

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

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

Grand Strand Regional Medical Center, LLC Respondent,
v.

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

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

Grand Strand Regional Medical Center, LLC Respondent,
v.

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

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

RECORD ON APPEAL – VOLUME 5 OF 10

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1 Q: Do you have an opinion on whether 21 or 25 is
2 the appropriate rule of thumb for determining
3 the average number of treatments per patient?

4 A: Well, national figures that are used are 25.
5 The 21 was, I believe, the actual in the region
6 in the year 2009, and technology changes,
7 treatments change, clinical protocols change.

8 Q: Okay.

9 A: But even back then, the national figure that
10 would have been used would have been 25.

11 Q: All right. So if the -- all right, let's move
12 -- let me ask you this question. You've opined
13 -- set some foundation, you've opined that if
14 the approval of two linear accelerators drives
15 the existing units below 80 percent that the
16 applications are competing and only one can be
17 approved, right?

18 A: That is correct.

19 Q: Let's assume for a moment that the approval of
20 both applications does not drive the existing
21 units below 80 percent, so the existing units
22 would remain slightly above 80 percent, could
23 the Department even under that factual
24 situation still conclude that there was not a
25 need for both linear accelerators and determine

1 that they were competing applications?

2 A: The trigger, if you want to call it that, is I
3 would call it a no go. If it's below, if the
4 utilization of the four existing units dropped
5 below 80 percent, no way could two be added.
6 If it was above 80 percent, there could be some
7 other mitigating circumstances that the
8 Department would consider in the CON
9 application. In this case, what's happening in
10 Murrells Inlet. For instance, the Department
11 approved for the Georgetown linear accelerator
12 to relocate to Murrells Inlet, I think it's
13 about 17 or 25 miles north. The patients from
14 Georgetown and west of Georgetown, would they
15 still seek treatments in the region if their
16 linear accelerator was moved further away from
17 them, what would happen with them, would they
18 choose to go to MUSC or to a facility in
19 Charleston. So you don't know what would
20 happen to the market since that's an unusual
21 circumstance. Also, the Department could in
22 its -- they would have to review a CON
23 application in its whole, compare it with all
24 of the criteria and determine if that service
25 and the location within the service area was

1 the best -- interest of the public. For
2 instance, in the CON Act, one of the four
3 purposes is to guide the distribution of
4 healthcare services to best meet the public's
5 need. They may determine, for instance in this
6 case, that having two within three miles of
7 each other was not in the best interest of the
8 public's need. So they would have to look at
9 the application and consider many other factors
10 before it was approved. It's not automatic.
11 I'm sorry, that was a long answer to your
12 question.

13 Q: No, I mean, it's -- well, let me ask you one
14 other. Now, this court sitting here today has
15 the benefit over the Department of having more
16 recent data, right?

17 A: Yes.

18 Q: And do you think that the more recent data, the
19 2012 and 20 in the first seven months of 2013
20 would indicate that these applications are
21 competing or that they're not competing?

22 A: Well, both Mr. Sullivan and I projected
23 continued growth in the need or the demand for
24 radiation therapy in the region for the
25 foreseeable future. I used approximately two

1 and a half percent. He used three percent.

2 But we know for the last several years, the

3 treatment volume at CRCC has been declining.

4 So that would be a factor. You would have to,

5 the Department would have to say, is 31,824

6 treatments, which I projected in the year 2017,

7 is that higher than it probably will be since

8 there's a recent very significant downward

9 trend.

10 Q: Let's take a look at CRCC Exhibit 139. If

11 you'll blow up those numbers. Can you tell me

12 what this exhibit represents?

13 A: My understanding, this is data that Grand

14 Strand requested from CRCC, wanted to see it

15 and it was produced.

16 Q: Was it the 2013 treatment data by month?

17 A: Yes.

18 Q: All right.

19 A: Compared to 2012.

20 Q: Have you made some calculations or made some

21 projections as to what you think based on the

22 2013 year to date data is as to what -- how

23 2013 will finish?

24 A: Well, in this case, since there is a

25 significant downward trend, we know year to

1 date, year to date for the first seven months
2 of 2012 compared to the first seven months of
3 2013, CRCC's volume's down 10.3 percent.

4 Q: Okay. Let's go and look at CRCC Exhibit 8, and
5 let's look at the 2013 column, if we can, on
6 the far right.

7 MR. LONG: Can you blow that up just a little bit,
8 maybe put it a little bit to the left there.
9 Okay. Well, I tell you what, that's not going
10 to work. I'm sorry. Do the top part of it,
11 Bronwyn, the whole thing. Yeah, there we go.

12 Q: Did you make a -- well, tell me what CRCC
13 Exhibit 8 is in its totality. And the book is
14 there if you need to look.

15 A: Yes, I do. What is the number?

16 Q: 8. Tab 8 in that book.

17 A: This was my analysis and I went back eight
18 years of data. Any good researcher or planner
19 is going to want to look at more than a year or
20 two of data, so I went back eight years. The
21 reason I went back just eight years, I'd like
22 to go back further, but the Ford Center came
23 online in 2005.

24 Q: Okay.

25 A: So that was a major change in the service area

1 and the market for the three-county service
2 area. So that's why I stopped there. I could
3 have gone back further. And I just put the
4 data. The treatments are from the Joint Annual
5 Reports that are published and reported to
6 DHEC. And we just got the 2012 data, so I knew
7 that. And then I was projecting for CRCC what
8 would it be doing this year and if year to
9 date, year to date it's down ten percent and
10 that trend continues, the total for the year
11 would be down a total of 10.3 percent.

12 Q: And how many treatments then would CRCC have in
13 2013 if it's down 10.3 percent?

14 A: 20,450.

15 Q: Okay. Now, you did not annualize the 2013
16 data, did you, to determine the total
17 treatments for 2013?

18 A: No, you don't annualize data if it's got a --
19 within the year it's got a significant trend
20 going up or down because you would under
21 predict the effect of that trend, whether it
22 was up or down if you just annualized it.

23 Q: Okay. If CRCC finished 2013 at, as you
24 projected, at 20,450, would they be below 80
25 percent capacity?

1 A: I'm sorry. Would you repeat the question?

2 Q: If CRCC finishes 2013 at 20,450 treatments,
3 would that be below the 80 percent capacity?

4 A: They would be, yes.

5 Q: Okay.

6 A: Because I calculated it here.

7 Q: And if you included a fifth machine, the Conway
8 machine, would it be above or below 80 percent
9 capacity based on five -- based on including
10 the Conway approval?

11 A: Well, I need to clarify. In the CRCC
12 calculations, I've included the Conway machine
13 because it shows in the DHEC inventory as
14 existing.

15 Q: Okay.

16 A: So with the fourth machines, they would be
17 below 80 percent.

18 Q: What about the whole service area if there were
19 five machines?

20 A: I projected it would be below -- let me add, I
21 don't have the benefit of knowing the year-to-
22 date numbers for the Ford Center. If you look
23 at the Ford Center column in the row under
24 treatments in 2012, they reported 5,361
25 treatments. You can see that's significantly

1 below their previous year, like it was for
2 CRCC, but I don't know what the Ford Center or
3 Georgetown is this year to date. I thought I
4 was generous. I just assumed it wouldn't
5 decrease at all, even though its trend is down
6 and CRCC's is down. So I think that was a
7 generous assumption that in 2013, their volumes
8 would stay the same since ours are down
9 significantly.

10 Q: So is the 2013 volume year to date a factor
11 that, in your opinion, this Court should
12 consider in determining whether these
13 applications are competing or not?

14 A: I'm not a legal person, but I assume this Court
15 would consider any information that's presented
16 that's judged to be factual in making a
17 decision, including that.

18 Q: Well, does the 2013 treatment volume at CRCC
19 indicate that the applications are competing or
20 the applications are not competing?

21 A: Absolutely competing.

22 Q: Okay. Let me ask you about capacity of these
23 machines.

24 A: Let me add to that. It would also indicate
25 that a fifth unit could not be approved. One's

1 been approved. It would indicate that the, for
2 this year, the total utilization of those
3 approved units would be less than 80.percent.

4 Q: Okay. Let's look at the next two charts on
5 Exhibit 8 and just kind of tell the Court kind
6 of briefly what these are, what they show you.

7 A: Well, you know, again as I teach my students,
8 pictures are worth 1,000 words, so I just
9 wanted to plot some of the data that really
10 comes from the previous page so we could see
11 from just a picture standpoint what the trends
12 look like. I've heard in the, of course in the
13 testimony and the trial all of this about the
14 growth in volume when CRCC was purchased by
15 21st Century. And certainly that is shown on
16 here with 2010 and 2011, but you can see the
17 downward trend for -- actual for 2012,
18 projected for CRCC for 2013 because we have
19 their figures year to date.

20 Q: Okay. How about Tolbert 12839, the next sheet.
21 What's different about this?

22 A: Well, this one is different because it looks a
23 little busier. But I was calculating the
24 utilization of individual providers and the
25 utilization for the service area. The service

1 area is the one that is a real consideration in
2 terms of the approval or the possibility to
3 approve say a fifth linear accelerator, and you
4 can see projected is a three year downward
5 trend in utilization of the units.

6 Q: All right. Switching gears here. Is
7 population per linear accelerator as a metric
8 to look at, is that a metric that you might
9 look at in regards to analyzing whether more
10 than one machine should be approved in this
11 service area?

12 A: Measuring utilization, or what healthcare
13 planners call use rate, is commonly done
14 comparing it to population. It's typically
15 done in comparing it to say hospital admissions
16 or discharges per thousand population, and you
17 can compare one county to the next. The
18 Department uses those type of metrics to
19 project bed needs based on population shifts.
20 People get healthcare services, and so the
21 demand for healthcare services is primarily
22 driven by the number of people that are in a
23 particular market or demographic area as you
24 defined it.

25 Q: Let's take a look at CRCC Exhibit 9. Is this

1 a chart that you prepared for the trial here?

2 A: Yes, and it was another one I did, I guess it's
3 my researcher curiosity side of me, I said, you
4 know, I wonder what the distribution is of
5 linear accelerators compared to the population.
6 And so I, in the State Health Plan, calculated
7 the number of people per linear accelerator in
8 all the different areas as the Department
9 defines service areas.

10 Q: Did you draw any conclusions from this?

11 A: Well, if you look at the very right side, the
12 state average, statewide we have about one
13 linear accelerator per 80,000 people. And with
14 the one approved for us in Conway, we're right
15 -- we're actually slightly below the state
16 average in terms of distribution, or pretty
17 close.

18 Q: Okay. I guess the next page, Tolbert 12841,
19 Exhibit 9 is the backup for that?

20 A: Yes, that's where I did the calculations. I
21 had to actually get the State Health Plan data
22 that was published in an Excel spreadsheet so
23 I could do the calculations and create the
24 chart.

25 Q: All right. Let's look at the third page,

1 Tolbert 12842.

2 A: Yes.

3 Q: All right. What is your -- what have you
4 calculated or presented here for the Court?

5 A: This was something that I did several -- I mean
6 two years ago when we were doing this
7 initially, and I remember Grand Strand was
8 pointing out that, you know, a very large
9 hospital needs a linear accelerator, and I knew
10 that some did. So I was just looking at the --
11 some of the larger hospitals in the state, and
12 I think they had a cutoff in whatever
13 documentation they provided about 50,000
14 patient days. Those are inpatient days. And
15 so I was just looking at those larger hospitals
16 to see if they had linear accelerators or not.
17 Q: Do you have an opinion as to whether a hospital
18 needs to have a hospital-based linear
19 accelerator? Is that something a hospital must
20 have?

21 A: No, a hospital does not have to have one.

22 Q: Okay. And why would you say that?

23 A: Well, because 99 plus percent of the treatments
24 are outpatients, and it's not a service that
25 has to be hospital based. In fact, it's

1 clearly not. There are many, many freestanding
2 treatment centers and there are many hospitals
3 that have their own linear accelerator that is
4 in a separate building on their campus. I was
5 thinking about two of my clients, Aiken
6 Regional Medical Centers and Self Regional
7 Healthcare. Self Regional Healthcare has it
8 connected to the hospital. Aiken, I helped
9 them with a CON a few years ago to do a new
10 cancer treatment center that's a separate
11 facility. You can't actually get to it. I
12 mean you can get to it, but there's a very big
13 hill between that you have to go up and down to
14 get to it if you walk to travel between it. So
15 one does, one doesn't.

16 Q: Okay.

17 A: The other thing is there are many -- many
18 hospitals have had hospital-based radiation
19 treatment centers and have had them for years.
20 In my opinion, the reason is they require a
21 huge investment of money. We've seen in this
22 case nine to ten million dollars, and many
23 hospitals were doing it initially because
24 physicians frankly couldn't afford the
25 investment. So they couldn't do it as a

1 private investor. But things have changed,
2 there are companies that specialize in it, so
3 there are other options.

4 Q: All right. What is -- I want to ask you about
5 the capacity of the Grand Strand machine. The
6 Clinac iX, Grand Strand has projected that
7 their capacity for their machine is 5,000
8 treatments per year. Do you have an opinion on
9 that?

10 A: Well, the other, we would call them standard or
11 traditional linear accelerators that CRCC
12 operates and that Georgetown operates, they've
13 not requested a lower capacity. They accepted
14 the state standard at 7,000. But also I'm
15 aware that a lot of people feel that the
16 machines have a capacity to easily do more than
17 7,000, and they both do a lot of IMRT and
18 specialized treatments.

19 Q: Well, you saw the treatment numbers for the
20 Tomo unit at CRCC, right?

21 A: Yes.

22 Q: Did you see those?

23 A: Yes.

24 Q: That's 100 percent IMRT?

25 A: Yes, it is.

1 Q: Okay.

2 A: That's all it does.

3 Q: And is that machine capable of doing well above
4 7,000 treatments?

5 A: Clearly it can and has.

6 Q: All right. So do you have any questions in
7 your mind about whether a Clinac iX can
8 actually do 8,000 treatments in a year at Grand
9 Strand hospital?

10 A: It can. Also, there's maybe a reason they
11 wanted to claim 5,000 treatments, and that's
12 they could be above 80 percent quicker and ask
13 for a second machine.

14 Q: Okay. Do you have an opinion as to whether the
15 2012- 2013 State Health Plan provides a --
16 shows a need for a linear accelerator for Grand
17 Strand in this case?

18 A: The current State Health Plan using the
19 calculations based on the data they had
20 available when they created it, does indicate
21 that the existing units are above 80 percent
22 and there's quote, a need.

23 Q: Okay. What does that mean in regards to this
24 Court? I mean does that mean that one should
25 be automatically approved?

1 A: No, that means ---

2 MR. THOMAS: Objection, Your Honor. I think this is

3 going for a legal conclusion by this expert.

4 And that's a question for you, not for Mr.

5 Tolbert, based on facts and expert testimony.

6 THE COURT: Response?

7 MR. LONG: Your Honor, I think I've asked the

8 question where I'm not calling for a legal

9 conclusion. I just asked him whether, he ---

10 THE COURT: Rephrase the question or re-ask it.

11 MR. LONG: Okay.

12 THE COURT: Either way.

13 MR. LONG: I'll try.

14 Q: You testified earlier about the analysis for

15 the approval of linear accelerators under the

16 State Health Plan?

17 A: Yes.

18 Q: Does the satisfaction of the 80 percent

19 threshold guarantee that a linear accelerator

20 should be approved?

21 A: I'm sorry, would you ---

22 Q: Does the satisfaction or exceeding the 80

23 percent threshold, does that mean that a linear

24 accelerator should be automatically approved?

25 A: No, and if I could explain. I had this happen

1 to me, and it was an unfortunate situation with
2 DHEC a couple of years ago, a hospital wanted
3 to apply for psychiatric beds. And we checked
4 with the Department and were told that ten beds
5 were available. I prepared a CON application,
6 took it to the Department, and then it was
7 discovered that some miscalculation had
8 occurred and the ten beds weren't there. There
9 wasn't a need. They returned the CON
10 application and our filing fee and didn't even
11 accept it for review because there was no need.
12 If the need had existed, they still would have
13 had to review the application in its whole, all
14 of it to see if it was approvable using all of
15 the other factors. So that one was rejected,
16 and I would expect it in this case if there
17 wasn't a need, they wouldn't even accept the
18 application. If they accept it, they still
19 have to review it and determine under all the
20 other criteria if it's approvable.

21 Q: Well, in your opinion as a healthcare planner,
22 if Grand Strand wanted the linear accelerator
23 designated in the 2012-2013 Plan, what's the
24 appropriate process for them to go about doing
25 that?

1 A: Apply.

2 MR. THOMAS: Objection, Your Honor. Again, I think
3 that's calling for a legal conclusion by this
4 expert. That's an issue in this case that I
5 actually put before you a summary judgment
6 motion a few months ago, so you've already
7 ruled on that issue.

8 THE COURT: If Grand Strand wanted blah, blah, blah,
9 what is the legal process?

10 MR. LONG: No, I said as a healthcare planner, if
11 Grand Strand wanted to apply for a linear
12 accelerator designated in the 2012-2013 State
13 Health Plan, what should they do.

14 THE COURT: I thought your question was what was the
15 legal process.

16 MR. LONG: Or what was -- I didn't say legal process.
17 I might have said what process should they do,
18 and I meant -- and I'll rephrase it and say
19 what should they do.

20 THE COURT: Okay.

21 MR. THOMAS: Well, Your Honor, I still think it's
22 irrelevant because Grand Strand is doing what
23 it's doing and it's already put it before you
24 in a summary judgment motion, and you said if
25 they're competing or not competing, you can

1 make that decision based on the facts of the
2 case.

3 THE COURT: Well, that would be a relevant
4 objection, which I probably ---

5 MR. THOMAS: Well, that's what ---

6 THE COURT: --- let me see what you -- I sustain
7 that one.

8 MR. THOMAS: Thank you.

9 MR. LONG: Okay.

10 THE COURT: Well, I'll hear your argument if you
11 want to make one.

12 MR. LONG: I'll move on, Your Honor.

13 THE COURT: Okay.

14 MR. LONG: I realize this is a --- sometimes there's
15 an overlap here.

16 Q: All right. During the review phase when you
17 were working on the CON, we're going to go
18 through that in a second, but just to kind of
19 finish up this about the competing applications
20 and the projections. During the review phase,
21 did you attempt to show the Department that the
22 approval of both Grand Strand and CRCC would
23 exceed the need?

24 A: Yes, I did. It was at the very end of the
25 review process.

1 Q: Okay. Let's look at Joint Exhibit 1, the CRCC
2 CON and page 630, I think is the key page.

3 A: Yes. This was an analysis I undertook
4 following the project review meeting to see if
5 basically the Department would have the
6 latitude if it even felt it was appropriate to
7 make that approval to.

8 Q: Okay. Prior to project review, did you recall
9 any provider stating to the Department that
10 they thought that both -- two applications
11 could be approved?

12 A: No, I honestly was surprised at project review
13 when it came up as a question.

14 Q: And can you kind of tell the Court what you did
15 or what you presented to the Department, just
16 give an overview of that.

17 A: I did the similar analysis that we've discussed
18 before on page one to basically project
19 volumes. And then on page two, I looked at
20 what if ours and North Strand's was approved
21 and compared volume projections on the existing
22 and the new units if two were approved.

23 Q: Okay. That's page 632 on the Bates.

24 A: Yes.

25 Q: Okay.

1 A: And then on the next page, I did the same
2 comparison if ours and Grand Strand was
3 approved.

4 Q: Okay. Did you do any independent projections
5 as to what the -- different from what the
6 applicants had projected?

7 A: No, I used their numbers.

8 Q: You just used their numbers?

9 A: Yes.

10 Q: Okay. And based on your calculation, based on
11 their numbers and on the information that was
12 available, you concluded -- what did you
13 conclude?

14 A: Well, I really did a similar analysis to what
15 you did up here. I projected the volumes of
16 treatments in the region, and in 2015, which
17 was let's call it the old year three, I knew
18 the region would be at 29,997 treatments.

19 Q: Okay.

20 A: And then I took what the applicants were
21 claiming they would do, and then CRCC would end
22 up with what was left, basically, and did the
23 calculations very similar to what we were doing
24 up there.

25 Q: Okay.

1 A: And concluded that in year three, the existing
2 units would be below 80 percent.

3 Q: Okay. Now, Mr. Thomas did some math for Ms.
4 Brandt on this board looking at that page on
5 Tuesday. Do you recall that in regards to her
6 testimony?

7 A: Yes.

8 Q: Okay. So I want to give you an opportunity to
9 respond to that or explain what was going on
10 there.

11 A: Well, I was surprised in discovery to see some
12 notes with a different calculation. And when
13 I saw that I said, man, I better go back and
14 look at my numbers again to see if I had a
15 formula error or missed something, and what I
16 discovered and what the Department was at
17 least, they calculated treatments in the region
18 above 29,977. And I wanted to see how in the
19 world did that happen. Well, they took our
20 projections in Murrells Inlet and the Ford
21 Center's projections in Murrells Inlet and
22 added them together. When we did our CON
23 application for Murrells Inlet, we assumed
24 there would be no other linear accelerator in
25 Murrells Inlet. When the Ford treatment center

1 did their projections for Murrells Inlet, they
2 assumed there wouldn't be someone else there,
3 so we both were counting on getting some more
4 patients from the same population, basically
5 the same patients. So that's where, quote, the
6 double counting is, and they didn't realize
7 that. I wish I had been called because I could
8 have explained you can't just add Murrells
9 Inlet, two different applications together and
10 assume those are all going to occur because
11 neither applicant assumed they would be near
12 each other. And so you have to start with the
13 total projections for the region and then back
14 down to the number, not take all the
15 applications and add it up.

16 Q: Did you -- all right. So your opinion based on
17 the information you were provided the
18 Department, the approval of both would drive
19 the existing providers below 80 percent?

20 A: Yes, using the correct projection of total
21 treatments that would be done in the region.

22 Q: All right. Let's take a -- let's turn now if
23 we could and start looking a little bit kind of
24 at the CRCC CON, okay? All right. And I think
25 it's there in front of you. It's Joint Exhibit

1 Number 1.

2 A: Yes.

3 Q: All right. First, can you explain to the Court
4 your role in preparing this certificate of need
5 for this linear accelerator in Conway?

6 A: I was engaged to prepare the CON application,
7 of course with support from a variety of people
8 on the team, prepare it, submit it to the
9 Department and then guide it through the review
10 process and was the point person, if you want
11 to consider me that, with the Department to
12 represent CRCC.

13 Q: Okay. And who were -- was it just you doing
14 the work on the CON or was there a group?

15 A: It was a large -- I mean it was a team of
16 people. I've had maybe two clients that really
17 it was a huge team effort, and this was one of
18 the two. It was -- a lot of people were
19 involved in helping.

20 Q: Okay. How would you describe people's roles
21 and what they were doing?

22 A: Rich Lewis was identified from 21st Century
23 corporate as the financial person who would do
24 the financial pro formas, and he and I
25 collaborated on that. We needed, of course, a

1 lot of input from the people at CRCC, so Ms.
2 Price was involved, Ms. Maynor was involved,
3 Dr. Francke was involved. And we had Doug
4 Bryant, who was also a consultant who was
5 actually engaged before I was, he was involved.
6 We had legal counsel involved from the
7 beginning, had lots of conference calls, lots
8 of, apparently lots of exchanges of emails. I
9 didn't realize I alone I guess produced 7,000
10 pages of emails as we developed this together.

11 Q: Did you have regularly scheduled conference
12 calls?

13 A: Well, they weren't like scheduled the first
14 Monday of each month, but they were pretty
15 frequent as needed.

16 Q: Did you typically schedule it when you were
17 doing a conference call? Like would you
18 schedule the next one?

19 A: Sometimes we would. Sometimes by email, we
20 would say well, it's time for us to talk again,
21 Tolbert's got some questions or whatnot and a
22 conference call would be scheduled.

23 Q: Okay. Do you remember generally when you were
24 kind of brought in by 21st Century initially,
25 the very first time you had contact with them?

1 A: It was late September, early October 2010.

2 Q: Okay.

3 A: Doug Bryant brought me into the process.

4 Q: And did you -- did you -- were you told at that
5 time what CRCC intended to do in regards to
6 moving, opening new centers?

7 A: The initial discussions were that they were
8 planning on, they do not have huge centralized
9 centers in a larger geographic area. They like
10 to put centers closer to populations they're
11 serving. Clearly they knew or were
12 anticipating they would have growth in volume
13 and would need to do something to grow and
14 expand.

15 Q: During the time that y'all were having
16 discussions prior to the filing of the CONs,
17 was there discussion about where a center or
18 centers should be located?

19 A: Well, there were ---

20 Q: Discussions within the group.

21 A: Well, there were certainly lots of discussions.
22 It's a three-county area, and I think early on,
23 certainly my Murrells Inlet CON application
24 that was done before this one, I undertook
25 analyzing population by zip code, drive time by

1 zip codes, and CRCC patient origin by zip code
2 to try and help them identify where their
3 patients were coming from and where the
4 potential other locations could be for
5 radiation treatment centers.

6 Q: Well, were there any other people who advocated
7 for locations other than Conway?

8 A: Well, there was a lot of discussion within the
9 team, and some people really not very much
10 involved with the project, everybody has an
11 opinion about where it might go. So there were
12 other opinions.

13 Q: Okay. Now, let's take a look at some of the
14 particulars of the CON application. First
15 let's turn to just page eight if we could.
16 When was the CON for CRCC-Conway actually
17 filed?

18 A: Well, I signed this March 9th. I think it was
19 filed on the 10th or the 11th. I don't exactly
20 remember the day.

21 Q: Okay. And, of course, was that well before
22 Grand Strand filed their application?

23 A: Yes, I believe they filed theirs in July.

24 Q: Were you even aware in March of whether Grand
25 Strand was going to file?

1 A: I wasn't.

2 Q: Okay. Did you see some -- there's certainly
3 been no notice in the paper or anything like
4 that?

5 A: No, no and ...

6 Q: All right. So let's look at page nine if we
7 could. This is the Part B, the description of
8 the project?

9 A: Yes, this is what we commonly refer to as the
10 narrative sections.

11 Q: Okay.

12 A: Part B, C and D.

13 Q: Who actually drafted those sections of the CON?

14 A: This one I typed them with my own fingers.

15 Q: But after you typed them, then what happened?

16 A: Well, they get, and this is what I do with all
17 clients, it is very important for me for a
18 client to know what's in here, because it's
19 being submitted on their behalf. So in this
20 case, drafts were circulated, reviewed,
21 comments were made. I edited it as I felt it
22 needed to be edited. When it was finalized,
23 quote, a final draft was sent out to the team.
24 I actually went to Myrtle Beach and met with
25 Ms. Price, who's the administrator, and

1 physically she looked at the applications, both
2 Murrells Inlet before they were submitted so I
3 could educate them and be sure everything I was
4 doing met their satisfaction.

5 Q: Okay. So you would travel --- how many times
6 did you travel to Myrtle Beach; do you recall?

7 A: I honestly don't. It may have been three
8 times.

9 Q: Okay.

10 A: So much of this can be done electronically, but
11 I physically did go there.

12 Q: And did people, the team effort, did they
13 actually make edits and suggestions to your
14 work?

15 A: Yeah. Yes they did, yeah. A lot of -- some of
16 it was important and some of it was writing
17 style differences, but I accept all
18 suggestions.

19 Q: Okay. Let's take a look at page nine. I
20 wanted to ask you, I'm just going to ask you
21 about some things in the application and get
22 you to comment on them whether you think
23 they're particularly important for the Court.
24 If you look in the subsection two here in the
25 second full paragraph, the sentence that starts

1 the medical building.

2 A: Yes.

3 Q: You see that? If you can kind of read that
4 sentence out for the Court and tell me why --
5 of you think that's important to this
6 application.

7 A: "The medical building was specially built for
8 an oncologic purpose and has a radiation
9 therapy vault and shielded area for a CT
10 simulator."

11 Q: And do you think that's important for helping
12 the Court make a decision here?

13 A: Well, it was a building originally intended for
14 what we were going to use it for. Clearly, as
15 the record indicates, there's some renovations
16 and rehabilitation that needs to be included.
17 I think there was about \$700,000 included for
18 that to make sure it would be perfectly
19 suitable for its planned purpose.

20 Q: Let's look at the paragraph right below that.

21 A: Yes.

22 Q: Could you comment on what you consider to be a
23 major advantage of this application?

24 A: Did you want me to read it, or?

25 Q: Read it or summarize it, whatever you prefer.

1 A: Well, a major advantage of the existing
2 facility is that -- is that much needed linear
3 accelerator can be brought online much quicker
4 than other options requiring construction of a
5 new facility. We certainly knew at this stage
6 the volumes of CCRC were going to be increasing
7 dramatically, the record indicates that, and we
8 knew that we needed an additional new linear
9 accelerator sooner than later. And this
10 building allowed us to get into it a year
11 quicker and meet the needs of the patients that
12 were being referred to CRCC.

13 Q: Okay. Let's look at the paragraph under that.
14 I want to ask you about two sentences. The
15 first one, it starts, "CRCC's current level of
16 utilization is a testimony of its strong
17 referral base. A new provider would not have
18 the level of support that CRCC has earned
19 within the provider community." When those
20 sentences were written in the application, were
21 they meant to be written as a comparison
22 between CRCC and Grand Strand?

23 A: No, one of the criteria for review of an
24 application is the referral sources. And I was
25 building our case that we are an existing

1 provider, we have lots of referrals and a
2 strong referral base to support that part of
3 the standard that would be reviewed under this.

4 Q: Okay. And the next sentence, "Also, CRCC has
5 tremendous economy of scale in its operation."
6 Do you consider that to be an important factor,
7 an important aspect of this project?

8 A: Yes. For instance, CRCC, Ms. Price is the
9 administrator. If they add a new unit, they
10 don't have to add another administrator. She
11 can handle the supervision of four linear
12 accelerators. They would have all -- their
13 billing system, they don't have to buy another
14 billing system. They've got one that can be
15 added to easily. So those are economies of
16 scale.

17 Q: Okay. Take a look at page 11 if we could.
18 What's the total project cost of the project?

19 A: Oh, I'm sorry. 5.1 million.

20 Q: Okay. And then on page 12, there's an
21 allocation for information technology, correct,
22 about midway down the page in Table 3?

23 A: Yes, there is.

24 Q: What's your understanding of what that is?

25 A: That's for all the network, computers, and some

1 of that would be clinical information, computer
2 technology too, that's a total of, or just at
3 a little over \$300,000.

4 Q: Do you find that to be significant?

5 A: That's a large number. I -- honestly, I was
6 surprised. That number seemed higher than --
7 but then that would include some of the
8 radiation treatment software, I believe.

9 Q: All right. Let's take a look over at the, or
10 tell the Court what B-11 is. It starts on page
11 16 of the application.

12 A: Well, those of us that do CON consulting
13 commonly refer to this as the need analysis,
14 and it's just B-11.

15 Q: Let me get to -- when you were putting together
16 the CON application, kind of walk me through,
17 if you would, what you did in regards to
18 analyzing the service area.

19 A: Well, in terms of the service area in B-11, you
20 start by if there are any standards in the
21 State Health Plan regarding utilization
22 projections, you need to consider those. The
23 CON application also does require you to look
24 at populations and projections of populations
25 and your target populations. And you can see

1 on Bates page 16, B-11 I have in here what the
2 application is that DHEC requires you to
3 respond to in the pages that follow. And so
4 you proceed to try and project utilization of
5 whatever service you're proposing using
6 population figures and whatever other
7 utilization metrics might be appropriate to
8 this type, a type of service, in this case
9 radiation therapy.

10 Q: All right. Turn over to the next page, page
11 18. Did you make some assumptions or groupings
12 of population based on the zip code?

13 A: Well, this is a six, excuse me, a three-county
14 service area. I believe there were 26 zip
15 codes. And knowing that CRCC and 21st
16 Century's kind of philosophy is to take linear
17 accelerator treatments, let's say, to the
18 people, I said, we need to look at population
19 by zip code. Well, it's hard to take 26
20 different zip codes and look at them all
21 individually, and I said there -- and I just
22 know there are natural groupings of zip codes
23 based on geography and based on locations and
24 based on populations. So the first thing I did
25 was take all 26 zip codes and then look at on

1 the map where those zip codes were and tried to
2 determine what would be a logical grouping.
3 And we know that Murrells Inlet was a -- this
4 is the process I started with the Murrells
5 Inlet application, which was a long time before
6 this one. So this is a take off on that same
7 analysis. I looked at the different market
8 areas for this type of service by grouping some
9 of the zip codes in the logical groups. And
10 how I did that was I had for each zip code the
11 latitude and longitude for the geographic
12 center of that zip code. So zip codes can be
13 real oddly shaped, and I just found the
14 geographic center of that zip code and measured
15 using Google maps. I know there's been a lot
16 of jokes about that, but that's -- I think it's
17 accurate and it's quick. But we had to do it
18 26 times, one for each zip code, and I measured
19 from that zip code the distance to the CRCC
20 current site, to the site in Murrells Inlet, to
21 the Georgetown site in Georgetown, the Ford
22 Center in Georgetown, and then to Conway. So
23 for each zip code, I had to do that four times
24 for 26 zip codes to find out the distances.
25 And so then I grouped the zip codes into the

1 areas that are shown here, the Conway area, the
2 Georgetown area, that would be excluding the
3 Murrells Inlet area, the Loris area, the Myrtle
4 Beach area and the North Myrtle Beach area.

5 This made it a whole lot easier to analyze in
6 terms of markets, instead of trying to do it 26
7 different zip codes.

8 Q: Okay. And, of course, these are multiple zip
9 codes for each one of these areas, right?

10 A: Yes, I -- some have four. Some may have a lot
11 more. I'd have to go back and look at the
12 breakout.

13 Q: Okay. And what did you do -- so what did you
14 conclude in regards to the -- well, did you
15 also do that with looking then at the patient
16 origin numbers?

17 A: Well, I was able to calculate the population
18 because I used Claritas data like Mr. Sullivan
19 did. It's a good database, and I had
20 population by zip code. And so I was able then
21 to group those zip codes and see how many
22 people would be in those groupings, and then I
23 wanted to compare that with CRCC's patient
24 origin to basically see where most of the
25 patients were coming from. And so this shows

1 the percentage of their patients that come from
2 those groupings or areas, and I also had the
3 population.

4 Q: What about Loris? Was that one that you made
5 some assumptions on as far as where it would be
6 more likely to be aligned, whether Conway,
7 North Myrtle, CRCC or ---

8 A: Loris, I kept it separate at this point because
9 from, as I measured it, we also at this point
10 knew there was a North Strand application, and
11 they were proposing to put a linear accelerator
12 in Little River right in the northeast corner
13 of the state in this region. And so I knew
14 from Loris to Conway and Loris to Little River,
15 it was about the same distance. And so I said
16 I need to keep that Loris area separate from
17 Conway at this point in time because those
18 patients could really kind of go either way
19 from a time and distance standpoint.

20 Q: Okay. Did later you make some assumptions in
21 regards to Loris as between those two areas?

22 A: Later, as we were looking at how many patients
23 would choose to come to Conway, I assumed those
24 patients would rather drive to Conway than all
25 the way into Myrtle Beach to get the linear

1 accelerator, so then I grouped Loris and Conway
2 together in analyzing our potential volume in
3 the Conway center.

4 Q: Let's look at page 18 in the -- no, I'm sorry,
5 page 19 in the application. Did you also do
6 some drive time analysis?

7 A: I looked at the distance just in absolute
8 driving miles and in driving time and then used
9 driving time to kind of group the zip codes
10 into these areas. This map looks a whole lot
11 better in color as it was in the original
12 application, because I wanted to show the
13 Department, trying to be totally transparent of
14 what I did, why I did it and how it looked, and
15 that's what this Figure 1 is.

16 Q: Is this the same map, CRCC Exhibit 37? I think
17 you might have added a little bit of
18 information to it for the trial in regards to
19 the numbers, but is that basically the map we
20 were looking at in the application?

21 A: Oh, it's here. It's the same map, same
22 population. Everyone on the team believed and
23 knew that as you moved inland, the
24 socioeconomic demographics of the population
25 lowers. You know, the wealthier more affluent

1 people are on the coast. The property is so
2 expensive. But when I was hearing the
3 testimony, I said, let me go back and look at
4 my original data. So I took the Claritas data
5 and looked at the per capita income, and then
6 I calculated the per capita income for each
7 area using the zip code data just so I could
8 see what the differences were, and I added
9 those dollar figures to this map.

10 Q: All right. And so clearly, is Conway less
11 affluent than Myrtle Beach?

12 A: Yes.

13 Q: And how about Loris?

14 A: It's less affluent than Conway.

15 Q: Now, in regards to the driving time, did you do
16 a drive time study and actually get in the car
17 and drive the distances?

18 A: Well, in my consulting career, I've only done
19 that once, and I hired someone to do it and it
20 was for an open heart CON application. I
21 didn't -- if you wanted one, a drive time study
22 done on 26 zip codes, and I think we may have
23 even discussed it with the team or it may have
24 been another client I was doing something
25 similar for, that's a very, very expensive

1 process, tens of thousands of dollars to pay
2 somebody to physically drive it, and even then,
3 unless they drive it multiple times, you don't
4 really know what the average is going to be.

5 I've always found Google maps when I travel to
6 be reasonably accurate.

7 Q: Well, I think you had in the application here,
8 you had ten minutes in regards to the Conway
9 application to CRCC; is that right?

10 A: Yes.

11 Q: One way? How did you determine the ten
12 minutes?

13 A: Well, the ten minutes is not just from Con- --
14 the town of Conway to our site in Myrtle Beach.
15 It's an average of the whole region, factoring
16 in population differences by zip code. And you
17 can look at this map and you can see, because
18 of the way the zip codes are configured, part
19 of the Conway area gets really close to Myrtle
20 Beach. And so, you know, that drive time would
21 be a lot less for the people that live -- and
22 that's the Carolina Forest area as I've heard
23 it referred to. Some others it would be more,
24 so I thought I had a conservative estimated
25 average of ten minutes.

1 Q: Okay. I want to look at a couple more pages in
2 the application, page 245.

3 A: Yes.

4 Q: I'm sorry, 246. Who provided you with this
5 information?

6 A: I don't remember if this came from Rich or from
7 someone else at the corporate office, but this
8 was their diagram of ownership, and I think it
9 was in one of the exemption requests that was
10 submitted to the Department earlier in 2010
11 when they were trying to replace some of their
12 equipment. So I think it came directly from
13 that.

14 Q: And let's look at page 345.

15 A: Yes.

16 Q: 344, 345. Why is the indigent care policy or
17 plan important in the CON application?

18 A: It's a -- in the application you're required to
19 submit an indigent care plan. I review a lot
20 of other CON applications that other people
21 prepare, and some people get very confused
22 about what the Department wants, but this is
23 how I present the indigent care plan, which is
24 a requirement.

25 Q: And is CRCC to treat -- in your opinion, does

1 CRCC present a reasonable indigent care plan?

2 A: I have clients that are physician practices,
3 ambulatory surgery centers, non-hospital
4 clients, and a percent of gross charges of 2.8,
5 2.1, 2.7 percent that are shown here is higher
6 than I usually see for my physician practices.
7 They typically are closer to one percent.

8 Q: Now, let's take a look at the -- as part of
9 your work for CRCC, did you help prepare the
10 project review presentation?

11 A: Yes, I created the PowerPoint slides. As I
12 recall, I think I created one draft that was a
13 huge number of slides. And the team looked at
14 it, we edited it down because you're only given
15 30 minutes to present. I think I had twice as
16 many slides as we could reasonably do in 30
17 minutes, so we had to cut a lot of them.

18 Q: All right. Let's take a look at 578 in the
19 application.

20 A: Yes.

21 Q: Is this your PowerPoint presentation or the
22 PowerPoint presentation for project review?

23 A: This was one that I -- I think I had some help
24 from some of my staff creating this.

25 Q: And did you present at the project review?

1 A: Yes, I was one of the presenters.

2 Q: I want to ask you about a couple of, just one
3 little area that's come up. Look at starting
4 on page 589.

5 A: Yes.

6 Q: And also over at pages -- well first, did you
7 recognize that there were other applicants in
8 your project review presentation?

9 A: Yes, there were two other applicants.

10 Q: And at project review, what are you trying to
11 do with the Department? What's your goal?

12 A: Your goal is to make your best case to them
13 face to face for approval of your project.

14 Q: Okay. And starting on page, say, 602.

15 A: Yes.

16 Q: Through, say, 608 or 9. Did you do some
17 comparison slides, or did you state between --
18 or CRCC-Conway compared to Grand Strand and
19 also North Strand?

20 A: I did a little of both. I was trying to
21 explain why our project was superior to the
22 other ones they were considering, and you want
23 to do it in a diplomatic and appropriate and a
24 factual way.

25 Q: Because, ultimately, it was your expectation

1 that the Department would have to pick?

2 A: That was my absolute expectation, they would
3 have to pick, and we wanted to be the ones they
4 were picking. And I thought we had a very good
5 case.

6 Q: All right. Just to identify, I think these
7 documents have probably been mentioned already,
8 but look at in the application page 623. That
9 was November 15th on the project review, right?
10 Let's look at 623.

11 A: Yes.

12 Q: Can you just identify what this document is.

13 A: In all the project review meetings that I've
14 attended that the Department has held, at the
15 end of the meeting. Well, let me back up. The
16 project review meetings are not considered
17 official, certainly nothing like this. Nobody
18 does the court reporting. Nothing you say is
19 recorded, and that's real clear. And so the
20 Department tells the applicants, you have so
21 many days after today to submit in writing
22 anything you want to submit based on what you
23 want us to have in writing and anything else
24 you heard said. Typically, the Department asks
25 you to bring copies of your PowerPoint slides

1 and share them if they're competing
2 applications. So we brought sets of slides so
3 we could exchange slides and we would have in
4 writing what was shown, say, on the screen.
5 And then you're given so many days to write
6 whatever you want back to the Department, and
7 that's what this is, is responding to their
8 request for follow-up information if you wanted
9 to present it. I've never not wanted to
10 present it, so you always do this.

11 Q: All right. Did you also write a second letter
12 to the Department on page 651? Well, let me
13 back up. Was that the letter, 623 on the
14 November 28, 2011, letter where you submitted
15 the analysis of why the Department should not
16 approve both?

17 A: Yes, that's one of the exhibits.

18 Q: That's one of the exhibits, right?

19 A: Yes, it's one of them.

20 Q: All right. Let's take a look at your letter on
21 page 651.

22 A: Yes.

23 Q: What is that letter?

24 A: Well, I'm not a legal person, but this would,
25 I guess, be called a rebuttal.

1 Q: Okay.

2 A: But it was like once everybody submits their
3 letters, if there's anything in it that really
4 causes you a lot of concern, and it did, I felt
5 we needed to do a second letter to clarify, as
6 it says here, inaccuracies.

7 Q: All right. And I guess the Department made
8 their decision on page 655?

9 A: Let's see. That was December 16th, and 655.
10 The decision was made on December 28th.

11 Q: And what was the decision?

12 A: To approve ours.

13 Q: And what about North Strand and Grand Strand?

14 A: Both were denied.

15 Q: In your opinion, did the Department make the
16 correct decision?

17 A: Absolutely made the correct decision.

18 Q: I want to ask you about, attached to the letter
19 is a number of pages starting on page 658
20 running to 675. What is that?

21 A: This is the -- kind of the Department, I would
22 describe it as the Department's findings as
23 they summarized everything they heard,
24 everything they reviewed in the file and drew
25 their own conclusions. I, be honest with you,

1 in earlier years, this would be very short.

2 This was a very extensive analysis which this
3 Ms. Brandt started doing, and I'm not sure why,
4 but this is a very extensive analysis. I've
5 had some that were not nearly this long or this
6 clear.

7 Q: Was it impressive?

8 A: Well, of course, she approved ours. I think
9 it's very impressive.

10 Q: But, now let me ask you about, I do want to ask
11 you about one sentence that she finds on page
12 669 in regards to discussing Grand Strand's
13 application at the bottom of the page.

14 A: Yes.

15 Q: Discussing the adverse impact. She says ---

16 A: Let me get there.

17 Q: I'm sorry, at the bottom of the page, starting
18 with, Mr. Sullivan. I'm read it out loud and
19 ask you if you can comment on it. "Mr.
20 Sullivan did not quantify the percentage or
21 number of patients, but 'significant
22 percentage' implies a sizable impact upon the
23 existing provider, CRCC, and Grand Strand
24 projects serving 220 (sic) radiation therapy
25 patients in the third year." Do you think that

1 the referrals from Coastal Cancer Center that
2 you projected are a significant percentage?

3 A: Well, earlier this morning if I'm remembering
4 correctly, the number in my projections was 58
5 percent shift. I would say, you know, my
6 interpretation of this would be at least that,
7 probably more.

8 MR. LONG: Your Honor, I'd like to keep moving if
9 it's okay with Your Honor, I mean, unless y'all
10 want -- I do want to go through this ---

11 THE COURT: When you say keep moving, how much
12 longer are we going to keep moving?

13 MR. LONG: Is it 12:20?

14 THE COURT: Uh-huh.

15 MR. LONG: I wanted to go through this Exhibit 6
16 with him and then I might be close to being
17 done, and I think I can certainly do this in
18 half an hour or less, unless you need a break.

19 MR. TOLBERT: I'm going to need a break before a
20 half hour, but.

21 MR. LONG: Okay.

22 MR. LONG: Your Honor, it's your preference.

23 Obviously, we're probably going to need to take
24 a couple of minutes for Mr. Tolbert.

25 THE COURT: I think we'll just go as long as Mr.

1 Tolbert can hold out, but if he can't hold out
2 any longer, you're going to have to quit, that
3 might be a good approach. No, no, I'm just
4 picking. Let's just take a quick break.

5 (Break from 12:21 p.m. until 12:27 p.m.)

6 Q: Mr. Tolbert, I just have one or two more
7 questions for you before we move on to CRCC 6.
8 Was the employment relationship of the
9 urologists by 21st Century known to the parties
10 prior to the decision, known to the other
11 applicants?

12 A: Yes. I mean, it's in our CON application when
13 you look at the ownership structure, Atlantic
14 Urology is fully disclosed.

15 Q: And did the other applicants, at least Grand
16 Strand, I think, comment on the referrals from
17 the urologists to CRCC?

18 A: I don't recall that.

19 Q: You don't recall that, whether that was an
20 issue or not in their project ---

21 A: No.

22 Q: Do you recall whether Mr. Sullivan acknowledged
23 or considered that Grand Strand would not get
24 referrals from urologists?

25 A: I don't recall that either.

1 Q: All right. Well, if the Department determines
2 that the applications are competing and they,
3 therefore, have to be compared, okay what
4 should the Department do in regards to that
5 process in order to determine which project
6 should be approved?

7 A: Well, first of all, for any CON application,
8 just because you submit it doesn't mean it gets
9 approved. The Department has to review it
10 based on the standards in the State Health
11 Plan, the criteria that they identify that are
12 important to review, and of course, the overall
13 purposes of the CON Act. When you have a
14 competing application, that comparison becomes
15 more critical because you have to pick one.
16 And so yes, they have to do a very careful
17 comparison between the applications to choose
18 the one that's superior.

19 Q: All right. Let's look at CRCC Exhibit Number
20 6. All right. Have you prepared a report here
21 for the Court here today comparing the Grand
22 Strand application and the CRCC application for
23 the Court's consideration?

24 A: Yes, in preparing for this hearing, first I
25 created what I call the matrix. I said we need

1 to look at the standards in the State Health
2 Plan, all the criteria. If you'll pardon me,
3 I'll use criteria and criterion. I know one's
4 plural and the other is singular. I'll just
5 use criteria. Every criteria that the
6 Department listed that the project would be
7 reviewed under, created a matrix and looked at
8 our application, looked at Grand Strand's
9 application and the information that we had
10 known at that point in time that had been
11 brought forward in discovery and created a
12 matrix, and the matrix then was converted to
13 PowerPoint slides because it was a huge
14 spreadsheet we couldn't really look at very
15 easily. So that's what this is.

16 Q: All right. Let's take a look then at Tolbert
17 12910. It's the first page here. And so can
18 you tell the Court what you're focused on in
19 regards to this particular slide?

20 A: In the State Health Plan, you have sections
21 that define specific healthcare services that
22 are reviewable, if you want to call it that,
23 under CON. And within each section there are
24 standards that define utilization rates or
25 other factors that would need to be met for a

1 project to be approved. And with following
2 those standards, there's a section in each part
3 of the State Health Plan that talks about
4 criteria for review. The number one listed on
5 every one of those, as far as I can recall, is
6 compliance with the, what is the current State
7 Health Plan, and that's what this is. It's the
8 first review point of the CON application, does
9 it comply with the State Health Plan?

10 Q: Just to clarify, are you talking about what was
11 commonly referred to as the project review
12 criteria?

13 A: The project review criteria.

14 Q: That's found at 61-15, I think, 802; does that
15 sound correct?

16 A: Yeah. Within the regulations, there's a long
17 list of ways you could evaluate a CON
18 application. If I recall right, there are 30
19 to 35 different criteria, and many of them have
20 subpoints.

21 Q: And the ones that you have analyzed here, what
22 -- did you analyze all the project review
23 criteria, or did you analyze specific ones?

24 A: In the review of every CON application, when
25 the Department feels you have responded to all

1 their questions, they send you what we commonly
2 refer to as the deemed complete letter, and
3 you'll get a deemed complete letter that says
4 you've responded, we think the file is complete
5 as far as we know at this point, and we're
6 going to look at your application and here's
7 the criteria we're going to use to evaluate
8 your application. And it's a subset of the
9 larger set. And so that was defined by the
10 Department, and that's what I used here because
11 that's what they said they would review it
12 based on.

13 Q: And is compliance with the State Health Plan
14 one of those criteria, this first one here?

15 A: It's the number one.

16 Q: All right. And so what's your opinion in
17 regards to these two applications in regards to
18 compliance with the State Health Plan?

19 A: Well, it shows here that we're in compliance,
20 Grand Strand's not. We're projecting the need
21 and show a need for one additional linear
22 accelerator and are asking that it be put in
23 Conway and that it will not adversely impact
24 other providers, that we documented properly
25 documented our referral sources and have

1 support from the local hospital for this
2 service. In comparison, Grand Strand's
3 projections, I felt, feel intentionally
4 understate the anticipated market share and
5 patient draw in order to minimize adverse
6 impacts on the existing units. The approval of
7 a machine less than three miles from the
8 existing provider, our center in Myrtle Beach,
9 will have a material adverse impact on our
10 volumes, and the approval of two additional
11 machines or units will drive the existing
12 providers below the 80 percent utilization.

13 Q: During the trial, you also heard evidence in
14 regards to Grand Strand's pro forma and their
15 approval of the project that you think may
16 impact this criteria?

17 A: During the trial, to be honest with you, I was
18 stunned when I saw there was a different set of
19 financial projections and treatment volume
20 projections that were reviewed by HCA in the
21 process of approving this project and that the
22 ones in the CON application were not the ones
23 that were used for approval.

24 Q: And do you think that's a factor under this?

25 A: Well, it's a factor to indicate that the

1 expectation, based on what I've seen and heard,
2 was that the volumes are going to be a lot
3 higher, almost twice as high as the projections
4 in the CON application by HCA?

5 Q: And also did the Department have the approved
6 numbers to analyze the application?

7 A: They only had what was submitted in the
8 application, which were lower volumes.

9 Q: Let's take a look at the next project review
10 criteria. It's 2a. Do you have an opinion as
11 to which application is superior in regards to
12 community need, 2a?

13 A: Well, I feel that our application, we
14 specifically identified a target population,
15 identified a location, how important it was to
16 distribute services to where the patients live
17 and discuss the socioeconomic status of the
18 population we were targeting versus Grand
19 Strand's population is clearly the patients
20 that are already being served at our center
21 three miles from their hospital.

22 Q: Well, how do you respond to Grand Strand's
23 position that there's a population of people
24 who need or want a hospital-based linear
25 accelerator?

1 A: I'm not sure how to respond to that. I don't
2 think, based on my knowledge, that when a
3 patient is selecting where to go for radiation
4 therapy, that if it's hospital based, connected
5 to the hospital, freestanding or three miles
6 away that would be a huge differentiator.

7 Q: And what about the actual inpatient volume as
8 a target population, inpatients in the linear
9 radiation therapy treatment?

10 A: Well, it was calculated in Court, the percent
11 of treatments that are on inpatients is
12 slightly under one percent, so 99 plus percent
13 of the treatments are on outpatients. So it's
14 not very many. I know hospitals have
15 freestanding centers that they own that are on
16 their campus. They have to put them in an
17 ambulance and transport them to the center just
18 like Grand Strand did for however many years to
19 CRCC up until recently.

20 Q: Are inpatients in the hospital a sufficiently
21 large group to constitute a target population
22 for a service like this?

23 A: No, you couldn't justify it based on the
24 inpatient volumes.

25 Q: Okay. Let's take a look at the next slide,

1 Tolbert 12912. This is community need 2b.

2 What's your opinion in regards to the
3 applications, the applicants?

4 A: The applicants have to project volume
5 projections based on some reasonable
6 assumptions. The preference is to use the
7 state demographer. In this case, both Mr.
8 Sullivan and I used Claritas data, and that's
9 because we could get that at zip code level and
10 the state demographer doesn't do that and both
11 of us use very similar population projections.
12 There's really no difference.

13 Q: Let's take a look at 2c or 12913. Do you have
14 an opinion as to which applicant is superior in
15 regards to project review criteria 2c?

16 A: Some of the criteria become a little
17 repetitive, touching on the same things. This
18 one again talks about the target populations,
19 and then it discusses the assumptions and
20 methods used. We proposed to bring services to
21 identified population that does not have easy
22 access to the existing services, closer to
23 where the people live. And Grand Strand's
24 basically proposing to serve the same
25 population that we currently serve.

1 Q: Take a look at Tolbert 12914, 2e. What's your
2 opinion in regards to that project review
3 criteria?

4 A: Well, at this stage when I prepared this, both
5 our utilization projections looked like they
6 were sufficient to expand or implement the
7 service. Theirs in the application, again, may
8 be near breakeven, as the testimony I've heard.
9 So based on when I prepared this, they both
10 meet the -- that requirement.

11 Q: All right. Let's take a look at Tolbert 12915.
12 That would be project review criteria 3a,
13 distribution (accessibility). Do you have an
14 opinion as to which application is superior in
15 regards to this project review criteria?

16 A: This is one that ties directly to the
17 legislative act. One of the four purposes of
18 the CON Act in South Carolina is to prevent
19 unnecessary duplication of services. Our
20 project brings new and superior technology to
21 an underserved population inland and Grand
22 Strand's unnecessarily duplicates ours within a
23 few miles of our existing service.

24 Q: All right. Tolbert 12916. Do you have an
25 opinion on which applicant is superior in

1 regards to project review criteria 3b?

2 A: Our CON application in the record shows that we
3 clearly identified we were going to a more
4 underserved population, socioeconomically as
5 well as from a geographic standpoint, and
6 again, Grand Strand is proposing to serve the
7 same population we're currently serving.

8 Q: All right. And Tolbert 12917. You have an
9 opinion as to which applicant is superior in
10 regards to project review criteria 3c?

11 A: This is an interesting one because it says
12 support services, but it doesn't define what
13 support services are. In hospitals, you may
14 have an assistant administrator over support
15 services. They're responsible for maintenance,
16 housekeeping, laundry, kitchen, dining
17 services, "support services." I don't think
18 that's what this is addressing from a clinical
19 standpoint. I think it's addressing what
20 services are available beyond the center to
21 support its operation. Clearly, CRCC with its
22 three linear accelerators in Myrtle Beach and
23 its 35 employees in Myrtle Beach has the
24 ability to quickly respond to needs that the
25 one unit would have in Conway. Grand Strand on

1 the other end implies that it will have support
2 from Trident Medical Center, which is a little
3 over 100 miles away. The file doesn't indicate
4 what support would be provided, what they would
5 do, how quickly they could do it. There's
6 nothing to indicate how that would occur. It's
7 just mentioned that it would occur.

8 Q: Would you have expected to see that in the
9 application?

10 A: If I was preparing the application for Grand
11 Strand knowing that this would be an issue, I
12 would've recommended they have a memo of
13 understanding or something in writing that
14 would say how they were going to work together,
15 because I would've anticipated the Department
16 would -- that would be an issue, knowing I was
17 competing against CRCC.

18 Q: All right. Let's take a look at Tolbert 12918.
19 Do you have an opinion in regards to project
20 review criteria 3e?

21 A: This one, the reading of it isn't as clear as
22 my interpretation. Generally, the Department
23 here is looking at are you going to, and I
24 don't mean discriminate in a civil rights
25 standpoint, but how selective are you going to

1 be on the patients you accept? Or are you
2 going to accept indigent care? And both have
3 indicated they will accept all patients that
4 are referred to them.

5 Q: All right. Tolbert 12919. Do you have an
6 opinion as to which one is superior in regards
7 to project review criteria 3f?

8 A: This again is one that ties back to kind of the
9 target population. This one addresses to what
10 extent all residents of the area, particularly
11 low income persons, persons that are typically
12 considered medically underserved would be.

13 Again, we're moving our -- adding a new unit
14 inland to a recognized less well served
15 population, and Grand Strand is wanting to
16 provide the same thing three miles from where
17 we currently have three units.

18 Q: Would the information you presented recently or
19 earlier in regards to Exhibit 37 where you laid
20 out the per capita income for the zip codes.

21 A: Yes.

22 Q: Is that important information in regards to
23 analyzing this particular project review
24 criteria?

25 A: It would be.

1 Q: Okay. Why is that?

2 A: Because those are lower income. It's lower
3 income.

4 Q: Okay.

5 A: I didn't have room on that slide to map the
6 racial mix, but it's lower as you move inland
7 from the coast.

8 Q: More minorities as you move in?

9 A: More minorities. Yes, more minorities.

10 Q: All right. Let's take a look at Tolbert 12920
11 project review criteria 13a, record of the
12 applicant.

13 A: Certainly Grand Strand has said it's a very
14 large, extremely financially successful
15 hospital, but the truth is Grand Strand has no
16 experience providing radiation therapy
17 services, but CRCC does in that location for 30
18 years.

19 Q: Okay. How about Tolbert 12921, 13b?

20 A: The ability to basically finance the project,
21 both large corporations can write a check and
22 probably not miss the dollars.

23 Q: Let's look at Tolbert 12922, project review
24 criteria 4a. Do you have an opinion as to
25 which applicant better satisfies project review

1 criteria 4a?

2 A: Both applicants submitted just lots of letters
3 of support, and you could stack one up against
4 the other. What makes ours, I think,
5 distinctive is we have the support of a
6 hospital that has no financial interest in
7 whether or not we do the project, and that's
8 the hospital in Conway that would very much
9 like it to serve the population in the Conway
10 and Loris areas.

11 Q: All right. Let's look at Tolbert 12923,
12 project review criteria 22. Can you kind of
13 comment generally on this one? Do you have an
14 opinion as to which application is superior?

15 A: Yes, I think ours is superior, and this talks
16 about the distribution of services and the
17 effect of the project on that distribution
18 should be carefully considered. You could also
19 describe that as a way of looking at adverse
20 impact, or does the service need to be where
21 it's being proposed from a distribution
22 standpoint. And we've repeatedly said that
23 ours is in a different geographic area meeting
24 a very specific target population and theirs
25 isn't.

1 Q: How do you respond to Grand Strand's position
2 that this project review criteria would, that
3 they would satisfy this criteria by offering
4 services at a hospital-based center?

5 A: Well, 99 plus percent of the treatments are to
6 outpatients. The outpatient gets in a car,
7 drives somewhere, parks, goes into the
8 building, my experience is typically a whole
9 lot longer distance from the car to the
10 building for a hospital, goes in, goes into a
11 vault. Once they're in the vault, they don't
12 know what it's connected to. It's the same
13 style vault, same machine, don't see how it
14 makes a big difference from a patient
15 standpoint.

16 Q: Is this project review criteria generally
17 focused on geography?

18 A: When you look at the State Health Plan, excuse
19 me, the CON Act, one of the other purposes is
20 to guide the distribution of the development of
21 healthcare services to best meet the public
22 need. So my view is you're guiding the
23 distribution of healthcare services to meet the
24 public need. Geography and where the people
25 are is where the need is, and so yes, I think

1 geography is a big consideration.

2 Q: Let's take a look at Tolbert 12924, adverse
3 effects on other facilities, 23a.

4 A: This is one that directly addresses adverse
5 impact.

6 Q: Okay. Do you have an opinion as to which one
7 is superior in regards to project review
8 criteria 23a?

9 A: I think we've demonstrated that Grand Strand's
10 project would have an adverse impact on CRCC's
11 ability to maintain its volumes and continue
12 what it's doing.

13 Q: In regards to the volumes, the impact on CRCC's
14 volumes, do you believe that that adverse
15 impact is material?

16 A: Oh, yes, I think it's material.

17 Q: All right. Let's take a look at Tolbert, also
18 could ---

19 THE COURT: When you say -- excuse me.

20 MR. LONG: I'm sorry.

21 THE COURT: The adverse impact you're relating to
22 now, is that if both of them are granted?

23 A: Good question. We can look at it two ways. If
24 Grand Strand opens using their projections,
25 let's say 5,500 linear accelerator treatments,

1 where would those have gone if Grand Strand
2 wasn't open? They'd all go to CRCC. The loss
3 of 5,500 treatments, regardless of if it's
4 Grand Strand's only or both of ours, is
5 significant.

6 Q: What if the treatments were 7,500 or 8,00?

7 A: That was using their very low number. If it's
8 8,000, it's even more significant impact.

9 Q: Is adverse impact -- does sometimes the
10 Department look at adverse impact in regards to
11 staffing?

12 A: Yes, they can. I've not seen that as a big
13 issue, but it's a factor. You could lose some
14 -- well, you'd have to lose some staff if your
15 volumes were impacted that much, or I believe
16 you would.

17 Q: If the testimony was and the Court concluded
18 from the testimony that CRCC would have to lay
19 off staff members if Grand Strand's project was
20 approved, or once it came online, is that
21 something that the Court should consider in
22 regards to adverse impact?

23 A: That would be a portion of adverse impact.

24 Q: Okay. Let's take a look at Tolbert 12925,
25 financial feasibility, number 15. Do you have

1 an opinion in regards to each applicant's
2 ability to satisfy project review criteria 15?

3 A: When I prepared this, my opinion was they both
4 satisfied this criteria. Now, I know there
5 were two different sets of financial
6 projections for Grand Strand and perhaps the
7 one in the application was not so financially
8 viable.

9 Q: Let's look at Tolbert 12926, cost containment,
10 16a. Do you have an opinion in regards to 16a?

11 A: As this criteria is written, they both satisfy
12 it.

13 Q: Okay. Well, let's look at the next page, which
14 is 16c, Tolbert 12927. Do you have an opinion
15 as to which applicant is superior in regards to
16 project review criteria 16c?

17 A: What I know in terms of what providers get paid
18 and I've heard it in Court to confirm that is
19 hospital-based services get paid more than
20 freestanding independent radiation therapy
21 services, and that's true for ambulatory
22 surgery, for a variety of other services. And
23 with Grand Strand's approval, Medicare,
24 Medicaid would be paying more than they would
25 have if those patients had received treatment

1 at CRCC.

2 Q: Are there other ways to look at cost
3 containment in regards to this project review
4 criteria here, 16c?

5 A: It's so interesting, people in my classes, and
6 I do some lectures for future nursing students
7 and everybody's concerned about the cost of
8 healthcare, and I tell them, you know, the cost
9 depends on who you are. We as taxpayers are
10 concerned about the cost of healthcare because
11 we fund oh, between 50 and 60 percent of
12 everything done in healthcare is funded by the
13 government through Medicare, Medicaid, through
14 the VA, through military healthcare services,
15 and so we're concerned about the total cost as
16 taxpayers. I said employers and insurance
17 companies are concerned about the cost because
18 they pay for a lot of healthcare services. And
19 so they view costs as what their premiums are.
20 And then we as patients get concerned about
21 healthcare costs and healthcare services
22 because we're concerned about our out-of-pocket
23 costs. So all three ways you could look at it,
24 cost of the system, cost of the insured payers
25 and the cost to the patient, it can be looked

1 at in a variety of different ways.

2 Q: And is CRCC superior in all of those different
3 ways of looking at cost containment?

4 A: Absolutely.

5 Q: Let's look at Tolbert 12928, project review
6 criteria 6a. Do you have an opinion as to
7 which application is superior in regards to
8 project review criteria 6a?

9 A: We're going to continue to provide the services
10 under the same charge system and reimbursements
11 that we're currently under. Grand Strand is
12 going to be a new provider and clearly the
13 Medicare, Medicaid will pay more for the same
14 service the patient would have received at
15 CRCC.

16 Q: Let's look at Tolbert 12929, project review
17 criteria 7, projected revenues and expenses.
18 Do you have an opinion as to which one, which
19 application is superior in regards to project
20 review criteria 7?

21 A: In this case, this is addressing your up front
22 cost. It's everything to get the program up
23 and running, and clearly ours was about half of
24 Grand Strand's.

25 Q: Okay.

1 A: As DHEC defines the total project cost.

2 Q: You're talking about the total project cost.

3 Ours was like five million I think.

4 A: 5.1 versus nine point something.

5 Q: All right. Let's look at Tolbert 12930. If
6 you could tell me what this chart represents.

7 A: This is one that just shows how much quicker we
8 could be meeting the needs of patients versus
9 Grand Strand's project.

10 Q: And you think that's a fact the Department
11 could and should compare?

12 A: Well, in the CON application, you have to
13 include a projected timeline. It's a factor in
14 the review of the CON application, and if there
15 is great need for a new linear accelerator,
16 getting it to the patients a year quicker is
17 important.

18 Q: Okay. Let's look at 12931 and then you see
19 932. I think these are kind of tied together.

20 A: Yeah.

21 Q: Can you tell me what these charts represent?

22 A: These are the total project costs as calculated
23 using the Department's formula, and the total
24 project cost is significantly high, like I
25 said, almost twice as high for Grand Strand's

1 project.

2 Q: Analyzing these projects under the project
3 review criteria, do you have an opinion as to
4 which project is superior between the two
5 applications overall?

6 A: When we went to project review meeting, I felt
7 our application was clearly superior then and
8 my opinion has not changed.

9 Q: Analyzing these two applications, looking at
10 the health plan, the project review criteria,
11 the purposes of the CON Act, what's your
12 opinion in regards to which application better
13 meets or better satisfies those criteria
14 overall?

15 A: I firmly believe that CRCC's is the -- not just
16 better, much better than the Grand Strand
17 application.

18 Q: Mr. Tolbert, we looked at all those project
19 review criteria, was there anything in any of
20 those project review criteria that discussed
21 competition?

22 A: No.

23 Q: Is there anything in the purposes of the CON
24 Act that says that the Department could
25 consider or promote competition?

1 A: No, the Act says should prevent unnecessary
2 duplication of services.

3 Q: Is there anything in the project review
4 criteria that would suggest or mandate to the
5 Department that a hospital should be favored
6 over a physician in regards to an application?

7 A: No, and in some cases in State Health Plans in
8 the past, hospitals have clearly been given
9 preference. For instance, MRI scanners used to
10 be included in the State Health Plan as a
11 specific section, and in that as I recall,
12 because I did this for several clients, it said
13 that a hospital would be given preference in
14 having an MRI. Of course, when the Department
15 feels, I believe when the Department feels a
16 preference is appropriate, it's stipulated.
17 It's stipulated now in terms of maternity
18 services. If you want a level 1, 2, 3 nursery,
19 it talks about what size hospital or level of
20 number of delivers you need to justify that
21 service. In this case, it's not mentioned.
22 Why? Because 99 percent of the patients that
23 get the treatments are for patients that are
24 outpatients not inpatients.

25 Q: Would that also be true for the project review

1 criteria? Is there anything in the project
2 review criteria that would mandate or suggest
3 to the Department that hospitals should be
4 favored over physicians?

5 A: No.

6 MR. LONG: If you could give me one minute here.

7 Q: Let's look at, I've got a couple of exhibits
8 here I just want to ask you about and we're
9 going to be close to the end. All right. Let's
10 look at Joint Exhibit 11.

11 A: Yes.

12 Q: Do you recognize what Joint Exhibit 11 is?

13 A: It's a, we commonly call these JARs or the
14 Joint Annual Report that different healthcare
15 providers or facilities are required to submit
16 to sometime -- it goes to Office of Research
17 and Statistics and DHEC. This is the one for
18 Georgetown Memorial Hospital and I'm not ---

19 Q: It is the one for Georgetown.

20 A: Yes.

21 Q: Did you use some of that information in regards
22 to your summary exhibits or your exhibits that
23 you presented earlier today in regards to
24 Georgetown's utilization?

25 A: For the 2012 data that's not in the State

1 Health Plan, those were submitted last spring,
2 so that's where I got these numbers here.

3 Q: Let's take a look at the South Carolina State
4 ...

5 MR. LONG: Your Honor, I believe we've concluded our
6 direct examination. I would like to have one
7 caveat, that if I think of something over
8 lunch, maybe I could ask a question or two when
9 I come back, but I believe I'm finished.

10 THE COURT: All right. I'll limit you to those two
11 questions.

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

13 THE COURT: Ms. Biggers?

14 MS. BIGGERS: I have no questions, Your Honor.

15 THE COURT: That moves us straight to cross, and I'm
16 going to break for lunch.

17 (Lunch break from 1:00 p.m. until 1:56 p.m.)

18 MR. LONG: Your Honor, that concludes our direct
19 examination of Mr. Tolbert.

20 MR. TOLBERT - CROSS-EXAMINATION BY MR. THOMAS:

21 Q: Good afternoon, Mr. Tolbert. How are you?

22 A: Good.

23 Q: Now, you would agree with me that CRCC's been
24 providing radiation therapy services in this
25 particular service area for over 30 years,

1 correct?

2 A: It has.

3 Q: Okay. And, in fact, the only radiation therapy
4 services that most physicians in Horry County
5 know are CRCC, correct?

6 A: The only ones they know?

7 Q: That they're familiar with.

8 A: I wouldn't say that's necessarily the case.

9 Q: Okay. What other ones are they familiar with?

10 A: Well, they would potentially be referring to
11 other radiation therapy centers depending on
12 the patient's preference.

13 Q: Do you think most of the patients in Horry
14 County would want to travel south to Georgetown
15 40 miles?

16 A: No, not necessarily.

17 Q: Do you think most of their patients would want
18 to travel east to Florence 60 miles?

19 A: No, but you're asking if that's the only one
20 they know.

21 Q: Well, I said the most that they would know.

22 A: I'm sorry. Maybe I misunderstood.

23 Q: I said the only radiation therapy program most
24 of those physicians in Horry County know about
25 is CRCC in terms of services, correct?

1 A: And I'm saying they're well aware, I would
2 assume, of CRCC and they could be aware of
3 other services.

4 Q: They could be aware of other services, but you
5 would imagine, based on your knowledge as an
6 expert in the field, that they're going to be
7 most familiar with CRCC, correct?

8 A: If they refer to CRCC.

9 Q: Because a lot of physicians who don't refer to
10 radiation therapy centers, correct?

11 A: I've not calculated the percent to know what a
12 lot is, but yes, some don't.

13 Q: Okay. Now, you worked at Mayo Clinic, correct?
14 You said you were like the youngest
15 administrator there of all time, right?

16 A: As far as I know.

17 Q: Okay. Did they retire your jersey?

18 A: No, and I've not checked back with them. When
19 I was there after they hired me, they called me
20 into human resources and said we didn't realize
21 you were the age you are, our insurance
22 policies only cover people 25 and older, so.

23 Q: I hear you. Well, you'd agree with me the Mayo
24 Clinic is kind of world renown for having a
25 comprehensive cancer center, correct?

1 A: It's world renown everything it does.

2 Q: Okay. Including having a comprehensive cancer
3 center, correct?

4 A: Yes.

5 Q: Okay. And I believe you said you worked at
6 Self Regional for what, 15 years, from 1986 to
7 2001; is that right?

8 A: 2000.

9 Q: Okay. So 14 years?

10 A: Fourteen years and I think eight months.

11 Q: Okay. Now, you were director of planning and
12 marketing while at Self, right?

13 A: Vice President and administrative director of
14 planning and marketing.

15 Q: Okay. And Self had a radiation therapy center
16 within the four walls of that hospital,
17 correct?

18 A: Yes.

19 Q: And it had what, two linear accelerators within
20 the four walls?

21 A: When I stated there, they had a very, very old
22 cobalt unit and I think one linear accelerator.

23 Q: And you had no oversight of that program,
24 right?

25 A: No, I did not.

1 Q: Okay. And you would agree with me that there
2 was a benefit to the inpatients at Self who had
3 cancer who needed radiation therapy because
4 they could just go down the hall, correct?

5 A: Those few treatments that were on inpatients,
6 there would be a benefit..

7 Q: Okay. And you would agree with me that when
8 you were at Self, I think you and Mr. Long
9 talked about this. When you were at Self, Self
10 didn't just stay static and not add any new
11 services, they added open heart, correct?

12 A: That's correct.

13 Q: And neurosurgery, right?

14 A: That's correct.

15 Q: Now, when you were deposed, I believe you said
16 that the other two -- you said that other than
17 the two CRCC linear accelerator CON
18 applications for linear accelerators, you had
19 worked on four others, correct?

20 A: Four other what?

21 Q: CON applications for linear accelerators.

22 A: I wasn't sure. I think I said I would have to
23 look at the list. So I was doing it from
24 memory.

25 Q: Okay. Well I mean ---

1 A: But I think that's about right. I'd have to go
2 back and think about it.

3 Q: Okay. And I think you said one was a
4 replacement CON application, so that's like
5 equipment replacing equipment, correct?

6 A: Yes.

7 Q: And then you said there were two for South
8 Carolina Oncology Associates, right?

9 A: Yes.

10 Q: And then I think you said you did one for Aiken
11 Regional, and you may have even referenced that
12 today; is that right?

13 A: I did.

14 Q: Okay.

15 A: I believe I did two for Self Regional -- Self
16 Memorial.

17 Q: Okay. And when you did the -- when you did the
18 ones for South Carolina Oncology Associates,
19 you actually had a chance to visit that center,
20 correct?

21 A: Yes, I did.

22 Q: And you were impressed by SCOA's operations?

23 MR. THOMAS: SCOA is South Carolina Oncology
24 Association, Your Honor.

25 Q: You were impressed by their operations, weren't

1 you?

2 A: It is a very nice facility.

3 Q: And one of the things that impressed you is
4 that they've got all the cancer treatment
5 capabilities under one roof, correct? Isn't
6 that what you testified to?

7 A: Except they don't do inpatient.

8 Q: Okay. But everything else they have under one
9 roof, right?

10 A: They do.

11 Q: Okay.

12 A: Also, they don't do surgery there, by the way.

13 Q: Okay. Are you sure about that?

14 A: As far as I know. I don't believe they're
15 licensed as a surgery center. I've not looked
16 that up lately.

17 Q: Okay. You haven't looked that up, but you know
18 that they employ cancer surgeons there,
19 correct?

20 A: When I did the CON application, I don't recall
21 discussing that with them.

22 Q: And you also know that they do diagnostic
23 radiation there, correct?

24 A: Diagnostic radiation?

25 Q: Radiology, excuse me.

1 A: Oh, you mean like regular x-ray service?

2 Q: Right. Right.

3 A: They, as I recall, they do have some x-ray

4 units.

5 Q: They do infusion therapy there, correct?

6 A: They do.

7 Q: They have a hospice program there, right?

8 A: There wasn't -- I didn't have anything to do

9 with that. I don't remember seeing it.

10 Q: You don't recall that?

11 A: Oh, I'm sorry, no.

12 Q: Okay.

13 A: I don't recall that.

14 Q: You would agree that one benefit at SCOA is

15 that the patients undergoing dual therapy can

16 get their chemotherapy and then go right down

17 the hall and get their radiation therapy,

18 correct?

19 A: Actually, it's on different floors.

20 Q: Okay. So they've got to take an elevator then?

21 A: Yeah.

22 Q: Okay.

23 A: As I recall.

24 Q: All right. And you worked on the linear

25 accelerator at Aiken, right?

1 A: That's correct.

2 Q: Okay. And that one you said is not actually
3 within the four walls of the hospital, was it?

4 A: It's a separate building.

5 Q: It's on its campus, right?

6 A: Yes.

7 Q: Okay. And you realize that, thanks to your
8 work, that Aiken Regional was actually able to
9 advertise itself on the website to its patients
10 that it offers a full continuum of care and
11 cancer services? Did you know that?

12 A: Did not know that.

13 Q: Do you agree with that statement that Aiken
14 Regional does do that?

15 A: I'm sorry?

16 Q: That they offer a full continuum of care for
17 their cancer patients?

18 A: I don't know if they have, for instance, a
19 gyn/oncologic surgeon on staff or not, so I
20 don't.

21 Q: So you didn't really get that involved. You
22 just did their CON application but didn't learn
23 much about the cancer program there?

24 A: I wasn't employed to help them with their
25 marketing of their programs.

1 Q: Well, I mean, you at least did the research
2 about what their cancer program was about,
3 right, or you did your CON analysis?

4 A: The CON analysis that I did dealt purely with
5 the linear accelerator.

6 Q: Okay. So you really just kind of walled off
7 the cancer program in Aiken and just
8 concentrated on the radiation therapy; is that
9 what you're saying?

10 A: What did you say?

11 Q: Let me ask you this. Do you know anything
12 about Aiken's cancer program?

13 A: I have not -- wasn't engaged to look at their
14 whole cancer program.

15 Q: So you don't know if they offer a continuum of
16 care at Aiken Regional for cancer patients?

17 A: I ---

18 Q: Fair enough. We'll move on. You don't know.
19 All right. Would you agree with me that a
20 primary purpose stated by CRCC to establish its
21 radiation therapy center in Conway is so that
22 it can bring radiation therapy services closer
23 to the patients it already serves in Conway.

24 Is that a fair statement?

25 A: That was a fair statement.

1 Q: Okay. Now, you would agree with me that
2 Georgetown has made the same claim in its
3 Murrells Inlet CON application, that it wants
4 to bring its services closer to the majority of
5 the patients that it serves in Georgetown
6 county, correct?

7 A: That was the claim in the CON application.

8 Q: Okay. And do you think that Georgetown's
9 volumes bare that out?

10 A: I'm sorry, I don't understand your question.

11 Q: Do you think that the radiation therapy volumes
12 bare that out?

13 A: I don't bare -- help me, bare?

14 Q: Bare out the statement that they want to bring
15 their services closer to their own patients.

16 A: I'm sorry, Mr. Thomas. I'm not understanding
17 what bare out means.

18 Q: All right. Do you think that ---

19 A: Are you ---

20 Q: --- Georgetown's volumes and their zip code
21 data justify what they said in terms of wanting
22 to bring their services to the patients in
23 Murrells Inlet and that part of Georgetown
24 County?

25 A: I believe that they were projecting higher

1 volumes if they relocated their center to
2 Murrells Inlet, and I also believe that they're
3 creating a disadvantage to the patients that
4 are in the Georgetown and the western part of
5 Georgetown County by moving it farther from
6 them.

7 Q: Well, didn't you testify that you think that
8 Georgetown County wants to move just to take
9 CRCC's market share? Isn't that what you
10 testified?

11 A: I believe that their increase in volume that
12 they were projecting assumed they would be
13 taking some of CRCC's existing patient
14 referrals from the Murrells Inlet area.

15 Q: Well, we can look at your testimony. You
16 testified that that was their reasoning, was to
17 take the market share from CRCC, right?

18 A: If they're increasing significant growth and
19 volume, and if all they're doing is treating
20 the patients they currently have, I concluded
21 that the growth in volume would have to come
22 from CRCC's patients.

23 Q: Well, do you think that the reasoning that
24 Georgetown used to bring its services closer to
25 the majority of the patients that it serves is

1 applicable, is justified, just as CRCC makes
2 the same statement?

3 A: I think they can justify it however they want
4 it. I could disagree with it.

5 Q: Do you think CRCC is the only magnanimous
6 applicant that's serving the service area by
7 wanting to bring their patient's services
8 closer?

9 A: Help me understand what you mean by
10 magnanimous.

11 Q: What do you think it means? You're a
12 professor.

13 A: Magnanimous, generous?

14 Q: Yeah, there you go.

15 A: Is that what you mean?

16 Q: Yeah.

17 A: Now, re-ask the question if you would, please.

18 Q: All right. Do you think that CRCC is the only
19 generous applicant that wants to bring services
20 closer to its patients?

21 A: I would think Grand Strand, North Strand, which
22 is not a part of this, and Georgetown are all
23 wanting to serve patients.

24 Q: Wanting to serve their patients?

25 A: And more.

1 Q: When I deposed you back in August, and when I
2 say August, August of 2013, I think it was
3 August 8th and I asked you about Ms. Brandt's
4 reasoning in this case regarding why she
5 thought Grand Strand would have an adverse
6 impact on Georgetown's relocated CON
7 application, do you recall that your response
8 at the time was that you didn't know?

9 A: I accept that.

10 Q: Okay. And you would agree with me that you've
11 done no analysis yourself with respect to what
12 kind of impact that Grand Strand would have on
13 Waccamaw or Georgetown Hospital for its
14 radiation therapy program, correct?

15 A: No.

16 Q: It's not correct, or?

17 A: The answer was no.

18 Q: Am I not correct?

19 A: That's correct. You're not correct.

20 Q: Okay. So tell me the analysis that you did,
21 because it hasn't been produced to me, with
22 respect to what kind of impact Grand Strand
23 would have on Waccamaw or Georgetown Hospital
24 and its radiation therapy program?

25 A: No, I looked at -- and I had not done it before

1 the deposition -- at market share by county and
2 discovered that Grand Strand has, I think it
3 was 8.5 percent market share of all of
4 Georgetown County. I didn't know that before,
5 well, when you asked that question in the
6 deposition. And I know in the Grand Strand
7 application, they assumed they would get one
8 percent of the market in Georgetown County, but
9 their inpatient market share was 8.5 percent.
10 That was information that I learned after the
11 fact.

12 Q: Okay. So do you think then that Grand Strand
13 is going to have an 8.5 percent impact on the
14 radiation therapy program at Georgetown based
15 on our inpatient market share?

16 A: I think it will be more than one percent.

17 Q: How many patients does CRCC get from
18 Georgetown?

19 A: It's not a lot. I don't remember that number.

20 Q: You think it's eight percent?

21 A: As I said, I don't remember that number.

22 Q: Well, let's go to Joint Exhibit 1, page nine.

23 A: Yes.

24 Q: Okay. And I want to, just for the record again
25 so I know, did you state that you drafted this

1 in kind of collaboration with a team?

2 A: That is correct.

3 Q: Okay. Now, you would agree with me, first of
4 all, that CRCC's facility can come online and
5 begin treating patients if both are approved a
6 year before Grand Strand's facility, correct?
7 I mean, you made a bar graph of that earlier --

8 -

9 A: Yes.

10 Q: --- is that a fair statement?

11 A: Yes.

12 Q: So CRCC and Conway would be well established
13 for a year before Grand Strand treats the first
14 radiation therapy patient, correct?

15 A: If they were both approved at the same time,
16 both initiated the project at the same time.

17 Q: Well, that's what you assumed, right?

18 A: Yes.

19 Q: And you would agree with me that CRCC's current
20 level of utilization is a testimony of its
21 strong referral base, right?

22 A: Yes.

23 Q: And you also agree that Grand Strand will not
24 have the level of support that CRCC has earned
25 within the provider community, correct? That's

1 a strong word there, isn't it, earned?

2 A: Earned based on past experience.

3 Q: Okay. Thank you. And you don't deny that CRCC
4 has greatly improved provider relations and
5 reversed historic patient outmigration,
6 correct?

7 A: Correct.

8 Q: And that's since 21st Century took them over,
9 correct?

10 A: That's correct.

11 Q: And they enhanced operational effectiveness; is
12 that right?

13 A: That is correct.

14 Q: And they enhanced technology there too, right?

15 A: That is correct.

16 Q: Okay. Now, back in August, August 8th I think
17 when I deposed you, I asked you if you had
18 asked to see what CRCC's volumes were for 2013,
19 and you said you hadn't done that, right?

20 A: That is correct.

21 Q: And the reason that you didn't ask for those
22 volumes is that you typically like to use a
23 full year of data when you're doing your
24 analysis, correct?

25 A: Typically.

1 Q: And the fact is you like to use a full year of
2 data because you're not 100 percent sure of
3 what's going to happen in the next five months,
4 correct?

5 A: That's correct.

6 Q: Okay. Now, Mr. Tolbert, with respect to Grand
7 Strand's reliance on support from Coastal
8 Cancer Center physicians, that's been a big
9 issue in this case, correct?

10 A: I've heard a lot of testimony about that.

11 Q: Right. Now, you would agree with that Grand
12 Strand Regional Medical Center was very open
13 about that support in its CON application,
14 right?

15 A: It is discussed in there.

16 Q: Okay. We can go through the application if you
17 want, but there are many, many references to
18 Coastal Cancer Center and within Section B of
19 the application, correct, and the support?

20 A: You say many, many. I haven't counted. I
21 don't know how many that is.

22 Q: Well, let's do it. Let's go to Grand Strand's
23 Joint 2, and go to page seven in Joint Exhibit
24 2 for me. Okay. And look at the bottom,
25 excuse me, look at under B-2, first full

1 paragraph and kind of come down almost to the
2 end there where it says, The location of Grand
3 Strand's radiation therapy facility; you see
4 that sentence?

5 A: Yes, I do.

6 Q: Okay. And it says, "On its hospital campus and
7 proximate to Coastal Cancer Center," correct?

8 A: It does.

9 Q: Okay. Now, turn the page over to, go over to
10 page 23 in Joint 2 for me.

11 A: So we were on seven and we're going to 20?

12 Q: 23.

13 A: 23.

14 Q: All right. Let me know when you get there.

15 A: I'm on 23.

16 Q: Okay. And then I believe this is 6B, and if
17 you look at the second full, excuse me, third
18 full paragraph.

19 A: Beginning with?

20 Q: Grand Strand coordinates.

21 A: Yes.

22 Q: And what does it say there? Who does they say
23 they coordinate care for cancer patients with?

24 A: The medical oncologists at Coastal Cancer
25 Center.

1 Q: Okay. And turn the page again for me to 24, if
2 you would, and that first full paragraph
3 starting with cancer treatment, right?

4 A: Yes.

5 Q: What does that, it says, With the addition of
6 radiotherapy services to a new facility located
7 on Grand Strand campus in close proximity to
8 whom?

9 A: Coastal Cancer Center.

10 Q: Okay. And the next sentence, "Radiation
11 oncologists and medical oncologists will be
12 practicing in close proximity," correct?

13 A: That's what it says.

14 Q: Okay. Turn to page 31 for me of Joint 2. And
15 do you see the map there?

16 A: I do.

17 Q: Look at the second first -- second full
18 paragraph on page 31 and read the first
19 sentence for me.

20 A: The medical oncologists at Coastal Cancer
21 Center are a major referral source for the
22 existing radiation radiotherapy programs in the
23 service area with the majority being referred
24 to CRCC.

25 Q: Okay. So there's a reference there too,

1 correct?

2 A: It is here.

3 Q: Okay. And look at the last sentence on the
4 page here. I'll read it. "The proposed Grand
5 Strand radiotherapy program will provide needed
6 capacity in Horry County and at the same time
7 permit Grand Strand and Coastal Cancer Center
8 to offer comprehensive cancer diagnosis and
9 treatment on adjacent campuses," correct?

10 A: That's what it says.

11 Q: Okay. Turn the page to page 37. Let me know
12 when you get there.

13 A: I am there.

14 Q: All right. Look under 12-2 there. There's
15 another reference here. It says, "For all the
16 reasons stated above, Grand Strand chose the
17 alternative to establish a radiation therapy
18 center on its campus which is adjacent to the
19 Coastal Cancer Center," correct?

20 A: That's what it says here.

21 Q: Right there, I think I counted seven references
22 to Coastal Cancer Center in Section B, correct?

23 A: You did.

24 Q: And you would have read Section B of Grand
25 Strand's application to get prepared for the

1 project review meeting, right?

2 A: Yes.

3 Q: Okay. And you would agree with me as well that
4 CRCC had the number of referrals from Coastal
5 Cancer Center physicians in 2011 at the time of
6 the project review meeting, correct?

7 A: I don't -- we didn't have the 2011 data.

8 Q: I'm sorry. Well, the year to date. You would
9 have had the year to date data, correct?

10 A: I don't believe I did at that time, but ---

11 Q: You could have gotten access to it, correct?
12 Because didn't you supply that very data to the
13 Department 15 days after the project review
14 meeting?

15 A: Yes, it was - it was supplied at the request of
16 the Department after the project review
17 meeting.

18 Q: Okay. Let me ask you this. Are you telling me
19 you wouldn't have access to the referral data
20 of Coastal Cancer Center before the project
21 review meeting; Is that your testimony today?

22 A: I'm sorry, would I or could I or what's your
23 ...

24 Q: Yeah, are you saying that you didn't have any
25 access, that you couldn't have called Rich

1 Lewis or Ms. Price or Ms. Maynor to ask for the
2 Coastal Cancer Center physicians referrals to
3 CRCC?

4 A: I certainly could have asked. I can tell you
5 they were very reluctant to give the data to
6 DHEC after DHEC asked because it was considered
7 proprietary information that they didn't want
8 in the public domain under Freedom of
9 Information.

10 Q: But you still supplied it, right?

11 A: Because they asked and we wanted to comply with
12 what the Department asked.

13 Q: So you couldn't have made an argument before
14 the Department that Coastal Cancer Center, at
15 the project review meeting that Coastal Cancer
16 Center was a major referral source and we were
17 going to lose a lot of patients from Coastal
18 Cancer Center? You couldn't have made that
19 argument?

20 A: We could have.

21 Q: But you didn't, right?

22 A: Did not see a need to.

23 Q: Never mentioned to the Department, hey, we may
24 lose 58 percent of our referrals from Coastal
25 Cancer Center because the proximity of Grand

1 Strand to Coastal and because of the
2 relationships between the Coastal Cancer Center
3 physicians and Grand Strand; you never made
4 that argument, did you?

5 A: Did not see a need to in the project review
6 meeting.

7 Q: In fact, the name Coastal Cancer Center doesn't
8 appear anywhere in your project review
9 analysis, does it?

10 A: Not that I recall.

11 Q: It doesn't appear in any single submission to
12 the department, and you submitted two letters,
13 not just one, because you wanted to do a
14 rebuttal as well, right? You submitted two
15 letters and not one makes a mention of losing
16 referrals from Coastal Cancer Center, the one
17 practice that was highlighted seven times in
18 Section B of Grand Strand's application,
19 correct?

20 A: Well, not to get picky, but it wasn't just in
21 -- I see what you're saying. No, we didn't.

22 Q: Okay. And I think you've heard testimony in
23 this case, and maybe you even believe this, but
24 that comprehensive cancer care can be well
25 accomplished over the phone and via email and

1 video conferencing. Do you believe that?

2 A: I believe today many physicians collaborate on
3 patient care without seeing each other face to
4 face.

5 Q: But you would agree with me that in terms of
6 the very best communications, the best way
7 preferably of any communications is face to
8 face, isn't it?

9 A: In fact, I would agree with you. That's what
10 I teach my students. In the time pressured
11 lives of physicians, that is very often not
12 feasible or possible.

13 Q: Well, business people also have time pressured
14 lives too, but let me ask you this. If that's
15 the standard for your management students,
16 face-to-face communications, wouldn't you agree
17 with me that would apply equally, if not more,
18 to physicians who are making life and death
19 decisions.

20 A: What I tell my business students is face to
21 face is the best way because you get body
22 language, you can see the person. But I also
23 tell them the vast majority of communications
24 that they will experience is via phone and
25 mostly email and text messaging, so you've got

1 to be good at that too.

2 Q: Right. You don't think they already know that?

3 A: My students?

4 Q: That the majority of their communications is
5 going to be by text messages, phones, and
6 email?

7 A: Not in the business world where they're headed
8 because they have no real experience at it.

9 Q: Well, when I deposed you back in August, you
10 had absolutely no idea at the time of the
11 treatment volumes of CRCC declined from 2011 to
12 2012, did you? That's what you testified to,
13 right?

14 A: That is correct.

15 Q: And, in fact, you told me on August 8th that
16 you hadn't spoken to anyone on the team at CRCC
17 for six to eight months, right?

18 A: That was the best of my recollection, yes.

19 Q: You would agree with me, Mr. Tolbert, that the
20 fact of Loris and McLeod filing a CON
21 application to open up a radiation therapy
22 center in North Myrtle Beach greatly
23 accelerated the process of getting the CON
24 application put together by you and filed with
25 the Department, that's something we can agree

1 on, right?

2 A: Yes.

3 Q: Okay. You would agree with me that as late as
4 February 16th, CRCC wasn't sure if it was going
5 to file the CON application in Conway because
6 it was still considering North Myrtle Beach as
7 a viable location, correct?

8 A: I don't -- no, necessarily agree with that.

9 MR. THOMAS: Get out the deposition. One second,
10 Your Honor.

11 Q: Go to page 297.

12 A: Would you mind repeating your question so I can
13 be sure I understand it?

14 Q: Yeah. I asked you if you would agree with me
15 that as late as February 16th, CRCC wasn't sure
16 that it was going to file a CON application for
17 a new center in Conway because it was still
18 considering a North Myrtle Beach location?

19 A: The -- and I've not looked at what I testified.
20 here in the deposition, a final decision had
21 not been made, if that's your question.

22 Q: Okay. And the reason the final decision hadn't
23 been made was because y'all were still
24 considering North Myrtle Beach as a potential
25 location, right?

1 A: My answer, and maybe I misunderstood your
2 question, I wasn't. Some people on the team
3 were debating about North Myrtle Beach versus
4 Conway.

5 Q: Okay. So you were kind of waiting for the
6 decision to be made; is that a fair statement?

7 A: Well, as I recall, I'd have to look at it. I
8 hadn't been engaged to do it yet, so we were
9 still talking about ...

10 Q: You don't think that by February 16th, you had
11 been formally engaged?

12 A: I just don't remember when that contract was
13 signed.

14 Q: Okay. But you think it was around that time?

15 A: For Conway.

16 Q: Okay. Well, that's what I'm asking.

17 A: I think so.

18 Q: And Conway, the application was submitted on,
19 it was received by the Department on March
20 10th, right?

21 A: Yes.

22 Q: So you put that application together pretty
23 quickly, didn't you?

24 A: Yes.

25 MR. THOMAS: Okay. Let's go to Petitioner's 47. If

1 you'd put that on the screen for me, Ms. Tuska.

2 All right. And let's blow up the bottom part
3 here, the email from Doug Bryant.

4 Q: And you're on this email, right, Mr. Tolbert?
5 Doug Bryant to Sam Tolbert December 22nd, 2010,
6 right?

7 A: I am.

8 Q: Okay. And on this one here, the very last
9 line, it says, "An expansion would be the
10 location of a facility in North Myrtle Beach.
11 We may plan for this but may not move on it
12 until later," right? You knew that, at least
13 you knew that was a location that was under
14 consideration, correct?

15 A: This email is from Doug Bryant, another
16 consultant. He's not the decision-maker. That
17 seems to be his opinion.

18 Q: Okay. Well, let's go up to the next one. And
19 you put Sam Tolbert, agreed, right? That's
20 what you say there, agreed.

21 A: Flip back to the email.

22 Q: Sure.

23 A: I'm not sure what I was agreeing to.

24 Q: It says, "The conference line died, so I'm
25 clarifying the following," ---

1 MR. LONG: Your Honor, we need to make an objection
2 here and just point out to the witness, you
3 know, this is difficult because he's doing a
4 string and he's only showing him parts of a
5 page. He's clearly missing an email in the
6 middle there, so ---

7 MR. THOMAS: All right. Hold on. Let's bring up.
8 Let's see the book.

9 MR. LONG: He's skipping over emails.

10 MR. THOMAS: I'm not skipping over anything. 47 for
11 me. Petitioner 47.

12 A: I'm at 47.

13 Q: Okay. I tell you what. Since, why don't you
14 just read what Doug Bryant wrote you.

15 A: Well, first of all, he wrote it to not just to
16 me, but it says, "The conference line died so
17 I'm clarifying the following. We will proceed
18 with the TrueBeam equipment as our replacement
19 linear accelerator. We should seek affiliation
20 with Duke or other entity. We should revisit
21 MUSC to determine if they can restart the
22 discussions. We need to discuss the confusion
23 regarding the expansion question. We're
24 relocating, not expanding by moving to Murrells
25 Inlet. I've discussed this issue with Wade

1 Mullins and he concurs. An expansion would be
2 the location of a facility in North Myrtle
3 Beach which we may plan for this but not move
4 forward until later. Thanks, Doug."

5 Q: Okay. And let's look at the next one, from you
6 to the same group of gentleman. What do you
7 say?

8 A: I just say agreed.

9 Q: Agreed, right? At that point in time, the
10 location was North Myrtle Beach and you made a
11 plan for that later, correct?

12 A: That's what the email says.

13 Q: Okay. Now, just for the record, because I've
14 heard seven different things. But your travel
15 time analysis at the end of the day found that
16 on average, a patient that's going to travel to
17 CRCC but that would otherwise use Conway, is
18 going to save about ten minutes travel time,
19 correct? One way travel time?

20 A: I believe that was each way.

21 Q: Okay. And coming back to Joint Number 1, if we
22 could, page 23. If you'd go down, Mr. Tolbert,
23 to the standard there.

24 A: Bear with Mr. Thomas. This book is not the
25 right one with that exhibit. Let's see, Joint

1 1.

2 Q: This one.

3 A: Thank you. What page?

4 Q: Let's go to 23.

5 A: Page 23?

6 Q: Right.

7 A: Or Bates 23?

8 Q: Bates 23, yeah. Everything is pretty much

9 Bates here.

10 A: Thank you.

11 Q: Okay. And on --- would you read, would you
12 have written this paragraph under Standard 8?

13 A: Yes.

14 Q: Okay. Can you read the first sentence for me?

15 I tell you what, just read the first two
16 sentences for me.

17 A: "The historical utilization of CRCC's service
18 clearly documents a strong and growing referral
19 base of patients. As noted, about 98 percent
20 of patients referred to CRCC are from
21 physicians and CRCC has a long history of
22 strong support in the medical community within
23 the three-county region."

24 Q: Okay. And that's evidenced by three decades of
25 service, correct?

1 A: It is.

2 Q: And would you agree with me, Mr. Tolbert, that
3 y'all made a lot of statements to DHEC that are
4 very similar to that in the application and
5 then in the project review meeting try and make
6 your case to hey, give us the fourth linear
7 accelerator, right?

8 A: Yes, we did.

9 Q: Okay. Go to CRCC DHEC record 623 for me.
10 That's Joint 1, 623.

11 A: Yes.

12 Q: Okay. And this is a letter from you on
13 November 28, 2011. This is the -- is this the
14 post project review letter?

15 A: It is.

16 Q: Okay. And you're responding -- well, you set
17 out a lot of statements about regarding Grand
18 Strand Regional Medical Center, correct?

19 A: Yes.

20 Q: Okay. And you've got some attachments on here,
21 right? I think that's the first attachment may
22 be the analysis of impact of approval of two
23 new linear accelerators, and that I think
24 starts on 631; is that right?

25 A: Yes.

1 Q: Okay. And the volumes that you used, that you
2 used here in Grand Strand which is for Grand
3 Strand is 4690, you used that from the
4 application, correct, to demonstrate what the
5 adverse impact would be in the year 2015,
6 right?

7 A: Mr. Thomas, where are you referring to?

8 Q: It's your document, right?

9 A: No, I'm asking, you're calling out a number.
10 Is it the one, you're talking about the bottom
11 right of the page?

12 Q: Correct.

13 A: Okay. Yes, it says 4,690.

14 Q: Okay. You actually used the higher one, chose
15 the higher one that Mr. Sullivan did from his
16 draw rate analysis, correct? That's not the
17 one that's originally that he did in the B-11
18 of the application, right?

19 A: I believe we used the one that he used in the
20 project review presentation.

21 Q: Okay. So you used that one. That's from his
22 draw rate analysis, right?

23 A: I don't recall exactly where that number came
24 from.

25 Q: Okay. And nowhere in this, nowhere in this

1 analysis of adverse impact do you reference, or
2 within the document, within your letter do you
3 reference that Grand Strand's market share
4 should be the metric used to show the real
5 impact of its program against CRCC, correct?

6 A: No, I did not at that time.

7 Q: Okay. And through the South Carolina Office of
8 Research and Statistic data back here in 2011,
9 you certainly had the access to what the
10 individual hospital market shares were for
11 particular counties for total inpatient
12 discharges, correct?

13 A: I did. I didn't need it because using his
14 numbers, they would have driven our utilization
15 of the existing providers below 80 percent.

16 Q: Okay. Well, that's just for one. That's if
17 you're assuming both are approved, correct?

18 A: That's correct.

19 Q: You never did an analysis assuming just one's
20 approved, right?

21 A: I was planning on ours to be approved.

22 Q: Okay. Again, I'll ask it. No market share
23 impact, correct?

24 A: I did not need to analyze that for this
25 purpose.

1 Q: Well, you didn't do it because it doesn't make
2 sense to apply inpatient market share to an
3 outpatient service, does it?

4 A: I disagree with that.

5 Q: And wouldn't you agree with me, Mr. Tolbert,
6 that another reason that you didn't do a market
7 share analysis that shows Grand Strand's going
8 to be operating off the charts by year three of
9 operations is that you didn't think that Grand
10 Strand would even be able to provide the
11 necessary resources to ensure the operating of
12 a quality radiotherapy program?

13 A: I'm sorry, could you break that into a smaller
14 piece for me?

15 Q: Well, I mean, isn't that one of the reasons you
16 didn't do the market share impact, which would
17 show 8,200 linear accelerator treatments
18 because you didn't even think Grand Strand was
19 able to pull off a good quality radiation
20 therapy program, right?

21 A: I wouldn't necessarily agree with that.

22 Q: Okay. Well, go to page 262 in your deposition
23 for me. Let me know when you get there.

24 A: I am there.

25 Q: Okay. Now, look at line 10 for me. I asked

1 you, "Do you think they are going to be able to
2 provide the necessary resources to ensure the
3 operating of a quality radiotherapy program,
4 yes or no?" And what do you say?

5 A: I said, "I'm not sure."

6 Q: You weren't sure that Grand Strand, the reason
7 you used their number 4,978 or whatever, or
8 4,690 was because you weren't even sure that
9 Grand Strand was going to be able to pull this
10 off, right? That's what you testified to.

11 A: Well, I think -- I thought later on we talked
12 about it and I said I believed they would give
13 it a lot of effort, but I couldn't guarantee it
14 so I wasn't sure.

15 Q: That's right. That's all I'm asking. You
16 weren't sure, correct? And you're still not
17 certain if Grand Strand has the ability to set
18 up a high quality program, correct?

19 A: I am not sure. I know they will give it their
20 best effort if they spend \$10 million on it.

21 Q: Okay. Well, that's what it costs to build one
22 of these things, right?

23 A: That's what their project costs are.

24 Q: Well, you already had a prefab modular house,
25 or CRCC-Conway was kind of prefab constructed,

1 correct? Y'all didn't actually have to build
2 something from the ground up, right?

3 A: There was an existing building. Was it prefab
4 modular?

5 Q: You don't know because you've never been inside
6 of it, right?

7 A: I visited the site. I didn't go inside the
8 building. The outside did not look like a
9 modular doublewide mobile home. It looked like
10 it was built onsite.

11 Q: I didn't call it a doublewide mobile home, did
12 I? I said modular, didn't I?

13 A: Modular prefab

14 Q: Okay. Now, go to kind of within the same
15 exhibit of Joint 1 there. Go to CRCC DHEC
16 record 641 for me.

17 A: Yes.

18 Q: Did you make this letter of support grid here
19 that you attached to your letter?

20 THE COURT: You said Joint 1, page what?

21 MR. THOMAS: Oh, excuse me, I'm sorry Judge, it's
22 actually Joint -- yeah, Joint 1, 641.

23 THE COURT: 641.

24 MR. THOMAS: Yeah. Sorry.

25 A: I don't recall that I typed this.

1 Q: Well, aren't there physicians on Grand Strand's
2 medical staff on this list?

3 A: Yes.

4 Q: Okay. And there's a lot of support from the
5 Conway medical staff too, correct?

6 A: Yes.

7 Q: And do we got any Coastal Cancer physicians on
8 here, or do those come later?

9 A: I'm sorry, Mr. Thomas, I don't have their names
10 memorized.

11 Q: Okay. That's fine. Turn the page for me to
12 642. Now, this is the patient referrals by
13 referring physicians for the previous 12 months
14 from November 2010 through October 2011,
15 correct?

16 A: Yes.

17 Q: Okay. And from this data, for this rolling
18 kind of 12 month period, we can find out what
19 each physician, how many patients under
20 treatments they referred to CRCC, right?

21 A: Yes, these are patients referred.

22 Q: All right. Turn over to page CRCC 646 for me
23 if you would. It's just a couple of pages to
24 the right.

25 A: I'm there.

1 Q: What's that total number of unique count of
2 patients treated at the end of that, it's a
3 nice round number, but at the end of the 12
4 month period?

5 A: The number is exactly 1,000.

6 Q: Okay. And so what's the average number of
7 treatments when you have prostate cancer in
8 the patient mix for linear accelerator
9 services?

10 A: I'm sorry, I was -- I was wanting to say I
11 don't believe these are patients. These are
12 patients referred, not ones that actually got
13 radiation therapy treatment.

14 Q: Look at the top of the right-hand column and
15 I'd like you to read that into the record for
16 me.

17 A: It says patients on treatment by a referring
18 physician.

19 Q: Unique count of patients treated, correct?

20 A: Yes.

21 Q: And what is -- what did you say earlier that
22 the average number of cancer treatments per
23 patient is?

24 A: Just a national number that's used is 25.

25 Q: Where's that natural number appear? What

1 document? You've referenced it a couple of
2 times. I'm just curious.

3 A: I said it's a generally accepted number that is
4 used. I'm not sure I quoted a specific
5 document or can sit here and cite it for you.

6 Q: So you're not certain where you're coming up
7 with that number; is that a fair statement?

8 A: I know it's commonly used. I see it in a lot
9 of CON applications I've looked at, so that's,
10 and I've heard testimony about it.

11 Q: Well, you knew, one thing you do know, that in
12 2009, you knew what the actual number was for
13 all the patients treated at CRCC and
14 Georgetown, correct?

15 A: I knew it for the region.

16 Q: Okay. And what was it?

17 A: Twenty-one point something.

18 Q: Okay. And so back to 646 in Joint 1, 1000
19 treatments right? Unique count of patients
20 treated. So if the average is 25 like you say,
21 what is that going to be for that rolling 12
22 month period?

23 A: If you accept the 1,000 of the patients that
24 were actually received radiation therapy, that
25 would be 25,000 if you multiple it by 25.

1 Q: Okay. Do you recall what the year end number
2 was, Mr. Tolbert, for 2011 for CRCC if we
3 accept that this is a unique count of patients
4 treated for 2012? Do you remember that, or
5 excuse me, for 2011. Do you recall what the
6 year end number was?

7 A: Twenty -- not off the top of my head. I'm sure
8 ---

9 Q: Do you agree with me it was 25,709?

10 A: That would be -- yes.

11 Q: Okay. And so this was tracking pretty close
12 for that rolling 12 month period. If we use
13 your number of 25, I multiply that by the
14 unique count of patients treatment, I come up
15 with 25,000, and then CRCC at the end of the
16 year in their JAR report for the calendar year
17 period reported 25 and change, correct?

18 A: What I would prefer to look at is their JAR
19 report for that year to see how many patients
20 they reported that were unduplicated patients,
21 but I don't remember that number.

22 Q: Well, I just read for you the State Health Plan
23 number. Where does the State Health Plan get
24 the number of treatments for the provider?

25 A: It's from the JAR report.

1 Q: Okay. Thank you. Now, go to CRCC 651 for me.

2 A: Yes.

3 Q: Okay. I think yesterday there was some
4 discussion by Ms. Price. You weren't here for
5 the testimony, right?

6 A: No.

7 Q: Okay. You weren't here yesterday, but do you
8 recall when Dr. Holt's letter went in to CRCC,
9 or excuse me, let me rephrase. Do you recall
10 when Dr. Holt's support letter for Grand Strand
11 went in for -- went into DHEC?

12 A: For what?

13 MR. THOMAS: Bear with me, Your Honor.

14 Q: Look in Joint Exhibit 2 for me. Sorry to make
15 you jump around. That's kind of how it works.
16 Joint Exhibit 2, page 891 of the Bates. It's
17 going to be towards the end there.

18 A: I'm on 891.

19 Q: And this is the support letter from Dr. Holt to
20 Beverly Brandt where Dr. Holt is stating they
21 support Grand Strand Regional Medical Center's
22 application, correct?

23 A: Correct..

24 Q: This is December 1st, right?

25 A: That's the date on the letter.

1 Q: And your letter that's in Joint 1, page 651,
2 what's the date on that?

3 A: That letter is December the 7th.

4 Q: I'm seeing December 16th, 2011.

5 A: Oh, I'm sorry. I'm on the wrong page.
6 December 16th.

7 Q: Okay. And my question to you was during that
8 two week period from December 1st when the
9 letter was received by DHEC and December 15th
10 or 16th when you wrote that letter, and
11 Beverly's pretty good about getting these out,
12 did you get any phone calls or anything frantic
13 from Ms. Price or Ms. Maynor or Mr. Lewis or
14 anybody at CRCC that Dr. Holt had sent in a
15 letter of support?

16 A: I don't remember.

17 Q: Okay. Also, you said something about Ms.
18 Brandt was very good about getting these out.
19 That's not my recollection.

20 Q: Okay. That's fine.

21 A: Requesting something under Freedom of
22 Information could take weeks to get processed
23 to know what might be put in the file.

24 Q: Let me ask you this. By December 15th in your
25 letter, and just for the record, there's no

1 other, there's no other references in here to
2 Carolina Regional Cancer Center being decimated
3 or devastated by Grand Strand's support from
4 Coastal Cancer Center, is there? Let me know
5 if there is.

6 A: Not to my -- no.

7 Q: And you would agree with me that you had
8 already, you had the data back from your
9 earlier letter with Exhibit D with the patient
10 referrals by referring physicians, so at this
11 point you knew and could have ascertained all
12 the different referrals from Coastal Cancer
13 Center, correct? I think there were over 260
14 referrals from Coastal Cancer Center, right?
15 You could have ascertained that information.

16 A: Well, that was a two-part question. Could I
17 have ascertained it? Yes. Did I? No.

18 Q: Thank you. Now, you believe -- well, let me
19 ask you this. I want to talk to you about some
20 insurance leverage issues. When I asked you
21 back in August if Grand Strand's presence in
22 the market could bring some leverage in for
23 third-party payers so they could negotiate
24 lower rates than maybe what's already in the
25 market, you said maybe they could, correct?

1 A: Maybe they could.

2 Q: Okay. Now, in terms of competition in the
3 market for inpatient services, all right, Grand
4 Strand does have to compete with five other
5 hospitals in the service area, correct? Is
6 that a fair statement?

7 A: Yeah, I'm counting. Yes, I think there are
8 five other.

9 Q: Okay. I want to go to Respondent's 9. I want
10 to get into some of your exhibits. And if we
11 can go to Tolbert 12842.

12 A: In Exhibit 9.

13 Q: Yes, please. I think it'll be the third page
14 of that exhibit. It's not a very big one.

15 A: Can you give me this number again, please?

16 Q: Yes, it's Respondent's 9.

17 A: I'm there.

18 Q: Tolbert, it's the third page in that. You've
19 got some -- it's your hospital data.

20 A: All right. 842?

21 Q: Yes.

22 A: Yes.

23 Q: Okay. Now, you would agree with me that the
24 third hospital down, St. Francis Downtown and
25 Millennium, correct? The number of linacs

1 there should not be zero because they were
2 approved a couple of years ago for an addition
3 -- for a linear accelerator, correct?

4 A: Yes, they -- I'm not sure it was a couple of
5 years ago.

6 Q: Are you aware that they were approved by DHEC?

7 A: Yes, because I worked on the project..
8 Actually, that was another linear accelerator
9 project. I assisted the Greenville Hospital
10 System with one for Easley Baptist.

11 Q: Okay. So you're aware of that one. So that
12 needs to be a one, not a zero, correct?

13 A: Oh, I see, yes. Yes..

14 Q: Okay. And you're aware, now let's go down.
15 The next one you've got is Providence Hospital,
16 right? And that's a zero still, isn't it?

17 A: As far as I know.

18 Q: Providence is kind of known for more of
19 cardiovascular services, correct?

20 A: Yes.

21 Q: And the one underneath that, Piedmont Medical
22 Center. You know that Rock Hill Radiation
23 Therapy Center, that's partly theirs; it's a
24 joint venture with Carolina Healthcare Systems.
25 Were you aware of that?

1 A: I was after I did this that it's on their
2 campus as a joint venture.

3 Q: Okay. And ---

4 A: This was done two years ago.

5 Q: Okay. But you included it as Exhibit 9,
6 correct?

7 A: Yes, based on what was in the State Health Plan
8 at that time.

9 Q: And so Piedmont Medical Center does -- they
10 have two linacs. They're not in the hospital
11 though, right, but they're on the campus,
12 correct?

13 A: Freestanding on the campus.

14 Q: Okay. And then so really, what that's going to
15 leave, it's going to leave in this list here
16 Grand Strand at zero and Providence at zero,
17 right?

18 A: From this list, yes.

19 Q: And Grand Strand, the total inpatient days at
20 Grand Strand, did you hear Mr. White's
21 testimony where he said that's now 71,000
22 inpatient days? Were you here for his
23 testimony?

24 A: No, I missed his testimony.

25 Q: Okay. Well, let's go to Petitioner 63. That's

1 an email from you, I believe.

2 A: That's a different book, isn't it?

3 Q: Unfortunately.

4 A: And it's Exhibit 63?

5 Q: I tell you what, don't worry about that one all
6 right. We're going to skip that one and kind
7 of move things along. All right. One thing
8 that CRCC's application had that Grand Strand's
9 didn't have was the support of Conway Medical
10 Center, right?

11 A: That is correct.

12 Q: Okay. And would you agree with me that the
13 reasons that Mr. Clayton -- now who is Mr.
14 Clayton? Phil Clayton?

15 A: He is the CEO of Conway Medical Center.

16 Q: And would you agree with me that the reasons
17 Mr. Clayton supported the project is that it
18 improves access and convenience to radiation
19 therapy services for the patients of Conway
20 Medical Center and the area?

21 A: I would have to look at his letter, but I
22 assume that's what it says.

23 Q: Okay. Well, would you agree with me that the
24 Conway Medical staff is very supportive of the
25 project?

1 A: Yes.

2 Q: Okay. I know we've kind of referenced Standard
3 8 a little bit earlier and talked about, you
4 know, projecting referral sources. You would
5 agree that like Grand Strand, CRCC did not
6 project forward the number of expected
7 referrals, correct?

8 A: We projected the number of radiation therapy
9 treatments we would do.

10 Q: Right. But not by a physician, right?

11 A: Not by a physician, and no.

12 Q: Okay. And Grand Strand also projected the
13 number of radiation therapy treatments it would
14 do, correct?

15 A: It did.

16 Q: Okay. Now, I think what I also asked you back
17 in August specifically was whether -- was what
18 Grand Strand is proposing to build as a linear
19 accelerator center in Myrtle Beach was
20 reasonable in terms of developing a hospital-
21 based radiation therapy program, and you had
22 indicated that you hadn't really looked at the
23 cost of other hospital-based linear accelerator
24 programs, correct?

25 A: No.

1 Q: Have you still done that, or have you still not
2 done that?

3 A: Well, at this point, I have not gone through
4 and tried to look at other, the cost of other
5 hospital-based programs.

6 Q: Well, you would agree with me that Georgetown's
7 program that it wanted to build was north of
8 \$10 million, correct, in Murrells Inlet?

9 A: Yes.

10 Q: And that one was approved by the Department,
11 wasn't it?

12 A: It was.

13 Q: Okay. Although I know you don't agree with
14 that. Let's go to Petitioner's 46 if we could.
15 That's right, Petitioner's 46. All right. And
16 if you'd go, once you get to Petitioner's 46,
17 if you'd go to CRCC 407 for me. And tell me
18 when you're there.

19 A: I'm at 407.

20 Q: Okay. And there's an email kind of in the
21 middle of the page that says from Sam Tolbert
22 to Norton Travis and I think Doug Bryant,
23 correct? Is that right?

24 A: Yes, yes.

25 Q: Okay. And so in the middle of the page, and

1 this is an email from you, and it says, My
2 suggestion is that we need to get a CON
3 attorney engaged now. We have plenty of time
4 to oppose the Georgetown application since it
5 has not been submitted yet. We need to get a
6 copy of it as soon as possible, as soon as it
7 is submitted and create a strategy. It says,
8 Meanwhile, we need to get ours done ASAP.
9 Please confirm that you will be adding a fourth
10 linac at the new location or if you will be
11 moving/replacing one of the existing, then I
12 will send you a proposal. And then you say,
13 Also, I had a meeting Monday evening with
14 Michael Asbill and some of the physicians at
15 Atlantic Urology about their ASC's and they
16 mentioned you would be moving a linac to
17 Conway. I did not tell them anything
18 differently since it would not have been
19 appropriate. Is that what you wrote?

20 A: That's what I wrote.

21 Q: Okay. And then Mr. Norton Travis right above
22 that, he replied back to you, right? And he's
23 replying back all the way over from the Middle
24 East, isn't he?

25 A: I believe he was in Israel.

1 Q: Right. He says, Sam, Greetings from Israel.

2 Our first choice plan is upgrade one linac in
3 Myrtle Beach, right?

4 A: Yes.

5 Q: And that was done, correct? That was actually
6 done; that's the Clinac iX, right?

7 A: I thought at that point that was already
8 approved by the Department.

9 Q: Well, it's September 30, 2010. It wasn't
10 installed until 2011, right?

11 A: Well, that's true, but I thought the approvals
12 were already in the process.

13 Q: Right. It says upgrade one linac in Myrtle
14 Beach.

15 A: Yes. I'm sorry. I was just clarifying.

16 Q: No, the second was relocate one linac to
17 Murrells Inlet area too, correct? That's
18 number two?

19 A: Yes.

20 Q: So that application has since been filed,
21 right? It was filed back in the spring of
22 2011, right?

23 A: Yes.

24 Q: Number three, add fourth location in Conway.
25 That's what it says, right?

1 A: That's what it says.

2 Q: Okay. And that application's been filed. And
3 then, number four, relocate Conway linac
4 if/when AUC does Carolina Forest project,
5 correct?

6 A: That's what it says.

7 Q: Okay. And it says, Others, please jump in if
8 you disagree. And then you replied back on
9 this very -- and replied to each one of these
10 tasks on the list, correct?

11 A: Yes.

12 Q: Okay. And as to relocate the Conway linac when
13 AUC does Carolina Forest project, you say "down
14 the road," right?

15 A: That's what I said.

16 Q: Okay. You would agree with me that Carolina
17 Forest is about four -- the entrance is about
18 four miles away from CRCC's Conway location
19 over there in Horry County, right? Do you know
20 where it is?

21 A: Well, I've been to the Carolina Forest property
22 that AUC owns.

23 Q: Okay.

24 A: I did not drive from there to CRCC-Myrtle Beach
25 and measure it, so I don't know the distance.

1 Q: Okay. But you know, you know they're fairly
2 close by, don't you?

3 A: Just looking at the map. I just don't know the
4 mileage.

5 Q: Okay. Now, wouldn't it be fair, Mr. Tolbert,
6 to add a few million dollars to CRCC's Conway
7 project costs in this case knowing that the
8 real plan is to move into a nice new facility
9 in Carolina Forest down the road? Wouldn't
10 that be fair, I mean, for this Judge to
11 consider?

12 A: No.

13 Q: No?

14 A: No.

15 Q: Well, that's what y'all are going to do, right?
16 You're going to move it from the building that
17 we've all looked at that looks nothing like any
18 of the other radiation therapy centers that are
19 going to be built to a nice facility over by
20 the urologists so they can be right next door
21 and have the surgery center next door; isn't
22 that the plan? It says down the road, right?

23 A: Down the road meant that would be discussed
24 down the road if and when that ever would
25 happen.

1 Q: All right. But the first three tasks on that
2 list, those are all completed, right? Those
3 are in motion. One of them is actually done,
4 isn't it? Is that right?

5 A: Yes.

6 Q: Okay. Let's talk about adverse impact. I
7 think Mr. Long said something along the lines
8 of the real issue in this case is whether two
9 can be approved, right?

10 A: Let me back up to the question. That number
11 four, by the way, would require a CON
12 application and would have had to have gone
13 through a review process if and when that ever
14 happened.

15 Q: That would be a CON to relocate an existing
16 one, right?

17 A: Because it would exceed the cost thresholds in
18 the regulations.

19 Q: Okay. Let's go to adverse impact.

20 THE COURT: Where would that location be? Would it
21 be closer to Myrtle Beach?

22 MR. THOMAS: Yes. Oh, I'm sorry.

23 MR. TOLBERT: Yes, Your Honor. The urologists own a
24 sizeable piece of property in this area called
25 Carolina Forest, and I provided the urology

1 group with some strategic planning advice.

2 They have two surgery centers. Both of them
3 are a little old, and they were asking me what
4 it would look like if we consolidated into one
5 large center, moved our practice, consolidated
6 some of our satellite offices into this
7 Carolina Forest property and built a large, you
8 know, multispecialty practice with ambulatory
9 surgery and with their office. They do
10 research. They have a research lab there, and
11 they were just brainstorming about what that
12 would look like. And if they did, they at that
13 point could make, want to have a single unit
14 linear accelerator there and it -- it turned
15 into a project, to my understanding, that was
16 going to be incredibly a lot of money, and I
17 don't think they'll do it anytime soon.

18 Q: All right. Now, Mr. Tolbert, you would agree
19 with me that in this case, depending on how you
20 look at it, but you did -- you did three
21 separate adverse impact analyses, correct? You
22 did the one in the CON application, right, that
23 compared them both? Excuse me, that's in the
24 CRCC DHEC record attached to your November 28th
25 letter, Exhibit A.

1 A: Okay. Yes.

2 Q: You did that one, and you did one that I got in
3 August before your deposition. That's the
4 market share analysis, correct, showing if two
5 are approved, what the outcome's going to be,
6 right?

7 A: That's correct.

8 Q: Okay. And then you did another one just a
9 couple of weeks ago, well I guess it's been
10 four weeks now, that shows the, what y'all call
11 the referral adverse impact analysis, correct?

12 A: You can call it whatever you want but there was
13 a recent one.

14 Q: Okay. And then I want to call the fourth one,
15 I'm going to say I'm going to move it up from
16 three to four, the one you did today, which is
17 where you said that you actually think that the
18 number of referrals from Coastal Cancer Center
19 are going to be even higher than 58 percent,
20 which is what you predicted or what you
21 projected four or five weeks ago, right? You
22 said that on the stand right there, correct?

23 A: That was based on Mr. Long's question and my
24 listening to testimony and hearing what was
25 going on the last few days.

1 Q: So you've changed your mind four times on
2 adverse impact and each time you change your
3 mind, the adverse impact gets worse on CRCC,
4 doesn't it? We can go through the numbers if
5 you want.

6 A: Each time I look at it, I look at it using a
7 different set of assumptions and some different
8 viewpoints and do an analysis and see what the
9 outcome is.

10 Q: Well, we'll get into that a little but. But
11 first of all, you would agree with me, you've
12 done no adverse impact analysis of what Grand
13 Strand's effect will be on Georgetown, right?
14 You haven't done that?

15 A: No.

16 Q: Okay. And just to get some background and some
17 context again, we know CRCC's been in the
18 market for 30 years, correct?

19 A: I think we've established that pretty solidly.

20 Q: And you would agree with me that CRCC enjoys
21 advantages in terms of being affiliated with
22 21st Century Oncology, correct?

23 A: I do.

24 Q: Okay. And those advantages include clinical
25 expertise, right?

1 A: Yes.

2 Q: Quality assurance expertise?

3 A: Yes.

4 Q: Marketing expertise?

5 A: Yes.

6 Q: Business operational expertise?

7 A: Yes.

8 Q: Purchasing power?

9 A: Yes.

10 Q: And the ability to provide substitute staffing
11 when they need it, right?

12 A: Yes.

13 Q: Okay. In terms of, and I think we've all
14 talked about that CRCC greatly improved
15 provider relations back in 2011, right?

16 A: Yes.

17 Q: Okay. And they did that by they upgraded the
18 equipment, right, and they added some new
19 equipment, right?

20 A: Yes.

21 Q: They focused on customer service, right?

22 A: Yes.

23 Q: I think they extended hours so people who
24 wanted to have their treatment after work could
25 do that too as well, right?

1 A: Yes.

2 Q: Okay. Now, you would agree with me that CRCC
3 is owned by an entity that employs the
4 urologists, correct?

5 A: Yes.

6 Q: Okay. And back in, I guess, 2012, and we can
7 look at your number if you don't remember, but
8 you would agree with me that that urology group
9 accounts for approximately 30 percent of
10 patient referrals that get under treatment at
11 CRCC, right?

12 A: I'll accept the number you're saying. I don't
13 remember it exactly.

14 Q: All right. And you would also agree with me
15 that in 2012, even though the urologists
16 account for 30 percent of the patients
17 referred, they actually account for 43.7
18 percent of the treatment volume, correct?

19 A: You would need to refresh my memory on how that
20 is calculated.

21 Q: Well, let's go to Petitioner's 52 if we could.
22 Let me ask you this, Mr. Tolbert. Were you
23 here for Mr. Lewis' testimony?

24 A: Yes.

25 Q: Okay. Let me know when you get to 52, and I'll

1 tell you a specific page to go to in 52, if you
2 would.

3 A: I am on 52.

4 Q: Okay. If you would go to CRCC 72 for me within
5 that document. You should see a Bates on the
6 bottom right-hand corner.

7 A: I'm on 72.

8 Q: Okay. Now, you were in here when Mr. Lewis
9 testified. I asked about, you know, what's the
10 diagnosis mix percentage. He said that was the
11 actual number of patients that are referred
12 under that diagnosis mix. I guess I was, I
13 said for prostate that the year for 2012 was
14 what, 30 percent. It's actually 28.4 percent,
15 correct?

16 A: I see that number.

17 Q: Okay. And then if you go down one category, it
18 says treatment diagnosis percentage. Mr. Lewis
19 testified, as you probably heard, that when I
20 asked him about what that 43.7 percent meant
21 for prostate treatments, he says that's the --
22 you take the total number of treatments, 43.7
23 percent of them would be prostate cancer,
24 correct?

25 A: That's what this says, yes.

1 Q: Okay. Now, let's try to keep this number. I
2 got it off one of your exhibits. I think it's
3 pretty established now that the number of
4 treatments, and I believe this is, if you want
5 to look at it, just look at Joint 12 for me,
6 and you can go in that --I'm sorry, not Joint
7 12. I apologize. Respondent's Number 12.

8 A: Am I going to need to remember these
9 percentages?

10 Q: I'll remember it for you. 43.7 percent. I'll
11 write it down.

12 A: Okay. Now where do you want me to go, Mr.
13 Thomas?

14 Q: If you would go to Respondent's Number 12 for
15 me. If you want, we've got it up on the
16 screen. I'm just going to ask you one quick
17 thing there. If you look on the bottom left-
18 hand corner under projected -- well, projected
19 radiation therapy utilization in the region,
20 you see the column that says actual?

21 A: Yes, I do.

22 Q: So what -- for the three existing linear
23 accelerators for CRCC, what's the actual number
24 of treatments there?

25 A: 22,798.

1 Q: 22,798. All right. So we know that is the --
2 we know that's the metric for 2012 in terms of
3 total linear accelerator treatments at CRCC,
4 correct?

5 A: Yes, that's that they reported on the Joint
6 Annual Report.

7 Q: Okay. Now, we know also if we look at Grand
8 Strand's Joint 2, let me see if I can just do
9 this by pulling it up on the screen so you
10 don't have to grab it. On Joint 2, page 22.

11 MR. THOMAS: And if you would blow up the Exhibit 3
12 portion, Roshel.

13 THE COURT: What page are we on?

14 MR. THOMAS: We're going to go to -- I'm sorry, Your
15 Honor, let's see here, make sure I've got it.
16 Yeah, I'm sorry, 21.

17 Q: And Mr. Sullivan did this analysis and what he
18 showed for 2009, we talked a little bit about
19 it, but that at Carolina Regional Cancer Center
20 when he took the total number of treatments and
21 divided it by the total number of patients, he
22 got 21.4, correct? You see that on this page?

23 A: No, I can't really read it. Could you enlarge
24 it just a little bit? But I believe the
25 numbers you're giving me, but you asked me if

1 I could read it.

2 Q: No, that's fair enough. Here is it. So he did
3 a calculation and for Carolina Regional Cancer
4 Center, the actual number of treatments per
5 patient was 21.4, correct?

6 A: That's correct.

7 Q: And then for Georgetown, I guess it was 20.3.
8 And then what was it for the total service
9 area?

10 A: Both -- I mean all added together, 21.1.

11 Q: Okay. And so if we look at, we know that the
12 number for 2012 because I wrote it down on a
13 sticky for linear accelerator treatments is
14 22,798, right?

15 A: Would you mind if I write that down?

16 Q: Absolutely.

17 A: Give me that number again, 22 ---

18 Q: 22,798 and that was from Joint Exhibit 12, I
19 believe. All right. And then if we go to and
20 hopefully we can do this by just pulling it up,
21 Joint Exhibit 10, it's not Joint Exhibit 10,
22 Respondent's 10, okay? And Mr. Tolbert, I
23 think this is from your referral analysis, but
24 you would agree with me that where it says
25 grand total here in the middle, 886, that was

1 the number -- that was the number of patients
2 who referred for treatment to CRCC, right?

3 A: No, that was the number of treatment plans, I
4 believe.

5 Q: Okay. Let's call it that. 886 treatment
6 plans. Okay. And you would agree with me that
7 how we can figure out the total number of
8 treatments in 2012 is we can take the number
9 you wrote down, 22,798, right, and divide that
10 by 886 treatment plans? Do you have a
11 calculator?

12 A: Yeah, I do. Is it okay if I use Mr. Long's?

13 Q: Sure.

14 A: So you want me to do the calculation?

15 Q: Yeah, 22,798 divided by 886 treatment plans.

16 A: Yes.

17 Q: Okay. And what does that come out to be?

18 A: 25.7

19 Q: So 25.7 treatments per patient, right?

20 A: And what I suggest is you may want to double-
21 check that 886 against the Joint Annual Report
22 where they report on duplicated patients
23 treated.

24 Q: Okay.

25 A: I don't know if those numbers are identical.

1 Q: Do you think 25.7 sounds about right?

2 A: That's what we've been discussing, yes.

3 Q: And what happened -- you would agree with me
4 that in 2010, that's when the urologists --
5 urologists purchased, or excuse me, 21st
6 Century bought the urology practices out in
7 Horry County, correct, and employed them,
8 right? That happened in 2010?

9 A: That was simultaneous with the acquisition of
10 CRCC, as I recall the testimony.

11 Q: Right. Okay. Now, when I asked you in your
12 deposition what's the reason that the number of
13 treatments would go from 21 in 2009 to 25 or
14 26, you said that one reason could be that the
15 mix of patients would change, right?

16 A: Yes.

17 Q: Okay. Now, you would agree with me, and we've
18 still got -- and let's go to Respondent's 10 up
19 here, your assumption for referral sources is
20 that all the urology referrals would go to
21 CRCC, right?

22 A: No, my assumption was all the -- all of their
23 referrals that had been going to CRCC would
24 continue to go to CRCC.

25 Q: Okay. And so you would agree with me that if

1 Grand Strand is granted or approved for a
2 linear accelerator, whether it's one or two,
3 it's not going to probably do that much
4 prostate work, correct? It's not going to be
5 too many -- too much prostate cancer treated at
6 Grand Strand?

7 A: Probably not.

8 Q: Okay. Let me ask you a question. I think you
9 may have answered this earlier and I apologize
10 because I don't want to be repetitive today,
11 but you would agree with me that you haven't
12 performed any financial adverse impact analysis
13 on Grand Strand's project on CRCC in the case
14 of if Grand Strand is the only project
15 approved, correct?

16 A: Correct.

17 Q: And you haven't performed that analysis if both
18 are approved either, correct?

19 A: I have not.

20 Q: Okay. And let me ask you this. All the
21 adverse impact analysis that you've produced,
22 and I think that you did and that we've
23 referenced here today, those have all been if
24 only one -- I mean, if both are approved,
25 correct?

1 A: That is correct.

2 Q: Okay. But we know there's a possibility in
3 this case that the judge could find that Grand
4 Strand should be approved and CRCC shouldn't be
5 approved, right? I mean, that's a possibility,
6 a possible outcome, right?

7 A: That's his prerogative, yes.

8 Q: Well, let me ask you this and maybe we can
9 dispense with this. Would you agree with me
10 that there's not a scenario that you've come up
11 with in terms of what is most likely going to
12 be the impact on Grand Strand on CRCC that if
13 only one were approved and it's Grand Strand,
14 that Grand Strand would not bring the linear
15 accelerator treatment number down for the
16 existing centers below 80 percent, is there?

17 A: I have not done that calculation.

18 MR. THOMAS: Can you go to Respondent's 12 for me.

19 Q: Now on Respondent's 12, if you can see the
20 screen, the treatments in the region for 2017,
21 which would be the third year of operations, is
22 what?

23 A: 31,824.

24 Q: 824, okay. 31,824. Now, if Grand Strand is
25 not factored in, CRCC is going to be at what,

1 24,000, what did we figure out, 24,560
2 treatments? Is that right? In other words, if
3 Grand Strand is not on the scene in 2017 and
4 CRCC-Conway is and the three existing, CRCC
5 existing linear accelerators are operating,
6 what would that number be in terms of total
7 treatments?

8 A: Mr. Thomas, let's go through that again a
9 little slower.

10 Q: Okay.

11 A: If you would, please.

12 Q: Yeah. Well maybe what you can do it just tell
13 me what's the total number of treatments at
14 CRCC if Grand Strand is not approved for 2017?
15 How would I figure that out?

16 A: Well, you would have to -- I mean are you
17 assuming Conway exists or doesn't exist? What
18 are you ...

19 Q: Yeah, I'm assuming Conway does exist.

20 A: Well, to back into that number, you could take
21 the Ford Cancer Center volume and just subtract
22 it from the total in the region and what would
23 be left would be CRCC's. Is that what you're

24 ---

25 Q: Yeah.

1 A: Okay.

2 Q: So can you do that calculation for me?

3 A: That would be 31,824 minus 7,263.

4 Q: And what do I get?

5 A: 24,561.

6 Q: 24,561. Now to get the existing -- to get the
7 existing treatments, I would back out, would I
8 back out CRCC-Conway from that number?

9 A: No, if Conway doesn't exist; is that what
10 you're ---

11 Q: I'm sorry, in 2017, to get the existing, just
12 the existing linear accelerators ----

13 A: Oh, I see what you're saying.

14 Q: Yeah.

15 A: Take the 4,934, excuse me, no, the 5,499 away.

16 Q: Okay. And what would that give me?

17 A: All right. Hold on.

18 Q: I'm taking out Conway, CRCC-Conway, right?

19 A: Yes.

20 Q: Okay.

21 A: That leaves 19,062.

22 Q: 062, right. Okay. And so that's, this would
23 be CRCC existing, right?

24 A: Yes.

25 Q: Okay. And if I then subtract Grand Strand from

1 that, what do we get?

2 A: Grand Strand 4,934, we'd get 14,128.

3 Q: Okay. And if I add back, so that would be the
4 existing, right, if it's just CRCC, right? I
5 mean, excuse me, if Grand Strand is in the mix,
6 right, 14,127?

7 THE COURT: I'm losing track. I thought you were
8 subtracting Grand Strand. What's your goal
9 here?

10 MR. THOMAS: I'm sorry. I'm just trying to see if
11 he can get me to the number of the percentage
12 with Grand Strand in the market if only Grand
13 Strand's in the market, how would I do that.
14 Maybe I should be asking the expert.

15 THE COURT: I thought you were originally asking
16 another question.

17 MR. THOMAS: Well, what I'm trying to do is if just
18 Grand Strand is approved and not CRCC-Conway.

19 THE COURT: Oh, okay.

20 MR. THOMAS: But I think I just answered my
21 question, Your Honor.

22 Q: 24,561 if only Grand Strand is approved and not
23 CRCC-Conway, CRCC would be doing 24,561
24 treatments, right?

25 A: That assumes the difference is the Ford Cancer

1 Center.

2 Q: Yeah, Ford. Now, if I subtract from 24,561
3 Grand Strand, what is Grand Strand in this
4 analysis? Is it 4,934?

5 A: I'm sorry. Maybe it's been a long day and I'm
6 just not following you.

7 Q: If 24,561 is the existing ---

8 MR. LONG: Your Honor, I'm just going to have to
9 object. I mean I ---

10 THE COURT: I can follow it now.

11 MR. THOMAS: Yeah, yeah.

12 MR. LONG: Okay.

13 THE COURT: I think we're on Respondent's 12.

14 MR. THOMAS: Yes.

15 MR. LONG: I'm just concerned that there's really no
16 questioning going on, it's just numbers.

17 MR. THOMAS: I'll get to it, Your Honor.

18 THE COURT: Okay.

19 MR. THOMAS: But I've got it now.

20 Q: The 24,561 is the existing. If Grand Strand is
21 not approved, it's 24,561 for CRCC-Conway,
22 correct? And it would be for Ford 7,263,
23 right? And that would give us the total,
24 correct?

25 A: Yeah -- I'm sorry, say that again so I can be

1 sure I'm following you.

2 Q: 24,561 is the total amount after you subtract
3 Georgetown from the treatments in the region,
4 right?

5 A: Yes.

6 Q: That's what CRCC would be doing if Conway
7 wasn't approved and Grand Strand wasn't
8 approved, correct?

9 A: Yes, 24,561. I've got that number.

10 Q: All right. Now, if Grand Strand is approved at
11 the levels that you projected from Mr.
12 Sullivan's levels ...

13 A: Well, I did not project Mr. Sullivan's levels.
14 Those are ---

15 Q: His projections to 2017?

16 A: Oh, I see what you're saying, based on his
17 original ---

18 Q: Right.

19 A: --- CON?

20 Q: Right. I get what? I get 19,627, right?
21 That's what I get if Grand Strand is approved,
22 CRCC-Conway is not, right?

23 A: Your math is correct.

24 Q: Okay. So that would be CRCC's existing number,
25 right, but to get -- for three linacs; is that

1 correct?

2 A: Yes.

3 Q: And I got, to get the total existing in the
4 area, right, I've got to add back what?
5 Georgetown? Francis Ford 7,263, right? And
6 what do I get there? I'm doing math. I get
7 26,890, correct?

8 A: Yes.

9 Q: 26,890 treatments. Okay. What is the -- what
10 is the capacity of those four units stated in
11 the health plan. I think you talked about that
12 with Mr. Long earlier today.

13 A: Well, there are four units, I hope you'll
14 correct me if I get the wrong number, but I
15 thought it was 26,000.

16 Q: 26,000. All right. Okay. So would you divide
17 26,890 treatments over 26,000 for me.

18 A: Yes.

19 Q: And what did we get?

20 A: Converted to percentages, which I assume you
21 want, it's 103 percent.

22 Q: Okay. So just, if just Grand Strand is
23 approved and CRCC-Conway isn't, in 2017, by
24 this calculation in Exhibit Respondent's 12,
25 the existing linear accelerators would be

1 operating at 103 percent, correct? Using Dan
2 Sullivan's number, right?

3 A: Yes.

4 Q: Okay. And so three years out, it's definitely
5 above the 80 percent threshold, right?

6 A: That's what the numbers indicate using the
7 numbers that were in the original CON
8 application adjusted for two years delay.

9 Q: Okay.

10 MR. THOMAS: I'm sorry about that, Your Honor. That
11 was a little around the elbow.

12 THE COURT: I'm there.

13 Q: All right. Back to Respondent's 12 on 1290 --
14 I'd like you to turn to page 12904 for me.

15 A: I'm sorry, which exhibit?

16 Q: Respondent's 12, same exhibit you should be in.

17 A: No, I'm not in that one.

18 Q: Oh, you weren't in that? Okay.

19 A: 12 in the ---

20 Q: Respondent's 12. It's going to be a CRCC.

21 A: Oh, thank you. I'm sorry. I'm not sure of all
22 the legal lingo. CRCC 12.

23 Q: Right.

24 A: I am there.

25 Q: Okay. Now, let's see if I can do this a little

1 bit more smoothly. Now, first of all, on
2 Tolbert 12904, analysis of adverse impact on
3 existing providers if both applications are
4 approved based on change in market share.

5 A: Yes.

6 Q: All right. Now, what you've got there is in
7 the middle, I think we're going to talk about
8 that in a little bit, that's the Tolbert
9 projected shift to Grand Strand from CRCC,
10 right? And we've got 8,210, and that's from
11 the referral analysis you did, right?

12 A: I'm sorry what column?

13 Q: C.

14 A: Yeah, I'm there. Yes.

15 Q: Okay. And what did you come up with? You came
16 up with 8,210 treatments, correct?

17 A: Yes.

18 Q: Okay. And I think you said -- I think you said
19 earlier that you like to see bar graphs and
20 things like that. Would you go to
21 Petitioner's, is it 3 or 2, let me check.

22 A: Petitioner's, that would be you, right?

23 Q: Well, I'm going to put it on the screen for
24 you, so hopefully you don't have to jump
25 around. Yeah, put up Petitioner's 2. All

1 right. I actually prepared this based on the
2 first adverse impact analysis you did where you
3 chose 7,951 for I guess the most likely, I
4 think it was the more likely adverse impact,
5 right?

6 A: I believe you're correct.

7 Q: Okay. And so just looking at this table here,
8 the average number of treatments per linear
9 accelerator for the top five centers is what?

10 A: 5,182.

11 Q: Okay. And the average volume per radiation
12 therapy provider in South Carolina with only
13 one linear accelerator in operation is what?

14 A: 4,819.

15 Q: Okay. And your number, the revised number of
16 8,210 that would be higher than 7,951 from the
17 earlier version you did, correct?

18 A: Yes, it was a little higher.

19 Q: Okay. And so Grand Strand's percentage
20 treatments of average single unit operator in
21 South Carolina based on our assumption is what?
22 How much higher are we going to be than the
23 average?

24 A: Well, assuming you did the math correctly, I
25 assume 165 percent of the ---

1 Q: And for the top five radiation therapy centers
2 by volumes, what is the percent treatment of
3 the average? It's 153 percent, isn't it?

4 A: Yeah, I'm looking at the numbers and wondering
5 if they're backwards.

6 Q: You had a chance to look at these, didn't you?

7 A: Well, I did, but I didn't look at it -- may I
8 do a calculation here just to ...

9 Q: Sure.

10 A: Yeah, the percentages are correct.

11 Q: Okay. All right. I'm going to try to go back
12 to Respondent's 12, because I'm going to use
13 the 8,210 number. I'm going to try to do this
14 a little better. If we go to Respondent's 12,
15 and again, that 2017 number is 31,824, right?
16 That's the total in the service area.

17 A: Yes.

18 Q: And so if I subtract Grand Strand from that,
19 that number of 8,210, what do I get? And this
20 is if CRCC is not -- is not approved but Grand
21 Strand is and Grand Strand's operating at 8,210
22 treatments.

23 A: There would be left for the other providers
24 23,614.

25 Q: 23,614 treatments on the existing providers,

1 correct?

2 A: Yes.

3 Q: And for those four units, what is the capacity?

4 A: 26,000, the same number as before.

5 Q: So would you divide 23,614 by 26,000?

6 A: That is 91 percent.

7 Q: Okay. So if Your Honor approves Grand Strand
8 and does not approve CRCC-Conway, the year
9 2017, using your calculation, the existing
10 providers are going to be 11 percent above the
11 80 percent threshold, correct?

12 A: Yes. The one unknown that we've come to
13 realize is the volume may -- they may not reach
14 31,824 treatments in 2017 because we have a
15 downward trend for the last few years.

16 Q: We'll get to that. It's not the last few
17 years. It's the last two years, right?
18 Because 2011 was the highest linear accelerator
19 volumes for CRCC's history, right?

20 A: My projection is -- well, the actual was down
21 in 2012 or 2011.

22 Q: So it was down ---

23 A: Down 2012.

24 Q: Okay. So it's not the last few years, the last
25 two years, right?

1 A: The last two years.

2 Q: Well, actually the last 18 months. You have
3 data through July, right?

4 A: That's correct.

5 Q: So that's the last 17 months, correct?

6 A: That's correct.

7 Q: Okay. Now, if all 8,210 treatments come out of
8 CRCC's utilization for 2017, which I believe
9 you said was 24,560 treatments, CRCC would be
10 left with 16,350 treatments, right?

11 A: Pardon me while I do the math.

12 Q: Okay.

13 A: So 16,351 approximately.

14 Q: Right.

15 A: Okay.

16 Q: Okay. And if they had three linear
17 accelerators at 19,000 capacity, 775, Tomo's
18 the five, they would be operating at what,
19 about 86 percent?

20 A: Eighty-six percent.

21 Q: Okay. And if instead it's Grand Strand, I
22 think we already looked at this calculation.
23 If we are using Grand Strand's numbers, 4,934
24 treatment, let's do that calculation. Would
25 you take 4,934 from 24,560. Let me say it

1 another way, 24,560 minus 4,934.

2 A: And where did the 24,560 come from?

3 Q: That's the amount that CRCC is going to be
4 doing if Grand Strand is approved. Remember,
5 if you take the 31,824 total treatments and
6 subtract out Ford Cancer Center.

7 A: Okay.

8 Q: All right.

9 A: 24,560, is that what you just said?

10 Q: 24,560 and take -- so if Grand Strand were to
11 be utilized at what Mr. Sullivan claims and
12 what you projected out from his number of
13 4,934, CRCC's actually going to be operating at
14 19,626 treatments, right?

15 A: 19,626.

16 Q: Right. And that's, I think we looked at that
17 earlier, but that's 103 percent of capacity,
18 right, for CRCC?

19 A: Yes, that would be 103 percent.

20 Q: Okay.

21 A: I didn't write that number down but it's just
22 slightly above capacity.

23 Q: Now, let's talk a little bit about your second
24 adverse impact analysis, which is Respondent's
25 39, and that's the one, I think that's the

1 first one you did showing if two were approved
2 by applying some market shares, correct? Go to
3 39 for me.

4 A: I'm on Exhibit 39.

5 Q: All right. Do you recognize this document?

6 A: Yes, it's the first one I prepared I think in
7 anticipation of the deposition.

8 Q: Right. This is the one I got back in August,
9 right?

10 A: Yes, I assume so. I don't remember the date,
11 but it says August 6th on here.

12 Q: Okay. Well, let me ask you this and look at
13 the very first page of that exhibit. That's
14 Tolbert 12734, correct?

15 A: Yes.

16 Q: All right. Well, let me ask you this. I see
17 where you did the forecasted for regions,
18 projected new cancer cases in the region of
19 2,698, you see that, for 2017?

20 A: Yes.

21 Q: All right. Now, did you ever look at that
22 number just to figure out how many cancer cases
23 that actually means for the region, because
24 don't you agree under treatments in the region,
25 that's just the number of treatments that are

1 actually done at CRCC-Conway and Georgetown,
2 correct? Is that a fair statement?

3 A: No, sir.

4 Q: It's not?

5 A: No.

6 Q: Oh, okay. So the 31,802 treatments in 2017
7 that you projected out, you say that's the
8 total number of treatments for every resident
9 in that county, in that three-county area?

10 A: No, it's my projection of treatments in the
11 region on the -- on units that would be in the
12 region that year.

13 Q: Right. For the existing providers, correct?

14 A: For any provider.

15 Q: Okay. So, well, let me ask you this. I want
16 you to look at the year 2017. How many
17 forecasted cancer patients are there do you
18 have for the region?

19 A: These are new cancer cases in the region 2017,
20 2,698.

21 Q: Right. And isn't there a pretty standard
22 metric out there with the American College of
23 Radiology that says that 55 percent of all new
24 cancer cases will be treated with radiation
25 therapy?

1 A: I've read that and heard that in the testimony,
2 yes.

3 Q: Okay. Do you disagree with that figure, and if
4 so, which one would you use?

5 A: I don't disagree with that figure.

6 Q: Okay. I want you to take 2,698 and multiply it
7 by .55.

8 A: Yes.

9 Q: What number did you get?

10 A: If I did it correctly, I got 1,484.

11 Q: 1,484. So that's the number that the ACR would
12 tell you would be the amount of patients that
13 would be treated with radiation therapy,
14 correct?

15 A: New cancer cases treated with radiation therapy
16 who reside in those three counties.

17 Q: Okay. Earlier you came up with a statistic for
18 me of 20, I think we came up with 25.7
19 treatments per patient, because I wrote it down
20 on a sticky. So would you multiply 1,484 by
21 25.7 for me.

22 A: Yes.

23 Q: What number do you get?

24 A: 138 -- excuse me, 38,163.

25 Q: You did 1,484 times 25.7?

1 A: You've already done the math. Did I get it
2 close?

3 Q: I got 38,138.

4 A: I got 38,136. Do you want to ---

5 Q: No, that's fine.. I think we can probably
6 choose something in between.

7 A: Okay.

8 Q: Let's just call it, round down to 38,100. All
9 right. So that's the number of treatments
10 based on your 2017 new cancer cases if you use
11 the ACR's 55 percent stat, correct?

12 A: Using those calculations that you just asked me
13 to do.

14 Q: Okay. And your projected treatments in
15 regions, in the region that was projected off
16 the growth in the area for the existing
17 providers based on Georgetown and Conway, or
18 excuse me, Georgetown and CRCC was 31,802
19 right?

20 A: That is correct.

21 Q: So by my math, Mr. Tolbert, I used 38,100 and
22 subtract 31,803, I got 6,297 treatments going
23 somewhere else other than CRCC and Georgetown
24 for radiation therapy using the American
25 College of Radiology numbers and your treatment

1 number of 25.7. Do you know where those are
2 going now?

3 A: No, I've not analyzed to see where they're
4 going now.

5 Q: Okay. But you would agree with me that based
6 on that number, there's probably a good amount
7 of outmigration, isn't there?

8 A: I would imagine there is from Williamsburg
9 County and the western side of Horry County,
10 but that data is not easy to come by.

11 Q: Okay. Well, but still, those are people
12 leaving the service area traveling somewhere to
13 get radiation therapy, correct?

14 A: That figure for the existing providers also
15 includes in-migration from North Carolina and
16 other counties other than the three, so they --
17 that's called in and outmigration.

18 Q: Okay. Well, do you think, Mr. Tolbert, that if
19 Grand Strand creates a world class cancer
20 center that maybe they can keep some of those
21 people from going to places like MUSC, McLeod
22 and up to Wilmington?

23 A: I'm not sure how that might play out.

24 Q: Okay. But it could ---

25 A: Particularly since it's within three miles of

1 the existing major provider.

2 Q: But if it can turn some of those folks that are
3 outmigrating and we know, and I can bring the
4 documents up if you want me to, but a lot of
5 cancer patients are going to MUSC and McLeod
6 and other places, places with comprehensive
7 cancer that if we were able to bring some of
8 that back in, these 6,297 treatments that are
9 leaving the service area, then there may be
10 enough to go around for everybody, isn't there,
11 Mr. Tolbert?

12 A: Well, and there's also the other side of the
13 coin that some of the patients that are coming
14 in from the surrounding counties might come
15 less, so there are a lot of what ifs in your
16 analysis.

17 Q: But you agree with me that MUSC provides
18 comprehensive cancer services, correct?

19 A: The Hollings Cancer Center is well known.

20 Q: Okay. And McLeod also touts itself as
21 providing comprehensive cancer treatment
22 centers, correct?

23 A: Yes, I'm not familiar with how they're set up.

24 Q: Okay. Well, let me ask you this. Would you go
25 -- you're at Respondent's 39. Turn over to

1 Tolbert 12735 for me. And I'm going to ask you
2 about Respondent's 39 because this is the
3 document I deposed you on.

4 A: I'm sorry, what exhibit?

5 Q: Respondent's 39.

6 A: Yes.

7 Q: Okay.

8 A: Which page?

9 Q: Go to Tolbert 12735.

10 A: Yes.

11 Q: All right. Now, you would agree with me that
12 when I deposed you back on August 8th, you
13 actually did this adverse impact analysis, you
14 started it on the Monday before I deposed you
15 on a Thursday, correct?

16 A: I believe that's correct.

17 Q: And all the SCORS data, and I think it was
18 produced to me that there was all types of
19 different inpatient and outpatient market share
20 data. That was all data that was available to
21 you back in 2011, correct, SCORS data showing
22 inpatient and outpatient -- inpatient market
23 share

24 A: I don't -- what is scores?

25 Q: Oh, South Carolina's Office of Research and

1 Statistics.

2 A: Oh, okay. I've never ---

3 Q: It's what we in the business call SCORS.

4 A: I've never heard it or referred to it as that.

5 The Office of Research, ORS is how I call it,
6 yes.

7 Q: Gotcha.

8 A: That data is generally available, although
9 lately their website has been totally down and
10 it's been a pain.

11 Q: Back in 2011 though, you could go to the
12 website and you could download inpatient market
13 share for any hospital you wanted in the state
14 of South Carolina, right?

15 A: Yes, certain market shares, not 100 percent
16 available.

17 Q: But you could get most of the inpatient market
18 share, correct?

19 A: You cannot get it for oncology.

20 Q: Well, you approximated using what I think you
21 said, the neoplasm data?

22 A: That's not a good, no, because it's such a low
23 number of cases, I never use them. The
24 neoplasm really doesn't work very well. It is
25 listed as a -- because it's a type of cancer,

1 but it doesn't include all of the cancer
2 oncology discharges.

3 Q: Okay. Is that something you've researched in
4 the past? How do you know it doesn't include
5 all the oncology?

6 A: Cancer is the second leading cause of death in
7 South Carolina unfortunately, and if you look
8 at any of the reports, the number of discharges
9 that are classified as neoplasm are very, very
10 low.

11 Q: Okay. So maybe a better source to determine
12 that would be actually from what the hospital's
13 market share data says, correct?

14 A: Yeah, to the extent they also know what the
15 other hospitals are doing.

16 Q: So you just don't trust -- you trust SCORS
17 inpatient market share data, but you don't
18 trust it for the oncology, right? Is that fair
19 to say? I think that's what I heard you say.

20 A: No, it's fair to say that the data that the
21 hospitals submit to the Office of Research and
22 Statistics is under a special agreement with
23 the hospitals, and early on the hospitals
24 agreed with ORS that they would share data that
25 could be used publicly for health planning

1 purposes by broadly categorizing hospital
2 discharges into surgery, medical, pediatrics,
3 OB and psychiatry, and then within surgery and
4 medical, they agreed to certain categories of
5 services. So cardiac and vascular are lumped
6 together. Urologic surgeries, there are about
7 12 surgical procedures that are agreed to make
8 public. There's no one category that captures
9 oncology because it cuts across various
10 specialty areas.

11 Q: Are you finished?

12 A: Yes, I am. I'm sorry if I talked too long.

13 Q: No, I was just -- most people who know me know
14 I've got a pretty bad back, so anytime I can
15 take a little pressure off, I'll do that.

16 A: Mr. Thomas, I didn't know that. I would be
17 fine if you wanted to sit down to ask me
18 questions.

19 Q: No, no, no. I'm good. You would agree with
20 me, Mr. Tolbert, that on Tolbert 12735, what
21 you did was you took Grand Strand's inpatient
22 market share for its primary service area and
23 its secondary service area and you applied it
24 to the three-county area, correct?

25 A: In preparing this analysis just a few days

1 before I was deposed, having the benefit of
2 some of the other documents that were available
3 in what's it called, discov- -- I mean,
4 whatever that is, there were two well, one
5 document that listed Grand Strand's market
6 share for overall, primary, secondary markets
7 of 35 percent, oncology at 30 percent. So
8 that's where those two numbers came from.

9 Q: Okay. But that's not the question I asked you.
10 I asked you what you did was you took the
11 oncology numbers, okay, and not just the
12 oncology numbers, you took the 2009 Grand
13 Strand oncology numbers, correct? For -- or
14 excuse me, the inpatient and the oncology
15 numbers for the what, the primary service area
16 and the secondary service area, correct?

17 A: I believe that's what their internal document
18 said.

19 Q: Okay. And you realize, so we don't have to go
20 there now since you said that, but you realize
21 that the primary service area and the secondary
22 service area for Grand Strand is not the three-
23 county area, correct?

24 A: Yes, it was not an identical match with the
25 three counties.

1 Q: Okay. And I asked you, I think it was over a
2 month ago in your deposition if you thought
3 Grand Strand actually had a 35 percent
4 inpatient market share for the three-county
5 area or in Georgetown or Williamsburg County,
6 right, and you said you would need more
7 detailed data to do that analysis, correct?

8 A: It sounds like that would be the answer.

9 Q: Okay. Well, go to 40 for me, Respondent's 40,
10 and I think you may have even referenced this
11 earlier.

12 MR. THOMAS: And, Roshel, if you could blow up kind
13 of the top part of this where it says total,
14 that category there. Yeah, that's it.

15 Q: If you can't see that, Mr. Tolbert, let me know
16 and we can go to Respondent's 40 for you in the
17 document.

18 A: I'm there in the document, so I'm good.

19 Q: Okay. Now, let's look at it. Now, this is
20 patient origin for select categories by
21 hospital, excluding newborns, and this is for
22 2010, right? It says includes inpatient
23 discharges from all non-federal acute care
24 hospitals in Georgia and North Carolina.
25 That's or 2010, right?

1 A: That is for 2010.

2 Q: Let's go in this document Tolbert 12749. Let
3 me know when you get there.

4 A: I'm sorry, yes, I'm there.

5 Q: Okay. So now you apply the 35 percent
6 inpatient market share from Respondent's 12 to
7 Georgetown. What is the market share there for
8 inpatient discharges for Georgetown?

9 A: I'm sorry, what was the first part of what you
10 said?

11 Q: Yeah, you applied, you just admitted that you
12 applied 35 percent inpatient market share, I
13 believe that's what Respondent's 12 says, to
14 the three-county service area, right?

15 A: I applied it to a three-county total service
16 area.

17 Q: Total service area. And you got that number
18 from Grand Strand's primary service area and
19 secondary service area out of the document in
20 Petitioner's 97, right? You got it out of the
21 slide that showed what Grand Strand's inpatient
22 market share was for 2009 for its primary
23 service area and secondary service area, right?

24 A: Yes, I think I'm following what you're saying.

25 Q: Now, on Tolbert 12749, what is Grand Strand's

1 inpatient market share in Georgetown County?

2 A: It's 8.5 percent.

3 Q: Okay. And what is it in Williamsburg County?

4 A: It's .7.

5 Q: It's less than one percent. But as far as your
6 analysis goes, it's 35 percent, right, because
7 you applied it equally to all the radiation
8 therapy treatments that were done in that
9 three-county area at CRCC and Georgetown,
10 correct?

11 A: Yes.

12 Q: Okay. Now, you also -- you would agree with
13 me, Mr. Tolbert, that radiation therapy is
14 primarily an outpatient service. I think we've
15 all been talking about that, and I think you've
16 said that, what is it, one percent or less than
17 one percent of the total treatments are going
18 to be inpatient for a given provider?

19 A: Generally speaking, yes.

20 Q: Okay. And you would agree with me that two
21 radiation therapy centers have been approved
22 for the Murrells Inlet area, correct?

23 A: Two replacement.

24 Q: Right, okay. Fair enough. I gotcha. But two
25 have been approved to move to Murrells Inlet,

1 South Carolina, right?

2 A: That is correct.

3 Q: Okay. Now, the primary -- you took, when you
4 did your analysis in Petitioner's 12, we're
5 going back to that. Oh, excuse me,
6 Respondent's 12. Okay. You did that analysis.
7 It says look at column E, based on Grand Strand
8 oncology market share, right? You used Grand
9 Strand's internal market share for its primary
10 service area and its secondary service area for
11 2009, correct?

12 A: Yes, I did.

13 Q: So you got that 30 percent there and you
14 applied it again to the whole three-county
15 area, all the treatments that were done in the
16 three-county area, correct? At CRCC and
17 Georgetown, right?

18 A: Yes.

19 Q: Okay. Now, you did that even though --

20 MR. THOMAS: If you'd put up Petitioner's 26 for me
21 real quick.

22 Q: Even though Grand Strand produced to you it's
23 three-county market share, internal three-
24 county market share for cancer, right?

25 MR. THOMAS: Blow up ---

1 THE COURT: Wait a second. Let me get there.

2 MR. THOMAS: Yeah.

3 THE COURT: It's Petitioner's what?

4 MR. THOMAS: Petitioner's 26.

5 THE COURT: All right. I'm there.

6 Q: Grand Strand actually produced to you this
7 document that shows what its market share is
8 for the three-county area, correct? That's
9 20.33 percent, right?

10 A: And I included that in this analysis.

11 Q: Okay. But you would agree with me that column
12 E, based on Grand Strand's oncology market
13 share, what you should have used is the 20.3
14 percent there because that's the best indicator
15 you had of what their market share was from
16 their internal data, correct?

17 A: I was not confident that this report was
18 accurate, so I was willing to use it just like
19 I used some of the other data points for
20 comparison purposes.

21 Q: But you were confident that it was a good idea
22 to apply Grand Strand's primary and secondary
23 service area oncology market share to a three-
24 county area, correct? And that market share
25 being from 2009, correct, from column E?

1 A: For this analysis just prior to the deposition
2 based on what I'd been provided by my
3 attorney's, I created several levels of
4 analysis, documented what I used as the data
5 source for each one of them.

6 Q: Okay. All right.

7 MR. TOLBERT: Your Honor?

8 THE COURT: You need a break?

9 MR. TOLBERT: I do. I don't know about anybody
10 else.

11 THE COURT: All right. Let's take a five minute
12 break.

13 MR. TOLBERT: Thank you.

14 (Break from 4:01 p.m. until 4:11 p.m.)

15 BY MR. THOMAS:

16 Q: Mr. Tolbert, you ready?

17 A: Yes, Mr. Thomas.

18 Q: Still in Petitioner's 39.

19 A: I'm sorry, I was on 12.

20 THE COURT: Well, I'm on Respondent's 26.

21 A: Which one? Grand Strand?

22 Q: It's Petitioner's 39.

23 THE COURT: Petitioner's or Respondent's 39?

24 MR. THOMAS: I'm sorry, you're right, Your Honor.

25 It's getting late in the day. Respondent's 39.

1 A: Okay.

2 Q: All right. So this is the one I think you
3 produced or that CRCC produced just prior to
4 the deposition.

5 A: This was the one we were looking at just before
6 we took a break.

7 Q: Right.

8 A: Yes.

9 Q: Okay. Now, you may recall when I deposed you
10 back in August, you told me that you hadn't
11 tested your assumptions to determine whether
12 the market share for inpatients translates
13 directly to market share for radiation therapy
14 patients, correct?

15 A: Yeah, I'm sorry. I don't remember if I used
16 the word tested or I needed to really think
17 about it, but yes.

18 Q: Okay. Now, I want you to look on the middle
19 column there, Respondent's 39 and on Tolbert
20 12735. Let's look at that one.

21 A: The middle column.

22 Q: Correct. And what you did here is you assumed
23 a market share of 25 percent, right, for Grand
24 Strand?

25 A: That's correct.

1 Q: And when you did that, when you took that 25
2 percent, you took 25 percent of the total
3 radiation therapy treatments in the entire
4 three-county market, correct? So I believe in
5 that same column, if you look up there, it's
6 31,802 total radiation treatments, right?

7 A: Yes, it is.

8 Q: So you multiplied 25 percent by 31,802, and
9 that gave you Grand Strand's figure of 7,951,
10 right?

11 A: Yes.

12 Q: All right. And am I correct that you assumed
13 that Georgetown's numbers would not change at
14 all? So Ford Cancer Center's numbers would not
15 change a bit in terms of what you decided that
16 would do in 2017; am I right about that?

17 A: That's right. I accepted that as a given.

18 Q: Okay.

19 A: If you want to call it that.

20 Q: So even though you applied the 25 percent
21 market share to the three-county area, you
22 assumed that Grand Strand would get nothing
23 from Georgetown, correct? From Francis Ford
24 Center, right?

25 A: It would not affect the projections we had or

1 they had presented in their CON application.

2 Q: Okay. Now, again, I'm going to try to do this
3 very simple. If I subtract the 7,237 that's
4 Georgetown treatments, right Francis Ford -- or
5 excuse me, Ford Cancer Center.

6 A: Here we go, subtract it from what?

7 Q: If I take 7,237 from 3,182.

8 A: Okay.

9 THE COURT: Hold on a minute.

10 A: 3,182?

11 Q: Yeah. What would that give me?

12 A: 3,182 minus 7,237.

13 Q: Right.

14 A: 3,182. 3,182 minus 7,237 is minus 4,055.

15 Q: If you take 31,802 and ---

16 A: I'm sorry, that's -- you said 3,182. You mean
17 31,802.

18 Q: Yeah. I'm sorry. Take the total radiation
19 treatments there, 31,802.

20 A: 31,802, okay.

21 THE COURT: Eight, zero, two.

22 Q: Yes.

23 A: Thank you. So let me do that again. 31,802.

24 Q: Yeah.

25 A: Minus 7,237.

1 Q: Right. What do you get?

2 A: What you get is 24,565.

3 Q: Okay. So that would be the total number of
4 treatments for CRCC if Grand Strand was not
5 approved and was not operating in the market,
6 correct?

7 A: Using these assumptions, yes.

8 Q: And these assumptions are your assumptions for
9 the record, correct?

10 A: No.

11 Q: The more likely Grand Strand market share 25
12 percent applied to 31,802 total radiation
13 therapy treatments is not your assumptions?

14 A: No, you asked if these are my assumptions.
15 Some of them are; some of them aren't.

16 Q: I asked you here on the -- kind of the middle
17 column.

18 A: Well, on the middle column, the Ford Cancer
19 Center, that's what they have as their
20 projections. I didn't assume that. I just
21 accepted it.

22 Q: You did assume it because you wrote it down
23 here 7,237, sir.

24 A: Okay. I guess we're talking about what an
25 assumption is versus taking someone else's

1 number.

2 Q: Okay.

3 A: So I'm okay with that.

4 Q: You assumed that Ford Cancer Center in this
5 analysis would be doing 7,237 treatments,
6 correct?

7 A: Based on the file that they submitted to DHEC.

8 Q: Okay.

9 A: I accepted that as ---

10 Q: So this is your adverse impact analysis you did
11 for the court, right?

12 A: I'm not going to argue with you about that.
13 I'm just going to say I misunderstood what you
14 meant by assumptions.

15 Q: All right. And so to come up with CRCC's
16 existing treatments, what you have is 11,135,
17 correct? In the middle column there, more
18 likely Grand Strand market share?

19 A: On the three existing units.

20 Q: Yes. That's 11,135, correct?

21 A: Yes, it is.

22 Q: Okay. Now, you would agree with me, Mr.
23 Tolbert -- well, let me ask you this. When you
24 took out Grand Strand's treatments, did they --
25 they all came out of Carolina Regional Cancer

1 Center's utilization, correct? In other words,
2 I think you just said none of them came out of
3 the Ford Cancer Center, right?

4 A: That's correct, because they would be within
5 three miles of each other.

6 Q: Okay. And you would agree with me, Mr.
7 Tolbert, that not all of CRCC's treatments are,
8 the term I would use is up for grabs, right?
9 So of the ---

10 A: I don't understand, quote, up for grabs.

11 Q: Well, I want to go back to that number when I
12 asked you to take the 31,802 -- 802, and
13 subtract 7,237. You came up with 24,565,
14 remember?

15 A: Yes, I did.

16 Q: And that 24,565 treatments, that's the number
17 that if Grand Strand is not in the market,
18 correct?

19 A: And if the Ford Cancer Center reaches its
20 target volume.

21 Q: Okay. Good. I'm glad we got that established.
22 Now, the 24,565, we know that a certain
23 percentage of those are going to be -- are
24 going to be urologists, right? Are going to be
25 urology referrals and prostate cancer. Is that

1 a fair statement?

2 A: Yes.

3 Q: And I think we talked earlier and I asked you
4 to write some numbers down that in 2012, it was
5 going to be 22,798 treatments, right? That was
6 the number for 2012. In fact, it's actually on
7 Respondent's 39 on Tolbert 12735. It's
8 actually on the document. Right here. Actual,
9 22,798, right?

10 A: That's correct. Thank you.

11 Q: Okay. Yeah, no problem. And what's CRCC's
12 market share there for the three-county market?

13 A: Where?

14 Q: Right underneath, CRCC total all linacs,
15 22,798, actual market share is what?

16 A: Eighty-one percent.

17 Q: You would agree with me that's a nice healthy
18 market share, correct?

19 A: Yes, that's a good market share.

20 Q: Now, I asked you to write down another number,
21 it was 43.7 percent, and that's the number of
22 the treatment percentage of the totals that was
23 done for prostate cancer in 2012, right?

24 A: Yes, you did, but I don't see where I wrote it
25 down. What was that number again?

1 Q: 43.7 percent.

2 A: Okay.

3 Q: Okay. Now, if I applied something along the
4 lines of 43.7 percent to 24,565 treatments in
5 2017, I get about 10,735 prostate treatments,
6 correct?

7 A: That's true if the percentage doesn't change.

8 Q: Okay. The percentage of it, that's the last
9 percentage we know, right, is 43.7 percent? We
10 can go back to the document if we need to.

11 A: No, I'm okay with that.

12 THE COURT: 43.7 percent was what?

13 MR. THOMAS: That's the number of prostate
14 treatments of the total number of treatments
15 for CRCC.

16 THE COURT: Okay.

17 A: In, refresh my memory, what year?

18 Q: 2017, if we applied ---

19 A: No, the 43.7 percent was what?

20 Q: Oh, that was from 2012. That was the last year
21 that I was given data. Okay? So if I multiply
22 43.7 percent time 24,565 treatments in 2017,
23 that gives me 10,735 prostate treatments,
24 correct?

25 A: 10,735 give or take one.

1 Q: Okay. Right. Now, you would agree with me,
2 Mr. Tolbert, you did an adverse impact
3 analysis, I believe it was Respondent's 10 and
4 we'll look at it in a little bit, but you
5 assumed that all the prostate cancer patients
6 from AUC to urology clinics were all going to
7 go to CRCC, correct? That was the assumption
8 in that document.

9 A: Would you ask the question again?

10 Q: Yes. In Respondent's 10, you assumed that all
11 the referrals from Atlantic Urology Clinics,
12 correct?

13 A: All the referrals the doctors make.

14 Q: Are going to go to CRCC, right?

15 A: No.

16 Q: Let's go to the document, Respondent's 10.

17 Okay. Referral source category one AUC, CRCC
18 100 percent to CRCC referral direction, AUC -
19 CRCC 100 percent. Referred to CRCC 263. That
20 wasn't your assumption?

21 A: No.

22 Q: Well, do you need to redo this document?

23 A: No, this document is perfectly accurate. Those
24 were the patients in 2012 that the Atlantic
25 Urology physicians referred to CRCC.

1 Q: Right.

2 A: That's not all the patients they referred for
3 radiation therapy. We don't know the others.
4 We know from an interrogatory that I think you
5 requested in that year, I think it was 19 of
6 their patients went to Georgetown for
7 treatment. So they referred them to
8 Georgetown, and those aren't in these numbers.
9 These are just the ones that they referred to
10 CRCC. It does not include the others. It also
11 doesn't include ones they may have referred to
12 Florence.. They may have seen a patient who was
13 a part-time residence at Myrtle Beach and
14 referred them back to their home in Michigan,
15 for all I know.

16 Q: Okay.

17 A: These are just the ones that were referred to
18 CRCC in the past, and I assumed they would
19 continue to do that same in the future.

20 Q: You assumed that Grand Strand would get none of
21 them, correct?

22 A: None of those.

23 Q: Right. None of the urology referrals, right?

24 A: None of the ones that in the past had gone to
25 CRCC.

1 Q: In fact, you projected that out, correct?

2 A: None of the ones that they had sent to CRCC in
3 the past did I assume would shift. Some of the
4 ones that they had sent to Georgetown might go
5 to Murrells Inlet, I mean to Grand Strand. I
6 don't know.

7 Q: Okay. Well ---

8 A: So now, that's not all of the patients they
9 refer.

10 Q: Well, let me ask you this. You would agree
11 with me that if there's 24,565 treatments that
12 CRCC is doing in 2017, they'd have a similar
13 treatment diagnosis mix, all right, and as they
14 did in 2012, about 10,735 prostate treatments
15 will result from that number, correct?

16 A: Using the percentage that we're using.

17 Q: Right, which was given to me by CRCC, right, in
18 discovery?

19 A: That's correct, based on the mix at that time.

20 Q: Now, you would agree with me, Mr. Tolbert, that
21 none of those are truly up for grabs. Grand
22 Strand doesn't have a shot at 43.7 percent of
23 CRCC's total because they're being referred by
24 the urologists who have an ownership, or excuse
25 me, pardon me, financial interest in CRCC,

1 right?

2 A: I'm sorry, would you repeat the question?

3 Q: Sure. You would agree with me that if there's
4 10,735 prostate treatments in 2017, based on
5 that 43.7 percent number that we were looking
6 at, that's 10,735 treatments that are pretty
7 much off the table for Grand Strand, right?

8 A: No.

9 Q: You don't agree with that?

10 A: No.

11 Q: Okay. So you're now telling me that Grand
12 Strand is going to get prostate cancer patients
13 from Atlantic Urology Clinic?

14 A: I think I testified earlier there would be
15 situations where employees of Grand Strand who
16 see the urologist may request to go to Grand
17 Strand who otherwise would be in that 263
18 patients. That's based on what I've heard in
19 court and the testimony I've heard the last
20 week.

21 Q: Well, what's the number because I'm -- this is
22 different. I mean, you've got a referral
23 analysis where you assumed referred to Grand
24 Strand zero, referred to CRCC 263. That's what
25 I've got to go on.

1 A: And I'm answering your question honestly based
2 on what I know right at this moment I believe
3 that Grand Strand's employees and their family
4 members might request. I know that based on
5 what I've heard that the urologists explain to
6 every patient their treatment options, not just
7 in terms of surgery versus radiation therapy
8 versus wait and see, but also if radiation
9 therapy is an option, they go to the radiation
10 oncologist and the radiation oncologist even
11 tell them you have treatment options. You can
12 go to Georgetown. And think to be fair, they
13 would also say and Grand Strand is an option.
14 I would be surprised if some of the employees
15 of Grand Strand didn't request to get treated
16 at their own facility, and they'd be urology
17 patients.

18 Q: Based on your, what you did or what you
19 submitted to Grand Strand, you assumed zero
20 would go to Grand Strand from AUC in 2012, and
21 you carried that number forward to 2017,
22 correct?

23 A: I did, and I believe I said that's a
24 conservative number. If I had been less
25 conservative and said maybe only 90 percent go

1 to the Atlantic, to CRCC, then the Grand Strand
2 number would be higher.

3 Q: But you didn't say that did you? You went zero
4 to Grand Strand from AUC, correct?

5 A: On this analysis, and I indicated it's a
6 conservative analysis. I think that benefitted
7 Grand Strand in terms of the numbers here.

8 Q: Okay.

9 THE COURT: Can I stop y'all?

10 MR. THOMAS: Yeah.

11 THE COURT: How many employees of Grand Strand do
12 you, or family members, do you project will get
13 prostate cancer each year?

14 MR. TOLBERT: I didn't go to that level of detail,
15 which is ---

16 THE COURT: Well, you just said 90 percent.

17 MR. TOLBERT: I said it could have been 90 percent,
18 I thought.

19 THE COURT: But you wouldn't project ten percent of
20 all prostate cancer treatments would be Grand
21 Strand employees, would you?

22 MR. TOLBERT: No, no, not necessarily.

23 THE COURT: Okay.

24 A: They have about, I heard testimony I believe
25 about 3,000 employees.

1 THE COURT: That's what I was ...

2 A: And covered lives typically could double that,
3 maybe one and a half, so it could be 6,000 to
4 8,000, quote covered lives, and then, you know,
5 the population, so it could be three percent of
6 the population in the county. But I didn't go,
7 I thought I was being generous here by CRCC
8 getting them all.

9 Q: Well, you would agree with me the urologists
10 are employed by AUC, correct?

11 A: Yes.

12 Q: You would agree with me urologists have a
13 financial incentive with CRCC in sharing
14 profits, correct?

15 A: I'm not sure how what I've heard called an
16 ancillary pool works.

17 Q: Okay. Well, if I did assume that 43, that the
18 43.7 percent of the 24,000 treatments in 2017
19 were prostate cancer treatments, that would be
20 10,735, correct?

21 A: Yes, that's where we were a few minutes ago.

22 Q: Okay. And if we go by your assumption that 100
23 percent to CRCC, correct? A hundred percent to
24 CRCC, we know that Grand Strand has no shot in
25 2017 of 10,735 treatments out of your total,

1 correct?

2 A: That's where we were a few minutes ago. You're
3 saying by your --

4 Q: I'm going by your ---

5 A: --- you're saying you're discounting that Grand
6 Strand would not get any of the urology
7 referrals by patient request?

8 Q: Correct. Just like you did, you went 100
9 percent to CRCC, correct?

10 MR. LONG: Your Honor, I'm going to have to object.
11 This is clearly asked and answered. It's in
12 his ---

13 MR. THOMAS: I don't know that it is.

14 MR. LONG: It's in his word choice in the question.

15 THE COURT: Well, I overrule that for right now.

16 MR. THOMAS: Thank you.

17 Q: Mr. Tolbert, if 100 percent of AUC's referrals
18 in 2017, going by your analysis in CRCC 10,
19 okay, go to CRCC for their treatment, that
20 leaves 13,830 treatments left over, correct,
21 for CRCC?

22 A: 13,830.

23 Q: Okay. So that's what's left. So the 10,735
24 prostate cancer patients would fill up all the
25 treatments over at CRCC-Conway, 5,499

1 treatments, I think that's what you assumed or
2 something close to it, correct?

3 A: Which part of the question are you asking me is
4 correct?

5 Q: The 5,499 treatments at CRCC-Conway; is that
6 the number you used?

7 A: That's the correct number. I didn't assume
8 those would all be urology.

9 Q: I understand that. I'm saying ---

10 A: That's what I thought you said.

11 Q: The 10,735 prostate treatments from the 43.7
12 percent, that would be enough treatments to not
13 only do all the 5,499 at CRCC-Conway, but we'd
14 have 5,256 treatments left over for CRCC and
15 Myrtle Beach, wouldn't we, just from the
16 urologists?

17 A: Yes, your mathematics are correct. There's no
18 -- I mean, there's really no logic that they
19 would all go to one unit and then what would be
20 left over would go somewhere else.

21 Q: I'm saying that if that were to occur, it would
22 fill up that much, right? That's enough
23 treatments, 10,735 prostate treatments would be
24 enough to fill up all of CRCC-Conway that you
25 assume the 5,499, plus to have 5,256 treatments

1 left over for another unit, correct?

2 A: That math is correct.

3 Q: Okay. And you didn't carve out, when you were
4 doing in Petitioner's -- excuse me,
5 Respondent's 39, you assumed in your analysis
6 that all the treatments in the service area
7 were up for grabs, correct? That's what you
8 did, you applied 25 percent as a Grand Strand
9 market share to the 31,802 total treatments,
10 right?

11 A: I applied it to the total treatments.

12 Q: And you didn't carve out, you didn't carve out
13 any of the urology treatments, right?

14 A: I did not in that global market share analysis
15 for the three counties.

16 Q: Okay. And, Mr. Tolbert, is the reason that you
17 didn't carve out of your market share impact
18 analysis the prostate cancer patients was
19 because you didn't know that the employed
20 urologists accounted for so many of the
21 referrals to CRCC?

22 A: I'm sorry, on this analysis that we were just
23 looking at I had the referrals, 263.

24 Q: Yeah, but ---

25 A: I knew those referrals.

1 Q: But did you know they were employed urologists?

2 A: I knew that two years ago.

3 Q: You sure?

4 A: When I did the original CON application.

5 Q: Well, let me ask you this. Did you know that
6 so much of the increase fro, the employed -- I
7 mean, that so much of the increase at CRCC from
8 2009 to 2011 was because of the urologists?

9 A: It was my understanding that they, with all of
10 the things we discussed, felt very comfortable
11 with CRCC treating their patients that they
12 referred to radiation therapy, and they
13 referred more patients.

14 Q: Well, look at page 233 in your deposition for
15 me. Let me know when you get there.

16 A: I am there.

17 Q: Okay. At the bottom of the page there, we're
18 talking about urologists on this page, okay.
19 If you look at your answer, it says, "My
20 discussion with --" ---

21 MR. LONG: Objection, Your Honor. He either needs
22 to allow the witness to refresh his memory with
23 the deposition or he needs to impeach him with
24 it, but he can't paraphrase from it. That's
25 what he's doing.

1 MR. THOMAS: I was trying to save some time, Your
2 Honor, but we'll do it this way.

3 THE COURT: Yeah.

4 Q: Okay. Let's go to page 233. I'm going to ask
5 you the question, and I'm going to ask you the
6 answer, correct? All right. Is that all
7 right, Mr. Tolbert, page 233? I'm going to
8 start with line six, "So I think that's what
9 that's saying. So did this mean then -- well,
10 let me ask you this. Other than the urologists
11 redirecting patients back into the region, are
12 you aware of any other physicians that did not
13 or that have changed their referral patterns
14 outside of the region back into the region?"

15 A: "My discussion with the team, as I recall, said
16 that they said the urologists were not the only
17 physicians that were not pleased with the
18 service at CRCC under the previous owner. I
19 didn't get specific names and didn't delve into
20 it beyond that."

21 Q: "How would you test that though, because who
22 would have known that?"

23 A: "The marketing people."

24 Q: "The marketing people would know that?"

25 A: "They're who call upon individual doctors and

1 chit chat with them."

2 Q: "Would you agree with though that the lion's
3 share of the increase from 2009 to 2010, 2011
4 came primarily from the urologists?"

5 A: "I don't know what lion's share is."

6 Q: "Let's call it the majority."

7 A: "I have not looked at it to see."

8 Q: Okay. So you would agree with me then as late
9 as August 8th, 2013, you did not know that the
10 urologists accounted for the lion's share of
11 the increase at CRCC's volumes from 2009 to
12 2011, right? That's what your testimony says
13 there, isn't it?

14 A: I don't recall looking at it by physician or
15 group at that time. I just don't remember it.

16 Q: Well, you hadn't seen the referral data
17 regarding urologists in 2009 to 2011, right?

18 A: I don't recall that.

19 Q: Well, you said that you hadn't seen it before
20 in your deposition.

21 A: I don't -- well, I haven't seen it. I don't
22 recall seeing it as I'm sitting here.

23 Q: Okay. So when you did this analysis on August
24 8th that I got and deposed you about on August
25 8th, this was before you did your referral

1 analysis, correct?

2 A: I'm sorry, what are you looking at?

3 Q: I'm looking at Tolbert 12735 in Respondent's
4 39.

5 A: That's the one with the 35/30 market share?

6 Q: Yes.

7 A: I had not analyzed referral data.

8 Q: Because at that time, you didn't know what the
9 urologist numbers were, correct, in terms of
10 their referrals to CRCC and the number of
11 treatments?

12 A: I had not done all the pivot table analysis
13 that was discussed this morning.

14 Q: And if you didn't know those numbers, you
15 wouldn't have known to even carve them out of
16 your market analysis, would you? If you didn't
17 know that the treatments, that 43.7 percent of
18 those treatments were not available to anyone
19 but CRCC, you wouldn't have known to even carve
20 them out, correct?

21 A: That's correct. I had not done that level of
22 analysis at that point in time.

23 Q: Okay. And when I asked you back in August if
24 you knew that the urologists accounted for 360
25 of the 1,000 patient treatments in a 12 month

1 period that was presented to DHEC, you said you
2 weren't aware of that and you hadn't looked at
3 the data before, correct?

4 A: That's correct.

5 Q: So you would agree with me, if I apply your
6 likely market share number, the 25 percent here
7 to what's actually up for grabs in the market,
8 which we know is 10,750 less in 2017, I'm going
9 to get something far less than what you got,
10 correct?

11 A: Why don't you help me walk through that number.

12 Q: Sure. What I'm saying is if you carve out the
13 urologists, because they're off the table,
14 they're not available to Grand Strand and their
15 prostate cancer treatments, that leaves us with
16 a number considerably less than, I think it was
17 24,565 treatments in 2017, correct?

18 MR. LONG: Your Honor, he keeps assuming these facts
19 not in evidence, and it's also inconsistent
20 with the witness' testimony. And it's just
21 because of the language he's using because it's
22 absolute, the language that he uses in the
23 questions. If he would ask the questions
24 properly based on the answers of the witness,
25 I think we can get through this, but he's using

1 just -- that's my objection.

2 MR. THOMAS: Your Honor ----

3 THE COURT: My answer is, he's on cross.

4 MR. THOMAS: Thank you.

5 Q: So, Mr. Tolbert, if we carve out the
6 urologists, we're going to get a number that's
7 a little bit -- I mean, far less than what you
8 got of 7,951 treatments fof Grand Strand,
9 correct, if we apply the 25 percent market
10 share?

11 A: If you disregard that, as I discussed, some of
12 the urology radiation therapy would likely be
13 referred to Grand Strand, I understand we can
14 debate about that.

15 Q: Sure.

16 A: If you assume none are shifted to Grand Strand
17 by patient preference or for whatever reason or
18 by managed care contract requires it or if a
19 benefit plan required it, then 10,735, would
20 based on your calculations, would be what you
21 say is not up for grabs.

22 Q: Okay. And so if you applied your market share
23 to the new number, it's going to be a number
24 that's far less than what you came up with for
25 Grand Strand's treatments and the more likely

1 Grand Strand market share column, correct?

2 A: It would, but using your assumptions in your
3 scenario, the market share of what's left might
4 be higher than 25 percent.

5 Q: So you're now saying that the market share of
6 what's left is different than 25 percent?

7 A: Because you changed the assumptions.

8 Q: Well, the only thing I did was take out the
9 urologists, correct? That's all I did.

10 A: That is a big assumption.

11 Q: That's an assumption you made. I know we've
12 rehashed this and I'll ask, that's the
13 assumption you made in your referral analysis,
14 correct?

15 A: In that first initial pass at looking at the
16 adverse impact, yes.

17 Q: Okay.

18 A: The hospital's market share in Horry County is
19 almost 40 percent of all inpatient services.
20 Would they -- using your scenario and if you
21 took the urologists off the table as you
22 described it, your question to me is of what's
23 left, what would they likely get, and if I
24 analyzed it, I might conclude they'd get more
25 than 25 percent of what's left.

1 Q: So what you're saying is you would apply a
2 different market share?

3 A: Using different assumptions, you could come to
4 different a conclusion.

5 Q: So if you take out the urologists, what you're
6 saying is you would change the market share
7 number to make sure that the adverse impact
8 number stayed high, correct?

9 A: I've not done that in any of these. I'm trying
10 to make an objective analysis in disclosing all
11 of my assumptions and where they're coming
12 from, and you're asking me a question what
13 would I do under this scenario, my answer would
14 be the 25 percent is not the same market. You
15 just changed the market.

16 Q: The only thing I did is I took away the
17 prostate cancer treatments, correct? Because
18 the urologists are aligned with CRCC. That's
19 the only change I made, correct?

20 A: You changed the market, and that's the big
21 change.

22 Q: All right.

23 THE COURT: Mr. Tolbert, where I can understand
24 this, you said that the market, the normal
25 market is 40 percent?

1 MR. TOLBERT: In Horry County for inpatient hospital
2 services, Grand Strand is 40 percent.

3 THE COURT: If I did 13,830 as the remaining
4 treatments that y'all were working the math
5 through, and I multiply that by 40 percent and
6 came up with 5,532, would that be a correct
7 analysis, or what would be wrong with that
8 analysis?

9 MR. TOLBERT: Well, it doesn't include, you know,
10 certainly Georgetown and Williamsburg Counties,
11 but that would say -- that would say they would
12 get 40 percent of what's "up for grabs."

13 THE COURT: All right. Sorry for interrupting.

14 MR. THOMAS: No, that's all right, Your Honor.

15 THE COURT: You're throwing so many numbers out, I'm
16 trying to figure it all out.

17 MR. THOMAS: Hopefully on the rebuttal case, Mr.
18 Sullivan will be a little bit more clear, Your
19 Honor.

20 A: I'm sorry if I'm not being clear.

21 Q: No, no, I was saying I wasn't clear.

22 A: Oh, okay. I'm sorry.

23 Q: All right. Let's look at Respondent's 10.
24 This is your referral analysis. Hopefully,
25 this will go a little bit more smoothly and

1 hopefully less math. All right. Let's get
2 some housekeeping and get that out of the way.
3 You would agree with me, Mr. Tolbert, that you
4 haven't spoken to a single physician who refers
5 patients to CRCC who has indicated that if
6 Grand Strand gets a linear accelerator they
7 will discontinue referring patients in any way,
8 shape, or form to CRCC?

9 A: In my analysis of physician referrals, I did
10 not call any on the list.

11 Q: You have no idea how many physicians who are
12 employed by Grand Strand are in a position to
13 refer patients to Grand Strand's radiation
14 therapy center, do you?

15 A: I'm sorry, what do you mean in a position to
16 refer?

17 Q: In a position to refer, like for instance,
18 Grand Strand may employ a certain type of
19 physician who may not ever refer to a radiation
20 therapist, correct?

21 A: Okay. That's a different question. I would
22 have thought they all would have the ability to
23 refer if they wanted to unless Grand Strand
24 restricted them.

25 Q: Right.

1 A: But you're asking do some of the physicians on
2 Grand Strand's medical staff not treat cancer
3 patients.

4 Q: No, what I'm asking is ---

5 A: I'm sorry.

6 Q: --- do you have any idea how many physicians
7 who are employed by Grand Strand are in a
8 position to refer or who would likely refer
9 patients to a radiation therapy center. Do you
10 know that number?

11 A: You mean like were six, seven, or eight
12 physicians?

13 Q: Yeah.

14 A: Is that your question?

15 Q: Yeah.

16 A: I don't have a list of the physicians that are
17 employed by Grand Strand.

18 Q: And you have no idea how many physicians are
19 employed by Grand Strand, correct?

20 A: I don't know that number.

21 Q: But you do know that they don't employ any
22 medical oncologists and urologists, correct?

23 A: I believe that is correct.

24 Q: And you agree with me that the medical
25 oncologists and the urologists are 60 percent

1 of the 2012 referrals to CRCC, give or take?

2 A: Ask that question again, please.

3 Q: Would you agree with me that the medical
4 oncologists and the urologists accounted for 60
5 percent of the patient referrals to CRCC in
6 2012 for the patients that are under treatment?

7 A: Well, for the sake of time, let me ask, I did
8 not add these numbers up for those groups and
9 divide it by the 886, but you're telling me if
10 I did it would be 60 percent?

11 Q: Close to 60 percent.

12 A: Without me doing the math, at this point, I'm
13 willing to accept that percentage.

14 Q: All right. But you know it's a large number,
15 correct? That those two providers are the
16 primary referral sources to CRCC in terms of
17 physician practices, medical oncologists and
18 urologists?

19 A: Yes.

20 Q: Okay.

21 A: Sixty percent, usually both Mr. Sullivan and I
22 would use -- you usually use when you capture
23 80 percent, that's your primary market. This
24 is 60, so you might add a few other high
25 referrers to get "primary." But I'm good with

1 60 percent if you did the math.

2 Q: Okay. Other than those two groups, can you
3 tell me of another single group that is a heavy
4 referrer to CRCC, or that refers a significant
5 amount of patients?

6 A: No, those are the two large groups.

7 Q: And you would agree with me in terms of patient
8 preference for a particular provider, that can
9 be based on several factors, including where
10 patient lives, the patient's family members or
11 friend's past experience, where they work,
12 where their physician may direct them?

13 A: In terms of the patient's preference or the
14 patients, how they make the decisions.

15 Q: Right.

16 A: Yes.

17 Q: And patient's preference can also be affected
18 by the quality of care and their perception of
19 the quality of care at the linear accelerator
20 facility, correct?

21 A: Yes.

22 Q: Would you agree that CRCC is a quality provider
23 of radiation therapy?

24 A: Yes.

25 Q: And you would agree with me that patients also

1 go on word of mouth as to other people's
2 experience at A provider?

3 A: Up until recently, that was about all they had
4 to go on. Now with Health Grades and some
5 other published data that's on the internet,
6 they can do some more research, but previously,
7 it was mostly word of mouth.

8 Q: And you would agree with me that you didn't
9 decide to do, and I'll just call this the read
10 of the records, the analysis of adverse impact
11 if both applications are approved based on
12 redirection and change in physician referral,
13 correct? You didn't think about really doing
14 this analysis until you heard or you found out
15 that Mr. Sullivan was thinking about doing one,
16 right, from his deposition?

17 A: In his deposition, it was mentioned and then
18 the data was available, and I undertook this
19 analysis, again, just a different way to look
20 at the potential volume that Grand Strand might
21 have.

22 Q: Okay. And we got this, I guess, about less
23 than two weeks ago, right? Would that be about
24 the time you finished it?

25 A: I don't remember the date, but all of this has

1 happened since my first deposition on August
2 the 8th or 10th.

3 Q: Okay. And you did this. You did this
4 analysis, even though you already had CRCC's,
5 you had access to CRCC's treatments by referral
6 source since 2011, right?

7 A: Patients by referrals, yes.

8 Q: Sure. You had that, right?

9 A: I did.

10 Q: Okay. Now, you would agree with me that your
11 analysis is based in part on two 30-minute
12 telephone calls that I think you had with Ms.
13 Price and Dr. Francke regarding their thoughts
14 about the physicians and where they might
15 refer; is that a fair statement?

16 A: I believe so. As I said, I didn't recall if it
17 was one long conversation or two shorter ones,
18 but it was -- it was lengthy and I had input,
19 their input.

20 Q: Okay. But there were two 30-minute phone
21 calls, that's what you testified at your
22 deposition, right?

23 A: And I believe I said I wasn't exactly sure if
24 it was one or two, but yes, I did talk with
25 them.

1 Q: You would agree with me that during those two
2 30-minute phone calls, y'all primarily focused
3 on the higher referral sources, right? The
4 ones where the doctor referred more than ten
5 patients, right?

6 A: Primarily, yes.

7 Q: Okay. You would agree with me that there are
8 a lot of low referral sources to CRCC, correct?

9 A: Yes.

10 Q: Okay. Look at category number, I think it's
11 category number eight on Tolbert 12844 in
12 Exhibit 10.

13 A: Is this ---

14 Q: It should be on the screen.

15 A: Oh, okay, it was on the screen.

16 Q: Category number eight says, other, I believe
17 it's other support CRCC and Grand Strand,
18 right?

19 A: Yes.

20 Q: Okay. And a lot of those that fell into the
21 other, those were less than ten referrals,
22 correct?

23 A: Most of them I think were less than five.

24 Q: Okay. So a low referral source?

25 A: Yes.

1 Q: You would agree with me that is, in terms of
2 the grand total there kind of the blue column
3 in the middle, that's the third highest
4 category out of the other eight, correct? So
5 you've got the urologists as number one, or
6 excuse me, Coastal Cancer Center number one,
7 urologists number two, and then other number
8 three, right?

9 A: I see what you're saying.

10 Q: Is that correct?

11 A: It's the third highest in terms of, in
12 situations like this, you normally apply what's
13 called the 80/20 rule, and how that works is 80
14 percent of your revenue comes from 20 percent
15 of your clients.

16 MR. THOMAS: Your Honor, I didn't -- pardon me, Mr.
17 Tolbert but I didn't ask him, I just asked if
18 it was the third highest category. I didn't
19 ask him anything other than that.

20 THE COURT: Mr. Tolbert, if you could respond to his
21 question and then if you believe that the
22 response needs explanation, then you can do
23 that at that time.

24 MR. TOLBERT: Okay. Thank you, Your Honor.

25 A: Yes, it is the -- of the numbers that appear on

1 this page, yes, there are nine numbers, it's
2 the third highest.

3 Q: Okay.

4 A: It is a number that represents, as you would do
5 this type of analysis, using the 80/20 rule.
6 This is 80 percent of their physicians fall
7 under this category that refer to them. It
8 represents less than 20 percent of the total
9 volume, so it becomes an area from a planning
10 standpoint or even from a business standpoint,
11 you don't worry as much about those as the ones
12 that are the -- create most of your revenue,
13 which are the ones above that.

14 Q: Mr. Tolbert, you would agree with me that you
15 didn't look at the medical staff affiliations
16 for all 140 of these physicians, did you?

17 A: I did not. Now, there's a problem looking at
18 medical staff affiliations. Hospitals have
19 medical staff bylaws. Hospitals that I deal
20 with categorize ---

21 MR. THOMAS: Your Honor, again, I didn't -- I just
22 asked him if he looked at the medical staff
23 affiliation. If Mr. Long thinks that's a topic
24 for cross ---

25 MR. LONG: I think he ---

1 MR. THOMAS: -- he can do that, but I just asked him
2 what the medical -- if he looked at the medical
3 staff affiliations.

4 MR. LONG: He's explaining why, and he's got every
5 right in the world to explain.

6 MR. THOMAS: I don't think he does. It's not
7 responsive.

8 THE COURT: He started going into what others at the
9 hospitals do.

10 MR. THOMAS: If Mr. Long thinks that's important, he
11 can ask him on redirect, but I just asked him
12 a simple question. We're going to be here
13 until 7:30 at night.

14 MR. LONG: It's not up to me, Your Honor. It's up
15 to the witness.

16 MR. THOMAS: It's not.

17 MR. LONG: The witness get to decide what to
18 explain.

19 THE COURT: Now, he can object it if the answer's
20 non-responsive, so that is my call on that.
21 But at this point in time, I'm going to let him
22 continue and I'll listen closely to whether or
23 not it sounds like it's ---

24 MR. THOMAS: All right.

25 THE COURT: So your answer, do the Q and A again.

1 MR. THOMAS: Okay.

2 Q: The question was, you didn't look at the
3 medical staff affiliations for all 140 of these
4 physician referral sources, did you?

5 A: No, I did not, and there was a reason I didn't.
6 The reason was there in this three-county
7 region, there are five hospitals. My working
8 with hospitals for 38 years now, medical staff,
9 being on the medical staff means you have to
10 apply and join the medical staff. Hospitals
11 have medical staff bylaws and you're given
12 privileges. My experience, there are three
13 levels of privileges, active medical staff
14 which means you admit to that hospital. You
15 have to usually you admit a certain number of
16 patients a year to be considered active. The
17 next level is consulting, and you would be on
18 a consulting medical staff if occasionally you
19 would be asked to go to a hospital and look at
20 a physician if you were a subspecialist. And
21 then there's a third level that's usually
22 called courtesy medical staff privileges. That
23 means you can claim to be on the medical staff,
24 but you really have no obligations to be on
25 committees, to do emergency room call or

1 anything. The websites for the hospitals get
2 real crafty. They don't typically indicate if
3 you're active, courtesy or consultant, so
4 you'll see a lot of -- a lot of physicians will
5 be on multiple medical staffs, and you really
6 can't tell if they're active, that means they
7 really admit patients to the hospital or not.
8 So it's good information but you can't draw
9 necessarily a whole lot of conclusions about
10 where the doctor primarily practices. I
11 apologize if that was too long.

12 Q: I just want to get it straight. Based on two
13 30-minute phone calls with Dr. Francke and Ms.
14 Price, you determined how a 140 physician
15 referral sources were going to refer in 2017 if
16 both Grand Strand and CRCC are approved for
17 linear accelerators, correct?

18 A: No, sir.

19 Q: Okay. Explain.

20 A: Explain. I'm sorry, explain what?

21 Q: You said no. I'm just asking you to explain
22 your answer.

23 A: That was, I didn't just rely on their input.
24 I considered it very heavily because they know
25 the doctors in that area and who they felt were

1 strongly aligned with them and who might refer
2 to Grand Strand.

3 Q: Okay.

4 A: So I listened to them. I really believe they
5 know what they're talking about. It was not
6 the only thing that I looked at.

7 Q: Okay. You would agree with me that neither
8 Sissy Price or Dr. Francke very much want Grand
9 Strand to have a radiation therapy center,
10 correct? You would agree with me on that?

11 A: I didn't hear either testimony, but I would
12 assume they would be very concerned about it.

13 Q: They don't want Grand Strand to have a
14 radiation therapy center, correct?

15 A: That's correct.

16 Q: So you would agree with me that when they're
17 giving you advice or information about where
18 referral sources may refer, that's not actually
19 going to be the most impartial information, is
20 it?

21 A: Well, I think I'm pretty good at asking
22 questions and trying to get good information
23 out of people. Yes, I would think they would
24 be biased. I was surprised the numbers here
25 weren't higher in terms of what their input

1 would have been on Grand Strand's ability to
2 influence referrals.

3 Q: So you think that Grand Strand, you thought it
4 was -- Grand Strand was going to do even more
5 than 8,195 treatments by the third year of
6 operations as a startup in a market dominated
7 by an alleged high quality entrenched provider
8 for 30 years?

9 A: Well, let me answer that question by saying I
10 listened to what they said and considered other
11 factors, and this was what I came up with. If
12 they had done it independent of me, would their
13 numbers have been higher? They might have
14 been, but that's why I'm involved, to hopefully
15 keep things more objective and less biased.

16 Q: All right. Go to Respondent's 11, Tolbert
17 12895. Let me know when you get there.

18 A: I'm there, Mr. Thomas.

19 Q: Okay. Now, you agree with me there's about 140
20 physicians on this list. Did you ever count
21 them up?

22 A: I thought it was about 150, but I didn't run a
23 total.

24 Q: Okay. And you testified in your deposition
25 that many of the physicians on the list you

1 never spoke about with Dr. Francke and Ms.

2 Price, right?

3 A: The ones that, I don't want to use an
4 inappropriate word, but we would call them the
5 onesie-tvosie referrals that refer one or two
6 patients.

7 Q: Okay. And so that would include, at least on
8 this list, the majority of the physicians,
9 correct?

10 A: I believe over 80 percent fall into that
11 category.

12 Q: And you would have to agree that you have no
13 firsthand knowledge of what most of these
14 physicians think about CRCC, correct?

15 A: As I testified, I didn't call any one of them.
16 I doubt that any one of them would have
17 returned my call, and in terms of their
18 relationship with CRCC, I relied primarily on
19 Ms. Price's and Dr. Francke's ---

20 Q: What Dr. Francke and Ms. Price told you, right?

21 A: What we discussed. It was a dialogue, not a
22 telling.

23 Q: Okay. Two 30-minute conversations or maybe one
24 one-hour conversation, correct?

25 A: That is correct.

1 Q: Okay. Turn to page one -- in this document 12,
2 I think it's 854. 12854. Now, find the
3 middle. Let me ask you this. Did you do this
4 analysis, Mr. Tolbert, and kind of assign the
5 patients, or excuse me, the categories like the
6 other and the Coastal category and that type of
7 thing?

8 A: You mean actually typing them in? I believe I
9 had somebody insert that data based on the
10 Coastal doctors and the Atlantic Urology
11 doctors and everybody else.

12 Q: But did you put them into categories like other
13 support, CRCC, AUC, CRCC 100 percent.

14 A: Slow down here, what column are you looking,
15 are you talking about?

16 Q: The third one or the fourth. Yeah, third one
17 from the right.

18 A: And your question again, please?

19 Q: Did you put these physicians into that
20 category?

21 A: Yes.

22 Q: Okay. Now, go to the bottom of that page for
23 me, and I want you to count up one, two, three,
24 four, five, six, seven, eight lines.

25 THE COURT: What page are we on?

1 MR. THOMAS: 12854.

2 A: How many lines?

3 Q: Eight.

4 A: From the bottom of?

5 Q: 12854.

6 A: I'm on the wrong page. Nine?

7 Q: The eighth line up.

8 A: It says North Myrtle Beach?

9 Q: It says Murrells Inlet.

10 MR. THOMAS: Can you maximize that on there?

11 Q: 12854, count up eight lines. One, two, three,
12 four, five, six, seven, eight.

13 A: I'm sorry, on mine apparently there, it was
14 three hole punched and some of the numbers are
15 not easy to read. The page number is?

16 Q: 12854.

17 A: I think I'm on that, I can see the page numbers
18 even on this one, I think that's it.

19 Q: Yeah.

20 A: And count up eight ---

21 Q: Eight lines for me.

22 A: I'm at eight, I think.

23 Q: Does that say Murrells Inlet and Murrells one?

24 A: Yes, it does.

25 Q: Read the name for me.

1 A: That's Dr. Francke.

2 Q: Yeah. Keep going over. He's with radiation
3 oncology. You've got Coral Springs, Florida,
4 there, right?

5 A: Yes.

6 Q: What category did you put him in?

7 A: Other support.

8 Q: And other support means that Dr. Francke, the
9 medical director of CRCC, is going to send four
10 out of every ten patients to Grand Strand,
11 right?

12 A: Yes, it does. And I'm trying to think how
13 that, I bet in their billing system, for some
14 reason they still had his address as Florida.

15 Q: Okay.

16 A: That's odd.

17 Q: Yeah. And you randomly assigned him to the
18 category that would send four out of every ten
19 of his radiation therapy referrals to Grand
20 Strand Regional Medical Center, right? That's
21 what it says there, doesn't it?

22 A: Your first part of that question was I what?

23 Q: You assigned Dr. Francke to the category other
24 support CRCC Grand Strand four, and what that
25 means -- well, first of all, did you do that?

1 A: What I did was follow the very low volume
2 physicians like one. I did not go through line
3 by line and look at their name.

4 Q: Right, because that's how the medical director
5 of CRCC got categorized ---

6 A: Yes.

7 Q: --- as sending four out of every ten of his
8 patients to Grand Strand, right?

9 A: That is the one patient that he referred, if
10 you're saying did that one get miscategorized?

11 Q: Yeah.

12 A: Yes, it did.

13 Q: That's the most obvious physician in this
14 group, isn't it? And the most obvious one got
15 miscategorized. How can we trust any of these
16 others?

17 A: I believe the analysis is valid for analyzing
18 market share.

19 Q: Go back to Respondent's 10 for me if you would.

20 A: Yes.

21 Q: Okay. I want to quickly go down these, and I
22 think one thing we actually agree about is that
23 -- is that AUC to CRCC 100 percent, right? I
24 mean you've got that as 100 percent, correct?

25 A: What part of that are we agreeing on?

1 Q: Well, I'm agreeing that 263 will be referred to
2 CRCC as what you put into that category.

3 A: What I have on this page is exactly what you
4 said, and I testified there it could be -- it
5 could be different.

6 Q: I understand. You're changing, that's adverse
7 impact analysis number four, right?

8 A: I'm just saying as we go through this process,
9 more information is discovered, assumptions can
10 be changed, can change, reasonably change.

11 Q: Now you heard -- let's go down to the next
12 category, Coastal Cancer Center, because that's
13 the largest referral source to CRCC in 2012,
14 correct?

15 A: I think when we looked at this in my last
16 deposition, it was slightly higher than
17 Atlantic Urology, yes.

18 Q: Okay. Now, you heard Sissy's comments about,
19 I shouldn't call her that, Ms. Price's comments
20 on Wednesday when she said CRCC was just a
21 little farther away from Grand Strand than
22 Coastal, correct? She said it took about three
23 minutes to go ---

24 A: Yes, yes, I'm remembering what you're saying.

25 Q: All right. And you believe, do you not, that

1 three miles is not a significant difference
2 that will affect a physician's referral
3 decision, correct?

4 A: I don't think, no, I don't think it would.

5 Q: Okay. And you also believe that the fact that
6 Grand Strand is three miles closer to the North
7 Myrtle Beach area is also not a driving factor
8 in terms of patient preference for the people
9 from that area, correct?

10 A: Once they're in the car and driving, that would
11 probably not be a big consideration.

12 Q: Okay. So you'd agree with me that from CRCC's
13 perspective, there's no real advantage to
14 Coastal's chemotherapy patients who need dual
15 therapy in terms of time or distance in a car,
16 correct?

17 A: Dual therapy meaning they have chemo in the
18 morning and a radiation treatment in the
19 afternoon?

20 Q: Correct.

21 A: That would probably not be a major issue.

22 Q: Okay.

23 A: Many times they would go home or go somewhere
24 for lunch and then go back wherever they're
25 having their radiation therapy treatment.

1 Q: So not an issue, right? You agree with that?

2 A: I said I don't think it's a major issue. I
3 don't think it would be a big issue.

4 Q: Okay.

5 A: You often say absolutes, and I'm just saying I
6 don't think it's a big issue. I'm sorry, at
7 least I perceive often your absolutes.

8 Q: You made no allowance in your analysis here for
9 the fact that Coastal Cancer Center has a
10 Murrells Inlet office either, correct, even
11 though CRCC will likely have a presence in
12 Murrells Inlet, correct?

13 A: No, I don't know how large that office is, to
14 what extent they provide infusion therapy. I
15 understand the Coastal office in Myrtle Beach
16 is about 35,000 square feet, so that's a huge
17 office for six physicians. A typical physician
18 office, you have about 1800 to 2000 square feet
19 per doctor, without considering other services
20 they might be provided. So I don't know what's
21 in Murrells Inlet. I believe what's in Myrtle
22 Beach is their main huge center.

23 Q: You don't know that, right? You didn't even
24 know when I deposed you a few days ago that
25 Coastal Cancer Center even had a Murrells Inlet

1 office, correct?

2 A: I told you that -- I believe I said that I knew
3 they had satellite offices. I did not have
4 memorized where they were located.

5 Q: You didn't know that they had one in Murrells
6 Inlet, right? That's the question I'm asking
7 you.

8 A: I did not know they had one in Murrells Inlet.

9 Q: Okay. You also weren't aware that Coastal
10 Cancer Center does infusion chemotherapy in all
11 of their offices, correct? When I deposed you,
12 you did not know that, when you did this
13 analysis?

14 A: I had not researched that subject.

15 Q: In fact, you weren't even sure which Coastal
16 Cancer Center physicians worked in which
17 offices, correct?

18 A: I told you I don't have their names memorized
19 at all, and wouldn't know which office they're
20 in. I could look up which ones gave us letters
21 of support for Conway.

22 Q: Do you know those names of those physicians
23 today?

24 A: I do not have those memorized. I'm sorry if I
25 should.

1 Q: Well, don't you agree that the fact that
2 Coastal Cancer Center has a Murrells Inlet
3 office and the fact that Coastal Cancer Center
4 does chemotherapy in all of their offices and
5 where the Coastal Cancer Center physicians were
6 are all pretty critical when doing a referral
7 analysis?

8 A: Not for what I was doing here. I think my
9 analysis is perfectly fine.

10 Q: Okay. So it doesn't matter where they are,
11 right? It doesn't matter where they're
12 located? It doesn't matter where the patients
13 live? It doesn't matter if the cancer centers
14 are near the radiation therapy centers?

15 A: I know they have multiple offices, one in North
16 Carolina, and I know they have six physicians.
17 I know that they would -- someone may be
18 primarily in one office, but they don't have
19 enough doctors to cover fully a 35,000 square
20 foot facility and then five satellite offices.

21 Q: Do you know what goes on in that 35,000 square
22 foot facility?

23 A: I do not know that.

24 Q: Have you ever toured it?

25 A: I have not.

1 Q: So you don't really know what the purpose of
2 all that space is, and you don't know if all
3 that space is being used, do you, Mr. Tolbert?

4 A: I know from what Ms. Price and Dr. Francke told
5 me that the primary place for infusion is the
6 Myrtle Beach office.

7 Q: Isn't it pretty key for when you're trying to
8 figure out where a patient from Murrells Inlet
9 is going to go, especially one that's
10 undergoing dual chemo and radiation therapy,
11 you don't think a physician is going to make
12 that patient drive from Murrells Inlet after
13 they have chemo up to CRCC or Grand Strand's
14 linear accelerator facility 20 miles through
15 heavy traffic north and then make them drive
16 all the way back to their house, do you?

17 A: Well, first of all, from what I know, the
18 number of dual treatment patients is not all of
19 them. It's not a really large number.

20 Q: It's about 30 percent. That's what Dr. Mantz
21 said in his deposition, isn't it? Did you read
22 his deposition?

23 A: I don't recall that.

24 Q: What do you think the percentage is?

25 A: I told you I don't know.

1 Q: Okay.

2 A: But I know that Dr. Francke and Ms. Price
3 indicated it's a low percentage.

4 Q: What you know -- what we know is Dr. Francke is
5 on that spreadsheet referring four patients out
6 of ten to Grand Strand, right?

7 A: I think we've established that he was
8 miscategorized because his address was still in
9 Florida.

10 Q: Now, would you agree with me on the Coastal
11 Cancer Center category, you decided to assign
12 75 percent of all the Myrtle Beach and North
13 Myrtle Beach patients to Grand Strand, correct?

14 A: I'm sorry, repeat that question.

15 Q: Yeah, on your analysis that you did a couple,
16 you know, three or four weeks ago, the referral
17 analysis, you decided to assign 75 percent of
18 all the Myrtle Beach and North Myrtle Beach
19 patients to Grand Strand despite Ms. Price's
20 testimony that there's no travel time advantage
21 for those Coastal Cancer Center patients,
22 correct? That's what you did.

23 A: No, sir.

24 Q: You didn't assign 75 percent of the Myrtle
25 Beach and the North Myrtle Beach patients to

1 Grand Strand?

2 A: No.

3 Q: Well, if there are 186 grand total, correct?

4 A: That's what it says.

5 Q: And all those, all 75 percent of those are
6 going to Grand Strand, that's what this exhibit
7 says, right?

8 A: That's correct.

9 Q: Okay. And we know Myrtle Beach and North
10 Myrtle Beach, you put 110 in that category,
11 right? On Grand Strand's line, right?

12 A: You could do that.

13 Q: Well, you did it. You did 110 on the line that
14 says from all else 75 percent to Grand Strand.

15 A: I'm looking at it on the piece of paper, yes,
16 sir.

17 Q: Okay. And then Murrells Inlet you did 42,
18 right?

19 A: That's what the ---

20 Q: And you put it in Grand Strand's, right?

21 A: No, sir.

22 Q: You put it in a category from all else 75
23 percent to Grand Strand, correct?

24 A: What I did, I took 186 patients.

25 Q: Right.

1 A: And 75 percent of those would go to Grand
2 Strand. I did not do the calculation. I
3 didn't look at maybe Myrtle Beach, North Myrtle
4 Beach, I didn't assume that would be 75 percent
5 exactly the others, I just didn't look at it
6 that way. I looked at it as the total.

7 Q: But let's look at it how you characterized it.
8 Patterns to CRCC in 2012. The categories,
9 Myrtle Beach and North Myrtle Beach and
10 Murrells Inlet, that's where these patients
11 resided, correct?

12 A: That's correct.

13 Q: Okay. So you put 110 MB and NMB in the
14 category from all else 75 percent to Grand
15 Strand, correct?

16 A: I just said I didn't do it that way.

17 Q: All right. Mr. Tolbert, it's on the line that
18 says from all else 75 percent to Grand Strand,
19 Myrtle Beach and North Myrtle Beach 110, right?
20 I'm just saying that's on the row it's on.

21 A: If we looked at the Excel spreadsheet, Mr.
22 Thomas, you would see where referred to Grand
23 Strand, which is what, 339, are you following
24 me?

25 Q: I don't see 339.

1 A: I'm sorry, 139. If you looked at the Excel
2 spreadsheet, you would see ---

3 THE COURT: I'm sorry, y'all. We need to take a
4 short five minute break.

5 (Break from 5:20 p.m. until 5:29 p.m.)

6 BY MR. THOMAS:

7 Q: Mr. Tolbert, let's go back to CRCC Exhibit 10
8 if we could, Respondent's 10. I'm going to
9 take you through this and just tell me if I've
10 gotten something wrong, okay? If we look at
11 category three Coastal - primary to GS, that's
12 Grand Strand, right?

13 A: Yes.

14 Q: With some to CRCC-Conway, correct?

15 A: Yes.

16 Q: Okay. If you split the cells, on the top row
17 you have from Conway and Loris 75 percent to
18 CRCC, correct?

19 A: That's correct.

20 Q: And then on the bottom cell, it says from all
21 else 75 percent to Grand Strand, correct?

22 A: That's correct.

23 Q: Okay. Now, we've got two grand totals in the
24 blue column, correct?

25 A: Two grand totals?

1 Q: Yes. In the blue column, grand totals, we have
2 two grand totals. We have 89 and 186.

3 A: Oh, yes, I see. Yes.

4 Q: And after that, we have several cells and
5 columns that say, that give a location,
6 correct?

7 A: Yes, we do.

8 Q: All right. And those locations, I think
9 everybody at this point knows where they are,
10 correct?

11 A: I believe so.

12 Q: And these are where these particular patients
13 in 2012 came from, from zip codes in these
14 location categories, correct?

15 A: Yes.

16 Q: So on the top, top cell of the split cells in
17 category three, 89 patients came from Conway
18 and the Loris area, correct?

19 A: And it's, that number's on there twice, yes.

20 Q: Okay. And so that was the grand total,
21 correct, for that category?

22 A: Yes.

23 Q: All right. What you did is you took that
24 number, 89 percent -- 89, and you multiplied it
25 by 75 percent, correct?

1 A: I did.

2 Q: And that meant 67 of those patients that reside
3 in the Conway and Loris area are going to be
4 referred to CRCC and 22 are going to be
5 referred to Grand Strand, correct?

6 A: That is correct.

7 Q: All right. I want you to drop down one cell to
8 the from all else 75 percent to Grand Strand.
9 We're going to do a similar exercise. The
10 grand total number is 186, correct?

11 A: That's correct.

12 Q: That grand total number was derived by adding
13 110 patients who reside in the Myrtle
14 Beach/North Myrtle Beach area, plus 42 patients
15 that reside in the Murrells Inlet area, plus
16 one patient that resides in the Georgetown
17 area, plus one patient that resides in the
18 Williamsburg area, plus 32 patients that reside
19 in the all other category, correct?

20 A: Yes.

21 Q: And what you did was you summed those to 186,
22 and you multiplied that number by 75 percent,
23 correct?

24 A: I did.

25 Q: Okay. And you came up with 47 of those

1 patients who reside in those various areas
2 going to CRCC, correct?

3 A: Well, that's not the 75 percent.

4 Q: Right.

5 A: That's 25 percent.

6 Q: And the 75 percent was 139 to Grand Strand,
7 correct?

8 A: That is correct.

9 Q: And you would agree with me that out of the
10 139, many of those patients are going to be
11 from Myrtle Beach, North Myrtle Beach, and
12 Murrells Inlet, correct?

13 A: Yes.

14 Q: Okay. And so you had decided to assign 75
15 percent of those patients that live in Myrtle
16 Beach and North Myrtle Beach among other places
17 to Grand Strand despite hearing Ms. Price's
18 testimony that there is no travel time
19 advantage for those Coastal Cancer patients,
20 correct?

21 A: Of the total, you said that correctly, and I
22 don't believe I indicated that travel time and
23 that distance was necessarily a big decider.

24 Q: Okay. But also, you made decisions there in
25 terms of the travel time. There are many out

1 of that 139 being referred to Grand Strand that
2 are going to come from Murrells Inlet, correct?

3 A: From the Murrells Inlet area.

4 Q: Right.

5 A: Not necessarily the municipality of Murrells
6 Inlet.

7 Q: You would agree with me that two CON
8 applications have been approved for relocations
9 to the Murrells Inlet area, correct?

10 A: They have been.

11 Q: And you would agree with me then that there
12 will be most likely one or two radiation
13 therapy centers in the Murrells Inlet area by
14 2017, correct?

15 A: Would you repeat that question?

16 Q: You would agree with me that there will be one,
17 perhaps two radiation therapy centers in the
18 Murrells Inlet area by 2017, correct?

19 A: If I could predict accurately what the
20 Administrative Law Court would do, I could
21 answer that question, but I'm not sure what the
22 end result's going to be.

23 Q: All right. Look on your own exhibit,
24 Respondent's 10. You created this, right?

25 A: Yes, I did.

1 Q: Okay. Well, look at the bottom. There's a
2 little footnote there, a little a. What did
3 you assume for the purposes of your exhibit?

4 A: For this exhibit for this purpose, I assumed,
5 and it's not a full analysis of the what if we
6 had one or two new or relocated centers in
7 Murrells Inlet, what I thought that had been
8 referred to CRCC might go to Georgetown if it
9 was in Murrells Inlet.

10 Q: You assumed Ford Center relocates to Murrells
11 Inlet; more analysis is needed to better
12 assess redirection of CRCC referrals to Ford,
13 which is not an issue in this case. That was
14 your assumption, correct?

15 A: That was my assumption for this purpose. I
16 felt it was important to look at what might
17 happen.

18 Q: You assumed that there would be in 2017 a
19 Murrells Inlet radiation therapy center,
20 correct?

21 A: For the purpose of this analysis, and I also
22 indicated that there's a court case -- I mean,
23 there's a case that hasn't been resolved.

24 Q: And even though you assumed that, you still
25 assumed a lot of people are going to be told to

1 drive up to Myrtle Beach and go to Grand
2 Strand's radiation therapy center in 2017 and
3 then drive back home to Murrells Inlet,
4 correct?

5 A: As I indicated, some of those that I assigned,
6 if you want to call it that, you might assume
7 would go to Grand Strand might be right between
8 the two in terms of the distances.

9 Q: And some of them might be right next to the
10 Murrells Inlet radiation therapy center,
11 correct?

12 A: That's correct.

13 Q: And you have testified that the location of the
14 radiation therapy center is important in terms
15 of patient physician preference, correct?

16 A: I've indicated that from a patient standpoint,
17 if they have to drive, they would rather drive
18 less than more unless the physician has some
19 other reasons that they accept.

20 Q: Mr. Tolbert, the whole reason for the CRCC-
21 Conway application is to bring the service
22 closer to the patients so they don't have to
23 drive as far, correct?

24 A: You characterize it as the whole reason: I
25 wouldn't call it the whole reason. That's a

1 major reason.

2 Q: Fair enough. And all the others you didn't
3 put, for all the other categories in CRCC or
4 Coastal primary to Grand Strand was some to
5 CRCC-Conway, that's category three, correct?
6 You see that?

7 A: I'm sorry, that was, I see it. What's your
8 question?

9 Q: All the others, you went ahead and put in the
10 lower cell, correct? And that would mean that
11 75 percent would go to Grand Strand, correct?
12 75 percent of 32 all other patients would go to
13 Grand Strand, right?

14 A: I'm sorry, where -- you mentioned 32?

15 Q: I'll show you on the screen. See that 32 right
16 here?

17 A: I see it.

18 Q: Okay. That's in the all the other category,
19 right?

20 A: It is all other.

21 Q: Those are all the single physicians -- well,
22 what is the all other category? Do you know
23 that sitting here today?

24 A: I do.

25 Q: What is it?

1 A: That is all the other places patients reside
2 other than everything to the left of it.

3 Q: Okay. So outside of this, these zip codes,
4 correct? Not in Williamsburg, not in
5 Georgetown, not in Conway and not in Myrtle
6 Beach, correct?

7 A: That's correct.

8 Q: And you decided to put all 32 of those in a
9 category where three out of every four would go
10 to Grand Strand, correct?

11 A: Well, those were patients that were being seen
12 by Coastal Cancer physicians who, for whatever
13 reason, didn't have a mailing address or their
14 residence claimed as one of the other
15 categories, so they were being seen by Coastal
16 Cancer physicians. Their place of residence
17 didn't fall in basically the service area of
18 the three counties where they lived. Those
19 could be patients that are part-time residents
20 in Myrtle Beach who are next to Grand Strand in
21 one of the high-rise condos and their permanent
22 residence that they have for, say, insurance or
23 benefit purposes is their tax residence which
24 as I said could be Michigan, could be anywhere.

25 Q: You have no idea where these patients reside

1 then, right?

2 A: Well, actually I do because I've got it by zip
3 code. I just grouped them all here together.

4 Q: Okay.

5 A: And I do know that they were being seen by
6 Coastal Cancer physicians in one of their
7 offices.

8 Q: And you don't know which office though, do you?

9 A: No, I don't.

10 Q: And they have five offices, correct?

11 A: I think we've determined that already.

12 Q: Right. But you decided to put them in the
13 category where three out of every four would go
14 to Grand Strand, right?

15 A: No, I did not do it that way.

16 Q: All right. Mr. Tolbert, you've got the number
17 32 in there, correct?

18 A: Yes, I do.

19 Q: If you add 32 to the grand ---

20 MR. LONG: Your Honor, he's been through this
21 before. Okay. Mr. Tolbert has explained to
22 him how he did it like four different times.
23 Just because he's got to insist on categorizing
24 it the wrong way, it's asked and answered.

25 THE COURT: Well, I'm still learning as he goes

1 through it, so I overrule your objection.

2 Q: What you did is you put the 32 all other into
3 the grand total in the bottom cell category
4 from all else 75 percent to Grand Strand,
5 correct?

6 A: It is in the total that we're looking at of
7 186.

8 Q: Yes. And what did you do in order to come up
9 with 47 referred to CRCC and 139 referred to
10 Grand Strand?

11 A: I multiplied 186 by 25 percent, and that went
12 into the CRCC number 47. I multiplied 75
13 percent by 186, and that is the number at 139.
14 What I did not do was I did not, if you look at
15 the Excel spreadsheet, that's what the formula
16 is. I did not assume that each one of these
17 areas, it would be necessarily the same
18 distribution. One could be higher, one could
19 be lower. I just did it in the total.

20 Q: Well, let me ask you this. If I multiplied 75
21 percent by the numbers on the bottom row on a
22 split cell, if I multiplied 75 percent by 110
23 and added that to 42 times 75 percent and added
24 that to one times 75 percent, and then added
25 that to one times 75 percent and added that to

1 32 times 75 percent, what number would I get?

2 A: I don't know. We'd have to do the mathematics.

3 Q: I'd get 139, wouldn't I?

4 A: You would probably get 139.

5 Q: Like algebra?

6 A: I'm answering that in terms of my assumptions,

7 I did not assume 75 percent would come from

8 each evenly.

9 Q: But that's how it works out though, doesn't it?

10 A: That's how if you made that assumption the math

11 could work out to the same. For instance, in

12 the Myrtle Beach/North Myrtle Beach area, they

13 might get more than 75 percent of the 110.

14 They might get more, they may get 100 percent

15 of the all other. I did not do it at that

16 level that you just described. The mathematics

17 certainly works out, but I am telling you if

18 you looked at this spreadsheet and we opened it

19 up and looked at the formula, what I did the

20 calculation based on.

21 Q: Now, when you were deciding how to net out the

22 Coastal Cancer Center referrals, Mr. Tolbert,

23 you testified in your deposition that you based

24 some of your decision on emails between Mr.

25 White and Dr. Holt, correct, whereby Grand

1 Strand was looking into buying some property
2 from Dr. Holt?

3 A: They were clearly in discussions about some
4 type of arrangement.

5 Q: And you realize that that deal for Grand Strand
6 to buy Dr. Holt's land for \$1.4 million fell
7 through, right?

8 A: It didn't happen.

9 Q: Okay. What weight did you give to that fact
10 that the deal fell through and Dr. Holt might
11 not be very happy with Grand Strand? Did you
12 give any weight to that factor?

13 A: What I believe as a hospital administrative
14 person is that the Grand Strand is not going to
15 have ill will with their only group of medical
16 oncologists in Horry County and that they will
17 make sure the relationship is not damaged.

18 Q: Do you agree with me that that didn't buy Dr.
19 Holt's land, correct?

20 A: They did not buy Dr. Holt's land.

21 Q: And you gave no shrift to the fact that Dr.
22 Holt might not be pleased about that, correct?

23 A: Yes, I did.

24 Q: You did? You actually considered that
25 analysis?

1 A: Yes.

2 Q: Dr. Holt -- what factor, how did that play in
3 from a percentage standpoint to the 75/25?

4 A: If they had made a financial deal with Dr. Holt
5 and his group, they might get 100 percent.

6 Q: Okay. Are you testifying here today that you
7 actually considered that, thought about that
8 and made a decision on how you were going to
9 net out?

10 A: You're asking me a question right now and I
11 would tell you that I could have put 100
12 percent going to Grand Strand if I believed
13 that Coastal Cancer was that closely aligned.
14 Based on what I've heard in the testimony now,
15 I'd say my assumption of 75 percent makes an
16 allowance.

17 Q: Okay. So did you consider it or not? You're
18 under oath, sir.

19 A: Consider?

20 Q: The fact that a deal with Holt and the hospital
21 fell through on the \$1.4 million land purchase.
22 Are you telling this court today you considered
23 that in your decision?

24 A: When I created this three weeks ago?

25 Q: Yes.

1 A: Probably not.

2 Q: Okay. Thank you. Now, on category number
3 four, Grand Strand committed on CRCC 10. Grand
4 Strand will get 90 percent. That's the
5 referral direction, correct?

6 A: Yes.

7 Q: Okay. Is it your testimony that all the
8 physicians in the Grand Strand committed
9 category are all employed physicians by Grand
10 Strand?

11 A: I don't believe they all are.

12 Q: Do you know if any of them are?

13 A: I thought that list included neurosurgeons who
14 I thought were.

15 Q: Okay. So that's two, right?

16 A: Two out of four.

17 Q: Okay. And keep your finger on that particular
18 spreadsheet there, but let's go to if we could
19 in Exhibit 11, Respondent's 11, let's go to
20 Tolbert 12895. Just let me know when you get
21 there.

22 A: I'm there.

23 THE COURT: I'm not.

24 MR. THOMAS: Okay.

25 THE COURT: You said 12895 or 59?

1 MR. THOMAS: 12895, Your Honor.

2 THE COURT: All right. Go ahead.

3 Q: Okay. Let's go to the Grand Strand committed,
4 right? All right. Thomas Anderson, he's one
5 of the neurosurgeons. Who is the other one?

6 A: I don't have the names memorized.

7 Q: You have no idea?

8 A: As I said, I don't have the names memorized.
9 At this point in my semester, I'm trying to
10 memorize a hundred student's names.

11 Q: Okay. Well, let's -- the one you do know
12 that's employed, Thomas Anderson, he's a
13 neurosurgeon. How many referrals did he make
14 to Grand Strand in 2012?

15 A: He made none.

16 Q: Or excuse me, CRCC? To CRCC in 2012?

17 A: The print is small. It looks like two.

18 Q: Two. Okay. How many treatments would you
19 think that would come up to be?

20 A: Well, if you use the average of 25, we don't
21 know what the diagnosis was and what the
22 treatment plan was for those two patients, but
23 if you used 25, that would be 50.

24 Q: Okay. And let's just say, let's assume all of
25 these, even though Doug White had never heard

1 of Anand Sharma before, let's just assume all
2 of the Grand Strand committeds are employed
3 physicians. How many treatments would that be?
4 Patient -- well, first of all patient
5 referrals?

6 A: It's 17.

7 Q: Okay. If I multiply that by 25, I get what?

8 A: 425.

9 Q: Okay. So 425 treatments if we assume all the
10 Grand Strand committeds are employed, correct?

11 A: Yes.

12 Q: All right. Now, in the Grand Strand primary,
13 the number five, you assume Grand Strand will
14 get 70 percent, right?

15 A: I did.

16 Q: Okay. And you assumed that seven out of every
17 ten of these, that these physicians will refer
18 seven out of every ten of their patients for
19 radiation therapy even though these physicians
20 have been referring to CRCC for what five,
21 perhaps ten, maybe even 15 years?

22 A: I don't know how long they've been practicing
23 in the Myrtle Beach area.

24 Q: Do you think the length of time they've had a
25 relationship with a certain provider is an

1 important factor?

2 A: I think it's an important factor. I also know
3 that hospitals have a lot of influence on
4 medical staffs and physicians in terms of
5 perhaps changing.

6 Q: Okay. But you would agree with me that if
7 you're on a medical staff and you're not
8 employed, you cannot be directed where to refer
9 a patient, correct?

10 A: I know that hospitals will be very careful to
11 not do anything that would be illegal or
12 unethical in terms of encouraging referrals.
13 I do know that inner referrals are really
14 encouraged.

15 Q: But the medical staff members are not required
16 to refer to the hospital on which they -- on
17 the medical staff on which they are, correct?

18 A: That is correct.

19 Q: Okay. Now, let's go to GS supported, correct?

20 A: Yes.

21 Q: Now, what's this category?

22 A: This was a category based on everything that
23 we've previously discussed that I determined
24 would likely split their referrals 50/50
25 between CRCC and Grand Strand.

1 Q: But you agree with me you don't know which
2 medical staff these various supportive
3 physicians are on, correct?

4 A: I think I testified that that's really not a
5 primary way you decide that for the reasons we
6 discussed before break.

7 Q: But would agree with me that if they're not on
8 Grand Strand's medical staff, they're going to
9 be less likely to refer to Grand Strand,
10 especially if they're on Conway's medical staff
11 or Loris' medical staff?

12 A: They might except for some other factors that
13 could affect that.

14 Q: And you also put a physician, I think when we
15 talked and discussed this in your deposition,
16 a fellow named Joseph Jenrette who has been
17 referring to CRCC for years, and do you recall
18 Dr. Jenrette?

19 A: Isn't he the MUSC---

20 Q: Right, he's on MUSC's staff.

21 A: Yes.

22 Q: Why is he all of a sudden going to start
23 referring 50 percent of his patients to Grand
24 Strand Regional Medical Center?

25 A: I would expect Grand Strand to contact

1 physicians even in Charleston and let them know
2 there's an option available.

3 Q: But if Dr. Jenrette has been referring patients
4 to CRCC for a long time, wouldn't you agree
5 with me that he's probably going to continue
6 referring patients to what he knows versus what
7 he doesn't know?

8 A: Yes, and what I'm saying here in this case,
9 we're talking about three patients, so one and
10 a half split either way.

11 Q: Okay. But you still, I mean, you went ahead
12 and divvied those up to halves, right?

13 A: I did.

14 Q: Okay. Now, let's go to category seven. That's
15 Georgetown and Murrells Inlet gets 100 percent,
16 right?

17 A: That's correct.

18 Q: But you would agree with me that CRCC was also
19 approved to put a linear accelerator in
20 Murrells Inlet right?

21 A: They were.

22 Q: Okay. And you would agree with me that CRCC
23 moving a facility to Murrells Inlet might cause
24 a change in referral patterns affecting Ford
25 Cancer Center in Murrells Inlet, correct?

1 A: It might.

2 Q: So in this particular analysis, you also have
3 something called the other category, correct?
4 And that's the split of 40-40-20. I think
5 we've mentioned that.

6 A: Yes.

7 Q: And that's the one that Francke is put into,
8 right? We've already talked about that.

9 A: We have. I'm looking at the list here under
10 other, and it's alphabetical and the print is
11 small.

12 Q: Well, Francke was from the 2011 spreadsheet we
13 did, correct?

14 A: Yes, this is 2012.

15 Q: That's right.

16 A: So to answer your question, Dr. Francke's not
17 on this list.

18 Q: I didn't say he was on this list. I said you
19 put him in that category, right?

20 A: Oh, I'm sorry. I thought we were looking at
21 the list here. He's not on this list.

22 Q: That's right. And the fact of the matter is,
23 you're not really sure how these other support
24 CRCC, Grand Strand and Ford are disbursed
25 because you didn't talk about any of those with

1 Dr. Francke and Ms. Price, correct? You've
2 already admitted that.

3 A: I don't think we really discussed or I even
4 wanted to ask them about the small volume,
5 let's call them small volume referrals.

6 Q: Let's talk about small volume referrals. Let's
7 go back to CRCC Respondent's 10.

8 A: Yes.

9 Q: On category eight under referral sources, other
10 support CRCC, Grand Strand and Georgetown,
11 right? First of all, you say other split 40-
12 40-20, correct?

13 A: Yes.

14 Q: Do you think those doctors are going to have,
15 and I was kind of trying to envision this in my
16 head, like a sack with four red marbles, four
17 blue marbles and two yellow marbles where red
18 is Grand Strand, blue is Georgetown and the
19 yellow -- or excuse me, the yellow is
20 Georgetown and the blue is CRCC and just shake
21 them up and then guess randomly where they go?
22 Because that's how you did it, right? You
23 assumed the doctors would do four to Grand
24 Strand, four to CRCC, and two to Georgetown,
25 right?

1 A: I did not do it the way you just described.

2 Q: Well, if they're going to split referrals 40-
3 40-20, that's what they pretty much have to do,
4 right?

5 A: No.

6 Q: So how are they going to make that decision?

7 A: Some of these physicians may prefer CRCC.
8 Others may prefer Grand Strand. I assumed over
9 the hundred of physicians, it would split out
10 40-40-20 for this analysis.

11 Q: Okay.

12 A: These are 127 patients spread over about a
13 hundred physicians, so their average would be
14 between one and two patients a year for the
15 whole year, and I did not look at it the way
16 you just described.

17 Q: All right. Well, look at the grand total there
18 for me for 127 and multiply that number by 25.
19 Now, how many referrals, excuse me, how many
20 treatments would that end up being?

21 A: 3,175.

22 Q: Okay. So that's a pretty hefty number if
23 you're a single unit operator, correct? I mean
24 that would almost get you up to 50 percent
25 capacity if capacity is 7,000 and if capacity

1 is 5,000 you'd be over 50 percent capacity just
2 on those others, correct?

3 A: It's a good number of treatments.

4 Q: All right. Now I want you to take that number
5 and multiply it by .4, and what do you get?

6 A: 1,270.

7 Q: Okay. So that's about 25 percent of Grand
8 Strand's utilization as determined by Mr.
9 Sullivan, correct?

10 A: I didn't do the math, but it looks right.

11 Q: You were able to add 1,270 treatments by
12 arbitrarily assigning that Grand Strand is
13 going to get 40 percent of the referrals from
14 the other category, correct?

15 A: I don't believe it was as you described,
16 arbitrary. I disclosed here what I did. I've
17 explained why I did it that way. That's my
18 judgment.

19 Q: And you just assumed that these hundred
20 physicians are going to start equally dividing
21 referrals between Grand Strand, CRCC and
22 Georgetown on a 40-40-20 split, right? That's
23 what you did?

24 A: That's what the assumption is here.

25 Q: Okay.

1 MR. THOMAS: Your Honor, I want to move at this time
2 that you exclude the referral analysis from
3 evidence, because I think it's wholly
4 unreliable. It's not scientific. We've seen
5 the mistakes that he's made where he's put Dr.
6 Francke into a category that would be Grand
7 Strand -- supportive of Grand Strand when he
8 sat right there in that chair and, you know,
9 testified passionately about CRCC. This is
10 clearly arbitrary, it's not scientific in any
11 way, shape, or form under Rule 703, and it just
12 needs to be excluded.

13 MR. LONG: Your Honor, that's ridiculous. It
14 clearly has been supported by his opinions;
15 he's testified about for hours. I want to
16 point out one thing about Francke.

17 THE COURT: Well ---

18 MR. LONG: Can I comment on Francke?

19 THE COURT: No, because I'm going to make my ruling
20 right now, and I deny the objection.

21 MR. THOMAS: Okay, Your Honor. That's fine.

22 MR. LONG: I would like to clarify his comments
23 about Francke, because what's going on here in
24 regards to the Dr. Francke thing is highly
25 misleading.

1 THE COURT: Well, he can ---

2 MR. THOMAS: I'd like to approach the bench before
3 he says anything because I don't think I want
4 the witness to hear this.

5 THE COURT: Well, I'm not going to let you go into
6 it. I'll let you go into it in closing
7 argument later on or however you wish, but I
8 don't think I'm so easily swayed by as the case
9 goes along. I'm hearing everything. I'm
10 making plenty of notes. Now that I've got my
11 ears cleaned out, I can hear really well.

12 Q: All right. Go to Tolbert in Exhibit 12 for me,
13 Respondent's 12.

14 A: Yes.

15 Q: Okay. Now, if you go to Tolbert 12908 in
16 there. Let me know when you get there. I've
17 got a couple of questions about this
18 spreadsheet.

19 A: Yes.

20 Q: All right. What is your Tolbert projection
21 using the linear regression?

22 A: For what?

23 Q: 2017.

24 A: Which projection are you asking about?

25 Q: The one on 12908 for growth based on linear

1 regression of new cancer cases 1998 to 2009.

2 A: Well, I mean, I see two projections here for
3 new cancer cases the projection, and again, the
4 number is small. Is it 2698?

5 Q: Are you on Tolbert 12908?

6 THE COURT: See the screen?

7 Q: Are you on that?

8 A: Yes, I'm looking at the bottom right number.

9 Q: Well, you have a category called growth based
10 on linear regression of new cancer cases 1998
11 to 2009, right?

12 A: I'm sorry. So you're looking at the 31,824?

13 Q: Right.

14 A: Okay.

15 Q: And what's Sullivan's projection?

16 A: 32,644.

17 Q: So you would agree with me that those are
18 pretty close together numbers, correct?

19 A: I think I said that this morning, the numbers
20 are relatively close.

21 Q: And even though you used linear regression and
22 Mr. Sullivan used compound average growth rate,
23 correct?

24 A: Yes, his is slightly higher is what was my
25 testimony this morning.

1 Q: And you realize that in his adverse impact
2 analysis where he showed there was no adverse
3 impact analysis when two are approved that he
4 actually used your number of 2017 cancer
5 treatments?

6 A: I believe you. I didn't remember that, but I
7 believe you're telling the truth.

8 Q: Okay. And on this page, there's no number for
9 2004 for Ford Cancer Center. Why is that?

10 A: I didn't recall there was one in the State
11 Health Plan reported for that year that was in
12 the State Health Plan. It may have been a
13 partial year. I don't recall.

14 Q: Well, go to Joint Exhibit 3 for me, which is
15 the State Health Plan for 2008-2009.

16 THE COURT: Where are we going?

17 MR. THOMAS: Joint Exhibit 3 ---

18 THE COURT: No, what page?

19 MR. THOMAS: Oh. II-67.

20 A: What page?

21 Q: II-67.

22 A: II-67?

23 Q: Yeah, II-67.

24 A: Yes.

25 Q: Are you there?

- 1 A: I am there.
- 2 Q: Okay. Look at the top of the page. I want you
3 to go to the column fiscal year 2004.
- 4 A: Yes.
- 5 Q: I want you to come down three lines, and
6 there's a number there. What's that number?
- 7 A: That number on here is 1,889, if I'm reading it
8 correctly.
- 9 Q: And that's the megavoltage visits from
10 Georgetown Memorial Hospital in 2004, correct?
- 11 A: That's correct. I believe that was for a
12 partial year, not a full year.
- 13 Q: Well, that was the startup year for Georgetown,
14 wasn't it?
- 15 A: No, sir. The startup year is the first 12
16 months of an operation.
- 17 Q: Okay. But in calendar year, fiscal year 2004,
18 that's 1,889, correct?
- 19 A: That's what the number says.
- 20 Q: Okay. So should we put that in here for 2004?
- 21 A: We would need to know how many months that was
22 because it wasn't a full year.
- 23 Q: Well, by the third year of operations,
24 Georgetown Memorial Hospital got up to how many
25 treatments?

1 A: I don't have that number memorized.

2 Q: Well, isn't it fiscal year 2006, right next to
3 fiscal year 2005?

4 A: That would not be the last 36 months.

5 Q: That's the third year of operations. What was
6 their treatment number in the third year of
7 operation?

8 A: I'm sorry. They -- each one of these is not a
9 full year of operations, so that last year is
10 not their full third year of operations. It's
11 a partial year if you counted 12 months, 12
12 months and 12 months.

13 Q: All right. Let's go to -- what would be? How
14 would I figure out what the third calendar year
15 of operations would be? If I went out one more
16 year to the fourth year, would that give me an
17 idea?

18 A: Well, you would -- you would know that was
19 definitely the third year plus a little into
20 the fourth year.

21 Q: Okay. Let's turn to tab four then and go to
22 IX-9 for me.

23 A: I'm there.

24 Q: What was Georgetown's volume in fiscal year
25 2007? I'll give you a hint. It's at the

1 bottom of the page.

2 A: I appreciate the hint. Thank you. 5,466.

3 Q: Okay. So somewhere between the third and the
4 fourth full year of operations, Georgetown had
5 5,466 treatments, correct?

6 A: That's correct.

7 Q: And that was in a county where there were what,
8 60,000 people?

9 A: It may be 70,000, but yes, somewhere in that
10 ballpark.

11 Q: And Williamsburg County is right next door with
12 25, 30,000 people?

13 A: Well, I do some consulting in Williamsburg. I
14 think it's 32,000. I did some research there.

15 Q: So give or take 100,000 people in Georgetown to
16 Williamsburg County, Georgetown locates right
17 there in the town of Georgetown and the best
18 they can do after somewhere between three and
19 four years of operations is 5,466 treatments,
20 right?

21 A: That is what it says here.

22 Q: And that's with no competition whatsoever in
23 Georgetown and Williamsburg counties, correct?

24 A: There's no other radiation therapy located in
25 those two counties.

1 Q: Okay. Now, in Respondent's 12, I want to go
2 to, I think this includes your referral
3 analysis. I've just got a couple questions on
4 that.

5 A: 12, Mr. Thomas?

6 Q: Yes, Respondent's 12.

7 A: Yes.

8 Q: If you'd go to Tolbert 12904 for me.

9 A: Yes.

10 Q: Okay. And this 8,210, that represents the
11 referral shift analysis that you did. You
12 dropped that number in there, correct?

13 A: I'm sorry, 8210?

14 Q: Yes, for Grand Strand.

15 A: Yes, that's what that number is.

16 Q: And I think you testified that in your
17 deposition that that's probably going to be the
18 most likely scenario, correct?

19 A: Oh, the second deposition?

20 Q: Yes.

21 A: Yes.

22 Q: Okay. And you also testified that you thought
23 -- well, I asked you a question about the
24 right-hand column, the 11,138. The 11,138
25 treatments for Grand Strand in the left-hand

1 column. Do you recall that?

2 A: Vaguely.

3 Q: Yeah. And I said that's pretty farfetched, and
4 you agreed with me, correct?

5 A: That's a lot of volume on a single machine.

6 Q: Okay. But you testified this morning -- well,
7 let me ask you this. You did that and you
8 applied the inpatient market share of 35
9 percent, correct?

10 A: Yes.

11 Q: Okay. Did I hear you correctly when you
12 testified this morning on direct with Mr. Long
13 that the inpatient is the -- the inpatient
14 market share is the best proxy to determine
15 radiation therapy treatments? That's what you
16 testified to, right?

17 A: It's -- I think it's a very good proxy.

18 Q: Yeah, but you also think that column on the
19 right is farfetched, correct? That was your
20 testimony two weeks ago when I deposed you,
21 right?

22 A: Yes.

23 Q: Okay.

24 A: I testified earlier that 35 percent is not the
25 exact same market in terms of ---

1 Q: I understand.

2 A: So it's not ---

3 Q: You said 11,138 treatments was farfetched, and
4 but you said this morning that the best proxy
5 to determine radiation therapy is going to be
6 to use the inpatient market share, correct?

7 A: And that's not the proper inpatient market
8 share to use. That's one that Grand Strand
9 provided in the deposition. I testified that
10 I did an analysis of the actual market share in
11 the three counties and adjusted it for
12 exceptional services and for urologists.

13 Q: We'll talk a little bit about that. Now, let's
14 go to 12906 if we could. Oh, and would you
15 agree with me for the record, though, that
16 these other columns are pretty close to, these
17 other columns in Exhibit 12, Respondent's 12,
18 are pretty close to in terms of market share
19 and treatment volumes what you created in
20 Respondent's 39, which was your first market
21 share adverse impact?

22 A: The treatment volumes ---

23 Q: Yeah.

24 A: --- are comparable?

25 Q: Yeah.

1 A: To 39?

2 Q: To Respondent's 39. I know they're all higher
3 in this one, but they're fairly comparable,
4 correct?

5 A: Well, the calculations were used doing -- using
6 different market share numbers, and the numbers
7 of volumes ended up close to the same, but the
8 drivers were different.

9 Q: And you're saying so the 35 percent Grand
10 Strand market share in Respondent's 12 in the
11 far right-hand column is different from the 35
12 percent market share in Respondent's 39?

13 A: If you want to get into more detail, the right
14 two columns are the same numbers, the 30
15 percent and the 35. The 26 and the 27, which
16 are labeled column C and D are different
17 assumptions in terms of that.

18 Q: Okay. I gotcha. All right. And column D came
19 from your adjusted market share analysis,
20 correct?

21 A: Yes, it did.

22 Q: Let's turn to that, and that's on Tolbert
23 12906, right?

24 A: Yes, it is.

25 Q: All right. I've got a couple of questions

1 about this one. Now, on this what you did, if
2 I heard you correctly this morning, is you
3 carved out vascular and cardio surgery and
4 urological surgery, correct, to get to come up
5 with an adjusted inpatient market share. Is
6 that right?

7 A: Not exactly. I also included medical
8 admissions, which are categorized here as
9 diseases of the genitourinary.

10 Q: Yeah. So you included that even though there's
11 a good chance that maybe more than half of
12 those wouldn't be urological medical
13 admissions, correct?

14 A: I didn't know what the percentage was, but I
15 thought it was fair to exclude those from the
16 market share since a number of those admissions
17 would be the urologist admissions.

18 Q: Okay. And you didn't exclude the neurosurgical
19 admissions, did you?

20 A: No, I didn't. I thought -- no, I didn't.

21 Q: You didn't exclude the orthopedic admissions,
22 did you, even though Grand Strand is probably
23 one of the premier orthopedic centers in the
24 three-county area?

25 A: No, I thought the service to exclude based on

1 their "centers of excellence" would be the
2 cardiac open heart because that's their big
3 claim, if you will.

4 Q: Well, who else is doing neurosurgery in that
5 area, inpatient neurosurgery?

6 A: I didn't look at that. Neurosurgery volume is
7 usually typically pretty low.

8 Q: All right. Well, let me ask you this. I guess
9 where I'm curious is that you thought it was
10 okay to carve out the urological surgery here,
11 correct? And you see that the market share for
12 Horry is what, 25.4 percent there. Is that
13 right?

14 A: I'm not sure where on the page you are. I'm so
15 sorry.

16 Q: Look under Grand Strand market share overall
17 and by special services related to this trial.

18 A: Yeah, if you'd point it out, that would help us
19 move along here.

20 Q: Yeah. And you've got, you've actually got
21 urological surgery and you've got 25.4 percent
22 market share for Horry, correct?

23 A: Yes.

24 Q: Okay. I guess I'm curious that you carved it
25 out of here, but why did you go ahead and carve

1 the urological treatments, the prostate
2 treatments out of your adverse impact analysis,
3 because you know the exact number of what those
4 are, don't you?

5 A: I do not. I didn't at this time know that
6 exact number. I didn't have it, didn't look at
7 it.

8 Q: So that's why you didn't carve it out, right?

9 A: No, I'm not -- I didn't say that. I'm not sure
10 I would have. I didn't do that analysis.

11 Q: Oh, you thought it was a good idea to carve it
12 out of an inpatient market share but not a good
13 idea to carve the urological prostate cancer
14 treatments out of your market share analysis
15 for the adverse impact, correct?

16 A: What I was doing here was accepting that
17 inpatient market share is an indicator of the
18 strength of a hospital's presence in a market,
19 and I made those adjustments.

20 Q: But you actually knew what the prostate cancer
21 surgery treatments were, right? 47, I mean
22 43.7 percent?

23 A: I did not calculate that number and didn't know
24 that number.

25 Q: Okay.

1 A: And that's a completely different analysis than
2 what I was doing here if I had proceeded.

3 Q: You would also agree with me that Grand Strand
4 has been around for a long time as an inpatient
5 tertiary care provider, correct?

6 A: It's been around a long time. I don't know
7 when it was founded or at what point it became
8 a tertiary facility.

9 Q: But you know it's an established provider,
10 right?

11 A: It is an established provider. It's got a huge
12 market share.

13 Q: Right. Inpatient market share, correct?

14 A: Inpatient market share.

15 Q: And you would agree with me that it has no
16 radiation therapy services, correct?

17 A: I think we all agreed to that, yes.

18 Q: That's the one thing you do know?

19 A: I'm sorry, I think I know a whole lot more.

20 MR. LONG: Your Honor ---

21 Q: I apologize. I didn't mean to say that. And
22 you would agree with me that CRCC's market
23 share is 81 percent, correct?

24 A: Of the patients that are receiving radiation
25 therapy treatments within the three counties.

1 Q: Okay.

2 A: We don't know what their market share is if you
3 looked at what's being referred out, because we
4 don't have that number.

5 Q: Let's go to Respondent's 139.

6 A: I'm on 139.

7 Q: Okay. And you received this data fairly
8 recently, correct?

9 A: Yes.

10 Q: Like a couple, three weeks ago?

11 A: I don't remember the date. I thought Grand
12 Strand and you asked for it.

13 Q: But you created the chart based on this data
14 that basically showed that, I guess, the year
15 2013 would be down for CRCC to 20,450
16 treatments, correct?

17 A: In that chart, I assumed that 2013 volume for
18 the whole year would be down 10.3 percent and
19 did the calculation.

20 Q: And you did that based on seven months of data,
21 correct?

22 A: I did.

23 Q: But you've already admitted that you always
24 prefer to use a full year's set of data when
25 doing your calculations, right?

1 A: Certainly, it's better.

2 Q: And can you tell me, Mr. Tolbert, for last year
3 in 2012 what the last five months of the year
4 looked like for treatment volumes?

5 A: I don't have -- I'm not aware of that by year.

6 Q: Okay.

7 A: I mean, excuse me, by month for the last five
8 months.

9 Q: Okay. You think that would be something
10 important to know to look what the last five
11 months looked like compared to the first 12
12 months -- I mean, the first seven months?

13 A: It could be.

14 Q: Okay. Well, let me ask you this. We know --
15 we know that 22,798 treatments were done by
16 CRCC in 2012, right? That's the number I asked
17 you to write down earlier.

18 A: 22,798.

19 Q: Right.

20 A: I've got that here.

21 Q: Okay. Would you write that down, and I want
22 you to do a calculation. All right. Would you
23 subtract 14,391, which is the first seven
24 months of 2012, from that total number of 2012?

25 A: Fourteen thousand and ...

1 Q: Three hundred and ninety-one, it's right there
2 on the spreadsheet. Subtract that from the
3 total number of treatments in 2012, 22,798.

4 A: That number is 8,407.

5 Q: Divide that by five.

6 THE COURT: What was that number again, excuse me?

7 MR. THOMAS: 8,407, Judge.

8 Q: That's for the remaining five months. I'd like
9 you to divide that by five and tell me what you
10 get.

11 A: 1,681.

12 Q: That's 1,681. That would be the average number
13 of treatments for the last five months of 2012,
14 correct? The average monthly treatment for the
15 last five months of 2012, right?

16 A: Oh, yes, I see what you're doing, yes.

17 Q: Okay. Now, you would agree with me, Mr.
18 Tolbert, and in not one month in 2013 did CRCC
19 slip below 1,700 treatments?

20 A: I would, but we don't know what their natural
21 seasonality is.

22 Q: Well, didn't Mr. Lewis testify in his
23 deposition that there is no seasonal variation
24 with linear accelerator treatments?

25 A: I don't have his testimony memorized, and I

1 know that Grand Strand and that area has a lot
2 of seasonality to the population influx going
3 in and out.

4 Q: Well, when do most of the seasonality, when do
5 most of the snow birds come down to Horry
6 County, Mr. Tolbert?

7 A: Well, if you're characterizing the visitors as
8 snow birds, they would be during the winter
9 months.

10 Q: Right.

11 A: Typically from January until April.

12 Q: The temporary residents of Horry County come
13 down in the winter months, don't they, so they
14 can play golf and do recreational activities
15 that they can't do in ---

16 A: And there are people that come in the summer
17 months, so.

18 Q: But those are more weekly visitors, correct?

19 A: I haven't analyzed the seasonal influx of that
20 population.

21 Q: You would agree with me that not one month in
22 2013 is below 1,700 correct? That much we can
23 agree on.

24 A: Yes.

25 Q: All right. And if you actually annualized

1 2013, what would the number be?

2 A: Annualized what number?

3 Q: The summary, the total treatments for the first
4 seven months of the year.

5 A: And you're wanting to know if I took the year-
6 to-date number and simply annualized it?

7 Q: Yeah, what would you get?

8 A: You would divide 120 -- excuse me, 129 -- you
9 would divide 12,904 divided by seven and you
10 would multiply it by 12.

11 Q: So what would you get?

12 A: You would get, using that method, 22,121.

13 Q: Okay. And so that's a little different than
14 20,000 and change that I think you found, what
15 was that, Exhibit 9? In Respondent's 9.

16 THE COURT: That was 22,000 what?

17 MR. TOLBERT: 22,121.

18 Q: Do you recall what the number was that you
19 found for 2013? I'll find the exhibit. Let me
20 see if I can find it. Do you recall what the
21 number was for 2013?

22 A: No, I don't.

23 Q: You think it was less than 22,000?

24 A: I believe it was.

25 Q: Okay. Well, let's go to Petitioner's 85.

1 A: I don't think that's the proper way to

2 annualize the number for 2013, by the way.

3 Q: Well, I know. You just decided to compare it

4 against the first five months, 2013 against the

5 first five months of 2012 to just one year,

6 correct? You didn't look at what happened in

7 2011, 2010, and 2009, correct?

8 A: I did not, and just annualizing this number is

9 not necessarily the proper way to project 2013

10 either.

11 Q: But you would agree with me ---

12 MR. LONG: Your Honor, I need to raise an objection

13 here. I object to this exhibit that's on the

14 screen, and I want to ask it be taken down.

15 THE COURT: I've got to look at it to decide whether

16 to rule on it, so.

17 MR. LONG: Well, I understand. That's part of my

18 objection.

19 THE COURT: Oh, taken it down as far as ...

20 MR. LONG: Him leaving it on the screen. I'm ---

21 MR. THOMAS: It's a summary document, Your Honor.

22 MR. LONG: I don't mind Your Honor looking at it. I

23 didn't mean to take it down immediately. I

24 received this yesterday at 6:00 p.m. It

25 purports to be a summary. I had no time to

1 review that. I mean today is the seventh day
2 of trial, okay. I have not reviewed it, and
3 like I said, have had no time to do it. Plus,
4 I don't think it's a summary. Skimming the
5 document, it does a mathematical calculation,
6 and it purports to summarize what is basically
7 Exhibit 139, I think, and I don't know, maybe
8 141. These are like three pages. And, I mean,
9 I like summaries. I mean, we had this
10 discussion earlier in the trial. I think
11 summaries are good, and Mr. Thomas, of course,
12 has objected to our summaries and had a
13 different view. But, I mean, to hand this over
14 to us on the seventh day of trial when an
15 expert is going at 9:00 in the morning ---

16 MR. THOMAS: Your Honor, let me tell you ---

17 MR. LONG: -- it's just improper to use it. I would
18 ask that it not be used and it not be left on
19 the screen as some sort of demonstrative
20 exhibit.

21 MR. THOMAS: Your Honor, this exhibit will save us
22 two hours. I will take him through this.
23 First of all, Mr. Long told me before trial
24 that as long as I got something to him the
25 morning of in terms of a demonstrative exhibit,

1 he'd be fine with it. I got this to him last
2 night.

3 THE COURT: Are you seeking to introduce this or a
4 demonstrative?

5 MR. THOMAS: Oh, I'm going to introduce it, Your
6 Honor. And the other thing is, let me tell
7 when I got CRCC's treatments plans by referring
8 physicians January 2013 through July 2013,
9 about three weeks ago. All right.

10 MR. LONG: Yeah, but before the deadline in the
11 order.

12 MR. THOMAS: Your Honor, it's brand new information
13 about their referral patterns from January 2013
14 to July of 2013. I got it a month after the
15 date it was available. I've just been able to
16 kind of look at it. They have 142 exhibits.
17 I was good to get through the first 138 that
18 they sent.

19 THE COURT: If this summary is based on documents
20 that are already into evidence and we go
21 through with the witness and he establishes the
22 accuracy of the summary, then I will rule on
23 its admission at that time -- well, the brain
24 trust is now giving you information.

25 MR. LONG: I know. She's just pointing out that the

1 exhibit contains annualized numbers which are
2 not on any of the documents, which is --- I
3 mean it's ---

4 MR. THOMAS: I just got him to, he just annualized
5 the numbers for me. He just did it.

6 MR. LONG: Well, anybody can annualize the number,
7 Your Honor. I'd done that a month ago. It's
8 not a complicated calculation.

9 THE COURT: Well, that kind of defeats your argument
10 though.

11 MR. LONG: Well, that's what I'm -- he's packaged
12 all this into the exhibit. I have no ability
13 to test it. I have no ability to talk to Mr.
14 Tolbert about it. I have no ability to do
15 anything about it. I mean it's a total -- I
16 mean this is and ---

17 THE COURT: Well, as he goes through it ---

18 MR. LONG: And then to say that he didn't have time.

19 THE COURT: I'm not going to rule on it at this
20 time. I'm going to allow him to utilize it in
21 his cross-examination. If indeed at the end of
22 the day -- well I don't know when that time
23 will come, but it's offered, then I will rule
24 on it at that time. Here, you want to take
25 this back?

1 MR. THOMAS: No, you can have it, Your Honor.

2 MR. TOLBERT: And, Your Honor, I need a break.

3 THE COURT: Okay. Well, we're going to take a five
4 minute break.

5 (Break from 6:30 p.m. until 6:40 p.m.)

6 MR. THOMAS: I think to move things along, Your
7 Honor, I'm going to take down proposed
8 Petitioner's 85 and probably just introduce
9 that through my rebuttal case with Mr.
10 Sullivan.

11 MR. LONG: I just want to be on the record I'll
12 object because, I mean, Your Honor, he ---

13 THE COURT: I'll rule on it then.

14 MR. LONG: Okay. We'll rule on it then. I don't
15 want ---

16 MR. THOMAS: And I also guess ---

17 THE COURT: I don't require lawyers to let me know
18 when they're going to object fortuitously.

19 MR. THOMAS: Right, and that also gives counsel the
20 weekend to look at the documents, Your Honor.

21 THE COURT: And to think about his objections.

22 MR. THOMAS: That's right. There you go.

23 Q: Let me ask you a couple of questions, a couple
24 things I don't think, you did with Exhibit 139,
25 and I would like you to also kind of turn over

1 to 142 if you would. Respondent's 142.

2 A: I am on 142.

3 Q: Let me ask you a couple of questions about,
4 about these Exhibits 139 and 142, because they
5 kind of go together, right?

6 A: They cover the same time period.

7 Q: Right. So we know that the -- we've got the
8 number of treatments, right, through I guess
9 January through July 2013. It's 12,904,
10 correct?

11 A: Yes, that's the number.

12 Q: And we've got the number of, I guess, CRCC
13 treatment plans by referring physician, right?

14 A: Yes.

15 Q: Okay. Now, can you tell me why the numbers
16 went from 14,391 to 12,904 from 2012 to 2013
17 for those first seven months?

18 A: From what I believe I heard in some of the
19 testimony is the urologists, the referrals from
20 urologists have gone down.

21 Q: And is it your understanding that it's all the
22 urologists or some of the urologists or one
23 particular urologist?

24 A: I recall from the testimony that there was one
25 who was a higher referrer whose practice is in

1 transition, and he's decreased significantly.

2 Q: And let me ask you this. Did you do any
3 analysis of Respondent's 142 to figure out what
4 the other physicians like the medical
5 oncologists were doing in terms of referrals
6 from 2012 to 2013?

7 A: Yesterday, or whenever I saw this and heard the
8 testimony, I did some calculations, basically
9 just with a pencil to try and figure that out.
10 I didn't really finish that analysis. So to
11 answer your question, I did look at it.

12 Q: Well, did you find that in terms of the medical
13 oncologists, the referrals from 2012 through
14 July compared to the -- or excuse me, the
15 medical oncologists' total referrals were about
16 the same if you annualized the July 2013 data?

17 A: Under oath, I can't swear for sure, but I
18 thought they were close to the same, but I
19 don't remember for sure.

20 Q: But I think your understanding is my
21 understanding that these numbers are generally
22 due, the CRCC treatment units going down are
23 generally due to the urologists, correct?

24 A: That's what I've heard the testimony to be.

25 Q: And the only group that really has any

1 affiliation, medical group in Horry,
2 Georgetown, Williamsburg County with CRCC are
3 the urologists, right? Atlantic Urology
4 Clinic?

5 A: You've described that as affiliation?

6 Q: Okay.

7 A: Yeah.

8 Q: They're affiliated with them, right?

9 A: Yes, they're part of the same organization.

10 Q: Okay. Turn over to Respondent 8 for me Mr.
11 Tolbert.

12 A: Yes, Mr. Thomas.

13 Q: Okay. I want you to look over at the 2013
14 projection. It's the far right-hand column.

15 A: Yes.

16 Q: Okay. Now, one of the assumptions you made is
17 that Georgetown is going to do exactly the same
18 number of treatments in 2013 as it did in 2012,
19 correct?

20 A: I did.

21 Q: You would also agree with me that this chart is
22 premature for 2013 for, you know, anyone to
23 make a decision on because it lacks five months
24 of data, correct?

25 A: Your question is is it premature to make a

1 decision based on using ...

2 Q: Determining what the capacity at the end of
3 2013 is going to be for these units because we
4 don't have all the data?

5 A: This data is not perfect. Can it be used to
6 make a decision? Yes.

7 Q: Okay. But you would agree with me it's not a
8 full year set of data, right?

9 A: I think we all agree it's not a full set year
10 of data.

11 Q: And you have no idea what Georgetown did for
12 the first seven months of July, correct?

13 A: And in my effort as I always do to fully
14 disclose it, I indicate down here what the
15 assumption is.

16 Q: And the assumption is assume no change from
17 2012 shown in DHEC inventory, right?

18 A: Yes, I would have liked to have had their seven
19 month volume figures, but ---

20 Q: Okay.

21 A: --- I just didn't think they would give it to
22 me if I called and asked for it.

23 Q: All right. Go to Respondent's 13. This is the
24 analysis of the Sullivan draw rate.

25 A: Yes.

1 Q: Okay. Now, in this draw rate, did you assume
2 that CRCC-Conway's radiation therapy center
3 would be established?

4 A: I don't recall as I was doing this that I did
5 or didn't to be honest with you.

6 Q: Okay. Well, wouldn't that be important to know
7 if there's a linear accelerator center in
8 Conway, South Carolina, when doing a draw rate?

9 A: I ---

10 Q: You projected a draw rate for 2015, right?

11 A: Yes, I did, based on the hospital's market
12 share by zip code as I was calculating it.

13 Q: Okay. That's what I'm trying to get at, is I'm
14 trying to figure out is that this assumes this
15 analysis of Grand Strand's expert draw rate
16 assumes that CRCC-Conway is there or does it
17 just assume that Grand Strand has a linear
18 accelerator in 2015?

19 A: And I'm -- for this analysis purpose, I'm not
20 sure that makes a huge difference.

21 Q: I'm just asking if you assumed it. If you
22 didn't, that's fine.

23 A: As I said, I don't recall if I did or didn't.

24 Q: So you don't know, right?

25 A: I don't recall sitting here since 9:00 this

1 morning if I did or didn't to be honest with
2 you.

3 Q: And the location of those centers can greatly
4 affect where patients are going to go, correct,
5 for radiation therapy treatment?

6 A: This analysis looked at patients that were
7 choosing to go to Grand Strand today, I mean,
8 based on these numbers.

9 Q: No, this is a projected patients, number of
10 patients, in the right, lower right-hand
11 corner, the 258.9, that is what you're assuming
12 is going to go to Grand Strand for radiation
13 therapy treatments, correct, in 2015; isn't
14 that what that number means?

15 A: That's what that number means. It's based upon
16 analyzing the inpatient discharges for Grand
17 Strand, so those are patients that are
18 physically in Grand Strand.

19 Q: And that's another thing. You used the
20 inpatient market share rate for this analysis,
21 correct?

22 A: Yes, and we've discussed that. Yes, I did.

23 Q: Did you use the three-county rate or did you
24 use Grand Strand's market share for primary
25 service area and secondary service area? Which

1 one did you use?

2 A: I used this list of zip codes and the number of
3 discharges per 1,000 that Grand Strand had for
4 2012 based on, I believe, what we had in the
5 discovery documents.

6 Q: But do you think that if CRCC-Conway is
7 established and operating in Conway, South
8 Carolina, that these numbers could look at
9 little different?

10 A: They possibly could. These are patients, as I
11 said, that were admitted and inside Grand
12 Strand as inpatients.

13 Q: But you did a projection to 2015, right?

14 A: Yes.

15 Q: And the whole reason that CRCC is -- well, one
16 of the primary reasons CRCC is establishing a
17 center in Conway is so that people in Conway,
18 South Carolina, won't have as far to go for
19 linear accelerator services, correct?

20 A: That is correct. This was another way to look
21 at Grand Strand's potential to get patients
22 based on the ones that were physically
23 discharged from their hospital, wherever they
24 lived had been -- went to that hospital
25 physically.

1 Q: I'm going to ask you again. Does this analysis
2 assume that there's a CRCC Murrells Inlet
3 radiation therapy center in 2015?

4 A: I think you've asked that question, and I think
5 I've answered.

6 Q: No, I didn't, I asked it for Conway. I asked
7 it for Conway.

8 A: Oh, I'm so sorry. Would you repeat the
9 question so I get it right?

10 Q: Yeah. So does the draw rate analysis also
11 assume that there is a linear accelerator
12 facility, one or two or none, you tell us, in
13 Murrells Inlet, South Carolina in 2015?

14 A: This draw rate, which is not a term I usually
15 use, made assumptions of how many of their
16 patients based on their inpatient discharge
17 they would likely get referred to their center.
18 I didn't really look at where the rest would
19 go.

20 Q: You would agree with me that in Horry County
21 and Georgetown County at Waccamaw Community
22 Hospital, Conway Memorial Hospital, Seacoast,
23 and Loris all treat cancer patients as
24 inpatients, correct?

25 A: I would believe that to be the case.

1 Q: You would agree that because radiation therapy
2 is an outpatient service, the location of the
3 radiation therapy center itself can greatly
4 influence the utilization by patients, correct?

5 A: I testified that that is a factor in the
6 patient's decision and CRCC's strategic
7 direction is to take linear accelerators to
8 where the patients live.

9 Q: Okay.

10 A: The purpose of this analysis was basically to
11 see what Mr. Sullivan came up with, which I'm
12 having to use my magnifying glass, was 202
13 patients using what I thought were more
14 appropriate assumptions about patients coming
15 from the different zip codes what I thought it
16 would be, which was 258.9 patients higher.

17 Q: Now, in terms of a couple of questions that Mr.
18 Long asked you about, but I want to get on the
19 record. Also, I think maybe even the Judge
20 asked you a question about it. You would agree
21 with me that you have no knowledge of Grand
22 Strand's employee's health plan, correct?

23 A: No, I don't. I don't. It's not published
24 where I could get that.

25 Q: Okay. And you would agree with me that

1 hospitals, even under their benefit plans,
2 cannot direct their patients who are neither
3 Medicare or Medicaid to use their facilities
4 for services, correct?

5 A: There are not many hospitals that have Medicare
6 or Medicaid, employees that are covered by
7 Medicare/Medicaid.

8 Q: But you would agree with that, correct?

9 A: If that ever happened.

10 Q: Okay. And you would agree with me, and I think
11 it's been said and established, that most
12 cancer patients, especially the ones that get
13 radiation therapy, are covered by Medicare and
14 Medicaid, correct?

15 A: I think that's about 50 to 60 percent.

16 Q: So, and just for the record, you never worked
17 at HCA, for Hospital Corporation of America,
18 have you?

19 A: I have never worked for them, don't anticipate
20 I'll ever be consulting for them either.

21 Q: Okay. And you never worked at the South
22 Atlantic Division in Charleston, have you, of
23 HCA?

24 A: No.

25 Q: Okay. Now, you would agree with me, and if you

1 don't remember, we can go to it, but the
2 internal rate of return for Grand Strand's
3 project was a positive number, correct?

4 A: Both sets of financials were positive numbers.

5 Q: Okay. And you would agree with me that Grand
6 Strand never said that 4,680 treatments was
7 going to be the cap, correct?

8 A: They did never say that was the cap.

9 Q: Right. That's what Mr. Sullivan predicted in
10 year three, correct?

11 A: That's what he predicted in -- projected in
12 year three.

13 Q: Projected, that's a better word.

14 A: Yeah.

15 Q: So they may do more in year four, year five or
16 year six, correct?

17 A: I believe they would want to do more.

18 Q: And if they did more, that would mean more
19 revenue, correct?

20 A: And more expenses.

21 Q: You would agree with me that Grand Strand's
22 level II trauma center is a loss leader,
23 wouldn't you? Those don't make money do they,
24 Mr. Tolbert?

25 A: Yes, a trauma center is the highest level of ED

1 services you provide. If you're talking about
2 the trauma center that's the portion of the ED.

3 Q: Right.

4 A: It would be a loss leader. A trauma center
5 generates surgeries, hospital admissions, other
6 services that they might make money on.

7 Q: A lot of folks that come in to level II trauma
8 centers, may not have any insurance, correct,
9 but require hundreds of thousands of dollars of
10 care, right?

11 A: They certainly could.

12 Q: And you would agree with me that hospitals lose
13 a lot of money on physician practices like
14 primary care physicians, right?

15 A: It's not their objective. Some do, some don't.

16 Q: So, if Grand Strand's objective is to
17 establish, as Mr. Long likes to call it, a
18 world class cancer center, then it might want
19 to, it may forego some profit in the early
20 years to establish a radiation therapy center,
21 correct?

22 A: They might.

23 Q: Now, would you agree with me that Grand Strand
24 has never said in this litigation, has never
25 said at any time during the CON review process

1 that by year three of operations it was going
2 to be a world class cancer center?

3 A: I don't believe it's really been explained what
4 a world class cancer center they really plan to
5 have.

6 Q: Okay.

7 A: The ones that I know of like the Gibbs Center
8 up in Spartanburg, the Hollings Cancer Center
9 are huge buildings with lots of services, and
10 I don't think -- I would have in this
11 application, if that was what I was pitching,
12 would have explained very clearly how this was
13 phase one and here's what the future phases
14 would look like and would be applied for CONs
15 required later.

16 Q: But you saw what they said. They wanted to
17 become a comprehensive cancer center, correct?

18 A: I saw what they said, yeah. I'm saying I would
19 have presented the information very differently
20 if I was, if that was the real plan.

21 Q: Do you think that CRCC's volumes are going to
22 continue to decline in 2014, based on your
23 analysis?

24 A: If I was engaged by CRCC to help them with some
25 long-range planning, I would undertake a very

1 extensive analysis of the physician referral
2 pattens, what's happened. I'd look back over
3 the last, probably since 2010, look at it by
4 physician name, see who's moved into the
5 market, who's moved. I would try to identify
6 what's caused that downward shift and then
7 determine if that downward shift would continue
8 into the future. That's something I do for
9 clients, and I've not been asked to do that in
10 this case, so I can't say if it would or
11 wouldn't.

12 Q: You made some predictions about the last five
13 months of the year, so I'm trying to ask you,
14 do you think the volumes are going to continue
15 to slide at CRCC in 2014?

16 A: I'm telling you that if you look at 2012, the
17 peak if you want to say that in 2011, 2012 is
18 down. Year to date, year to date, they're down
19 another ten percent. There is a downward
20 trend. It's a short one. I'm sure they're
21 hoping it's not going to continue forever, but
22 it might. That would require some analysis
23 into 2014.

24 Q: Do you think that they will have a need for a
25 fourth linear accelerator?

1 A: Using the Department DHEC's analysis, we would
2 have to look at if there would be a need for a
3 fourth one, 2014-15, if that downward trend
4 continues.

5 Q: Okay. I'm going to put Respondent's 23 up on
6 the screen, and let me know if you can't read
7 it. Just trying to keep you from having to go
8 to -- these are Grand Strand Regional Medical
9 Center inpatient referrals to CRCC that your
10 client produced, and let's look at 2012 if we
11 would. I think you've discussed quite a -- you
12 testified that there's just not enough
13 inpatients really to utilize an inpatient-based
14 radiation therapy center to justify it,
15 correct?

16 A: Inpatients only.

17 Q: Yeah. Do you think these 31 patients that,
18 obviously we don't have a name, but do you
19 think they would care about whether or not they
20 were transferred out to a outpatient center?
21 Do you think that would be important to them?

22 A: They would probably in the greater scheme of
23 things prefer not. These patients get placed
24 on a gurney, strapped in, rolled in the
25 elevator, rolled down and for a hospital that

1 has it connected to the facility to the
2 radiation therapy department where they wait
3 for treatment. Unfortunately, my experience in
4 hospitals, often they wait a long time, and
5 then they're treated and then they're put back
6 on the elevator, taken upstairs. If they have
7 to go to a freestanding center, which many,
8 many, many do, they're put on the gurney,
9 strapped in, taken downstairs to an ambulance
10 who drives them to the center. They are rolled
11 into the facility. They're treated. Usually
12 makes what I believe and I -- is that the
13 ambulance will wait rather than 15 minutes
14 later have to come back, and the patient is
15 taken back.

16 Q: Okay. So are you saying, is it your testimony
17 today that if you're in a hospital, you're
18 going to be put on a gurney and just have to
19 wait in the hall, but if you get taken to a
20 freestanding center, you're going to get
21 treated right away. Is that your testimony,
22 Mr. Tolbert?

23 A: It is my understanding that's what CRCC does.

24 Q: Okay. And you have no idea how Grand Strand is
25 going to do that, do you?

1 A: I know my experience from ---

2 Q: You have no idea how Grand Strand is going to
3 do it, do you?

4 MR. LONG: Your Honor ---

5 MR. THOMAS: I didn't ask him about his experience,
6 I asked him about ---

7 THE COURT: I overrule that.

8 A: My answer to that is I do not know what Grand
9 Strand plans to do.

10 Q: Thank you.

11 A: I have experience in many hospitals ---

12 Q: I appreciate that. I'm just asking you about
13 Grand Strand right now.

14 MR. LONG: And I know it's late, but that was a
15 clear interruption, Your Honor.

16 THE COURT: I'll let him if it's not, unless it's
17 non-responsive.

18 MR. THOMAS: I think it is non-responsive. I'm not
19 asking about all the hospitals he may have
20 experience with. That's not relevant. I'm
21 asking about Grand Strand Regional Medical
22 Center.

23 THE COURT: Okay. Let's move on.

24 MR. LONG: Well, Grand Strand's program doesn't
25 exist, so the question is just ridiculous

1 anyway.

2 MR. THOMAS: Mr. Long can ---

3 MR. LONG: He asked him do you have any experience
4 with Grand Strand having a program that doesn't
5 exist.

6 THE COURT: No, I think he asked, well ---

7 MR. THOMAS: If he has knowledge of what Grand Strand
8 is going to do. That's what I asked.

9 Q: You've seen no emails? You've seen no
10 documents that indicate that Grand Strand is
11 going to cause its patients to wait, correct?

12 A: That is correct.

13 Q: Okay. Now, were you here for the testimony of
14 Dr. Collins?

15 A: He was on the first day ---

16 Q: Correct.

17 A: --- with Doug White? No, I wasn't.

18 Q: So you didn't hear his testimony?

19 A: Wait a minute, no, no, I'm sorry. It's been so
20 many days, so many witnesses. Yes, he was from
21 Trident.

22 Q: Correct.

23 A: Yes.

24 Q: You did hear his testimony?

25 A: Yes.

1 Q: So you heard how occasionally he has a
2 ventilator patient, a patient on a vent,
3 correct?

4 A: I heard him say that could happen.

5 Q: Okay. No, he actually said it did happen, that
6 he had a patient on a ventilator that had he
7 not been transferred out would have died. So
8 my question is, do you think the fact that they
9 have an inpatient center at that hospital was
10 important to that particular patient and his
11 family, Mr. Tolbert?

12 A: So you said he had a ventilator patient who he
13 transferred out or the patient would have died?

14 Q: No, he didn't transfer him ---

15 A: Oh, I'm sorry. I misunderstood.

16 Q: --- they had an in-hospital radiation therapy
17 center.

18 A: Okay.

19 Q: Do you think that was important to that patient
20 that they had an in-hospital radiation therapy
21 facility?

22 A: That may have been important to that family,
23 yes.

24 Q: And you would you agree with me, Mr. Tolbert,
25 that Murrells Inlet, that CRCC's Murrells Inlet

1 application was filed as a response to
2 Georgetown and its moving and relocating its
3 linear accelerator to Murrells Inlet?

4 A: What I know is that CRCC was seeing growth in
5 their treatment volumes, anticipated the need
6 to expand, their strategy is to expand in the
7 geographic areas where the patient lives. I
8 also know that when Georgetown announced or
9 published that they would want to completely
10 relocate their facility from Georgetown to
11 Murrells Inlet, directly in CRCC's, one of its
12 prime target market areas, their response was
13 if we need to distribute our linear
14 accelerators elsewhere, this is a good place to
15 do it. Additionally, CRCC had a very old six
16 megavolt unit that they tried to get approved
17 for a like kind replacement. The Department
18 said no you ---

19 THE COURT: A what kind? Like kind?

20 MR. TOLBERT: Like equipment replacement.

21 THE COURT: Okay.

22 A: There's a procedure where if you can
23 demonstrate there -- it's a newer machine but
24 it does the same thing at the same volume, the
25 Department will allow you to replace it without

1 a certificate of need. We commonly call that
2 a like kind replacement. And that was denied
3 by the Department. In my discussions with
4 them, the discussion was you need -- you want
5 to replace this whole piece of equipment. I
6 can do a CON for you to replace it where it is.
7 If you do, and it gets approved, which I think
8 it would've, you would have to completely take
9 the old one out of service for probably months
10 while the new one, the room's fixed and the new
11 one's installed. So I said if Georgetown is
12 wanting to move into your market, you need to
13 replace this old six megavolt unit, why don't
14 we do the CON to replace that one but do it in
15 Murrells Inlet so the six megavolt could be
16 continued to be used until you switch the one
17 at Murrells Inlet, no loss of units out of
18 service, and it accomplished a lot of goals
19 simultaneously. One of them was to protect
20 their market.

21 Q: That was the primary goal, correct, protect the
22 market?

23 A: That was one of the primary goals, yes.

24 Q: Thank you.

25 A: I think I said the other goal is they wanted to

1 take units where the population they serve
2 lives, and they wanted to replace an old piece
3 of equipment, and they needed to do a CON for
4 it anyway.

5 Q: Mr. Tolbert, we can look at the emails, but you
6 would agree with me that what the emails
7 indicate is that you found out through the
8 paper, a notice that was published in the
9 paper, that Georgetown was going to relocate
10 one of its units from Georgetown, South
11 Carolina, to Murrells Inlet and the decision
12 was almost instantaneous to go take one of
13 those units from CRCC and move it down to
14 Murrells Inlet, right? In fact, we talked
15 about the Dosoretz email the other day.

16 A: I saw Dr. Dosoretz' email.

17 Q: Okay. Do you disagree with it?

18 A: I'm sorry, I don't know what I'm disagreeing
19 with.

20 Q: Well, I'm asking you if you disagree with the
21 point that there were no emails about all the
22 stuff that you just talked about. It was an
23 instantaneous reaction, get our team down there
24 to buy land and establish a CON, I mean
25 establish -- to establish a linear accelerator

1 facility in Murrells Inlet, correct?

2 A: From an email standpoint, the answer is no. I
3 don't know about conversations that they had
4 strategically.

5 Q: You said that you were stunned when you found
6 out that Mr. Grace had doubled Mr. Sullivan's
7 projections, correct, and done some financial
8 analysis?

9 A: Well, that's not exactly what I said, but I did
10 say stunned that they approved the project
11 based on a different set of financial
12 projections than were in the CON application.

13 Q: Well, that's not what the witnesses testified
14 to, correct? Mr. Grace testified that it was
15 proved based on Dan Sullivan's numbers in his
16 ---

17 A: That's what he testified to.

18 Q: Okay. And Mr. Grace also ---

19 MR. LONG: Your Honor ---

20 Q: Mr. Grace also ---

21 THE COURT: Wait ...

22 MR. LONG: Your Honor, first, that is pitting. I'd
23 move to strike that.

24 THE COURT: Well ---

25 Q: Did you hear Mr. Grace's testimony?

1 MR. THOMAS: I can ask him what he heard. I can ask
2 him what he heard. That is not pitting the
3 witness.

4 THE COURT: Well, you can ask him what he heard,
5 yeah.

6 MR. THOMAS: Right.

7 Q: Did you hear Mr. Grace's explanation?

8 THE COURT: I never ruled on the striking thing.

9 You never argued about it. I tell you what.

10 I'm going to strike his previous testimony, and

11 I will allow you to proceed down the path

12 you're going.

13 MR. THOMAS: That'll work.

14 THE COURT: Until I get another objection.

15 MR. THOMAS: Okay.

16 Q: Do you recall Mr. Grace's testimony of how he
17 came up with the numbers?

18 A: I do not -- yes, I recall it. I can't quote it
19 word for word.

20 Q: Would you agree with me what he said was that
21 he took Dan Sullivan's volumes and doubled
22 them?

23 MR. THOMAS: That is not pitting the witness.

24 MR. LONG: He said he didn't know, and now he's
25 telling him what he said. So he is pitting.

1 MR. THOMAS: I'm trying to refresh his recollection.

2 THE COURT: Yeah, I'll let him go down that path.

3 He's getting close though.

4 MR. LONG: Okay.

5 Q: Do you recall that Mr. Grace said that he took
6 Mr. Sullivan's numbers and doubled them?

7 A: I recall that and some discussion about 15
8 percent market share and using 30 percent,
9 which doubles the numbers too.

10 Q: Right. Well, let me ask you this. Do you
11 think that by virtue of Mr. Grace's simply
12 doubling of Mr. Sullivan's numbers, his
13 volumes, that that's going to come to fruition?
14 Is that -- is that how easy it is in hospital
15 management if you take the planner's numbers
16 and you double them, that it happens?

17 A: Well, you don't know that the planner's numbers
18 are going to happen either. Doubling them,
19 you've just made your assumption that you could
20 double what the planner projected.

21 Q: Correct. And if he tripled them, he tripled
22 them, right?

23 A: He tripled them, and again, you don't know if
24 you'll really achieve your planner's numbers.

25 Q: Correct. Let me ask you this. There were some

1 questions about patient choice from Mr. Long.

2 Let me ask you this. Do you think a patient
3 that wants to go to a radiation therapy center
4 that doesn't use financial incentives to entice
5 its referral sources, do you think that patient
6 should have a choice to go somewhere else?

7 A: I'm sorry, would you -- would you say that
8 again?

9 Q: Do I need to? Do you think that a patient who
10 wants to go to a radiation therapy ---

11 A: I just didn't hear the question clearly. I'm
12 asking you to repeat it. I'm sorry.

13 Q: Do you think that a patient who wants to go to
14 a radiation therapy center that doesn't use
15 financial incentives to entice referral sources
16 should have the choice to go somewhere else?

17 A: Well, the first part of that, a center that
18 uses financial incentives to entice referrals,
19 you have to be really careful you're not
20 violating Stark.

21 Q: I agree, sir.

22 A: So I -- and so your question is should the
23 patient be given a choice. The patient should
24 always be given a choice.

25 Q: I agree. Thank you.

1 A: The patient should be given full knowledge
2 about their options, not just for radiation if
3 they have cancer, but other modes of treatment.

4 Q: I'm talking about the choice of having to go to
5 one center that doesn't use financial
6 incentives as opposed to one that does.

7 A: I think they should be given choices, all
8 options that are there and available to them
9 and let the patient choose.

10 Q: Now, you would agree with me that you've done
11 no analysis to determine from an adverse impact
12 perspective what would happen to staff at CRCC
13 if Grand Strand gets a linear accelerator and
14 achieves the volumes that have been projected
15 by Mr. Sullivan, have you?

16 A: I did no specific analysis in that regard. I
17 am aware that CRCC has the best trained, really
18 the only radiation therapy staff in Horry
19 County.

20 Q: You don't think -- well, let me ask you this.
21 When Georgetown was established back in what,
22 2004, did they raid CRCC's staff?

23 A: I'm not aware that they did. It's 40 miles
24 away instead of three miles away, so it's a
25 different, completely different situation.

1 Q: And do you think that perhaps if there is staff
2 that goes from CRCC to Grand Strand, they're
3 not actually losing their jobs, are they?
4 They're just maybe getting a better one because
5 they decided to switch, right?

6 A: Or they're getting a job because they lost the
7 one they had and needed to go to a different
8 provider that had picked up the business.

9 Q: So you agree with me there would be no job
10 loss?

11 A: Not for those that get hired who CRCC ---

12 Q: You just said CRCC had the best staff, right?

13 A: I'm sorry, I didn't finish my -- I thought my
14 answer.

15 Q: I'm sorry. Go ahead and finish.

16 A: Well, I've even lost my train of thought. So
17 continue, please.

18 MR. THOMAS: One second, Your Honor, may be done.

19 MR. TOLBERT: If we are done, I'm going to need
20 another short break.

21 THE COURT: I will know in just a moment.

22 MR. TOLBERT: Oh, I'm sorry.

23 MR. THOMAS: I'm done, Your Honor.

24 THE COURT: Any redirect?

25 MR. LONG: Short, Your Honor.

1 THE COURT: Then we're going to have to take a --
2 your witness wants a break.

3 (Break from 7:15 p.m. until 7:21 p.m.)

4 THE COURT: I'm ready when you are.

5 MR. LONG: Thank you, Your Honor.

6 MR. TOLBERT - REDIRECT EXAMINATION BY MR. LONG:

7 Q: You were asked about the Georgetown treatments
8 in the third year for that county, right? Do
9 you recall that testimony?

10 A: For that county?

11 Q: I mean, for Georgetown's program.

12 A: For the Ford Cancer Center projections in year
13 three?

14 Q: No, their actual projections in the third year
15 of operation, when we looked at the health
16 plan.

17 A: Yes.

18 Q: Do you recall that? It was around 5,500 I
19 think is what they ---

20 A: Yes.

21 Q: --- get in the third year.

22 MR. LONG: Could you pull up the exhibit -- I'm
23 sorry, Your Honor. Can we pull up CRCC Exhibit
24 42.

25 Q: You can look at it on the screen if you want

1 to. Look at Georgetown's population,
2 Georgetown County's population in the 2000
3 census, in the 2010 census.

4 THE COURT: This is Respondent's 42?

5 MR. LONG: CRCC, yes, it's Respondent's 42.

6 THE COURT: All right.

7 A: Oh, thank you. It's blown up. Georgetown, the
8 2010 census was 60,158.

9 Q: Okay. What would it have been in the 2000
10 census?

11 A: Well, according to this, which is I believe
12 from the state demographer, it was 55,797.

13 Q: So they did 5,500 treatments on a population of
14 55,000 ---

15 A: Well, yes ---

16 Q: --- in the third year?

17 A: Their service area is technically the three-
18 county region. I'd have to look at where they
19 came from. I'd assume predominantly it was
20 from that area.

21 Q: And does Georgetown have a comprehensive cancer
22 center when it first opened its doors?

23 A: No, I'm not aware that they have a
24 comprehensive cancer center like we were
25 describing it.

1 Q: All right. And is Georgetown Hospital a member
2 of the largest for-profit hospital chain in the
3 United States?

4 A: No, it's an independent hospital that's managed
5 I believe by the Quorum Group.

6 Q: Okay. And does Grand Strand, I mean, does
7 Grand Strand have the ability to -- does Grand
8 Strand have a greater ability to attract
9 patients in Horry County than Georgetown does
10 in Georgetown County?

11 MR. THOMAS: Your Honor, I think that's a leading
12 question.. I know it's late but ...

13 THE COURT: Well, it is leading, and it's not
14 refreshing his memory as to a previous
15 question, so I sustain the objection.

16 Q: Which of the two hospitals between Grand Strand
17 and Georgetown has the greater resources to
18 operate a radiation therapy program?

19 A: Well, he Georgetown Health Systems, I believe
20 it's called, they operate two hospitals. The
21 one in Georgetown we just know from hospital
22 administrative and consulting people has
23 struggled financially. Waccamaw Hospital has
24 been more successful, but Grand Strand makes a
25 lot of money..

1 Q: And is there anything that would prevent Grand
2 Strand from hiring a urologist to come to Horry
3 County to treat patients who have prostate
4 cancer?

5 A: There's nothing that would prevent them to do
6 that, and if I was advising, that would be
7 something I'd look at.

8 Q: Would they have the ability then to attract
9 those type of patients if they were to hire
10 physicians who might be allegiant -- have
11 allegiance to them?

12 A: From a strategy standpoint, if I was advising
13 Grand Strand, I would tell them you need to
14 weigh the advantages of working with the
15 existing urologists who may or may not be as
16 supportive of you versus recruiting your own
17 and competing with them. That would be just a
18 strategic decision that needed to be discussed.

19 Q: Let's take a look at CRCC Exhibit 10. This was
20 the physician referral exhibit.

21 MR. LONG: Can you blow that up a little bit.

22 A: Yes, I'm here.

23 Q: In Grand Strand's application, is Grand
24 Strand's application based on the result of the
25 kind of division of the medical community of

1 Horry County ---

2 MR. THOMAS: Objection, Your Honor.

3 Q: --- where the urologist go to one practicing --
4 go to one linear accelerator and medical
5 oncologists and the surgeons go to another
6 linear accelerator?

7 THE COURT: Hold on.

8 MR. THOMAS: That's a leading question, Your Honor.

9 MR. LONG: I tried to ask him where I didn't think
10 it was leading.

11 THE COURT: I don't think it is, no. Is Grand
12 Strand -- I don't ---

13 MR. THOMAS: I think the question is what is Grand
14 Strand's application based on.

15 MR. LONG: That's not the question.

16 THE COURT: Go ahead.

17 A: Well, I don't recall the Grand Strand -- the
18 record, they did an analysis like this.

19 Q: But isn't there -- how much influence or
20 importance is Coastal Cancer Center and the
21 surgeons to the success of the Grand Strand
22 application?

23 A: Well, to CRCC in this year, I think, I'm
24 remembering the number, CRCC received 275
25 referrals from Coastal. I would expect Grand

1 Strand is hoping and expecting to get a bunch
2 of those. In my estimate here, I assumed 58
3 percent.

4 Q: In regards to Dr. Holt, Mr. Thomas asked you
5 about the deal going bad regarding Dr. Holt.
6 Did Dr. Holt still write a letter of support
7 for Grand Strand?

8 A: Yes.

9 Q: And did that letter come early or late in the
10 process?

11 A: That came late. Didn't we look at it and it
12 was December 2011?

13 THE COURT: I was going to say, you can ask
14 questions.

15 A: No, sir.

16 Q: We can pull it up, Joint Exhibit 2, page 891.

17 A: From memory, I thought it was in December of
18 2011.

19 Q: Page 891 of Grand Strand's.

20 A: 891? Yes, this letter signed by Dr. Holt is
21 December 1, 2011, if I'm reading it correctly.

22 Q: That would have been after the project review,
23 right?

24 A: It was after the project review.

25 Q: Okay. Let's look at Grand Strand's CON

1 application, page 37. Let's look at this
2 subparagraph two here if you would.

3 THE COURT: I'm sorry I was ---

4 MR. LONG: Page 37 of Joint Exhibit 2, Grand Strand's
5 CON application.

6 THE COURT: Okay.

7 MR. LONG: If we can blow up this little
8 subparagraph two at the top of the page.

9 Q: Based on your experience, do physicians have to
10 disclose information about their practices like
11 where their patients come from or where they're
12 treated?

13 A: No.

14 Q: And generally, if you're representing a
15 physician and you want to learn information
16 about another physician in the community, is
17 that information readily available to you?

18 A: There's very little, if any, hard data
19 available to you.

20 Q: But here, their application states that 70
21 percent of all new cancer patients in Horry
22 County were seen at the Myrtle Beach office for
23 Coastal Carolina, Coastal Cancer, right?

24 A: As I mentioned earlier from what I understand
25 is a huge office, so I would expect it would be

1 the main place where patients were seen. The
2 others are satellite offices.

3 Q: So the number I think is 1,054 patients being
4 seen there?

5 A: That's what this number says.

6 Q: Could you have obtained that number from a
7 public source, or would you ...

8 A: No.

9 Q: So other than Dr. Holt's group, do you know of
10 anybody who would have had that kind of
11 information?

12 A: No, because this is internal practice data of
13 the patients that are seen, where the new ones
14 are seen.

15 Q: Okay. You were asked a question about -- you
16 were asked some questions about the decision to
17 do the Murrells Inlet relocation project. I
18 think you said that Georgetown's decision to
19 move to Murrells Inlet enhanced that project.
20 Was there a timeline, in your opinion, as to
21 when such CRCC had to file that relocation
22 project? Was it under a timeline?

23 A: It was.

24 Q: A time limit?

25 A: Well, it was under a timeline once Georgetown

1 submits theirs and the review process begins.
2 Depending on when the Department deems
3 Georgetown's application complete and issues
4 the deemed complete letter, the applicant has
5 to submit a major portion, about half of their
6 CON fee, and then the notice is published in
7 the State Register. Once it's published in the
8 State Register, competing applications have to
9 be submitted within 15 days. So that created
10 a hard deadline, and that was assuming the
11 applications were competing, which I said we
12 needed to assume. The Department judged they
13 weren't because they approved both.

14 Q: Right. But your advice to them was they should
15 assume those applications would be competing?

16 A: I wanted to absolutely be sure they were
17 reviewed in the same, you could call it, cycle
18 or simultaneously, not separately.

19 Q: So you made the decision if CRCC or 21st
20 Century waited say six months to try to start
21 to move that application to Murrells Inlet,
22 could it have been foreclosed by competing
23 application rules?

24 A: It would have been by competing application
25 rules.

1 Q: Right. So is that the reason that the
2 Georgetown application accelerated the Murrells
3 Inlet project?

4 A: Yeah. Well, I honestly don't know what the
5 time table was for Murrells Inlet, when they
6 would have decided to do it, but Georgetown
7 created a hard deadline where they had to make
8 a decision or they could lose a potential
9 portion of their patients, a large portion.

10 Q: Let's go back to CRCC Exhibit 10 again. On the
11 category of the -- the bottom category other
12 physicians. Well, first, are all of these
13 based solely on 2012? You want to show the
14 whole sheet again?

15 A: Yeah, these were -- I had data for 2011 and
16 2012 in the same spreadsheet. I decided to use
17 the most recent year, which was the 2012 data.

18 Q: So if Dr. Francke's referral was from 2011,
19 would it have been included?

20 A: Well, as it was pointed out ---

21 Q: Included in this summary?

22 A: I didn't -- no, it would not have been -- it
23 was not included, and I hope if it was when I
24 looked at the list of the doctors for 2012, I
25 would have noticed his name. I didn't.

1 Q: Well, if you had a -- if you had a doctor that
2 referred one patient in the year, would you
3 divide the patient 40 percent to one provider,
4 40 percent to the other and 20 percent or would
5 you ...

6 A: No, you ---

7 Q: Couldn't do that?

8 A: You can't. Yeah, we're not Solomon splitting
9 the baby in half here.

10 Q: All right. Okay. And so in your -- in your
11 overall projections, did you assume that some
12 of these locations would send more patients to
13 Grand Strand than other locations?

14 A: I actually made no assumption. I really didn't
15 look at it by area. I just looked at it in
16 total, like I testified, and just assumed 40
17 percent. That 40 percent might be higher or
18 lower from one area to the next depending on
19 what the market -- what happens in the market.

20 Q: Other than that one email that you were shown,
21 was there ever any discussion about doing
22 anything at Carolina Forest?

23 A: No, I -- no, there wasn't. I know the
24 urologists and Mr. Asbill really would like to
25 use that property, and so they talked with me

1 about ambulatory surgery centers, how to master
2 site plan the property. They want to use it,
3 but there's nothing that I know that's on the
4 drawing boards.

5 Q: Can we go to Joint Exhibit, the 2010-2011 State
6 Health Plan. This would be Exhibit 4, Joint 4,
7 IX -- IX-9. Are you there?

8 A: I'm looking at it on the screen here. I didn't
9 pull it out.

10 Q: All right. First, are there providers in a
11 single unit -- are there single unit providers
12 that have more than 7,000 treatments on one
13 machine, like Eastside in Greenville?

14 A: I would -- I mean, we could go down this list
15 and identify them. I'm going to have to
16 squint, and I'm not seeing the -- that have
17 more than 7,000? I'm probably going to have to
18 pull out the exhibit. I believe the answer is
19 yes, but if you want me to read it ---

20 Q: Well, let's not worry about that one.

21 A: --- read it in the record.

22 Q: Would it be unusual or impossible for a single
23 unit provider to achieve the volume projections
24 that you testified to today?

25 A: We clearly know that the modern linacs can

1 exceed 7,000 treatments, whether it's one in
2 one facility or like CRCC's that has three.
3 They all can run more than that depending on
4 what the need is and the patients that need to
5 be seen.

6 Q: Did you do your calculations based on the
7 linear regression model looking at treatments
8 and calculating increases in treatment volume
9 to make your projection?

10 A: No, I used the linear regression on new cancer
11 cases to give me the percent growth in the
12 market of new cancer cases, and then I used
13 that percentage and applied it expecting the
14 growth in radiation therapy would be the same
15 percentage.

16 Q: The growth in treatments would be the same as
17 the growth in the cancer center?

18 A: Yes.

19 Q: Okay. So, and it's your projection that in
20 2017, it would be 31,800 treatments in the
21 market?

22 A: Yes, approximately that number.

23 Q: You've opined that the Coastal Cancer market
24 share, Grand Strand would get I think 58
25 percent of the Coastal Cancer patients in the

1 physician calculations?

2 A: That's correct. I didn't look at it that way
3 when I was doing the analysis, but when we
4 looked at the end result in total, it was 58
5 percent of the patients in the past that had
6 been referred to CRCC.

7 Q: Okay.

8 A: I don't know who else they're referring
9 elsewhere.

10 Q: The only -- the other hospitals in the service
11 area or in the county would not be competitors
12 for those patients, would they, since they
13 don't offer radiation therapy?

14 A: No, they wouldn't.

15 Q: All right. Are there -- can you give the court
16 some reasons as to why you think the Coastal
17 Cancer Center market share percentage for Grand
18 Strand, Grand Strand's market share percentage
19 for the Coastal Cancer patients would be higher
20 than their inpatient discharge market share?

21 A: I'm so sorry, I don't ---

22 Q: Why do you think that they would be -- how do
23 you think that they would be able to attract 58
24 percent of the Coastal Cancer and other
25 surgeons radiation therapy patients?

1 A: Based on testimony and what I know as a
2 hospital person, that medical oncologists at
3 Coastal are the only ones in Horry County and
4 that the hospital would do what's necessary to
5 encourage them, of course within legal and
6 ethical bounds, to send their patients to
7 support the hospital. The way that discussion
8 goes is doctor, we really, we have this new
9 radiation therapy service. We really need it
10 to be successful, and if it's successful we
11 will have more cash and can buy other equipment
12 and other things that ---

13 MR. THOMAS: Your Honor, I'm going to have to object
14 to this. He's speculating about some
15 conversation in the future.

16 THE COURT: I can sustain that one.

17 Q: Do you have other reasons as to why you would,
18 or did you think that covered it?

19 A: They would want to keep Dr. Holt and his group
20 happy for many reasons, not just for radiation
21 therapy, but because they -- if they want to
22 have a comprehensive cancer center, they have
23 to have the medical oncologists on board 100
24 percent.

25 Q: And based on the testimony that you heard from

1 Dr. Francke -- well, Dr. Francke testified, I
2 don't think you were here yesterday, but based
3 on your experience, would it be uncommon if a
4 physician decided to change his referral
5 pattern to move the entire referral pattern to
6 the new provider and literally start referring
7 all of the patients to a new provider if that
8 was his decision?

9 A: It would not be uncommon if the service quality
10 is as good, the level of service is good. I
11 don't believe there would necessarily be a lot
12 of allegiance if Grand Strand does what they
13 say they're going to do in terms of trying to
14 create a world class service.

15 Q: And Mr. Thomas asked you about an MUSC
16 physician who I think refers a couple of
17 patients, but is MUSC affiliated with 21st,
18 with CRCC anymore?

19 A: It used to be, and then they also have a,
20 actually in the Ford Cancer Center, MUSC, it's
21 my understanding, is an owner, part owner. And
22 when the Murrells Inlet applications were being
23 reviewed, MUSC, who had a contractual
24 relationship with CRCC, decided to terminate
25 it. So they terminated that. And there was

1 some emails about Doug Bryant and some other
2 people trying to get it reinstated because it
3 was a good working relationship with a major
4 research center. As a result, I believe CRCC
5 entered into some discussions with Duke Medical
6 Center.

7 Q: Do you think that MUSC then would be not likely
8 to refer their patients to CRCC since that
9 relationship doesn't exist anymore?

10 A: Well, I think ---

11 MR. THOMAS: Objection, Your Honor. I think that
12 also calls for him to speculate on some
13 relationship between MUSC and Georgetown and
14 other things, and I just think that's a little
15 bit far afield.

16 MR. LONG: I'll rephrase it.

17 Q: In your opinion, do you think that MUSC will
18 refer patients to CRCC, or do you think they'll
19 refer them to other providers, based on your
20 knowledge of the former relationship?

21 A: Well, they no longer have a contractual
22 relationship. I didn't really ---

23 MR. THOMAS: Your Honor, I'm sorry ---

24 MR. LONG: But he does know that. He testified ---

25 MR. THOMAS: I'm going to object now because it's

1 not MUSC, it's a specific physician I asked him
2 about, a guy named Dr. Jenrette. All right.
3 Not MUSC and MUSC doesn't employ Dr. Jenrette.
4 That's not on the record or anything like that,
5 so he doesn't know what Dr. Jenrette is going
6 to do in the future. It's pure speculation.

7 MR. LONG: He called him an MUSC physician in cross.

8 I mean ---

9 THE COURT: Well, you were asking him a general
10 question about MUSC. You want to make it more
11 narrow.

12 MR. LONG: Yeah, let me try it this way.

13 (Pause)

14 MR. LONG: That's all I have, Your Honor. Thank
15 you.

16 MR. THOMAS: I'm done.

17 THE COURT: Oh, well, you can step down. I assume
18 y'all want -- you have no problem with him
19 being dismissed?

20 MR. THOMAS: I don't.

21 THE COURT: Ms. Biggers, I didn't ask you.

22 MS. BIGGERS: I don't have any questions.

23 THE COURT: And that was said with emphasis.

24 MR. LONG: That's right. Your Honor, I guess 9:30
25 on Monday? That leaves our rebuttal case.

1 MR. THOMAS: Thank you, Your Honor.

2 (There being nothing further, the hearing recessed
3 for the day at 7:45 p.m.)

4 DAY 8 - MONDAY, SEPTEMBER 23, 2013:

5 THE COURT: All right. Another day.

6 MR. LONG: Another day, Your Honor. Your Honor,
7 before we get started today, I wanted to ask
8 Your Honor's preference on whether you wanted
9 us to do an oral closing argument or whether
10 you just wanted us to allow -- we're obviously
11 going to submit detailed orders to you, I
12 assume, so.

13 THE COURT: Yeah.

14 MR. LONG: And it's just really your preference,
15 Your Honor. We hadn't talked among ourselves.

16 THE COURT: I honestly don't have a preference. I'm
17 going to either read it or listen. There's
18 advantages to both, be honest with you. So I
19 don't care. One of them is I can carefully
20 read it; the other is I can ask questions
21 during it. So I don't care one way or the
22 other. What's y'all -- do y'all have a
23 preference?

24 MR. THOMAS: My preference is just do a closing.

25 Just kind of a wrap up.

1 THE COURT: All right.

2 MR. LONG: Do an oral closing?

3 MR. THOMAS: Yeah.

4 THE COURT: Are you prepared? I mean, are you
5 ready?

6 MR. LONG: No, I'm not prepared to do that today.

7 THE COURT: Okay.

8 MR. LONG: I could do that as early as Tuesday
9 afternoon probably or later in the week. I
10 mean, whatever the Court's preference is. Or
11 even next week, whatever the Court's preference
12 is. I mean, sometimes I think -- sometimes I
13 know judges like a little delay on it and other
14 times not, so whatever your preference.

15 THE COURT: I don't. I prefer to do it as soon as
16 possible, while it's still fresh in my mind.
17 Not that I don't think it's going to get vague
18 on this case, but what were you going to say?

19 MR. THOMAS: My thought was to do it today, Your
20 Honor. I mean, it's the last day of trial.

21 THE COURT: Well, if he's not ready to go forward on
22 it. And to be honest, most of the time people
23 do say put it in the proposed orders. So I can
24 see where you'd be caught off guard by that a
25 little bit. But let's plan on doing it

1 Tuesday. I can't say that, I don't know the
2 court's schedule.

3 MR. LONG: I think we had this week reserved, Your
4 Honor.

5 THE COURT: Oh, we had -- okay.

6 MR. LONG: I mean, I have to look at the schedule,
7 but that's what ---

8 THE COURT: Will Tuesday afternoon, one o'clock?

9 MR. THOMAS: Tomorrow then?

10 THE COURT: Yeah.

11 MR. LONG: Tomorrow one o'clock?

12 THE COURT: Yeah.

13 MR. LONG: Okay.

14 THE COURT: Okey-doke.

15 MR. LONG: And one last, in regards to the
16 witnesses, Your Honor, we had the deposition of
17 Jamie Thomas, we were going to put that in for
18 the court. And I think we've gotten that
19 almost ready. They need some time to review
20 that, Your Honor, this morning. So we should
21 have that certainly for you by tomorrow
22 afternoon, and if not, later today. So with
23 that deposition being submitted in the future
24 then CRCC would rest.

25 THE COURT: Okay. So that's going to be submitted by

1 this afternoon you think?

2 MR. LONG: Yes, Your Honor.

3 MR. COURT: All right.

4 MR. THOMAS: Grand Strand would call Dan Sullivan as
5 its rebuttal witness, Your Honor.

6 THE COURT: All right.

7 DAN SULLIVAN, being duly sworn, testifies as follows:

8 MR. SULLIVAN - REBUTTAL DIRECT EXAMINATION BY MR.

9 THOMAS:

10 Q: Good morning, Mr. Sullivan.

11 A: Good morning.

12 Q: Mr. Sullivan, you heard Ms. Price testify that
13 the oncologists, medical oncologists that
14 practice in Horry County were right next door
15 and that would lead to most referrals from
16 Myrtle Beach, from their Myrtle Beach office
17 going to CRCC. What, if any, opinions do you
18 have about that testimony?

19 A: Well, I also heard her testify that it was only
20 a five minute drive from the medical oncologist
21 office in Myrtle Beach to the CRCC operation.
22 So I don't see there being any significant
23 geographic advantage to, you know, in terms of
24 proximity, according to her testimony. And,
25 you know, I think that the oncologists have

1 been referring to CRCC for many years and some
2 of their patients and their families have used
3 CRCC in the past. So I mean, I certainly
4 wouldn't expect all of the referrals from the
5 Myrtle Beach office to go to Grand Strand. In
6 fact, I think, as I projected in my various
7 submissions to DHEC, I think it'll be a ramp up
8 period. There will be a gradual growth in the
9 volumes at Grand Strand.

10 Q: Do you recall the physicians that are actually
11 practicing in CRCC-Conway?

12 A: I do. There are three medical oncologists who
13 practice primarily out of the Conway office.
14 And I believe that there was an email that was
15 brought in from Ms. Price that talked about the
16 three. And I believe that's Cody, Goldberg,
17 and Karpenko. And so I, you know, and I think
18 she indicated in that email that, you know,
19 these are the important ones for us to get in
20 terms of the Conway operation.

21 Q: Are you referencing Petitioner's 50?

22 A: I am.

23 Q: Okay. And it's the one that states medical
24 oncologists of Coastal -- Goldberg, Cody,
25 Karpenko have all agreed to sign those as

1 support?

2 A: Yes.

3 Q: Go to Respondent's 142 for me, if you would.

4 If you can't read this, let me know.

5 MR. THOMAS: Can we blow up that grid there.

6 Q: Okay. I think you mentioned Dr. Cody. How
7 many referrals did she have through the first
8 12 months, or seven months of 2013?

9 A: She had 36.

10 Q: And how about Dr. Goldberg?

11 A: He had 33.

12 Q: Can you go to the next page? How about
13 Karpenko?

14 A: He had 31.

15 Q: Did anyone have any more than those three
16 doctors who practice at Conway?

17 A: You mean of the medical oncologists?

18 Q: Yes.

19 A: No. Dr. Holt I think was the next highest and
20 he had 30. So those three alone represented
21 100 referrals from the medical oncology group.
22 And I would expect that they practice in the
23 Conway area that the majority of those
24 referrals would go to the ---

25 MR. LONG: Your Honor, he's mischaracterizing Dr.

1 Francke's and other witnesses' testimony about
2 those witnesses. I mean, this is a concern for
3 me. He's asked him, he's put it in -- I mean,
4 he ---

5 MR. THOMAS: Go back to the Petitioner's 50.

6 MR. LONG: Well, that's -- I mean, that's my problem
7 with Petitioner's 50 being an exhibit on
8 rebuttal, because he's asking him, he's using
9 that exhibit to pit those witnesses against
10 each other.

11 MR. THOMAS: I'm not pitting witnesses, Your Honor.

12 This is a document written by Dr. Francke.

13 He's made a couple comments that CRCC's -- he
14 testified that CRCC's association with medical
15 oncologists would decimate CRCC.

16 THE COURT: Yeah, I don't -- he had the -- the way I
17 perceived it, correct me if I'm wrong, is he
18 brought his attention to the testimony of --
19 and that was of -- I can't ---

20 MR. THOMAS: Ms. Price.

21 THE COURT: Ms. Price, and then he referenced this,
22 which he can certainly respond to this because
23 this is an exhibit to the statements made in
24 that exhibit. So I don't perceive that as
25 pitting the witnesses.

1 MR. LONG: He mischaracterized the testimony.

2 THE COURT: Okay. Now, how has he mischaracterized
3 it?

4 MR. LONG: Because he said that these three doctors
5 testified primarily in Conway, which was not
6 the testimony. The testimony was the opposite,
7 that they rotate through Conway and that only
8 one of the doctors really goes to Conway a lot,
9 that the other ones don't. That they all
10 rotate around, that was the testimony.

11 THE COURT: Well, I don't remember that distinctly
12 one way or the other. But if we could just --
13 Mr. Sullivan, if you could answer the -- well,
14 I mean he can answer the question based on
15 their perception of their case, and then I'll
16 hear from you. I tell you what, if you'd lay
17 a foundation as to ---

18 MR. THOMAS: Sure, sure.

19 THE COURT: --- his understanding of that.

20 Q: Would you read the very first sentence of Dr.
21 Francke's email in Petitioner's 50, Mr.
22 Sullivan?

23 A: Sure. "The medical oncologists at Coastal
24 Cancer Center at Conway, Drs. Goldberg, Cody,
25 and Karpenko, have all agreed to sign letters

1 of support for our CON for Conway."

2 Q: Is that your understanding in terms of where
3 those physicians practice?

4 A: Yes.

5 Q: Okay. And ---

6 MR. LONG: He hasn't laid the foundation because he
7 needs the next question, which is where?

8 Q: Well, here does it say from Dr. Francke that
9 they practice here? In the very first line.

10 A: At Conway.

11 Q: The medical oncologists at Coastal Cancer at
12 Conway. What does he say in the parenthesis?
13 I didn't ask you to read that earlier, what
14 does he say there?

15 A: He's talking about, you mean about Dr. Holt?

16 Q: No, I'm sorry, the second parenthetical starts
17 with, he did not.

18 A: "He did not though volunteer to submit a letter
19 of his own, but it is the support of the three
20 med oncs that service Conway that we really
21 need anyway."

22 Q: Okay. Thank you. I believe both Dr. Francke
23 and Ms. Price testified that CRCC would lose up
24 to 50 percent of their patients to Grand
25 Strand. What, if any, opinions do you have

1 about that testimony?

2 A: Well, I mean I guess to start off with, I
3 fundamentally disagree with that. That would
4 be somewhere between eleven and twelve thousand
5 treatments, if that were to be the case. I
6 don't think there's any practical way that a
7 single linear accelerator at Grand Strand could
8 service that many patients. And Mr. Tolbert,
9 when he was talking about one of his
10 projections that projected over 11,000
11 treatment impact, said he thought that was
12 farfetched.

13 Q: Do those numbers comport with your projections,
14 Mr. Sullivan?

15 A: They don't. I mean, that would mean that they
16 would be getting almost three times as much or
17 two and a half times as much volume, that Grand
18 Strand would be getting two and a half times as
19 much volume from CRCC as what I projected. I
20 just don't think that's reasonable.

21 Q: Okay. We also heard some testimony from Ms.
22 Price about employed physicians at Grand
23 Strand. Let's go to Respondent's 11. Tolbert
24 12895 within that document. Tolbert 12895.

25 THE COURT: You said Respondent's 11?

1 MR. THOMAS: Yes, sir. All right. Here we go. I'd
2 like you to blow up for me, Roshel, if you
3 could, in the area of GS committed. Can you
4 blow it up?

5 Q: Can you see that, Mr. Sullivan?

6 A: I can.

7 Q: In this Grand Strand committed category, do you
8 know which physicians are employed, Mr.
9 Sullivan, at Grand Strand?

10 A: Dr. Anderson and Dr. Giddens.

11 MR. LONG: Objection. Lay some foundation as to how
12 we know that, Your Honor.

13 Q: What's your understanding of how they're
14 employed by Grand Strand?

15 A: I asked Mr. White.

16 Q: Okay. For Anderson and Giddens, how many
17 treatment plans did they have in, I guess, 2012
18 referred to CRCC?

19 A: Two for Anderson and six for Giddens.

20 Q: Okay. In using Mr. Tolbert's, I guess, average
21 treatment plan assumption of 25, how many
22 treatments would that be?

23 A: 200.

24 Q: Okay.

25 THE COURT: What were those names again, Anderson?

1 MR. THOMAS: Anderson and Giddens.

2 Q: In terms of Jennifer Harper and Anand Sharma,
3 do you know what medical staffs they're on?

4 A: I looked at the various listings of the
5 hospitals in the area, and the only two medical
6 staffs they appeared on were Georgetown
7 Memorial Hospital and Medical University.

8 Q: Do you have any opinions as to whether those
9 physicians would be particularly loyal to Grand
10 Strand?

11 A: I don't have any reason to think they would be.
12 I mean, they're not on the medical staff at
13 Grand Strand, and Georgetown and the Medical
14 University have an affiliation.

15 Q: Let me ask you this. Have you ever testified
16 against an HCA affiliate in a CON case?

17 A: Many times.

18 Q: Okay. Ms. Price indicated that the DRG payment
19 for Grand Strand includes the radiation therapy
20 service. What is your understanding of how
21 that process works?

22 A: The DRG payment is tied to the principal
23 diagnosis and to any significant procedures
24 that are done while the patient's in the
25 hospital. And I believe that the testimony

1 that we've heard from the clinical witnesses is
2 that, typically, the patients who are
3 inpatients are coming in the hospital not to
4 get radiation therapy, but for some other
5 medical problem. So their DRG would be
6 unrelated to the radiation therapy treatment.
7 So I don't believe that there's any aspect of
8 the DRG treatment that would be specifically
9 for radiation therapy. The hospital's not
10 going to get paid any more or wouldn't put the
11 patient in a different DRG category simply
12 because they have radiation therapy while
13 they're in the hospital. So there would be no
14 incremental revenue for inpatient -- Medicare
15 inpatients and Medicaid inpatients to the
16 hospital if they receive radiation therapy. So
17 from that standpoint, Grand Strand's not going
18 to get any more money for treating those
19 inpatients. But under the current setup, if
20 they were -- if Grand Strand were to continue
21 to transfer those patients to CRCC, for
22 example, as they did before December of 2012,
23 someone's going to have pay the cost of
24 transporting those patients by ambulance from
25 Grand Strand to CRCC and back. And those

1 ambulance charges, just from personal
2 experience I've had with family members, are
3 several hundred dollars. And that cost is
4 either borne by the patient, Medicare, or in
5 some cases the hospital has to absorb that cost
6 if patients doesn't have the ability to pay.
7 So that actually increases cost to the system.

8 Q: I think Ms. Price, both Ms. Price and Ms.
9 Maynor testified that Grand Strand would cause
10 staff to be laid off as a result of their
11 project. And what, if any, opinions do you
12 have about that testimony?

13 A: Well, I think it's important to remember that
14 when we're talking about impacts in 2017, even
15 in Mr. Tolbert's projections, he's projecting
16 there's going to be an increase in volume of
17 treatments in the service area like over 4,000
18 treatments, I believe, over the historical
19 period. So there's incremental growth in the
20 market. I think in the CON application in the
21 additional information, I projected that when
22 you net out the growth against the projected
23 volume to Grand Strand that the impact on CRCC
24 would only be in the range of six to seven
25 hundred treatments. Certainly, a loss in that

1 range would not result in any significant
2 decrease in staff. And to the extent that, for
3 whatever reason, that staff was reduced, I
4 mean, there will be other opportunities for
5 those folks in the community. And certainly,
6 Grand Strand's going to be developing a program
7 under that scenario, aAnd they would be hiring
8 experienced people if they were looking for a
9 job.

10 Q: Would the loss of six to seven hundred
11 treatments affect the quality of services at
12 CRCC, in your opinion?

13 A: That would seem to be a fairly de minimis
14 change. I can't envision it having a quality
15 impact.

16 Q: Now, Dr. Francke, I think, testified that one
17 of the reasons for the slow down at CRCC from
18 the urologists, I guess from 2011 to 2012 and
19 continuing into 2013 was the PSA guidelines.
20 Have you had the opportunity to review those
21 guidelines?

22 A: I have. And the guidelines were released by
23 the American College of Physicians, which is
24 sort of a professional organization for
25 internal medicine doctors and some other

1 doctors, and they were first announced on April
2 9, 2013. They were actually published in the
3 May 21st --- .

4 THE COURT: They were announced when, April?

5 A: April 9, 2013. And they were published in the
6 May 21st edition of the Annals of Internal
7 Medicine, which is the official publication of
8 the American College of Physicians. And so I
9 don't believe those guidelines would have been
10 in place long enough to have impacted on the --
11 significantly on the referral volumes. In all
12 fairness, I mean there's been debate about this
13 PSA issue over the last couple of years. There
14 have been, you know, several articles in the
15 press where people have been bantering back and
16 forth about what the appropriate standard is.
17 But in any event, even if there was some
18 decline associated with reduction of the number
19 of PSAs performed, that's a short-term effect.
20 First of all, not every man has a physical
21 every year, and I can attest to that. And if
22 you haven't had a physical for two or three
23 years, the guideline's really not going to have
24 any impact on whether you get a PSA test or
25 not. Secondly, for those folks who do have

1 physicals every year, that just means a delay
2 of one or two years before they have the PSA.
3 And so even if there's a short-term reduction
4 in urological referrals from PSA tests that's
5 going to be caught up over time when the tests
6 are actually performed.

7 Q: Mr. Lewis in his testimony kind of discounted
8 the private pay aspect of cost containment and
9 kind of focused on Medicare and Medicaid.

10 What, if any opinion, do you have ---

11 MR. LONG: Your Honor, I'm going to have to object,
12 okay. Almost every question he's asked is
13 improper because he's pitting every witness.
14 And he's also leading the way he's asking,
15 because he gives this whole long soliloquy of
16 what the testimony is and then he says what's
17 your opinion on it. So he's testifying to the
18 testimony.

19 THE COURT: Well, I disagree with you on that. I
20 think, and explain to me where I'm wrong, but
21 I have actually preferred attorneys to draw
22 attention to where they're asking the question,
23 and therefore, we'll know whether it is proper
24 rebuttal testimony. If he starts asking the
25 question, sometimes lawyers will say well, I

1 object, that wasn't -- that wasn't in, and then
2 the next thing I know I'm having the lawyer
3 draw the attention to why he's asking the
4 question. So this kind of saves that time. So
5 under that theory, as long as he's drawing my
6 attention to wherein derives the reason to ask
7 a question and then ask a non-leading question
8 following that, how is that in error?

9 MR. LONG: Well, Your Honor, I think that's the
10 correct way to do it. He should ask the
11 question by saying I want to draw your
12 attention to this subject, and then give the
13 subject and then ask him his opinion or comment
14 on that as opposed to telling him the testimony
15 and then asking him to comment based on it.
16 Because if the -- I mean, it's leading when he
17 does that. I mean, that's the -- I mean, so I
18 do think there is a difference and it's not
19 really subtle.

20 THE COURT: I don't have the question sufficiently
21 memorized.

22 MR. THOMAS: First of all, Your Honor, I mean, I
23 think you're absolutely right. That's how I've
24 done rebuttal in the past, is because if I
25 don't draw the witness to the testimony, then

1 I'm, you know, the objection will be based on,
2 well, I never brought that up. I mean, that
3 happens. And I'm only bringing up testimony
4 that Mr. Sullivan's heard, everybody in this
5 courtroom's heard, and then I'm asking him what
6 his opinion is on it. It's about open-ended as
7 you can possibly get.

8 MR. LONG: Well, I would say almost every question
9 has mischaracterized what I remember the
10 testimony to be, and that's the point. He
11 needs to bring the attention to the matter, to
12 the subject, not the actual -- his rendition of
13 what the witness actually testified to. I
14 don't have a problem with him saying, do you
15 recall Dr. Francke testimony -- like for
16 example on the question we just had, do you
17 recall Dr. Francke's testimony on the PSA test?
18 Okay, what's your opinion on that, as opposed
19 to telling him what the testimony was and then
20 asking for his comment.

21 THE COURT: Any final comment?

22 MR. THOMAS: No, I think the way I'm doing this is
23 proper and this is the way I've done in this
24 court before.

25 THE COURT: Proceed, and if I perceive that you're

1 doing it improper I'll either address it myself
2 or entertain an objection.

3 MR. THOMAS: Okay.

4 Q: Mr. Lewis testified about the cost containment
5 aspects of hospitals versus freestanding linear
6 accelerator facilities; do you recall that?

7 A: I do.

8 Q: Okay. And Mr. Lewis also focused on CMS,
9 Medicare and Medicaid services, are there other
10 components that -- or payers, that CRCC relies
11 on?

12 A: There are. They get a material percentage of
13 their -- CRCC gets a material percentage of its
14 revenue from PPOs, preferred provider
15 organizations.

16 Q: Can you explain to the Court, just for the
17 record, what a PPO is?

18 A: Sure. Preferred provider organization is
19 essentially an insurance plan that contracts
20 with providers, hospitals, physicians, other
21 types of providers. And in exchange for making
22 them preferred or in-network providers, those
23 providers offer a discount to the insured that
24 are under the PPO plan. And so it's just a
25 different form of insurance in where rates are

1 negotiated between the insurance company and
2 the providers.

3 Q: Okay. I put up on the screen, Petitioner's 52,
4 this is CRCC 72, for the record. And there's
5 a payer mix percentage there for, I think it's
6 the fourth category down.

7 A: I see it.

8 Q: What is the payer mix percentage per PPO?

9 A: It's 32.1 percent, so almost a third of the
10 revenue would be associated with PPO plans.

11 Q: Okay. And in terms of the next category down,
12 revenue by RVU by payer, what, if any, opinions
13 do you have about that column or that row?

14 A: Well, the PPO revenue per RVU is substantially
15 higher than it is for the other categories of
16 payers. If you see that, it's \$52.62, the
17 overall average is \$34.92, which is -- in
18 Medicare it's \$30.73. So the PPO pays
19 materially more for services than the
20 governmental payers. And certainly, I believe
21 Mr. Lewis' testimony was that there's really no
22 advantage to having another provider in the
23 market, that the leverage that the insurance
24 companies would gain wouldn't be significant.
25 And in part that had to do with his feeling

1 that the insurance companies couldn't leave
2 hospitals out of their networks. Well, that
3 may be true, but hospitals typically remain in
4 insurance plan networks, particularly a large
5 hospital like Grand Strand. That doesn't mean
6 that there wouldn't be leverage available to
7 the insurance company if they had more than one
8 provider. You know, if you only have one
9 provider, you have no leverage. If you have
10 two, even though the hospital may have a
11 different cost structure and may typically get
12 higher charges, you can still play the two off
13 against each other.

14 Q: What, if any, opinions do you have with the
15 aspect of leverage as it relates to cost
16 containment?

17 A: I mean, it's an important consideration in cost
18 containment. You know, when you have a single
19 provider in a geographic area, that's obviously
20 a concern from the standpoint of their ability
21 to raise prices in a way that it wouldn't be
22 possible in a more competitive market, and so
23 having that leverage has a cost containment
24 feature.

25 Q: You heard testimony from Rich Lewis about a

1 breakeven analysis that he did. What, if any,
2 opinions do you have -- first, if you can
3 recall what breakeven analysis was and what, if
4 any, opinions would you have about the
5 breakeven analysis?

6 A: Yeah, I believe his testimony was that he had
7 looked at some data from the freestanding
8 radiation therapy industry and had determined
9 that somewhere around 4,900 treatments was the
10 breakeven point for a freestanding radiation
11 therapy center. My opinion about that is it's
12 interesting, but not particularly applicable to
13 this project.

14 Q: Why not?

15 A: This is a hospital-based facility. Unlike a
16 freestanding center, the hospital's not going
17 to have to duplicate all the overhead expenses
18 you would if you were a provider setting up a
19 freestanding center. They already have an
20 administrative team. They already have a
21 billing system. You know, they already have a
22 lot of the infrastructure. They have a
23 maintenance department and an environmental
24 services department. So they wouldn't have to
25 duplicate all of those overhead costs.

1 Secondly, as Mr. Lewis himself testified to,
2 hospitals typically get reimbursed a bit more
3 than freestanding radiation therapy centers.
4 So their revenue profile is different, so
5 obviously their breakeven point would be
6 different. And just by the way of example,
7 Georgetown Memorial Hospital has been averaging
8 a little bit more than 4,900, around 5,300
9 treatments over the last several years.
10 Apparently, they are doing well enough that
11 they want to invest ten million dollars in a
12 new center in Murrells Inlet.

13 Q: Even assuming Mr. Lewis' breakeven point, if
14 we're assuming it's applicable, do you have any
15 opinions about Grand Strand's volume levels
16 past year three of operations?

17 A: Sure. You know, I think -- well, I don't want
18 to imply anything in terms of what he said,
19 infer anything into what he said, but you know,
20 I think he was saying that at 4,690 projected
21 treatments, that that wouldn't be a breakeven
22 proposition for Grand Strand. Well, I don't
23 think we've ever indicated in the application
24 or anything else we've presented to DHEC that
25 the volume was going to stop at 4,690

1 treatments. I think the expectation is as the
2 market continues to grow and as Grand Strand's
3 reputation hopefully would increase and that
4 those volumes would continue to grow over time.
5 So, I mean, my expectation would be that the
6 volumes would certainly get above the levels
7 projected in year three in the application as
8 we go farther out in time.

9 Q: Okay. Mr. Lewis made a reference to Grand
10 Strand's charges for PPO being five times as
11 high as Medicare charges for, I guess, a
12 similar service. What, if any, opinions do you
13 have about that testimony?

14 A: I mean, I think he was initially looking at
15 what was in Mr. Grace's model. But then I
16 think he extrapolated that to say that Medicare
17 should have been 900, and therefore, the charge
18 to PPOs would have been \$4,500 per treatment,
19 which I think you did some math with him and it
20 worked out to be about \$150,000 per course of
21 treatment. If that were true, I don't think
22 there are many payers who would want to pay
23 that, and I don't think there's many patients
24 who would want to go to Grand Strand if they
25 had co-insurance deductibles and so forth that

1 they had to pay on a service that high. So, I
2 mean, I just --I think that was sort of taking
3 the information in Mr. Grace's model to the
4 extreme. I don't think there's any likelihood
5 that Grand Strand's going to charge PPOs \$4,500
6 per treatment.

7 Q: What, if any, opinions do you have about
8 whether or not a PPO would negotiate that level
9 of price?

10 A: Well, I mean, they would be crazy to. I can't
11 imagine that under any scenario.

12 Q: Let me talk to you a little bit about Ms.
13 Brandt's testimony. I think Ms. Brandt stated
14 that Grand Strand, there was some testimony
15 about Grand Strand could have applied in 2010.

16 A: Yes.

17 Q: Do you recall that testimony?

18 A: I do. I think she said, you know, I think she
19 was asked the question about whether or not
20 Grand Strand could have applied earlier than
21 they had, whether they could have applied back
22 in 2010. And she said yes, they could have.

23 Q: We don't have to put it up there, but Joint 4
24 was the 2010-2011 South Carolina Health Plan.
25 I'm just going to hand that to you. What's the

1 effective date of the 2010-2011 South Carolina
2 Health Plan?

3 A: November 12, 2010.

4 Q: Okay. And is this the health plan that
5 identified the need for a linear accelerator in
6 the service area?

7 A: It is.

8 Q: Do you recall when Grand Strand made a decision
9 to apply for it?

10 A: There was an email that I recall from Mr. White
11 to Jamie Thomas, the president of the division,
12 Southeast Division on November 10th, so two
13 days before the plan was adopted asking for
14 authorization to move forward.

15 Q: Ms. Brandt seemed to be somewhat -- do you
16 recall the issue of two CON applications being
17 raised at project review?

18 A: I do.

19 Q: How was it raised?

20 A: Well, I brought it up first of all. And there
21 were questions asked by staff of the different
22 parties, and then we were asked subsequent to
23 that to submit additional information on the
24 issue of two units being approved. So, I mean,
25 that issue was aired first at project review

1 and then subsequently followed up with various
2 submissions by the applicants.

3 Q: Ms. Brandt testified on her direct regarding
4 your inclusion of a statement, of your
5 statement and a document about significant
6 referrals from medical oncologists being an
7 influence on her decision to find the potential
8 for adverse impact. What, if any, opinions do
9 you have about that testimony?

10 A: I have a few. I mean, first of all, I did
11 state that. Secondly, I'm not sure when you
12 have a situation where you only have a single
13 provider in the market how Ms. Brandt thought
14 that Grand Strand could initiate services
15 without impacting CRCC since they were the only
16 operator in Horry County. Also, Ms. Brandt
17 didn't acknowledge anywhere in the decision
18 that there was this relationship with Atlantic
19 Urology where a significant percentage of the
20 referrals that were going to CRCC were not
21 really available to Grand Strand. So I think
22 her analysis was just simply flawed.

23 Q: Did you bring that relationship up or bring Ms.
24 Brandt's attention to that relationship between
25 CRCC and AUC?

1 A: I did in a subsequent letter.

2 Q: Do you recall what you stated?

3 A: Just that they had an employed urological group
4 that would not be sending patients to the
5 Grand Strand.

6 Q: Ms. Brandt, she also testified about the
7 adverse impact of Georgetown's project in
8 Murrells Inlet. What, if any, opinions do you
9 have on that topic?

10 A: I think that she says that her concern was that
11 there were six overlapping zip codes between
12 the service areas of Georgetown and Grand
13 Strand. But, you know, despite that, the two
14 facilities would be 20 miles apart, and it
15 seemed somewhat ironic that she would find the
16 potential for impact in that circumstance and
17 yet approve two replacement linear accelerators
18 to be operating a half mile apart in Murrells
19 Inlet and didn't find that they would adversely
20 impact each other. So, I mean, I think that's
21 just inconsistent and I think it just -- just
22 from a factual standpoint, it doesn't seem to
23 be a logical conclusion given the distance and
24 the things I've already talked about in terms
25 of the distinct medical staffs and different

1 referral patterns that are in place at
2 Georgetown and Grand Strand.

3 Q: Do you have any opinions regarding Ms. Brandt's
4 overall conclusion that only one could be
5 approved and that CRCC improves the
6 geographical access?

7 A: I do have an opinion.

8 Q: What is it?

9 A: Well, first of all, I disagree that only one
10 can be approved because I think that the
11 volumes would support two. Secondly, I think
12 Ms. Brandt looked at access in a very limited
13 way, just looked at Conway versus Myrtle Beach.
14 And without repeating all my direct testimony,
15 I believe that the accessibility to a provider
16 that would be hospital based, have a more
17 comprehensive array of services and also be
18 available to inpatients is a dimension of
19 accessibility that Ms. Brandt never considered.

20 Q: Okay. What, if any, opinions do you have about
21 CRCC's project being less costly?

22 A: Well, it is short term. They're purchasing an
23 older building and that's a significant savings
24 and cost. I know there was some testimony, I
25 believe with Mr. Tolbert, where you were

1 looking at an email that talked about an option
2 that CRCC was considering about ultimately
3 replacing that facility and putting it on some
4 land in the Carolina Forest area. So, I mean,
5 whether that happens or not, there's certainly
6 the potential, given the size of the building
7 where CRCC is proposing to locate this being
8 much smaller than other facilities they
9 typically operate. I think the testimony was
10 being an older facility that they would have
11 expend those funds at some point in the future
12 to replace that facility to have a higher
13 quality offering. So I don't think the cost
14 difference is that big a factor in my
15 evaluation of the projects because I think it's
16 sort of you get what you pay for. In one case
17 you're getting a hospital-based comprehensive
18 center and the other place you're getting a
19 small unit operating in a building that's older
20 and with limited square footage.

21 Q: I want to talk lastly about the testimony of
22 Mr. Tolbert on Friday. What are your opinions
23 regarding his use of linear regression versus
24 your use of compound average growth rate in
25 projecting treatments for the service area?

1 A: I mean, first of all, I think he said that
2 linear regression is always superior to other
3 forms of projection. And I've been doing this
4 for 33 years and most health planners rarely
5 use linear regression in doing projections.
6 And the reason is linear regression is a very
7 crude tool for projecting utilization. I think
8 Mr. Tolbert explained it, but basically, you
9 have a series of data points, historical data
10 points and linear regression just tries to fit
11 a line through those data points. Sometimes
12 the numbers fit well to that straight line and
13 sometimes they don't. But the problem too is
14 that it assumes whatever is going on in the
15 past is going to continue in the future, and we
16 know in healthcare that things change,
17 demographics change and so forth. And so what
18 I do and I think is commonly done by health
19 planners is look at the individual component
20 parts that go into demand, such as population
21 by age, incidence rates of disease, in this
22 case cancer by age, number of patients with
23 that disease who require the type of treatment,
24 the number of treatments per patient, look at
25 those factors individually and project them out

1 into the future, which is the way that I did
2 it. And maybe just to make another point, Mr.
3 Tolbert used linear regression to look at what
4 the historical trend was in the number of new
5 cancer patients, and then he used it to project
6 the number of treatments. If you recall his
7 graph showing the trend and the number of
8 treatments, there was a steep upward slope to
9 it and then it went down again. And if you try
10 to fit a line through that, you're going to get
11 a much different picture from a linear
12 standpoint. It's not a linear function in
13 terms of what's happened with treatments in the
14 service area in recent years. And so he didn't
15 actually used linear regression for treatments.
16 To project treatments he used linear regression
17 for new cancer patients to project treatments.
18 And I think that was inappropriate. But the
19 bottom line is, you know, his number came up
20 pretty close to the one that I came up with.
21 I mean, I'm just addressing his point about
22 linear regression.

23 THE COURT: He used linear regression to address
24 what, but not what? I didn't catch it.

25 MR. SULLIVAN: He looked at the trend in new cancer

1 cases over the last, I think it was, 15 years
2 or 14 years in the service area. Then he
3 calculated what the slope of the line would be
4 to fit those new cancer cases. He then took
5 that trend in new cancer cases and applied it
6 to treatments, which is a different number. It
7 had a different historical pattern, if we
8 recall the testimony that it was flat for a
9 while then jumped up in 2010, really went up in
10 2011 and then went down a little bit in 2012.
11 He then assumed that the trend in new cancer
12 patients would be the same trend for linear
13 accelerator treatments. And I wouldn't have
14 made that connection. But in any event, I
15 mean, I think, you know, in some cases it's a
16 distinction without a difference because we
17 ended up pretty close to the same place.

18 Q: What 2017 year projection did you use in your
19 analysis for the adverse impact if two are
20 approved?

21 A: I used Mr. Tolbert's.

22 Q: Now, I believe Mr. Tolbert testified that DHEC
23 expects for a project to be mature by the third
24 year of operations. Do you agree with that?

25 A: I don't. I think that the third year of

1 operation probably represents a more reasonable
2 picture of where a project is going. If you
3 haven't been able to get up to a sufficient
4 level of volume by year three, you're probably
5 going to have some problems. I mean, but even
6 the State Health Olan anticipates that you're
7 not going to be at maturity in the third year
8 because it only requires that applicants
9 project that you be at 50 percent utilization
10 of the unit, and yet it has a standard in terms
11 of when you need a new unit of 80 percent. So
12 I think the assumption is the third year you
13 kind of get to a reasonable volume, but you're
14 not going to be where you're going to be
15 ultimately in the utilization of the service.

16 Q: I think there's been some references, there was
17 references in Mr. Tolbert's testimony about
18 Grand Strand achieving some kind of world class
19 status of a comprehensive cancer care by year
20 three. Do you agree with that?

21 A: I don't think that was ever stated in the CON
22 application. At least I certainly never wrote
23 that in the CON application. We did talk about
24 the concept of a comprehensive cancer center,
25 but we saw that as an evolutionary process, you

1 know, and the -- the hospital already has a
2 designation as a community hospital cancer
3 program. Radiation therapy would be the next
4 step along that continuum towards providing
5 comprehensive services, but that's going to be
6 an ongoing process. I mean, just as Mr. White
7 described what happened with cardiac services,
8 it's going to take many years to develop a
9 comprehensive program on Grand Strand's campus.
10 But without having the radiation, I don't think
11 it's likely that that's going to happen.

12 Q: Mr. Tolbert also mentioned that Grand Strand
13 might get referrals from the CRCC affiliated
14 urologists based on Grand Strand's health plan.
15 Do you recall that testimony?

16 A: I do.

17 Q: What, if any, opinions do you have about that?

18 A: I mean, it's theoretically possible that would
19 happen. But I wouldn't think it would be a
20 very large number of referrals. If you've ever
21 been in a hospital, one thing you might notice
22 when you're walking around, it's a very female
23 dominated environment. So a lot of the
24 employees don't have prostates. In addition,
25 the majority of the people who receive

1 treatment for prostate cancer are individuals
2 age 65 and older who typically wouldn't be
3 employees of Grand Strand. So to the extent
4 that the employees were referred by the
5 urologists to Grand Strand, I would think that
6 would be a relatively small number.

7 Q: Mr. Tolbert, I think he referenced the what if
8 analysis that Grand Strand CFO, Robert Grace,
9 did and I think he mentioned that he was
10 stunned there was the second set of numbers.
11 What, if any, opinions do you have about that
12 testimony?

13 A: Well, first of all, I wasn't stunned to learn
14 that. You know, big companies often run
15 multiple scenarios. But I think if you look at
16 what Mr. Grace did, look at the email traffic
17 around that time, and if you look at what he
18 said on the stand in here, there's no basis for
19 doubling the numbers under that what if
20 scenario. I mean, he just simply took my
21 numbers and he didn't quite double them, but,
22 you know, almost doubled them without any
23 basis. And I think he freely admitted that in
24 this case.

25 Q: You heard some testimony from Mr. Tolbert

1 regarding Grand Strand should have used 25
2 treatments per patient instead of 21 treatments
3 per patient. What, if any, opinions do you
4 have about what the average number of
5 treatments per patient Grand Strand should have
6 used?

7 A: Well, first of all, my opinion is the 21 that
8 I used is reasonable, and I believe that all of
9 Mr. Tolbert's impact analyses are overstated
10 because he used the 25 number. And we can
11 actually, you know, calculate from CRCC's own
12 information what the treatment profile looks
13 like for urology patients versus all other
14 patients.

15 Q: How would you go about doing that?

16 A: Well, if you took the -- let's take 2012, for
17 example. There were 22,798 treatments total
18 for CRCC in 2012. We know from that exhibit
19 that you showed me a little while ago that 43.7
20 percent of all the treatments were associated
21 with urology. And so that works out to be
22 about 99, a little over 9,900 treatments. And
23 so the remainder 12,000 and change are related
24 to other patients, the non-urology patients, if
25 you will. Okay. If we divide the urology

1 treatments by the 263 referrals that the AUC
2 doctors had in 2012, that would give you about
3 38 treatments per patient for the urology
4 patients. If we do the same calculation for
5 the remaining treatments, the non-urology
6 treatments and divide that by the 623 non-
7 urology referrals, that comes up to be about
8 20.8 or 20.9 treatments per patient.
9 Coincidentally, very close to the 21 number
10 that I assumed in my projections. And since we
11 know that those urology patients aren't going
12 to Grand Strand, then the treatment profile of
13 the patients that Grand Strand would treat, and
14 since they're coming primarily from CRCC's
15 patient base would be more along the lines of
16 that 21 treatment. And it's possible that
17 Grand Strand's going to actually be a little
18 bit lower, because if they had more inpatients
19 that were getting palliative treatment and only
20 receiving two or three or four treatments, that
21 could bring the average down. But I feel very
22 comfortable with the 21 number, and I think Mr.
23 Tolbert overstated his impact.

24 Q: Mr. Long and Mr. Tolbert did what I'll call a
25 tipping point analysis on the whiteboard.

1 What, if any, opinions do you have about the
2 tipping point analysis, and if you could
3 explain to the judge just from a contextual
4 standpoint what that means?

5 A: Yeah. I mean, without going through all the
6 numbers again, I believe that the calculation
7 was that Mr. Tolbert looked at a 26,000
8 capacity of the existing machines and applied
9 80 percent to that and came up with 20,800 as
10 being -- that would be the 80 percent point.
11 So the existing providers couldn't drop below
12 20,800 treatments. And then he calculated what
13 would be projected for Conway and deducted
14 that, and then figured out that that left 5,525
15 treatments. Any more than that would drop the
16 existing providers below that 20,800 number.
17 So his tipping point was 5,525.

18 Q: You think that's -- what, if any, opinions do
19 you have that Grand Strand will get to the
20 tipping point by 2017?

21 A: You know, based on my projections, they would
22 not. And even if I was off a little bit, 5,525
23 is almost 18 percent higher than what I
24 projected. And I think -- I can't envision a
25 scenario where the volumes would be that much

1 higher than what I projected. I would also
2 point out a couple of other things, and that is
3 that for Conway, CRCC, an existing provider, a
4 high volume provider, that's going to be
5 operating a center in an area that's 14 miles
6 away from the next closest competitor with the
7 newest and latest technology, was only
8 projecting 5,499, I think, treatments in 2017.
9 So they weren't even projecting Conway was
10 going to get the 5,525 under what I would
11 consider to be sort of ideal circumstances,
12 where you had an existing patient base, you
13 could just shift over there and you had a, you
14 know, relatively competition free market, you
15 know, with your closest competitor being
16 Georgetown, either in Georgetown or in Murrells
17 Inlet, some distance away. So if CRCC doesn't
18 think that Conway can get the 5,525, I don't
19 why they think Grand Strand can.

20 Q: I think Mr. Tolbert stated that Grand Strand
21 should have used a higher capacity for its
22 Clinac iX, 7,000 instead of 5,000. What, if
23 any, opinions do you have about that?

24 A: Well, I used the 5,000 because the State Health
25 Plan says if you're expecting to perform a

1 significant percentage of your treatments as
2 IMRT or IGRT treatments, then the capacity is
3 5,000. But I was following what was in the
4 State Health Plan. So I think what I did was
5 consistent with the actual standards in the
6 State Health Plan.

7 Q: Well, let me ask you this. I think you
8 mentioned that the reason for doing that was so
9 that Grand Strand could apply for a second unit
10 quicker than if they set it at 7,000. Do you
11 have any opinions about that?

12 A: Well, I can tell you I certainly wasn't
13 thinking about that at the time. You know, my
14 concern was that Grand Strand was trying to
15 enter a market with a very formidable
16 competitor located, you know, three and a half
17 miles away that had an employee urology group.
18 I certainly wasn't thinking about a second
19 unit. I was just trying to come up with
20 reasonable projections that would justify the
21 first unit. And, you know, I think -- I mean
22 I can understand why existing providers want to
23 use a higher capacity because that presents a
24 bar to new applicants that are in the market.
25 The higher you can make the capacity, then the

1 lower the utilization rates are at the existing
2 provider. So I think Mr. Tolbert assumed that
3 I did something that I didn't do.

4 Q: Okay. Mr. Tolbert and the other CRCC witnesses
5 testified that, you know, this idea of a
6 comprehensive cancer treatment setting wasn't
7 all that important if you've got the
8 freestanding centers around and that, you know,
9 communications in this day and age can be
10 accomplished through ---

11 MR. LONG: Objection, Your Honor, I mean he's
12 clearly now -- he didn't do it for a while, but
13 now he's slipping back into basically
14 testifying again. So I object to the question.

15 THE COURT: Any response or you're going to just
16 rephrase it?

17 MR. THOMAS: Yeah, I'll rephrase it.

18 Q: You heard testimony that comprehensive cancer
19 treatment settings not important because of
20 modern communication. What, if any, opinions
21 do you have about that?

22 A: I mean that's just contrary in my experience in
23 working with cancer providers, radiation
24 therapy providers. You know, pretty much
25 uniformly, they talk about the importance of

1 being able to have immediate access to other
2 professionals who are involved in the
3 treatment. Now, obviously, you can't always
4 have everything under one roof, but to the
5 extent that you can bring the various providers
6 who offer the continuum of services that cancer
7 patients need closer together -- I was involved
8 with a center in Tennessee last year where they
9 put a radiation therapy unit adjacent to the
10 offices of medical oncologists. They weren't
11 under the same organizational umbrella, but
12 there was a hearing on that and there was
13 testimony regarding the benefits of the
14 radiation oncologists being able to just walk
15 across the hall as opposed to trying to track
16 down the medical oncologists on the phone,
17 which sometimes is a difficult process, or send
18 an email that might be returned four or five
19 hours later when they needed an answer right
20 then. And, you know, and also in looking at
21 the resumes of the radiation oncologists who
22 practice at CRCC, it appears that all of them
23 trained at comprehensive cancer centers. Dr.
24 Francke, for example, was trained at University
25 of Kentucky medical center, which I know very

1 well. I've done a lot of work in Lexington,
2 Kentucky. They were recently designated by the
3 National Cancer Institute as a comprehensive
4 center. And the other two, I think were at
5 large centers elsewhere. So I think most
6 people would agree that comprehensive treatment
7 is the goal. You can't always do that in every
8 community because every community is not big
9 enough and has the resources to support that.
10 But to the extent that we can foster improved
11 communications and greater coordination, I
12 think that's a benefit to the healthcare
13 system.

14 Q: In terms of -- do you have any opinions with
15 respect to the comprehensive cancer center and
16 potential to reverse outmigration?

17 A: I mean, certainly, there is that potential.
18 Most of my experience, when people travel some
19 distance to get treatment, they're usually
20 going to bigger centers. They're going to Mayo
21 or they're going to Sloan-Kettering or they're
22 going to Duke or someplace like that that has
23 a national reputation because the sense is that
24 they can get everything they need in one stop.
25 And to the extent that we could provide more of

1 that in Horry County, I think that would have
2 the potential to reverse outmigration to a
3 certain extent. I mean, it's still not going
4 to be able to compete on equal footing with the
5 large national centers. But at least for
6 patients who felt like they had to drive to
7 Charleston, maybe they would feel like we can
8 get, you know, most of what we need here at
9 Grand Strand.

10 Q: I think there's testimony of Mr. Tolbert and
11 other witnesses who discounted the benefits of
12 an in-hospital provider to inpatients. What,
13 if any, opinions do you have of that testimony?

14 A: Well, I guess I just disagree with that. You
15 can't always have a hospital-based option.
16 Some communities are simply not big enough and
17 you can only have one provider and that
18 provider merely would exist in a freestanding
19 setting. But when you have a large community
20 and you have the option to do that, I think
21 it's a good alternative to have for folks. I
22 mean, Grand Strand, I think their historical
23 data showed that somewhere between 30 and 40
24 patients a year, inpatients were being referred
25 for radiation treatment. And if we assume

1 three treatments per patient, that's 90 to 120
2 separate trips those patients would have to
3 make. I mean, certainly for those patients the
4 presence of a hospital-based provider would be
5 a benefit. You know, and I've had some
6 experience myself with my father-in-law who was
7 undergoing radiation treatment in Athens,
8 Georgia, on an outpatient basis and because of
9 the treatment he was debilitated and dehydrated
10 and was admitted to the hospital. And he, for
11 two days, they transported him by the
12 ambulance, but by the third day, he was too
13 weak and just said I can't do that again. And
14 so they had to stop treatment for a while.
15 And, you know, again, it's not the only way to
16 provide services, but when you have a big
17 enough market to support both alternatives,
18 freestanding and hospital based, it's certainly
19 beneficial to have a hospital-based option.

20 Q: And is Horry County and the service area a big
21 enough market in this case?

22 A: It certainly is given the number of treatments
23 that are being done and with a population
24 approaching 300,000.

25 Q: I think Mr. Tolbert spoke about or testified

1 about Grand Strand not having the experience,
2 and this is in the comparison charts, of
3 providing or delivering radiation therapy
4 services. What opinions do you have with
5 respect to that testimony?

6 A: Well, I mean, certainly Grand Strand doesn't
7 have experience but HCA, its parent affiliate
8 has, you know, loads of experience as we heard
9 testimony about that. And also, again, it
10 seems ironic that we're talking about the lack
11 of experience and at the same time talking
12 about Grand Strand being able to come in and
13 within three years do 8,000, 9,000, 10,000
14 treatments. So apparently, it's not a
15 significant enough detriment that they can't
16 come in Mr. Tolbert's view and take a large
17 share of the market.

18 Q: I think Mr. Tolbert also testified there's no
19 mention of the word competition in the State
20 Health Plan, the CON regulations, or the CON
21 Act purposes in the statute. What, if any,
22 opinions do you have about this testimony
23 regarding competition?

24 A: Well, I agree with him that that word itself
25 doesn't appear there. But certainly, in the

1 purposes of the Act, two key purposes are cost
2 containment and quality. And competition has
3 the ability to enhance both cost effectiveness
4 and quality. Cost effectiveness I think we've
5 already touched on earlier in terms of
6 negotiating rates and so forth. And then with
7 respect to quality, when you have another
8 provider, you know, everybody has to step up
9 their game to a certain extent, not only in
10 terms of clinical care, but also in terms of
11 patient processes to try to provide the best
12 possible experience to the patient.

13 Q: I believe he also testified there was no
14 mention in the State Health Plan or the CON Act
15 or its regulations that hospitals should be
16 favored over physicians. Do you have any
17 opinions about that testimony?

18 A: I guess I would say the reverse. I mean,
19 there's nothing in any of the statute or
20 regulations that favors freestanding centers
21 and physicians over hospitals. But again, I
22 think as it goes to the issues of accessibility
23 and cost containment and quality, having a
24 hospital-based alternative certainly would
25 enhance those objectives.

1 Q: I want to go over some of the exhibits that Mr.
2 Tolbert discussed

3 MR. THOMAS: And can we pull up Exhibit 10,
4 Respondent's Exhibit 10 on the computer.

5 Q: Can you read that?

6 A: I can.

7 Q: Well, first of all before I ask you a question
8 about this. Do any of Mr. Tolbert's adverse
9 impact analyses reflect any change in the
10 outmigration of the three counties?

11 A: They do not. You know he -- I think he sort of
12 interchangeably talked about his projections as
13 being what the existing providers are going to
14 do in the future and also what the service area
15 needed in the future. I don't think his
16 projections, because all he did was take the
17 historical level of treatments performed by
18 providers in the service area and inflated that
19 forward I don't think he took into account the
20 outmigration of patients in any way. So his
21 numbers don't reflect the demand in the total
22 service area.

23 Q: For the record, I guess Respondent's 10 is Mr.
24 Tolbert's referral analysis and Respondent's 11
25 is kind of the backup that goes to it. Are you

1 familiar with those documents?

2 A: I am.

3 Q: And you heard Mr. Tolbert's testimony about
4 them?

5 A: I did.

6 Q: Did you have an opportunity to review them?

7 A: I did.

8 Q: What are your overall opinions with respect to
9 Respondent's 10 and the backup data in
10 Respondent's 11?

11 A: That this analysis is, I guess my overall
12 opinion would be unreliable. I mean, I would
13 certainly agree with Mr. Tolbert in that the
14 AUC physicians are likely to go 100 percent to
15 CRCC. I would agree with it for those eight
16 referrals that we saw for the two employed
17 Grand Strand doctors that those would probably
18 go to Grand Strand. But everything else I
19 think is mere speculation. I looked at the
20 backup and how we assigned physicians to
21 different groups, but I couldn't -- when I
22 heard his testimony about it I just couldn't
23 see that there was any, you know, any certainty
24 or, you know, any reasonableness in the way
25 that was done. And, you know, just by way of

1 example, the last category on here, the other
2 category, which my understanding is those are
3 the doctors that aren't affiliated with any
4 medical staff in the community, they may be out
5 of area doctors who were referred in, you know,
6 from North Carolina or farther away. And for
7 some unexplained reason, he projected that
8 these patients who were 100 percent going to
9 CRCC in the past were now suddenly going to
10 split 40/40 and 20 when the Grand Strand
11 project was approved. It seems arbitrary and
12 I just don't see any basis for it.

13 Q: There's a statement here on the bottom of the
14 page, it's like a little a, assumes forward
15 center relocation to Murrells Inlet. What are
16 your comments about that assumption?

17 A: I thought it was interesting since both Grand
18 Strand -- I'm sorry, Georgetown and the Ford
19 Center at Georgetown Memorial and CRCC were
20 both approved that he only assumed that the
21 Georgetown project would be there and not the
22 CRCC project.

23 Q: Why is that important?

24 A: Well, I mean, as it relates to impact. If you
25 have two facilities located to the south of

1 Grand Strand, south of Myrtle Beach right on
2 the border between Horry and Georgetown
3 Counties, I mean that's a large population base
4 and a growing population base. I mean that
5 would effectively preclude many of those
6 patients from traveling up to Myrtle Beach for
7 services. You've got two close options, why
8 would you drive 20 miles to Myrtle Beach to get
9 your radiation treatments. So, you know, by
10 only assuming one, I'm not sure why he assumed
11 one or why he didn't assume it would be CRCC's
12 since his position was there's no need for the
13 Georgetown project. But in any event, the
14 presence of one or two centers to the south of
15 Myrtle Beach is going to further limit Grand
16 Strand's ability to be able to capture market
17 shares.

18 Q: Do you agree with Mr. Tolbert's testimony with
19 respect to his analysis or his decision not to
20 really focus on medical staff membership?

21 A: I do.

22 Q: Do you recall?

23 A: I do recall.

24 Q: Did you agree with that estimate?

25 A: I don't. I mean I would agree with him that

1 it's certainly not a perfect predictor of what
2 people are going to do. But to sort of ignore
3 medical staff membership entirely, I mean, if
4 the doctor is only on Conway's medical staff,
5 for example, and not on Grand Strand's medical
6 staff, there might be a greater tendency for
7 that doctor to refer patients to a facility in
8 Conway than to Grand Strand. I don't think
9 he's given any consideration to that in this
10 analysis.

11 Q: Let's go to Respondent's 12, if we could. On
12 this first page here, Tolbert 12903 again, this
13 is an adverse impact analysis Mr. Tolbert did.
14 I believe it updates Respondent's 39. We'll
15 focus on 12 for the sake of time. Did you have
16 an opportunity to review the documents in
17 Respondent's 12?

18 A: I did.

19 Q: Okay. First of all, on Tolbert 12903, there is
20 a row kind of towards the bottom of the page,
21 it says treatments in region projected 2017?

22 A: Yes.

23 Q: Can you explain what that number means, that
24 31,824.

25 A: Sure. As I was discussing earlier, what Mr.

1 Tolbert did is he looked at the historic volume
2 of treatments done by providers in the service
3 area, I mean Georgetown and CRCC historically,
4 and then inflated that forward using a growth
5 rate of about 2.4, 2.5 percent. But that's not
6 the total treatments in the region because we
7 know that there is outmigration. I think in
8 questioning by you, I think he talked about 20
9 percent or about 6,000 additional treatments
10 potentially going outside the market to other
11 providers. So we know that the total market is
12 larger than this. And so he didn't give any
13 effect to outmigration or in-migration in doing
14 his projections.

15 Q: And just for the record, what does Mr. Tolbert
16 list there for treatments at CRCC in Conway?

17 A: Yes. 2017, he has 5,499. And just for the
18 record, what he projected in his application
19 was 5,235, which was only a bit higher than
20 what Grand Strand predicted.

21 Q: All right. If you turn over to 12904, Tolbert
22 12904.

23 MR. THOMAS: So it would be the very next page, Ms.
24 Tuska.

25 Q: Dan, can you read that?

1 A: If you could blow it up a little bit.

2 MR. THOMAS: Can you get it a little bit bigger,
3 12904.

4 A: I can read it now.

5 Q: I'm going to start with column F, if we could.
6 And I believe the title there is based on Grand
7 Strand's overall market share?

8 A: Yes.

9 Q: First of all, do you have an opinion as to
10 whether it's proper to apply inpatient market
11 share here?

12 A: I do have an opinion.

13 Q: And what is it?

14 A: I do not believe it's appropriate. And I won't
15 repeat my testimony from direct. But the
16 inpatient acute care market is much different
17 from the outpatient radiation therapy market.
18 In terms of the number of competitors, the
19 historical reputation and presence of those
20 competitors, there would be no reason to expect
21 -- another concern that I have that goes across
22 all of these different columns is Mr. Tolbert
23 never made any adjustment for the AUC patients,
24 which we know were 44 percent roughly of the
25 total treatments in 2012. And so he's applying

1 the market share to the totality of the
2 treatments that he's projected when we know
3 that 44 percent of those are not really in play
4 for Grand Strand. Another concern I have is
5 that the 35 percent number apparently came from
6 a presentation made at Grand Strand that
7 reflected 2009 acute care market share data
8 rather than using more recent data. And not
9 only that, but he took a number that was market
10 share just for Grand Strand's primary and
11 secondary service area, which is much smaller
12 than the three-county area, and then applied
13 that market share to the three-county area. So
14 I think there's a number of deficiencies with
15 it. I think it's a poor metric to use to begin
16 with to project radiation therapy treatment
17 when you have such an entrenched provider as
18 you have in this case with CRCC. He's using
19 old data. I think he's inappropriately
20 applying the market share to the entire market.

21 Q: I believe Mr. Tolbert indicated that if you
22 carved out the prostate cancer treatments that
23 would cause you to have to adjust market share.
24 Did you understand what he meant by that?

25 A: I think I did. I think what he was saying,

1 well, if you shrunk the market then you would
2 assume that the market share would be higher.
3 But that would not be giving proper effect to
4 the fact that a portion of the market is simply
5 not available. If you think about it, Grand
6 Strand, if they get approved, and let's assume
7 that CRCC is also approved, then CRCCs going to
8 have four units. They're going to have them
9 potentially in three different locations. And
10 Grand Strand will have one unit. So they would
11 have 20 percent of all the units. And
12 geographically, they would not be as well
13 positioned as CRCC would within Horry County in
14 order to -- and Georgetown County to serve that
15 population.. So it's hard to envision a
16 scenario where 44 percent of the market is not
17 in play, you've only got 20 percent of the
18 units, you're a brand new provider up against
19 entrenched existing provider and you're going
20 to get 35 percent of the market. I just don't
21 see how that all works out.

22 Q: Okay. In terms of inpatient market shares, do
23 you have an opinion with respect to the overall
24 use of that metric to estimate Grand Strand's
25 year three volumes?

1 A: Yeah, I think it's totally inappropriate, and
2 I think Mr. Tolbert, more or less, agreed with
3 me because I think he said in his testimony and
4 in his deposition that he thought that the
5 result of this, that Grand Strand would be
6 serving 11,138 patients was farfetched.

7 Q: Look at column E for me, it's right next to F
8 on Tolbert 12904 in Respondent's 12?

9 A: Yes.

10 Q: What, if any, opinions do you have about what
11 Mr. Tolbert did in column E?

12 A: Well, my understanding that the 30 percent
13 oncology market share that he used here came
14 from that same presentation at Grand Strand
15 that was relying on 2009 data. And again, it
16 was service area, market share that he applied
17 to a broader area, which is inappropriate.
18 It's old data and he didn't make any adjustment
19 for the AUC volumes in the market.

20 Q: You think it's appropriate to apply oncology
21 inpatient market share to the outpatient
22 radiation therapy treatments?

23 A: I don't. I mean, particularly given all the
24 circumstances that I've already described in
25 terms of the structure of the market and the

1 historical presence of CRCC. You know, it's
2 closer than acute care market share, but I
3 think it still has deficiencies as I described.

4 Q: And does column E account for the prostate
5 cancer treatments referred by AUC?

6 A: It does not. It's applying 30 percent to the
7 entire data market. And let me just make my
8 other point that I made earlier just to
9 reiterate it. He's calculating the treatments
10 based on 25 treatments per patient when I
11 believe that the number should be 21. So I
12 think all these numbers should be reduced by
13 about 20 percent.

14 Q: What, if any, opinion do you have with respect
15 to the use of the inpatient oncology market
16 share metric to estimate the radiation therapy
17 volumes for Grand Strand's year three of
18 operation?

19 A: I just don't think it's directly applicable for
20 projecting that. I think you have to kind of
21 build up the market share for radiation
22 separately. The inpatient oncology market is
23 much different. You've got different
24 competitors and different locations and you've
25 got a different pool of patients you're dealing

1 with. Not patients that have to come 30 or 40
2 times on a daily basis for treatment, they're
3 coming one time to the hospital. So patients
4 might be willing to travel farther for a one
5 time hospital stay than they would be for 35
6 treatments.

7 Q: Let's look at column D in Respondent's 12 on
8 Tolbert 12904. I think this one's entitled
9 Grand Strand actual 2012 market share
10 (adjusted) in region. What's your
11 understanding of what Mr. Tolbert did here?

12 A: Based on his testimony and reviewing the
13 exhibit, he attempted to adjust Grand Strand's
14 inpatient market share.

15 MR. THOMAS: Roshel, will you go to page Tolbert
16 12906 for me.

17 Q: Is this that adjustment analysis?

18 A: It is.

19 Q: What opinions do you have with respect to what
20 Mr. Tolbert did here?

21 A: I believe that the adjustments he made are
22 really inadequate to deal with all the issues
23 associated with determining market share for
24 radiation therapy services in this
25 circumstance. First of all, for the first

1 time, he looked at what Grand Strand's market
2 share was in all three counties, rather than
3 just in their primary and secondary service
4 areas, so I think that's more appropriate. But
5 rather than reduce the size of the market by
6 the urologist patients, he simply backs out
7 urological surgery patients from Grand Strand's
8 historical base, and which is a much smaller
9 impact in terms of looking at the overall
10 market. In fact, Grand Strand's market share
11 of urological surgery was 25.4 percent. And
12 without getting too detailed into the math
13 here, he actually increased Grand Strand's
14 market share by taking urological surgery out
15 of this because urological surgery had a lower
16 market share than the rest of the acute care
17 services. So rather than adjusting it
18 downward, he adjusted it upward by taking
19 urological surgery out in this fashion.

20 Q: You think that was proper?

21 A: It was not. You know, and generally this
22 suffers from the same overall problem I had
23 with column F, and that is that it's using
24 inpatient market share as the metric he used to
25 project outpatient radiation therapy market.

1 Q: What's your overall opinion with respect to the
2 use of this metric in column D to estimate
3 Grand Strand's radiation therapy volumes for
4 three year of operation?

5 A: I think it's inappropriate and without
6 foundation.

7 Q: Would you go back to Tolbert 12904 for me in
8 Respondent's 12. Take a look at column C
9 there, Mr. Sullivan, Tolbert projected shift to
10 Grand Strand from CRCC. What are your opinions
11 about the column C analysis?

12 A: Well, you know, it again is based on an
13 unadjusted market without taking out the
14 urological referrals.

15 Q: Let me ask you this. On C, is this -- hold on.
16 It that the one based on ...

17 A: It's based on his 2012 impact analysis of
18 referrals.

19 Q: In Respondent's 10?

20 A: It is.

21 Q: Okay. All right.

22 A: And so that was that referral analysis. I
23 think I've already talked about what I thought
24 was deficient with that one.

25 Q: Okay. You think that, just for the record,

1 that was an appropriate metric to use to
2 project Grand Strand's volume for year three of
3 operations?

4 A: I don't.

5 Q: Okay. And in column B, I think it's entitled
6 2012 oncology market share reported by
7 Sullivan. What, if any, opinions do you have
8 about this column?

9 A: First of all, I don't think it was reported by
10 me. I think this was internal data that Grand
11 Strand had produced from the Office of Research
12 and Statistics. So and, you know, this number
13 is getting closer, I mean in terms of, you
14 know, what I think a reasonable number is in
15 terms of market share. I mean it's close to
16 what I projected in the CON application when
17 I did the three-county analysis for Horry
18 County. But it still overstates it for the
19 three-county area. If you remember back to
20 that exhibit we looked at a minute ago, Grand
21 Strand has a relatively high market share in
22 Horry County, but only had a 8.5 percent market
23 share in Georgetown County and less than a one
24 percent market share in Williamsburg County.
25 And so I think this is -- it suffers from the

1 same flaws as the other methodologies in that
2 it doesn't consider the specific factors. It
3 doesn't adjust for the urological patients that
4 are not in play and it uses the 25 treatments
5 per patient method.

6 Q: Okay. Do you have an opinion with respect to
7 the use of this metric to estimate Grand
8 Strand's third year volumes?

9 A: Again, I think it's not reliable.

10 Q: Let's look at column A. Well, first of all, in
11 your opinion, are the analyses, or any of the
12 analyses set forth in B through F reliable?

13 A: No.

14 Q: Column A, what are your opinions about column
15 A?

16 A: Well, first of all, it's based on what I did in
17 the application reflected forward to 2017, so
18 I like it in that regard. I think he, again,
19 uses the 25 treatments per patient, which I
20 think is inappropriate. And had he used 21
21 there, I think he would have gotten a different
22 market share instead of 15.5, it would have
23 been higher. It would have been more like 18
24 percent, which I think is reasonable for the
25 three-county area. So I think this column,

1 which is based on my projections, is a
2 reasonable reflection of what the impact is
3 going to be on the existing providers. And if
4 we look at the line that says utilization of
5 existing machines that's in the middle of the
6 page, it shows that all the providers would be
7 above 80 percent under that scenario.

8 Q: And is that 82.3 percent for, is that third
9 year of operations?

10 A: It is for 2017.

11 Q: Do you expect growth in the market beyond the
12 third year of operations?

13 A: I would. I mean the population is growing and
14 aging in Horry and the other two counties.
15 Based on the cancer incidence data that I've
16 seen, the cancer incidence rates are relatively
17 stable in the market. You know, we've done a
18 good job in terms of death rates from cancer,
19 but incidence rates remain sort of stubbornly
20 high in a lot of areas. It appears that this
21 area is one of those. And so I would expect
22 there to be future growth, yes.

23 Q: Do you have any opinions as to whether CRCC is
24 going to be financially harmed at the levels
25 reflected in column A?

1 A: In my opinion, they would not. As I said
2 before, you know, my projection was that they
3 would lose six to seven hundred treatments for
4 scope of operations they have and the level of
5 profitability that we looked at earlier. In my
6 direct testimony, I don't see any potential for
7 serious financial harm to CRCC.

8 Q: Okay. Let's go to Respondent's 8, if we could.
9 I think this goes along with maybe 139 and 142.
10 So we'll get to those. But, first of all, in
11 terms of the analysis done on Respondent 8,
12 first of all, what is this analysis of, if you
13 could let the court know?

14 A: I believe that this is what Mr. Tolbert
15 testified to was he was looking at the first
16 requirement in the State Health Plan for
17 approval of the new unit, that is that existing
18 providers be above 80 percent utilization,
19 which is sort of a trigger, I think he called
20 it a trigger, for a need determination. And I
21 think what he was doing here was calculating
22 what that number would be in 2013 based on some
23 estimates that he knew.

24 Q: What opinions do you have with what he did on
25 this page here?

1 A: Well, I think I understand what he did and from
2 looking at the exhibits and his testimony. He
3 took seven month's worth of data from CRCC and
4 then assumed that there was going to be a 10.3
5 percent annual reduction in CRCC's volume in
6 2013. And he assumes that Georgetown's volume
7 would be the same in 2013 as it was in 2012.
8 Then he calculated what the utilization rate
9 would be of the existing machines under those
10 assumptions.

11 THE COURT: Did 10. what percent?

12 MR. SULLIVAN: 10.3 percent downward reduction in
13 CRCC's volume.

14 Q: And go to Respondent's 139 for me. Is this
15 your understanding of how Mr. Tolbert
16 calculated the ten point -- the negative 10.3
17 percent?

18 A: It is.

19 Q: What, if any, opinions do you have ---

20 THE COURT: That's Respondent's?

21 MR. THOMAS: 139, Your Honor.

22 Q: What opinions, Mr. Sullivan, do you have about
23 the way Mr. Tolbert arrived at this number,
24 negative 10.3 percent, the projection for 2013
25 as a whole?

1 A: Well, he looked at what happened during the
2 first seven months and saw that there was a
3 10.3 percent reduction. And he said, you know,
4 he was basing that on what happened in 2012.
5 Well, there's no evidence that 2012 was
6 representative of what the first seven months
7 typically looks like. It could have been
8 aberrational. He didn't look at earlier years
9 to see if there was indeed a seasonality trend
10 in the volumes where you have a
11 disproportionate percentage of your treatments
12 in the first seven months of the year versus
13 the last five months of the year. If you
14 simply annualize these numbers and that is
15 divide the 12,904 by seven and then multiply
16 that by 12, you come up with a very small
17 difference between 2012 and 2013. You come up
18 with about 22,000 treatments in 2013 on an
19 annualized basis. So if he had annualized
20 these numbers, you know, he would have found
21 that the decline would have been very small.
22 I mean, I think less than maybe one percent or
23 two percent. And so he chose to do it this
24 way. I don't think it's really based on
25 anything other than just take a one year

1 snapshot of what happened in 2012.

2 Q: What, if any, opinions do you have about this
3 idea, suggestion that maybe radiation therapy
4 treatments are influenced by seasons?

5 A: I've not seen that in my experience, I mean
6 other than during the holidays, a lot of people
7 will delay treatment between Thanksgiving and
8 Christmas and not start until after the
9 holidays are over. But, you know, in the work
10 that I've done in the past I've not noticed a
11 strong seasonality trend. That may be
12 different if you were living, you know, in some
13 part of the country where, you know, there was
14 some explanation for that. But I just haven't
15 seen it in my work.

16 MR. THOMAS: Would you put up Respondent's 142.

17 Q: Did you have an opportunity to kind of look at
18 the different referrers and compare them to the
19 previous years?

20 A: I did.

21 Q: And is this the list you looked at for January
22 2013 through July 2013?

23 A: It is.

24 MR. THOMAS: Put up Petitioner's 85.

25 MR. LONG: Your Honor, I want to renew my objection

1 to this exhibit and ask that he not be allowed
2 to ask questions about it. It was produced to
3 us on Thursday night at the conclusion after
4 the sixth day of trial. It's based on -- it's
5 well past the deadlines. It's based on
6 information that was provided within the
7 deadlines and then they waited until every
8 witness in the case but one had testified. And
9 then they sent it to me at six o'clock at
10 night. And I think it comes too late, and so
11 I don't think it's appropriate to be used as an
12 exhibit. I don't even think it's even a proper
13 summary because it's not a summary of
14 voluminous data. It's a summary of these pages
15 here, but it doesn't -- it does math
16 calculations on it. So it's not like it's, you
17 know, the first column you could say, well,
18 that might be a summary because it lists those
19 doctors with their 2012 to date, but then you
20 look at the next column and -- or I could say
21 maybe it's the first two columns might be a
22 summary, but then he does math. He gives
23 percentages on it, which are not contained in
24 the document at all. I just think, I mean,
25 it's just, you know, it just comes way late in

1 the case, Your Honor. I mean, Mr. Thomas is
2 taking a pretty -- you know, he's objected to
3 our exhibits and stuff. And I just think this
4 comes too late and it's fundamentally unfair.

5 MR. THOMAS: First of all, I don't think it's
6 fundamentally unfair. Like Mr. Long said, he
7 told me that he was going to object to this
8 Friday if I tried to introduce it with Mr.
9 Tolbert. And so I didn't. I didn't introduce
10 it with him and told him I would on Monday. So
11 I don't think there's anything in here that's
12 particularly earth shattering. A lot of the
13 different exhibits we've already done.
14 Certainly, new calculations and new math are
15 present to mathematical calculations. Your
16 Honor, I'll be perfectly honest with you, you
17 know, I wish I could think of every single
18 exhibit before any deadlines, but I got
19 Respondent's 142 on like the last day, sometime
20 in very late August and, you know, didn't have
21 a chance to look at it as closely as I would
22 have. What I can do, I mean I'd like to get
23 it in as an exhibit, Petitioner's 85. I could
24 certainly just use it demonstratively and have
25 Mr. Sullivan explain what he did and how he did

1 it and what it says. And then that's all in
2 the record anyway, but this just makes it a lot
3 easier for Your Honor to understand or to
4 comprehend it in kind of the post-trial phase.

5 MR. LONG: Your Honor, I would also point out that
6 while Mr. Thomas' objection that he basically
7 has ruled it out because it's obviously a new
8 matter for rebuttal. He didn't ask Mr. Tolbert
9 about it and he's apparently going to say to
10 Mr. Sullivan did the work ---

11 THE COURT: Well, my ruling was going to be that
12 I'll allow him to use it as a demonstrative
13 exhibit and then at the conclusion examining
14 Mr. Sullivan about it, I will make a
15 determination at that point in time whether
16 I'll allow it into evidence.

17 MR. THOMAS: This is certainly not a new matter.
18 They discussed Respondent 8 as well.

19 THE COURT: I can determine that as we go through the
20 testimony.

21 MR. THOMAS: All right.

22 Q: Mr. Sullivan, can you take the court through
23 what you did here on this particular exhibit?

24 A: Sure. I mean, the top half of this is
25 addressing the issue of what happened between

1 2012 and 2013 overall for CRCC. The top line
2 says that there were 22,798 total treatments in
3 2012, 12,904 treatments through July 2013 for
4 seven months. And as I just described, I
5 annualized it by dividing by seven and
6 multiplying by 12. And that shows about a
7 three percent reduction I think. I think I
8 said one to two, it's about a three percent
9 reduction in volume in 2013 over 2012. Total
10 treatment plans are down six percent using this
11 approach. AUC treatment plans are down,
12 however, 19 percent. And when we look at the
13 total treatment plans from the Coastal Carolina
14 medical oncologists, they're down only very
15 slightly, less than one percent. And then the
16 total from other physicians are essentially
17 flat with almost no change. So really all of
18 the -- or not all of it, but the significant
19 majority of the change that occurred between
20 2012 and 2013 was in the urologists.

21 Q: Okay. So what's the bottom half of the chart
22 tell you?

23 A: It shows for the AUC physicians the comparison
24 between '12 and '13 for those physicians. And
25 what it shows is that overall they were down by

1 58 referrals, which is 19 percent as shown
2 above, and that more than half of that was
3 attributable to one doctor, Dr. Gangi. I know
4 there was some testimony about Dr. Gangi being
5 in a transition period, bringing on a new
6 associate, but we don't see that volume
7 necessarily shifting over to some other
8 provider. So what we have is a seven month
9 snapshot. You see one doctor's practice
10 heavily influencing that change that occurred
11 between 2012 and 2013. We don't know whether
12 this is a one time aberration. We don't know
13 whether it's just a short-term aberration that
14 going to be a change in the second-half of the
15 year that Dr. Gangi is going to do more volume.
16 We don't know whether a new associate or some
17 other doctor's going to pick up additional
18 patients because Dr. Gangi is doing less.
19 There's many things we don't know. But I think
20 what it points out is there's this sort of
21 anomaly in the utilization pattern that
22 occurred by the employee physician group. And
23 certainly, I wouldn't want to base any
24 decisions on a snapshot for seven months out of
25 the year when we see an anomaly like this and

1 we don't know whether this is something that's
2 going to continue on in the future.

3 MR. THOMAS: Your Honor, at this time I would ask
4 that Petitioner's 85 be an exhibit, introduced
5 into evidence.

6 MR. LONG: Same objection, Your Honor. He didn't
7 ask him if he prepared this. That was going to
8 be my first question on cross-examination, if
9 he actually did the work on this or not.

10 Q: Did you prepare this, Mr. Sullivan?

11 A: I did.

12 MR. LONG: I still stand on the same objections,
13 Your Honor. I think this comes late. It's
14 unfair.

15 THE COURT: I don't find the prejudice in that
16 regard, especially since he just testified. So
17 I'm going to overrule your objection.

18 MR. THOMAS: Thank you, Your Honor.

19 Q: Mr. Sullivan, if you would turn, well, I'm not
20 going to make you turn to this one. Mr.
21 Tolbert went through a comparative review of
22 compliance with the State Health Pplan and
23 project review criteria I think in Respondent's
24 6. Did you have an opportunity to review that?

25 A: I did.

1 Q: Okay. And did you do a similar comparison on
2 direct exam?

3 A: I did.

4 Q: And do you stand by the testimony that you did
5 on direct?

6 A: I did. I mean nothing that Mr. Tolbert
7 testified to changed my initial opinions.

8 Q: Okay. Based on the testimony of Mr. Tolbert
9 and the other, I guess, fact and expert
10 witnesses for CRCC, has your opinion changed
11 regarding whether both applications can be
12 approved without bringing the existing
13 providers under the 80 percent threshold?

14 A: My opinion hasn't changed. I believe they both
15 can be approved without dropping the two
16 existing providers below 80 percent.

17 Q: What opinions do you have with respect to Grand
18 Strand's project adversely impacting either
19 CRCC or Georgetown Murrells Inlet projections
20 based on the same testimony of those fact and
21 expert witnesses for CRCC?

22 A: Well, I don't believe there's any evidence that
23 Grand Strand would have any material effect on
24 Georgetown. And I believe that the impact on
25 CRCC, because of the growth in the market, is

1 going to be, on an absolute basis, it's going
2 to relatively small, and that from a scope of
3 operation standpoint, the impact in terms of
4 financial is going to be small. So I don't
5 think that the impact is really, should be
6 given any significant weight in the evaluation
7 of this project.

8 Q: Based on the testimony of Mr. Tolbert and the
9 other fact and expert witnesses for CRCC, has
10 your opinion changed regarding whether both CON
11 applications of standing alone in a non-
12 competing situation can be approved under the
13 State Health Plan and CON Act?

14 A: My opinion remains the same.

15 Q: Which is?

16 A: That each standing alone could be approved.

17 Q: And if this Court finds that they are
18 competing, the applications are competing, as
19 Mr. Tolbert has alleged, has your opinion
20 changed as to what project should be approved
21 based on the testimony of CRCC's fact and
22 expert witnesses?

23 A: It has not. Based on everything that I
24 testified to previously, I believe that Grand
25 Strand presents the best alternative and should

1 be the applicant approved if these were deemed
2 competing.

3 Q: Please answer any questions that Mr. Long has
4 for you.

5 MR. LONG: Your Honor, I would like to take a break,
6 if I could for a few minutes.

7 THE COURT: All right. Take a short break.

8 MR. LONG: Thank you.

9 (Break from 11:07 a.m. until 11:17 a.m.)

10 MR. SULLIVAN - REBUTTAL CROSS-EXAMINATION BY MR.

11 LONG:

12 Q: All right. Mr. Sullivan, just a little while
13 longer, not much. Now, you realize that Grand
14 Strand has the burden of the proof in this
15 case, right?

16 A: I do.

17 Q: And in regards to that, you never did an
18 analysis of the physician referrals or the
19 redirection or change in physician referrals
20 from Grand Strand becoming a provider. You
21 just never did that analysis, did you?

22 A: Right. I think as I testified on my direct, I
23 started down that path, but then realized I
24 couldn't do it reliably.

25 Q: You actually suggested it in your deposition,

1 right?

2 A: I said it was something that I was going to
3 look at because I had gotten the referral data
4 and I hadn't had a chance to really analyze it
5 in-depth, so.

6 Q: So Mr. Tolbert did what you suggested in a
7 deposition and then, of course, he got cross-
8 examined for a few hours on it. But you never
9 did do the analysis, right?

10 A: I did not. I mean I started on the path, but
11 I never completed it.

12 Q: All right. And you never did, you never
13 revised your projections from the original CON
14 applications regardless of any additional
15 information that's been provided, right?

16 A: True.

17 Q: You actually have not even come to court and
18 revised it for 2017, have you? You've just
19 relied on Mr. Tolbert's work in doing that,
20 right?

21 A: Yeah, I just thought rather than argue about
22 that, that I would just adopt his numbers.

23 Q: And you've opined and I guess criticized in a
24 professional way Mr. Tolbert's market share
25 work, right?

1 A: I have.

2 Q: And a big portion of that has been a resulted
3 of a relationship -- the relationship that
4 exists between the physicians, urologists, and
5 CRCC, right?

6 A: That's a significant factor, yes.

7 Q: Okay. Now, in your analysis of doing market
8 share, well, let's take a look at Grand Strand
9 Exhibit Number 16, which was purported to be
10 your backup work for your analysis, your backup
11 paper, I guess it was called or whatever. Do
12 you agree with that characterization?

13 A: Yes.

14 Q: At this exhibit, will you take the book,
15 because it's a few pages and you can confirm it
16 for me without it.

17 THE COURT: You said Petitioner's 16? That's
18 emails, isn't it?

19 MR. LONG: Yeah, I'm sorry. It Petitioner's 16,
20 right.

21 THE COURT: Okay.

22 MR. LONG: The first page is an actual email, then
23 there's pages afterwards.

24 THE COURT: Oh, okay. Sure.

25 Q: And since it is kind of somewhat voluminous, we

1 can roll through it on the screen if you want.

2 But if you could just tell me -- I don't see
3 any market share data in this exhibit at all.

4 I see population. I see zip codes. I see ACR
5 guidelines. I don't see anything that relates
6 to market share.

7 A: You're probably correct. I was familiar with
8 Grand Strands market share because I had just
9 done a couple of acute care projects for them.
10 So I didn't -- I mean, I knew what their market
11 shares were. I didn't have to re-analyze that
12 for this project.

13 Q: You just knew off the -- I mean, what did you
14 know the market share percentage was?

15 A: Well, I knew, for example, I had the data
16 already because I had done their acute care
17 expansion application where they went for
18 additional beds. I think that was either right
19 around this time or shortly before or shortly
20 thereafter and I had that data in that file.
21 And so I knew what their market shares were for
22 their primary/secondary service area because I
23 used that data directly in projecting volumes
24 for that.

25 Q: But you made no calculations in regards to this

1 case as to what, or no analysis really of what
2 the market share would be like Mr. Tolbert did
3 in Exhibit 12, right?

4 A: I would disagree with that. I mean I knew what
5 the inpatient market shares were, but I thought
6 that this project was so different in terms of
7 the market in which they would be operating, so
8 I really had to start from scratch. And so I
9 think I described in my direct exam how I went
10 about doing that.

11 Q: Well, it's not really a different market. I
12 mean, you've done radiation therapy projects
13 before, right?

14 A: I have.

15 Q: And you criticized the use of inpatient market
16 shares, a proxy for radiation therapy, correct?

17 A: In this case, yes. Because of the, you know,
18 each market is different. You know, if there
19 were no competitor in the market, you might
20 start off looking at inpatient market share as
21 a base, but in this case where you had an
22 entrenched competitor, I didn't think inpatient
23 market share was a good reflection.

24 Q: Well, you still have not put forward a proxy
25 market share in your testimony as what you

1 think should have been done, right?

2 A: I think what's in the application is my -- I
3 didn't put a proxy for it. I put what I think
4 is reasonable in light of all the factors that
5 I've already discussed in terms of the number
6 of units, the distribution of units, the
7 significant operating history of CRCC. So I
8 knew that -- I knew what the market shares were
9 for acute care. My expectation was that the
10 market shares for radiation were going to
11 materially less than that.

12 Q: And so you just picked them. You basically
13 were familiar with their market share from a
14 different application and then you just picked
15 market share numbers that you thought would be
16 reasonable yourself, right?

17 A: That's true.

18 Q: With no other analysis of other service lines
19 or actually doing analysis for this case?

20 A: Well, not exactly true. I had all kinds of
21 market share data for Grand Strand from my
22 other work with them. So I had a pretty good
23 idea of what their market shares were. I
24 thought I adjusted everything downward for
25 radiation therapy.

1 Q: Well, none of that information was produced in
2 the case related to this case, right?

3 A: It wasn't because I didn't use it directly in
4 this case.

5 Q: And now you actually -- you also have never
6 done an adverse impact analysis in this case
7 either, have you?

8 A: In the application and in additional
9 information, I presented an adverse impact
10 analysis.

11 Q: Well, Mr. Sullivan, you've done this work for
12 a long time. Isn't it typical in many cases
13 that experts would do a formal adverse impact
14 analysis where they actually calculate the
15 exact number of lost cases and then what the
16 impact would be on their providers by looking
17 in the future, calculating the lost cases and
18 then calculating what everyone's utilization
19 would be? You never did that in this case, did
20 you?

21 A: I guess I would disagree with that. In both
22 the application and the additional information,
23 I talked about what the growth was going to be
24 in the market, what our projection was, and the
25 difference between those being the -- and I

1 gave a specific number being the adverse impact
2 on CRCC.

3 Q: And you presented, but you have no ---

4 THE COURT: Wait a second, you've looked at -- I
5 didn't catch all. You looked at the growth in
6 what?

7 MR. SULLIVAN: In the market, I looked at, you know,
8 how much there was going to be an increase in
9 utilization in the market as a whole in the
10 three-county area. And I don't remember the
11 numbers exactly -- well, maybe I do. I
12 projected there were going to be 194 additional
13 cases in the market area. We were projecting
14 220 patients, and so I projected the impact on
15 CRCC would be 26 lost cases net over where they
16 are today and multiplied that by 21 and came up
17 with an estimate of 500 and something
18 treatments. And I think revised that slightly
19 in the additional information to about 600.

20 Q: Basically, what you did is you assigned all of
21 the growth in the service area to Grand Strand
22 and then you just subtracted out what the
23 difference would be and you said that's the
24 impact to CRCC, right?

25 A: Not exactly. I mean, what I did is I said if

1 there are X number of patients today and
2 there's Y number of patients in the future and
3 we take Z patients from there, how many are
4 left over for everybody else. And the pool
5 that's left over for everybody else is 26 less
6 than what was projected for Grand Strand.

7 Q: And the pool that's left over for everybody
8 else gets assigned 100 percent to Grand Strand,
9 except for the 26, but it's assigned 100
10 percent to Grand Strand?

11 A: If you want to look at it that way. I mean,
12 what I'm saying is the market as a whole is
13 expanding. In theory, if Grand Strand takes
14 220 cases out, that means that the rest of the
15 market is still available to Georgetown and to
16 CRCC.

17 Q: And you have certainly opined in other cases
18 that existing providers are entitled a
19 percentage of any growth in the market, right?

20 A: Sure. I mean, if you're looking at sort of
21 incremental financial impact, then I would
22 assign growth and, you know, and sort of dead
23 weight loss, you know, to that impact.

24 Q: Other than what you did in the application,
25 which was filed in July of 2011, you presented

1 no exhibits of any updated, revised adverse
2 impact analysis?

3 A: Well, at this ---

4 Q: There's no exhibit from you that has a adverse
5 impact analysis, is there?

6 A: I believe that I presented an exhibit that took
7 Mr. Tolbert's number and looked at what I
8 thought was a realistic adverse impact using
9 his assumptions.

10 Q: Well, you have criticized Mr. Tolbert's work,
11 but I'm talking about your work.

12 A: I didn't do one independently, no.

13 Q: That was my question. Now, have you -- you
14 have also not done an independent statistical
15 analysis of how the approval of both
16 applications would drive the existing units
17 below 80 percent, have you, independent?

18 A: Well, I think I have. I've analyzed Mr.
19 Tolbert's exhibits in several different ways.

20 Q: Exactly. You've analyzed Mr. Tolbert's work
21 and given opinions off of it. I'm asking you
22 if you have presented an exhibit to this court
23 that is your independent work of what you think
24 the result would be if the approval of the --
25 whether the approval of both would drive the

1 existing units below 80 percent?

2 MR. THOMAS: I'm going to object on the relevance,
3 Your Honor. I mean, Mr. Sullivan's testified
4 that he did do an analysis using Mr. Tolbert's
5 work, and I don't see how the fact that he did
6 something, just starting from scratch on his
7 own is even relevant.

8 THE COURT: I overrule that objection.

9 MR. LONG: Thank you.

10 A: Other than taking Mr. Tolbert's assumptions and
11 applying what I thought were more realistic
12 assumptions, no, I haven't done anything else.

13 Q: Okay. Now, you think or you have opined about
14 this impact that the market share numbers need
15 to take into consideration the AUC referrals
16 staying with CRCC. If the vast majority, if
17 not the totality, of the Atlantic Urology
18 referrals would stay with AUC, you've opined
19 that that should be considered, right?

20 A: Yeah, I think you have take it off one side or
21 the other. You either have to produce the
22 market share to take that into account that
23 you're not going to be able to capture as high
24 a percentage of the market, or you have to
25 reduce the size of the market by the AUC volume

1 and then apply it with, you know, what you
2 think is a realistic market share to that. So
3 it has to come off one side or the other.

4 Q: Wouldn't you likewise agree that the
5 relationship Dr. Holt and the Grand Strand
6 should be considered to determining market
7 share?

8 A: Sure. I mean, you know, Grand Strand had to
9 get referrals from somewhere and our assumption
10 was that we would get them in large part from
11 the medical oncologists.

12 Q: Okay. And since this case, since we began the
13 discovery phase of this case when we moved it
14 to the Administrative Law Court, we've learned
15 that the very first phone call that you ever
16 had with Grand Strand, Dr. Holt was on the
17 line, right?

18 A: The first ---

19 Q: The first conference you had with Grand Strand
20 about this application Dr. Holt was on the
21 line?

22 A: I think that's correct.

23 Q: And we've heard no testimony that Dr. Holt was
24 ever on a phone call with any other applicant,
25 right?

1 A: I've not heard any testimony.

2 Q: Okay. You've also heard the testimony and seen
3 the emails about this timeline, number seven,
4 which I understand is not in evidence, it's a
5 demonstrative, that there were months of
6 conversations between Grand Strand and Dr. Holt
7 about locating the radiation therapy center not
8 at the hospital but in Dr. Holt's parking lot,
9 right?

10 A: Right.

11 Q: Which would have been a freestanding center if
12 it was in the parking lot, right?

13 A: It would.

14 Q: And since the case, or we also know from the
15 case that you -- well, let's look in the
16 application at some of the many places in which
17 Dr. Holt is referenced, okay? Let's take a look
18 at Grand Strand Joint Exhibit Number 2.

19 A: Okay.

20 Q: The Grand Strand CON. Joint Exhibit Number 2.

21 A: Okay.

22 Q: First page would be page seven.

23 A: Yes.

24 Q: All right. Question two, which is a
25 description of the project and the very first

1 paragraph at the bottom of the paragraph is two
2 or three sentences that reference Coastal
3 Cancer Center, right?

4 A: True.

5 Q: And it talks about the convenience to the
6 patients of having a radiation therapy center
7 close to Coastal Cancer Center, right?

8 A: Yes.

9 Q: As a place where y'all would get -- where Grand
10 Strand would get patients, right?

11 A: Correct.

12 Q: Look over at 23, the bottom of that page.
13 Several paragraphs, right at the beginning of
14 B, under the Section B there?

15 A: Right.

16 Q: Talking about emphasizing for the Department
17 Grand Strand's relationship with the medical
18 oncologists of Coastal Cancer, right?

19 A: True.

20 Q: It talks about all the different things,
21 services Coastal Center provides, right?

22 A: Right.

23 Q: And how close their office is to Grand Strand?

24 A: Correct.

25 Q: And how important it is for the close proximity

1 -- how beneficial it is for the close
2 proximity, right?

3 A: Yes.

4 Q: So these are the things that Grand Strand,
5 through yourself are emphasizing to the
6 Department, right? The relationship between
7 Grand Strand and Dr. Holt, correct?

8 A: Or Coastal Cancer Center.

9 Q: Or Coastal Cancer Center. Page 31, we're now
10 in the B -- now we're in the B-11 analysis that
11 you prepared, right?

12 A: Correct.

13 Q: And at the bottom of page 31, you emphasized
14 that the medical oncologists of Coastal Cancer
15 Center are a major referral source. That would
16 be a major referral source for Grand Strand,
17 right?

18 A: Correct.

19 Q: Page 33, second full paragraph, second
20 sentence. Grand Strand has received
21 significant support from medical oncologists,
22 surgeons and other physicians who are potential
23 referral sources for radiation therapy
24 services. It's discussed in more detail under
25 criteria 8. So those are the actual referral

1 sources for the Grand Strand facility, right?

2 Medical oncologists, surgeons, other
3 physicians?

4 A: Yes.

5 Q: Page 36. I want to talk to you about this.

6 This is actually question 12 where Grand Strand
7 discusses for the Department the alternatives,
8 okay?

9 A: Yes.

10 Q: And in the first alternative it says maintain
11 the status quo. And it says, basically, if we
12 don't get a center, the patients of Coastal
13 Cancer Center will not be able to receive this
14 benefit that we're going to offer, right? So
15 when we look at the first question is, maintain
16 the status quo. In other words, not build it,
17 the reason to build it is because of Coastal
18 Cancer Center, right? That's what it says,
19 right?

20 A: Yeah. I mean, it says other things too, but
21 that's part of the reason.

22 Q: Now, let's look at question number two on the
23 next page. It says on the second sentence,
24 "Coastal Cancer Center estimated that
25 approximately 70 percent of all of its new

1 cancer patients in Horry County, which numbered
2 1,054 in 2010, were seen in its Myrtle Beach
3 office." First, did you get information
4 directly from Coastal Cancer Center in regards
5 to its volumes?

6 A: I did not. I saw this information in the draft
7 of the application I reviewed. I didn't
8 prepare this section of the application.

9 Q: So you did not write this?

10 A: Not this section.

11 Q: Do you know who did?

12 A: I don't for sure.

13 Q: All right. Can you get -- you can't get
14 information about -- you can't get this kind of
15 information about the number cases that Coastal
16 Cancer Center would have seen in the Myrtle
17 Beach office from any sort of published source,
18 can you?

19 A: You cannot.

20 Q: Okay. And really the only way this information
21 could have been provided to Grand Strand was
22 for Coastal Cancer Center to have voluntarily
23 give it to them, right?

24 A: I would agree with you.

25 Q: Okay. So, obviously, someone, not yourself,

1 was talking to Coastal Cancer Center and asking
2 them to give them information, statistical
3 information about their practice to use in the
4 application, right?

5 A: I think that's a logical inference.

6 Q: Okay. And that's a very significant number,
7 isn't it, a 1,054 patients in 2010?

8 A: Right. Now, not all of those were new
9 patients. But, I mean, obviously because the
10 area didn't -- I don't think would have that.

11 Q: It says new in the sentence.

12 A: Does it say that?

13 Q: Yeah. It says new. They treated about 1,054
14 new patients in 2010.

15 A: Okay. Well, maybe that's right. Yeah, I don't
16 know the source of it, but yeah. That's a
17 large number.

18 Q: You know we never saw any documents or
19 communications between Grand Strand and Coastal
20 Cancer Center about this information or really
21 any information. Do you have any explanation
22 for that?

23 A: I would assume everything was done via
24 telephone calls.

25 Q: Okay. If 1,054 cancer patients are seen in the

1 Myrtle Beach office at Coastal Cancer Center
2 and 55 percent of those patients were treated
3 for radiation therapy, wouldn't that be 580
4 radiation therapy patients in 2010 at Coastal
5 Cancer Center?

6 A: 577, but we know that's probably not correct
7 because based on the data that I've seen from
8 CRCC's production, I never saw a number that
9 high coming from the doctors at Coastal Cancer
10 Center.

11 Q: You cast doubt on this data in the application,
12 right?

13 A: Well, I mean, I don't know. I wasn't involved
14 in collecting the data. But, you know, I
15 recall in 2012 the Coastal Cancer physicians
16 referred 275 patients.

17 Q: Well, they also could have referred patients to
18 Georgetown, right?

19 A: It's possible. My understanding was the
20 majority of their referrals went to CRCC.

21 Q: But they could have treated patients in Myrtle
22 Beach that they referred to Georgetown for
23 radiation, right?

24 A: It's possible. I mean, would be half of their
25 volume? That seems unlikely.

1 Q: Well, if this number is correct and you apply
2 the assumptions that we always apply in regards
3 to this service line, then it would be almost
4 580 patients getting radiation therapy. And
5 just even doing 21 treatments for 580, can you
6 do the math on that?

7 A: Sure. That would be over 10,000.

8 Q: That would be over 10,000 potential treatments
9 in the Myrtle Beach office at Dr. Holt's
10 Coastal Cancer Center, right?

11 A: Sure. I mean, that doesn't seem reasonable to
12 me, but that's what the math works out to be.

13 Q: You knew this fact though, right, when you were
14 preparing your work, right?

15 A: I didn't know it at the beginning. I certainly
16 knew it by the time we filed the application.

17 Q: Right. And you knew it before the time that
18 you did your additional information where you
19 answered Ms. Brandt's questions, and you --
20 then you went through your detailed draw rate
21 analysis, right? Went through your draw rate
22 analysis?

23 A: Yes.

24 Q: Okay. But you did not consider at all the
25 patients that are seen in Myrtle Beach by

1 Coastal Cancer Center in determining your
2 projections for market share, did you?

3 A: Well, I think I did. I mean, as I said, we
4 assumed that Coastal Cancer Center was going to
5 be the significant contributor to Grand Strand's
6 project. You know, they were physically
7 proximate to Grand Strand's campus at one of
8 their offices, and we knew that the urologists,
9 who are the other -- I didn't know the extent
10 of their referrals, but I knew they were
11 another large referral source would not be
12 available. So we assumed that our patients
13 were going to come from medical oncologists and
14 the surgeons and some of the other physicians
15 who are lesser referrals.

16 Q: I'm talking about doing a mathematical
17 calculation, Mr. Sullivan. You certainly could
18 have used this information and calculated the
19 total number of radiation therapy treatments
20 that were going to be at Coastal Cancer
21 Center's Myrtle Beach office and included that
22 analysis in the application. You could have
23 done that, but you chose not to?

24 A: Well, I had no understanding of how the numbers
25 were pulled together or what they represented,

1 so I didn't. If I had had detailed information
2 about where those referrals were made and so
3 forth, maybe I would have considered including
4 them.

5 Q: Okay. Well, you certainly weren't prohibited
6 from asking your client to find that out, were
7 you?

8 A: I was not.

9 Q: Okay. And they obviously were talking to
10 Coastal Cancer Center about this very
11 information?

12 A: Somebody was, definitely.

13 Q: Other places in the application where you
14 mentioned Coastal Cancer Center, page 38 of the
15 application, you mentioned the medical
16 oncologists, right? First paragraph, at the top
17 of the page.

18 A: Yes.

19 Q: Page 39, first paragraph under question 19,
20 again mentions Coastal Cancer Center, right?

21 A: Yes.

22 Q: Okay. Skip ahead to page 41, you mention the
23 medical oncologists again?

24 A: Yes.

25 Q: Under question 23?

1 A: I see that.

2 Q: We'll move ahead to the project review
3 criteria, page 845 of your presentation. The
4 last bullet on that page.

5 A: We do talk about Coastal Cancer Center there.

6 Q: And page 854, you mention Coastal Cancer Center
7 again, right?

8 A: We do.

9 Q: And page 866, you mention Coastal Cancer Center
10 in your letter to Ms. Brandt and the medical
11 oncologists?

12 A: I do.

13 Q: Page 881, the second letter to Ms. Brandt?

14 A: Yes.

15 Q: You also mention the advantages of Coastal
16 Cancer Center?

17 A: I do.

18 Q: And page 891, after the project review in
19 November, Dr. Holt made a point to write the
20 Department again and tell them that he
21 supported the Grand Strand project, right?

22 A: That's true.

23 Q: And so apparently in December 2011, there was
24 no problems between Dr. Holt and Grand Strand
25 and he still continued to fully support the

1 project, right?

2 A: Yes.

3 Q: And in the formal timeline, your analysis of
4 what the market share would be for Grand Strand
5 was completed and done and in the books in July
6 of 2011, right?

7 A: The initial one. And then I did an updated one
8 in my additional information letter.

9 Q: Right, which came a couple month -- like a
10 month later.

11 A: I think so.

12 Q: So it was done and in the books in August, I
13 guess, right, would be more fair, right?

14 A: That's true.

15 Q: Okay. Now, did you ask, did you testified
16 earlier this morning as to who the employed
17 physicians were on Mr. Tolbert's Exhibit Number
18 10, CRCCs Exhibit 10?

19 A: Right.

20 Q: Did you ask Mr. White to give you the names of
21 all the other employed physicians that Grand
22 Strand has?

23 A: I think I asked him in the context of the
24 referral data that we got from CRCC. And as I
25 recall, there were four total physicians who

1 are represented on that list, and we talked
2 about Giddens Anderson and there were two more
3 that weren't in that Grand Strand committed
4 column. I think they just had one or two
5 referrals each.

6 Q: Okay. Well, they actually have more than four
7 employee physicians, don't they?

8 A: My understanding is they do, but as far as what
9 was represented on the referral list for CRCC,
10 there were only four, as I recall.

11 Q: And those physicians that are employed are not
12 in the column that says they would refer 90
13 percent of their patients to Grand Strand? Mr.
14 Tolbert actually estimated they would refer
15 less, right?

16 A: Apparently, yeah.

17 Q: Now, let's go and look at Mr. Tolbert's CRCC
18 Exhibit 10.

19 MR. LONG: Let's look at the bottom part of this.

20 We need to capture the other categories that --
21 just blow it up the best you can. Thank you.

22 Q: Okay. First thing, these are only CRCC
23 patients, right?

24 A: True.

25 Q: So there are no Georgetown patients on this

1 chart at all. He's just looking at physician
2 referrals to CRCC, correct?

3 A: Well, he's allocating some of those to
4 Georgetown, but as far as historical, it was
5 based on CRCC's historical data.

6 Q: Right. Because this is based on 2012 data, 889
7 patients, or I'm sorry, 886 patients in 2012.
8 And that's 100 percent to CRCC. So Mr.
9 Tolbert, because Georgetown has been approved
10 to move to Murrells Inlet, actually assigns 69
11 patients that would -- on the CRCC list to
12 Georgetown, right?

13 A: He does.

14 Q: Okay. Now, if he were going to divide those
15 and give a market share to Grand Strand, a
16 portion of those patients would be in Grand
17 Strand's column, right? But he doesn't do
18 that, does he?

19 A: I'm not sure I quite follow that question.

20 Q: Well, you would agree with me that Grand Strand
21 is going to have a market share. They're going
22 to get patients and they're going to patients
23 that went to CRCC, right?

24 A: That's my expectation.

25 Q: Okay. And so if you were to apply then any

1 market share at all to these patients that he
2 has in this row right here, any market share
3 number, that would mean patients would be over
4 in the Grand Strand column? But he doesn't do
5 that, he just said, well, these physicians, we
6 think they're going to Georgetown in the
7 future?

8 MR. THOMAS: Your Honor, I'm going to object. It's
9 a compound question, two or three questions may
10 be in there.

11 THE COURT: Let's just be specific. Because you
12 started with one and you went with another.

13 MR. LONG: I'll try it again.

14 THE COURT: I kind of thought the last one was the
15 one you had stuck with, but ---

16 Q: You want me to stat over. Okay. These
17 patients on this list are 2012 CRCC only
18 patients, right?

19 A: My understanding, yes.

20 Q: Okay. And Mr. Tolbert, even though these 2012
21 patients had gone to CRCC, Mr. Tolbert projects
22 for this analysis that 69 patients will go to
23 Georgetown because of the Murrells Inlet
24 facility there, right?

25 A: He did.

1 Q: And if he were to assign a market share to
2 Grand Strand of the CRCC patients, then Grand
3 Strand would have gotten some of those 69
4 patients?

5 A: So you're saying as opposed to allocating them
6 all to Georgetown if he had just put them in
7 the mix and then applied a market share to it?

8 Q: Right.

9 A: That's true. I mean, I think that doesn't
10 overcome the many other flaws in this analysis.

11 Q: But it causes the Grand Strand number to be
12 lower, doesn't it, the overall total number?

13 A: Only in that one category. I think it's
14 overstated in several others.

15 Q: All right. And let's look at the other
16 category. Mr. Tolbert testified, and you've
17 seen the background on this, that these
18 patients in the other category are referrals
19 from physicians who refer a very small number
20 of patients, right?

21 A: Right. Just eyeballing his chart it looked
22 like a lot of these were out of area
23 physicians, you know, from North Carolina, from
24 other states and so forth.

25 Q: All right. Now, you would agree with me that,

1 for example, like a surgeon will have
2 substantially more interaction with a hospital
3 than with a radiation therapy center, right?

4 A: Except for urological surgeons, I would say
5 that's probably true.

6 Q: Okay. As a matter of fact, well, there are
7 surgeons doing urological procedures at Grand
8 Strand, aren't they?

9 A: They are. I'm just saying that urologists
10 probably have a closer relationship with
11 radiation therapists in general than do other
12 surgeons because they send a high proportion of
13 their patients to radiation.

14 Q: But other surgeons would have a closer
15 relationship with the hospital than they would
16 a radiation therapy center, right?

17 A: Possibly, yes.

18 Q: Well, that's where they're doing their surgery,
19 right?

20 A: It might not be a close relationship. That
21 might be where they're doing their surgery, but
22 it might not be a close relationship.

23 Q: Well, they interact with the hospital on a much
24 more frequent basis, right?

25 A: Sure, if they're doing surgery two or three

1 days a week.

2 Q: Yeah. They're interacting with the hospital
3 administrators and the people at the hospital
4 two to three days per week, right?

5 A: Generally, that's true.

6 Q: And other physicians that would potentially
7 refer cases would have patients that would be
8 in the hospital, right, where they might make
9 rounds on them?

10 A: Sure.

11 Q: We know that, right?

12 A: Sure.

13 Q: Because it's always a certain amount of pride
14 among the medical community to their local
15 hospital, right?

16 A: There is. I mean, it varies from physician to
17 physician.

18 Q: But you would expect a tertiary hospital like
19 Grand Strand to have that kind, that would be
20 local pride in regards to that hospital, right?

21 A: It's hard for me to make generalities about
22 medical staff. I think generally the people
23 who are on one medical staff and not on other
24 hospital's medical staff tend to have a little
25 more alliance to the single hospital medical

1 staff that they're a part of. But when they
2 have multiple affiliations, it's hard to make
3 that.

4 Q: And if you're only referring one patient to
5 radiation therapy a year, one per year, that's
6 not much of an interaction with the facility
7 here?

8 A: It's not.

9 Q: So based on that interaction, it's certainly
10 reasonable that a significant percentage of
11 those doctors would shift their patients, these
12 small number of referrals to Grand Strand,
13 correct?

14 A: I simply don't know.

15 Q: Well, it's certainly not unreasonable to do
16 that?

17 A: Well, I mean if they had a good relationship
18 with CRCC historically and their patients had
19 good outcomes, they might continue to refer
20 them there.

21 Q: Well, some might. But also if you're only
22 doing one per year, you're not going to have
23 much of a relationship, are you?

24 A: I don't have any -- that's why I didn't do a
25 referral analysis because I was sort of delving

1 down into this, you know, pool of speculation,
2 I just didn't feel comfortable.

3 Q: Now, let's talk about the Conway physicians,
4 all right. You mentioned the Conway physicians
5 at the beginning of your testimony. The
6 testimony was that there were three doctors in
7 Dr. Holt's group who rotated through the Conway
8 office; isn't that correct?

9 A: I think I heard Dr. Francke say that.

10 Q: Yeah. And then actually maybe one of the
11 doctors went there more than the others, two of
12 them rarely went there, but three of them
13 rotated through that, right?

14 A: That's my understanding.

15 Q: And there are also other offices that these
16 doctors rotate through, right?

17 A: They have five offices. As I gathered from
18 looking at their website they're less
19 frequently in, like the Supply, North Carolina
20 office than they would be in Horry County
21 offices.

22 Q: Well, obviously from the application
23 information that we went over a while ago,
24 they're treating a very large number of
25 patients in Myrtle Beach, right?

1 A: Sure.

2 Q: In a very large facility, 35,000 square feet,
3 right?

4 A: That's a good size facility. They've got a big
5 operation.

6 Q: Mr. Tolbert takes into consideration in this
7 exhibit the Conway patients, actually splits
8 them out and assigns them assuming that CRCC-
9 Conway would exist, right?

10 A: He does.

11 Q: Now, Mr. Tolbert also -- let's look at CRCC
12 Exhibit 12. Well, let's go back to 10, I want
13 to do one more, I'm sorry. Let's go back to
14 10. We also note from the backup data that the
15 overwhelming majority of these patients on this
16 chart reside in Horry County; isn't that right?

17 A: I believe that's true. I'm trying to think of
18 the patient origin data. My recollection is
19 yeah, that the majority of this, there's some
20 from Georgetown. There's some from North
21 Carolina. There's some from, I mean, I think
22 we saw that list of zip codes and they had, I
23 don't know, probably 100, 150 zip codes outside
24 of Horry County where they had one patient.
25 So, I mean, the majority come from Horry,

1 that's for sure.

2 Q: It's more than 50 percent though. It likes an
3 overwhelming majority, isn't it?

4 A: I don't know the percentage. It's more than 50
5 percent.

6 Q: Let's take a look at -- well, let's take a look
7 at CRCC Exhibit 5, which is the CRCC -- this is
8 the CRCC patient origin board here. And it's
9 pretty obvious from looking at this 2012 data
10 that the overwhelming majority of the CRCC
11 patients come from Horry County, right?

12 A: Yeah, I mean you've got Georgetown, you've got
13 what's 66, 71. You've got four in -- no five
14 in Williamsburg at 76.

15 Q: Well, let's slow down a second

16 A: Okay.

17 Q: You're counting this Murrells Inlet as
18 Georgetown, which is 56 of the total. If you
19 exclude that one, in every one of these zip
20 codes in Georgetown and Williamsburg, the
21 highest one is five, right?

22 A: Right. Yeah I'm not disagreeing with you. I'm
23 sure the majority come from Horry. I just
24 don't what the percentage is.

25 Q: Okay. Include that zip code. So all of these,

1 this is where like, I mean just looking at
2 this, this looks like 90 percent of the
3 patients, right?

4 A: Yeah, you're not showing the out-of-service
5 area patients. But, you know, if I had to
6 guess I would say it's probably 80 percent come
7 from Horry County.

8 Q: All right. So even though almost the -- a
9 large number of the patients on this physician
10 referral chart come from Horry County, all
11 right, the total market share projection
12 assigning 100 percent of the AUC patients to
13 CRCC is still 33 percent of the total patients,
14 right? That's what Grand Strand would get
15 according to -- you want to go back to Exhibit
16 10? Exhibit 10, right? 328 and if you take
17 the 889 and you add the additional growth in
18 the market share?

19 A: I haven't done the math, but it's ...

20 Q: Doesn't it look like it's about a third? I
21 think the total is 1,002.

22 A: Then it would be about a third.

23 Q: Okay. Of the total of these Horry County
24 patients. Now, when you go to CRCC Exhibit 12
25 and look at the third page over to, I'm sorry,

1 the fourth page, Tolbert 12946, Mr. Tolbert
2 actually did the market share analysis by
3 county to prepare for this trial, right? And
4 that's what that top column, that top box is,
5 right?

6 MR. LONG: If we could blow that up.

7 A: He did the inpatient market share by county.

8 Q: Okay. And the weighted market share for Grand
9 Strand, taking into consideration that
10 population is 30 percent, right?

11 A: Right, 29.9.

12 Q: So even with 100 percent assigning the AUC
13 patients to CRCC, he still had a market share
14 number pretty close to what the regular
15 inpatient number would be for Horry, right?

16 A: Higher. But again, I don't think this
17 inpatient market share number is meaningful
18 either.

19 Q: Well, you actually not have opined in this case
20 what you think the appropriate proxy should be,
21 have you?

22 A: But there is no appropriate proxy in this
23 situation because it's a very unusual
24 circumstance in this market. I mean, you have
25 to ---

1 Q: It's unusual because they don't have the
2 service ---

3 MR. THOMAS: Your Honor, let him finish.

4 THE COURT: I sustain that.

5 MR. LONG: I thought he was finished. I apologize.

6 A: I think you have to look at the fact that
7 you're starting at zero and that you're
8 building up a market share over time against
9 significant competition. So, I mean, this is
10 a classic issue that comes up in many projects
11 that I work on. And, you know, there isn't a
12 perfect proxy for it. You have to use
13 reasonable judgments.

14 Q: Well, it's also appropriate to use reasonable
15 proxies, right?

16 A: Sure, if you could find one.

17 Q: Okay. And in regards to using the inpatient as
18 a potential proxy, you would agree with me that
19 radiation therapy services is a tertiary
20 service, right?

21 A: I wouldn't agree with that. It's a specialized
22 service, but it's provided -- I mean, tertiary
23 services, to me, are provided by specialized
24 centers relatively small in number. And with
25 radiation therapy, it's very frequently

1 performed. And the other thing is it's not
2 performed very often. Tertiary services tend
3 to be lower volume services. Radiation therapy
4 is a very specialized service and it should be
5 limited in some respects, but not to the same
6 extent as you would open heart surgery, for
7 example.

8 Q: Well, even if being a --- even you concede that
9 it's a a specialized service, it's still one
10 that is important enough to be considered in
11 the State Health Plan, right?

12 A: Sure.

13 Q: It's certainly one that comes under the
14 Certificate of Need program, right?

15 A: It is.

16 Q: Okay. And it's one who the number of providers
17 is therefore limited by the program, right?

18 A: It is.

19 Q: And it's certainly very different from, say, an
20 emergency department, right?

21 A: Sure. There's a lot more emergency departments
22 than there are radiation therapy.

23 Q: And a lot more visits, right, in an emergency
24 department, right?

25 A: Sure.

1 Q: And that's one of the reasons that outpatient
2 data for something like radiation therapy
3 doesn't work very well because there's so many
4 more visits, and it's not a special -- this is
5 not a specialized service, right?

6 A: That's true. You've got lab tests that are
7 relatively brief encounters that don't require
8 a high degree of specialization. You've got
9 the emergency department visit. You've got a
10 number of things that go into outpatient that
11 make it difficult to calculate accurate market
12 shares.

13 Q: And also the referral sources for radiation
14 therapy are most usually specialists?. They're
15 providing highly technical medical services,
16 medical oncologists, urology, cancer surgery?

17 A: Yeah. I mean, you do have a minority of the
18 patients referred by internists, general
19 surgeons, but by and large, it's coming from
20 specialists.

21 Q: And that is the reason that people use
22 inpatient market shares and proxy because of
23 the specialization of the radiation therapy,
24 that's why people do it? I understand you're
25 criticizing it in this case, but that's why

1 other professionals do it, isn't it?

2 A: I don't know why other people do it. I just
3 don't think it applies in this particular
4 market.

5 Q: Now, the State Health Plan looks at the third
6 year because it's considered that after the
7 third year you won't be in a startup phase
8 anymore. But that's why you use the third
9 year, isn't it?

10 A: Right. And you're expected to get to 50
11 percent. I don't think that implies that would
12 be your steady state forever.

13 Q: Well, what the health plan says is you have to
14 get to at least 50 percent or they're not
15 going to approve the project, right?

16 A: That's what it says.

17 Q: So they expect you to exceed 50 percent by the
18 third year, and if you can't, then they're not
19 going to approve, right?

20 A: That's what it says.

21 Q: Because that would mean it wasn't a sufficient
22 population base or sufficient referral source
23 to justify or support the service, right?

24 A: Right. And I think the assumption is they want
25 you to be at a above breakeven level and

1 somebody somewhere along the lines assumed 50
2 percent.

3 Q: And if you can't get to 50 percent by the
4 maturity date then you don't need to have the
5 service, and that's the reason for the rule,
6 right?

7 A: I'm not going to agree with maturity. You
8 know, I mean, it's giving you a chance to ramp
9 up. It's giving you a three year period to
10 ramp up and show you can get to at least 50
11 percent. I don't think there's any expectation
12 stated in the State Health Plan that that would
13 be your maximum volume or where you would
14 expect to land for a long period of time.

15 Q: Let's address a couple of issues specifically
16 you were asked about. Now, you testified about
17 the DRG payments for inpatients?

18 A: Yes.

19 Q: If a patient in the hospital is in the hospital
20 because they have a cancer-related DRG, then
21 the radiation therapy services would be
22 covered, right?

23 A: I don't think so. I mean, generally the --
24 yeah, mean, I guess in a very oblique way
25 that's possible that there would be some small

1 part of that DRG payment that would have
2 related to patients having a few radiation
3 therapy treatments.

4 Q: And usual the reason these inpatients have a
5 few radiation therapy treatments is they'll
6 have some sort of pressure by the tumor that
7 needs to be relieved quickly and promptly,
8 right, and that's why it's just a few
9 treatments?

10 MR. THOMAS: Objection, Your Honor. That calls for
11 expert testimony by a physician.

12 MR. LONG: I'll move on.

13 Q: Okay. You testified about the idea of
14 leverage, that if Grand Strand comes into
15 market that it will provide leverage for the
16 insurance companies to reduce reimbursement,
17 which would therefore reduce cost; is that your
18 testimony?

19 A: Yes.

20 Q: All right. But the greatest leverage that the
21 insurance company has is that they can restrict
22 the provider. They can declare you to be out
23 of network, right? That's their leverage,
24 right?

25 A: That's the greatest leverage.

1 Q: Okay. And it makes no sense for any PPO
2 provider to declare CRCC out of network when
3 the alternative costs more, does it?

4 A: I mean, I wouldn't expect CRCC to be cut out of
5 any networks just because of their breadth of
6 services.

7 Q: As a matter of fact, the leverage is that the
8 PPO providers would go to Grand Strand and say
9 they want to cut them out, right?

10 A: Either cut them out or they want them to drop
11 their rates to something that's close to what
12 CRCC is charging.

13 Q: And HCA would do that negotiation on behalf of
14 Grand Strand, wouldn't they?

15 A: They have a managed care division that handles
16 those negotiations.

17 Q: And that's certainly the advantage for Grand
18 Strand to be in a hospital system like HCA
19 that's the largest hospital system in the
20 United States, right, is they get the benefit
21 of that group negotiation, right?

22 A: I'm not sure it's so much group negotiation as
23 it is you just have skilled professionals doing
24 negotiations.

25 Q: But they also have the weight of all of HCA,

1 right?

2 A: Sure. But I mean if -- I don't think a
3 provider is going to look at how many hospitals
4 they have in Texas in determining whether they
5 want to sign a contract with Grand Strand.

6 Q: But if the provider wants to sign a contract
7 with HCA, he's going to have to include the HCA
8 hospitals, right?

9 A: That's true. But I mean, my experience has
10 been these negotiations are more local.

11 Q: And because HCA, because Grand Strand is the
12 only tertiary hospital in Horry County, right,
13 declaring them to be of network is really
14 almost impossible, right?

15 A: I mean, it's not impossible. I mean, if their
16 rates were really out of line with what the
17 insurers thought they were willing to pay, they
18 would exclude them. I mean, even big systems
19 like HCA get in contract disputes with the big
20 insurance companies, the Blue Crosses and the
21 Aetnas and the, you know, others, United. So,
22 I mean, yeah. But the thing is if you have two
23 people in a market negotiating, insurance
24 companies have some ability to play them off
25 against each other, which they don't now.

1 Q: Only if they're the same type of provider.

2 That was the point Mr. Lewis made, right? Do
3 freestanding, you have leverage. Do hospitals,
4 you have leverage. Hospital and freestanding,
5 no leverage?

6 A: I don't agree with that.

7 Q: Now, let's talk about your testimony in regards
8 to competition. All right. Grand Strand
9 certainly doesn't take the position that if
10 there were more open heart providers in Horry
11 County that they would do a better job of open
12 heart surgery, do they?

13 A: No. I think open heart you'd really compete on
14 a regional basis for those services. I mean,
15 you've got a volume quality issue with open
16 heart. I mean, the literature's pretty clear
17 that volume and outcomes are related in
18 providing open heart, another specialized
19 interventional cardiac procedure. And so
20 you're willing to trade a little competition
21 for higher quality and services like open
22 heart.

23 Q: And that's the premise behind all of these
24 services like radiation therapy in the health
25 plan is the more you do it, the more proficient

1 you are at it and the higher the quality.

2 That's the theory, right?

3 A: Is it. But the clinical evidence is strongly
4 there for open heart. It wouldn't be for
5 things like home health services or other
6 services. You know, I haven't seen clinical
7 studies that say that radiation therapy
8 providers are better at 20,000 treatments than
9 they are at 15,000 treatments. I haven't seen
10 that evidence. There's probably a threshold.
11 If you did, you know, one treatment a day you
12 probably wouldn't be as good as you would be if
13 you 10 a day. But if you do 40 a day and you
14 drop to 35 a day, I've not seen any evidence
15 that that would impair quality.

16 Q: Well, you have heard evidence in this courtroom
17 about how specialized the service is, right?

18 A: Well, sure. I mean, it requires unique skills
19 of the physicians and the technicians who
20 provide the services.

21 Q: And it's very technical; you'd agree with that,
22 right?

23 A: It is.

24 Q: And these machines require a calibration that
25 you and I just could not deal with in our daily

1 life, right?

2 A: I didn't take many physics courses after high
3 school. So, I mean, the physicist, the
4 dosimetrist play a vital role in the delivery
5 of the treatments.

6 Q: Yeah. I mean, I'm not even sure I've ever met
7 a physicist. It's a pretty rare occupation,
8 isn't it?

9 A: It would be a good thing for your kids to go
10 into. They get paid very well.

11 Q: But just to finish up my point, the CON Act and
12 regulations are premised on this concept that
13 the more proficient you are, the higher the
14 quality?

15 A: I guess I would disagree with that. I think
16 it's premised on that for selective services.
17 I think the other piece of the puzzle is the
18 cost containment and the idea of unnecessary
19 duplication would drive up costs.

20 Q: Okay. Well, the idea of that is that if you
21 have too much of something that it would be
22 more expensive because either people will
23 overuse it or you're just injecting all this
24 additional cost, this capital cost in the
25 system, which would then have to be paid by

1 somebody?

2 A: Right, you'd have excess capacity.

3 Q: And that's not a good thing, is it?

4 A: No, it's not.

5 Q: And the CON program is designed to try to stop
6 that?

7 A: That's true.

8 Q: And competing applications is a very important
9 way for the Department to control the
10 overutilization of services because it requires
11 them by statute to choose, right?

12 A: That's true. And when that applies, that's
13 what they have to do.

14 Q: Okay. Now, in regards to the testimony you
15 made about whether Grand Strand could have
16 applied earlier, Ms. Brandt's testimony, I
17 think that they could have applied earlier in
18 2010, the actual draft of the health plan was
19 available, certainly, in the spring of that
20 year, wasn't it?

21 A: It was. Though the plans do change, in that,
22 I believe it was that very same plan, I started
23 writing a CON application for a client for
24 inpatient rehabilitation beds because it was
25 shown in the draft of the plan. We were ready

1 to go when the plan was adopted. And when the
2 plan came out, we needed to adjust it downward
3 and there was no need for the project.

4 Q: Well, in this case though, what you're really
5 focused on in regards to it is whether the
6 existing units satisfied the 80 percent
7 trigger, right?

8 A: Right.

9 Q: And that's based on the utilization data that
10 is set out in the plan, right?

11 A: Right. And sometimes they make errors.

12 Q: And it's also based on the JARS, right?

13 A: It is.

14 Q: And let's look at Joint Number 6 very quickly.
15 If you look in the bottom left-hand corner on
16 that. That is -- well, first, that's the CRCC
17 JAR, correct?

18 A: True.

19 Q: Okay. And if you look at the bottom left-hand
20 corner, when was that filed with the
21 Department?

22 A: March 30, 2010.

23 Q: So over six months before the Health Plan was
24 finalized, right?

25 A: Yes.

1 Q: And that information is available on FOIA for
2 anybody who would it, right?

3 A: It is.

4 Q: You could send an email over there and they'll
5 send it to you, right?

6 A: They will.

7 Q: It's very public information. And there was
8 nothing to prevent Grand Strand from calling
9 you or any other consultant that had
10 availability and telling them, go ahead and
11 start preparing that CON application; we want
12 to file it as soon as the health plan is
13 finalized?

14 A: They could have done that. They could have
15 taken a risk that the need would stay. They
16 could have done that.

17 Q: Now, you would have to admit that the CRCC-
18 Conway facility is closer to, geographically
19 distributes the services in the county, right,
20 from a geographic point of view, more than
21 Grand Strand, right?

22 A: I would agree with you.

23 Q: Okay. And even though you may like the age of
24 the building and your clients may not like the
25 size of the building, the patients who live in

1 Conway will certainly benefit from having a
2 facility close to their home, right?

3 A: Sure. I mean, I think anytime you reduce
4 travel time, that's beneficial to patients.

5 Q: Okay. Now, you and Mr. Tolbert have a
6 disagreement about linear regression. But the
7 reality is that the two of y'all projected
8 pretty similar numbers in regards to the total
9 number of treatments in the service area in
10 2017, right?

11 A: That's true.

12 Q: And he fully disclosed on his exhibits what
13 your projections were when he did his, right?
14 He just added a line on there that's says
15 Sullivan projection and it's got your number,
16 right?

17 A: He does.

18 Q: And the number's correct, right?

19 A: Yes.

20 Q: And now the work that Mr. Thomas went through
21 with Mr. Tolbert, you testified a little bit
22 about this that seemed to imply that there was
23 some sort of outmigration, okay? There's no
24 evidence of testimony of outmigration,
25 certainly to the extent that Mr. Thomas

1 testified to, is there?

2 A: Mr. Tolbert.

3 Q: I mean, Mr. Tolbert testified in response to
4 Mr. Thomas' question?

5 A: I mean, I'm sure there is outmigration because
6 I projected the number of patients who would
7 require radiation therapy, and that was greater
8 than the numbers that were served at Georgetown
9 and CRCC in 2009, 2010. So I knew there was
10 some outmigration, but we have no data source
11 that allows us to measure exactly what the
12 outmigration was.

13 Q: Well, your conclusion on that is based on your
14 assumptions as to the number of patients that
15 would require radiation therapy. You didn't
16 actually go look at actual hard numbers and
17 determine that, did you? You're basing that
18 off your assumption?

19 A: No, I'm talking about the number of patients
20 before you get to treatments. Yeah. Yeah; it
21 is. So 55 percent, yes, that was an
22 assumption.

23 Q: And if you drop that assumption to 50 percent,
24 and the range is 50 to 60, right?

25 A: It is.

1 Q: And you chose 55. But if you dropped it to 50
2 that would pretty much eliminate all of that
3 potential outmigration, wouldn't it?

4 A: I don't know. I didn't do that calculation.

5 Q: But it would substantially limit it?

6 A: It would reduce the number by roughly 10
7 percent.

8 Q: Okay. And then reduce the number of patients
9 in radiation therapy by 10 percent?

10 A: Right.

11 Q: And then you would multiply that 10 percent by
12 the number of treatments, whether it's 21 or
13 25, so it would be a substantial number. It
14 would be certainly in the thousands, right, of
15 treatments?

16 A: Of treatments. Ten percent of -- yeah, it
17 would probably be between two and three
18 thousand treatments.

19 Q: Comprehensive cancer centers are traditionally
20 or typically under one roof, right?

21 A: Yeah. I mean, I think when you think of the
22 National Cancer Institute Comprehensive Cancer
23 Center, that's everything under one roof, under
24 one organizational structure.

25 Q: And unless there is some tearing down of some

1 buildings, Grand Strand will never have all of
2 the services under one roof, right?

3 A: I mean, not during the first three years of
4 operation for sure. But whether somewhere down
5 the line they could have a more comprehensive
6 center, I don't know the answer to that.

7 Q: Well, they would have to tear down Dr. Holt's
8 practice and move it to Grand Strand, or they
9 would have to tear down their linear
10 accelerator and move it to Dr. Holt, I mean,
11 right?

12 A: Yeah. I mean, obviously to get them under one
13 roof, something would have to change.

14 Q: All right. Let's look at Petitioner's 85, the
15 new exhibit today. Do we have it? All right.
16 First thing, you might need to do a little math
17 on this if you can, but we know the total
18 number of treatments in 2012 for CRCC, right?
19 Do you recall what the number is off the top of
20 your head?

21 A: 22,798.

22 Q: Okay. So do 22,798 minus 14,000 ---

23 MR. LONG: Can you blow up the top part.

24 Q: Minus, I guess, yeah 12 -- I'm sorry. Hold
25 that, we've got 22,798. Let's take a look at

1 CRCC 139. These are the 2012 numbers, right?

2 A: Okay.

3 Q: And what's the first nine -- first seven months
4 of 2012, how many treatments were there?

5 A: 14,391.

6 Q: 14,391. So 22,798 minus 14,391, just tell the
7 court what that is.

8 A: 8,407.

9 Q: Okay. So that means in the last five months of
10 2012, CRCC had 8,407 treatments, right?

11 A: Right.

12 Q: And if you were to divide that by five, how
13 many -- average that, how many treatments would
14 that be per month?

15 A: 1,681.

16 Q: Okay. Then I want you to look at the monthly
17 totals for 2012 for the first seven months.
18 And we've got a single month up there that's as
19 low 1,681?

20 A: That's true.

21 Q: So what that shows is, is that in the second
22 half of the year, or certainly from August to
23 December, that the number of treatments at CRCC
24 was declined, and declined fairly dramatically,
25 right?

1 A: Apparently did.

2 Q: Okay.

3 A: The average went down.

4 Q: All right. So if you were going to compare and
5 annualize the approach, okay, and you just
6 annualized the first seven months in 2012 and
7 the first seven months of 2013, you would lose
8 the impact of those last five months of 2012,
9 right?

10 A: You would. I mean, I guess what I stated I
11 think earlier was I don't know whether 2012 was
12 representative of all years or was it just an
13 aberration on here that you had a significant
14 drop in the last five months.

15 Q: But what it certainly could be is it's just a
16 trend line of increasing volume, right, that's
17 accelerating? The trend line's down, right?

18 A: It's not down because if the average for the
19 last five months was 1,681, we look at the
20 first seven months of 2013, there's no month in
21 which the volume was below 1,720. And so
22 whatever happened in the second half of 2012 at
23 least seems to have corrected itself in some
24 way. I mean, that's the problem with using
25 this partial year data.

1 Q: Well, what it would tend to show is that the
2 last five months of the year are slower than
3 the first seven months of the year?

4 A: It's a sample size of one.

5 Q: Now, let's go back to 85. But as Mr. Tolbert
6 testified, one of the reasons that you would
7 compare the first seven months of 2012 to the
8 first seven months of 2013 is that you would
9 then take into account these last five months,
10 right? What happened in the last five months
11 of 2012, it would take that into account,
12 wouldn't it?

13 A: But you would assume that that would be
14 representative of what would happen in the last
15 five months of 2013. I don't whether that's
16 true or not.

17 Q: Okay. Let's look at the bottom of the page.
18 Okay. The testimony was that Gangi is either
19 retiring or not taking patients or whatever and
20 that his patients are moving to Krzyzaniak that
21 was the testimony, wasn't it?

22 A: It is.

23 Q: Okay. And everyone of those urologists, except
24 for Young, is going to have a decrease in 2013
25 from 2012, except for Krzyzaniak? Or

1 Grudzinski. Yeah, it's Grudzinski is how I
2 should say it, right?

3 A: I can't remember now which one it was, he was
4 transitioning to. But, yeah, I mean Grudzinski
5 is having an increase.

6 Q: I mean, that would make sense. So actually,
7 Grudzinski's increase is fairly dramatic since
8 every other urologist is going down except for
9 him, right?

10 A: Well, Young is.

11 Q: Flat.

12 A: And Roberts is.

13 Q: There are negative numbers on everybody but
14 Young and Grudzinski?

15 A: Roberts looks like a positive three to me.

16 Q: Okay. But to be a positive when everybody --
17 when you other declines, that makes it even
18 more dramatic, doesn't it?

19 A: I mean, it's not a big number. But it's
20 certainly different than going down by 32, yes.

21 Q: And that certainly would support the testimony
22 when Gangi is now moving patients to
23 Grudzinski?

24 A: Yeah. I mean what it doesn't say is there's
25 some imperfection in that process of

1 transitioning. That, you know, whatever this
2 transition is then next year it's not going to
3 be the same magnitude in terms of a decrease.

4 Q: Well, except that we know that urology
5 referrals for radiation therapy are down all
6 across the nation, right?

7 A: I've not seen that personally. I know that's
8 what was testified to, but I've not seen that
9 personally.

10 Q: Well, don't you think Mr. Lewis would know
11 because he has access to data for over a
12 hundred centers?

13 A: I haven't seen the data. I can't comment one
14 way or the other.

15 Q: That was his testimony that it was down across
16 the nation, right?

17 A: It is his testimony.

18 Q: And ,Mr. Sullivan, radiation therapy services
19 is not a loss leader for a hospital, is it?

20 A: I mean, generally long term it's not.
21 Sometimes hospitals will absorb losses in the
22 early years in order to initiate the service.
23 But long term I think most hospitals find
24 radiation therapy profitable.

25 Q: Based on the data you've seen in the case, the

1 emails and all, you don't think taht HCA is
2 planning on losing a lot of money with this
3 linear accelerator, do you?

4 A: No. I mean, in fact, they projected in the
5 application that it was going be profitable.

6 Q: And internally, they projected that is was
7 going to be very profitable, didn't they?

8 A: Well, that was the what if scenario.

9 Q: All right. Thank you.

10 MR. LONG: Thank you, Your Honor.

11 MR. THOMAS: I've just got a few, Your Honor.

12 THE COURT: All right.

13 MR. THOMAS: And we'll be done.

14 MR. SULLIVAN - REBUTTAL REDIRECT EXAMINATION BY MR.
15 THOMAS:

16 Q: Mr. Sullivan, if you would turn to, I guess
17 it's page 37 in Joint 2. Talk to you a little
18 bit about that 1,054 number of new cases.

19 A: I'm there.

20 Q: All right. So, you have a calculator up there,
21 sir?

22 A: I do.

23 Q: Can you do a 1,054 times the, I guess, what's
24 the ACR percentage of cancer patients?

25 A: Between 50 and 60.

1 Q: Again, what do you typically use?

2 A: Fifty-five.

3 Q: Okay. Would you do 1,054 times .55.

4 A: That's 580.

5 Q: Okay. And then use Mr. Tolbert's number of 25
6 treatments per patient? What do you get?

7 A: 14,493.

8 Q: 14,493 what?

9 A: Treatments.

10 Q: All for what practice?

11 A: Oh, I'm sorry. For Coastal Cancer Center.

12 Q: Okay. Does that seem reasonable to you?

13 A: It doesn't, because that would exceed the total
14 -- yeah, if we know that the urologists did a
15 little less than 10,000 treatments in 2012, and
16 there were only 22,798 total treatments done,
17 then that would mean that the medical
18 oncologists did more than what the total
19 treatments were. So, I mean, obviously this
20 number looks high.

21 Q: Does it seem reasonable to you that that's a
22 basis for the number of radiation therapy
23 treatments in 20 -- gosh, when was this
24 written, in 2010?

25 A: It doesn't. I mean, I haven't vetted this

1 number. I don't know where it came from, but
2 it looks too high.

3 Q: Well, what we do know is how many treatments
4 they did at CRCC in 2012, right?

5 A: Yes.

6 Q: Okay. Do you recall that number? We can go to
7 if we need to.

8 A: I remember the referrals, it was 275. I don't
9 remember the treatments.

10 Q: All right. So it's 275 referrals, let's assume
11 this number of 1,054 is right and it yields
12 14,493 treatments. How many of the 275
13 referrals multiply that by, I guess we figured
14 out 21?

15 A: Yeah.

16 Q: What is that number for the medical
17 oncologists?

18 A: 5,775.

19 Q: Okay. What's the difference between the 14,493
20 and 5,775?

21 A: A little less than 9,000.

22 Q: Okay. So how many treatments were at
23 Georgetown in 2012; do you recall that number?

24 A: 5,304 or something like that.

25 Q: Okay. So is Coastal Cancer Center, to your

1 knowledge, responsible for all the treatments
2 at Georgetown?

3 A: Not to my knowledge. They have their own
4 referral sources there besides Coastal Cancer.

5 Q: So if this number is accurate, what does that
6 tell you in terms of outmigration?

7 A: Well, they must be referring a lot of patients
8 out of the area, which wouldn't -- again,
9 wouldn't make sense to me.

10 Q: Let's go to Petitioner's 41, if we could. I
11 think Mr. Long asked you some questions about
12 adverse impact and whether you had done
13 anything on your own. What is this
14 Petitioner's 41?

15 A: This was an impact analysis that I had prepared
16 based on Mr. Tolbert's second adverse impact
17 analysis.

18 Q: Well, wasn't it just based on one number from
19 Mr. Tolbert?

20 A: The total treatments in the area. That is
21 correct.

22 Q: What was your number of total treatments in the
23 area that you did off on a little different,
24 didn't use linear regression?

25 A: It was higher by about 600, so 32,400 roughly.

1 Q: Okay. So by using a lower number, what did you
2 do?

3 A: I enhanced what the impact would be on the
4 existing provider.

5 Q: Okay. Thank you. Mr. Long asked you questions
6 about the location and the proximity of Coastal
7 Cancer Center to Grand Strand, whether you took
8 that into account. Were you here for Ms.
9 Price's testimony?

10 A: I was.

11 Q: What did she say about the proximity of CRCC
12 and Grand Strand to Coastal; do you recall?

13 A: Yes. She said she didn't see that there was
14 any great advantage to Grand Strand's location
15 vis-a-vis CRCCs, the difference in time was
16 just a couple minutes.

17 Q: Okay. I think Mr. Long went through, kind of
18 did what I did with Mr. Tolbert's terms of the
19 Coastal Cancer Center references, but he took
20 it a bit further and I think even went to some
21 of the documents you submitted to the
22 Department. But despite all the references to
23 Coastal Cancer Center, including the 1,054
24 treatments that were in Section 12 of the B-2,
25 what number did Mr. Tolbert use in his adverse

1 impact analysis in terms of volume for Grand
2 Strand at the project review meeting?

3 A: He used the number that was projected in the
4 application, 4,690.

5 Q: Okay. And there was Dr. Holt's letter I think
6 Mr. Long referenced as well, December 1st,
7 2011. Let's go to Joint 1, if we could. I
8 promise we don't have much more to go because
9 I know you've got to catch a flight. And go to
10 page 651 in Joint 1 for me. Let me know when
11 you get there.

12 A: I'm there.

13 Q: Okay. Now, this is a letter that Mr. Tolbert
14 -- this is a letter that Mr. Tolbert submitted,
15 I guess by my math, 13 or 12 days before Ms.
16 Brandt made her decision, which would have come
17 two weeks after Dr. Holt's letter that's in the
18 record. Are there any references to Dr. Holt
19 in this letter that you're aware of, by Mr.
20 Tolbert?

21 A: I don't recall that he mentioned that, no.

22 Q: Okay. Let's go to Respondent's 10 if we could.
23 Mr. Long asked you a couple questions about
24 this. And he mentioned the fact that, I guess
25 that all the referred to Georgetown category

1 down there, you know, Georgetown and MI gets
2 100 percent; you see that reference there?

3 A: I do.

4 Q: Okay. And I want you to go up -- well, first
5 of all, in terms of that number for all going
6 to Georgetown and those referrals, I suppose,
7 and the treatments that would flow from those,
8 does that number reduce in any way the volumes
9 of existing providers for the purpose of the
10 threshold?

11 A: No, it's just taking them out of one pocket and
12 putting them in the other. It's still
13 transferring the volume from one existing
14 provider to the other, so it doesn't affect the
15 calculation.

16 Q: okay. I'd like you to go up, if you would, to
17 that category three under the referral source
18 there, Coastal - primary to Grand Strand with
19 some to CRCC-Conway.

20 A: Yes.

21 Q: And it says, from all else to 75 percent to
22 Grand Strand. What did Mr. Tolbert assume for
23 the 42 in the Murrells Inlet category; you see
24 that there?

25 A: Yes.

1 Q: How many did he say Grand Strand would get out
2 of that category, or how does the calculation
3 work?

4 A: Well, he assumed that 75 percent of the
5 patients in each of those categories went to
6 Grand Strand and 25 percent went to CRCC. So
7 the 42 would say that 75 percent of the 42
8 would go to Grand Strand.

9 Q: So those people in Murrells Inlet would need to
10 kind of not consider the two that have been
11 approved in their backyard, correct?

12 A: Right.

13 MR. LONG: Your Honor, I'm going to object and move
14 to strike that. That is not a characterization
15 -- that is not what he testified to. They
16 spent an hour telling -- explaining to Mr.
17 Thomas that that's not what he meant.

18 MR. THOMAS: Well, that's what I ---

19 MR. LONG: And he just asked him ---

20 MR. THOMAS: I didn't say that Mr. Tolbert said
21 that.

22 MR. LONG: He did, he prompted it on him.

23 MR. THOMAS: I did not say that.

24 MR. LONG: He did, he asked a leading and then he
25 said it.

1 THE COURT: Well, I'll -- he was leading his
2 witness. If you want to object on that but ---

3 MR. LONG: I do.

4 THE COURT: Okay.

5 MR. THOMAS: That's fine, I'll rephrase.

6 Q: Okay. Of the 42 patients that are in the
7 Murrells Inlet category, 75 percent of which,
8 if you do the math, 75 percent are going to
9 Grand Strand there, correct?

10 A: Right, that would be roughly 32.

11 Q: Okay. What if ---

12 MR. LONG: I'm going to move to strike that as
13 leading also. I mean he just -- he's
14 mischaracterizing the testimony; he's pitting
15 the witness against another ---

16 MR. THOMAS: All right. Let me ask it this way.

17 MR. LONG: That is not what he testified.

18 Q: How does the math work, Mr. Sullivan, in terms
19 of this row in apportioning Grand Strand
20 patients or patients to Grand Strand?

21 A: Well, if you look at the sort of brown shaded
22 column that says Referred to Grand Strand.

23 Q: Uh-huh (affirmative response).

24 A: If we take the 139 and divide it by 186, which
25 is the total number of patients in that

1 category, that comes out to be 74.7 percent.

2 So essentially, 75 percent of all the patients
3 along that same line under those various
4 geographic locations were allocated to Grand
5 Strand.

6 Q: And in terms of the Murrells Inlet area, what
7 has the Department done in terms of radiation
8 therapy centers for Murrells Inlet?

9 A: They've approved two to be relocated there.

10 Q: And in terms of a Murrells Inlet resident, if
11 Grand Strand were approved, would the Murrells
12 Inlet resident have to drive by CRCC and Myrtle
13 Beach to get to Grand Strand?

14 A: Generally that would be true, or certainly it
15 would be much closer to one of those two
16 approved providers and to Grand Strand.

17 Q: Okay. Thank you. Do surgeons also do cancer
18 -- where else do surgeons do cancer surgery
19 other than in the hospital?

20 A: Sometimes in freestanding surgery centers.

21 Q: Let me ask you this. Last week Mr. Lewis
22 testified that he'd recently sat down with Dr.
23 Holt to discuss some arrangements of potential
24 employment, correct?

25 MR. LONG: Objection, that is not the testimony.

1 Mischaracterizes the testimony.

2 MR. THOMAS: I think it is the testimony, Your

3 Honor. The record will speak for itself. Mr.

4 Lewis sat right there and said that he spoke

5 with Dr. Holt's group recently about

6 employment.

7 MR. LONG: He said he spoke with Dr. Holt and there

8 was no testimony about that. In fact, I think

9 he said he never talked to him. And I'll also

10 say, Your Honor, I didn't get into that on

11 cross.

12 MR. THOMAS: It's all about adverse impact, Your

13 Honor, and he did get into ---

14 THE COURT: Well, I'll let you go into adverse

15 impact.

16 MR. THOMAS: This goes straight to that because he

17 is trying to imply that Dr. Holt is, you know,

18 the key to the adverse impacts on CRCC.

19 THE COURT: Well, as far as -- I don't remember

20 specifically one way or the other about what

21 exact phrase was used concerning Dr. Holt, but

22 ask the question again. Let me see if we can

23 ---

24 MR. THOMAS: Let me see if I can do it this way.

25 THE COURT: I'll let you go into the adverse impact.

1 Q: Were you here when Mr. Lewis testified that
2 he'd recently met with Dr. Holt; were you here
3 for that testimony?

4 MR. LONG: Mischaracterizes the testimony and it
5 pits the witness. That is not what the
6 testimony was.

7 MR. THOMAS: That's what I remember, Your Honor.

8 THE COURT: I'll overrule that.

9 MR. LONG: And also I want to say, Your Honor, I
10 mean, this is redirect of rebuttal. Okay.
11 There's maybe one question he can ask on this
12 that wouldn't be objectionable; he won't ask
13 it. I mean if he would just ask it and we
14 could move on. It's redirect on rebuttal and
15 I didn't go into any of that particular stuff.
16 I just went through the application.

17 MR. THOMAS: His redirect -- I mean, his cross was
18 longer than my direct on rebuttal, Your Honor.
19 I'm just trying to tie things up.

20 THE COURT: Go ahead and ask the question and we'll
21 go from there.

22 MR. THOMAS: Okay.

23 Q: Were you here for the testimony when Mr. Lewis
24 said he'd recently met with Dr. Holt?

25 A: I was.

1 MR. LONG: I want to make the same objection to
2 strike, Your Honor. I understand your ruling.

3 THE COURT: Well, are you ...

4 MR. LONG: I mean, he continues to ask a question
5 that is mischaracterizing the record, and he
6 should just, you know, it's misleading, it's
7 improper, and I just don't think he should be
8 allowed to answer. So I just want that
9 protected in the record.

10 THE COURT: Now, I will agree with you on the where
11 you said Mr. Lewis met with Dr. Holt, that I
12 just don't remember one way or the other
13 specifically in the record. I'm not saying it
14 wasn't.

15 MR. THOMAS: Right.

16 THE COURT: I'm saying I don't remember. So if we
17 could phrase it in a more general term ---

18 MR. THOMAS: Well, I think it'll speak for itself
19 and I can ask another question and move us
20 along, Your Honor.

21 THE COURT: Okay.

22 Q: You had one phone call to Dr. Holt, correct,
23 that Dr. Holt was on?

24 A: That's it.

25 Q: Was there any reference to his group being

1 employed by Grand Strand on that phone call?

2 A: No.

3 Q: And the service area, who was the only
4 significant referral source employed by a
5 provider of radiation therapy services?

6 A: Atlantic Urology.

7 Q: Mr. Long asked you some questions about the DRG
8 payments. In terms of -- does Grand Strand
9 have to pay CRCC something for an amount for
10 the patient to be treated at CRCC?

11 A: Sure, they negotiate a contract with CRCC, so
12 Grand Strand is paying for the treatment
13 itself, and then with some payers you might be
14 able to pass that on. For Medicare and
15 Medicaid they would have to absorb that in
16 whatever fixed payment they get.

17 Q: Okay. Would Grand Strand have to make such a
18 payment to CRCC if it has an inpatient center?

19 A: It would not.

20 Q: And would either the patient or Grand Strand
21 not have to pay for an ambulance transfer to
22 and from?

23 A: That's true.

24 Q: Let me ask you this. I keep hearing testimony,
25 Mr. Long asked you about competition and

1 quality. Are the laws of economics suspended
2 when speaking about radiation therapy, Mr.
3 Sullivan?

4 A: They are not.

5 Q: And in terms of the number of open heart
6 surgeries that Grand Strand does, do you happen
7 to know that number, or ...

8 A: It's roughly 450, as I recall.

9 Q: Where?

10 A: At Grand Strand.

11 Q: Okay. So in terms of a radiation therapy
12 center that does over 20,000 treatments a year
13 and an open heart program, what, in your
14 opinion, is there a reasonable comparison to be
15 made between the two in terms of quality if
16 there's an impact on the numbers?

17 A: No, I mean I -- I think, as I said, I think you
18 would have to have a pretty dramatic shift in
19 volume in a radiation therapy center to impact
20 quality because you're doing multiple
21 treatments a day.

22 Q: Could you turn to Joint Exhibit 5 for me real
23 quick. Well, let me ask you this, you may
24 remember this and we don't even need to go to
25 the exhibit. But in 2012, do you recall how

1 many -- or excuse me, in 2011, how many
2 treatments Georgetown did?

3 A: It was a little over 6,000, if I could see the
4 ...

5 Q: Let's do this, let's go to 2012 if we could,
6 and I think that number was presented on
7 Exhibit Respondent's 8. I think it was
8 presented twice. What did Mr. Tolbert put down
9 for 2012 at Ford Center?

10 A: He put down 5,361.

11 Q: What's your understanding of the accreditation
12 status of Georgetown Memorial Hospital's
13 Francis Ford Center?

14 A: I believe they are ACR accredited.

15 Q: Okay. So 5,300 treatments?

16 MR. LONG: Objection, Your Honor. I didn't ask any
17 questions about Georgetown.

18 MR. THOMAS: Your Honor, what he implied was that if
19 you reduce the numbers down low then there's a
20 quality issue, and so I'm making my point that
21 at 5,300 treatments, Georgetown was ACR
22 accredited.

23 MR. LONG: Way beyond what I asked about.

24 THE COURT: I overrule that.

25 Q: What does ACR accredited mean?

1 A: Just means that you meet certain standards in
2 terms of program organization and quality and
3 proficiency.

4 Q: And based on your adverse impact analysis,
5 either on -- you know, the one, Petitioner's 41
6 or the one that was done in the CON
7 application, under any of those scenarios is
8 CRCC reduced to a volume that could affect its
9 quality?

10 A: Not in any of the scenarios I've seen.

11 MR. THOMAS: I have no other questions, Your Honor.

12 We rest our case.

13 THE COURT: Any recross on new matters? Well,
14 before you rest, and Mr. Biggers?

15 MS. BIGGERS: No questions, Your Honor.

16 MR. SULLIVAN - REBUTTAL RECROSS-EXAMINATION BY MR.

17 LONG:

18 Q: Didn't you hear the testimony by Mr. Tolbert
19 that when you calculated the Coastal Cancer
20 Center patients outside of the Conway area that
21 he applied 75 percent to the total number of
22 treatments? Don't you recall that testimony?

23 A: I do.

24 Q: And he specifically testified that he did not
25 apply it to each individual location despite

1 Mr. ---

2 A: He did say that. He said it could be higher in
3 some and lower i the other, but at 75 percent,
4 it doesn't give you a lot of room to be much
5 higher in other locations.

6 Q: But it was 75 percent of the total, right?

7 A: It was.

8 MR. LONG: Just give me one second, Your Honor, I
9 know there was one other question I wanted --
10 I guess not, Your Honor. Thank you. I have no
11 further questions.

12 THE COURT: You may step down.

13 MR. SULLIVAN: Thank you.

14 THE COURT: And you said you rest?

15 MR. THOMAS: We rest, Your Honor.

16 THE COURT: All right. I guess we'll reconvene 1:00
17 tomorrow.

18 MR. THOMAS: Sounds good.

19 (There being nothing further, the hearing recessed
20 for the day at 12:48 p.m.)

21 DAY 9 - TUESDAY, SEPTEMBER 24, 2013:

22 THE COURT: I'm ready when y'all are.

23 CLOSING STATEMENT - BY MR. THOMAS:

24 MR. THOMAS: Good afternoon, Your Honor. Your
25 Honor, you're being asked by Grand Strand to --

1 two cases have been consolidated. Grand
2 Strand, of course, has asked the Court to
3 review DHEC's decision to approve CRCC and to
4 review DHEC's decision to deny its application.
5 And Grand Strand has also asked the Court to
6 approve both projects if it finds that the
7 applications are not competing. We believe
8 that the evidence shows, as we go through the
9 presentation here, that the applications are
10 not competing. And lastly, if the court finds
11 that only one radiation therapy center can be
12 approved, we believe that the evidence will
13 show based on the State Health Plan, the CON
14 regulations, and the CON Act that Grand Strand
15 is the obvious choice and should have been
16 approved by DHEC. Here's what we know about
17 CRCC, Your Honor. CRCC has been the only
18 provider in Horry County for over 30 years.
19 CRCC has an 81 percent market share in the
20 service area. The last year of data that we
21 have kind of shows all the providers in the
22 state of South Carolina, which is the 2012-2013
23 State Health Plan, CRCC was the highest volume
24 operator by more than nearly 4,000 treatments.
25 CRCC only operates freestanding services in the

1 service area. It also has affiliated with it
2 an Atlantic Urology Clinics, which is a urology
3 group that has a financial interest in CRCC,
4 it's the owner of it, and it accounts for 30
5 percent of CRCC patients under treatment. And
6 the data showed, Petitioner's 52 and through
7 Rich Lewis' testimony, that nearly 44 percent
8 of all the patients, all the treatments that
9 are delivered at CRCC are done by referrals
10 from that one group. It's kind of their
11 starting point. They actually start at 44
12 percent treatment of those treatments in the
13 service area. We know that CRCC's parent
14 company is 21st Century Oncology, which
15 witnesses for CRCC admitted, one of which was
16 the vice president of finance for that company,
17 that 21st Century successfully and profitably
18 operates radiation therapy centers all across
19 the United States. And I believe they even
20 said they also operate internationally, having
21 a lot of centers in Argentina. Ms. Maynor
22 admitted that 21st Century successfully
23 operates in markets that have hospital
24 radiation therapy providers, and I believe she
25 mentioned that just a little bit north of us in

1 Greenville, North Carolina, that's the case.
2 CRCC has the benefit of 21st Century's kind of
3 marketing expertise or technical equipment
4 expertise, their financial expertise, their
5 operational expertise. I don't think there's
6 any dispute about that. So a company that only
7 focuses on radiation therapy, you know, has an
8 operation center that CRCC can rely on for a
9 lot of support. CRCC has the support of the
10 medical oncologists who practice in Conway, the
11 Conway medical staff, and the Conway CEO who
12 actually came and spoke at the project review
13 meeting as you heard. And here's what we know
14 about Grand Strand. Grand Strand's going to be
15 a startup provider. It's got, you know, no
16 radiation therapy program. It's inpatient
17 oncology market share as of 2012 for the three-
18 county area is 21 percent, not 81 percent, but
19 21 percent. Grand Strand employs only a
20 handful of physicians that are the type of
21 physicians that will refer their radiation
22 therapy center. I believe the testimony from
23 Mr. Sullivan yesterday was that those referrals
24 from its employed physicians at CRCC accounted
25 for about 200 treatments, so that would be less

1 than one percent of the total treatment number
2 at CRCC. Grand Strand does not employ the
3 local medical oncology group, and you heard
4 from the administrators they don't have any
5 plans to do so. Grand Strand -- we also know
6 Grand Strand won't get any referrals from the
7 urologists, you saw that on Respondent 10..
8 We'll talk a little bit about -- I'll talk a
9 little bit about kind of a new theory that
10 emerged later on. Grand Strand does not have
11 Conway Hospital's support, and it doesn't have
12 Loris and McLeod Hospital's support. And
13 McLeod's a big system that now owns Loris, so
14 there's not a lot of love loss there. Grand
15 Strands wants to establish a comprehensive
16 cancer center in a county that currently
17 doesn't have a comprehensive cancer center,
18 Your Honor. In fact, you've seen data that
19 shows that a lot of people will leave Horry
20 County for inpatient services at McLeod and at
21 MUSC, and you also heard testimony that they
22 may go to Duke and some other -- some other
23 places as well. While Grand Strand doesn't
24 have experience in delivering radiation
25 therapy, it does have HCA, which operates, I

1 believe the testimony was, 40 radiation therapy
2 centers across its hospitals across the United
3 States, over 80 radiation therapy units or
4 linear accelerators, but also has a sister
5 hospital down in Charleston, South Carolina,
6 which is Trident Medical Center, which operates
7 two linear accelerators and has been approved
8 for three. We believe, as I said, the Court
9 can approve both projects, so I don't think we
10 need to go through the whole definition of
11 competing applicants, but at the end of the day
12 the question is if you -- if you approve both
13 of these is that going to exceed the need for
14 services in the area. And we believe based on
15 the fact and the expert, the credible expert
16 witness testimony that you heard, the documents
17 that you've seen, that the evidence
18 demonstrates that this Court can easily approve
19 both CON projects because doing so doesn't pull
20 in 2017 or maybe even further out, doesn't pull
21 the existing providers underneath the 80
22 percent threshold, which is really kind of the
23 bar. It is the bar. It's the State Health
24 Plan Standard 6B that Grand Strand recognizes
25 it has to achieve. It cannot take any of those

1 existing operators, and that's Georgetown and
2 CRCC, under the 80 percent threshold. Now what
3 do we know. What do kind of the official
4 documents say? Well, we know that the State
5 Health Plan, the 2012-2013 State Health Plan
6 shows a need for a sixth linear accelerator
7 even after CRCC's linear accelerator was
8 approved. So there's still a need for another
9 one. CRCC's agent, former DHEC commissioner,
10 Doug Bryant, he recommended that CRCC actually
11 apply for a new unit. And Mr. Lewis'
12 testimony, he acknowledged that they likely
13 will apply for that unit. So the question is
14 if there's no need for a sixth unit, why is
15 CRCC interested in applying for it or their
16 documents say that? This is just something
17 you've already seen before, but this is
18 straight out of Joint Exhibit 5. It shows that
19 there is a need. The word need is actually
20 prominently displayed for Georgetown, Horry,
21 and Williamsburg County. And then based on,
22 this is Petitioner's 36, based on the 2012
23 numbers that have been officially reported to
24 the State Department of Health and
25 Environmental Control on JAR reports, there is

1 still a need in the service area based on the
2 2012 volumes. We believe, Your Honor, that the
3 evidence is overwhelming ---

4 THE COURT: When you say need, I mean, you do
5 recognize the other elements of need so that's
6 just a first level need?

7 MR. THOMAS: Correct. Correct. And let me go back
8 to that one, Your Honor. So in the -- for the
9 2012 radiotherapy need, what this basically
10 tried to mimic is what a new State Health Plan
11 based on 2012 numbers would look like.

12 THE COURT: Yeah.

13 MR. THOMAS: And so if the service area would still
14 be operating at 85.3 percent, so we believe
15 that in that category of, you know, unmet need
16 it would say need for that.

17 THE COURT: Okay.

18 MR. THOMAS: So yes, you're right. The very first
19 threshold and still have to show the other
20 elements of the standards, the nine standards
21 in the State Health Plan. We believe the
22 evidence is overwhelming that if you approve
23 both projects then the need for services would
24 not be exceeded. So what's the evidence here?
25 Well, Grand Strand's projected volumes in its

1 CON applications are very typical of what a
2 startup provider in a market dominated by two
3 well entrenched providers would be.
4 Interestingly, if you'll kind of look at --
5 let's look at the other providers. Georgetown
6 has been operating in the service area for
7 about ten years and in 2012 did 5,300
8 treatments. Georgetown's in a county with no
9 other linear accelerators, with 65,000 people,
10 and right next door is Williamsburg County with
11 twenty-five, thirty thousand in that area with
12 no linear accelerators. So literally 90,000
13 people kind of captive and they're doing 5,300
14 treatments. You look at CRCC, they said that
15 Conway has got with the zip codes there is an
16 area of 80,000 people, and they're only
17 projecting 5,499 treatments in their third year
18 of operations, Your Honor. And that's for a
19 facility that where the nearest facility, even
20 you included Murrells Inlet in there, the
21 nearest facility would be 13 miles away. And
22 so they're only saying they're going to do
23 5,499 treatments. And then we know in Myrtle
24 Beach CRCC is going to at least have two units
25 in Myrtle Beach, most likely, or maybe three,

1 but most likely they'll have one in Murrells
2 Inlet, and there will be another unit in
3 Murrells Inlet as well for Georgetown. So
4 Grand Strand's going to be one unit trying to
5 break into this market where it doesn't have
6 any experience as CRCC's expert testified. And
7 if you just look at the State Health Plan, look
8 at the well entrenched single unit providers in
9 South Carolina, they average about 4,819
10 treatments a year and only a couple of them
11 exceed 6,000 treatments a year and that's the
12 ones that have been around for a decade. CRCC
13 acknowledged that they have strong referral
14 relationships that they I think had to earn.
15 And how long did it take them to earn that?
16 Three decades. They've got a reputation that
17 spans back three decades. So the idea that a
18 physician is just going to turn on a dime and
19 start going to Grand Strand is, we believe,
20 preposterous. CRCC's witnesses all testified
21 that they've greatly improved provider
22 relations and they also represented that
23 improvement to the DHEC -- to the DHEC staff at
24 the project review meeting when they were
25 trying to justify the reason why they should

1 get a fourth linear accelerator. CRCC also
2 showed that it greatly improved its technology.
3 And then CRCC made a big deal about having the
4 support of the Conway medical staff and the
5 Conway Hospital. So, you know, they're going
6 to have all this support over there and be 13
7 miles away from the nearest competitor and --
8 including themselves, and they're only going to
9 do 5,499 treatments in the third year of
10 operations, and that's the 2017 number.
11 Interestingly enough, that's below the tipping
12 point that Mr. Tolbert established in his
13 testimony of 5,525 treatments. What was
14 interesting is that CRCC is claiming that Grand
15 Strand's going to have this incredible program
16 and that physicians are going to want to refer
17 to the program; however, Mr. Tolbert
18 acknowledged on the stand right before you that
19 he wasn't sure if Grand Strand would even be
20 able to establish a quality program. So, you
21 know, it's baffling. It's kind of speaking out
22 of both sides of his mouth. Well, you're going
23 to be incredible, you're going to get all these
24 referrals, everybody's going to go to your
25 program, but on this side we don't think you're

1 going to be that good. It doesn't make any
2 sense. CRCC's Conway facility would have an
3 entire 12 month head start on anything Grand
4 Strand would build. You saw the bar graphs,
5 Grand Strand says that to get their center up
6 from scratch it's going to take about 18
7 months. CRCC says they can do everything in
8 six months, so they've got a year head start.
9 CRCC acknowledged in Petitioner's 50 that the
10 only support it needed for the Conway facility
11 were the three Coastal Cancer Center physicians
12 that actually practice there in that building.
13 That's Goldberg, Cody, and Karpenko. And
14 they've got that; they got that support. And
15 if you -- and we'll look -- I'm going to look
16 at that -- the verbiage from that email later,
17 but you know what, we never heard testimony,
18 and even Dr. Francke's own email indicates that
19 I don't know that anyone ever asked for Dr.
20 Holt's support. We believe that for these
21 reasons, CRCC's referrals and corresponding
22 treatments are going to remain strong, Your
23 Honor. Again, I mentioned -- I've already
24 mentioned this that Conway's facility's
25 operating 5,499 treatments in year three in a

1 very large area. So Grand Strand's estimate of
2 4,690 in year three has got to appear
3 reasonable next to that projection and next to
4 Georgetown's actual operating history. CRCC,
5 and this is -- was kind of downplayed, because
6 I think -- I think that CRCC had to downplay
7 it, but they were approved for a Murrells Inlet
8 location. And they're going to have certain
9 geographical advantages that Grand Strand
10 simply isn't going to have, especially for an
11 outpatient service where everybody's kind of
12 said, well, the closer you are to the patient
13 that needs it, yeah, that patient's probably
14 going to prefer to go there and the physician's
15 not going to make the patient travel a long
16 distance.

17 THE COURT: That approval occurred before or after
18 the decision at DHEC in this case?

19 MR. THOMAS: Before.

20 THE COURT: Okay.

21 MR. THOMAS: Yeah, both of them were approved, Your
22 Honor. I think that was Petitioner's 28 and
23 29, and I want to tell you that the date was
24 well before December 28, 2011. So the fact
25 that these locations have been approved we

1 believe is going to limit Grand Strand's
2 ability to draw a whole lot of treatments from
3 those areas. And lastly, well, CRCC's
4 radiation oncologists are known to the referral
5 sources in the area, including the ones on
6 Grand Strand's medical staff. And so again,
7 Grand Strand's going to have to earn that
8 trust. Now, how do we know that Grand Strand's
9 not going to bring the existing providers under
10 the 80 percent threshold by year three of
11 operations? Well, it all comes down to the
12 math, and unfortunately, for CRCC, the math
13 doesn't work. Grand Strand's expert showed in
14 an adverse impact analysis that even if you use
15 Mr. Tolbert's highest market share assumption,
16 which we don't agree with, but even if you use
17 that, and by the way, Mr. Tolbert acknowledged
18 it was farfetched, Grand Strand can't bring the
19 existing providers, Georgetown, CRCC, below
20 that 80 percent threshold. So what did Grand
21 Strand's expert do? He basically went to the
22 analysis that Mr. Tolbert had done and chose
23 his number, I think it was 31,872 treatments
24 for 2017. Mr. Sullivan's number was actually
25 higher. So he used the lower one that would

1 actually provide an advantage from the adverse
2 impact analysis to CRCC. And what he did, as
3 you saw in Petitioner's 41, is he carved out
4 what everybody knows Grand Strand's not going
5 to get. And those are the prostate cancer
6 treatments, all right. He carved them out
7 based on the financial loyalty and using kind
8 of Mr. Tolbert's highest market share
9 assumption Grand Strand would do 4,703
10 treatments. At that level, all existing
11 providers are going to be above 80 percent per
12 the tipping point that was established by Mr.
13 Tolbert in the calculation that he did with Mr.
14 Long. Mr. Tolbert also admitted that as of his
15 deposition date, and I think this is a pretty
16 critical fact, he wasn't fully aware of the
17 magnitude of the urologist referrals to CRCC
18 and just how many treatments are kind of
19 responsible -- I mean, that the urologists are
20 responsible for. He just he didn't -- he
21 didn't know. He knew they were employed, but
22 he didn't really understand that they accounted
23 for up to, in 2012, it was 43.7 percent of all
24 treatments. And that's on Petitioner's 52.
25 That's where I go next. Mr. Sullivan actually

1 assumed 46 percent in his analysis, which was
2 an estimate. But even if you kind of reconcile
3 those two, the difference is about 573
4 treatments, so again, even under the most
5 aggressive analysis Mr. Tolbert does, if you
6 added those back to Grand Strand in 2017,
7 there's still a 5,260 treatments, which is
8 still below that kind of magical 5,525 tipping
9 point. Now we think what's pretty interesting
10 is the draw rate analysis Mr. Tolbert did kind
11 of using Grand Strand's inpatient market share.
12 And this use of the term market share here
13 really should be patient origin with market
14 share applied. But he performed his own draw
15 rate analysis, Your Honor ---

16 THE COURT: Patient origin?

17 MR. THOMAS: Yeah, where he looked at the inpatient

18 ---

19 THE COURT: Oh, where the patient -- okay.

20 MR. THOMAS: Yeah, for the inpatients. And you'll

21 recall Mr. Sullivan looked at where did the

22 cancer inpatients come from in the zip codes.

23 Mr. Tolbert said that violated the law of large

24 numbers, and so he decided to use the total,

25 the totality of inpatient, which Mr. Sullivan

1 said was wrong. Why? Because there is a
2 hospital in Conway that has inpatient cancer.
3 There's a hospital in Waccamaw that has
4 inpatient cancer services. There's a hospital
5 up in the north area that has inpatient cancer
6 services, Seacoast. So to just use the
7 entirety of the inpatient discharge analysis is
8 going to give you a skewed number, but let's
9 look at what happens when you -- when you
10 actually use the law of large numbers. Mr.
11 Tolbert's very aggressive draw rate analysis
12 where he does apply this inpatient discharge
13 origin to an outpatient startup service, he
14 arrives at 259 patients that would go to Grand
15 Strand for radiation therapy. That's on
16 Respondent's 13. So if you take that number,
17 multiply it by 21 treatments per patient,
18 that's 5,439 treatments at Grand Strand, which
19 is still below the tipping point that CRCC
20 established. So this analysis applies an
21 improperly high market share assumption and
22 still shows that Grand Strand's not going to
23 get to the tipping point established by CRCC.
24 Now, we know that there's been a dispute over
25 the 21 treatment per patient number, but the

1 facts, again, this is simple math. The
2 evidence has shown that when a provider isn't
3 doing any prostate cancer treatment, the
4 average treatment per patient is going to be a
5 lot lower, something along the lines of 21
6 treatments per patient. And that Joint 2, page
7 21, that's Grand Strand's CON application where
8 the only thing Mr. Sullivan did was he took the
9 actual number of treatments reported in the
10 JARS by CRCC and Georgetown, and he divided
11 them by the actual number of patients treated
12 at these radiation therapy centers, and it came
13 up to 21 treatments per patient. The one thing
14 we knew back then was that the urologists
15 weren't referring to CRCC because of a business
16 dispute with Dr. Bass that Ms. Price testified
17 about. And Mr. Tolbert acknowledged on the
18 stand that CRCC's treatments per patients could
19 have increased because of the change in service
20 mix at CRCC, and so what we saw was from 2009
21 to 2011, we saw CRCC's treatments per patient
22 go from somewhere around 21 to somewhere around
23 26 per patient.

24 THE COURT: And when you say because of the change
25 of service mix, you mean?

1 MR. THOMAS: I mean the addition of all the prostate
2 cancer patients.

3 THE COURT: Yeah.

4 MR. THOMAS: Okay. So let's kind of look at how did
5 that service mix change at CRCC from 2009 to
6 2011. Well, I think the testimony from most of
7 the witnesses, not all, confirmed that the
8 increase in treatments at CRCC was due entirely
9 to the urology patients. So in 2009, they did
10 15,613 treatments and in 2011 they did 25,709.
11 So they had a 64.7 percent increase in
12 treatments over a two year period. And when
13 you kind of take that out, CRCC out of the
14 equation for what everybody else in the state
15 did, statewide treatments only went up 2.2
16 percent over that two year period. And we know
17 during that two year period from 2009 to 2011
18 that 21st Century Oncology purchased the
19 urology practice that wasn't referring to Grand
20 Strand, and we also know from the data in
21 Petitioner's 38 that urology consult referrals
22 went from 39, this is to CRCC, went from 39 in
23 2009 to 406 in 2011, which is a 1,041 percent
24 increase. And even, you know, this number --
25 radiation therapy treatments or radiation

1 therapy treatment plans come out of consults.
2 You don't have any consults, you're not going
3 to get any radiation therapy patients. Again,
4 the math, you just can reduce this to good old
5 fashion math. We know that CRCC performed
6 22,798 treatments in 2012. We know that the
7 number of treatment plans in 2012 is 886, that
8 was all over Respondent's Number 10. We know
9 that if you just do that math there, 886 into
10 22,798 you get 25.7 treatments per patient.
11 And we know that CRCC's prostate treatment mix
12 is 43.7 percent in 2012. So that means in
13 2012, 9,963 prostate treatments come from the
14 urologists, that's what they did. And Your
15 Honor, that's enough to fill up that Tomo, to
16 bring that TomoTherapy machine that's at 5,000
17 treatment capacity, 100 percent utilized, and
18 then that's enough to put the remainder,
19 basically 5,000 patients on CRCC's, one of
20 their 7,000 capacity machines. That's almost
21 what, 85 or 75 percent utilized, if not a
22 little higher, by one practice group, the
23 captive urology practice. We know that from
24 Respondent's 10 that AUC accounted for 263
25 treatment plans, so that means that all the

1 other physicians that aren't urologists that
2 aren't going to be referring prostate cancer,
3 that means that there's 623 treatment plans
4 from them. So if we do this equation, that
5 means there's 12,835 treatments from other
6 referral sources in 2012. And you just do that
7 math, simple math, 12,835 treatments divided by
8 623, gives you 20.6 treatments per patient.
9 That's the math. And so what does that tell
10 you? Well, you take the remainder from the
11 urologists, you just divide 263 into what they
12 did and that shows that for every urology
13 referral you get 37.8 treatments per patient.
14 What's interesting is that reimbursement is by
15 treatment, not by patient. So Mr. Tolbert's
16 intuition about the change in patient ---

17 THE COURT: Is that in the record?

18 MR. THOMAS: I believe so, Your Honor.

19 THE COURT: Okay. I just don't remember it.

20 MR. THOMAS: Mr. Tolbert's intuition about the
21 change in the patient mix was correct. And
22 what's interesting about that draw rate
23 analysis that he did, Your Honor, I asked him
24 if he assumed that CRCC-Conway or CRCC Murrells
25 Inlet was going to be in operation at the time,

1 because it was a projection. He said that he
2 didn't remember. He'd done it six weeks
3 previous, and he didn't remember if he factored
4 that into the analysis, and that's a pretty big
5 omission if you think about it, because again,
6 there would be an impact for Conway location on
7 what Grand Strand's going to pull out of
8 Conway, and there would be an impact by
9 Murrells Inlet location, either one or two
10 linear accelerator facilities down there, on
11 what Grand Strand pulled from down there. Your
12 Honor, nobody has denied that the location of
13 radiation therapy service is going to affect
14 where a patient goes because physicians
15 typically want to minimize unnecessary travel
16 time. Location is a primary reason CRCC, not
17 the only one, but it's a primary reason CRCC
18 claims it sought to establish their center in
19 Conway, so they could bring the services closer
20 to the patient. I believe Ms. Maynor talked
21 about that, Ms. Price talked about that, Mr.
22 Lewis talked about that. And I would imagine
23 the same would be true for the Murrells Inlet
24 location. But Mr. Tolbert couldn't remember
25 whether or not he factored in those two

1 facilities into the analysis. What was
2 interesting to us is that all of Mr. Tolbert's
3 adverse impact analyses continued to evolve
4 even during trial, and they were all extremely
5 aggressive. But we think they had to be
6 aggressive because that's the only way they're
7 going to show that CRCC would be impacted by
8 something that Grand Strand would do. We think
9 that, and Mr. Sullivan showed Petitioner's 41,
10 I think 39 and 40 go along with those, Your
11 Honor, but he showed on a spreadsheet that once
12 you account for the urology advantages, I'll
13 call it, under none of Mr. Tolbert's market
14 share percentages that he used 25, 30, or 35,
15 do the existing providers get pulled below 80
16 percent if you approve both. Therefore, Grand
17 Strand's project would comply with Standard B
18 of the radiotherapy standards. But there are
19 other obvious reasons, Your Honor, we believe
20 that you should not pay shrift to Mr. Tolbert's
21 adverse impact analysis. First of all, what
22 did Mr. Tolbert do at the project review? Mr.
23 Tolbert originally relied on Grand Strand's
24 projected treatment volumes from its CON
25 application extended under his own analysis to

1 2015 to try to show that Grand Strand would
2 bring -- if two were approved, Grand Strand
3 would bring the existing providers under 80
4 percent. But we did the math with Ms. Brandt
5 to show that if you make the assumptions of
6 what everybody said they were going to do that
7 there was an error. She acknowledged the
8 error. She acknowledged Les Shelton told her
9 about the error, but for some reason, she
10 ignored it. But we did the math and showed
11 that they would still be operating above 80
12 percent if both were approved. But here's the
13 deal, those are 2015 numbers and good or bad
14 how our process works is time can go by before
15 a case is going to be tried because of the
16 discovery period and things of that nature. So
17 that's going to put potentially the third year
18 out at 2017. I say potentially because there's
19 always the chance that there's an appeal, but
20 he knew now that his original analysis, which
21 we showed to be erroneous, wouldn't stand the
22 test of time because of growth in the market.
23 One of the reasons I say that 2017 is probably
24 not even likely the third year of operations,
25 Your Honor, is that it's highly unlikely that