

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

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

v.

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

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

Roper St. Francis is the Respondent/Appellant.

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

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

v.

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

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

Roper St. Francis is the Respondent/Appellant.

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(caption continued from cover page):

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

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

v.

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

Of whom Trident Medical Center, LLC is the Appellant.

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1 you perform there?

2 A: Yeah. Well, obviously, you have to become
3 familiar with, if there's a second application
4 in the cycle, as there was in this cycle, their
5 information, their -- the case that they made,
6 what they rely on, what their numbers show.
7 And you try to look at the interaction of the
8 two and whether that changes the assumptions
9 that were made in the original applications.
10 You also try to become familiar, especially if
11 you know who the witnesses are on the other
12 side, with prior testimony they've offered.
13 I've actually been in cases before with both
14 Mr. Knapp and Mr. Richardson, sometimes on the
15 same side, sometimes on opposite sides. But
16 you look for the most relevant cases, similar
17 cases, particularly in the same state. You
18 know, how somebody testifies in Florida where
19 they may have different rules, they may have
20 different definitions of adverse impact, for
21 instance, is not the same as what someone may
22 offer as testimony in South Carolina where, for
23 instance, on something like adverse impact, the
24 definition hasn't changed, you know, over the
25 last however many years, certainly since I've

1 been involved in this state. So I did become
2 familiar in this case with the testimony that
3 was offered by both Mr. Knapp and Mr.
4 Richardson in the Grand Strand case.

5 Q: Now, let me ask you a few more questions. Is
6 it a routine and common practice in your
7 profession, as an expert witness in this area,
8 to review those transcripts in a given case?

9 A: Yes.

10 Q: Okay. Now, let's talk about putting things
11 into context, okay? What was the percentage
12 hit to net income of the Grand Strand hit?

13 MR. LONG: Objection, Your Honor. I think this is
14 beyond the scope of rebuttal. Here's the
15 testimony that's occurred in Grand Strand.
16 There were questions asked in the pre-filed
17 testimony is an exhibit, it is an exhibit. And
18 Mr. Knapp did answer questions about that. But
19 the questions that he's asking Mr. Baehr are
20 extremely broad. In other words, he's
21 basically going to try to walk him through this
22 issue when we have no ability for Mr. Knapp to
23 respond to that at all in rebuttal. I mean, if
24 he wanted to attack Mr. Knapp, he could have
25 done it in his primary case. I mean, his

1 questions are extremely board. He hasn't even
2 narrowed it to just -- what's been before Your
3 Honor is the pre-file testimony is an exhibit
4 and then Mr. Knapp was asked very specific
5 testimony on the pre-file. And that's it. I
6 think anything beyond that is inappropriate for
7 rebuttal.

8 **MR. SUMMER:** May I respond, Your Honor?

9 **THE COURT:** Yes, sir.

10 **MR. SUMMER:** What Mr. Knapp testified to was that in
11 Grand Strand the decrement to Grand Strand, the
12 lost contribution margin was somewhere between
13 three or four million dollars. And he said
14 that was a big hit, okay? A much bigger hit
15 than what's here today. That's not the case.
16 It's actually contrary. And so I think I've
17 laid the appropriate foundation. As an expert,
18 he's entitled to rely on hearsay if he needs
19 to, if it's ordinary and common within his
20 profession to do so. He's testified that he
21 routinely reviews transcripts and that he has
22 reviewed this transcript. And the only
23 question I asked him was what was the
24 percentage of that three to four million dollar
25 hit, what percent of that was that to net

1 income. That is the context, I think is the
2 word Mr. Knapp used, the context. But he
3 didn't give specifics. All I want him to do is
4 tell the court what that context is to rebut
5 Mr. Knapp's testimony.

6 **MR. LONG:** And, Your Honor, I would just point out
7 for the court, I've got a case here of McGaha
8 versus Moseley, 322 S.E.2d 461 where our Court
9 of Appeals kind of laid out the standard for
10 rebuttal. And this is what the court says,
11 "The plaintiff in a Civil Action must first
12 produce and disclose the entire evidence in
13 support of his case. After the defendant has
14 offered all of his evidence, the plaintiff will
15 reply. Reply testimony should be limited to
16 rebuttal of matters raised in defense. It
17 should not be used to complete the Plaintiff's
18 case in chief." And, of course, it's at your
19 discretion, Your Honor. I mean, that's the
20 next line there is it's at the court's
21 discretion. This is a classic example of them
22 trying to expand rebuttal because Mr. Knapp
23 didn't testify anything about that information
24 in our case. He brought it out on cross and
25 now he's trying to use a different witness to

1 try to fulfil what he should have done in his
2 original case if that's an area that he felt
3 like was critical to go into. He brought it
4 out on cross. It's their exhibit. Not mine.

5 **THE COURT:** Well, I feel like the door's been opened
6 and I overrule the objection.

7 **MR. SUMMER:** Thank you, Your Honor.

8 **Q:** The three to four million that Mr. Knapp
9 referred to, what was the ratio or relative to
10 net income in that case?

11 **A:** All right. As I recall, the range was, I
12 believe, \$3.3 to \$4.6 million of adverse
13 financial impact. And the Grand Strand
14 facility they had through, I believe it was
15 nine months, 29 million of net income. So on
16 an annualized basis, it was about 38 million.
17 So the adverse impact of 3.3 would range, at
18 the low end eight percent. At 4.6 million, it
19 would range more about 12 percent of the
20 hospital's net income.

21 **Q:** Now, how does that compare to the amount of
22 adverse impact as expressed in your exhibit,
23 Petitioner's 46. In this case? What is the
24 percentage there?

25 **A:** The adverse impact here is a higher percentage.

1 of Trident's projected net income. In the
2 material that was submitted as part of the
3 application, which represents the entire
4 Trident System and included with Berkeley and
5 the other half of the hospital without
6 Berkeley, those numbers had net income numbers
7 in the range of the mid-40 million dollar
8 level. \$16 million is a significant hit to
9 that. And I understand in some of the recent
10 years Trident's performed better than that.
11 Their net income has been higher. I think in
12 the range of \$60 to \$70 million in some years.
13 In any case, \$16 million, if that turns out to
14 be the adverse impact, is certainly in excess
15 of 20 percent even of the high-end type net
16 income numbers that have been seen in recent
17 years. And a higher percentage than that of
18 the numbers that were projected.

19 Q: So it's more than double than Grand Strand?

20 A: Yes, sir.

21 Q: All right. My recollection is Mr. Knapp found
22 that to be a material adverse impact at Grand
23 Strand, didn't he?

24 A: Correct.

25 Q: Okay. Before we leave Mr. Knapp's testimony,

1 is there anything else that you want to take
2 issue with?

3 A: Yeah. There are a couple of things I heard
4 yesterday that I thought were kind of
5 interesting. One was -- or maybe it was two
6 days ago Mr. Knapp testified. The days sort of
7 run into each other when you've been in the
8 courtroom three weeks. But you -- when you
9 were cross examining him, you walked through an
10 attempt to take his incremental model and
11 translate it into a full hospital model. And
12 when that same exercise was carried out in Mr.
13 Knapp's deposition, Mr. Knapp had come up with
14 numbers that produced a bottom line of about
15 \$22 million, I believe, for the Roper St.
16 Francis Berkeley facility, which he said he
17 thought was high, higher than he would have
18 anticipated. The same exercise they went
19 through here, pretty much the numbers and what
20 Mr. Knapp offered in response was pretty much
21 the same in every category except one and that
22 was on corporate administration he threw in \$10
23 million based on a test that he used looking at
24 the financial information by the Roper St.
25 Francis Health System for the period ending

1 June 30, 2010, in which he could calculate the
 2 ratio of the corporate administration allocated
 3 to the Mount Pleasant facility compared to the
 4 net revenues of the Mount Pleasant facility.
 5 So he then applied that same ratio to his final
 6 year numbers at Berkeley for the Berkeley
 7 facility for Roper at Carnes Crossroads, and he
 8 came up with \$10 million. Now, since he's
 9 basing it on volume, presumably half of that is
 10 associated with incremental and half of it is
 11 associated with building up to the full model.

12 Q: If you're going to be consistent?

13 A: If you're going to be consistent. So remember
 14 you have the Mount Pleasant facility presumably
 15 has both redirected patients, it was assumed to
 16 have a significant number of redirected
 17 patients, as well as patients that are picked
 18 up from market share. The same in the case in
 19 their model for Roper St. Francis Berkeley.
 20 Then you go back to the financials that were
 21 submitted by Roper St. Francis for this
 22 application to the Department. They never sent
 23 them a full hospital model. And I'll say right
 24 here, I think the Roper St. Francis Hospital,
 25 if you look at the full hospital, it'll make

1 money. It'll be profitable. I think it's
2 feasible. I absolutely do not dispute that.
3 The Department, however, never saw any full
4 hospital model. The only thing they saw was
5 the incremental model. The incremental model
6 is barely break-even. They make a little bit
7 of money in year three. Now, we're saying
8 there's five million dollars they missed.
9 That's a big number. Now, in the Mount
10 Pleasant application, they also missed it.
11 There's a very modest number, to use Mr.
12 Knapp's language, modest, I think of \$600,000
13 that was included for corporate administration
14 in that application and that number's going to
15 turn out to be significantly higher than that.
16 The point is there's no evidence that the
17 Department took these financials when they saw
18 them as -- as they were presented, they were
19 barely break-even in year three. And it's only
20 for half a hospital. They never requested the
21 numbers for the full hospital. At Mount
22 Pleasant they had the full numbers available.
23 Never requested them, never saw them, never had
24 any questions about the financials. And as a
25 result, based on what they submitted, if you

1 include the appropriate share of the corporate
2 overhead, based on what they submitted, their
3 project is infeasible. It would have lost five
4 million dollars in the third year. That's
5 important. All right? This is one more piece
6 of evidence that the Department, when it came
7 to the Roper Application, dropped the ball.
8 They didn't look at need in the area where beds
9 were being transferred. They didn't look at
10 the financials very seriously. They didn't ask
11 them what run zip codes, where they were going
12 to take patients from, how much adverse impact
13 it caused individual providers, they didn't do
14 any of that. They didn't request any of that.
15 I mean, I'm familiar with the responses that we
16 had to prepare when Trident submitted its
17 application based on need in the Plan. Not a
18 transfer, it was a need. They based their
19 application on need. And we had a series of
20 requests. One of which required a fairly
21 substantial amount of work to respond to. I
22 didn't see the same level of scrutiny in terms
23 of what was done on the Roper side. That's one
24 thing. The second is that \$13 million number,
25 if that's the real number -- and I've got to

1 tell you, I'm skeptical about any of the stuff
2 in here because it doesn't look like it was the
3 same level of detail and care I'm used to
4 seeing in these kind of projections. I know
5 what went into the Trident numbers and the
6 number of passes and back and forth and the
7 very serious financial people at the
8 institution who didn't just give it a ten
9 minute cursory review, but looked at it
10 carefully, had comments work back and forth,
11 produced information so that Mr. Woodford could
12 come up with an accurate forecast, okay?
13 That's one way to prepare financials. Here you
14 have, in Mr. Knapp's numbers, a compound rate
15 of growth in net revenues per adjusted
16 admission of almost six percent per year. All
17 right? When you had Mr. Knapp and you were
18 cross examining him, and he basically said 70
19 percent of the patients were Medicare and
20 Medicaid, that that patient population, that
21 rate of increase per year, net revenues might
22 be two to two and a half percent a year, and he
23 said maybe there's a little bit extra for
24 coding. But I've got to say, for the kind of
25 sophistication that the Roper System is paying

1 for, presumably everything they're going to
2 squeeze out of coding they've already done.
3 I'm not quite sure how much juice is left to
4 squeeze out of that lemon. So two to two and
5 a half percent for 70 percent of their
6 population, patient population, how do you get
7 almost a six percent increase in net revenue?
8 Well, I did the calculation. It would require
9 an annual rate of increase in the amount of
10 money received of 13.5 percent per adjusted
11 admission for the 30 percent of payers who are
12 not Medicare and not Medicaid. That number is
13 unreasonable. It is more than double the
14 document I've reviewed that Roper submitted
15 showing the rates of increase that they were
16 expecting to receive as a result of contracts
17 negotiated with third-party payers who fall
18 into that 30 percent category. If you can't
19 get it from Medicare and Medicaid, because
20 they're only going to grow their numbers by a
21 small amount, given the pressure on the budgets
22 in Washington and the pressure on the budgets
23 in the state, money isn't being given away to
24 those programs. In fact, the Healthcare Reform
25 Act that was passed takes money out of the

1 Medicare program, \$500 billion over ten years,
2 okay? That's not where you're going to see
3 those kind of growth numbers. It's got to be
4 in that remaining 30 percent. The numbers
5 don't work. I am unfamiliar with hospitals
6 anywhere that I've worked in any of the states
7 that are seeing compound rates of growth of 13
8 or 14 percent per year in what they're getting
9 from those kind of third-party payers, the
10 major insurance companies.

11 Q: All right. Thank you. Let's move over to Mr.
12 Richardson's testimony.

13 A: Sure.

14 Q: And what I think I want to do is do this in
15 terms of kind of key categories. Do you recall
16 that he had a great deal of discussion about
17 need and various opinions regarding need? Do
18 you recall that?

19 A: Yes.

20 Q: This is Regulation 61-15 and it's Section, I
21 believe is, it 802 or 803? 802(1). Can you
22 read this into the record for me, please?

23 A: "The proposal shall not be approved unless it
24 is in compliance with the State Health Plan."

25 Q: Okay. That's the threshold question, isn't it?

1 A: Correct.

2 Q: And that's the threshold question on

3 determining need?

4 A: Yes.

5 Q: Okay. Let's take a look, if you don't mind, at

6 the 2008-009 plan.

7 A: All right. Could you direct me?

8 Q: I'm going to give it to you. It should be

9 Joint 4, I believe.

10 A: Okay.

11 Q: Okay. Joint 4?

12 A: Yeah. I've got that here.

13 Q: If we go to Roman Numeral II-18 --

14 A: Okay.

15 Q: -- and II-19 --

16 A: Sure.

17 Q: -- how is need determined for Trident Medical

18 Center?

19 A: Okay. Trident is on page II-18. The

20 Department has information for the year 2006

21 for Trident Medical Center, as for these other

22 hospitals that are in the Tri-county area in

23 terms of their volume of patient days divided

24 into various age categories. Those patients

25 who are under age 18, those patients who are 18

1 to 64, those patients who are 65 and older,
2 okay. They then have populations for, in the
3 same year, 2006, in this case for the Tri-
4 county area.

5 Q: And are those broken down by age cohort as
6 well?

7 A: Same age cohorts as the utilization
8 information. What the Department does is it
9 projects population within each specific age
10 category to the year 2013. It's always seven
11 years ahead of the year they use historically.
12 It's always -- for as long as I've been
13 involved in this state, it's been seven years.
14 And so for 2013, in a sense, is the forecast of
15 the future patient days that the hospital will
16 experience in each of those age groupings,
17 based on how much population is growing over
18 that seven year period in each of those age
19 groupings. So, for instance, you look at
20 Trident Medical Center under 18 and you see
21 2006 population 143,670; 2013, 145,480. Now,
22 that's not a lot of growth. That's only one
23 thousand -- you see right next to it, 1,830 --
24 excuse me, the growth is 1,810, okay, in terms
25 of the population for that age segment. That's

1 the difference between 145,480 and 143,670. I
2 just calculated that myself. Okay?

3 Q: Okay.

4 A: That's the number of patient days for that
5 group. It just happens turns out to be a
6 number very similar. This is an odd case where
7 a lot of numbers turn out to be very similar,
8 even though they're used for different things.
9 The first case I've actually ever been involved
10 with where it's worked out that way, where the
11 number of patient days in a new hospital turns
12 out to be the same as the level of growth in a
13 market. I mean, it's very unusual to get
14 exactly, almost exactly the same numbers. But
15 they were the case in this case. Anyway,
16 that's not much growth. That's about 1.3
17 percent growth over seven years in that age
18 category. It says that for the age population
19 under 18, not substantial growth, okay? Then
20 if you look at the 65 and over, 68,000 to
21 89,720, that's pretty substantial growth.
22 That's growth of roughly 30 percent over seven
23 years. So, yes, we're all aging, but those who
24 are in the 65 and older category are by far
25 growing the fastest. That matters because the

1 state calculates a base year use rate. In
2 other words, they look at the number of patient
3 days in each of these age segments divided by
4 the population in that age segment. All right.

5 Q: It's a historical use rate?

6 A: Historical use rate. And they carry forward
7 that use rate so that at this population growth
8 there's going to be a certain number of
9 additional patients forecast. So for Trident
10 Medical Center, when they carry forward these
11 growth rates, based on the population, they
12 come up with projected average daily census
13 falling into each of these age categories.
14 Essentially, what they've done is they've taken
15 their projected patient day number divided by
16 365, okay? So they expect five beds to be
17 filled for those under age 18; 120 for those
18 who are 18 to 64; 122 for those who are 65 and
19 over. In total, they expect to fill 247 beds.
20 Given Trident Medical Center's size, which is
21 296 beds, their target occupancy is 70 percent.
22 So if you divide 247, which is the number of
23 projected days filled on average, average daily
24 census by .70, you come up with a need for 352
25 beds. But Trident only has 296, so they have

1 a net need of 56 beds. All right?

2 Q: And that's --

3 A: One thing I just want to add here. This is
4 very important in the case of Trident. Look at
5 the total population growth from 588,000 to
6 628,000. That's a growth of about seven
7 percent roughly over a period of seven years.

8 Q: Are you now looking for the whole service area?

9 A: I'm looking at the whole service area, all age
10 groups together.

11 Q: Three counties?

12 A: Three counties, 588,900, 2006; 628,520 in 2013.
13 That's a growth of almost 40,000. It's about
14 seven percent. If you look at the projected
15 bed need, a 56 bed need for Trident Medical
16 Center, that's a projected increase in their
17 capacity of close to 20 percent. What it says
18 is even without growth, based on the number of
19 projected, number of days actually served by
20 Trident Medical Center in 2006, they would have
21 had a bed need even without the growth. And
22 they have a larger bed need as a result of the
23 growth. All right? So Trident's occupancy
24 level has been high enough to justify being one
25 of only two hospitals in this Tri-county

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1 service area to show a bed need and by far the
2 largest bed need.

3 Q: Okay. Now, the formula that you just went
4 through, DHEC uses that same formula with all
5 the hospitals in South Carolina, right?

6 A: Correct. Though each -- you know, in other
7 counties they would use the population data for
8 those specific counties. Here they use the
9 population data for the sum of Dorchester,
10 Berkeley and Charleston County.

11 Q: Okay. All right. So based upon your review of
12 everything in this case, is there a need for
13 Trident to build a new hospital?

14 A: Absolutely there's a need. Trident, at the
15 time this application was filed, had need for
16 beds under the 2004-2005 Plan. 2008-2009 Draft
17 Plan was already being circulated, which showed
18 a much more substantial need. The projections
19 we prepared and developed suggested that the
20 system would have enough growth to support the
21 new hospital in Moncks Corner, which the people
22 at Trident believed was the best site to locate
23 it to serve residents of that community and
24 improve access, a conclusion I agree with. And
25 the need is there and access is improved.

1 Q: Let's look now and turn our attention to
2 whether or not there's need for Roper to either
3 add beds or build a hospital.

4 A: Okay.

5 Q: Okay. And this is the Plan that Roper applied
6 under, correct?

7 A: It is.

8 Q: First of all, does Roper have a need for beds
9 expressed in the State Health Plan?

10 A: They do not.

11 Q: Okay. And what's the deficit there?

12 A: Roper is a deficit of six. It's sister
13 hospital downtown, Bon Secours, is a deficit of
14 17, which means they have more beds now than
15 they're projected to need seven years in the
16 future, after growth. In other words, after
17 you apply the seven percent population growth
18 on average and build their numbers up by that
19 population growth, they still will not have
20 need in the future.

21 Q: Okay. So through 2013, they have no need for
22 beds?

23 A: That's correct.

24 Q: Let's look now at what Mr. Richardson was
25 testifying about regarding the hospital

1 transfer section.

2 A: Okay. Let me get that. I think --

3 Q: That will be on Roman Number, it starts on II-9
4 and goes over to II-10.

5 A: Okay.

6 Q: Everything we've looked at heretofore has been
7 looking at the service area, which is the three
8 counties.

9 A: Correct.

10 Q: But I want to turn your attention to this
11 criteria number five. Can you read that into
12 the record, please?

13 MR. LONG: Your Honor, I want to just object and ask
14 for some clarification from the court on your
15 earlier ruling. Okay. This is clearly an
16 issue that he raised on cross. I didn't ask
17 Mr. Richardson about any of this in our case in
18 chief. And so I -- and that was part of my
19 objection earlier. So, you know, I object to
20 him going into matters that he only raised on
21 cross examination, unless I misunderstood Your
22 Honor's earlier objection -- your earlier
23 ruling.

24 MR. SUMMER: May I respond, Your Honor? His expert
25 testified there is need for the hospital. And

1 what I'm trying to determine -- the only way we
2 know that there's need is through this section.
3 That was clear from Mr. Richardson's testimony.
4 What I'm going to ask this witness is, how do
5 you determine need, okay? Because it's clearly
6 not in the other portions of the State Health
7 Plan. We know that it's got -- whatever
8 they're doing, whatever these people want to
9 do, it's got to be consistent with the Plan.
10 And all I'm trying to do is walk him through
11 that. That's all I'm trying to do and it's
12 responding to the expert opinion that was
13 solicited that there's need for a hospital at
14 Carnes Crossroads.

15 **THE COURT:** Overruled.

16 Q: All right. What, if any, relevance does number
17 five have to whether or not there's need for a
18 hospital at Carnes Crossroads? What does it
19 say?

20 A: I think this is actually a very key part of
21 this. As I testified before, I don't believe
22 this section allows Roper to do what they did
23 in Mount Pleasant or what they're proposing to
24 do here.

25 Q: The English language you read is --

1 A: It's pretty plain.

2 Q: Okay.

3 A: It couldn't be clearer.

4 Q: All right.

5 A: And I think this section absolutely applies to
6 a particular circumstance of two hospitals
7 moving beds between each other. That's what
8 it's talking about. Now, let's assume you take
9 the state's position that somehow they can
10 ignore the plain language and they can use this
11 section to allow a hospital that doesn't have
12 a bed need to move beds somewhere else.

13 Q: To a cow pasture?

14 A: Yeah. To an area that doesn't have them. If
15 you accept the state's logic, section five says
16 the facility receiving the beds must
17 demonstrate the need for the additional
18 capacity both on historical and projected
19 utilization patterns. What that means is this,
20 what is this whole transfer section about?
21 It's about, in a sense, distributing assets
22 from a health system to more efficiently use
23 them where patient population is, okay? In
24 essence, why would you transfer out of hospital
25 X? Well, because you have too many beds there.

1 You built them however many years ago, length
2 of stay declined, surgeries went to outpatient,
3 you're not filling as many of your beds for
4 whatever reason. So now you want to move them
5 somewhere else where presumably there's more
6 growth. You have to make the case. You have
7 to prove that there's actually need under this
8 section, if you accept that this Section allows
9 transfers. And that isn't need in the Tri-
10 county area. It has to be need where you're
11 moving the beds. Because otherwise this would
12 make no sense. If you're moving the beds from
13 A to B and the only way you're determining
14 whether there's need is on a Tri-county area,
15 there's no improvement. If you're making the
16 case that they're better off in site B than
17 there were in site A, which is where you took
18 them from, then you have to prove it. This
19 says, show that where the receiving facility is
20 getting the beds has a need for them. What
21 that means is, in this case, you have a
22 hospital that had need, 56 beds in the 2008-
23 2009 Plan when this case was decided, had 17 in
24 the 2004, but that number was clearly outdated
25 by the time, you know, the state made this

1 determination. They knew what the bed need was
2 in 2008-2009 for Trident. You can run the
3 numbers just like you did yesterday with Mr.
4 Richardson and it produces a bed need of 50.

5 Q: Well, let's do that.

6 A: Let me just finish my point. If you're
7 approving a second hospital based on this
8 transfer language, that's 50 beds, you've got
9 to show a need for another 50. You've got to
10 show a need for the 50 that's based on need, on
11 growth, that's in the hospital's State Health
12 Plan. And you've got to show a need for the
13 other 50, which is coming as a result of this
14 transfer. The idea that transferring beds and
15 you're therefore absolved, you don't have to
16 make a case, you can just say, there's no harm
17 done -- what's the worst I do? Oh, I spent a
18 150 million in an area where there's no need.
19 That's harm. That's duplication. You've got
20 to make the case that there's enough need,
21 especially in this case, for the hospitals
22 applying with need, as well as for the
23 hospitals applying without need in the area
24 where they're trying to get the beds moved.

25 Q: I understand the planning area is a three

1 county area and that you have not based your
2 opinions on Berkeley County population. But
3 let's go to Mr. Richardson's exhibit that he
4 testified about so much.

5 A: Could you give me a hard copy of those?

6 Q: I can. Exhibit Number 70, Respondent's 70.
7 And we will pull that up on the screen as well.
8 Okay. And I'm going to come back and ask you
9 some questions about the first page. But let's
10 go to the second page.

11 A: Sure.

12 Q: Exhibit 70 at page two, which is Richardson
13 Berkeley 684. Do you see that?

14 A: Correct.

15 Q: All right. The first thing I want to do is
16 compare the two numbers that we did with Mr.
17 Richardson yesterday and that would be the line
18 of estimated patient dates in 2010 of 55,629.

19 A: Correct.

20 MR. SUMMER: No, just the 55, please. Estimated
21 patient day of 55,629. And would you go and
22 highlight that for me, please? And then we'll
23 go to 2017 and do the same one for the 6783.
24 Okay.

25 Q: Now, do you recall Mr. Richardson's testimony

1 regarding this particular calculation?

2 A: Yes. I mean, he calculated a difference which
3 was 12,201 days.

4 Q: All right.

5 A: You could -- then you asked him to divide that
6 by 365 to get an average daily census.

7 Q: Okay.

8 A: And then applying the 65 percent facility size
9 target occupancy rate, you came up with a need
10 of 51 beds in Berkeley County between 2010 and
11 2017, the current seven -- the most current
12 seven year planning horizon, given the last
13 data that was available was at 2010 at the time
14 this information was prepared by both myself
15 and Mr. Richardson, that's enough for one 50
16 bed hospital, not two.

17 Q: Do you agree with Mr. Richardson that that
18 projection of 51 needed beds is consistent,
19 that methodology is consistent with the state
20 of South Carolina's methodology in the State
21 Health Plan?

22 A: Yes, it is.

23 Q: Okay.

24 A: The only difference is the growth is faster
25 because it's based on the Berkeley numbers.

1 And the Berkeley growth numbers are faster
2 overall than the growth numbers in the Tri-
3 county area. So here, in these estimates,
4 you're getting the full benefit of the high
5 growth rate in Berkeley County.

6 Q: Okay. Now, there was, after this computation,
7 a great deal of emphatic of, well, you've got
8 to remember the baseline. You've got to
9 remember the base. Okay. What is the base?

10 A: I heard what Mr. Richardson said and I see the
11 numbers on this page. And I hate to say it,
12 but the idea that somehow the base number of
13 days, which was a 55,629, in any way, shape or
14 form can be regarded as bed need is
15 preposterous. It's embarrassing to put that
16 forward as a healthcare expert given that that
17 represents the days that are now being served
18 at all of the institutions in the Tri-county
19 area. They're included with all the other days
20 being included at those hospitals that are
21 coming from Dorchester County or from
22 Charleston County or from out of the county,
23 out of the three counties because there is some
24 in-migration from other areas for other
25 services. Those patient days are included,

1 they're included in the current inventory of
2 beds. And remember, the current inventory of
3 beds, according to the state, is too high.
4 There's an excess. You've got an excess in the
5 2008-2009 Plan of 48 beds. To follow what Mr.
6 Richardson was saying, he draws a wall around
7 Berkeley County and he says this is the number
8 of days we have in the base. We have 55,629
9 days. We need a hospital to serve those days.
10 So I'll just take that volume, apply the 65
11 percent occupancy rate, which is wrong. Even
12 if this were growth, you wouldn't apply a 65
13 percent occupancy because of the size of the
14 facility. Okay, it would be higher. Why you
15 would present something that is clearly wrong
16 on its face, I don't know. But he did. He
17 uses 65 percent on the pages. It's wrong,
18 okay? Seventy is the appropriate number if you
19 had facilities of that size. But in any case,
20 there's no need for 275 new beds in Berkeley
21 County unless what the state wants to see is
22 excess beds of 275 plus the 48 they already
23 have, which would get you to 323. The beds
24 that are being filled at the existing hospitals
25 in Charleston County and Dorchester County are

1 serving the patients from Berkeley County that
2 are reflected in this base number. They are
3 not isolated without a hospital, not being
4 recorded somewhere, on an island in need of a
5 hospital, okay? They are being served.
6 They're being counted and the excess bed
7 calculation the state makes fully incorporates
8 all of these days when they make a
9 determination about whether there's a need for
10 beds in the entire service area, which there is
11 not. And when there's no need in the entire
12 service area, the only hospitals that can apply
13 for new beds based on need are those that show
14 it. That's Trident Medical Center and
15 Summerville Medical Center. They both applied
16 for beds because they had need for them.

17 Q: Okay. So what Roper's basically doing is
18 they're trying to piggy back on Trident's bed
19 need for that area, aren't they?

20 A: They are trying to take advantage, I believe,
21 of Trident's growth to get their project
22 approved. But in the second, they're creating
23 what I think -- and this has been throughout
24 this case, since the time I first got involved,
25 once Roper got involved and I saw what they

1 said at project review: They've made this
2 argument. They showed these maps yesterday
3 suggesting Berkeley County is left adrift. The
4 only other counties in the state that don't
5 have hospitals only have 20,000 people. We've
6 got other counties that are about the same size
7 that have two hospitals. What they continue to
8 ignore every step of the way is that there's a
9 296 bed tertiary hospital less than a mile that
10 was created at the epicenter of the north part
11 of Charleston County, Dorchester and Berkeley.
12 It was ideally suited to serve the population
13 it was expected to serve when the two
14 hospitals closed in Dorchester County and
15 Berkeley County. It has been perfectly
16 positioned to absorb that growth. Adding a
17 hospital in Dorchester, which has been by far
18 the fastest growing hospital, made sense. But
19 to assume that somehow there are no beds
20 serving Berkeley when Trident is right on the
21 doorstep. If you could move the hospital a
22 mile, all of the maps Mr. Richardson provided
23 are worthless. So the question is, if they're
24 worthless if the hospital is one mile further
25 -- one mile into the county and they're one-

1 tenth of a mile into the county instead of
2 nine-tenths of a mile out, I think they're
3 worthless when you ignore Trident Medical
4 Center when it's just outside the county line.

5 Almost half of the patients at Trident Medical
6 Center come from Berkeley County. Eighty-five
7 percent of the patients from Berkeley County
8 who are seen in the Trident Health System are
9 seen at Trident Medical Center, about 15
10 percent at Summerville. Trident is there to
11 serve Berkeley County and has since the time it
12 was built. To ignore it and to come up with
13 these absurd ratios that say, Berkeley, zero
14 beds divided by 177,000 is wrong. It is
15 misleading. It was an attempt to mislead, I
16 believe, the Department. It's an attempt to
17 mislead the court. And it's really, in my
18 judgment, really bad planning to make that kind
19 of argument based on those circumstances.

20 Q: Is it consistent with the State Health Plan?

21 A: No.

22 Q: Okay. Because when you look at if there's need
23 at Carnes Crossroads, Mr. Richardson's own
24 exhibit disproves that, doesn't it?

25 A: It proves there is a need for one 51 bed

1 hospital in Berkeley County.

2 Q: Okay. And the only hospital in the planning
3 area with need to apply for a hospital has done
4 so, hasn't it?

5 A: Correct.

6 Q: Okay. Let's talk a little bit while we're up
7 here. I pulled this map up because I like it.
8 1,739 beds, that's not an insubstantial number
9 of beds, is it?

10 A: It is not.

11 Q: Well, talk a little bit about maldistribution?

12 A: Yeah. I heard that a lot. And basically there
13 are the 94 beds that are right now in
14 Dorchester County and the remaining beds, Mr.
15 Richardson says, are in Charleston County, and
16 a disproportionate number of those are on the
17 peninsula where Roper is and where Medical
18 University of South Carolina is. All right?
19 A couple of comments. If you look at that bed
20 inventory of 1,739, you look at the two
21 hospitals that have had need that are proposing
22 to add beds, 50 beds for Berkeley Regional
23 Medical Center for the Trident System in Moncks
24 Corner, 30 beds in Summerville for the -- in
25 Dorchester County for the Summerville Medical

1 Center; you add those 80 beds, you'd have
2 1,819. Essentially the two hospitals would
3 need -- would have 80 beds. Roughly half those
4 beds, roughly half, are not in the peninsula.
5 They are, in fact, around the service area in
6 areas of growth, which is exactly where you
7 would expect them to be. But there's still a
8 lot of beds in the peninsula. There aren't
9 enough people on the peninsula to support 900
10 beds. No medical university in the country
11 that has a large teaching hospital is there to
12 serve a two mile service area around it. The
13 Medical University of South Carolina is not
14 there to serve the peninsula. Roper Hospital
15 was never designed to serve the peninsula. It
16 is common, and I have worked in this business
17 37 years and I've worked in dozens of states,
18 that in every major metropolitan area there are
19 a concentration of hospitals that provide
20 tertiary services or teaching hospitals that
21 are located in the inner core of cities. And
22 if you look at the number of beds in those
23 facilities, it is disproportionate to the
24 population around them. The reason is not
25 every hospital's a tertiary hospital. Those

1 hospitals are expected to get patients from
2 other areas. Not every hospital is a teaching
3 hospital. They're going to have different
4 services, they're going to have speciality
5 services that will serve large populations.
6 There is an expected migration from outlying
7 areas to inner-city hospitals where you have
8 more sophisticated tertiary services or
9 teaching hospitals. That is the pattern
10 everywhere. This is not to make a case to say
11 that the percentage of all beds that should be
12 in the peninsula is X. I'm not making that
13 case. But if you look, for instance, at Mr.
14 Richardson's, you know, population numbers
15 here, Berkeley and Dorchester County from 1990
16 to 2010, those two counties combined have gone
17 from about 42 percent of the population of the
18 Tri-county area, to about a little over 47
19 percent. They're growing their share. But
20 it's not like they've become 70 or 80 percent.
21 In fact, Charleston County added more people
22 between 1990 and 2000 than either of the other
23 two counties, and the same between 2000 and
24 2010. And Charleston had its fastest growth
25 rate in population between 2000 and 2010 that

1 it had in its entire 40 year history. So the
 2 idea that somehow all of the beds now -- there
 3 should be this massive transfer of beds out of
 4 the downtown core to Berkeley and Charleston,
 5 you know, to Berkeley and Dorchester County is
 6 wrong. In fact, what you went through
 7 yesterday with Mr. Richardson showed that beds
 8 have been added proportionate to the growth.
 9 All right. The bed to population ratios in the
 10 two fastest growing counties in the Tri-county
 11 area have actually grown slightly since the
 12 hospital was -- since the Trident Medical
 13 Center was established.

14 Q: Well, let's talk about what relevance, okay,
 15 from a health planning perspective. What
 16 relevance does the history of Trident Hospital
 17 have to your analysis?

18 A: Trident was built in cooperation with county
 19 people and people who had run the hospitals in
 20 Moncks Corner and in Dorchester County which
 21 closed in anticipation of a new provider coming
 22 into the market willing to invest capital, and
 23 to create a more modern up-to-date competitive
 24 facility with a broader range of services that
 25 would replace the two small county hospitals

1 and bring better healthcare, better quality
2 healthcare, broader range of services, closer
3 to patients in those communities. All right?
4 And that's what they've been doing really since
5 1975 when the hospital was built.

6 Q: Okay. And I'm going to come back to that
7 history in a minute because you also heard
8 testimony regarding mission, right? And I want
9 to talk about mission and that word as Mr.
10 Richardson used it. And we'll come back to
11 that in a minute. While we're here, I think
12 it's a good place for us, having had this need
13 discussion, is to turn our attention to the
14 regulations for just a minute. Do you have a
15 copy of the regs with you by any chance?

16 A: I believe I -- you gave it to me. Yes.

17 Q: Let's go over what Mr. Richardson was
18 discussing yesterday about this notion of
19 whether or not these are competing
20 applications. And in particular, let's focus
21 on this notion of whether or not the approval
22 of both would exceed the need for the facility.

23 A: Uh-huh (affirmative response).

24 Q: Based upon your prior testimony regarding that
25 criteria number five, in the bed transfer

1 section --

2 A: Uh-huh (affirmative response).

3 Q: -- on Roman Number II-10 of the 2008-2009 Plan,
4 okay, which requires you to look at the need of
5 the receiving facility, or the receiving cow
6 pasture in this case, okay, what, if any,
7 opinion do you have about whether or not the
8 approval of both of these applications exceeds
9 the need in -- or exceeds the need -- it
10 doesn't even say for the services -- it says
11 exceeds the need for a facility?

12 A: Yes. It exceeds the need by adding one
13 unnecessary duplicative facility.

14 Q: And that's based upon your reading of number
15 five, but also based upon Mr. Richardson's
16 Exhibit Number 70?

17 A: Yes.

18 Q: Respondent's 70?

19 A: Correct. And other work that I've done in this
20 case. I mean, I developed exhibits and I
21 showed population, the number of days growing
22 by 12,269. Mr. Richardson was 12,201. Our
23 numbers were almost a mirror of each other. We
24 both came up with the same calculation showing
25 that the growth in the market in Berkeley

1 County supports one 50 bed hospital.

2 Q: And that's consistent with the State Health
3 Plan, isn't it?

4 A: That's correct.

5 Q: That's what the State Health Plan says in terms
6 of growth, right?

7 A: Correct.

8 Q: So what is your opinion as to whether or not
9 these applications are competing?

10 A: I absolutely believe they're competing and they
11 meet every test easily.

12 Q: Let's go back now and talk about this mission
13 issue.

14 A: Uh-huh (affirmative response).

15 Q: You've heard the testimony regarding the
16 mission of the Trident System and that going
17 back to Summerville was part of that mission,
18 okay?

19 A: Yes.

20 Q: And that building a hospital in Moncks Corner
21 was part of that mission?

22 A: Correct. And Moncks Corner is, in fact, a part
23 of the county most in need of a hospital given
24 that the southern part of the County is well-
25 served by Trident Medical Center and

1 Summerville Medical Center.

2 Q: And we're going to get into the criteria and
3 we're going to talk about that in a minute as
4 well. But accepting for a moment, Mr
5 Richardson's, one of his various definitions
6 regarding adverse impact, one of the was -- do
7 you recall his testimony about whether or not
8 the impact or the hit would affect the ability
9 of a hospital or a system to carry out its
10 mission? Do you remember that testimony?

11 A: I do remember that.

12 Q: Okay. What, if any, effect, adverse effect as
13 to mission, is the Roper facility, and Roper
14 right now, having on Trident's ability to
15 fulfil its mission?

16 A: Well, the Trident project was submitted, was
17 approved, and if it had been the only applicant
18 in the cycle, I'm certain it was approved too.
19 I haven't yet found anyone who thinks the
20 Trident project in Moncks Corner is not needed.
21 As a result of having a second hospital applied
22 for and approved in a location that will
23 severely impact the ability of the Berkeley
24 Regional Medical Center, the hospital in Moncks
25 Corner, to succeed, if both hospitals are

1 approved, it's my understanding that the
2 Trident System has decided they will not go
3 ahead with the Moncks Corner facility which
4 would mean that you would be adding a third
5 hospital to an area that's already well served
6 and not add the hospital in the area of the
7 county where 30,000 people who are not now
8 within 30 minutes drive time of a hospital
9 would now be within that range if Moncks Corner
10 was built. That is a severe adverse impact in
11 terms of access for the residents of the
12 northern part of the county, which would occur
13 because an unnecessary hospital is being built,
14 which will deprive the Moncks Corner facility
15 of the ability to financially survive.

16 Q: What effect does opposing Summerville's
17 expansion have on Trident's mission?

18 A: Same thing. Summerville is applying under bed
19 need. It had a 24 bed need when it applied and
20 applied for 30 beds. Summerville is the
21 fastest growing county in the Tri-county area.
22 And as best I understand it, pretty much in Mr.
23 Richardson's exhibits as well as what Mr.
24 Bowling said, they think Summerville needs to
25 wait to see what happens first with regard to

1 the new Roper Hospital. And if Roper Hospital
2 takes enough business away from Summerville,
3 then maybe there's no need for Summerville
4 beds. Talk about living off someone else's
5 growth, there's no better example.

6 Q: I'd like to turn your attention now to --

7 MR. SUMMER: If we could, pull up Petitioner's --
8 well, wait a minute. Before we leave that,
9 let's go back -- that's all right. Go ahead
10 and go to 104. I think he's testified about
11 that.

12 Q: Do you remember the various witnesses who've
13 testified about this?

14 A: Yes.

15 Q: Mr. Bowling testified about this exhibit. Do
16 you remember that?

17 A: Yes, sir.

18 THE COURT: What exhibit are you referring to, 104?

19 MR. SUMMER: This is 104, Your Honor. Petitioner's
20 104.

21 Q: And then Mr. Richardson testified at length
22 about it yesterday, do you remember that?

23 A: Correct.

24 Q: Okay. Let's turn our attention first to page
25 11. This is talking about Mr. Richardson's

1 qualifications and experience. Do you dispute
2 that at all?

3 A: No, Mr. Richardson has had a distinguished
4 career.

5 Q: It's referring to what? What's the title of
6 this?

7 A: Independent Analysis Conducted By and then the
8 bullet points.

9 Q: All right. So when you read that, who do you
10 assume has put this analysis together?

11 A: This certainly reads as if Mr. Richardson
12 prepared the analysis.

13 Q: You know, I feel the way you do. The plain
14 English language hasn't been working real well
15 for me in this case.

16 MR. SUMMER: Let's go to the next slide, please? If
17 we could, let's move this up so --

18 Q: Now, I know you heard Mr. Richardson's
19 testimony yesterday regarding this and that
20 it's not his work and that he didn't do it. Do
21 you remember that?

22 A: I do.

23 Q: Okay. There's no way for us to know who did
24 this. But what we do know in terms of
25 testimony is that this has been presented all

1 over Moncks Corner to different groups. You
2 heard that testimony, right?

3 A: Yes, sir.

4 Q: To public leaders, to the Chamber of Commerce,
5 and to their very own Roper Berkeley Board.
6 They have an advisory board. They told their
7 own board this stuff, right?

8 A: Yes.

9 Q: Okay. What relevance -- what relevance does
10 this analysis have to you as a healthcare
11 planner in this case?

12 A: Well, there are two things that immediately
13 stand out. One is if you were going to be
14 putting a hospital in Moncks Corner, why would
15 you select a seven mile radius around the site
16 to define your population. This is obviously
17 a less densely populated part of the county,
18 more rural area. There are clearly communities
19 that it would serve just as the emergency
20 departments at both hospitals are now serving.
21 So doing a seven mile radius around Moncks
22 Corner is simply an improper way to evaluate
23 the potential need for a hospital in Moncks
24 Corner. The second is, there's an assumption
25 in either both the Moncks Corner column or the

1 Carnes Crossroads column that the application,
2 which would be Roper St. Francis Berkeley,
3 whether they chose to be in one location or
4 another, could achieve a 65 percent market
5 share. That's an astounding number for a
6 provider that currently has a share of 23
7 percent. So all redirection language and
8 explanation aside, if they were thinking 65
9 percent market share on a hundred bed hospital
10 in Carnes Crossroads, there's only one possible
11 implication of that. They are out to devastate
12 existing providers because right now 77 percent
13 of the market doesn't belong to them. If you
14 want to get to 65 percent of the market, you
15 are effectively tripling your share and you are
16 doing enormous damage to existing providers.

17 Q: Again, we don't know if this is Mr.
18 Richardson's number -- he says it's not his --
19 or Mr. Bowling's. But is it fair to say that
20 the 65 percent market share is a goal of
21 management?

22 A: It appears to be.

23 Q: Okay.

24 A: Because it's in both columns.

25 Q: So is that good evidence of the intent of Roper

1 Hospital?

2 A: Yeah. I've read that aggressive growth is one
3 of the key strategies of the Roper System.
4 This is aggressive carried to a couple powers.

5 Q: It's predatory, isn't it?

6 A: It is designed to basically take the heart out
7 of existing providers' business in this area.

8 Q: Let's put this in Mr. Richardson's terms.
9 Would that kind of market share at a Carnes
10 Crossroads hospital impair Trident's mission?

11 A: Yes.

12 Q: How?

13 A: It would have an enormous impact, financial
14 adverse impact on the hospital, which would,
15 given that Trident is part of a multi-hospital
16 system where decisions are made about where
17 corporate investments are made, a hospital
18 system that looked like it was beginning to
19 decline because it was losing significant
20 market share to a very aggressive competitor
21 who was getting the benefit of state
22 interpretations of State Health Plan, which
23 appear to me to be utterly inconsistent with
24 what the language says, would be damaging to
25 the future. They would probably be able to

1 find lots of other markets where prospects were
2 better.

3 Q: Now, this may be the intent of management, but
4 did they ever show DHEC these numbers?

5 A: My understanding is no.

6 Q: Okay. You remember the math that I took Mr.
7 Richardson through yesterday and --

8 MR. SUMMER: Let's just leave this up. I think it's
9 important to see.

10 Q: But let's go back to Respondent's Number 70.
11 Do you have that handy?

12 A: I have it.

13 Q: Now, it's convenient because of the ADC
14 calculations, but do you remember I took him
15 over to -- I basically had him calculate for us
16 the number of patient days -- let's talk about
17 this. How would you describe the bed need
18 analysis in Roper's CON application, which is
19 Joint 2?

20 A: It's complicated. It relies on different
21 assumptions than I have traditionally seen
22 which generally relate to population, use
23 rates, market shares, length of stay. This is
24 a mix and match of redirection, market share
25 gains, and out of area that's left

1 indeterminate as to whether that is market
2 share pick up or redirection. There's a lot of
3 guesswork for one in the application, which
4 could explain why Mr. Richardson and Mr. Knapp
5 were not on the same page.

6 Q: If the 65 percent, this aggressive growth
7 strategy that we know that system has embraced,
8 if that is -- if that maximizes injury, if you
9 would, on Trident, would you agree with me that
10 the convoluted need analysis in the application
11 minimizes adverse impact?

12 A: Yes. As the hospital has moved, as Roper has
13 moved forward in their planning -- they had a
14 50 percent market share model, they had a first
15 draft of the application which had, I think,
16 1,380 or 1,390 redirected patients. Now, in
17 this latest version, the one they submitted to
18 the state, they have 1,775 redirected patients.
19 Essentially, as the models have moved forward,
20 there's more and more attempt to argue that
21 they're just serving their own patient
22 population, and they're going to do less harm
23 to others. Because when you get before the
24 state, they have definitions of adverse impact
25 and those definitions include damaging

- 1 hospitals current and projected volume levels.
- 2 Q: Right. There's actually a statutory
- 3 definition. We're going to look at that
- 4 eventually. Mr. Richardson didn't espouse it,
- 5 but we'll look at it in a minute. Let's do
- 6 this. Your prior testimony is, is that the
- 7 contribution margin per case number of 4,985 --
- 8 A: Per adjusted admission.
- 9 Q: -- per adjusted admission, okay, was not
- 10 challenged by the Roper folks in this
- 11 proceeding, was it?
- 12 A: No, Mr. Knapp had a lot of comments about stuff
- 13 I did, but he didn't make any comment about
- 14 that one.
- 15 Q: All right. What I'd like to do and, again, if
- 16 you would pull up Number 70 and if you would go
- 17 to the last page.
- 18 A: I'm there.
- 19 MR. SUMMER: And what I want you to do, if you
- 20 could, on the screen, can you freeze on three
- 21 and four and bring three and four up so that we
- 22 can all see that.
- 23 Q: Do you remember a line of testimony yesterday
- 24 regarding basically extrapolating the total
- 25 number of patient days by using Mr.

1 Richardson's own methodologies?

2 A: Uh-huh (affirmative response).

3 Q: Okay. If we accept what Mr. Bowling and Roper
4 told the public repeatedly --

5 A: Uh-huh (affirmative response).

6 Q: -- regarding what they intended to do at Carnes
7 Crossroads with 65 percent --

8 MR. LONG: Your Honor, I would object to that.
9 That's clearly beyond the scope of the
10 testimony in the case. I mean, that is -- he
11 has no idea what Mr. Bowling told anybody
12 except what Mr. Bowling testified.

13 THE COURT: The question has been withdrawn.

14 MR. SUMMER: I'll withdraw it.

15 MR. LONG: Thank you.

16 Q: If we take that 65 percent that Mr. Richardson
17 discussed with us yesterday --

18 A: Okay.

19 Q: -- and we applied it to get the patient days,
20 if we do likely scenario -- he says, likely
21 scenario, 73 percent market capture. Let's
22 talk about this. What we basically did or what
23 he did yesterday, summarize it for me because
24 I want to ask you some questions about your
25 opinion on it.

1 A: Actually, the approach he takes in scenario
2 three is exactly the approach that I used to
3 calculate adverse impact, which is to take
4 historical market shares, and in this case he
5 looks at -- ignore Roper's business, just look
6 at everybody left in the market. We have
7 Trident, you have Medical University of South
8 Carolina and you have a little bit going
9 elsewhere. Of all the non-Roper patients
10 coming out of Berkeley County, 73 percent are
11 served by Trident or the Trident System. Now,
12 we've heard before Trident has a market share
13 overall of 54 percent. Okay? But that 54
14 percent includes when Roper's part of the
15 picture. You take Roper out and then instead
16 of having 100 percent of the market to divide,
17 you only have the 77 percent that's left after
18 you exclude Roper, and of that 77 percent --

19 Q: Seventy-three percent?

20 A: It's 77. It's 77 percent of the market and 73
21 percent of that 77 percent is what goes, that
22 he assigns to Trident. That's the correct way
23 to do it. That's historical. It is what I did
24 in my adverse impact analysis of Roper St.
25 Francis Berkeley on Trident. So the only area

1 really of disagreement between me and Mr.
2 Richardson is how much Roper volume to assume
3 gets assigned to Roper when you do adverse
4 impact.

5 Q: Okay. Well, if we go back to the slide that
6 was presented with the 65 percent on it, how
7 can you then use number three, likely
8 scenario, to extrapolate those cases?

9 A: Sure. If you look at Roper's current market
10 share of 23 percent, all right, and they're
11 going to have an average -- and they're going
12 to grow that 23 percent into 65 percent in a
13 100 bed facility, all right? That's what they
14 were projecting here.

15 Q: Right.

16 A: That's growth essentially of instead of --
17 essentially 42 percent in market share.

18 Q: New market share?

19 A: New market share. Okay? Forty-two percent in
20 new market share is equivalent in a 100 bed
21 hospital to an average daily census of 42. All
22 right. So if you fill 65 beds, all right, 23
23 of those beds would be filled from essentially
24 Roper's current market share and 42 beds would
25 be taken from others because you'd be growing

1 the market share to 65 percent.

2 Q: Okay.

3 A: Of those 42 days, every day that you're taking
4 from other providers -- not all of them would
5 be taken from Trident. If you divide up
6 between Trident and, say, MUSC, Trident gets
7 about a little less than 31 of the 42, MUSC and
8 other providers get about 11. Okay?

9 Q: Okay.

10 A: All right. So you have an average daily census
11 of 30.7.

12 Q: So what you've done is multiplied what by 42?

13 A: Seventy-three percent.

14 Q: Okay. So you're taking 73 percent of the 42.

15 A: Yeah. Mr. Richardson did that correctly.
16 Between Roper and -- between MUSC -- and, I'll
17 just for convenience say MUSC represents all
18 the non-Trident. Between MUSC and Trident,
19 Trident basically is 73 percent, MUSC is 27
20 percent. So Trident gets the big hit and you
21 have a hit basically of 30.7 average daily
22 census coming out of this hospital. Multiply
23 that by 365 days, it's 11,206 days that
24 Trident would lose, which it would have not
25 lost had the Roper project not been approved

1 and realized this market share.

2 Q: So if we take Roper management's statement of
3 their goal and take Mr. Richardson's
4 methodology, we come up with an average daily
5 census in the new Carnes Crossroads hospital of
6 almost 31?

7 A: Thirty-one from Trident.

8 Q: From Trident. Can you dollarize that for me?

9 A: Sure. I can go to my original adverse impact
10 model.

11 Q: That's in Petitioner's --

12 A: Forty-six, I believe.

13 Q: -- 46. What page do you want to go to?

14 A: It's towards the back.

15 MR. SUMMER: Just pull the last page up. Is that
16 where it --

17 A: If I could have the exhibits, I could give the
18 -- I could tell you exactly what page.

19 Q: Okay.

20 A: Thank you.

21 THE COURT: That's 46?

22 MR. SUMMER: Yes, Your Honor.

23 A: Now, this would be on page 1626 of Exhibit 46.

24 Q: 1626, okay. And what is that?

25 A: Okay. This is our adverse impact model, which

1 basically goes year by year applying what we
2 believe was -- what I believe was the
3 appropriate reduction in Trident System days
4 that would result from the Roper St. Francis
5 Berkeley facility. And my, the way I
6 calculated this was I looked at historic market
7 shares. Trident had basically a 53, 54 percent
8 share, Roper was 23, 24 percent, other
9 providers made up the difference. A little
10 over 20 percent.

11 Q: Okay.

12 A: In other words, if Roper's built, okay, it'll
13 hurt itself by its historic market share, which
14 is 23, 24 percent.

15 Q: Right.

16 A: It'll hurt Trident according to Trident's
17 historic market share, which is 54 percent.
18 That's what produces the number of lost days,
19 6,257, okay?

20 Q: Right.

21 A: Now, if you look down, that produces an adverse
22 impact, just those non-tertiary days, of a
23 little over \$14 million.

24 Q: In year one?

25 A: In year three.

1 Q: Year three, okay.

2 A: If you apply a factor related to the
3 relationship between tertiary and non-tertiary
4 days, you get another add-on of about 15
5 percent that gets you down to 16,595,000. So
6 in essence, if Roper took 6,257 days from
7 Trident, this is the impact. If it takes
8 11,000 days --

9 Q: And, again, that's using management's goal and
10 Mr. Richardson's methodology, right?

11 A: Right.

12 Q: Okay.

13 A: You would then wind up with a number in excess
14 of 29 million.

15 Q: \$29 million. Well, that's substantially larger
16 than what you had predicted, isn't it?

17 A: Correct. Because the model that I used -- Mr.
18 Richardson assumes a third year volume of 35,
19 average daily census of 35. If 54 percent of
20 that is lost to Trident, essentially -- or
21 taken from Trident, that's 18. That's an
22 average daily census of 18. Now we're talking
23 about losing an average daily census of almost
24 31 because the hospital is going to have a much
25 higher market share than I'm assuming.

1 Q: Okay. Well, what if we look at Mr.
2 Richardson's worst case scenario? In other
3 words, take his worst case scenario, which was
4 number four, on his Exhibit 70, and that's a
5 total loss of how many patient days?

6 A: Yeah, 15,330. But I've got to say this. I
7 don't believe under any scenario that all the
8 lost patient days would be coming from Trident.
9 That's unreasonable, all right? I respect the
10 historic market shares, I rely on them. In
11 almost every case I've been involved in in
12 states around the country when consultants
13 calculate adverse impact and they look at
14 historical market shares, I have done nothing
15 different in this case than what I do when I
16 assign impact based on new projects and how the
17 market would have been different in the absence
18 of the project. That's the test, all right?
19 If you didn't have the project, where would the
20 volume grow. Now you have the project, the
21 volume is gone, where did it go to and where
22 has it been taken from, okay? The 100 percent
23 share assumes that the Medical University of
24 South Carolina gets no impact from this,
25 Trident gets all of it. I think that's silly

1 on its face in what Mr. Richardson applied as
2 number four, and it would be kind of a -- not
3 a very worthwhile exercise even for the 65
4 percent market share either.

5 Q: What would the number be?

6 A: It would be about -- it would be in excess of
7 \$40 million.

8 Q: Now, if they had a 100 bed hospital, it might
9 be different, might not it?

10 A: Correct. Now, to say this, though, if they
11 only have a 50 bed hospital, okay, all right,
12 and they got to a volume level of 42, all right
13 -- I believe Mr. Severance was arguing, he
14 thinks 80 percent is easy enough to do these
15 days. That's kind of his target. And
16 obviously they are a larger facility, their
17 target occupancy is 70 percent. I think 84
18 percent's probably too high, but let's say they
19 got enough patients arriving at the door so
20 they could have filled 42 beds using these
21 market share assumptions. Well, if they don't
22 keep all the patients there because it's not
23 appropriate or it doesn't work well, they can
24 move them somewhere. They could send them to
25 Mount Pleasant, they could send them to Roper

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1 Downtown, they could send them to West Ashley
2 to Roper St. Francis Hospital. There's no --
3 the 50 beds is an effective limit in terms of
4 average daily census. It's not an effective
5 limit to the adverse impact that this project
6 could potentially cause.

7 Q: That's a good point. Do you remember Mr.
8 Severance's testimony about what he would do if
9 he had an extra patient?

10 A: If the hospital were full, completely full.

11 Q: And he had an extra patient?

12 A: He said he would not send them across the
13 street to Medical University of South Carolina,
14 he would send them -- he would find an empty
15 bed somewhere else in their system.

16 Q: As a health planner, what's your reaction to
17 that kind of comment from an administrator?

18 A: Well, if the patient is stabilized, you know,
19 maybe there's no potential harm; if that's not
20 the situation, I think you're potentially
21 damaging quality.

22 Q: When you look at this computation of
23 management's goal and Mr. Richardson's scenario
24 number three --

25 A: Uh-huh (affirmative response).

1 Q: -- that \$29 million adverse impact number; is
2 that material?

3 A: Oh, for sure.

4 MR. LONG: Your Honor, I am going to object again.
5 And I just want to be clear for the record. He
6 continues to say management's goal, what Mr.
7 Bowling said and all of that, he's got a
8 PowerPoint with a number on it. That's all
9 that's in the record. I just want to clarify
10 that.

11 MR. SUMMER: I'll withdraw. I'll withdraw.

12 MR. LONG: They're absolutely over the top and have
13 been for at least 15 --

14 MR. SUMMER: I withdraw the question.

15 THE COURT: He's withdrawn the question.

16 Q: Do you consider \$29 million to be a material
17 adverse impact?

18 A: Absolutely.

19 Q: Okay. All right.

20 A: I think \$16 million is material.

21 Q: All right. In light of this information, what,
22 if anything, does that do to validate your
23 prior opinion?

24 A: Yeah. My opinion is that there's a need for
25 one hospital. And if a second hospital comes

1 in, it will basically take volume away from
2 other hospital -- from the other hospital
3 that's trying to meet -- demonstrate a need and
4 is building upon that need, and also that if
5 it's the only provider, based on its location
6 and based on current market shares in the area,
7 will do significant damage to existing
8 providers financially. And, again, adverse
9 impact always has to be weighed against access
10 improvement. And I think the access
11 improvement in the case of where Roper St.
12 Francis has chosen to locate their facility is
13 de minimis. It's not -- this is not a need
14 case based on improved access. It's one based
15 on convenience for patients who have gone to
16 Roper Hospitals in the past. That is not
17 anything that the State Health Plan speaks to.
18 Q: Let's talk a little bit about the various
19 iterations. The first one I want to ask you
20 about is going to be Petitioner's 156.
21 A: Okay.
22 Q: Now, all this prior evidence dealt with before
23 Trident had filed its certificate of need
24 application. Have you got a copy of 156 by any
25 chance?

- 1 A: I don't know. It says 76 to 153 and then 158.
- 2 Q: Here you go?
- 3 A: Thank you.
- 4 Q: All right. Mr. Richardson testified about this
- 5 yesterday. This is the earlier draft of the
- 6 certificate of need application B11. Do you
- 7 recall that testimony?
- 8 A: I do.
- 9 Q: Okay. And I just want to go over -- now, this
- 10 is before it's filed. And I asked him about
- 11 page, it was 4199 at the bottom.
- 12 A: Okay. Give me a second. Okay.
- 13 Q: All right. At this presentation, what's the
- 14 total number of number three of the Roper
- 15 aligned non-tertiary, non-specialty discharges
- 16 that they hoped to redirect?
- 17 A: 1,393.
- 18 Q: 1,393. How does that differ from that CON
- 19 application that was actually filed?
- 20 A: It's 1,775, so it's an increase of 382 or
- 21 almost 30 percent.
- 22 Q: Okay. So had they filed this application, it
- 23 would have shown a greater adverse impact on
- 24 other providers?
- 25 A: Yes. I mean, they're still projecting the same

1 70 percent occupancy in year three, okay? So
2 the difference between the number of discharges
3 required to get to the 70 percent occupancy and
4 the number that they are redirecting, the rest
5 are taken from others. Now, they've always
6 left very vague who essentially is going to --
7 where they're going to get the patients, what
8 they call, out of market. And we don't know
9 how much of that's redirection and how much of
10 that's going to be market share pick up. The
11 only thing certain about redirection are the
12 number they list here, and it's 400 fewer,
13 which means in the next -- there's 400
14 potential cases more adverse impact here with
15 382 than there is in what was submitted in the
16 certificate of need application.

17 Q: Okay. If you go to Joint 2, which is the
18 certificate of need application, I'll turn your
19 attention to page 30.

20 A: Okay.

21 Q: This is what was actually submitted to the
22 Department, right?

23 A: Yes.

24 Q: Okay. And there you see they've increased
25 their redirection number there, haven't they?

1 A: They have.

2 Q: And that further minimizes potential adverse
3 impact by portraying it that way, doesn't it?

4 A: Right. What's happened is now they're looking
5 at Roper St. Francis numbers from the whole
6 county. In the prior scenario, the earlier
7 draft, they looked at Roper St. Francis numbers
8 from within a seven mile radius. They applied
9 the same 50 percent redirection percentage, but
10 it's a smaller pool.

11 Q: Do we really know where these patients are
12 going to come from based on this analysis?

13 A: No. I mean, I think it's a serious shortcoming
14 that there's no zip code analysis here.
15 Remember that Trident applied, they applied in
16 Moncks Corner. I put together a very detailed
17 forecast by zip code. I broke all the zip
18 codes in the Tri-county area into areas where
19 I thought this hospital would attract more
20 patients or fewer patients. And because up
21 around the lake, those patients are the most in
22 need of a new hospital, I assumed what I'll
23 call a high redirection percentage. The zip
24 codes in Charleston County and Goose Creek, I
25 didn't think a lot of patients would be moving

1 north to Moncks Corner for medical care, our
2 redirection percentage was one or two percent.
3 Very important to note this because this has
4 been thrown around, the language, and it's
5 incorrect throughout this trial, that says I've
6 assumed a 100 percent redirection. Not true.
7 What I've assumed is that about on average, 30
8 percent of the Trident patients in the county
9 would be seen at Moncks Corner in the year
10 2017. About almost 7,000 of those patients
11 represents the growth for Trident in that
12 market. This is not simply taking static
13 patient volumes and moving them from A to B.
14 There's growth in Berkeley County. The
15 hospital is being located in Berkeley County,
16 okay? Trident can use its growth in Berkeley
17 County to fill most of the beds it's trying to
18 fill. And the remainder it can fill with its
19 growth from the rest of the market, which is
20 what bed need means. Because Trident Medical
21 Center had a need for 56 beds, not just based
22 on Moncks Corner, partially based on its
23 service in Dorchester, partially based on
24 Charleston and, again, the Berkeley piece is
25 substantial. So, you know, there's talk that

1 somehow I just threw 100 percent redirection.
2 It's mostly growth. That's first. Mostly
3 growth in the county.

4 Q: Is that consistent with the State Health Plan?

5 A: Absolutely consistent with the State Health
6 Plan. And the second is that somehow there's
7 been this comparison that I redirect a hundred
8 percent of Trident volume and Roper's only
9 doing 50. The real numbers are these. Roper's
10 redirecting 50 percent of their patients in the
11 county. Trident is redirecting a drop less
12 than 30 percent of the patients that they will
13 see in the county. Because they see enough
14 patients in the county, that fills the
15 hospital. But that redirection is largely
16 composed of growth in Berkeley County. The out
17 of market is largely going to come, we expect,
18 from Dorchester County, which would be
19 essentially growth supported by Trident growth
20 in Dorchester. And even the Charleston piece,
21 there's growth in the Charleston area. This is
22 a growth model. The hospital is supported by
23 growth in the market. This is not simply
24 saying, I'm seeing 3,000 patients in Berkeley
25 County and they don't want to go downtown

1 anymore, now, they've been bypassing closer
2 hospitals for years, but they don't want to go
3 downtown anymore, so I'm going to put a
4 hospital up and we'll serve them here. That's
5 entirely different from the way we based our
6 model, which was based on Trident System
7 growth, a substantial portion of which is in
8 Berkeley County.

9 Q: What need analysis is more precise, Trident's
10 or Roper's?

11 A: Clearly, a zip code analysis is better. Now,
12 obviously, when you've got to make an
13 assumption for 15 or 20 or 30 zip codes,
14 there's more chance you could be wrong than if
15 you just make one assumption. I told Mr. Long
16 in my deposition, I told him when he was cross
17 examining me, that the 50 percent assumption on
18 redirection in some of the zip codes around the
19 lake, it could be higher. Maybe the 20 percent
20 assumption for zip code 29483 is a little too
21 high. I am absolutely comfortable with the
22 fact that someone could look at those numbers
23 and say it's not going to be exactly what you
24 forecast. I am also a hundred percent
25 comfortable that Trident will be able to fill

1 this hospital with its patients, but needs
2 significant volume coming out of two key zip
3 codes; 29461, the Moncks Corner zip code, which
4 it shares with the Carnes Crossroads hospital,
5 and 29483, which is the cross county zip code
6 in Dorchester and Berkeley, which borders the
7 Carnes Crossroad hospital.

8 Q: Okay. I think the last iteration of need
9 analysis is actually in Respondent's 70, isn't
10 it?

11 A: Yes, sir.

12 Q: Okay. And what's your opinion of this need
13 analysis?

14 A: Well, I think Mr. Richardson ran the numbers
15 correctly, just as I think, you know, Mr.
16 Knapp, when he was looking at my contribution
17 margins, his calculations are okay. I don't
18 disagree with an incremental number of patient
19 days that Mr. Richardson calculated. I think
20 the numbers work. You do get 12,201 days.
21 Unfortunately for him, it doesn't support two
22 hospitals. It supports only one.

23 Q: Okay. And what we really don't know, okay, is
24 where those patients are really going to come
25 from, do we?

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1 A: Yeah. This is critical because at project
2 review and also during this trial we've heard
3 an argument that the two hospitals that are
4 being built, yeah, they're in the same county,
5 yes, they're on the same road, yes, they're in
6 the same zip code, yes, they have the same
7 services, yes, we're going to be competing in
8 the same markets in certain zip codes, but
9 they're really different. One's up north
10 serving Moncks Corner, and the other is in the
11 south serving Goose Creek. Well, the
12 application for Roper no longer relies on seven
13 miles radius. It says it's serving the whole
14 county. All right? We know from the
15 application from Moncks Corner where Trident
16 expects to get its patients. We do not know
17 where Roper expects to get its patients. When
18 it showed its math the other day where it
19 expects to get its patients from, it gets a lot
20 of patients from St. Stephen. I mean, that was
21 one of the, I think, top five zip codes. And,
22 yeah, they get more from Goose Creek. They
23 get more from Moncks Corner. They get more
24 from that 29483 Summerville zip code, which
25 crosses county. But they also get a fair

1 number of patients up north. Well, where are
2 they going to get them from? Where's the
3 adverse impact? Who's going to be impacted?
4 How do they build their model? How can you
5 judge the level of competition between the two
6 hospitals if we don't know where they're
7 getting their patients from? We did hear Mr.
8 Bowling and Mr. Richardson say this is where
9 they're getting them from, we think most of
10 them will be from the south. Well, Moncks
11 Corner is one of the two most important zip
12 codes from this area for Roper. It's one of
13 the two most important zip codes for the Moncks
14 Corner facility. All right. 29483 is one of
15 the three most important zip codes in terms of
16 patient volume for Roper. It's one of the two
17 most important zip codes for Berkeley, for the
18 Moncks Corner facility. To argue that somehow
19 because the hospitals are a few miles apart in
20 different business centers in the county that
21 they're not competitive is utterly unrealistic.
22 Even with higher market shares, the Moncks
23 Corner facility could not be filled with just
24 patients from the zip codes around the lake,
25 okay? It needs some patients from the south.

1 It needs patients from the Moncks Corner zip
2 code, for which it will be competing with them
3 directly now with a hospital in Carnes
4 Crossroad.

5 Q: Turn your attention -- I want to go through
6 about four or five elements or topics that Mr.
7 Richardson mentioned regarding the notion of
8 competing applications. So if you can get your
9 definition in 61-15 out.

10 A: Okay. Thank you.

11 Q: And that, again, is section 103, subsection
12 six.

13 A: Say it again?

14 Q: 103, subsection six. It should be on page five
15 of what you've got there. This again goes
16 under the category -- it's not in the language,
17 but we feel like it's there. Let's start with
18 number one, if it's a transfer it cannot be
19 competing. Now, do you have an opinion on that
20 assertion?

21 A: Say it again. I didn't catch it.

22 Q: Okay.

23 MR. LONG: I just want to clarify for the record
24 that these opinions are as a health planner.

25 THE COURT: As a health planner.

1 MR. SUMMER: Absolutely. So stipulated.

2 Q: You heard Mr. Richardson's comment, it's a
3 transfer so therefore it can't be competing.
4 What's your opinion on that?

5 A: I think that's nonsense. You have to
6 demonstrate need. Even if you follow the logic
7 of the state or the illogic of the state in
8 ignoring the plain language of the transfer
9 section and saying you can do a transfer, you
10 still have to show need at the delivery site
11 where it's being received.

12 Q: That's under paragraph five?

13 A: Paragraph five. So the idea that somehow you
14 get a pass on competing applications when
15 you've got to show that there's enough need for
16 what you're doing with the transfer, and this
17 is the second straight time that Roper's piggy-
18 backed on top of another hospital that had
19 need, to drop a hospital -- to drop beds and a
20 new hospital into a service area. So
21 absolutely they're competing. I mean, they
22 talked about filing a competing application
23 when they met with their own management
24 committee. Now, you know, they come to the
25 state and they say it's non-competing. So we

1 now have something called the non-competing
2 application. But really, it's just a lack of
3 transparency. I mean, having the transfer
4 language does not give you a pass and as a
5 result, you never can be considered as a
6 competing applicant. That's wrong.

7 Q: Because the threshold question is need, isn't
8 it?

9 A: Yes. The whole transfer section again is to
10 distribute assets from where they're no longer
11 needed to where they're needed. Well, show
12 they're needed.

13 Q: And that demonstration hasn't been made?

14 A: Has not been made.

15 THE COURT: Let me ask him a question here, if I
16 may, please.

17 MR. SUMMER: Sure.

18 THE COURT: We're talking about a three county
19 service area. And under Roper's theory of the
20 case, they're not increasing the number of beds
21 in the county.

22 THE WITNESS: I agree with that.

23 THE COURT: Now, square that with what you've just
24 said.

25 THE WITNESS: Sure. The transfer section talks

1 about redistributing beds, okay? So you're not
2 increasing the total supply. However, what's
3 happening is you're taking beds from an area
4 where there's no need and you're -- presumably
5 you're putting them in an area --

6 **THE COURT:** Wait. But remember we're talking about
7 a three county service area.

8 **THE WITNESS:** I understand. But the transfer
9 language speaks about showing need at the
10 receiving facility.

11 **Q:** And that's on the State Health Plan Roman
12 Numeral II-10, number five. That's a
13 requirement.

14 **A:** You've got to show need at the receiving
15 facility. It doesn't say you've got to show
16 need in the Tri-county service area. It says
17 you've got to show need at the receiving
18 facility. So if you accept the transfer
19 language means you can move beds from someplace
20 to a greenfield, under this language, well, you
21 know, that's not how I read it. But even under
22 that sort of notion, which I think's wrong, you
23 still have to show that there's a need for the
24 beds where you're dropping them off. And that
25 cannot be, that cannot be a test of the Tri-

1 county area. It has to be a test for the
2 facility receiving the beds in whatever area
3 its proposing to serve. Because what's the
4 benefit of transfer unless you're taking beds
5 where they're not needed and moving them where
6 they're needed? In other words, to get a net
7 zero, what's the advantage if you move them
8 from an area where they're not needed and you
9 move them to another area where they're not
10 needed? You haven't increased the bed
11 capacity, but the system is now going to have
12 another \$115 million for a duplicative,
13 unnecessary facility because there's not enough
14 need for two 50 bed hospitals in this service
15 area.

16 **THE COURT:** I understand the logic of what you last
17 said and that satisfies me for the time being.
18 Proceed, Mr. Summer.

19 **MR. SUMMER:** Thank you.

20 **Q:** Now, Mr. Baehr, you were just reading from
21 Roman Numeral II-10 the 2008-2009 Plan, which
22 is Joint 4. And that's number five. And would
23 you read it into the record again, please?

24 **A:** Give the page again. I've lost it.

25 **Q:** It's on the screen in front you, if you will?

- 1 A: Okay. "The facility receiving the beds must
2 demonstrate the need for the additional
3 capacity based on both historical and projected
4 utilization patterns." There's nothing in here
5 whatsoever that speaks to Tri-county service
6 area need or county-specific service area need.
- 7 Q: Okay. Now, in going over that provision of the
8 bed transfer section, you're not agreeing that
9 the bed transfer section applies here, are you?
- 10 A: I do not. I think that language does not
11 support what's being done here or in Mount
12 Pleasant or other places where it's been done,
13 Parkridge.
- 14 Q: But in your professional opinion as a
15 healthcare planner, has there been a
16 demonstration of need for capacity at Carnes
17 Crossroads?
- 18 A: No.
- 19 Q: Okay. And has that been -- was there any
20 historical or projected utilization patterns
21 that would demonstrate need at that site?
- 22 A: Yes. You can look at a service area in which
23 these two hospitals will be competing, you'll
24 look at whether there's a need for both of them
25 if they're both added and that's a fairly easy

1 thing to do. There are traditional tests. The
2 State Health Plan lets you know how they
3 determine whether there's growth enough in the
4 market to support additional beds. You apply
5 those tests here. I did it. Mr. Richardson
6 did it. Both of our numbers suggest the growth
7 supports one 50 bed hospital.

8 Q: So what is your professional opinion on whether
9 or not these applications are competing?

10 A: They are competing because they are two or more
11 applicants, same service area, same services,
12 and if both were approved, it would result in
13 unnecessary duplication.

14 Q: It would exceed the need?

15 A: It would exceed the need by one 50 bed
16 hospital, correct.

17 Q: I'm going to try and finish up this section and
18 move on. Another concept that Mr. Richardson
19 embraced was these are two separate parts of
20 Berkeley County therefore, they're not
21 competing. What's your opinion on that?

22 A: I think there are, as Mr. West talked about,
23 there are cultural differences. There are
24 different histories to the southern and
25 northern parts of the county. But both

1 hospitals have identified as their service area
2 the entire county. Both of them rely to a
3 large extent, certainly in the case of Trident
4 where we specified, but if you look at Roper's
5 history, which they say will be their model,
6 even though they refuse to give you any zip
7 code information, they're also relying, to a
8 large extent, on those central zip codes as
9 well as the cross-county zip code. The only
10 one I think that's an important zip code to
11 Roper that we don't believe would be important
12 to Moncks Corner would be the Goose Creek zip
13 code. I don't there's going to be a lot of
14 competition between the two hospitals in the
15 Goose Creek zip code. But there would be a lot
16 of competition between Trident Medical Center,
17 Summerville Medical, but particularly Trident
18 Medical Center and Roper in Goose Creek. It's
19 not as if Goose Creek's not served. I mean,
20 Trident Medical Center is a lot closer to the
21 middle of the town center of Goose Creek than
22 it is to the center of North Charleston. I
23 mean, it is a hospital right on the doorstep
24 of Goose Creek. So, will Moncks Corner be
25 competitive in Goose Creek? No. But Trident

1 certainly is and that's where a lot of this
2 adverse impact's going to come from.

3 Q: Well, wait a minute. I thought the testimony
4 yesterday was that Trident was a Charleston
5 County Hospital?

6 A: That's an absurdity. Charleston serves the
7 county, but the percentage of all patients in
8 the Trident System that come from Charleston
9 County is about ten percent of their total
10 volume.

11 THE COURT: Wait a minute. You said, "Charleston
12 serves the county."

13 THE WITNESS: I'm sorry.

14 THE COURT: Do you mean Trident serves the county.

15 THE WITNESS: My mistake. Thank you very much, Your
16 Honor.

17 A: Trident Health System serves three counties.
18 It has Dorchester and Berkeley between them are
19 close to 85 percent roughly of the volume.

20 Q: For the Trident System?

21 A: For the Trident System. Close to 85 percent.
22 Charleston county, ten, 11 percent depending on
23 the year, the remainder coming from other
24 places. Some of the remainder, they represent
25 a larger share of days than they do of

1 discharges, which makes sense because the
2 tertiary hospital, Trident, they get some
3 patients from out of the area who have longer
4 lengths of stay for more serious cases.
5 Trident Health System's market share in
6 Charleston County is probably in the mid-single
7 digits, okay? It is not a primary competitor
8 in Charleston County. I mean, it is around
9 those two zip codes, right around where the
10 hospital is. But for most of Charleston
11 County, it is not a serious competitor in the
12 Mount Pleasant area, it's not a competitor in
13 West Ashley, it's not a competitor downtown.
14 Yeah, you'll get the isolated patient. It is
15 serving the area it was designed to serve, that
16 very little tip of North Charleston and the two
17 counties, Dorchester and Berkeley.

18 Q: Do you have any concern as a planner that on
19 the one hand Mr. Richardson was saying, this is
20 a Charleston County hospital, yet he had no
21 knowledge of the market share or patient origin
22 in Charleston County?

23 A: I can only speak for what I've said.

24 Q: Okay.

25 A: But, again, to say something like that and not

1 have the backup is problematic.

2 Q: Another aspect of the competing hospital
3 definition and the defense of competing
4 hospitals, was they're small, they're small
5 hospitals, let's don't worry about it, approve
6 them both.

7 A: There is zero in this language that speaks to
8 particular circumstances of the kind that Mr.
9 Richardson raised yesterday. Such as, if the
10 medical staffs don't overlap, then they can't
11 be competing or if they're small, they can't be
12 competing. I mean, those, you know, you can
13 raise an issue every day when you don't have a
14 need case to make. The fact of the matter is
15 the non-compete language is what it is and it
16 speaks to essentially they're serving the same
17 service area, same types of facilities, same
18 services, and it produces -- and do they
19 produce essentially more than is needed? And
20 the answer to that is, yes, in every case.

21 Q: You've read the regulations. Were you able to
22 find a small hospital exception to the
23 competing application?

24 A: I was not.

25 Q: Okay. The next thing he testified about was

1 this notion of if you're going to redirect
2 patients; you're not going to be competing,
3 okay. Do you agree with that?

4 A: No.

5 Q: Okay. And why?

6 A: First of all, the redirection assumption is
7 potentially a very self-serving assumption,
8 okay? If you're a hospital that has no need in
9 your system and you're trying to use the
10 transfer application to move into an area where
11 another system has need and they're trying to
12 use that need and build a facility, okay, and
13 you come in and say, well, I'm not going to do
14 any harm or I'm not going to do much harm
15 because I'm basically just taking care of my
16 own patients, well, that doesn't mean,
17 especially in this case where they say they're
18 still relying on about, I think Mr. Knapp's
19 assumption was 50 percent incremental patients,
20 which means half the hospital is supposedly
21 being taken from other hospitals in the absence
22 of this facility, all right, that's certainly
23 competition. What if their redirection number
24 is too high? What if it only is their
25 historical share? In other words, they're only

1 going to take 23, 24 percent from themselves
2 and they'll take 54 percent from Trident and 23
3 or 20-whatever percent from MUSC and the
4 others, which is what their history is, the
5 best guide to what will happen, not a string of
6 changing assumptions made in different
7 presentations and different applications all
8 designed to eventually come up with a larger
9 amount of redirection and a smaller amount of
10 adverse impact, that's why I trust the history
11 more than I do what you see in the application.
12 And I will say this. In the exhibits I
13 presented in this court, I calculated not only
14 adverse impact of Roper on Trident, I
15 calculated adverse impact of Trident on others,
16 all right? I did it fairly. Now, Trident
17 doesn't have as much impact because the others
18 have smaller shares. Another hospital's,
19 approved they have a bigger impact because
20 Trident has a bigger share. But I try to be
21 consistent when I'm doing that kind of analysis
22 if it's, you know, one hospital's approved and
23 you ask me to do adverse impact, that's the way
24 I'll do it. Redirection simply doesn't remove
25 you from the equation, just as the transfer

1 doesn't remove you from the competing section.

2 MR. SUMMER: Your Honor, this is probably a good
3 place to break for lunch.

4 THE COURT: Very Well. It is agreeable with all
5 that maybe we shorten the lunch period by 30
6 minutes? Will an hour give you enough time to
7 eat without indigestion?

8 MR. SUMMER: Yes, sir.

9 THE COURT: Well, what time do you have?

10 MR. SUMMER: I've got about 1:15 so we'll be back at
11 2:15?

12 THE COURT: We'll be back at 2:15. Recess until
13 2:15.

14 MR. SUMMER: Thank you, Your Honor.

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

16 THE COURT: Mr. Summer.

17 MR. SUMMER: Thank you, Your Honor.

18 Q: Next what I'd like to do is turn your attention
19 to the Roper DHEC record, Joint 2. And if you
20 would, turn over to page 1107. Now, you recall
21 Mr. Richardson's testimony that the Plan was --
22 excuse me -- that the application was compliant
23 with the Plan and the regulations. Do you
24 recall that?

25 A: Yes, sir.

1 Q: Okay. What is this letter right here, 107 and
2 108?

3 A: I guess it's called a complete letter.

4 Q: Okay. And it --

5 THE COURT: 107 or 1107?

6 MR. SUMMER: 1107 and 1108, Your Honor, of Joint 2.

7 Q: The criteria that's listed on 1108, what's
8 their relevance?

9 A: It's basically these are the criteria that the
10 state will use to measure the project as to
11 whether it's in compliance or not and whether
12 it should be approved.

13 Q: And I think we've already --

14 A: The other is there's a ranking. And as I read
15 this, at the bottom of 1007 it says, "These
16 criteria are ranked according to their relevant
17 importance with the most important being listed
18 first. All other relevant criteria will be
19 given equal importance." Which I take to mean
20 number one matters the most and two through
21 five matter equally.

22 Q: Okay. Let's talk now about compliance with the
23 State Health Plan. That's number one.

24 A: Okay.

25 Q: You would agree with me that we've kind of

- 1 plowed that ground already, wouldn't you?
- 2 A: Yes.
- 3 Q: All right. And if we're looking at the Roper
- 4 St. Francis application, let's go to -- what
- 5 I'd like to do is we're going to start going
- 6 through these regulations, okay?
- 7 A: Okay.
- 8 Q: And let's go next to number one. And that'll
- 9 be in 61-15?
- 10 A: Okay. Can you give me a page number or
- 11 section?
- 12 Q: Sure. It's going to be 802 and it's going to
- 13 be -- I'll start on page 23.
- 14 A: Twenty-three of the regulations?
- 15 Q: Right.
- 16 A: Okay. I see the page now. I've got it. Okay.
- 17 Q: All right. So the first thing the Department
- 18 says they're going to look at is compliance
- 19 with the State Health Plan. Is there anything
- 20 else you want to add in response to Mr.
- 21 Richardson's testimony regarding this point as
- 22 to Roper?
- 23 A: No. I think it's either in compliance or it's
- 24 not and my view is it's not.
- 25 Q: Okay. For reasons you've previously covered?

1 A: Yes.

2 Q: Okay. Let's start, look next at community need
3 documentation, 2(a). If you would read that
4 into the record?

5 A: 2(a)?

6 Q: Yes, sir?

7 A: The target population should be clearly
8 identified as to the size, location,
9 distribution and socioeconomic status if
10 applicable.

11 Q: Okay. Did Roper achieve this?

12 A: In part. In the application they say that
13 their service area is Berkeley County, and they
14 then identified a subset of residents or
15 patients within the county who are a primary
16 target of the project, that population being
17 existing Roper patients, what they call Roper
18 aligned patients.

19 Q: Did they clearly identify these patients?

20 A: No, because I don't think Roper aligned
21 patients is actually a meaningful term in terms
22 of the State Health Plan for demonstration of
23 community need. It's a shifting group from
24 year to year, and I think the testimony of Mr.
25 Richardson is that nobody's in a frequent

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1 hospital club. You know, some patients are
2 Roper patients one year, some may be another
3 year. You know, no one, you know, wears a t-
4 shirt, I don't think, that says they're in or
5 they're out.

6 Q: Okay. In your profession as a health planner,
7 how do people usually identify that target
8 population?

9 A: Well, they usually identify an area that
10 they're serving and it's usually the entire
11 area, not usually just a subset of the
12 population.

13 Q: Okay. Is this where zip code analyses come
14 into play?

15 A: Yeah. But it's -- even if you did the county
16 population, you say it's the whole county is
17 your target, as opposed to a subset of the
18 county, meaning those patients who have
19 historically had any affinity for the Roper
20 System. But if you do it by zip code, if it's
21 not going to be equal draw from all the zip
22 codes in the county, all parts of the county,
23 that's helpful to know, especially since this
24 was the second application in the cycle. We
25 knew where the Moncks Corner facility was --

1 where they expected most of their patients. It
2 would have been useful, I think, for this
3 hospital to do the same.

4 Q: Okay. Look at 2(b) --

5 A: Uh-huh (affirmative response).

6 Q: -- projections of anticipated population
7 changes should be reasonable --

8 A: Uh-huh (affirmative response).

9 Q: -- and based upon accepted demographics,
10 statistical methodologies, or assumptions and
11 methodologies clearly presented in the
12 application. The applicant must use population
13 statistics consistent with those generated by
14 the state demographer and the State Budget and
15 Control Board. What, if any, opinion do you
16 have on this?

17 A: I think they did okay on that.

18 Q: Okay. Let's go to 2(c). Proposed projects
19 should provide services that meet an
20 identified, documented need of the target
21 population. The assumptions and methods used
22 to determine a level of need should be
23 specified in the application and based on a
24 reasonable approach as judged by the reviewing
25 body. Any deviation from the population

1 projection used in the State Health Plan should
2 be explained. Now, what's your opinion
3 regarding their ability to meet this criteria?

4 A: I don't think they meet up on this one. The
5 identified need of the target population is
6 going to be a need based on a growth model or
7 an identified subset of the population for
8 which there is an identifiable access issue,
9 whether geographic or financial. I don't think
10 they've met that test.

11 MR. LONG: Your Honor, I'm going to have to object
12 to this line of questioning. This is clearly
13 just a rehash of his testimony from a week and
14 a half ago. I mean, Mr. Richardson did not go
15 through all these criteria like this
16 individually and he's just asking him, pull the
17 criteria up. He's not responding to Mr.
18 Richardson. He's just testifying to the same
19 stuff he testified a week and a half ago.

20 MR. SUMMER: May I respond, Your Honor?

21 THE COURT: Yes, sir.

22 MR. SUMMER: Several observations. First is counsel
23 is right. Mr. Richardson really didn't look at
24 regulations or the State Health Plan. His
25 entire testimony was based on, in Trident's

1 opinion, things he created or made up. What
 2 we're doing is we're going through what DHEC
 3 said were the rules that should be followed and
 4 applied. He had a cursory statement at the end
 5 of his testimony that they're compliant with
 6 the Plan and meet the requirements and the
 7 regulations. Well, our position is -- we're
 8 using this information twofold. One to say is
 9 that this, you know, these rules according to
 10 Roper or Richardson, these ethereal rules,
 11 don't exist. What do exist are what DHEC said
 12 should be reviewed, all right? And number two
 13 is, to his cursory comment as oh, oh, yeah, we
 14 complied with all of that, we're going through
 15 step by step on what DHEC said should be the
 16 analysis to show that, no, Mr. Richardson is
 17 wrong, that is not what occurred.

18 **MR. LONG:** He's clearly doing the case over again,
 19 Judge. Mr. Richardson could have been asked
 20 about all of this on cross examination. He
 21 wasn't. And, you know, the DHEC witnesses were
 22 called in their case. Mr. Baehr testified
 23 after the DHEC witnesses and this whole line of
 24 questioning -- if he's going to walk him
 25 through the regs just like the -- I mean, he

1 just said, what do you think? What do you
2 think? That's not a rebuttal going on here.

3 THE COURT: I warrant there's some redundance. But
4 Mr. Richardson's testimony generally touched on
5 this sort of subject and I'm going to allow it
6 so you're overruled.

7 MR. SUMMER: Thank you, Your Honor.

8 Q: Let's see where we were. We were on 2(c). And
9 did Roper meet this or not meet it?

10 A: Again, I don't think they did a very good job
11 on this.

12 Q: Okay. And why is that?

13 A: 2(c)?

14 Q: Yes.

15 A: Yeah. Because their targeted population is a
16 subset of the entire population and as need is
17 defined in the State Health Plan, I don't think
18 accommodates aligned patients of an individual
19 facility. It's not hospital specific in terms
20 of need for a service area.

21 Q: Okay. Let's take a quick look at 2(e).
22 Current and projected utilization should be
23 sufficient to justify the expansion or
24 implementation of the proposed service. Did
25 they meet this criteria?

1 A: Well, they provided a projection that gives
2 them adequate occupancy. It relies on
3 redirection of existing patients and market
4 share gains from others.

5 Q: Okay. All right. Do you believe that it's
6 sufficient enough to -- for it to create need
7 for a new hospital?

8 A: No. I don't think the ability to fill up beds
9 is proof that you have need for a project. If
10 you're serving a growing population, if you are
11 addressing a particular access issue in a
12 service area, that's one thing. Convenience,
13 I don't think, falls under this.

14 Q: Okay. And let's go next to 3(a) in the DHEC
15 record. 3(a) is distribution and
16 accessibility. First of all, in your mind as
17 a planner, what does this notion of
18 distribution and accessibility mean?

19 A: Well, the first sentence basically tells you
20 that this is to, as the certificate of need law
21 itself, is designed to avoid unnecessary and
22 costly duplication. So if you have a project,
23 and there are lots of worthy projects, you have
24 to -- it has to be justified. Not all projects
25 are, obviously, going to be justified.

1 Q: All right. So as to 3(a), was this unnecessary
2 duplication?

3 A: I believe it's unnecessary. I don't think
4 there's a need for this project as well as the
5 Moncks Corner project.

6 Q: Okay. Let's next go to 3(b), please.

7 A: Uh-huh (affirmative response).

8 Q: A service should be located so that it may
9 serve medically underserved areas or an
10 underserved population segment and should not
11 necessarily duplicate existing services or
12 facilities in the proposed service area. What
13 is your opinion as to Roper's ability to meet
14 that requirement?

15 A: Yeah. I think that where they've located their
16 facility is clearly duplicative of existing
17 services that are being provided by existing
18 hospitals. And, you know, there is a medically
19 underserved population in the Goose Creek area
20 and pretty much every part of the state, pretty
21 much every part of the county and probably most
22 every part of the state. The question is
23 whether where this facility is located they're
24 providing any new service to that population
25 and whether this project, which is an expensive

1 project, addresses the needs of that
2 population which right now does not have good
3 access. And I think in that they fail.

4 Q: Okay. Take a look at (c) and see if it applies
5 or if you have an opinion regarding (c)?

6 A: Yeah. I'm not concerned about that.

7 Q: Okay. Go next to (d)?

8 A: Which one?

9 Q: (d), 3(d), which would be the proposed facility
10 should not restrict admissions. Do you have --

11 A: I think they're fine on that.

12 Q: Okay. 3(e), the applicant must document the
13 means by which a person will have access to its
14 services?

15 A: I think that's fine. I don't have any problem
16 with it.

17 Q: All right. 3(f), the applicant should address
18 the extent to which all residents of the area,
19 in particular low income persons, racial and
20 ethnic minorities, women and elderly,
21 handicapped persons and other medically
22 underserved groups are likely to have access to
23 those services being proposed?

24 A: Yeah. I mean, there's language in the
25 application that they'll address these issues.

1 But the location is certainly not the ideal
2 location to serve the populations most in need
3 who have geographic and financial access issues
4 now.

5 Q: Where are those populations?

6 A: Primarily in the northern parts of the county.

7 Q: Moncks Corner and beyond?

8 A: Correct.

9 Q: Okay. Let's go next to financial feasibility,
10 number 15. The applicant must have projected
11 both immediate and long-term financial
12 feasibility with the proposal. Such
13 projections should be reasonable and based upon
14 accepted accounting procedures. First, I want
15 to ask you, have they met the requirement to
16 show this to DHEC?

17 A: Well, I don't think they showed enough and I
18 think the level of information they provided
19 was inadequate for a determination to be made
20 by the Department. But as I said earlier, if
21 you look at the full venue numbers, even if you
22 disagree or quibble with an assumption or two,
23 I don't have a concern as to whether they'll
24 make money by the third year.

25 Q: And your adverse impact analysis shows they're

1 going to be making money?

2 A: Yeah. Though adverse impact is based off of
3 really what impact they have on existing
4 providers based on their contribution margin.

5 Q: All right. Let's go next to acceptability,
6 which is 4(a).

7 A: 4(a)?

8 Q: 4(a), the proposal and applicant should have
9 the support of affected persons including local
10 providers and target population. A lack of
11 opposition should not be considered support for
12 the purposes of the criteria.

13 A: Okay.

14 Q: What's your opinion regarding their ability to
15 meet that criteria?

16 A: I think again they satisfy in part. There's
17 clearly community support in the Goose Creek
18 area. There are physicians who are supportive
19 of the project. There are two local hospitals
20 that did not support the project, who did
21 support the Moncks Corner project. That is, I
22 think, a somewhat significant issue.

23 Q: Okay. What is the relevance of MUSC giving a
24 letter of support to Trident but declining to
25 give that letter of support to Roper?

1 A: Yeah. I don't know the whole history, the
2 interaction between the hospitals, so I can't
3 speculate about that. What I can say is that
4 the MUSC market share in Berkeley County is not
5 dissimilar from Roper's. It's a little bit
6 less. Some parts of the county it's higher,
7 some parts it's lower. If there's one new
8 provider or two new providers, they will
9 probably have adverse impact on MUSC's volume
10 in the county. The fact that they're
11 supporting one applicant at one location but
12 not another applicant at a second location I do
13 think is meaningful.

14 Q: Okay. And what, if any, relevance does the
15 East Cooper letter of support have?

16 A: Well, I think the same. East Cooper clearly
17 has less overlapping with the service areas
18 that these hospitals are proposing. It's a
19 little bit on the eastern part of Berkeley
20 County. I mean, East Cooper obviously has some
21 experience with the Mount Pleasant facility and
22 Roper so they're more direct competitors. But,
23 again, it's -- a hospital that's built in
24 Berkeley County will have some impact on the
25 facilities in the Mount Pleasant area because

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1 there is an overlap area in that eastern part
2 of Berkeley county, which can be attracted to
3 patients in Mount Pleasant or it can be
4 attracted to patients in hospitals in Berkeley
5 County. And the fact that they're willing to
6 support one of them is, again, I think a
7 positive sign for that applicant.

8 Q: (b) would be, where documented opposition
9 exists to a proposal, such opposition will be
10 considered along with the application. Was
11 there opposition to the Roper application?

12 A: Well, clearly the Trident System has a major
13 problem with it. And it appeared that the
14 Medical University of South Carolina actually
15 composed a letter and explained that they --
16 they could have just taken a pass and ignore
17 something, but they actually wrote a letter and
18 said they were not --

19 MR. LONG: I object, Your Honor. There's no letter
20 in the record from MUSC opposing the location.

21 THE COURT: I agree with that. I don't remember any
22 opposition letter.

23 Q: Well, let me ask you about opposition in
24 general. Do you believe that the Department
25 sufficiently considered Trident's opposition?

1 A: Trident's opposition?

2 Q: To Roper.

3 A: They considered the argument that I made at
4 project review, that I followed up with in
5 letters, about the financial impact of having
6 two hospitals being built, how it would ensure,
7 I thought, that both of the hospitals would
8 fail to meet their goals and as a result would
9 not, you know, be feasible under the DHEC
10 standards in terms of showing improving
11 performance, and showing positive bottom-line
12 within a reasonable period of time. I didn't
13 see any -- in fact, I believe I heard Ms.
14 Brandt's testimony that she may not have
15 actually fully understood what I was saying in
16 my letter, but --

17 MS. BIGGERS: Objection, Your Honor. I think that
18 mischaracterizes the evidence in the record.

19 MR. SUMMER: Your Honor, the evidence, as I recall,
20 is that she acknowledged that she did not
21 understand what the term contribution margin
22 was at the time. She didn't know what the word
23 meant nor was she sure about what adjusted
24 admissions meant. And that was clearly
25 established in my examination of that witness.

1 So I think he's spot-on with his recollection.

2 **MR. LONG:** Well, the actual evidence and testimony
3 by Ms. Brandt was that she did consider what he
4 proposed at project review, that's what he's
5 talking about. He didn't give any of that
6 information to the Department at project
7 review. He dumped it on them two to three days
8 before the decision was due to be made. And so
9 her testimony was she did consider it. She
10 absolutely testified that she considered
11 everything that was presented at project
12 review. She just rejected it for plenty of
13 good reasons which we went through on cross and
14 will do again if we need.

15 **MR. SUMMER:** I don't doubt that she testified that
16 she considered it. His comment was I don't
17 believe she understood it. And so --

18 **THE COURT:** What was your question to him?

19 **MR. SUMMER:** My question to him was whether or not
20 he thought the Department had adequately
21 considered Trident's opposition or properly
22 considered Trident's opposition. His testimony
23 was, no. And one of the points he made that
24 they objected to --

25 **THE COURT:** Well, when you say Trident's opposition

1 --

2 MR. SUMMER: To Roper's application.

3 THE COURT: Okay.

4 MR. SUMMER: And his comment was, no, that he didn't
5 believe they did. And he said, and I do not
6 believe she understood the opposition. That's
7 clearly based upon him sitting in here and
8 listening to her testimony. If she does not
9 understand what the term contribution margin
10 meant, the whole adverse impact analysis that
11 he gave to her fell on deaf ears. And I think
12 that's clear in the record because she said,
13 no, I did not understand it. She said that.

14 MS. BIGGERS: Your Honor --

15 MR. LONG: Your Honor --

16 MS. BIGGERS: -- I disagree. She did not say that.

17 MR. LONG: And it's bad enough that Mr. Summer is
18 giving a closing argument on every question in
19 rebuttal, because it's incredibly unfair to the
20 Respondents because we have no ability to call
21 witnesses. We can only cross examine Mr.
22 Baehr. I understand Your Honor's got
23 discretion with regards to the scope of how
24 it's going to go, but that's what's going on
25 today. Because he's making -- he's making all

1 of these comments because he's asking the
2 questions incorrectly. He's either asking them
3 with inflammatory comments before he asks the
4 actual question or he asks a leading question
5 like that one. The whole problem with this
6 exchange right here is because the question is
7 improper. He should have lead in him down and
8 asked him what should Ms. Brandt have
9 considered and lead him in, let him talk, not
10 the lawyer. And that's what's been going on
11 all day today.

12 **THE COURT:** Well, that should be your objection
13 then.

14 **MR. LONG:** Well, that is now.

15 **MS. BIGGERS:** I agree with that objection and think
16 that it's a fundamental unfairness to allow it
17 to continue.

18 **MR. SUMMER:** Perhaps I should rephrase the question,
19 Your Honor.

20 **THE COURT:** Rephrase your question in a non-leading
21 manner.

22 **MR. SUMMER:** Okay.

23 Q: What is your opinion on whether the Department
24 adequately considered Trident's opposition to
25 Roper?

1 A: I don't believe they adequately considered it.

2 Q: And why?

3 A: Well, there are arguments that were made, what
4 I'll call qualitative arguments. And there
5 were arguments that were made that were
6 financial arguments. The qualitative
7 arguments, which are fairly straightforward in
8 the letter and are also part of my
9 presentation, oral presentation at project
10 review, had to do with whether there is enough
11 utilization need for two hospitals, why two
12 doesn't work, why two will do damage
13 essentially to the ability of either to
14 succeed. I've also provided, you know, some
15 numbers that -- in a slide, actually, at
16 project review. So this was in late May,
17 third, fourth week, well more than a month
18 before the decision was made. Now, you know,
19 I am aware that Mr. Knapp and I, to some
20 extent, speak in a different language when we
21 do this kind of stuff, and it can be complex,
22 confusing for lay people, a lot of the
23 terminology and the rest, but those were big,
24 big adverse impact numbers that were presented
25 at project review. And from my perspective, to

1 simply dismiss them without making sure that
2 one understands what's behind them, and if
3 someone says that contribution margin, adjusted
4 admissions are not concepts they're
5 particularly familiar with, I don't see how
6 it's possible to have really considered what I
7 submitted or said.

8 Q: Thank you. Now, let's move on to 4(c). I
9 don't think this really -- both applicants
10 showed transfer agreements, didn't they?

11 A: 4(c)?

12 Q: Yes.

13 A: Yeah, I don't have any problem with that.

14 Q: Let's next go to a more important issue, which
15 is 23(a).

16 MR. SUMMER: Can we put 23(a) up and highlight that,
17 please?

18 Q: What is 23(a)?

19 A: Adverse impact on other facilities.

20 Q: Okay. Would you read that definition?

21 A: Sure. In (a), 23(a)?

22 Q: Yes.

23 A: The impact on the current and projected
24 occupancy rates or use rates of existing
25 facilities and services should be weighed

1 against the increased accessibility offered by
2 the proposed services.

3 Q: Okay. Now, just to put this into context,
4 okay? There's also a relevant part of the
5 State Health Plan here --

6 MR. LONG: Your Honor, I object. He can't put stuff
7 in context, okay? This has been going on all
8 day long. He needs to ask questions to the
9 witness and elicit answers and quit giving
10 commentary like, most important or this is
11 really a big deal or can you believe that or
12 sigh, or whatever else he's doing today. He's
13 doing everything he can to make his closing
14 argument to the court. It's inherently unfair
15 to the Respondents.

16 THE COURT: That's a proper objection and I sustain
17 it. Don't -- other than laying a foundation,
18 which you must do by proper questions.

19 Q: If you would, please turn to Roman II-9 in the
20 2008-2009 State Health Plan, Joint 4.

21 A: Joint 4? Okay. Number 4. Okay.

22 Q: And I want you to turn to page II-11, please.

23 A: I have it.

24 Q: First let's talk about the regulation that's up
25 on the board, okay? Which is -- you've just

1 read it.

2 A: Correct.

3 Q: Adverse effects on other facilities, which is
4 one of the criteria that DHEC said they were
5 going review this by, right?

6 A: Correct.

7 Q: And it states, the impact on the current and
8 projected occupancy rates or use rates of
9 existing facilities and services should be
10 weighed against the increased accessibility
11 offered by the proposed services.

12 A: Correct.

13 Q: Okay. First, how does this comport with the
14 various definitions of adverse impact that were
15 espoused by Mr. Knapp and Mr. Richardson?

16 A: Well, Mr. Richardson and -- Mr. Knapp basically
17 says, for the purposes of adverse impact, he
18 relies on Mr. Richardson and he has calculated
19 it. So he's given an impact number in terms of
20 cases and he makes a calculation and that's the
21 role he has. So he doesn't, per se, define
22 adverse impact from a planning perspective.
23 Mr. Richardson did say something yesterday
24 which caught my attention when he said that
25 from his perspective, adverse impact means

1 you're less well off than you are now. In
2 other words, take your current volume and if
3 you lose something off of your current volume,
4 that's adverse impact. And I think that
5 definition may have been one, as I understand
6 Mr. Richardson from reading his deposition,
7 actually I attended it, was a judge in a
8 Florida case had used, had accepted that
9 definition. It's clearly not the definition in
10 South Carolina.

11 Q: What does the word projected mean in that
12 definition?

13 A: Projected means you have to look at growth and
14 there's an impact if you take someone's growth
15 away.

16 Q: That is the definition in South Carolina?

17 A: Right. Remember, again, that the State Health
18 Plan projects future volume. They use that to
19 determine whether there's a need for additional
20 beds at individual facilities, the bed needs
21 created by your current volume and your
22 projected volume. So the impact on current and
23 projected are both important if a hospital
24 undertakes a project in accordance with
25 projected need, which is a factor, which is a

1 product of current utilization and future
2 utilization, and it's impacted by another
3 provider, that is adverse impact. It's not
4 just on current volume. It's on projected
5 volume.

6 Q: As a health planner, what is more relevant to
7 you and your opinions in this case, the
8 Regulation 23(a) or the various definitions
9 espoused by Roper's experts?

10 A: I think the Regulation, in effect, 23(a) as
11 well as the language of the State Health Plan
12 is what should be followed.

13 Q: Okay.

14 MR. SUMMER: Now, if we could, put Roman Numeral II-
15 11 of the '08-'09 Plan on the board.

16 A: II-11?

17 Q: II-11.

18 A: Okay.

19 Q: Okay. What I want to ask you is when you look
20 at the last sentence there on that page, see
21 that?

22 A: Yes, sir.

23 Q: The benefits of improved accessibility will be
24 equally weighed with the adverse effects of
25 duplication in evaluating certificate of need

1 applications for these beds. Do you see that
2 sentence?

3 A: I do.

4 Q: Okay. Very carefully, I want to ask this
5 question. What, if any, relevance does that
6 have to your opinion of adverse impact in this
7 case?

8 A: Yeah. I think in the case of Trident it weighs
9 heavily in favor of approval of the project in
10 Moncks Corner. And in the case of the
11 application at Carnes Crossroad, that it would
12 read negatively, that the adverse impact is
13 more severe than what I think are fairly
14 minimal improvements in access that are
15 generated by that project.

16 Q: Okay. What, if any, relevance to the reference
17 of 30 minutes in this particular section of the
18 State Health Plan, what, if any, relevance does
19 that have to your opinion about accessibility
20 in this case?

21 A: Yeah. I prepared a number of tables and maps
22 demonstrating where there would be an
23 improvement in access for those who were
24 currently now not within 30 minutes of a
25 facility, at either the proposed Moncks Corner

1 facility or the facility that Roper's proposing
2 in Carnes Crossroad. And I thought -- think
3 the differences were fairly stark in terms of
4 where there was significant access improvement
5 and where there was substantially less.

6 Q: Okay. What does it mean that the benefits of
7 improved accessibility will be equally weighed
8 with the adverse effects. What does that --

9 A: Well, it means essentially you have to measure
10 both. Is the access a very strong case? Are
11 they doing something really significant? Or is
12 the access improvement fairly modest? All
13 right? On the adverse impact, is it a small
14 number or is it a big number? If you have big
15 improvement in access, small adverse impact
16 calculation numbers, a small financial impact,
17 that's a fairly easy call. If you have an
18 improvement in access and you have adverse
19 impact, it becomes a tougher choice. And I
20 personally think the case I was in six years
21 ago with the open heart case was closer in
22 terms of weighing and balancing those.

23 Q: What, if any, opinion do you have on whether or
24 not Roper's application improves access?

25 A: I think it has a very modest improvement of

1 access. By the calculations I did, if the
2 Moncks Corner facility is approved and
3 established, which adds about 30,000 people in
4 the northern part of the county, bringing them
5 better access than they had before, bringing
6 them within 30 minutes drive time where they
7 didn't have it before, what extra benefit do
8 you get from now adding Roper St. Francis
9 Berkeley in Carnes Crossroads to the mix?
10 Another 940 people. That, to me, is truly what
11 I guess Mr. Knapp would call very modest.

12 Q: Let's talk about the adverse impact. How would
13 you categorize the degree of adverse impact in
14 this case?

15 A: Right. Well, the adverse impact is what I
16 calculated. And what I've calculated is based
17 on the application that was submitted. It's
18 not based on anything else. It's based on the
19 application that was submitted, not the prior
20 draft. It is what was in the application. And
21 it assumes the historical distribution of
22 cases. So if Roper has a 24 percent share,
23 they can absorb 24 percent of the impact of
24 their project.. In a sense, that's a
25 redirection to their own project. Trident gets

1 hit by whatever their market share is, 53, 54
2 percent; other providers, including Medical
3 University, for whatever their share is. That
4 is the historical approach. It is the only
5 approach that avoids the potential bias of
6 either being an applicant or being an opponent.
7 I wouldn't argue -- for instance, Mr.
8 Richardson had a slide where he said, and then
9 we could assume 100 percent impact on Trident.
10 That's wrong. It's not going to be 100 percent
11 of all the adverse impact that occurs is not
12 going to come at Trident's expense. At the
13 same time, if you have an applicant saying,
14 well, half my patients are redirected, don't
15 worry about them, you're only going to have
16 adverse impact on the rest, well, that's that's
17 not, I think, an ideal way to make the
18 calculation. I think the calculation should
19 reflect the historic shares and that's the way
20 I've done it. And, again, I've done it both
21 ways. Roper on Trident, Trident on Roper.

22 Q: Do you agree with Mr. Richardson that
23 historical performance is an indication of
24 future events?

25 A: Yes. Again, trends can change, patterns can be

1 different, but if you're going to predict, if
2 you're going to make projections, you try to
3 get the history and you try to get the trend.
4 Those are the two things you have working at
5 your disposal.

6 Q: Was redirection one of the theories in the
7 Mount Pleasant case?

8 A: Yes, it was.

9 Q: How is that working? How is redirection
10 working there?

11 A: Again, it's early. I think they're in the
12 fourteenth month and the data I've seen is
13 through about ten months, I think. So far it
14 appears the redirection part is not working, at
15 least not on the inpatient side.

16 Q: All right. Let's go now -- first of all --

17 MR. SUMMER: Yeah. That's fine. Go ahead and go to
18 the last criteria DHEC identified, which is
19 distribution, number 22. Can you pull that up
20 and highlight it, please?

21 Q: The existing distribution of health services
22 should be identified and the effect of the
23 proposed project upon that distribution should
24 be carefully considered to functionally balance
25 the distribution to the target population.

1 A: Uh-huh (affirmative response).

2 Q: What, if any, relevance does this have as to
3 your opinion regarding the Roper application?

4 A: Again, the Roper application was the second one.
5 in a cycle and the proposed distribution that
6 they had in their application would serve, I
7 think, to have a significant impact on the
8 existing market and a negative impact,
9 particularly on the ability of another
10 applicant in the cycle, which is targeting and
11 would, if successful and built, have a very
12 positive impact on improving access. So the
13 concept of distribution to have your assets
14 essentially to move things to the right places,
15 be efficient with your assets, I don't have a
16 big problem with that. But if you create
17 unnecessary duplication, if you create more
18 facilities than are needed, you add an
19 unnecessary \$115 million to the healthcare
20 system for a second 50 bed hospital when
21 there's need for only one, that's not serving
22 any useful purpose just because you moved beds
23 out of a facility that shows no need.

24 Q: Okay. I want to stay on this concept, talk
25 about another Roper exhibit and what Mr.

1 Richardson talked about.

2 MR. SUMMER: If we could, let's take just the
3 Berkeley and Tri-county area. That's good.
4 Pull that up.

5 Q: Let's take a look at that. When I look at this
6 rule that you just read, the existing
7 distribution of health services should be
8 identified. You heard all of the testimony
9 yesterday about Berkeley, Berkeley, Berkeley,
10 right?

11 A: Correct.

12 Q: Does this identify existing resources in
13 Berkeley County?

14 A: No.

15 Q: Okay. What's wrong with the whole concept of
16 that?

17 A: Well, there is a hospital that is within a mile
18 of the county. It serves -- that serves a
19 significant part of the population of that
20 county which is now seeking hospital services
21 and was built and designed to serve the
22 population of that county. So the concept that
23 Berkeley has nothing, I think, is just
24 inappropriate. It's wrong.

25 Q: Okay. So if we're going to identify the

1 existing services in the area, is this a better
2 map to look at? What's the service area,
3 Berkeley County?

4 A: Well, it's a Tri-county service area.

5 Q: Okay. And what are those services available
6 there?

7 A: There are facilities in Charleston County and
8 Dorchester and potentially soon in Berkeley
9 County and right now just outside Berkeley
10 County is a very significant facility.

11 Q: Okay. And how many beds are in this service
12 area?

13 A: 1,739.

14 Q: Okay. And does this criteria require that you
15 consider those?

16 A: Of course.

17 Q: Then the second part of this criteria is, and
18 the effect of the proposed project upon that
19 distribution should be carefully considered to
20 functionally balance the distribution to the
21 target population.

22 A: Uh-huh (affirmative response).

23 Q: As a health planner, what does that mean to
24 you?

25 A: You want basically to have facilities to serve

1 populations where they are.

2 Q: And when we look at Carnes Crossroads, is that
3 population currently being served today?

4 A: Carnes Crossroads? Absolutely.

5 Q: Okay.

6 A: And I think the southern part of Berkeley
7 County is, by no stretch of the imagination, an
8 area that one could make an argument that
9 they're lacking adequate or even convenient
10 hospital services.

11 Q: Is convenience a standard in the Health Plan?

12 A: No, it's not.

13 Q: Is convenience addressed in the regulations?

14 A: It is not.

15 Q: A couple of things. One comment that Mr.
16 Bowling made was this notion that somehow the
17 Roper System needed this project.

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

19 Q: What's your opinion on that?

20 A: Well, I've seen their financials that have been
21 put together I believe by financial people at
22 the System, which show continuing improvement
23 in net income and EBITDA on an annual basis,
24 without the Berkeley project, out to something
25 like 2016, 2017. The numbers get to be quite

1 high, I mean, approaching \$100 million.

2 Q: Okay. Take a look at Joint 2, which is their
3 application.

4 A: Okay.

5 Q: And go to page 468 and 469.

6 A: Sure. 468, 469? Okay. I have it.

7 Q: When you look at the Roper System without
8 Carnes Crossroads, those financials, what, if
9 any, relevance does that have to your opinion
10 regarding Roper's health?

11 A: I think Roper's financial health is healthy.
12 Their net income projection reads like this
13 across the years starting in 2008, which is the
14 first projected year, 26 million, then 47 --
15 basically 47 million, and then 53 million, then
16 61 million, then 69 million, then 76 million,
17 then 80, then 82, then 87, then almost 93.
18 Every year up and by, you know, a nice five,
19 six, seven percent clip. This is a system
20 that's projecting, even without the new
21 hospital, any new hospital in Berkeley County,
22 to do quite well over the next -- we're now in
23 2012, certainly over the next five years.

24 Q: Do you remember Mr. Knapp's testimony regarding
25 that he viewed the Moncks Corner demographics

1 payer mix to be better than that at Carnes
2 Crossroads?

3 A: I heard him say that.

4 Q: Okay. I'm going to hand you two exhibits.
5 This is Petitioner's 73 and Petitioner's 98.
6 And just ask you what, if any, information
7 there regarding the demographics in the
8 community are relevant to you in responding to
9 Mr. Knapp?

10 A: Yeah. I actually prepared material comparing
11 the demographics of the two hospital
12 communities. In fact, more than just Moncks
13 Corner, all of the northern communities, as
14 well as the county as a whole, as well as Goose
15 Creek. And the general conclusion I reached
16 from this is there are more people in the Goose
17 Creek area, more people in the southern part of
18 the state, so there are more people in every
19 category. But in terms of median household
20 income, it's lower in the Moncks Corner area.
21 In terms of the percentage of the population in
22 the lower income brackets, it's higher in the
23 Moncks Corner area in the northern part of the
24 county.

25 MR. SUMMER: I beg the court's indulgence.

1 Q: Do you believe that Trident's application is
2 compliant with the Plan?

3 A: I do.

4 Q: Okay. Let's take a look at -- I want to ask
5 you about one last thing.

6 MR. SUMMER: Let's put up the State Health Plan one
7 more time, that section five.

8 THE COURT: Which years?

9 MR. SUMMER: 2008-2009, Joint 4, Your Honor. Roman
10 Numeral II-10, criteria number five in the
11 transfer section.

12 Q: The last thing I want to discuss with you, do
13 you remember the line of questioning with Mr.
14 Bowling where he was asked about, well, under
15 the transfer section anything goes, it's a free
16 for all. What if --

17 MR. LONG: Object. That is ridiculous. That is not
18 even close to being a characterization of Mr.
19 Bowling's testimony.

20 MR. SUMMER: I'll rephrase it.

21 MR. LONG: It gets back to the same objection I had.
22 He needs to ask questions and not make
23 arguments.

24 MR. SUMMER: I'll rephrase it, Your Honor.

25 THE COURT: Thank you.

1 Q: Do you remember when Mr. Bowling was asked
2 under Roper's view of the transfer section,
3 what if MUSC were to drop a 50 bed hospital in
4 Mount Pleasant; do you remember that testimony?

5 A: I do.

6 Q: Okay. And what was his response?

7 A: He said that probably would be a bad idea
8 because that area's over bedded so that
9 transfer would not work.

10 MR. LONG: Your Honor, I just want to move to
11 strike. I mean, that's not what he said. I
12 mean, he -- and see, that's the problem with
13 the question.

14 THE COURT: Well, you can impeach him on cross
15 examination.

16 MR. LONG: Well, I can't really because he's just
17 said what Mr. Bowling said. And, see, that's
18 the problem with the question. He needs to
19 just not ask him to repeat what other witnesses
20 said. He needs to ask him for his opinion
21 about the testimony that he heard.

22 THE COURT: Well, do you want me to have the court
23 reporter stop and go find the testimony or the
24 lack of it?

25 MR. LONG: Well, I mean, not -- that would be a

1 lengthy process, but I mean I think the better
2 thing is just to strike it and ask him to ask
3 the question correctly.

4 **MR. SUMMER:** Well, what he's saying is he didn't
5 like the answer.

6 **MR. LONG:** No, no. I didn't like -- no. He didn't
7 answer the question. His answer was
8 unresponsive and he should not ask him, tell
9 the court what Mr. Bowling said. That's the
10 answer that he elicited.

11 **MR. SUMMER:** Well, my option, Your Honor, was to do
12 this, was to give my recollection, which is
13 being objected to --

14 **MR. LONG:** And that would be improper.

15 **MR. SUMMER:** So I was asking his recollection, which
16 he has now espoused. And if it's inaccurate,
17 the record will speak for itself.

18 **THE COURT:** Overruled.

19 **Q:** What, if any, relevance to your opinions does
20 Mr. Bowling's response about Mount Pleasant and
21 MUSC have to this number five criteria?

22 **A:** Well, I think need matters. The question is
23 whether it's too late in the Mount Pleasant
24 area, and hopefully, it's not too late here to
25 make an appropriate decision, which would be to

1 use the transfer section and to override the
2 fact that there's need for only one facility
3 and award two simply because one of them is
4 being transferred.

5 Q: All right. Are there any other criticisms of
6 your work or any other opinions espoused that
7 you want to respond to?

8 A: No.

9 Q: Okay. If you would be so kind as to answer any
10 questions that Mr. Long has.

11 A: Could I have about a three minute break?

12 MR. LONG: Your Honor, could I have about five
13 minutes to get organized?

14 THE COURT: How much do you need, Mr. Long?

15 MR. LONG: If I could get ten, I have to go to the
16 restroom too.

17 THE COURT: Ten minutes. We're in recess.

18 MR. LONG: Thank you, Your Honor.

19 (Off the Record from 3:05 p.m. until 3:15 p.m.)

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

21 MR. LONG: Thank you, Your Honor.

22 MR. BAEHR - CROSS REBUTTAL EXAMINATION BY MR. LONG:

23 Q: All right. Mr. Baehr let's talk about -- let's
24 start today talking about the criteria again in
25 the regulations.

1 A: Sure.

2 MR. LONG: Okay. Can we go to 61-15? And go to
3 Section 8 to page 23, probably. I think it's
4 going to be the one before that. No, no, it's
5 a little further. I'm sorry. You've got to go
6 further. I'm sorry, Your Honor. I thought --
7 I should have had this up before you came back
8 in. It'll be 802. There we go. Let's leave
9 it right there. That page right there,
10 subsection 2(b).

11 A: Now, which page, Mr. Long?

12 Q: You can look at it on the screen or in the
13 book. If you've got the book in front of you,
14 it's on page forty --

15 A: Oh, I see.

16 Q: I think it's in the low thirties. It's 32 --
17 34. Okay. Now, did I understand your
18 testimony today that you think that the Roper
19 St. Francis application for the hospital at
20 Carnes Crossroads does not satisfy criteria
21 2(a) and 2(b)?

22 A: What I said about 2(a) is as best I understand
23 what's in the application, the target
24 population are two that are mentioned. One is
25 the Roper aligned patient population, whatever

1 that means, okay? The second is the population
2 in the southern half of Berkeley County, more
3 particularly Goose Creek, the south of the city
4 is mentioned several times.

5 Q: And so you thought that their identification of
6 those two subsets was inadequate under the
7 regulations? Is that your opinion?

8 A: Well, what I'm saying -- yeah. Well, Roper
9 aligned patients I certainly think doesn't fit
10 a traditional definition of the targeted
11 population, okay? It's not a group you can
12 identify by geography, financial status, even
13 necessarily location. If you saw a thousand of
14 them in a crowd, you wouldn't know them. As
15 far as the identification of Goose Creek, they
16 certainly identify it. They also say that
17 they're going to serve the whole county. My
18 problem was, I guess, what I'll call the
19 confusion between going back and forth between
20 the two without identifying where, in fact,
21 their population would come from in terms of
22 the geographic regions of the county.

23 Q: But in the application that you prepared for
24 Trident Health Systems, your subset is the
25 Trident aligned patients.

1 A: Well, what we did was we identified the regions
2 of the, of the Berkeley County -- of Berkeley
3 County where we thought this particular
4 hospital, if located in Moncks Corner, would
5 best serve the community, essentially have the
6 communities where they would be the most likely
7 transfer of business, taking advantage of the
8 growth at the Trident System was likely to
9 generate, which was why they had a bed need, so
10 we identified portions of the county, again the
11 entire county. Buy every single zip code, an
12 assumption was made about future utilization.
13 You could actually see what the utilization
14 would be in every zip code in the county. If
15 someone wanted to make an adverse impact
16 calculation, if somebody wanted to dispute what
17 I said, and say you're not going to rely at all
18 on redirection, we think you're going to
19 actually impact us by X percent, you could have
20 done that based on where I thought the patient
21 population would come from.

22 Q: Right. But the patient population that you
23 projected for these zip codes is only Trident
24 patients. Isn't it correct that you have a
25 subset in your application that's limited to

1 Trident patients?

2 A: That's a threshold for the purposes of
3 preparing a utilization forecast. In other
4 words, and I actually described it as a
5 threshold, meaning that Trident has a certain
6 volume in the county, Trident is going to have
7 certain growth in the county and that growth is
8 substantial to us, 6,700 patient days over the
9 next seven years. Trident can fill, just on
10 growth from Berkeley County and the out of
11 county area, two-thirds of the beds here. So
12 what do you need then, another 4,000 days
13 redirection either from within Trident, okay,
14 which can be supported by the additional growth
15 in the system outside. So it's a calculation
16 of where we thought the patients would come
17 from. And in essence, we skipped a step, like
18 you're saying market share stays the same, this
19 is the Trident volume, this is the share of the
20 Trident volume that we think this hospital will
21 obtain. But the Trident volume is based on
22 growth, okay? And the growth model is what we
23 used to forecast this.

24 Q: Let's look at the -- so is your opinion the
25 Trident application complies with this

1 regulation?

2 A: I believe it does.

3 Q: Okay. Even though --

4 A: We have a forecast of the number of patients
5 who will be served by zip code and we use the
6 methodology you've described, all right, to
7 come up with that calculation. And as I
8 admitted to you in a deposition and admitted to
9 you on my cross examination, the exact
10 calculations and assumptions and percentages
11 could vary. I even admitted that the market
12 share, there may be a market share gain. We
13 actually did a scenario in my updated
14 projections which showed a market share gain in
15 Berkeley County. All of those I think are
16 reasonable. But what we used was a methodology
17 to see where the patients would come from.
18 That was the target; where in the county would
19 most of these patients likely come from.

20 Q: Let's look at page 73 of the Trident
21 application.

22 A: That's 1?

23 Q: Seventy-three from Exhibit 1.

24 A: Yeah, sure.

25 Q: It'll be on the screen here.

1 A: Sure. Okay.

2 Q: Just read for the court the two sentences that
3 are in bold?

4 A: Sure. The two sentences in bold?

5 Q: This is your application, correct?

6 A: Uh-huh (affirmative response).

7 Q: It was prepared by Mr. Davidson and yourself?

8 A: Correct.

9 Q: And you put these two sentences in the
10 application in bold to emphasize them. Can you
11 just read those two sentences?

12 A: Chart 15 presents projections of the market
13 share that the proposed Berkeley Medical Center
14 will obtain within the Trident System.

15 Q: And the "within the Trident System" is in bold?

16 A: Correct.

17 Q: Because you're limiting your patients to the
18 Trident System.

19 A: This is a basis --

20 Q: That's your subset, right?

21 A: It's a basis for making a forecast in coming up
22 with a number of patients by geography. That's
23 the purpose of this exercise.

24 Q: Okay. And then the last sentence in bold?

25 A: No declines in market share are forecast for

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1 any other providers.

2 Q: So in other words, you're not going to take any
3 market share from any other provider. It's
4 only Trident Health System patients, right?

5 A: A redirection essentially of about 30 percent
6 of the Trident volume in the county will get
7 this hospital to where it needs to be, and most
8 of that redirection comes from growth, growth
9 of the Trident System in Berkeley County.

10 Q: Do Trident Health System patients have name
11 tags?

12 A: They do not.

13 Q: Arm bands?

14 A: No.

15 Q: Do they have arm bands? Do they have marks on
16 their forehead?

17 A: Not that I'm aware of.

18 Q: Okay. And so, but in your opinion the
19 application that you filed with the Department
20 complies with the criteria 2(a) and 2(b) and
21 the one that Roper St. Francis filed does not;
22 is that correct?

23 A: And the problem is you're mischaracterized what
24 I said.

25 Q: Answer my question, please?

1 A: Because I gave, I thought, not a full yea or
2 nay on that particular question where Mr.
3 Summer asked me that issue. And, again, this
4 is where there's some, I think,
5 differentiation. In the application for
6 Trident Medical Center, we made clear that we
7 were doing a threshold test. A test. And that
8 was whether there was enough growth overall in
9 the Trident System to support a new hospital in
10 Berkeley County. The answer to that was, yes.
11 Given that there's enough growth in the Trident
12 System to support the new hospital, the second
13 question is where would the patients come from.
14 We prepared this methodology to find out where
15 the patients would likely come from to get to
16 the volume you need. It turns out it relies on
17 about a 29 to 30 percent share overall for the
18 county of the Trident patient volume. But it's
19 different by zip code. It's not -- we don't
20 know what Roper's numbers are. We don't know
21 whether it's 70 percent redirection in one zip
22 code and 20 percent in another. We've no way
23 of knowing because we don't know where they're
24 getting their patients from. I will grant you
25 that the way this reads, the way this reads, is

1 that it says what it says. But I will also
2 tell you that in the application it
3 specifically says, this was an exercise and a
4 test to see how you get to the volume levels
5 and where within the county those patients
6 would be.

7 **MR. LONG:** Your Honor, I'd ask for your help in
8 directing the witness to answer the question
9 because he certainly didn't answer the question
10 I just asked him, so I'm going to ask him
11 again. And I'd ask for your help.

12 **MR. SUMMER:** Your Honor --

13 **Q:** In your opinion, does the Roper St. Francis --

14 **MR. SUMMER:** I'd like to pose an objection, counsel.
15 The editorializing can go both ways. His
16 question was responsive -- the answer was
17 responsive. Mr. Long might not have liked the
18 answer, but it was responsive. And I would
19 simply appreciate that the witness be continued
20 to allow to answer the question as best he can.

21 **THE COURT:** Mr. Long, at the least, I thought I
22 understood the question and I was following the
23 answer and I thought it was at least marginally
24 responsive. But if you'll ask him again, I'll
25 pay attention in light of what your request is.

1 MR. LONG: Well, the problem with the
2 responsiveness, Your Honor, he gave a long
3 answer, okay, but the question was a yes or no
4 question. And there was no yes or no given or
5 anything even close to it. The question I ask
6 him was --

7 THE COURT: And you didn't object soon enough for me
8 to stop him, so go ahead with your question.

9 MR. LONG: Well, that's the thing. I would -- Your
10 Honor, thank you. But in deference to Mr.
11 Summer and others, I let him finish. I didn't
12 want to interrupt him so I waited until he was
13 done.

14 Q: But is it your contention that the Roper St.
15 Francis application does not comply with
16 sections 2(a) and 2(b)?

17 A: I think that the concept --

18 THE COURT: Wait a minute.

19 THE WITNESS: Yeah.

20 THE COURT: I do think that fundamentally you can
21 answer that without any equivocation.

22 THE WITNESS: Okay.

23 THE COURT: Okay. So --

24 THE WITNESS: Okay. Your Honor, if I may say one
25 thing. This is where there's an important

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1 point of distinction here. There's a hospital
2 applying with bed need --

3 MR. LONG: Your Honor --

4 A: All right. From the perspective of what you
5 just asked, if you're talking about alignment,
6 yes, both of them rely on, to some extent,
7 different extents, different percentage
8 redirection, redirection of their patient
9 populations.

10 Q: So they both comply with the criteria, don't
11 they?

12 A: Both of them rely on redirection and there are
13 differences because the Trident number is a
14 calculation designed to find out
15 geographically. It is not a sense of all of
16 these patients are permanently aligned with the
17 Trident System. It's looking at a future
18 volume in the county which comes from growth,
19 which is entirely new patient population. It's
20 not current patients, which is largely the case
21 with Roper. I mean, there are distinctions.

22 Q: Do they comply with the criteria?

23 A: I could give them credit, yes.

24 Q: Let's look at 3(b).

25 A: 3(b), okay.

1 Q: Now, was it your opinion that the Roper St.
2 Francis application does not comply with
3 criteria 3(b)? Did I get that in my notes
4 correctly?

5 A: I think the second part; should not
6 unnecessarily duplicate existing services or
7 facilities in the proposed service area.

8 Q: Okay. The Trident Medical Center is a full
9 tertiary hospital, isn't it?

10 A: It is.

11 Q: Other than maybe transplants or one or two
12 other very high-end services, they offer
13 everything, don't they?

14 A: Pretty much, yes.

15 Q: So under your analysis of this, is there any
16 way that any provider could ever offer any
17 services near Trident without it being an
18 unnecessary duplication?

19 A: Yes, if there's need. If there's need for the
20 services and the beds.

21 Q: Okay. And you define need as limited solely to
22 growth?

23 A: No. I think need is a function of several
24 things. One is growth, which I think is a way
25 to measure it. And the state obviously uses

1 that to determine bed need for individual
2 hospitals. So that certainly is a pretty
3 important factor. The second is need is
4 related to access improvement. If you're on
5 top of other facilities, there's not a long
6 drive time right now within the area you
7 propose to serve, you're close to existing
8 facilities, and you may cut a few minutes drive
9 time off, you may make the services more
10 convenient, but they don't really improve
11 access to a significant population, that is a
12 test, also, of whether you might be
13 unnecessarily duplicating. If you're spending
14 -- if there's no need under the formula in
15 terms of bed need and you don't significantly
16 improve access, then, yes, you're unnecessarily
17 duplicating.

18 Q: Fifty percent of the people in Berkeley County
19 travel outside the county to seek services from
20 providers, other than Trident or Summerville,
21 correct?

22 A: Close to 50 percent.

23 Q: Close to 50 percent. But in your opinion those
24 47 percent of the people of Berkeley County
25 should not be counted for access to determine

1 whether or not --

2 A: No, not in the least. There's a choice being

3 made either by physicians or by patients, all

4 right? If the physicians are directing them,

5 then -- we know from the testimony we heard

6 last week that Roper is diligent about keeping

7 people within their system. We've seen the

8 records of the Moncks Corner outpatient

9 facility and the emergency department and where

10 those patients are sent. They're not sent to

11 the closest hospital. I think 70 or 80 percent

12 went to the two Trident facilities and the

13 doctors, you know, were recommending, who were

14 filling out the orders in that emergency

15 department, are sending them 20 miles further

16 down the road. But you've got to understand

17 what I said earlier today. It is absolutely

18 consistent with what goes on in every major

19 community in the country that patients travel

20 from outlying areas to go to large tertiary,

21 facilities in the city or teaching facilities

22 because of their reputation, because they sense

23 that they're going to get a broader, more

24 sophisticated care than they may get in the

25 small community hospital. And even when you

1 build small community hospitals, it improves
2 access, there are some patients who choose to
3 go there, and there are others who will still,
4 for whatever reason, including the reason I
5 just stated, continue to go somewhere else
6 because they think -- perception -- the care is
7 better.

8 Q: Small community hospitals improve access, don't
9 they?

10 A: They can improve access, depending, of course,
11 on where they're located. If they're located
12 seven miles from an existing facility, no. If
13 they're located 20 miles from an existing
14 facility in an area where half the population
15 is more than 30 minutes drive time from an
16 existing facility, yes, that small hospital can
17 improve access.

18 Q: So seven is not good, but 20 is okay? Is that
19 a Richard Baehr formula?

20 A: The issue is the 30 minute drive time. It's
21 not any standard that I set.

22 Q: Is it more than a 30 minute drive time from
23 Trident Medical Center to Summerville Medical
24 Center?

25 A: No.

1 Q: Those facilities are six miles from each other,
2 right?

3 A: Six and change, yes.

4 Q: So when HCA decided to relocate a new hospital,
5 they chose to go six miles down the road,
6 right?

7 A: What they those chose to do is they had bed
8 need that showed the ability to create a new
9 hospital. They went forward with a plan, which
10 has always been consistent with a plan they've
11 had for the two counties they served when those
12 hospitals closed, started with outpatient
13 facilities and then eventually adding inpatient
14 facilities to serve those communities with
15 hospitals. What happened in Dorchester County
16 is now the path that Trident Health System is
17 attempting to accomplish in Berkeley County.
18 At the start, those little community hospitals
19 were not providing adequate care. The
20 community leaders agreed on that. They wanted
21 a much better-funded institution that had
22 capital to come up with a high quality
23 institution to serve them. Over time,
24 population moves out, they've moved facilities,
25 both outpatient and inpatient and now a

1 proposed inpatient, to serve those communities
2 better. I don't see what the problem is with
3 that.

4 Q: Did you ever ask the people at Trident when you
5 were doing your investigation for this
6 application why they waited 43 years to file
7 the application for Berkeley County? Did you
8 ever ask them that?

9 A: Forty-three years?

10 Q: Yeah. Because they built the hospital in the
11 early '70s and now it's 2008. Did you ever ask
12 them why they waited 43 years to file the
13 application for the hospital?

14 A: That's kind of an odd question because, first
15 of all, Trident --

16 Q: Does that mean you didn't?

17 A: No, I didn't ask them the question.

18 Q: Okay.

19 A: Trident Medical Center was built in 1975 with
20 the agreement of the people in Berkeley County
21 and Dorchester to close their hospitals, all
22 right? Outpatient facilities have been located
23 in the northern part of the county, which is
24 the part of the county that has the biggest
25 access issues. And the hospital in Trident and

1 now in Summerville have served those growing
2 populations in southern Berkeley County and in
3 Dorchester. With the bed need that Trident had
4 now, it made a conscious decision -- it could
5 have added more beds to Trident as it has in
6 the past, or it could locate a small hospital
7 back in Moncks Corner, which is what they
8 attempted to do. I don't -- I couldn't tell
9 you any reason or lack of reason for why they
10 might not have done something in 1990, why they
11 did Dorchester first. I wasn't involved in any
12 of that. But the progression, outpatient first
13 and then inpatient, to me makes a lot of sense.
14 And I think in the case of Roper with the
15 property they had, they could have certainly
16 started with outpatient facilities. I look at
17 the Roper numbers and their ratio in 2010 of
18 outpatient to inpatient revenue, is a 140 to
19 100. I mean, this is a striking change in the
20 last couple of years. The growth in their
21 model and the growth in the systems right now
22 are on the outpatient side. You don't have to
23 have your inpatient hospital to be able to have
24 a significant presence in a market. And, you
25 know, Roper chose -- they have to follow

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1 Trident in two months later with an
2 application, just like they did in Mount
3 Pleasant. That's not the only path they had if
4 they wanted to serve the communities in
5 southern Berkeley County on the land they had
6 purchased.

7 MR. LONG: Your Honor, I asked him if he asked them
8 a question about why they waited 40 years to
9 file the application in Berkeley County. And
10 somewhere in that answer, that went on for a
11 long time, he started talking about our
12 facility in Moncks Corner. So I mean, I would
13 just ask for an instruction of the witness to
14 try to answer the question and be responsive.

15 MR. SUMMER: Excuse me, Your Honor. I do believe
16 the answer was responsive. He first answered
17 no, and then he explained. The question was
18 pretty absurd, why didn't they do this 43 years
19 ago? Well, that would have been synonymous
20 with the closure, so he explains that. And
21 then he explains what the progression was and
22 why it's now. It was responsive. I understand
23 that Mr. Long doesn't like the answer, but the
24 answer was responsive.

25 THE COURT: Well, in this case, I disagree, and I

1 sustain Mr. Long's objection. Mr. Baehr, I
2 have watched you and listened to you testify
3 for a good many hours over the last three
4 weeks. And of one thing I am certain, you have
5 the intelligence to answer in shorter fashion
6 than you are doing, and I ask that you do that.

7 **THE WITNESS:** Happy to, Your Honor, thank you.

8 **THE COURT:** All right.

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

10 Q: Going back to 3(b), okay, and this mentions
11 services, right?

12 A: Correct.

13 Q: Do you remember in the open heart case you
14 testified that opening an open heart program
15 seven miles from Providence was improving
16 access and therefore that program should be
17 approved, right? That was your testimony,
18 correct?

19 A: It was my testimony and largely based on the
20 number of transfers and the volume of
21 cardiology business that was already present at
22 Lexington Medical Center.

23 Q: Exactly. So you looked at a factor, which was,
24 in your mind, the volume of emergency cardiac
25 cases going to the Lexington Medical Center and

1 you said seven miles didn't matter, right?

2 A: Seven miles in the case of someone who is
3 suffering a heart attack and has to be
4 transferred to another hospital is meaningful.
5 If you can serve a hospital (sic) at the
6 facility -- at the facility where a patient
7 arrives, and Lexington did a great job of
8 getting patients from their county into their
9 facilities with all of their outreach and
10 outpatient facilities, they were attracting
11 these patients. They were showing up there.
12 This was their hospital closest to them. It
13 was a hospital of choice. Did they need to be
14 transferred downtown for open heart surgery or
15 for emergency angioplasty? That was a big
16 issue in that case.

17 Q: Yeah. Just like the way Roper St. Francis is
18 attracting patients into their system in
19 Berkeley County, correct?

20 A: There's a big difference, I think, between the
21 transfer of a patient who's in cardiac arrest
22 than having a patient who's transferred 20
23 miles because physicians want to keep somebody
24 within their system. I think it's a big
25 difference.

1 Q: Well, let's talk about the market share.
2 Trident claims it's full, right? It has a bed
3 need. It's applying for more beds, right? It
4 has a need for more beds; isn't that correct?

5 A: They had a bed need in 2004-'05, and an even
6 larger need, substantially larger, at the time
7 they filed the application in 2008.

8 Q: And it is contending that it needs more beds,
9 doesn't it?

10 A: The Trident System, Trident Medical Center
11 needs more beds, correct?

12 Q: Okay. And Summerville Medical Center needs
13 more beds --

14 A: Correct.

15 Q: -- according to Trident, okay?

16 A: According to the state.

17 Q: So if the -- but according to the Trident
18 Health System, also?

19 A: They agree. They're trying to address need
20 which has occurred in their system because
21 their hospitals are full enough and with the
22 population growth, they show positive bed need
23 out into the future.

24 Q: And yet those 47 percent of the people in
25 Berkeley County who choose to drive by Trident

1 Medical Center and go downtown, if they
2 actually went to Trident Medical Center, the
3 hospital couldn't hold them, could it? It's
4 not big enough, is it?

5 A: If all of them showed up?

6 Q: Yeah. If all of them showed up.

7 A: Yeah, Trident would be more than 100 percent
8 full. That's correct.

9 Q: Yeah. Actually, if really a small percentage
10 showed up, they'd be full, wouldn't it?
11 Because they're basically full with a 53
12 percent market share, aren't they?

13 A: What they were was they met the 70 -- they met
14 the need for beds at the 70 percent target
15 occupancy based on growth seven years out into
16 the future. We heard testimony last week that
17 larger hospitals can certainly tolerate 80
18 percent, but the state calculates need based on
19 70. Could they handle additional patients
20 beyond the 70 percent, yeah, I think they
21 could.

22 Q: A few, right?

23 A: Some, sure.

24 Q: Not 47 percent of the people in Berkeley
25 County?

1 A: Right. I agree with you. I agree with you.
2 I don't think they can handle -- with the
3 current volumes, they couldn't handle all of
4 the patients coming out of the county.
5 Q: All right. Let's take a look at criteria 23.
6 A: Okay.
7 Q: I'm sorry, 22.
8 A: Oh, sure.
9 Q: Which is distribution.
10 A: Okay.
11 Q: Okay. I want to look carefully at this. In
12 your opinion the --
13 MR. LONG: No, no, I'm sorry, 22. No, it's criteria
14 22 so it's going to be a couple of pages over,
15 about three or four pages over. That's
16 distribution accessibility. This is just
17 distribution. There it is. That one right
18 there.
19 Q: Did I understand your testimony to say that the
20 Roper St. Francis application did not comply
21 with this criteria?
22 A: I want to apologize because I read this
23 distribution and assumed it was the same as the
24 earlier one. It's not. The other one is the
25 accessibility issue, which is -- I was happy

1 with what I said there. With this one, it
2 appears to be just the specific services that
3 are offered as opposed to location.

4 Q: Okay. Well, the one, the distribution
5 accessibility; we just talked about that.
6 That's three, right?

7 A: It's three in several parts. There are several
8 sections of that.

9 Q: Right. But you testified, the ones we asked
10 about, was (a) and (b), I think, were the ones
11 you said Roper St. Francis -- this is
12 distribution 22.

13 A: Right.

14 Q: Right?

15 A: Right.

16 Q: So do you change your testimony now; does Roper
17 St. Francis comply with the criteria?

18 A: Yeah. I would actually tell you I couldn't
19 totally understand -- I don't totally
20 understand what this means, given the language
21 in number three, to what extent this is saying
22 the same thing a different way or whether it's
23 referring to something differently. So I
24 couldn't offer you a comment one way or the
25 other.

- 1 Q: Well, let's look at the language of it --
- 2 A: Uh-huh (affirmative response).
- 3 Q: -- as a health planner, this one talks about
- 4 existing distribution, right?
- 5 A: Uh-huh (affirmative response). Correct.
- 6 Q: And existing distribution would be the patients
- 7 that are currently going to Roper St. Francis,
- 8 right? That's their distribution network,
- 9 right?
- 10 A: Correct.
- 11 Q: And it should be identified. And we know it's
- 12 24 percent of the patients in Berkeley County?
- 13 A: Correct.
- 14 Q: And the effect of the proposed project upon
- 15 that distribution should be carefully
- 16 considered, okay?
- 17 A: Uh-huh (affirmative response).
- 18 Q: Don't you think the Roper St. Francis
- 19 application, which is designed to treat those
- 20 24 percent of the population in Berkeley County
- 21 that uses their services, is carefully
- 22 considering that in its project?
- 23 A: If you read it the way you just described it,
- 24 I think that's fine. I read this now, just
- 25 after you asked the question, as more splits

1 between inpatient/outpatient services,
2 particular services.

3 Q: And you carefully consider the impact of that
4 and then you functionally balance the
5 distribution to the target population. So 50
6 beds to Berkeley when you have over 3,000
7 inpatients in the system from Berkeley County.
8 That's a pretty functional balance, isn't it?

9 A: No. This is where we disagree. I don't think
10 this section overrides the need argument, state
11 health planning argument, the other issues
12 about unnecessary duplication. That could all
13 be well and true that you have a certain couple
14 thousand patients who are now going into the
15 city, but if there's no need for an existing
16 hospital, there's no bed need to justify that
17 existing hospital, then I don't think this
18 section trumps essentially all of the other
19 arguments that are need-based and access
20 improvement based. This is hospital specific
21 distribution is the argument you are making.
22 Does that trump everything else? And I would
23 say, no.

24 Q: Well, Mr. Baehr, the Department identified this
25 criteria as one of the most important criteria

1 to be considered with the applications,
2 correct?

3 A: Yeah, I saw the list.

4 Q: Okay. And this one's on there, isn't it?

5 A: It's on the list.

6 Q: And the fact is that not only does Roper St.
7 Francis comply with this criteria, it's the
8 whole crux of why it should be approved, isn't
9 it? Because that's exactly what our
10 application is doing, isn't it?

11 A: I don't believe the state has ever said that
12 any hospital can justify a need for a new
13 inpatient facility based on this criteria,
14 based on the fact that it's got patients in a
15 particular location. If that were the case,
16 there would be no need for any bed need
17 formula. Any hospital could say we have
18 patients in any location and as a result we
19 have the need for beds. This, to me, is an
20 argument for looking at the services you're
21 providing, looking at the services you're
22 proposed to provide, is it an appropriate mix?
23 I can make an argument that adding inpatient
24 beds is not an appropriate mix, that given the
25 over-bedding and the duplication, it's a

1 mistake; that, in fact, more outpatient
2 services in Goose Creek would be a much better
3 solution than adding a hospital in Goose Creek,
4 okay? That's my opinion. So from that
5 perspective, if the argument is that this
6 distribution means anybody that's got
7 inpatients and only now has outpatients, that
8 that's a justification for a new hospital, I do
9 not agree. I would not support this under
10 those circumstances.

11 Q: You think the Roper St. Francis application
12 complies with 22, distribution?

13 A: If the argument is that because you have an
14 existing patient population, that that
15 justifies a new hospital because that is a more
16 -- that's appropriate distribution, I'd say the
17 answer is no, if, in fact, there are superior
18 alternatives to that distribution. And that
19 could be geographic, that could mean having
20 outpatient facilities in Goose Creek in
21 addition to the facilities that are now in
22 Moncks Corner. This could not be used and
23 would be a mistake to be used as a license to
24 allow any hospital to add beds because they
25 serve a patient population That's the same

1 mistake that's occurred with the transfer
2 language.

3 Q: Isn't Trident Health System proposing to build
4 a hospital in Moncks Corner because they have
5 patients there that they want to serve, isn't
6 that the whole crux of the application for
7 Trident?

8 A: They're trying to improve access to a patient
9 population that right now has very lengthy
10 drive times to acute care facilities on those
11 occasions when they need to go to a hospital.
12 And Moncks Corner is the ideal location in the
13 county to place a new hospital to address the
14 portion of the county that does not now have
15 good access to acute care services. The
16 southern part of the county does.

17 Q: But it's only the Trident patients that you're
18 trying to improve access to. This is what the
19 pink means, 50 percent of the 50 percent.

20 A: This was a calculation methodology and I've
21 said that several times before. I can say it
22 again. It was an exercise to see where the
23 patients in the county would likely come from
24 and we did that by going through the Trident
25 volume, going through their market shares and

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1 making assumptions about what percent within
2 each zip code would be likely to show up at the
3 new hospital.

4 Q: Okay. Now, you also testified today that the
5 Department did not carefully consider Trident's
6 opposition, right?

7 A: I believe that.

8 Q: Now, you heard Ms. Brandt testify that she did
9 consider it?

10 A: She said she considered it.

11 Q: And she rejected it, right?

12 A: She didn't accept the argument.

13 Q: All right. Now, at project review, your
14 argument to the Department was if you allow
15 both, both will fail, right?

16 A: Correct.

17 Q: And in the letter that you sent to Ms. Brandt
18 in May, a few weeks after project review, the
19 only thing you said about adverse impact on
20 Trident Medical Center or Summerville Medical
21 Center is that there would be a transfer, there
22 would be some shift in market share. That's
23 all you said, isn't it?

24 A: In which letter?

25 Q: In the letter you sent in May?

1 A: That there would be a transfer of market share.

2 Q: Yeah. There would be a shift in market share.

3 That was the only thing you said in regards to
4 adverse impact on Trident Medical Center or
5 Summerville Medical Center. Isn't that
6 correct?

7 A: Correct, to those two. But in terms of the
8 impact -- the argument I made at project review
9 was not about that issue.

10 Q: Right.

11 A: The argument at project review was whether both
12 hospitals could survive if there's only enough
13 incremental volume for one. That's an entirely
14 different adverse impact argument and those
15 numbers had been provided at project review,
16 the slides were presented after the
17 presentation, so Ms. Brandt had them. And,
18 again, there was a full month, if she wanted to
19 explore those, if she didn't understand them,
20 she saw a big boxcar numbers and she said this
21 can't be right, what's wrong, explain this to
22 me, never got any kind of call or contact of
23 any sort.

24 Q: Well, you heard the testimony in the trial
25 about what happened in regards to that. There

- 1 was the project review in May.
- 2 A: Uh-huh (affirmative response).
- 3 Q: Your letter the end of May, right? You wrote
- 4 a letter at the end of May?
- 5 A: It's four steps. You're missing two. There's
- 6 project review, there's the submission of the
- 7 project review documents that were sent to the
- 8 Department.
- 9 Q: Oh, okay. Yeah, you gave them the PowerPoint.
- 10 A: Okay. They had the PowerPoints and that has
- 11 the slides in it. That has the two-hospital
- 12 slide in it. Then I sent another letter at the
- 13 end of May.
- 14 Q: Okay.
- 15 A: And then I sent the fourth --
- 16 Q: Okay. There's another step. So those three
- 17 things happened, and then Trident Health System
- 18 called the Department and requested a meeting
- 19 with Ms. Brandt, and they went --
- 20 A: I was unaware -- I was utterly unaware of that
- 21 at the time. I had no role in that.
- 22 Q: Yeah. Exactly. Because they didn't tell you
- 23 about it or bring you to it, did they?
- 24 A: They did not.
- 25 Q: Okay. And Mr. Gallati went to the meeting.

1 Now, do you think maybe Ms. Brandt might have
2 thought that the reason they wanted to come to
3 the meeting was to explain what you had
4 presented at project review; wouldn't that be
5 a reasonable assumption on her part?

6 A: My understanding of the purpose of that meeting
7 was to discuss issues related to one hospital
8 versus two, which is an issue that had been
9 laid out in those numbers. And if Mr. Gallati
10 had gotten any feedback whatsoever at that
11 meeting that Ms. Brandt was having problems
12 interpreting what I said, again, there's plenty
13 of time to pick up the phone. There's plenty
14 of time to then to call me and let me know that
15 I should be more aggressive in reaching out to
16 the Department. Ms. Brandt never raised the
17 issue with them, which suggests to me that she,
18 whatever analysis she had done, she had done
19 and that was it. If you don't understand
20 something and you've got a representative of
21 the hospital who had a consultant prepare
22 something that you might not have adequately
23 understood, that would be certainly
24 opportunity. They had their purposes for the
25 meeting. You get also feedback when you go to

1 a meeting like that from the Department. The
2 Department tells you what issues they have.

3 Q: I know. And Mr. Gallati testified to his
4 purpose for the meeting, which was to try to
5 bully Ms. Brandt into telling him the decision
6 on June the 9th. And that's the only thing he
7 recalled; isn't that right?

8 MR. SUMMER: Okay. I will object to the
9 characterization on that. There's nothing in
10 the record to suggest it. And now Mr. Long's
11 editorializing.

12 THE COURT: I agree. And ratchet it back a little
13 bit, Mr. Long.

14 MR. LONG: I'll take a drink of water. Thank you,
15 Your Honor.

16 Q: Just a few more questions, Mr. Baehr, on this
17 topic. So I'd ask that you be responsive to
18 the question.

19 A: Sure.

20 Q: You did not know anything about the June 9th
21 meeting between Trident Health System and the
22 Department?

23 A: They didn't ask me to attend. That's correct.

24 Q: That's right. And after that meeting was over,
25 you did not call Ms. Brandt or send her

1 anything until June 23rd, correct?

2 A: Correct.

3 Q: And you knew the decision was due to be made on
4 June 26th?

5 A: I actually didn't know that, that date. That
6 may have been familiar to my attorneys. It's
7 not a date that I was aware of. I put together
8 that letter because I think that was a second
9 issue that had been addressed in my May 28th
10 letter, and I wanted to provide some more meat
11 on the bone, so to speak, about the adverse
12 impact if only one was approved because I
13 thought it was a possibility as a result of
14 what had happened at project review, that there
15 would be only one hospital selected. Now,
16 obviously, I thought that the Moncks Corner
17 facility was a superior alternative if only one
18 was going to be picked. But if Roper were the
19 hospital picked, I prepared a letter to explain
20 what I thought the impact would be on Trident
21 Medical Center in Summerville if that occurred.

22 Q: Now, we're talking -- let's go back to this
23 issue of access for just a second.

24 A: Sure.

25 Q: Let's look at Petitioner 46.

1 A: Sure. Petitioner 46. It's Baehr 1600.

2 Q: Okay. You recall this slide, right?

3 A: Yes.

4 Q: Okay. Now, there are more people living in
5 southern Berkeley County than in northern
6 Berkeley County, right?

7 A: That's correct.

8 Q: And you just testified earlier this morning
9 about the percentage of people in the north who
10 would have greater access?

11 A: Correct.

12 Q: There's a greater percentage in the north,
13 right?

14 A: Correct. Much greater.

15 Q: And if you've got two buckets of apples and in
16 one bucket you have a lot of apples and in one
17 bucket you have a very few apples --

18 A: Uh-huh (affirmative response).

19 Q: -- and you have two bad apples in the small
20 bucket and you have 25 in the big one, the
21 percentages could be the same, couldn't they?

22 A: Here the difference, I think, is more or less
23 on the order of magnitude of less than ten
24 percent. Actually, maybe ten percent versus
25 close to 50 percent. That's a pretty big

1 difference.

2 Q: Okay. There are 14,331 people within 30
3 minutes of the Carnes Crossroads site who would
4 have improved access to a hospital if it was
5 constructed, right? That's what your slide
6 says --

7 A: If Roper --

8 Q: -- on the 15 -- it's 15 miles (sic). It's
9 actually 14,331 people, right?

10 A: Yeah. If Roper is the only hospital added,
11 they improve access to 14,000.

12 Q: Okay.

13 A: If Moncks Corner is the only hospital added,
14 they add improved access to about 29,000. If
15 both are added, then the increment for Moncks
16 Corner is 15,000, roughly and the increment for
17 Roper St. Francis is 1,940.

18 Q: Let's consider the applications separately.

19 A: Okay.

20 Q: Is 14,331 people a sufficiently high enough
21 number for you to say that that's an
22 improvement in access?

23 A: It is a modest improvement of access. And this
24 is the bigger problem. Because of the fact
25 that it might lead to the Moncks Corner not

1 being built, it actually reduces the net
2 improvement in access that is possible in this
3 market if only one hospital were approved,
4 which I think is the appropriate thing to do
5 because of the need, and that hospital was in
6 the area where the greatest need is and where
7 the greatest access improvement occurs.

8 Q: Let's talk about this issue of competing.

9 A: Sure.

10 Q: Are you aware that the Supreme Court in South
11 Carolina has held that the decision of whether
12 the approval of two applications exceeds the
13 need is a factual question for the court? It's
14 based on facts. Are you aware of that?

15 A: I'm not familiar with the Supreme Court
16 decision.

17 Q: Have you ever read the case of Cancer Centers
18 of the Carolinas v. Spartanburg Regional
19 Medical Center --

20 A: I am not.

21 Q: -- that was decided in our Supreme Court in
22 2010?

23 A: I've not read it.

24 Q: Okay. So in your -- do I understand your
25 testimony to be that these applications are

1 competing because the growth in the area, in
2 your opinion, only supports 50 beds?

3 A: It's a series of reasons. There are different
4 factors you have to satisfy to make them
5 compete, okay? You could have facilities that
6 are 30 miles apart, 40 miles apart, no overlap
7 in service area whatsoever, okay? That's a
8 different issue than you have here. The facts
9 and circumstances matter.

10 Q: Okay.

11 A: Are the hospitals -- do you have a 200 bed
12 hospital and a 50 bed hospital, no. You have
13 two hospitals the same size, same services.
14 Two hospitals in the same zip code. Two
15 hospitals that are going to rely to a large
16 extent on the same service area. And the
17 growth in the market does not support two
18 hospitals.

19 Q: Well, I just want to talk about the part of the
20 definition --

21 A: The growth?

22 Q: No. That says, when the approval of both would
23 exceed the need. That's the language, right?

24 A: Correct.

25 Q: Okay. The approval of both cannot exceed the

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1 need. And, in your opinion, the reason they're
2 competing is because the growth only supports
3 one 50 bed hospital. Is that basically it?

4 A: Growth is, in fact, the measure of whether
5 these facilities are duplicative. In other
6 words, whether you're over-bedding an area.
7 Fifty beds is what the growth pattern shows.
8 So I think that's meaningful.

9 Q: So the court should not consider the fact that
10 Roper St. Francis is transferring beds and not
11 adding beds to the service area?

12 A: Yeah.

13 Q: That's not an important fact to you, is it?

14 A: In fact, it's irrelevant. Because even under
15 the best, most lenient interpretation of the
16 transfer section, you still have to show that
17 there's a need for the facility in the area
18 where it's being located and that need has to
19 be considered in conjunction with how need is
20 ordinarily determined.

21 Q: How about the fact that these projects are
22 going to serve distinct communities?

23 A: I don't believe that's the case. I believe
24 that Moncks Corner and Goose Creek are distinct
25 communities, but there are plenty of areas of

1 overlap in the service area of the two
2 hospitals.

3 Q: Well, you --

4 A: Moncks Corner itself -- because the Moncks
5 Corner zip code is critically important to the
6 Roper facility right now and to the Roper draw
7 out of Berkeley County right now. It's the
8 largest -- I think it's two discharges fewer
9 than come out of Goose Creek. The Moncks
10 Corner zip code is one of the top two,
11 virtually tied for the lead.

12 Q: Well, Mr. Baehr, over the last three weeks,
13 I've certainly heard many times about how this
14 application at Moncks Corner is going to serve
15 the people in the northern part of Berkeley
16 County. Isn't that right?

17 A: Moncks Corner Hospital. But the Moncks Corner
18 zip code is a long zip code and it goes from
19 where the Moncks Corner Hospital will be
20 located and includes where the Carnes Crossing
21 zip code will be located. And Carnes Crossing
22 may be technically in Goose Creek, but it's in
23 the same zip code, on the same road as the
24 Moncks Corner facility. So in other words, the
25 communities of Goose Creek and Moncks Corner

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1 may be distinct; the zip code that both
2 hospitals are located in is by no means
3 distinct. And there's an area between these
4 two hospitals that would absolutely be
5 competitive for these hospitals as well as zip
6 code 29483, as well as others.

7 Q: Do you realize that Trident Medical Center and
8 Lexington Medical Center are on the same road,
9 I-26?

10 A: Trident Medical Center?

11 Q: And Lexington Medical Center are on the same
12 road, I-26.

13 A: Okay. And they're not 11 miles apart, however.

14 Q: Yeah. There's no stop light between those two
15 hospitals.

16 A: It would still take you longer than it would to
17 go from Moncks Corner to Carnes Crossroads,
18 because I've driven on that road, twice.

19 MR. SUMMER: And I just want to note for the record,
20 Your Honor. I drive between those two
21 facilities all the time and there are two stop
22 lights in between.

23 A: But it's nice to know that the two clients I've
24 served in the state are both --

25 Q: On the same road.

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1 A: -- on the same road.

2 Q: Now, do you think -- so, now, clearly you'd
3 have to agree that these projects are going to
4 serve separate and distinct patient
5 populations, right?

6 A: Well, a patient goes to hospital A or goes to
7 hospital B at any one point in time. I'm not
8 sure what you mean beyond that. Distinct
9 populations? No, I think there's broad service
10 areas where the population could go to A or
11 they could go to B. They could go to one
12 hospital or they could go to another.

13 Q: Don't you think the medical staffs are separate
14 and distinct in Berkeley County between Roper
15 St. Francis and Trident Medical Center?

16 A: I think they will become less distinct if Roper
17 has a hospital inside the community whether or
18 not the Moncks Corner facility is built.

19 Q: Other than you, has any other witness testified
20 to that in the case?

21 A: I don't know. I'm basing my testimony --

22 Q: You were here the whole time.

23 A: -- on what I've seen essentially in the market
24 at East Cooper, Mount Pleasant and what has
25 occurred there since the decision was made to

1 approve two -- you know, one hospital and the
2 replacement and expansion of another.

3 Q: Do you think the court should ignore the fact
4 that both of the applicants project that they
5 can fill the hospitals to capacity based on
6 their own patients primarily?

7 A: That's not a justification for a \$115 million
8 hospital if there's only a need based on the
9 growth in the county, which by the way, is
10 slowing. And there was even testimony on this
11 in the last week that it's slowing in Mount
12 Pleasant. It's slowing in Berkeley County.
13 And if that's the case, if it's slowing, if the
14 growth is slowing, it will not even be as easy
15 to get to the volume numbers to get to the
16 census for one hospital with 50. You may not
17 get to 12,000 days. If the population growth
18 is not going to be producing two and a half
19 percent more patients per year and it starts
20 producing one and a half percent more patients
21 per year, you certainly are not going to be
22 able to claim that there's enough need for two.
23 And it's going to push it a little further on
24 the need for one.

25 Q: Let's look at Respondent's 59.

1 A: 59? Are you going to put it on the screen?
2 Q: This is the population data, right, from the
3 census.
4 A: Sure.
5 MR. LONG: Can you blow up the middle part of the
6 numbers there?
7 A: Correct.
8 Q: In 2000 Berkeley County had a population --
9 what was Berkeley County's population?
10 A: 2000?
11 Q: 2000?
12 A: 142,651.
13 Q: And what was Berkeley's population in 2010?
14 A: The census number is 177,843.
15 Q: And can you calculate the increase in
16 population in the ten years between 2000 and
17 2010?
18 A: 35,192.
19 Q: Okay. 35,192. Okay. Can you calculate what
20 the population would be if the growth was the
21 same, same growth rate from 2000 to 2010?
22 A: Same growth in number?
23 Q: No, same -- well, we can it do that way. But
24 actually, it would be higher if it was the same
25 growth rate, wouldn't it?

- 1 A: Correct.
- 2 Q: Okay. Can you calculate that quickly?
- 3 A: Well, this is about --
- 4 Q: In 2020?
- 5 A: Yeah. If it's the same in number, it would
- 6 take you to about 213,000, okay?
- 7 Q: Okay.
- 8 A: And that's assuming basically a constant
- 9 addition of two and a half percent a year. I
- 10 don't have a fancy calculator here to do a
- 11 compounding, but it would probably be a little
- 12 bit higher.
- 13 Q: It would be higher, wouldn't it?
- 14 A: It would be higher.
- 15 Q: Okay. So in 20 --
- 16 A: Now, let me just say though, populations get to
- 17 a certain level and it becomes harder to
- 18 maintain the same progression growth rate as
- 19 over smaller populations. That's the first.
- 20 The second is there is clear evidence based on
- 21 the housing starts in Berkeley County that
- 22 since 2007 there has been a slow down in the
- 23 population growth because the number of housing
- 24 starts is an important issue in in-migration,
- 25 okay? Births and deaths are one issue. In-

1 migration versus out-migration is the other.
2 My guess is most of the increase between 2000
3 and 2010, a disproportionate share probably
4 occurred from 2000 to 2007. I'm fairly
5 confident, based on the housing start numbers,
6 that the growth rate from 2007 to 2010 has been
7 slower than the average rate over the full ten
8 years.

9 Q: Right. So that means the population would have
10 been even higher in 2010, right?

11 A: If the pace from 2007 had continued. But it
12 hasn't. And the question is, is it more likely
13 from 2010 to 2017 -- which is now the seventh
14 year of this forecast, and we're already out to
15 2012. We have housing starts data now through
16 2011, these numbers have not rebounded in any
17 significant way. We know the volumes overall
18 are not growing at the rate that would -- the
19 population model works. The number of patient
20 days should be growing by, assuming length of
21 stay stays the same, by about two and a half
22 percent a year.

23 Q: Okay.

24 A: We don't see that.

25 Q: Let's look at Respondent's 7.

1 A: Okay.

2 Q: This is what the state projected the population
3 would be in 2010, which was the basis of the
4 applications, right?

5 A: Correct.

6 Q: The projection was 162,370?

7 A: Correct. This was made, I believe, in about
8 2004, 2005 because they have -- no, 2005 is an
9 estimate. I'm trying to make sure I understand
10 this interpretation. This looks like an
11 estimate for each year --

12 Q: Right.

13 A: -- rather than a 2010 estimate at that time
14 period. That's the way I interpret this.

15 Q: Yeah. It's for each year, and the estimate for
16 2010 is 162,370.

17 A: No, no, I wanted to make sure that it wasn't an
18 estimate for 2010 that was made in each of
19 those years.

20 Q: No.

21 A: It's not that.

22 Q: Okay. And this was the information that the
23 applications would have been based on because
24 that was the best you had at the time, right?

25 A: That's correct.

1 Q: But now you know from the census there were
2 177,000 people there, right?

3 A: Uh-huh (affirmative response)

4 Q: So it was 15,000 more people than it projected,
5 right?

6 A: Right.

7 Q: And you just told me that in 2020 with the same
8 growth, it'll be 213,000 people living in
9 Berkeley County.

10 A: And I can tell you that the models that both
11 Mr. Richardson and I developed incorporate the
12 latest population information, the age
13 distribution, and they produce growth in volume
14 projected over the future to roughly two and a
15 quarter, two and a half percent. Mr.
16 Richardson's is actually higher than mine,
17 slightly higher. So it's all baked in. In
18 other words, the population growth that got you
19 to this high number in 2010 is baked into the
20 models now. So the only issue that's left is,
21 is that new model too high based on the most
22 recent information, which suggest a slowing in
23 Berkeley County.

24 Q: Well, what happened in the census was is that
25 the -- it would suggest that the forecasting

1 was way too modest, right? Let's look at the
2 second page of Respondent's 7 and let's look at
3 when the state projected that Berkeley County
4 would finally surpass 200,000. These were
5 projects that were made before the 2010 census.

6 A: Correct.

7 Q: But after the 2000 census --

8 A: Yeah. They were low on pretty much everything.

9 Q: Look at -- what year did the state project that
10 Berkeley County would surpass 200,000 in
11 population?

12 A: Between 2015 and 2020.

13 Q: No, it's 2030.

14 A: No, I'm looking at Berkeley County --

15 Q: Berkeley County, above 200,000 in population?

16 A: Oh, above 200,000. I thought you said the 177
17 number. My apologies. The number that was
18 reached in 2010, okay. But, and again, the
19 state's forecasting appears to have been
20 consistently low. I should tell you that the
21 numbers we used in our forecasting model, which
22 were zip code based because we got them from
23 Claritas, actually had higher overall forecasts
24 than the state model for the county as a whole.
25 We were much closer to the numbers that came

1 out.

2 Q: And so the court should not consider this
3 population data in the state's -- in the
4 determination of whether these applications are
5 competing?

6 A: No, I didn't say that at all. The population
7 data is the basis for the growth model that
8 allows you to determine how many new -- how
9 much new volume's going to be created and how
10 many beds are needed based on that incremental
11 volume. The population numbers are a part of
12 that. They're there and they reflect the
13 latest information. This doesn't reflect the
14 old estimates that were too low. It reflects
15 the latest census numbers and a much
16 accelerated growth rate going forward. I'm
17 saying in the same way that they underestimated
18 before, new estimates could be too high, at
19 least in this short-term period, because it
20 appears that the recessionary impact has had a
21 role in in-migration certainly for some of the
22 fast-growth counties.

23 Q: All right. Let's look at these bed need
24 calculations for just for Berkeley County.
25 Now, you actually did a bed need calculation

1 just for Berkeley County yourself, right,
2 Petitioner's 227?

3 A: I did.

4 Q: And it's very similar to Mr. Richardson's,
5 isn't it?

6 A: Yeah, with --

7 Q: You projected the bed need just for Berkeley
8 County --

9 A: Correct.

10 Q: -- to be 304, right, in 2017?

11 A: This was a response to show the absurdity, the
12 absurdity that even -- you know, the argument
13 was made that there's nothing serving this
14 area, okay? We're showing that there are, in
15 fact, 296 beds there. In other words, I'm
16 counting Trident as being part of the
17 inventory, just as it was in the State Health
18 Plans through, I don't remember the last year,
19 2001, 2002. Because I'm responding here to
20 documents I've seen that show licensed beds as
21 zero. So the real bed need is 218, 265 because
22 none of it's being used. In essence, Berkeley
23 County -- the Trident Medical Center here is
24 serving -- because it's the closest facility as
25 a source of patients. But the reality is the

- 1 real source of patients is not just Trident,
2 it's every facility that now gets patients from
3 Berkeley County, all of which is factored into
4 the state's bed need methodology, which right
5 now shows excess beds overall in the Tri-county
6 area.
- 7 Q: Let's just take the number on your sheet, 304,
8 okay, is the bed need. Now, Trident Health
9 System --
- 10 A: My bed need is 304?
- 11 Q: The bed need is 70 percent, 304 in 2017. There
12 it is.
- 13 A: Okay. What you have -- that's for all things,
14 including tertiary facilities.
- 15 Q: Okay. Well, did you do a different
16 calculation?
- 17 A: Yeah. We did it below.
- 18 Q: 265?
- 19 A: Correct. With 296 beds.
- 20 Q: Okay.
- 21 A: But this is --
- 22 Q: Now, let's look at Respondent's 81.
- 23 A: Let me just say something. There's more than
24 296 beds. It's 1,739 beds that are available
25 to treat Berkeley residents, whether they're

1 downtown in the peninsula, whether it's in
2 Mount Pleasant, whether it's in Dorchester
3 County or whether it's at Trident Medical
4 Center. This is a convenience to show that one
5 hospital -- that the calculations were made to
6 show there's zero beds in the county. The only
7 purpose of this, and I don't want to give it
8 any more credence than it deserves, is that I'm
9 saying what if the hospital was a mile further
10 -- a mile from where it is, so if it was inside
11 the county. If it was inside the county, the
12 comment I made this morning is every one of
13 those maps, every one of those calculations
14 that Mr. Richardson made would be utterly
15 useless because you couldn't say zero, you'd
16 have to say 296 and there's no bed need.
17 That's all this was designed to do. My
18 argument that I made this morning is not that
19 Trident is the only facility that's serving
20 these patients. It's all of the facilities
21 where Berkeley County residents now go, the
22 capacity to serve those patients is there, and
23 there's more capacity than is needed because
24 there's a net surplus of beds in the three
25 county area.

1 Q: Okay. Did Mr. Gallati ever take you to any of
2 these town meetings he's done to tell the
3 people at Berkeley, Moncks Corner and Goose
4 Creek that they have 1,700 beds available to
5 them? Did you ever go to any of these meetings
6 with Mr. Gallati?

7 A: No, I'm not saying that all 1,700 beds are
8 going to filled with Berkeley County residents.
9 That's -- if you're suggesting I'm saying that,
10 the answer is, no.

11 Q: Let's look at Respondent's 81.

12 A: And remember, Berkeley --

13 Q: These are non-tertiary discharges from Trident
14 Health System, okay, split out by the -- for
15 Berkeley County only. So can you calculate the
16 need -- you testified earlier that half of
17 Trident's inpatients came from Berkeley County.
18 So will you use these numbers and calculate the
19 actual percentage --

20 A: I didn't say that. I said close to 50 --

21 THE COURT: Just wait a minute. Let him finish, Mr.
22 Baehr.

23 MR. BAEHR: Okay.

24 Q: Calculate the actual percentages of the people
25 from Berkeley County, the percentage from

1 Trident Health System that constitutes
2 residents of Berkeley County?
3 A: Okay. I've got to read this slide because I'm
4 not familiar with it. Let me see what this is.
5 Q: Sand if you'd tell the year.
6 A: Looks like it's through April of 2010.
7 Q: Okay. Don't use the April 2010, but use a
8 different --
9 A: Okay. Pick a different year?
10 Q: Pick a different year.
11 A: Okay. It shows that Trident Medical Center has
12 6,417 patients from Berkeley County.
13 Q: No, it doesn't show that. That's both. Just
14 do Trident Medical Center.
15 A: Oh, I'm sorry.
16 Q: The line above.
17 A: 5,335.
18 Q: Okay. That's 2009 you're using, so they had
19 5,335 --
20 A: Okay.
21 Q: -- inpatients.
22 A: Uh-huh (affirmative response).
23 Q: Out of a total of 18,876. No, I'm sorry. Out
24 of a total -- we'll have to add them together.
25 A: I'm missing something.

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- 1 Q: No, I'm sorry. I'm sorry. I'm sorry. No, no,
2 wait a minute. Wait a minute.
- 3 A: I'm missing something. If this is just Trident
4 utilization, this is not --
- 5 Q: No, I'm sorry. Let's start over. Let's start
6 over.
- 7 A: All right.
- 8 Q: I didn't ask the questions well. Respondent's
9 81 has inpatient discharges for non-tertiary
10 DRGs for each year.
- 11 A: Uh-huh (affirmative response).
- 12 Q: It has the total for each of the two Trident
13 Health System hospitals, and then it carves out
14 the Berkeley County portion.
- 15 A: Okay.
- 16 Q: You see that?
- 17 A: I see it.
- 18 Q: So if you take the Berkeley County number,
19 5,335, and divide it by the 18 --
- 20 A: I can tell you, I have different numbers that
21 are more current than this that basically had
22 -- that had 72,000 non-tertiary days in the
23 Trident System, of which 29,000 were coming
24 from Berkeley County, 34,000 were coming from
25 Dorchester County and I believe 8,000 or 9,000

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1 were coming from Charleston County. Those were
2 the non-tertiary days. And of the 29,000 days
3 that were coming from Berkeley, roughly 85
4 percent of them were Trident rather than
5 Summerville. And you can see that ratio here.
6 The Trident number is always roughly five times
7 or more the level from Summerville. So of the
8 29,000 that were coming from Berkeley County
9 that were going to Trident Health System,
10 roughly 24,000, 25,000 of them were going to
11 Trident Medical Center and the remainder to
12 Summerville.

13 Q: The problem with that calculation is that
14 you're using the entire system instead of
15 looking just at Trident Medical System.

16 A: No, no, I just broke it out. I just broke it
17 out between the two.

18 Q: Okay.

19 A: In other words, the historic ratio between the
20 two is somewhat over 80 percent of the Trident
21 Health System volume from Berkeley County is
22 seen at Trident Medical Center and the
23 remainder is seen at Summerville.

24 Q: Let's look at the inpatient days on this
25 document right here, Respondent's 81, which is

- 1 their --
- 2 A: This is not days. This is discharges.
- 3 Q: Right. It's discharges. Okay, 5,335
- 4 discharges from Berkeley County.
- 5 A: Okay.
- 6 Q: And add that to 8,271 discharges from
- 7 everywhere else?
- 8 A: Uh-huh (affirmative response).
- 9 Q: And my calculation gives you a total of 13,606
- 10 discharges, right?
- 11 A: Correct.
- 12 Q: Okay. And what is 5,335 divided by 13,606?
- 13 A: Roughly 40 percent.
- 14 Q: Roughly 40 percent, all right.
- 15 A: And as I said before, it's over 40 percent, not
- 16 50. I don't think my answer was wrong.
- 17 Q: But on your bed need calculation, you put 100
- 18 percent of the Trident Medical Center beds in
- 19 Berkeley County instead of 40 percent of the
- 20 beds, right?
- 21 A: What I did was I made the same kind of
- 22 calculation to show the absurdity of what I
- 23 thought were these attempts to say that there
- 24 were zero beds in Berkeley County, to show that
- 25 in all the other counties that were shown, you

1 counted the total number of beds there, whether
2 or not the patient population that was served
3 by those hospitals in those other counties was
4 100 percent from those counties or not. In
5 other words, you were giving full value to all
6 the beds in those counties. For instance,
7 hospitals in Richland County get a lot of
8 patients from Lexington County. Lexington
9 County gets a fair number of patients from
10 Richland County. We just did a ratio of the
11 number of patients from, essentially beds per
12 thousand, you would miss essentially the fact
13 that they're -- it'd be inaccurate because
14 hospitals serve more than a particular county.
15 The 296 was just as a response to what I
16 considered to be an unfair attempt to influence
17 first DHEC and then this court that Berkeley is
18 a step-child without any beds, and as a result,
19 we can ignore Trident Medical Center because
20 it's located nine-tenths of a mile away in
21 North Charleston. And the issue is are all 296
22 beds at Trident Medical Center used for
23 Berkeley? Of course not. Of course not. But
24 they have by far, of any of the hospitals, the
25 largest share. The system is 54 percent.

1 Forty-five or 46 of that 54 percent is at
2 Trident Medical Center. The other basically
3 nine percent is at Summerville Medical Center.
4 And those numbers are fairly consistent with
5 what I've seen in the last year or two, later
6 data than you have here.

7 Q: Let's go back and look at your Exhibit 227,
8 your bed need calculation for Berkeley County.

9 A: Sure.

10 Q: And you calculated --

11 A: This is not --

12 Q: Well, just answer my questions, Mr. Baehr.

13 A: It's a mischaracterization.

14 Q: Okay. You calculated a bed need of 304. It's
15 the top number there. And what is 40 percent
16 of 296?

17 A: It's about 120.

18 Q: Okay. It's actually 118 or 119, but I'll take
19 the 120.

20 A: I'm doing rounding.

21 Q: 304 -- I know.

22 A: To move the court along.

23 Q: You're great at math. I'm right with you. 304
24 minus 120, how much is that?

25 A: 184.

1 Q: Okay. Subtract out the 100 beds that have been
2 approved by the court. How many is that?

3 A: Subtract out 100 beds?

4 Q: Yeah?

5 A: They haven't taken 100 beds from Trident
6 Medical Center.

7 Q: Well, let's just look at Berkeley County?

8 A: Okay.

9 Q: 120 beds.

10 A: Okay.

11 Q: You've got a bed need of 304, and you've got --
12 you give Berkeley County 40 percent of Trident,
13 that's 120; you give them Moncks Corner, that's
14 50; Carnes Crossroads, that's 50 --

15 A: Uh-huh (affirmative response).

16 Q: -- and you still don't hit the 304 bed need, do
17 you?

18 A: And what I'd argue is because there are all
19 kinds of existing facilities currently serving
20 that population, which will continue to serve
21 that population, you could add -- you could put
22 300 beds in Berkeley County. It would be way
23 too many and a significant portion of the
24 population of Berkeley County would continue,
25 for the reasons I mentioned earlier, to go to

1 MUSC, to go to Roper Downtown, to go to St.
2 Francis Downtown, because of the fact that
3 smaller hospitals, especially smaller community
4 hospitals, are not going to have the same
5 appeal for some residents who have long
6 experience with particular institutions, and
7 especially as they get older and Medicare
8 populations are sometimes half the population
9 of a hospital, may not think that for their
10 care the best facility is a 50 bed hospital.
11 They would rather be downtown where they get a
12 different kind of comprehensive care, so it's
13 perception.

14 Q: So in your opinion is this exhibit that you
15 prepared irrelevant to the court's
16 determination in this case?

17 A: What it is is a response to the argument that
18 there is zero beds in Berkeley County. It has
19 nothing more, nothing less. It's no attempt --
20 it is not by any stretch of the imagination an
21 attempt to argue that all of Trident Medical
22 Center's beds are there to serve Berkeley
23 County. What it is is to show that the idea
24 that there are zero beds is nonsense. Because
25 if Trident Medical Center was inside the

1 county, a mile away, these would be the
2 calculations Mr. Richardson would do. And as
3 a result of that, he'd never submit them. We
4 would have never seen them because they
5 wouldn't have been helpful to the case. The
6 only reason we saw what we saw is because they
7 could draw a wall around Berkeley and say there
8 are zero beds there. This is simply a
9 response, well, what if Berkeley was a mile
10 away, Trident was a mile away inside the
11 county, this is what Mr. Richardson's slide
12 would look like. It is not an attempt by me to
13 argue that this is what bed need is. And when
14 we went through this in my deposition, I think
15 I explained that fairly clearly.

16 Q: Mr. Baehr, you're the one who moved the
17 hospital down the road and put it in Berkeley
18 County on your exhibit, and I just said put 40
19 percent of the hospital in Berkeley County and
20 you still have a bed need for both these
21 applications and more. Isn't that right?

22 A: That's an improper way to read this, especially
23 since there's -- again, I'll leave it at what
24 I said.

25 Q: Let's look at Respondent's 91. Now, you and

1 Mr. Summer had a number of questions about this
2 PowerPoint that Mr. Bowling prepared or that
3 was prepared by the Roper St. Francis people
4 with the -- do you recall the PowerPoint that
5 had the 65 percent market share on it?

6 A: I do. I do.

7 Q: Okay. Look at Respondent's 91. This is the
8 actual utilization and market share numbers for
9 all of Berkeley County 2010.

10 A: Okay. Uh-huh (affirmative response).

11 Q: And if you look at -- and let's go down to the
12 bottom, because the bottom one excludes
13 newborns. We'll take the babies out.

14 A: Okay.

15 Q: Okay. You see that. How many total --

16 A: Can you make it a little bit bigger?

17 Q: Yes. She's going to make it bigger for you.
18 How many inpatients were there in Berkeley
19 County, excluding the babies, in 2010 for the
20 year, total number?

21 A: Berkeley County's total?

22 Q: Yeah, just looking at Berkeley.

23 A: 15,165..

24 Q: That's 15,165 inpatients, right?

25 A: That's correct.

1 Q: Now, both of the hospital applications
2 projected that they would be fully occupied, 70
3 percent occupancy, in the third year, right?

4 A: Correct.

5 Q: And both of the hospitals projected that they
6 would be around --

7 A: Actually, the Moncks Corner is slightly less
8 than 70 percent.

9 Q: Like 69.4, something like that, right? 69.4
10 percent.

11 A: Uh-huh (affirmative).

12 Q: And both of the applicants projected that 70
13 percent occupancy on a 50 bed hospital would be
14 right at 3,000 patients, right?

15 A: 3,000 discharges.

16 Q: Discharges, right? Okay. So if Roper St.
17 Francis obtained a 65 percent market share in
18 Berkeley County, how many discharges would that
19 be in a year?

20 A: That's not what the proposal is, though. The
21 proposal is not a 65 percent market share in
22 Berkeley County. It was a 65 percent market
23 share in the seven mile area around Carnes
24 Crossroads, of which 35 percent of the
25 population isn't even in Berkeley County..

- 1 Q: Okay. I didn't -- I need you to answer my
2 question. What would 65 percent market share
3 be of Berkeley County in the number of
4 inpatients --
- 5 A: If you apply it to 15,165?
- 6 Q: Right.
- 7 A: You'd have about 9,800 cases.
- 8 Q: Almost 10,000 cases.
- 9 A: Correct.
- 10 Q: So that would be three times the volume
11 projected for the 50 bed hospital at Carnes
12 Crossroads, right?
- 13 A: Correct.
- 14 Q: More than three.
- 15 A: I don't think anyone was ever talking about a
16 65 percent market share in the entire county.
17 In fact, the population within the seven mile
18 radius that's in Berkeley County is only
19 65,000.
- 20 Q: Okay. So, now, you don't really know what Mr.
21 Bowling told anybody in Moncks Corner about
22 that, do you?
- 23 A: I wasn't at the meeting. I just see the
24 slides. I have no idea what he said.
- 25 Q: Well, you heard his testimony?

1 A: I heard his testimony.

2 Q: Okay. And did you hear him testify that that
3 65 percent meant that that's what they were
4 going to try to do, is get a 65 percent market
5 share?

6 A: The only thing I know a presentation is
7 prepared. It has the name of one of my peers
8 in the business for many years, who is a
9 consultant who has a good reputation. And it's
10 presented to people in a community and it's
11 being used as justification for locating in
12 site A, rather than site B. Now, maybe they
13 came up with a 65 percent number and didn't
14 really think through the implication of that
15 too carefully. I don't know. I wouldn't have
16 put my name down to a 65 percent market share
17 for a provider that has a 23 percent market
18 share. I mean, I think that's unrealistic,
19 certainly countywide. I mean, the question you
20 ask me I think strains credibility. I don't
21 think any new provider is going to get 65
22 percent of the county anytime soon.

23 Q: Well, let's just talk about the actual
24 possibility of it. It's impossible because the
25 hospital at Moncks Corner -- I mean, the

1 hospital at Carnes Crossroads only has 50 beds.

2 Isn't that right?

3 MR. SUMMER: Your Honor, I want to object --

4 THE COURT: There's an objection.

5 MR. SUMMER: Please, counsel? I'd like to object to
6 this line of questioning in terms of relevancy.
7 And let me tell you why. This witness
8 attempted to explain to Mr. Long that 65
9 percent was the seven mile radius of the Carnes
10 Crossroads site. He continues to ask him
11 questions of the 65 percent market share for
12 the entire county, okay? So my objection is
13 that it's not relevant. If he wants to ask him
14 about 65 percent within the seven mile radius
15 of Carnes Crossroads site, that's relevant.
16 That's in evidence. But if he wants to ask him
17 about a 65 percent market share for the entire
18 county, no one has testified that that was the
19 goal or objective of management. The testimony
20 is that management wanted 65 percent of the
21 seven mile radius. It says right here on this
22 slide, based on seven mile radius of site. So
23 my point simply is, is that we can go on and on
24 with the numbers game, but it doesn't -- it's
25 not probative. It's not probative to any issue

1 in the case because it's not relevant. And so
2 my objection is, is that it's wasting the
3 court's time and it's confusing the issues in
4 the court.

5 **THE COURT:** Mr. Long.

6 **MR. LONG:** Your Honor, he raised the issue. The man
7 calculated an adverse impact, a number, this
8 morning on the 65 percent market share. And,
9 again, Mr. Summer's doing what he's done all
10 day, which is make his closing argument. That
11 was a completely improper objection. He went
12 on and on and on and tried to coach the witness
13 on his answer. That's the reason I tried to
14 interrupt at the beginning. And, Your Honor,
15 I think it's a very valid question. I'm
16 getting there. I've heard his answer. And,
17 you know, Mr. Baehr, he doesn't answer the
18 question, so it's hard to do the cross when the
19 witness doesn't answer the question, so I'm
20 doing the best I can with it.

21 **THE COURT:** Well, at a more basic level, this is
22 cross examination and I have no way of knowing,
23 I don't have second sight to know where he's
24 going with this, so I overrule the objection.

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

1 Q: Now, to get a 65 percent market share in
2 Berkeley County in a 50 bed hospital is
3 impossible, isn't it?

4 A: Well, a 65 percent market share of essentially,
5 essentially of your patient population
6 essentially. If you're serving a particular
7 service area that's got 65,000 people in
8 Berkeley County, okay, and another 35,000
9 outside, okay, that's roughly -- the county has
10 a 177,000 population, so it's about 35 to 40
11 percent of the county's population. The
12 exercise we went through this morning showed
13 for a 100 bed hospital, okay, how much impact
14 that would have. Meaning how many additional
15 patients would have to be drawn from over and
16 above the current market share to get that
17 number. That number, using the 73 percent was
18 31, okay? That's 31 increase in market share
19 over and above what their current share was.
20 So if you're going from 23 to 65, and not all
21 of the impact is on us, essentially it means
22 that Roper is overall close to tripling their
23 share. You'd have to look at the size of the
24 facility versus the population you have there
25 to be able to calculate exactly what, you know,

1 their overall volume would be and what the bed
2 size would be to do that. The calculation we
3 made was a different one, which simply was if
4 they essentially reallocated that many patients
5 from Trident to someone else, what's the
6 impact, and can you come up with that number
7 based on an increase in that share for a 100
8 bed hospital. That's the only calculation I
9 did.

10 Q: Okay. So you're not contending to the court
11 that your adverse impact numbers from this
12 morning on the 65 percent market share are
13 relevant to the case since the hospital has
14 only 50 beds, right?

15 A: The point I'm making is that if that were the
16 goal, and if that were to be achieved, that,
17 no, in a 50 bed hospital you wouldn't get 65
18 because even with that 31, that only represents
19 the increment. It wouldn't represent the base
20 of the 23 percent. But I made the other
21 comment, which is that if, in fact, a new
22 hospital were so successful that its effective
23 share were very high, even with a small size,
24 and there are empty beds other places in the
25 system, and the system has a policy of when

1 they get extra patients in the door that they
2 can't treat at an existing hospital, moving
3 them somewhere else, then the effective
4 capacity of the hospital is beyond 50.

5 Q: You're not really going to contend that Roper
6 St. Francis would move a patient that was not
7 stable, are you?

8 A: No. And I thought the -- again, that whole,
9 that whole questioning exercise is a little bit
10 odd because I think for the most part -- and
11 I'm surprised Mr. Severance gave the answer
12 that he did. I think the appropriate answer
13 was we'd keep them in a holding area or
14 somewhere until a bed showed up, all right? If
15 you're only dealing with an excess of one, I
16 don't think you'd necessarily have to transfer
17 them. They'd find some way to deal with it.
18 I thought his answer was surprising because it,
19 you know, suggested this sort of possessiveness
20 of the patient, and he didn't qualify it. He
21 did not qualify it by the patient's condition.
22 I simply said I'd be surprised if they'd
23 transfer a patient that wasn't stable that was
24 in that condition. But, again, it was a
25 hypothetical. You're asking me about a

1 hypothetical someone else answered. I never
2 have to make that decision.

3 Q: Okay. Do you remember your testimony about the
4 earlier draft of the Roper St. Francis CON
5 application that used the seven mile radius?

6 A: Correct, which is similar to what was in that
7 presentation that was made.

8 Q: And you said or Mr. Summer asked you about the
9 subsequent iterations that increased the
10 redirection numbers; do you recall that?

11 A: Yeah. Between that first draft -- and there
12 may have been more drafts. I mean, people have
13 plenty of drafts and that's okay.

14 Q: Have you seen any more from Roper?

15 A: I haven't seen any more. All I'm saying is
16 there was a difference of about, close to 400
17 in the number of patients redirected. Same
18 number of overall patients in the hospital, but
19 I think there were 382 more redirected in the
20 application than in this first draft.

21 Q: But it's the same percentage, isn't it?

22 A: Same percentage.

23 Q: And the reason the number's higher is because
24 the population base is higher?

25 A: It's all the county rather than seven miles.

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1 That's correct.

2 Q: Right. And you testified earlier this morning
3 that you did not have a problem with anybody
4 quibbling over any of your market share
5 projections for any of your zip codes, right?

6 A: I certainly believe that you could make a
7 reasonable critique and say the 50 percent
8 should have been 60 percent. Market share
9 maybe should have grown by two, three percent
10 in this area. That's fine.

11 Q: But you were very confident about the total,
12 right?

13 A: Yes. I believe that if that the distribution
14 of patients was approximately correct -- it
15 might be somewhat different, but approximately
16 correct -- it would not be changed by big
17 orders of magnitude.

18 Q: Yeah. And the total is the county because it
19 includes all of the zip codes in the county.
20 That's the total. So you're confident in the
21 county number. You're not confident in the
22 individual zip code numbers, correct?

23 A: Right. It was based off of what was the
24 population estimate at that time, which was
25 based off again of projected growth in the

1 population and bed need. I did the same thing
2 now with updated numbers, come up with 12,200
3 days roughly, shows that there's a need for an
4 average -- an additional average daily census,
5 3,334, which matches what we have.

6 Q: And you have done need analysis B11
7 calculations for CONS in South Carolina that
8 use the county and not the zip code, correct?

9 A: For the open heart, that is correct.

10 Q: But yet you criticize Mr. Richardson for using
11 county instead of zip code.

12 A: Correct.

13 Q: Is that your testimony?

14 A: Yes. I don't see any reason why this should
15 have been different than Mount Pleasant where
16 they used zip codes. And they also started off
17 there with circles that were drawn a certain
18 number of miles there, when they first did
19 their analysis there. The explanation to me
20 didn't make a lot of sense. The argument was
21 that some of the particular zip codes had odd
22 shapes and they might have gone outside the
23 county, so what? A health planner can make the
24 same kind of allocations that we did between
25 what's in the county and what's not in the

1 county. That's not a particularly difficult
2 chore. It's a little more effort. It means
3 getting a little more detailed population data.
4 I think the county is the appropriate way to
5 look at open heart surgery.

6 Q: And Mount Pleasant, if you did a county for
7 Mount Pleasant, you'd have to do all of
8 Charleston County, which would include West
9 Ashley, James Island, John's Island, and the
10 peninsula.

11 A: Correct. Correct.

12 Q: So you don't see any difference between doing
13 an analysis for Mount Pleasant and an analysis
14 for Berkeley County?

15 A: I don't have a problem with his doing the whole
16 county. My problem is that he doesn't go
17 beyond that. Because how do you know where the
18 adverse impact is? How do you know where
19 they're getting their patients from? How do
20 you know what are, in fact, the areas they're
21 proposing to serve? If, in fact, most of the
22 patient population, if it turns out they did
23 those numbers and 80 percent of the population
24 was going to come from that seven mile circle,
25 that's more adverse impact on Trident Medical

1 Center than if the distribution, say, was 50
2 percent from the north and 50 percent from
3 within the seven mile circle.

4 Q: Well, let's look at adverse impact. Let's look
5 at Respondent's 70, which is Mr. Richardson's
6 calculations on page 689.

7 A: Okay. I see it.

8 Q: Now, you understand this, right?

9 A: I do.

10 Q: You understand everything Mr. Richardson did,
11 correct?

12 A: I follow the methodology.

13 Q: Okay. And you testified this morning that the
14 worst case scenario that Mr. Richardson laid
15 out is not going to happen, right? Now, I
16 heard you say pretty clearly this morning say
17 that's not going to happen, right?

18 A: That's correct. There is, however, major,
19 major, problem with both three and four that
20 have nothing to do whether the allocation's 73
21 percent or 100 percent. There's something
22 missing. And what's missing is Summerville
23 Medical Center has applied for 30 beds based on
24 a need of 24 beds in the State Health Plan and
25 is going to require close to 2,000 discharges

1 of its own to meet its need. These two models,
 2 both in number three and the number four,
 3 ignore Summerville Medical Center as using part
 4 of the entire Trident Medical, the Trident
 5 System need, and instead say, forget
 6 Summerville. We don't even bring it up here.
 7 It's not on the chart. Mr. Baehr did it. I
 8 did it in my projections that I presented. I
 9 had the growth coming out of Summerville and I
 10 had the growth coming out of Berkeley Regional
 11 Medical Center and I compared it to the overall
 12 Trident System growth. What Mr. Richardson
 13 does here is he ignores the Summerville number
 14 and he says Trident growth is there to support
 15 two things, the Berkeley Hospital in Moncks
 16 Corner, the Trident Hospital in Moncks Corner,
 17 and then whatever's left over can go for the
 18 Roper St. Francis. But there isn't anything
 19 left over. When you throw Summerville in the
 20 mix, the 80 bed need for the two hospitals is
 21 taken up by the growth in the system that
 22 supports those two. There isn't anything left
 23 for Roper St. Francis Berkeley to take patients
 24 away. This basically says Roper can take the
 25 growth that's there for Summerville. And

1 that's wrong.

2 Q: Well, Mr. Richardson said there was zero lost
3 cases, so he calculates no adverse impact
4 because of the growth for Trident Health
5 System, zero impact.

6 A: But he ignored -- he only included part, one of
7 the two, Trident projects which is approved.
8 Summerville's approved.

9 Q: Well, you calculated -- let's go to
10 Petitioner's 46, page 33.

11 A: Sure.

12 Q: You made the same calculation, didn't you? You
13 made it right here.

14 A: I include Summerville. Mr. Richardson did not.
15 I mean, that's, I think, a fatal flaw to this
16 page. He's arguing that you can put all the
17 patients -- you can take care of all the volume
18 needed for the hospital in Moncks Corner and
19 there's enough left over in the total Trident
20 System model, total Trident System growth to
21 support what we need to take from you to fill
22 our hospital in Carnes Crossroads, but that's
23 wrong.

24 Q: Mr. Baehr, you calculated the forecasted growth
25 for the Trident Health System to be 50 patients

1 per day.

2 A: Correct.

3 Q: An ADC of 50.

4 A: Right. And then look above it on the same
5 slide, above it, you can't ignore the top.
6 Berkeley Regional Medical Center takes 35,
7 Summerville Medical Center takes 23, the total
8 is 58. It's more than the growth. Meaning
9 they have to dig into the base already or take
10 tertiary growth, which is not shown here,
11 that's another five or six, to fully support
12 that. There isn't a day available to give to
13 Roper St. Francis Berkeley, when you consider
14 that there are two approved projects, both of
15 which are based on Trident growth, both of
16 which reflected in the State Health Plan with
17 need, and they're going forward with them.

18 Q: Mr. Baehr, there are three approved projects.

19 A: But only two of them rely on Trident System
20 growth. What Mr. Richardson says is ignore one
21 of the Trident projects, which is based on
22 growth, and take my project, which is based on
23 a transfer into the area from a hospital that
24 has no need and rely on that need which should
25 be for Summerville to support their project,

1 and instead apply it to the Roper St. Francis
2 Berkeley facility.

3 Q: Just to be clear, Mr. Richardson and Roper St.
4 Francis contend that there is no adverse impact
5 on Trident Health Systems from its application
6 at Carnes. Isn't that correct?

7 A: Correct. And I am convinced they're wrong.
8 Even on Mr. Richardson's test they're wrong
9 because if you throw in the Summerville
10 project, which he ignored, every admission they
11 take from Berkeley doesn't come out of the
12 growth anymore. It's coming out of the base.
13 They ignore the fact that both projects rely on
14 the growth. There's a 56 bed need at Trident,
15 there was 24 at Dorchester -- in Summerville,
16 80 bed need overall. What did they apply for?
17 Fifty at Trident, and which they're locating in
18 Moncks Corner; 30 at Summerville. All of their
19 system growth is gone to support those two
20 hospitals. Now you've got Mr. Richardson
21 saying we're going to take volume from you, but
22 it doesn't count because we're only taking from
23 the growth. The growth's accounted for.

24 Q: Well, if you ignore the Summerville expansion,
25 there is enough growth to basically support the

1 two hospitals, isn't there?

2 A: Why would you ignore the Summerville project,
3 which is based on bed need in the State Health
4 Plan. I need a drink of water real fast here.

5 THE COURT: All right. A five minute recess.

6 (Off the Record from 4:41 p.m. until 4:50 p.m.)

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

8 MR. LONG: Thank you, Your Honor.

9 Q: All right. Let's look at Petitioner's 46.

10 A: Okay.

11 Q: Pages 623, 624. Do you have those in front of
12 you up there?

13 A: Yeah. I actually have a hard copy.

14 Q: Okay. I'm sorry 1623. It's actually
15 Petitioner's Exhibit 46, page 35.

16 A: Okay.

17 Q: Okay. And this slide at the bottom here with
18 the highlighted portion is your calculation of
19 the impact of Roper St. Francis Berkeley on
20 Trident Medical Center, right?

21 A: Right.

22 Q: And you calculated 2017 and that would be 6,257
23 patient days; is that right?

24 A: It's actually calculation of Roper's impact on
25 Trident on Roper itself, which is, I'll call a

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1 measure of redirection and other area
2 hospitals.

3 Q: Right. And 6,257 patient days, right --

4 A: That's correct.

5 Q: -- is the impact of Roper St. Francis on
6 Trident Medical Center.

7 A: Based on historical distribution of patient
8 population.

9 Q: Okay. And then on the next page you calculate
10 the impact of Berkeley Regional Medical, the
11 hospital in Moncks Corner, on Trident Medical
12 Center to be 6,013 days, right? Right above
13 the Roper St. Francis line there, the yellow.
14 That's your impact?

15 A: Yes. That's the impact on themselves, which is
16 effectively their transfer patients to
17 themselves.

18 Q: Right. And then right below that you have the
19 impact of Roper -- you have the impact of the
20 Summerville Medical Center 30 bed project --

21 A: Correct.

22 Q: -- on Trident Medical Center and you calculate
23 that to be 1,249 patient days, right?

24 A: On year three, yes.

25 Q: On year three. We're just looking at the year

1 three on that, okay?

2 A: Okay.

3 Q: So we total up those three numbers.

4 A: Uh-huh (affirmative response).

5 Q: Have you got a calculator, you want to go with

6 me? 6,257.

7 A: 6,257, okay.

8 Q: 6,257, 6,013.

9 A: 013?

10 Q: 013.

11 A: Okay.

12 Q: And 1,249.

13 A: Okay.

14 Q: That's 13,519 patient days, right?

15 A: Correct.

16 Q: Calculate the average daily census for 13,519

17 patient days with a 425. Or actually, you just

18 divide it by 365, don't you?

19 A: Let me see. Okay.

20 Q: And that's an average daily census of 37,

21 right?

22 A: Correct.

23 Q: And on page two earlier we were just looking

24 at, you calculated the total growth, right

25 there --

1 A: Uh-huh (affirmative).

2 Q: -- you calculated the total growth for just the
3 Trident Health System alone at 50.4 average
4 daily census, right?

5 A: Correct.

6 Q: And so by your own calculations, there's 13
7 more patients per day available for Trident
8 after the construction of both hospitals and
9 the Summerville 30 bed, correct?

10 A: If you accept this adverse impact model, which
11 means you accept the level of redirection
12 that's assumed in here, which is different than
13 what's in the application from both Trident and
14 for Roper St. Francis Berkeley.

15 Q: Okay. Well, let me --

16 A: Which you've been disagreeing with up until now
17 consistently through the trial.

18 Q: Well, our disagreement is -- well, we'll get to
19 that in a second. Okay. We'll get to that in
20 a second. And this one right here is actually
21 what the Summerville projects. They project
22 that increase in market share, right?

23 A: That's right.

24 Q: They project they're going to have more
25 patients because it's --

1 A: A small increase in market share in Dorchester
2 County.

3 Q: And so they project 56.4, so that would
4 actually be almost 20 patients per day that
5 would be left for the Trident Health System
6 after both hospitals are constructed and the
7 Summerville 30 bed application --

8 A: I'm not following what you're saying here,
9 Jimmy. Would you go back?

10 Q: Well, we just calculated the ADC as 37?

11 A: Correct.

12 Q: When you -- you did 50.9, but if you did a
13 three percent increase in market share growth,
14 it's 56.4, isn't it?

15 A: It's a three percent market share increase in
16 Berkeley County, correct.

17 Q: Right. And so 56.4 minus 37 is nearly 20
18 patients per --

19 A: And remember, that three percent was, in
20 effect, a response to the fact that I was
21 challenged on whether 100 percent redirection
22 could occur. So it was an alternative, a
23 sensitivity test, I put in the three percent as
24 an option.

25 Q: And, of course, you're not even considering in

1 your adverse impact calculations in your
2 exhibit the redirection of patients. You're
3 not even -- let me just expand on that. You're
4 not even considering the fact that more
5 patients will go to the Carnes Crossroads
6 facility that have traditionally have gone to
7 Berkeley, that there'll be a shift, a
8 redirection on those patients. You're not
9 considering that?

10 A: No, actually it's wrong. I'm considering -- I
11 am assuming that the redirection of patients
12 from the Roper St. Francis System to the new
13 hospital will exactly reflect the historic
14 distribution of patients in the area, which
15 means if Roper had a 24 percent share of the
16 market or 23 percent share of the market, and
17 a new hospital, they build a new hospital, then
18 they can expect that 23 percent of the impact
19 of that hospital will be on itself, which is
20 redirection. The other 77 percent is changes
21 in market share on the existing providers.

22 Q: So your application to Moncks Corner is 100
23 percent redirection and now you're contending
24 that the redirection for Roper St. Francis is
25 23 percent?

1 A: This is an attempt because --
2 Q: Is that correct?
3 A: Let me expand on it. You have two
4 applications. Each one relies on models, all
5 right? One of them argues that there is going
6 to be some adverse impact. Until this point in
7 the trial, really, I've never actually heard
8 anyone from your side, in fact, because no
9 argument was made to calculate what the adverse
10 impact of the Trident project would be in
11 Moncks Corner on Roper St. Francis Berkeley.
12 I calculated a number. Mr. Knapp didn't take
13 that number and calculate an adverse impact on
14 Roper. I don't have the internal financials at
15 Roper to be able to make essentially a
16 contribution margin analysis for that hospital.
17 The applications are what the applications are.
18 They were drawn as they were drawn, they were
19 drafted as they were. The application in the
20 case of Roper St. Francis, in the case of
21 Berkeley and Moncks Corner, relied on growth in
22 the Trident system. The Summerville
23 application relies on growth in the Trident
24 System, particularly in their market. All
25 other things being equal, the Trident System

1 growth supports, almost supports, almost
2 supports those two projects, okay? All right.
3 So these calculations --

4 Q: It more than supports it. You're showing a 50
5 ADC and we just did the calculations --

6 A: These calculations --

7 Q: -- for all three projects would be 37.

8 A: If you're willing to accept that essentially
9 this level of adverse impact is the appropriate
10 level of adverse impact, I'm fine with it. All
11 I tried to do with these models is to calculate
12 a consistent approach to calculating adverse
13 impact, not one that says, well, I don't care
14 that the state is concerned with growth, that
15 that's real adverse impact. I don't consider
16 it that way because some judge in Florida said
17 he's only concerned with whether you wind up
18 below the base. I'm trying to find a
19 consistent way to evaluate adverse impact,
20 that's what I've done. The applications stand
21 on what they've said. And they are -- they
22 were before the Department in the form they
23 were before the Department. This is an
24 exercise to try to consistently apply a
25 methodology so I could make a calculation of

1 adverse impact.

2 Q: Why don't you consistently use, apply the
3 assumptions in both applications instead of
4 changing the one for Roper St. Francis; have
5 you considered that?

6 A: We actually can make that calculation. I mean,
7 we've got -- for instance, in Mr. Richardson's
8 last analysis on page 689, he's got his number
9 of 839. He assumes it comes from the growth.
10 It doesn't come from the growth. Follow his
11 approach. All of that is taken from the base
12 of Trident Medical Center because the Trident
13 Medical Center project, all of their growth
14 goes to support Summerville Medical Center and
15 the Moncks Corner facility.

16 Q: 897 is only a ADC of ten.

17 A: What it means --

18 Q: That's ten patients a day, right?

19 A: If you accepted his number, which is about 900
20 as opposed to my number, which was fifteen-
21 hundred-some-odd, then the adverse impact would
22 be more in the range of about ten million
23 rather than 16 million. It's a big number.

24 Q: And it could be ten patients a day. 897 is
25 just ten patients a day, right?

1 A: 897 is about 4,000. It's more like 11. And
2 then you've got the impact on the outpatient
3 side. And I can tell you that right -- if we
4 redid these calculations now, the adjusted
5 admissions number would climb because of the
6 significant growth in the outpatient volume at
7 Roper St. Francis. Right now the translation
8 from inpatient to adjusted admissions is much
9 higher than it was at the time we did this.
10 That would impact all of these adverse impact
11 numbers and drive them up.

12 Q: And Mr. Baehr, you, yourself, have done an
13 adverse impact analysis in the courts in South
14 Carolina --

15 A: Correct.

16 Q: -- that opine that if the existing provider was
17 better off at a future date than they were on
18 the original date, that there was no adverse
19 impact. You have opined that in this court,
20 haven't you?

21 A: What I opined -- I opined it in an open heart
22 case where there is a specific adverse impact
23 test that's in the open heart rule. And that
24 is, are you going to drive a provider below a
25 certain volume number. My adverse impact test

1 was, do either of these hospitals fall below
2 that number; has the new applicant, which is
3 Lexington Medical Center, driven any hospital
4 as a result of their approval below that
5 number. That is the language of the open heart
6 case at the time that I testified in -- it's
7 very different than this. This is a growth
8 model. Their adverse impact is considered very
9 significant. Why? Because the overall market
10 is not growing that rapidly. In fact, at that
11 point, it was beginning to show evidence of
12 decline.

13 Q: Mr. Baehr, you calculated that in regards to
14 the interventional caths, and you found in a
15 growing market interventional caths, that since
16 the existing providers would have more cases in
17 the future year, in the third year of the new
18 program, that there was no adverse impact.
19 That was your opinion.

20 A: I calculated both impacts. I calculated both
21 impacts. The impact under essentially taking
22 account of the growth model and without it. I
23 provided both to the court. I provided every
24 scenario with both of those options, which by
25 the way, I might mention, your witness, Mr.

1 Levitt prepared six options and only showed the
2 one that was most favorable to his side. I did
3 not do that. I prepared four different
4 scenarios. In each of those scenarios I
5 calculated adverse impact two different ways
6 and I provided that to the court. I walked
7 them through it so they'd understand. If you
8 follow this adverse impact model, this is the
9 impact and if you follow the other model, this
10 is the impact. There was nothing hidden. Both
11 were on display and the motivation was because
12 there is very specific language dealing with
13 open heart.

14 Q: Let's just be clear, Mr. Baehr.

15 A: I'm happy to be.

16 Q: There will be more patients at Trident Medical
17 Center in 2017 than there are in 2010, even
18 with the hospital being built at Carnes
19 Crossroads; isn't that correct?

20 A: I am not necessarily willing to accept that.
21 I think a lot depends on what's being built in
22 the market, okay? A lot depends on the market
23 shares. A lot depends on whether they, in
24 fact, get their redirection or whether they
25 take a very substantial share from Trident

1 Medical Center. A lot depends on whether two
2 years after they're in the ground they transfer
3 50 more beds from downtown to the site they now
4 have. The transfer rule makes it real easy
5 once you have a receiving facility, nobody can
6 fight it then. Once you've got 50 beds in the
7 ground, then you can transfer 50 beds, you can
8 transfer 100 beds. You can attack Dorchester
9 County, too, by essentially making the hospital
10 big enough where it is, given it's on the
11 border almost of Dorchester County. There is
12 nothing to prevent that ultimate goal that was
13 in that original presentation of not occurring,
14 once Roper is in the ground, given the way they
15 operate, and the way the transfer rule would
16 then operate once you have an existing
17 facility.

18 Q: And let's just be clear. Trident Medical
19 Center will make more money in 2017 than it
20 does in 2010, even if there's a hospital
21 constructed at Carnes Crossroads?

22 A: I will not agree to that. First of all, one
23 could not speculate on what's going to change
24 in the payment system, given whether we don't
25 know whether there's going to be healthcare

1 reform or not. We don't know whether the
2 court's going to throw out part of it or all of
3 it. We don't know whether the Medicare cuts
4 are in effect. We don't know whether another
5 hospital, Medical University, chooses to enter
6 a market based on the same transfer language
7 that was used to support the Mount Pleasant
8 project and the Roper St. Francis Berkeley
9 project. These are imponderables. Why would
10 Roper be the only provider in the market that
11 takes advantage of that? If the Medical
12 University chooses to look at these target
13 markets and throw some beds in there where they
14 already have significant inpatient --
15 outpatient populations, and already directing a
16 lot of patients to their hospital. They've got
17 aligned patients. I don't see how anyone can
18 speculate 2017. There is enormous risk in the
19 healthcare system and there's particular risk
20 in South Carolina because the Department has
21 seen fit to use this transfer language to allow
22 hospitals with no need to move into areas where
23 there are hospitals with need and basically
24 take some of that need to support their
25 facility and fill it. That's what's going on

1 here. It happened in Mount Pleasant. It was
2 a mistake. It's happening -- it may happen
3 again here, depending on the decision of the
4 court. I think the Department made a mistake
5 in both cases in how they viewed this, not
6 viewing them as competitive in particular, not
7 -- how can you justify 225 beds in the Mount
8 Pleasant area when you have 100 before the two
9 projects were approved? Is there a 125 percent
10 increase in the likely patient population in
11 that area? It's not happening. Maybe out by
12 2050 or so.

13 Q: Wouldn't you agree with me that both of these
14 healthcare systems are very successful
15 financially?

16 A: They are successful right now and all I can
17 tell you is that there is great risk in being
18 in this business at this point, given the level
19 of uncertainty and the change that's coming.
20 The country, in my opinion, I'm a healthcare
21 planner and I also write opinion articles on
22 all kinds of other stuff, if the country does
23 not address the entitlement issues right now
24 with Medicare and Medicaid, the country goes
25 broke. What does that mean? That means long-

- 1 term you're going to have some sort of system
2 that provides fewer dollars to those programs.
3 Do they do it rationally? Do they do it
4 through just cuts to rates that affect all
5 providers? I don't know. Is it top-down? Do
6 they introduce competition? I don't know.
7 What I can tell you is there is going to be
8 some change that's going to dramatically reduce
9 the level of government support for the
10 healthcare system and that makes any future
11 projection of financial performance at risk,
12 which is why no hospital would willingly absorb
13 a loss of \$16 million and say, eh, no big deal.
- 14 Q: We agree that both hospitals have sophisticated
15 financial people. Certainly HCA does in
16 Nashville, correct?
- 17 A: Yes, and I think Roper is well run. I think
18 they -- they make substantial money. They've
19 shown improving performance. They had some bad
20 investments in a year where everybody else,
21 including me, had a bad year, so.
- 22 Q: You heard Mr. Johnson. He's certainly a
23 sophisticated enough person, correct?
- 24 A: Yeah. He seemed like a capable guy.
- 25 Q: Now, do you think that Roper St. Francis would

1 invest \$100 million in a hospital at Carnes
2 Crossroads and then not oppose the hospital --
3 not contend that the hospital at Moncks Corner
4 was competing if they thought they were going
5 to lose money if both hospitals were
6 constructed?

7 A: I think the risk to Roper if two hospitals are
8 approved is substantially less than the risk at
9 Moncks Corner given the concentration of
10 population, the payer mix between the two areas
11 and the fact that there's a high market share
12 for a competitor, a higher market share for
13 Trident in the south than there is up north,
14 where Roper has actually competed fairly
15 effectively because of its outpatient facility
16 there. And as a result there is much more risk
17 to Trident than there is to Roper and I'm --
18 you know, I think Roper sees an opportunity
19 here. They move into this market with 50.
20 What's to stop them from it being 100, 150,
21 200.

22 Q: Now, Mr. Baehr, I'm going to ask you a couple
23 of real easy questions.

24 A: Okay.

25 Q: Hopefully, if you'll stick with me and just

1 answer those because I'm just trying to set up
2 a discussion with you, okay?

3 A: No problem. That's fine.

4 Q: All right. Payer mix is a word that healthcare
5 professionals use to talk about the different
6 sources of payment that hospitals receive.

7 A: Correct.

8 Q: All right. And some of those sources are
9 considered to be more favorable than others,
10 right?

11 A: Correct. The ratio of net revenue to gross
12 revenue is usually how its measured, whether
13 it's better or worse.

14 Q: Well, that's one way. But one way when you
15 look at these different payers, they're kind of
16 four main -- and some people might have more,
17 but at least four categories of payers or non-
18 payers. First you have the Medicare program,
19 right?

20 A: Correct.

21 Q: And that's primarily for people over the age of
22 65.

23 A: And disabilities..

24 Q: And disabilities.

25 A: Which is -- it's a hugely growing segment is

- 1 the disability portion.
- 2 Q: It's growing. But most of the people on
- 3 Medicare are over 65?
- 4 A: Correct.
- 5 Q: And the second source of payment is commercial
- 6 insurance companies, right?
- 7 A: Yeah, the commercial --
- 8 Q: The HMOs, PPOs, whatever --
- 9 A: Correct.
- 10 Q: -- is the way we've seen it in this case, but
- 11 that's what commonly might be referred to as a
- 12 health insurance company, right?
- 13 A: The managed cared models.
- 14 Q: The managed care models. And the third source
- 15 of payment is Medicaid, right?
- 16 A: Correct.
- 17 Q: Which is a state program designed for people
- 18 with low incomes, right?
- 19 A: It's a joint federal/state --
- 20 Q: Joint federal --
- 21 A: -- program that's actually financed at least 50
- 22 percent, sometimes more, by the federal
- 23 government.
- 24 Q: Yeah. And thanks for correcting me on that.
- 25 It is a joint program. And then the last

1 category we have is basically the charity care
2 patients, the people who just don't pay, right?
3 Self-pay.

4 A: Well, it's people who are uninsured, some of
5 whom qualify for charity and whatever the
6 standards are set up, some of whom -- I mean,
7 I think Mr. Richardson or Mr. Knapp, I don't
8 remember which one of the two, said there are
9 some patients who essentially go naked with
10 insurance, they don't buy insurance.

11 Q: Right. Take their chances.

12 A: They'll pay out of their pocket. I did that.
13 I did that for my father-in-law who came over
14 Slovenia because he didn't have insurance here
15 and was treated for Cancer in Northwestern and
16 I thought he would have died at home and I was
17 willing to bring him here and pay out of my own
18 pocket, so I know what those things cost, okay?

19 Q: And it's a lot.

20 A: What's that? They cost a lot. Yes, they do.

21 Q: Okay. But those four payers, those are kind of
22 the four major classes, right?

23 A: Correct.

24 Q: And did I rank them in the order kind of best
25 to worst, Medicare --

- 1 A: No, I think commercial would be first.
- 2 Q: Commercial would be first, Medicare second.
- 3 A: That depends on the state. Medicare and
- 4 Medicaid, generally Medicare is second,
- 5 generally Medicaid is considered third, and
- 6 then uninsured would be considered fourth.
- 7 Q: Okay. Let's look at Respondent's Exhibit 104.
- 8 A: Okay.
- 9 Q: All right. Now, the reason I pulled this one,
- 10 this starts with an email from Mr. Woodford --
- 11 A: Okay.
- 12 Q: -- to Andrea Brisbin on October 10, 2008, which
- 13 is after the filing of the certificate of need
- 14 application.
- 15 A: Correct.
- 16 Q: He's sending her the financials --
- 17 A: Right. This is --
- 18 Q: -- that he had used. So would you agree with
- 19 me that this is the backup for the financials
- 20 in the CON if it's attached to an email?
- 21 A: Yeah. What I can't tell from this is, there
- 22 were requests from the Department for
- 23 additional information and I don't know whether
- 24 this is part of preparing a response or whether
- 25 this is related to something else. I can't

1 tell from this.

2 Q: All right. Okay. We'll, we're not really
3 talking about -- they asked to split out the
4 hospitals. I'm not asking you about that right
5 now.

6 A: Okay.

7 Q: Let's turn to page -- and just to be clear, you
8 testified to this earlier in the case, you had
9 nothing to do with the preparation of these pro
10 formas, right?

11 A: That's correct, other than providing volumes,
12 volume numbers.

13 Q: You did the volumes. You and Mr. Davidson gave
14 the volumes. That is all you did, okay?

15 A: That is correct.

16 Q: All right. Now, let's turn over to page --
17 Trident 281, which I think is going to be three
18 over.

19 MR. LONG: We're going to have to blow this up,
20 okay?

21 A: It's still real small on my screen.

22 MR. LONG: Blow up that -- there you go. Right
23 there. Blow that up. This part right here.

24 Q: Okay. This is the payer mix, the inpatient
25 payer mix, and you remember the backup

1 materials. I can show you my sheet. The
2 notebook's right there if you want to look at
3 it. It's over there to the right?

4 A: Okay. Which page again?

5 Q: 104.

6 A: 104?

7 Q: Respondent's 104.

8 A: Okay. Give me a second.

9 Q: I want to get you to jot down a few numbers on
10 this, too, so we can remember them.

11 A: Sure.

12 Q: All right.

13 A: Let me get my pad out too. All right.

14 Q: Okay. All right?

15 A: Okay.

16 Q: So do you agree with me that this is the payer
17 mix for -- this is the backup for the pro forma
18 and he's got the payer mix listed right here at
19 the bottom of this page, right?

20 A: On 281?

21 Q: Yes?

22 A: Yes.

23 Q: Okay. And he lists Medicare at 47.29 percent,
24 right?

25 A: That's their share of total utilization.

- 1 Q: Right. And then Medicaid, 11.2 percent, right?
- 2 A: Correct.
- 3 Q: HMO/PPO, that's commercial insurance, right?
- 4 A: Correct.
- 5 Q: HMO, that would be 29.02?
- 6 A: Correct.
- 7 Q: And the charity is 2.18, right?
- 8 A: Correct.
- 9 Q: Okay. Let's go look at Respondent's 85.
- 10 A: That is in a different book?
- 11 Q: It's probably right there. No, I think it's
- 12 that book.
- 13 A: This one?
- 14 Q: No, you're right.
- 15 A: Oh, this one.
- 16 Q: 85, at the beginning.
- 17 A: I'm sorry.
- 18 Q: This is one of the exhibits that we got in
- 19 discovery that actually is the Trident
- 20 Summerville -- Trident Health System payer mix
- 21 --
- 22 A: Okay.
- 23 Q: -- listed out by each institution. And since
- 24 we were using '07, I believe, to do the pro
- 25 forma, let's look at the '07 number.

1 MR. LONG: Do you want to blow it up even more.

2 Q: So let's just take them one at a time. Let's
3 look at Trident Medical Center. What's the
4 number for Medicare that's proposed for the
5 Moncks Corner facility?

6 A: Okay. First thing is, these look a little
7 different actually. What was the other number
8 104?

9 Q: Yes, sir.

10 A: Okay. In 104, if you look at page 281, there
11 are fewer categories.

12 Q: Okay.

13 A: The reason is some of them are consolidated.
14 So, for instance, you have HMO/PPO, 29 percent
15 --

16 Q: Well, let's add them up.

17 A: No, no, no.

18 Q: We can do it on this sheet right here. Let's
19 combine them. Let's look at Medicare. That
20 would be -- Medicare is 38.1, plus managed
21 Medicare is 3.2, right?

22 A: On 2007?

23 Q: On 2007.

24 A: For Trident Medical Center?

25 Q: Well, just do Trident at the moment.

1 A: Okay. That would be 41.3.

2 Q: Okay. And the proposed Medicare percentage for
3 the Moncks Corner facility was 48, right?

4 A: Correct.

5 Q: So more Medicare at Moncks Corner than at
6 Trident Medical Center, correct?

7 A: Correct.

8 Q: All right. Let's look at the HMO/PPO.

9 A: Yeah. This is where I think the problem comes
10 in, Jimmy -- excuse me, Mr. Long. I'm sorry.
11 I get too familiar here and I apologize for
12 that. I believe that the managed care number
13 in 104 includes the managed Medicare and
14 managed Medicaid, so it's a composite number of
15 commercial managed care and government managed
16 care.

17 Q: Okay. Well, that would actually mean that --
18 so you're saying that the Medicare number is
19 actually even higher in Moncks Corner than 48
20 percent?

21 A: No. What I'm saying is -- you call it what you
22 call it and whether you think it's accurate or
23 inaccurate, but the HMO/PPO number here, for
24 instance, is 29 percent, and the Medicare
25 number is 47 percent. It's impossible to tell

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1 from this whether Medicare managed care and
2 Medicaid managed care are within that 29
3 percent number or not. And at this point, I
4 have to tell you I don't remember. It's been
5 a while since I looked at this, but --

6 Q: Well, I mean -- well, you never really looked
7 at it, you just placed a phone call to Mr.
8 Woodford?

9 A: Not true at all. Those are the kinds of
10 questions I asked back in October, November
11 when I had conversations with them.

12 Q: Well, you've testified to this court that the
13 Moncks Corner Hospital has a weaker payer mix,
14 but you can't sit here today and tell me what
15 the Medicare, Medicaid, commercial pay, or
16 charity numbers are for the Moncks Corner
17 Hospital, compared to the actual numbers for
18 Trident Health System?

19 A: No. That's not true.

20 Q: You can?

21 A: Yeah. I --

22 Q: Well, then let's hear it. Let's see them.

23 A: Yeah. And, in fact, I actually had information
24 for 2011, which I've actually obtained, for
25 Trident Medical Center. And they're clearly,

1 they're clearly more favorable for Trident
2 Medical Center and Summerville Medical Center
3 than they are for what was projected. So
4 there's --

5 Q: Let's look at 2007 numbers --

6 A: Right.

7 Q: -- for the Trident Health System.

8 A: So if you get Medicare here of 38 percent and
9 you get managed Medicare of 3.2, you get 41.3.

10 Q: Which is less than the Medicare number on the
11 Moncks Corner sheet, correct?

12 A: Right. If you look at Medicaid.

13 Q: Let's look at Medicaid. Do the Medicaid and
14 the managed Medicaid together?

15 A: Okay. At Trident Medical Center?

16 Q: Sure.

17 A: That would be, it looks like 1.7 and 14 would
18 be 15.7.

19 Q: Okay. What's your Medicaid number on the
20 Moncks Corner facility?

21 A: Now, again, these numbers, by the way, are
22 quite different for Summerville. And remember
23 the --

24 Q: I know. We're going to talk about Summerville
25 in one second.

1 A: Okay. And the numbers we looked at were, if
2 you remember, to come up with our model, we
3 looked at the payer mix coming out of nine zip
4 codes?

5 Q: What was your total --

6 A: Okay.

7 Q: -- on the Medicaid number for Trident Medical
8 Center?

9 A: 15.7.

10 Q: And the number for the Moncks Corner Hospital
11 is 11.2, right?

12 A: Correct. But there may be, very well, a piece
13 that's inside that HMO/PPO number.

14 Q: But looking at the numbers, it suggests more
15 Medicaid at Trident Medical Center than at
16 Moncks Corners, right?

17 A: Except if there is a significant piece of
18 Medicaid within that HMO/PPO number. And,
19 again, it's not fair to compare just Trident
20 Medical Center with the projection for Moncks
21 Corner. You would need to compare the
22 composite for the two. And the Summerville
23 numbers, for instance, are substantially more
24 favorable in terms of much higher PPO/HMO than
25 they are at Trident Medical Center. And the

1 ratio between the two, okay, is what comes up
2 with the total composite number for the system.

3 Q: All right. HMO --

4 A: It's an unfair comparison --

5 Q: And the HMO/PPO --

6 MR. SUMMER: Excuse me, Your Honor. Let the witness
7 please finish his answer.

8 MR. LONG: I thought he was.

9 A: Yeah. It's simply wrong to compare something
10 that may be two-thirds of the pie to something
11 else when you could, in fact, come up with the
12 composite number, which is what we had at the
13 time, and those numbers are not the same as
14 either of these two columns.

15 Q: Well, you certainly -- I mean, you didn't do
16 it, right?

17 A: No, no, but those numbers were available.

18 Q: Well, I'm looking at the documents that were
19 the backup to the thing. Now let's look at
20 what Moncks Corner HMO/PPO percentage is.

21 A: Correct.

22 Q: It's 29 percent.

23 A: Correct. But that could include --

24 Q: What's the Summerville HMO/PPO number?

25 A: It's apples and oranges. The HMO/PPO number

1 here could include, and I'm fairly certain it
2 does include, a piece of Medicare and Medicaid
3 managed care, which would mean the actual
4 HMO/PPO number for Moncks Corner is lower than
5 the 29 percent.

6 Q: Well, the total for HMO/PPO --

7 A: In other words, you have --

8 Q: -- is about 34 percent, right?

9 MR. SUMMER: He continues to talk over the witness,
10 Your Honor.

11 MR. LONG: Your Honor, I've been very patient today
12 in the non-responsiveness to my questions.

13 THE COURT: And I understand that, but let him
14 finish.

15 THE WITNESS: Your Honor, you want me to finish or -
16 -

17 THE COURT: Finish your answer, please.

18 A: Yeah. There are two apples versus oranges
19 problems here. One is there are two different
20 facilities and you have to weight-average the
21 two of them to be able to come up with a number
22 for the Trident Health System. That's first.
23 The second is the payer categories are
24 organized differently on the phoenix hospital
25 on page 281 of Exhibit 104 than the way they're

1 laid out here, which has many more categories.
2 And the best of my recollection is that the
3 HMO/PPO category for the Moncks Corner facility
4 includes the managed Medicaid and the managed
5 Medicare, which would mean the pure HMO/PPO,
6 not having to do with governmental programs,
7 would be lower than the 29 percent. And the
8 Medicare and Medicaid numbers that are listed
9 on page 281 would be higher. How much higher,
10 I don't have those numbers. I'd have to go
11 back and ask for the additional breakout, which
12 was done at one point by Mr. Woodford to come
13 up with this consolidations.
14 Q: But you don't have it --
15 A: I don't have it here today, but I can --
16 Q: Well, let's look at those numbers on 85,
17 because those numbers are actually small, the
18 managed Medicare number for Trident Medical
19 Center is 3.2 percent, right?
20 A: Okay.
21 Q: And for Summerville, it's 2.8. Does that look
22 right to you?
23 A: Let me find the right line. Yes, that's
24 correct.
25 Q: Okay. And then the managed Medicaid for

1 Trident Medical Center is only 1.75, right?

2 A: Okay.

3 Q: And you agree. And for Summerville, it's 1.1,
4 right?

5 A: But --

6 Q: And the difference--

7 A: Okay.

8 Q: -- the difference between the Medicare number
9 at Moncks Corner is greater than the amount of
10 the managed Medicare number set forth on this
11 chart, isn't it?

12 A: Okay. Let me --

13 Q: Between Moncks Corner and Trident Medical
14 Center; isn't that right?

15 A: No. I think you're missing the point of this
16 analysis. If you look at the Trident 118 on
17 Exhibit 85, the combination is 23.2 percent for
18 Trident Medical Center, 34.7 percent for
19 Summerville Medical Center. You wouldn't
20 exactly average them. The reason being Trident
21 is a bigger hospital and for the Trident Health
22 System would represent a bigger share. Compare
23 that number to what you get on Trident 281
24 where the HMO/PPO number is 29 percent. That's
25 exactly halfway between the Summerville and the

1 Trident number, but that 29 percent number, if
2 it includes the same five percent
3 Medicare/Medicaid managed care would be lower
4 than the composite for HMO/PPO on page 118,
5 which would support the argument that the payer
6 mix overall for the Trident Health System is
7 superior to what was projected for Berkeley
8 Regional Medical Center.

9 Q: But the Medicare number for the Moncks Corner
10 Hospital is higher than either one of the two
11 hospitals regardless of the managed Medicare
12 number, where the managed Medicare number is,
13 isn't it?

14 A: And that number is based exclusively on the
15 actual patients who arrived at Trident Health
16 System from nine specific zip codes, the non-
17 tertiary patients. It's not an estimate. It
18 wasn't a guesstimate. It wasn't someone
19 pulling a number out of the air. It's the
20 actual number and that was considered to be the
21 most accurate way to go forward with this.

22 Q: Right. And what it shows is, is that a
23 substantial portion of the people in the Moncks
24 Corner and the northern Berkeley County area
25 are covered under Medicare and commercial

1 insurance. This payer mix is no different than
2 what is in the Trident Health System, is it?

3 A: The payer mix is quite a bit different. You're
4 just saying that the Medicare number is lower
5 for these two hospitals.

6 Q: Right.

7 A: It's higher for the sub-segment of the northern
8 part of Berkeley County. Why that should be a
9 surprise to anyone, I don't know.

10 Q: Now, you have testified that the pro forma for
11 Roper St. Francis, the project of Roper St.
12 Francis at Carnes Crossroads is financially
13 feasible, correct?

14 A: On a full venue, if you had the entire
15 hospital, whatever errors Mr. Knapp made, I'm
16 comfortable that the hospital would have a
17 positive bottom line. My comment on
18 feasibility, the other comment was, they never
19 submitted that to the Department. They only
20 submitted the half hospital model. That one is
21 barely break even and there are significant
22 expenses missing based on what Mr. Knapp
23 testified to two days ago.

24 Q: And just to look at exhibit, Petitioner's 219.

25 A: Uh-huh (affirmative response). Petitioner's

1 219: That's a different -- that's one of the
2 new ones?

3 Q: You may have that --

4 A: Is that one of the ones we discussed earlier
5 this morning?

6 Q: Yes.

7 A: Give me a second, Mr. Long. Let me see if I
8 can find it. I've got it.

9 Q: These are the documents that you created in
10 response to Mr. Knapp's calculation of how the
11 pro forma set forth in the Roper -- I mean, in
12 the Moncks Corner, Trident Health System Moncks
13 Corner hospital underestimated or was too
14 modest in calculating its profitability, right?

15 A: Correct.

16 Q: And you took the numbers and you have actually
17 increased the contribution margin on the third
18 page, Baehr 1846.

19 A: Fourth page.

20 Q: Fourth page. Higher than what's reflected in
21 the pro forma, right?

22 A: I didn't increase it. The only thing I did was
23 I added back essentially the portion of the
24 hospital that was not represented because there
25 was all of the inpatient but only part of the

1 outpatient. So when you add the outpatient
2 back, essentially, is the dynamic model that
3 Mr. Woodford had. You can essentially change
4 an assumption and the assumption was not to
5 suppress the outpatient volume that was already
6 there, to include it. And all the other
7 assumptions, every other assumption remained
8 the same in terms of staffing ratios, in terms
9 of payer mix, everything else changed (sic) the
10 same. The only thing that was different is you
11 have a new slice of gross revenue, you have
12 deductions and you have some additional
13 expenses.

14 Q: And by adding the outpatient half of this --
15 this increased outpatient volume, you increased
16 the contribution margin by like \$1,600 per
17 adjusted admission, right?

18 A: Wrong. No. It goes from --

19 Q: How much was the number?

20 A: No. The number --

21 Q: The increase?

22 A: The number was, as calculated by Mr. Knapp at
23 3,853. The number that I calculated is 5,071.
24 So the difference is \$1,218.

25 Q: So \$1,200 dollars in profit for every adjusted

1 admission, based on this additional outpatient
2 revenue, right?

3 A: Right. And this, if you remember and if you go
4 through these models, and we went through this
5 in detail in my testimony in my deposition,
6 there are big increases as volume increases.
7 You can see that in the Roper model. You can
8 see it in ours. The more volume, the better
9 you do. This is more a slice of volume being
10 added when the hospital already has its fixed
11 costs in place. So you have a difference
12 between the net revenue received, the
13 incremental expenses that basically serve to
14 lift the margin somewhat. Why do they lift the
15 margin? It's all outpatient. The ratio of net
16 to gross on outpatient in the Berkeley model is
17 higher than the ratio of net to gross for
18 inpatient. If it were the other way around, if
19 the increment had been on the inpatient side
20 and not the outpatient side, it would not have
21 added as much because of that one change in
22 terms of the difference in the ratio of net to
23 gross.

24 Q: Okay. And if you have a higher contribution
25 margin, you will make more money on the same

1 number of admissions; isn't that correct?

2 A: We haven't changed contribution margins.

3 Q: I said if --

4 A: Yeah.

5 Q: -- you increase the contribution margin, you
6 will make more money than you would with the
7 same, with the same volume, right?

8 A: But this is the point that's being missed here.
9 It's apples and oranges.

10 Q: Just please answer the question.

11 A: Yeah. If you were adding \$1,200 to the model
12 that's just the three-quarters of a hospital,
13 then I'd say yes.

14 Q: Okay.

15 A: But if all you're doing is reflecting the full
16 hospital to adding the piece that was missing
17 and you wind up with a higher contribution
18 margin, that's simply reflecting a whole
19 hospital. Think of what happened with Mr.
20 Knapp's model that went from break even to a
21 gain of \$13 million when he added in the other
22 half. Here we're going from -- we add about
23 four to five million dollars in net income and
24 the contribution margin grows as a result of
25 adding half the outpatient, okay?

1 Q: And all Mr. Knapp did in his calculation was
2 say, with a higher contribution margin, you're
3 going to make more money. And if you -- and if
4 you have a higher contribution margin, you can
5 break even with a less, lower volume. And both
6 of those facts are correct, right?

7 THE COURT: Now, Mr. Baehr, he's asked you a
8 question.

9 THE WITNESS: Yeah.

10 THE COURT: Answer it yes or no and then --

11 A: The answer is no. The answer's no. Because
12 two things happen. First of all, if the
13 contribution margin is larger, then, yes, the
14 base income of the -- all things being equal,
15 if you're looking at the same model -- in other
16 words, Mr. Knapp was right and we
17 underestimated what the contribution margin was
18 for the incremental model. That's what he
19 said, we underestimated for the incremental
20 model. And my answer to that is no, we didn't.
21 The difference between what he calculated at
22 Trident Medical Center or Trident Health System
23 and the Berkeley model is explained in large
24 part because of the fact he's comparing apples
25 and oranges. He was comparing three-quarters

1 of a hospital to a health system with two full
2 hospitals. You won't get the same answer. The
3 second part, if you accepted Mr. Knapp's model,
4 and let's say it was right, that, in fact, it
5 should have been \$1,000 higher or \$1,200
6 higher, two things happen. Your net income's
7 higher on the front end, adverse impact costs
8 you more. Instead of losing at a rate of
9 \$3,800 per adjusted admission, you're losing at
10 a rate of 5,000 or \$6,200, if that's the number
11 he generated. There's a point which is going
12 to be reached fairly quickly where whatever
13 advantage you got from having a higher net
14 income is going to be gone because the adverse
15 impact is going to be larger per case lost.
16 Mr. Knapp never considered that in the
17 adjustment he made.

18 Q: And, Mr. Baehr, that's the point. You use the
19 higher contribution margin to tell the court
20 how much the adverse impact would be on Trident
21 Medical Center and you use the lower
22 contribution margin to tell the court, woe is
23 me, you can't build both.

24 A: Absolutely not.

25 Q: Isn't that correct?

1 A: Absolutely not. There's two entirely different
2 calculations. One is a calculation of impact
3 on Trident Medical Center and Summerville
4 Medical Center. That's the contribution margin
5 developed by the Trident Health System because
6 the impact is on them. What we -- what was put
7 together in the Moncks Corner pro forma is a
8 contribution margin for lost cases at that
9 facility. That facility is not the same as the
10 Trident Health System. Their adverse impact
11 number should not be the same. No one picked
12 and chose. The appropriate contribution margin
13 was used in each case. When you're looking at
14 Roper impact on Trident and Summerville, you
15 need to look at the contribution margin at
16 Trident Health System. When you're looking at
17 the impact of losing cases at Berkeley Regional
18 Medical Center in Moncks Corner, you need to
19 look at the impact based on the contribution
20 margin at that facility. They should not be
21 the same. If you use one for the other, that
22 would be a serious error.

23 Q: I'm going to ask you a hypothetical. If you
24 increase the contribution margin at the
25 facility, and you can make -- you can break

1 even with smaller volume, isn't that correct,
2 all else being equal?

3 A: In the specific model for the three-quarters
4 hospital, is that what you're asking me?

5 Q: I'm just asking you hypothetically.

6 THE COURT: Wait a minute. In terms of simple
7 mathematics is what he's talking about.

8 A: It's an obvious answer if you say if the
9 contribution margin's 4,000 and you make it
10 5,000, then do you make more money with more
11 patients and you don't need as many to break
12 even. That's obvious. The question is,
13 though, what gives you the ability to say the
14 contribution is X instead of Y? You've got to
15 justify that. They're attempting to justify it
16 by saying it should be the same as Trident
17 Health System. It shouldn't --

18 THE COURT: No, Mr. Baehr, let him ask the question
19 if he's interested in that.

20 THE WITNESS: Okay. Thank you, Your Honor.

21 THE COURT: It's difficult for me to follow when --

22 THE WITNESS: No, no, this is very complex stuff and
23 all I'm saying is there are two different
24 adverse impacts here, Your Honor. There's an
25 adverse impact on existing providers and an

1 adverse impact that occurs --

2 THE COURT: Let him ask the question if he's
3 interested in that.

4 THE WITNESS: Okay. Thank you. I'm sorry, Your
5 Honor.

6 Q: Let's move to our final topic.

7 A: Okay.

8 Q: As a healthcare planner, would you ever file a
9 certificate of need application that you did
10 not believe complied with the State Health
11 Plan?

12 A: No, but I have supported in my 37 year history,
13 and regretted it, an application that I thought
14 was consistent but was still weak, which was an
15 open heart case in South Carolina. And in
16 retrospect, I would have preferred I had not
17 taken the case. I --

18 Q: Lexington?

19 A: No, no, not South Carolina. West Virginia.
20 Wrong state.

21 Q: You said South Carolina.

22 A: I have South Carolina on my mind. It was in
23 West Virginia and it was for a hospital that
24 could have reached the volume number, which was
25 the only real test in terms of the consistency

- 1 with the Plan, the major test. But it was
2 still hard to argue that it was necessary.
3 It's very similar in some ways to what's going
4 on here. You can fill Roper St. Francis
5 Berkeley, but does that mean it's needed? That
6 hospital could have potentially gotten the
7 volume that they wanted, but the question was,
8 was the program needed, given everything else
9 that was around. In retrospect, I think the
10 answer was, no. And I regretted that I had
11 been involved, that I'd been involved in that
12 case and pushed the argument.
- 13 Q: Generally, as a healthcare planner, you would
14 not file an application that you did not
15 believe complied with State Health Plan?
- 16 A: No, even that one I thought was consistent with
17 the State Health Plan.
- 18 Q: Okay. Could we look at Joint Exhibit 3, which
19 is the '04-'05 Health Plan?
- 20 A: Oh, sure. That's in this book.
- 21 Q: One of the books right there.
- 22 A: Oh, you're going to have them on the screen?
- 23 Q: It'll be on the screen too.
- 24 A: Okay.
- 25 Q: Okay. And you would agree with me that Trident

1 Health System applied; its hospital application
2 at Moncks Corner is under the '04-'05 Plan,
3 right?

4 A: Right. I understand that.

5 Q: There's been a lot of testimony about the '08-
6 '09 Plan, but they filed under the '04-'05
7 Plan, right?

8 A: Correct.

9 Q: And they filed under section D --

10 A: Correct.

11 Q: -- of page II-7 of the Plan, right? We're
12 going to pull it up for you.

13 A: Sure, thanks. Okay.

14 Q: Okay. And section D says, should there be a
15 need shown for additional beds for a hospital,
16 that an increase may be approved in order to
17 provide for a cost-effective addition up to the
18 greater of 50 beds, or the actual projected
19 number of additional beds may be approved,
20 provided the hospital can document and
21 demonstrate the need for additional beds.

22 A: Correct.

23 Q: Now, I want to ask you, where in that paragraph
24 does it say that a hospital can transfer bed
25 need to a greenfield to construct a hospital?

- 1 A: Well, the first thing I would say is I don't
2 think where they were transferring the beds was
3 a greenfield because there was, operating under
4 the hospital license, an emergency department
5 and outpatient facilities that were already in
6 place that had been there for a significant
7 period of time. They were adding services to
8 it. Second is, my understanding is that
9 whatever year the project was approved for the
10 Summerville Medical Center in Dorchester also
11 was derived out of the bed need for Trident
12 Medical Center which existed at that time, and
13 there was no reason for me to think that this
14 kind of language where there was bed need that
15 allowed you to create that additional hospital
16 was inconsistent with the Plan. Now, the
17 language could be written better. It was
18 improved, I think, in the 2008-2009 Plan. But
19 the number of additional beds to be approved,
20 the greater of 50, it doesn't say, it does not
21 say they have to be on the site of the existing
22 facility.
- 23 Q: Okay. It actually says hospital. It doesn't
24 say hospitals, plural, does it?
- 25 A: Correct. But there's one license. For

1 instance, there's a single license that exists
2 -- that I understand existed with that
3 emergency department and Trident Medical
4 Center. So you can make an argument that what
5 they were doing is essentially moving beds
6 essentially to a facility based on the growth
7 in their system.

8 Q: Do you think under the Health Plan that Trident
9 Medical Center can transfer beds to Summerville
10 Medical Center without a CON?

11 A: No, I don't think anybody can do anything --

12 Q: Right. They're under the same license.

13 A: Transfers are under the same language. New
14 hospital beds or new beds, my understanding,
15 where there's need, falls under this section.
16 Now, is this written with the greatest clarity
17 similar to some other sections of the plan?
18 I'd say probably no. I think that's why it was
19 improved on. This is a big, big issue that you
20 raise, though.

21 Q: Yeah.

22 A: No one ever changed the transfer language.
23 They did change the language on this one to
24 make it clear and the language that they
25 changed it to made it clear that what Trident

1 did was acceptable.

2 Q: Well, there was no reason to change the
3 language because the DHEC Board spoke on what
4 it meant in regards to the bed transfer, right?

5 A: But they also had consistently spoken that when
6 hospitals had bed need, they could use it for
7 A or for B. The difference is this is need.
8 These are hospitals with need. These are, to
9 some extent, the good guys, the ones who have
10 filled their hospitals enough to justify
11 expansion.

12 Q: I'm not talking about the philosophy behind it
13 or the healthcare planning reasons why you
14 might allow it.

15 A: Okay.

16 Q: I'm just talking about the language itself.
17 Does the language itself allow you to transfer
18 beds to a greenfield to construct -- transfer
19 a need for beds to a greenfield to construct a
20 hospital? In your opinion as a healthcare
21 planner, does the language allow it?

22 A: I think it does allow it.

23 Q: Okay. And part --

24 A: It's not written to say these are the three
25 things allowed by this provision. It's not

1 written that way.

2 Q: And part of the reason that -- is part of the
3 reason that you believe it's allowed because
4 it's not prohibited?

5 A: No. Because it's simply not spelled out in
6 detail the various things that fall under this
7 option. In other words, this could mean
8 several things. It doesn't say that 50 beds
9 have to be added at the site. It doesn't say
10 that.

11 Q: Okay.

12 A: It doesn't say that.

13 Q: I know it doesn't. And of all those things
14 that you think it could mean, are all of those
15 allowed?

16 A: You do have in this case where there's a
17 specific section for a particular type of
18 situation, where there's positive bed need.
19 There is, obviously, a history of how DHEC has
20 interpreted these. And my understanding is,
21 these were never really challenged until that
22 Fort Mill case occurred. And that lead, to
23 some extent, to the change that occurred in the
24 2008-2009 Plan. It's a very different
25 situation than the transfer language, which is

1 very specific about what it allows, a very
2 detailed section, a lot bigger than this one,
3 and mentions receiving facility three or four
4 times, talks about need having to be
5 demonstrated. There's a lot of stuff in there.
6 And even if you interpret it that this was
7 designed just to allow Palmetto to move beds
8 from Baptist to Richland, they still have to
9 demonstrate need, even on that kind of
10 transfer.

11 Q: Well, wouldn't it be likely to believe that
12 since you have more criteria to follow in
13 regards to the bed transfer provision, that it
14 was more likely that it was allowed since this
15 has almost criteria?

16 A: But this is bed need. This is positive bed
17 need.

18 Q: For a hospital, as mentioned?

19 A: For a hospital, which has, as I mentioned
20 before -- again, I'm not an attorney. I'm
21 giving you my opinion. That given where they
22 were locating the beds, it's not to a
23 greenfield, which is the situation at Carnes
24 Crossroads, it's to an existing site which has
25 an emergency department and part of the

1 hospital license and has outpatient facilities.

2 Q: All right. Mr. Baehr, when you say that, that
3 is incorrect because Trident Health System
4 doesn't even own the land where they're going
5 to build the hospital. They do not own that
6 land, do they?

7 A: My understanding is there's an option that have
8 in place.

9 Q: They have an option, which means you don't own
10 it. Isn't that correct?

11 A: No, they have the right to purchase it.

12 Q: You have the right to purchase it. And since
13 they don't own it, it cannot be the same site
14 as where they have a facility that they own.
15 Do you agree with me on that?

16 A: The property is adjacent to the site where they
17 have the other facilities. I would no not,
18 under any stretch of the imagination, consider
19 them separate sites.

20 Q: Okay. And since the Department changed the
21 language in the '08-'09 Plan, in your opinion,
22 that DHEC erred in allowing the transfer under
23 this provision since it predates the language
24 that allows the transferring of bed need --

25 A: No, the major clarification --

1 Q: -- to construct the hospital.

2 A: The major clarification, I think, that came out
3 of the '08-'09 section is that where there's
4 positive bed need, that the -- and there's
5 positive bed need in the overall area, that you
6 can have applicants come in who aren't even
7 from the area to apply for the bed need. And
8 we can go to the '08-'09 Plan and I can show
9 you what the -- I think we went through that
10 language once before. But it's a more detailed
11 section, clearly, than what's in here and
12 allows for more different circumstances to
13 spell out in case this is too ambiguous for
14 people.

15 MR. LONG: May I have one moment. That's all I
16 have, Your Honor. Thank you.

17 THE COURT: Mr. Summer.

18 MR. SUMMER: Thank you, Your Honor.

19 MR. BAEHR - REDIRECT REBUTTAL EXAMINATION BY MR.

20 SUMMER:

21 Q: How you holding up?

22 A: I'm doing all right. If anyone wants to do one
23 more three minute break, I'm all for it. I've
24 gone through four bottles of water.

25 MR. SUMMER: Can we take a little short break, Your

1 Honor?

2 THE COURT: Yes, sir.

3 MR. SUMMER: Thank you.

4 (Off the Record from 5:45 p.m. until 5:48 p.m.)

5 THE COURT: Mr. Summer. Back on the record.

6 MR. SUMMER: Thank you, Your Honor.

7 Q: Let's try and get out of the weeds. I'm going
8 to work backwards a little bit and the first
9 thing I want to do is take you to Roman Numeral
10 II-7 of the '08-'09 Plan, which is Joint 4.

11 A: Number 4, right?

12 Q: Right. And go to the new section D that you
13 were referring to when you were talking to Mr.
14 --

15 A: Okay.

16 Q: II-7, section D.

17 A: Okay.

18 Q: How did the Department revise this section from
19 the '04-'05 language that you were reading?

20 A: Well, they -- let me read through it because I
21 want to compare it to the other one. Part of
22 it is actually quite similar, though it adds a
23 caveat that up to 50 additional beds or the
24 actual projected need may be approved for a
25 hospital to allow for the construction of an

1 economical unit on either the existing hospital
2 site or another site if the hospital is
3 relocating or has relocated in whole or in part
4 to that site. So that's new language that's
5 specific to a hospital that shows need when the
6 county, or in this case, the three counties
7 does not show need. The second part is you've
8 got to document the need for additional beds
9 beyond those indicated as needed by the
10 methodology stated above based on historical
11 and projected utilization. Additional beds
12 will only be approved for a specific hospital
13 indicating a need. Section E actually is the
14 section that relates to when there is a need
15 within the county or if it were a case here,
16 that were net positive need within the Tri-
17 county. And they separate that out to indicate
18 that in that case -- well, the rules are what
19 the rules are.

20 Q: Okay. Let's go back to D.

21 A: Okay.

22 Q: So DHEC made a change to make it real clear now
23 it could be at that site or another site,
24 right?

25 A: Correct.

1 Q: Okay. If you go over to J, that's the exact
2 same transfer section. They didn't make any
3 change, did they?

4 A: They did not.

5 Q: Okay. But they certainly could have made a
6 clarification to J if they wanted to?

7 A: Of course.

8 Q: Okay. All right. Now, let's go back to the
9 '04-'05 Plan because I want to talk about a
10 couple of other points just to make it clear
11 for the record. If you look at D under the
12 '04-'05 Plan.

13 A: Okay. That's number three, right? Okay.

14 Q: A couple of clarifying questions. Trident,
15 under its existing license today, operates an
16 emergency department 24/7 in Moncks Corner,
17 doesn't it?

18 A: Correct.

19 Q: Okay. So it will be moving that bed need to
20 its emergency department up there, correct?

21 A: It would be moving it up to land that is
22 adjacent to where that facility is in this --
23 basically, the same location.

24 Q: And under the current hospital license?

25 A: Under the current license.

1 Q: Okay. Thank you. It's basically the same
2 situation as was when the Seacoast, isn't it?

3 MR. LONG: Objection. I mean, he's just starting
4 off with cross examining his own witness.
5 Every question he's asked is leading. I know
6 it's late in the day, but --

7 MR. SUMMER: I'll try to move it along, Your Honor.
8 I'll rephrase the question.

9 THE COURT: Sustained.

10 Q: What, if any, similarity is there between
11 Trident and the Seacoast case?

12 A: Yeah. I concentrated, I'd have to say, on the
13 Seacoast case mostly on what I read, particular
14 sections of Mr. Richardson and Mr. Knapp, but
15 my understanding is there was also moving beds
16 to create a new hospital, similar
17 circumstances.

18 Q: Thank you. All right. Now, let's go back and
19 talk about a few things. There was an awful
20 lot of questions regarding the payer mix --

21 A: Uh-huh (affirmative response).

22 Q: -- and whether or not the payer mix at Moncks
23 Corner was accurate. Do you recall all of
24 that?

25 A: Correct.

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1 Q: Okay.

2 A: Actually, the questioning was more relative to
3 Moncks Corner's numbers versus the two Trident
4 Hospital numbers.

5 Q: Okay. Do you believe that the Moncks Corner
6 numbers are accurate?

7 A: I believe they are.

8 Q: Okay. But would you just briefly explain to
9 the court why you believe that?

10 A: Yeah. This was actually, I think, very
11 carefully done. The hospital is going to be
12 located in a specific county and the individual
13 who put together the financial projection knew
14 from our section B11, our forecast of
15 utilization, where we expected the patients to
16 be. He looked at all the zip codes in the
17 north and in Moncks Corner where we projected
18 a 50 percent transfer. And then he added one
19 zip code, which was 29483, which is the cross-
20 county zip code between Dorchester County and
21 Berkeley, because that contributed a lot of
22 patients. So for those nine zip codes, and
23 only those nine zip codes, he took all the non-
24 tertiary volume that came out of those zip
25 codes and arrived at either Trident Medical

1 Center or Summerville Medical Center. He
2 looked then at what the payer mix was for those
3 patients coming from those zip codes, because
4 he thought that would be the best way to
5 forecast what the payer mix would be for the
6 new hospital. I think that's, in fact, the
7 best way to do it, is to look at the historical
8 experience for the specific payers for the
9 specific patient population you expect to
10 serve.

11 Q: Thank you. This discussion between open heart
12 and a community medical center, do you believe
13 that's a relevant comparison?

14 A: No.

15 Q: And explain why?

16 A: Yeah. I think the access issues as related to
17 the serious cardiac problems of the kind that
18 are treated in what's considered tertiary
19 facilities, open heart surgery is considered a
20 tertiary service, there are not a lot of
21 programs around the state. There are a lot
22 more hospitals that have acute beds that have
23 open heart surgery programs. And within open
24 heart surgery, the volume of open heart
25 surgeries have begun to decline, but the level

1 of angioplasties and those kind of cardiac
2 interventions has been rising. The state,
3 there was a period where they approved a lot of
4 the programs and then almost nothing. And the
5 Lexington Medical Center case was really the
6 first one that came around in a long time. The
7 issues that were raised in that case are
8 qualitatively different in terms of what access
9 means and what access improvement means.
10 Having a five minute reduction in drive time is
11 not the same thing as what a potential hour can
12 mean going from a hospital to another hospital,
13 being transferred from an emergency room so
14 someone can open your artery. That's a
15 different kind of issue. That's the access
16 issue that was involved in that case. There
17 was adverse impact, okay? I calculated it.
18 The other parties in that case were very
19 concerned about it because they saw the open
20 heart numbers overall beginning to decline
21 because the interventional cardiology, the
22 angioplasties, and the , stents, that was
23 growing. Open hearts declined. If you get
24 approved for a program, you get both. My view
25 was the open hear number is slightly declining.

1 The cardiology numbers, on the other hand, were
2 rising, but you needed to get the open heart
3 program to be able to do both, and that access
4 issue was very important and outweighed the
5 adverse impact. Again, as I said before this
6 morning, it was a tough, difficult case, close
7 call. All right? It didn't go the way in the
8 original trial the way Lexington wanted. They
9 subsequently have applied a second time and
10 gotten the program. But there were real issues
11 raised on both sides and I think they were
12 raised constructively.

13 Q: Okay. Just for the record, if you look at the
14 '08-'09 Plan --

15 A: Yes, sir.

16 Q: -- would you please look at Roman Numeral II-39
17 all the way through to II-58 and identify that
18 for the court, please?

19 MR. LONG: Your Honor, I think I know what it is. I
20 was going to object.

21 MR. SUMMER: I'm not going into it.

22 MR. LONG: Well, I'm not going -- Your Honor, I'm
23 going to object because we were -- we put the
24 State Health Plans in for the relevant sections
25 for this case, okay? And we had those listed.

1 The whole State Health Plans are not in and I
2 object to going into all of this about the
3 State Health Plan in regards to cardiac care.

4 **THE COURT:** And what page was it, II-39?

5 **MR. SUMMER:** II-39, Your Honor, to II-50.

6 **THE COURT:** I don't remember that ever being brought
7 up previously.

8 **MR. SUMMER:** No. Your Honor, here's the thing.
9 There's a great deal of question regarding
10 adverse impact, access and open heart, okay?
11 Mr. Long went through a lot of that. I'm
12 simply trying to identify the apples and
13 oranges difference and I'm simply identifying
14 that portion of the Plan where the oranges are,
15 that's all I'm doing. I'm just saying, look,
16 it's in a completely different section and I
17 think that's fair.

18 **MR. LONG:** Well, Your Honor, the problem is -- it's
19 not and he's putting it in as an exhibit. When
20 he mentions it, he's just putting it in. I
21 object to that coming in as an exhibit.

22 **MR. THOMAS:** The Plan is in.

23 **MR. LONG:** No, it's not. It absolutely is not. We
24 did not agree to that. It is not.

25 **MS. BIGGERS:** We stipulated, both sides, that it

1 would be only parts.

2 MR. LONG: It's only the parts about healthcare we
3 agreed with your office to put in the -- what
4 do you call it at the end -- the inventory?

5 MS. BIGGERS: The inventory at the end.

6 MR. LONG: There was some testimony with Mr. Shelton
7 about the inventory at the end, but the entire
8 Health Plans are not in. It's just the
9 relevant sections.

10 MR. SUMMER: It's a public document.

11 MR. THOMAS: Wrong, Your Honor, I didn't stipulate
12 to that for the record. The '04-'05 and the
13 '08-'09 Plans, what I thought were totally in
14 because they're relevant. I think we also put
15 portions of the 2001 and 2003 State Health
16 Plans, just portions.

17 MR. SUMMER: I don't really need the court to look
18 at it. All I'm trying to do is make a -- I
19 want to distinguish the apples and the oranges.
20 It's a public document. It's readily
21 available. It's just like if we were citing a
22 case. It's published by the state of South
23 Carolina. So it's a treatise, if nothing else.
24 I don't want to spend a lot of time on this.
25 The hour is late. I have other things I want

1 to move on to. But I think it's important for
2 the court to note that the entire line of
3 questioning had nothing to do with the
4 standards and criteria that are at issue in
5 this case. I just merely want to point that
6 out for the record.

7 **MR. LONG:** And, Your Honor, I also would say going
8 into the Health Plan on open heart is
9 irrelevant and it's irrelevant. What I asked
10 him about on cross, and I was very specific in
11 my questions on cross, I asked him did you
12 opine. He gave a long answer, but that was my
13 question. Did you opine in the open heart case
14 about the method.

15 **THE COURT:** I agree and I'm going to sustain that.

16 **Q:** There was a great deal of discussion about
17 increase of access between the two
18 applications. Do you remember that line of
19 questioning?

20 **A:** I do.

21 **Q:** Okay. And do you believe -- what is your
22 opinion as to the amount or substantialness of
23 new access created regarding Moncks Corner?

24 **A:** It's substantial because the 15 mile travel
25 time around Moncks Corner has basically

1 insignificant overlap with a 15 mile circles
2 drawn around the two existing hospitals,
3 Trident Medical Center and Summerville Medical
4 Center. So there's a substantial portion of
5 new population that's brought in, and a large
6 portion of that population, a significant
7 percentage of them are lower income.

8 Q: Okay. What about the Carnes Crossroads
9 property, is that substantial or de minimis?

10 A: Yeah. If they're the only hospital in the
11 market, their 15 mile circle has substantial
12 overlap with the service areas of Trident
13 Medical Center and Summerville Medical Center,
14 but there is a piece to the north that
15 basically is in the Moncks Corner area, though
16 not to the other communities around the lake,
17 but in the Moncks Corner area, which is --
18 which would improve access. It's slightly less
19 than half as many people as would be the case
20 of the Moncks Corner application if that was
21 considered alone.

22 Q: Would you take a look -- you were asked a
23 series of questions regarding Exhibit 46,
24 primarily pages 1622, 1623 and 1624. Do you
25 remember those?

1 A: I do.

2 Q: Okay. You were asked -- if I remember
3 correctly, you were asked to total the cases
4 that Trident would lose to Moncks Corner with
5 the cases that Trident would lose to Roper and
6 the cases that Trident would lose to
7 Summerville. Do you remember that?

8 A: I do.

9 Q: Okay. I'm not sure about the relevancy of
10 that, but would you agree with me that the
11 Trident doesn't lose cases to itself, does it?

12 A: Well, what happens is, there's obviously less
13 financial gain if you're transferring a patient
14 essentially from hospital A to hospital B than
15 if you're picking up market share. What is
16 different, and this is a significant issue in
17 this case, is that even though there's a
18 redirection of patients in the Trident
19 application, that they are essentially, the
20 forecast model was based on a percentage of
21 Trident volume, that volume, the Trident
22 volume, included a significant growth
23 component. That growth component is what
24 matches what was in the State Health Plan. So
25 as a result, you have a situation where the

1 redirection is redirection of growth that's
2 occurring in that market, all right? You have
3 a new provider in the market, you have growth
4 in the market. In sense you're assigning your
5 system's growth in the market to the new
6 hospital, all right? That's the basis of our
7 model. Now, if you pick up patients from
8 hospital A or hospital B that you never had
9 before, that's more profitable. But, you know,
10 but growth is profitable too, whether it's at
11 Trident Medical Center or at Berkeley Regional
12 Medical Center in Moncks Corner.

13 Q: Okay. And I think it was -- and look at page
14 1621 where Mr. Long was asking you to ignore
15 Summerville. Do you remember that?

16 A: Yes.

17 Q: Okay. Would it be consistent with the State
18 Health Plan to ignore Summerville, its
19 application and its need?

20 A: No. I really didn't follow the line of
21 questioning and I don't understand why Mr.
22 Richardson excluded it from his document.

23 Q: Okay. Well, do you have an opinion as to
24 whether or not Summerville's application is
25 consistent with the State Health Plan?

1 A: Yes, it is. I was filed under a need, an
2 expressed need in the State Health Plan of 24,
3 they applied for 30, and the project was
4 approved by the Department.

5 Q: And as to its application, Trident's
6 application, to take beds and put them at the
7 ED in Moncks Corner, does Trident have a
8 positive bed need?

9 A: Yes.

10 Q: Okay. Does Roper have a positive bed need?

11 A: No.

12 Q: Okay. Does Roper have excess beds?

13 A: Yes.

14 Q: Okay. Now, there was an interesting line of
15 questioning, I'm going to refer to it as the
16 absurdity exhibit, because that's what you
17 referred to as 227, Petitioner's 227.

18 A: Okay.

19 MR. SUMMER: Could we get that up on the board,
20 please?

21 Q: Do you have copies that you can look at?

22 A: Is this in this packet?

23 Q: No, I don't think Petitioner's 227 is there.
24 It's on the screen. Can you see it?

25 A: Oh, okay.

1 Q: Now, if you would, remind the court why you put
2 this thing together anyway?

3 A: Yeah. Basically, the argument has been made
4 consistently, since Roper applied, it's
5 included in the argument in their application,
6 it was included at the argument at project
7 review, it was included in the arguments that
8 were offered by their consultants, that
9 Berkeley County has no beds. And as a result,
10 Trident's applying for 50, Roper's applying for
11 50, that's no big deal. It's only 100. Look
12 how big the county is. It's got 177,000
13 population, 100 beds is not a problem for a
14 county that size because look at all the other
15 counties around the state that have smaller
16 populations and have even more beds. And this
17 was prepared because that analysis is wrong.
18 It ignores Trident Medical Center, which is,
19 again, nine-tenths of a mile from the county
20 line. If Trident Medical Center was in the
21 county, every one of those maps that were
22 offered by Mr. Richardson to try to show that
23 Berkeley County was lacking in beds would be
24 gone. Because there would be a 296 bed
25 hospital in the county. And the point is if

1 you added beds to take care of Berkeley County
2 as if there was nothing serving them now, and
3 you said, okay, we've got all of these days in
4 Berkeley County, 65,000 days, that enables us
5 to add 304 beds in 2017 and 255 in 2010, what
6 you would be doing would be adding that to the
7 excess capacity for the region, because that --
8 other than the growth, other than the growth
9 between 65,000 and 77,000, that's real, that's
10 associated with new bed need. All the rest is
11 now being served at existing facilities,
12 whether at Trident, at Summerville, at MUSC, at
13 Roper St. Francis, at Roper Downtown, at Mount
14 Pleasant, or at East Cooper, or even hospitals
15 that are outside of the service area. The
16 point is, Berkeley County is not absent beds to
17 serve them and all of that patient population
18 is figured into the calculations that the state
19 makes, which enables them for the Tri-county
20 region to conclude were over-bedded. Even with
21 all of this volume from Berkeley County and
22 whatever volume comes from Dorchester County
23 and all the volume that comes from Mount
24 Pleasant and the rest of Charleston County,
25 there are more beds than are needed to be

1 projected as of 2017, given that there's a big
2 supply of beds and the patient population, as
3 large as it is, isn't enough to meet the
4 state's standards. That's why you have a net
5 excess. The only hospitals with bed need are
6 the two in the Trident System. They both
7 applied to fill that need, they both addressed
8 it. I think they did it in an appropriate
9 fashion. And to me, they're almost no-brainers
10 in terms of why they should be improved.
11 Entirely different situation with Roper.

12 Q: All right. Now, do you remember the -- there
13 was a lot of math that you were asked to
14 perform. But do you remember the match that
15 you did where Mr. Long asked you to basically
16 impute Trident -- just Trident's, not
17 Summerville, he ignore Summerville, but
18 Trident's market share to those 296 beds, to
19 drop that number and said isn't there 200 more
20 bed left?

21 A: Right.

22 Q: Okay. Let's go to --

23 A: They're serving -- I mean, Trident's beds are
24 serving Berkeley County, Dorchester County, to
25 a much lesser extent Charleston, and out of

1 county, out of those three counties.

2 Q: All right. Let's go to Respondent's 91. If
3 we're going to do that, if we're going to say,
4 okay, well, let's just only look at the beds
5 that Trident has.

6 MR. LONG: Judge, he's back to doing it. He's
7 giving his opinions, comments, and leading all
8 the way through testimony. Just ask the
9 question.

10 THE COURT: Well, I didn't hear the entire question.
11 All I heard was let's look at Trident. So
12 we'll start there.

13 Q: Would you look at number 91, this is
14 Respondent's 91?

15 A: Can you make that a little bigger on --

16 Q: I'm going to give it to you. All right. What
17 is that document?

18 A: This is market shares, South Carolina market
19 shares, it appears for -- by county --

20 Q: Right.

21 A: -- for the, what's called the HCA South
22 Atlantic Region, which are Trident Health
23 System, which is two hospitals, Colleton
24 Medical Center and Grand Strand Medical Center
25 as well as MUSC, the three Roper Hospitals and

1 East Cooper.

2 Q: Okay. Does it demonstrate the market shares
3 that the various hospitals have for Berkeley
4 County?

5 A: Yes.

6 Q: Okay. So do those beds also serve Berkeley
7 County?

8 A: Yes, of course. A significant number of them
9 serve Berkeley County.

10 Q: Okay. And now go to Roman Numeral II-9 of the
11 State Health Plan.

12 A: Okay.

13 Q: Actually, let's go to II- -- the '08-'09 Plan.

14 A: '08-'09?

15 Q: Yeah. Let's go back to the bed inventory
16 section, which begins on II-18.

17 A: Okay.

18 Q: How many of these hospitals listed, Trident
19 Medical Center, Summerville Medical Center,
20 MUSC, Roper, Roper Mount Pleasant, Bon Secours,
21 and East Cooper, how many of those facilities
22 serve patients from Berkeley County?

23 A: Every one of them does.

24 Q: Okay. So, again --

25 A: Charleston Memorial Hospital I don't know

1 anything about.

2 Q: It has been subsumed into the Medical
3 University.

4 A: Okay.

5 Q: So what's the total bed compliment for the
6 region?

7 A: 1,739.

8 Q: Okay. And Berkeley County residents, do they
9 have access to those beds?

10 A: Yes. I mean, they obviously use some more than
11 others.

12 Q: There's been a lot of talk about population
13 data. I do not want to go through every one of
14 these exhibits that Mr. Long went through. But
15 what I do want to do is go back to Petitioner
16 -- excuse me, Respondent's 70.

17 MR. SUMMER: Can we pull up the first page of
18 Respondent's 70?

19 A: I think that's this book.

20 Q: It's going to be on the screen. I think you'll
21 be able to see it.

22 A: Okay. All right. Oh, okay. I actually have
23 that one.

24 Q: Okay. Let's just look at the top part, which
25 is the county population.

1 MR. SUMMER: Can you zoom in on that, please?

2 A: Yeah, I see it.

3 Q: Okay. Now, rather than going through all the
4 different population data that we looked at,
5 that you looked at with Mr. Long, I'd like to
6 respond to all of that testimony by letting you
7 make some observations regarding the
8 population. Is population growing in the
9 region?

10 A: It's growing in all of the counties in the
11 region. And it's growing in the region at a
12 very solid clip.

13 Q: All right. Do you remember Mr. Richardson's
14 testimony where he basically went from 1980
15 through 2010 and did the beds per thousand; do
16 you remember that computation yesterday?

17 A: I do.

18 Q: Okay. Did you agree with those computations?

19 A: Yeah.

20 MR. LONG: Objection. I did not ask him about the
21 Richardson calculations on cross. I didn't do
22 any bed calculations per thousand. I just
23 talked -- actually, I didn't even talk about
24 this page of the Richardson exhibit. I just
25 talked about the population growth on the

1 census.

2 **THE COURT:** Mr. Long, the questions covered such a
3 broad array regarding that subject, that I'm
4 going to overrule the objection.

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

6 **Q:** Do you recall that in 1980 Mr. Richardson
7 calculated 1.3 beds per thousand for Dorchester
8 and Berkeley Counties?

9 **A:** Yes.

10 **Q:** Okay. And then for 2010, he calculated --

11 **MR. LONG:** Objection, Your Honor.

12 **A:** Actually the calculation was --

13 **MR. LONG:** Your Honor, I ask --

14 **A:** I'm sorry.

15 **THE COURT:** Wait a minute.

16 **MR. LONG:** See, the problem is he's leading him and
17 if the witness doesn't remember, he doesn't
18 remember, and move on.

19 **A:** Yeah. I'd rather do the calculation myself.

20 **Q:** That's fine. We'll just do it.

21 **MR. SUMMER:** I'm really just trying to save us some
22 time, but I understand Mr. Long is technically
23 correct.

24 **THE COURT:** I sustain the objection.

25 **A:** Okay.

1 Q: Just wait a second, I'll get you the
2 information.

3 MR. LONG: Well, I resent the technical part. I
4 mean, it's the rules and there's a reason for
5 it.

6 THE COURT: You're two seasoned lawyers and neither
7 one of you should feel resentment over one or
8 the other raising a reasonable objection.

9 MR. SUMMER: My feelings were not hurt, Your Honor.

10 A: It's basically 0013, so it's .13 beds per --
11 yeah, I'm reading this, 1.3.

12 Q: Okay. And then if we go to 2010 and make the
13 same calculation --

14 A: Per thousand, right?

15 Q: Yeah.

16 A: 1.3 per thousand.

17 Q: And we go to 2010 and make the same calculation
18 on 390 beds?

19 A: I believe it was 1.45 or 1.5, but I'll do the
20 calculation. And that's with 390?

21 Q: Correct. And those are the existing beds that
22 are in the Trident System.

23 A: Okay. Give me one second. Yeah. It was a
24 drop less. 1.24 per thousand.

25 Q: And then would you do it for the 470 beds,

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1 which includes all beds that DHEC has now
2 approved for Trident. So 470 beds on the 2010
3 population in Berkeley and Dorchester?

4 A: Okay. 1.49.

5 Q: Okay. Even though the population has
6 increased, do you have an opinion as to whether
7 or not the state health planning process has
8 kept up with that population?

9 A: It appears to be working with regard to two
10 rapidly growing counties.

11 Q: Okay. All right. Now, one of the other things
12 that you did comment on, and I don't need to
13 pull the exhibit up, but we've seen it. Is the
14 use rate remaining constant as this population
15 grows?

16 A: The use rate within an age segment is projected
17 to remain constant. The overall use rate is
18 actually projected to increase, because there
19 is a slightly higher percentage of older
20 population and they use hospital services more
21 than younger people do.

22 Q: Well, let me take you to another exhibit.
23 Petitioner's Exhibit 231.

24 A: Okay.

25 Q: Does this refresh your recollection about

1 whether or not the use rate is constant or
2 declining?

3 A: Yeah, no, during a three year period the number
4 of overall discharges coming out of Berkeley
5 County, there have been declines for the major
6 hospitals that are drawing patients and the --
7 this would suggest there's slightly different
8 rates for each hospital. But this is not what
9 you'd expect to see in a market where
10 population growth was growing by two and a half
11 percent per year. You could have a patient day
12 number that was slightly different if length of
13 stay was falling. Because the number of
14 patient days are the number of discharges times
15 the average length of stay at the hospital. If
16 length of stays are shorter, that can reduce
17 the number of patient days. But this is just
18 discharges. Discharges per thousand should
19 rise with population. So during a three year
20 period where you would have expected maybe
21 seven and a half percent population growth if
22 it was the average for the ten year period, you
23 saw instead a decline of two and a half
24 percent, so you're off by ten percent. If you
25 assume population didn't grow quire as quickly

1 during those three years, which I think, is more
2 realistic, it's -- maybe it was one and a half
3 percent per year, that still should have shown
4 an increase of 4.5 percent over three years,
5 and instead you get a decline of 2.5. This is
6 the kind of data that would suggest that being
7 too aggressive and approving too many hospitals
8 in markets that have historically been high
9 growth is not a great idea. But the second
10 thing is you would never do it if one of the
11 hospitals you're approving is not even needed
12 based on the growth using the historic numbers.
13 Using the two and a half percent going forward,
14 it still only justifies one hospital. So if
15 the rate of growth in volume is slowing, it
16 certainly would argue against approving a
17 second, even more so than the argument I've
18 made already.

19 Q: Okay. There was some questions regarding the
20 two applications and do either one of the two
21 applications anticipate the other or address
22 the other?

23 A: No. The Trident Medical Center application,
24 and I know I participated in helping put that
25 application together, there was no.

1 consideration of another hospital coming in.
2 They were applying and they did not expect that
3 there would be a second, they didn't anticipate
4 it. When Roper filed a few months later, they
5 obviously had to be aware that Trident had
6 applied, okay. We had seen some emails
7 suggesting that filing a competing application,
8 that language was used, was discussed. So the
9 application, other than a couple of very small
10 parts, has no consideration for the Trident
11 application. And certainly the financials seem
12 to be based on there being only one hospital.
13 So the presumption is with that second
14 application, they just either ignored Trident
15 or they thought these were competing and theirs
16 would win so they only needed to present theirs
17 and not take account of the one that was prior
18 in the cycle. I think you've got to be more
19 specific. If you're the second one in, you
20 have to say one of the two; we think ours is
21 superior or we think both can make it and
22 here's why.

23 Q: Okay. I want to look at a couple of these
24 criteria in the regulations.

25 A: Okay.

1 Q: Mr. Long first asked you about 802. Go to 802.
2 A: I have it.
3 Q: First let's go to 2(a).
4 A: 802(2)(a). Okay. Give me a second. Yeah. I
5 see.
6 Q: You remember a discussion he had with you
7 regarding that?
8 A: Yeah. I gave some ground on that and I think
9 that was appropriate.
10 Q: Okay. My original question had been, would the
11 target population should be, quote, clearly
12 identified.
13 A: Uh-huh (affirmative response.)
14 Q: If we look at -- and I just want you to look in
15 Joint 1, Trident application.
16 A: Do I have it?
17 Q: We're not going to put this up on the screen.
18 We're just going to make some quick
19 observations.
20 A: You can just give me a page.
21 Q: Okay. I want to start on page 24 regarding
22 target population.
23 A: Okay.
24 Q: Briefly, could you please describe, if we go
25 from 24 forward, your use of zip codes to

1 definitively describe the target population?

2 A: Correct. Yeah.

3 Q: Did Roper do that?

4 A: They did not. I mean that is -- they described
5 the location as the county, but they didn't
6 specify within the county where they expected
7 to receive most of their volume. In this case
8 they've pointed to historic volumes, but they
9 didn't take that step in what was submitted --
10 where is that -- to the Department. That was
11 one of the reason I was critical I think when
12 you first asked me the question.

13 MR. SUMMER: Pull up 53. I don't have a hard copy
14 of that. Respondent's 53.

15 Q: Okay. Have you seen this before?

16 A: Yes.

17 Q: Okay.

18 THE COURT: Let me identify it for the record. This
19 was Respondent's 53.

20 MR. SUMMER: Respondent's 53.

21 Q: Okay. Can you just explain what it is?

22 A: Yeah. This is a list from Bon Secours on the
23 top and then Roper Hospital on the bottom of
24 zip codes and it identifies Berkeley County
25 discharges by zip code, either tertiary or non-

1 tertiary in 2010 and year to date 2011. I
2 might note that all the zip codes are not
3 specifically Berkeley County zip codes.

4 Q: Can you tell from this whether or not Roper had
5 information that they could have shared with
6 DHEC regarding patient origin?

7 A: Yes, of course. They have their own patient
8 origin data and they certainly could have used
9 that to make estimations of whether the
10 redirection percentage would have been constant
11 county wide or would have been different in
12 different parts of the county, how much -- what
13 percentage of their volume they expected to get
14 from this seven mile circle, which they
15 continued to address in the application.

16 Q: Looking at the -- I think that's fine. The
17 point is they had it if they wanted to use it,
18 right?

19 A: Yes.

20 Q: Let's see. Go next to -- talked a little bit.
21 I think, Mr. Long did, about three, first I
22 think talked about 3(a) and then 3(b). Take a
23 look at 3(a) for me.

24 A: Okay, sir.

25 Q: Distribution, can we pull that up?

1 A: Yes.

2 Q: I think your testimony was that you did believe
3 this was unnecessary duplication, the Roper
4 application?

5 A: Yes. I don't think there's a need for a second
6 hospital here.

7 Q: Do you also remember the discussion about
8 Trident building beds at Summerville?

9 A: Yes.

10 Q: Was that consistent with or not consistent with
11 Trident's mission?

12 A: Both projects are consistent with their
13 mission.

14 Q: When you say both projects?

15 A: The Summerville project and the project in
16 Moncks Corner.

17 Q: Okay.

18 A: If they were proposing to add beds in Mount
19 Pleasant, I'd say no.

20 Q: I'm not sure we want to rule that out yet.
21 Let's finish up and talk -- let's go back to,
22 first I want to start with Petitioner's 104,
23 please.

24 A: Okay.

25 Q: I'd like to go to page 12.

1 A: Okay. It's on the screen.

2 MR. SUMMER: And if we could blow that chart up for
3 me, please, ma'am.

4 Q: First of all, you had discussions regarding
5 seven miles versus entire county. What does
6 this chart propose to do?

7 A: This basically calculates a projected
8 population five years out in two different
9 parts of Berkeley County, one of which the
10 seven mile circle would be entirely within, the
11 other of which it would not, about two-thirds,
12 a little less than two-thirds would be in the
13 county and your third would be not.

14 Q: All right. So is it whole county?

15 A: No.

16 Q: All right. Let's just focus on the seven miles
17 because we know they're not going to do
18 anything in Moncks Corner. Let's focus on the
19 seven miles; that seven miles radius around
20 Carnes Crossroad.

21 A: Uh-huh (affirmative response).

22 MR. LONG: Your Honor, the comments have started
23 again. It seems to happen a lot with this
24 exhibit.

25 MR. SUMMER: I like this exhibit.

1 MR. LONG: Well, can you just ask him questions
2 instead of commenting?

3 MR. SUMMER: I will, Your Honor.

4 THE COURT: He will do that. But let me say, Mr.
5 Long, that -- and I know you're aware of this,
6 but there's no jury here and I've been around
7 awhile, I know what to disregard.

8 MR. LONG: Your Honor, I'm well aware of that, and I
9 certainly we can have that discussion on the
10 table, but -- and we know that. But also the
11 reason I make the objection is because if
12 someone ever was to read this transcript later,
13 it can get really muddy when there's a lot of
14 comments like this. And when I'm just sitting
15 here and not raising it, it starts to get --
16 that's my point.

17 THE COURT: I understand.

18 MR. LONG: That's my point in raising the -- really
19 that's the only reason I'm making these
20 objections.

21 THE COURT: I understand. He has relented and said
22 he will rephrase it.

23 MR. SUMMER: I'll rephrase it.

24 Q: Let's just focus on Carnes Crossroads only,
25 please.

1 A: Okay.

2 Q: Okay. When you said the seven mile radius for
3 Carnes Crossroad, is that all in Berkeley
4 County?

5 A: No.

6 Q: And what's significant about what's not in
7 Berkeley County with that seven mile radius?

8 A: About two-thirds of the part that's not in the
9 county is in Dorchester County and about one-
10 third is in Charleston County.

11 Q: Are those high density population areas?

12 A: They are.

13 Q: Okay. Are those demographics for a hospital?

14 A: They are.

15 Q: Okay. And when we go back and we're not going
16 to go through the entire analysis again, but do
17 you remember taking Mr. Richardson's numbers
18 and computing, based on growth, the growth
19 numbers in his Exhibit 70, a need for a 51 bed
20 hospital?

21 A: Correct.

22 Q: Okay. You also recall your computation of
23 looking at scenario three and four in his
24 Exhibit Number 70?

25 A: Yes.

1 Q: And do you remember computing the number of \$29
2 million of adverse impact regarding scenario
3 number three by utilizing the 65 percent market
4 share from Petitioner's 104?

5 A: If you had essentially of about 31 patients of
6 Trident's market share, correct.

7 Q: And I think you had previously testified that
8 you didn't believe his scenario four was
9 realistic, correct?

10 A: No.

11 Q: Okay. So when we look at this --

12 A: Scenario four is unrealistic I think under any
13 set of assumptions because I don't think you'd
14 have all of the loss from a Roper facility on
15 Trident. There would be some loss on MUSC and
16 other facilities.

17 Q: You can't put 31 patients in a 50 bed hospital,
18 can you?

19 A: Correct. The only thing to note is that 31
20 patients is an increment to a base share. So
21 -- because you're going from 23 to 65 and in
22 essence for Trident you're going from 23 to
23 about 54, okay. So the 54 size would be big
24 for a 50 bed hospital. But again, that's where
25 what do you do with additional patients who

1 show up at the hospital and if there's -- the
2 hospital's busy and it's popular, then there's
3 always the ability to move those patients to
4 other facilities that have empty beds that are
5 in the system.

6 Q: As Mr. Severance discussed?

7 A: Correct.

8 Q: I want to refer back to, and we're not going to
9 put it on the screen, just leave everything
10 what we've got here, but Petitioner's 46 is
11 your exhibit; is that correct?

12 A: That's correct.

13 Q: And would you turn in that exhibit to where you
14 calculated your adverse impact number?

15 A: Yes. There are again two different what I'll
16 call adverse impact models here. There's the
17 first one on page 1619, which is the model for
18 what happens if both hospitals are approved and
19 built in Berkeley County and how much weaker
20 the financial performance of each of the
21 hospitals would be if both of them are built as
22 compared to what they projected in the
23 application.

24 Q: I appreciate that. I'm more interested in if
25 only the Carnes Crossroads hospital was built.

1 A: Okay. That analysis is on pages 1623 and then
2 carries over to 1626.

3 Q: Okay. Again, your contribution margin, case
4 contribution margin as to Trident, was how
5 much?

6 A: 4,985.

7 Q: And was that challenged at all by Roper?

8 A: No.

9 Q: The issue is one of just how many lost cases
10 are there?

11 A: Correct.

12 Q: Okay. What is the adverse impact to the
13 Trident System in year three based upon your
14 calculations on 1626?

15 A: \$16,595,687.

16 Q: Is it fair to say that that adverse impact is
17 somewhere between that number and 29 million?

18 A: It is somewhere between -- I mean, I'm
19 comfortable with the 16 million number here
20 with one exception. I think it could be higher
21 because of the fact that Trident's market share
22 in the service area, particularly the southern
23 part of Berkeley County, which I think is the
24 area most likely where the Roper Hospital would
25 be successful, would locate and draw patients

1 from, Trident's market share is higher there.
2 My model is based on the history, and the
3 history is county wide. Trident would lose 54
4 percent of its patients. Fifty-four percent of
5 whatever volume Roper gets would come out of
6 Trident's volume, 23 percent out of Roper's and
7 the rest out of MUSC. But if they had
8 identified the zip codes where they were going
9 to get their patient population, we could have
10 done a more precise calculation. You could
11 have looked at zip code 29455 and here
12 Trident's market share is 60 percent. So if
13 you did it that way, then the volume would be
14 -- the impact would be based on Trident's share
15 in that zip code applied to what Roper's volume
16 in that zip code. Since Trident's market share
17 is higher in the southern part of the county,
18 the county wide average of 54 percent for
19 Trident could be low. So if it turns out to be
20 60 percent, you would add another million six,
21 million seven to this number. It's more
22 likely, in my judgment, the number would be
23 higher than lower because the market share is
24 for Trident and the zip codes that are closest,
25 within the seven mile, closest to Carnes

1 Crossroad and within the seven mile circle, are
2 zip codes where Trident has an above average
3 market share as compared to its county market
4 share.

5 Q: DO you have an opinion about whether or not
6 your number of 16,595,687 is conservative or
7 liberal?

8 A: I think it's a fair estimate. The way to
9 refine that estimate would have been if I had
10 known where Trident -- where Roper was getting
11 its patients from. It's conservative because
12 I think it's more likely that their patient
13 population would come from those higher Trident
14 market share zip codes. So if I had seen a zip
15 code analysis, I think it's quite -- better
16 than 50/50 chance the number would have been
17 higher than I've calculated.

18 Q: And we know that they had the ability to do it.
19 We've seen the exhibit, right?

20 A: We know what their target was, sure.

21 Q: But I mean they had the ability to give you zip
22 code numbers?

23 A: Oh, for sure, for sure. It's not hard at all.

24 Q: Do you think they hid the ball?

25 A: What's that?

1 Q: Do you think they hid the ball?

2 A: In the prior draft they had the seven miles,
3 they had the zip codes identified, they had
4 less redirection, okay. If that's where they
5 really believe they're serving and the case
6 that's made in this application is really not
7 about this expansion north in Moncks Corner,
8 that's not the argument that's made in this
9 application. The argument that's made in this
10 application is Goose Creek is a big city, it's
11 growing fast, it needs its own hospital, we've
12 got a lot of patients in the county, they
13 shouldn't have to drive downtown. Those are
14 the arguments that are made. So that suggests
15 that the patient population is going to come
16 from that area.

17 Q: Okay. Let's go next to, this is Roper 70, this
18 is again Mr. Richardson's work, correct?

19 A: I have it.

20 Q: Okay. We're not going to go through it again,
21 but this is where you've made your calculations
22 regarding future growth?

23 A: Yes.

24 Q: Okay. And your testimony was that's consistent
25 with the way DHEC does it, right?

1 A: And the way I calculated it as well in my
2 exhibits.

3 Q: Okay. And based upon that, you identified a
4 bed need in the future in 2017 of 51 beds using
5 DHEC's methodology, correct?

6 A: That's Mr. Richardson's calculations using the
7 approach which I believe is consistent with the
8 state's methodology.

9 Q: Okay. And --

10 A: My number is the same.

11 Q: All right. If you would, let's go next to
12 Roman Numeral II-18.

13 A: In the --

14 Q: '08-'09 Plan.

15 A: Juggling books here. II-18?

16 Q: Yes.

17 A: Okay.

18 Q: All right. Knowing that DHEC has approved the
19 Summerville project for 30 beds and the Trident
20 project for 50 beds --

21 A: Yes.

22 Q: -- do you believe that the bed calculation Mr.
23 Richardson did on future need is consistent
24 with the State Health Plan?

25 A: The calculation in which he calculated a need

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1 of 51?

2 Q: Yes.

3 A: Yes.

4 Q: Okay. And then the other thing I want to do is
5 go back to --

6 A: The only thing I'd add again is he used the
7 Berkeley County population numbers which get
8 you a faster growth rate than what's applied to
9 any of these individual hospitals to create
10 their bed need, because they it's the Tri-
11 county population, population growth rate.

12 Q: Again, I understand that the service area is
13 the three county region, but --

14 A: Correct.

15 Q: -- his exhibit and testimony focused only on
16 Berkeley County.

17 A: That's correct.

18 Q: Okay.

19 A: Followed the same methodology, applied it to
20 Berkeley County.

21 Q: I want to finish with Roman Numeral II-10.

22 A: Okay.

23 Q: Go there. And we'll pull up that number five
24 again, criterion five, bed transfer section.

25 THE COURT: This is '08-'09?

1 MR. SUMMER: Yes, Your Honor.

2 A: Okay.

3 Q: Okay. Again, based on Mr. Richardson's
4 calculations that is a need for 51 beds in his
5 Exhibit 70, do you have a professional opinion
6 as to whether or not Roper met its obligation
7 under criteria number five in the bed transfer
8 section?

9 A: I do not believe they did.

10 Q: And why?

11 A: What they did is they showed how they could
12 fill their beds. They didn't show there was a
13 need for their hospital in addition to the
14 hospital in Moncks Corner.

15 Q: At the physical location, correct?

16 A: At the physical location, correct.

17 Q: I think the language says additional capacity
18 at the receiving facility, the beds must
19 demonstrate a need for additional capacity.
20 And there is no need for additional capacity at
21 Carnes Crossroad?

22 A: Absolutely not.

23 Q: Is there any need for the Roper application?

24 A: I believe not.

25 Q: Okay. And does approving it exceed the need

1 under this section of the Plan?

2 A: Yeah, I think quite clearly it does.

3 MR. SUMMER: That's all, Your Honor.

4 THE COURT: Thank you. You may step down, Mr.
5 Baehr. I assume that in lieu of any sort of
6 closing arguments you would consent to
7 submitting proposed orders?

8 MR. SUMMER: That's fine with us, Your Honor. I
9 think a proposed order is all that's necessary
10 after this.

11 THE COURT: Mr. Long?

12 MR. LONG: Whatever suits you, Your Honor. Whatever
13 you'd like to see.

14 THE COURT: What about the exhibits and the
15 designations? You want to handle those now?
16 You want to come back in the morning and do it.

17 MR. SUMMER: We can do it in the morning. What's
18 y'all's pleasure?

19 MR. LONG: It shouldn't take very long. We just
20 need to read them into the record.

21 THE COURT: I'm fine with right now.

22 MR. THOMAS: We don't need to read the deposition
23 designations in. I think we're going to submit
24 a document, right? And then we'll give you an
25 actual notebook, Your Honor, that you can read

1 in your time.

2 **THE COURT:** But we need to get it on the record. Do
3 you have it now or do you --

4 **MR. THOMAS:** We have the designations, but do we
5 have the notebooks that -- how do you want to
6 do it, Madam Court Reporter?

7 **COURT REPORTER:** Y'all are going to submit the
8 designations that are highlighted? I mean --

9 **MR. THOMAS:** Actually, I don't know if they'll be
10 highlighted. They'll just be the actual --

11 **COURT REPORTER:** Just the depositions?

12 **MR. THOMAS:** -- transcript from the witnesses that
13 were submitted.

14 **MR. SUMMER:** Why don't we do it with a certification
15 from counsel. That would be an easy way to do
16 it.

17 **THE COURT:** With no excess. If you're not going to
18 --

19 **MR. THOMAS:** Yeah, no excess, that's right.

20 **MS. HOLLINGSWORTH:** Only the designated excerpts from
21 --

22 **MR. LONG:** All the excerpts, right. We'll just
23 submit that. I think it's already prepared. I
24 think ours are done. We certainly could get
25 that to Your Honor, you know, by Tuesday I

1 would think.

2 **THE COURT:** One other thing I want to suggest and I
3 don't want to burden y'all with. Y'all got a
4 lot of other stuff to do. But it seems to me
5 that you could agree on a glossary to attach to
6 this record.

7 **MR. SUMMER:** We actually did one for Judge Kittrell.

8 **THE COURT:** You've given me the definitions, but an
9 appellate court has got to dig through the
10 whole record to find it.

11 **MR. SUMMER:** We have one that was done for Judge
12 Kittrell and it was based off of something the
13 South Carolina Hospital Association had
14 promulgated and I will go and look in my file
15 -- I can't remember which case. May have been
16 in the South Cross actually. It may be that
17 far back. I don't have a problem looking and
18 seeing if we can agree on something, do you?

19 **MR. LONG:** I think there was some exchange we did
20 with each other earlier in the case on that.
21 Could we -- I don't know if I could find it.

22 **THE COURT:** Well, let's put this on the record then
23 that there will subsequently be a glossary
24 agreed upon by counsel included in the record.
25 We're not going to open the record back up.

1 It's simply being closed, but subject to this
2 provision.

3 MR. SUMMER: All right.

4 MR. LONG: Your Honor, when would you like the
5 proposed orders?

6 THE COURT: Well, it's going to be a month of
7 Sundays before you get the transcript.

8 MR. LONG: And that's fine. I mean actually we'll
9 just say a date after we get the transcript,
10 whether it be 45, 30.

11 THE COURT: I would say at least 45 days after you
12 get the transcript. Another thing I'd like to
13 say is even though the computer screens are
14 kind of fuzzy, we owe a debt of gratitude to
15 our ladies who handled the information
16 technology. Thank you so much. Flawless job.
17 And the court reporter too. Thank you so much.
18 Good night for all of you.

19 COURT REPORTER: We're going to do the exhibits,
20 too, Your Honor, right? I think that the
21 attorneys would prefer to do them on the record
22 just so we have it.

23 THE COURT: Okay. Go ahead.

24 MR. LONG: I think the lawyers can read them out and
25 Ms. Hollingsworth will do that for us or

1 whatever.

2 (Off the Record Discussion)

3 **THE COURT:** All right. The exhibits.

4 **COURT REPORTER:** Okay, yes, sir. Joint Exhibits 1
5 through 12 and then also 15 and 16.

6 **MS. TYER:** I have 13.

7 **MS. HOLLINGSWORTH:** 13 is an exhibit that's related
8 to a deposition designation.

9 **COURT REPORTER:** So that is admitted through
10 deposition. Which deposition, just so we have
11 a record of it.

12 **MS. TYER:** Mr. Severance?

13 **MS. HOLLINGSWORTH:** I have Mr. Sullivan. The 2010
14 portion -- Joint 13 is in Mr. Sullivan's.

15 **COURT REPORTER:** Okay. And then Petitioner's
16 Exhibits 1 through 4, 1 through 5 are admitted.

17 **MS. HOLLINGSWORTH:** I don't have Petitioner's 2.

18 **COURT REPORTER:** Oh, I'm sorry. I just need to do
19 them one at a time. Okay. I have 1, 3, 4, 5,
20 17.

21 **MS. TYER:** Whoa --

22 **MS. HOLLINGSWORTH:** You know what might be easiest,
23 because mine is color coded, let her go through
24 what she has and then we can go through the
25 deposition ones.

1 MS. TYER: Okay.

2 MS. HOLLINGSWORTH: And then as long as you and I
3 match up, then we'll know.

4 COURT REPORTER: Okay. Because I won't have the
5 deposition -- sorry.

6 MS. HOLLINGSWORTH: That's okay.

7 COURT REPORTER: So I'm going to start over with the
8 Petitioner's Exhibits.

9 MS. HOLLINGSWORTH: Yes, ma'am.

10 COURT REPORTER: We have 1, 3, 4, 5, 17, 18, 20, 31,
11 37, 38, 39, 40, 41, 42, 45, 46.

12 MS. HOLLINGSWORTH: If I could stop you right there.

13 COURT REPORTER: Yes, ma'am.

14 MS. HOLLINGSWORTH: I do have Petitioner's 43 that
15 came in through Mr. Baehr.

16 COURT REPORTER: Oh, that was something that came in
17 today?

18 MS. HOLLINGSWORTH: It's not from today.

19 MR. THOMAS: It's from his testimony, yeah.

20 COURT REPORTER: Okay. Didn't have that one on
21 there, but that's agreeable to everybody for
22 43? Okay. And then we have 45, 46, 54, 57,
23 58, 59, 62, 66, 69 and 70, 86 --

24 MS. HOLLINGSWORTH: If I could stop you right there.

25 COURT REPORTER: Yes, ma'am.

1 MS. HOLLINGSWORTH: Petitioner's 73 came in today
2 through Mr. Baehr.

3 MR. THOMAS: Correct.

4 COURT REPORTER: Thank you. Okay. And I said 86
5 and then we go to 88, 89.

6 MS. REID: What about 75, Petitioner's 75?

7 MS. HOLLINGSWORTH: Petitioner's 75 is not on my
8 list.

9 MS. TYER: Huh-uh. It's not on my list either.

10 MS. REID: I had that marked down for Mr. Baehr and
11 for Mr. Richardson.

12 MR. THOMAS: 75?

13 MS. TYER: 75?

14 MR. THOMAS: Petitioner's 75, let's see what we've
15 got there.

16 COURT REPORTER: It says it's the bed needs estimate
17 and it also says contingent upon Baehr's slides
18 coming in on mine.

19 MS. TYER: I have Roper 75 coming in.

20 MS. HOLLINGSWORTH: I think it's Respondent's 75.

21 MR. THOMAS: Well, it's Petitioner's -- I think this
22 basically came in through Petitioner's 70 --
23 Respondent's 70.

24 MS. HOLLINGSWORTH: I don't have this being written
25 as an exhibit. Can we just leave that off and

1 then we will confirm?

2 COURT REPORTER: All right. So I'm just going to
3 keep going in number order. I might have said
4 some of these. 86, 88, 89, ,92, 93, 95, 97,
5 102.

6 MS. HOLLINGSWORTH: Ma'am, if I could, Petitioner 98
7 came in today through Mr. Baehr.

8 COURT REPORTER: I'm sorry about the ones for today.
9 I haven't updated for today.

10 MS. HOLLINGSWORTH: And I don't mean to interrupt
11 you.

12 COURT REPORTER: It's goo. It's great. It will
13 make it much easier. I'm probably going to
14 miss the ones from today.

15 MS. HOLLINGSWORTH: Absolutely.

16 COURT REPORTER: And then I have 102, 104, and then
17 109. Then we skip down to 119, 125, 128, 136,
18 137.

19 MS. HOLLINGSWORTH: I have Petitioner's 130 came in
20 through Mr. Gorrell.

21 COURT REPORTER: Does everybody agree on that?

22 MS. HOLLINGSWORTH: Petitioner's 130.

23 MR. THOMAS: Yes.

24 COURT REPORTER: Okay, through Gorrell, Petitioner's
25 130 is in. Okay. 136, 137, 143, 144, 146,

1 148.

2 MS. HOLLINGSWORTH: I don't have 146.

3 MS. TYER: That came in through Johnson.

4 COURT REPORTER: Yeah, Johnson is who I have

5 indicated.

6 MS. HOLLINGSWORTH: Okay.

7 COURT REPORTER: Is everyone agreeing on 146?

8 MS. HOLLINGSWORTH: Yes, ma'am.

9 COURT REPORTER: Okay. 148 and 150. Then we go to

10 156, 160.

11 MS. HOLLINGSWORTH: Actually, I have 159 as coming

12 in through trial.

13 MS. TYER: Who did it come through?

14 MS. HOLLINGSWORTH: Mr. Knapp.

15 MS. TYER: I do not have that.

16 MR. THOMAS: I'll see what it is.

17 COURT REPORTER: Do you have 160?

18 MS. HOLLINGSWORTH: Well, I have it as a deposition.

19 MS. TYER: You had 159?

20 MS. HOLLINGSWORTH: I do.

21 MS. TYER: For is it Knapp?

22 MR. THOMAS: I don't see it in my cross.

23 MS. TYER: I have Petitioner just 59.

24 MR. THOMAS: Yeah, Petitioner's 59 I think did come

25 in.

1 COURT REPORTER: Yes, I have that too. So we're not
2 going to include Petitioner's 159 then. That
3 is not an admitted exhibit. Okay. And then
4 160 was coming through deposition. 162, 163,
5 164, 165, 166, 167, 168. I believe 169.

6 MS. HOLLINGSWORTH: Yes, ma'am.

7 COURT REPORTER: 174, 175, 177, 181, 182, that came
8 through Richardson.

9 MS. HOLLINGSWORTH: Do you have 182?

10 MS. TYER: Through Richardson through y'all.

11 MS. HOLLINGSWORTH: Okay.

12 COURT REPORTER: We agree on 182?

13 MS. HOLLINGSWORTH: Yes, ma'am.

14 COURT REPORTER: Okay. 189, 196.

15 MS. HOLLINGSWORTH: I do not have 196.

16 COURT REPORTER: I have that came in through
17 Johnson, but -- no, y'all don't have that one.
18 Sorry. Take that one off. So we're not
19 admitting 196. The next one is 201 and 202,
20 206, 207, 211, 212, 214, 215, 216, 219, 220,
21 221, 222, 225, 227, 230, 231, 232, 233, 234,
22 235. Then I go to 238.

23 MS. HOLLINGSWORTH: Which is a proffer.

24 COURT REPORTER: You're right, it's written here
25 proffer. Then we have 240 it looks like

1 through 243, and then 244 is a proffer.

2 MS. HOLLINGSWORTH: Yes, ma'am.

3 COURT REPORTER: And I believe that's all I have for
4 Petitioner's.

5 MS. HOLLINGSWORTH: That's all that I have as well.

6 COURT REPORTER: Okay.

7 MR. THOMAS: Petitioner's 75, we're fine with that
8 one being excluded for the record, because we
9 didn't have it on our list. I don't think you
10 had it on your list.

11 COURT REPORTER: So Petitioner's 75 is or is not?

12 MR. THOMAS: Well, let me look at it.

13 MR. LONG: 75 shouldn't be in.

14 MS. HOLLINGSWORTH: 75 is not.

15 COURT REPORTER: Okay. So that concludes the
16 Petitioner's Exhibits that are admitted. And
17 I believe we've indicated all the --

18 MS. HOLLINGSWORTH: Well, let's finish the trial
19 exhibits and then we'll --

20 COURT REPORTER: And just confirm, there were only
21 two proffers made by the petitioners and you
22 all marked those as 238 and 244, correct?

23 MS. HOLLINGSWORTH: That's what I have.

24 COURT REPORTER: Okay. Next is Respondent's
25 Exhibits. We have 1 and 2, 5, 7, 9, 10, 11,

1 15, 16, 20, 23, 25, 27 through 31, 36, 37 and
2 38, 41, 45, 50, 52, 53. And then we go from 59
3 all the way through 70.

4 MS. HOLLINGSWORTH: I do not have 61 marked.

5 COURT REPORTER: Oh, I'm sorry, 61 was not included.
6 So 59 land 60, and then 62 through 70. Okay.
7 And then 73 through 77. So we've gone through
8 77 I believe.

9 MS. HOLLINGSWORTH: Yes, ma'am.

10 COURT REPORTER: The next is 81 and 82, then we go
11 to 89.

12 MS. HOLLINGSWORTH: I have 85 was in today through
13 Mr. Baehr.

14 COURT REPORTER: Okay. Thank you. So that's
15 Respondent's 85. Okay. 89, 91. And then we
16 go down to 97.

17 MS. HOLLINGSWORTH: I have 93.

18 COURT REPORTER: 93, did that come in today?

19 MS. HOLLINGSWORTH: No, I have it through Mr.
20 Johnson. That's probably a error on our chart.

21 COURT REPORTER: So we're not admitting 93 for the
22 Respondent's.

23 MS. HOLLINGSWORTH: No, ma'am.

24 COURT REPORTER: Do you guys have 97?

25 MS. HOLLINGSWORTH: Yes, ma'am.

1 COURT REPORTER: And then we go to 104, 105, 106,
2 107, 108.

3 MS. TYER: I do not have 107.

4 COURT REPORTER: Oh, my gosh, I don't either. Okay.
5 Okay, so let me do that again. 104, 105, 106,
6 108, 110, 111 and then we go to 116. All
7 right. And then we go over to 124, 125, 126,
8 127, 130, 131, 132, 136, 137, 138. Then down
9 to 144, 146.

10 MS. TYER: I have 145.

11 MS. HOLLINGSWORTH: I have 145.

12 COURT REPORTER: 145, okay. Who did we admit that
13 through?

14 MS. HOLLINGSWORTH: Mr. Gunn.

15 COURT REPORTER: And we all agree on 145 coming in.
16 146, 148, 150, 151, then we go down to 158,
17 159, 160, and then it looks like we jump to 63
18 -- 161, I'm sorry. 161, 163, then 167 and 168.

19 MS. HOLLINGSWORTH: I have 164.

20 MS. TYER: I have 164.

21 COURT REPORTER: I have those too. I'm sorry, some
22 of mine are out of order because they weren't
23 on the sheet.

24 MS. HOLLINGSWORTH: I have 163 through 168.

25 COURT REPORTER: That's what I have too. And then I

1 also have a 171, which I think was marked.
2 Okay. And then y'all had -- did you just have
3 the one proffer for the testimony of Mr.
4 Gorrell?

5 **MR. LONG:** Yes.

6 **COURT REPORTER:** Okay. So do you want to mark that
7 as 172, okay. So that will be Respondent's 172
8 will be the proffer of Mr. Gorrell. Okay. As
9 far as deposition designations, y'all can put
10 those on the record, please, and let me know
11 what I need to include.

12 **MR. THOMAS:** Petitioner's 10, Petitioner's 11,
13 Petitioner's 12, Petitioner's 19, Petitioner's
14 77, Petitioner's 82, Petitioner's 83,
15 Petitioner's 87, Petitioner's 95, which is
16 already in. Petitioner 112, Petitioner 118,
17 Petitioner 124, Petitioner 126, Petitioner 129,
18 Petitioner 133, Petitioner 134, Petitioner 138,
19 Petitioner 158. I have Petitioner 218, and
20 that's it.

21 **COURT REPORTER:** Okay. And the respondents don't
22 have any? And this might sound like a dumb
23 question, but I'm going to ask it. The
24 exhibits that are attached to the depositions
25 that were offered for the witnesses to read, do

1 I include those with the record as well?

2 MR. LONG: Depositions shouldn't be included. Only
3 the reading, the reading is in the transcript.
4 The entire deposition or whatever would not go
5 in the record.

6 MR. THOMAS: That's right.

7 THE COURT: Just the designations.

8 MR. THOMAS: The designations are going to come in a
9 separate notebook. But when witnesses were
10 asked to read from their own deposition, those
11 depositions --

12 COURT REPORTER: So all the original depositions you
13 guys can have back then.

14 MR. LONG: Is that okay with you, or should she keep
15 them as some sort of -- I guess you transcribe
16 the --

17 COURT REPORTER: Oh, yeah, I'll transcribe what was
18 read for sure, yes. But I didn't know if these
19 needed to travel with the record or not.

20 MR. LONG: Yeah, that was a problem in a case I had
21 that went up on appeal because that got
22 included in the record and I didn't think it
23 was appropriate. So I think they should be
24 taken back.

25 MR. THOMAS: Yeah. I'll take them back.

1 THE COURT: Is that is?

2 COURT REPORTER: Yes, sir, I believe that's it for
3 the exhibits.

4 THE COURT: Any reason why we should not now
5 adjourn?

6 MR. LONG: Just to clarify we can come tomorrow and
7 get our stuff.

8 MS. BIGGERS: Can I just clarify the letters of
9 support, those are part of Joint 1, right?

10 MR. LONG: I believe so.

11 MR. THOMAS: They're definitely part of Joint 1.
12 They are part of the DHEC record.

13 MS. BIGGERS: Right.

14 THE COURT: All right. I declare us adjourned.

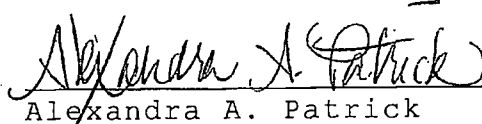
15 (There being nothing further, the hearing concluded
16 at 7:00 p.m.)
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CERTIFICATE

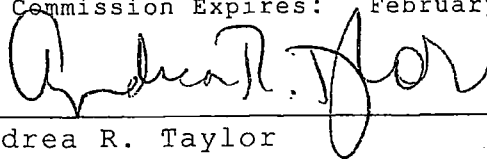
This is to certify that the within hearing consisting of Three Thousand Seven Hundred Ninety-Three (3793) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenomask with Backup.

We further certify that we are neither employed by nor related to any of the parties in this matter or their counsel; nor do we have any interest, financial or otherwise, in the outcome of same.

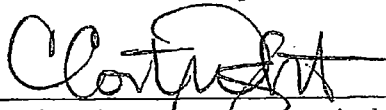
IN WITNESS WHEREOF we have hereunto set our hand and seal on March 28, 2012.



Alexandra A. Patrick
Court Reporter
Notary Public for South Carolina
My Commission Expires: February 13, 2019



Andrea R. Taylor
Court Reporter
Notary Public for South Carolina
My Commission Expires: April 27, 2014



Christine A. Cortright
Court Reporter
Notary Public for South Carolina
My Commission Expires: August 28, 2016

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RECORD 004259

ANALYSIS OF NEED FOR ACUTE CARE HOSPITAL SERVICES IN BERKELEY COUNTY SOUTH CAROLINA

RICHARD A BAEHR AND ASSOCIATES

JANUARY 2012

**ATTORNEY EXPERT EYES
ONLY**

RECORD 004260

Baehr_01591

TABLE OF CONTENTS

- I. IMPROVEMENT IN PATIENT ACCESS**
- II. UTILIZATION TRENDS**
- III. APPROVAL OF TWO HOSPITALS WILL LIKELY RESULT IN THE FINANCIAL FAILURE OF BOTH**
- IV. IMPACT ON EXISTING PROVIDERS**

SECTION I : TECHNICAL APPENDIX

SECTION II: TECHNICAL APPELNDIX

SECTION III: TECHNICAL APPENDIX

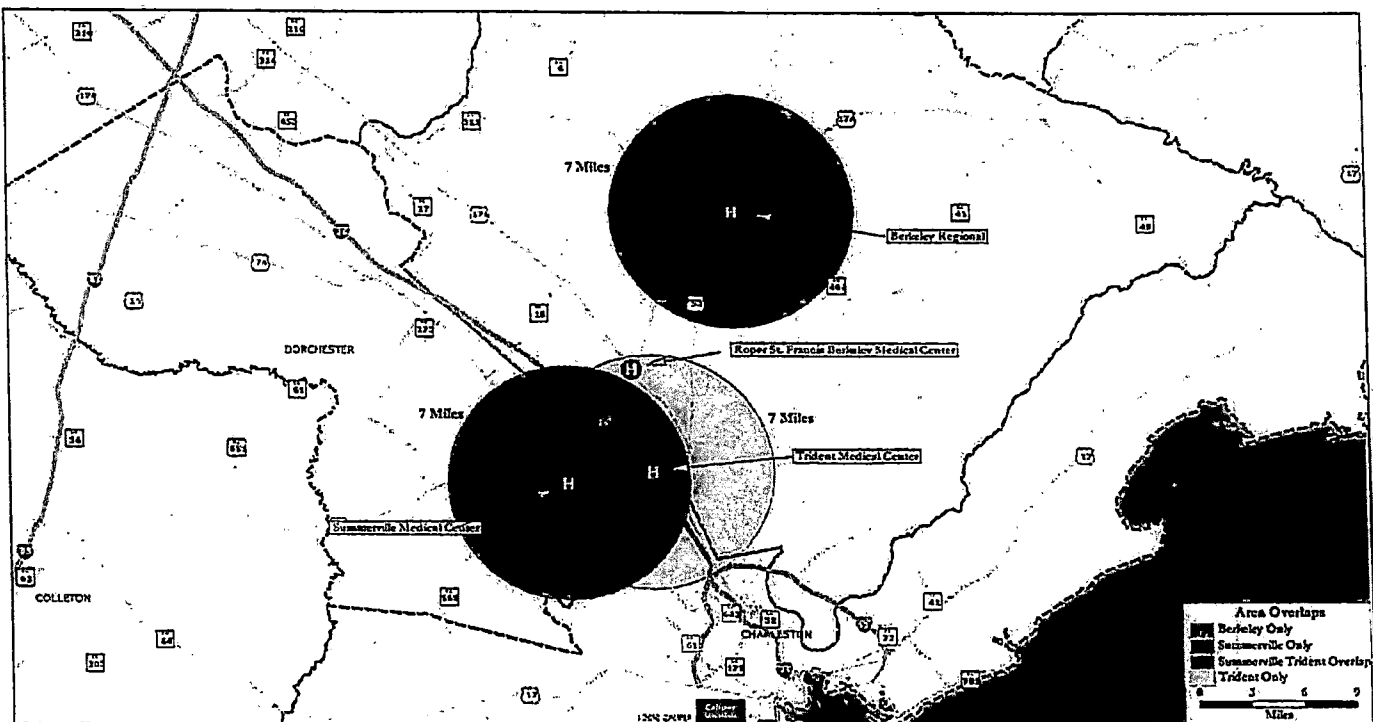
SECTION IV: TECHNICAL APPENDIX

I. IMPROVEMENT IN PATIENT ACCESS

7 and 15 MILE RADIUS ANALYSIS: BERKELEY REGIONAL MEDICAL CENTER.

- A 7-mile Radius Drawn Around Berkeley Regional Medical Center Does not Intersect with 7 Mile Radii Drawn Around Any Other Hospitals.
- A 15-mile Radius Drawn Around Berkeley Regional Medical Center Intersects With Between a Third and a Quarter of the Service Areas Defined by 15-Mile Radii Drawn Around Summerville Medical Center and Trident Medical Center.
- Based on a 7-Mile Standard, Berkeley Regional Medical Center would Place 20,698 persons who are not now Within 7 Miles of an Acute Care Hospital within 7 Miles of Berkeley Regional Medical Center. (See page I-vii)
- Based on a 15-Mile Standard, Berkeley Regional Medical Center would Place 29,836 persons who are not now Within 15 Miles of an Acute Care Hospital within 15 Miles of Berkeley Regional Medical Center. (See page I-iv)

Trident Summerville Berkeley 7 Mile Bands



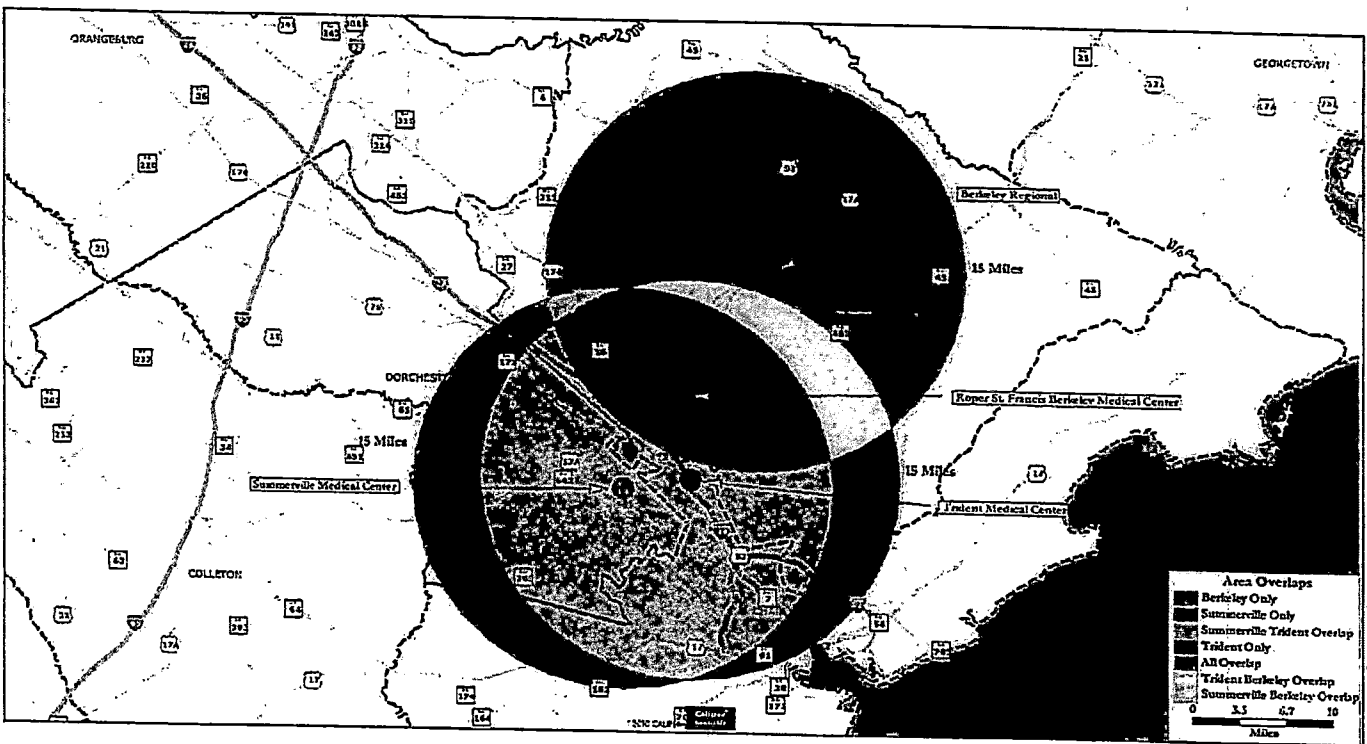
Petitioner's Exhibit 046-004

ATTORNEY EXPERT EYES
ONLY

RECORD 004263

Baehr_01594

Trident Summerville Berkeley 15 Mile Bands



Petitioner's Exhibit 046-005

ATTORNEY EXPERT EYES
ONLY

RECORD 004264

Baehr_01595

If Berkeley Regional Hospital is Approved
How Many People Will Enjoy Improved Access to Acute
Hospital Services ?

If Improved Access Means Living Within

15 Miles of An Acute Care Hospital
7 Miles of An Acute Care Hospital

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER		TOTAL
6,578	11,242	7,387	4,629		29,836
4,430	7,806	5,301	3,161		20,698

Source: Claritas

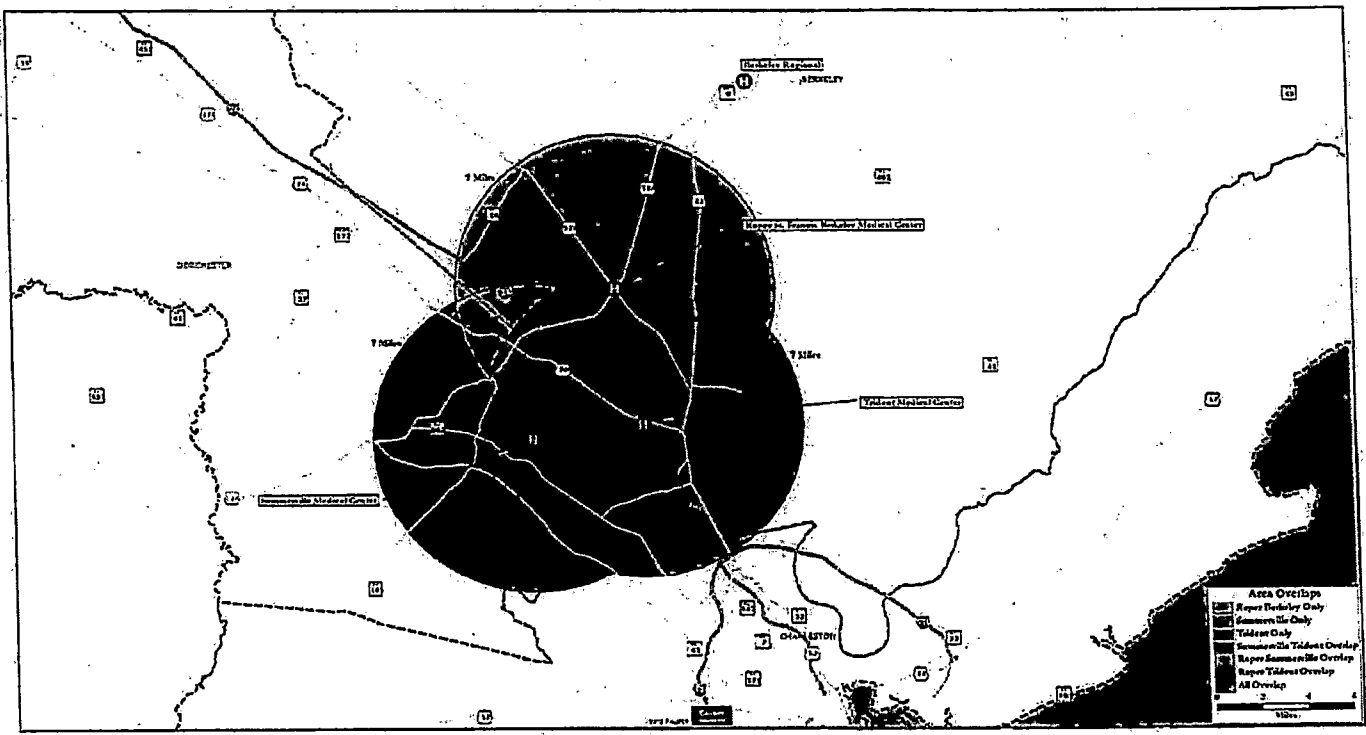
7 and 15 MILE RADIUS ANALYSIS: ROPER ST. FRANCIS BERKELEY

- **A 7-mile Radius Drawn Around Roper St. Francis Berkeley Intersects With Approximately 40 to 50 Percent of the Service Area Defined by a 7-Mile Radius Drawn Around Trident Medical Center, and with about 25 to 30 Percent of the Service Area Defined by a 7-Mile Radius Drawn Around Summerville Medical Center.**
- **A 15-mile Radius Drawn Around Roper St. Francis Berkeley Intersects With Between a Two Thirds and Three Quarters of the Service Areas Defined by 15-Mile Radii Drawn Around Summerville Medical Center and Trident Medical Center.**
- **Based on a 7-Mile Standard, Roper St. Francis Berkeley would Place 10,386 persons who are not now Within 7 Miles of an Acute Care Hospital within 7 Miles of Roper St. Francis Berkeley. (See page I-vi)**
- **Based on a 15-Mile Standard, Roper St. Francis Berkeley would Place 14,331 persons who are not now Within 15 Miles of an Acute Care Hospital within 15 Miles of Roper St. Francis Berkeley. (See page I-ii)**

If Berkeley Medical Center is Approved and Constructed, the Construction of Roper St. Francis Hospital Berkeley would add virtually no incremental access to health care services. Based on a 15-Mile Standard, the addition of Roper St. Francis would enhance access for only 940 persons. (See page I-ii)

If Roper St. Francis Hospital Berkeley is Approved and Constructed, the Construction of Berkeley Regional Medical Center would still increase access for 14,335 persons, based on a 15-Mile Standard. (See page I-iv)

Roper Trident Summerville 7 Mile Bands



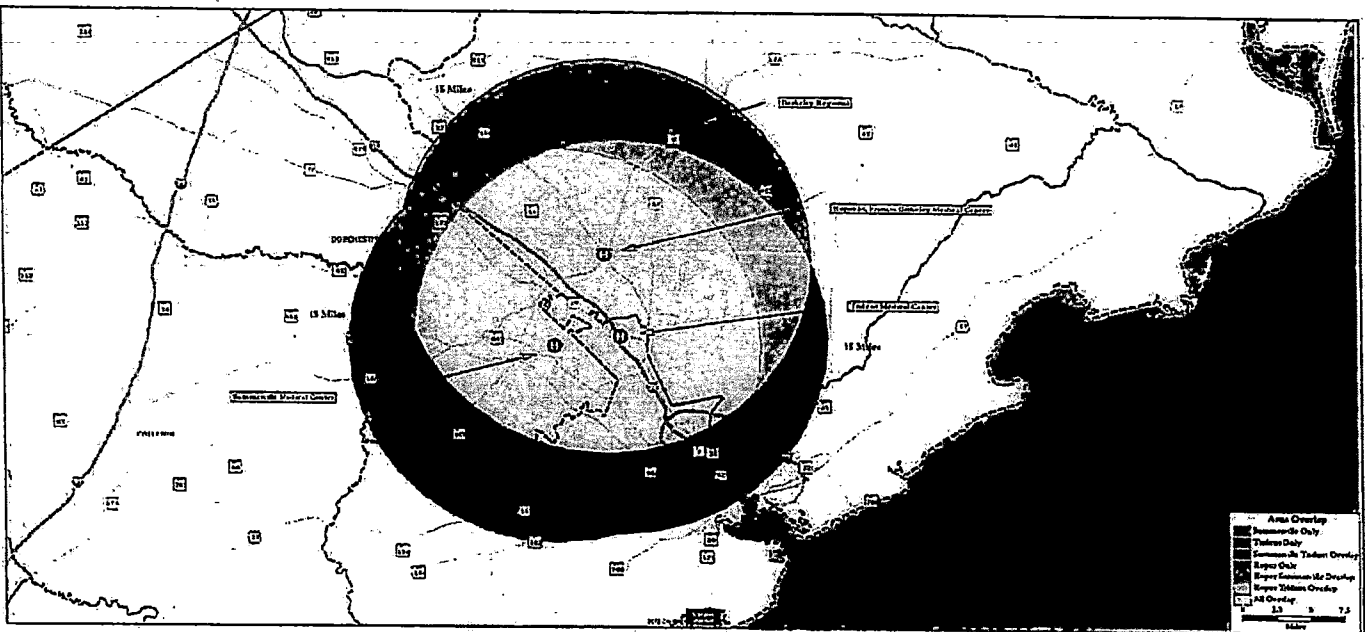
Petitioner's Exhibit 046-008

ATTORNEY EXPERT EYES
ONLY

RECORD 004267

Baehr_01598

Roper Trident Summerville 15 Mile Bands



ATTORNEY EXPERT EYES
ONLY

RECORD 004268

Bachr_01599

**If Roper St. Francis Berkeley Hospital is Approved,
How Many People Will Enjoy Improved Access to Acute
Hospital Services?**

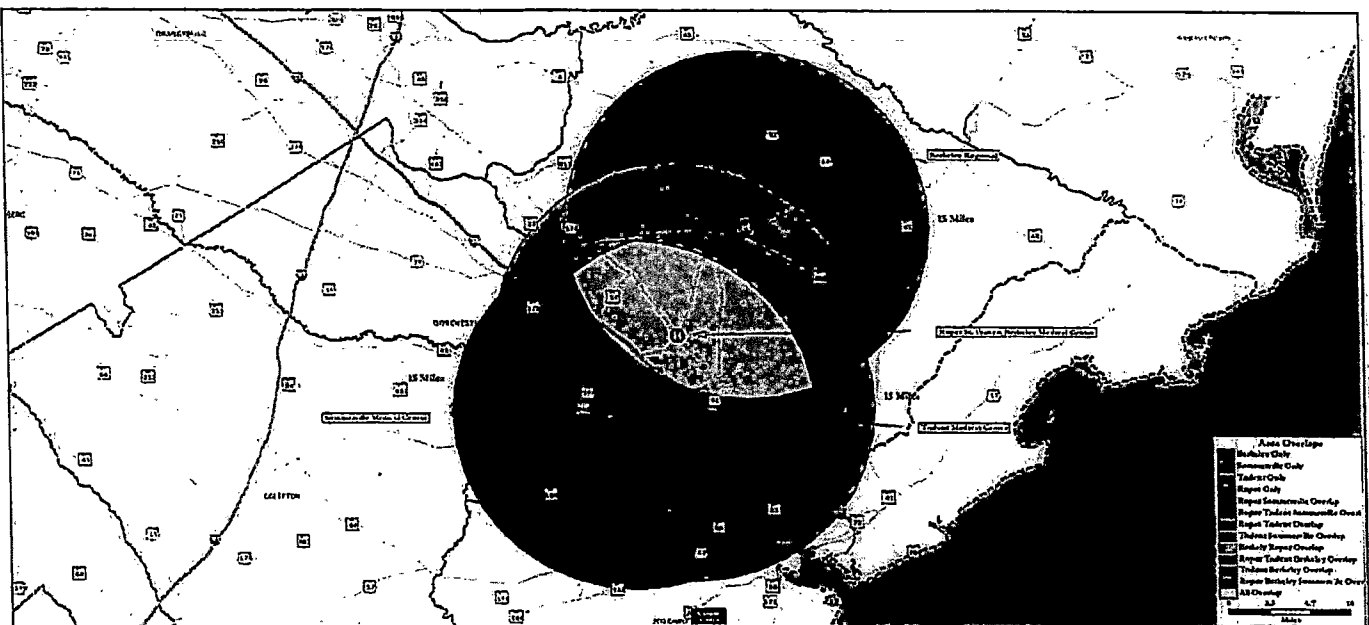
If Improved Access Means Living Within

15 Miles of An Acute Care Hospital
7 Miles of An Acute Care Hospital

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER		TOTAL
2,918	5,563	3,681	2,170		14,331
2,000	3,836	3,045	1,506		10,386

Source: Claritas

Roper Trident Summerville Berkeley 15 Mile Bands



Petitioner's Exhibit 046-011

ATTORNEY EXPERT EYES
ONLY

RECORD 004270

Baehr_01601

If Berkeley Regional Medical Center is Approved,
How Many More Persons Will Enjoy Improved Access
if Access is Defined as Residing Within 15 Miles of
An Acute care Hospital if Roper is Approved As Well?

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER	TOTAL	
80	508	255	96	940	

Persons With Improved Access

If Roper St. Francis Hospital Berkeley is Approved,
How Many More Persons Will Enjoy Improved Access
if Access is Defined as Residing Within 15 Miles of
An Acute care Hospital if Berkeley Regional is Approved As Well?

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER	TOTAL	
3,326	5,380	3,397	2,231	14,335	

Persons With Improved Access

Source: Claritas

It is inconsistent with sound planning principles to approve a second hospital to increase access for only 940 residents.

- **Only a small fraction of those 940 persons will require acute inpatient services in any given year.**
- **All of the 940 patients live within 15 to 20 miles of an acute hospital now anyway. The improvement in access is marginal even for those persons who might require inpatient services.**

The negative impact on the health system of the second hospital is, however, significant.

- **50 Unneeded Beds will be added to the Service Area's Inventory.**
- **\$112,978,119 in unnecessary capital costs will be incurred.**
- **Because there will not be enough increased demand for inpatient services in Berkeley County to support both hospitals, both hospitals will likely lose many millions of dollars each and every year for the foreseeable future.**

FINANCIAL ACCESS

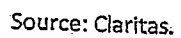
- Roper St. Francis Berkeley will be Located in a Relatively High Income Area
- Berkeley Regional Medical Center will be Located in a Relatively Low Income Area

ATTORNEY EXPERT EYES
ONLY

RECORD 004273

Baehr_01603

**ATTORNEY EXPERT EYES
ONLY**

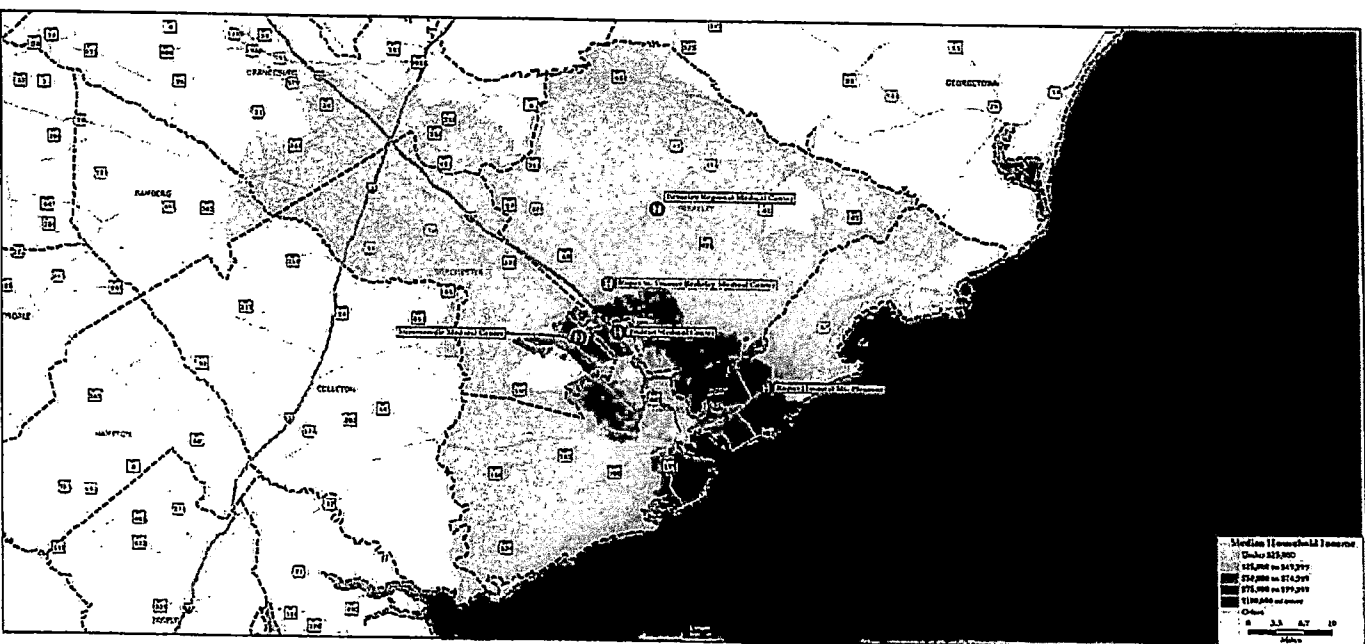


Petitioner's Exhibit 046-015

RECORD 004274

Baehr_01604

Median Household Income 2016



Source: Claritas.

Petitioner's Exhibit 046-016

ATTORNEY EXPERT EYES
ONLY

RECORD 004275

Baehr_01605

ATTORNEY EXPERT EYES
ONLY

FINANCIAL ACCESS

ALTHOUGH RELATIVE LARGE NUMBERS OF LOW INCOME PERSONS LIVE WITHIN 7 OR 15 MILES OF THE PROPOSED ROPER ST FRANCIS BERKELEY CAMPUS, MOST OF THOSE PEOPLE ALREADY ENJOY GOOD GEOGRAPHIC ACCESS TO HOSPITAL SERVICES.

BY CONTRAST, THE BERKELEY MEDICAL CENTER PROJECT IN MONCK'S CORNER WILL ENHANCE GEOGRAPHIC ACCESS TO POPULATIONS THAT ARE ACTUALLY BURDENED BY GEOGRAPHIC BARRIERS TO CARE.

RECORD 004276

Baehr_01605 A

Petitioner's Exhibit 046-017

CONCLUSIONS:

- **BERKELEY REGIONAL MEDICAL CENTER WILL ENHANCE GEOGRAPHIC AND FINANCIAL ACCESS TO ACUTE CARE SERVICES TO A MUCH GREATER EXTENT THAN WILL ROPER ST. FRANCIS BERKELEY.**
- **ROPER ST. FRANCIS BERKELEY WILL UNNECESSARILY DUPLICATE SERVICES AND WILL MATERIALLY IMPAIR THE ABILITY OF BOTH NEW HOSPITALS TO SUCCEED.**

ATTORNEY EXPERT EYES
ONLY

RECORD 004277

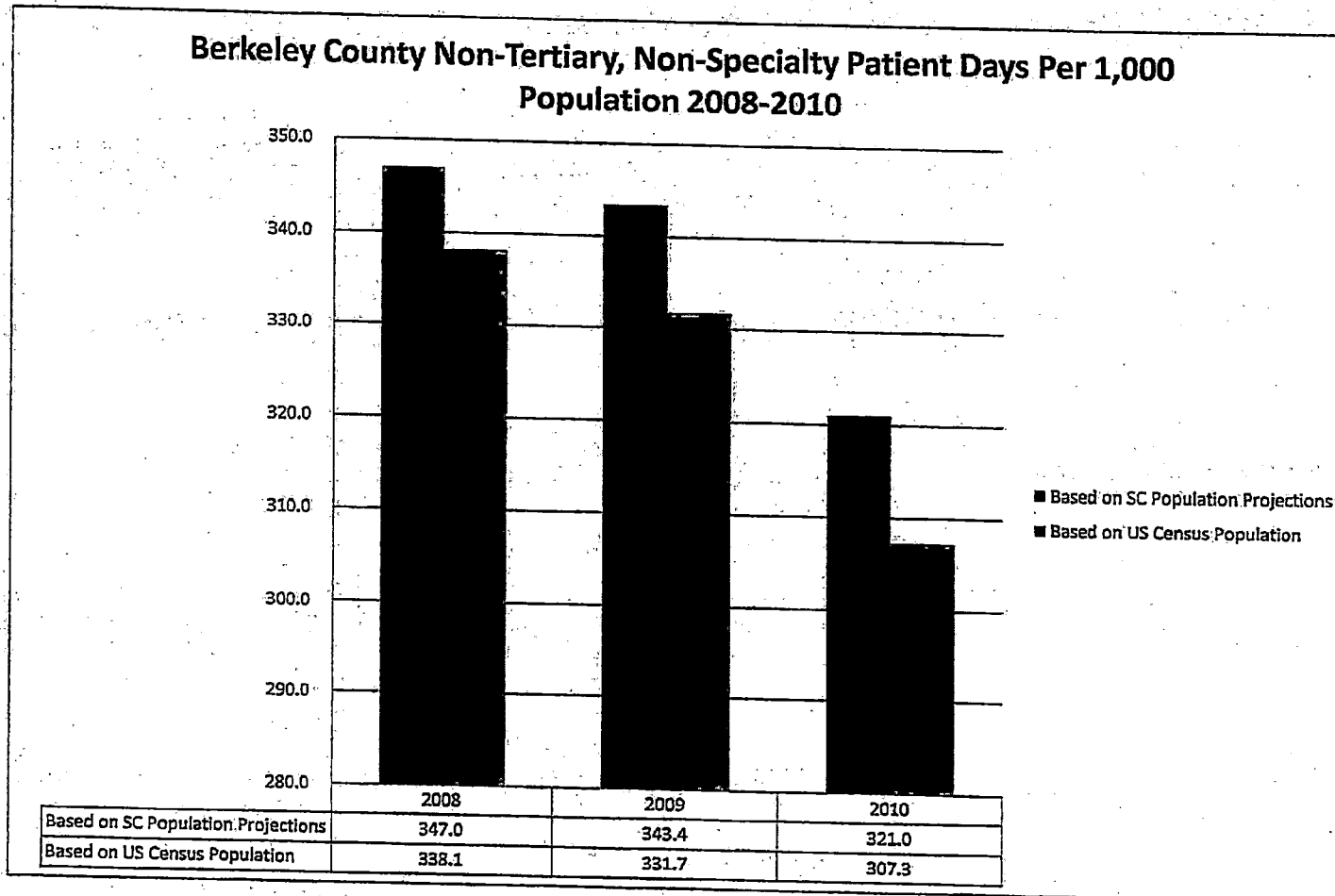
Baehr_01606

II. UTILIZATION TRENDS

- BETWEEN 2008 AND 2010, THE VOLUME OF NON-TERTIARY AND NON-SPECIALTY DISCHARGES FOR BERKELEY COUNTY RESIDENTS DECLINED, AS DID THE VOLUME OF NON-TERTIARY AND NON-SPECIALTY PATIENT DAYS.
- CONCURRENTLY, THE POPULATION OF BERKELEY COUNTY WAS GROWING.
- USE RATES FOR NON-TERTIARY AND NON-SPECIALTY MEDICAL SERVICES HAVE DECLINED SHARPLY SINCE 2008, WHETHER RECKONED IN TERMS OF DISCHARGES OR PATIENT DAYS.
- SINCE 2006, THE VOLUME OF BUILDING PERMITS ISSUED IN BERKELEY COUNTY FOR SINGLE FAMILY HOMES HAS DECLINED BY MORE THAN TWO THIRDS.

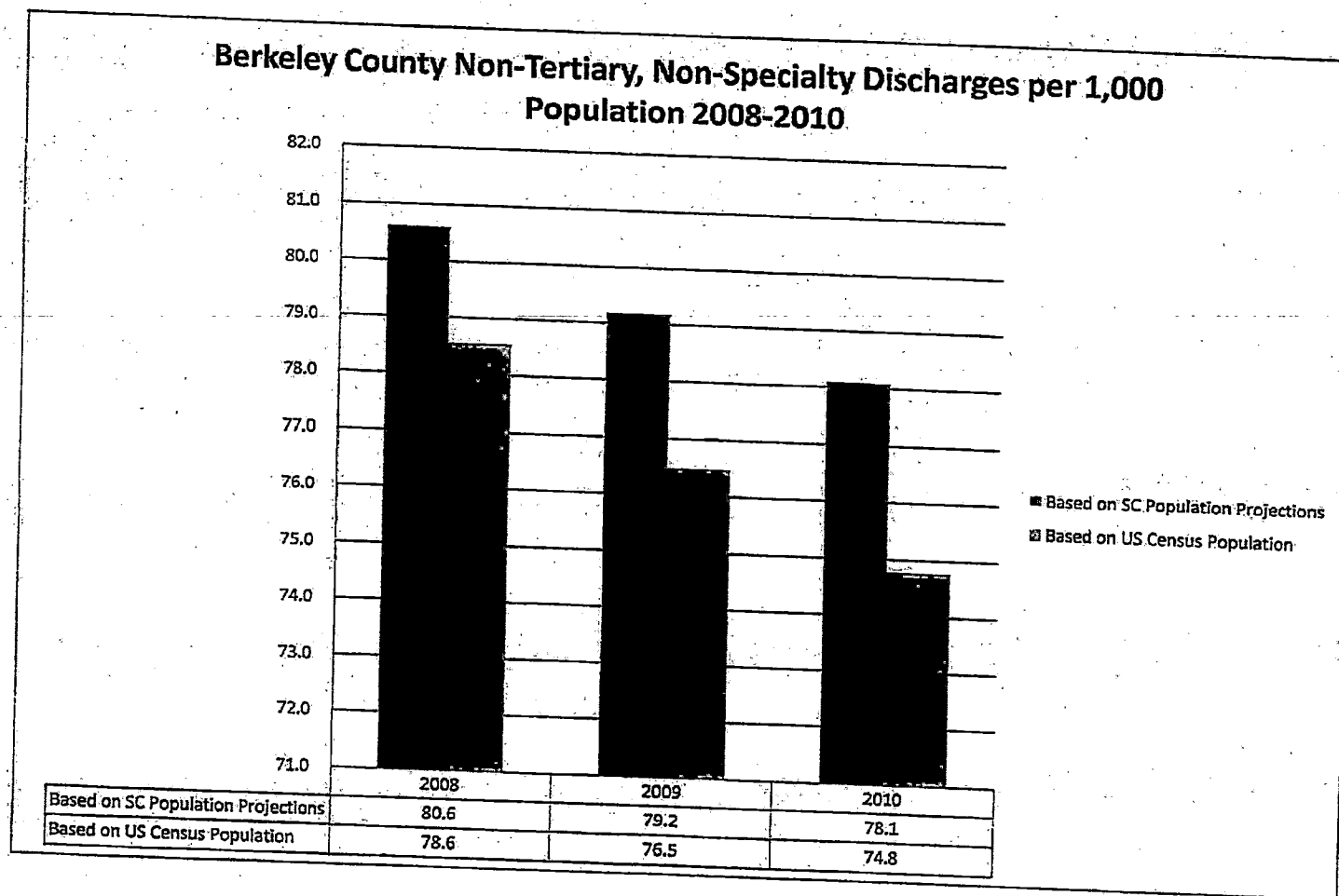
CONCLUSION:

THE DECLINE IN DISCHARGES AND PATIENT DAYS IN RECENT YEARS, DESPITE POPULATION GROWTH, IS NOT SUPPORTIVE OF APPROVAL OF TWO NEW HOSPITALS IN BERKELEY COUNTY.



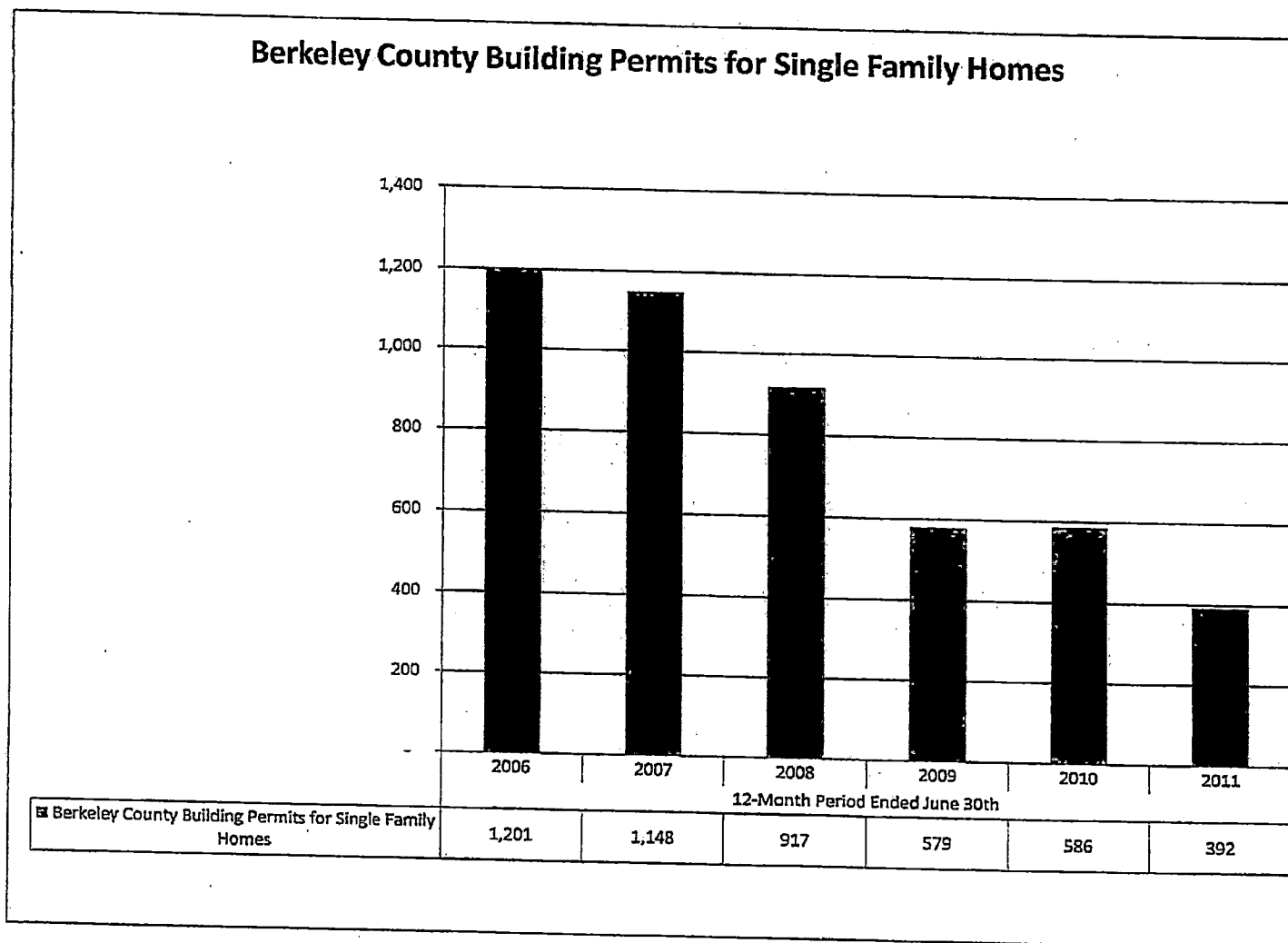
Source: SC State Data, SC State and County Population Projections for years shown, US Census 2000 and 2010, interpolated to compute 2008 and 2009 populations.

Market Shares 2008-2010



Sources: SC State Data, SC State and County Population Projections for years shown, US Census 2000 and 2010, interpolated to compute 2008 and 2009 populations.

Market Shares 2008-2010

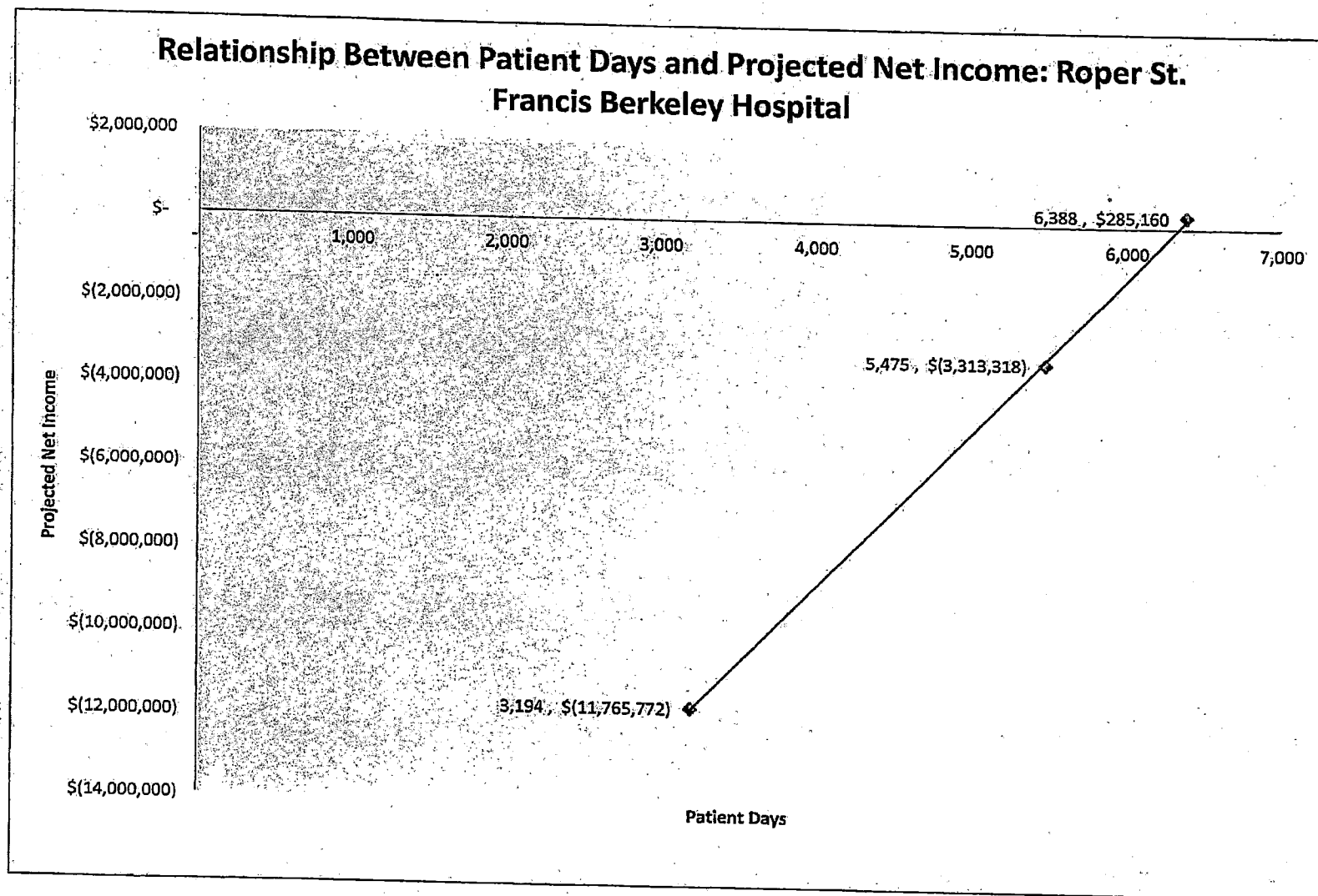


Source: Berkeley County Permitting Department Web Site.

III. APPROVAL OF TWO HOSPITALS WILL LIKELY RESULT IN THE FINANCIAL FAILURE OF BOTH

- BOTH HOSPITALS PROJECT VERY SLENDER NET INCOMES IN YEAR THREE, WHEN BOTH HAVE ACHIEVED APPROXIMATELY 70 PERCENT UTILIZATION.
- AT LOWER VOLUMES, IN YEARS 1 AND 2, BOTH PROJECTS FORECAST MULTI-MILLION DOLLAR LOSSES.
- THE LOSSES SHOWN FOR ROPER ST. FRANCIS BERKELEY WILL LIKELY BE EVEN LARGER THAN SHOWN. THE FINANCIAL PROJECTIONS FOR THE ROPER PROJECT ARE UNREALISTICALLY OPTIMISTIC.
- NEITHER PROJECT IS PREMISED UPON THE APPROVAL OF THE OTHER, DESPITE ROPER ST. FRANCIS BERKELEY'S APPLICATION BEING FILED AFTER BERKELEY REGIONAL MEDICAL CENTER'S.
- BOTH PROJECTS RELY ON LARGE INFLUXES OF PATIENTS FROM THE SAME SECTIONS OF BERKELEY COUNTY.
- BASED ON 2010 ACTUAL PATIENT DAYS AND FORECAST POPULATION GROWTH IN BERKELEY COUNTY, ONLY 12,269 INCREMENTAL PATIENT DAYS ARE FORECAST FOR ALL OF BERKELEY COUNTY BY 2017.
- 12,269 PATIENT DAYS IS ENOUGH UTILIZATION TO SUPPORT ONE AND ONLY ONE 50-BED HOSPITAL.
- IF TWO 50-BED HOSPITALS ARE CONSTRUCTED, THE PATIENT DAYS REQUIRED TO SUPPORT THE SECOND WOULD HAVE TO COME BY REDUCING CURRENT LEVELS OF INPATIENT UTILIZATION AT EXISTING PROVIDERS.
- ALTERNATIVELY, AND MORE PROBABLY, BOTH OF THE NEW HOSPITALS WOULD FAIL TO ACHIEVE THEIR UTILIZATION TARGETS AND BOTH WOULD SUFFER SIGNIFICANT AND RECURRING FINANCIAL LOSSES.

ATTORNEY EXPERT EYES ONLY

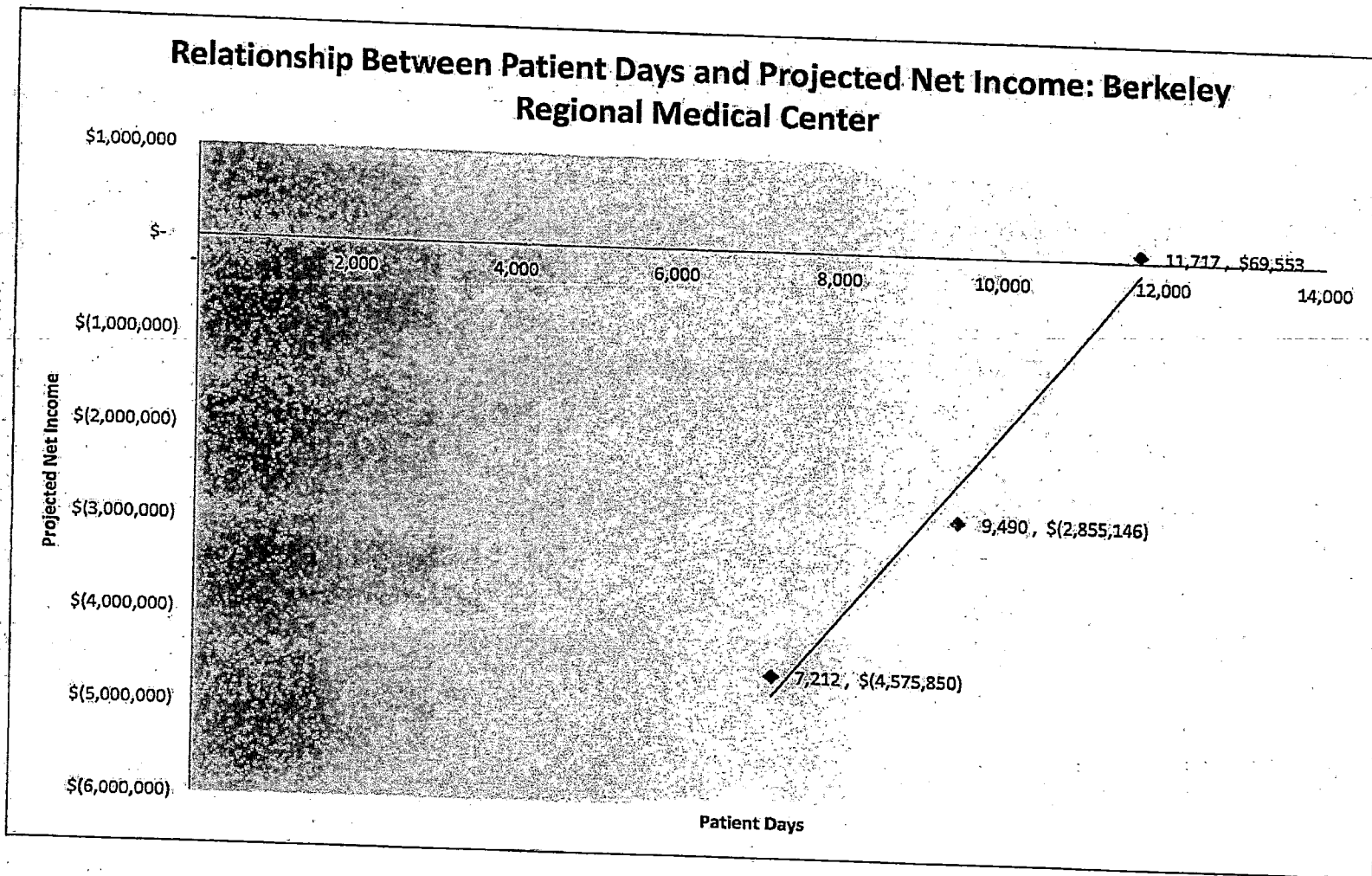


Bachr_01612

Petitioner's Exhibit 046-024

RSFB 462-463 Patient day volumes are 6,388; 10,950; and 12,775 for year 2013-2015. Half of days are redirected and half are new. Changes in volume impact both types equally. An increase of 1,000 patient days increases net income by \$3.77 million.

ATTORNEY EXPERT EYES ONLY

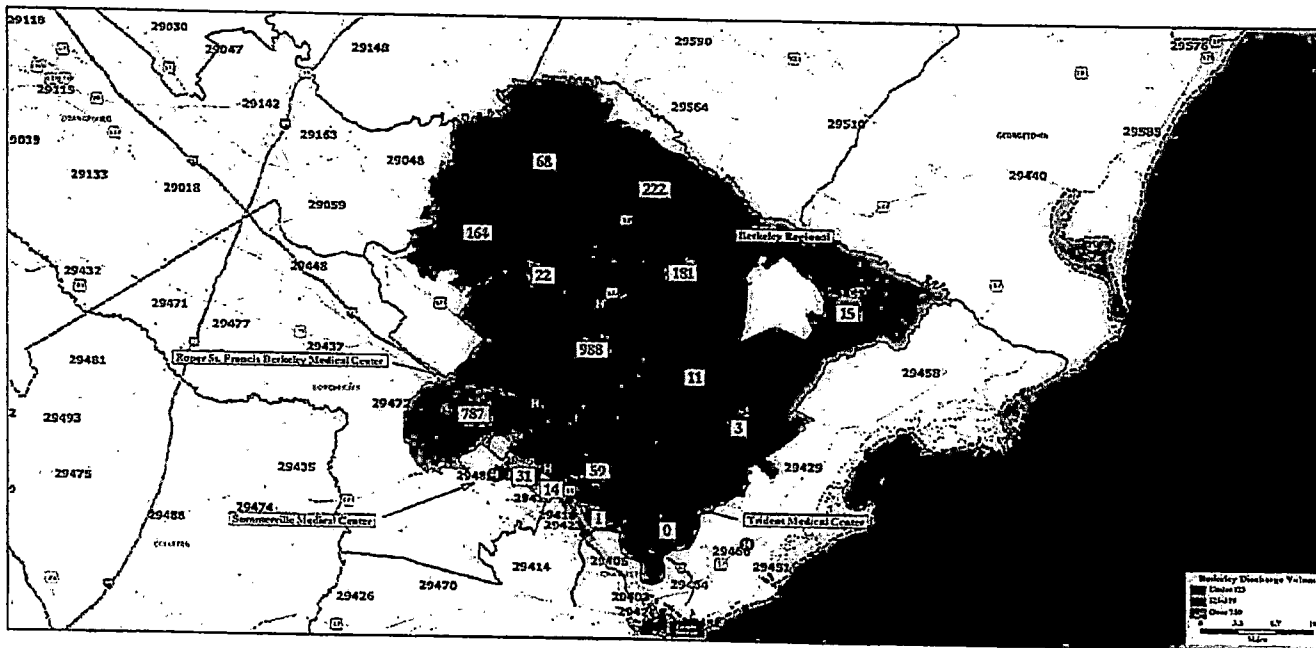


Source: BRMC Application pp. 36 and 644. Indicated Income Levels are for 7,212; 9,490 and 11,717 patient days. Year Three patient days reflect impact of cannibalized days.

Each additional 1,000 patient days increases net income by \$1.03 million.

Baehr_01613

BRMC Projected Year 3 Berkeley County Admissions by ZIP Code



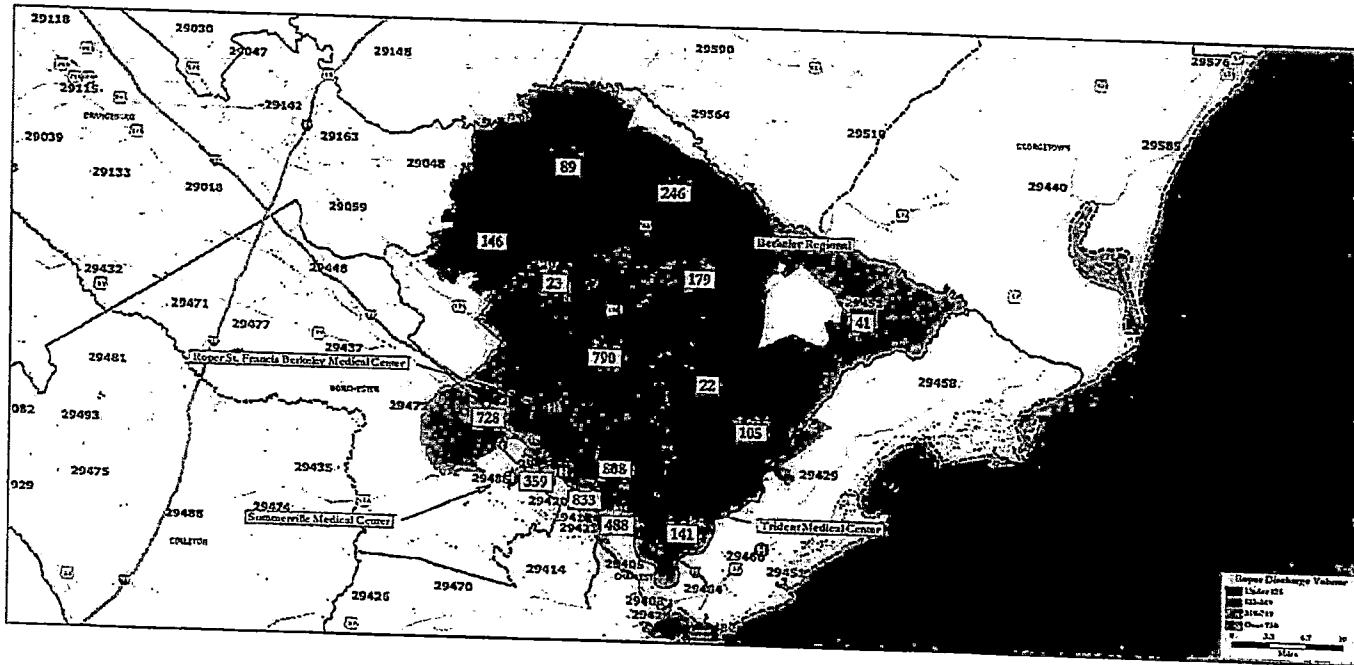
Source: Trident Projections of BRMC Utilization Based on 2010 SC Data and Age
and ZIP Code Specific Population Projections from Claritas.

RECORD 004285

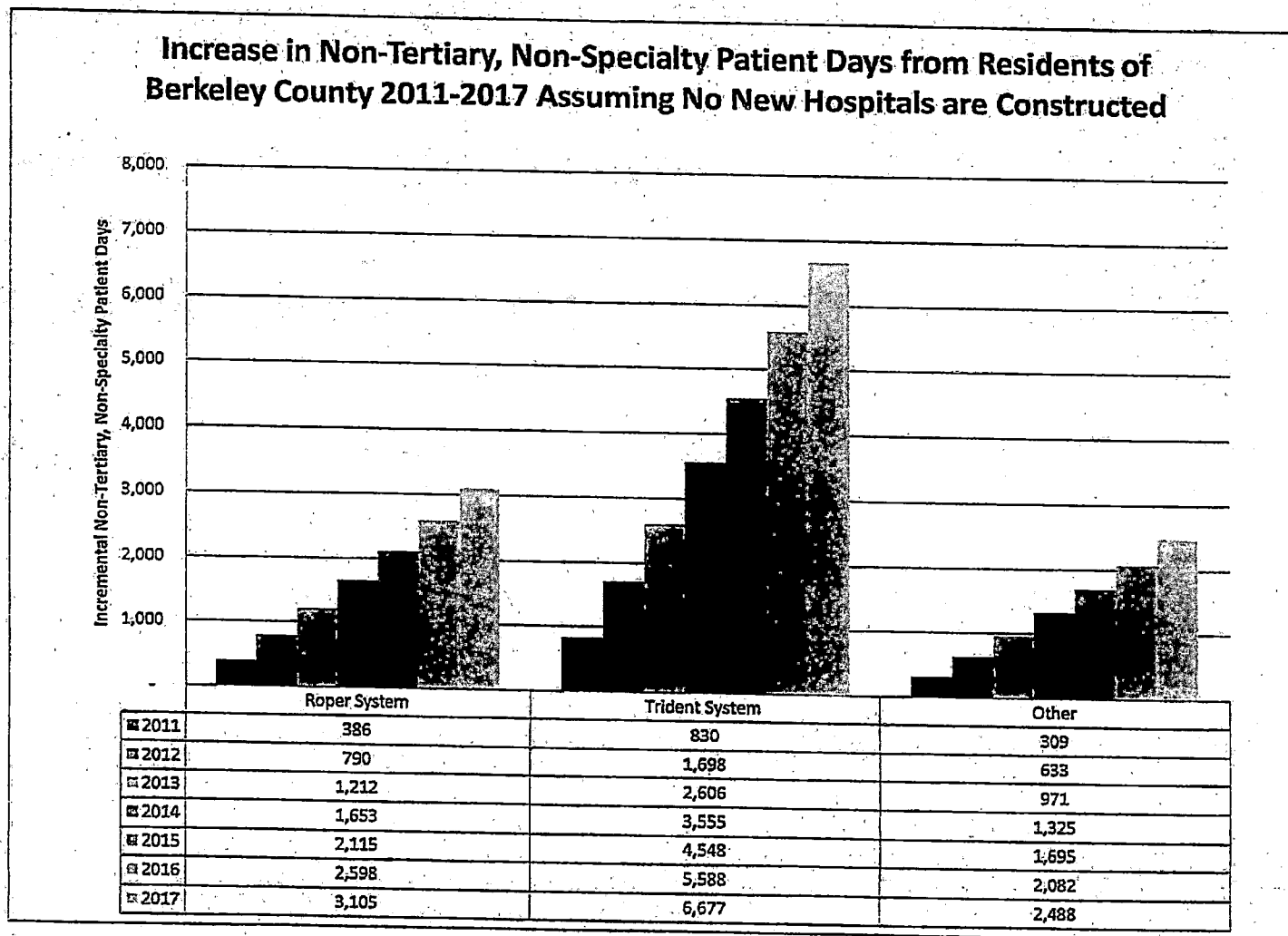
Bachr_01614

Petitioner's Exhibit 046-026

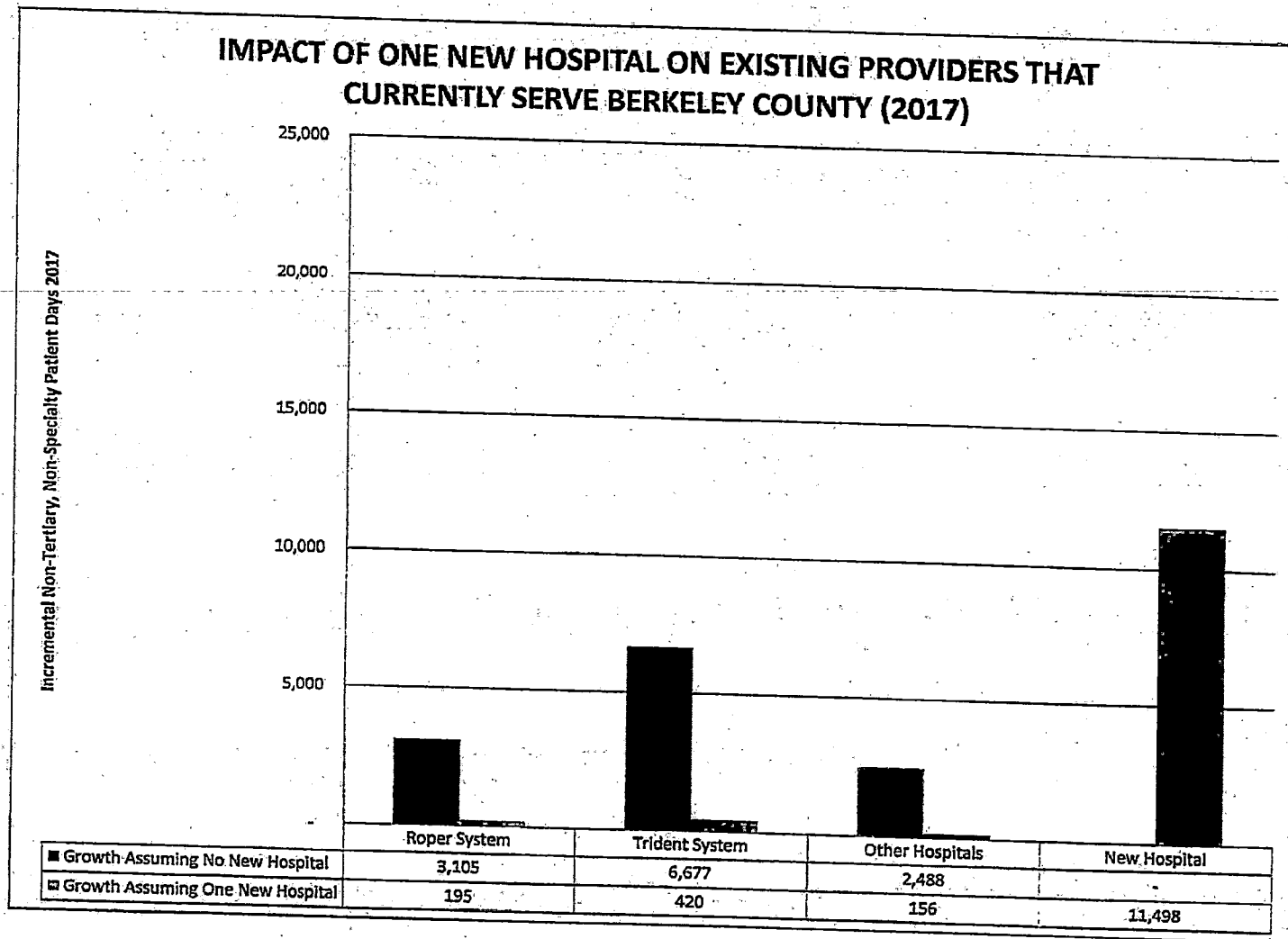
Roper System 2010 Berkeley County Admissions by ZIP Code



Source: Roper Discovery pp. 4527-4528 and
4535-4536. Discharges include normal
newborns.

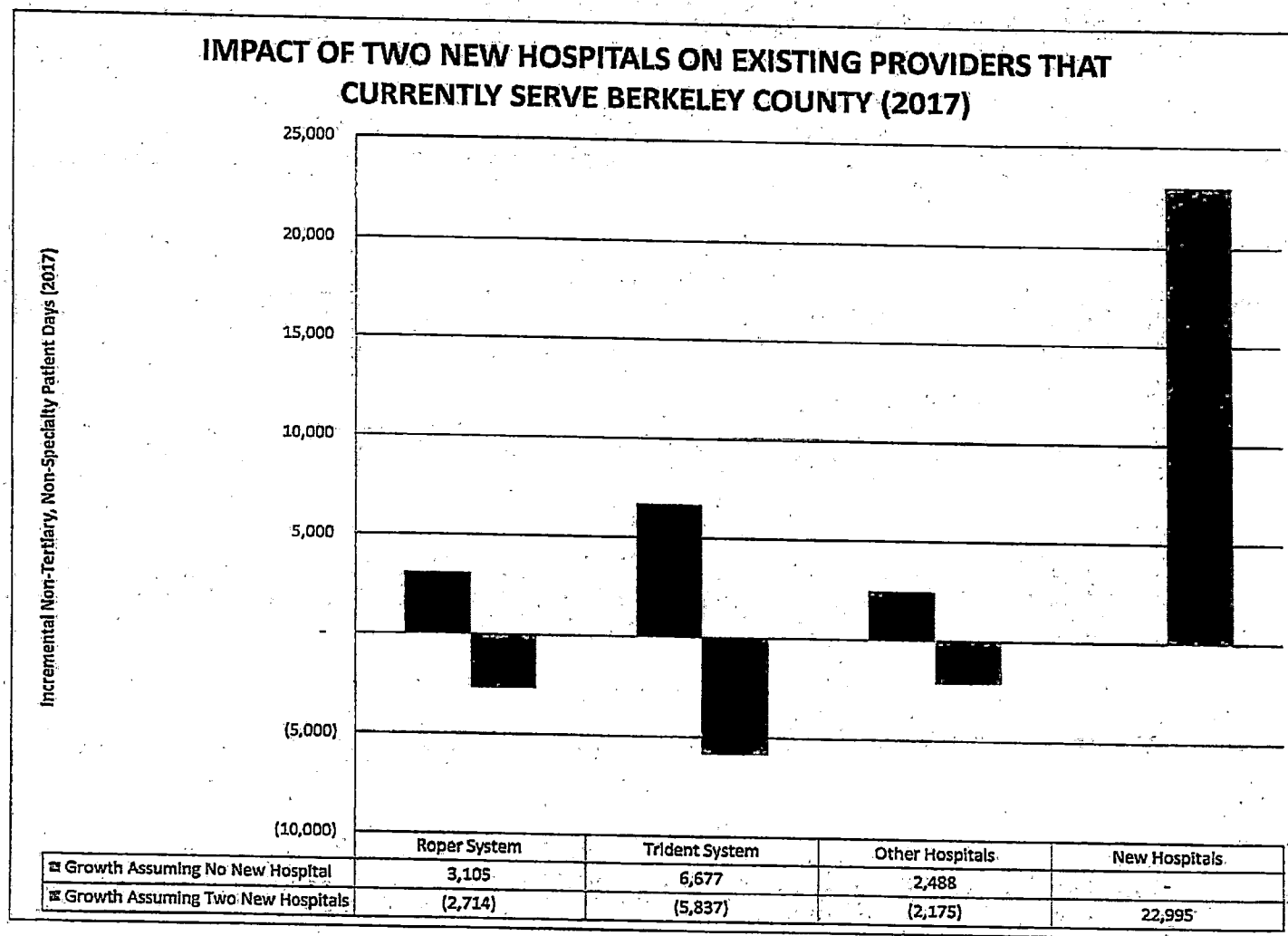


Based on projection of 2010 SC Data Set Berkeley County patient days applying Age and ZIP-Code specific population projections from Claritas. Historical market shares are preserved throughout the projection period.

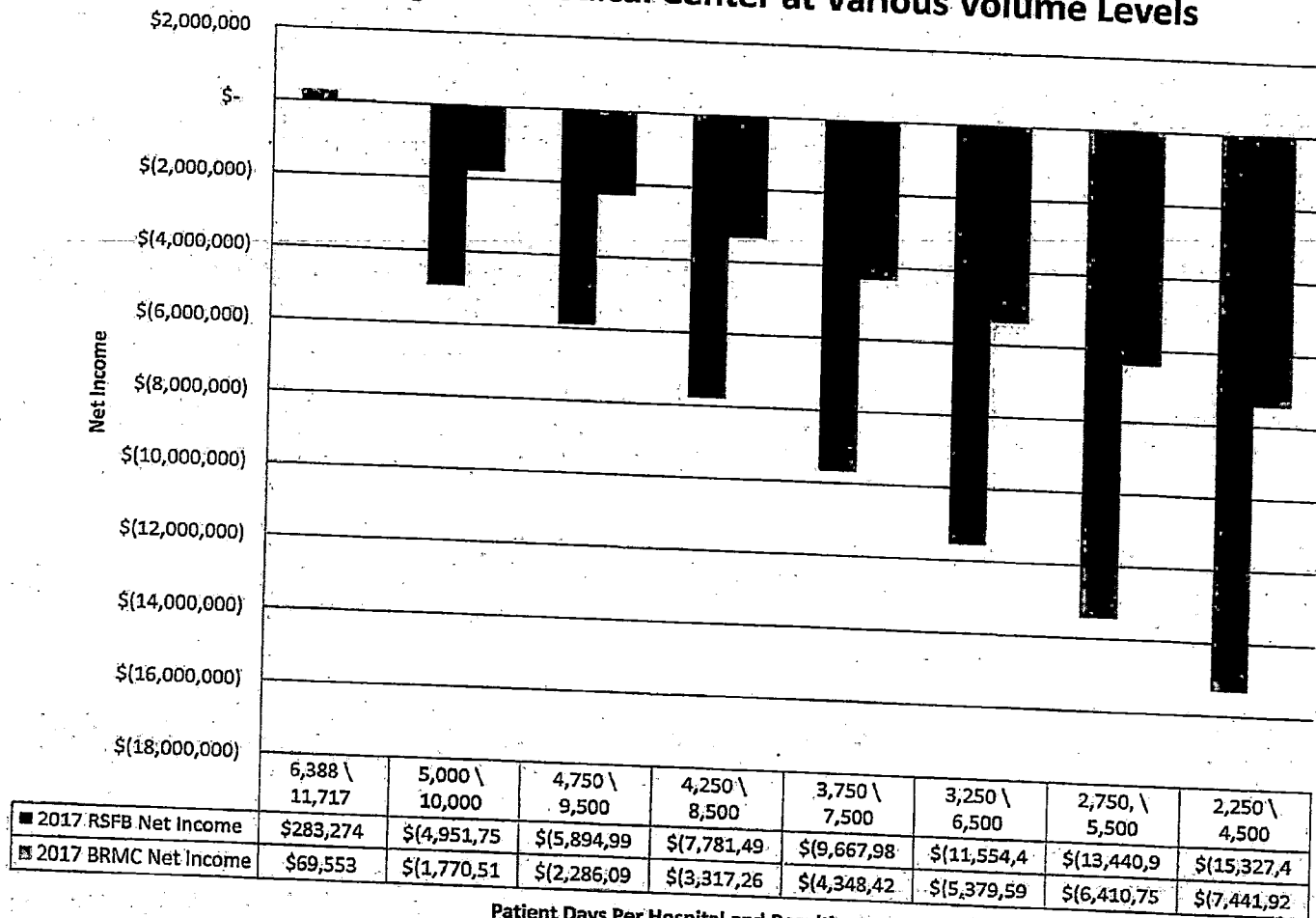


See Page III-iii

See Page III-iii



Estimated 2017 Net Income Projections Roper St. Francis Berkeley and Berkeley Regional Medical Center at Various Volume Levels



Patient Days Per Hospital and Resulting Net Income Estimates

See Page III-iv

ATTORNEY EXPERT EYES ONLY

Baehr_01619

Petitioner's Exhibit 046-031

IV. IMPACT ON EXISTING PROVIDERS

- **BECAUSE OF THE DECLINE IN NON-TERTIARY AND NON-SPECIALTY PATIENT DAYS RECORDED IN BERKELEY COUNTY BETWEEN 2009 AND 2010, BOTH APPLICANTS' PROJECTS WILL AFFECT EXISTING PROVIDERS, INCLUDING THEIR OWN HOSPITALS.**
- **THIS WILL BE TRUE EVEN IF ONLY ONE NEW HOSPITAL IS APPROVED.**
- **ROPER ST. FRANCIS BERKELEY WILL AFFECT EXISTING NON-ROPER PROVIDERS MORE THAN BERKELEY MEDICAL CENTER WILL AFFECT EXISTING NON-TRIDENT PROVIDERS BECAUSE OF ROPER'S LOWER MARKET SHARE IN THE TARGET SERVICE AREA.**
- **IT IS UNLIKELY THAT ROPER ST FRANCIS BERKELEY WILL OBTAIN HALF OF ITS UTILIZATION FROM REDIRECTION OF PATIENTS FROM ROPER HOSPITALS.**
- **IN FACT, THE ROPER PROJECT MUST OBTAIN THE GREAT MAJORITY OF ITS PATIENTS FROM OTHER PROVIDERS IN ORDER TO SUCCEED FINANCIALLY.**
- **AS SHOWN ABOVE, THE ROPER PROJECT CANNOT REALLY BREAK EVEN WITH A CENSUS OF 17.5 PATIENTS. IT MUST DRAW A MUCH LARGER VOLUME OF NEW PATIENTS THAN FORECAST IN ORDER TO BE FINANCIALLY VIABLE.**
- **IN ADDITION TO IMPACTING THE TRIDENT SYSTEM'S NON-TERTIARY AND OUTPATIENT UTILIZATION, APPROVAL OF ROPER ST. FRANCIS BERKELEY WILL AFFECT TERTIARY UTILIZATION AT TRIDENT MEDICAL CENTER.**
- **BY PROJECT YEAR THREE, TRIDENT ESTIMATES THAT APPROVAL OF ROPER ST. FRANCIS BERKELEY WOULD REDUCE THE TRIDENT SYSTEM'S NET INCOME BY OVER \$16 MILLION.**

ABILITY OF TRIDENT SYSTEM TO
FILL PROPOSED NEW BEDS AT BRMC
AND SMC BASED ON PROJECTED
POPULATION GROWTH AND/OR
INCREASED MARKET SHARE

Berkeley Regional Medical Center

Berkeley
Charleston
Dorchester
Subtotal

ASSUMING NO INCREASE IN TRIDENT SYSTEM MARKET SHARE

Incremental Utilization Required to Meet Utilization Projections

2013	2014	2015	2016	2017
		16.6	22.3	29.4
		0.3	0.4	0.5
		2.9	3.9	5.1
0.0	0.0	19.7	26.6	35.1

Sammerville Medical Center

Berkeley
Charleston
Dorchester
Subtotal

Incremental Utilization Required to Meet Utilization Projections

2013	2014	2015	2016	2017
		4.8	5.6	6.3
		1.0	1.1	1.2
		11.2	13.5	15.6
0.0	0.0	16.9	20.6	23.0

Combined

Berkeley
Charleston
Dorchester
Subtotal

Incremental Utilization Required to Meet Utilization Projections

2013	2014	2015	2016	2017
-	-	21.4	27.9	35.7
-	-	1.2	1.5	1.7
-	-	14.0	17.7	20.7
0.0	0.0	36.7	47.1	58.1

Forecast Growth in Trident System Utilization

Berkeley
Charleston
Dorchester
Subtotal

Increase in ADC at Trident Providers Based on Population Growth

2013	2014	2015	2016	2017
7.6	10.3	13.2	16.3	19.4
1.3	1.7	2.2	2.7	3.2
10.9	14.9	19.2	23.6	28.2
19.8	27.0	34.6	42.5	50.9

Excess (Deficit)

Berkeley
Charleston
Dorchester
Subtotal

ADC Required Less Growth Resulting from Population Increase

2013	2014	2015	2016	2017
7.6	10.3	(8.2)	(11.6)	(16.3)
1.3	1.7	0.9	1.2	1.5
10.9	14.9	5.1	5.9	7.5
19.8	27.0	(2.1)	(4.5)	(7.3)

Sources: Sammerville ADC from Sammerville
Medical Center 10 bed CON Application, Trident
and BRMC ADC from Age and ZIP Code Specific
Projections of 2010 SC Data. All Data Reflect
Non-Tertiary, Non-Specialty Utilization.

1/16/2017 1:17 PM Trident System

ATTORNEY EXPERT EYES
ONLY

RECORD 004292

Baehr_01621

ABILITY OF TRIDENT SYSTEM TO
FILL PROPOSED NEW BEDS AT BRMC
AND SMC BASED ON PROJECTED
POPULATION GROWTH AND/OR
INCREASED MARKET SHARE

ASSUMING BERKELEY COUNTY MARKET SHARE INCREASES BY 3% BY 2017

Berkeley Regional Medical Center

	2013	2014	2015	2016	2017
Berkeley	-	-	16.6	22.3	29.4
Charleston	-	-	0.3	0.4	0.5
Dorchester	-	-	2.9	3.0	3.1
Subtotal	0.0	0.0	19.7	26.5	35.1

Incremental Utilization Required to Meet Utilization Projections

Summerville Medical Center

	2013	2014	2015	2016	2017
Berkeley	-	-	4.8	5.6	6.3
Charleston	-	-	1.0	1.1	1.2
Dorchester	-	-	11.2	13.8	15.6
Subtotal	0.0	0.0	16.9	20.6	23.0

Incremental Utilization Required to Meet Utilization Projections

Combined

	2013	2014	2015	2016	2017
Berkeley	-	-	21.4	27.9	35.7
Charleston	-	-	1.2	1.5	1.7
Dorchester	-	-	14.0	17.7	20.7
Subtotal	0.0	0.0	36.7	47.1	58.1

Incremental Utilization Required to Meet Utilization Projections

Forecast Growth in Trident System Utilization

	2013	2014	2015	2016	2017
Berkeley	7.6	10.3	15.8	19.8	24.9
Charleston	1.3	1.7	2.2	2.7	3.2
Dorchester	10.9	14.9	19.2	23.6	28.2
Subtotal	19.8	27.0	37.1	46.1	56.4

Increase in ADC at Trident Providers Based on Population Growth and Market Share

Excess (Deficit)

	2013	2014	2015	2016	2017
Berkeley	7.6	10.3	(5.6)	(8.1)	(10.8)
Charleston	1.3	1.7	0.9	1.2	1.5
Dorchester	10.9	14.9	5.1	5.9	7.5
Subtotal	19.8	27.0	0.5	(1.0)	(1.8)

ADC Required Less Growth Resulting from Population Increase

Sources: Summerville ADC from Summerville
Medical Center 10 bed CON Application Trident
and BRMC ADC from Age and ZIP Code Specific
Projections of 2010 SC Data All Data Reflect
Non-Tertiary, Non-Specialty Utilization

ROPER ST FRANCIS BERKELEY PROJECTED BERKELEY COUNTY UTILIZATION
AND IMPACT ON EXISTING PROVIDERS

ALL DATA REFLECT NON-TERTIARY, NON-SPECIALTY UTILIZATION

	2015	2016	2017
INCREMENTAL PATIENT DAYS ORIGINATING FROM BERKELEY COUNTY REQUIRED TO SUPPORT ROPER ST FRANCIS BERKELEY (1)	5,749	9,855	11,498
MARKET SHARES OF EXISTING PROVIDERS (see p. II-III)			
	2010		
TRIDENT			
ROPER	54.4%		
OTHER	25.3%		
	20.3%		
TOTAL	100.0%		

IMPACT OF ROPER ST FRANCIS BERKELEY REQUIRED BERKELEY
COUNTY UTILIZATION ON:

	2015	2016	2017
TRIDENT MEDICAL CENTER	3,129	5,363	6,257
ROPER SYSTEM	1,455	2,494	2,909
OTHER AREA HOSPITALS	1,166	1,998	2,331
TOTAL	5,749	9,855	11,498

(1) These Patient Day Projections Reflect the Actual CON Projections in the Roper CON

Combined Impact Analysis

TRIDENT SYSTEM BERKELEY COUNTY PROJECTED UTILIZATION
AND IMPACT ON EXISTING PROVIDERS

ALL DATA REFLECT NON-TERTIARY, NON-SPECIALTY UTILIZATION

INCREMENTAL PATIENT DAYS ORIGINATING FROM BERKELEY COUNTY
REQUIRED TO SUPPORT:

	2015	2016	2017
BERKELEY REGIONAL MEDICAL CENTER (1)	6,478	8,521	11,050
SUMMERVILLE MEDICAL CENTER EXPANSION	1,755	2,059	2,296
TOTAL	8,234	10,580	13,346

MARKET SHARES OF
EXISTING PROVIDERS (See p. II-III)

	2010
TRIDENT	54.4%
ROPER	25.3%
OTHER	20.3%
TOTAL	100.0%

IMPACT OF BERKELEY MEDICAL CENTER REQUIRED BERKELEY COUNTY
UTILIZATION ON:

	2015	2016	2017
TRIDENT MEDICAL CENTER	3,525	4,637	6,013
ROPER SYSTEM	1,639	2,156	2,796
OTHER AREA HOSPITALS	1,314	1,728	2,241
TOTAL	6,478	8,521	11,050

IMPACT OF SUMMERVILLE MEDICAL CENTER REQUIRED INCREMENTAL BERKELEY
COUNTY UTILIZATION ON:

	2015	2016	2017
TRIDENT MEDICAL CENTER	955	1,121	1,249
ROPER SYSTEM	444	521	581
OTHER AREA HOSPITALS	356	418	465
TOTAL	1,755	2,059	2,296

(1) Patient Day Projections reflect data from the original application and pro formas. All utilization from
ZIP Code 29483 is treated as Berkeley County utilization. Year 3 forecast patient days do not reflect adjustment for cannibalization because this
methodology assumes cannibalization based on historical market share.

	Adms	ALOS	P Days
Year 1	1,457	4.4	6,478
Year 2	1,916	4.4	8,521
Year 3	2,486	4.4	11,050

Continued Impact Analysis

ROPER SYSTEM INPATIENT ADMISSIONS
NON-TERTIARY, NON-SPECIALTY CASES 2010-2011

ZIP CODES IN PSA OF	2010		
	ROPER	BON SECOURS	TOTAL
29429	65	7	72
29450	85	20	105
29451	86	9	95
29464	853	136	989
29466	290	85	375
29482	44	5	49
29492	111	30	141
TOTAL	1,534	292	1,826

Jan - Aug 2011		
ROPER	BON SECOURS	TOTAL
37	6	43
76	12	88
52	5	57
511	87	598
235	62	297
23	7	30
66	36	102
1,000	215	1,215

Annualized 2011		
ROPER	BON SECOURS	TOTAL
56	9	65
114	18	132
78	8	86
768	131	898
353	93	446
35	11	45
99	54	153
1,502	323	1,825

SOURCE: ROPER DISCOVERY PP: 4527-4528 & 4535-4536

ATTORNEY EXPERT EYES ONLY

Bachr_01625

Patient Redirection History

Petitioner's Exhibit 046-037

RECORD 004296

ESTIMATION OF FINANCIAL IMPACT OF LOST
UTILIZATION ON THE TRIDENT SYSTEM RESULTING FROM ROPER ST FRANCIS BERKELEY

PART 1: NON-TERTIARY, NON-SPECIALTY ADMISSIONS AND ASSOCIATED OUTPATIENT IMPACT

	Year 1	Year 2	Year 3
REDUCTION IN TRIDENT SYSTEM INPATIENT DAYS RESULTING FROM THE OPENING OF ROPER ST FRANCIS BERKELEY	3,129	5,363	6,257
REDUCTION IN TRIDENT SYSTEM ADMISSIONS	736	1,262	1,472
ADJUSTED ADMISSION MULTIPLIER	1.96	1.96	1.96
REDUCTION IN TRIDENT SYSTEM ADJUSTED ADMISSIONS RESULTING FROM THE OPENING OF ROPER ST FRANCIS BERKELEY	1,441	2,471	2,883
TRIDENT CONTRIBUTION MARGIN PER NON-TERTIARY, NON-SPECIALTY ADJUSTED ADMISSION	\$ 4,985	\$ 4,985	\$ 4,985
FINANCIAL IMPACT OF LOSS OF INPATIENT DAYS AND OUTPATIENT UTILIZATION TO ROPER ST FRANCIS BERKELEY	\$ 7,185,850	\$ 12,317,635	\$ 14,370,574

PART 2: IMPACT ON TERTIARY AND SPECIALTY SERVICES

ROPER NON-TERTIARY, NON-SPECIALTY ADMISSIONS 2010 FROM BERKELEY COUNTY	3,121		
ROPER TERTIARY AND SPECIALTY ADMISSIONS 2010 FROM BERKELEY COUNTY	454		
RATIO	14.5%		
PROJECTED LOSS OF TERTIARY ADMISSIONS AT TRIDENT SYSTEM	107	184	214
AVERAGE CONTRIBUTION MARGIN PER TERTIARY AND SPECIALTY ADMISSION	\$ 10,390	\$ 10,390	\$ 10,390
REDUCTION IN TRIDENT SYSTEM NET INCOME	\$ 1,112,643	\$ 1,907,239	\$ 2,225,112
PART 3: COMBINED TERTIARY, NON-TERTIARY, SPECIALTY AND OUTPATIENT IMPACT	\$ 8,298,493	\$ 14,224,874	\$ 16,595,687

NOTES:				
ALL DOLLAR AMOUNTS REFLECT JULY 2010 - JUNE 2011 OPERATIONS AT TRIDENT HEALTH SYSTEM.				
ADJUSTED ADMISSIONS MULTIPLIER COMPUTATIONS SHOWN BELOW:				
PROJECTED INPATIENT REVENUES ROPER ST FRANCIS BERKELEY	Roper CON Attachmer	26,778,724	49,115,987	61,317,923
PROJECTED TOTAL REVENUES ROPER ST FRANCIS BERKELEY	Roper CON Attachmer	52,436,329	96,175,681	120,068,706
ADJUSTED PATIENT DAY MULTIPLIER	Line 4 / Line 3	1.96	1.96	1.96

ATTORNEY EXPERT EYES
ONLY

RECORD 004298

Baehr_01627

**RELATIONSHIP OF TERTIARY/SPECIALTY TO NON-TERTIARY DISCHARGES
AMONG BERKELEY COUNTY RESIDENTS CALENDAR YEAR 2010**

Discharges	Tertiary & Specialty	Non-Tertiary Non-Specialty	Total
Roper	454	3,121	3,575
Trident	919	7,291	8,210

Percentage of Discharges	Tertiary & Specialty	Non-Tertiary Non-Specialty	Total
Roper	12.7%	87.3%	100.0%
Trident	11.2%	88.8%	100.0%

Source: SC Data

Combined Impact Analysis

SECTION I: Technical Appendix

**ATTORNEY EXPERT EYES
ONLY**

Baelr_01629

RECORD 004300

CENSUS BLOCKS THAT CURRENTLY DO NOT LIE ENTIRELY WITHIN 15 MILES
OF AN ACUTE CARE HOSPITAL THAT WOULD IF ROPER ST. FRANCIS
BERKELEY WERE CONSTRUCTED

CENSUS BLOCK	APPROXIMATE PERCENTAGE WITHIN 15 MILES OF ROPER	TOTAL 2015 POPULATION BY AGE				
		UNDER 15	15-44	45-64	65 & OVER	TOTAL
450150201004	35% (1)	229	1,452	729	275	2,685
450150201003	60%	428	716	489	247	1,881
450150205011	100%	491	804	546	292	2,133
450150205014	70% (2)	582	1,109	702	339	2,032
450150205015	60% (3)	587	806	343	274	1,610
450150205022	100% (4)	520	728	387	160	1,775
450150205016	100%	287	521	357	243	1,418
450150205024	100%	598	989	575	347	2,487
450150204012	20% (5)	488	073	680	376	2,495
450150205012	100%	149	521	444	338	1,452
450150203004	70%	188	404	294	193	1,071
450150205013	75%	97	160	171	103	531
TOTAL		4,533	8,963	5,687	3,187	22,370
Less Census Blocks Included in 15-Mile Radius of BRMC		229	1,452	729	275	2,685

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER	TOTAL	
80	508	255	96	940	
257	430	293	148	1,129	
491	804	546	292	2,133	
477	776	491	237	1,982	
232	384	206	164	966	
52	73	37	16	178	
287	521	367	243	1,418	
596	989	575	347	2,487	
97	195	132	75	499	
149	521	444	338	1,452	
126	283	206	135	750	
73	120	128	77	398	
2,918	5,583	3,681	2,170	14,331	
80	508	255	96	940	

Notes:

- (1) Although 75 Percent of this Block is within 15 miles of the proposed Roper facility, about 40 percent of it is within 15 miles of Summerville Medical Center and/or Trident Medical Center
- (2) Although 80 Percent of this Block is within 15 miles of the proposed Roper facility, about 20 percent of it is within 15 miles of Summerville Medical Center and/or Trident Medical Center
- (3) Although 100 Percent of this Block is within 15 miles of the proposed Roper facility, about 40 percent of it is within 15 miles of Trident Medical Center
- (4) Although 100 Percent of this Block is within 15 miles of the proposed Roper facility, about 90 percent of it is within 15 miles of Trident Medical Center
- (5) Although 50 Percent of this Block is within 15 miles of the proposed Roper facility, about 25 percent of it is within 15 miles of Trident Medical Center

Source: Claritas

ATTORNEY EXPERT EYES
ONLY

RECORD 004302

Baehr_01631

CENSUS BLOCKS THAT CURRENTLY DO NOT LIE WITHIN 15 MILES
OF AN ACUTE CARE HOSPITAL THAT WOULD IF BERKELEY REGIONAL
MEDICAL CENTER WERE CONSTRUCTED

CENSUS BLOCK	APPROXIMATE PERCENTAGE WITHIN 15 MILES OF BRMC	TOTAL 2016 POPULATION BY AGE					2016 POPULATION WITH IMPROVED ACCESS				
		UNDER 15	15-44	45-64	65 & OVER	TOTAL	UNDER 15	15-44	45-64	65 & OVER	TOTAL
450150202004	75%	383	691	425	266	1,765	287	518	319	200	1,324
450150201004	5% (1)	229	1,452	729	275	2,685	11	73	36	14	134
450150201002	70%	524	884	607	422	2,437	387	619	425	295	1,706
450150201003	60%	429	718	489	247	1,881	257	430	293	148	1,129
450150205014	80% (2)	682	1,109	702	339	2,832	546	887	562	271	2,266
450150205016	100%	287	521	367	243	1,418	287	521	367	243	1,418
450150205024	100%	596	969	575	347	2,487	596	969	575	347	2,487
450150205011	100%	491	804	546	292	2,133	491	804	546	292	2,133
450150205012	100%	149	521	444	338	1,452	149	521	444	338	1,452
450150205013	100%	97	160	171	103	531	97	160	171	103	531
450150205015	60% (3)	387	606	343	274	1,610	232	364	206	164	966
450150205022	10% (4)	520	728	367	160	1,775	52	73	37	16	178
450150203005	100%	494	901	717	555	2,667	494	901	717	555	2,667
450150203006	100%	401	666	419	261	1,747	401	666	419	261	1,747
450150202005	100%	396	497	225	221	1,339	396	497	225	221	1,339
450150202001	70%	604	913	519	315	2,351	433	762	489	260	1,944
450150203001	50%	481	847	543	289	2,160	433	762	489	260	1,944
450150203002	100%	514	705	404	191	1,814	514	705	404	191	1,814
450150203004	100%	180	404	294	193	1,071	180	404	294	193	1,071
450150204012	75% (6)	488	973	660	376	2,495	365	730	495	282	1,871
TOTAL		8,330	15,057	9,546	5,727	38,670	6,578	11,242	7,387	4,828	29,835
Less Census Blocks within 15 Miles of Roper		4,026	7,556	4,588	2,815	18,985	3,326	5,380	3,397	2,231	14,335

Notes:

- (1) Although 20 Percent of this Block is within 15 miles of the proposed BRMC facility, most of that area is also within 15 miles of Summerville Medical Center and/or Trident Medical Center
- (2) Although 100 Percent of this Block is within 15 miles of the proposed BRMC facility, about 20 percent of it is within 15 miles of Trident Medical Center
- (3) Although 100 Percent of this Block is within 15 miles of the proposed BRMC facility, about 40 percent of it is within 15 miles of Trident Medical Center
- (4) Although 100 Percent of this Block is within 15 miles of the proposed BRMC facility, about 90 percent of it is within 15 miles of Trident Medical Center
- (5) Although 100 Percent of this Block is within 15 miles of the proposed BRMC facility, about 25 percent of it is within 15 miles of Trident Medical Center

SOURCE: CLARITAS

ATTORNEY EXPERT EYES
ONLY

RECORD 004304

Baehr_01633

CENSUS BLOCKS THAT CURRENTLY DO NOT LIE WITHIN 7 MILES
OF AN ACUTE CARE HOSPITAL THAT WOULD IF ROPER ST. FRANCIS
BERKELEY WERE CONSTRUCTED

CENSUS BLOCK	APPROXIMATE PERCENTAGE WITHIN 7 MILES OF ROPER	TOTAL 2015 POPULATION BY AGE				
		UNDER 15	15-44	45-64	65 & OVER	TOTAL
450150207012	50%	1,858	3,626	2,773	1,370	9,627
450150207013	75%	362	655	481	233	1,731
450150207011	100%	249	523	458	221	1,451
450150206001	75%	333	673	541	287	1,834
450150206002	50%	178	328	431	192	1,127
450150207071	50%	426	680	436	227	1,769
TOTAL		3,404	6,485	5,120	2,530	17,539

2015 POPULATION WITH IMPROVED ACCESS				
UNDER 15	15-44	45-64	65 & OVER	TOTAL
929	1,813	1,387	685	4,814
272	491	361	175	1,299
249	523	458	221	1,451
259	505	406	216	1,376
88	154	216	96	554
213	340	218	114	885
2,000	3,836	3,045	1,506	10,387

ATTORNEY EXPERT EYES
ONLY

RECORD 004305

Baehr_01634

CENSUS BLOCKS THAT CURRENTLY DO NOT LIE WITHIN 7 MILES
OF AN ACUTE CARE HOSPITAL THAT WOULD IF BERKELEY REGIONAL
MEDICAL CENTER WERE CONSTRUCTED

CENSUS BLOCK	APPROXIMATE PERCENTAGE WITHIN 7 MILES OF BRMC	TOTAL 2015 POPULATION BY AGE				
		UNDER 15	15-44	45-64	65 & OVER	TOTAL
450150205014	35%	682	1,109	702	339	2,832
450150206001	85%	333	673	541	287	1,834
450150206002	10%	176	328	431	192	1,127
450150204012	35%	486	973	660	375	2,495
480150207011	25%	249	523	459	221	1,451
450150205013	95%	97	160	171	103	531
450150203005	50%	494	901	717	555	2,667
450150203003	65%	256	398	278	153	1,085
450150203004	100%	180	404	294	193	1,071
450150205012	100%	149	521	444	338	1,452
450150205011	100%	491	804	546	292	2,133
450150205024	100%	598	959	575	347	2,487
450150205019	100%	287	521	357	243	1,418
450150205015	100%	387	606	343	274	1,610
450150205022	100%	520	728	367	160	1,775
450150205023	100%	543	927	569	271	2,310
TOTAL		5,926	10,545	7,463	4,344	28,278

SOURCE: CLARITAS

2015 POPULATION WITH IMPROVED ACCESS					
UNDER 15	15-44	45-64	65 & OVER	TOTAL	
239	388	248	119	991	
283	572	460	244	1,559	
18	33	43	19	113	
170	341	231	132	873	
62	131	115	35	363	
92	152	162	98	504	
247	451	359	278	1,334	
186	259	181	99	705	
180	404	294	193	1,071	
149	521	444	338	1,452	
491	804	546	292	2,133	
596	959	575	347	2,487	
287	521	367	243	1,418	
387	606	343	274	1,610	
520	728	367	160	1,775	
543	927	569	271	2,310	
4,430	7,806	5,301	3,161	20,698	

Petitioner's Exhibit 046-048

SECTION II: Technical Appendix

ATTORNEY EXPERT EYES
ONLY

Baehr_01636

RECORD 004307

BERKELEY COUNTY UTILIZATION TRENDS AND
MARKET SHARE INFORMATION 2008-2010

Utilization

	Trident Health System		Roper Health System		All Other		Total		Berkeley Co Population		SC Population Based Use Rates Per 1,000		US Census Based Use Rates Per 1,000	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days	SC	US Census	Discharges	Patient Days	Discharges	Patient Days
2008	7,133	30,722	3,343	16,283	2,891	10,537	13,367	57,542	165,830	170,171	80.6	347.0	78.6	338.1
2009	7,249	30,305	3,286	16,795	2,770	10,608	13,305	57,708	168,050	173,964	79.2	343.4	76.5	331.7
2010	7,291	29,741	3,121	13,829	2,865	11,082	13,297	54,652	170,270	177,843	78.1	321.0	74.8	307.3

Market Share

	Trident Health System		Roper Health System		All Other		Total	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
2008	53.4%	53.4%	25.0%	28.3%	21.6%	18.3%	100.0%	100.0%
2009	54.5%	52.5%	24.7%	29.1%	20.8%	18.4%	100.0%	100.0%
2010	54.8%	54.4%	23.5%	25.8%	21.7%	20.3%	100.0%	100.0%

Source : SC Data and South Carolina State and County Population Projections
US Census figures based on 2000 and 2010 Census Data Interpolated.

Baehr_01638

ADGHSADV\
Market Shares 2008-2010\

Source: DSS: SC-ORS

Run Date: 09/21/11
Page 1 of 2

Petitioner's Exhibit 046-050

Disch Year-11	County Name	Trident Health System			M. U. S. C. Medical Center			Roper Hospital, Inc.			Top Competitors			East Cooper Regional	
		Cases	LOS	Market	Cases	LOS	Market	Cases	LOS	Market	Cases	LOS	Market	Cases	LOS
	Berkeley County, SC	7,133	30,722	53.36%	2,163	8,099	16.18%	2,206	11,541	16.50%	1,137	4,742	8.51%	583	1,818
	Charleston County, SC	2,174	9,428	6.88%	11,382	44,887	36.00%	9,164	49,780	28.98%	5,486	23,739	17.35%	8,111	10,888
	Dorchester County, SC	7,897	34,347	66.62%	1,930	7,400	16.28%	748	3,730	6.31%	605	2,017	5.10%	243	628
	Berkeley County, SC	7,249	30,305	54.48%	2,128	8,438	15.99%	2,079	11,351	15.63%	1,207	5,444	9.07%	506	1,506
	Charleston County, SC	2,286	9,161	7.44%	11,046	45,483	35.93%	8,833	46,863	28.73%	5,492	23,300	17.87%	2,842	10,104
	Dorchester County, SC	7,928	34,116	67.09%	1,862	7,849	15.76%	704	3,508	5.96%	628	1,958	5.31%	224	524
	Berkeley County, SC	7,281	29,741	54.83%	2,209	8,846	16.61%	1,922	9,156	14.45%	1,199	4,673	8.02%	515	1,505
	Charleston County, SC	2,112	8,417	7.00%	10,792	44,968	35.77%	8,805	44,393	29.19%	5,263	21,523	17.45%	2,808	9,367
	Dorchester County, SC	8,157	34,322	66.94%	1,958	9,030	16.07%	724	3,364	5.94%	671	2,317	5.51%	211	544
	Grand Total	52,227	220,559	81.02%	45,470	185,000	27.01%	35,185	183,686	20.90%	21,688	89,713	12.88%	11,043	36,884

Fiscal Year-1	County Name	Trident Health System			Mt. U. S. C. Medical Center			Roper Hospital, Inc			Top Competitors			East Cooper Regional	
		Cases	LOS	Market	Cases	LOS	Market	Cases	LOS	Market	Cases	LOS	Market	Cases	LOS
2008	Berkeley County, SC	7,133	30,722	53.36%	2,153	8,099	16.18%	2,206	11,541	16.50%	1,137	4,742	8.51%	583	1,818
	Charleston County, SC	2,174	9,428	6.88%	11,382	44,887	36.00%	9,164	49,780	28.98%	5,486	23,739	17.35%	3,111	10,888
	Dorchester County, SC	7,897	34,347	66.62%	1,930	7,400	16.28%	748	3,730	6.31%	605	2,017	5.10%	243	628
2009	Berkeley County, SC	7,249	30,305	54.48%	2,128	8,438	15.99%	2,079	11,351	15.63%	1,207	5,444	9.07%	506	1,506
	Charleston County, SC	2,286	9,161	7.44%	11,046	45,483	35.93%	8,833	45,863	28.73%	5,482	23,300	17.87%	2,842	10,104
	Dorchester County, SC	7,928	34,116	67.09%	1,862	7,849	15.76%	704	3,508	5.96%	628	1,958	5.31%	224	524
2010	Berkeley County, SC	7,291	29,741	54.83%	2,209	8,346	16.61%	1,922	9,156	14.45%	1,199	4,673	9.02%	515	1,505
	Charleston County, SC	2,112	8,417	7.00%	10,792	44,968	35.77%	8,805	44,993	29.19%	5,263	21,523	17.45%	2,808	9,367
	Dorchester County, SC	8,157	34,322	66.94%	1,958	9,030	16.07%	724	3,364	5.94%	671	2,317	5.51%	211	544
Grand Total		52,227	220,559	31.02%	45,470	185,000	27.01%	35,185	183,686	20.90%	21,688	89,713	12.88%	11,043	36,884

SECTION III: TECHNICAL APPENDIX

ATTORNEY EXPERT EYES
ONLY

Baehr_01640

INCOMPATIBILITY OF PROJECTED MARKET GROWTH WITH THE
CONCURRENT APPROVAL OF TWO NEW HOSPITALS IN BERKELEY COUNTY

BACKGROUND

2010 Total Berkeley County Non-Tertiary, Non-Specialty Patient Days

54,652

Trident System Market Share (2010)	54.4%
Roper System Market Share (2010)	25.3%
All Other Market share (2010)	20.3%

	Total Patient Days	Incremental Patient Days
2011	56,178	1,526
2012	57,773	3,121
2013	59,440	4,788
2014	61,185	6,533
2015	63,010	8,358
2016	64,920	10,268
2017	66,921	12,269

Incremental Berkeley County Patient Days by Provider			
Roper System	Trident System	Other	Total
386	830	309	1,526
790	1,698	633	3,121
1,212	2,606	971	4,788
1,653	3,555	1,325	6,533
2,115	4,548	1,695	8,358
2,598	5,588	2,082	10,268
3,105	6,677	2,488	12,269

(1) Market share based on patient days in 2010 as reported by the state of South Carolina. See page II-III.

IMPACT OF ADDING A SINGLE NEW HOSPITAL ON 2017 UTILIZATION OF EXISTING PROVIDERS

INCREMENTAL 2017 PATIENT DAYS ASSUMING NO NEW HOSPITAL

BERKELEY COUNTY PATIENT DAYS REQUIRED TO ENABLE A 50-BED HOSPITAL TO ACHIEVE A 70 PERCENT OCCUPANCY RATE, ASSUMING 90 PERCENT OF TOTAL PATIENT DAYS COME FROM BERKELEY COUNTY

INCREMENTAL 2017 PATIENT DAYS AVAILABLE TO EXISTING PROVIDERS

Incremental Berkeley County Patient Days by Provider			
Roper System	Trident System	Other	Total
3,105	6,677	2,488	12,269
2,909	6,257	2,331	11,498
195	420	156	772

IMPACT OF ADDING TWO NEW HOSPITALS ON 2017 UTILIZATION OF EXISTING PROVIDERS

INCREMENTAL 2017 PATIENT DAYS ASSUMING NO NEW HOSPITAL

BERKELEY COUNTY PATIENT DAYS REQUIRED TO ENABLE TWO 50-BED HOSPITALS TO ACHIEVE A 70 PERCENT OCCUPANCY RATE, ASSUMING 90 PERCENT OF TOTAL PATIENT DAYS COME FROM BERKELEY COUNTY

INCREMENTAL 2017 PATIENT DAYS AVAILABLE TO EXISTING PROVIDERS

3,105	6,677	2,488	12,269
5,819	12,514	4,663	22,995
(2,714)	(5,837)	(2,175)	(10,726)

NOTES: REQUIRED PATIENT DAY COMPUTATIONS

Projected Project Size
Target Occupancy Rate

Required Patient Days (2017)

Percentage of Patients From Berkeley County

REQUIRED BERKELEY COUNTY ADC (2017)

Proposed Acute Hospital Projects in Berkeley County			
Roper System	Trident System	Other	Total
50	50		100
70%	70%		70%
12,775	12,775		25,550
90%	90%		90%
11,498	11,498		22,995

PART 2: ASSUME A LIMITED EFFECT ON EXISTING PROVIDERS.

IN THIS SECTION, WE ASSUME THAT THE EXISTING PROVIDERS IN THE SERVICE AREA WILL BE RELATIVELY SUCCESSFUL COMPETITORS AGAINST THE TWO NEW HOSPITALS.

RATHER THAN DIVERTING ENOUGH UTILIZATION TO MEET THEIR UTILIZATION TARGETS, THE TWO HOSPITALS JOINTLY ACHIEVE THE LOWER LEVELS OF UTILIZATION.

IN THE SCENARIOS SHOWN A RANGE OF UTILIZATION ASSUMPTIONS IS EMPLOYED TO ILLUSTRATE THE EFFECTS OF LOW UTILIZATION AT VARIOUS LEVELS ON THE TWO PROPOSED FACILITIES

		NET INCOME AT INDICATED VOLUME		DEFICIT OF PATIENT DAYS BY EXISTING PROVIDERS				
TOTAL ALY COUNTY PATIENT DAYS/TENT DAYS PER HOSPITAL/R HOSPITAL		ROPER ST FRANCIS BERKELEY	BERKELEY REGIONAL MEDICAL CENTER	TOTAL BERKELEY COUNTY DAYS	DEFICIT RELATIVE TO AVAILABLE DAYS	TRIDENT	ROPER	OTHER
12,775	11,498	\$ 283,274	\$ 69,553	22,995	(10,726)	(5,837)	(2,714)	(2,175)
10,000	9,000	\$ (4,951,751)	\$ (1,770,512)	18,000	(5,731)	(3,119)	(1,450)	(1,162)
9,500	8,550	\$ (5,894,999)	\$ (2,286,095)	17,100	(4,831)	(2,629)	(1,222)	(980)
8,500	7,650	\$ (7,781,494)	\$ (3,317,261)	15,300	(3,031)	(1,649)	(767)	(615)
7,500	6,750	\$ (9,667,989)	\$ (4,348,427)	13,500	(1,231)	(670)	(311)	(250)
6,500	5,850	\$ (11,554,485)	\$ (5,379,593)	11,700	569	310	144	115
5,500	4,950	\$ (13,440,980)	\$ (6,410,758)	9,900	2,369	1,289	599	480
4,500	4,050	\$ (15,327,475)	\$ (7,441,925)	8,100	4,169	2,269	1,055	845

	Berkeley Regional Medical Center		
	Patient Days	Net Income	ADC
Year 1	7,212	\$ (4,575,850)	19.8
Year 2	9,490	\$ (2,855,146)	26.0
Year 3	11,717	\$ 69,553	32.1

4,505 \$ 4,645,403

1,031

11,717	-	69,553
10,000	(1,717)	(1,770,512)
9,500	(2,217)	(2,286,095)
8,500	(3,217)	(3,317,261)
7,500	(4,217)	(4,348,427)
6,500	(5,217)	(5,379,593)
5,500	(6,217)	(6,410,759)
4,500	(7,217)	(7,441,925)

	Roper St. Francis		
	Patient Days	Net Income	ADC
	3,194	\$ (11,765,772)	8.8
2,281	5,475	\$ (3,313,318)	15.0
913	6,388	\$ 285,160	17.5

3,194 \$ 12,050,932

3,773

6,388	(1)	\$ 283,274
5,000	(1,388)	\$ (4,951,751)
4,750	(1,638)	\$ (5,894,999)
4,250	(2,138)	\$ (7,781,494)
3,750	(2,638)	\$ (9,667,989)
3,250	(3,138)	\$ (11,554,485)
2,750	(3,638)	\$ (13,440,980)
2,250	(4,138)	\$ (15,327,475)

3,194	\$	(11,765,772)
5,475	\$	(3,313,318)
6,388	-	\$ 285,160
10,950	4,562	\$ 17,497,543
12,776	6,388	\$ 24,387,024

NON-TERTIARY

Berkeley County, SC	TOTAL 2010 Trident Health System		Projected Year 3 BRMC		Roper Actual 2010		
	Cases	Days	Patient Days	Admissions	Roper	Bon Secours	Roper System Total
29406	991	4,376	58	13	461	372	833
29410	21	70	2	1	287	201	488
29431	293	980	606	181	105	74	179
29434	20	68	39	11	17	5	22
29436	284	1,324	767	164	89	57	146
29445	2,194	8,393	225	59	423	385	808
29450	12	50	13	3	85	20	105
29453	50	196	58	15	37	4	41
29456	1,196	4,803	124	31	182	177	359
29461	1,587	6,547	4,075	988	505	285	790
29468	113	621	376	68	65	24	89
29469	37	113	66	22	19	4	23
29479	393	1,691	957	222	145	101	246
29483	4,124	17,740	4,827	1,122	371	357	728
29492	1	2	0	0	111	30	141
All Other	119	548	-	-			0
Total	11,435	47,522	12,193	2,901			

Source: Roper Discovery pp. 4527-4528 and 4535-4536 and Trident Projections of BRMC Utilization Based on 2010 SC Data, and Age and ZIP Code Specific Population Projections from Claritas.

Roper utilization includes normal newborns.

ATTORNEY EXPERT
EYES ONLY

Baehr_01645

Petitioner's Exhibit 046-057

RECORD 004316

SECTION IV: TECHNICAL APPENDIX

ATTORNEY EXPERT EYES
ONLY

Baehr_01646

Trident Health System
Inpatient and Outpatient Discharges for July 1, 2009 to June 30, 2010

	Cases	Days	Total Charges	Net Revenue	Variable Cost	Contribution Margin	Contribution Margin Per Case
Inpatient	24,093	99,129	936,341,597	208,375,118	82,205,002	126,170,116	5,237
Outpatient	213,078	-	556,768,929	120,070,178	36,654,761	83,415,417	391
Grand Total	237,171	99,129	1,493,110,527	328,445,295	118,859,763	209,585,532	884
Tertiary and Specialty Sut	2,050	11,118	155,982,537	34,526,333	13,226,329	21,300,004	10,390

ATTORNEY EXPERT EYES
ONLY

RECORD 004318

Baehr_01647

Non-Tertiary Contribution Margin Per Adjusted Admission

Inpatient Charges	\$ 936,341,597
Tertiary and Specialty IP Charges	<u>\$ 155,982,537</u>
Non-Tertiary Inpatient Charges	\$ 780,359,061
Outpatient charges	\$ 556,768,929
Total Non-Tertiary	<u>\$ 1,337,127,990</u>
Adjusted Admission Multiplier	1.71
Total Admissions	24,093
Tertiary and Specialty Admissions	<u>2,050</u>
Non-Tertiary Admissions	22,043
Adjusted Non-Tertiary Admissions	37,770

ATTORNEY EXPERT EYES
ONLY

RECORD 004319

Baelr_01648

Net Revenues	\$	328,445,295
Net Tertiary and Specialty Revenues	\$	34,526,333
Net Non-Tertiary Revenues	\$	293,918,962
Variable Expenses	\$	118,859,763
Variable Tertiary and Specialty Expenses	\$	13,226,329
Variable Non-Tertiary Expenses	\$	105,633,434
Non-Tertiary Contribution Margin	\$	188,285,529
Non-Tertiary Contribution Margin Per Adjusted Admission	\$	4,985
Tertiary Contribution Margin		21,300,004
Tertiary Contribution Margin Per Admission	\$	10,390

ATTORNEY EXPERT EYES
ONLY

RECORD 004320

Baelur_01649

From: Cantwell Shannon
To: Johnson Bret
CC: Bowling Douglas; Steffensen Shannon D
Sent: 9/24/2007 1:18:45 PM
Subject: RE: pts re: hospital services in Berkeley County

Medical Center Berkeley- March 1992, Roper Berkeley ASF February 2002 and Goose Creek August 2006

From: Johnson Bret
Sent: Monday, September 24, 2007 12:23 PM
To: Cantwell Shannon
Cc: Bowling Douglas; Steffensen Shannon D
Subject: RE: pts re: hospital services in Berkeley County

Shannon, thanks for the info. Can you tell me what year we constructed the Berkeley facility as well as our Goose Creek location?

From: Cantwell Shannon
Sent: Monday, September 24, 2007 12:22 PM
To: Johnson Bret
Cc: Bowling Douglas; Steffensen Shannon D
Subject: pts re: hospital services in Berkeley County
Importance: High

Hi Bret,
Shannon relayed your request for information relative to Trident Medical Center and the decision to construct the hospital in Charleston versus Berkeley County. Upon researching the history, it turns out that DHEC "guided" Trident's location (a fact that may not be lost to some council members), so I can only offer the following points:

- Both Berkeley and Dorchester Counties had county-owned hospitals that closed prior to the licensure of Trident Medical Center in 1975
- According to Joel Grice the reasons DHEC issued a CON to Trident Medical Center in 1972 were two-fold: for the construction of a "replacement hospital" which would now serve both Berkeley and Dorchester counties and to locate a hospital in North Charleston
- Trident Medical Center has a satellite facility in Berkeley County, Moncks Corner Medical Center, which provides emergency services, physician services, imaging, lab, physical therapy and sports medicine
- Roper St. Francis has a satellite facility in Berkeley County, Roper St. Francis Medical Center Berkeley, which also provides emergency services, physician services, imaging, lab, and physical therapy. In addition, it provides occupational therapy, outpatient cancer therapy, wound care, vascular services, pain management, cardiac testing, and surgical services
- If/when the population warrants it, either hospital will have the ability to use an institutional bed need in order to construct a new hospital in Berkeley County (analogous to what Roper St. Francis is doing in Mount Pleasant)



October 14, 2010

Mr. Will Thomas
Parker Poe Adams & Bernstein, LLP
1201 Main Street, Suite 1450
Columbia, SC 29201

RE: Travel Time Study: Berkeley County, SC

Dear Will:

SRS Engineering, LLC (SRS) has completed travel runs within Berkeley County between specified population areas and existing/proposed hospital facilities. This letter is provided to present the methodology and results.

METHODOLOGY

Travel runs were conducted for the following origins/destinations:

1. Cross, SC to Moncks Corner Medical Center (MCMC) which is the location of the proposed hospital in Moncks Corner;
2. St. Stephen, SC to MCMC;
3. Bonneau, SC to MCMC;
4. Jamestown, SC to MCMC;
5. Carnes Crossroads to Trident Medical Center;
6. Carnes Crossroads to Summerville Medical Center; and
7. Carnes Crossroads to MCMC;

With regards to the ending point (destination), the emergency room parking lot was selected for each respective destination. With regards to starting point (origin) logical locations within the specified Town/area were selected as described below:

Cross, SC: US Post Office – 1836 Ranger Drive, Cross, SC 29436;
St. Stephen, SC: Town Hall – 124 Hood Street, St. Stephen, SC 29479;
Bonneau, SC: Town Limit Sign on US 52 entering Bonneau from the north;
Jamestown, SC: US Post Office – 4354 N. Highway 17A, Jamestown, SC 29453; and
Carnes Crossroads: Farmers & Merchants Bank of SC parking lot in northern quadrant of intersection of US 17A at US 176. It should be noted that this is in close proximity to the proposed hospital facility at Carnes Crossroads.

Mr. Will Thomas
 October 14, 2010
 Page 2

The method/technique used to perform the travel times was the "Maximum-car technique which defines the vehicle speed at the posted speed limit unless impeded by actual traffic conditions" (i.e., traffic congestion, traffic signals, STOP signs/intersections, etc.). The most logical routes were utilized in all runs and are summarized below:

1. Cross to MCMC: SC 6 to US 17A to MCMC;
2. St. Stephen to MCMC: Hood St. to Elm St. to US 52 to US 17A to MCMC.
3. Bonneau to MCMC: US 52 to US 17A to MCMC.
4. Jamestown to MCMC: US 17A to US 52 to US 17A to MCMC;
5. Carnes Crossroads to Trident Medical Center: US 17A to College Park Road to I 26 to US 78 to Medical Plaza Drive to Trident Medical Center;
6. Carnes Crossroads to Summerville Medical Center: US 17A to College Park Road to Ladson Road to Midland Pkwy to Summerville Medical Center;
7. Carnes Crossroads to MCMC: - US 17A to MCMC.

All travel runs were conducted on a weekday and runs were conducted for each route during the AM peak period (7-9 AM), Midday peak period (11 AM-1 PM), and PM peak period (4-6 PM) in order to provide a good sampling of data for the area for a typical day. Travel runs were conducted on the following days:

Tuesday September 21, 2010;
 Wednesday September 22, 2010;
 Thursday September 23, 2010;
 Wednesday September 29, 2010; and
 Thursday September, 30, 2010.

GENERAL TRAFFIC OBSERVATIONS

Traffic congestion was generally not a factor for the routes that ended at MCMC as many of these roads are rural in nature and underutilized. There was some congestion at the intersection of US 17A at SC 6 in Moncks Corner but it was not observed to be excessive. It should be noted that US 17A is currently being widened south of Moncks Corner and a 45 mph speed limit was in effect. Three school zones were encountered on the route from Cross to MCMC during the AM peak period that required a slower speed.

While traffic was observed to be more pronounced for the routes from Carnes Crossroads to Trident & Summerville Medical Centers, the only significant congestion observed was on Ladson Road during the PM peak run from Carnes Crossroads to Summerville Medical Center. At this time Ladson Road moved very slowly due to heavy commuter traffic.

RESULTS

The results of the travel runs are summarized in the attached Table 1. Individual travel runs are documented and a summary is also provided for each location that provides the average travel time, and also the shortest and longest documented travel times. As shown, all runs were conducted in less than 30 minutes.

The routes with the longest travel times were Cross to MCMC and Jamestown to MCMC with average travel times of 25:07 and 25:01 respectively. The route with the shortest average travel time was

Mr. Will Thomas
October 14, 2010
Page 3

Bonneau to MCMC with an average travel time of 12:36.

I trust that this letter and accompanying data provides a good indication of the travel times between pertinent areas and hospital facilities (existing/proposed) within this area of Berkeley County. If you have any questions, please contact me at 803-252-1799.

Sincerely,

SRS ENGINEERING, LLC

A handwritten signature in black ink, appearing to read "Mike Ridgeway".

Mike Ridgeway, P.E.

Attachment

SRS 00003

RECORD 004324

TABLE I
Berkeley County Travel Time Summary

From Cross	To Moncks Corner NC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
Post Office			9/21/2010	7:00 AM	25:38	17.1	
							Cross to Moncks Corner Summary
							Average Shortest Longest
	To Moncks Corner MC	Midday Peak	9/21/2010	11:05 AM	22:58	17.1	25:07 22:58 26:43
	To Moncks Corner MC	PM Peak	9/21/2010	4:00 PM	26:43	17.1	
From St. Stephen Town Hall	To Moncks Corner MC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/21/2010	7:51 AM	20:57	15.3	
							St. Stephen to Moncks Corner Summary
							Average Shortest Longest
	To Moncks Corner MC	Midday Peak	9/21/2010	11:51 AM	20:23	15.3	20:41 20:22 20:57
	To Moncks Corner MC	PM Peak	9/21/2010	4:48 PM	20:45	15.3	
From Bonanza Town Link Sign North Side	To Moncks Corner MC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/21/2010	7:59 AM	12:30	9.1	
							Bonanza to Moncks Corner Summary
							Average Shortest Longest
	To Moncks Corner MC	Midday Peak	9/21/2010	12:03 PM	12:30	9.1	12:30 12:20 12:50
	To Moncks Corner MC	PM Peak	9/21/2010	4:56 PM	12:39	9.1	
From Jamestown Post Office 29453	To Moncks Corner MC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/20/2010	7:07 AM	25:18	19.8	
							Jamestown to Moncks Corner Summary
							Average Shortest Longest
	To Moncks Corner MC	Midday Peak	9/29/2010	11:08 AM	24:29	19.8	25:01 24:29 25:18
	To Moncks Corner MC	PM Peak	9/29/2010	4:13 PM	25:15	19.8	
From Carvers Crossroads	To Tidwell MC (US 78)	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/22/2010	8:30 AM	15:30	7.9	
							CCR to Tidwell Summary
							Average Shortest Longest
	To Tidwell MC (US 78)	Midday Peak	9/22/2010	11:30 AM	15:17	7.9	14:59 14:09 15:30
	To Tidwell MC (US 78)	PM Peak	9/22/2010	4:30 PM	14:09	7.9	
From Carvers Crossroads	To Summerville MC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/20/2010	7:56 AM	19:38	10.3	
							CCR to Summerville MC Summary
							Average Shortest Longest
	To Summerville MC	Midday Peak	9/20/2010	11:39 AM	18:41	10.3	20:20 18:38 21:04
	To Summerville MC	PM Peak	9/29/2010	4:58 PM	24:04	10.3	
From Carvers Crossroads	To Moncks Corner MC	AM Peak	Date	Time Start	Duration (Minutes/Seconds)	Miles	
			9/23/2010	7:30 AM	21:35	11.8	
							CCR to Moncks Corner Summary
							Average Shortest Longest
	To Moncks Corner MC	Midday Peak	9/22/2010	11:20 AM	19:34	11.8	20:41 19:34 21:35
	To Moncks Corner MC	PM Peak	9/22/2010	4:21 PM	20:55	11.8	

SRS 00004

RECORD 004325

CONFIDENTIAL

RECORD 004326

3 School Zones Flashing
25mph
Mild Congestion
at 555/174

MIDDAY NO CONG.

PM RAIN
Congestion at
206/174

AM NO CONGESTION

MIDDAY NO CONG.

AM NO CONG
START 6:12

6:12

MIDDAY NO CONG.

Cross
Post Office

To Moncks Corner

AM Peak

Date 9/21/10 Time Start 7:00 Duration 25:38:34 Miles 17.1

To Moncks Corner

Midday Peak

9/21/10 11:05 22:58:10 17.1

To Moncks Corner

PM Peak

9/21/10 4:00 26:43:28 17.1

St Stephen

Town Hall
124 Hood St.

To Moncks Corner

AM Peak

Date 9/21/10 Time Start 7:51 Duration 20:57:46 Miles 15.3

To Moncks Corner

Midday Peak

9/21/10 11:55 20:22:81 15.3

To Moncks Corner

PM Peak

9/21/10 4:48 20:45:69 15.3

Bonneau

To Moncks Corner

AM Peak

Date 9/21/10 Time Start 7:59 Duration 12:50:75 Miles 9.1

To Moncks Corner

Midday Peak

9/21/10 12:03 12:20:40 9.1

To Moncks Corner

PM Peak

9/21/10 4:56 12:39:38 9.1

START AT
TOWN LIMIT
5:42
AS 52
ADDITIONAL

SRS_00013

u

				Date	Time Start	Duration	Miles
# school name 17th Jamestown Post Office 29453 RAIN No CONF. RAIN No CONF.	To Moncks Corner	AM Peak		9/30/10	7:07	25:18:46	19.8
	To Moncks Corner	Midday Peak		9/29/10	11:08 AM	24:29:00	19.8
	To Moncks Corner	PM Peak		9/29/10	4:13 PM	25:15:66	19.8

			Date	Time Start	Duration	Miles
From Carnes Crossroads No Cong.	Summerville MC	AM Peak	9/30/10	7:56	18:38:03	10.3
~~NO Cong.~~	Summerville MC	Midday Peak	~~9/30/10~~ 9/30/10	~~11:39~~ 11:39	~~18:41:79~~ 18:41:79 (8:41:79)	10.3
Rain some Moderate Congestion on Radson Road	Summerville MC	PM Peak	9/29/10	4:55	24:04:46	10.3

CONFIDENTIAL

RECORD 004329

SRS_00016

START	END	Start Time	End Time	Total Time	Notes
SAME	Trident Tech (US73) Medical Plaza Bldg. (Circle loop on back) S. 11:50	11:50		15:18:48 7.93 15:17:32 7.9	NO SIGNIFICANT ISSUES / NORMAL COND
		14:50		14:10:02 7.95 14:09:24 7.9	Secured to hit every SRS on 11:50 no work time @ 11:50
		15:30		15:30:15 7.96 15:30:14 7.9	S. 15:30 Coll. on 15:30

Notes

Trip to 9330 Medical Plaza Dr
Charleston, SC 29406-9104
8.01 miles - about 12 minutes

 Carnes Crossroad, SC

1. Start out going NORTHWEST on ST JAMES AVE / US-176 toward S LIVE OAK DR / US-17 ALT. go 0.0 mi
2. Turn LEFT onto N MAIN ST / US-17 ALT. go 1.4 mi
3. Turn LEFT onto COLLEGE PARK RD. go 4.1 mi
4. Merge onto I-26 E via the ramp on the LEFT toward CHARLESTON. go 1.7 mi
5. Merge onto US-78 E via EXIT 205B toward US-52 / GOOSE CREEK. go 0.5 mi
6. Turn RIGHT onto MEDICAL PLAZA DR. go 0.2 mi
7. 9330 MEDICAL PLAZA DR is on the LEFT. go 0.0 mi

 9330 Medical Plaza Dr, Charleston, SC 29406-9104
Total Travel Estimate : 8.01 miles - about 12 minutes

Route Map [View](#)

START	END	START TIME	END TIME	TOTAL TIME	MILES	NOTES
Chiropractic X-Rays	Monkeys (Cage)	11:00 AM	11:20	19:54.62	11.88	
From Prison 2nd row IN Prison 3: 1st row NTS BIRTH	LTD PRISON PRISONER ER @ Medical Center			19:54.62	11.8	

11:40 AM 11:21

20:56-50 11.90
20:56-54 11.8

~~11:41~~
11:02 AM

11:30

21:56-50 11.88
21:56-54 11.8

- Max Contraction
- 1st row 1st row IV
- School 12:00 AM
- took a lot of time in the



Notes

Trip to 401 N Live Oak Dr
Moncks Corner, SC 29461-5603
11.88 miles - about 17 minutes

Carnes Crossroad, SC



1. Start out going NORTHWEST on ST JAMES AVE / US-176 toward N MAIN ST / US-17 ALT.

go 0.0 mi



2. Turn RIGHT onto S LIVE OAK DR / US-17 ALT.

go 11.9 mi



3. 401 N LIVE OAK DR is on the LEFT.

go 0.0 mi



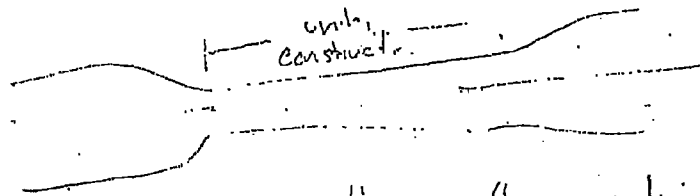
401 N Live Oak Dr, Moncks Corner, SC 29461-5603

Total Travel Estimate : 11.88 miles - about 17 minutes

Route Map File

(Note) Stop for consist. @ B. min (K. min)
 9. 1000 → 96

- Acc'd. with 9 in back to 4 lanes
- All between (2.5 mi) is under const.
- Big road
- Signed @ 4.5 mi for whole section under construction with exception of narrow drive under 10 ft wide



- Don't know what "normal" speed limit is

PERCENTAGE OF EACH APPLICANT'S BERKELEY COUNTY
HISTORICAL AND PROJECTED NON-TERTIARY, NON-SPECIALTY PATIENT DAYS TO BE
SERVED IN PROPOSED NEW HOSPITALS

	ROPER SYSTEM	TRIDENT SYSTEM
2010 BERKELEY COUNTY PATIENT DAYS	13,829	29,741
2017 BERKELEY COUNTY PATIENT DAYS	16,934	36,418
BERKELEY COUNTY PATIENT DAYS TO BE DELIVERED AT PROPOSED NEW HOSPITALS	11,498	10,745
PERCENTAGE OF TOTAL TO BE SERVED IN PROPOSED NEW HOSPITALS	67.9%	29.5%

Source: Historical Patient Days Based on SC State Data.

2017 patient days projected on the basis of age and ZIP Code specific population growth forecasts provided by Claritas applied to 2010 historical data.

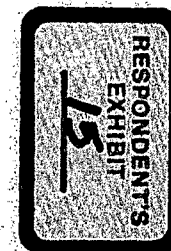
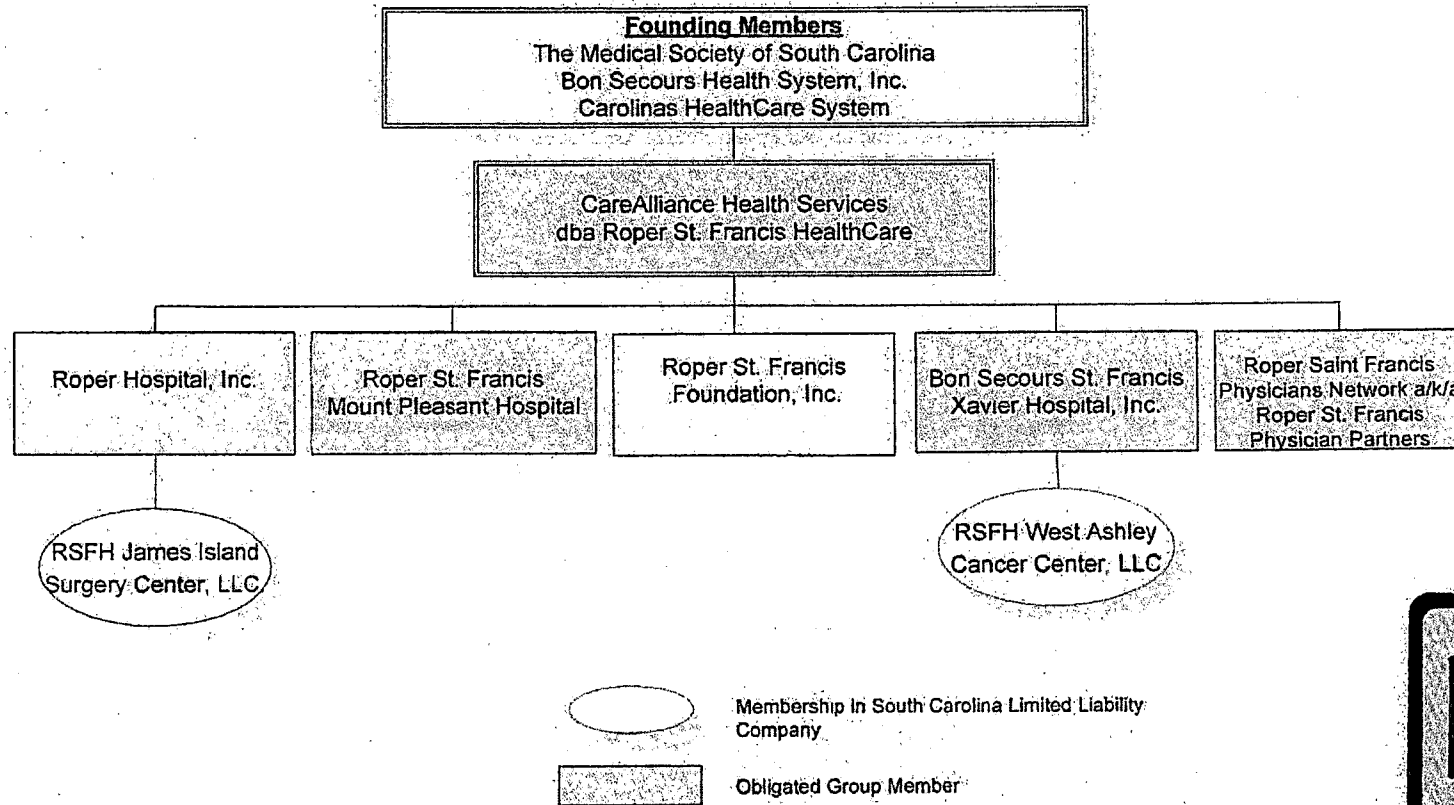
Roper Berkeley County patient days to be served at RSFB based on 90 percent of 12,776 patient days.

Trident System patient days to be served at BRMC based on ZIP Code specific market share projections from original CON applied to updated utilization projections.

Adverse Impact Graphs:

ATTORNEY/EXPERT EYES ONLY

Organizational Chart
CareAlliance Health Services d/b/a
Roper St. Francis Healthcare



ROPER-BERKELEY001192

From: Cassella Mike
To: Severance Matt
Sent: 10/22/2008 1:01:09 PM
Subject:
Attachments: rhi_bed_analysis.ppt



Roper Bed Analysis

September 9, 2008

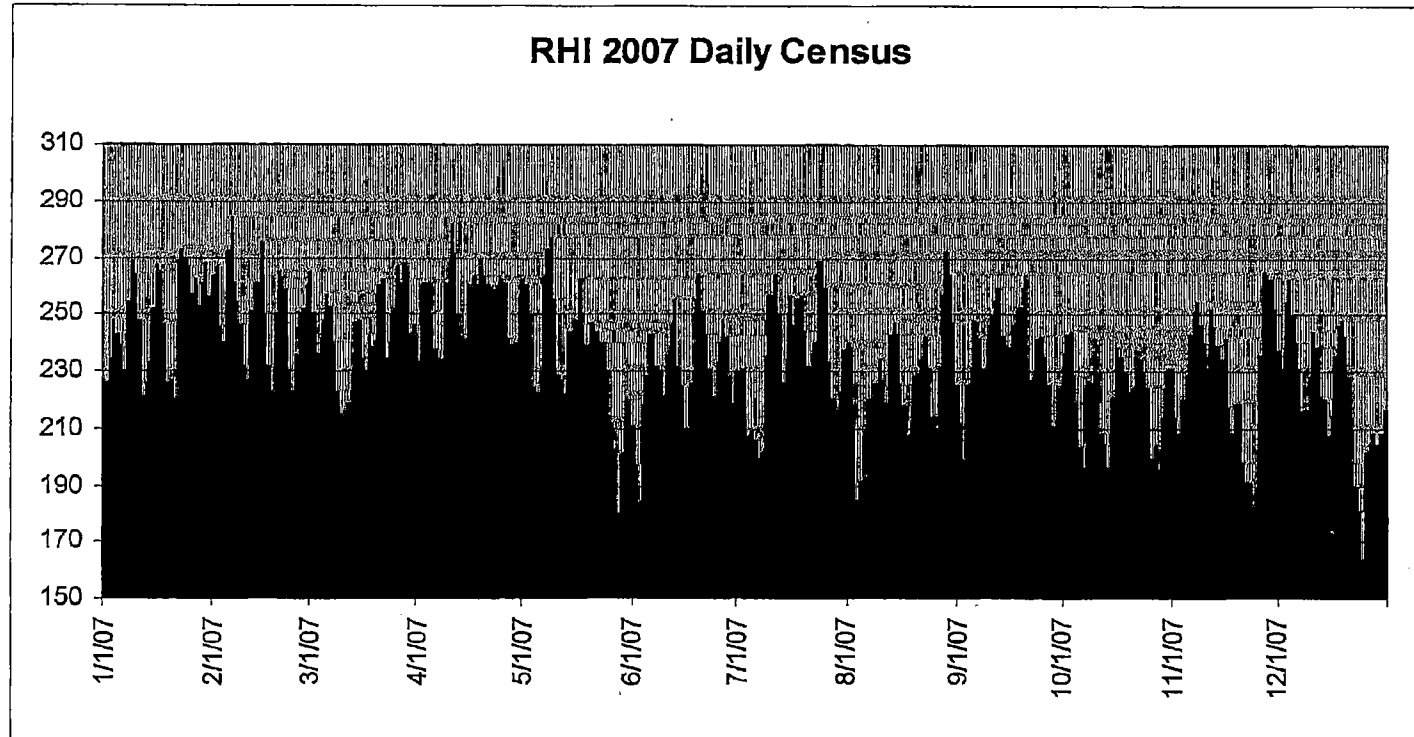
RECORD 004337

Roper Licensed Bed Summary

Current Licensed Beds (Excluding Rehab)	414
Less Transfer to BSSFH	<u>(13)</u>
Total Licensed Beds	401
Less Transfer to Mt Pl. Hospital	<u>(85)</u>
Total Licensed Beds	316
Less Transfer to Carnes Crossroads	<u>(50)</u>
Total Licensed Beds	<u><u>266</u></u>

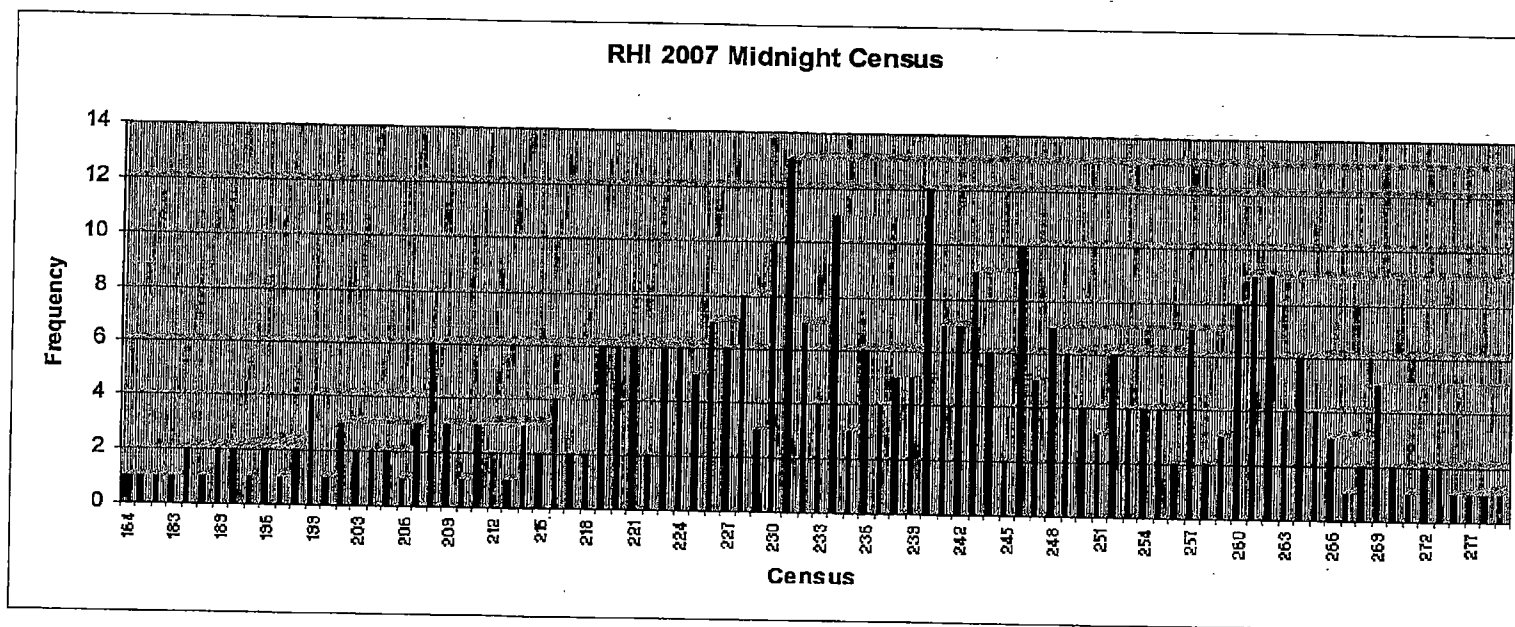
RECORD 004338

Roper Census



414 Licensed Bed total never approached, with a peak census of 284.

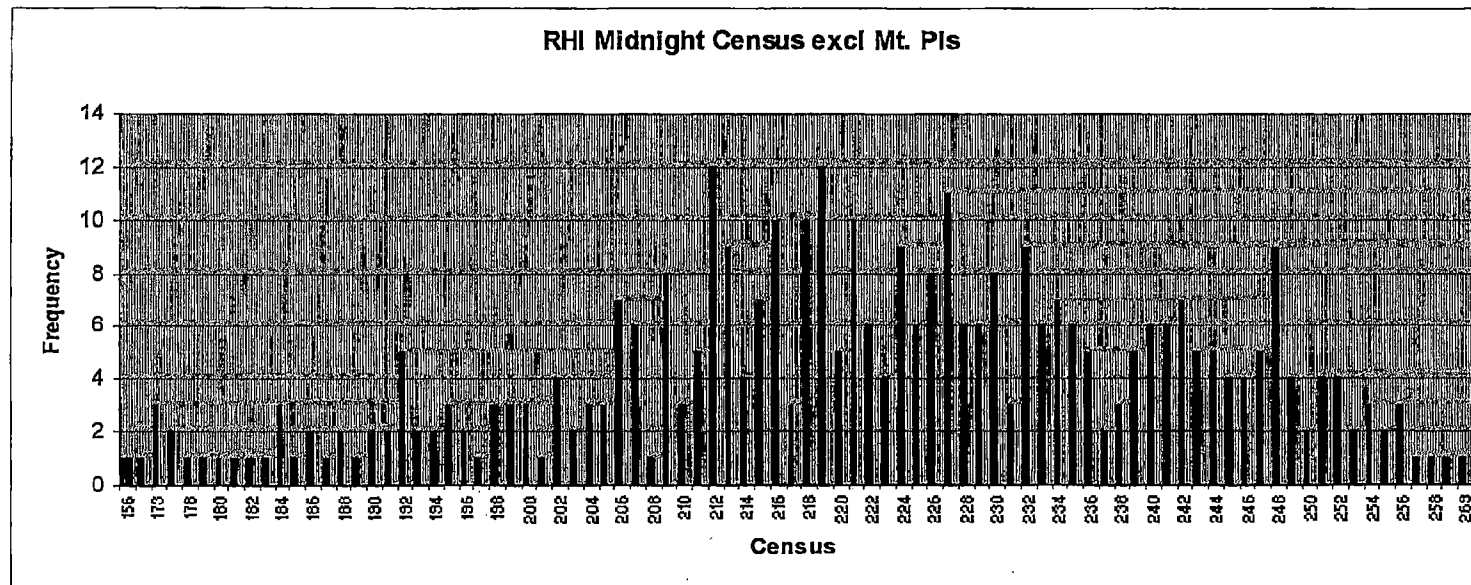
Roper Census Frequency



Most frequent census is 231 occurring 13 times in 2007.

RECORD 004340

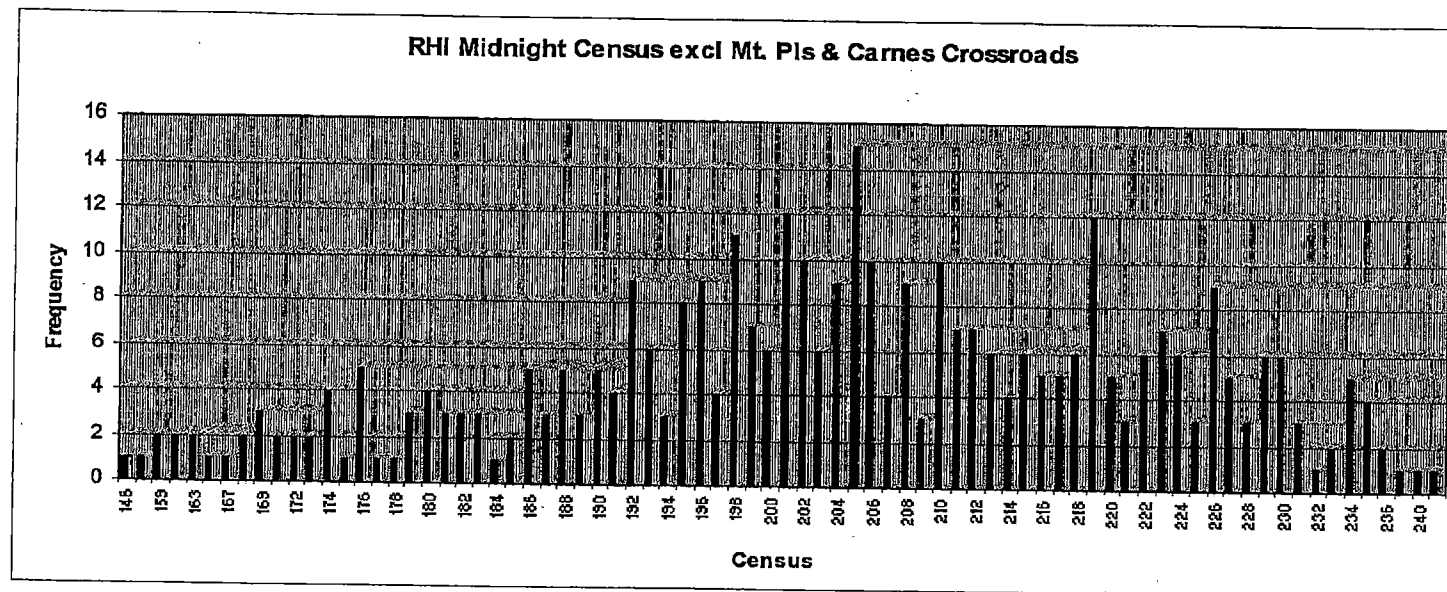
Roper Census Estimate with Mt. Pleasant Hospital



- 316 Licensed Bed total never approached, peak census of 269.
- RHI to operate at an occupancy rate greater than 80% for 14 days or 3.8% of the year.

Note: Census estimates include no LOS reduction or volume growth assumptions but does factor in shift of Obstetrics back to BSSF.

Roper Census Estimate with Carnes Cross Roads



- 266 Licensed Bed total never approached, peak census of 245.
- RHI to operate at an occupancy rate greater than 80% for 123 days or 33.7% of the year.

Note: Census estimates include no LOS reduction or volume growth assumptions but does factor in shift of Obstetrics back to BSSF.

Admissions to Roper Hospital & Bon Secours St. Francis Hospital
 Non-Tertiary DRGs
 2007 - YTD November 2010
 Request for Production # 12

	Inpatients from Berkeley County				Total Inpatients			
	2007	2008	2009	YTD 11/10	2007	2008	2009	YTD 11/10
Bon Secours St. Francis Hospital	1,180	1,257	1,388	1,218	8,522	8,191	8,415	7,184
Roper Hospital	2,105	2,275	2,208	1,829	14,550	13,842	13,292	11,594
Roper St. Francis Healthcare Total	3,285	3,532	3,596	3,047	23,072	22,033	21,707	18,778

RECORD 004343

RFP 12

ATTORNEY/EXPERT EYES ONLY

ROPER-BERKELEY004272



Roper Exhibit 036-001

**RESPONDENT'S
EXHIBIT****38**

**RSF Berkeley Emergency Department Visits & Transfers to Hospitals
2007 - 2010
Request for Production # 15**

Year	ED Patients	Transfers
2007	14,476	1,279
2008	13,909	1,150
2009	14,928	1,149
2010	15,137	1,109

RFP 15

ATTORNEY/EXPERT EYES ONLY

ROPER-BERKELEY004274

RECORD 004344

RESPONDENT'S
EXHIBIT41

Third Request for Production

RFP # 12

Roper St. Francis Berkeley

Emergency Room Visits by Zip Code, 2010

EMERGENCY DEPARTMENT BERKELEY	ED Visits
8285	1
21558	1
29085	2
29131	1
29408	2
29444	1
29467	1
92576	2
06102 HARTFORD, CT	1
07002 BAYONNE, NJ	1
07305 JERSEY CITY, NJ	1
07306 JERSEY CITY, NJ	1
07462 VERNON, NJ	1
07666 TEANECK, NJ	2
07735 KEYPORT, NJ	2
07740 LONGBRANCH, NJ	1
07826 BRANCHVILLE, NJ	1
08053 MARLTON, NJ	1
08096 WOODBURY, NJ	1
08724 BRICK, NJ	1
08759 MANCHESTER TOWNSHIP, NJ	1
08854 PISCATAWAY, NJ	1
10019 NEW YORK, NY	1
10456 BRONX, NY	1
10954 NANUET, NY	1
11207 BROOKLYN, NY	1
11216 BROOKLYN, NY	1
11236 BROOKLYN, NY	1
11412 SAINT ALBANS, NY	1
11434 JAMAICA, NY	3
11954 MONTAUK, NY	1
12701 MONTICELLO, NY	1
12901 PLATTSBURGH, NY	1
14201 BUFFALO, NY	1
14606 ROCHESTER, NY	2
17403 YORK, PA	3
17601 LANCASTER, PA	1
17603 LANCASTER, PA	1
17745 LOCKHAVEN, PA	1
18015 BETHLEHEM, PA	1
19132 PHILADELPHIA, PA	1
20019 WASHINGTON, DC	1
20032 WASHINGTON, DC	1
20155 GAINESVILLE, VA	1

EMERGENCY DEPARTMENT BERKELEY	ED Visits
20176 LEESBURG,VA	2
20202 WASHINGTON,DC	1
20745 OXONHILL,MD	1
21009 ABINGDON,MD	1
21030 COCKEYSVILLE,MD	1
21207 GWYNNOAK,MD	1
21218 BALTIMORE,MD	1
22031 FAIRFAX,VA	1
22102 MCLEAN,VA	1
22307 ALEXANDRIA,VA	1
22551 SPOTSYLVANIA,VA	1
23325 CHESAPEAKE,VA	1
23454 VIRGINIABEACH,VA	1
23462 VIRGINIABEACH,VA	1
23805 PETERSBURG,VA	1
24016 ROANOKE,VA	1
24901 LEWISBURG,WV	1
26426 SALEM,WV	1
26461 WILSONBURG,WV	1
27107 WINSTONSALEM,NC	1
27262 HIGHPOINT,NC	1
27609 RALEIGH,NC	1
28078 HUNTERSVILLE,NC	1
28079 INDIANTRAIL,NC	1
28086 KINGSMOUNTAIN,NC	2
28092 LINCOLNTON,NC	1
28146 SALISBURY,NC	1
28152 SHELBY,NC	1
28209 CHARLOTTE,NC	1
28216 CHARLOTTE,NC	1
28217 CHARLOTTE,NC	1
28273 CHARLOTTE,NC	1
28301 FAYETTEVILLE,NC	2
28306 FAYETTEVILLE,NC	2
28314 FAYETTEVILLE,NC	1
28320 BLADENBORO,NC	1
28429 CASTLEHAYNE,NC	1
28436 DELCO,NC	1
28461 SOUTHPORT,NC	1
28501 KINSTON,NC	1
28516 BEAUFORT,NC	1
28525 DEEPRUN,NC	1
28543 TARAWATERRACE,NC	1
28551 LAGRANGE,NC	1
28570 NEWPORT,NC	2
28574 RICHLANDS,NC	1
28577 SEALEVEL,NC	1
28677 STATESVILLE,NC	1
28689 UNIONGROVE,NC	1
28693 WARRENSVILLE,NC	1

EMERGENCY DEPARTMENT BERKELEY	ED Visits
28712 BREVARD,NC	1
29001 ALCOLU,SC	2
29018 BOWMAN,SC	2
29030 CAMERON,SC	2
29033 CAYCE,SC	1
29038 COPE,SC	3
29044 EASTOVER,SC	1
29047 ELLOREE,SC	2
29048 EUTAWVILLE,SC	274
29054 GILBERT,SC	3
29056 GREELEYVILLE,SC	16
29059 HOLLYHILL,SC	66
29063 IRMO,SC	1
29069 LAMAR,SC	3
29072 LEXINGTON,SC	2
29073 LEXINGTON,SC	2
29080 LYNCHBURG,SC	1
29101 MCBEE,SC	1
29102 MANNING,SC	3
29105 MONETTA,SC	1
29115 ORANGEBURG,SC	8
29118 ORANGEBURG,SC	1
29123 PELION,SC	2
29125 PINWOOD,SC	1
29135 SAINTMATTHEWS,SC	1
29142 SANTEE,SC	8
29148 SUMMERTON,SC	1
29150 SUMTER,SC	3
29162 TURBEVILLE,SC	1
29163 VANCE,SC	4
29169 WESTCOLUMBIA,SC	1
29170 WESTCOLUMBIA,SC	1
29203 COLUMBIA,SC	1
29210 COLUMBIA,SC	2
29229 COLUMBIA,SC	1
29341 GAFFNEY,SC	1
29374 PAULINE,SC	2
29379 UNION,SC	1
29401 CHARLESTON,SC	4
29403 CHARLESTON,SC	8
29404 CHARLESTONAFB,SC	1
29405 NORTHCHARLESTON,SC	19
29406 CHARLESTON,SC	58
29407 CHARLESTON,SC	14
29410 HANAHAN,SC	47
29412 CHARLESTON,SC	11
29414 CHARLESTON,SC	11
29415 NORTHCHARLESTON,SC	3
29418 NORTHCHARLESTON,SC	23
29419 NORTHCHARLESTON,SC	2

EMERGENCY DEPARTMENT BERKELEY	ED Visits
29420 NORTHCHARLESTON,SC	24
29423 CHARLESTON,SC	1
29429 AWENDAW,SC	3
29430 BETHERA,SC	5
29431 BONNEAU,SC	1,477
29433 CANADYS,SC	3
29434 CORDESVILLE,SC	109
29435 COTTAGEVILLE,SC	3
29436 CROSS,SC	908
29437 DORCHESTER,SC	9
29439 FOLLYBEACH,SC	1
29440 GEORGETOWN,SC	9
29445 GOOSECREEK,SC	364
29448 HARLEYVILLE,SC	15
29449 HOLLYWOOD,SC	5
29450 HUGER,SC	130
29451 ISLEOF PALMS,SC	1
29453 JAMESTOWN,SC	347
29455 JOHNSISLAND,SC	3
29456 LADSON,SC	100
29458 MCCLELLANVILLE,SC	6
29461 MONCKSCORNER,SC	6,177
29464 MOUNTPLEASANT,SC	18
29465 MOUNTPLEASANT,SC	2
29466 MOUNTPLEASANT,SC	3
29468 PINEVILLE,SC	574
29469 PINOPOLIS,SC	108
29470 RAVENEL,SC	4
29472 RIDGEVILLE,SC	138
29474 ROUND,SC	13
29475 RUFFIN,SC	2
29476 RUSSELLVILLE,SC	38
29477 SAINTGEORGE,SC	3
29479 SAINTSTEPHEN,SC	2,296
29482 SULLIVANSISLAND,SC	1
29483 SUMMERVILLE,SC	406
29484 SUMMERVILLE,SC	7
29485 SUMMERVILLE,SC	51
29488 WALTERBORO,SC	5
29492 CHARLESTON,SC	7
29493 WILLIAMS,SC	1
29501 FLORENCE,SC	4
29503 FLORENCE,SC	1
29505 FLORENCE,SC	2
29510 ANDREWS,SC	35
29519 CENTENARY,SC	1
29526 CONWAY,SC	3
29527 CONWAY,SC	1
29532 DARLINGTON,SC	3
29545 GREENSEA,SC	1

EMERGENCY DEPARTMENT BERKELEY	ED Visits
29554 HEMINGWAY,SC	2
29555 JOHNSONVILLE,SC	2
29556 KINGSTREE,SC	17
29560 LAKECITY,SC	7
29564 LANE,SC	23
29565 LATTA,SC	1
29566 LITTLERIVER,SC	1
29588 LONGS,SC	1
29570 MCCOLL,SC	1
29575 MYRTLEBEACH,SC	2
29576 MURRELLSINLET,SC	1
29577 MYRTLEBEACH,SC	1
29579 MYRTLEBEACH,SC	2
29581 NICHOLS,SC	1
29585 PAWLEYSISLAND,SC	1
29588 MYRTLEBEACH,SC	2
29590 SALTERS,SC	9
29591 SCRANTON,SC	1
29611 GREENVILLE,SC	1
29662 MAULDIN,SC	2
29670 PENDLETON,SC	1
29680 SIMPSONVILLE,SC	1
29687 TAYLORS,SC	4
29689 TOWNVILLE,SC	2
29745 YORK,SC	3
29803 AIKEN,SC	1
29809 NEWELLENTON,SC	8
29827 FAIRFAX,SC	1
29902 BEAUFORT,SC	1
29907 LADYSISLAND,SC	1
29910 BLUFFTON,SC	1
29922 GARNETT,SC	1
29932 LURAY,SC	1
30028 CUMMING,GA	1
30030 DECATUR,GA	1
30087 STONEMOUNTAIN,GA	1
30114 CANTON,GA	1
30132 DALLAS,GA	1
30204 BARNESVILLE,GA	4
30236 JONESBORO,GA	2
30252 MCDONOUGH,GA	2
30310 ATLANTA,GA	3
30439 METTER,GA	1
30635 ELBERTON,GA	2
30736 RINGGOLD,GA	1
30813 GROVETOWN,GA	2
30904 AUGUSTA,GA	1
31021 DUBLIN,GA	1
31023 EASTMAN,GA	1
31313 HINESVILLE,GA	1

EMERGENCY DEPARTMENT BERKELEY	ED Visits
31321 PEMBROKE,GA	1
31406 SAVANNAH,GA	1
31532 DENTON,GA	1
31558 SAINTMARYS,GA	2
31907 COLUMBUS,GA	2
32065 ORANGEPARK,FL	1
32065 ORANGEPARK,FL	1
32068 MIDDLEBURG,FL	1
32206 JACKSONVILLE,FL	1
32208 JACKSONVILLE,FL	2
32566 NAVARRE,FL	1
32570 MILTON,FL	2
32656 KEYSTONEHEIGHTS,FL	1
32724 DELAND,FL	1
32757 MOUNTDORA,FL	3
33054 OPALOCKA,FL	1
33062 POMPANOBACH,FL	1
33542 ZEPHYRHILLS,FL	1
33785 INDIANROCKSBACH,FL	2
34667 HUDSON,FL	1
36206 ANNISTON,AL	1
36804 OPELIKA,AL	1
37365 PALMER,TN	3
37601 JOHNSONCITY,TN	1
37663 KINGSPORT,TN	1
37766 LAFOLLETTE,TN	1
38059 NEWBERN,TN	1
38611 BYHALIA,MS	1
38655 OXFORD,MS	1
39437 ELLISVILLE,MS	1
39553 GAUTIER,MS	1
39828 CAIRO,GA	1
41042 FLORENCE,KY	1
43080 UTICA,OH	1
43105 BALTIMORE,OH	1
43822 FRAZEYSBURG,OH	1
44129 CLEVELAND,OH	1
44130 CLEVELAND,OH	1
44312 AKRON,OH	3
45218 CINCINNATI,OH	2
45895 WAPAKONETA,OH	1
47265 NORTHVERNON,IN	1
47401 BLOOMINGTON,IN	2
48457 MONTROSE,MI	1
48505 FLINT,MI	1
48625 HARRISON,MI	1
48642 MIDLAND,MI	1
48761 SOUTHBRANCH,MI	1
70115 NEWORLEANS,LA	1
71635 CROSSETT,AR	1

EMERGENCY DEPARTMENT BERKELEY	ED Visits
71913 HOTSPRINGSNATIONALPARK,AR	1
72023 CABOT,AR	1
73521 ALTUS,OK	1
74133 TULSA,OK	1
75081 RICHARDSON,TX	1
75401 GREENVILLE,TX	1
76549 KILLEEN,TX	1
76801 BROWNWOOD,TX	1
77007 HOUSTON,TX	2
78209 SANANTONIO,TX	1
78217 SANANTONIO,TX	1
78251 SANANTONIO,TX	1
78572 MISSION,TX	1
85051 PHOENIX,AZ	4
85369 YUMA,AZ	1
89523 RENO,NV	1
90802 LONGBEACH,CA	1
92652 LAGUNABEACH,CA	1
96797 WAIPAHU,HI	1
98387 SPANAWAY,WA	1
EMERGENCY DEPARTMENT BERKELEY	14,382

Third Request for Production

RFP # 21

2010 Market Share for Berkeley County and Tri-County area for Roper St. Francis Healthcare hospitals

Total Inpatient Discharges (excluding Normal Newborns):

	Roper Hospital	Boh Secours St. Francis Hospital	Roper St. Francis Mount Pleasant Hospital	Roper St. Francis Healthcare Total	Total Discharges in County
Berkeley County	2,225	1,274	25	3,524	14,837
Charleston County	10,423	5,607	132	16,162	35,002
Dorchester County	885	717	3	1,605	13,638
Tri-County	13,533	7,598	160	21,291	63,477

Market Share:

	Roper Hospital	Boh Secours St. Francis Hospital	Roper St. Francis Mount Pleasant Hospital	Roper St. Francis Healthcare Total
Berkeley County	15.0%	8.6%	0.2%	23.8%
Charleston County	29.8%	16.0%	0.4%	46.2%
Dorchester County	6.5%	5.3%	0.0%	11.8%
Tri-County	21.3%	12.0%	0.3%	33.5%



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ROPER-BERKELEY004517

Roper Exhibit 045-001

RECORD 004352

RESPONDENT'S
EXHIBIT**59****Werdenie, Sharon A.**

From: Long, James G.
Sent: Wednesday, March 23, 2011 3:14 PM
To: Werdenie, Sharon A.
Cc: Hollingsworth, Jennifer J.
Subject: Fw: 2010 Census total data v ORS data
Attachments: Initial 110323 release.xls

Sharon, pls print email and attachment

From: RKABOSTN@cs.com <RKABOSTN@cs.com>
To: Shannon.Cantwell@RoperSaintFrancis.com <Shannon.Cantwell@RoperSaintFrancis.com>;
 Douglas.Bowling@rsfh.com <Douglas.Bowling@rsfh.com>; Long, James G.; Barbier, Ralph W.
Cc: kray@richardsonknapp.com <kray@richardsonknapp.com>
Sent: Wed Mar 23 14:50:39 2011
Subject: 2010 Census total data v ORS data

Good afternoon.

Please see below the comparison of actual 2010 Census total population data compared to ORS projected total population data for Berkeley County and other Charleston area counties. ORS was low in each of its projections for these three counties (4.4% low for Berkeley County) -- and for the State as a whole. I have also attached the Census Excel file for SC with the first wave of released data. The ORS data is from the current online SC Statistical Abstract, Population, Table 5.

	2000 Pop	ORS 2010	Census 2010	ORS Shortfall (% / #)
Berkeley Co	142,651	170,270	177,843	4.4% / 7,573
Charleston Co	309,969	348,370	350,209	0.5% / 1,839
Dorchester Co	96,413	129,450	136,555	5.5% / 7,105
South Carolina	4,012,012	4,549,150	4,625,364	1.7% / 76,214

As I see any other applicable Census data I will send it across.

Mark M Richardson

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RICHARDSON-Berkeley000283

RECORD 004353

Table 1. The Most Populous Counties and Incorporated Places in 2010 in South Carolina: 2000 and 2010

¹For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/p194-171.pdf>

Population rank		Geographic area	Population		Change, 2000 to 2010	
2010	2000		2000 ¹	2010	Number	Percent
		South Carolina.....	4 012 012	4 825 384	613 352	15.3
		COUNTY				
1	1	Greenville County.....	379 616	451 225	71 609	18.9
2	2	Richland County.....	320 677	384 504	63 827	19.9
3	3	Charleston County.....	309 969	350 209	40 240	13.0
4	4	Spartanburg County.....	253 791	284 307	30 516	12.0
5	6	Horry County.....	196 629	269 291	72 662	37.0
6	5	Lexington County.....	216 014	262 391	46 377	21.5
7	8	York County.....	164 614	226 073	61 459	37.3
8	7	Anderson County.....	165 740	187 126	21 386	12.9
9	9	Berkeley County.....	142 651	177 843	35 192	24.7
10	12	Beaufort County.....	120 937	162 233	41 296	34.1
11	10	Aiken County.....	142 552	160 099	17 547	12.3
12	11	Florence County.....	125 761	136 885	11 124	8.8
13	15	Dorchester County.....	96 413	136 555	40 142	41.8
14	13	Pickens County.....	110 757	119 224	8 467	7.6
15	14	Sumter County.....	104 646	107 456	2 810	2.7
16	16	Orangeburg County.....	91 582	92 501	919	1.0
17	21	Lancaster County.....	61 351	76 652	15 301	24.9
18	20	Oconee County.....	66 215	74 273	8 058	12.2
19	19	Greenwood County.....	66 271	69 661	3 390	5.1
20	18	Darlington County.....	67 394	68 681	1 287	1.9
		INCORPORATED PLACE				
1	1	Columbia city.....	116 278	129 272	12 994	11.2
2	2	Charleston city.....	96 650	120 083	23 433	24.2
3	3	North Charleston city.....	79 641	97 471	17 830	22.4
4	6	Mount Pleasant town.....	47 609	67 843	20 234	42.5
5	5	Rock Hill city.....	49 765	66 154	16 389	32.9
6	4	Greenville city.....	56 002	58 409	2 407	4.3
7	12	Summerville town.....	27 752	43 392	15 640	56.4
8	8	Sumter city.....	39 643	40 524	881	2.2
9	9	Hilton Head Island town.....	33 862	37 099	3 237	9.6
10	10	Florence city.....	30 248	37 056	6 808	22.5
11	7	Spartanburg city.....	39 673	37 013	-2 660	-6.7
12	11	Goose Creek city.....	29 208	35 938	6 730	23.0
13	14	Aiken city.....	25 337	29 524	4 187	16.5
14	15	Myrtle Beach city.....	22 759	27 109	4 350	19.1
15	13	Anderson city.....	25 514	26 686	1 172	4.6
16	19	Greer city.....	16 843	25 515	8 672	51.5
17	16	Greenwood city.....	22 071	23 222	1 151	5.2
18	20	Mauldin city.....	15 224	22 889	7 665	50.3
19	18	North Augusta city.....	17 574	21 348	3 774	21.5
20	17	Easley city.....	17 754	19 993	2 239	12.6

¹ Census 2000 counts are as published in Census 2000 reports and thus do not include any changes published subsequently due to boundary changes or to the Count Question Resolution program.

Source: U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Table PL1, and 2010 Census Redistricting Data (Public Law 94-171) Summary File, Table P1.

Table 2. Population by Race and Hispanic or Latino Origin, for All Ages and for 18 Years and Over, for South Carolina: 2000 and 2010

This table provides a state summary of the data included in the 2000 and the 2010 Redistricting Data Summary Files. Data are shown by age for the Hispanic or Latino population, as well as for people who reported one race and for people who reported two or more races. The population of One Race is the total of the population in the 6 categories of one race. The population of Two or More Races is the total of the population in the 57 specific combinations of two or more races. The redistricting files include data for all 63 groups. This table also shows the numeric and percent change in the population by race and Hispanic origin between 2000 and 2010.

(For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/pl94-171.pdf>)

Age, race, and Hispanic or Latino origin	2000		2010		Change, 2000 to 2010	
	Number	Percent of total population	Number	Percent of total population	Number	Percent
ALL AGES						
RACE						
Total population.....	4 012 012	100.0	4 626 364	100.0	613 352	15.3
One Race.....	3 972 062	99.0	4 545 429	98.3	573 367	14.4
White.....	2 695 560	67.2	3 060 000	66.2	364 440	13.5
Black or African American.....	1 185 216	29.5	1 290 684	27.9	105 468	8.9
American Indian and Alaska Native.....	13 718	0.3	19 524	0.4	5 806	42.3
Asian.....	36 014	0.9	59 051	1.3	23 037	64.0
Native Hawaiian and Other Pacific Islander.....	1 628	-	2 706	0.1	1 078	66.2
Some Other Race.....	39 826	1.0	113 484	2.5	73 538	184.2
Two or More Races.....	39 950	1.0	79 935	1.7	39 985	100.1
HISPANIC OR LATINO AND RACE						
Total population.....	4 012 012	100.0	4 626 364	100.0	613 352	15.3
Hispanic or Latino (of any race).....	95 076	2.4	235 682	5.1	140 606	147.9
Not Hispanic or Latino.....	3 916 936	97.6	4 389 682	94.9	472 746	12.1
One Race.....	3 883 646	96.8	4 325 486	93.5	441 840	11.4
White.....	2 652 291	66.1	2 962 740	64.1	310 449	11.7
Black or African American.....	1 178 486	29.4	1 279 998	27.7	101 512	8.6
American Indian and Alaska Native.....	12 765	0.3	16 614	0.4	3 849	30.2
Asian.....	35 568	0.9	58 307	1.3	22 739	63.9
Native Hawaiian and Other Pacific Islander.....	1 270	-	2 113	-	843	66.4
Some Other Race.....	3 266	0.1	5 714	0.1	2 448	75.0
Two or More Races.....	33 290	0.8	64 196	1.4	30 906	92.8
18 YEARS AND OVER						
RACE						
Total population.....	3 002 371	100.0	3 644 890	100.0	642 519	18.1
One Race.....	2 979 745	99.2	3 506 755	98.9	527 010	17.7
White.....	2 097 372	69.9	2 431 038	68.8	333 666	15.9
Black or African American.....	815 702	27.2	939 461	26.5	123 759	15.2
American Indian and Alaska Native.....	9 964	0.3	14 590	0.4	4 626	46.4
Asian.....	27 466	0.9	45 228	1.3	17 762	64.5
Native Hawaiian and Other Pacific Islander.....	1 218	-	1 963	0.1	745	61.2
Some Other Race.....	28 003	0.9	74 475	2.1	46 472	166.0
Two or More Races.....	22 626	0.8	38 135	1.1	15 509	68.5
HISPANIC OR LATINO AND RACE						
Total population.....	3 002 371	100.0	3 644 890	100.0	642 519	18.1
Hispanic or Latino (of any race).....	67 122	2.2	154 178	4.3	87 056	129.7
Not Hispanic or Latino.....	2 935 249	97.8	3 390 714	95.7	455 465	15.5
One Race.....	2 916 603	97.1	3 360 355	94.8	443 752	15.2
White.....	2 066 282	68.8	2 365 787	65.7	299 485	14.5
Black or African American.....	811 439	27.0	932 882	26.3	121 443	15.0
American Indian and Alaska Native.....	9 275	0.3	12 613	0.4	3 338	36.0
Asian.....	27 155	0.9	44 696	1.3	17 541	64.6
Native Hawaiian and Other Pacific Islander.....	955	-	1 562	-	607	63.6
Some Other Race.....	1 497	-	2 825	0.1	1 328	88.7
Two or More Races.....	18 646	0.6	30 359	0.9	11 713	62.8

- Represents zero or rounds to 0.0.

Note: The observed change in Hispanic origin and race counts between Census 2000 and the 2010 Census could be attributed to a number of factors. Demographic change since 2000, which includes births and deaths in a geographic area and migration in and out of a geographic area, will have an impact on the resulting 2010 Census counts. Additionally, some changes in the Hispanic origin and race questions' wording and format since Census 2000 could have influenced reporting patterns in the 2010 Census. Also, in Census 2000 an error in data processing resulted in an overstatement of the Two or More Races population by about 1 million people (about 15 percent) nationally, which almost entirely affected race combinations involving Some Other Race. Therefore, data users should assess observed changes in the Two or More Races population between Census 2000 and the 2010 Census with caution.

Source: U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Tables PL1, PL2, PL3, and PL4, and 2010 Census Redistricting Data (Public Law 94-171) Summary File, Tables P1, P2, P3, and P4.

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RECORD 004355

Table 3. Population by Race Alone or in Combination and Hispanic or Latino Origin, for All Ages and for 18 Years and Over, for South Carolina: 2000 and 2010

This table provides a state summary of the data included in the 2000 and the 2010 Redistricting Data Summary Files. Data are shown by age for the Hispanic or Latino population, as well as for the 6 race alone or in combination categories. The concept "race alone or in combination" includes people who reported a single race alone (e.g., Asian) and people who reported that race in combination with one or more of the other major race groups (i.e., White, Black or African American, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, and Some Other Race). The concept "race alone or in combination," therefore, represents the maximum number of people who reported as that major race group, either alone, or in combination with another race(s). The sum of the 6 individual race "alone or in combination" categories may add to more than the total population because people who reported more than one race were tallied in each race category. This table also shows the numeric and percent change in the population by race and Hispanic origin between 2000 and 2010.

(For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/pl94-171.pdf>)

Age, race alone or in combination, and Hispanic or Latino origin	2000		2010		Change, 2000 to 2010	
	Number	Percent of total population	Number	Percent of total population	Number	Percent
ALL AGES						
RACE ALONE OR IN COMBINATION ¹						
Total population.....	4 012 012	100.0	4 625 364	100.0	613 352	15.3
White.....	2 727 208	68.0	3 127 075	67.6	399 867	14.7
Black or African American.....	1 200 901	29.9	1 332 188	28.8	131 287	10.9
American Indian and Alaska Native.....	27 456	0.7	42 171	0.9	14 715	53.6
Asian.....	44 931	1.1	75 674	1.6	30 743	68.4
Native Hawaiian and Other Pacific Islander.....	3 778	0.1	5 880	0.1	2 102	55.6
Some Other Race.....	51 346	1.3	128 464	2.8	77 118	150.2
HISPANIC OR LATINO AND RACE ALONE OR IN COMBINATION ¹						
Total population.....	4 012 012	100.0	4 625 364	100.0	613 352	15.3
Hispanic or Latino (of any race).....	95 076	2.4	235 682	5.1	140 606	147.9
Not Hispanic or Latino.....	3 916 936	97.6	4 389 682	94.9	472 746	12.1
White.....	2 679 236	66.8	3 017 747	65.2	338 511	12.6
Black or African American.....	1 192 582	29.7	1 316 691	28.5	124 099	10.4
American Indian and Alaska Native.....	25 480	0.6	36 942	0.8	11 462	45.0
Asian.....	43 679	1.1	73 426	1.6	29 747	68.1
Native Hawaiian and Other Pacific Islander.....	3 049	0.1	4 709	0.1	1 660	54.4
Some Other Race.....	9 328	0.2	9 086	0.2	- 242	-2.6
18 YEARS AND OVER						
RACE ALONE OR IN COMBINATION ¹						
Total population.....	3 002 371	100.0	3 544 890	100.0	542 519	18.1
White.....	2 114 633	70.4	2 461 269	69.4	346 636	16.4
Black or African American.....	821 988	27.4	953 961	26.9	131 973	16.1
American Indian and Alaska Native.....	19 776	0.7	30 497	0.9	10 721	54.2
Asian.....	32 558	1.1	53 956	1.5	21 398	65.7
Native Hawaiian and Other Pacific Islander.....	2 632	0.1	3 956	0.1	1 324	50.3
Some Other Race.....	35 497	1.2	82 618	2.3	47 121	132.7
HISPANIC OR LATINO AND RACE ALONE OR IN COMBINATION ¹						
Total population.....	3 002 371	100.0	3 544 890	100.0	542 519	18.1
Hispanic or Latino (of any race).....	67 122	2.2	154 176	4.3	87 054	129.7
Not Hispanic or Latino.....	2 935 249	97.8	3 390 714	95.7	455 465	15.5
White.....	2 080 722	69.3	2 390 080	67.4	309 358	14.9
Black or African American.....	816 958	27.2	945 330	26.7	128 372	15.7
American Indian and Alaska Native.....	18 425	0.6	27 223	0.8	8 798	47.8
Asian.....	31 736	1.1	52 689	1.5	20 953	66.0
Native Hawaiian and Other Pacific Islander.....	2 124	0.1	3 192	0.1	1 068	50.3
Some Other Race.....	5 724	0.2	5 128	0.1	- 596	-10.4

Note: The observed changes in Hispanic origin and race counts between Census 2000 and the 2010 Census could be attributed to a number of factors. Demographic change since 2000, which includes births and deaths in a geographic area and migration in and out of a geographic area, will have an impact on the resulting 2010 Census counts. Additionally, some changes in the Hispanic origin and race questions' wording and format since Census 2000 could have influenced reporting patterns in the 2010 Census. Also, in Census 2000 an error in data processing resulted in an overstatement of the Two or More Races population by about 1 million people (about 15 percent) nationally, which almost entirely affected race combinations involving Some Other Race. Therefore, data users should assess observed changes in the Two or More Races population between Census 2000 and the 2010 Census with caution.

¹ The alone or in combination categories are tallies of responses rather than respondents. That is, the alone or in combination categories are not mutually exclusive. Individuals who reported two races were counted in two separate and distinct alone or in combination race categories, while those who reported three races were counted in three categories, and so on. For example, a respondent who indicated "White and Black or African American" was counted in the White alone or in combination category as well as in the Black or African American alone or in combination category. Consequently, the sum of all alone or in combination categories equals the number of races reported (i.e., responses), which exceeds the total population.

Source: U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Tables PL1, PL2, PL3, and PL4, and 2010 Census Redistricting Data (Public Law 94-171) Summary File, Tables P1, P2, P3, and P4.

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RICHARDSON-Berkeley000286

RECORD 004356

Table 4. Population by Race, Including All Specific Combinations of Two Races, for South Carolina: 2010

This table provides a state summary of the data included in the 2010 Redistricting Data Summary File. Data are shown for people who reported one race and for people who reported two or more races. In addition, the table shows the population in each of the 15 specific combinations of two races. People who reported two races constitute the vast majority of the Two or More Races population.

In addition to the 15 combinations of two races (e.g., White and Asian), there are 20 combinations of three races (e.g., White and Asian and Native Hawaiian and Other Pacific Islander), 15 combinations of four races, 6 combinations of five races, and 1 combination of 6 races. The redistricting file includes data for the population in each of these 57 combinations of two or more races.

(For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/p194-171.pdf>)

Race	Number	Percent of total population
Total population.....	4 825 364	100.0
One Race.....	4 545 429	98.3
Two or More Races.....	79 935	1.7
Two races.....	74 382	1.6
White; Black or African American.....	27 432	0.6
White; American Indian and Alaska Native.....	13 910	0.3
White; Asian.....	10 461	0.2
White; Native Hawaiian and Other Pacific Islander.....	935	-
White; Some Other Race.....	9 236	0.2
Black or African American; American Indian and Alaska Native.....	4 156	0.1
Black or African American; Asian.....	2 227	-
Black or African American; Native Hawaiian and Other Pacific Islander.....	481	-
Black or African American; Some Other Race.....	2 636	0.1
American Indian and Alaska Native; Asian.....	301	-
American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander.....	71	-
American Indian and Alaska Native; Some Other Race.....	473	-
Asian; Native Hawaiian and Other Pacific Islander.....	445	-
Asian; Some Other Race.....	1 137	-
Native Hawaiian and Other Pacific Islander; Some Other Race.....	281	-
Three or more races.....	5 553	0.1

- Represents zero or rounds to 0.0.

Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File, Table P1.

Table 5. The Most Populous Counties and Incorporated Places by Race and Hispanic or Latino Origin in South Carolina: 2010

This table provides, for selected geographic areas, a state summary of data included in the 2010 Redistricting Data Summary File. Data are shown for the most populous counties and incorporated places in 2010 by people who reported one race, two or more races, and Hispanic or Latino origin.

(For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/p194-171.pdf>)

Popu- lation rank	Geographic area	Total population	Race								Two or More Races	Hispanic or Latino (of any race)
			Total	White	Black or African American	One Race			Some Other Race			
						American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander				
	South Carolina.....	4 625 384	4 545 428	3 060 000	1 290 684	19 624	69 061	2 708	113 444	79 935	235 682	
	COUNTY											
1	Greenville County.....	451 225	442 755	333 084	81 497	1 401	8 849	257	17 667	8 470	36 495	
2	Richland County.....	384 504	378 073	181 974	178 538	1 230	8 548	425	7 358	8 431	18 637	
3	Charleston County.....	350 209	344 712	224 910	104 239	1 068	4 719	299	9 477	5 497	18 877	
4	Spartanburg County.....	284 307	279 555	205 680	58 585	764	5 746	86	8 714	4 752	16 658	
5	Horry County.....	269 291	264 039	215 071	38 202	1 279	2 818	305	8 366	6 252	16 683	
6	Lexington County.....	262 391	257 522	208 023	37 522	1 134	3 729	130	6 984	4 869	14 529	
7	York County.....	228 073	221 892	189 158	43 003	1 934	3 413	126	4 258	4 181	10 075	
8	Anderson County.....	187 128	184 264	149 818	30 020	478	1 405	43	2 500	2 882	5 447	
9	Berkeley County.....	177 843	173 033	118 232	44 514	1 067	4 046	184	4 990	4 810	10 755	
10	Beaufort County.....	162 233	158 900	118 606	31 290	481	1 889	119	8 515	3 333	19 587	
11	Alcon County.....	160 099	157 009	111 457	39 354	682	1 328	61	4 128	3 090	7 824	
12	Florence County.....	138 885	135 328	75 118	58 506	484	1 671	23	1 548	1 567	3 030	
13	Dorchester County.....	136 555	132 867	92 621	35 286	904	2 052	146	1 978	3 588	6 075	
14	Pickens County.....	119 224	117 448	105 747	7 854	230	1 913	14	1 890	1 776	3 743	
15	Sumter County.....	107 456	105 426	51 825	50 414	389	1 188	99	1 511	2 030	3 532	
16	Orangeburg County.....	92 501	91 405	31 770	57 535	491	752	14	843	1 096	1 787	
17	Lancaster County.....	76 652	75 683	54 844	18 278	235	494	17	1 815	969	3 384	
18	Oconee County.....	74 273	73 098	65 177	8 513	176	438	10	1 586	1 175	3 349	
19	Greenwood County.....	69 681	68 842	43 783	21 848	188	572	25	2 420	819	3 789	
20	Darlington County.....	68 681	67 947	38 368	28 573	194	203	8	603	734	1 140	
	INCORPORATED PLACE											
1	Columbia city.....	129 272	128 713	66 777	54 537	434	2 879	184	1 922	2 559	5 622	
2	Charleston city.....	120 083	118 318	84 258	30 491	271	1 971	122	1 205	1 785	3 451	
3	North Charleston city.....	97 471	95 052	40 514	45 964	453	1 897	157	6 087	2 419	10 817	
4	Mount Pleasant town.....	67 843	67 079	61 938	3 439	188	1 115	25	396	784	1 850	
5	Rock Hill city.....	66 154	64 788	38 147	25 348	322	1 118	69	1 782	1 368	3 781	
6	Greenville city.....	58 409	57 358	37 358	17 519	148	793	54	1 486	1 053	3 443	
7	Summerville town.....	43 392	42 128	31 271	9 304	173	557	40	591	1 266	2 165	
8	Sumter city.....	40 524	39 691	18 359	19 889	133	554	50	606	833	1 467	
9	Hilton Head Island town.....	37 099	36 648	30 751	2 788	57	339	22	2 713	451	5 861	
10	Florence city.....	37 056	36 586	18 635	17 038	106	680	11	216	470	553	
11	Spartanburg city.....	37 013	36 359	18 877	18 255	80	667	14	466	654	1 264	
12	Goose Creek city.....	35 938	34 681	25 605	6 580	184	1 340	47	925	1 277	2 203	
13	Alcan city.....	29 524	29 084	19 729	8 401	107	567	21	259	440	768	
14	Myrtle Beach city.....	27 109	26 378	19 588	3 784	199	389	81	2 347	731	3 708	
15	Anderson city.....	26 686	26 134	18 382	8 959	72	260	5	456	552	1 089	
16	Greer city.....	25 515	24 674	18 071	4 405	67	570	14	1 847	541	3 687	
17	Greenwood city.....	23 222	22 897	10 387	10 369	89	235	15	1 802	325	2 550	
18	Mauldin city.....	22 889	22 390	15 731	5 152	62	808	18	619	499	1 756	
19	North Augusta city.....	21 348	20 927	15 837	4 382	54	238	8	428	421	890	
20	Easley city.....	19 993	19 638	16 621	2 277	32	154	4	550	355	1 115	

Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File, Table P1.

RESPONDENT'S
EXHIBIT
70

I. TRI-COUNTY POPULATION TRENDS

County Population Data

	<u>1970</u>	<u>1980</u>	<u>1990</u>	<u>2000</u>	<u>2010</u>
Berkeley County	56,199	94,727	128,776	142,651	177,843
Dorchester County	32,276	58,761	83,060	96,413	136,555
Charleston County	247,650	276,974	295,039	309,969	350,209

Town Population Data

	<u>1980</u>	<u>1990</u>	<u>2000</u>	<u>2010</u>
Goose Creek (city)	17,811	24,692	29,208	35,936
Moncks Corner (town)	4,179	5,599	5,952	7,885
North Charleston (city)	62,479	70,304	79,641	97,471
Summerville (town)	6,492	22,519	27,752	43,392

Source: U.S. Census Data and DHEC

II. BED NEED ESTIMATES**Berkeley County****2010**

Total Discharges	15,517
Estimated Patient Days	65,171
Bed need @ 65% occ.	275

Non-Tertiary Discharges	13,568
Estimated Patient Days	55,629
Bed need @ 65% occ.	234

RSF Non-Tertiary Discharges	3,239
Estimated Patient Days	13,280
Bed need @ 65% occ.	56

Trident Health System Non-Tertiary Discharges	7,291
Estimated Patient Days	29,741
Bed need @ 65% occ.	125

2017

Total Discharges	18,470
Estimated Patient Days	77,574
Bed need @ 65% occ.	327

Non-Tertiary Discharges	16,150
Estimated Patient Days	67,830
Bed need @ 65% occ.	286

RSF Non-Tertiary Discharges	3,860
Estimated Patient Days	16,212
Bed need @ 65% occ.	68

Trident Health System Non-Tertiary Discharges	8,736
Estimated Patient Days	36,833
Bed need @ 65% occ.	155

III. VOLUME FORECASTS -- FROM RSF BERKELEY CON

1. 2006 Berkeley County Non-Tertiary Resident Discharges -- data from ORS

Non-Tertiary Total	13,732	discharges
RSF Non-Tertiary	3,152	(23.0% market share)
Other Non-Tertiary	10,580	discharges

2. 2010 - 2015 Berkeley County Resident Volume Growth Rate

Total population growth	12.4%

3. Forecast 2015 Berkeley County Non-Tertiary Resident Discharges

Non-Tertiary Total	15,435	discharges
RSF Non-Tertiary	3,550	(23.0% market share)
Other Non-Tertiary	11,885	discharges

4. Forecast 2015 RSF Berkeley Volume

50% redirection of RSF non-tertiary volume	1,775 discharges
10% capture of non-RSF non-tertiary volume	1,188 discharges
10% in-migration from beyond Berkeley County	329 discharges
Total forecast of RSF Berkeley non-tertiary volume	3,292 discharges
Total forecast of RSF Berkeley non-tertiary patient days	13,991 (patient days @ 4.25 ALOS)
Facility patient days capped @ 70%	12,775 patient days (9% reduction from forecasted patient days)
	3,006 discharges

IV. BERKELEY COUNTY VOLUME FORECASTS (2010 - 2017)

1. 2010 Berkeley County Resident Discharges -- data from ORS

Total	15,517 discharges
RSF Total	3,632 (23.4% market share)
Non-Tertiary	13,568 discharges
RSF Non-Tertiary	3,239 (23.9% market share)

2. 2010 - 2017 Berkeley County Resident Volume Growth Rate

Berkeley Medical Center 2010-2017 Discharge Volume CAGR of 2.52%

3. Forecast 2017 Berkeley County Resident Discharges

Total	18,470 discharges
Non-Tertiary	16,150 discharges

4. Comparison of Forecasted New Hospital Volume to Berkeley County Volume

RSF Berkeley and Berkeley Medical Center combined forecast of 2017 Berkeley County Volume	5,258 discharges

Combined forecast from both CON applications is 28.5% of the total volume in Berkeley County and 32.6% of the total non-tertiary volume in Berkeley County in 2017

V. VOLUME FORECASTS -- UPDATED TO REFLECT 2010 DISCHARGE DATA

1. 2010 Berkeley County Non-Tertiary Resident Discharges -- data from ORS

Non-Tertiary Total	13,568	discharges
RSF Non-Tertiary	3,239	(23.9% market share)
Other Non-Tertiary	10,329	discharges

2. 2010 - 2017 Berkeley County Resident Volume Growth Rate

Berkeley Medical Center 2010-2017 Berkeley County Discharge Volume CAGR of 2.52%

3. Forecast 2017 Berkeley County Non-Tertiary Resident Discharges

Non-Tertiary Total	16,150	discharges
RSF Non-Tertiary	3,860	(23.9% market share)
Other Non-Tertiary	12,290	discharges

4. Forecast 2017 RSF Berkeley Volume

50% redirection of RSF non-tertiary volume	1,930	discharges
10% capture of non-RSF non-tertiary volume	1,229	discharges
10% of total volume from non-Berkeley County residents	351	discharges
Total forecast of RSF Berkeley non-tertiary volume	3,510	discharges
Total forecast of RSF Berkeley non-tertiary patient days	14,742	(patient days @ 4.2 ALOS)
Facility patient days capped @ 70%	12,775	patient days (13% reduction from market forecast)
	3,042	discharges

VI. BERKELEY COUNTY VOLUME COMPARISONS

1. 2017 New Hospital Volume Forecasts -- non-tertiary only

RSF Berkeley	3,042	total discharges	
	2,738	Berkeley County discharges (90% of total)	
Trident Monck's Corner	2,998	total discharges	
	2,520	Berkeley County discharges (90% of total)	

2. Forecast 2017 Berkeley County Volumes

Roper / St. Francis	4,323	total discharges	
	3,860	non-tertiary discharges	(versus 2,738 needed for RSF new hospital)
Trident Health System	9,772	total discharges	
	8,736	non-tertiary discharges	(versus 2,520 needed for Trident new hospital)
Total all providers	18,470	total discharges	
	16,150	non-tertiary discharges	(versus 5,258 needed for both new hospitals)
			<i>28.5% of total market</i>
			<i>32.6% of total non-tertiary market</i>

VII. RSF and TRIDENT NET HOSPITAL VOLUME FORECAST SCENARIOS

1. 2017 Trident Berkeley Medical Center Volume Forecast

2,998 Total discharges
2,998 Discharges redirected from Trident

2. Forecast 2010 - 2017 Trident Health System Non-Tertiary Volume Growth

17,560 2010 THS Tri-County discharges
21,330 2017 THS Tri-County discharges (apply 2.25 CARG)

3,770 2010-2017 THS Tri-County discharge growth
4,143 2010-2017 THS total discharge growth (with 9% of patients from beyond the Tri-County per ORS)
Complete offset of patients shifted to Berkeley Regional Medical Center

3. Likely Scenario --73% of RSF Market Capture as Lost Discharges from Trident

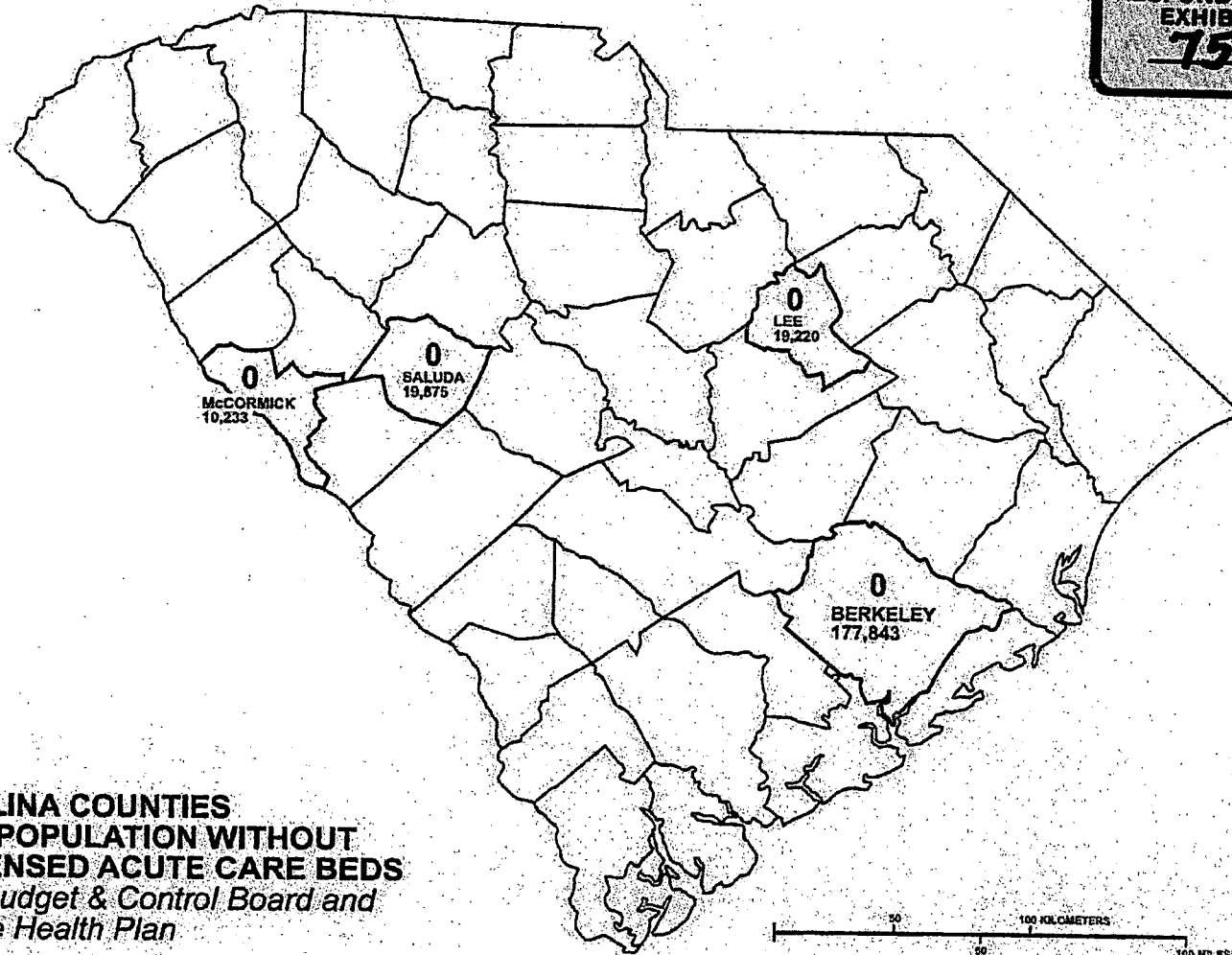
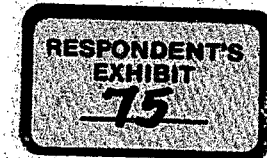
1,229 RSF Berkeley discharges redirected from all non-RSF providers
897 RSF Berkeley discharges redirected from Trident (73% of non-RSF market share)
2,998 BRMC discharges redirected from Trident
3,895 Total Trident lost cases
0 Lost Trident cases after offsetting for Trident +4,143 discharge growth

4. Worst Case Scenario --100% of RSF Market Capture as Lost Discharges from Trident

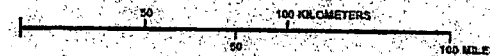
1,229 RSF Berkeley discharges redirected from Trident (100% of market re-direction)
2,998 BRMC discharges redirected from Trident
4,227 Total Trident lost cases
84 Lost Trident cases after offsetting for Trident +4,143 discharge growth

(All analysis excludes growth in Trident Health System tertiary / specialty case volume)

SOUTH CAROLINA



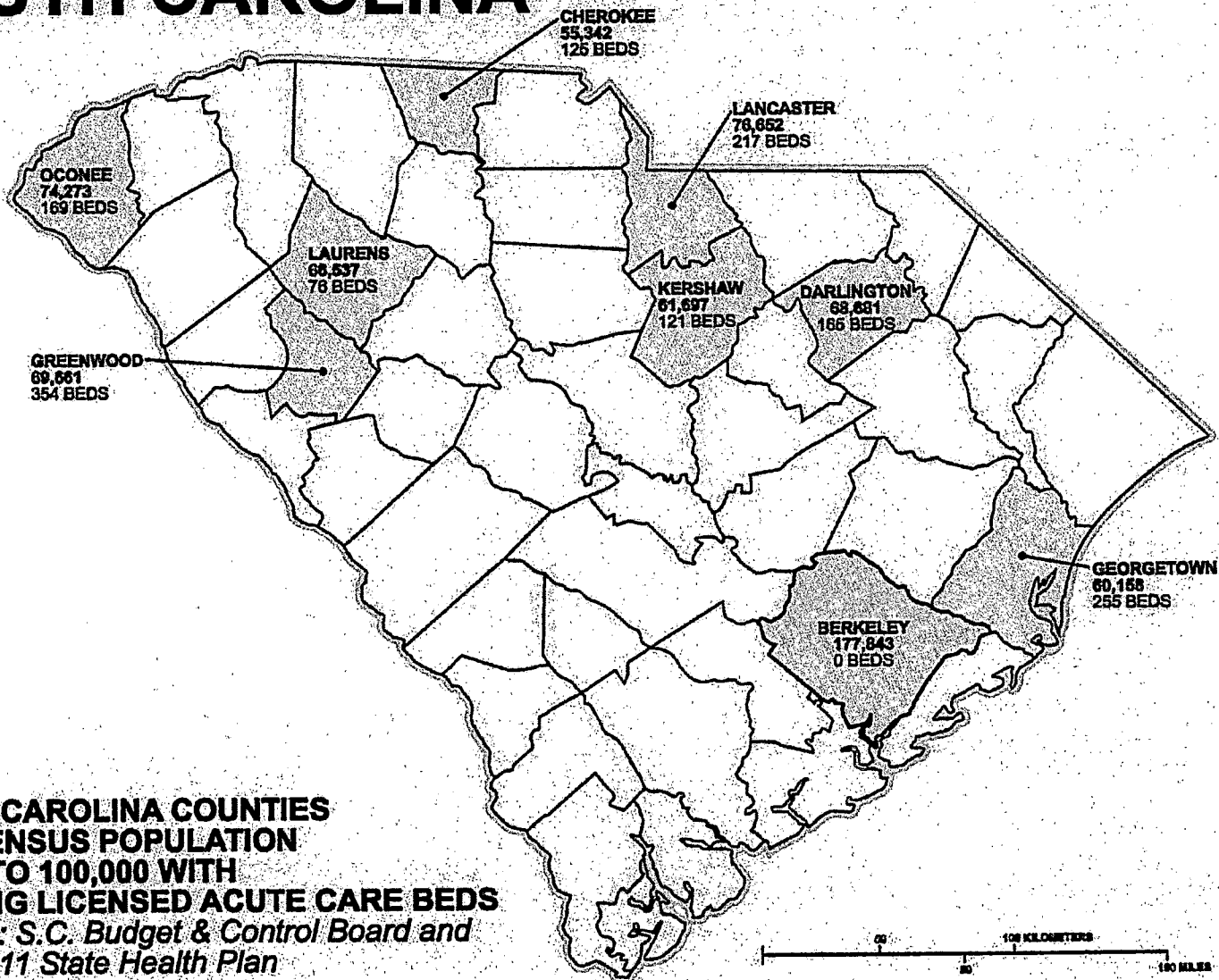
**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION WITHOUT
EXISTING LICENSED ACUTE CARE BEDS**
*Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan*



ROPER-BERKELEY004701

RECORD 004366

SOUTH CAROLINA

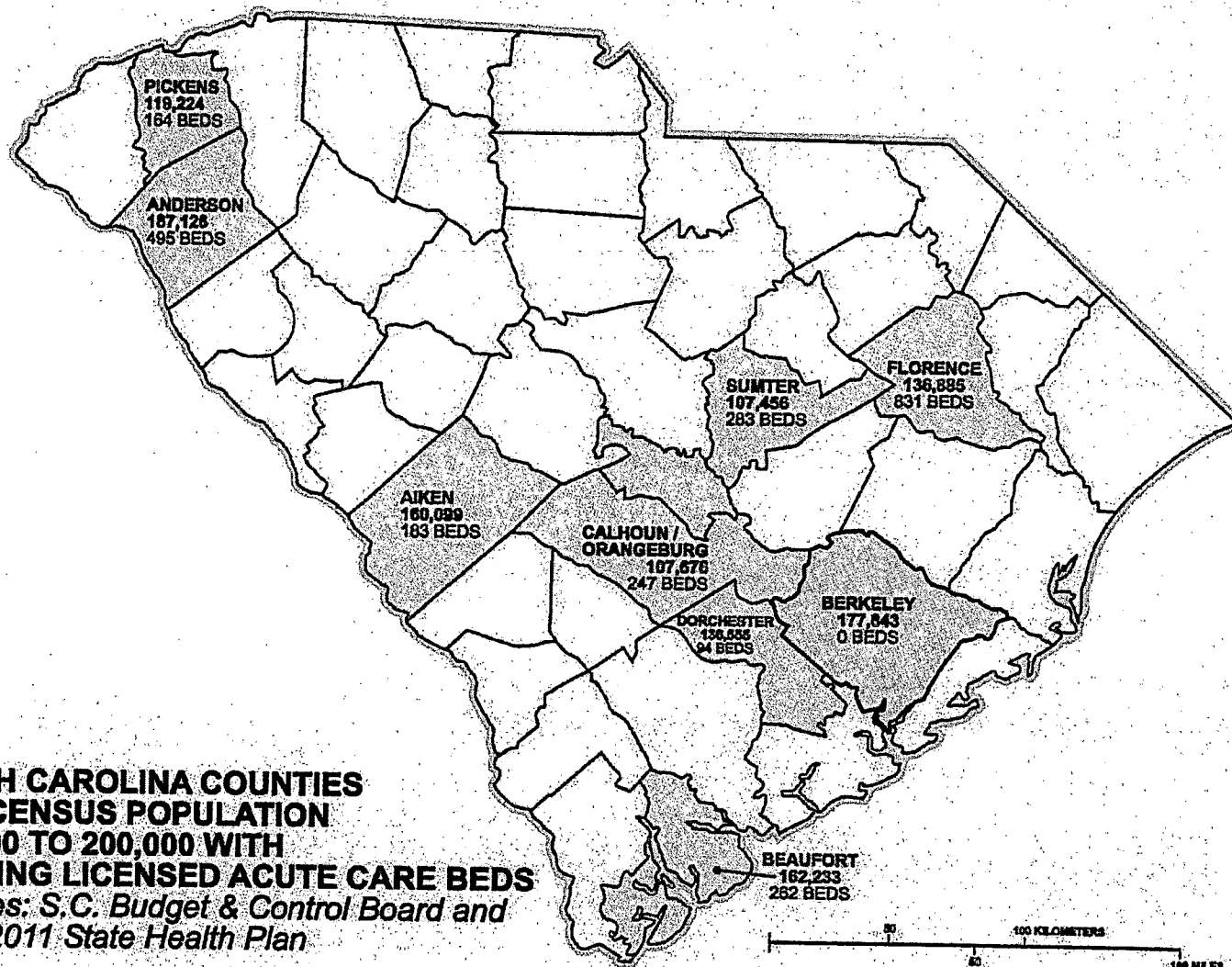


**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
50,000 TO 100,000 WITH
EXISTING LICENSED ACUTE CARE BEDS**
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

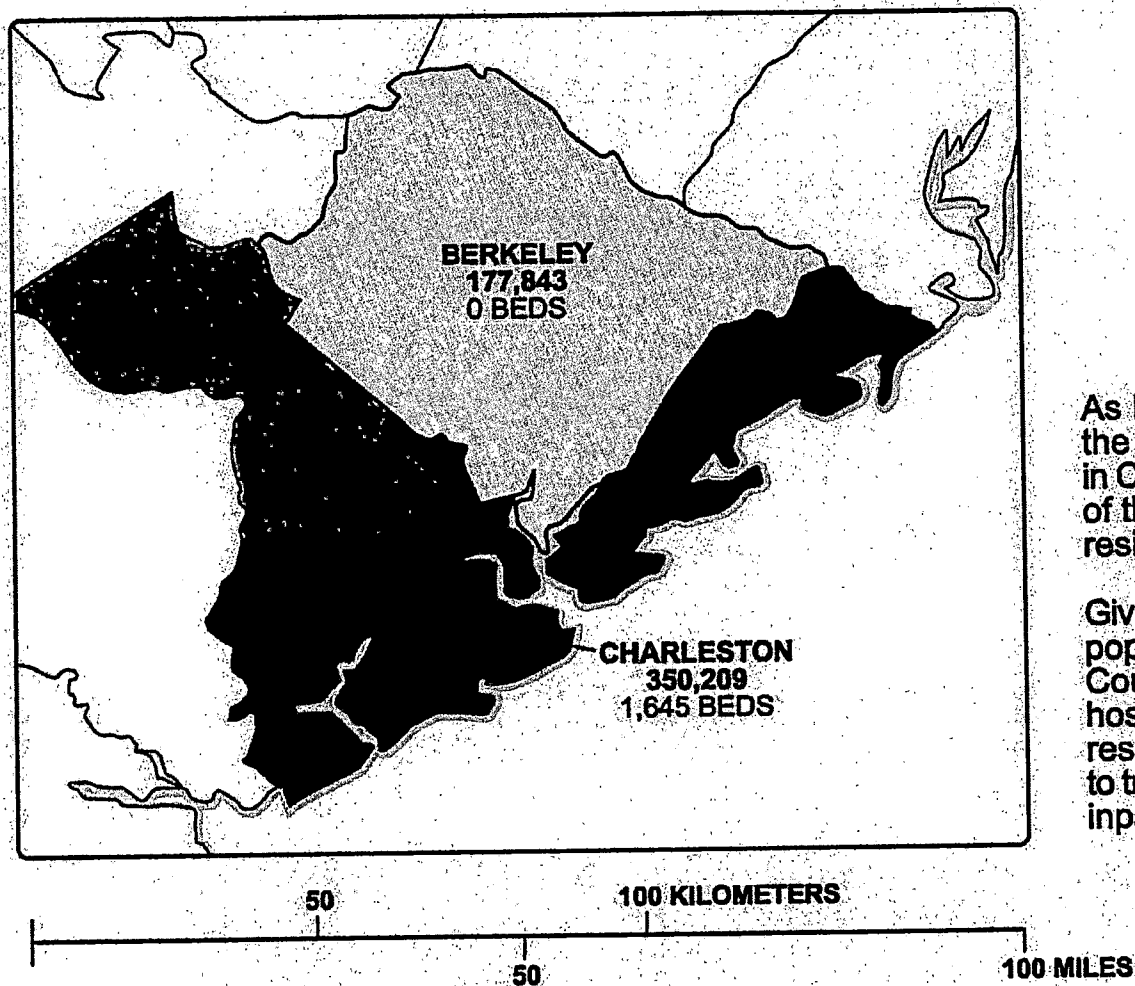
RECORD 004367

SOUTH CAROLINA

RECORD 004368



**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
100,000 TO 200,000 WITH
EXISTING LICENSED ACUTE CARE BEDS**
*Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan*



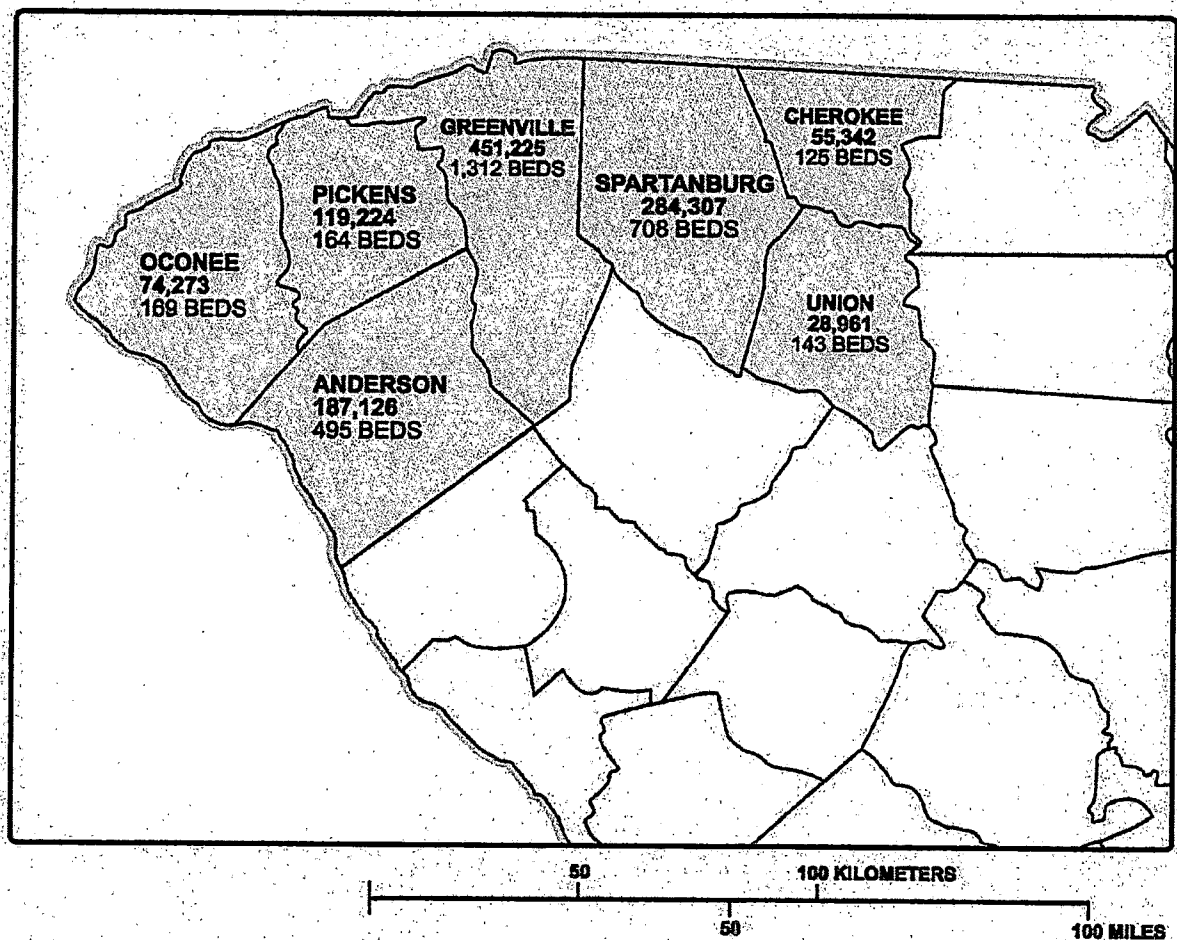
As Illustrated to the left, 95% of the Tri-County Beds are Located in Charleston County, yet only 53% of the Service Area population resides in Charleston County.

Given that 27% of the Service Area population resides in Berkeley County, where there are no hospital beds, one in every four residents of the Service Area has to travel out of their county to obtain inpatient hospital care.

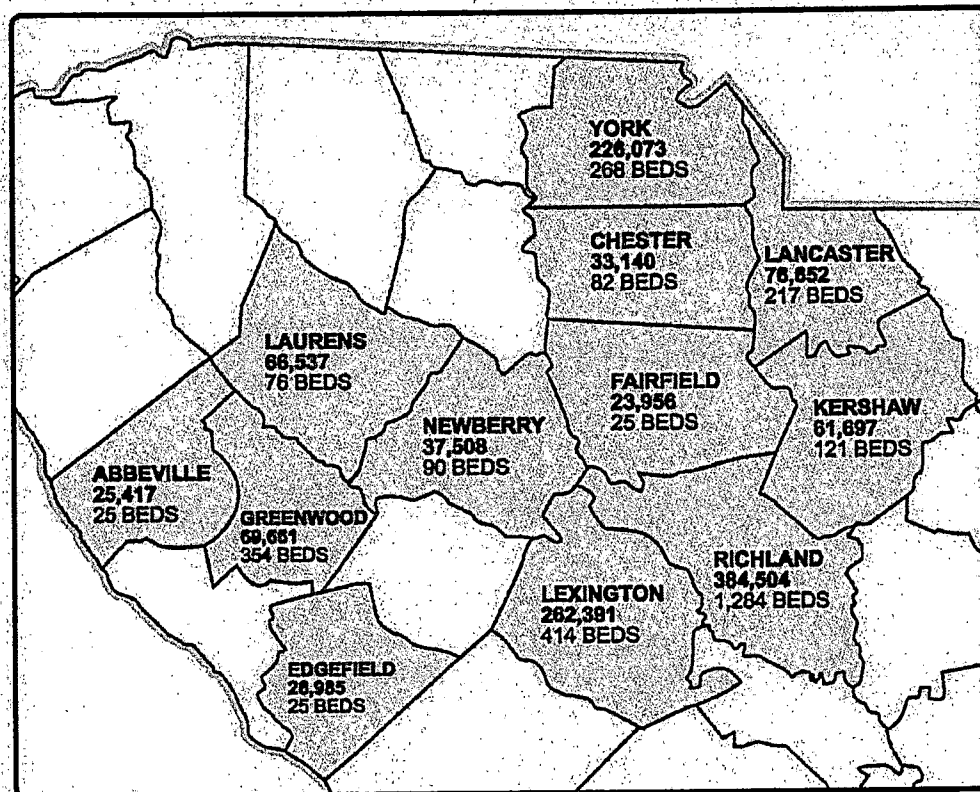
**SOUTH CAROLINA COUNTIES
TRI-COUNTY SERVICE AREA
EXISTING LICENSED ACUTE CARE BEDS**

Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

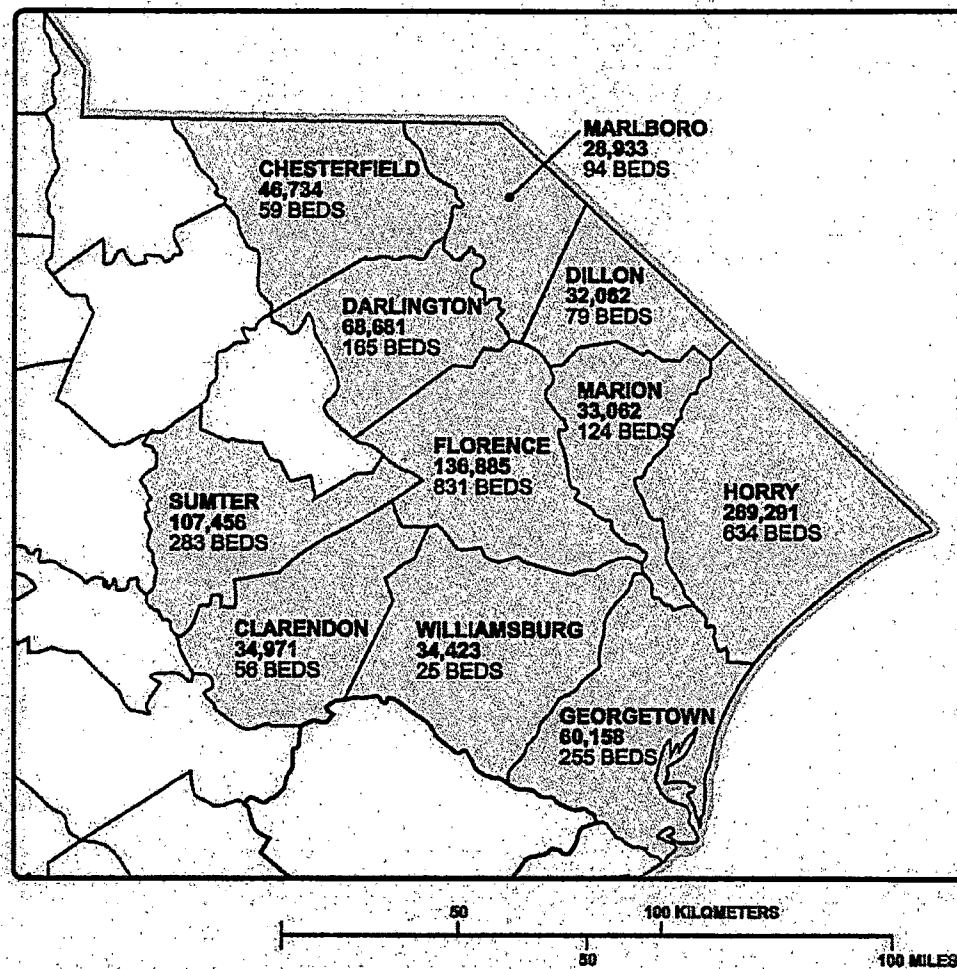
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**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATIONS
DHEC REGION I
EXISTING LICENSED ACUTE CARE BEDS**
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

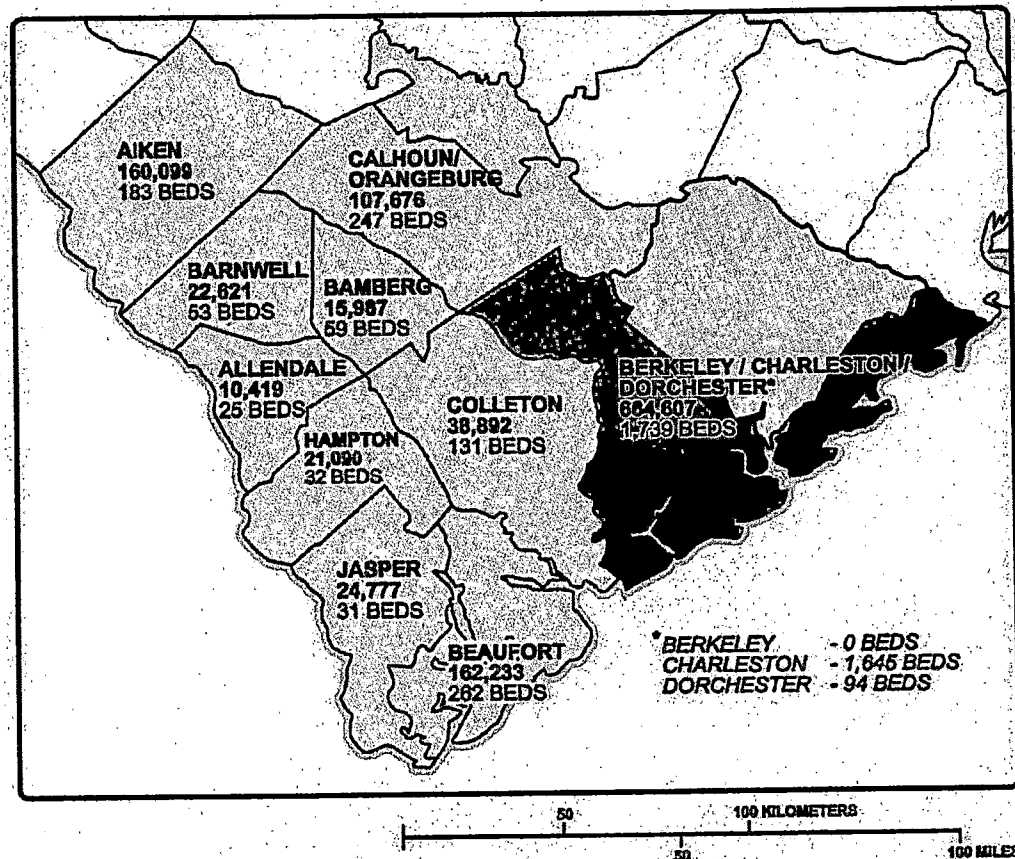


SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
DHEC REGION II
EXISTING LICENSED ACUTE CARE BEDS
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan



**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
DHEC REGION III
EXISTING LICENSED ACUTE CARE BEDS**
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

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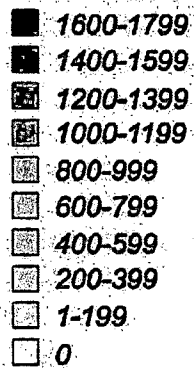


**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
DHEC REGION IV
EXISTING LICENSED ACUTE CARE BEDS**
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

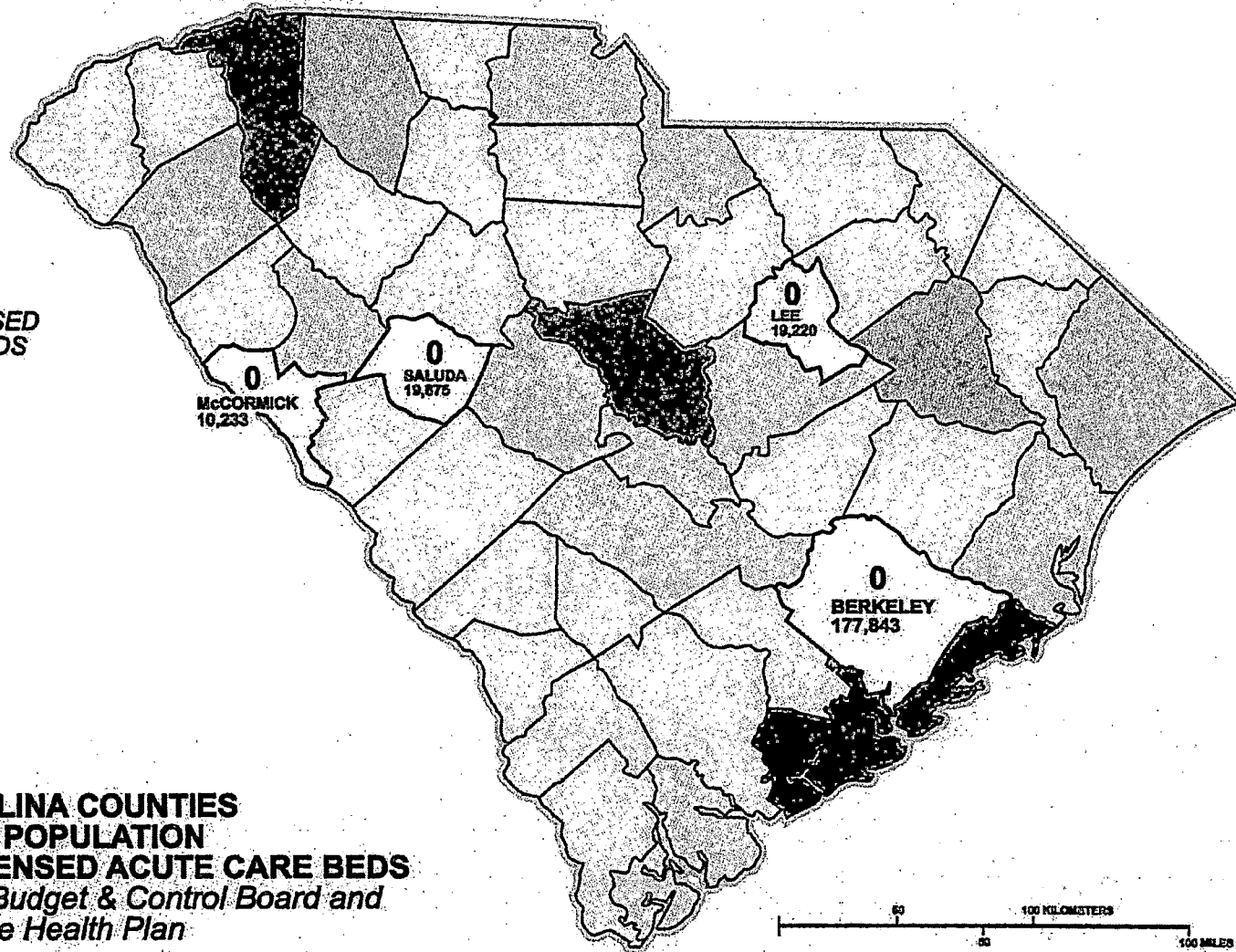
SOUTH CAROLINA

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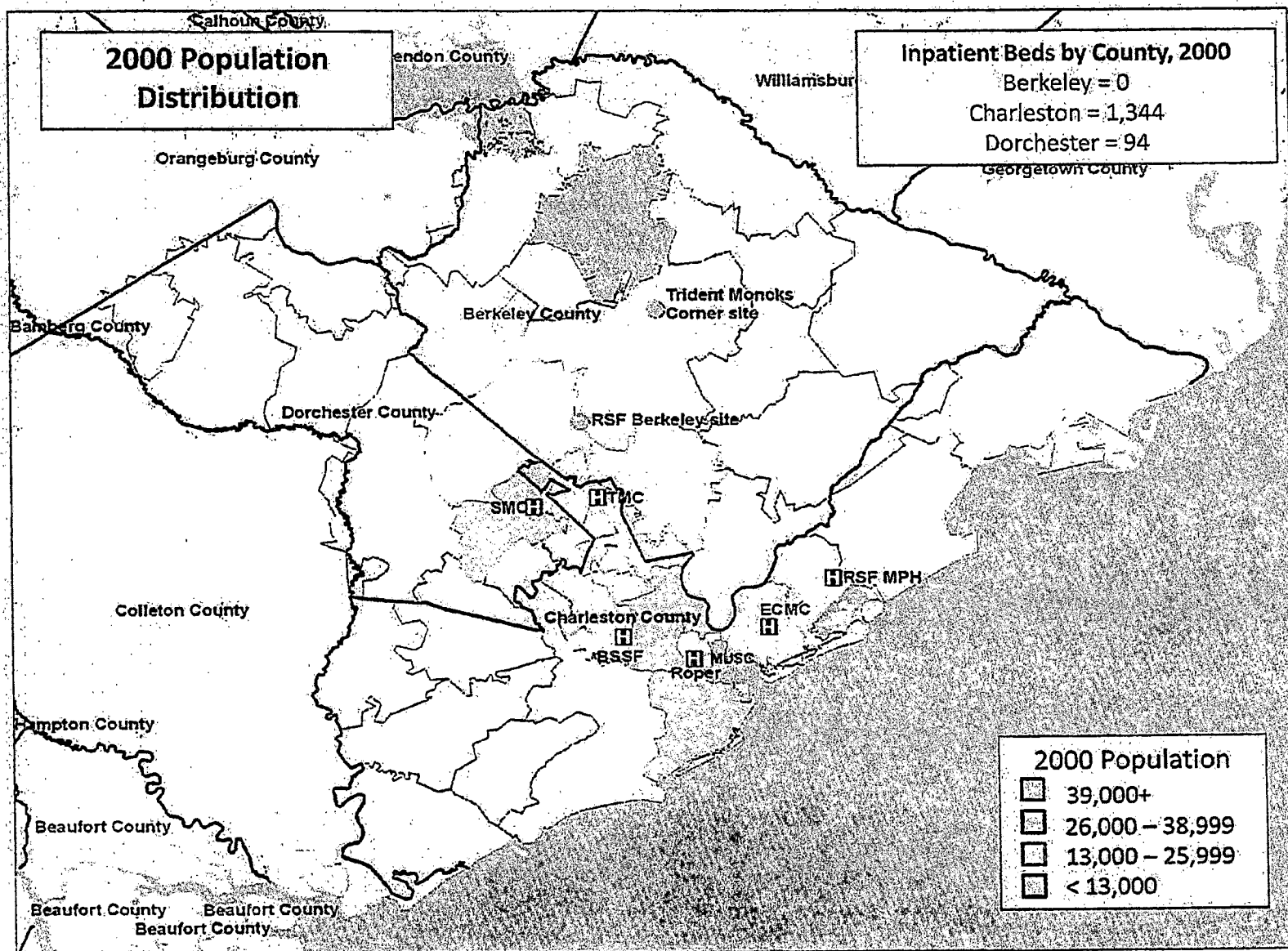
EXISTING LICENSED ACUTE CARE BEDS



**SOUTH CAROLINA COUNTIES
2010 CENSUS POPULATION
EXISTING LICENSED ACUTE CARE BEDS**
Sources: S.C. Budget & Control Board and
2010-2011 State Health Plan

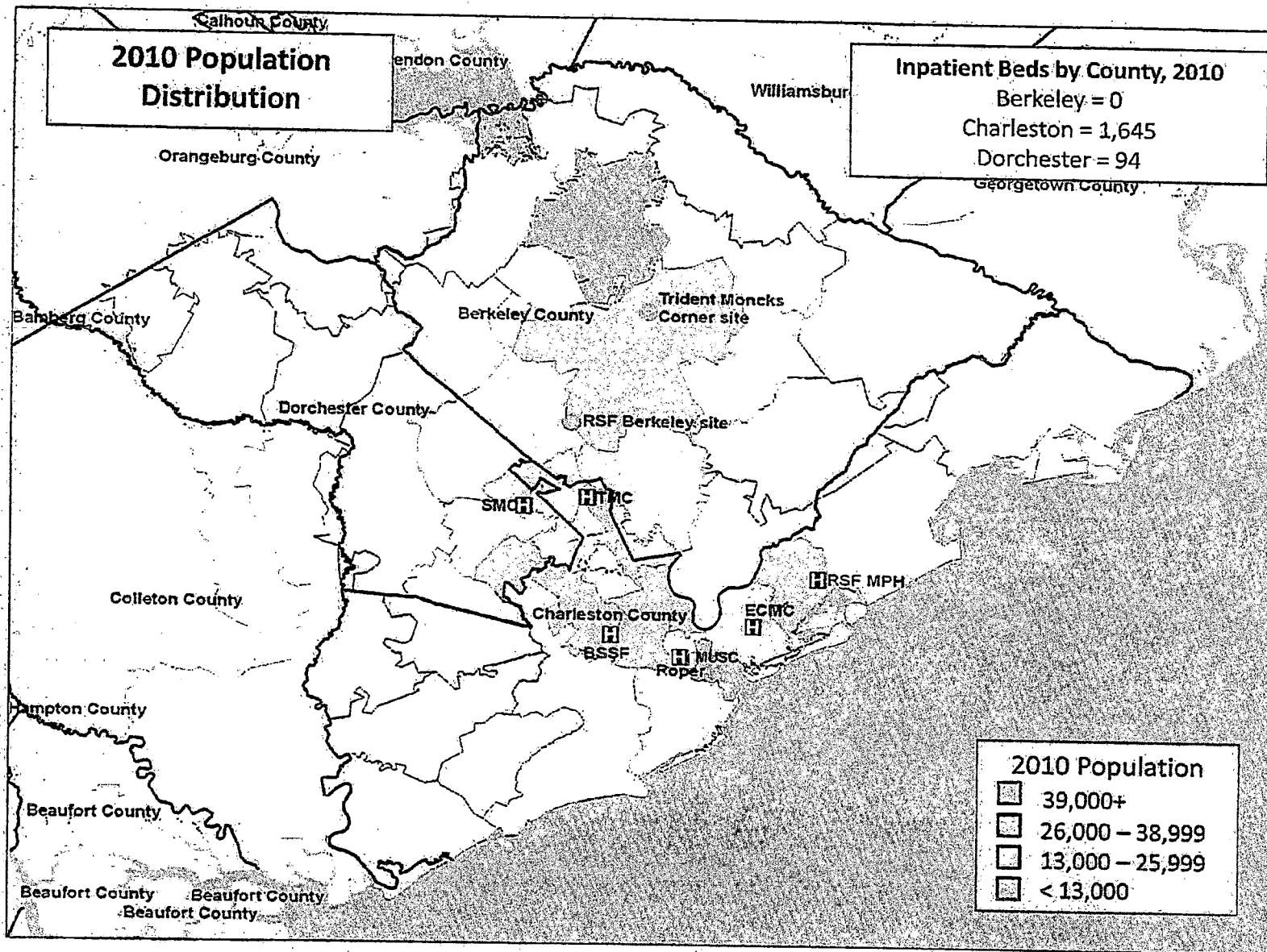


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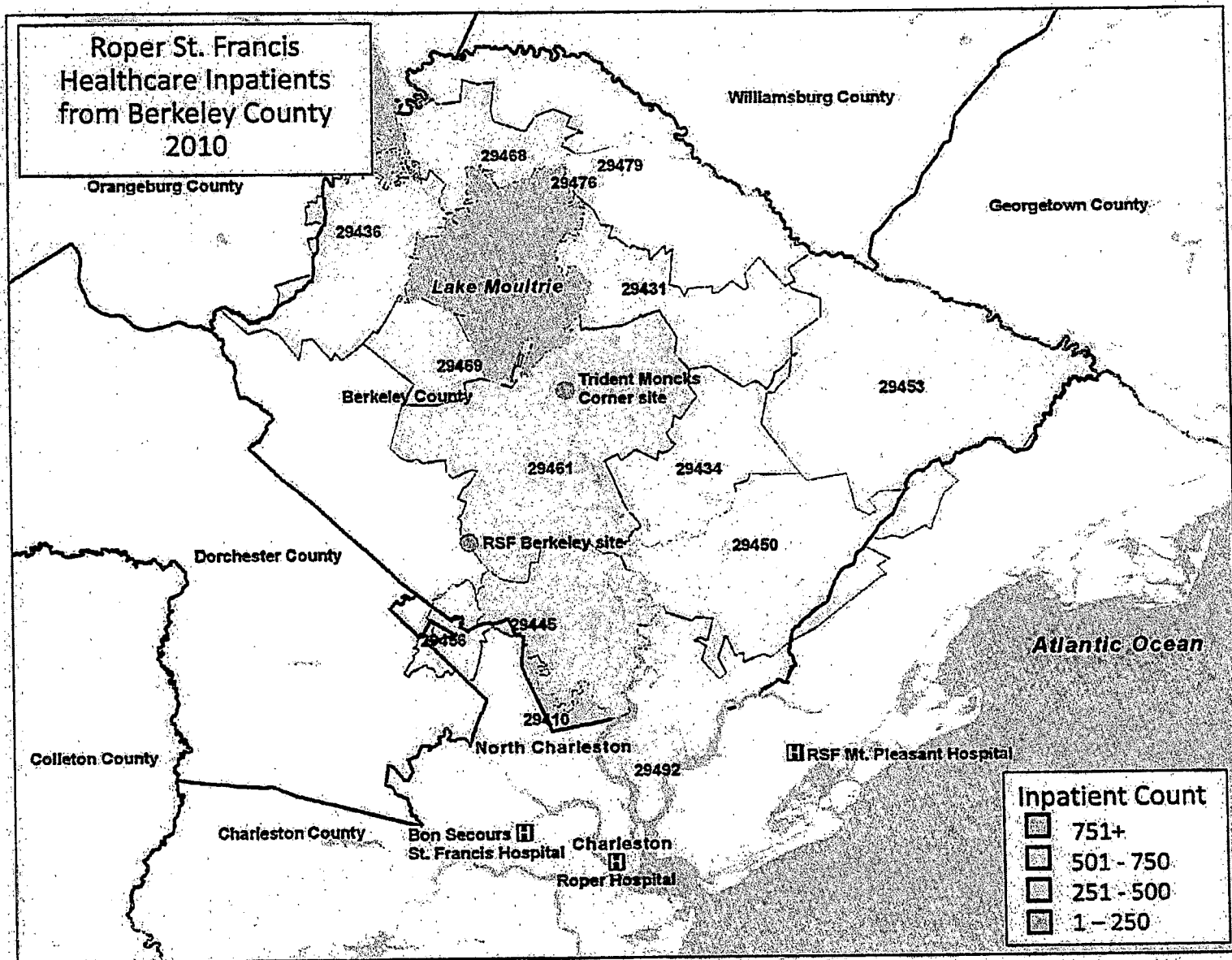


ROPER-BERKELEY004710

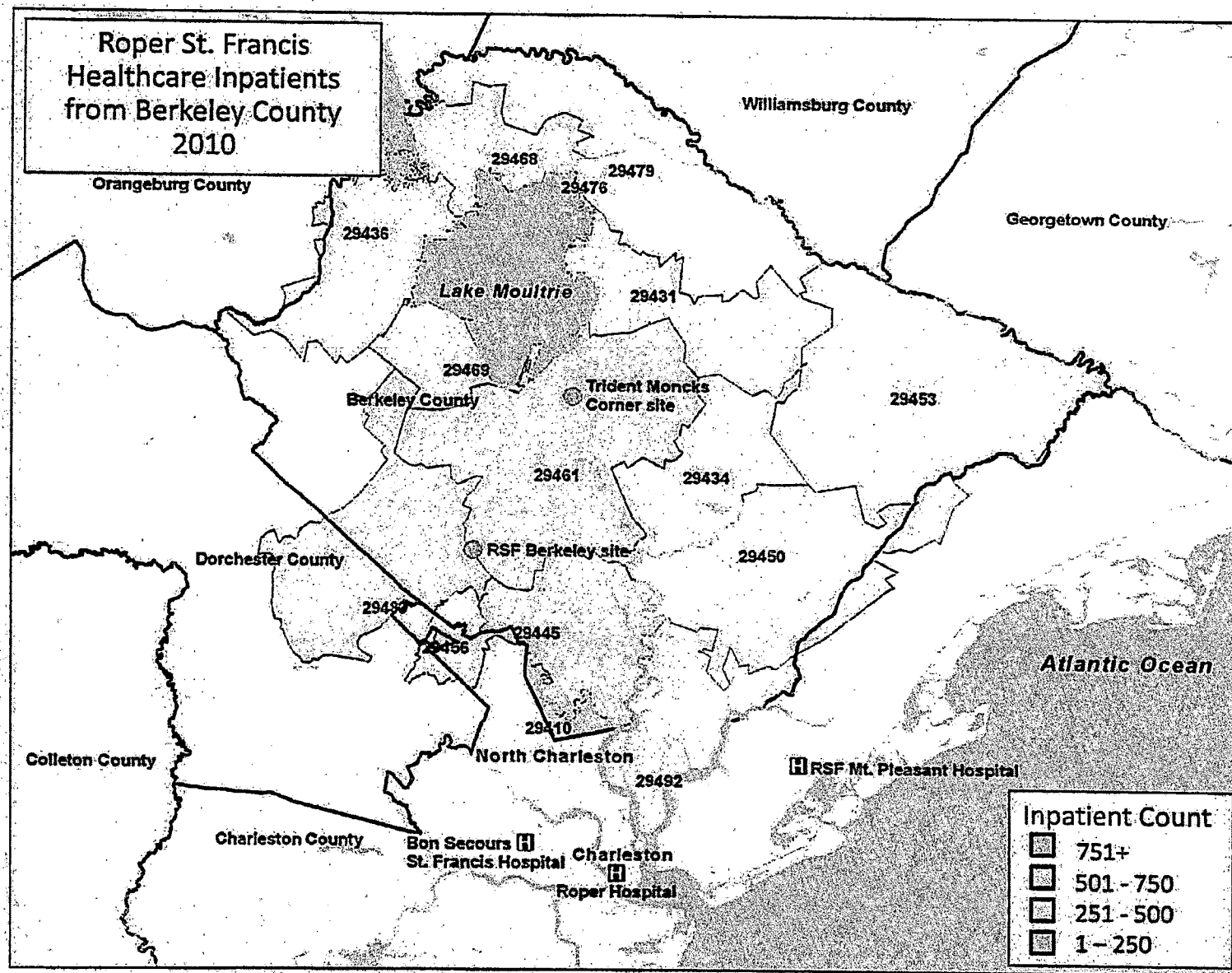
Roper Exhibit 076-001



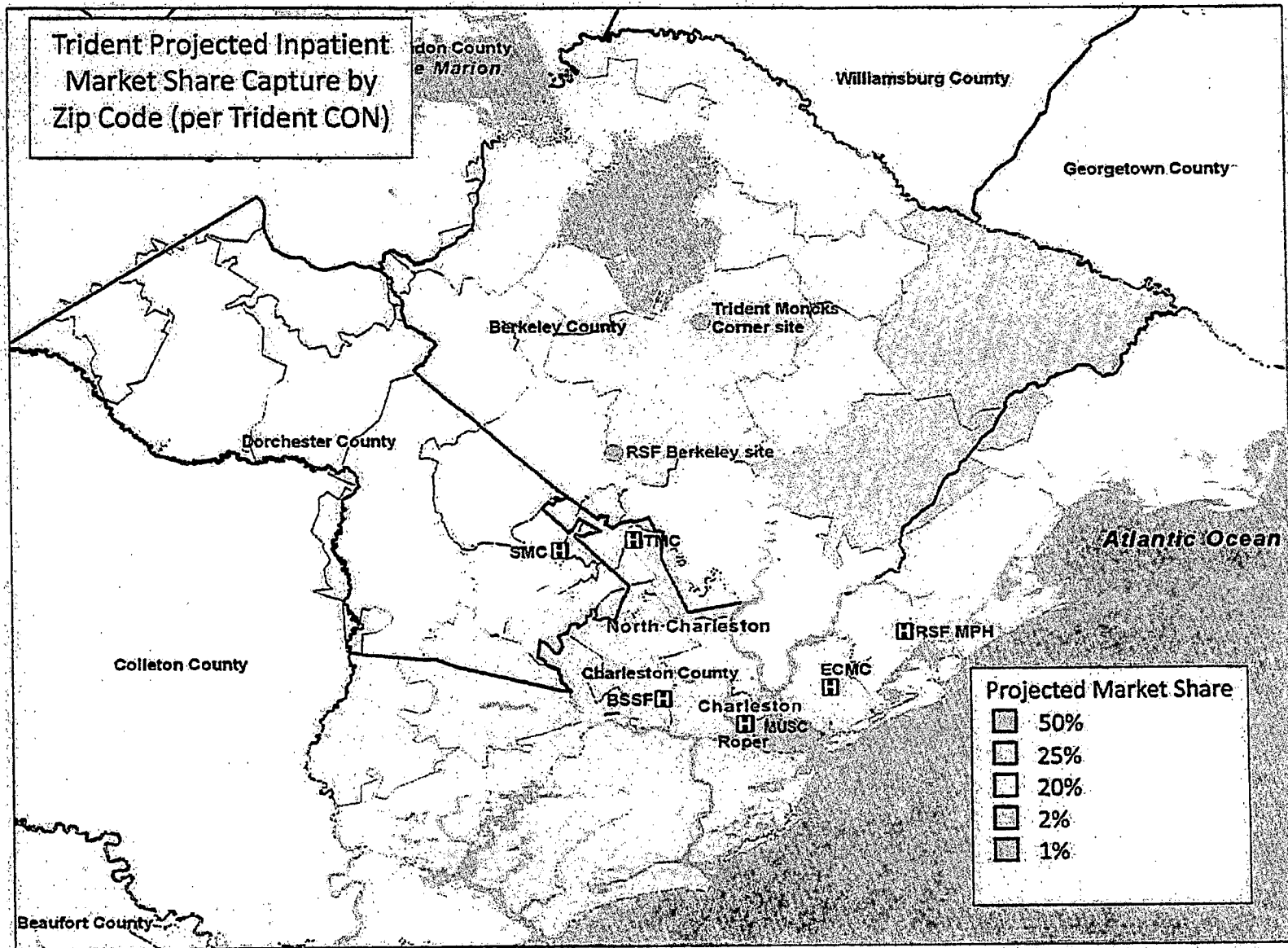
ROPER-BERKELEY004711



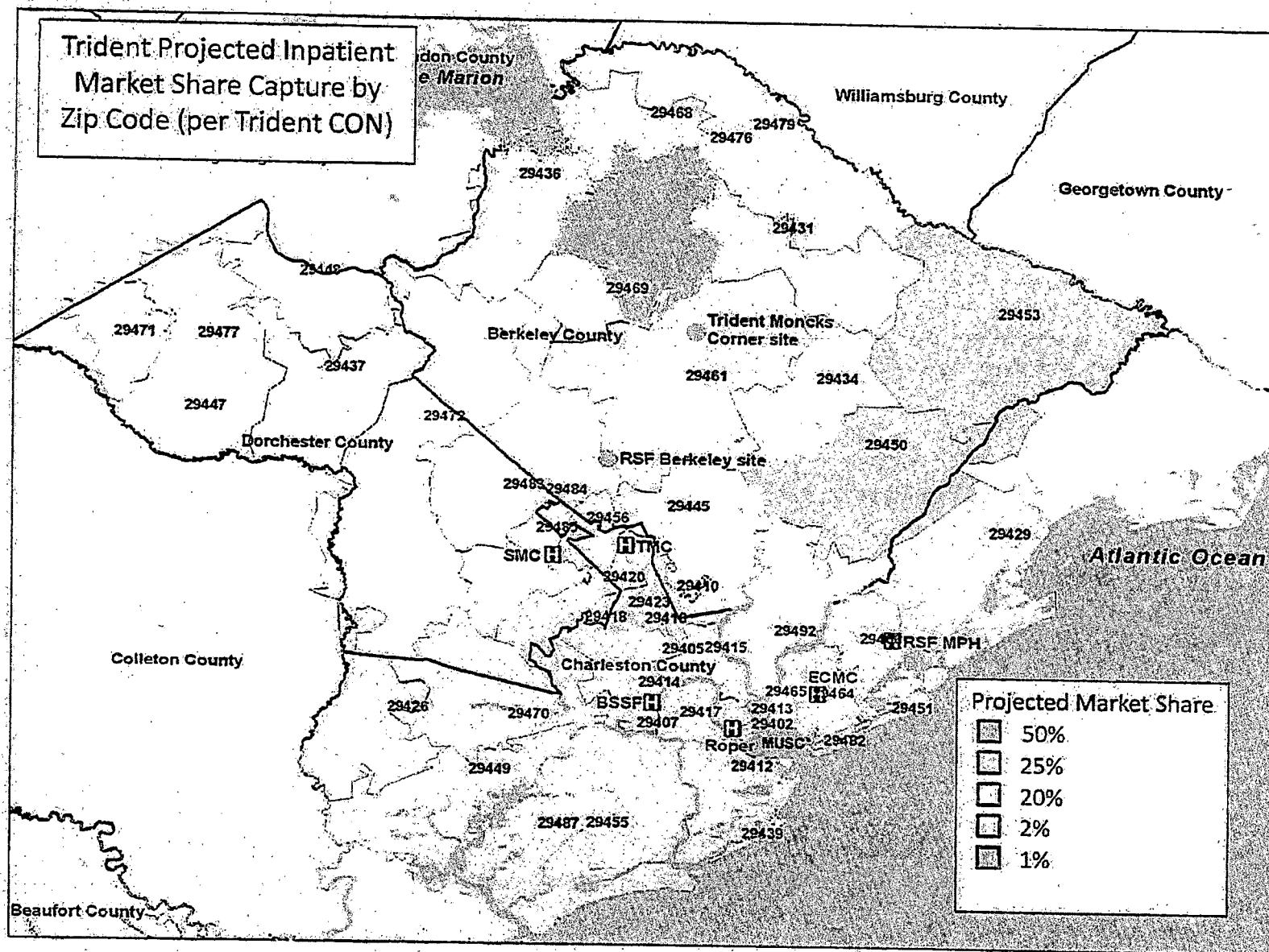
ROPER-BERKELEY004712



ROPER-BERKELEY004713

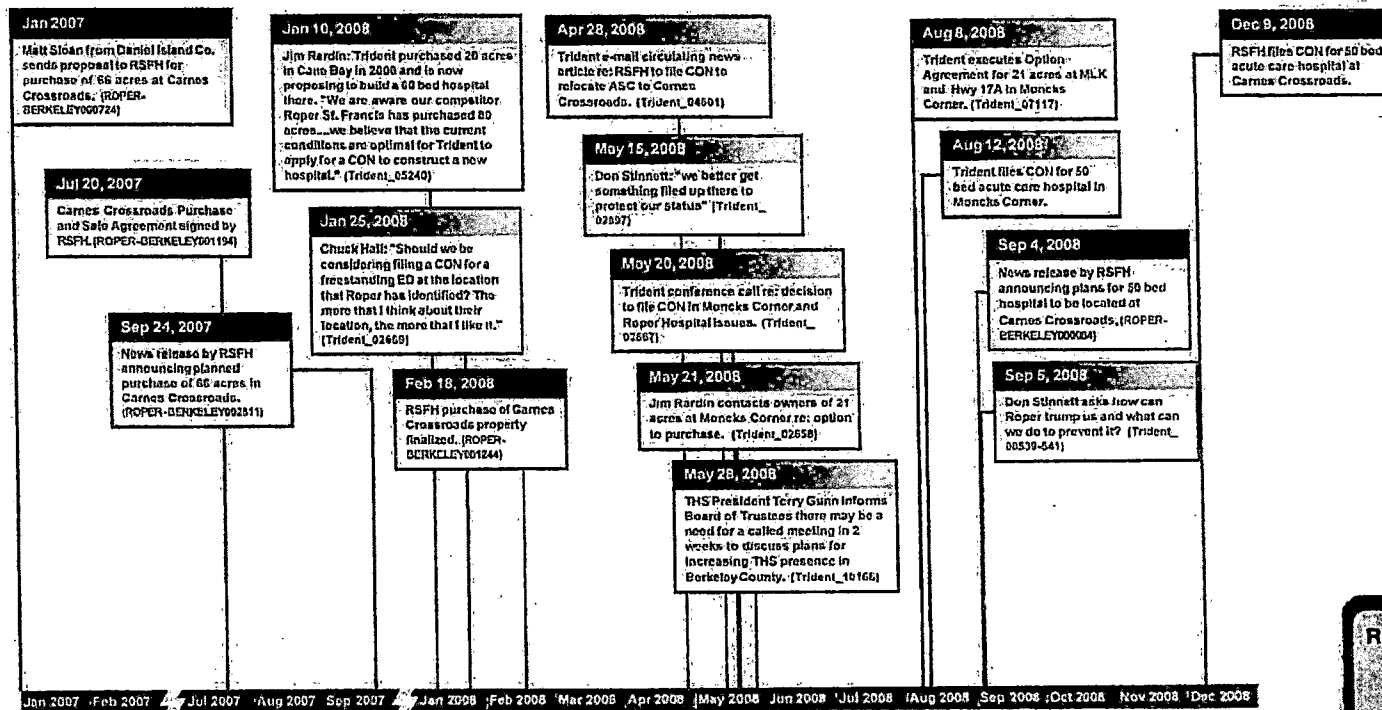


ROPER-BERKELEY004714



ROPER-BERKELEY004715

Roper St. Francis Hospital-Berkeley Timeline



ROPER-BERKELEY004716

Roper Exhibit 077-001

RECORD 004381

RESPONDENT'S
EXHIBIT

82

Trident Health System

Moncks Corner by ZIP Code

Inpatient Discharges

January 2007 - April 2010

**Includes Normal Newborns: Classic DRGs 390 & 391

ZIP Code	City	2007	2008	2009	April 2010	Grand Total
29461	MONCKS CORNER	33	69	154	48	304
29479	SAINT STEPHEN	17	36	54	16	123
29431	BONNEAU	14	29	27	18	88
29436	CROSS	12	14	27	13	66
29468	PINEVILLE	2	8	13	6	29
29483	SUMMERVILLE	5	7	11	2	25
29453	JAMESTOWN	1	9	7	2	19
29469	PINOPOLIS	1	2	3	5	11
29434	CORDESVILLE		3	4	2	9
29445	GOOSE CREEK	1	1	5		7
29048	EUTAWVILLE		2	2	2	6
29059	HOLLY HILL	1	2	2		5
29472	RIDGEVILLE	1		3		4
29456	LADSON	2	1		1	4
29485	SUMMERVILLE		1		2	3
29510	ANDREWS				2	2
29451	ISLE OF PALMS			1	1	2
29476	RUSSELLVILLE		2			2
30467	SYLVANIA			1		1
29681	SIMPSONVILLE		1			1
29148	SUMMERTON		1			1
29150	SUMTER			1		1
29853	WILLISTON			1		1
29172	WEST COLUMBIA	1				1
29142	SANTEE			1		1
29406	CHARLESTON				1	1
29621	ANDERSON			1		1
29420	N CHARLESTON			1		1
29803	AIKEN	1				1
31410	SAVANNAH			1		1
29906	BEAUFORT				1	1
33880	WINTER HAVEN			1		1
16052	PROSPECT			1		1
60473	SOUTH HOLLAND			1		1
43209	COLUMBUS		1			1
28371	PARKTON		1			1
28214	CHARLOTTE		1			1

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THS Admits 2007 - April 2010.xlsx\

24-Admits- Moncks Corner by ZIP

Source: DSS: Business Objects
Case mix H

Run Date: 5/12/2010

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Trident_00036

Attorney Expert Eyes Only

RECORD 004382

ZIP Code	City	2007	2008	2009	April 2010	Grand Total
28160	SPINDALE			1		1
Grand Total		92	191	324	122	729

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THS Admits 2007 - April 2010.xlsx
24-Admits- Moncks Corner by ZIP

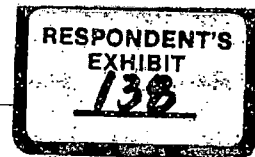
Source: DSS: Business Objects
Casemix H

Run Date: 5/12/2010
Page 37 of 38

Trident_00037

Attorney Expert Eyes Only

RECORD 004383



From: Stinnett Donald
To: Gunn Terry
CC: Stinnett Donald; Hall Chuck
Sent: 5/15/2008 8:44:24 AM
Subject: Declined: Updated: CON Berkeley Co/Roper Hosp Issues w/Chuck, Don, Terry, Karl, Jim, David

I have a conflict with an Ethics and Policy Committee Meeting at that time Terry. I've missed the last 3 and have been told I need to be there.....doesn't look good when the Groups provide no input through lack of attendance.

I'm sure you can proceed with Chuck. Sounds to me like we better get something filed up there to protect our status. It seems it would be a huge strategic mistake to let Roper or MUSC jump over us.

Don

Trident_02897

From: Rardin Jim - South Carolina
To: Rardin Jim - South Carolina
Sent: 1/10/2008 9:54:31 AM
Subject:

RESPONDENT'S
EXHIBIT

146

Trident Health System purchased twenty acres in the 4000 acre planned development of Cane Bay Plantation in January 2006. Cane Bay is located in Berkeley County, South Carolina. Cane Bay is a planned 10,000 home community currently under construction. According to the Berkeley County Planning Office, within a five mile radius surrounding Cane Bay will yield over 30,000 new homes in the next 10 years. The projected growth in the greater Charleston area will reach 113,000 new homes and 269,000 people in the next 10 to 20 years.

We are proposing to build a 60 bed satellite hospital on the 20 acres. This strategic move meets the standards set forth in the State Health Plan of South Carolina. We are aware our competitor Roper St Francis has purchased 80 acres within the stated five mile radius mentioned above. They are on the public record stating they will bring healthcare services and a new hospital to Berkeley County.

According to our legal counsel we believe that the current conditions are optimal for Trident to apply for a CON to construct a new hospital in Berkeley County based on the following:

Trident is in the best and most defensible legal position to receive a CON for the new hospital because the 2004-2005 health plan standards only consider the facility-specific bed need of a hospital. Trident and Summerville are the only hospitals in the Tricounty showing a bed need.

The new 2007-2008 plan will show an aggregate bed need excess in the Tricounty Region and show Trident and Summerville are the only hospitals with the need. The 2007-2008 plan places a priority on the Regions aggregate bed need over facility-specific bed need. Our application for a new hospital under the 2007-2008 plan will be at greater risk to legal challenges based on varying interpretations of the Plan's language.

Trident_05240