value a pro forma for a satellite
9 hospital. Do you remember his testimony about
10 that?

11 A: Yes, sir.

12 Q: Of course you chose a different approach right?

13 A: I have.

14 Q: And your approach is?

15 A: Incremental.

16 Q: Incremental approach. Now, of the two
17 approaches, full venue or incremental, which
18 one is the more difficult or rigorous to show
19 net income, positive net income?

20 A: Clearly an incremental construct of a pro forma
21 would be -- would give rise to a greater
22 difficulty in showing financial feasibility.

23 Q: Can you explain that a little bit?

24 A: Certainly. The incremental volume is going to
25 be less than the venue volume. In this

1 situation in our pro forma, the venue volume is
2 actually twice as much as the incremental
3 volume. So clearly the lower volume, all else
4 equal, is going to give rise to a lower net
5 income number than a higher volume number.

6 Q: Okay. And you've also heard experts or even
7 courts set forth a test for financial
8 feasibility that -- to be can the applicant
9 afford to do the project?

10 A: Yes, sir.

11 Q: Okay. And actually has the Department put that
12 forward at times to your knowledge?

13 A: Yes, sir, they have.

14 Q: South Carolina DHEC?

15 A: Yes.

16 Q: All right. And does that test recognize that
17 some worthwhile projects may not make money for
18 three to five years?

19 A: Yes.

20 Q: Okay. Now, looking at both of the -- well,
21 let's look at the Roper St. Francis Berkeley
22 project first. If the test is can the
23 applicant afford to do the project, is this
24 project financially feasible and viable?

25 A: Yes, sir, it's a slam dunk.

- 1 Q: Okay. How about Trident's project in Moncks
2 Corner? If the test is can the applicant
3 afford to do the project, in your opinion is
4 the project financially feasible and viable?
- 5 A: Yes, sir, it is. I think it would be fair to
6 say that is also a slam dunk.
- 7 Q: Okay. Now let's look at Mr. -- at the full
8 venue approach. If you were to do a financial
9 pro forma for the Roper St. Francis Berkeley
10 with the full venue approach, what's your
11 opinion in regards to whether the project is
12 viable or financially feasible or viable?
- 13 A: It clearly would be financially feasible.
- 14 Q: Okay. And what about in regards to the Trident
15 Moncks Corner project?
- 16 A: Same answer, clearly financially feasible.
- 17 Q: All right. Now, under your approach, the
18 incremental approach, what is your opinion or
19 can you discuss the financial feasibility or
20 viability of the two projects?
- 21 A: Certainly. I would direct your attention to
22 Bates 462 in Joint Exhibit 2. I'm showing a
23 year three positive bottom line of
24 approximately \$285,000. I conclude from that
25 that this project is indeed financially

- 1 feasible.
- 2 Q: Okay.
- 3 A: And your question also related to Berkeley
- 4 Regional Medical Center?
- 5 Q: Berkeley Regional Medical Center, right.
- 6 A: Yes. My understanding of the Berkeley Regional
- 7 Medical Center pro forma as it was constructed
- 8 is that there is zero incremental inpatient
- 9 volume, that there is a layer of incremental
- 10 outpatient volume. On an incremental basis,
- 11 clearly that would not be a financially
- 12 feasible project.
- 13 Q: But on the full venue approach, do you reach a
- 14 different conclusion?
- 15 A: Yes, sir.
- 16 Q: Is there a -- all right. Let's take a look --
- 17 all right. Let's move over to the issue -- you
- 18 attended the depositions of Mr. Davidson and
- 19 Mr. Baehr correct?
- 20 A: Yes, sir, I did.
- 21 Q: All right. And during those depositions was
- 22 there testimony in regards to the contribution
- 23 margin that they had used in some of their
- 24 calculations?
- 25 A: Yes.

1 Q: Can you explain to the court what you heard in
2 the testimony in those depositions?

3 A: As I recall -- yes, sir. As I recall, I think
4 there were two key numbers that were advanced
5 by Mr. Davidson and Mr. Baehr in terms of
6 contribution margin per adjusted admission.
7 This would have been an integral part of the
8 adverse impact analysis advanced by Mr. Baehr.
9 As I recall, Mr. Baehr and/or Mr. Davidson went
10 to the decision support system at Trident
11 Health Systems. Again, Trident Health Systems
12 is Summerville Medical Center and Trident
13 Medical Center. And decision support systems
14 generate contribution margin. That is the
15 difference between net revenues, which would be
16 green dollars bills that the hospital takes in
17 and variable or marginal cost. The difference
18 between net revenues and marginal cost is
19 contribution margin. And that is the impact on
20 the bottom line for every increase or decrease
21 involved. The first number that I saw in
22 discovery, I think it was a 2009 number, was
23 \$4,522. Again, this is net revenues minus
24 marginal or variable costs, 4,522. And what
25 that means, Your Honor, is that for every

1 additional admission or every admission that
2 you lose, that impacts the bottom line by
3 4,522. The other contribution marginal per
4 adjusted admission number that I became aware
5 of, and I think this one is embraced in some of
6 Mr. Baehr's work product, is 4,985. And this
7 purports to represent the contribution margin
8 per adjusted admission for Trident Health
9 System for non-tertiary, since both these
10 hospitals will not be dealing with tertiary
11 services, for non-tertiary services. This is
12 about a -- I think about a ten percent increase
13 from the 4,522 to the 4,985, which was for the
14 12 months ending June 30, 2010.

15 Q: Well, when you heard the testimony with this
16 number, I think the 4,985 number, did you go
17 back and look at the pro forma that was
18 submitted by Berkeley Regional Medical Center?

19 A: I did.

20 Q: All right. Let's take a look at Respondent's
21 Exhibit 73. Do you have that in front of you?

22 A: Yes, sir, I do.

23 Q: It's actually in that book right there. It's
24 on the screen and it's also in the book right
25 there.

- 1 A: Oh, yeah. I can see it.
- 2 Q: Okay. What is Respondent's Exhibit Number 73?
- 3 A: Yeah. This is basically an outgrowth of my
- 4 kind of testing the hypothesis that at first
- 5 glance it seemed to me that the Berkeley
- 6 Regional Medical Center, which is the Trident
- 7 pro forma for their proposed hospital, that the
- 8 pro forma, in fact, didn't seem to be robust
- 9 enough financially to comport with a
- 10 contribution margin, for example, of 4,985
- 11 which Trident was using as part of their
- 12 adverse impact analysis.
- 13 Q: Does that mean that you thought the
- 14 contribution margin in the pro forma was lower
- 15 than what you heard in the testimony?
- 16 A: Yes, sir. That was my hypothesis. And then I
- 17 had some corroborating evidence that HCA, and
- 18 I'm not being critical necessarily, but HCA in
- 19 their projection work product seems to do much
- 20 better actually than what they project. And I
- 21 would give as an example for 2010, as I recall,
- 22 HCA actually did or Trident Health System
- 23 actually exceeded its projected pretax income
- 24 by something on the order of \$25 million. So
- 25 there was a seed planted in my brain that I've

1 got a hypothesis that I think the DRMC pro
2 forma comports with a modest or understated
3 contribution margin, vis-a-vis the 4,985 within
4 their decision support system.

5 Q: Yeah. Let's look on the page the way you did
6 in regards to these calculations. Take the
7 first little part if you could, the Trident
8 Health System non-tertiary, and what does CMPAA
9 mean?

10 A: CMPAA is contribution margin per adjusted
11 admission fr the 12 months ending June 30,
12 2010.

13 Q: Okay. And what is that --

14 A: And this is for non-tertiary services.

15 Q: So tell me what that number -- where did you
16 get the 4,985?

17 A: 4,985, and basically what that is saying is
18 that every incremental adjusted admission is
19 worth \$4,985 to the bottom line.

20 Q: Okay. And is this -- where did that number
21 come from again?

22 A: That was from the Trident Health System
23 decision support report for the 12 months
24 ending June 30, 2010.

25 Q: And was that tested -- that was also testified

1 to, right?

2 A: That's correct.

3 Q: All right. So tell me what you did, trend
4 forward, factor to 2017 --

5 A: Yeah. Trending forward to year 2017, and the
6 reason I'm doing that is I'm going to in a few
7 minutes basically extract the contribution
8 margin per adjusted admission from the DRMC, or
9 the Trident proposed hospital pro forma. And
10 so I take the 4,985, trend forward using a
11 three percent annual inflation factor. So I'm
12 basically trending forward approximately seven
13 and a half years to get to 2017. 1.03 to the
14 seven and a half power, so to speak --

15 Q: Okay.

16 A: -- is the 1.2482, which then multiplied by the
17 actual contribution margin per adjusted
18 admission of 4,985 gives rise to an actual
19 estimated contribution margin per adjusted
20 admission for 2017 of 6,222. So I'm basically
21 trending forward the contribution margin that
22 Trident has used for its -- its adverse impact
23 analysis.

24 Q: Is this similar to the contribution margin that
25 Mr. Baehr is using in his adverse impact

1 analysis that he presented the court?

2 A: It's not only similar, the 4,985 exactly
3 comports with the adverse impact analysis that
4 Mr. Baehr generated.

5 Q: Okay. Now let's look at the second section of
6 Trident Regional Medical Center pro forma. So
7 tell me what you did in regards to these --
8 what these calculations represent.

9 A: Yes, sir. This -- basically looking at the pro
10 forma, and I've got a subsequent exhibit that
11 underpins or provides support for the 3,856,
12 the contribution margin per adjusted admission
13 extracted from the BRMC pro forma for the year
14 2012 is \$3,856. Then I likewise trend that
15 forward to the year 2017 using a three percent
16 annual inflation factor. That's the 1.03 to
17 the fifth power, which is 1.1593. And I get an
18 actual estimated contribution margin per
19 adjusted admission for the year 2017 of 4,471.

20 Q: What does this number, this represent -- how
21 did you -- well, let's turn over quickly to the
22 next page. If you could just kind of -- and
23 tell me what this page is here of your
24 exhibits.

25 A: Sure. I'm going to go to -- oh, here we go.

1 Yeah, that's good. In order -- in order to get
2 a or to develop a credible contribution margin
3 per adjusted admission number, what you have to
4 do --
5 Q: For a pro forma or actual?
6 A: Actually, pro forma and actual.
7 Q: Okay.
8 A: In this case it would be a function of the BRMC
9 pro forma, the Trident pro forma. What I did
10 was to compare the 2016 number in the pro forma
11 with the 2012 number, and looking both in terms
12 of net revenues and expenses. Now, there are
13 two reasons why the 2016 number would be higher
14 than the 2012 number. One is inflation. The
15 other reason is volume is growing. So those
16 are the two reasons for that. What one has to
17 do then to compare those two is to squeeze the
18 inflation component out of the 2016 number. In
19 other words, to restate the 2016 expenses in
20 2012 dollars. And then compare that number to
21 the real 2012 number. Any difference between
22 those is a function of differences in volume,
23 because I've squeezed out or washed out the
24 impact of inflation. And that's really what
25 I'm doing here. That the contribution margin

1 per adjusted admission, when I go through that
2 process, is \$3,856.

3 Q: All right. Let's go back and look at the first
4 page, 461. So the top part of the page you've
5 calculated contribution margin for the -- from
6 decision support, right?

7 A: Correct.

8 Q: Second part of the page you calculated the
9 contribution margin in the pro forma; is that
10 right?

11 A: That's correct.

12 Q: Okay. And can you tell me at the bottom what
13 you're -- what you're purporting to do here and
14 what your conclusion is?

15 A: Yes, sir. Now that I've got, off the decision
16 support system, I've got a 2017 contribution
17 margin per adjusted admission of 6,222. Then
18 I've got a 2017 contribution margin per
19 adjusted admission in effect extracted from the
20 BRMC pro forma of 4,471. My hypothesis has
21 been confirmed. That is that the pro forma
22 seems to reflect an understated contribution
23 margin profile. I then take the difference
24 between the 6,222 and the 4,471, and that gives
25 rise to the \$1,752, which is the difference in

1 the contribution margin per adjusted admission.

2 I then multiply that --

3 Q: Stop for a second there.

4 A: Sure.

5 Q: So this 1,752 represents -- what is it? Can
6 you say again exactly what it represents?

7 A: Sure. This represents the understatement
8 embedded in the pro forma of the contribution
9 margin profile vis-a-vis THS's trended forward
10 2010 contribution margin per adjusted
11 admission.

12 Q: Okay. Can you explain the rest of it?

13 A: Yes, sir. Then I -- so I take that 1,752
14 understatement, if you will, \$1,752 times the
15 adjusted admissions, which are 300 -- I'm
16 sorry, 3,648, which gives rise to an increase
17 in pretax profit of almost \$6.4 million.
18 Really what I'm doing here is I'm saying okay,
19 if we take the decision support contribution
20 margin profile which Trident saw fit, and
21 rightly so, to be part of their adverse impact
22 analysis, that should comport with the pro
23 forma in terms of contribution margin profile.
24 It doesn't. But to bring the pro forma up to
25 the decision support profile would add about

1 \$6.4 million to the pretax bottom line at BRMC.

2 Q: Okay. So --

3 **THE COURT:** Excuse me. Let me ask this. What is
4 the point of those numbers? I realize they
5 have a point. But is it to say that Berkeley
6 Regional Medical Center has forwarded some
7 figures that would help them some way or the
8 other?

9 A: In my opinion, Your Honor, the Berkeley
10 Regional Medical Center pro forma is extremely
11 modest in its profitability profile.

12 **THE COURT:** And in being modest, is that modesty
13 helpful to Berkeley Regional Medical Center?

14 A: It is helpful to them in the sense that they
15 can advance some whoa is me, the hospital is
16 going to lose a lot of money if both -- if two
17 hospitals are built in Berkeley County.

18 **THE COURT:** All right. And what about the affect on
19 adverse impact? Is there a component of that
20 in there also?

21 A: This really -- this really doesn't speak to
22 adverse impact, other than I'm using the
23 component of adverse impact. That is the
24 contribution margin per adjusted admission from
25 their decision support system to test the

1 magnitude of modesty or the magnitude of
2 understatement embraced in the BRMC pro forma
3 itself. I'm taking the position that BRMC has
4 understated its profitability in its pro forma.

5 **THE COURT:** And if that is true, and I don't say it
6 is or it isn't, but if it were true, it would
7 support that contention that two hospitals
8 shouldn't be built there. That's what we're
9 talking about here.

10 A: It would actually undermine somewhat their --
11 their claim of they would be devastated. In
12 other words, I'm taking the position, Your
13 Honor --

14 **THE COURT:** So it would undermine it if your
15 assessment is correct?

16 A: That's correct.

17 **THE COURT:** I see.

18 A: That's correct.

19 **THE COURT:** Thank you.

20 Q: Let me ask this question. You've got here on
21 here, BRMC CON stated pretax profit in year
22 three of \$283,402, right?

23 A: Correct.

24 Q: With the same volume at Berkeley Regional
25 Medical Center that is on the pro forma, in

1 your opinion how much pretax profit will they
2 actually have?

3 A: 6.672 million.

4 Q: With the same volume?

5 A: Same volume.

6 Q: Okay. So is that, in your opinion, is the
7 hospital in Moncks Corner more profitable than
8 what is submitted on the pro forma?

9 A: Yes.

10 Q: By Trident Regional Medical Center?

11 A: Yes, profoundly more profitable.

12 Q: All right. Let's go over to pages four and
13 five of your exhibit Knapp Berkeley 464. We'll
14 put that on the screen there. Okay. Now, did
15 you then take that -- these assumptions that
16 you made and this opinion and did you try to
17 see what the impact would be in regards to
18 patient days at the hospital?

19 A: Yes, sir.

20 Q: In Moncks Corner?

21 A: Yes, sir.

22 Q: Okay. So let's walk me through if you would
23 page four. And tell us what the title is and
24 what you're trying to show on this page.

25 A: Yeah. The title is the volume necessary for

1 BRMC to achieve actual estimated pro forma
2 pretax profit. In other words, given the fact
3 that BRMC has understated its profitability in
4 its pro forma, what could the volume fall to
5 relative to what they actually projected in
6 such a fashion that they would reach their
7 projected pro forma net income.

8 Q: Okay. And so how do you do -- and so kind of
9 walk us through that calculation and what you
10 concluded?

11 A: Yes, sir. The first actually top half of this
12 exhibit will I think look a little bit familiar
13 because some of the numbers are exactly the
14 same numbers on the earlier exhibit. Again,
15 the 2010 contribution margin per adjusted
16 admission for Trident Health System non-
17 tertiary trended forward to 2017, \$6,222.
18 You've seen that number before. We've also
19 seen the next number which is the 2012
20 contribution margin per adjusted admission for
21 BRMC extracted from their pro forma and trended
22 forward, 4,471. The magnitude of modesty or
23 the magnitude of understatement in terms of
24 contribution margin in their pro forma, \$1,752,
25 multiplied times the adjusted admissions of

1 3,648 gives rise to the 6,389,499
2 understatement.

3 Q: Okay. These are actually admissions right, not
4 days?

5 A: It's actually adjusted admissions.

6 Q: Adjusted. That's right, adjusted admissions.
7 So you're talking admissions, these are
8 individual people and not patient days,
9 correct?

10 A: That's correct. They're admissions and then
11 adjusted to give effect to the outpatient
12 component.

13 Q: Okay. Now, in your -- in this calculation
14 you're using a 1.3 adjustment factor, right?

15 A: That's correct.

16 Q: And in the Roper St. Francis pro forma, you
17 used 1.96, right?

18 A: That's correct.

19 Q: And why is that?

20 A: The 1.3 really arises from the BRMC pro forma.
21 Their outpatient profile, I believe it's the
22 last three years of their pro forma, is 1.3.
23 That is total gross revenues divided by
24 inpatient revenues, approximately 1.3.

25 Q: Does that mean they project more or less

1 outpatient revenue at their hospital than Roper
2 St. Francis?

3 A: Less.

4 Q: All right. Look at the -- if you go to the
5 next and do the calculation there.

6 A: Certainly. I would direct your attention to
7 line six or row number six. The adjusted
8 admissions necessary to generate an actual
9 pretax profit of 1,027. And that arises from
10 a calculation where I'm looking row five, which
11 is that 6.4 million, divided by row one, which
12 is the \$6,222, gives rise to the adjusted
13 admissions necessary to generate that chunk,
14 that 6.4 million, 1,027 adjusted admissions.
15 And ultimately I want to get to patient days
16 because I want to see how far can patient days
17 fall relative to what was represented in the
18 BRMC pro forma in such a fashion that they come
19 back to their projected bottom line. So the
20 1,027 adjusted admissions, I take that and
21 address row number seven, which is adjusted
22 patient days, which is basically taking the
23 average length of stay contemplated in BRMC's
24 pro forma of 4.45, times the 1,027, gives rise
25 to an adjusted days number of 4,570. Now,

1 those are adjusted days. They give effect to
2 that outpatient component. So now I have to
3 divide the 4,570 by the 1.3 outpatient
4 adjustment factor to give rise to 3,515 patient
5 days. It's my professional opinion that the
6 pro forma could lose 3,515 patient days in
7 concert with the decision support contribution
8 margin, a more enhanced decision support
9 contribution margin per adjusted admission,
10 would bring them back to what they had actually
11 forecasted in their pro forma. In other words,
12 their pro forma says they're going to do 12,470.
13 days. Indeed, they could do, and I would
14 direct your attention to row or line number
15 ten, 8,955 patient days to get to the same
16 place in terms of pretax income.

17 Q: Okay. And how many -- what's the average daily
18 census of 8,955 days?

19 A: Approximately 24.5 ADC.

20 Q: So if they have an average daily census of 24.5
21 --

22 A: Yes.

23 Q: -- will they make money in your opinion?

24 A: Yes.

25 Q: Okay. Now, is the information that you have

1 done to do this calculation readily available
2 to the people at Trident?

3 A: Yes.

4 Q: It comes from their decision report?

5 A: It does.

6 Q: Turn over to the next page. I just want to
7 clarify, Mr. Knapp, for the record that you use
8 the term "earlier exhibit." But this is all
9 the same Exhibit 73, right, that we're talking
10 -- when you say earlier exhibit, you mean
11 earlier pages, right?

12 A: That's correct.

13 Q: All right. Turn over to page five and just
14 kind of quickly walk us through this
15 calculation. Or what's different about this
16 calculation on page five than the one we just
17 looked at on page four?

18 A: Yeah. Page five is almost exactly the same
19 thing as page four except for one thing. Page
20 four basically said what kind of volume
21 decrease can BRMC absorb in order to reach the
22 pretax bottom line they actually forecasted in
23 their pro forma. Page five goes a little bit
24 further and basically says, if -- what kind of
25 reduction in patient days could they absorb in

- 1 such a fashion as to break even, not make
2 \$285,000, but to break even. And you can --
3 and I would direct your attention to row 12,
4 the actual patient days necessary to achieve
5 break even is 8,799.
- 6 Q: Okay. And what's the average daily census for
7 8,799 patient days?
- 8 A: 24.1.
- 9 Q: 24.1?
- 10 A: Correct.
- 11 Q: Okay. So in your opinion does the Roper
12 Regional -- does the Berkeley Regional Medical
13 Center show a positive net income with an
14 average daily census of 24.1?
- 15 A: It actually shows a break even.
- 16 Q: Break even.
- 17 A: At 24.1.
- 18 Q: Now I want to direct your attention, if I
19 could, to Trident Medical Center's pro forma.
20 And that is page 642, Joint 1. It starts on
21 642.
- 22 A: Yes, sir, I'm there.
- 23 Q: All right. You testified earlier that there
24 was other information available to you that
25 caused you -- that suggested to you that the

1 pro forma may be modest I believe is the word
2 you've been using.

3 A: Exactly.

4 Q: Okay. Looking at their pro forma starting on
5 page 643, or we can use 645, whichever one you
6 prefer.

7 A: Either one is fine with me.

8 Q: All right. We can look at 645 which is --
9 includes the hospital. Did you hear the
10 testimony earlier in the trial about the
11 operating margin reflected on this pro forma
12 that's in the certificate of need application?

13 A: I did.

14 Q: Okay. And what is -- and what is happening
15 with the operating margin on this page 645?

16 A: As one goes to the right in terms of columns,
17 that is as years go by, the operating margin is
18 indeed decreasing over time.

19 Q: Do you remember the actual numbers?

20 A: I think one of them was like a 19 percent. I
21 don't know if that was EBITDA or pretax income.

22 Q: Well, what is operating margin?

23 A: Operating margin would be your net revenues
24 minus operating expenses.

25 Q: As a percentage?

- 1 A: Of net revenues.
- 2 Q: Is 19 percent a healthy operating margin or a
3 typical operating margin?
- 4 A: It's healthy, yes.
- 5 Q: Okay. And then in later years, maybe look at
6 2016, what is happening to the operating
7 margin?
- 8 A: The operating margin was shrinking somewhat.
9 I think by the last year it was down to 13
10 percent.
- 11 Q: Okay. And what would that suggest to you as an
12 expert in healthcare finance?
- 13 A: I just see evidence of modesty again. I see
14 evidence of, you know -- I really don't think
15 that's a reasonable expectation.
- 16 Q: Because what is it saying when the operating
17 margin drops over time; what's happening to the
18 hospital or the system?
- 19 A: It becoming less profitable.
- 20 Q: When you look at the raw numbers on this page
21 645, you see the difference from say 2009 or
22 the actual projection for 2008, the net revenue
23 of 371,610,000, right?
- 24 A: Correct.
- 25 Q: And then in 2016 total net revenue is how much?

- 1 A: 665 million --
- 2 Q: 605?
- 3 A: Yeah. I'm breaking out my magnifying glass
- 4 here.
- 5 Q: Yeah.
- 6 A: 605,198,000.
- 7 Q: Okay. Do you have an opinion as to whether it
- 8 is a healthy or not healthy growth in net
- 9 revenue?
- 10 A: That's a healthy growth.
- 11 Q: Okay. More than \$200 million, right?
- 12 A: Yes, sir.
- 13 Q: Okay. Look at their EBITDA number and its
- 14 growth in 2008 to 2016.
- 15 A: It's going from 72 million to 83 million, a
- 16 less than proportional increase relative to the
- 17 growth in net revenue.
- 18 Q: And with that kind of growth in net revenue,
- 19 would you expect to see the earnings before
- 20 interest, taxes and depreciation rise more than
- 21 what's reflected on the sheet?
- 22 A: Absent compelling information to the contrary,
- 23 yes, I would.
- 24 Q: And then what would that -- so what would that
- 25 suggest to you?

- 1 A: That would suggest to me again that the pro
2 forma, especially in the out years, is
3 understated relative to what I would expect as
4 a reasonable profitability profile.
- 5 Q: Okay. Let's look at -- keep your finger there
6 on that page. Maybe jot down for me what the
7 EBIT earnings before interest, taxes and
8 depreciation number was for 2010 on that pro
9 forma?
- 10 A: 75,757,000.
- 11 Q: Okay. Let's take a look at Respondent's
12 Exhibit 167. Do we have 167? And what was the
13 number you just gave me, what they projected in
14 the CON for 2010?
- 15 A: 2010 was 75,757,000.
- 16 Q: What's the earnings before interest, taxes and
17 depreciation that was actually earned by
18 Trident Health System?
- 19 A: 92,862,000.
- 20 Q: And what would that suggest to you?
- 21 A: It would suggest to me that once again the
22 continuing trend where -- where Trident Health
23 Systems, and good for them, actually -- their
24 actual bottom line in the profitability profile
25 exceeds in a significant way what they had

- 1 budgeted for that same time frame.
- 2 Q: Is there a compounding piece to this also when
- 3 you underestimate profitability --
- 4 A: Yes, sir. It's compounding it in a sense --
- 5 Q: -- when you forecast it?
- 6 A: Yeah, there would be a compounding in a sense.
- 7 It's like when you put money in a savings
- 8 account at five percent, it doesn't take 20
- 9 years to double. It takes 14 years to double
- 10 because of the compounding effect. So if
- 11 you've got modesty, upon modesty, upon modesty,
- 12 it can give rise, especially in the out years,
- 13 to an extremely low projected profit vis-a-vis
- 14 what I would consider to be a reasonable
- 15 expectation in terms of profitability.
- 16 Q: Okay. Let's go to Petitioner's 46, page 31.
- 17 You were here for Mr. Baehr's testimony, right?
- 18 A: I was.
- 19 Q: Okay. And these are some of his exhibits he
- 20 submitted during his testimony right?
- 21 A: I haven't seen it yet.
- 22 Q: Here's the front page right here. Right?
- 23 A: Yes, sir.
- 24 Q: Okay. Let's go to page 31, Baehr 1619.
- 25 A: Yes.

- 1 Q: Okay. Do you recall hearing Mr. Baehr's
2 testimony in regards to this page right here?
- 3 A: I do.
- 4 Q: All right. What does this page purport to
5 represent?
- 6 A: As I understand this page, it purports to
7 represent both the Roper St. Francis net income
8 and the BRMC net income at various volume
9 levels. I think Mr. Baehr characterized that as
10 a sensitivity analysis.
- 11 Q: Okay. What contribution margin is he using to
12 make these calculations?
- 13 A: It would appear that he is using the
14 contribution margin implied or extracted from
15 the BRMC pro forma.
- 16 Q: Okay. Not the contribution margin that you
17 calculated that actually came from decision
18 support?
- 19 A: Correct.
- 20 Q: If you were to use the contribution margin from
21 decision support, what would that do to this
22 chart?
- 23 A: For example, I would direct your attention to
24 the column entitled 5,000/10,000.
- 25 Q: Okay.

- 1 A: I would also direct your attention in that
2 column to the 2017 BRMC net income of a loss of
3 1,771,000. That, in fact, by virtue of another
4 section of work product that Mr. Baehr
5 generated I believe had something on the order
6 of \$2.1 or \$2.2 million amount.
- 7 Q: Okay.
- 8 A: It was in Petitioner's 219, which I don't think
9 came into evidence.
- 10 Q: Well, let's look at what you -- you calculated
11 a break even number for Berkeley Regional
12 Medical Center would be how many patient days?
- 13 A: I believe it's 8,000. Let's see, 24.1 ADC.
- 14 Q: Take a quick look at 37. I can show you here.
15 What did you calculate the break even would be
16 in patient -- needed in patient days for
17 Berkeley Regional Medical Center?
- 18 A: 8,799.
- 19 Q: Okay. So if you use that number, 8,799, on Mr.
20 Baehr's chart here, look at the forty-two fifty
21 eighty-five hundred.
- 22 A: In my opinion, Mr. Baehr's chart here is way to
23 gloom and doom for BRMC.
- 24 Q: Okay. If they had 8,500 patient days, or if
25 they had 87 or 8,800 patient days --

- 1 A: They'd break even.
- 2 Q: And he's got them showing at 8,500 patient
- 3 days. What is he showing at 8,500 patient
- 4 days?
- 5 A: 3.3 million loss.
- 6 Q: Okay. So do you agree that -- what's your
- 7 opinion in regards to this page in Mr. Baehr's
- 8 exhibit?
- 9 A: This page suffers from the same frailty or
- 10 fault that the BRMC pro forma within the four
- 11 corners of the CON application contains.
- 12 Q: Okay. Now, also on this document he's
- 13 comparing a -- venue pro forma to an
- 14 incremental pro forma, is he?
- 15 A: I believe he is, yes.
- 16 Q: Because Roper St. Francis is an incremental pro
- 17 forma, right?
- 18 A: Correct.
- 19 Q: So if Roper St. Francis was -- if he was using
- 20 venue days for Roper St. Francis Berkeley
- 21 instead of incremental days, would Roper St.
- 22 Francis be more profitable than reflected on
- 23 that?
- 24 A: Significantly more profitable than reflected,
- 25 yes.

- 1 Q: Okay. You find it -- do you have an opinion on
2 the fact that he projects that if the two
3 hospitals are built that the losses will be
4 greater on Roper St. Francis Berkeley than they
5 are on the Berkeley Regional Medical Center in
6 Moncks Corner?
- 7 A: He projects -- again, when you compare
8 incremental to full venue, yes.
- 9 Q: Well, do you think that the Roper St. Francis
10 Berkeley Hospital is significantly less
11 profitable than the Berkeley Regional Medical
12 Center project, all things being equal?
- 13 A: No.
- 14 Q: Okay. Does this -- does this document suggest
15 otherwise?
- 16 A: It does.
- 17 Q: Let's take a look at Petitioner's Exhibit 219
18 as it also relates to this document we were
19 just -- page we were just looking at:
- 20 A: Okay.
- 21 Q: Have you had an opportunity to review
22 Petitioner's 219?
- 23 A: I have.
- 24 Q: Okay. What is Petitioner's -- what does
25 Petitioner's 219 purport to be?

- 1 A: Baehr 1844, which is this particular page,
2 would appear to be the five year pro forma
3 generated by Ronnie Midgett and contained
4 within the BRMC CON pro forma or CON.
- 5 Q: Okay. And are there changes to it?
- 6 A: Not yet.
- 7 Q: Okay.
- 8 A: This comports exactly.
- 9 Q: Okay. That's exactly the pro forma that's in
10 the CON application?
- 11 A: Correct.
- 12 Q: Go to page 2. Is this page 2?
- 13 A: It is.
- 14 Q: And what does this page purport to represent?
- 15 A: This would appear to be Mr. Baehr's attempt to
16 -- similar to what I explained earlier in terms
17 of deflating dollars from one year to another,
18 and then comparing those two years with the
19 deflated dollars in terms of generating an
20 estimated contribution margin per adjusted
21 admission. And I can see that Mr. Baehr, it
22 looks like he is comparing year five to year
23 one, then year four to year one, year three to
24 year one, year two to year one. And I have no
25 problem with that. I think that's a very

1 appropriate approach. And it gives rise to a
2 contribution margin per adjusted admission at
3 the bottom of the page.

4 Q: Okay. And how much is that contribution margin
5 per adjusted admission?

6 A: I -- can we make that bigger? It ranges from
7 around 3,750 to 4,700. It's about a thousand
8 dollar range, depending on which two years you
9 pair up and deflate to give rise to
10 contribution margin per adjusted admission.

11 Q: And what is the result of this calculation
12 compared to the page that we just looked at in
13 Petitioner's 46, page 31?

14 A: Well, the two observations I would make are
15 number one, this would suggest that
16 contribution margin per adjusted admission,
17 especially in the early years of operation,
18 tends to be nonlinear. In other words, you
19 can't just draw a line on a graph. It tends to
20 be nonlinear. And the reason I say that is by
21 Mr. Baehr's form of work product, his
22 contribution margin per adjusted admission is
23 ranging from around \$3,700 to \$4,700. Now, the
24 fact that it's different from year to year does
25 not surprise me. I'm certainly not critical of

1 that. But it certainly calls into question the
2 notion of the linearity of a contribution
3 margin per adjusted admission calculation in
4 the early years of operation. The other
5 observation I would make is that I would direct
6 your attention to the right most column in the
7 bottom row, the 3,853 is really the same number
8 as I had in my exhibit earlier in my direct
9 examination of 3,856. And that's, you know,
10 perhaps a rounding difference. So I see what
11 he's doing here.

12 Q: All right. Is there another page in this
13 exhibit or is that the same page?

14 A: That's the second page. There are -- there's
15 another one or more.

16 Q: All right. What does this page purport to
17 represent?

18 A: This is Baehr 1846. This would appear to be a
19 restatement of the Midgett pro forma that was
20 included in the CON application. And it looks
21 like, and I tried to do some reverse
22 engineering here, it looks like two things are
23 going on here relative to Midgett. Number one,
24 it looks like Mr. Baehr has given a full venue
25 outpatient profile. Whereas Midgett just

1 looked at incremental outpatient, this would
2 appear to look at total outpatient. But it
3 also looks like he's given effect to an
4 enhancement in terms of the contribution margin
5 per adjusted admission. He may have, in fact,
6 looked at the contribution margin in the
7 decision support information, the 4,985, and in
8 some way, as I did, baked that into the pro
9 forma to adjust the Midgett pro forma.

10 Q: Okay.

11 A: And you can see the pretax income numbers are
12 much more robust than the CON pro forma.

13 Q: Okay. And also, are these numbers more robust
14 than what is set forth on Petitioner's 46, page
15 31? Can you go back to that? Do you want to
16 jot those numbers down? You want to jot
17 anything down?

18 A: Yeah, if I could. Okay.

19 Q: Okay. Can you compare that to Petitioner's 46,
20 page 31?

21 A: Yeah. For example, under the left most column,
22 2,017 BRMC net income of basically \$69,000 or
23 \$70,000. For I think very similar or almost
24 exactly the same volume, Mr. Baehr is coming up
25 with \$5,178,000 pretax bottom line.

1 Q: So what do you conclude from that?

2 A: I conclude from that that Baehr 1846, in fact,
3 is a good faith effort to bake the decision
4 support profitability profile into the Ronnie
5 Midgett pro forma.

6 Q: Okay. So that was Petitioner's 219 you're
7 talking about?

8 A: That's correct.

9 Q: Talking about that Petitioner's 219 is a good
10 faith effort to increase the contribution
11 margin of the Midgett pro forma?

12 A: Baehr 1846 page of Petitioner's Exhibit 219 is
13 a good faith effort to make the Midgett pro
14 forma more realistic vis-a-vis the decision
15 support profitability profile at THS.

16 Q: Okay. And what is your opinion in regards to
17 the usefulness of Petitioner's 46, page 31 in
18 regards to this lawsuit?

19 A: The usefulness of Petitioner's 46, page 31 is
20 not high at all. Given the fact that it
21 appears to reflect the very modest-like
22 profitability profile and does not comport with
23 the thought process that went into Baehr 1846,
24 which is part of Petitioner's Exhibit 219.

25 Q: Let me -- let's turn over to the Roper St.

1 Francis pro forma for a second. You heard the
2 testimony from Mr. Baehr on the issue of the
3 Roper St. Francis pro forma showed or that the
4 project would have a \$24 million profit in the
5 third year?

6 A: Yes, sir.

7 Q: Do you remember that testimony?

8 A: I do.

9 Q: Do you think it's realistic --

10 A: No.

11 Q: -- a 50 bed hospital would make \$24 million in
12 the third year?

13 A: No, I don't.

14 Q: Okay. Can you comment on your -- in your
15 opinion as to what some of the calculations
16 that he was using in the rest of that
17 discussion?

18 A: Yeah. I think Mr. Baehr used a kind of a quick
19 and dirty, which I have done in the past too,
20 to be fair to him, a quick and dirty estimate
21 of contribution margin per adjusted admission
22 by what I call straight-lining it. In other
23 words, it looked like he compared year three
24 Roper St. Francis with year one Roper St.
25 Francis, looking at two data points, volume and

1 bottom line. And that basically comes out to
2 about \$8,000 per adjusted admission, which is
3 really, really a pretty high number. If you
4 deconstruct that and similar to what Mr. Baehr
5 did in Baehr 1846 which is part of Petitioner's
6 Exhibit 219 and what I did in my earlier
7 exhibit that I testified to in direct
8 examination, if, in fact, you compare year
9 three to year two for Roper St. Francis but
10 deflate the dollars and then compare the
11 resulting dollar amounts, compare the
12 difference in volume, I come up with a Roper
13 St. Francis contribution margin per adjusted
14 admission extracted from the Roper St. Francis
15 pro forma of about \$7,000 year one, about
16 \$5,400 year two, and then if you compare year
17 three to year one, it's about \$6,500. So what
18 happens is, for Roper St. Francis, and I
19 address this in my deposition, because the core
20 staff is in place, for awhile Roper St. Francis
21 will kind of live off that core staff, and that
22 tends to minimize their variable cost or
23 marginal cost giving rise to a high
24 contribution margin per adjusted admission for
25 the first year. By the time we get to the

1 second year and the third year, we are down to,
2 again when I compare year three to year two,
3 about \$5,400 per adjusted admission, vis-a-vis
4 the 8,000 that I think Mr. Baehr used to
5 generate the 24 million.

6 Q: Okay. Now, wouldn't you say in your opinion,
7 however, that if you were to do a venue pro
8 forma for the Roper St. Francis CON and you
9 merely doubled the volume in the -- on the pro
10 forma, would you make more money than doubling
11 the revenue over expenses? Would it be simply
12 doubling of it?

13 A: It wouldn't simply be a doubling of it, no,
14 because you'd have fixed cost. You'd have
15 variable cost and fixed cost. You can't just
16 double it.

17 Q: Okay. So would the revenue over expenses be
18 higher then than the simple --

19 A: Yes.

20 Q: So if you just double the revenue, would the
21 revenue over expenses be more than two times
22 what it is on --

23 A: It would. The reason for that is, for example,
24 harkening to my contribution margin per
25 adjusted admission of \$5,400, comparing year

1 three Roper St. Francis with year two Roper St.
2 Francis doesn't get you anywhere near the 24
3 million.

4 Q: Okay. All right. What does it mean to
5 dollarize something?

6 A: To dollarize something is that you take a non-
7 dollar phenomenon, typically it's a volume
8 number, and give effect to the net revenues and
9 expenses that are associated with that degree
10 of volume.

11 Q: Okay. And is that something that you do in
12 your -- in your work as an expert in healthcare
13 and finance when you're looking at adverse
14 impact?

15 A: Yes, sir.

16 Q: Who actually would provide the volume to you
17 for you to --

18 A: Mr. Richardson.

19 Q: -- for you to dollarize it?

20 A: Mr. Richardson. In regard to health planning,
21 Mark would do that.

22 Q: Okay. Now can you tell me a little bit about
23 the process as to how you would do a adverse
24 impact analysis?

25 A: It's -- it's very similar to how Mr. Baehr

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1 described the situation where I would take --
2 I agree with Mr. Baehr in a sense that one
3 should take a contribution margin per adjusted
4 admission to dollarize what I'm going to
5 characterize as the adverse impact volume. In
6 this case it's the adverse impact volume would
7 be in terms of adjusted admissions.

8 Q: Okay. And then what would you do after you do
9 that?

10 A: I would multiple the, again using the THS as an
11 example, the \$4,985 contribution margin per
12 adjusted admission times the number of adjusted
13 admissions that Mark would characterize as the
14 adverse impact volume.

15 Q: Okay. And then that would ultimately give you
16 a number?

17 A: It would.

18 Q: To look at in that regard?

19 A: Correct.

20 Q: All right. Let's look at -- let's look at
21 Respondent's Exhibit Number 70. Now, you
22 didn't actually prepare Respondent's Exhibit
23 70, did you?

24 A: I did not.

25 Q: Is that Mr. Richardson's work?

- 1 A: It must be.
- 2 Q: Okay.
- 3 A: It looks like a planner's work, yeah.
- 4 Q: I'm going to -- I'm not going to ask you to
- 5 explain the page. I know that's for Richardson
- 6 a little bit later. But I just want you to
- 7 basically comment for me, okay? If you were --
- 8 if Mr. Richardson concludes on this sheet that
- 9 the lost cases to Trident Medical Center from
- 10 the Roper St. Francis Berkeley Hospital are
- 11 zero --
- 12 A: Okay.
- 13 Q: -- okay, how would you dollarize that?
- 14 A: Well, zero times anything is zero.
- 15 Q: Okay.
- 16 A: So any contribution margin per adjusted
- 17 admission that one could credibly come up with
- 18 or incredibly come up with times zero lost
- 19 cases would be -- would give rise to a zero
- 20 adverse impact.
- 21 Q: Okay. Now, if you were to conclude that the
- 22 number of lost cases was 84, okay, as you see
- 23 at the bottom of that page --
- 24 A: Yes, sir.
- 25 Q: -- how would you do the calculation? Do you

- 1 have it available there or do you need some
2 more documents in front of you?
- 3 A: No. I'm fine.
- 4 Q: Okay.
- 5 A: I can see that. Eighty-four times 4,985 is
6 \$419,000.
- 7 Q: Okay. And why are you using the 4,985?
- 8 A: That's the contribution margin advanced by Mr.
9 Baehr arising from the THS non-tertiary
10 decision support system for the 12 months
11 ending June 30, 2010.
- 12 Q: Okay. Does he trim that?
- 13 A: He does not.
- 14 Q: Okay. And so once you do a calculation, 84
15 lost cases, you came up with 400,000?
- 16 A: 419,000. Yes.
- 17 Q: In doing the analysis, okay, is, in the first
18 calculation, the zero, is there any impact on
19 existing providers --
- 20 A: No.
- 21 Q: -- with the project?
- 22 A: No.
- 23 Q: Any financial impact?
- 24 A: No.
- 25 Q: Okay. All right. In your -- in the second

1 analysis is there some impact?

2 A: There is.

3 Q: So what's the issue or the question in your
4 mind as a planner in regards to how you analyze
5 that particular number?

6 A: Well, I think you then have to look at context
7 in terms of -- which is kind of the second part
8 of adverse impact is how is the entity doing
9 that is alleging adverse impact. Are they
10 breaking even? Are they, you know, is their
11 profitability very strong? Can they -- in
12 effect, can they take a punch? And \$419,000 is
13 not a trivial amount of money, but when you
14 compare it to the swings that routinely -- and
15 again, I'm not being critical of THS at all.
16 But when you compare that to the profitability
17 swings at THS, it's not unusual to have a 15 or
18 20 or \$25 million swing up or down at THS just
19 as a function of normal operating financial
20 performance. This \$419,000 is relatively
21 insignificant certainly compared to those
22 swings.

23 Q: Let's take a look at Petitioner's 150 just to
24 point out some of those swings. And you're
25 familiar with Respondent's 150, right?

- 1 A: Yes.
- 2 Q: And let's go to page three. Jot down a couple
- 3 of numbers for me if you would. For the 2007
- 4 financials, what's the EBIT number, the
- 5 earnings before interest, and tax?
- 6 A: \$83 million.
- 7 Q: Almost \$83 million. What's the net income
- 8 number?
- 9 A: Net income is pretax is 56.7 million.
- 10 Q: Okay. Let's go over to 2008. And there we
- 11 are. Okay. And then in 2008 what's the EBDIT,
- 12 earnings before depreciation, interest and
- 13 taxes?
- 14 A: 56.9 million.
- 15 Q: Okay. And then what's the net income number?
- 16 A: Pretax is 33.7.
- 17 Q: Okay. So can you kind of quickly tell me how
- 18 much of a decrease in earnings before
- 19 depreciation, interest and taxes that Trident
- 20 Heath Systems had comparing '07 to '08?
- 21 A: Well, EBITDA decreased from '07 to '08
- 22 approximately 26 million. And pretax income
- 23 decreased approximately 23 million from '07 to
- 24 '08.
- 25 Q: Okay. What was filed in 2008?

- 1 A: The Berkeley Regional Medical Center Moncks
2 Corner Certificate of Need.
- 3 Q: Okay. So how much is the capital investment on
4 the project?
- 5 A: Something on the order of \$115 million.
- 6 Q: So what would you conclude from the fact that
7 they had those kind of decreases in their
8 earnings and in their net income from '07 to
9 '08, but they still filed a CON application for
10 \$115 million project?
- 11 A: Well, apparently a \$23 million pretax speed
12 bump was not sufficiently large enough to
13 preclude Trident Health System from filing a
14 CON?
- 15 Q: Okay. And when you look at -- is that
16 something that you, as the healthcare -- or
17 expert in healthcare finance think was the
18 appropriate context?
- 19 A: Yes.
- 20 Q: Okay. Now let's take a look at what Mr. Baehr
21 -- let's go into Joint Exhibit 1, page 832.
- 22 A: Yes, sir, I'm there.
- 23 Q: Okay. And you were involved in the actual CON
24 project, right?
- 25 A: Correct.

- 1 Q: Correct?
- 2 A: Yes.
- 3 Q: And so whenever either side submits
- 4 documentation of the CON -- when Trident
- 5 submitted documentation regarding their CON,
- 6 you have reviewed, right?
- 7 A: Yes.
- 8 Q: The financial issues?
- 9 A: Yes, sir.
- 10 Q: All right. Look at page 830. This letter
- 11 right here, is this Baehr's letter to the
- 12 Department, correct?
- 13 A: Correct.
- 14 Q: What's the date on it?
- 15 A: May 28, 2009.
- 16 Q: So we know that would be after project review,
- 17 right?
- 18 A: Correct.
- 19 Q: But before the decision was to be made?
- 20 A: Correct.
- 21 Q: All right. Let's go over to section four of
- 22 the letter.
- 23 A: Yes, sir, I'm there.
- 24 Q: Okay. And that's on page 836.
- 25 A: Yes.

1 Q: Okay. Prior to this letter, had you heard
2 Trident make any allegation that the Carnes
3 Crossroads hospital would have material adverse
4 impact on Trident Medical Center or Summerville
5 Medical Center?

6 A: No, sir.

7 Q: Let's look at paragraph four in this letter to
8 the Department. Can you summarize these two
9 paragraphs for the court?

10 A: It looks like Mr. Baehr is representing that
11 if, in fact, Roper St. Francis builds its
12 hospital in Carnes Crossing, that indeed the
13 market share for Trident Medical Center will
14 decrease.

15 Q: Okay. Does he contend that that's a material
16 adverse impact?

17 A: He -- he does contend that that's a material
18 adverse impact.

19 Q: Okay. Now, you've been doing adverse impact
20 analysis for how many years?

21 A: Probably more than 30.

22 Q: Okay. And is that an adverse impact analysis?

23 A: It's certainly part of one. Again, this is a
24 function of my financial discipline I guess, is
25 I expect to see at least some reference in the

1 verbiage to dollar amount, some order of
2 magnitude, which I don't see here. And I
3 certainly don't see any kind of quantification
4 or estimation of financial adverse impact.

5 Q: Is there any way for the Department to draw a
6 conclusion in regards to adverse impact based
7 on these two paragraphs?

8 A: I don't think there is.

9 Q: Okay. Now, Mr. Baehr did submit a second
10 letter on June 23, 2009, right?

11 A: I believe he did, yes.

12 Q: That's the 900. That was three days before the
13 decision?

14 A: I believe so, yes, sir.

15 Q: Now, in this letter can you just kind of
16 describe this letter what he's submitted here
17 in regards to the issue adverse impact?

18 A: Yeah. Here he goes into much more detail. At
19 least from my perspective, you know, he goes
20 into much more financial detail, speaking to
21 what he contends to be an order of magnitude
22 for adverse impact over a three year time
23 frame. He also goes into kind of the approach
24 that he used, that he in effect married a
25 contribution margin per adjusted admission to

- 1 an adjusted admission loss number. In other
2 words, he's estimating what the volume loss
3 would be if, in fact, RSFD is built and he
4 marries that with the contribution margin per
5 adjusted admission of 4,985.
- 6 Q: Is there much time for the Department to
7 analyze those numbers?
- 8 A: I believe --
- 9 Q: This is on June 26th.
- 10 A: Yeah. There's not a whole lot of time to, you
11 know, to analyze that.
- 12 Q: Is there really much time for you to do it as
13 being employed by an affected person?
- 14 A: No, sir. I would like correct one thing I just
15 said. I thought this -- or I indicated a few
16 minutes ago that the contribution margin
17 utilized was 4,985, which again was a 2010
18 number. So they used the year earlier
19 contribution margin per adjusted admission of
20 4,522.
- 21 Q: Okay. Now, in regards to this issue about the
22 contribution margin, again, just to kind of
23 clarify this for the court, the decision
24 support contribution margin number is higher
25 than the contribution margin essentially in the

- 1 pro forma, right?
- 2 A: Correct.
- 3 Q: Which contribution margin did Mr. Baehr use to
- 4 calculate adverse impact to Trident Medical
- 5 Center?
- 6 A: Decision support. The 4,985.
- 7 Q: The higher number?
- 8 A: Correct.
- 9 Q: Which number, contribution margin number, did
- 10 he use to try to calculate the losses to the
- 11 facilities if both projects were built?
- 12 A: He didn't use a contribution -- well, he, in
- 13 effect, used the contribution margin embedded
- 14 or contained within the BRMC pro forma, which
- 15 is a lower contribution margin per adjusted
- 16 admission number.
- 17 Q: Okay.
- 18 MR. LONG: Your Honor, it's about 3:30 now. If I
- 19 could have maybe just a five minute break? I
- 20 may be close to being wrapped up here. Just
- 21 need to talk to my colleague here.
- 22 THE COURT: Let's take a ten minute.
- 23 MR. LONG: Thank you, Your Honor.
- 24 (Off the Record from 3:25 p.m. 3:36 p.m.)
- 25 THE COURT: Mr. Long.

1 MR. LONG: Thank you, Your Honor. A few more
2 questions.

3 Q: Mr. Knapp, in your position as an expert in
4 healthcare finance, do you keep tract of the
5 reportings and financials of the major hospital
6 systems in for-profit companies of the United
7 States?

8 A: I do.

9 Q: Okay. Have you heard testimony earlier in the
10 trial about the effective tax rate of HCA?

11 A: Yes, sir.

12 Q: Remember Mr. Thomas' questions about that?

13 A: Yes, sir.

14 Q: Okay. Were you privy to the report, reported
15 earnings or reported financials submitted by
16 HCA for 2011?

17 A: Yes, sir.

18 Q: Okay. And how did you become aware of that
19 information?

20 A: HCA had an earnings conference call, and in
21 conjunction with that, issued a report speaking
22 to the fourth quarter profitability for 2011.
23 That report also goes into the entire year of
24 2011, and it speaks to volume statistics,
25 various financial indicators, speaks to pretax

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1 income, income taxes, Things of that nature.

2 Q: Okay. Did they in that report state what their
3 effective tax rate was for HCA for 2011?

4 A: They didn't state it per se, but they reflected
5 pretax income and they reflected income taxes,
6 and it turned out to be I believe 20.1 percent
7 or 20.9 percent, one of the two. I think it
8 was 20.1 percent effective tax rate for 2011.

9 Q: Okay. And do they also report a dividend?

10 A: They did. It was a special dividend of \$2.00
11 per share.

12 Q: And so how much would \$2.00 per share dividend
13 be for a company like HCA?

14 A: Pretty close to one billion dollars.

15 Q: And a dividend paid the shareholders?

16 A: Correct.

17 MR. LONG: Your Honor, that's all I have for Mr.
18 Knapp.

19 THE COURT: Mr. Thomas?

20 MR. THOMAS: Thank you, Your Honor.

21 MR. KNAPP - CROSS EXAMINATION BY MR. THOMAS:

22 Q: Good afternoon, Mr. Knapp.

23 A: Good afternoon, Mr. Thomas.

24 Q: Do you recall when Trident filed its CON
25 application or when it made the decision to

1 apply?

2 A: No, sir, I don't.

3 Q: In May 2008; does that sound about right?

4 A: Yeah, that sounds about right.

5 Q: Okay. And what happened in the latter part of
6 2008 economically; do you recall?

7 A: Well, the -- I think what people characterize
8 as the financial meltdown.

9 Q: Okay. So HCA made the decision or Trident made
10 a decision to apply for its CON prior to the
11 meltdown that really occurred in the later part
12 of the year, correct?

13 A: I think there were some elements of the
14 meltdown that were starting to manifest itself.
15 But I would agree with your assertion that it
16 was before the real meltdown which was, I
17 believe was in September of 2008.

18 Q: Okay. Thank you. And, Mr. Knapp, is it fair
19 to say you never operated as an CFO in a
20 hospital setting?

21 A: Yes. I think the only exception would be, and
22 this is very, very small. I was the acting
23 CEO, CFO of a 35 bed hospital in Bonifay,
24 Florida for about three days.

25 Q: Okay. So you were a CFO for about three days?

1 A: Correct.

2 Q: Now, at the time I deposed you, I believe you
3 said that you only performed a cursory review
4 of the depositions of Mr. Woodford and Mr.
5 Midgett, who were the two gentlemen who worked
6 on developing Trident pro formas. Do you
7 recall that?

8 A: Yes, I do.

9 Q: Okay. And have you done a more thorough review
10 of their depositions?

11 A: I have not done a more thorough review of their
12 depositions.

13 Q: Okay. In terms of the exhibits to Mr.
14 Woodford's deposition, you said that you did
15 kind of a less cursory review of those correct?

16 A: That's a fair statement, yeah.

17 Q: Okay. And at the time I deposed you, you
18 hadn't reviewed the deposition of Karl Gorrell,
19 who was the CFO at the time Trident filed its
20 CON application, right?

21 A: That's correct.

22 Q: Okay. And you still haven't or have you
23 reviewed his deposition?

24 A: I have not.

25 Q: Okay. Now, in terms of work for Roper St.

1 Francis, you've only done work on one other CON
2 hospital project for them, right?

3 A: That's correct.

4 Q: All right. And which one was that?

5 A: Mount Pleasant.

6 Q: Okay. And you've never worked, just for the
7 record, you've never worked as an employee for
8 Roper St. Francis, have you?

9 A: That's correct.

10 Q: Now, I just -- if I think I heard your
11 testimony, you just said that the effective tax
12 rate for 2011 for HCA was 20.5 percent,
13 something like that?

14 A: I think it was -- it was either 20.1 or 20.9.
15 I think it was 20.1 for 2011.

16 Q: Okay. And has it always been that?

17 A: It has not.

18 Q: Okay. In fact, it's been 30 percent some
19 years, hasn't it?

20 A: I would not be surprised.

21 Q: Well, didn't you testify in your deposition
22 that you looked at it and it was 29 or 30
23 percent?

24 A: It was 28 percent. That was I think the third
25 quarter of 2011 or it could have been 2010.

- 1 Q: Okay. So it's not always 20 percent, is it?
- 2 A: That's correct.
- 3 Q: Okay. And you were interested in that number
- 4 because you wanted to determine what the after
- 5 tax dollar amount or dollarized amount of Mr.
- 6 Baehr's adverse impact number was, correct?
- 7 A: Right.
- 8 Q: So that's why you were looking at it, right?
- 9 A: Correct.
- 10 Q: Okay. So when you're talking about nine or ten
- 11 percent tax rate on \$60 million, that could be
- 12 a very significant number, can't it?
- 13 A: I would agree.
- 14 Q: Now, if you'd look in Joint 2 at page 462 for
- 15 me, I believe that's your pro forma.
- 16 A: Yes, sir, I'm there.
- 17 Q: All right. Now, this is your work product,
- 18 correct?
- 19 A: That's correct.
- 20 Q: All right. And would you agree with me, Mr.
- 21 Knapp, that your underlying work papers don't
- 22 look anything like this report that actually
- 23 appears in the CON application?
- 24 A: My underlying work papers don't -- they have
- 25 different formats?

- 1 Q: Right.
- 2 A: Yes, I would agree.
- 3 Q: And you don't submit your underlying work
- 4 papers to DHEC, do you, that go along with your
- 5 pro formas? I didn't see any in here.
- 6 A: Typically not, no.
- 7 Q: Okay. In fact, you use a Florida -- I think you
- 8 testified in your deposition you use a Florida
- 9 template to do -- kind of do your pro formas?
- 10 A: Did on the revenue side, yes, sir.
- 11 Q: Okay.
- 12 A: For the CON, yes.
- 13 Q: And on the expense side, what did you do there?
- 14 A: Expenses looked at year to date 2008 and
- 15 trended forward giving back to the projected
- 16 volume.
- 17 MR. THOMAS: Sara, would you put up Petitioner's 66
- 18 for me?
- 19 Q: And you can stay right there, Mr. Knapp.
- 20 A: Sure.
- 21 Q: And does this look familiar, this document
- 22 here?
- 23 A: It does.
- 24 Q: Okay. Is this your -- is this your work paper,
- 25 like an example of your work papers? Does that

1 look familiar, the Schedule 7A what you call it
2 for the Goose Creek Hospital?

3 A: Yes, sir.

4 Q: Okay. And then in Petitioner's 66, I don't
5 know if you've got it in front of you. But
6 there's maybe -- let me see if I can find that.

7 MR. THOMAS: Your Honor, it might be easier --

8 THE COURT: Thank you.

9 MR. THOMAS: -- to look at.

10 Q: These are your work papers, correct, that
11 underline the pro formas?

12 A: Correct.

13 Q: And, of course, as we can tell just by looking
14 at Petitioner's -- at Joint 2, page 462, these
15 look very different than what actually appears
16 in the CON application, correct?

17 A: Correct.

18 Q: Now, would you agree with me that these are not
19 your final work papers?

20 A: Yes, I would agree.

21 Q: Okay. And you don't -- do you actually know
22 where those are? Because I think you said you
23 were going to get them to me in your deposition
24 and I never got them.

25 A: I should have. I didn't.

- 1 Q: Do you have them?
- 2 A: Not with me.
- 3 Q: So I really don't have any way to check your
4 revenue work, do I?
- 5 A: That's a fair statement.
- 6 Q: Okay. Let's go back to 461 on the screen. Go
7 to 461. Now, this is a statement I believe Mr.
8 Long asked you about. These are accurate and
9 prepared -- or to knowledge you believe them to
10 be accurate forecasts?
- 11 A: Yes.
- 12 Q: Correct?
- 13 A: Yes.
- 14 Q: And you do that for any South Carolina CON when
15 you submit a pro forma, correct?
- 16 A: Correct.
- 17 Q: Okay. You have to attest to them, right?
- 18 A: Correct.
- 19 Q: Okay. Now, just in terms of these pro formas
20 and the assumptions, you didn't have any
21 involvement with Mr. Johnson, Bret Johnson,
22 Roper's CFO, when you developed and created the
23 pro formas. Is that a fair statement?
- 24 A: That is a fair statement.
- 25 Q: In fact you would agree with me that Mr.

1 Johnson, Roper's CFO, had absolutely no input
2 into the financial assumptions in your pro
3 formas, right?

4 A: That's a fair statement.

5 Q: Okay. And prior to developing the pro formas,
6 you didn't have any substantive conversations
7 about them, the assumptions, with Mr. Bowling,
8 the chief strategy officer, or the chief
9 financial officer, correct?

10 A: Correct.

11 Q: Okay. And you didn't have any conversations or
12 subsequent conversations about the assumptions
13 in the pro formas with David Dunlap, the CEO of
14 the Roper System, did you?

15 A: Correct.

16 Q: Okay. And with respect to what we see on this
17 page 462 and the assumptions that follow on
18 463, 464 and 465, is it fair to say that nobody
19 at Roper St. Francis made any adjustments at
20 all to these pro formas or the assumptions
21 therein?

22 A: That's a fair statement, yeah.

23 Q: Okay. Now, I think you testified, correct me
24 if I'm wrong, but you actually created the pro
25 formas that appear in the Roper St. Francis

1 Mount Pleasant CON application; is that right?
2 A: That is correct.
3 Q: Okay. And you had a similar attestation as to
4 their accuracy that you had to submit to DHEC
5 as well?
6 A: Yes, sir.
7 Q: Okay. Now, do you recall Mr. Johnson? Were
8 you here for Mr. Johnson's testimony?
9 A: I was.
10 Q: Okay. And do you recall him sitting on the
11 stand saying that only he would present pro
12 forma information to the rating agencies
13 because they want to hear from him on financial
14 matters?
15 A: I heard him say that.
16 Q: Okay. And with respect to the Mount Pleasant
17 project, when Mr. Johnson presented the pro
18 formas, he didn't use your work product, did
19 he?
20 A: I think that's correct.
21 Q: Okay. Even though you had done pro formas for
22 the Mount Pleasant CON application, right?
23 A: Correct.
24 Q: Okay. So it's fair to say that Roper St.
25 Francis uses Rick Knapp for DHEC submissions,

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1 but uses CFO management work for its rating
2 agency submissions?

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

4 Q: Now, for your pro formas, you dealt with
5 someone in Trident's decision support -- or
6 excuse me, Roper's decision support department.
7 His name was Mike Cassells I believe.

8 A: That's correct.

9 Q: Okay. Does he have a background in finance?

10 A: I'm not exactly sure what his background is.
11 Clearly he has a good understanding of finance
12 because my communication with him was effective
13 in the sense that he understood what I was
14 looking for. And I think to be in decision
15 support you do have to have some understanding
16 of finance.

17 Q: Okay. But you don't know his background, do
18 you?

19 A: No, I don't.

20 Q: Okay. He's no longer with Roper anymore, is
21 he?

22 A: That's correct.

23 Q: Okay. And basically what he did is you've told
24 him I need payer mix data or I need revenue or
25 gross revenue or net revenue data and he got it

1 for you, right?

2 A: Correct, for 2007, and eight months ending
3 August 31, 2008.

4 Q: Okay. Fair enough. Did he ever sign off or
5 check your work?

6 A: To my knowledge, no.

7 Q: Okay. Did you work with anyone else when you
8 were developing the pro formas other than Mr.
9 Richardson?

10 A: I think I had a little input, as I indicated in
11 my deposition, with Shannon Cantwell.

12 Q: Right.

13 A: In terms of patient charge increase
14 assumptions.

15 Q: Did she provide you some information regarding
16 a net revenue increase going from three to
17 seven percent?

18 A: It was actually charge master increases, it
19 would be gross revenues.

20 Q: Gross revenues. Okay. Now, does Ms. Cantwell
21 work in Roper's finance department?

22 A: Does not.

23 Q: She's a regulatory affairs specialist, right?

24 A: That's correct. I believe she reports to Mr.
25 Bowling.

1 Q: Okay. But you relied on the financial
2 information that you received from her, right?

3 A: That is correct.

4 Q: Okay. Now, prior to doing the pro formas for
5 Roper St. Francis Berkeley, you didn't have any
6 conversations with management about aggressive
7 growth strategies or business plans for the
8 upcoming years, did you?

9 A: No.

10 Q: When you finally completed your pro formas and
11 you sent them to Roper St. Francis, nobody at
12 Roper St. Francis ever asked to see your work
13 papers underlying those pro formas, did they?

14 A: That's correct.

15 Q: Okay. And you certainly didn't forward your
16 work papers to Roper St. Francis for their
17 review, did you?

18 A: Correct.

19 Q: Okay. So pretty much Roper St. Francis accepted
20 your pro formas without question, as is, we're
21 going, we're going forward.

22 A: I think with one minor exception. I think Mr.
23 Johnson indicated that he reviewed the pro
24 forma in a cursory fashion or something like
25 that.

- 1 Q: Fair enough. He said in his deposition he
2 glanced at them, right?
- 3 A: Yes.
- 4 Q: Mr. Knapp, are you familiar with the phrase,
5 garbage in, garbage out?
- 6 A: I am.
- 7 Q: What does that mean to you?
- 8 A: GIGO. If the input is impaired in some
9 fashion, there's a strong likelihood that the
10 output will likewise be impaired.
- 11 Q: Okay. So basically if inputs like patient day
12 volumes are adjusted patient days that come to
13 you are faulty or wrong, then the pro forma
14 that results from your work product based on
15 those assumptions that you're giving will be
16 faulty or wrong, correct?
- 17 A: In either direction, yes.
- 18 Q: Okay.
- 19 Q: Let's go to Petitioner's 167, if we could.
20 Now, these are the Roper St. Francis financial
21 highlights. Have you had an opportunity to
22 review these?
- 23 A: I have. I believe this was a deposition
24 exhibit.
- 25 Q: Okay.

1 MR. THOMAS: And if we could go to page five, maybe,
2 Sara. There you go. Let's blow up the bottom
3 if we could.

4 Q: This is Roper Berkeley 4369 for the record.
5 And you were also here, I believe, for Mr.
6 Johnson's testimony. We got kind of the middle
7 of the page there, it says Roper -- or RSF
8 Mount Pleasant Hospital, correct?

9 A: Yes, sir.

10 Q: And this is a half year pro forma, isn't it?

11 A: It is. It would appear to be the six months
12 ending June 30, 2011.

13 Q: Okay. And you were here for Mr. Johnson's
14 testimony when he stated that the actual, you
15 know, end of the year losses were about \$11
16 million, correct?

17 A: Yes, sir.

18 Q: Okay. And you were also here for his testimony
19 saying that the interest expense wasn't
20 included in that, right?

21 A: I did hear that, yes.

22 Q: Now, do you recall the interest expense that
23 you included in the Roper St. Francis Mount
24 Pleasant pro forma, in the venue pro forma?

25 A: Roper St. Francis? I would have to --