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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 4 OF 10

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1 A: Purchasing would require a willing participant
2 to be purchased. There would be nothing
3 stopping us from recruiting and employing our
4 own separate new medical oncologist.

5 Q: Okay. So, and you would agree with me that one
6 way to build volume for a facility is to
7 establish a group practice and pay the
8 employees of that practice certain profits
9 flowing from a Stark -- Stark compliant,
10 ancillary profit formula from revenues
11 generated from the referrals to the linear
12 accelerator facility, correct? That's one way
13 to do it, right?

14 A: Yeah, that is a way, yes.

15 Q: Okay. And that's a strategy 21st Century has
16 used, correct?

17 A: Correct.

18 Q: Who makes the decision in the company, Mr.
19 Lewis, as to what kind of linear accelerators
20 are placed into service at 21st Century?

21 A: Our chief of our physics department, Daniel
22 Galmarini.

23 Q: Does anyone else but him have the say or input
24 into the type of equipment that is actually
25 placed at the facility?

1 A: He will collaborate with the local physicians.

2 He'll collaborate with our CEO, Dr. Dosoretz.

3 Q: When you say local, local physicians,
4 physicians like Dr. Francke who's in the room
5 with us?

6 A: Correct.

7 Q: And I think it's well established CRCC did
8 replace one of its facilities -- excuse me, one
9 of its linear accelerators in early 2011 with
10 the Clinac iX, correct?

11 A: Correct.

12 Q: Okay. And 21st Century Oncology wouldn't have
13 done that if they thought that the Clinic iX
14 was an inferior piece of equipment, correct?

15 A: It was the state of the art machine at the
16 time.

17 Q: Okay. But you agree with me that 21st Century
18 would never install a piece of equipment that's
19 not a good quality piece of equipment that is
20 going to provide the standard of care?

21 A: Correct.

22 Q: Okay. And you agree that the Clinac iX they
23 did install is a good quality unit, right?

24 A: It is a -- yes, it's a good machine.

25 MR. THOMAS: Can we call up Respondent's 22, please?

1 Q: I think Mr. Long may have asked you a couple
2 questions about this. And if you can read it
3 on the machine, on the screen, let me know. If
4 you can't, we can go to the notebook if you
5 want.

6 A: Correct.

7 Q: Let's look in the year 2012, the Clinac ix
8 actually did more treatments than any other
9 linear accelerator at CRCC, correct?

10 A: Correct.

11 Q: Okay. And the total there I guess is 22,767
12 for 2012?

13 A: Correct.

14 Q: And let me ask you this. I was curious. On
15 the 2010 column there, is that 15,417, is that
16 part -- did you say that was partial year
17 treatments for 2010?

18 A: Yeah, that would be May -- May 2010 forward,
19 May 4th, 2010 forward.

20 Q: Okay. So y'all did report on JARS a certain
21 number, correct? I think something in the area
22 of 20,000?

23 A: It was twenty thousand nine something I
24 believe.

25 Q: I won't hold you to it, but it's in the State

1 Health Plan, right?

2 A: Correct.

3 Q: Okay. Good. And on the chart above in
4 Respondent's 22, in 2012 the number of IMRT
5 treatments, is that 17,763?

6 A: Correct.

7 Q: And in 2010 it was 10,920, correct?

8 A: Right, but again, those aren't comparable
9 numbers.

10 Q: Okay. Because there are four months of data
11 that aren't in 2010, right?

12 A: Correct.

13 Q: Okay. Good. And just for the record, you
14 don't -- CRCC doesn't have any plans to replace
15 the Clinac iX anytime soon, correct?

16 A: No.

17 Q: And you would agree with me that the Clinac iX
18 is capable of treating just about any
19 diagnosis, right?

20 A: Yes.

21 Q: And when 21st Century moves into a community
22 and acquires a radiation therapy center, and
23 it's done that before, right?

24 A: Yes.

25 Q: Okay. One of the things that 21st Century

1 prides itself on is making the center better,
2 correct ---

3 A: Correct.

4 Q: --- than it was before, right? Is that right?

5 A: Correct.

6 Q: Okay. So 21st Century, one of the things they
7 may do is they're going to try to bring the
8 physician community together, correct?

9 A: Correct.

10 Q: They're going to establish, I think you
11 mentioned earlier in your direct, clinical
12 protocols that are kind of companywide; is that
13 right?

14 A: Yeah, we have protocols, yes, that our chief
15 medical officer and other physicians work on
16 and there are company protocols.

17 Q: Just for the record, who is the chief medical
18 officer?

19 A: Dr. Connie Mantz.

20 Q: And you would agree with me that CRCC provides
21 a good service and a good product for the
22 patient, right?

23 A: Yes.

24 Q: And one good thing about that is those patients
25 who have been treated well at CRCC are going to

1 go out in the community and spread the word
2 that CRCC does a good job, right?

3 A: That could happen, yes.

4 Q: And you believe that 21st Century and CRCC can
5 do a good job, right?

6 A: Yes.

7 Q: A great job, right?

8 A: A very good job.

9 Q: Okay. Look at Petitioner's 37 for me. And you
10 can look at it on the screen or you can open it
11 up.

12 A: I can see it here.

13 Q: Okay. I know there's been talk about volumes
14 and why it's happened. But you would agree
15 with me that from 2009 to 2011 CRCC's
16 treatments went up approximately 65 percent,
17 correct?

18 A: That's what this says, yes.

19 Q: Okay.

20 A: And it's come back down actually on a full year
21 basis below 2010 annualized for 2013. We're
22 trending below 2946 full year 2013.

23 Q: Okay. Well, that's your testimony, correct?

24 A: Correct.

25 Q: All right. And one of the reasons for that is,

1 and I think you said it earlier, is that
2 urology treatments have come down, correct?

3 A: Correct.

4 Q: And something significant that happened at the
5 -- in November of 2012 was that there was a
6 national media story that focused in part on
7 CRCC and Atlantic Urology Clinics, correct?

8 A: No, that's -- can you rephrase that?

9 Q: Yeah. Well, I think we've called it in this
10 courtroom is the Bloomberg article.

11 A: Right.

12 Q: Okay. And you've had an occasion to read that
13 article?

14 A: Correct.

15 Q: And that happened towards the end of 2012,
16 right?

17 A: Yeah, that sounds correct.

18 Q: And what that article did was kind of
19 spotlighted on how treatment patterns had
20 changed in Horry County, correct?

21 A: I don't remember exactly, but yeah, it -- it
22 did talk about Horry County.

23 Q: Okay. Well, and specifically it talked about
24 CRCC, right?

25 A: Correct.

1 Q: Okay. And do you think that may have had
2 anything to do with the falloff on the urology
3 -- urologist treatments?

4 A: That specific article, no.

5 Q: Do you know that for a fact?

6 A: No.

7 Q: Now, you realize that the state of South
8 Carolina at the same time as Petitioner's 37
9 says that if you take CRCC out of the equation,
10 linear accelerator treatments went up 2.4
11 percent from 2009 to 2010, and then 2011, over
12 20, 2009 was only 2.2 percent, right?

13 A: That's what this says, but there again, it's
14 going to, if you took that out to present, it's
15 going to be back down to 2010 levels.

16 Q: Okay. Well, the only practice, you would agree
17 with me, that CRCC -- or excuse me, that 21st
18 Century controls is the urology practice,
19 right? That's -- I mean that's the only
20 practice they control. They employee those
21 folks, right?

22 A: I wouldn't say we control them. We do employ
23 them.

24 Q: And you said there's absolutely no requirement
25 to refer, correct?

1 A: Correct. And they do refer to -- they continue
2 to do surgeries. They do refer to Georgetown
3 Hospital. We do not track the patient that
4 they've seen in their center to make sure they
5 get radiation therapy at our center. That is
6 not done.

7 Q: How do you know they refer to Georgetown
8 Hospital? Have you seen Georgetown's numbers?

9 A: No. But I've had, you know, conversations with
10 the people, you know, Rosa and others with the
11 -- directly with the practice administrator at
12 the group.

13 Q: Is that a number that AUC tracks?

14 A: No. I just said we don't track how many
15 referrals go to Georgetown. We don't have that
16 data.

17 Q: So you have no idea what it is?

18 A: No, I don't know what it is, but I do know
19 urologists do support the radiation center in
20 Georgetown.

21 Q: Will they continue to support it if Murrells
22 Inlet is put -- Georgetown's Murrells Inlet
23 linear accelerator facility locates there?

24 A: My understanding is that we explain to the
25 patient there's two treatment options, two

1 radiation therapy facilities, and it's their
2 choice as to which one they go to.

3 Q: Okay. Well, we know in 2012 263 of those
4 patients chose CRCC, correct?

5 A: I believe that's what's in the data, yes.

6 Q: Just for the record, I mean, CRCC is something
7 called an ACR accredited facility, correct?

8 A: Yes.

9 Q: Okay. And does that mean anything to you?

10 A: Yeah. It's a very rigorous program. I'm not
11 probably the best one to speak about it, but
12 it's a very rigorous program that not all
13 radiation therapy centers try to get because
14 there is such a rigid requirement to go through
15 to become accredited.

16 Q: Okay. And to your knowledge, CRCC was already
17 ACR accredited before 21st Century acquired it,
18 correct?

19 A: I don't know that.

20 Q: Are you aware that Georgetown is also ACR
21 accredited?

22 A: I've heard that, yes.

23 Q: And they're a single unit operator, right?

24 A: I believe they are.

25 Q: Okay.

1 A: I do not believe the other centers that have
2 been mentioned, MUSC I don't believe is, I
3 don't believe Trident is.

4 Q: Do you know if they're ACRO accredited?

5 A: I don't know.

6 Q: Okay. That's another accreditation ---

7 A: Yes, it is.

8 Q: Would you agree with me though that if the --

9 I think you mentioned that maybe one of the
10 reasons that the urology consults and
11 treatments have come down is because there have
12 been a change in the PSA guidelines, right?

13 A: Yes. That -- I mean, our data across a hundred
14 centers definitively shows that the timing of
15 that announcements, you know, lagging a couple
16 months beyond that, which would be the natural
17 time frame from when the tests stopped to when
18 the patients would be referred, it is that
19 point in time that across our company, across
20 the nation, urology -- referrals to urologists
21 went down, therefore, referrals out from
22 urologists to other specialties, i.e.,
23 radiation oncology went down.

24 Q: You would agree with me that a decree from the
25 federal government or from a urology

1 professional organization isn't going to have
2 an effect on the actual rate of cancer, is it?

3 A: No.

4 Q: It's just going to have an effect on the rate
5 of the detection of that cancer, correct?

6 A: Right. And in this case, our position is an
7 adverse impact on the detection of -- you know,
8 I've had numerous discussions with many
9 physicians in our organization and what that is
10 going to do is result in patients being
11 referred to the urologists and to the radiation
12 oncologists or whatever modality they take, and
13 they're going to have a more advanced stage of
14 cancer or even a metastasized cancer.

15 Q: Okay.

16 A: A cancer that's spread that could have been
17 treated sooner.

18 Q: Could have been treated sooner, correct?

19 A: Uh-huh (affirmative response).

20 Q: And so when did that -- when did that
21 moratorium or that recommendation on limiting
22 the amount of PSA tests come out?

23 A: I believe, I don't have the exact date, but
24 well over a year and a half or more ago.

25 Q: And the recommendation was then for men a

1 certain age to have instead of every year a PSA
2 test, perhaps every two or three years?

3 A: I don't recall exactly. I think less frequent,
4 and maybe the PSA has different levels of
5 scoring. You know, depending on the frequency
6 and the level, different guidelines.

7 Q: So you would agree with me though that if it is
8 -- if the recommendation is every three years,
9 if there's a PSA test for a man every three
10 years and it kind of all started at the same
11 time, because you said you saw it companywide,
12 correct, or about two months after those
13 guidelines came out?

14 A: Yes.

15 Q: Yeah, so about every three years you're going
16 to get a big bolus of prostate cancer
17 treatments, correct?

18 A: I can't say that.

19 Q: That's how the math would work out, right?

20 A: Mathematically that would -- theoretically that
21 could be correct.

22 Q: Now, CRCC has stated that freestanding clinics
23 like CRCC are a less expensive treatment
24 alternative than hospital radiation therapy,
25 right? And you and Mr. Long went through a --

1 I guess through an exercise with one of the
2 exhibits, correct?

3 A: I'm sorry. I didn't hear that. Could you just
4 say that one ---

5 Q: Yeah. Didn't you say earlier that a
6 freestanding clinic like CRCC is going to be a
7 less expensive treatment alternative than a
8 hospital?

9 A: Correct.

10 Q: Okay. And you realize there are certain policy
11 reasons why the government would reimburse a
12 hospital higher than a freestanding clinic,
13 correct?

14 A: The way they reimburse hospitals is very much
15 different than a freestanding provider.

16 Q: And it's not just a willy nilly reason. I
17 mean, there's a reason for a higher
18 reimbursement level, correct?

19 A: I wouldn't say that the Medicare reimbursement
20 rules are, you know, straightforward common
21 sense.

22 Q: I would agree with you there.

23 A: Yeah, yeah.

24 Q: But CRCC has kind of made that point in this
25 litigation that they're going to be a less

1 expensive alternative from a cost containment
2 perspective, correct?

3 A: We are. Because for the exact same -- if a
4 patient gets 50 procedure codes, 50 procedures,
5 when you value those procedures through the
6 hospital reimbursement versus the physician
7 reimbursement, the hospital is going to get
8 reimbursed more, so therefore, it is more
9 costly to the taxpayers and everybody who is
10 funding Medicare.

11 Q: Okay. But you would agree with me there are
12 hospital-based programs all throughout South
13 Carolina, right?

14 A: Yeah, there's -- sure.

15 Q: And there are freestanding clinics, too,
16 correct?

17 A: Right.

18 Q: But you would -- actually if this Court were to
19 grant two, Grand Strand's and CRCC's, you would
20 agree with me that CRCC then would have an
21 advantage, correct, in terms of -- especially
22 for people in HSA plans like myself that have
23 got to come out of pocket?

24 A: Right.

25 Q: Because they would be a less expensive

1 alternative, correct?

2 A: Right. We would be a less expensive
3 alternative. I have an HSA, too, so, yeah.

4 Q: So you're going to shop around and find the
5 best price, especially when you're still in
6 that deductible period, right, that high
7 deductible?

8 A: Right.

9 Q: Now, you would agree with me that 21st Century
10 goes into markets where there is competition
11 already and they acquire radiation therapy
12 centers, correct?

13 A: Yes.

14 Q: Okay. Do you agree with me that in those
15 markets that they go into they compete
16 successfully and they do well from a profit
17 standpoint?

18 A: We compete in markets at differing degrees of
19 success, yes.

20 Q: Now, you testified during your deposition that
21 Grand Strand, I think the word you used was
22 devastating, that Grand Strand would have a
23 devastating impact on CRCC, correct?

24 A: Yes.

25 Q: And at the time you made that statement, your

1 basis for that was Grand Strand is very reliant
2 on the local medical oncology group, right?

3 A: They are.

4 Q: Now, at the time that you made that statement,
5 did you realize that Coastal Cancer Center's
6 physicians, I think they've got six of them,
7 are all on -- are on several different medical
8 staffs?

9 A: Yeah, they -- I know they have offices in
10 different areas with hospitals nearby, so that
11 would make sense.

12 Q: They have an office in Conway, right?

13 A: Right.

14 Q: Okay. They do chemo in Conway, right?

15 A: Yes, I believe they do. I don't know if they
16 do chemo at every office.

17 Q: Did you not hear the testimony that they do do
18 chemo in every office? Or maybe you weren't
19 here then.

20 A: I may not have been ---

21 Q: That's fine.

22 A: --- here.

23 Q: But they do have an office in Murrells Inlet,
24 correct?

25 A: Correct.

1 Q: And CRCC is proposing to move a facility, a
2 linear accelerator unit there, and actually has
3 been approved for that, correct?

4 A: Correct.

5 Q: Okay. And they have an office in Loris, right?

6 A: Yes.

7 Q: They have one in Myrtle Beach that we all ---

8 A: Yes.

9 Q: --- know about. It's right next to the
10 hospital.

11 A: Correct.

12 Q: And then they have one -- were you aware that
13 they have one in Supply, North Carolina?

14 A: Yes, I knew they had one I think which is just
15 over the border.

16 Q: Okay. Now, when you made this statement that
17 Grand Strand was going to devastate CRCC in
18 terms of adverse impact, at that time --
19 because of their relationship with the medical
20 oncologists -- at that time, you hadn't had any
21 conversations with any medical oncologists
22 regarding their referral patterns or how they
23 would change, correct?

24 A: No. Correct.

25 Q: And in fact, the Coastal Cancer Center group

1 was CRCC's largest referral source in 2012,
2 wasn't it?

3 A: It was number one or two, yes.

4 Q: Do you know? Because that's important, isn't
5 it, if it's number one or two? Weren't they
6 higher than the urologists?

7 A: Well, it depends on how you define number one.
8 Patients, treatments, how are you defining it?

9 Q: Well, how would you define it?

10 A: You know, number one patients, I believe we've
11 established there were more referrals from the
12 -- well, I'd have to look at the ---

13 Q: Well, let's look at Respondent's ---

14 A: --- I'd have to look at exhibits because you're
15 ---

16 Q: That's fine.

17 A: Yeah.

18 Q: Let's look at Respondent's 10 if we could.

19 A: Respondent's 10.

20 Q: That was a summary done by CRCC's expert. It's
21 got some 2012 data in there for us. You there?

22 A: Yes.

23 MR. THOMAS: Your Honor, are you there?

24 THE COURT: Not yet, but I will be.

25 MR. THOMAS: Okay. All right, and just for the

1 record, this is Tolbert 12844.

2 Q: And in terms of the referral source, what we
3 have here is AUC to CRCC, correct, Atlantic
4 Urology Clinics?

5 A: Correct.

6 Q: All right. It says referred to CRCC 263,
7 right?

8 A: Correct.

9 Q: All right. And I understand -- look at the
10 grand total there if you would because that's
11 -- I think that's really the total for that
12 year in the other two columns are Mr.
13 Tolbert's, I think his projections about where
14 these patients would go. And he's got two
15 categories for Coastal, but one of them, the
16 top one is 89 patients and the bottom one is
17 186, right?

18 A: I have not reviewed this before so let me take
19 a look at it.

20 Q: Yeah, sure.

21 A: So -- okay, I see the 89. Coastal primary to
22 Grand Strand with some to CRCC. And where's
23 the other one?

24 Q: Eighty-nine and then right underneath, but it
25 says Coastal ---

1 A: Oh.

2 Q: --- is 186, right?

3 A: Right.

4 Q: So that total is 275, correct?

5 A: Okay.

6 Q: All right. So Coastal was first with 275.

7 A: Right.

8 Q: And then AUC was 263.

9 A: Right.

10 Q: And then I think kind of another category that
11 would comprise the rest.

12 A: Yes, everybody else.

13 Q: Okay. But you're aware that in that other
14 category there's not a, kind of a dominant
15 physician practice, is there?

16 A: Correct.

17 Q: Okay. And you would agree with me that members
18 of Coastal Cancer Center group wrote letters of
19 support for the CRCC-Conway, correct?

20 A: I believe some of them did, not all.

21 Q: Wasn't it the three physicians, Goldberg,
22 Karpenko and Cody, that actually practiced in
23 Conway that wrote them; do you remember?

24 A: I don't -- I don't know.

25 Q: Okay. I think that will come out in other

1 testimony. And CRCC doesn't discriminate in
2 terms of how they treat referral source
3 patients. They're going to give every patient
4 the best service they can, correct?

5 A: Correct.

6 Q: Okay. And you agree with me, Mr. Lewis, that
7 the Coastal Cancer Center physicians at the end
8 of the day are going to do what's best for the
9 patient, aren't they?

10 A: They should, yes.

11 Q: Okay. Now, if Grand Strand's project is
12 approved, all right, 21st Century and CRCC are
13 going to market CRCC as being superior and they
14 might actually try to add medical oncologists,
15 too, correct?

16 A: Can you ---

17 Q: That's what you testified to in your ---

18 A: Yeah.

19 Q: --- deposition, right?

20 A: Yes. If your question was if Grand Strand is
21 approved and we lose a significant referral
22 source, yes, we will seek to replace that
23 referral source by adding to our group
24 practice, yes.

25 Q: Would you agree with me that CRCC does a good

1 job educating referring physicians about what
2 it offers and how it can benefit their
3 patients?

4 A: I would say we do an excellent job.

5 Q: Okay. That's fair enough. And you would agree
6 with me that 21st Century has facilities
7 throughout the United States that actually
8 compete with other radiation therapy facilities
9 that are closer than three miles away, wouldn't
10 you?

11 A: Yes.

12 Q: Do you know that the -- strike that. Now, a
13 little bit more about adverse impact. Back
14 when I deposed you in June I asked you
15 specifically if you had done any type of
16 financial impact analysis to determine what
17 kind of impact Grand Strand's center would have
18 on CRCC, correct?

19 A: Correct.

20 Q: Okay. And Mr. Long took you through, I guess,
21 the breakeven analysis. I want to get this
22 straight for the record. Is it your testimony
23 that Grand Strand is not going to be able to
24 break even?

25 A: Yes, the Grand Strand internal analysis shows

1 it will not break even.

2 Q: Even though you said that their reimbursement
3 rates are faulty, correct? I mean, that was
4 your testimony, wasn't it?

5 A: Yeah. I would discount their entire analysis
6 from a -- from a -- it has so many errors in
7 it, it you know ...

8 Q: So it's your testimony it's not going to break
9 even, it's going to do under 5,000 treatments,
10 right?

11 A: It ---

12 Q: It has to in order under your model, correct?

13 A: And that's in the, yeah, in the third year of
14 treatment, it -- right, it's right at the
15 teetering point of a freestanding center at a
16 minimum breaking even.

17 Q: That's your testimony, will not break even
18 because it will do less than 5,000 treatments,
19 right?

20 A: Eighteen per day is what that analysis would
21 show.

22 Q: Okay. And just for the record, you never did
23 any kind of contribution margin analysis,
24 right, to determine per each treatment that
25 CRCC loses to Grand Strand, what that will mean

1 from a financial perspective?

2 A: To CRCC?

3 Q: Yes, to CRCC.

4 A: No. But I mean, we were already down 20
5 percent. The referral source that is obviously
6 supporting the hospital at their busiest center
7 where we get our most referrals is going to
8 change that pattern. So that will be a very
9 significant impact above and beyond what we're
10 already dealing with in the past two years.

11 Q: Okay. But you've already testified you hadn't
12 talked to anyone at Coastal Cancer Center to
13 determine how their referral patterns have
14 changed, correct?

15 A: No, you asked me if I had met with any medical
16 oncologists, and you asked me earlier today
17 when I traveled there, and I said I met with a
18 practice administrator. . So I have talked with
19 one person at Coastal since our deposition.

20 Q: Who was that?

21 A: Alice Canterbury, I believe, is her last name.

22 Q: Formerly Pickering, correct?

23 A: I don't know. Just Canterbury since I've met
24 her.

25 Q: And did she -- did she indicate that the

1 Coastal Cancer physicians were going to
2 radically change their practice referrals?

3 A: She implied that they would definitely be
4 supporting that practice and their -- you know,
5 we've been, as I think I told you, we've talked
6 with that group times before and they're
7 continuing not to want to partner until I think
8 this situation is cleared up.

9 Q: You would agree with me, Mr. Lewis, that the
10 medical oncologists supported the project in
11 the CON application, correct, the Grand Strand
12 project?

13 A: Yeah.

14 Q: The medical oncologists.

15 A: All of them.

16 Q: There's been no secret to that, correct?

17 A: Right. All of them supported it.

18 Q: Okay. And they also supported North Strand,
19 correct?

20 A: I believe they did. I don't know if all six of
21 them did.

22 Q: And they also supported the Coastal CRCC area
23 practice, correct?

24 A: Well, based on what you said, they supported
25 the Conway application, three of them.

1 Q: So you met with Alice Pickering because you
2 approach -- you were approaching the medical
3 oncologists to buy their practice, correct?
4 You just said, didn't you, that they didn't
5 want to partner with you because they were
6 waiting to see what was happening in this
7 litigation, right?

8 A: There's been an open dialog with them many
9 years before I met with her. I was requested
10 to go meet with her, and they continue to want
11 to be independent. There's -- you know, there
12 was no deal structure map.

13 Q: They want to be independent, correct?

14 A: Uh-huh (affirmative response).

15 Q: And you would agree with me that when CRCC was
16 doing 20,000 treatments, it was -- it had a net
17 income of five million dollars, correct?

18 A: What are you looking at?

19 Q: Yeah, go to the CON application and page 300.

20 MR. THOMAS: Joint 1, Your Honor.

21 A: Page 300?

22 Q: Correct.

23 A: What was the question?

24 Q: Well, I'm looking at 300. What's the net
25 income for 2010? And that was actual, right?

1 2011 was projected. 2010 was actual. At
2 20,946 treatments, what was the net income at
3 CRCC?

4 A: This would show five million.

5 Q: Okay. And then at 22,000 treatments the net
6 income is close to 7.5 million, right,
7 projected?

8 A: Correct.

9 Q: Correct?

10 A: Correct.

11 Q: Okay. Now, you would agree with me that
12 prostate cancer is primarily treated with IMRT
13 these days, correct? Is that the ---

14 A: Well, it ---

15 Q: From a radiation therapy ---

16 A: Yeah, from a radiation therapy perspective, the
17 standard of care is IMRT, IGRT.

18 Q: And you testified I believe at your deposition
19 that generally works out to about 40 to 45
20 treatments per patient, correct?

21 A: That's the protocol.

22 Q: And urologists are going to be the primary
23 referral sources for prostate cancer, correct?

24 A: Correct.

25 Q: All right. Now, you also testified I think

1 that urologists may also refer bladder, the
2 occasional bladder cancer patients.

3 A: Correct.

4 Q: And then anything else was kind of few and far
5 between?

6 A: Bone mets if the prostate cancer is
7 metastasized.

8 Q: Has there been any discussion based on this --
9 this PSA, this change in the PSA
10 recommendations that the cancers -- I think you
11 may have just talked about this, but I want to
12 get it straight -- that if the cancer is kind
13 of a later stage, it could have actually
14 metastasized and ...

15 A: Right. That's what I've learned from talking
16 with different physicians in our organization.

17 Q: Okay. And you would agree with me that CRCC
18 receives around 30 to 35 thousand dollars per
19 prostate cancer patient from CMS; is that about
20 right?

21 A: If it treats to the -- through the full course,
22 yes.

23 Q: Now, when I deposed you, you indicated that the
24 typical IMRT patient just kind of across the
25 board would receive about 20 treatments, right?

1 A: I don't think I said that.

2 Q: You don't think you said that. Well, let me
3 ask you this. Do you agree with me that with
4 patients who have metastatic disease,
5 palliative patients, those patients are only
6 going to get ten to 15 treatments?

7 A: It can vary by diagnosis, but yeah, that --
8 some diagnosis that sounds right.

9 Q: Okay. For some reason you've got three
10 volumes.

11 A: Yeah, I know. It was a lot of reading.

12 MR. LONG: Your Honor, is Mr. Thomas trying to
13 impeach the witness? I didn't hear a question.

14 THE COURT: I haven't heard anything either.

15 MR. THOMAS: Can I get out the deposition, please?

16 THE COURT: I'm not restricting you on that either.

17 MR. THOMAS: Got to do one at some point.

18 Q: Okay. I did ask you, Mr. Lewis, did I not,
19 that when I deposed you, you stated the typical
20 IMRT patient received about 20 treatments and
21 you said you didn't think you said that, right?

22 A: Yeah, let me see your question to me.

23 Q: Yeah, Exhibit 121 if you would -- page 121 we
24 can read along. All right. We can start at
25 the top of the page if you want. How about I

1 ask the question, you say the answer?

2 A: Sure.

3 Q: Okay. Question: "Do you have any data, like
4 what the average number of IMRT treatments per
5 patient generally is? Is that something that
6 you would know?"

7 A: I said, "No, it's all dependent on diagnosis
8 mix."

9 Q: I said, "You can find an average, right? You
10 would take the number of patients treated with
11 IMRT and divide it by the total number of
12 treatments, correct?"

13 A: "Right, but that's historical."

14 Q: "That's what I'm asking you."

15 A: "Yeah."

16 Q: "Do you have any idea what it is?"

17 A: "I believe -- for what, CRCC?"

18 Q: "Companywide."

19 A: "It's probably 70 percent."

20 Q: "I'm talking about like what a typical IMRT
21 patient would get in terms of treatments. I'm
22 sorry, I may have misstated that question."

23 A: "Number of treatments, it's probably close to
24 20."

25 Q: Okay. That was your testimony back in June,

1 correct?

2 A: I -- that's what I said, yes.

3 Q: Okay. And let's go to Respondent's 21. I
4 think that may be an exhibit you and Mr. Long
5 looked at. Let me know if you can't read that,
6 feel free to go to the book. I know I can
7 hardly read it on the paper. Can you see it
8 all right?

9 A: Yeah.

10 Q: Okay. And in terms of the prostate count,
11 these are actually patients treated by
12 diagnosis, right? The actual number of
13 patients. It's not consults, is it?

14 A: Right. Patients treated by diagnosis by year.

15 Q: All right.

16 A: And again, the 2010 would be a partial year.

17 Q: Okay. What's the number there though in terms
18 -- let's look at 2012.

19 A: Okay.

20 Q: All right. And the bladder count, what's the
21 bladder count for patients treated? Can you
22 read that?

23 A: I better pull it.

24 Q: Yeah, why don't you pull it up. It's not, like
25 I said, it's not good.

1 A: Which document?

2 Q: It's Respondent 21.

3 A: The bladder for 2012 says eight.

4 Q: Okay. And the metastasis count is what?

5 A: 138.

6 Q: And in that 138, that can be a lot of
7 palliative, correct?

8 A: Could be.

9 Q: And of course the highest one is the prostate
10 cancer, right, and that's ---

11 A: 304.

12 Q: 304. Bear with me. Now, would you look at the
13 Petitioner's 45 for me. Remember that the
14 prostate count is 304 on Respondent's 21.

15 A: Petitioner's?

16 Q: Yeah, now I'm going to show you Petitioner's
17 45. And I think you might be able to read this
18 on the screen so you don't have to get it.

19 A: Okay, yeah.

20 Q: And this says consults, correct?

21 A: Consults, correct.

22 Q: And this lists all of the urologists under the
23 kind of the Atlantic Urology Clinic umbrella,
24 doesn't it?

25 A: Correct.

1 Q: What's the number of consults for 2012?

2 A: 303.

3 Q: Okay. And what's the number, what's the
4 prostate count ---

5 A: 304. But I can -- that -- you're -- your
6 consult and treatment plans, especially in
7 certain diagnoses, including prostate, don't
8 always happen within the same week or month.
9 They can be sometimes months apart. So what
10 you have is in that the patients treated, many
11 of those patients were -- you're comparing
12 patients treated to consults, but those
13 consults would have occurred in 2011 in many of
14 the cases. Plus the fact that the prostate
15 volumes have been declining continuously. So
16 you can't compare the 303 to the 304 in this
17 scenario. If you want to get the true consult
18 -- actually treatment plan to consult ratio,
19 you would need to do it at the actual patient
20 level to allow -- to compensate for that lag.

21 Q: Okay. But even though there's a little bit of
22 a lag, you'd agree that these numbers are
23 pretty close, correct? I mean, if you look at
24 the ---

25 A: They're close but just coincidently. There's

1 no significance of the relationship.

2 Q: Well, that's your testimony, correct?

3 A: It's an accurate testimony.

4 Q: Well, what's the percentage of treatments that
5 companywide come out of the consults?

6 A: Treatments out of consults or ---

7 Q: Yeah.

8 A: --- do you mean treatment plans out of
9 consults?

10 Q: Treatment plans out of consults.

11 A: Seventy-five to 80 is what I would say is a
12 general normal percentage.

13 Q: Okay.

14 A: We spend a lot of time educating the referring
15 physicians to know what types of diagnoses are
16 treated by radiation. We don't want -- we
17 don't want physicians to send us every patient
18 because then you would have a huge number of
19 consults for patients that shouldn't be there
20 and that does add expense to the healthcare
21 system and adds no benefit to us because a
22 consult reimburses so low.

23 Q: So it's a reimbursement issue, correct?

24 A: No. It -- to me it's common sense. You spend
25 the time educating your referring physicians,

1 they know what our capabilities are, they know
2 what type of patients they should send to us,
3 and then that ratio of treatment plan to
4 consult will be in that 75, 80 percent range,
5 which I would -- I would say is normal.

6 Patients that don't get treated maybe choose a
7 different modality, or maybe they pass away, as
8 I said earlier. We definitely do not treat all
9 of our prostate patients that are referred.

10 Q: Well, what you have here on the treatments by
11 diagnosis back on 21 is you treat a lot of
12 prostate cases, don't you?

13 A: We treat a lot. We don't treat every. We
14 don't even get -- we don't treat every -- we
15 don't treat every prostate patient that gets
16 radiation. Georgetown treats some of them.

17 Q: Okay. You would agree with me that Georgetown
18 doesn't treat nearly as many prostate cancers
19 as CRCC, do they?

20 A: I'm sure that's probably correct.

21 Q: And you would agree with me that CRCC's current
22 level of utilization when I deposed you back in
23 June, which was what we had at that time was
24 twenty-two thousand and seven hundred and
25 something and some change, right, for 2012?

1 A: Right.

2 Q: That is a testimony of its strong referral
3 base, correct?

4 A: Well, it's actually a decline of ten percent
5 from the prior year and we're now in another
6 ten percent decline this year.

7 Q: Okay. Well, that's your testimony. You think
8 that the numbers definitively show that you're
9 ten percent decline, correct?

10 A: I believe we showed a year to date July
11 schedule on that.

12 Q: That was just a one year comparison, correct?

13 A: Seven months to seven months.

14 Q: Seven months to seven months.

15 A: Uh-huh (affirmative response).

16 Q: And you just already testified earlier you
17 didn't really look at where the breakdown was
18 coming from, correct?

19 A: No.

20 Q: But you knew that one person accounted for a
21 lot of it, right, Dr. Gangi?

22 A: No, that's what you said. I said I had done a
23 thorough analysis of the revenue and I know
24 that our loss in revenue from our employed
25 urologists more than accounts for the loss in

1 revenue that we have in the market and that we
2 have an uptick from all other specialties.
3 That was my testimony.

4 Q: Let me ask you this. Did the other specialties
5 get an increase in reimbursement for those
6 treatments for Medicare?

7 A: Did they get ---

8 Q: Yeah, did the ---

9 A: The other specialties aren't our employees.

10 Q: Bad question. Withdraw it. The treatments
11 from the other specialties, did those
12 reimbursement rates increase from 2012 to 2013?

13 A: No. We took about a ten percent decline as
14 we've been year after year. So what that means
15 is not only did they refer enough patients to
16 increase a significant amount of revenue, they
17 increased an additional amount to completely
18 offset the decline.

19 Q: I'm going to ask you a question. Did you look
20 from year to year referrals, okay, did you take
21 out the urologists and then see what the number
22 was?

23 A: Yes, that's exactly what I did.

24 Q: Okay.

25 A: And everything -- the urologists are down year

1 after year.

2 Q: Right.

3 A: The others are up.

4 Q: Are you sure about that?

5 A: Yes. In the revenues.

6 Q: Okay. I'm talking about referrals, sir.

7 A: Oh, no, referrals, no. Referrals don't tie to

8 revenue one to one.

9 Q: But you say the revenues are up from that same

10 pool of referral sources, correct?

11 A: Which -- which pool?

12 Q: The non-urology.

13 A: Correct.

14 Q: Okay. But there has been no rate increase that

15 you're aware of, right?

16 A: No, we've had successive year after year

17 decline.

18 Q: Okay. And you got no -- just so we can close

19 this down. You got no increases on your PPO

20 contracts either, right?

21 A: I'm not aware ---

22 Q: For CRCC?

23 A: I'm -- no, not that I'm aware of. I can't ---

24 Q: And you would be aware of it because you did

25 the revenue analysis, right?

1 A: I would not be aware. I'm not fully aware of
2 what our managed care department negotiates.

3 Q: Okay. Let me ask you this. And you may or may
4 not know that sometimes CON litigation in South
5 Carolina can take a few years; did you know
6 that?

7 A: I knew that coming into this. You know, we
8 were educated in that up front that this could
9 be a multi-year proposition.

10 Q: Okay. Now, if this is a multi-year proposition
11 and if one or other of the parties appeals the
12 Honorable Judge Anderson's decision in this
13 case, during that four, five year period, a
14 linear accelerator that's better than the
15 TrueBeam from Varian comes out on the market,
16 and CRCC is ultimately approved, will CRCC be
17 content with still putting the TrueBeam in its
18 facility?

19 A: I can't answer ---

20 Q: Or are you going to put the best technology in
21 the facility possible?

22 A: I'm not the one that makes that decision, but
23 you know, we would put in whatever were
24 approved to put in at the time.

25 Q: Well, let me ask you this. Would you go back

1 to the State if five years passed by and say,
2 look, that TrueBeam that we had a quote for
3 five years ago, it's a little stale and the
4 technology has changed, wouldn't that be what
5 CRCC would do?

6 MR. LONG: Objection. I mean, the question is so
7 out there it's just clearly speculative. It's
8 just ---

9 MR. THOMAS: It's not speculative, Your Honor.

10 MR. LONG: I don't know if it's an opinion or
11 whatever, but I mean, he asked him out five
12 years in the future.

13 MR. THOMAS: Piedmont ---

14 MR. LONG: Objection is to being speculative.

15 MR. THOMAS: I could have gone eight, but I went
16 five.

17 THE COURT: I'll overrule that.

18 Q: You're going to put the best technology you can
19 in, right?

20 A: That's what we generally do, yes.

21 Q: Okay. So if five years pass and there's a new
22 generation of Varian, that's what you're going
23 to ask the State to put in there if you can and
24 if it's a similar cost, right?

25 A: We would put in what we're approved to put in.

1 Q: Okay. So you're telling today, that's your
2 testimony, you're going to put a TrueBeam in?

3 A: No, if -- I can't project what two years the
4 technology is going to be and what we would do
5 two years out. There might -- I don't know, I
6 don't make the technology decisions. I
7 participate in that process, but I don't know
8 what's on the horizon from a TrueBeam Plus.

9 Q: Do you think that the TrueBeam five years from
10 now, six years from now, is going to be the
11 latest and greatest?

12 A: Based on prior trends, no.

13 Q: Okay.

14 A: But I don't think we're five years out in this.
15 We're already three years into it.

16 Q: Exactly. Three years ago, right?

17 A: Uh-huh (affirmative response).

18 Q: Now, you're familiar with the Murrells Inlet
19 CON application, correct?

20 A: Yes.

21 Q: CRCC filed a Murrells Inlet application,
22 correct, to relocate I think you said it's a
23 6EX, but then make that the TrueBeam, right?

24 A: Correct.

25 Q: Would you look on the cart there, Mr. Lewis,

1 and get out Joint Exhibit 13, for me.

2 THE COURT: Joint Exhibit 13?

3 MR. THOMAS: Joint 13, Your Honor.

4 THE COURT: I don't have that one.

5 MR. THOMAS: I might have a copy for you over here.

6 THE COURT: That's okay. I'll look at it on the
7 screen.

8 A: I've got 1 through 5.

9 Q: Let's see if I can help you out over there.

10 MR. LONG: It's Notebook 5.

11 A: Notebook 5.

12 Q: Yeah, I'm sorry, it's called Joint Exhibit,
13 Notebook 5, but Exhibit 13 would be ---

14 A: Oh, Notebook 5.

15 Q: There you go. Sorry about that. Okay. You
16 would have looked over this CON application
17 before it was submitted, correct?

18 A: Correct.

19 Q: And I think this application was submitted in
20 March of 2011, just like the CRCC Myrtle Beach
21 application was, correct?

22 A: That sounds correct, yes.

23 Q: And if you turn the page in the application, I
24 just want to ask you a couple questions about
25 this, if you'd go to page Bates 12 for me.

1 A: Okay.

2 Q: Okay. On this page at the very top there's
3 Table 3, right?

4 A: Correct.

5 Q: Under fixed equipment, what's the cost of the
6 Varian TrueBeam system there?

7 A: Three million six hundred thousand.

8 Q: Okay. So you were able to get the Varian
9 TrueBeam that's in the CRCC-Conway application,
10 you were able to get a quote for \$2.4 million
11 for that one, correct?

12 A: Correct.

13 Q: Okay. So even though you applied with a quote
14 of \$3.6 million, you don't expect DHEC to keep
15 you to that, do you, if you can get it for
16 cheaper?

17 A: Right. We will be able to get that one for 2.4
18 million as well.

19 Q: Okay.

20 A: I testified to that in my deposition.

21 Q: Okay. Unfortunately though I've got to ask you
22 these questions today.

23 A: That's fine.

24 MR. THOMAS: Okay. Let's go -- if you could put
25 Respondent 15 on the screen for me.

1 Q: That's all the questions I have for you in that
2 exhibit, Mr. Lewis.

3 A: Okay.

4 Q: Now, do you recognize this facility?

5 A: Yeah, that is the proposed Conway site.

6 Q: Okay. That's the Conway site, okay. And I
7 think you testified that maybe there's going to
8 be a little bit of an addition coming off the
9 front door here ---

10 A: Right. There ---

11 Q: --- to expand the waiting room a little bit?

12 A: Expand the front entryway, yes.

13 Q: Okay. And you would agree with me that
14 compared to other 21st Century radiation
15 therapy facilities, this one is kind of
16 atypical in terms of its size?

17 A: It's -- I testified it's on the small end. And
18 I was able to confirm we do have several,
19 probably at least five that are of similar
20 size.

21 Q: But you would agree with me that the typical
22 size of 21st Century radiation therapy
23 facilities are between five and 12,000 square
24 feet, wouldn't you?

25 A: Yes.

1 Q: And this one is roughly 3,600 square feet,
2 right?

3 A: I thought it was closer to 4,000, but ---

4 Q: Well ---

5 A: --- with the modifications.

6 Q: Okay. Well, let me ask you this. We can go
7 back into the exhibit if we have to. But the
8 Murrells Inlet facility that CRCC is proposing
9 to build is closer to 7,000 square feet,
10 correct?

11 A: Correct.

12 Q: So at least for Murrells Inlet, CRCC didn't
13 decide to go down there and put up what looks
14 like a modular building with a vault, right?

15 A: I disagree with your modular. I don't think
16 it's modular, it's not a trailer. I believe
17 it's a real constructed building. And it's
18 going to look much different, if you read our
19 application, with the modifications we're going
20 to make to it.

21 Q: Well, the modification is, at least from the
22 outside, you agree with me you're not going to
23 brick it ---

24 A: No, I believe our application said we're going
25 to build an expanded entryway. We're going to

1 put an awning on the front. We're going to
2 paint. I believe there's roof repairs. So
3 there will be quite a few cosmetic, in addition
4 to structural changes to the front appearance
5 of the building.

6 Q: But it's still going to be about 2,200, 2,300
7 square feet inside, correct?

8 A: Plus the vault, which I believe is 1,800. So
9 that gets you to about 4,000 square feet.

10 Q: But the vault is a very large vault, isn't it?

11 A: It is a very large vault.

12 Q: That's not something that CRCC or 21st Century
13 would build today, correct?

14 A: I don't make those decisions, but the vault
15 sizes typically are -- that would be on the
16 higher end of vault size.

17 Q: And you would agree with me -- well, you
18 haven't been in this facility, correct?

19 A: No, I have not.

20 Q: Do you know whether it's sprinkled in case of
21 fire?

22 A: No, I do not.

23 Q: Okay. Because Mr. Long asked you about fire
24 and life safety, and you said it would be
25 compliant with fire and life safety, correct?

1 A: What I said in my deposition I'm going to say
2 here today, is the building will have to be to
3 code or we won't get a certificate of occupancy
4 to operate it. So it will meet all local
5 building codes.

6 Q: Do you know if this particular building has
7 been wind tested for hurricanes?

8 A: I know nothing -- very little about the
9 building.

10 Q: Do you know that it is in a hurricane zone,
11 correct?

12 A: Right. And there again, I'm sure it was built
13 to the specifications, as I testified in my
14 deposition. They don't tear down buildings
15 just because they no longer meet the current
16 code.

17 Q: But you have no idea when this building was
18 built, do you?

19 A: It was built, as I testified, as part of a
20 prior failed attempt of a CON, which I believe
21 was in the 2000s, so not, you know, not
22 significant in building terms ago.

23 Q: You don't know? You don't know the date that
24 it was built?

25 A: I don't know the date.

1 Q: Okay. Now, who is Sissy Price?

2 A: She's the practice administrator for CRCC.

3 She's here in the courtroom today.

4 Q: And Ms. Price, she's been -- she was with --
5 been in radiation therapy at CRCC for something
6 like 33 years, hasn't she?

7 A: Again, I didn't realize it was that long, but
8 yeah, a long time.

9 Q: She was working in radiation therapy when you
10 were probably what, 11, 12 years old?

11 A: Well, if it's 33, then yeah, I would have been
12 12.

13 Q: She's probably forgotten more about how to --
14 sorry, Ms. Price. But you agree that she's
15 probably forgotten more about how to operate a
16 radiation therapy center than you know; is that
17 a fair statement?

18 A: No.

19 Q: You don't think so? She's been in the business
20 for 33 years.

21 A: Right. But say that again.

22 Q: Well, she's been operating a radiation therapy
23 facility for 33 years, correct?

24 A: Correct.

25 Q: And how long have you been operating ---

1 A: I've been in ---

2 Q: --- single operation?

3 A: --- in radiation therapy for eight years
4 almost.

5 Q: Okay. So less than a quarter of the time Ms.
6 Price has been operating a radiation therapy
7 facility?

8 A: Correct.

9 Q: Go to Petitioner's 64 for me. If you can read
10 this, but it was sent March 8, 2011, correct,
11 from Sissy Price to you among others?

12 A: Right.

13 Q: Okay. And she's saying, "Sam, you may want to
14 add the following to the improvement list."
15 She talks about dressing areas need to be
16 located. One of the exam rooms needs to be
17 modified for head and neck patients. Front
18 office needs cabinets, new counter tops.
19 Treatment vault will need additional cabinets,
20 counter tops, plus doors added to shelving.
21 Major electrical work needs to be added for
22 network. What was your response?

23 A: "Sam, please disregard Sissy's changes below
24 and remain with what I provided in my email.
25 What I provided is directly from the

1 architects."

2 Q: Okay.

3 A: By architects, I mean our own in-house person
4 who has been building/designing hundred -- you
5 know, all of our -- is responsible for all of
6 our radiation therapy centers. We currently
7 have a hundred. Over the years we've had, you
8 know, many more buildings than that, and those
9 changes came from him. So I was just telling
10 Sam to please not change based on what Sissy
11 said, we've already got our expert team who I
12 provided that data to him to do it.

13 Q: And Ms. Price who sent some modifications to
14 that facility we were just looking at that you
15 said was nice, based on that 33 years of
16 experience, you just said -- somebody who
17 actually works in a radiation therapy center,
18 you disregarded them, didn't you? That's what
19 you did.

20 A: Because we had -- she probably was not aware
21 that we had already submitted the changes from
22 our, you know, area that handles this all the
23 time. That's what that email is about. And I
24 don't think she'll disagree with that when you
25 ask her.

1 Q: I'm sure she won't. Let's go -- I want to talk
2 a little bit about non-governmental third-party
3 insurance, PPO, HMO, that type of thing. You
4 would agree with me that the only game in town
5 for any third-party payer to negotiate with in
6 Horry County is CRCC, correct?

7 A: In Horry County, yes, but it's not the only ---

8 Q: The other ---

9 A: It's not the service. It's not the only one in
10 the service area, and that's what pertinent, to
11 my understanding for the CON case, is the
12 service area.

13 Q: Okay. Well, patients don't want to have to
14 drive 40 miles south from Myrtle Beach to get
15 their radiation therapy?

16 A: Right. And that's why we want to move our
17 centers out to the patients.

18 Q: Well, we'll see what the emails say about that.
19 But my question to you is, you have no idea how
20 negotiations would go in Horry County with
21 third-party payers because you haven't had to
22 negotiate against anybody else, have you?

23 A: I don't -- you know, I can't answer as to what
24 our managed care department has or has not
25 negotiated.

1 Q: Okay. But you testified a lot to about what
2 the rates could be and would be, right?

3 A: Right.

4 Q: And you would agree with me there's only one
5 provider of urological services in the three-
6 county area, and that's Atlantic Urology
7 Clinics, correct?

8 A: It is the only urology provider, yes.

9 Q: And you would agree with me, Mr. Lewis, that
10 for inpatients who undergo radiation therapy
11 services at an in-hospital, the same in-
12 hospital facility, that they cannot be charged
13 separately for that service, right?

14 A: Oh, inpatient. Yeah, my understanding is
15 they're covered under a DGR or a DRG.

16 Q: DRG.

17 A: Right, DRG. And yes, there is typically not
18 additional reimbursement to the hospital. It's
19 all inclusive.

20 Q: I thought that's what you testified to.

21 A: Medicare also does require the hospital to
22 negotiate a contract with the provider of
23 radiation and does require us to have a
24 contract with the hospital when we provide
25 treatment to that patient, and it cannot be

1 done for free. So those arrangements can be
2 done in several different ways. It can be a
3 blanket rate that's applied to all patients, or
4 it can be an agreement for every patient.

5 , Q: But for the inpatients that are being treated
6 in the hospital, which is my question, that
7 charge is going to be rolled up into a DRG,
8 correct?

9 A: It is. And that's the way Medicare has
10 required it on you and us.

11 Q: Okay. You would agree that Conway and Loris
12 aren't likely going to transfer their
13 inpatients to Grand Strand for radiation
14 therapy treatment, correct?

15 A: Conway not likely because they supported our
16 project and the center would be right there.
17 I can't -- I don't know about Loris, I don't
18 know what their ---

19 Q: Do you know they are affiliated with a large
20 provider called McLeod?

21 A: Okay.

22 Q: Do you know what McLeod is?

23 A: It's -- you know, it's a large hospital, yeah.

24 Q: In Florence?

25 A: I can't tell you what they're going to do.

1 Q: But you feel confident about the Conway?

2 A: Regardless, it's insignificant, immaterial.

3 Q: I didn't ask you that. I just asked you in
4 terms of the referral.

5 A: I don't know what they'll do.

6 Q: Well, when you testified in your deposition you
7 actually agreed that Conway and Loris probably
8 weren't likely going to refer patients, their
9 inpatients to Grand Strand, right?

10 A: Probably not to -- if they consider you a
11 competing -- not you, Grand Strand a competing
12 hospital, probably not.

13 Q: Okay. And you would also agree with me that if
14 this Court approves two CON applications, both
15 of them at issue in this case, that CRCC will
16 have a one year head start in Conway by virtue
17 of the fact that they can get their project
18 going that much quicker, correct?

19 A: Yeah, I don't know if -- yeah, our project
20 timeline is one year quicker than theirs.

21 Q: You would be in that market operating a year
22 sooner than Grand Strand would be operating in
23 Myrtle Beach, correct?

24 A: Right. I wasn't agreeing with you that two
25 should be approved, but if two were ---

1 Q: I understand.

2 A: Right.

3 Q: If you were, we wouldn't be here today, right?

4 A: Yeah.

5 Q: Be out in that beautiful weather..

6 A: I couldn't make that decision.

7 Q: You would agree with sme, I know there's been
8 some testimony about this, but that if Grand
9 Strand would have dropped its CON application
10 and reapplied under the 2012-2013 State Health
11 Plan, that CRCC would have either opposed that
12 application or applied for a competing
13 application?

14 A: That's correct. We -- you know, here again,
15 you don't need a center three miles from ours.
16 The next area of need in the county is the
17 north. If we're allowed to do our project in
18 Murrells Inlet and Conway that we both have
19 approvals pending through the litigation, have
20 the center in Myrtle Beach and then put one to
21 the north, that serves those four pockets of
22 population and where we're drawing our patients
23 from today and puts the care out to the where
24 the patients are and need it.

25 Q: Well, you would agree with me that Grand

1 Strand's three miles to the north of CRCC,
2 correct?

3 A: Yeah. Three miles isn't significant.

4 Q: That's not significant, right?

5 A: No.

6 Q: Okay.

7 A: We dismissed locations that were, you know,
8 closer than what we settled on for that very
9 reason. It doesn't do the patient the benefit.

10 Q: And you would agree with me, Mr. Lewis, that
11 CRCC, just like Grand Strand plans to do, is
12 going to contract -- CRCC contracts with
13 medical physicists, correct? They don't employ
14 them?

15 A: Yeah, in this market we actually do have a
16 contract, which is not our normal model. We
17 normally employ. But I think the model that
18 was in place was working, so we kept it.

19 Q: Let's pull up Respondent's 27. I think that's
20 an email that you and Mr. Long looked at.

21 THE COURT: 27 or 127?

22 MR. THOMAS: 27.

23 Q: All right. And if you turn to I think -- look
24 at the Bates labels just like on the other one
25 -- CRCC1682 for me.

1 A: Correct.

2 Q: Okay. Now, you told Mr. Long, I believe, that
3 a decision had already been made to kind of
4 deploy these radiation therapy units out in the
5 population, correct?

6 A: Correct.

7 Q: Now, what I see here on this page, and I
8 believe it's September 29th, 2010, right?
9 Roman numeral two, preparing and submitting a
10 CON application to expand our current radiation
11 therapy service at an alternate location within
12 the service area, right?

13 A: Right.

14 Q: It says expand to a fourth linear accelerator
15 and a second site, right?

16 A: Correct.

17 Q: So that was the idea?

18 A: Correct.

19 Q: Okay. So at this point though, you would agree
20 with me that there is no mention of Murrells
21 Inlet, right?

22 A: At this point in time we hadn't done the
23 analysis to know where it needed to go.

24 Q: Yeah.

25 A: I mean, we were only five -- four months into

1 the acquisition. I got involved right after
2 the acquisition. I researched the CON
3 requirements to replace, expand, relocate.
4 That's what I do as part of my job. So I had
5 done my internal research, was reaching out to
6 Doug, who was at that time a relatively -- a
7 different consultant than I was originally
8 working with to really get to know and
9 understand these different things that we had
10 been working on.

11 Q: The only question I have though is at this
12 point in time on this day you had no idea that
13 you were --- CRCC -- I mean, you had no plans
14 to go down to Murrells Inlet with CRCC,
15 correct? That's a fair statement, isn't it?

16 A: I would say at that time we had plans to expand
17 but did not know where we were going, correct.

18 Q: Okay. Let's go to Petitioner's 46. I think
19 that's another one that Mr. Long may have asked
20 you about.

21 A: Petitioner's ---

22 Q: Yeah, in a new notebook.

23 A: Yeah. I'm ---

24 Q: Maybe just put that one up there. We may go
25 back to that. And if you turn to the last page

1 in that exhibit and talk about the emails that
2 you're on here. CRCC 409.

3 A: Correct.

4 Q: This is an email from Rosa Maynor to you,
5 correct?

6 A: Well, to me and others.

7 Q: Fair enough. And that's the same day of the
8 email we were just looking at right, September
9 30th?

10 A: I think it was the day after, wasn't it?

11 Q: Could have been, maybe so. But September 30th,
12 either the same day or a day later, right?

13 A: Right.

14 Q: Okay. What is Ms. Maynor telling you here,
15 among others?

16 A: I think I already read it into the record, but,
17 "In today's paper, Georgetown has placed their
18 public notice to move their center from
19 Georgetown to Murrells Inlet. If they are
20 allowed to do this, it will take patients from
21 the Myrtle Beach radiation site. The public
22 notice is attached."

23 Q: Okay. And if you go up, turn the page over,
24 CRCC 408, and we know how these email chains
25 work.

1 A: Right.

2 Q: Ms. Maynor again to you, among others,
3 indicates that the notice is to relocate the
4 radiation therapy service ---

5 A: Right.

6 Q: --- to Georgetown. And then she mentions it's
7 a relocation of services, correct?

8 A: Right.

9 Q: And then Mr. Travis emails back and says,
10 "Doug, this is a change of plans. We need to
11 act asap. Didn't think needed CON to
12 relocate." Correct?

13 A: Right, that's what it says.

14 Q: Now, if we go up to what Mr. Bryant, is that
15 it?

16 A: Yeah, Doug Bryant.

17 Q: Tells the group, your CON consultant basically
18 talks about needing clarification. "Previously
19 discussed relocating our own machine to the
20 Murrells Inlet area; however, I was told
21 yesterday by Rich that he did not think we are
22 pursuing moving to the Murrells Inlet area. We
23 were possibly moving equipment to Conway. I
24 need to know if we have decided on a direction
25 we plan to pursue." So at this point in time,

1 Mr. Bryant is saying, he's referencing you that
2 y'all are going to relocate equipment to Conway
3 but not to Murrells Inlet, right? That's what
4 he says. Do you dispute what he says?

5 A: Where exactly were you reading?

6 Q: Right in the middle of the page, the top email.

7 A: All right. Okay. There's that one. Yeah, we
8 talked about many different, we talked about
9 Conway, we talked about Murrells Inlet, we
10 talked about -- I mean, it's all in your
11 documentation -- Carolina Forest, we talked
12 about north. You know, we didn't have set in
13 our mind what we were doing at that point in
14 time.

15 Q: Okay. But at the end of the day, so what
16 you're saying is you were considering all the
17 options, right?

18 A: Yes, we were considering many options as the
19 documentation would clearly demonstrate.

20 Q: All right. And look at the bottom there of Mr.
21 Bryant's email. It says, "Simple answer is if
22 we just want to delay a new machine in Murrells
23 Inlet, file an appeal of Georgetown and let Sam
24 provide a competing application." Correct?

25 A: That's what it says, yeah.

1 Q: And that's what y'all did, too, isn't it?

2 A: I don't think we filed an appeal. I think we
3 filed an application that is now, I don't want
4 to use the word competing, but I think it's a
5 -- I don't know. It's ---

6 Q: You filed an application and you filed an
7 appeal, correct?

8 A: I know we filed an application.

9 Q: Do you not ---

10 A: Oh, yeah, we're -- yes, we're currently
11 appealing the decision. Both were approved and
12 we don't support both being approved, if that's
13 -- yes.

14 Q: Okay.

15 A: And we are appealing -- we are -- yes.

16 Q: Okay. Turn the page over to CRCC 407 for me,
17 please.

18 A: CRCC 407?

19 Q: Yeah, you want to go back to ---

20 A: One page.

21 Q: --- to the page to the right. Are you there?

22 A: C ---

23 Q: CRCC 407, the same Exhibit 46.

24 A: Yes.

25 Q: Okay. Are you there?

1 A: I'm there.

2 Q: Okay. And then Norton Travis, the general
3 counsel for 21st Century Oncology states to
4 you, among others, that, "Doug, unfortunately
5 we were unable to update Rich on the relocate
6 to Murrells concept. My view is that we should
7 oppose Georgetown and apply to relocate, but
8 need input from our local partners." Correct,
9 that's what it says there, right?

10 A: Correct.

11 Q: And that's what eventually happened. You don't
12 dispute that?

13 A: Right, that is eventually what happened. We
14 applied to relocate to Murrells Inlet as well.

15 Q: Okay. Now, Mr. Lewis, are you aware of any
16 discussions about relocating the Conway linac
17 from that 3,000 square foot facility to a place
18 in Carolina Pines closer to where the
19 urologists practice and had their ASC?

20 A: Yeah. I know there's an email on that, but
21 that, just like everything else, are just
22 ideas, suggestions, and would not make sense,
23 probably would not even be approved if it -- if
24 it were something that were applied for.
25 Carolina Forest is too close to -- it's one of

1 the locations we've discussed and at the
2 present, isn't an area that needs a linear
3 accelerator.

4 Q: Well, Carolina Forest is in the town and the
5 zip code 29526, the Town of Conway, correct?

6 A: But it's closer to the coast, more further
7 inland, I believe.

8 Q: But it's still on the other side of the
9 Intracoastal Waterway, isn't it? You don't --
10 you don't doubt that?

11 A: Yeah, I believe you're right, but it's not --
12 it's not the best location to put -- and that's
13 why we ended up with our current Conway
14 location.

15 Q: Well, you ended up there because you had a
16 facility available, correct?

17 A: That's part of the decision, yes.

18 Q: Well, look up at the top here on the same page.

19 A: Uh-huh (affirmative response).

20 Q: You mentioned, you reference a discussion of
21 this.

22 A: Right here?

23 Q: It says, "Sam, Greetings from Israel. Our
24 first choice plan is upgrade one linac in
25 Myrtle Beach." Y'all did that, right?

1 A: We upgraded the 6EX.

2 Q: Okay. You did that.

3 A: And we replaced -- well, it depends on what --
4 define upgrade. We upgraded one and we
5 replaced one.

6 Q: You upgraded to -- you upgraded one, the 6EX,
7 correct?

8 A: With better imaging.

9 Q: Okay. And you also, the plan was relocate one
10 linac to Murrells Inlet area, correct? Y'all
11 applied for that, right?

12 A: Applied and have approval pending the
13 litigation.

14 Q: Add fourth location in Conway. Y'all put in a
15 CON application ---

16 A: Right.

17 Q: --- for that and you got approved for it,
18 right?

19 A: Right.

20 Q: And then number four on this list is relocate
21 the Conway linac if/when AUC does Carolina
22 Forest project, right?

23 A: That was an item that was discussed and isn't
24 in the -- it hasn't probably been discussed
25 definitely anytime recent.

1 Q: Okay. But you would agree with me the first
2 two -- the first three items on that list are
3 done in terms of everything you could possibly
4 do to get there, but then you've obviously got
5 some state and legal issues, correct?

6 A: On two and ---

7 Q: Yeah.

8 A: --- three we do, yes.

9 Q: Correct. But you're saying four, even though
10 it's down here on the list.

11 A: It would not be to relocate the Conway. The
12 only way you would ever get into the Carolina
13 Forest would be after a linear accelerator to
14 the north is installed and then after that, if
15 the volume supported it, which they don't
16 because, as I've mentioned several times,
17 volumes are down. If you did the State Health
18 Plan today, I don't think a linear accelerator
19 would still be approved. That project is not
20 feasible.

21 Q: Okay. Well, if you look up right at the email
22 right above that, it says, "Relocate the Conway
23 linac if/when AUC does Carolina Forest
24 project," it says, "down the road," doesn't it?

25 A: Right. The road has changed many times since

1 then.

2 Q: And the roads get even rosier, correct?

3 A: (No response.)

4 Q: Now, go to Petitioner's 51 for me, if you
5 would. Same one.

6 A: Same one, sorry..

7 Q: Yeah. Hopefully this is going to be the last
8 few are going to be easy I hope.

9 A: That's all right.

10 Q: Famous last words. Okay. Now, this is an
11 email, kind of interesting, if you look on page
12 CRCC 1685, correct?

13 A: Okay.

14 Q: All right. This is an email from Mr. Tolbert
15 to Norton and Rich, and Norton is the general
16 counsel and you're the Rich, right?

17 A: That would be correct, yes.

18 Q: Now, turn the page over to 1686, CRCC 1686.

19 A: Okay.

20 Q: This is an email from Daniel Dosoretz. Now,
21 what's interesting about this is you're not on
22 this particular email, right?

23 A: That is correct.

24 Q: But you are on the one, you would have seen
25 what Mr. Dosoretz said, correct?

1 A: Yes.

2 Q: Okay. And Mr. Dosoretz is, I think you
3 mentioned that he is the CEO of 21st Century
4 Oncology based in Fort Myers, Florida, correct?

5 A: Right. It's actually Dr. Dosoretz. He's a
6 practicing radiation oncologist.

7 Q: You are correct. I knew that. And it says,
8 "See below." All right, let's read this. "It
9 is clear that they are relocating their CON.
10 As per my discussion with Doug Thursday, we
11 need to apply for the same." And that's Doug
12 Bryant, correct?

13 A: That would be correct.

14 Q: "Jay and Jason, we need to define the land
15 within the next three weeks." All right. Is
16 that right?

17 A: That's what it says.

18 Q: Okay. So they needed -- Jay Bunnell and
19 whoever Jason is, they needed to go down and
20 find land in Murrells Inlet area so you could
21 build this project to meet Georgetown head to
22 head, correct?

23 A: Correct.

24 Q: Okay. Then it says, "Please report to me daily
25 progress as I can see how this part is what is

1 going to delay us, something we cannot
2 tolerate!!!!!" Correct?

3 A: Yes.

4 Q: Okay. And then it says, "Ricardo, we need
5 drawings for this site for one vault asap as
6 you get back from the wedding. Andrew, please
7 start marshaling the forces for the battle
8 coming up. Rich Lewis, you are in charge of
9 helping Doug and Sam with whatever info they
10 need." Correct?

11 A: Yes, that's what it says.

12 Q: "We need to move here." Right?

13 A: Yeah, but he didn't put me on there.

14 Q: He didn't put you on the email, right?

15 A: Right.

16 Q: So luckily someone copied you.

17 A: Yes.

18 Q: Mr. Tolbert copied you so you would know to
19 marshal the forces for battle, correct?

20 A: Correct.

21 Q: Okay. Turn over to Petitioner's 54 for me.

22 A: 54. Okay.

23 Q: All right. And again, let's go to 1708,
24 because that's where the email is going to
25 start.

1 A: Okay.

2 Q: At the end it's an email from Doug Bryant to
3 you and Mr. Tolbert, correct, cc'ing the
4 general counsel of the company?

5 A: Yes.

6 Q: Okay. And you met with Sallie to go through
7 what -- Doug Bryant, he's meeting with Sallie,
8 that's Sallie Harrell at DHEC; is that right?

9 A: Yeah, I couldn't remember her last name, but
10 now that you say that, yeah, Sallie Harrell.

11 Q: Okay. And let's turn the page over. And then
12 you sent an email to Mr. Bryant and Mr.
13 Tolbert; is that correct?

14 A: And copied Norton at November 9th, 2010, 5:36
15 p.m. or ---

16 Q: Yeah, that one there.

17 A: That one, okay.

18 Q: Okay. And it sounds like y'all are trying to
19 figure out where Loris McLeod are going to
20 locate their CON -- their CON project, correct?
21 "Is this location also known as Seacoast or
22 different?"

23 A: Yeah, obviously I'm trying to understand lay of
24 the land there and historical ...

25 Q: Okay. And then if we go to, turn over to CRCC

1 1706 for me.

2 A: Okay.

3 Q: All right. And this is an email from Mr.
4 Bryant directly to you, right?

5 A: Yeah.

6 Q: You may have to look at 1705 at the bottom of
7 the page.

8 A: Where are you starting at?

9 Q: Yeah. It says Doug Bryant, to Rich Lewis,
10 Norton Travis and then Sam and others, the CEO
11 of the company and others are copied, correct?

12 A: Okay.

13 Q: All right. And so at this point in time, it
14 says, you know, "Would it be possible to have
15 a conference call?" The next sentence, "Sam
16 and I agree the best option is to move forward
17 with the relocation to Murrells and prepare a
18 second CON for a new unit in the Conway or
19 northern Horry County." Correct?

20 A: Correct, that's what it says.

21 Q: It says, "DHEC will be more favorably inclined
22 to support a relocation over a new unit."
23 Right?

24 A: That's what it says.

25 Q: Okay. So that's what Mr. Bryant is informing

1 you that, hey, DHEC will be more favorably
2 inclined to do this, to do X, if we do Y,
3 correct?

4 A: Yes.

5 Q: Okay. And he states, "As of today no
6 application exists for North Strand, but if a
7 CON is submitted, we should be ready to submit
8 the second CON for a new unit." It says, "We
9 are the existing provider closest to the Little
10 River, North Myrtle Beach area and DHEC
11 generally favors an existing provider."
12 Correct?

13 A: Correct.

14 Q: Is that what it says?

15 A: Yes. And alls I can say to all of this is we
16 did our analysis, developed our plan and we're
17 doing exactly what we had set out to do before
18 all these different items popped up, was get
19 the care closer to where our patients currently
20 reside.

21 Q: Okay. Well, you agree with me that that may be
22 true for one of them, but you didn't have any
23 plans to relocate the Murrells Inlet. The plan
24 was ---

25 A: We had plans to expand in the market area, and

1 we had other people that accelerated those
2 plans and we had to react to them. But we are
3 doing exactly what we were going to set out to
4 do anyway, absent those other plans.

5 Q: The plan was to take one, apply to get -- for
6 the new one, and apply and locate that
7 somewhere else. That was what we saw in the
8 first email that we talked about earlier and
9 that Mr. Long and you talked about, correct?
10 There was no mention about relocating one to go
11 down to the southern flank in Murrells Inlet,
12 correct?

13 A: I believe ---

14 Q: We can go back to the email if you want.

15 A: We talked about expanding within the market,
16 which you can expand by relocating or adding
17 new. And I believe these emails are consistent
18 on both of those points.

19 Q: Come down a little bit in that same block of
20 text that we were just looking at. It says,
21 "With two separate CONs, we protect both our
22 northern and southern service area. Worse
23 case, we end up in court on both CONs and no
24 one moves forward until the courts decide. Let
25 me know if you want the conference on Monday or

1 another time."

2 A: Right.

3 Q: "Doug."

4 A: That's the process in South Carolina.

5 Q: Yeah, that's what's happening here, right?

6 A: Yeah.

7 Q: Nobody is moving forward, correct?

8 A: Right.

9 Q: Is that right?

10 A: That's correct.

11 Q: And Mr. Travis on the page above, the general

12 counsel of the company, agreed with Mr.

13 Bryant's analysis, correct?

14 A: That's what it says.

15 THE COURT: Where are you talking about?

16 MR. THOMAS: I'm sorry, Judge.

17 THE COURT: You said page above?

18 MR. THOMAS: 1705, yeah. I'm sorry, CRCC 1705.

19 Q: Flip back to me, if you would, Mr. Lewis, to

20 Petitioner's 53.

21 A: Okay.

22 Q: Okay. So would you agree with me that

23 sometime, I guess it was December of 2010, you

24 found out that Grand Strand was going to be

25 applying for a linear accelerator to be located

1 at their hospital, right?

2 A: Where are you looking at?

3 Q: Let's look at, on 1698, come down a few lines,
4 it says, it's Doug White to -- first of all,
5 you're copied on this email from Rosa Maynor on
6 December 15th, 2010.

7 A: Correct.

8 Q: Okay. And if we go down a few lines, there's
9 an email from Doug White.

10 A: Correct.

11 Q: CEO of Grand --- ex-CEO of Grand Strand. He
12 says, "Please send me a draft with all the
13 blanks filled in we can put on a letterhead and
14 send. Will you folks also support our CON
15 application if we apply to put a linac in the
16 hospital?" Correct?

17 A: Right, that's essentially his notice to us that
18 they're going to apply as well.

19 Q: Okay. And go to on the next page, CRCC 1699,
20 for me.

21 A: Okay.

22 Q: Did you read -- I don't know if you would have
23 read the entire stream, but, you know, you're
24 copied on this email.

25 A: Right.

1 Q: And there's one from Patricia Price. It says,
2 "Doug, please see the information below.
3 Please let me know if you have any additional
4 information. Thanks." And it gives the
5 address, Courtfield Drive, Murrells Inlet and a
6 tax map number because it doesn't have a
7 physical address, right?

8 A: Right.

9 Q: And it says, "Ten percent of our patients are
10 coming from the Murrells Inlet area." Correct?

11 A: That's what it says.

12 Q: Okay. You don't think Ms. Price knows where
13 her patients come from in the Myrtle Beach area

14 ---

15 A: I don't know ---

16 Q: --- she lived in three decades?

17 A: I don't believe that's the accurate percent at
18 all, no.

19 Q: That's not the analysis that Mr. Tolbert did,
20 right, where he took a bunch of Myrtle Beach
21 zip codes, seeded them in to Murrells Inlet,
22 right?

23 A: Murrells Inlet area would be multiple zip codes
24 and could cross counties because it's right on
25 the county line. That would make sense.

1 Q: Okay. Did you look at his zip code analysis
2 closely?

3 A: Yeah. I haven't looked at it -- well, what --
4 I looked at what was done in the initial
5 application.

6 Q: You saw how he grouped Murrells Inlet and
7 Myrtle Beach and Conway and all those different
8 zip codes, correct?

9 A: Right. How else would you group the areas
10 between the cities?

11 Q: Well, how about the Myrtle Beach zip codes to
12 Myrtle Beach and the Murrells Inlet zip codes
13 to Murrells Inlet and the Conway zip codes to
14 Conway? You don't think that's a logical way
15 to group zip codes?

16 A: It depends on how those are cut off. If
17 they're cut off at the county line, no, that
18 wouldn't make sense.

19 Q: It depends on what kind of case you need to
20 make to the State of South Carolina to justify
21 a need in a place where ten percent of your
22 patients comes from, doesn't it?

23 A: I disagree that ten percent come from the
24 southern part of our service area.

25 Q: Okay. Let's go to Petitioner's 47.

1 A: Okay.

2 Q: Okay. This is in December, right, Doug Bryant
3 emails you, Ms. Maynor and Mr. Tolbert, and
4 also with a copy to Mr. Mullins here and Mr.
5 Norton Travis, too, right?

6 A: Okay.

7 Q: Okay. So you would agree, first of all, your
8 legal counsel was heavily involved in this
9 process, correct?

10 A: Yeah, he's -- that -- yeah, he was very
11 involved..

12 Q: Both your outside counsel and your inside
13 counsel, correct?

14 A: Correct.

15 Q: I mean, that's not unusual to you, right?

16 A: No.

17 Q: Okay. Now, this is an email chain between the
18 people I've just mentioned, and in this email
19 the expansion idea is now North Myrtle Beach,
20 right?

21 A: I've got to read it.

22 Q: Yeah, look at the bottom there. Let me just
23 ask you, did you read it?

24 A: Yeah.

25 Q: Okay. So as of December 22nd, y'all still

1 didn't know whether or not this thing was --
2 this new linear accelerator, the fourth one,
3 was going to be in North Myrtle Beach or
4 Conway, correct?

5 A: Doug's email says North Myrtle Beach at this
6 point in time, but ---

7 Q: Well, then Sam says, "Agreed. I have another
8 conference call." And then you say, "Rich
9 Lewis, agree."

10 A: Yeah, well, I could be agreeing to I can talk
11 anytime after 11:00 a.m. today, too. I mean,
12 I -- you know, like I said, we talked through
13 many different areas and it wasn't until our
14 analysis was complete, we chose -- we ended up
15 with the two largest population centers where
16 our patients were coming from to get the --
17 those were the ones with the largest need.

18 Q: Okay. But as of December 22nd, Doug Bryant is
19 under the impression that an expansion would be
20 the location of a facility in North Myrtle
21 Beach. "We may plan on this but not move
22 forward until later." Correct?

23 A: That's what his email says, yes.

24 Q: Okay. Thank you. Go to Number 48 for me,
25 Petitioner's 48.

1 A: Okay.

2 Q: And turn to 435 within that email if you would.

3 A: Okay.

4 Q: Again, this is Norton Travis informing you and
5 Ms. Maynor and others, "Doug, Sam, seems to me
6 that we need to file for the CON asap, agreed?"
7 And that's in response to the public notice ---

8 A: Okay.

9 Q: --- that was published by Loris and McLeod,
10 correct ---

11 A: Yes.

12 Q: --- for their Myrtle Beach CON, right?

13 A: That's what it -- yeah, that's what he's
14 saying.

15 Q: Okay. And did you have any discussions with
16 the AUC practice administrator, Michael Asbill,
17 about where he thought it should go?

18 A: They were -- yes, they were on a very limited
19 number of the discussions, but they have
20 property in Carolina Forest, it's undeveloped,
21 they want to develop. That was not chosen.
22 It's not the best location. It's too close to
23 the current Myrtle Beach office. And, but they
24 were a very less significant part of this
25 project. They are employees of the company,

1 part of, you know, our collaborative team.

2 Q: Okay. Well, look at CRCC 434 within the same
3 exhibit.

4 A: Right.

5 Q: Mr. Asbill states that, "Conway is only 16.7
6 miles from CRCC and the Myrtle Beach facility
7 covers this area well. I think the reason they
8 are looking at North Myrtle Beach because the
9 area covers Loris, North Myrtle Beach, and
10 Little River."

11 A: Yeah, I don't think he was -- he definitely, as
12 the practice administrator of the urology
13 group, isn't familiar with all of the radiation
14 patients. He doesn't have access to or see or
15 review that information.

16 Q: But he knows where 43.7 percent of them come
17 from, doesn't he?

18 A: 43.7, what are you ---

19 Q: That was the treatment diagnosis percentage,
20 correct? That's what the urologists, the
21 prostate cancer that you do?

22 A: Oh.

23 Q: I mean, he's familiar with where the prostate
24 cancer comes from, right?

25 A: Whether he -- I don't know. I don't know what

1 he analyzes. The data would be available to
2 him, yes. But North Myrtle Beach was
3 considered. It was not where we ended up going
4 because it would have been, in the pecking
5 order, it would be the fourth of four parts of
6 Horry County.

7 Q: But two months before y'all applied, North
8 Myrtle Beach was on the table, correct? I
9 mean, that's what the email says.

10 A: I would say no, the practice administrator who
11 was not a significant part of the project threw
12 that idea out and it wasn't ...

13 Q: Well, Doug Bryant threw that idea out, correct?

14 A: But that -- he threw that out, I believe that
15 was a month or two or more earlier than this
16 email.

17 Q: December 22nd. Let's go back to ---

18 A: Right. That's two months before the February
19 16th email.

20 Q: That's what I said. I said two months before
21 y'all ---

22 A: Oh, okay, then I misunderstood what you said..
23 Sorry.

24 Q: I said two months before y'all applied,
25 actually a little bit -- a little bit after

1 that ---

2 A: Well, December of -- yeah, three months maybe,
3 I don't know.

4 Q: Two and a half, three months before you
5 applied, North Myrtle beach was on the table,
6 correct?

7 A: Per that email, that's what it stated, yes.

8 Q: Okay.

9 A: I -- we never identified a location, we never
10 did significant -- it was a discussion topic
11 but it was never a serious contender.

12 Q: Well, it's not where you ended up applying,
13 right?

14 A: And we didn't go out and secure property, yes.

15 Q: Go to Petitioner's 59 for me if you would.

16 A: Okay.

17 Q: This is an email, April 2011, from Norton
18 Travis to you, among others. And this is where
19 there is a discussion about a joint venture
20 with Georgetown Radiation Therapy and CRCC,
21 correct?

22 A: Yeah. Norton and others had discussions with
23 Georgetown.

24 Q: The only question I've got on this, That was
25 y'all were looking maybe to do a deal together

1 in Georgetown and to compromise, and I
2 understand that. My question is at the very
3 top of this email it says, "Note also that
4 while it seeks to restrict us from adding
5 additional MDs, it doesn't include their
6 commitment to not hire additional urologists as
7 they agreed." Correct?

8 A: That's what it says.

9 Q: Okay. So y'all are basically trying to carve
10 up the market, correct?

11 MR. LONG: Objection, Your Honor.

12 Q: You're trying to say they don't get any
13 urologists and you get all the urologists,
14 correct? And so that would keep your flow of
15 prostate cancer patients coming into the
16 market, right?

17 THE COURT: He's got an objection.

18 MR. LONG: Objection, Your Honor.

19 MR. THOMAS: Oh, I'm sorry. I didn't hear it.

20 MR. LONG: I mean, the email is clearly about
21 private negotiations related to other
22 litigation first. So I think it should be
23 excluded under settlement negotiation rule and
24 rules of evidence. And it's also, he's asking
25 him about what he personally -- he's asking the

1 question with the expectation that he drafted
2 the email, and of course he didn't, so he's not
3 the proper person to ask about it, if it was
4 admissible -- it wasn't excluded under the
5 other rule.

6 MR. THOMAS: It's not excluded under 408. This
7 isn't a settlement compromise negotiation
8 between Grand Strand and CRCC. Secondly, this
9 is a business record; it was produced. So
10 under 803(8), I can ask about it. Thirdly, Mr.
11 Lewis, this email is from the general counsel
12 of 21st Century Oncology to Mr. Lewis, the vice
13 president of operations and business
14 development for the company. 803(6), yeah,
15 records. So I'm sorry, but the objection has
16 no basis, Your Honor. This is fair game.

17 THE COURT: Well, the only thing -- I overrule the
18 objection all the way to the point of you can't
19 ask him what someone else may think. So ...

20 MR. THOMAS: I'm not asking him what he thinks. I'm
21 asking him what's stated in the email here,
22 okay.

23 THE COURT: You can definitely ask him that. I
24 thought your question went a little further
25 than that.

1 MR. THOMAS: Well, I can rephrase. That wasn't the
2 objection. The objection was that settlement
3 compromise doesn't come in.

4 THE COURT: Well, he did ---

5 MR. LONG: A couple of objections. That's one of
6 them. But, Your Honor, all he can do, based on
7 what you just ruled there, is to ask him to
8 read it, which has already occurred. So there
9 is no follow-up ---

10 MR. THOMAS: I can ask him questions about his
11 knowledge of it. I sure can.

12 THE COURT: He can ask -- I disagree with you. He
13 can -- if he has knowledge about that, he can
14 ask him about that.

15 MR. LONG: Well, then if he could lay the foundation
16 see whether the witness has any knowledge.

17 THE COURT: Well, I just said earlier that's how --
18 the approach he's going to have to take.

19 Q: Mr. Lewis, this is an email sent to you
20 regarding the joint venture with Georgetown,
21 correct? It says, the subject line is
22 Georgetown Radiation Therapy Center, correct?

23 A: Yeah, it's about Georgetown. I don't know if
24 it's about the joint venture or not.

25 Q: Okay. Well, let's go back to the beginning.

1 MR. LONG: Your Honor, there's only one question he
2 can ask him to lay the foundation, and so he
3 just needs to ask him the question. Do you
4 know anything about the negotiations?

5 MR. THOMAS: No, Your Honor, I don't have to ---

6 MR. LONG: That's the only question he can ask.

7 MR. THOMAS: --- start there. I do not have to
8 start there.

9 THE COURT: I'm not going to limit lawyers in how
10 they go about approaching.

11 MR. THOMAS: Thank you, Your Honor.

12 MR. LONG: Well, I -- okay. Well, he can't ---

13 Q: Now, on the email ---

14 THE COURT: Let me hear the questions and I'll rule
15 on each one of the questions.

16 MR. LONG: Okay. Thank you.

17 MR. THOMAS: It's a very sensitive email. I mean, I
18 understand.

19 MR. LONG: It's not particularly sensitive, Your
20 Honor. It's just improper questions. I'm
21 going to stand here and I'm going to make the
22 objections if he doesn't do it properly.
23 That's the rule.

24 MR. THOMAS: Mr. Long tends to do a lot of
25 inappropriate improper objections ---

1 THE COURT: Look, I'm going -- as this path goes, I
2 will hear the objection.

3 MR. THOMAS: Thank you.

4 THE COURT: I will rule on the objection.

5 MR. THOMAS: Thank you.

6 Q: Now, Mr. Lewis, look on Tolbert 155.

7 A: Right.

8 Q: Okay. Now, emails from Mr. Moran to Edward
9 Wade Mullins and Bruce Bailey and a couple
10 other folks. And Bruce Bailey is at where,
11 Georgetown Hospital Systems?

12 A: That's my understanding. I've never met or
13 talked with him.

14 Q: And Rick Kaylor is from Georgetown Hospital
15 Systems?

16 A: I don't know him. I don't know Tom Moran.

17 Q: What's that?

18 A: I don't know who Tom Moran is.

19 Q: Well, you're on the email so I'm going to ask
20 you some questions about this.

21 A: Right.

22 Q: It says, "Please find attached a proposed term
23 sheet for the Georgetown Radiation Therapy
24 Center joint venture, along with the
25 confidentiality agreement so that we can begin

1 to exchange information. Please let me know of
2 any comments. If the confidentiality agreement
3 is acceptable to you, please have an authorized
4 person to execute on 21st Century's behalf, and
5 I will do the same on my end."

6 A: Right.

7 Q: You saw that.

8 A: I ---

9 MR. LONG: Your Honor, objection, move to strike.

10 He's not on the email.

11 MR. THOMAS: He is on the email, Your Honor. Go to
12 the ---

13 MR. LONG: He's not.

14 MR. THOMAS: No, no, no. Your Honor, you've got to
15 go to the first page of Petitioner's 59, okay.
16 He got the benefit of the entire email so he
17 would have read the entire email, okay.

18 THE COURT: He just testified that he was on the
19 email I thought.

20 MR. THOMAS: Yeah.

21 MR. LONG: No, Your Honor. Mr. Thomas said he was
22 on the email.

23 THE COURT: Sir, did you just testify that you were
24 on the email.

25 MR. LEWIS: No, I testified that I was reading what

1 he was reading to me.

2 THE COURT: Okay.

3 MR. LONG: Mr. Thomas published an email that's from
4 a man named Tom Moran to a group of people not
5 including Mr. Lewis.

6 MR. THOMAS: All right. Look ---

7 MR. LONG: And that's the testimony. So there's no
8 foundation and he's not on the email. .

9 MR. THOMAS: Your Honor ---

10 Q: Okay, turn to page Tolbert 153. At the top
11 does your name appear in the "to" category?

12 A: Yes, I'm on that email.

13 Q: Okay. So you would have gotten all of the
14 emails in this string in this business record,
15 correct?

16 A: Correct.

17 Q: Isn't that how it works?

18 MR. LONG: Your Honor, I object to the business
19 record characterization. It's not a business
20 record.

21 MR. THOMAS: Absolutely it's a business record.

22 THE COURT: Well, I don't need to go into that right
23 now.

24 MR. THOMAS: Okay. Okay.

25 THE COURT: He just said he got it, he was on the to

1 part, so ...

2 MR. LONG: It's an email string, as you know, Your

3 Honor, so I mean --- .

4 THE COURT: I know. And but then when you get the

5 email string you get all the rest of the emails

6 that are on that string.

7 MR. THOMAS: Correct, Your Honor.

8 THE COURT: You're not arguing about that, are you?

9 MR. LONG: I'm not sure whether he did or not, but I

10 -- I mean, I would have to ask him, but usually

11 that's the case.

12 THE COURT: I think I just heard you did.

13 MR. LEWIS: Did what, received the email?

14 THE COURT: Did you receive the email where it had

15 an email string of all the other emails,

16 correct?

17 MR. LEWIS: Yes. I'm on the email string, yes.

18 THE COURT: All right. That's good.

19 Q: You're on the top part of the email string,

20 which indicates you would have gotten all the

21 other emails within the string, correct, Mr.

22 Lewis?

23 A: That's normally how emails work, yes.

24 Q: Okay. Thank you. And the discussion here, Mr.

25 Wade -- let's look at this. On the middle of

1 Tolbert 154 states on April 1, 2011, at 10:04
2 p.m., Wade Mullins wrote, "See attached."
3 Correct?
4 A: Yes.
5 Q: Okay. And at the top, let's go to Tolbert 153.
6 A: All right.
7 Q: All right. This is from Norton Travis.
8 THE COURT: Hold on, I've got to get there.
9 MR. THOMAS: Sorry. Sorry, Your Honor.
10 THE COURT: Mr. Long is still standing. I'm going
11 to be try to be very careful with all this.
12 MR. LONG: No reason to sit down, Your Honor, with
13 the last few questions.
14 Q: So we're there, right? And this is where Mr.
15 Travis copies you, correct, on the bottom email
16 there, Subject RE: Georgetown Radiation Therapy
17 Center, right?
18 A: Actually, I'm one of the "to".
19 Q: Right, you're on the "to".
20 A: Right. You said copied on the ---
21 Q: That's right. So he -- that means he wanted
22 you to take a look at this, right? You're not
23 a cc, you're on the "to" line, right?
24 A: I'm on the "to" line, yes.
25 Q: And he states, "Unless I'm mistaken, the north

1 border of their proposed service area," and

2 that's Georgetown, Murrells Inlet, correct?

3 Correct?

4 A: Yes.

5 Q: It says, "Highway 501 is absurd. It's all the
6 way north to the airport. Can I get some local
7 input on this?" And then Michael Asbill, who
8 is the Atlantic Urology Clinic, I think you
9 said is the practice administrator; is that
10 right?

11 A: He's in the urology -- yes.

12 Q: He says, "You are right. That would be all the
13 way past the airport. Unbelievable. I guess
14 they are shooting for the moon."

15 A: That's what it says.

16 Q: And then Mr. Travis ---

17 THE COURT: You're going too fast for me.

18 MR. THOMAS: I'm sorry, Your Honor.

19 THE COURT: I thought you were going up. You must
20 have been going down.

21 MR. THOMAS: I am going up, yes, Your Honor. I'm
22 going like this from the ---

23 THE COURT: Okay.

24 MR. THOMAS: --- earliest to the latest.

25 Q: Okay. And ---

1 THE COURT: I see it.

2 Q: All right. And then Mr. Travis says, "Note
3 also that while it seeks to restrict us from
4 adding additional MDs," that's doctors, right?
5 MDs, that's what that normally stands for?

6 A: Yes, physicians.

7 Q: "It doesn't include their commitment to not
8 hire additional urologists as they agreed. If
9 everyone would get me their thoughts, Wade and
10 I will collate them and get back to GTH to see
11 if they're serious about making a deal."

12 A: That's what it says, yeah.

13 Q: Okay. And so what they're saying ---

14 MR. LONG: Your Honor, I again renew my objection
15 under 408. I mean it's clearly settlement
16 negotiations that's going on there. And the
17 term sheet is not attached.

18 MR. THOMAS: Your Honor ---

19 MR. LONG: And it's clearly settlement negotiations
20 in ---

21 THE COURT: How would I know ---

22 MR. LONG: --- litigation that's currently pending
23 in another court. It's completely irrelevant
24 too, to this litigation.

25 MR. THOMAS: Oh, it's very relevant.

1 THE COURT: Well, under what theory would I go that
2 it's settlement negotiations. You said that
3 it's -- that there's litigation pending in
4 another court. How would I ---

5 MR. LONG: I mean in this court, but in another
6 lawsuit.

7 THE COURT: How do I know that? I mean ---

8 MR. LONG: Because there's litigation pending between
9 Georgetown -- there's been plenty of testimony
10 in this lawsuit about the linear accelerators
11 in Murrells Inlet. So if they're either
12 talking about the linear accelerators in
13 Murrells Inlet, which would therefore mean it's
14 settlement negotiations, or they're not, which
15 means it's irrelevant.

16 THE COURT: Mr. Long, this is -- when you say
17 there's been information about the other
18 lawsuits, that may be true. Until now, I can't
19 divine, at least -- or maybe I don't understand
20 all the nuances of every -- of the case to know
21 that this occurred during the pendency of a
22 lawsuit. So when you made your previous
23 objection, I didn't recognize that any lawsuit
24 was going on and how this related to any
25 lawsuit.

1 MR. THOMAS: In fact, Your Honor, in April 2011

2 these parties hadn't sued each other.

3 THE COURT: Okay.

4 MR. LONG: Well, Your Honor, they've also got the

5 competing applications during this period of

6 time. This is April of 2011 and the

7 application ---

8 THE COURT: That can just be ---

9 MR. LONG: Which -- yeah ---

10 THE COURT: That could just simply mean that there -

11 - there are negotiations going on, but they're

12 not necessarily settlement negotiations.

13 Settlement negotiations have to do with the

14 settlement of a litigation.

15 MR. THOMAS: And in fact, Your Honor -- in fact,

16 Your Honor, the decisions hadn't even been made

17 in those cases yet. Haven't even been made.

18 And I'll just offer on 408, even though I don't

19 think it applies here, it says this rule does

20 not require the exclusion of any evidence

21 otherwise discoverable merely because it is

22 presented in the course of compromise

23 negotiation. This rule also does not require

24 exclusion when the evidence is offered for

25 another purpose, which is proving bias or

1 prejudice of a witness, negating a contention
2 of undue delay or proving an effort to
3 obstruct. But the fact of the matter is, Your
4 Honor, it wasn't a compromise negotiation, it
5 wasn't during litigation. I can establish that
6 if I have to. And I've just got a few
7 questions about it.

8 THE COURT: I overrule your objection on those
9 grounds.

10 MR. LONG: Thank you, Your Honor.

11 Q: Mr. Lewis, what it says here is it says, "Note
12 also that while it seeks to restrict us from
13 adding additional MDs," which you said are
14 physicians, "it doesn't include their
15 commitment to not hire additional urologists as
16 they agreed." You would agree with me what
17 this email is stating is that CRCC was trying
18 to keep Georgetown from adding urologists to
19 its medical staff, as they apparently agreed,
20 so that CRCC continued to get all the prostate
21 cancer in the service area, correct, all of
22 those referrals? That's what it says.

23 A: No, I wouldn't -- I wouldn't agree with that.

24 Q: Well, what's your explanation? This email is
25 to you from the general counsel of the

1 corporation of 21st Century Oncology. What's
2 your explanation?

3 A: I don't really have an explanation for what
4 discussions went on with Georgetown. I was on
5 a few emails. Most of those discussions were
6 handled by Norton because of the CON
7 applications, and I don't remember responding
8 to this email. I may have, but there were many
9 discussions that went on to try to work
10 together. Those broke down and we're not in
11 litigation. That's about all I know about the
12 discussions with Georgetown.

13 Q: All right. The email speaks for itself,
14 correct?

15 A: No, I don't -- I'm not -- I did not write it.
16 I can't agree with your interpretation of it.

17 Q: Well, as the vice president of operations for
18 21st Century, you're saying you just don't know
19 anything about the division of the physicians
20 in the service area; is that your testimony
21 today?

22 A: I was not involved in those discussions with
23 Norton or with Georgetown. I don't know what
24 they discussed.

25 Q: You were copied on the emails, though, weren't

1 you?

2 A: I am copied on lots of emails every day.

3 Q: And you weren't just cc'd, this was to you,
4 right?

5 MR. LONG: Your Honor, object.. I mean, he's already

6 ---

7 THE COURT: Well, that's asked and answered, so.

8 MR. THOMAS: All right. We'll move on, Your Honor.

9 I think the email does speak for itself.

10 Q: Let's go to Petitioner's 74 if we could.

11 MR. LONG: Your Honor, I'd move to strike Mr.

12 Thomas' little self-serving comment from the
13 record.

14 THE COURT: Actually, my response to that off the
15 cuff was going to be they always do.

16 MR. THOMAS: Thank you, Your Honor.

17 THE COURT: At least if they're admitted into
18 evidence, so.

19 Q: Look at Petitioner's 74 for me if you would.

20 A: Tolbert 1352?

21 Q: Yes. I believe that this is an email again
22 that you're copied at the top, very top email,
23 Richard Lewis?

24 A: Yes, I was cc'd.

25 Q: And this email, if you would agree with me --

1 turn the page, if you would, to 1353.

2 A: Okay.

3 Q: Email from Doug Bryant to Norton Travis. And
4 it says, "Norton, if possible, it would be
5 helpful to have Sam or Rich on the call." And
6 he says, "My recommendation is certainly to
7 apply for the new machine based on our past
8 strategy." Correct?

9 A: Correct.

10 Q: Is that right? And then you said, "The new
11 location should logically follow our patient
12 distributions"?

13 A: That's what it says.

14 Q: Okay. And it says, "I know our patient load
15 increased significantly from 2010-2011. Having
16 Sam or Rich available to discuss patient origin
17 may be helpful." Correct?

18 A: That's what it says.

19 Q: And in this email, you state, "If we have a
20 machine in Myrtle Beach, we will have to
21 address where we locate the new linac since we
22 have not moved the existing linac to MI."
23 Correct?

24 A: You jumped on me. Read that again.

25 Q: Well, I didn't jump on you. That's the way

1 it's written. It says, "If we add a machine
2 in" -- I'm sorry, it's the last sentence there.

3 A: Yeah, I know. You jumped from the top of the
4 paragraph to the bottom.

5 Q: I apologize for that.

6 A: Yeah. Go ahead.

7 Q: It says, "If we add a machine in MB, we will
8 have to address where we locate the new linac
9 since we have not move," I think you meant to
10 say moved, "the existing linac to MI." MI is
11 Murrells Inlet, right?

12 A: That would be my understanding.

13 Q: So Sunday, September 30, 2012, at this point
14 the idea is we're going to apply for the sixth
15 one in the State Health Plan, correct? Did I
16 get that right?

17 A: Yeah, we -- that's never been a question. We
18 will apply for, as I said.

19 Q: Okay.

20 A: If there's still one to be had, because the
21 volumes have come back down. The volumes today
22 would not support one.

23 Q: Well, that's your opinion, correct?

24 A: We're 5,000 treatments down from 2011.

25 Q: Well, we'll talk about that. Let's talk a

1 little bit about the project review meeting.

2 Now, did you assist with the project review
3 presentation and kind of review the PowerPoint
4 slides that Mr. Tolbert had drafted up?

5 A: Did I -- I would have helped gather data. I
6 probably did review the PowerPoints, but I was
7 not at nor attend that meeting.

8 Q: But you assisted with the preparation of the
9 presentation, correct?

10 A: Yes, I would have.

11 Q: Okay. And I tell you what, why don't you go
12 ahead and just get out Joint Exhibit 1. I just
13 have a couple questions about this.

14 A: Okay. What page?

15 Q: Go to DHEC record 613.

16 A: Okay.

17 Q: All right. This is the portion of the project
18 review that deals with adverse impact, correct?

19 A: That's what it deals with.

20 Q: And if you flip through this page and the next
21 couple of pages, you would agree with me that
22 there are no references to a loss or mass
23 defection or loss of any referrals from Coastal
24 Cancer Center, correct? It's not mentioned in
25 here, is it?

1 A: It doesn't mention Coastal.

2 Q: Okay. And you would agree with me -- well, go
3 to Petitioner's 50 for me if you would, and
4 I'll just put it up on the screen. Yeah, you
5 can put that away.

6 A: We're done with this book?

7 Q: Yeah.

8 A: Oh, wait, I'm in the wrong ---

9 Q: Petitioner's. I'm sorry.

10 A: Yeah.

11 Q: That's right.

12 A: CRCC 1609?

13 Q: Correct.

14 A: Okay. I'm there.

15 Q: Okay. Now, this is an email from Dr. Francke
16 to you, among others, correct?

17 A: Yes, I'm on the "to".

18 Q: And this was all the way November 23, 2011,
19 right, so about a month and a week before the
20 decision was made in this case, correct?

21 A: I don't remember exactly but yes, probably
22 that's when it was made, yes.

23 Q: And what Dr. Francke says here is, "The medical
24 oncologists at Coastal Cancer Center at
25 Conway," and he mentions them by name, Dr.

1 Goldberg, who I think Mr. White says drives a
2 Bentley, which I thought was -- "Dr. Cody and
3 Dr. Karpenko have all agreed to sign letters of
4 support for our CON for Conway. I did ask Dr.
5 Holt's permission his associates and he said
6 yes." I'm not sure what that means. But he
7 said, "He did not though volunteer to submit a
8 letter of his own but it is the support of the
9 three med oncs that service Conway that we
10 really need anyway." And so those are the
11 letters that you got, correct?

12 A: Those are the letters we received -- well, I
13 don't know. Based on what you said, those --
14 I don't know the letters we received.

15 Q: You're not aware that you actually received
16 those letters of support?

17 A: I -- no, I do not know the detail of the
18 letters of support we received.

19 Q: Okay. Well, you agree with me that's what Dr.
20 Francke said, though, that ---

21 A: You read the email, yes.

22 Q: He said the ones that you really needed were
23 those three docs at Conway, correct?

24 A: That's what the email says.

25 Q: Okay. And you would agree with me that if

1 Grand Strand and CRCC-Conway are approved or if
2 just Grand Strand is approved, CRCC and 21st
3 Century are going to do everything they can to
4 maintain and continue to maintain good provider
5 relations and provide good services to patients
6 so that other folks in the community and other
7 patients and potential patients in the
8 community are going to know to go to CRCC for
9 good quality service, correct?

10 A: Can you restate that again? I got a little ---

11 Q: Yeah. Well, is CRCC and 21st Century going to
12 do everything they can to do -- they can do to
13 compete against Grand Strand if Grand Strand is
14 approved?

15 A: We will be forced to, yes.

16 Q: Okay. Let me ask you this, Mr. Lewis. I don't
17 think I asked you this. But if the Court does
18 approve both projects at issue in this
19 litigation, will CRCC still build its facility
20 in -- or still open and operate its facility in
21 Conway to bring those services closer to the
22 patients?

23 A: I don't see why we wouldn't.

24 Q: Okay. I want to ask you a couple of questions
25 about the documents that Mr. Long went over

1 with you. And we may start with -- a lot of
2 these we actually covered. One thing you said
3 that was interesting to me, you mentioned about
4 the linear accelerators and you stated that
5 when you add a linear accelerator or you
6 upgrade one, that doesn't necessarily mean --
7 what that means is you're going to spend more
8 money, correct?

9 A: Right.

10 Q: Okay. But aren't some of the linear
11 accelerators faster than others, so that allows
12 more throughput and it allows you to increase
13 your revenue? Is that not an element?

14 A: More throughput could mean more patients, if
15 the patients are there to be had.

16 Q: And well, they're certainly there in Horry
17 County, correct, I mean in the 22,000 treatment
18 range, right?

19 A: No, today there are about 20,000.

20 Q: Okay. Well ---

21 A: Actually, the current volumes wouldn't even
22 trend to that, if you just take current volume.

23 Q: Let me ask you this. I mean, Ms. Maynor
24 testified in June that in May, and if you don't
25 know this, just let me know, but that in May

1 CRCC was open 15 hours a day and all three
2 units were actively utilized.

3 A: Maybe at that point in time, I don't know.

4 Q: So did the falloff just occur in June and July?

5 A: We've had a steady decline over two years.

6 There's been some fluctuations. The volume has
7 gone back up, volume has gone back down. But
8 if we were to draw a trend line, we're down ten
9 percent year over year. So 20 percent from
10 2011 or approximately 5,000 treatments on an
11 annual basis. I believe we're treating in the
12 70s this week, which, you know -- let's just
13 say 80. Eighty times 255 is 20,000.

14 Q: Are you done? Are you done with your answer?

15 A: Yes.

16 Q: Okay. You mentioned something about capacity
17 earlier, and I just want to make sure I've got
18 this straight for the record. You used 255
19 treatment days, correct?

20 A: Correct.

21 Q: And you assume three treatments per hour?

22 A: Correct.

23 Q: Okay. Now, in terms of -- in order, first of
24 all, in order to do 10,000 treatments on a
25 machine you've got to have 10,000 treatments to

1 do, right?

2 A: Correct.

3 Q: You've got to have a certain number of patients
4 to get up there, correct?

5 A: Yeah, that's what I just said.

6 Q: Let's see here. Look at Joint Exhibit 5 for
7 me. And it should be the 2012-2013 State
8 Health Plan.

9 A: Okay. Which page?

10 Q: IX-9. So Roman numeral nine dash nine.

11 A: Okay.

12 Q: Okay. I want you to look down this page, and
13 it does go over to the next page. But I want
14 to look at single unit operators, okay, in
15 South Carolina.

16 A: Okay.

17 Q: And I want you to tell me how many single unit
18 operators operate at 7,000 or more treatments
19 a year, okay, based on the last full year of
20 data we got is fiscal year 2011.

21 A: Just based on 2011 ...

22 Q: I can make it easy for you. The answer is
23 zero, isn't it?

24 A: Yeah, there's some in prior years.

25 Q: Okay. But in 2011 the answer is zero, right?

1 There's not a single one performing over 7,000
2 that's a single unit operator, correct?

3 A: Right. But there's ones with two units
4 producing 17, so that's an average of more than
5 7,000. I don't know where you're going with
6 your question.

7 Q: I asked you just a single unit operator,
8 they're going to have a little different
9 situation than a double unit operator, correct?
10 Some of them, they may get downtime on the
11 machine, right?

12 A: No. If you're -- no.

13 Q: No downtime, is that your testimony?

14 A: Downtime on the machine, you don't take a
15 machine out of -- what do you mean by downtime?

16 Q: If it needs repair or it breaks down.

17 A: Right, but you can't just switch a patient from
18 one machine to another unless it's an identical
19 machine because radiation therapy is very
20 specific to the patient, the tumor, the
21 machine. So unless you have two identical
22 machines, you can't just flip them from one to
23 the other.

24 Q: And that could hurt utilization, right?

25 A: Right.

1 Q: So if you just have one and you have downtime,
2 I mean you've got to get Varian or someone in
3 there and fix your unit, correct?

4 A: Right, unless you ---

5 Q: But you just looked at every single unit in
6 2011 and not a single one that only operates as
7 a single unit operator does over 7,000
8 treatments, correct?

9 A: That's what it says.

10 Q: Okay. And you would agree with me that in
11 terms of capacity numbers, I mean it's a
12 function of how long you can keep your center
13 open and the number of patients you have,
14 right? I mean, at the end of the day, you work
15 more hours, have more patients, you can
16 actually keep the machines operating, correct?

17 A: Right. Or you can keep the machines, the hours
18 open to be convenient for the patients but be
19 treating fewer per hour.

20 Q: Let's go to -- let's go to Exhibit 139, if we
21 could.

22 A: Which book, please?

23 Q: Oh, I'm sorry, Respondent's.

24 A: So CRCC 139?

25 Q: Yes.

1 A: All right. I'm there.

2 Q: Okay. Is this what you were talking about,
3 this is 139, that you're down in treatments
4 from 2012 to 2013, correct?

5 A: Yeah.

6 Q: Okay. Would you take 12,904, though, 12,904,
7 that's for seven months, right? Seven months.
8 And divide that number by seven?

9 A: I don't know. This doesn't say that it's seven
10 months.

11 Q: Are the treatment units, that one, two, three,
12 four, five, six, seven, it's not by months?

13 A: Oh, it is by months, okay, yeah.

14 Q: Okay.

15 A: I just want to make sure that's -- that didn't
16 work. That would be 22, but ---

17 Q: 22,121 treatments if you annualize it, right?

18 A: If you annualized it, but that wouldn't --
19 yeah, I mean that's what it would annualize to,
20 yes.

21 Q: Okay. And could you turn in that same book
22 over to 142 for me.

23 A: Yes.

24 Q: Okay. And this is a summary, correct, of the
25 CRCC treatment plans by referring physician,

1 January 13 through July 13, so it's for that
2 seven month period, correct?

3 A: Correct, treatment plans.

4 Q: Okay. What's the number there by Glenn R.
5 Gangi?

6 A: Sixteen.

7 Q: Now, do you have any idea what Glenn R. Gangi
8 did in 2012?

9 A: 2012 it was a larger number I'm sure. Most of
10 our urologists are down.

11 Q: It was close to 60, wasn't it, in 2012?

12 A: I don't know. I'd have to see the schedule we
13 produced.

14 Q: Go to in that -- let's go to Respondent's 11.

15 A: Respondent's 11?

16 Q: Yeah, let me see if I help you out. I'll tell
17 you what page to go to.

18 A: Okay.

19 Q: In Respondent's 11 if you would go to Tolbert
20 12895. 12895.

21 A: Okay.

22 Q: All right. And you'll see there, this says
23 financial year sum of treatment plans for 2012,
24 correct? And if you look, go down under AUC
25 CRCC 100 percent to CRCC.

1 A: Right.

2 Q: Go down to Gangi.

3 A: Yeah.

4 Q: Pull your finger all the way across.

5 A: Yeah, it's 59.

6 Q: He did 59?

7 A: Right.

8 Q: All right. And he's on track to do in the
9 20's, right, for 2013, right?

10 A: Correct.

11 Q: Okay. And he is by far the biggest decrement
12 and the reason y'all are down for 2012, right?

13 A: Well, he's also the most productive urologist.
14 There's, you know, urologists can work as hard
15 as they want to work to make, you know, the
16 lifestyle they want to make, and so it would
17 make sense that your most productive urologists
18 would have the largest decline in their volume
19 when, you know, the industry's experiencing
20 fewer patients being referred.

21 Q: Is that your explanation of why Dr. Gangi's
22 down?

23 A: There's, you know, I've talked with Michael
24 Asbill and there's no specific explanation
25 other than they're seeing fewer patients, which

1 is the common answer we get from, you know, our
2 -- we know from our internal urologists because
3 we have the data and from external urologists
4 we have discussions with.

5 Q: Okay.

6 A: And he's a very -- I don't want to overstate.
7 He's a highly productive urologist. He sees a
8 lot of patients.

9 MR. THOMAS: One second, Your Honor. Mr. Long has
10 some follow-up questions for you, Mr. Lewis.

11 MR. LONG: I'd like to request that we take a short
12 break. I don't think my redirect will be long,
13 I don't really. I'm going to try to figure it
14 out.

15 THE COURT: All right. I hope it will be short, but
16 every time I go out of this courtroom
17 somebody's grabbing me.

18 (Break from 3:42 p.m. until 3:51 p.m.)

19 MR. LEWIS - REDIRECT EXAMINATION BY MR. LONG:

20 Q: Mr. Lewis, let's look at Exhibit 139 again.

21 THE COURT: Respondent's I assume?

22 MR. LONG: CRCC 139. Thank you, Your Honor,
23 Respondent's 139.

24 A: Yes.

25 Q: All right. Is CRCC down ten percent for the

1 first seven months of the year?

2 A: Yes, we are.

3 Q: Okay. If you were going to try to anticipate
4 what your volume would be for 2013 for the
5 year, would you then do ten percent down for
6 all of 2012?

7 A: Correct.

8 Q: Okay. And if you're ten percent down from
9 2012, where are you going to be?

10 A: Around 20,000.

11 Q: Okay. Was Conway always under consideration at
12 all times as a potential location for a new
13 machine?

14 A: Yes.

15 Q: Did you ever identify a piece of land or
16 location in North Myrtle Beach ---

17 A: No.

18 Q: --- that you would put a linear accelerator?

19 A: No.

20 Q: Or build a building?

21 A: No.

22 Q: Did you ever have your architecture
23 construction team prepare detailed schematic
24 drawings of a building in North Myrtle Beach?

25 A: No.

1 Q: Okay. You were asked questions about HSA plans
2 or for patients; do you recall that?

3 A: Correct.

4 Q: Okay. To seek treatment at a linear
5 accelerator, does a patient have to have a
6 referral from a physician?

7 A: Yeah. I mean, patients don't self-refer.

8 Q: They don't show up at radiation therapy centers
9 and say they want some radiation from you,
10 right?

11 A: Correct.

12 Q: And they don't show up at the center shopping
13 the price of what they would ---

14 A: No.

15 Q: --- like an automobile or something ---

16 MR. THOMAS: Objection, Your Honor. He's leading
17 the witness.

18 MR. LONG: I'll rephrase it.

19 Q: How do -- do patients appear at radiation
20 therapy centers without referrals?

21 A: No. No, they don't.

22 Q: Is price an option -- is something that's part
23 of -- in your experience of running radiation
24 therapy centers, do patients have a lot of
25 knowledge about the price?

1 A: No. We actually -- no, they don't. We have
2 people that counsel them on the price.

3 Q: And what their expenses will be -- what they'll
4 be expected to pay?

5 A: Correct.

6 Q: Okay. In regards to the service?

7 A: Correct.

8 Q: And for Medicare, government payers, they're
9 pretty much the same for everybody, right?

10 A: Yeah, it -- yeah, Medicare Part B, Medicare
11 will pay 80 percent but the patient's
12 responsible for 20 percent. The patients
13 usually have supplemental insurance to help
14 with their portion of the payment.

15 Q: Okay. One of the emails that was shown, and I
16 can try to find and put it up but maybe you'll
17 recall it, one of the emails that was shown
18 earlier mentioned something about
19 brachytherapy.

20 A: Correct.

21 Q: At the CRCC unit, did -- can you tell me about
22 brachytherapy at CRCC?

23 A: Yeah. We -- one of the projects I worked on
24 with Dough was to get approval to install an
25 HDR unit, high dose rate, also known as

1 brachytherapy. And what that is, it's
2 different from -- it's radiation treatment, but
3 it's different from a linear accelerator in
4 that linear accelerator produces the radiation
5 through electricity and shoots a beam. The
6 brachytherapy is a live source of radiation
7 that is housed within a self-contained unit and
8 that radiation is delivered to the patient
9 either putting the -- if it's external skin
10 cancer, the live source would be put near the
11 skin cancer, or it can be inserted into the
12 body through a catheter and put inside the body
13 to treat the patient, and then at the end of
14 the prescribed treatment time, the source is
15 removed again and back into the self-contained
16 unit.

17 Q: Do the patients receive -- that have that
18 treatment, I think is it sometimes referred to
19 as HDR?

20 A: Yeah, HDR. High dose rate.

21 Q: Do the patients who receive that, do they
22 receive treatments also?

23 A: They can. You can do what I'd call combination
24 therapy. They can have external beam and HDR
25 both.

1 Q: Okay. Do you count the HDR treatments as part
2 of the treatment volume?

3 A: Yes.

4 Q: You do?

5 A: Yes.

6 Q: And so how many treatments does a patient
7 usually ---

8 A: Well, in our financial reports, we do. In the
9 reports submitted to DHEC, no, because they're
10 asking specifically for linear accelerators.
11 They would not be included in the linear
12 accelerator treatment count.

13 Q: All right. But that's -- is that an
14 improvement that was added to the CRCC location
15 after the acquisition?

16 A: Yes.

17 Q: Did they have that when you acquired them?

18 A: No, they did not.

19 Q: There's nothing to prevent Georgetown -- I
20 mean, Grand Strand from employing Dr. Holt's
21 Coastal Cancer group, is it?

22 A: No, they could -- they could employ him if he
23 chose.

24 Q: If he chose to? And Grand Strand currently
25 employs the neurosurgeons, right?

1 A: That is my understanding, yes.

2 Q: And that's a referral source for CRCC, right?

3 A: That is correct.

4 Q: And there are no neurosurgeons in Horry County
5 that are not employed by Grand Strand?

6 A: That is my understanding.

7 Q: And there are also surgeons that are employed
8 by Grand Strand, right?

9 A: Correct.

10 Q: And those are referral sources to CRCC?

11 A: Correct.

12 Q: Okay. I want to ask you about -- you were
13 asked some questions about your breakeven
14 analysis at 18 treatments per day, okay?

15 A: Correct.

16 Q: All right.- So your -- and in looking at the
17 financials off of that?

18 A: Yes.

19 Q: Okay. So was it your testimony that you
20 thought that Grand Strand would only do 18
21 treatments per day?

22 A: Based on what their -- I think the number was
23 4,620. Divide that by, you know, 4,620 divided
24 by 255 would be 18.1, or even if you did 4,620
25 divided by 250, it's 18 and a half.

1 Q: Now, what if you were --- well, let's go to
2 CRCC Exhibit 115, page GSRMC 1639. You can
3 look at the tag line on the bottom of this.
4 This is the "what if" CAM, you know.

5 A: I'm in the wrong ---

6 MR. THOMAS: Your Honor, I don't recall asking Mr.
7 Lewis about this exhibit.

8 MR. LEWIS: I think I'm in the wrong book.

9 MR. LONG: He didn't ask him about this particular
10 exhibit ---

11 THE COURT: Yeah.

12 MR. LONG: --- but he actually raised the issue.

13 THE COURT: I think we went through that on the
14 opposite way previously where he objected. If
15 it's the same -- same theory if he can --
16 because he used another exhibit to ask about an
17 issue that you raised, I'll allow him to do
18 that, but if it's not an issue that you raised
19 then I'll hear your objection.

20 Q: If you'd turn over, you can look on the screen,
21 too, if it's more convenient. 1639 is the
22 bottom page.

23 A: Okay. All right. I'm there.

24 Q: Are you there?

25 A: I'm there.

1 Q: Okay. This is the "what if" CAM. Let's look
2 at the financials of that.

3 A: Okay.

4 Q: You know the treatments on this particular CAM
5 model are significantly higher. I think Mr.
6 Sullivan said they were double. I don't know
7 if that's exactly double, but do you recall
8 that testimony?

9 A: He added it. 8,000 is the number I remember.

10 Q: Okay. Look at the financials on this
11 particular -- look at the analysis on this
12 particular estimate. The net present value of
13 1.54?

14 A: Right. So the \$1.54 return on every dollar
15 spent.

16 Q: Okay. The five year average EBITDA ROI?

17 A: Is a good one.

18 Q: Thirty-two percent?

19 A: Yeah, 32.8 percent. That's an acceptable
20 amount.

21 Q: Okay. And the discounted cash payback of 6.3
22 years?

23 A: Yes.

24 Q: Okay. Would you do this deal?

25 A: Yes. This would show that everything's

1 positive. It would be a good project to do.

2 Q: Okay. Have you ever known radiation therapy
3 centers to be loss leaders for hospitals?

4 A: No.

5 Q: You ever heard of that?

6 A: No.

7 Q: Okay. In the work that was done on the CON
8 application for CRCC, okay, you had advice from
9 a number of different people?

10 A: Correct.

11 Q: Is that correct? Okay. Did the lawyers write
12 the application?

13 A: No.

14 Q: Okay. Did the lawyers make the decisions?

15 A: No.

16 Q: Okay.

17 MR. LONG: That's all we have, Your Honor.

18 THE COURT: Ms. Biggers?

19 MS. BIGGERS: Nothing, Your Honor.

20 MR. THOMAS: I've just got one question, Your Honor.

21 THE COURT: About a new matter?

22 MR. THOMAS: Yeah, it's about a new matter.

23 THE COURT: Okay.

24 MR. THOMAS: I mean, because he asked him about
25 whether or not he knew ---

1 MR. LEWIS - RECROSS-EXAMINATION BY MR. THOMAS:

2 Q: Mr. Long asked you about whether or not you've
3 ever known a hospital to use radiation therapy
4 as a loss leader, correct?

5 A: Correct.

6 Q: Grand Strand's financials don't show, first of
7 all, that it's a loss leader, correct?

8 MR. LONG: Your Honor, that's not a new matter. I
9 mean, he asked him about -- he used the word
10 loss leader in cross.

11 THE COURT: Well, we're going into the hospital?

12 MR. THOMAS: Correct.

13 THE COURT: So I overrule that because you
14 introduced the hospital on ...

15 Q: You've never worked in a hospital, have you?

16 A: No.

17 Q: You've never been the CFO at a hospital, have
18 you?

19 A: No.

20 Q: Thank you.

21 THE COURT: You may step down.

22 MR. THOMAS: Thank you, Mr. Lewis, for your time.

23 MR. LONG: All right. Mr. Mullins and I are going
24 to switch places.

25 MR. MULLINS: Do you want us to move the next

1 witness, Your Honor, or do you want to take a
2 break?

3 THE COURT: Well, I can go. Well, how long is the
4 next witness going to be?

5 MR. MULLINS: That's a good question. I don't
6 anticipate this witness being too long on
7 direct, not as long as Mr. Lewis.

8 THE COURT: We can always do the direct now and
9 cross tomorrow morning, so let's keep it going.

10 MR. MULLINS: Your Honor, we would call Sissy Price.

11 THE COURT: Does anybody else have anything y'all
12 want to -- are y'all in agreement on that?

13 MR. CARTIN: Your Honor, that's fine with us.

14 MR. THOMAS: Yes, Your Honor, that's fine.

15 PATRICIA A. "SISSY" PRICE, having been duly sworn,
16 testifies as follows:

17 MS. PRICE - DIRECT EXAMINATION BY MR. MULLINS:

18 Q: Good afternoon, Ms. Price.

19 A: Good afternoon.

20 Q: If you would, please tell the Court your full
21 name and where you live.

22 A: My full name is Patricia Ann Price. Everybody
23 knows me as Sissy. I live -- I'm a native of
24 North Myrtle Beach. I've lived there all my
25 life. For the past 33 years I've been working

1 at Carolina Regional Cancer Center.

2 Q: Okay. And if you'll just try to speak up a
3 little. The court reporter and the judge need
4 to make sure that everyone can hear you.

5 A: Okay.

6 Q: Let's, if you will, give the Court a little bit
7 of background on your education. Graduated
8 from high school?

9 A: I graduated from high school from Wampee, which
10 is now known as North Myrtle Beach High School,
11 that was in 1970. A year later I attended a
12 hospital-based program for x-ray technology and
13 also attended the Florence-Darlington Technical
14 College and got an associate degree in Allied
15 Health. Worked as an x-ray therapy -- x-ray
16 technologist for about three years and then
17 went back to school in Charlottesville,
18 Virginia, and went for radiation oncology. I
19 was a radiation therapist.

20 Q: And you got your credentials for certification
21 as a radiation therapist?

22 A: I do. And as a x-ray technologist, too.

23 Q: Okay. And so you did your radiation therapist
24 training at McLeod?

25 A: No, I took my x-ray training at McLeod. I took

1 my radiation therapy at Charlottesville at the
2 University of Virginia.

3 Q: Okay. Gotcha. What did you do after that?

4 A: I went to Florence and worked at McLeod
5 Hospital as a radiation therapist, I think for
6 about three years, with a physician by the name
7 of Dr. Arthur Woodward, who him and a group of
8 associates from MUSC decided there was a need
9 for a radiation therapy center in Myrtle Beach,
10 so there were five entities that went together
11 and developed a center in Myrtle Beach, and
12 that was in 1980. There was two employees. I
13 was the radiation therapist. There was a front
14 office lady who took all the information,
15 helped with charts, and filed insurance.

16 Q: All right. And was that the -- that was known
17 as the Myrtle Beach Radiation Therapy Center?

18 A: At that time, it was Myrtle Beach Radiation
19 Therapy.

20 Q: Okay. And that's the predecessor to Carolina
21 Regional Cancer Center?

22 A: That is correct.

23 Q: Okay. And we'll only say it maybe one or two
24 more times, but you've been working there for
25 how long?

1 A: Thirty-three years.

2 Q: Thirty-three years st CRCC?

3 A: Yes, sir.

4 Q: All right. And I think you said you started as
5 a radiation therapist?

6 A: I did. For many ---

7 Q: Okay. How long ---

8 A: For many years I treated all of the cancer
9 patients. We had one treatment unit, which was
10 a 4MEV linear accelerator, and after about four
11 or five years there, they changed it to a 6MEV.
12 And then in 1992 our patient base was around 50
13 and we acquired another linear accelerator, and
14 we hired another radiation therapist. In 1994,
15 the company was sold to Dr. Steve Bass. And at
16 that time, I was still treating patients,
17 started doing some of the mapping and helping
18 with the initial simulations. As the company
19 grew, Dr. Bass started to depend on me more and
20 more, and so this developed into being in
21 charge of running the office.

22 Q: Okay. And what was your job title? So your
23 job title transferred to what?

24 A: Basically, the administrator of the office.

25 Q: Okay. And explain how your -- the scope of

1 your duties changed when you transferred to the
2 administrative role.

3 Q: There was -- there would be different areas
4 that I would have people that would answer to
5 me. In the operational, we'd have a chief
6 therapist. We'd also have a dosimetry
7 department and physics department that would
8 account to me also. We would have discussions
9 about equipment and advances. Insurance
10 departments would report monthly. Codings, far
11 as our billing coding, they would report
12 monthly to me.

13 Q: Okay.

14 A: I had a one-on-one relationship with Dr. Bass.
15 It was quite easy. If our center needed
16 equipment or anything with new advancements, it
17 was very easy to address those. And I think
18 the history for CRCC speaks for itself as far
19 as being one of the most aggressive centers in
20 the South to maintain new technology.

21 Q: All right. Well, let's talk a little bit about
22 that. You started explaining some of the
23 technology and then you stopped and we were
24 talking about your job. In 1994 when Dr. Bass
25 took over the center, how many linear

1 accelerators were there?

2 A: We had two at that time.

3 Q: All right. And ---

4 A: We had a 21C by Varian and a 6MEV by Varian.

5 Q: Okay. And take us forward a little bit in
6 terms of the advancement of the center.

7 A: As radiation therapy has been in effect many,
8 many years, but in the last 15 years tremendous
9 changes have been made. First, we had the
10 development of three dimensional treatment
11 planning. CRCC was one of the first in the
12 Southeast to master that and start that. After
13 about I would say five or six more years there
14 was another advancement called IMRT, and that
15 was a technology of modulating beam. We were
16 one of the first freestanding centers that
17 started that again in the Southeast. It was
18 essential and has always been the motto to
19 provide the best treatment to our patients that
20 we possibly can. We were the first center in
21 the -- South Carolina to be ACR accredited.
22 That took extensive work between physicians,
23 physics staff, myself and some of the
24 therapists. This was well over a year and a
25 half that we met every Friday to make sure that

1 our center was in compliance.

2 Q: All right. You've heard some discussion about
3 the TomoTherapy. At what point in time did the
4 center acquire that capability?

5 A: I don't know the exact year, but I think we had
6 an appeal process going through a CON with a --
7 with a Atlantic Urology, and I think at that
8 time, Dr. Holt was in with that CON.

9 Q: How long has the center had the TomoTherapy?

10 A: Since 2005.

11 Q: Okay. All right.

12 A: This CON I think caused a very bad vibes
13 between the urologists and Dr. Bass.

14 Q: Okay. All right. We'll talk about that in a
15 minute in a little bit more detail. Explain
16 for us, if you will from your standpoint,
17 you've overseen this center from its infancy --

18 -

19 A: I have.

20 Q: --- correct?

21 A: I have.

22 Q: All right.

23 A: And very proud of it.

24 Q: Right. And you've got a -- how would you
25 describe your feelings towards cancer

1 treatment? Is that your livelihood?

2 A: It's my livelihood. I think it was basically
3 my calling. I enjoy it. I care very deeply
4 about our patients and their concerns. And
5 also, personally, I've had a sister with breast
6 cancer, so I took that even to a deeper aspect
7 having a family member with cancer.

8 Q: All right. From your role in that capacity and
9 your role as the administrative director, give
10 the Court, if you will, just your perspective
11 in terms of the patient experience. Patient
12 becomes a candidate, potential candidate for
13 radiation therapy. What happens?

14 A: Well, first of all, the front office gets a
15 referral, and right now we have three
16 physicians. We look at their schedule, and
17 they are assigned a referral. We try to get
18 our patient referrals in within a five day
19 window. If any referral is an emergency, we
20 work it in that day. After we get all the
21 patient's information and records, we call,
22 remind them of their appointment. Then they
23 will come in. They are greeted by our nurse.
24 Our nurse takes them in the exam room, gets all
25 their vitals, medication and goes over this and

1 reviews with our physician that is going to see
2 the patient. The patient -- examines the
3 patient, goes over the history and why they're
4 there. After that they discuss their options.
5 In all of our patients there's initial consult
6 or you could call them an office visit. They
7 will tell the patient here is your options,
8 this is how we feel, if you're a candidate for
9 radiation, and then the patient decides if they
10 want to be a candidate for radiation if our
11 doctors have decided that.

12 Q: Okay. So after spending time with the
13 radiation therapist, I guess not all patients
14 become candidates for treatment and actually
15 receive treatment?

16 A: No, they do not, not all patients.

17 Q: All right. What happens ---

18 A: I would say in as -- as we've looked at it
19 about 80 percent of our patients we actually
20 treat that are referred to our office.

21 Q: What happens to those patients that are not ---

22 A: A letter is sent back to the referring
23 physician and with a comment from our radiation
24 oncologist as to what they think is the better
25 course for the patient, and they do not feel

1 that radiation is at this time.

2 Q: All right. So they're sent back to their
3 referring physicians?

4 A: That is correct.

5 Q: All right. Those that do end up receiving
6 treatment, just explain, give us a little
7 overview as to how that process occurs.

8 A: If the patient is decided for them to get
9 radiation, they will have an appointment and
10 they will go through our CT scanner. They are
11 put in a comfortable position, depending on the
12 tumor area that we're going to treat, and we
13 try to mobilize them so that -- it's essential
14 that the patient holds still during treatment.
15 So we scan them. That information is given to
16 our physician. He draws a tumor volume.
17 Depending on how complicated the case is and
18 how many critical structures are surrounding
19 this tumor, it is determined then as to which
20 machine they'll go on.

21 Q: Okay.

22 A: After the tumor volume is determined, our
23 dosimetrist, who helped with the planning, they
24 run multiple plans, and that is given to the
25 physician and he determines as to which machine

1 it goes on. So they're not assigning it to an
2 IMRT machine or another machine that could
3 treat palliative, it's what -- which plan
4 works out best for the patient.

5 Q: All right. And depending on which cancer or
6 what type of cancer, you've heard some
7 discussion about that in the trial ---

8 A: Uh-huh (affirmative response).

9 Q: --- impacts the number of treatments that that
10 potential -- that that patient would get?

11 A: Yes, that's true.

12 Q: All right. And do all -- and you heard those
13 numbers that Dr. Collins went through in terms
14 of 35 and 30 for ---

15 A: Uh-huh (affirmative response).

16 Q: --- brain and head and neck and all the other
17 cancer types that he went through. In terms of
18 looking at the overall average treatment that
19 a ---

20 A: I think the historic ---

21 Q: --- number of treatments that a patient would
22 get, what would you consider and what do you
23 think the average number of treatments would
24 be?

25 A: Historically, before IMRT that was put into our

1 market most natural would put a number of 21 as
2 an average treatment. As technology has
3 advanced, we can take the tumor volume a little
4 higher and protect the surrounding tissues, so
5 most people naturally use a 25 number for an
6 average course. That is putting curative
7 patients, palliative patients -- we have a few
8 patients that are on clinic trials, which that
9 is a high dose of radiation in a short period
10 of time. So I would say that the average
11 national number for a course of radiation is
12 25.

13 Q: That would take into account some of the
14 factors you just described that may reduce the
15 number from the typical course of treatment
16 that Dr. Collins was describing?

17 A: That is -- that is true.

18 Q: Okay. All right. You had mentioned -- you
19 were discussing the CON matter relating to the
20 -- to the TomoTherapy.

21 A: Uh-huh (affirmative response).

22 Q: And ultimately CRC -- CRCC got the CON for the
23 TomoTherapy and added that machine, correct?

24 A: That is correct.

25 Q: All right. And who -- who was seeking to add

1 the linear accelerator during that CON issue
2 that you were discussing?

3 A: I think there were several players in that CON
4 battle. I think McLeod's was one. There was
5 another group out of Charlotte, and then there
6 were the local urologists/Dr. Holt were
7 together.

8 Q: All right. Did Grand Strand apply?

9 A: No.

10 Q: All right. And the -- I think you said the
11 Tomo linear accelerator, when did that come
12 online or when did that ---

13 A: Well, it came online -- that's what we had
14 applied for because, again, I think that just
15 gives you the history of CRCC. Tomotherapy was
16 one of the most advanced pieces of equipment
17 that you could possibly own at that particular
18 time. It was the only one that was providing
19 like a CT scan. You could scan the patient
20 prior to your treatment and make sure you were
21 on your target. So again, we were trying to
22 provide Horry County patients and the service
23 area with the best equipment possible at that
24 time.

25 Q: All right. In your role as the administrative

1 director for the center, are you familiar, or
2 do you track or pay attention to the referral
3 patterns with regards to CRCC?

4 A: Yes, sir, I do, and our recent tracking, we had
5 an incline with our patient volume when the
6 center was sold to 21st. Most of that was
7 urology. From the previous CON battle there
8 had been, I guess, hard feelings just like
9 probably this one would result in some hard
10 feelings. So it could never be resolved;
11 therefore, I can't tell you where the urology
12 patients went. But after the center got sold,
13 Dr. Bass retired and our -- we had an influx or
14 increase of urology patients.

15 Q: All right. And we'll talk about that in a
16 little bit more detail, the impact of the 21st
17 Century acquisition. You mentioned the
18 urologists. Are they a -- they're a primary
19 referral source?

20 A: Yes, they are.

21 Q: All right. Who else are your primary referral
22 sources?

23 A: Coastal Cancer Center, and they have been our
24 main, basically, provider for many, many years,
25 and we've had a close working relationship with

1 Dr. Holt. When I first came to the center as
2 a very young therapist, Dr. Holt would call me
3 after he made rounds to the hospital if he had
4 any patients, so we had a very close working
5 relationship.

6 Q: All right. How would you describe Dr. Holt's
7 role with the Coastal Cancer Center?

8 A: Dr. Holt is president of that company, and he
9 pretty much, if you want to call him the CEO.

10 Q: So you were discussing the impact of the
11 dispute with the urologists and CRCC as a
12 result of the last CON application.

13 A: Yes, sir.

14 Q: And you may have stated this, but when the
15 TomoTherapy unit was installed ---

16 A: Uh-huh (affirmative response).

17 Q: --- did the referral -- what happened to the
18 referral -- referrals from the urologists?

19 A: During the whole time of the CON problems, we
20 were getting very little referrals from
21 urology.

22 Q: Okay.

23 A: Even though TomoTherapy was one of the better
24 ways to treat prostate cancer, we still got
25 very little referrals.

1 Q: All right. And you were talking about -- you
2 were beginning to talk about the transition
3 from Dr. Bass to 21st Century.

4 A: That is correct.

5 Q: Tell me about that occurred -- when did that
6 occur?

7 A: What ---

8 Q: When did the transition from -- when did 21st
9 Century acquire CRCC?

10 A: May 2010.

11 Q: Okay. And as a result of the acquisition, how
12 would you describe -- well, how would you
13 describe the changes, if any, that occurred
14 after 21st Century acquired CRCC?

15 A: Initially, we got quite busy because Dr. Bass
16 retired. New ownership. We had an increase in
17 patients. We also -- 21st provides a staff
18 member which is called a physician liaison.
19 That physician liaison goes out marketing, and
20 if we get any new technology, she goes around
21 telling the doctors about our new technology.
22 We've had a few conferences at our office
23 explaining the new equipment. We added I
24 think -- we still are the only center in South
25 Carolina with Calypso, which that's like a GPS

1 tracking device for prostate as you treat your
2 patients, so I think we're the only center in
3 South Carolina that provides that for our
4 patients. They've added the HDR.

5 Q: All right. Hold on. Let's walk through this.
6 I asked you what changes occurred when 21st
7 Century acquired CRCC, and the first thing I
8 think you mentioned was that there was an
9 increase in ---

10 A: Patient volume.

11 Q: --- patient volume. Why do you think there was
12 an increase in patient volume?

13 A: I think previously that there was still a lot
14 of animosity between CON fight, and they could
15 never resolve their issues with that. And so
16 when Dr. Bass left, I felt that they obviously
17 wanted to start referring to our center.

18 Q: All right. And the -- Dr. Francke became the
19 medical director; is that correct?

20 A: That's a true statement. Uh-huh (affirmative
21 response).

22 Q: Okay. And what efforts were undertaken -- I
23 think you were discussing some aspects of
24 marketing. Specifically, what was 21st Century
25 trying to do with regards to its referring

1 physicians?

2 A: We have a position that was opened and it's
3 nationwide with 21st that they have people
4 that market, and it's called the physician
5 liaison. She makes appointments with the
6 doctors to go to other physician's office and
7 educate, or she can just take literature to the
8 other doctors about some new technology that
9 we're doing. She makes speaking engagements
10 for our doctors. I know Dr. Andrews recently
11 has spoken at the lung tumor boards, and we've
12 been heavily involved with Zero, which is a
13 prostate -- that supports prostate patient
14 campaign national wide, and I think that Dr.
15 Francke spoke with that. So we have a lot of
16 community involvement with ---

17 Q: What's the purpose for that? What's the reason
18 for doing that?

19 A: Well, to educate; to let the physicians know
20 that we're there; to also let them know what
21 kind of equipment we have and how we try to
22 keep updated with technology.

23 Q: All right. And let's -- if we could pull up
24 Joint Exhibit 1, 588. You can grab it if you
25 want. You can see it on the screen.

1 A: I can see it.

2 Q: 587.

3 A: Is it the same as it was on the screen?

4 Q: 587.

5 A: Okay.

6 Q: All right. You were talking about some
7 equipment that had been acquired by 21st
8 Century, and again, we're talking about the
9 point in time where 21st Century has acquired
10 CRCC. There's a list of -- this is a slide
11 from the PowerPoint presentation made at
12 project review. Do you recall seeing this?

13 A: I do.

14 Q: Okay. And what is this?

15 A: This is the list of the equipment and
16 technology and treatment planning that we have
17 at CRCC.

18 Q: Okay. And there's --

19 A: They have ---

20 Q: --- some aspects of it that are bolded or some
21 of the equipment that are bolded. What are
22 those?

23 A: The one that are -- that is bolded is the ones
24 that have been improved since the acquisition.
25 We changed out the 21C to a 23iX. We brought

1 HDR to the center. We also brought a large
2 bore CT. Select patients, if they were
3 extremely obese, we had problems with our
4 previous CT scanner, and we conveyed this to
5 21st and they helped us acquire a large bore
6 CT. And then we -- the Varian Eclipse planning
7 system was updated. The Portal Imaging that we
8 had some problems on a few of our machines far
9 as visualization for the images prior to
10 treatment, so that was also improved. And then
11 again, as I had mentioned before, I think we're
12 the only one and still the only one in South
13 Carolina with a Calypso tracking device.

14 Q: All right. And all of these equipment
15 improvements benefit the services ---

16 A: The patients.

17 Q: --- that CRCC was providing?

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

19 Q: Okay. What other benefits did 21st Century
20 offer, or did you see in terms of resources or
21 otherwise when they acquired the facility?

22 A: I think one of them, the main things with a
23 corporate, you get a lot of support in several
24 areas, one being, as we all know, you have
25 OSHA. They have a staff that just addresses

1 OSHA. It doesn't have to be one staff member
2 at CRCC that that's their job. So HR, you have
3 a complete HR department that if you have any
4 questions, you get total support there.

5 Previously myself and the physics team and
6 maybe one of our technical staff would review
7 equipment, and I think we always try to get the
8 most -- the latest technology, but there is a
9 complete physics team with 21st Century that
10 that is their job and that's all they do. So
11 there's been many advantages to that.

12 Q: All right. All of these which benefit the
13 patient?

14 A: They benefit the patients.

15 Q: All right. Has your role within the center
16 changed since 21st Century acquired the center?

17 A: My role had changed far as the technical
18 aspect. I do more administrative work. I also
19 do more reports. I am not involved with the
20 patients as much as I had previously been.

21 Q: All right. Who do you report to?

22 A: I report to Rosa Maynor, the regional director.

23 Q: In terms of the center itself, feet on the
24 ground, do you still have oversight
25 responsibility ---

1 A: I do.

2 Q: --- for the administrative functions?

3 A: I do. We -- several departments have
4 department heads and they report to me, and if
5 we have any problems within the office, we work
6 together to solve them. I also, other than
7 reporting to Rosa Maynor, I report to Dr.
8 Francke. He's the medical director there.

9 Q: All right. Let's talk a little bit about --
10 well, let me ask you this. I think you had
11 started to talk about this. You mentioned that
12 the referrals from the urologists increased
13 after 21st Century acquired CRCC and that
14 relationship was repaired?

15 A: Yes.

16 Q: All right. What has -- and then you talked
17 about these other advantages and the equipment
18 advantages that 21st Century got for the center
19 upon its acquisition.

20 A: Yes.

21 Q: And all of those things, I think you indicated,
22 were beneficial to the patient and helped you
23 in terms of educating the physicians?

24 A: That is correct.

25 Q: And your referrals for 2010 came in at about

1 20,000?

2 A: Yes.

3 Q: And then what happened in 2011?

4 A: I think our numbers kept -- they were still
5 steadily -- they had increased.

6 Q: Okay. They were up to about 25,000 ---

7 A: Yes, it was about 25,000. And I think our
8 basic referral pattern was pretty much still
9 the same. Urology and Coastal Cancer Center
10 was our main referral base. We also would see
11 surgeons and -- but those two were our main
12 referral base.

13 Q: All right. And what has happened in terms of
14 the referrals since 2011, or your utilization
15 since 2011?

16 A: We have seen a steady decline in our prostate
17 referrals. In working with these patients, and
18 we also have been involved with a, you know, a
19 group called Zero. We worked with them, it's
20 a non-profit, with a recent golf tournament
21 that we had. We had two screenings at the
22 local -- it was called Martin's Golf Course at
23 that time. And we also saw a steady decline of
24 people -- of men coming in that were getting
25 the screenings. These screenings were free, so

1 I just think this national news about the
2 change in the PSA, I think that that has made
3 a difference. And I know that the -- the word
4 Dr. Gangi and his change of pattern --
5 personally, I'm a patient of Dr. Gangi's and I
6 -- we were talking one day. He said that he is
7 no longer seeing any patients that ---

8 MR. CARTIN: Objection, Your Honor, that's hearsay.

9 THE COURT: I'll sustain that.

10 MS. PRICE: No, it's not hearsay. He told me.

11 MR. CARTIN: No, ma'am. That's what hearsay is.

12 Q: Let me ask you ---

13 THE COURT: The next time there's an objection,
14 they're to respond to it. If you do, you're
15 not going to like the results.

16 MS. PRICE: I'm sorry.

17 THE COURT: No, that's okay. Next time. But I
18 sustain the objection.

19 Q: Let me ask you this, Ms. Price. Based on your
20 role as the administrator of the center, you
21 receive -- you're aware of the referral
22 patterns and you're -- and you receive reports
23 that relate to referrals ---

24 A: Yes.

25 Q: --- don't you? And you saw and heard, you've

1 seen the numbers and you heard testimony
2 earlier about the dip in the, or the reduction
3 in referrals from Dr. Gangi from 2011 to 2012;
4 do you recall seeing that?

5 A: I do.

6 Q: All right. And were you aware of that as your.
7 -- based on your role as the administrator,
8 were you aware that his referrals had dropped?

9 A: I was -- I was very aware of that, yes.

10 Q: All right. Is there another physician whose
11 corresponding referrals have increased during
12 that period of time?

13 A: Dr. Gangi's partner, Grudzinski, his numbers
14 have increased.

15 Q: All right. And is it your understanding that
16 Dr. Grudzinski is now taking all the new -- all
17 the new patients that would otherwise be --
18 that are coming into that -- when you say
19 partner, what do you mean?

20 A: They work together as a team.

21 Q: Okay.

22 A: And they go to the same offices. They cover
23 several offices in, you know, in our county.

24 Q: Right.

25 A: I think the patient base for Dr. Gangi was

1 greater, so therefore, they would like for Dr.
2 Grudzinski to increase his patient base.

3 Q: All right. So the new patients that you're
4 coming -- it's your understanding the new
5 patients that are coming in are being seen by
6 Dr. Grudzinski?

7 A: That is a correct statement.

8 Q: And that's reflected by the increase in
9 referrals that you've gotten from Dr.
10 Grudzinski during this time period?

11 A: That is true.

12 Q: But the overall, looking at the urologists as
13 a whole, their referrals ---

14 A: Have decreased.

15 Q: --- have decreased?

16 A: Have decreased.

17 Q: Okay. And you were saying that you believe
18 that the news, the issue relating to the
19 monitoring and PSA testing has had an impact on
20 the referrals?

21 A: I don't think I -- I'm the only person that
22 thinks that. I think it's been on the national
23 news so much. I think that the support system
24 that we just held with the golf tournament,
25 Zero, they are seeing a steady decline in

1 patients getting free PSA screenings. So I
2 think this is national information, not just
3 Myrtle Beach.

4 Q: And that downward trend that is -- that began
5 to occur last year is continuing this year?

6 A: Yes.

7 MR. CARTIN: Objection, Your Honor. He's leading
8 the witness.

9 THE COURT: I'll sustain that.

10 Q: Let's move on and talk about the CON
11 application that brings us here today.

12 A: Yes.

13 Q: Or your participation in the CRCC application
14 process.

15 A: Okay.

16 Q: Well, just tell the Court what your role in the
17 process by which CRCC put together their
18 application and participated in the review.

19 A: The application basically -- we have a DMR
20 system that keeps account of how many
21 treatments are delivered. I was asked to run
22 a report for certain time frames for maybe the
23 past three years. I was also asked to get
24 letters of support from the surrounding
25 physicians and the hospitals and different

1 politicians in the area and the American Cancer
2 Society, people that we had worked with. But
3 that was pretty much my role in it.

4 Q: Okay. Let me ask you this. What do you know
5 about why CRCC chose to expand to Conway?

6 A: I think that they chose to expand there
7 because, basically, I knew from my past history
8 working with CRCC that there was a vault over
9 there. We also knew that there was a need.
10 And the numbers were looked at, and the vault
11 being there, it was a corporate decision that
12 we would go with the larger population in
13 Conway.

14 Q: Were you involved in those discussions or was
15 that conversation ---

16 A: I just ---

17 Q: --- or that was a decision made by the team as
18 a whole?

19 A: It was made by corporate. I told them about
20 the vault, where it was located, and I also
21 gave them numbers with zip codes and for
22 treatment hours. And that's pretty much my
23 involvement.

24 MR. MULLINS: Let's pull up Respondent CRCC's 29.

25 Q: The email at the bottom of the page there.

1 A: Uh-huh (affirmative response).

2 Q: If you'll review that, that's an email from

3 you. Do you see that? Do you want to turn --

4 can you see that or do you want to turn ---

5 A: I can see. No, I can see it.

6 Q: All right. That's an email from you?

7 A: Yes.

8 Q: To Dr. Dosoretz?

9 A: From Patricia Price to Dr. Dosoretz about my

10 conversation with the CEO, Doug White, at Grand

11 Strand.

12 Q: All right. What's the date on this?

13 A: This is Friday, November the 5th, 2010.

14 Q: Okay.

15 A: At 10:25 a.m.

16 Q: And what is this email about?

17 A: That he would support us over the Loris,

18 Georgetown CON.

19 Q: And you had a conversation with Mr. White?

20 A: I've had numerous conversations with Mr. White.

21 Q: Okay. Well, you had a conversation with Mr.

22 White somewhere around November 5th, right?

23 A: Yes.

24 Q: Okay. Tell us what happened during that

25 conversation.

1 A: Doug White said that if I got ---
2 MR. CARTIN: Objection, Your Honor, that's hearsay.
3 MR. MULLINS: It's not hearsay. He's a party and
4 it's an admission of a party opponent and ---
5 MR. CARTIN: Not every statement made by a party is
6 an admission by a party opponent.
7 MR. MULLINS: Yeah, he's testified.
8 THE COURT: That goes back to the old case of State
9 v. Caldwell, but I overrule your objection.
10 A: It says per my conversation with Doug White,
11 that he would support our application for the
12 linear accelerator over Loris/McLeod.
13 Q: Okay.
14 A: And Georgetown.
15 Q: Did you have that conversation with him?
16 A: Yes.
17 Q: He said he was going to support the
18 application?
19 A: Yes, he did.
20 Q: Okay. And what happened after that?
21 A: Well, we've had numerous conversations. I
22 think that he did. He also gave me a letter.
23 You have to have a transport letter that they
24 will transport patients. I got a letter of --
25 from the CEO of Grand Strand for that also.

1 Q: All right. But that's a transfer agreement,
2 right?

3 A: Yes, a transfer agreement.

4 Q: Okay. Hospital's regularly provide the
5 transfer agreement?

6 A: That's right.

7 Q: Okay. What did Mr. White say with regards to
8 his support of the application?

9 A: He also asked me that would we support ---

10 Q: This is -- now, this is later down the road?

11 A: This is later down the road, and I cannot give
12 you the dates unless you bring an email out.

13 Q: Okay. Let's do that. Why don't we --

14 A: We'll have to get an email.

15 Q: --- go to 53.

16 THE COURT: Mr. Mullins?

17 Q: Oh, I'm sorry. It's -- this is Petitioner's
18 53. Do you see the email that's about two-
19 thirds of the way down, Mr. White to you?

20 A: I do.

21 Q: All right.

22 A: He says ---

23 Q: So you had a conversation about somewhere
24 around that period of time?

25 A: Yes. "Please send me a draft with all of the

1 blanks filled in that we can put on letterhead
2 and send them. Will you folks also support our
3 CON application if we apply to put a linac in
4 the hospital."

5 Q: All right. So ---

6 A: With having that conversation, I couldn't make
7 the decision for corporate. I told Mr. White
8 that we had always had a good working
9 relationship, and I hoped that we could
10 maintain that, but I was not in a position,
11 corporate would have to make that decision as
12 far as they decided to have a CON.

13 Q: Okay. And they ultimately -- Grand Strand
14 didn't support the application, correct?

15 A: Well, I can't remember -- I thought he had
16 given us a letter initially.

17 Q: The transfer agreement is what you're talking
18 about?

19 A: Yes, he gave me that.

20 Q: Okay.

21 A: He gave me the transfer agreement.

22 Q: All right. Let's -- so at this point in time,
23 you became aware that Grand Strand was going to
24 file an application for the linear accelerator
25 in the hospital?

1 A: He implied that. He did not seem so strong
2 willed about it. It was like a question mark
3 would you --- you know, if we decide, would
4 y'all support us?

5 Q: Uh-huh (affirmative response).

6 A: It wasn't like, Sissy, we're going to apply.

7 Q: Okay. All right. Let's get back to talking
8 about your participation with the -- in the CON
9 application.

10 A: Uh-huh (affirmative response).

11 Q: I think you mentioned that you were involved in
12 getting letters of support?

13 A: I was.

14 Q: Okay. And how successful were you in getting
15 letters of support?

16 A: I felt we were very successful. I mean, we
17 went through trying to get letters for Murrells
18 Inlet and the ones for Conway. I think that we
19 had local community support. With the Conway
20 CON, the CEO, Mr. Clayton, was very happy to
21 hear that we were going to bring a linear
22 accelerator close to his hospital so that we
23 could better serve his patients. So I think we
24 did quite well in the community.

25 Q: All right. The CEO of Conway Hospital

1 supported the application?

2 A: Yes, Mr. Phil Clayton.

3 Q: All right. He came and spoke at project
4 review?

5 A: He did come and speak.

6 Q: All right. And what were his -- what was the
7 substance of his comments at project review?

8 A: One of the main things that he had always over
9 the years been very pleased with the care that
10 CRCC had given his patients and the Conway
11 patients, and that he was very happy for us to
12 be providing that service in his area.

13 Q: All right. And ---

14 A: And he thought also that this was an area that
15 there was a lot of indigent patients that
16 needed this help, especially around -- I think
17 it's like 701, there is a lot of patients
18 without insurance.

19 Q: You gathered letters of support. I think you
20 said you ran reports ---

21 A: Yes.

22 Q: --- if asked. What involvement did you have in
23 any of the substantive pieces or components of
24 the application?

25 A: I was -- I just supplied information that I was

1 requested to get.

2 Q: Okay. All right.

3 A: The only when I was -- I will say that when
4 asking for letters of support, the only person
5 that called me personally was Dr. Larry Holt.
6 Dr. Larry Holt called me and said that he could
7 ---

8 MR. CARTIN: Objection, Your Honor, that is hearsay
9 since Dr. Holt is not ---

10 THE COURT: I'll sustain that one.

11 Q: Did Dr. Holt provide a letter of support?

12 A: No.

13 MR. MULLINS: Pull up Respondent's 1 if you will.

14 Q: You were talking a minute ago about the CRCC-
15 Conway location, the decision to go to Conway.

16 A: Yes, sir.

17 Q: All right. You've seen some of these maps that
18 we've been looking at during the ---

19 A: I have.

20 Q: --- trial, haven't you?

21 A: I have.

22 Q: Okay. The population map, I think you had
23 mentioned that your under -- one of your
24 understandings as to the reason that Conway was
25 chosen was because of the -- because it would

1 take -- provide a location closer to the
2 patients?

3 A: That is my understanding. We looked at North
4 Myrtle Beach and Conway and felt that Conway
5 would be the better location.

6 Q: All right. And population density is one of
7 the factors that you would look at based on
8 your understanding of the referral patterns in
9 the area. Population is one of the factors
10 that you would look at in terms of location?

11 A: That is true, that is -- that statement.

12 Q: And you've seen this map, which is Respondent's
13 5.

14 A: Uh-huh (affirmative response).

15 Q: That closely mirrors the population map.

16 A: Uh-huh (affirmative response).

17 Q: That's the patient origin by zip code for CRCC.

18 A: Okay.

19 Q: Does that look accurate based on your ---

20 A: It does.

21 Q: --- experience and knowledge as the
22 administrator?

23 A: It does.

24 Q: Okay. And is that -- in terms of the location
25 of the CRCC-Conway facility, does that provide

1 a benefit to the patient base that's in that
2 Conway/Loris area?

3 A: I personally think that it would and ...

4 Q: Why is it important to have radiation therapy
5 closer to the patient?

6 A: Well, first of all, most of these -- a portion
7 of the patients are getting chemo also, and so
8 a lot of times they're very sick. Some of the
9 other patients, you wouldn't know; they walk in
10 and they do perfectly fine. But about half of
11 them, I would say, especially the palliative
12 ones, it's very painful for them to even get in
13 the car and drive. But so that would be -- for
14 us to have a closer access, that would help the
15 patients tremendously.

16 Q: Okay. And is that common knowledge within the
17 industry that it benefits the patient to have
18 the services closer to the patient?

19 A: Certainly it benefits the patients. But we've
20 gone over technology, these machines cost such
21 an extreme amount, you can not have and give
22 good quality cancer care, provide the most
23 updated equipment to your patients and have one
24 five minutes away. I think that ---

25 Q: Well, you've anticipated my next question.

1 A: Okay.

2 Q: This is the map that shows the existing
3 locations in the Grand Strand proposed
4 location.

5 A: Okay.

6 Q: Right? You see that?

7 A: I do.

8 Q: Okay. And how far away is Grand Strand
9 proposing to locate their machine?

10 A: Driving distance, I would probably say you've
11 got about a five minute, and you've got two
12 stop lights.

13 Q: All right. You've been driving around there
14 for 33 years, right?

15 A: Yes.

16 Q: All right. And that's your -- do you run stop
17 watches, or is that just your general
18 understanding based on your --

19 A: That's just my general feeling you -- a lot of
20 doctor's offices are located on 82nd Avenue,
21 which when you turn on to go to the hospital.
22 Same difference, Dr. Holt's office has two stop
23 signs, not stop lights but two stop signs. One
24 coming out of the hospital, you get on 82nd,
25 then you take a right at the stop sign right

1 there and go on Rourk Street. So the distance
2 between the two is very similar, maybe one
3 mile, one and a half mile difference to CRCC.

4 Q: Okay.

5 A: The patient, regardless of whether they go to
6 CRCC or Coastal Cancer, the patient will have
7 to get in a ambulance and will have to be put
8 on a stretcher. You cannot take a patient
9 through the woods, and you can't put them in a
10 wheelchair. So both patients, if you have a
11 comprehensive cancer center, he is going to be
12 segmented.

13 Q: All right. I'm going to ask you about that in
14 a second.

15 A: Okay.

16 Q: All right. What I want to ask you about is the
17 Grand Strand application and their location.
18 It's, you said five minutes down the road?

19 A: Yes.

20 Q: All right. In terms of the benefit that we've
21 been talking about in having the patients have
22 closer proximity to the services, does the
23 Grand Strand location improve that in any way?

24 A: Repeat that one more time, please.

25 Q: We were talking about the benefit of having the

1 machines closer to the patients.

2 A: Uh-huh (affirmative response).

3 Q: Do you recall that?

4 A: Yes.

5 Q: Okay. Currently, you've got three machines at
6 Myrtle Beach five minutes away from Grand
7 Strand.

8 A: Right.

9 Q: Right? Would locating a machine at Grand
10 Strand hospital provide the benefit that we
11 were talking about in terms of taking the
12 services to the patient?

13 A: I do not think it would benefit our patients.
14 The only patients, which is a very small
15 percentage, would be inpatients. Inpatients,
16 regardless of whether you are freestanding or
17 hospital, you have to take them out of their
18 bed at the hospital. You put them on a
19 stretcher and you take them to the hall. Now,
20 you don't know when that patient is going to
21 get treated or what the policy is. You can lay
22 in the hall for a long time at the hospital,
23 but you both are on a stretcher. The
24 difference between a freestanding is you would
25 have to provide an ambulance trip to our center

1 and that ambulance trip -- truthfully, we've
2 talked about DRGs. DRG is based off the
3 diagnosis that the patient goes in the hospital
4 with. That is coded as cancer. They get --
5 they get payment for a cancer patient, which
6 may include chemotherapy, radiation, or
7 ambulance service. So, in essence, you don't
8 see a difference, but if you have a cancer
9 patient that doesn't need radiation, that helps
10 the hospital. If they don't need chemo, that
11 helps the hospital because all of the DRG
12 payment stays within the hospital, but if the
13 patient has to go outside of the hospital, you
14 have to share that payment.

15 Q: All right. Let's talk about the policy or how
16 you operated in terms of treating these
17 inpatients when Grand Strand was transferring
18 these patients to you or having you treat their
19 inpatients ---

20 A: When we get a referral ---

21 Q: Let me ask you this first. Are you currently
22 treating Grand Strand's inpatients?

23 A: Currently, we are not unless it's an extreme
24 emergency and they cannot get them to Trident
25 or MUSC. Majority of our referral patients

1 have been referred to Trident. We have had a
2 few that have gone to MUSC.

3 Q: All right. And when did that start -- when did
4 they stop having you treat their inpatients on
5 a regular basis?

6 A: I am sorry, I could not remember the day, but
7 I would say that it's been going on for maybe
8 a year, eight months to a year.

9 Q: Okay. Before they did that, explain to the
10 Court very briefly what CRCC does in terms of
11 preparing and handling an inpatient if it would
12 be transferred to CRCC or have CRCC ---

13 A: We would get a referral, and looking at our
14 doctor's schedule, our doctor would go to the
15 hospital. He would do a consultation with the
16 patient and if their family was there, talk
17 with the patient and exam. Our doctors would
18 always, if they could, wait to deliver the
19 radiation treatment because we know that the
20 hospital has to pass through their DRG. We
21 would delay it until they got out of the
22 hospital, but there's certain cases, spinal
23 cord, some of the brains, and like SVC patients
24 that they need their treatments immediately.
25 So they would say that the patient needs to

1 start treatment. The patient is immediately
2 transported to our center, they're simmed,
3 they're planned, and they're treated. Same
4 day. If the patient has to have three or four
5 treatments, after the planning stage, when they
6 bring to us everything -- the last patient is
7 -- that's taken off of our treatment unit, then
8 our hospital patient goes in. There is no wait
9 and so they can get back to the hospital. That
10 is the policy of CRCC.

11 Q: All right. So the policy is to ensure that if
12 a patient is put on an ambulance and taken over
13 there that there's not going to be a wait?

14 A: That is true.

15 Q: All right. And that would be how you would
16 handle the inpatients if they were still being
17 transferred to ---

18 A: That is true.

19 Q: All right. Tell me about, you mentioned that
20 Dr. Holt's group was your major referral.
21 Urologists and Dr. Holt's group are the two
22 main referrals?

23 A: That's a true statement. Uh-huh (affirmative
24 response).

25 Q: All right. Tell me what you believe, if Grand

1 Strand is able to implement its project as
2 described, tell me what you believe the impact
3 would be to CRCC.

4 A: I think the numbers will be devastating to our
5 center. Being in the medical community and
6 seeing how our -- the medical care has been
7 changing, and when I say changing, most solo
8 practices cannot survive with the reimbursement
9 that we are getting, so physician's offices --
10 I think every career, as you will see, a lot of
11 them are being bought by the local hospitals,
12 and some of them are called hospitalists, some
13 surgeons. Grand Strand is doing this. So is
14 Georgetown. The largest center that Dr. Holt
15 has is on 82nd Avenue. He has already shown
16 that he will support the hospital. So when you
17 take the progress of what is happening in
18 medicine and the buying of physician's
19 practices and giving them to the hospital and
20 Dr. Holt not giving us support, who is one of
21 our main referrals, again, we'll be very
22 passionate about this. We have 35 employees.
23 They have families; they have children; they
24 have home loans. And we have three physicians.
25 When you cut that number down, we will probably

1 lose a physician. We will lose some nurses,
2 and we will also lose radiation therapists.
3 And they would have to move out of the area.

4 Q: All right. You've described Dr. Holt's -- the
5 -- Dr. Holt's group and the surgeons and other
6 physicians that would be affiliated with the
7 hospital. Those were reasons that you were --
8 well, why did you mention them? What impact do
9 all of those -- do those relationships have on
10 your referrals?

11 A: CRCC has been a very good company to work for
12 whether it's owned -- we were owned by Dr. Bass
13 or 21st. We have very little turnover with our
14 employees, so therefore, you get to know your
15 employees quite well. Every employee knows
16 that our main emphasis, and it has been, is
17 patient care. So we get response from our
18 patients, and we're at the 90 percent response
19 far as care and attentive to our patients, but
20 it's also you get to be like a family with
21 these employees and you would hate to see that
22 happen. And I know that we would have to lay
23 off some of our employees.

24 Q: All right. You had mentioned Dr. Holt's being
25 on 82nd Avenue. I just want to clear up for

1 the record. That main -- and that's their main
2 office which is behind the hospital?

3 A: You come -- you come out of the hospital, you
4 get on 82nd, you go down -- I believe it's one
5 or two blocks to Rourk Street. That is where
6 his office is located.

7 Q: Okay. And they do most of their infusions out
8 of that main office?

9 A: They do most of theirs. I think all of the
10 other offices that they have, they're very
11 smaller satellite offices but if -- I mean,
12 take a look. They've just added several
13 thousands of square feet to their infusion
14 center. They also own and operate the PET/CT
15 scanner, which is an essential part of a
16 comprehensive cancer center.

17 Q: All right. So you believe that Dr. Holt will
18 redirect a significant number of patients?

19 A: I do believe that.

20 Q: Okay. All right. You were talking about
21 comprehensive cancer center. Let me just ask
22 you -- ask you this. What is your
23 understanding of a, and this has sometimes been
24 used interchangeably in this trial,
25 comprehensive cancer center or

1 interdisciplinary cancer care. What is your
2 understanding of that?

3 A: It is my understanding of that that you have
4 several specialties, medical oncologists,
5 radiation oncologists, surgeons, pathologists,
6 radiologists. You review some of the difficult
7 patients, or you could review all. In Horry
8 County right now we have tried very diligently
9 for ten years working with HCA to develop a
10 breast navigation program. CRCC has pushed and
11 pushed to get HCA to help with this, and in the
12 last three years, they -- they have been
13 trying. We have some heavy competition in the
14 Georgetown area. So with this competition,
15 doctors have to be involved. Now, it is
16 ideally because you get to meet doctors that
17 you can go to every tumor board, and matter of
18 fact, CRCC doctors are scheduled to go to all
19 tumor boards. They go; they attend HCA tumor
20 boards; they attend Loris Hospital's tumor
21 boards and Conway tumor boards. Dr. Francke,
22 he is assigned to go to Georgetown and
23 Waccamaw, and he does that most of the time at
24 Waccamaw through the telecommunications that
25 they do. And they discuss breast patients and

1 they discuss general, all tumors. The newest

2 ---

3 Q: All right. So the interdisciplinary, the
4 interaction between the specialists, that's
5 what you are describing as the
6 interdisciplinary cancer care?

7 A: Yes.

8 Q: And that occurs at these tumor board and
9 operational specific, cancer specific committee
10 meetings?

11 A: Yes, it does.

12 Q: All right.

13 A: And we are heavily, heavily involved in all of
14 those. And as you heard Dr. Collins'
15 testimony, when he worked at CRCC he was
16 involved with the tumor board. So Dr. Steve
17 Andrews attends. And they have developed a new
18 tumor board for pulmonary cancer. He has been
19 a speaker and very heavily involved working
20 with the two local pulmonologists. Once a
21 month on Thursday, our doctors attend HCA's
22 general tumor board. Dr. Steve Andrews attends
23 twice a month Loris' tumor board. So CRCC is
24 involved, and that is interdisciplinary action,
25 and it has been going on for a long time. It

1 also can be done, you can be right in your --
2 the way technology is today, you can be right
3 in your office. We have a large conference
4 room, and we have had disciplinary conferences
5 with MUSC with our head and neck patients. And
6 that's what ---

7 Q: All right. So CRCC is performing the
8 interdisciplinary cancer care now?

9 A: Yes, they are. And they are involved with
10 radiology, pathology.

11 Q: All right. You heard earlier some suggestion
12 that CRCC has not been attending these tumor
13 boards. Who does the scheduling for these
14 committee meetings?

15 A: I do the scheduling.

16 Q: All right. And ---

17 A: And the scheduling is allowed for every one of
18 our doctors to attend these. The only time I
19 have seen that they have not been there if
20 maybe they're on vacation, but there's hardly
21 -- you could not say there's another practice
22 that's been any more heavily involved than
23 CRCC.

24 Q: Okay.

25 A: And the way technology is, I mean, anybody can

1 have a x-ray put on their screen and ask the
2 radiologist to let's go over it.

3 Q: All right. And that's a PACS program that ---

4 A: That's the PACS program. Our doctors are
5 connected with HCA to get their images. They
6 have give permission to all physicians and all
7 the nurses so that this can be allowed.

8 Q: You had mentioned in terms of your role of
9 supporting -- I think you mentioned this. Mr.
10 Tolbert was the consultant that was involved in
11 the CON application.

12 A: Uh-huh (affirmative response).

13 Q: And you provided assistance to him in terms of
14 these reports you were talking about?

15 A: Zip codes and treatment numbers offered by the
16 EMR system.

17 Q: Okay. All right. And you recall that there
18 was information that you consulted with Mr.
19 Tolbert about relating to referrals; do you
20 recall that?

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

22 Q: Okay. And there was an effort to try to
23 determine physicians, this third bucket of
24 physicians that we're talking about, not Dr.
25 Holt's group, not the AUC positions, but the

1 third bucket of physicians.

2 A: Uh-huh (affirmative response).

3 Q: Tell me about your communication and
4 involvement with Mr. Tolbert on that.

5 A: I had an email and was given a list to review.
6 I reviewed it, and I was with Dr. Francke in
7 his office. Basically, I told them where they
8 were located and what their specialty was.

9 Q: All right. And was there any other information
10 that would have been discussed that may have
11 related to what ---

12 A: Just the location and demographics, where they
13 were from and if you thought, you know, it
14 would affect you. That was pretty much -- that
15 was it.

16 Q: All right. So that information was provided by
17 you to Mr. Tolbert and Mr. Tolbert made some
18 decisions with regards to referrals?

19 A: That's all.

20 Q: You weren't involved with that?

21 A: I was not involved with that part of it.

22 Q: Okay. All right. Just a few more questions,
23 Ms. Price. In response to some of my questions
24 you had referred to HCA. You were referring to
25 Grand Strand -- you meant Grand Strand when you

1 were referring to HCA, didn't you?

2 A: Yes. Yes. But it is a subsidiary of HCA.

3 Q: Okay. But you ---

4 A: Just like Trident is.

5 Q: All right. You were referring to Grand Strand
6 when you --

7 A: I was referring to Grand Strand.

8 Q: All right. The Conway -- the H -- th eCRCC-
9 Conway facility, you've been by there?

10 A: I have.

11 Q: You've been inside of it?

12 A: I have.

13 Q: Okay. Do you have any reservations about the
14 facility and CRCC's ability to offer care at
15 this facility?

16 A: I do not. Actually, the vault is very large.
17 It's larger than one of our vaults at CRCC.
18 And it will be a satellite facility, so I think
19 the size will be fine, other than the plans to
20 enlarge the waiting area. And with technology
21 the way it is, our dosimetrist and our physics
22 staff will be housed at CRCC. So we have two
23 exam rooms for our patients. We have a
24 physician's office. I think it will be quite
25 adequate, other than the cosmetic appearances

1 that needs to be improved. And again, you're
2 going to have to have IT because -- and that's
3 where, as they were discussing, that we needed
4 to update the electrical.

5 Q: And you mentioned cosmetics. Your
6 understanding is is that CRCC intends to
7 provide cosmetic improvements ---

8 A: Yes.

9 Q: --- to both the exterior and the interior?

10 A: I think that's been put in the application and
11 a substantial amount of money has been supplied
12 for that to occur.

13 MR. MULLINS: Put Grand Strand 64 on the screen if
14 you will.

15 Q: You heard when Mr. Lewis was on the stand some
16 questions about -- do you recall providing some
17 input to him -- if you'd scroll down on that
18 email -- providing some input on the facility?

19 A: I do.

20 Q: Okay. And -- well, let me ask you this. Based
21 on your experience with 21st Century since the
22 acquisition, are you aware that they have an
23 in-house facilities and construction and design
24 department that deals with all of their
25 facilities?

1 A: A lot of times you will get multiple people
2 that are copied on emails and they're asking
3 your opinion. I am aware that they have a
4 construction area. This was -- to me, I was
5 asked my opinion. And so people get the emails
6 when you're in the corporate world at different
7 times. I could have been very busy for the
8 first 24 hours and addressed this before the --
9 I mean, the architect could have already looked
10 at it, and that's why he could have said that.

11 Q: All right.. Do you have -- do you have any
12 reason to believe that the design and
13 facility's department is not going to design a
14 fully compliant and acceptable facility?

15 A: I think the facility will be fine.

16 Q: Do you have any concerns about the response
17 that's indicated in this email to ---

18 A: No, I do not.

19 Q: Okay. One more thing, Ms. Price. We were
20 talking about Grand Strand's decision to stop
21 having CRCC treat inpatients; you recall that
22 conversation?

23 A: I do.

24 Q: Okay. Did you ever do anything to try to
25 address that problem with Grand Strand?

1 A: I certainly did. I called the CEO at Grand
2 Strand.

3 Q: Mr. White?

4 A: Mr. White.

5 Q: Okay.

6 A: Mr. White, because I've been there a long time
7 and he was there a long time. And as he
8 stated, his father had been sick; we helped
9 with his father's care. In turn, my sister had
10 been sick and they had -- so we had got to
11 basically have a good relationship. I asked if
12 we could meet and try to resolve the issue on
13 the inpatients.

14 Q: And when did this occur? Within the past --
15 this is since they stopped transferring the
16 patients?

17 A: Yes.

18 Q: Okay.

19 A: I cannot give you the date.

20 Q: All right.

21 A: And I told him that our medical director would
22 like to meet with us also. He states he is not
23 interested in meeting with us unless we wanted
24 to do a deal. I state this is a legal issue.
25 Please, let's do not get patient care involved.

1 I also stated, Mr. White, you know your father
2 was sick, my sister was sick. I could not have
3 continued to work if you take her to
4 Charleston, and so you should think about the
5 patient and the patient's family. Family has
6 to go with a patient that has cancer. And
7 that's the way we left it.

8 Q: Did he change his position on that at all?

9 A: He did not change his position.

10 Q: Okay. Thank you, Ms. Price. Answer any
11 questions that Mr. Cartin may have.

12 THE COURT: Well, we're going to ---

13 MR. CARTIN: Yeah, Your Honor, it's ---

14 THE COURT: Ms. Biggers, do you ---

15 MS. BIGGERS: I don't have any questions, Your
16 Honor.

17 THE COURT: All right.

18 MR. CARTIN: Your Honor, it's 5:20. I may, after
19 Mr. Lewis' cross-examination today, Mr. Thomas
20 and I may be able to get together and cut this
21 down, but I would prefer to start in the
22 morning.

23 THE COURT: That's fine. I think that's what we
24 said earlier we were going to do anyway.

25 MR. CARTIN: Thanks.

1 MR. LONG: Your Honor, I just want to let the other
2 side know that we're going to flip our
3 witnesses and do Dr. Francke after Ms. Price
4 because he's got patients he's got to be
5 finished so, on Friday. And then we will do
6 Ms. Maynor. I'm still confident that we will
7 have Mr. Tolbert on Friday morning, but maybe
8 not, but I hope so.

9 THE COURT: All right.

10 MR. MULLINS: He also said we were going to do three
11 witnesses.

12 THE COURT: Yeah, two and a half. All right. So
13 we're starting back tomorrow when?

14 MR. THOMAS: 9:30.

15 THE COURT: 9:30? All right. Do we need to start
16 earlier or do you think we can ...

17 MR. THOMAS: The only reason I'd like to start at
18 9:30, Your Honor, is so I can make some --
19 between 8:00 and 9:00 I've got some other
20 clients, so.

21 THE COURT: All right. That's fine. All right.

22 Thank y'all.

23 (There being nothing further, the hearing recessed
24 for the day at 5:21 p.m.)

25 DAY 6 - THURSDAY, SEPTEMBER 19, 2013:

1 THE COURT: All right. Everybody good to go? You
2 ready, Ms. Biggers?

3 MS. BIGGERS: Yes, Your Honor.

4 MS. PRICE - CROSS-EXAMINATION BY MR.CARTIN:

5 Q: Good morning Ms. Price. I'm Walt Cartin. We
6 met before at your deposition, and the good
7 news this morning is I promise I don't have any
8 math problems for you to do ---

9 A: Well, that's great.

10 Q: --- because I can't do math nearly as well as
11 Mr. Thomas can. But what I want to do right
12 off the bat is go through a couple of things
13 and establish some stuff for the record. Now,
14 you do not hold yourself out as an expert in
15 healthcare planning, correct?

16 A: I do not. I have 33 years in radiation therapy
17 experience, though.

18 Q: And you're not an expert in healthcare finance?

19 A: No.

20 Q: And you have no firsthand knowledge about
21 inpatient reimbursement works, do you?

22 A: I do.

23 Q: You've never been a CFO of a hospital, have
24 you?

25 A: I have not.

1 Q: Never been an administrator of a hospital?

2 A: No.

3 Q: And you've never submitted a claim for
4 inpatient reimbursement inpatient, have you?

5 A: I have worked with Grand Strand on submitting
6 claims for inpatients.

7 Q: But you've never personally signed a claim on
8 behalf of CRCC for inpatient reimbursement of
9 any type?

10 A: Yes, I have sent billing in to Grand Strand
11 general for inpatients.

12 Q: But that's different than submitting it to CMS,
13 correct?

14 A: That has to go through the hospital.

15 Q: Right. So you don't ---

16 A: So we send ---

17 Q: --- submit directly to CMS?

18 A: We send our bill that we have the contract
19 service with Grand Strand general to the
20 hospital.

21 Q: Okay. Now, you haven't analyzed any actual
22 data regarding adverse impact either, have you?

23 A: I have not.

24 Q: And you haven't created any financial pro
25 formas or anything like that either, have you?

1 A: I have not.

2 Q: And you haven't created a formal adverse impact
3 analysis either, have you?

4 A: I have not.

5 Q: And Mr. Tolbert has not adopted on behalf of
6 CRCC your 50 percent adverse impact number
7 either, has he?

8 A: He has not.

9 Q: And you're not an HCA executive, are you?

10 A: I am not.

11 Q: You're not a Grand Strand administrator either,
12 are you?

13 A: I am not.

14 Q: Do you know how many physicians Grand Strand
15 employs?

16 A: No, I do not. I think there's a number like
17 270, but I don't know that for factual.

18 Q: Do you know how many Grand Strand employed
19 physicians actually sent patients to CRCC in,
20 say, 2012?

21 A: Off the top of my head, I look at reports, but
22 I couldn't tell you right here.

23 Q: But you don't know off the top of your head?

24 A: No, I do not.

25 Q: Do you know what percentage of CRCC's total

1 treatments are attributable to referrals from
2 Grand Strand employed physicians?

3 A: I do not.

4 Q: And you don't have any firsthand knowledge
5 regarding whether Grand Strand actually plans
6 to employ any more physicians, do you?

7 A: I do not have firsthand knowledge, but as the
8 healthcare is moving forward, the hospitals,
9 not just Grand Strand, Georgetown are
10 continuing to buy small practices -- solo
11 practices, and this is national, not just in
12 Myrtle Beach.

13 Q: But you're not involved in the hiring or firing
14 decisions for Grand Strand hospital, are you?

15 A: I am not.

16 Q: Okay. So I believe from your deposition you
17 told me that your belief that you would lose
18 about 50 percent of your patient referrals was
19 based on the fact that Dr. Holt did not give
20 you a letter of support, correct?

21 A: I think that's -- that's part of it, yes.

22 Q: It's the primary basis for it?

23 A: Not the primary. We have gone through history
24 -- CRCC has gone through a history of numerous
25 CON battles And as you can see, it causes us

1 -- it makes an effect on your referral basis of
2 patients. It shouldn't, but it does.

3 Q: And so you would agree with me after having sat
4 here for a week that a CON battle is something
5 that a physician might want to stay out of?

6 A: I think that it's difficult for the cancer
7 patients or any specialty..

8 Q: That wasn't what I asked. I said a physician
9 would not want to be involved in CON
10 litigation, right?

11 A: I think most people wouldn't, but yes.

12 Q: Most rational human beings would not.

13 A: That's right.

14 Q: I understand that.

15 A: That's right.

16 THE COURT: Except lawyers.

17 Q: Except for lawyers, that's right.

18 A: Yeah.

19 Q: Now, yesterday you testified that inpatients at
20 Grand Strand would have to wait in the hall on
21 a stretcher, right? Do you remember that
22 testimony?

23 A: I do.

24 Q: But you don't have any actual knowledge that
25 that would be the case at Grand Strand?

1 A: Actually, I do.

2 Q: Ms. Price, Grand Strand doesn't have a
3 radiation therapy program yet, do they?

4 A: Well, I'm saying outpatients. When you're
5 inpatient, -- I recently was a patient there.
6 - I waited in the hall for my MRI until it was
7 canceled. I sat for an hour.

8 Q: But you weren't a patient for radiation
9 therapy, were you?

10 A: No.

11 Q: So Grand Strand doesn't have a radiation
12 therapy program, so any projection about what
13 might happen is just speculation, right?

14 A: It is. Some of the procedures that you go
15 through as an inpatient, I've had family
16 members that you wait a good while for
17 services.

18 Q: But you don't actually have any copies of Grand
19 Strand's policies or procedures or anything
20 like that that you've reviewed to make your
21 determination that inpatients are going to have
22 to wait in some sort of hallway?

23 A: No.

24 Q: Okay. Let me ask you, do you know that Grand
25 Strand has a PET/CT?

1 A: I do know that they have one on the South
2 Strand that, from my understanding, it comes in
3 two days a week.

4 Q: Is that a mobile PET/CT?

5 A: That is, from my understanding.

6 Q: So you would expect that if Grand Strand were
7 to have a radiation therapy program, they might
8 move that mobile PET/CT to Grand Strand?

9 A: I would not know that.

10 Q: But it's possible?

11 A: It is possible, but I think that would be the
12 first step that I would do with the
13 comprehensive cancer center, to have one on my
14 main campus.

15 Q: Okay. Now, you've been a licensed radiation
16 therapist for quite a while now, right?

17 A: Yes.

18 Q: What year were you first licensed?

19 A: I'm trying to go back. I think it was
20 probably, as a radiation therapist, probably in
21 '77.

22 Q: And so but for the past 15 years or so, you've
23 been involved in the management and operation
24 side of CRCC?

25 A: That is correct.

1 Q: So you're very experienced when it comes to
2 running a freestanding radiation oncology
3 center?

4 A: That is -- that's true.

5 Q: That's a very fair statement, I think.

6 A: That is.

7 Q: And you've spent most of your adult life
8 working for CRCC, correct?

9 A: I have.

10 Q: And so you care very deeply about CRCC?

11 A: I surely do.

12 Q: You care for its patients?

13 A: I care for our patients. I care about our
14 employees.

15 Q: Right. So you have an interest in making sure
16 the staff keeps their jobs, right?

17 A: Very much so.

18 Q: And as a manager, you're actively involved in
19 the day-to-day operations at CRCC?

20 A: That is correct.

21 Q: So you're very familiar with the history in the
22 service area, correct?

23 A: I am.

24 Q: All right. Let's go to Petitioner's 61. Ms.

25 Price, I'm going to open up my copy, then I'll

1 bring one to you. When I say Petitioners, it
2 will be in the green books, okay?

3 A: Okay. Would it be on the screen also?

4 Q: It will. It will, but it may be kind of small
5 for you, so you want to -- if you wear glasses
6 like me.

7 A: No, I can see it.

8 Q: So you need to open it up ---

9 A: I have problems with distance but not close up.

10 Q: All right. Do you recognize this email?

11 A: Yes. Certainly I've seen the email.

12 MR. CARTIN: Can you scroll down to the next page,
13 please. Your Honor, this would be page Tolbert
14 453.

15 Q: Take a look at this document for me. Is this
16 a history of Carolina Regional Cancer Center
17 that you drafted?

18 A: I don't know that I drafted it. I gave them
19 information on the history.

20 Q: And so all of this history in here, is this
21 accurate?

22 A: Well, I would have to read it totally if that's
23 what you'd like me to do.

24 Q: You can if you want to.

25 A: I mean, is there something particular in

1 question?

2 Q: Well, let's just look at the third paragraph
3 down that begins with, "Over the years." Why
4 don't you read that first sentence to me.

5 A: "Over the years, CRCC has developed a highly
6 respectable reputation with the community,
7 local hospitals, and physicians."

8 Q: And is that a true statement?

9 A: I feel that it is a true statement.

10 Q: Is that a very strong relationship they've
11 developed over the years?

12 A: Yes.

13 Q: Because you -- have you developed a reputation
14 for quality?

15 A: Very much so.

16 Q: Okay. And if we look at these bullet points
17 down here, it looks like you have always
18 strived to provide the most technologically
19 advanced equipment, correct?

20 A: We have.

21 Q: And you guys have been on the cutting edge of
22 radiation oncology in South Carolina, right?

23 A: We'd have a history of that.

24 Q: It's made you one of the most successful
25 providers in South Carolina?

1 A: That is correct.

2 Q: Got a high patient satisfaction rate?

3 A: That's a true statement.

4 Q: That's right. Keep your referral sources
5 happy, correct?

6 A: We try.

7 Q: Okay. Keep ---

8 A: But first of all, we try to keep our patients
9 happy.

10 Q: Absolutely. And do you have -- I suspect you
11 have had patients whose family members come
12 back to see you to ---

13 A: Oh, yeah, we do.

14 Q: All right. And you would expect that in the
15 future CRCC would continue to be on the cutting
16 edge of technology, correct?

17 A: Certainly that is what we want and that is what
18 we hope for. And I think that 21st has shown
19 that they are interested in doing that with
20 CRCC.

21 Q: And so I think you mentioned that CRCC has
22 become known for its patient care throughout
23 the region, right?

24 A: Yes, sir.

25 Q: And so have you done marketing activities and

1 so forth?

2 A: We have done marketing, and actually, we have
3 recently with 21st Century, we have a physician
4 liaison that that is her primary job ---

5 Q: That's right, her ---

6 A: --- marketing and visit physicians, and let our
7 physicians speak in community activities.

8 Q: Okay, good. Now, CRCC is also a well utilized
9 provider right now, right?

10 A: It is.

11 Q: Okay. And you're operating 12 hours a day or
12 more?

13 A: We are not. Well, I say that. Certain units
14 are. We have one unit, the 6EX, that starts at
15 8:00 and usually is finished by 4:30. The
16 other two units can start at six in the morning
17 and we're -- probably we're finishing at six
18 now. I think yesterday we treated 73 patients
19 total.

20 Q: Have you in the past operated sometimes 15
21 hours a day?

22 A: We have when we had the initial influx of
23 patients with the change in ownership and Dr.
24 Bass no longer being there. And then the other
25 time that we stayed late was when we changed

1 out machines. We only had two operational, and
2 we had to stay late because we were putting in
3 a 23iX, so.

4 Q: Okay. So you're a busy center, correct?

5 A: We're busy.

6 Q: Now, let's talk about the CON application a
7 little bit. You'd help CRCC, I believe you
8 testified, prepare a portion of the CON
9 application, right?

10 A: That is true. I gave information. I didn't
11 prepare it, but I gave them some information
12 from our EMR system.

13 Q: Understood. And you have a great deal of
14 institutional memory, correct?

15 A: Yes.

16 Q: Probably more than anybody there at CRCC?

17 A: Well, I think so.

18 Q: You have a great deal of operational experience
19 as well too?

20 A: I do.

21 Q: You know what makes things go smoothly,
22 correct?

23 A: Yes.

24 Q: You know what patients like to see; what makes
25 them comfortable, correct?

1 A: Right.

2 Q: Now, the CON application, was it primarily put
3 together by you or by someone else?

4 A: Someone else.

5 Q: Okay. And was that Mr. Tolbert that primarily
6 put that together?

7 A: It was.

8 Q: And the input you provided, I think you said
9 you gathered some letters of support; is that
10 correct?

11 A: Letters of support, some zip codes from our EMR
12 as to the patient base they're coming from.

13 Q: So you provided some data to the expert?

14 A: Yes.

15 Q: We'll talk a little bit more about records in
16 a bit. You provided the history that we went
17 through a little bit earlier, correct?

18 A: I did.

19 Q: And participated in the project review, right?

20 A: I did.

21 Q: And did you give a little spiel on the history
22 of CRCC?

23 A: I did. I told about the history of CRCC.

24 Q: Were you the one that provided utilization
25 numbers for 2008, 2009, and 2010?

1 A: They came out of our EMR because 21st did not
2 have that information. So yes, I had to get
3 that information out of the EMR system.

4 Q: What year did your -- can you tell me what year
5 your EMR, what year did 21st Century Oncology's
6 EMR system become effective such that it could
7 provide data and at what point did you have to
8 rely on CRCC's former EMR system to get data?

9 A: Well, I would think that was from acquisition
10 that they do that in May 2010, they started
11 recording treatments.

12 Q: So anything before May 2010, you had to pull
13 off CRCC's data?

14 A: That is correct.

15 Q: Okay. Now, based on your many years of
16 experience at running CRCC, you provided some
17 input on the design of the project, correct?

18 A: The design? No.

19 Q: Yeah, the design. Let's pull Petitioner's
20 Exhibit 64.

21 A: I was asked to look at -- you know, go --
22 you're talking about the Conway Center?

23 Q: Yes, ma'am.

24 THE COURT: So Petitioner's ---

25 A: Yes, I did go look at it.

1 MR. CARTIN: Petitioner 64, Your Honor.

2 Q: See this one?

3 A: Yes.

4 Q: I think we talked about this yesterday. I'm
5 not going to rehash it. As I understand your
6 testimony from yesterday, and also Mr. Lewis',
7 CRCC has architects that do projects for it
8 throughout North and South Carolina, right?

9 A: That is -- that is true.

10 Q: Okay. And Mr. Lewis said these changes were --
11 he didn't want to deviate from what the
12 architect said, correct?

13 A: That's right.

14 Q: But would you agree with me that each of the
15 points that you referenced there, points one
16 through five, were all points that you found to
17 be at least important as an administrator,
18 correct?

19 A: That's a true statement. And as technology has
20 improved, the building has been there for a
21 while, so the IT needs to be improved there.
22 But again, in our CON, there has been a lot of
23 money for these improvements.

24 Q: Okay. Understood. And these changes, the
25 specific changes you referenced there, those

1 were not actually included in the CON, correct?

2 A: Well, the architect did not put that in there.

3 Q: Understood. Let's go to, speaking of the
4 facility, let's go to Exhibit 14, Respondent's
5 Exhibit 14. All right. And is that a picture
6 of CRCC's existing Myrtle Beach facility?

7 A: That is. And CRCC went through a major
8 renovation in 2001, so it did not look this way
9 in 2001. But it's a very large, nice facility.

10 Q: And so you ---

11 A: But it did not start that way.

12 Q: Right. Did you update the facade and
13 everything like that?

14 A: Yes.

15 Q: Re-did floors?

16 A: We did.

17 Q: Re-did the counter tops?

18 A: We did.

19 Q: Make it generally more functional and pleasing
20 to the eye?

21 A: We added more administrative offices for the
22 physicians because, as the practice has grown,
23 we've added more physicians.

24 Q: Right. How many physician offices do you have
25 now?

1 A: We have four.

2 Q: And that's for one for each of your radiation
3 oncologists?

4 A: Yes.

5 Q: And I guess some ---

6 A: Some other administrative people can use the
7 other office.

8 Q: Okay. Let's go to Joint Exhibit 13. And we're
9 gong to go to the first -- actually, the second
10 page of that, which is page 1 of -- excuse me
11 -- page 2 of the DHEC record. Let me find that
12 for you. I believe that's correct but let me
13 find it. Ms. Price, do you recognize what
14 Exhibit 13 is?

15 A: I do.

16 Q: It says right there, this is the application to
17 replace an existing linear accelerator and
18 relocate it to a new office in Murrells Inlet,
19 South Carolina?

20 A: Murrell. Uh-huh (affirmative response).

21 Q: Let's turn to page 7 of that record, so if
22 you'd will flip over a little bit more.

23 A: Okay.

24 Q: How many square feet will your proposed
25 Murrells Inlet facility be?

1 A: 6,893.

2 Q: And what's the total project cost listed right
3 down there at the bottom?

4 A: \$7,993,972.

5 Q: Now, let's flip to page 261. There's a bit of
6 housekeeping I've got to do here.

7 MR. CARTIN: We all kind of -- Your Honor, we split
8 up responsibilities for making copies of the
9 Joint Exhibit. For some reason, I think this
10 part got cut off, it got turned sideways in the
11 PDF. I have a copy. Roshel, do you have those
12 copies of the actual exhibit? We printed out
13 from our records from what we produced to ---

14 THE COURT: One second.

15 MR. CARTIN: We fixed it in here in the actual ---

16 THE COURT: Well, what I'm trying to catch up. What
17 was the square foot of the Murrells Inlet?

18 MS. PRICE: Six thousand ---

19 THE COURT: I got it, 6,890.

20 MR. CARTIN: This is a corrected picture of it.

21 THE COURT: All right.

22 MR. CARTIN: And I would ask, Your Honor, that we
23 substitute this page of the record with the
24 exhibit that I've given.

25 THE COURT: Well, y'all going to take care of that?

1 Are you requesting ---

2 MR. CARTIN: Is there any objection ---

3 MR. MULLINS: No objection.

4 MR. CARTIN: --- that we correct that particular
5 page?

6 THE COURT: Ms. Biggers?

7 MS. BIGGERS: No objection.

8 THE COURT: All right. Well then, so ordered.

9 Q: Well, I just want to take a look at this
10 facility and -- how many accelerators can be
11 placed in here?

12 A: Looks like they've got one vault.

13 Q: And were you involved in the design of this at
14 all?

15 A: No, sir.

16 Q: In your opinion, is this a -- would this be a
17 state of the art facility they were going to
18 build there?

19 A: I would think they would want to, but if I
20 understand, the population in the Murrells
21 Inlet area is a little higher than the Conway
22 zip code area.

23 Q: Does this schematic that you see right here
24 contain all the things you would expect to see
25 in a radiation therapist center?

- 1 A: Well, this -- even on your print here, this is
2 pretty small for me to go through the whole
3 thing to tell you that I think everything is
4 covered.
- 5 Q: And is this the first time you've ever seen
6 this schematic?
- 7 A: I have not reviewed the Murrells Inlet because
8 I wasn't involved in the design.
- 9 Q: Okay. But this -- what size did you say this
10 facility was again? Read it back to me.
- 11 A: It was six thousand, I think, eight hundred
12 ninety-three or something like that.
- 13 Q: And how big is your existing facility in CR --
14 in Myrtle Beach?
- 15 A: Well, it's over 10,000, but we've got three
16 vaults.
- 17 Q: Okay. Right. And you've got four physician
18 offices?
- 19 A: That's right.
- 20 Q: Staff waiting area?
- 21 A: Correct. We have two waiting rooms.
- 22 Q: Dressing rooms?
- 23 A: We have dressing rooms for the units, and we
24 have nursing stations.
- 25 Q: Did you say you have a large conference room as

1 well?

2 A: We do have conference rooms.

3 Q: And it has video conferencing capability in
4 there?

5 A: Yes, it does.

6 Q: And that's where you said Dr. Francke and some
7 of the other doctors will participate in tumor
8 boards, correct?

9 A: They can do it that way. At our particular
10 office that we have teleconferencing was mostly
11 with MUSC for head and neck patients.

12 Q: Is this part of a telemedicine program, or?

13 A: Yes. Dr. Francke actually does his
14 teleconferencing with the tumor board at
15 Waccamaw Hospital.

16 Q: Okay. Now let's bring up Respondent's Exhibit
17 15. This is an image of CRCC's Conway's
18 current existing building, correct?

19 A: That is correct.

20 MR. CARTIN: Roshel, can you go to the next page.

21 MS. TUSKA: 16 or?

22 MR. CARTIN: No, the next page of this exhibit.

23 THE COURT: The next exhibit?

24 MR. CARTIN: Same exhibit, should be the -- there we
25 go.

1 Q: Looking at this exhibit, Ms. Price, is that
2 white garage looking type building the vault to
3 the right of ---

4 A: That is external of the concrete, which is a
5 portion of the vault.

6 Q: And the main portion of the facility is kind
7 of, it's hard to tell from this angle, but
8 would you agree that if you were to stand in
9 that parking lot facing it, the vault is
10 actually kind of much bigger part, it's
11 appended onto the smaller building?

12 A: The vault is in the posterior part of this
13 construction, yes.

14 Q: And how big is this facility; do you know?

15 A: Right off, I do not.

16 Q: Does about 3,600 square feet sound right?

17 A: That's what has been put in some records.

18 Q: And that's significantly smaller than your
19 Murrells Inlet location?

20 A: That is true.

21 Q: Significantly smaller than your current
22 location in Myrtle Beach, correct?

23 A: Yes, sir.

24 Q: Does this have a large conference room in it?

25 A: It has an extra office in it close to the CT

1 scanner that would be utilized. And this
2 particular center would not house our dosimetry
3 or physics, that would be the main office in
4 Myrtle Beach.

5 Q: And does this facility have a sprinkler system?

6 A: It does not that I know of but it would have --

7 -

8 Q: Are you aware of ---

9 A: --- to be up to code before we could utilize
10 it.

11 Q: Are you aware of any plans to add a sprinkler
12 system to it?

13 A: I would be aware that it would be up to code.

14 Q: We don't know what the code is right now?

15 A: I don't know what the code is.

16 Q: Well, wouldn't that code specify that a
17 sprinkler system be added?

18 A: We do not have a sprinkler system at CRCC, and
19 it's passed all codes.

20 Q: Do you know whether this facility has been
21 tested to withstand hurricanes?

22 A: I do not know that.

23 Q: When was this facility built?

24 A: I know that it was previously. I would say
25 it'd have to be in the early 2000s, because

1 there had been some issues with CON and not
2 going through utilization for CON. They were
3 trying to bypass that.

4 Q: Now, if we compare this facility with your
5 existing one, they're much different in
6 appearance, correct?

7 A: That is true. But the CON had a lot of money
8 for this to have cosmetic improvement, enlarge
9 the waiting area, plus the most latest
10 technology that Varian has. So I think the
11 equipment is more important than the patients
12 and the kind of treatments that they get versus
13 a cosmetic appearance.

14 Q: Understood. And I just want to confirm that
15 patients will pay the same amount of money for
16 treatments provided in this center as they will
17 in CRCC's Myrtle Beach facility, correct?

18 A: MRI treatment -- a MRI treatment would be paid
19 the same.

20 Q: What do you mean by MRI?

21 A: I mean IMRT, I'm sorry.

22 Q: IMRT, I've got -- okay. Understood. Okay.
23 Now we talked a little bit a -- a little bit
24 ago about your work with helping CRCC gather
25 letters of support, right?

1 A: Yes, sir.

2 Q: And you stated yesterday that you were very
3 successful in your efforts, correct?

4 A: Well, we had two going on. We had the Conway
5 and the Murrells Inlet. So talking with Conway
6 area physicians, we did get a lot of support
7 there.

8 Q: And you said the CEO of Conway Medical Center
9 as well provided you a letter?

10 A: Yes. He actually came and spoke at project
11 review because he was so pleased that we were
12 bringing radiation very close to the hospital.

13 Q: So that means its inpatients would have a much
14 shorter drive to get radiation therapy, right?

15 A: We've done maybe five inpatients this year from
16 Conway.

17 Q: And did you get letters of support from members
18 of the board of Conway Medical Center?

19 A: I think that we did.

20 Q: You got letters of support from physicians who
21 are on the staff at Conway Medical Center,
22 right?

23 A: We did.

24 Q: And you got letters of support from physicians
25 who were employed by Conway Medical Center,

1 correct?

2 A: That is true.

3 Q: And I understand from our testimony yesterday
4 that you asked Dr. Holt, one of the local
5 medical oncologists, for a letter of support as
6 well?

7 A: Yes.

8 Q: And Dr. Holt indicated that he didn't want to
9 get involved in the big CON fight, correct?

10 A: That is a correct statement. He said he didn't
11 want to get involved. And then when we went to
12 project review, because of the good
13 relationship with Dr. Holt for the many years,
14 I was actually shocked that he had supported
15 the two hospitals and not supported CRCC.

16 Q: Let's confirm this. Nobody's actually
17 indicated that they are not going to send any
18 more patients to CRCC if Grand Strand gets a
19 linear accelerator program, have they?

20 A: We have had support letters from the physicians
21 that cover the Conway hospital.

22 Q: Correct. But in general, no physician has ever
23 indicated that once Grand Strand is up and
24 running, CRCC will no longer get patients from
25 them?

1 A: They have not told me that, no.

2 Q: You talked a second ago about the Conway
3 Coastal Cancer Center doctors. They each gave
4 you letters of support. Was Dr. Karpenko one?

5 A: From my understanding, Dr. Karpenko was.

6 Q: Dr. Goldberg?

7 A: Dr. Goldberg, and I think Dr. Cody, if I'm not
8 mistaken.

9 Q: That's exactly right. And Dr. Goldberg, does
10 he drive a Bentley? Is that what Doug White
11 said in his testimony?

12 A: That's what he said. He'd been involved with
13 the Coastal Cancer for a long time.

14 Q: Medical oncology must be better than being a
15 lawyer, so. Now at the time these guys
16 provided the letters for you, these three
17 doctors associated with Coastal Cancer Center
18 who are in Conway, did they provide those
19 letters on Coastal Cancer Center letterhead?

20 A: Now I don't have the letter in front of me, but
21 I would have to assume that it was.

22 Q: And so I think in your deposition you told me
23 that CRCC's actually had a longstanding, good
24 relationship with the medical oncology
25 practice, right?

1 A: We have, but I also stated that they were in a
2 previous CON battle between -- with the
3 urologists, so.

4 Q: Okay. Let's talk about -- let's go through
5 project review a little bit as we're kind of
6 going down this process of developing the CON
7 application and then making our presentation to
8 DHEC. You participated in project review,
9 correct?

10 A: I did.

11 Q: And I guess there was a -- you participated,
12 Dr. Francke participated. Who were the other
13 participants on behalf of CRCC at project
14 review?

15 A: Of course the lawyers, and we had the CEO of
16 Conway Hospital.

17 Q: And his name is Phil Clayton, correct?

18 A: That is correct.

19 Q: And he liked your project enough to drive all
20 the way to Columbia to ----

21 A: Yes, he did.

22 Q: Okay. Good. And how long was his little talk
23 there at project review; do you recall?

24 A: I do not recall. Maybe five minutes. I don't
25 know.

1 Q: And is it your understanding at project review
2 it's kind of your opportunity to make your case
3 publicly to DHEC for why your project should
4 be approved?

5 A: That's true.

6 Q: And you would suspect that when you make a
7 presentation to DHEC like that, you would want
8 to include the things that are important to
9 you, the kind of the major points that make
10 your project the project to pick, correct?

11 A: Yes, sir.

12 Q: And you would also if you're in a competing
13 applicant situation, you would also want to
14 include information that might be a good reason
15 to deny the other competing applicants; is
16 that so?

17 A: Uh-huh (affirmative response).

18 Q: And your answer was yes?

19 A: Yes.

20 Q: Okay. And I just want to confirm, did CRCC
21 mention in its project review meeting or in its
22 slides that it presented to DHEC that it
23 thought it would lose all of the medical
24 oncologist referrals?

25 A: I do not think that that was an issue that was

1 brought up. I think that we had looked at not
2 having support from them because we didn't
3 think they were going to get into the CON.
4 They weren't going to supply letters for
5 anybody.

6 Q: Understood. But it was not actually included
7 in the project review either, the slides or the
8 presentation made?

9 A: No, it was not.

10 Q: Now, the AUC urologists, let talk about these
11 guys. AUC stands for?

12 A: Atlantic Urology Center.

13 Q: And radiation therapy is a referral driven
14 practice; is that fair to say?

15 A: That is a true statement.

16 Q: Now, your largest referral source for CRCC is
17 medical oncologists; is that correct?

18 A: Yes.

19 Q: But neck and neck right up there with it is the
20 AUC urologists, correct?

21 A: That is true.

22 Q: And all of the urologists in Horry County are
23 associated with AUC; is that correct?

24 A: That is correct.

25 Q: And AUC is actually an owner of CRCC, correct?

1 A: From my understanding, but I do not know the
2 structure of the ownership there.

3 Q: Okay. Fair enough. Now, prostate cancer
4 patients are the single largest grouping of
5 patients by diagnosis for CRCC; is that
6 correct?

7 A: I would think that they would be right there at
8 the top of the list.

9 Q: But urologists have not always been the second
10 largest referral source for CRCC, have they?

11 A: No, I think that you are aware there was a
12 previous CON battle ---

13 Q: That's right.

14 A: --- and it could not be resolved with the
15 personality conflicts of the urologists and Dr.
16 Bass.

17 MR. CARTIN: And let's bring up Petitioner 56. Can
18 you blow that up, Roshel?

19 Q: And this is data, it's been discussed before in
20 the trial, but this shows, you would agree with
21 me, the 2009 consults that were sent from the
22 physicians listed there, correct?

23 A: Yes, sir.

24 Q: And those physicians are AUC physicians; is
25 that right?

1 A: That is correct.

2 Q: And the numbers you would suspect serve as
3 consults, and so that doesn't necessarily mean
4 that's all treatment plans; that's just
5 patients they sent there, correct?

6 A: That is referrals.

7 Q: So some of those patients may have received
8 treatment; some may not have?

9 A: That's correct.

10 MR. CARTIN: Now, let's go to Petitioner's 45. Blow
11 that up for me, please, Roshel. Thank you.

12 Q: Now this is a similar chart, but it's got more
13 years worth of data, correct?

14 A: That is correct.

15 Q: And it appears that the physician names listed
16 there match up with the names in the exhibit we
17 saw before, correct?

18 A: Yes, sir.

19 Q: And the numbers we see for 2010, 2011, 2012 are
20 significantly higher than the numbers we saw
21 for 2009; is that correct?

22 A: That is correct.

23 Q: So if we're looking at this data, we would
24 suspect that something happened around 2010
25 that caused the physicians, the AUC physicians

1 to come back into the fold, so to speak

2 A: And, obviously, Dr. Bass retire with the sell
3 of the center; the bad communication from the
4 previous CON battle. I think it was a great
5 thing that the patients in the area stayed in
6 the area. I do not know where they went
7 previously.

8 Q: Gotcha. Now let's talk about Dr. Bass a little
9 bit. I think you and I both have a very mutual
10 respect for Dr. Bass.

11 A: We do.

12 Q: He was the prior owner of CRCC, correct?

13 A: That's correct.

14 Q: He bought it in what year did you say
15 yesterday?

16 A: 1994.

17 Q: Okay. And you worked very closely with him,
18 correct?

19 A: Very closely.

20 Q: And during Dr. Bass' tenure as the owner of
21 CRCC, you would agree with me that CRCC
22 remained a high quality -- maintained a high
23 quality radiation therapy program, correct?

24 A: Yes.

25 Q: And just to confirm, Dr. Bass when he sold

1 CRCC, all of his linear accelerators in this
2 high quality radiation therapy program were in
3 one spot at Myrtle Beach, correct?

4 A: That is correct.

5 Q: And during his time, Dr. Bass and CRCC were
6 well respected members of the medical community
7 in Horry County, correct?

8 A: Yes, we were. But we did have some issues with
9 the CON, previous CON battle.

10 Q: Right, right, understood. And you continue to
11 have a good reputation in the community ---

12 A: Yes, we do.

13 Q: Okay. You mentioned Dr. Bass and the AUC
14 urologists did not have a good relationship,
15 correct?

16 A: They did not.

17 Q: And one of the reasons for that was a CON fight
18 that went on in what, 2004 time frame?

19 A: Yes.

20 Q: And when that CON fight began, did you see a
21 decrease in the amount of referrals from the
22 AUC urologists?

23 A: Yes.

24 Q: And the referrals from those guys did not pick
25 back up until Dr. Bass left, as you said

1 earlier, correct?

2 A: That is correct.

3 Q: So the only reason urologists were not
4 referring to CCC was that -- and your
5 understanding was that they had a dislike for
6 Dr. Bass?

7 A: That is my understanding.

8 Q: So they let maybe a business relationship get
9 in the way of patient care, correct?

10 A: That's what it seems or appears.

11 Q: All right. Let's go to Joint Exhibit 1. It's
12 the CRCC DHEC record at page 521.

13 THE COURT: What was that again, CRCC what?

14 MR. CARTIN: It's Joint Exhibit -- excuse me --

15 THE COURT: Oh, Joint.

16 MR. CARTIN: Joint Exhibit 1 at page 521.

17 Q: And actually, let's look first at page 519.

18 A: Okay.

19 Q: Let me get that as well. Okay. Have you seen
20 this document before, Ms. Price?

21 A: Yes, I have.

22 Q: Will you look at page 519 at the top there
23 under the words, Dear Ms. Brandt, can you read
24 that first sentence for me?

25 A: This letter is in follow up to your request for

1 a additional information on April 5, 2011,
2 relative to the above referenced project. Your
3 requests are shown below is initialized and
4 your response italicized follows in regular
5 type face.

6 Q: Now we'll turn to page 521 now.

7 A: 521, okay.

8 Q: And let's look at italicized number 8, okay?

9 And this is a question, you would agree with me
10 this is a question from the Department?

11 A: Yes.

12 Q: And then below that in the non-italicized
13 portion is CRCC's response, correct?

14 A: Correct.

15 Q: Now, if you'll go down to into the italicized
16 portion of number 8 and please read me the
17 sentence that begins with please provide.

18 A: Please provide an explanation for the increase
19 in the radiation treatments from 15,613
20 treatments in 2009 to 20,946 treatments in
21 2010. Please indicate if the 2010 treatment
22 data is actual or annualized based on the most
23 recent six months.

24 Q: Okay. Now, let's look at the response. Let's
25 start with the second sentence of the response

1 and please read that sentence for me.

2 A: The new ownership of CRCC and a renewed focus
3 on physicians referral relationship have
4 clearly increased the utilization of CRCC's
5 services.

6 Q: Read one more sentence for me.

7 A: Radiation Therapy Services, Incorporation, with
8 its national scope and depth of experience in
9 the field has helped CRCC better educate
10 referral physicians and create a greater
11 understanding of the appropriate use of
12 radiation therapy for their patients.

13 Q: And you would agree with me that there is no
14 explicit reference to the urologists in that
15 sentence or in that paragraph there, correct?

16 A: I do not see anything in this paragraph.

17 Q: Okay. And you would also agree that the
18 significant driver in the volume for the 2009
19 and 2010 for CRCC was the urologists coming
20 back into the fold, correct?

21 A: I think your data shows that.

22 Q: Okay. There's a reference here to some of the
23 -- CRCC's participation in the community and
24 some of the physician outreach that they had.
25 You've been at CCC for a long time, had you

1 guys been engaged in those types of activities
2 before the 21st Century took over?

3 A: We were.

4 Q: You were involved in the American Cancer
5 Society, correct?

6 A: We were, but we didn't have one employee that
7 that was her job title to help go out in the
8 community like that, but we were involved.

9 Q: And I guess it's fair to say that Dr. Bass'
10 efforts in that area had been successful
11 because you'd grown, you know, again the most
12 successful radiation therapy practice in South
13 Carolina that time, correct?

14 A: Yes.

15 Q: Now when you started with CRCC in 1980, CRCC
16 had one linear accelerator; is that correct?

17 A: That is correct.

18 Q: So from 1982 until 1992, I think you said.

19 A: I think it's '92.

20 Q: You operated as a single linear accelerator
21 provider?

22 A: Yes.

23 Q: And during that time, you provided good care,
24 good quality care to folks, correct?

25 A: I think so.

1 Q: And Georgetown still operates a single linear
2 accelerator program, correct?

3 A: From my understanding, yes.

4 Q: And is it your understanding that they are a
5 good, generally good as far as quality goes,
6 program?

7 A: I know that they are accredited.

8 Q: And you guys are accredited too, right?

9 A: We were the first ones in South Carolina.

10 Q: And what year did that happen?

11 A: Maybe 2003 somewhere around there.

12 Q: So you've been, for a while you guys have been
13 ACR credited?

14 A: Yes.

15 Q: That's the ACR --

16 A: Actually, I'm very proud of it because I did a
17 lot of work on that, and we were the first ones
18 in South Carolina.

19 Q: Now, what group of physicists do you guys use?

20 A: They've changed hands. It's called Landauer is
21 the name of them now. It's a contract service.
22 They have been a contract service for CRCC for
23 many years, and I, as they said, normally this
24 is not what 21st does, but usually they
25 maintain employees, so they kept contract

1 service.

2 Q: Is that Bill Root's group?

3 A: Bill Root. Uh-huh (affirmative response).

4 Q: He's been doing it for a long time, hadn't he?

5 A: Many years.

6 Q: As long as you've been at CRCC?

7 A: Actually no, there was a previous one by the
8 name of Jimmy Finn who was one of the original
9 owners.

10 Q: Understood. Now, I think we talked about this
11 in your deposition, but I'll bring it up here,
12 and I think Mr. Lewis alluded to it as well.
13 These different linear accelerators that you
14 have, they have great service and maintenance
15 packages, correct?

16 A: That is true.

17 Q: They're very highly responsive, right?

18 A: That's right.

19 Q: And when a machine goes down, they get over
20 there ASAP because they know it's your bread
21 and butter, right?

22 A: That's exactly what they try to do. And when
23 you have to order parts, sometimes it's a
24 little bit of a delay if you don't have the
25 part right on hand for the service guys, so --

1 but usually we'll treat on Saturday if a
2 patient misses more than one treatment.

3 Q: So there are, I guess, accommodations you can
4 make to make sure you ---

5 A: We make the accommodations.

6 Q: To keep up with that course of treatment,
7 right?

8 A: That is correct.

9 Q: Now, CCC currently operates three linear
10 accelerators, right?

11 A: That's correct.

12 Q: One of those is a Clinac iX?

13 A: 23 IX.

14 Q: 23 IX?

15 A: Uh-huh (affirmative response).

16 Q: Which is another word for, or can also in
17 lawyer vernacular being referred to as a Clinac
18 iX?

19 A: I guess so, but we call it 23 IX.

20 Q: Understood, understood. Now, is it basically
21 the same model, in your understanding, of what
22 Grand Strand proposes to add at its facility?

23 A: It is my understanding, but I don't know. I
24 think y'all cut some of the bells and whistles
25 that we may have, but ---

1 Q: But in general, it's a good quality machine,
2 right?

3 A: Yes. Yes.

4 Q: It can treat the vast majority of different
5 types of cancer, right?

6 A: Yes, that is true.

7 Q: And it does it safely?

8 A: Yes.

9 Q: And you're the chief administrator at CRCC's
10 Horry County facility; is that right?

11 A: Well, I'm the regional administrator. With the
12 corporate change, we have different names that
13 they call you.

14 Q: So you'll be in charge of Murrells Inlet,
15 Myrtle Beachm and Conway if all three are
16 approved, correct?

17 A: That is my understanding.

18 Q: So you really will be regional. You won't be
19 in just one office anymore, huh?

20 A: That's right.

21 Q: Now, in that capacity you report certain
22 information up to 21st Century Oncology,
23 correct?

24 A: Most of my information goes to Rosa Maynor, who
25 is the regional director.

1 Q: And Rosa is -- Ms. Maynor, pardon me, is
2 employed by 21st Century, correct?

3 A: Yes.

4 Q: And the types of information that you send up
5 there, you send up referral data, correct?

6 A: I do.

7 Q: You send up the number of treatments, correct?

8 A: I do.

9 Q: And do you separate it out by linear
10 accelerator?

11 A: Well, we also have a technical director that he
12 sends -- he reports to another subhead as to
13 the number of treatments that we're delivering.

14 Q: And those reports are generated from the EMR
15 system; is that correct?

16 A: They are not out of my EMR now. Since we've
17 gone corporate, like I said, since May 2010,
18 that is done more at the corporate office with
19 their system?

20 Q: So if Mr. Lewis or somebody else up at
21 corporate needs, say, the number of treatments
22 that have been performed in a particular month,
23 that's something they can access fairly easily?

24 A: Yes, and Rich Lewis would usually provide that.

25 Q: And if they wanted to see where the referrals

1 were coming from, is that something they could
2 access fairly easily as well?

3 A: They should, from their system.

4 Q: Now, yesterday, I just want to confirm your
5 testimony, you said that there was no
6 significant difference in the time it takes to
7 travel from Coastal Cancer Center to Grand
8 Strand and the time it takes to travel from
9 Coastal Cancer Center to CRCC; is that correct?

10 A: I don't think there's a significant difference.
11 It's a tad longer to get to our office, but not
12 enough that you wouldn't be able to transport
13 a patient. And again, my recollection, there
14 is two stop lights that you would go through
15 from Grand Strand Hospital to get to our
16 office. Coming out of the parking lot from
17 Grand Strand, you've got a stop sign. You get
18 on 82nd. You go one or two blocks, you hit
19 another stop sign, and you go down that street,
20 which is Rourk Street. So you may could get to
21 his office in five minutes, but again, you've
22 got to find somewhere to park because there is
23 an issue with parking there. But you probably
24 could get to our office in five to six minutes,
25 so ---

1 Q: And from a clinical standpoint, five to six
2 minutes is not a significant amount of time?

3 A: Well, no, I don't think so. It depends on the
4 shape of the patient.

5 Q: We mentioned tumor boards yesterday and you
6 said that you assign doctors to the various
7 tumor boards, correct?

8 A: Yes.

9 Q: What are the various tumor boards that you've
10 got out there. Can you count those for me?

11 A: They have -- now if you're talking about Grand
12 Strand; is that where you would like me to
13 start?

14 Q: Yes, ma'am.

15 A: Grand Strand in the last, I would say the last
16 six to eight months, they had developed a lung
17 tumor board which Dr. Steve Andrews attends,
18 and he's very involved. Actually, he's been
19 involved with the two pulmonologists very
20 deeply. We've just began a new procedure
21 called putting in markers for lung patients.
22 And he's been a speaker there. So his schedule
23 is -- I make sure that he has allotted in his
24 schedule that he can attend that. When they
25 have a general tumor board on, I think, once a

1 month on Thursdays that at least one of our
2 physicians attend.

3 Q: Okay.

4 A: They have started in the last three years with
5 we're pushing, pushing, pushing from CRCC to
6 develop a breast program. Dr. Sophia Bennett,
7 her schedule is adjusted for her to attend.

8 Q: And so you, are you the one that adjusts their
9 schedule?

10 A: I do.

11 Q: And do you actually confirm their attendance at
12 the different board meetings?

13 A: It can usually be pulled, the log, because they
14 get CME's for that.

15 Q: Okay.

16 A: And so I think that all the logs could be
17 pulled and you would see that our doctors are
18 very much present.

19 Q: All right. If you'll give me one minute to
20 talk to Mr. Thomas.

21 (Pause)

22 Q: Okay. Just a few more questions, none of which
23 are math problems. They do involve numbers.
24 You stated earlier that 270 physicians are
25 employed by Grand Strand?

1 A: Now, I don't know that. I do not know that,
2 not employed but on staff.

3 Q: On medical staff. That's different than being
4 employed.

5 A: There's a big difference, you're right.

6 Q: Now, you mentioned something about the Murrells
7 Inlet population a moment ago. You said that
8 it's double that of the Conway area?

9 A: I didn't say doubled. If I did, that was a
10 mistake. I know it's larger.

11 Q: Okay. I don't have any further questions for
12 you right now

13 A: Okay.

14 THE COURT: Redirect?

15 MR. MULLINS: Your Honor, just a couple of questions
16 on redirect, two to five questions.

17 MS. PRICE - REDIRECT EXAMINATION BY MR. MULLINS:

18 Q: Ms. Price, Petitioner's Exhibit 64 was an email
19 that Mr. Cartin had you look at. That was the
20 email relating to the Conway facilities and
21 some suggestions that you made.

22 A: Yes.

23 Q: About the facility itself.

24 A: Right.

25 Q: Do you recall that?

1 A: I do.

2 Q: And I think your testimony was that, or has
3 been that you had -- you've got confidence that
4 the construction and facility design department
5 for CRC -- or for 21st Century would design and
6 construct a capable facility at Conway,
7 correct?

8 A: There is no doubt that they would do that.

9 Q: Okay. And there were some suggestions that you
10 made in that email, and you can flip to it if
11 you want, but Mr. Cartin has asked you I think
12 about some of them, the -- you had some
13 concerns about cabinets and counter tops being
14 added and some concerns about exam rooms being
15 modified for head and neck patients. Do you
16 recall making those suggestions?

17 A: I do.

18 Q: And let me ask you this. If you would turn to
19 in Joint Exhibit 1, CRCC record, page 189.

20 A: Who's exhibits? Right here?

21 Q: The Joint Exhibit, that would be that one right
22 there in front of you.

23 A: This? What page?

24 Q: 189.

25 A: Okay.

1 Q: That's a list of furniture and fixtures that
2 was going to be incorporated into the Conway
3 facility; you recognize that?

4 A: Yes.

5 Q: And there are certainly references to cabinets
6 or desks and hutches and bookcases in there,
7 correct?

8 A: Yes, sir.

9 Q: And look down there at the bottom, you see the
10 -- under exam, you see the reference to head
11 and neck?

12 A: Yes.

13 Q: All right. So there was going to be equipment
14 that would address the head and neck patients,
15 correct?

16 A: That is true.

17 Q: Those were things that you referenced in your
18 email, right?

19 A: Yes, sir.

20 Q: And I think you also mentioned that -- - in
21 your email that there would be, and you
22 testified that you felt there needed to IT,
23 significant IT work done?

24 A: That is correct.

25 Q: Correct?

1 A: Uh-huh (affirmative response).

2 Q: All right. Flip over to 190. Do you see page
3 190?

4 A: Information technology budget.

5 Q: All right. Flip over to 191.

6 A: Okay.

7 Q: All right. What is that? Does that look like
8 the IT budget for the Conway facility?

9 A: It says IT cost and it's got a summary.

10 Q: Okay.

11 A: Grand total of \$100,696.

12 Q: All right. So what was ultimately incorporated
13 into the application addressed to that --
14 addressed that concern that you raised,
15 correct?

16 A: Yes.

17 Q: And let me ask you to turn to page 13, back to
18 page 13, the front of the application. All
19 right. And if you look under question 5 there.

20 A: Yes.

21 Q: The response that's talking about the facility,
22 what's the second sentence there? Read that.

23 A: "The building has never been occupied and will
24 require refurbishing and renovation for it to
25 be acceptable for use by CRCC."

1 Q: And you've got no doubt that that's going to
2 occur as represented in the application?

3 A: Yes, I'm 100 percent sure it's going to happen.

4 Q: Okay. Mr. Cartin had asked you about the
5 support from Dr. Holt at Coastal Cancer; do
6 you recall that?

7 A: Yes.

8 Q: And I think you had mentioned that you were
9 shocked at -- at project review when you saw
10 the significance of the support being provided
11 by ---

12 A: I was.

13 Q: Okay.

14 MR. CARTIN: Objection, Your Honor. That's leading.

15 Q: Let me ask you to turn ---

16 MR. MULLINS: Withdraw.

17 THE COURT: Okay.

18 Q: Let me ask you to turn to Joint Exhibit 2 which
19 is here.

20 A: What page?

21 Q: Page 891.

22 A: Okay.

23 Q: And project review, I believe, occurred in
24 October or November of 2011; do you recall
25 that? You were there ---

1 A: I was there. I don't recall the exact date,
2 but that sounds familiar.

3 Q: All right. We can look at the PowerPoint just
4 to confirm the days. Just flip to 578 so we
5 can confirm the date of project review on Joint
6 Exhibit 1. Hold your place on that one.

7 A: Okay.

8 Q: That was in the other book, Joint Exhibit 1.
9 Okay. I'm sorry stay with that one, stay back
10 on Joint Exhibit 2. Turn to 972. Hold your
11 place there.

12 A: Okay. Project review November the 15th ---

13 Q: Does that look like Grand Strand's project
14 review presentation?

15 A: Grand Strand Regional.

16 Q: And the date of that is November 15th?

17 A: Yes.

18 Q: Okay. And you stated that the project review
19 is when you -- well ---

20 A: Project review is when I found out that Dr.
21 Holt had supported both of the hospitals, and
22 it was very, very hurtful because we had worked
23 with him for, as you know, many, many years.

24 Q: Okay. Now look -- flip back to 891.

25 A: 891.

1 Q: That's a letter from Dr. Holt?

2 A: Yes.

3 Q: What's the date on that?

4 A: December the 1st, 2011.

5 Q: Okay. And that's after project review?

6 A: Yes.

7 Q: Read that second paragraph.

8 A: "A vast majority of Coastal Cancer Center's
9 greater Myrtle Beach patients are seen at their
10 main office in Myrtle Beach, which is located
11 on property adjacent to the Grand Strand's main
12 campus." You want me to read the whole
13 paragraph?

14 Q: Yes.

15 A: Grand Strand's program will be very convenient
16 for our patients who are currently treated in
17 our greater Myrtle Beach office, especially
18 those requiring dual therapy treatment,
19 chemo/radiation. Moreover, for those cancer
20 patients who are hospitalized, but who are also
21 require radiation therapy, a hospital-based
22 program would be a tremendous benefit to the
23 patient and their family members.

24 Q: What was your reaction when you read that
25 letter?

1 A: My reaction was, again, very hurtful, very
2 alarming and very concerned for our center and
3 our employees.

4 Q: Okay. Thank you.

5 THE COURT: Ms. Biggers?

6 MS. BIGGERS: No questions, Your Honor.

7 THE COURT: You may step down.

8 MR. MULLINS: Your Honor, do you want to take a five
9 minute break before we put up our next visit?

10 THE COURT: Do you want to take a five minute break?

11 MR. MULLINS: I think that would helpful.

12 THE COURT: Okay. Then I will.

13 (Break from 10:27 a.m. until 10:34 a.m.)

14 MR. MULLINS: Your Honor, we would call Dr. Patrick
15 Francke to the stand.

16 PATRICK M. FRANCKE, M.D., having been duly sworn,
17 testifies as follows:

18 DR. FRANCKE - DIRECT EXAMINATION BY MR. MULLINS:

19 Q: Good morning, Dr. Francke.

20 A: Good morning.

21 Q: Can you provide your full name for the record?

22 A: Patrick Michael Francke.

23 Q: Have you ever testified in a courtroom before,
24 Dr. Francke?

25 A: No.

1 Q: All right. Make sure you speak up so the judge
2 and the court reporter can hear us.

3 A: Okay.

4 Q: What's your relationship with Carolina Regional
5 Cancer Center?

6 A: I am presently the medical director and staff
7 radiation oncologist.

8 Q: All right. If you would for the Court, provide
9 us with a little bit of background on your
10 education.

11 A: I went to medical school at the University of
12 Louisville.

13 Q: We'll start -- where did you go to college?

14 A: Undergrad, Western Kentucky University.

15 Q: All right.

16 A: And then medical school at University of
17 Louisville. And I did my internship at Saint
18 Vincent's Hospital in Indianapolis, Indiana,
19 and then I did my training for radiation
20 oncology at the University of Kentucky in
21 Lexington. I was invited to stay on faculty.
22 I was assistant professor there for two years.
23 Then I went into private practice in Lexington
24 area.

25 Q: Okay. Distinction of being the chief resident

1 at University of Kentucky?

2 A: Yes, I was a chief resident at UK.

3 Q: All right. And then you stayed on -- I
4 interrupted you. You stayed on and you went to
5 work where?

6 A: At Lexington Clinic. We opened a satellite
7 clinic in Richmond, which is about 30 miles
8 south of Lexington.

9 Q: What is Lexington Clinic? What does it do?

10 A: Lexington Clinic is a multidisciplinary clinic
11 that has, you know, at that time I think they
12 had approximately 50 to 100 physicians
13 employed.

14 Q: What were you doing for Lexington Clinic?

15 A: I was the radiation oncologist and the director
16 of the image satellite clinic in Richmond.

17 Q: And how long were you at that facility?

18 A: For about three years. I left for -- I met my
19 wife in Lexington, and she was from South
20 Florida, so we relocated, you know, for family
21 reasons to South Florida, and that's when I now
22 was -- met up with 21st Century Oncology and
23 went with them.

24 Q: All right. So you went to work for 21st
25 Century Oncology. When -- about what time was

1 that?

2 A: That was in 1999, April of '99.

3 Q: All right. And what did you do? Did you work
4 with different facilities down there, or what
5 did you do when you were working in Florida for
6 21st Century?

7 A: They had several offices and I was the
8 radiation oncologist that would see patients.
9 I would consult patients in the office that
10 were referred to me. I would formulate
11 treatment recommendations if it was appropriate
12 and then, of course, take charge of the patient
13 during their treatment and follow up.

14 Q: What different types of facilities did you work
15 at down there?

16 A: We had both freestanding centers that were
17 owned and operated by 21st Century. We also
18 had a practice or maybe two, I think, that were
19 contracted out to hospitals that were hospital-
20 based centers. We also had a contract with US
21 Oncology to provide their radiation services
22 for a US Oncology owned center.

23 Q: Okay. So varied experience in both hospital
24 and freestanding?

25 A: That's correct. I also had -- when I was at my

1 internship in Saint Vincent's, they are a
2 hospital-based center there.

3 Q: All right. And at some point, you came up to
4 South Carolina with Carolina Regional Cancer
5 Center. When was that?

6 A: Correct. In 2010, they asked, in August, I
7 became the medical director. I made a few
8 trips up here between August and October and
9 moved myself and family up here and began
10 working onsite October 1st, 2010.

11 Q: Okay. And describe for the Court what your
12 functions are as the medical director for
13 Carolina Regional Cancer Center.

14 A: Well, I would say that my primary job is to
15 still be a radiation oncologist, that's what I
16 do 90 percent of the time, and medical
17 directorship is ten percent of my time and 90
18 percent of my stress.

19 Q: I understand.

20 A: But that job really entails, you know,
21 promoting and protecting the practicing
22 interest in the community, looking out for
23 what's best for the patients at large and
24 looking out what's best for the practice. So
25 one of the first things I did when I got here,

1 just to survey the, you know, practice was to,
2 as I usually do as I did in Florida, go out and
3 meet the referring physicians. Radiation
4 oncology is a in referral, you know, business
5 and practice.

6 Q: So that would be one of the functions of the
7 medical director?

8 A: Correct.

9 Q: And, but you also said you're still -- 90
10 percent of the time a large part of what you're
11 doing is radiation oncology practice?

12 A: Generally I usually carry one of the heaviest
13 patient loads.

14 Q: All right. Let's talk about in terms of your
15 practice or qualifications. Professional
16 memberships, are there associations that you're
17 involved with in connection with your practice?

18 A: Yes. Well, I'm a member -- our largest
19 professional scientific organization society is
20 ASTRO, American Society for Therapeutic
21 Radiology and Oncology. I've been a member of
22 that since my residency. I've served on
23 several committees, including CME education for
24 that organization. I regularly attend their
25 conferences, both educational and professional

1 meetings. Also, I had been very involved in
2 ACRO, which is American College of Radiation
3 Oncology. Also served on committees in that
4 organization, including membership and also a
5 scientific committee for meeting in the past
6 few years ago.

7 Q: Is that a research-based committee, scientific?

8 A: That was a -- yes, it was to set -- to look at
9 to help set up the scientific program for the
10 upcoming meeting to review abstracts for the,
11 for acceptance, to select a resident award for
12 the best abstract, you know, that sort of
13 thing. Additionally, I was in charge of --
14 there's a new program with American College of
15 Radiology with board certification called MOC,
16 Maintenance of Certification, and that is
17 something that I helped initiate for ACRO to
18 have maintenance certification credits, self-
19 assessment modules at their meetings.

20 Q: All right. Do you participate in any other
21 educational programs?

22 A: Well, you know, I would -- I've submitted
23 abstracts for journals. The last one was a few
24 years ago, several years, maybe four or five
25 years ago for the American Radiative Society on

1 small cell carcinoma of the bladder. And also
2 would routinely give talks to local support
3 groups, cancer support groups, when invited,
4 and also to grand rounds at hospitals when
5 invited. Updates, those sorts of things, and
6 of course, routinely talk at -- to awards,
7 etcetera.

8 Q: All right. Are you board certified?

9 A: Yes, 1995. And I was -- I was the first year
10 that they began the recertification program
11 where they were time limited certificates
12 beginning 1995. So I have the distinction of
13 being the first year ---

14 Q: Bad luck there.

15 A: But it's ever ten years, so I was certified,
16 then recertified, so 2005.

17 Q: So how long in total have you been practicing
18 radiation therapy?

19 A: Since 1994, board certified since '95, so
20 almost 20, going on 20 years.

21 Q: All right.

22 A: Nineteen years.

23 MR. MULLINS: Your Honor, at this time we would
24 offer Dr. Francke as an expert in the practice
25 of radiation therapy.

1 MR. CARTIN: No objection.

2 MS. BIGGERS: No objection.

3 THE COURT: He's so qualified.

4 MR. MULLINS: Thank you.

5 Q: Dr. Francke, if you would, and we've been at
6 this for a week now and the judge has heard a
7 lot about radiation therapy practice, but can
8 you tell us from your perspective just briefly
9 the cancers that are commonly treated with
10 radiation therapy?

11 A: Well, we -- you know, I've heard it explained
12 as radiation oncology being high tech family
13 practice. And by that, one would say that we
14 see it all. And we do see it all except, you
15 know, I would make the exception of pediatric
16 patients. Those patients would be funneled to
17 tertiary pediatric programs such as Saint
18 Judes. But we do see it all from head to toe
19 and -- but our primary, you know, if you were
20 to ask me what we see the most of, it would be
21 GU illnesses including prostate, lung cancer,
22 breast cancer and GI malignancies.

23 Q: Prostate is one of the more prevalent types of
24 ---

25 A: It is ---

1 Q: --- cancers that you see?

2 A: It is nationally and it is in our practice. It
3 was in Florida. It is in South Carolina.

4 Q: All right. And again, if you could just give
5 us a brief, from your perspective, the
6 different types of treatment that are available
7 from a radiation therapy perspective.

8 A: Well, radiation therapy is employed, you know,
9 to -- in different settings as definitive
10 treatment when there is no other modality such
11 as surgery or chemotherapy. Sometimes it's
12 employed adjunctively in addition to surgery.
13 Sometimes concurrently with chemotherapy. One
14 of the things that attracted me to radiation
15 therapy is, of the oncology malignancies, it's
16 focus is, of course, you know, optimizing
17 survival and outcome for patients, but at the
18 same time improving or maintaining their
19 quality of life. So organ preservation has
20 always been a hallmark of radiation therapy.
21 We see it in larynx preservation, breast, and
22 avoiding amputations for sarcomas. And, you
23 know, of note is of course avoiding colostomies
24 for rectal cancer. And with prostate too
25 preserving potency and urinary continence. So

1 that ---

2 Q: And what type of treatment accomplishes that?

3 A: The main type of treatment that is given in a
4 radiation therapy facility, including ours, is
5 external beam radiotherapy, and that's -- you
6 know, it's change -- you know, radiation
7 therapy, radiation oncology is a very technical
8 dependent specialty. And as technology has,
9 you know, increased exponentially over the last
10 15 to 20 years during my career, so has our
11 treatment options and treatment modalities.
12 The treatments have improved. So external beam
13 is a rather large category, but today, you
14 know, the best type of external beam is
15 IMRT/IGRT. It's very focused, very precise,
16 very small treatment fields, and because of
17 that, less side effects. The opposite of
18 external beam radiation would be brachytherapy,
19 coming from the Greek word close, meaning that
20 the radiation source is put directly next to or
21 within the tumor. And it used to be that low
22 dose brachytherapy was given with live
23 radioactive sources that would be left in the
24 patient for hours to days, and now most of
25 those programs and the low dose resources have

1 gone away. Today, high dose brachytherapy is
2 the mainstay of brachytherapy when it's being
3 utilized. And that was one of the pieces, the
4 technologies that I wanted to be brought to
5 Carolina Regional Cancer Center when I agreed
6 to come up to have a comprehensive radiation
7 therapy program.

8 Q: All right. And as far as your role as the
9 medical director, you had mentioned your goal
10 of, or one of your duties was to get out and
11 communicate with the referring physicians?

12 A: Correct.

13 Q: Why do you do that, and what is the
14 relationship that you're trying to create with
15 referring physicians?

16 A: Well, naturally I wanted to know where we stood
17 with the -- you know, you -- part of it is
18 education; part of it is just customer service
19 101 or practice building 101. You want to make
20 sure that, one, they get to meet you. They
21 want to know who their patients are going to.
22 They want to know who to call if there is an
23 issue or if there is a question. Two, I wanted
24 to know if they were happy with the services up
25 to date or when they sent patients to CRCC. I

1 thought that was something I needed to know, if
2 there were any issues or any ways we could
3 improve things in terms of, you know,
4 scheduling, in terms of communication, in terms
5 of treating their patients, those sorts of
6 things.

7 Q: And did you learn, through that exercise, did
8 you learn of some things that could be done or
9 changed that would improve that relationship?

10 A: By and large, the feedback I got was very
11 favorable that, you know, we have good
12 experience with our patients going there, thank
13 you for coming, nice meeting you. And I also
14 met with the hospital administrators as well at
15 that time.

16 Q: All right. And why is it important to have a
17 good relationship with the referring
18 physicians?

19 A: Because, you know, we are, you know, we're
20 partnering with them to take care of their
21 patients. There's a lot at stake. It's all
22 about the patient. They're entrusting their
23 patients to us to take care of them for their
24 cancer diagnosis. We're taking over the
25 patient's care for that several week course of

1 treatment, and then, you know, passing the
2 patient back to their care, or are continuing
3 to follow them. So I think a lot of it comes
4 down to trust, to confidence, and to education
5 to make sure that they're aware of what we can
6 do. My goal was to -- you know, to have CRCC
7 be a regional center of excellence so that
8 patients would not have to leave their families
9 and leave the area to go to Duke or MUSC or
10 outside the area. Eighty percent of cancer
11 care in this country is delivered in community
12 cancer centers. The standards of care today
13 are no longer defined by community standards
14 but by national standards. The standards of
15 care -- you know, one thing I love about
16 radiation oncology, the one thing that, you
17 know, 21st Century has always embraced and
18 pushed is evidenced-based care. I guess it's
19 somewhat similar to law. The case law is based
20 upon evidence, based upon studies, based upon
21 randomized perspective study. That's why and
22 how we treat a patient a certain way. Not all
23 patients fall into -- it's not always black and
24 white and that's what -- that's -- trying to
25 determine the different shades of gray is what

1 makes it interesting, and it's always changing,
2 always evolving, but we're never deviating from
3 the standards of care.

4 Q: All right. You were talking about the
5 relationship with the referring physicians. Is
6 there an ongoing communication with these
7 referring physicians during your treatment,
8 during the time that you're treating?

9 A: Yeah. One of the -- I never knew how much
10 dictations that I would be doing in the field
11 of radiation oncology. A great deal of what we
12 do is communication. When we dictate a
13 consultation note, we dictate follow-up notes,
14 treatment summary notes. We call the
15 physicians on a, you know, frequent basis. We
16 call them instantly if there's an issue with
17 their patient.

18 Q: And what's the purpose of that?

19 A: To inform them, to consult with them. If they
20 are, you know, if they're a medical oncologist
21 or surgeon again, it's discussing the -- it's
22 the didactic communication that is being done,
23 the multidisciplinary dialogue that has taken
24 place, whether it be in a teleconference or on
25 a telephone or face to face, the same thing was

1 being done, and it's all for the better care of
2 the patient.

3 Q: All right. And have you heard the term, you
4 mentioned mulit-disciplinary care,
5 interdisciplinary cancer care; have you heard
6 that term?

7 A: Correct.

8 Q: All right. Is that what you described? What
9 is your understanding as to what that
10 represents?

11 A: That is not -- that is not a new term, but it's
12 something that, again, I would say -- not to
13 overuse this term -- but it is more or less the
14 standard of care of what is done today. When
15 we see a patient we don't just think okay, this
16 is what we're going to do. We think of the
17 patient as a whole in terms of their cancer, in
18 terms of the diagnosis. What do the standards
19 of care dictate what is the appropriate
20 treatment for them in terms of whether it be
21 concurrent treatment with another modality or
22 sequentially, how we would coordinate such
23 treatment and working that out and discussing
24 the nuances of the treatment with the doctors.

25 Q: All right. And Does CRCC participate in that

1 aspect, that what you described,

2 interdisciplinary cancer care?

3 A: They most certainly do.

4 Q: You had mentioned the tumor board, and I think

5 -- well, let me ask you this. Does CRCC

6 participate in the tumor board?

7 A: We attend the cancer conferences. The tumor
8 board is a multidisciplinary cancer conference.

9 It's where more than one modality should be

10 there, the surgeons, the medical oncologists,

11 the radiation oncologists, and of course, the

12 pathologist and radiologist. We consistently

13 attend those conference. There are three

14 physicians. We go to different hospitals. I'm

15 assigned to Waccamaw Hospital. I physically

16 attend those conferences. It's only by

17 teleconferencing at Georgetown Hospital, which

18 is the sister hospital of Waccamaw or vice-

19 versa is done, but I physically attend those

20 conferences. They have a breast

21 multidisciplinary conference, which is actually

22 -- you know, a very good conference, as well as

23 a general tumor conference. There are

24 conferences at Grand Strand.

25 Q: Do the physicians at CRCC attend the

1 conferences at Grand Strand?

2 A: Yes, consistently.

3 Q: All right.

4 A: And we get CME credit. We sign in. I have
5 attended those conferences when they -- when
6 one of our doctors is out on vacation, such as
7 Dr. Andrews who regularly attends, I go.

8 Q: So if one of the physicians can't make it,
9 another one will go instead?

10 A: We do. We consider that as our, you know,
11 responsibility to be plugged into the community
12 in terms of the other physicians as well. So,
13 and in addition to that, the hospitals that
14 host such tumor boards rely on us being there
15 for accreditation, such as American College of
16 Surgeons. We've always supported them, not
17 just the tumor boards, but we're also involved
18 in -- we sit on the cancer committee there, Dr.
19 Andrews sits on the cancer committee. So we
20 also participate in the tumor registries giving
21 feedback to the hospital in terms of the status
22 of their patients. We get correspondence from
23 them on a regular basis, weekly, on a number of
24 patient cases in terms of the status. We give
25 them feedback. sometimes. We also have,

1 within in our office, weekly chart rounds where
2 peer to peer review, which is critical in terms
3 of, again, justifying why a patient is being
4 treated, making sure that standards of care are
5 being adhered to, discussing perhaps a new
6 article that's for such a treatment. We have
7 a M&M conferences; we have quality assurance
8 conferences. So all of that is taking place
9 at our center as well, so.

10 Q: So your interdisciplinary cancer care that
11 you've discussed occurs in the tumor board, and
12 as you have described examples, essentially on
13 a daily basis?

14 A: That's correct, yes. That's common.

15 Q: Okay. So you've practiced, I think you've
16 described your history, practice history
17 involves hospital-based and freestanding
18 centers. What is your opinion in terms of the
19 advantages or disadvantages that are present
20 with a hospital-based facility?

21 A: Well, as a radiation oncologist, we never -- if
22 we were to draw a plum line between a good
23 cancer center and sub-optimal cancer center, we
24 would not use the metric of whether it's
25 hospital based or not as the parameter. There

1 are so many other things. You know the field
2 of radiation oncology grows or branched out
3 from the department of radiology, and that's
4 how a lot of these hospital-based centers
5 began, as parts of the department of radiology.
6 And that's why you find a lot of the older ones
7 still in the basements of the hospital, and in
8 fact, even the -- most of them have retired or
9 close to retirement, but even the older
10 radiation oncologists are double boarded in
11 both radiology and radiation oncology because
12 that's the way they were grandfather in. And
13 it used to be 15, 20 years ago that it was
14 nice, it was nice to have the department of
15 radiology adjacent to the hospital -- I mean
16 adjacent to the cancer center so that if there
17 needed to be a curbside consult about a
18 patient's films, you could, you know, walk it
19 over to the radiologist. Today with
20 technology, again, that's changed our field,
21 that geographic proximity is no longer
22 required.

23 Q: All right. Well, let me ask you this. You
24 mentioned radiologists. That's one of the
25 specialists that you confer with as part of

1 your interdisciplinary care? Is that one of
2 the specialists?

3 A: We, you know, we look at scans and films, you
4 know, on a daily basis many, many times a day.
5 So most of the time we, you know, our -- I
6 would never say our knowledge is as good as the
7 radiologist, but it's -- you know, we look at
8 a lot of scans. But if there -- if a question
9 ever arises as to a finding on a report or some
10 question, we can look at the -- we can look at
11 the scan with the radiologist on call or we
12 have PACS. I, you know ---

13 Q: I'm sorry, can you explain to the -- when
14 you're saying on the phone or via PACS, what
15 are you talking about?

16 A: The PACS? Well, the patient's films show up,
17 we have access to the hospital's radiology
18 films and scans via computer. It's the same
19 system that the radiologist looks at when they
20 read the images. So that's what I'm talking
21 about. So we can go over the patient's scans
22 without being physically standing next to each
23 other. I had a -- I remember it was about a
24 year ago, I saw a patient in the emergency room
25 at Grand Strand and she was ---

1 Q: You were in the hospital at Grand Strand?

2 A: Right. I went -- we get called to see patients
3 at the hospital, so -- it was on the weekend,
4 so I called -- I was in the ER to see a
5 patient. It was superior vena cava syndrome.
6 I was looking at the patient's scans, there was
7 a question and I picked up the phone to call
8 the radiologist in the radiology department ---

9 Q: And I'm sorry, where's the -- you pick up the
10 phone. Where were you, in the ER?

11 A: In the ER.

12 Q: All right. And you were calling the radiology
13 department in the hospital?

14 A: Right.

15 Q: Okay.

16 A: But, you know, so he explained right over the
17 phone. But turns out that after talking with
18 him he wasn't even in the hospital, he was in
19 the office, one of their offices offsite that
20 was actually right down -- you know, a couple
21 doors down from where our office is on
22 Oleander. So I guess the point is that the
23 department -- you know, with technology today,
24 again, so much of it is done in a different
25 manner than being physically right next to each

1 other.

2 Q: All right. So I just want to make sure I
3 understood you. The radiologist you were
4 talking to was in an office ---

5 A: Three miles down the road.

6 Q: --- next door to your office on -- your
7 radiation oncology?

8 A: And talking about a patient that was right in
9 front of me.

10 Q: So proximity, physical proximity is -- doesn't
11 factor in ---

12 A: Multidisciplinary care can take place, you
13 know, in a number of different ways. Even when
14 a patient goes to Memorial Sloan-Kettering or
15 Duke, you know, where all the specialists are
16 under one roof, that's one gigantic roof and,
17 you know, the specialists are even found in
18 different floors, different departments. It's
19 not, you know, it's no longer required that
20 they are all in the same examination room with
21 the patient. Things are done sequentially more
22 in terms of evaluating the patient than
23 simultaneously.

24 Q: All right. We were discussing the advantages
25 or disadvantages of a hospital based. I want

1 to ask you about inpatient, treatment of
2 inpatients. What advantages may there be for
3 the treatment of inpatients for a hospital-
4 based radiation therapy program?

5 A: Ninety-nine percent of radiation oncology by
6 and large is an outpatient procedure. Our
7 patients are outpatients. Our average patient
8 is a patient with early cancer who goes on to
9 work or plays golf and comes in for their
10 treatment, they're in and out of the office in
11 15 or 20 minutes. But there's still the
12 emergency, there's still the occasional
13 inpatient emergency, whether it be a spinal
14 cord compression or a newly diagnosed brain
15 metastasis or airway obstruction or superior
16 vena cava obstruction, those are things that
17 get us out of bed; those are things that get we
18 get to the hospital to treat that same day.
19 Those are the emergencies that should be
20 treated, so we see the patient and we usually
21 bring them over to our office, whether or not
22 that office is right next to a hospital or down
23 the street, whether or not inpatient radiation
24 is -- where it would truly be beneficial or
25 where I would say inpatient radiation is

1 mandatory would be in the pediatric patient who
2 requires anesthesia, and that is such an
3 unusual -- you know, those patients should not
4 be in a community setting. Those patients
5 should definitely be in a tertiary pediatric
6 oncology center that do day in day out like St.
7 Jude's. Those are not the type of patients
8 that we find in our Myrtle Beach community.
9 And occasionally we might have a ventilator
10 patient. Those patients I can count on one
11 hand or maybe half a hand the number of
12 ventilator patients I've had in 20 years.
13 We've had a number -- you know, in south
14 Florida we worked with seven or eight
15 hospitals, and we would see emergencies. And
16 we worked very well with those hospitals, as
17 well as we do with Grand Strand and other
18 hospitals here in terms of seeing their
19 patients in a very timely manner within hours
20 of getting those patients over for treatment,
21 getting -- stopping everything else we're doing
22 in terms of treatment planning, getting those
23 patients planned, treated, and getting them out
24 the door. And I think it's worked very well.
25 It worked very well in Florida as well. And

1 inpatient radiation, even for those
2 emergencies, we know it's emergency, so we
3 treat them differently. We'll use larger doses
4 to get them out of harm's way and usually they
5 are stabilized to the point that they're
6 discharged, or if they're going to a rehab
7 facility and radiation continues from there or
8 if they're home, they're usually out of the
9 hospital in a day or two. Patients don't
10 usually have inpatient radiation for weeks,
11 that's absurd.

12 Q: So from a timeliness standpoint based on your
13 experience when you served in hospital based
14 and your experience at CRCC, do you see any
15 difference in the timeliness of treatment in
16 how long it would take an inpatient to get
17 treatment?

18 A: I've worked in a number of inpatient radiation
19 offices and hospital based, and again, I have
20 witnessed and I've seen patients brought down,
21 you know, to the hospital-based department from
22 the floor. They could be waiting there for
23 assimilation, that is, the treatment planning
24 portion. They could be waiting for their
25 treatment plan to be done. They could be

1 waiting for treatment. While they're waiting,
2 they could be waiting for their medication.
3 They could be run out of medications to be
4 brought down, and then they could be waiting
5 for the orderly to take them back to the floor.
6 So having it geographically present right there
7 at the hospital does not necessarily translate
8 into quicker or better care. You know, again,
9 I would go back to the quality of the radiation
10 the facility is so much more than the
11 geographic location of the facility. It's what
12 goes on once the patient is there.

13 Q: Let's talk about, you had touched on some of
14 the advantages that 21st Century as a company
15 has. Based on your extended period of time
16 with 21st Century Company, describe to the
17 Court from a practice standpoint what we see
18 the advantages are.

19 A: Well, I wasn't there, you know, before -- you
20 know, before 21st Century ---

21 Q: I'm talking about 21st Century, the company.

22 A: Okay. Well, for one, they've never told me how
23 to treat a patient. They've never picked up a
24 film or emailed me, and they don't do that
25 other -- you know, the types of -- they

1 encourage evidence based standard of care. If
2 you don't treat a patient by standards of care,
3 then you, like anywhere else, you'd be called
4 into question, well, why are you treating the
5 patient this way. So there's never a --
6 there's never been a conversation a dialogue,
7 of, you know, you treat the patient this way.
8 We're autonomous. As long as we're putting
9 them -- I look, you know, I look at them as
10 facilitating my ability to carry out radiation
11 oncology the way I've been trained to do it in
12 the evidence based way. They give me the
13 tools; they give me good equipment and a staff,
14 a good very well trained staff. Radiation
15 therapy is not -- is a very team approached
16 modality, much like it is in the OR. I could
17 never do it by myself. A linear accelerator
18 does not a cancer center make, I often say,
19 there's so much more to it. And, you know, we
20 have the medical physicist. You want a very
21 well trained and seasoned medical physics team.
22 And at 21st Century we also have the additional
23 backup of the medical physics department and,
24 you know, I think Galmarini is one of the
25 smartest people I've ever met. And ---

1 Q: Who is that? He's with 21st Century?

2 A: We have created physics protocols and policies
3 and procedures that no patient would ever know
4 about that ensures that the dose that is coming
5 out of the machine with very sophisticated
6 intensity modulated radiotherapy is the dose
7 that is prescribed. There have been accounts
8 of some centers in this country where patients
9 were overdosed or under-dosed, and even some
10 accidents have taken place in even some
11 hospital-based centers. And that's not to say
12 hospital-based center are themselves bad,
13 they're not; or say all freestanding centers
14 are good. I'm just saying that that geographic
15 metric should not be used to divide centers
16 just by that metric alone, they're great
17 centers ---

18 Q: All right. Now, you had mentioned on your --
19 I'm sorry, I interrupted you.

20 A: So, but in terms of providing equipment and in
21 terms of policies and procedures and adequate
22 staffing, they allow us to do what we're
23 supposed to do.

24 Q: You had described earlier that your work
25 experience with 21st Century involved other

1 specialties, specialists when you were down in
2 Florida.

3 A: Right, well ---

4 Q: Is that correct?

5 A: Of course.

6 Q: And you've got a relationship with the
7 specialists a CRCC?

8 A: You have to. You have to, otherwise you would
9 -- your office would be empty.

10 Q: Have any other specialists ever had to -- your
11 relationship with these specialists impact the
12 way you treat your patients at all?

13 A: No. I'm bound by the standards of care and my
14 obligation to the patient. I've often
15 sometimes have told a referring physician, I
16 have to treat the patient this way or that way.
17 I don't work for the referring -- I don't work
18 for -- I ultimately consider myself working for
19 the patient.

20 Q: Let's talk about your arrival at Carolina
21 Regional Cancer Center, which was shortly after
22 the acquisition by 21st Century, correct?

23 A: Yes.

24 Q: All right.

25 MR. MULLINS: And if you'll bring up Joint Exhibit

1 1, page 587.

2 Q: You were present at the project review meeting
3 that took place in connection with this review
4 process?

5 A: Yes.

6 Q: Okay. And you can turn to it if it's more
7 helpful to you.

8 A: Okay. It would be 587?

9 Q: Yeah. And I just, I bring this up just for
10 ease of reference, there's already been some
11 discussion, but you do recall that there was
12 some equipment improvements made during that
13 period of time when you arrived at CRCC that
14 first year, correct?

15 A: Correct. Correct, I mean, when I was in
16 Florida they had acquired, you know, other
17 centers as well and we routinely had to go in
18 and upgrade the equipment to our standards.

19 Q: And there's already been testimony about the
20 different types of equipment upgrades that were
21 made specifically in this case and you can
22 mention them specifically if you want, but I
23 guess I'm just interested in your opinion as to
24 whether that improved the treatment and your
25 practice abilities with regards to the treating

1 of patients?

2 A: I think it made a very good center better. I
3 mean, it's all about the patient, it's all
4 about more precise delivery. It's, you know,
5 a hallmark of radiation therapy today is that
6 IMRT is given, image guided radiotherapy for
7 ordinates that may move around or may be in a
8 different position each day. It's critical to
9 make sure we're hitting the target, make sure
10 we're lining up the treatment to the target
11 itself and not the patient's external anatomy.
12 Traditionally patients would have marks or
13 tattoos on their skin, and it's been well
14 demonstrated that a prostate can move as much
15 as a half an inch day to day. So it's -- you
16 know, when we're treating such a small field,
17 which is what our technology allows us to do
18 today, it's critical that -- it's paramount
19 that we're right on the mark when we treat the
20 patients. And also the Calypso is a new -- is
21 a smart mark that allows us to actually track
22 the prostate actually during treatment
23 delivery, so if the patient were to cough or
24 hiccup, the machine would turn off. And the
25 HDR, we're seeing high dose brachytherapy

1 utilized more and more. You know, for breast
2 cancer, for example, we can -- for the
3 appropriate patients we can, instead of a six,
4 six and a half week treatment, we can do the
5 treatment in one week, which is very welcome in
6 some very busy women or either are limited in
7 their time or distance of travel. We also, you
8 know, it pains me sometimes to see a patient
9 who's had a skin cancer and half their nose or
10 half their ear is missing. With the skin
11 surface brachytherapy, that was something that
12 I started in south Florida on over 200
13 patients, and I wanted to bring that knowledge
14 to the area. So we can treat a skin cancer,
15 basil cell or even a squamous cell, on the
16 face, for example, avoid them having
17 disfiguring surgery and give the treatments in
18 six treatments or nine treatments that take two
19 minutes each with a 98 percent control rate.
20 So those are the types of things that I can say
21 firsthand that we've brought to the area and
22 improved the quality of the patients that were
23 seen.

24 Q: Okay. Flip back to one page, 586. Again, this
25 is the project review PowerPpoint presentation.

1 You made certain -- you presented at project
2 review and you touched on those aspects that
3 you just mentioned. Do you recall that?

4 A: Yes.

5 Q: And then there was also some discussion about
6 the change in ownership and other aspects of
7 the impact of the change of ownership?

8 A: Correct.

9 Q: And that's reflected on page nine. Can you
10 expand on what you believe the impact of the
11 acquisition by 21st Century?

12 A: Well, again, a lot of it has to do with going
13 out and meeting with physicians. But I think
14 one point that everyone's making is, you know,
15 the bump or surge of patients from urologists.
16 I don't know why. I was not here, that pre-
17 dates me as far as why the urologists were not
18 sending patients to CRCC before. And I know
19 that they were, you know, in competition with
20 getting their own linear accelerator, but, you
21 know, 21st Century was able to -- I'm a
22 clinician, but I'm not so naive to think that
23 they are not business implications of medicine,
24 and that's just the reality and something we
25 have to deal with. But it's something that

1 should not get in the way of us taking care of
2 patients. But I was not involved at all in
3 21st Century's acquisition of CRCC or their
4 dealings with AUC before I came. But what I do
5 know is that when I came, we definitely had a
6 surge of patients of from the urologists,
7 primarily. And I can tell you again firsthand
8 that those patients were no longer being --
9 going 40 miles outside the area for radiation.
10 They were being treated with the latest in
11 terms of IMRT and IGRT. They were no longer
12 heavily considering surgery. You know,
13 radiation -- more and more prostate patients
14 today are being treated with radiation therapy
15 than surgery, and that continues to be the
16 case. The data for surgery versus radiation
17 therapy is identical in terms of outcome for
18 low risk, intermediate risk across the cancer,
19 and high risk, all patients are treated with
20 radiation. The difference is, you know,
21 patients who have surgery have a real risk of
22 incontinence and erectile dysfunction, and
23 that's a big difference for a man in their 60s
24 and 70s and very productive retirement years,
25 and a lot of patients are those we see in south

1 Florida -- I mean, South Carolina, and south
2 Florida. So I can tell you again firsthand
3 that that's the, you know, the quality of life
4 difference that we're seeing in patients. With
5 IMRT and IGRT, I'm the benefactor of the
6 technology that we have today. I didn't invent
7 this technology, but I'm sure glad it's there
8 for me. When I started practicing, you know,
9 in the early -- in training, we were treating
10 prostate cancer with large treatment fields, a
11 lot of side effects, not nearly the outcome.
12 The cure rate for low risk prostate cancer is
13 93 percent. For intermediate risk prostate
14 cancer it's 85 percent with radiation.
15 Patients tolerate the radiation quite, quite
16 well. They come in for their treatment, they
17 go home, they go play golf or they go to work.
18 They're very happy patients. They're not
19 miserable. The side effects are very minimal.
20 That's the, you know -- you know, patients
21 thank me and everything, but it's the
22 technology that we're able to pass onto the
23 patient.

24 Q: The urologists that you were talking to, any of
25 these urologists ever tell you how these

1 patients should be treated?

2 A: No.

3 MR. CARTIN: Objection, Your Honor.

4 Q: Have you ever been told ---

5 THE COURT: He objected but he said no, so I think
6 it took care of the objection.

7 MR. MULLINS: Right.

8 Q: Does anybody ever dictate how you treat these
9 prostate patients?

10 A: No. No, when I ---

11 Q: Are all patient -- all prostate patients that
12 are referred to you, are they all treated using
13 radiation therapy?

14 A: No, not at all. When I see a patient for the
15 first -- when I see them in consultation, I
16 tell -- they're there for evaluation. I'm
17 there -- I consider those patients -- because
18 they've already seen a doctor. In this case,
19 usually a urologist. They've already been made
20 aware of their diagnosis. I'm there again as
21 a second opinion and to help them facilitate
22 making a decision. I first ask them if they
23 have any questions about their diagnosis, if
24 there is any more that needs to be done in
25 terms of staging work up based upon guidelines,

1 we'll order a CAT scan or bone scan. But we'll
2 spend a lot of time talking about their
3 diagnosis and what their diagnose -- what their
4 stage might be. Then I pull out the NCC
5 guidelines, which I do with every patient,
6 every prostate patient. And those guidelines,
7 it's a flow sheet and depending on whether they
8 have low risk, immediate risk, or high risk
9 prostate cancer, for low risk there's three
10 clear options: active surveillance, external
11 beam radiotherapy with or without
12 brachytherapy, or brachytherapy and surgery.
13 And we talk about each one of those, and I go
14 into detail about how, what the implications
15 are with all of those, and for immediate risk,
16 we do the same things. More and more radiation
17 oncology physicians are using the guidelines,
18 and you know, that's what I've come back to in
19 terms of we're promoting standards of care.
20 We're promoting evidence-based treatment. But
21 no physician calls and tells me how to treat a
22 patient. I'm disappointed in, you know, some
23 physicians who think -- not urologists per se,
24 but who think a patient should have this or
25 that, and I say well, the standard is this and

1 if you can tell me why that, I'll be more than
2 happy to listen ---

3 Q: All right. So you ---

4 A: --- but I'm bound by the standards of care.

5 Q: All right. So you will sit down with a patient
6 and go through that process with each patient?

7 A: And usually the wife or the family.

8 Q: All right. And the patient and you, after that
9 consultation, will decide whether radiation
10 therapy is appropriate or not?

11 A: Yes after the -- we never, you know, push them
12 to make a decision right then and there. If
13 they want more time -- if they need more time
14 to think it over, it's usually -- it's more for
15 information gathering at that point. Some
16 patients do come with they've already done
17 their research. They have already done, you
18 know, they made their mind up. But just the
19 same, at the point of being redundant, I go
20 over everything once again to make sure that
21 they're quite comfortable and well informed in
22 terms of the what the treatment involves.

23 Q: All right. And those that ultimately opt for
24 radiation therapy, do you treat all of them?

25 A: No. No, I have on occasion sent -- you know,

1 if a patient lives closer to a facility,
2 whether it be Georgetown or Florence, I've sent
3 patients there. Sometimes have, you know,
4 gotten a call from a physician saying well --
5 I said well, that center is closer to them. So
6 that's where they -- you know, that's where
7 they want to go. We could treat them, but you
8 know, the patient really, you know, wants to be
9 treated closer to home, and I think that's
10 fine.

11 Q: So you will discuss that with the patient, too?

12 A: Yes.

13 Q: All right.

14 A: As well as after surveillance and surgery. I
15 really want the patient to make sure that all
16 the options on the table have been discussed.
17 I would never want a patient to come back and
18 say, I didn't know I could have surgery, or I
19 didn't know I could just watch this. And I
20 don't think any of my patients could ever say
21 that.

22 Q: All right. Let's talk about the treatment
23 volumes at CRCC. You can flip to Respondent
24 CRCC's Exhibit 22. It's going to be in the
25 book here, but you can look at it on the screen

1 if you want.

2 A: Yeah, I'll just look at it here.

3 Q: Okay. I think there's some testimony, I just
4 want you to look at the bottom there, the
5 treatment totals. I think there's been
6 testimony the 2010 volume was a partial year.
7 Can you tell the Court from your perspective as
8 the radiation therapist at CRCC and the medical
9 director how your -- what happened to your
10 volume since you got there?

11 A: Well, I came when it was busy, again -- so the
12 surge sort of predated me a few months. And a
13 lot of that was, you know, from the urologists
14 as I understand. But boots on the ground, you
15 know, perspective, yes, I was seeing a lot of
16 prostate patients, but I was also seeing a lot
17 of other things. We did not treat every
18 prostate patient we saw. I cannot explain ---

19 Q: Let's just look at the numbers and talk about
20 the volumes ---

21 A: Okay.

22 Q: --- and I want you to explain to the Court what
23 the volumes did.

24 A: So there was an increase of patients.

25 Q: From 2010 to '11?

1 A: Yeah. Uh-huh (affirmative response). From
2 2010 to 2011, treatments increased on
3 TomoTherapy and ---

4 Q: And we've already discussed that 2010 was a
5 partial year of those numbers, correct?

6 A: Correct.

7 Q: All right. I just want you to look at the
8 totals.

9 A: Okay. Okay. And there was actually a decrease
10 from 2011 to 2012.

11 Q: All right. And talk to the Court about the
12 decrease in the volumes. What have you seen
13 from 2011 forward?

14 A: Well, we've slowed down considerably. You
15 know, we -- we only -- you know, as a radiation
16 oncologist, again, you know, we know when
17 patients come in to see us, we don't know when
18 they don't, we don't know why they don't, but
19 I can tell you is we're seeing less patients,
20 we're a lot less busier than, you know, that
21 first year or two that I was here.

22 Q: All right. How about the urology referrals;
23 are you familiar with what had happened with
24 those?

25 A: I think those have dropped off considerably as

1 well, you know, and that may be multifactorial.
2 There's been a lot said about, you know,
3 screening for prostate cancer. There was a
4 study that came out, you know, by some
5 statisticians that not all prostate cancer
6 needs to be treated, so therefore, screening is
7 superfluous, and I disagree with that. I see
8 where they're going as a whole, but I've seen
9 a number of -- you know when you make such a
10 broad policy change like that, there are going
11 to be individual patients, and I've seen a
12 number of individual patients in their 50s and
13 60s that if it were not for the PSA screening,
14 their highly aggressive prostate cancer would
15 not have been found in the early stage. They
16 tried something similar with mammography a few
17 years ago and that lasted all about a week, so.
18 But the screening, the cutback in screening is
19 a reality, and I think that's part of it.
20 There's some other nuances perhaps. The
21 economy, I think that would have a significant
22 impact. I think there are less people perhaps
23 in Myrtle Beach and not as many people coming,
24 who are coming to Myrtle Beach or less people
25 going to the doctor, less people getting exams.

1 Maybe cancer being found at a later stage and
2 going straight to hospice. So it's
3 multifactorial. We never know. We never have
4 the forensic analysis to why patients aren't
5 coming. And those are just, you know, my
6 suspicions doing this a while.

7 Q: What we were looking at on the screen was
8 through 2012. 2013, has that trend continued?

9 A: Definitely, we're slow.

10 Q: And you may be a little thrown by looking at
11 annual volumes. You oftentimes think of volume
12 based on patients per day?

13 A: That's correct.

14 Q: All right. And you were -- before the decrease
15 you were seeing ---

16 A: Well, yeah, our first year we averaged or we
17 were a little bit over 100 then, and 2011 we --
18 -

19 Q: Per day?

20 A: Yeah. In 2011, it was probably high 90s. In
21 2012, it was probably 90 something. Now we're
22 definitely, you know, 80. So, you know, and
23 that's with three machines and that's what the,
24 you know ...

25 Q: All right. Respondent CRCC's 23. Can you see

1 that on the screen or do you need to turn to
2 it?

3 A: Okay. I can see it.

4 Q: Those are the inpatients that have been treated
5 at CRCC beginning in 2010?

6 A: Uh-huh (affirmative response).

7 Q: Okay. Tell me about -- you're familiar that
8 CRCC did, at one point, treat Grand Strand's
9 inpatients?

10 A: Correct.

11 Q: Tell me what, from your perspective, what has
12 transpired with regards to your treatment of
13 the Grand Strand inpatients?

14 A: Well, we -- about a year ago we, you know, when
15 we did get called to come see an inpatient, we
16 would see the patient and write the
17 consultation note, and then found out that the
18 patient was being transferred to Trident or to
19 MUSC. And it really bothered me because, you
20 know, these patients were not -- I didn't see
21 it as the best, or didn't see it as being
22 necessary for their care that they were being
23 displaced over 100 miles. And then their
24 families, the families were upset, and the --
25 you know, it also delayed their treatment.

1 They were getting their treatment, you know, I
2 know in some cases I saw two days later, where
3 they could have their radiation the same day.
4 And for some of these emergencies, timing is
5 everything. And now we're not even being asked
6 to see the inpatients. From my understanding,
7 they're being sent directly to Trident or MUSC.
8 That decision is being made outside of our
9 input.

10 Q: You're aware that CRCC is proposing to install
11 a TrueBeam, Varian TrueBeam?

12 A: Yes.

13 Q: And your understanding that Grand Strand
14 proposed to install a Varian Clinac iX?

15 A: Yes.

16 Q: All right. And you believe that the Varian
17 TrueBeam is superior in terms of its treatment
18 capabilities?

19 A: Yes. I mean, there are continuously
20 incremental improvements. The trend is towards
21 faster, more accurate treatment, faster time to
22 -- which would translate into more patient
23 comfort, so less movement, less time on the
24 table with more precision with treatment,
25 actually not just localization during treatment

1 or before treatment but localization during
2 treatment. So again, the big picture is
3 better, you know, more precise treatment,
4 better treatment, and more precise treatment
5 should translate into better outcomes and
6 lesser side effects.

7 Q: Okay.

8 A: So that's the big picture expect -- you know,
9 or trajectory that we're seeing with the
10 improvement of technology. It continues to be
11 that way. They're continuing to improve that.

12 Q: Let's look at Joint Exhibit 1, 540. I want to
13 talk with you briefly about the proposed CRCC-
14 Conway facility. It might be easier for you to
15 actually look at that. All right. Why don't
16 you pull it, unless you can see it on the
17 screen. All right. You're familiar with the
18 proposed facility in Conway that CRCC seeks to
19 -- where CRCC seeks to establish their
20 radiation therapy program?

21 A: Yes.

22 Q: Okay. And what you have in front of you is the
23 proposed floor plan for the CRCC facility.
24 Have you seen that?

25 A: Yes, this -- yeah. Yes.

1 Q: All right. Well, let me just ask you this.

2 Have you had any concern about the size of the
3 facility based on what is being proposed here
4 for CRCC in Conway?

5 A: Not really. I mean, this is very similar to
6 the size of the center that we -- that I had in
7 Richmond. It was about the same square
8 footage. And even back then, we -- and it was
9 a similar setup because we had a sister
10 facility to that where dosimetry was staffed
11 and physics was staffed. And that would be the
12 case with this where dosimetry and physics
13 staff would -- their primary hub would be at
14 our facility and they would, you know, come to
15 this center as well. So not as much, you know,
16 space as needed, and even at that center in
17 Richmond, we treated 25 patients, 20 to 25
18 patients a day. So, you know -- you know, I
19 know firsthand 21st Century has taken over a
20 number of facilities and they may not, you
21 know, would have built them that way, but it
22 would be wasteful to just completely take the
23 wrecking ball and demolish them when
24 modifications can be made to make them usable,
25 and who knows, further modifications down the

1 road to make them even bigger and better. You
2 know, I saw a photograph of how CRCC looked 10,
3 15 years ago, and it looks nothing like it does
4 today. It was a one-story building so, you
5 know, for the use that this building and
6 facility is going to be, I have no problems
7 with it.

8 Q: All right. The size of the vault, you've
9 looked at the -- you're familiar with the size
10 of the vault. Do you have any concern about
11 the size of the vault?

12 A: As long as it's big enough to -- I mean, to --
13 equipment. The machine -- I mean, size is not
14 everything; it's what goes in. And you can
15 have lean, mean, you know, treatment facility
16 here if you had the top notch technology in
17 there, and it could be very streamlined. So
18 I'd rather have this than a gigantic, enormous
19 Taj Mahal with a 6-100 MI, that's an older
20 machine.

21 Q: All right. And the exam room and the other
22 aspects of the facility, you don't see any
23 problems with what's being proposed?

24 A: Two exam rooms is what I would want. Reception
25 area, I understand that's going to be

1 upgraded. And, you know, I think that's nice.
2 The simulator, you know, I am not the -- I do
3 not routinely -- I'm a clinician. I know what
4 is adequate and I know what's workable, and if
5 this is conducive to patient's comfort and
6 patient's treatment and the quality of
7 treatment that they're getting, I'm fine with
8 it. I don't build; I don't design, you know,
9 that's a whole different specialty unto itself,
10 so. This is something I would not look -- I
11 would look at and I would never say just tear
12 this down, we can't work with this. For the
13 use and for the purpose and everything I think
14 -- I've seen 21st Century take centers like
15 this and really turn it into something nice and
16 they become an integral component of our, you
17 know, service area.

18 Q: You're aware that Grand Strand is proposing to
19 add a hospital-based linear accelerator?

20 A: I am.

21 Q: Okay. And you understand that would be in the
22 hospital?

23 A: Three miles down the road.

24 Q: Tell the Court from your perspective as the
25 medical director and the radiation oncologist

1 at CRCC what you believe the impact that the
2 approval of this project would have on your
3 practice and CRCC's utilization?

4 A: It would be bad news. It would be decimation.
5 I mean, I don't think it would be an
6 exaggeration to say that we'd lose 35, 40
7 percent of our patient base. We are very
8 heavily dependent upon referrals, and a good
9 portion of those referrals come from medical
10 oncologists and physicians that are in close
11 proximity to Grand Strand that have association
12 with Grand Strand, that are employed by Grand
13 Strand, and I have looked at physician lists
14 and 35, 40 percent drop is not out of -- is not
15 exaggerating.

16 MR. CARTIN: Your Honor, I just want to make one
17 point. He's an expert radiation oncologist,
18 not an adverse impact or any other kind of
19 health planning. So for the record, if this is
20 being proffered as an expert opinion ---

21 MR. MULLINS: I just asked him from his practice
22 experience what he thought the impact ---

23 MR. CARTIN: And as long as this is just fact
24 testimony from his perspective, that's fine.

25 THE COURT: He's testifying so it goes in the

1 record. If you believe it's speculative, you
2 need to object to that, but I mean ---

3 MR. CARTIN: He's not an expert in healthcare
4 planning.

5 MR. MULLINS: It's cross-examination.

6 THE COURT: Well, he's not objecting, so you're
7 giving me a narrative here that I'll take the
8 narrative for what it's worth.

9 Q: Dr. Francke, just -- you're aware of -- well,
10 let me ask you this. What is your
11 understanding as to Dr. Holt's group's
12 involvement in this project, or the impact that
13 it would have? That ---

14 A: It's concerning. And while I'm not an expert
15 on what counsel said, a radiation oncologist
16 has a very good feel for where their patients
17 come from and what their rapport and
18 relationship is with those physicians. And
19 taking into account the close proximity of this
20 facility to our existing facility and the
21 association with the physicians, I know Dr.
22 Holt has lent his support to this project. I
23 know in the Grand Strand CON application that
24 they said that they would count on that Dr.
25 Holt would offer significant referrals in

1 support to their center; that when I see that
2 sort of language, that concerns me deeply. I
3 know that they had full support from all of
4 their medical oncologist, and we did not have
5 Dr. Holt's personal support for our center. And
6 given the relationship, longstanding
7 relationship and the fact that we've had no
8 falling out, that we had good rapport with him
9 on a clinician standpoint, professional
10 standpoint, and that he has no issue with how
11 we treat his patients, the close proximity of
12 this facility to then, to Coastal Cancer Center
13 and to the fact that HCA is a formidable force
14 that I have great respect for as a hospital
15 provider and one that continues to employ
16 physicians and employ more and more physicians,
17 it troubles me greatly that this is going to be
18 in our backyard.

19 Q: Thank you Dr. Francke.

20 THE COURT: Ms. Biggers?

21 MS. BIGGERS: No questions.

22 THE COURT: I tell you what, do y'all want to just
23 break for lunch now? I don't know how long.
24 your cross is going to be. We can just come
25 back earlier than normal.

1 MR. CARTIN: We can do that.

2 THE COURT: I'm just asking.

3 MR. CARTIN: What time is it now? We can break for
4 lunch.

5 MR. THOMAS: Like one or something?

6 THE COURT: Yeah, that's what I was thinking.

7 (Lunch break from 11:44 a.m. until 1:14 p.m.)

8 THE COURT: All right. Y'all ready?

9 MR. CARTIN: Ready to go.

10 DR. FRANCKE - CROSS-EXAMINATION BY MR. CARTIN:

11 Q: Good afternoon, Dr. Francke. I'm Walt Cartin.
12 We met before at your deposition. Let me ask,
13 is quality slipping at CRCC?

14 A: No, why would you say that?

15 Q: Because you just told me that you're going to
16 lose 35 to 40 percent of your patients if Grand
17 Strand, a startup facility, starts its own
18 program.

19 A: You know, losing patients isn't necessarily a
20 reflection that our quality is slipping. We
21 don't control physicians sending us patients.
22 That's a decision that they make on their own
23 for a myriad of reasons. Despite the quality
24 of care that we deliver to our patients, we can
25 still lose patients. And as I've said, if

1 Grand Strand did acquire their own linear
2 accelerator, quality then probably would slip
3 because we'd lose about 40 percent of our
4 patients. We'd be treating about 40 patients
5 on four linear accelerators. That's ten
6 patients a day on each machine. Our day would
7 be over at 10:30, 11:00 in the morning. We
8 would no longer be -- we'd lose a critical mass
9 of patients, so we would not have the nidus to
10 attract stellar physicians. We just acquired
11 a -- recruited a physician from Memorial Sloan-
12 Kettering, which is a very big plus for the
13 area. We're able to recruit patients on
14 national cooperative trials such as the RTOG
15 that we have participated in. With such a drop
16 in volume of patients, we would not be able to
17 put, you know, to buy the newest, nicest thing
18 for in terms of quality equipment. So it's not
19 slipping yet, but it very well could be as a
20 result of this.

21 Q: Let me ask you, you're not holding yourself out
22 as an expert healthcare planner, are you?

23 A: No. I'm a radiation oncologist. I treat
24 patients. I'm the boots on the ground guy.

25 Q: You're not an expert in healthcare finance

1 either, are you?

2 A: No.

3 Q: Okay. And you haven't done a formal adverse
4 impact analysis to substantiate anything you
5 just said, have you? .

6 A: I'm a radiation oncologist that sees patients.
7 Been doing it for 20 years.

8 Q: And your own expert has not adopted the
9 analysis you just provided for the Court, have
10 they?

11 A: I'm not sure. I'm not aware of that.

12 Q: And you haven't prepared any financial pro
13 formas or utilization projections for this
14 project, have you?

15 A: That's not my job.

16 Q: And you didn't prepare any technical adverse
17 impact analysis for this case either?

18 A: That's not my job.

19 Q: And as a physician, you know there are going to
20 be ebbs and flows in your patients day to day,
21 correct?

22 A: Day to day, yes. But this is not what we're
23 talking about here.

24 Q: But as long as you keep those referral sources
25 informed and the patients happy, you know

1 you're going to continue to have patients;

2 isn't that right?

3 A: There are some circumstances -- there are some
4 things that are out of our control, and we, you
5 know, referring physicians have a whole list of
6 reasons as to why they may start to send
7 patients elsewhere. They don't call us and say
8 we're going to stop sending patients elsewhere;
9 they just don't come anymore. I've seen this
10 in Florida. This is what, you know,
11 competition does when it's a few -- a few miles
12 away.

13 Q: Certainly there are some things you can't
14 control, right?

15 A: Obviously, with everything.

16 Q: But there are some things you can control?

17 A: Some things with every -- yes, with everything
18 that's a ---

19 Q: You can keep referral sources informed, right?

20 A: Yes.

21 Q: And you guys are doing that right now, correct?

22 A: (Nods head affirmatively.)

23 Q: You provide high quality -- for the record,
24 that was a yes?

25 A: Yes. Yes.

1 Q: Sorry. You can make sure your patients get the
2 best care possible, correct?

3 A: Yes.

4 Q: And you guys are doing that right now?

5 A: Yes.

6 Q: Now, you enjoy working for 21st Century
7 Oncology, right?

8 A: Yes. I mean, as long as they continue to allow
9 me to practice radiation oncology with the best
10 standards of care, state of the art equipment,
11 yes.

12 Q: And earlier in your testimony you mentioned
13 that 21st Century likes to stay on the cutting
14 edge of technology, correct?

15 A: Yes.

16 Q: And you like to engage in research that allows
17 you to come up with new policies and procedures
18 to help you provide the best patient experience
19 possible, correct?

20 A: Yes.

21 Q: Okay. And when you develop those policies and
22 procedures at 21st Century, those are actually
23 implemented at the facility level; is that
24 right?

25 A: Yes.

1 Q: And they're implemented through medical
2 directors like yourself and other physicians?

3 A: Yes.

4 Q: Now, when 21st Century took over operating
5 CRCC, and you mentioned some of these before,
6 and I want to go back through them. You did
7 some clinical upgrades, correct?

8 A: Yes.

9 Q: You added an HDR program, which I know you're
10 very -- from your deposition, you're very proud
11 of, right?

12 A: Yes.

13 Q: You upgraded most of the equipment in the
14 physical plant, correct?

15 A: Yes.

16 Q: All right. Since you've been there, you've
17 added about \$3.5 million in equipment; is that
18 also right?

19 A: That sounds about right.

20 Q: And you've updated your imagining equipment as
21 well?

22 A: Yes.

23 Q: Okay. And so, you know, the result is that
24 21st Century is providing right now high
25 quality cancer program, cancer radiation

1 therapy treatment program?

2 A: Yes.

3 Q: Petitioner's 71, please.

4 A: Is this on the screen?

5 Q: It'll be on the screen, if you can read that.

6 All right. Dr. Francke, do you recognize this
7 email?

8 A: Yes.

9 Q: Did you create the email?

10 A: Yes.

11 MR. CARTIN: Go to the next page, Roshel.

12 Q: Do you recognize the attachment?

13 A: Yes. I think those were my talking notes for
14 the project review for the Conway CON.

15 Q: And did you create those?

16 A: I did, yes.

17 Q: Is this fairly representative of what you felt

18 ---

19 A: Would you like me to read this, or?

20 Q: No, you don't need to read it.

21 A: Okay.

22 Q: You can just confirm that the points made in
23 there are fairly representative of what you put
24 forth at project review.

25 A: Yes.

1 Q: And you still believe them to be true?

2 A: Would you like me to read this so I can affirm
3 that?

4 Q: Sure, sure. Take your time.

5 A: Okay.

6 Q: Okay. And this is still accurate today?

7 A: Yes. I mean, the overall theme here is that,
8 you know, trying to deliver quality, you know,
9 care to the patient and to the community and
10 outreach, you know, reaching out to the
11 patients to where they are.

12 Q: And this highlights some of those points that
13 I guess set 21st Century apart from the
14 competition, correct?

15 A: Yes.

16 Q: Give you a competitive advantage in the
17 marketplace?

18 A: Correct, trying to -- that's what 21st Century
19 does.

20 Q: Okay. Now, you stated earlier that you're the
21 medical director of CRCC, and you went through
22 your list of duties. Okay. In that capacity,
23 you work to make sure your cancer center is
24 providing the best quality care possible,
25 correct?

1 A: Yes.

2 Q: And you make sure patients are being handled
3 appropriately by your staff, right?

4 A: Yes.

5 Q: And you would say that CRCC has a high patient
6 satisfaction rate, correct?

7 A: We do, based on the reports and verbal reports
8 from patients.

9 Q: And as the medical director, you help manage
10 relationships with referral sources?

11 A: Yes.

12 Q: You also promote the practice and look out for
13 its best interests, correct?

14 A: To the best of my ability.

15 Q: Now, there are currently two radiation, two
16 other radiation oncologists at CRCC; is that
17 correct?

18 A: Yes.

19 Q: Okay. What are their names?

20 A: Doctor Steven Andrews, who trained at Fox
21 Chase. He was there along with Dr. Bass for a
22 few years, and he remains there now; and Dr.
23 Sophia Edwards-Bennett, who was trained at
24 Memorial Sloan-Kettering, was at Moffitt Cancer
25 Center when we recruited her. She's been there

1 a year and a half.

2 Q: And both of these physicians are competent
3 physicians, correct?

4 A: Very much so.

5 Q: Okay. And when you -- you don't have any
6 quality issues with either one of them,
7 correct?

8 A: No.

9 Q: And when you came to CRCC, you didn't have any
10 serious concerns about the quality of the
11 services that were being provided, did you?

12 A: That was -- my medical directorship was going
13 forward, not in retrospect. The company may
14 have made some assessments in that regard.

15 Q: But you didn't discover anything shocking that
16 was going on at CRCC when you took over in
17 2010?

18 A: Shocking, no.

19 Q: Okay. Now, Dr. Andrews has actually been
20 associated with CRCC for what, six or seven
21 years?

22 A: That sounds about right. I can't tell you the
23 exact year.

24 Q: He predated you at CRCC?

25 A: Yes, he did.

1 Q: And it's your understanding that he was there
2 when Dr. Bass was there?

3 A: Yes.

4 Q: And he was treating patients that were referred
5 to CRCC prior to 2010?

6 A: Yes.

7 Q: When you took over CRCC in 2010, with the
8 exception of the AUC urologists, did pretty
9 much everyone else in the medical community
10 have a high opinion of CRCC?

11 A: To the best of my knowledge, yes. I never
12 heard anything negative.

13 Q: And it's your testimony today that CRCC has
14 actually improved upon that reputation for
15 quality, correct?

16 A: Yes, we continue to, and we hope to continue to
17 improve to the best of our ability. But like
18 you say, there -- you know, we have -- there's
19 limitations on some things we cannot control.

20 Q: So you were good before, but you're better now,
21 right?

22 A: We continue to be that way. I think that would
23 be true with a medical group. If we're not
24 improving, we're stagnant. We're always
25 looking for ways to better treat patients and

1 to better deliver the care that is up to the
2 standards of care and state of the art
3 equipment.

4 Q: 21st Century has a number of facilities in
5 different markets across the country, right?

6 A: Yes.

7 Q: And some of those markets, like South Florida,
8 are very, very competitive, you agree?

9 A: Yes.

10 Q: And in order to compete with other radiation
11 therapy providers in a place like Florida, you
12 do kind of private practice 101 type tasks,
13 correct?

14 A: Yes.

15 Q: And that would include take care of the
16 patient, right?

17 A: Yes.

18 Q: Take care of the referring doctors, right?

19 A: Yes. Communicate with them readily and educate
20 them appropriately.

21 Q: That's right. Keep them informed about what's
22 going on with their patients, correct?

23 A: Yes.

24 Q: And then you market your services, right?

25 A: Yes.

1 Q: And I think Ms. Price mentioned you have a new
2 physician liaison whose job full time is to go
3 out there and market to different physicians,
4 correct?

5 A: Yes.

6 Q: And you provide a good, quality service.
7 That's kind of the last thing you can do to
8 make sure that you're competitive in the
9 market?

10 A: Yes.

11 Q: And CRCC, again to confirm, is doing all those
12 things right now?

13 A: Yes, to the best of our ability.

14 Q: And as the medical director, you have no
15 intention of seeing that any other way; it's
16 going to continue to do those things in the
17 future, right?

18 A: Absolutely, to the best of our ability.

19 Q: Now, isn't employing physicians another way to
20 compete in the market?

21 A: Yes, I would say so.

22 Q: And 21st Century employs physicians, right?

23 A: I'm employed.

24 Q: That's right. So they employ radiation
25 oncologists?

1 A: (Nods head affirmatively.)
2 Q: Do they employ medical oncologists?
3 A: In our market?
4 Q: Not in your market, not in this market
5 necessarily, but just anywhere?
6 A: I believe they do. But I can't -- can't tell
7 -- I think they do. I can't tell you where and
8 what and how many.
9 Q: Do they employ urologists?
10 A: Yes.
11 Q: Do they employ surgeons?
12 A: Yes.
13 Q: What about gynecological oncologists?
14 A: In some markets, yes.
15 Q: So there is a precedent for 21st Century
16 employing physicians, correct?
17 A: Similar to the hospitals who employ physicians,
18 similar model.
19 Q: Fair enough. And you would expect that if CRCC
20 were faced with competition for the first time
21 in 30 years in Horry County, they would
22 probably look to employ some physicians,
23 correct?
24 A: I can't tell you they will employ them. I'm
25 not in strategy planning as you say, but you

1 know, looking at other markets, that's quite,
2 you know, that's definitely a possibility.

3 Q: So that's a yes, right?

4 A: I don't know. It's a -- I think it would have
5 to determine on what the market would be able
6 to offer if we did and what competition we're
7 up against.

8 Q: You told me in your deposition with no
9 qualification that they absolutely would, so I
10 can bring that up or so your answer is ---

11 A: If they've done it in other markets, I'm sure
12 that that's something they would, you know,
13 definitely have to look at doing in our market.

14 Q: Okay.

15 A: Since I don't make that decision per se, I, you
16 know ---

17 Q: I understand.

18 A: --- I would say that's a qualified yes.

19 Q: I understand. CRCC has two primary referral
20 sources, right?

21 A: I don't know what you mean by primary. I would
22 say, you know ---

23 Q: Largest.

24 A: Okay. Okay. Right, the medical oncologists
25 and the urologists and then a collection of

1 others.

2 Q: And are these folks usually neck and -- these
3 two groups usually neck and neck with
4 referrals?

5 A: I don't look at it to look at the numbers, but
6 I do get cc'd on the reports retrospectively,
7 and that seems about right. That's usually 35,
8 30 percent, 40 percent, you know, in that area.

9 Q: Now, AUC sends you a significant number of
10 patients, right?

11 A: They have. It's been on the -- you know,
12 definite decline over the last, you know, year
13 and a half.

14 Q: When did those PSA requirements, when were
15 those published?

16 A: That was sometime in mid-2012, it could have
17 been late 2011.

18 Q: Are you sure it wasn't maybe April 2013?

19 A: No, it was -- it was before then, because I
20 spoke about it at a prostate gala event for
21 prostate screening, and that would have been in
22 August of 2012. So it had come out earlier
23 that year.

24 Q: Were they proposed at that time, proposed
25 changes?

1 A: No. No, it was a report that had came out from
2 statisticians. These are not medical
3 physicians. These were health statisticians.

4 Q: Okay. Well, that was an aside just out of my
5 own curiosity.

6 A: Health department ---

7 Q: But 90 percent of the patients AUC sends you
8 are prostate cancer cases, correct?

9 A: The vast majority are, right.

10 Q: The rest are bladder?

11 A: Bladder, we are -- since you brought up
12 bladder, that is something that we are opening
13 a protocol on for bladder, for bladder
14 preservation so patients don't have to have
15 cystectomies. So hopefully, as you know, it's
16 a protocol that we're participating in, so
17 hopefully as time goes on we'll be seeing more
18 and more bladder patients.

19 Q: And the standard of care right now for treating
20 prostate patients is what, using IMRT?

21 A: Not necessarily. It all depends on if they're
22 low risk, intermediate risk, or high risk. For
23 low risk prostate cancer patients, the
24 standards of care could be active surveillance,
25 radiation therapy, brachytherapy or surgery,

1 which could be robotic assisted. The standards
2 of care for intermediate are what I just said
3 minus the active surveillance. And the
4 standards of care for the high risk prostate
5 cancer, which we still find with PSA screening,
6 because prostate cancer is a silent disease.
7 It is with hormone treatment and radiation
8 therapy.

9 Q: If you're going to have radiation therapy ---

10 THE COURT: Prostate cancer is a what disease?

11 DR. FRANCKE: Silent.

12 THE COURT: Oh, silent?

13 DR. FRANCKE: Silent disease.

14 THE COURT: I thought you said solid.

15 DR. FRANCKE: Silent.

16 THE COURT: Okay.

17 Q: It can be but ---.

18 A: Without the PSA, my point is without the PSA
19 screening, Your Honor, it can advance in stage
20 without anyone knowing.

21 THE COURT: I understand.

22 A: Even the physical exam and digital rectal exam
23 has been -- misleading catching disease at a
24 late stage. So the screening brings the
25 patients to the doctor's awareness, and then

1 the decision should be made whether to treat or
2 not to treat. In my opinion, it should not be
3 don't screen anybody.

4 Q: Now, when you do decide to treat with radiation
5 therapy, the overwhelming majority of the time
6 it's going to be IMRT treatment, correct?

7 A: IMRT and IGRT is the standard of care.

8 Q: And a small amount to be brachytherapy?

9 A: Or external beam. In some patients
10 brachytherapy has fallen off quite a bit, but
11 brachytherapy is still done in different
12 markets.

13 Q: Now, the normal, I guess, number of treatments
14 for an IMRT is what, 40 to 45 treatments?

15 A: We usually -- that would be about right. It,
16 again, falls back to the -- what kind of
17 prostate cancer they have, whether it's low
18 risk, intermediate risk, or high risk. But it
19 can vary anywhere from 38 to 45 treatments. We
20 actually have some dose escalation trials going
21 on, and that is actually going up to 48
22 treatments or 86 gray, which is -- that's what
23 we're adopting from Memorial Sloan-Kettering.
24 So again, we're pushing the envelope with what
25 -- the standards of care are constantly

1 evolving, and we're bringing that to the
2 community. So with some patients, we may be
3 giving up to 48 treatments.

4 Q: So the other types of cancer that you routinely
5 treat, it's going to be something less than 40
6 normally?

7 A: Well, I would feel more comfortable if we went
8 site by site. It's hard to generalize for the
9 overall population, but prostate cancer, as a
10 group, is a longer treatment, longer duration.

11 Q: Well, let me ask you this. As medical
12 director, you would agree that IMRT treatments
13 attributable to prostate cancer are a
14 disproportionately large number of the
15 treatments you provide at CRCC compared to
16 other forms of cancer?

17 A: Depending on -- depending on the patient census
18 at the time. I mean, as I said, our prostate
19 numbers have fallen off quite a bit. And at
20 one point we could have a number of head and
21 neck cancer patients under treatment, which is
22 a laborious type of treatment where IMRT/IGRT
23 is intensively employed, and some lung cancers
24 and a lot of GI cancers and even some
25 gynecologic cancers are treated with IMRT.

1 Q: But as far as the entire year, those prostate
2 treatments are going to be over 40 percent of
3 your -- prostate IMRT treatments are going to
4 be over 40 percent of your revenue -- or your
5 treatments, aren't they?

6 A: See, that sounds about right, but I can't tell
7 you the exact percentage of that -- if that
8 number is correct or not.

9 Q: Over 40 percent doesn't sound right?

10 A: I don't track that number like someone at
11 corporate may, but that may be about right.
12 Anywhere from 30 to 40, 45. I don't know.

13 Q: In your deposition, you and I discussed an
14 article that was published in November 2012 in
15 the Bloomberg news. I know you've read it, and
16 I want to ask you a couple questions about some
17 of the facts that are asserted in that article
18 versus your theory that you provided for where
19 the urologists were sending the patients prior
20 to 2010. Now, you stated earlier that after
21 2010 -- that prior to 2010, the urologists were
22 sending those patients for radiation treatment
23 somewhere outside of the service area.

24 A: Somewhere besides CRCC.

25 Q: That's right. And you can't actually track

1 where they were going because you don't have
2 that data, right?

3 A: You don't know what you're not getting.

4 Q: Now, the facts asserted in that article painted
5 a different picture, correct?

6 A: Well, the article was -- yeah, it -- I don't
7 know. I don't know exactly what part of the
8 article you're referring to.

9 Q: Well, I think it said in 2009, 19 percent of
10 the county's prostate cancer patients had their
11 glands surgically removed, 60 percent had
12 brachytherapy, and then 32 percent received
13 IMRT; does that ring a bell?

14 A: Okay. It's been a while since I've looked at
15 that article, but ...

16 Q: And then it says that in 2011 after AUC
17 acquired CRCC, the IMRT jumped to 61 percent
18 and surgery fell to five percent and the seed
19 implants dropped to two percent. Sound
20 generally what the substance of the article
21 said?

22 A: That's -- that's similar to what we -- what
23 I've witnessed boots on the ground in terms of
24 our prostate numbers going up and them not
25 going out -- them not being referred outside

1 CRCC.

2 Q: Do you disagree with the facts asserted in that
3 article?

4 A: I -- that article, you know, mischaracterizes,
5 you know, 21st Century as -- you know, what
6 that article is really talking about and what
7 has happened across this country is that
8 urology companies, urology groups, such as
9 Urorad, have acquired linear accelerators,
10 they've employed radiation oncologists, or
11 we've see -- personally I've seen this happen
12 in south Florida as well with US Oncology where
13 medical oncologists owns a linear accelerator,
14 and at that point, it's a completely different
15 picture, a completely different animal than
16 what 21st Century has done. We don't, you
17 know, the radiation oncologist is autonomous.
18 The urologist does not tell us who to -- who to
19 treat or how to treat that patient. I have
20 seen in these sorts of practices where the
21 owner of the facility will call the radiation
22 oncologist and tell them to find something to
23 treat, and it's very distasteful. That is
24 where business interferes with delivery of
25 treatment. 21st Century has offered a remedy

1 for -- with the problem in providing, you know,
2 or removing the obstacle for those urologists
3 to send those patients elsewhere. But we
4 retain our autonomy. We treat those patients
5 hands off the urologist, hands off from
6 corporate. And I'm very proud to say that we
7 treat those patients with the standard of care.
8 And I'm proud to say that those patients are
9 being better treated with IMRT in some
10 instances where brachytherapy is not
11 necessarily the cure all for all prostate
12 cancer, nor is surgery, and surgery definitely
13 has a higher instance of urinary incontinence
14 and erectile dysfunction. I know, I see those
15 patients. And those patients who had those
16 procedures, you know, they tell me about their
17 surgery versus -- and they're glad they had
18 radiation. So, in that instance where I think
19 21st Century came into the market where that
20 problem existed, they fixed it and the patients
21 in the community are better off for it.

22 Q: So from 2009 to 2010, there was a 700 percent
23 increase in the number of referrals from the
24 AUC urologists to CRCC?

25 MR. LONG: Objection, Your Honor. I mean, he hasn't

1 laid a proper foundation for that. He is ---

2 MR. CARTIN: Okay. Well, we'll do it this way.

3 MR. LONG: -- quoted some article that he vaguely

4 recalls remembering and now ---

5 THE COURT: Well, I thought the 700 percent had to

6 do with CRCC, but still he hadn't ----

7 MR. CARTIN: We can pull up Petitioner ---

8 THE COURT: This individual said he doesn't know the
9 numbers, so.

10 Q: Let me do this. We'll pull up Petitioner's 56.

11 Dr. Francke, do you recognize the physicians'
12 names on the left-hand side of that page?

13 A: Yes, sir. Those are urologists with Atlantic
14 Urology Clinics..

15 Q: If you'll look at the top of that page, it says
16 2009 Consult Data, correct?

17 A: Uh-huh (affirmative response).

18 Q: If you'll look down the side, it has a number
19 listed beside each physician that lists the
20 number of consults, correct?

21 A: Yes.

22 Q: Okay. Now, let's pull up Exhibit 45, please.

23 Okay. And there, you'd agree with me that we
24 see the same list of physicians. And who are
25 those physicians?

1 A: Those, again, are the urologists at Atlantic
2 Urology Clinic, physicians.

3 Q: And the numbers we see there as far as consults
4 go for 2010, 2011, and 2012 are significantly
5 higher than they were for 2009; is that a fair
6 statement?

7 A: No doubt. No doubt.

8 Q: I don't want to make you do the math. I
9 promised I wouldn't make you do any math
10 problems, but that's a significant increase
11 from 2009 to 2010?

12 A: It is an increase, but even at those numbers,
13 that is -- that is, you know, our -- that's not
14 -- that's still about 35, 40 percent of our --
15 I mean, our practice even in 2011, 2012 did not
16 consist solely of urology patients. It's still
17 a -- basically a third of our practice.

18 Q: But the vast majority of the year over year
19 growth from 2009 to 2010 for all of CRCC came
20 from ---

21 A: If you look at those -- if you look at those
22 three years, or the difference, yes, that was
23 definitely a day and night change because of
24 the change, the acquisition.

25 Q: Okay. Now, you're fond of the saying that a

1 linear accelerator does not a cancer center
2 make, correct?

3 A: Yes. Yes, I -- the point is that, you know,
4 radiation therapy is a team -- is very much a
5 team effort in terms of what's within that
6 center and in terms of the technical, you know,
7 qualifications or specifications of the
8 machine. Not just that, but the relationships
9 between the physician and the referring
10 physicians that sometimes take years to
11 cultivate and to earn their trust. And so, you
12 know, you can have a brand spanking, you know,
13 Taj Mahal with the latest equipment and Ivy
14 League radiation oncologist, and unless I know
15 more about what goes on in that center in terms
16 of the policies and procedures and how they
17 treat their patients and standards of care that
18 they utilize and how they work with physicians,
19 you know, I would need to know more because,
20 you know, I know where all the pitfalls can
21 occur.

22 Q: Now, if Grand Strand were to start a program,
23 they would be starting it from scratch, right?

24 A: Yes. But they're HCA, so I'm sure that they
25 have a lot of resources that they can draw

1 from.

2 Q: But it's fair to say CRCC would have some
3 competitive advantages that would not be
4 afforded to Grand Strand immediately?

5 A: Well, we're there first. That, you know, that
6 advantage I would say we have. But there are
7 some things, like you said before, that we
8 cannot control.

9 Q: You've got a 30 year head start, right?

10 A: Well, if they have a strong relationship with
11 Coastal Cancer Center, that 30 years doesn't
12 mean much.

13 Q: Well, you've got the policies and procedures
14 developed by 21st Century that sets you guys
15 apart, right?

16 A: With the patients that we see that come through
17 our door that are referred to us, absolutely,
18 quality will continue.

19 Q: Well, Grand Strand won't have that?

20 A: But we can't -- but if the patients aren't
21 coming, what good is that?

22 Q: Well, you still have a name that's synonymous
23 with quality radiation therapy services.

24 A: You could, but you could be seeing half the
25 volume. So unless the patients are sent by the

1 referring physicians, all the quality in the
2 world is going -- is going to go to waste.

3 Q: Well, I mean you guys have greatly improved
4 provider relationships since 2010, right?

5 A: To the best of our ability.

6 Q: But they're going to evaporate overnight when
7 Grand Strand gets a linear accelerator?

8 A: Potentially they're -- you know, if there's an
9 association between Coastal Cancer Center, one
10 that has been shown in the application, Grand
11 Strand's application for the CON, that they
12 will strongly support and, you know, offer a
13 significant number of referrals, we can do
14 everything within our power to provide the very
15 best quality, but if there's, you know, if
16 there's an association between Coastal Cancer
17 Center or other physicians in the Grand Strand
18 proximity, there -- you know, with 14 years of
19 experience that I've had in south Florida,
20 there are some things that you cannot, you
21 know, overcome.

22 Q: Let me get one thing right, you're not aware of
23 any formal relationship between Grand Strand
24 and the medical oncologists, are you?

25 A: I'm aware of what's -- I'm aware of what -- of

1 the proximity between Coastal Cancer Center and
2 Grand Strand, and I'm aware of the worry and
3 the -- that is in the C -- Grand Strand's CON
4 application. I'm aware of Coastal Cancer
5 Center ---

6 Q: What worry are you referencing? You've said
7 that a couple times.

8 A: I think it was Mr. Sullivan's support, or Mr.
9 Sullivan's letter that's part of the
10 application there that he -- that it is
11 mentioned, or that it is stated, I should say,
12 in the CON application that Coastal Cancer
13 Center, being a large medical oncology group
14 provider, the largest in the area, intends to
15 send a significant number of patients to Grand
16 Strand. And also the fact that they have
17 supported fully Grand Strand's CON, and which,
18 you know, we did not get Dr. Holt -- we got
19 half their -- we got the support of three of
20 the Conway physicians, and also the fact that
21 I have not been given any great reassurance by
22 Dr. Holt that he would continue to support our
23 center the way they have in the past.

24 MR. CARTIN: Let's pull up Petitioner's 50, please.

25 And blow up that top paragraph, Ms. Tuska.

1 Q: All right. Dr. Francke ...

2 A: Yes, I remember this email.

3 Q: Yeah, would you start reading from, I did ask.

4 A: I did ask Dr. Holt's permission his -- for --
5 his associates and he said yes. He did not
6 though volunteer to submit a letter of his own,
7 but it is the support of the three med oncs
8 that service Conway that we really need anyway.
9 I was trying to put a positive spin on it, but
10 I remember I was quite disappointed that Dr.
11 Holt would not support our Conway center.

12 Q: And who are those three doctors that you
13 referenced there?

14 A: The three doctors are the three doctors that
15 are at -- that rotate through the Conway
16 center, Dr. Cody, Dr. Karpenko, and Dr.
17 Goldberg.

18 Q: And let me make sure I've got this down.
19 You're not personally aware of any formal
20 agreement between Grand Strand and the medical
21 oncologists for some sort of exclusive
22 relationship?

23 A: Only what has been stated in the CON is what
24 I'm aware of, and it makes me uncomfortable.

25 THE COURT: Docor, just because a doctor's office is

1 close in proximity to the hospital, why would
2 that mean that the doctor would refer all those
3 patients to that hospital? And the reason I
4 ask is, there's a lot of evidence in this case
5 about individuals going from different zip
6 codes and the convenience to the patients, so
7 is all of that just something I don't need to
8 consider and what I really do need to consider
9 is only where the doctor's office is located?
10 I'm not following the logic of what you're
11 saying.

12 DR. FRANCKE: Your Honor, the proximity is just one
13 aspect. The fact that I lack the reassurance
14 from Dr. Holt, who I know very well, and he's
15 not come out and said, Patrick, you know, you
16 have our continued support; we will continue to
17 support you wholeheartedly and send you all of
18 our patients as we've done in the past. That
19 is painfully absent. Also ---

20 THE COURT: Well, when you get a lack of
21 reassurance, that doesn't mean -- that just, to
22 me, what I'm hearing from you is I'm not
23 getting assurance, but I'm not getting, on the
24 other hand, a statement to the contrary. It
25 sounds like he's being Switzerland.

1 DR. FRANCKE: Your Honor -- Your Honor, also the
2 language that's in the CON application how they
3 haven't had conversations with Coastal Cancer
4 Center and that they would support their new
5 linear accelerator, in 20 years, I've never --
6 of practice, I've never had a physician call me
7 and say he was going to quit sending me
8 patients. They just don't come anymore. He's
9 not going to be confrontational about it. They
10 just don't come anymore. So all of that
11 together gives me pause and does not give me a
12 great deal of confidence that Grand Strand is
13 not going to significantly, you know, adversely
14 affect, you know, our patient census.

15 THE COURT: Have you ever had a doctor tell you they
16 are going to send you patients and not do it?

17 DR. FRANCKE: I've had physicians say yes, they're
18 going to send me patients. No. No, usually if
19 they say they're going to send you patients,
20 they send them.

21 THE COURT: All right.

22 DR. FRANCKE: They send you patients.

23 Q: Just to confirm, the short answer to the
24 question was that you've never had any 100
25 percent indication from Dr. Holt or any of the

1 other medical oncologists that they're going to
2 cease to send all business to CRCC if Grand
3 Strand gets a linear accelerator?

4 A: To cease all business, no, I would not say --
5 I would say yes, that is correct.

6 Q: Let's pull up Petitioner's 72, please. Do you
7 recognize this email, Dr. Francke?

8 A: I can't -- it's kind of small.

9 MR. CARTIN: Let's see if we can blow it up there.

10 Can you blow up the top paragraph, Ms. Tuska.

11 A: Okay. Yes.

12 Q: And this email shows that you had the support
13 of Phil Clayton, Conway's CEO, correct?

14 A: Correct.

15 Q: And is it fair to say he was very supportive of
16 your project?

17 A: He was.

18 Q: In your proposed location, CRCC-Conway would be
19 a stone's throw from the hospital, correct?

20 A: Yes.

21 Q: It's just kind of right around the corner,
22 maybe two or 300 yards from the hospital?

23 A: Yes.

24 Q: And by hospital, I mean Conway Medical Center?

25 A: Yes.

1 Q: And Mr. Clayton actually was so supportive he
2 came and spoke at project review, correct?

3 A: He offered to and he asked me what he could
4 speak with, we gave him some talking points and
5 ---

6 Q: Put up Petitioner's 49.

7 A: --- he ended up talking off the hip.

8 Q: And do you recall receiving this email?

9 A: Yes. Phil Clayton had asked me what he could
10 speak on, and he asked me to send him some
11 talking points, and I gave him those.

12 Q: And did you agree with Mr. Bryant's talking
13 points that he put forward there?

14 A: Yes. As to how they're provided to him, yes.
15 They're the experts in that area.

16 Q: And a number of Conway Medical Center
17 affiliated physicians provided letters of
18 support, right?

19 A: Correct.

20 Q: A number of Conway Medical Center board members
21 provided letters of support, correct?

22 A: Yes.

23 Q: And CMC, Conway Medical Center rather employs
24 physicians, right?

25 A: Yes, I believe they do.

1 Q: And given the close proximity of Conway Medical
2 Center to CRCC, you might expect to get some
3 referrals from CMC physicians, correct?

4 A: Yes.

5 Q: Now, you participated at project review in
6 front of DHEC, right?

7 A: Yes.

8 Q: That's the little dog and pony show, I think
9 it's been referenced earlier this week, in
10 front of DHEC. Would you agree with me that's
11 kind of the opportunity for parties to present
12 their case to DHEC in a public format?

13 A: Yes.

14 Q: Okay. And you would think that an applicant
15 who wants to support their project would want
16 to put their best foot forward on that,
17 correct?

18 A: Yes.

19 Q: They would want to put their best arguments
20 actually in the presentation that they make to
21 DHEC, correct?

22 A: Yes, I would say so.

23 Q: You're aware that in ---

24 THE COURT: Hold on one moment.

25 (Pause)

1 THE COURT: All right.

2 BY MR. CARTIN:

3 Q: And I just want to confirm that in your project
4 review presentation, did CRCC make any mention
5 to the Department of Health and Environmental
6 Control that they thought they would lose the
7 majority of their medical oncologist referrals?

8 A: I don't -- not that I can recall.

9 Q: Let's talk a little bit about Grand Strand's
10 equipment. Now, you're aware that Grand Strand
11 has applied to place a Varian Clinac iX in its
12 radiation therapy center. I think during your
13 deposition you told me that was a good solid
14 machine, correct?

15 A: Yes.

16 Q: It provides standard of care treatment for the
17 vast majority of cancer, right?

18 A: Yes.

19 Q: And I think it's kind of a work horse. I think
20 it's one of the busiest machines at CRCC-
21 Conway, right?

22 A: That would be correct. It's a versatile and
23 it's ...

24 Q: Certainly the Varian TrueBeam is a more
25 advanced type of technology?

1 A: Right. Varian is a good name and the TrueBeam
2 is the latest in technology.

3 Q: And are you aware that Grand Strand has taken
4 the position in this litigation that two linear
5 accelerators can be approved?

6 A: Yes, I've heard that.

7 Q: And as a radiation oncologist, could you fault
8 Grand Strand if it ultimately gets a linear
9 accelerator program for wanting to maybe ask
10 the Department if they can get a Varian
11 TrueBeam?

12 A: I don't fault Grand Strand for trying to do
13 that. I just -- but within a CON contain --
14 you know, to where we can lose a significant,
15 you know, drop 40 percent of our patients and
16 have 40 patients over four machines treating
17 ten patients a day, I can't see how -- I don't
18 fault Grand Strand for trying, but I can't see
19 how that would be conducive within the CON
20 environment.

21 Q: And my question is more ---

22 A: That's why I came to South Carolina away from
23 south Florida where that sort of environment
24 exists to where you're treating low numbers at
25 different centers and you take away from the

1 individual center just prospering and offering,
2 you know, the latest in terms of protocols and
3 things like that.

4 Q: Now, you testified there is some limited value
5 to having an inpatient radiation therapy
6 program at a hospital, right?

7 A: I would say limited in terms of infrequent,
8 yes. When you need it, you need it. You just
9 don't need it very often, not very often at
10 all.

11 Q: So the benefits of that program would flow to
12 a very limited number of patients, right?

13 A: Very, very limited. I mentioned a pediatric
14 patient that requires anesthesia. I mentioned
15 the ventilator patient. Patients otherwise
16 could be treated as an inpatient quickly in a
17 facility outside of the hospital as easily as
18 they can in a facility within the hospital.
19 It's hard to say one is definitely better than
20 the other until a study is done and you have
21 someone standing there with a stopwatch.

22 Q: But you would agree that if you're one of those
23 limited numbers of patients, it's probably
24 pretty significant to you, isn't it?

25 A: If I'm on a ventilator, I want to be treated at

1 an inpatient radiation center.

2 Q: Because you can't get it anywhere else, can
3 you?

4 A: You can get it at an inpatient radiation
5 center, but as I said before, I've had that
6 come up two to three times in 19, 20 years.

7 Q: Okay. Now, with regard to the -- of the
8 transfers from Grand Strand to Trident you
9 referenced earlier, Mr. Mullins tossed up a
10 list of transfers, correct?

11 A: Yes.

12 Q: And I just want to confirm, you have not
13 personally treated each and every one of those
14 patients on that list, have you?

15 A: No, we've treated some. I know of one in
16 particular that I know very well that we
17 treated in the past.

18 Q: But you're not familiar with the circumstances
19 and the patient files of each and every one of
20 those patients, are you?

21 A: Each and every one, I'd have to look as to how
22 many. I can't say that because there were some
23 patients that we were never even consulted on.

24 Q: So how many treatments does the typical
25 inpatient get?

1 A: Before they -- here or before they're ---

2 Q: Before they're discharged?

3 A: Before they're discharged. Typically, one,
4 two, three would be a safe number to say.

5 Q: So if you had -- let's just pick three. If you
6 had to have three treatments while you were an
7 inpatient in a hospital, that could be a what,
8 week long stay, two week stay, something like
9 that?

10 A: No, no, not necessarily. It could be -- as
11 long as they -- they're not typically in the
12 hospital to get the radiation, but while
13 they're in the hospital being stabilized from
14 a medical standpoint, waiting discharge finally
15 to a rehab hospital, we could continue
16 radiation as long as they're there to further
17 stabilize it. They no longer -- if they're out
18 of harm's way, then they would -- you know,
19 hold the treatment until they're discharged.
20 Remember when you're treating usually a larger
21 -- for an extreme palliative situation, such as
22 what these inpatients often find themselves in,
23 we are treating larger doses of compaction to
24 hasten the response to get them out of harm's
25 way. For example, to shrink their tumor out of

1 or away from the airway or away from the
2 superior vena cava. So that along with
3 steroids usually makes a significant
4 improvement, even within a 24 hour period to
5 where the patient can be discharged.

6 Q: So if they're an inpatient in a hospital where
7 there is no inpatient radiation therapy
8 program, in order for them to receive that
9 radiation therapy one time, two times, three
10 times, how ever many times it is, the patient
11 has to be taken out of the bed, put on a
12 stretcher, right?

13 A: (Nods head affirmatively.)

14 Q: Okay. And they have to be transported down the
15 hall, right?

16 A: Uh-huh (affirmative response).

17 Q: Put on an ambulance?

18 A: Yes.

19 Q: Be driven to the radiation therapy center,
20 right?

21 A: Yes.

22 Q: And they're going to be put on your couch for
23 radiation therapy treatment, right?

24 A: Yes.

25 Q: You're going to bring them back; you're going

1 to put them back on the stretcher, right?

2 A: Yes.

3 Q: And then you're going to put them back in the
4 ambulance, right?

5 A: Yes.

6 Q: You drive them back to the hospital, right?

7 A: Yes.

8 Q: Correct? And so then once we get to the
9 hospital, we're going to get back in the bed,
10 correct?

11 A: Yes.

12 Q: Okay. Now, if you transfer an inpatient once
13 to a hospital that has a radiation therapy
14 program, how many times do they have to get in
15 an ambulance?

16 A: You know, once for a very long time, for 100
17 miles in this instance going to be Trident.

18 Q: But it's once?

19 A: And it's not the distance so much as the
20 timing. Timing is critical in initiating
21 radiation therapy. In some of those instances,
22 for whatever reason, there were some
23 significant delays in the treatment.

24 Q: Do ambulance rides cost money?

25 A: Yes, they -- I'm not -- I'm not in billing, but

1 I do know they cost money.

2 Q: And each one ---

3 A: Everything costs money.

4 Q: That's fair. That's a good statement. That's
5 true, that's very true. Is there any value to
6 face-to-face communication with physicians?

7 A: Yes. I mean, it's always good face to face.
8 Is it always necessary? No.

9 Q: Okay. I've got a few questions here to kind of
10 wrap things up, Dr. Francke. What do the PSA
11 guidelines say as to how often men should have
12 a PSA test?

13 A: Well, it used to be age 40. If you have a
14 strong family history, you ought to be getting
15 it at age 35. Unfortunately, I've seen some 35
16 and 40-year-old patients with prostate cancer.
17 So for that reason, a strong family history
18 earlier, and I would keep with the annual
19 screening. But at least today I think the
20 standards I think have kind of gone to age 50
21 and then once a year, once every two years.
22 Some say three, but ---

23 Q: What is the current recommendation?

24 A: Most primary care physicians are falling back
25 to, as I understand, giving them when they come

1 in for their checkups.

2 Q: Who issued those guidelines, do you know?

3 A: The ---

4 Q: Was it the American College of Physicians?

5 A: It may have been. But it wasn't based a -- it
6 wasn't based on clinical -- based on clinical
7 studies.

8 Q: Now, to your knowledge, nothing prevents AUC
9 from recruiting medical oncologists, correct?

10 A: Right, that would be ---

11 Q: And nothing prevents them from recruiting
12 surgeons?

13 A: AUC?

14 Q: Uh-huh (affirmative response).

15 A: Not that I -- no, I never thought they were
16 anything more than a single specialty group,
17 so.

18 Q: And has CRCC been actively recruiting a
19 surgeon?

20 A: They -- maybe.

21 Q: What do you mean maybe? You're the medical
22 director.

23 A: I'm not directly involved in recruitment of any
24 physicians, but they may be talking to surgeons
25 to increase their referral base for certain

1 specialties, much like the hospital is with
2 hiring surgeons.

3 Q: Well, what other types of surgeons are CRCC
4 interested in?

5 A: I'm not directly involved with that, but breast
6 surgeons would be one.

7 Q: Okay.

8 A: Because breast surgery is a significant portion
9 of patients, and again, we've been -- the area
10 has seen a breast surgeon coming from the south
11 side away from Myrtle Beach and taking some of
12 those patients outside Myrtle Beach for
13 treatment, and if that is something that we
14 need to do to ensure that patients can stay in
15 the area for treatment then we will.

16 Q: Okay. And I've got one final question.
17 Memorial Sloan-Kettering is a state of the art,
18 world class comprehensive cancer center,
19 correct?

20 A: Yes, most definitely.

21 Q: That's all I have right now. Thank you, Dr.
22 Francke.

23 MR. MULLINS: Your Honor, a couple questions.

24 THE COURT: All right.

25 DR. FRANCKE - REDIRECT EXAMINATION BY MR. MULLINS:

1 Q: Mr. Cartin asked you, he put up on the screen
2 the email that related to the support letters
3 from the three Coastal physicians that practice
4 in Conway or visit the office in Conway; do you
5 recall that?

6 A: Yes.

7 Q: Okay. To your knowledge -- the main office for
8 Coastal Cancer is adjacent to the hospital; is
9 that your understanding?

10 A: Yes.

11 Q: And how would you describe the office in
12 Conway; is that a smaller satellite facility?

13 A: Yes. The office at -- the Coastal Cancer
14 Center at -- office near Grand Strand is quite
15 large.

16 Q: The three physicians that supported -- that
17 issued the letter of support, do they practice
18 solely in Conway, or do they rotate out to the
19 Conway facility?

20 A: They rotate. Dr. Cody spends most of her time
21 at Conway. The other two physicians spend some
22 time at Conway, but they do -- they all rotate.

23 Q: If they're rotating, they would spend the
24 better part of their time back at the main
25 campus or one of the other satellite offices?

1 A: Correct.

2 Q: Let me have you look at Respondent CRCC's
3 Exhibit 17, and we can just flash it on the
4 screen.

5 MS. ELLINGTON: 16.

6 Q: 16. Does that look like your CV?

7 A: Yes.

8 Q: Just want to make sure we got that in there.

9 THE COURT: She did good.

10 MR. MULLINS: She did. Thank you. No more
11 questions, Your Honor.

12 THE COURT: Ms. Biggers?

13 MS. BIGGERS: No questions.

14 THE COURT: Any questions on a new matter raised?

15 MR. CARTIN: No, Your Honor.

16 THE COURT: You may step down.

17 DR. FRANCKE: Thank you.

18 THE COURT: And I assume y'all want to let him go?

19 MR. MULLINS: Yes, if we could, Your Honor.

20 THE COURT: You're dismissed.

21 MR. CARTIN: No objection.

22 THE COURT: All right.

23 MR. MULLINS: Your Honor, do you want to keep going?

24 THE COURT: Yes.

25 MR. MULLINS: Going to trade out.

1 MR. LONG: Switching places, Your Honor.

2 THE COURT: You said trade out?

3 MR. MULLINS: Trade out.

4 THE COURT: Well, are we going to consider a witness
5 here?

6 MR. LONG: Yes, Your Honor, we would call Rosa
7 Maynor to the stand. Thank you. We will
8 consider a witness.

9 ROSA L. MAYNOR, having been duly sworn, testifies as
10 follows:

11 MS. MAYNOR - DIRECT EXAMINATION BY MR. LONG:

12 Q: Can you state your full name, please?

13 A: Yes, it's Rosa Lee Maynor.

14 Q: And Ms. Maynor, where are you employed now?

15 A: I'm employed, my paycheck comes from Radiation
16 Therapy Associates because I live in western
17 North Carolina and that's our North Carolina
18 entity, but I'm employed by 21st Century
19 Oncology.

20 Q: Okay. And what is your occupation at 21st
21 Century?

22 A: I'm the regional director for Region III, which
23 is the Southeast Region. It's North Carolina,
24 South Carolina, Alabama and northwest Florida.

25 Q: Okay. So does Ms. Sissy Price report to you?

1 A: Yes.

2 Q: All right. Let me ask you a little bit --
3 before we talked about your occupation and
4 what's your background. Can you give us your
5 educational background, please?

6 A: Sure. Right out of high school I went to
7 school at McDowell Tech and received my LPN,
8 licensed practical nurse. I worked as a
9 licensed practical nurse from 1981 to '83 at
10 Mission Hospital in Asheville on the medical
11 oncology floor. I took a couple years off with
12 my kids from '83 to '85. Then I went back to
13 work at St. Joseph's Hospital in Asheville on
14 the medical oncology floor. Went on to school,
15 received my associate degree in nursing and
16 continued to work as a RN while I went to
17 school and received my bachelor's degree and
18 then by MBA in healthcare management.

19 Q: Okay. So you're an RN, you have a bachelor's
20 in business administration and a master's in
21 business administration?

22 A: Yes.

23 Q: And let's look at CRCC Exhibit 18. Can you
24 tell me what this document is right here?

25 A: That's my resume.

1 Q: Okay. And how long have you been working with
2 21st Century?

3 A: They acquired our practice in 2002.

4 Q: And in your current role, what other jobs did
5 you have at 21st Century?

6 A: When we bring on a new practice, I go and I
7 train the staff. I manage the centers. I'm
8 responsible for the operations of the centers.

9 Q: Okay. And how many centers are you currently
10 responsible for total?

11 A: I have 17 radiation centers and 31 multi-
12 specialty centers.

13 Q: And what states again?

14 A: North Carolina, South Carolina, Alabama and
15 northwest Florida.

16 Q: And do you travel to those centers?

17 A: Yes, I do. I try to make it to all of them at
18 least once a month.

19 Q: So you're on the road a good bit, right?

20 A: Uh-huh (affirmative response). I am.

21 Q: Okay. And what are your specific duties you do
22 to help manage the operations of these centers?

23 A: I like to take a hands-on approach, so I don't
24 rely totally on numbers. Nursing is my
25 background, so the patients are more important

1 to me than the numbers at the center. So I try
2 to make sure that I'm there to make sure people
3 are following procedure, that the patients are
4 being taken care of, that there's nobody in
5 those waiting rooms waiting, that they're
6 coming in, they're getting called back, they're
7 getting taken care of, and they're getting out
8 the door. I work with the staff to see if
9 there's any issues, and if there's issues, I
10 take care of those while I'm onsite.

11 Q: Do you have any oversight responsibility for
12 Atlantic Urology?

13 A: Atlantic Urology will call me if they have
14 issues as far as their computers not working,
15 they need corporate support. I'm the liaison
16 between the field and the corporate office.
17 But as far as day-to-day management, no, I do
18 not.

19 Q: They're not one of the centers or clinics
20 that's you're -- that are under your
21 responsibility?

22 A: No. I'm their resource if they need assistance
23 with something from corporate. But as far as
24 telling them what to do, when to do it, or how
25 to do it, no, I don't.

1 Q: But CRCC-Myrtle Beach, you are the ---

2 A: Yes.

3 Q: --- responsible for ---

4 A: Yes.

5 Q: --- telling them what to do and when to do,
6 right?

7 A: Correct.

8 Q: Tell the Court about the philosophy of 21st
9 Century to have a number of different offices
10 in a market.

11 A: Yeah. The philosophy of 21C is, you know,
12 we're healthy, we're the caregivers. The
13 patients are sick, so it needs to be us that's
14 traveling to the patient, not the patient
15 coming into the center to see us. So in
16 Western North Carolina, for example, where I
17 live and where I started with them, we have
18 seven centers. Asheville is our central site,
19 and then we have satellite offices 63 miles out
20 all the way around. And patients that weren't
21 able, because of economic reasons or whatever,
22 to travel into Asheville can now get treated,
23 which wasn't happening 30 years ago when I
24 started in medical oncology in Asheville. So
25 we're seeing patients sooner, the tumors aren't

1 as bad when they come in to start treatment.

2 Cancer care is better. The patients are
3 getting better care because of that.

4 Q: But from a business or management point of
5 view, would it be easier on you if you had
6 fewer centers and more machines?

7 A: It would be easier on me to have fewer centers.
8 It wouldn't be better for the patient. It
9 would be more financially reasonable to have
10 less centers. It costs more to run more
11 facilities, I think.

12 Q: All right. And was Myrtle Beach assigned to
13 you almost immediately after the acquisition?

14 A: Yes, it was.

15 Q: And so did you travel to Myrtle Beach shortly
16 afterwards as part of your responsibilities?

17 A: Yes. I almost lived in Myrtle Beach from May
18 through December of 2010.

19 Q: Okay. And what did you find when you got there
20 in May of 2010?

21 A: The practice was, it's a very nice practice.
22 Sissy always ran it very well. There was an
23 excellent staff there. Our numbers started
24 increasing. They were staffed higher than we
25 typically do for the numbers that they had at

1 the time. CRCC explained some of that to me,
2 and we kept the staff, everybody stayed. We
3 kind of rearranged the positions a little bit
4 and reorganized because a lot of the support,
5 billing, collections, that went to Florida.
6 Some of those positions went away, but we were
7 able to put those people into front desk
8 positions or others to keep them employed. Our
9 numbers started increasing because I guess the
10 relationship between the urologists that had
11 prevented them from sending patients in the
12 past was resolved, so they started sending
13 patients. The numbers were going up. We ended
14 up adding therapists so that we could run two
15 shifts to get all the patients taken care of.

16 Q: Okay. And did that increase in treatments
17 continue on into 2011?

18 A: It did.

19 Q: Okay.

20 A: Into 2011. Toward the end of 2011, the
21 consults started to reducing and the treatments
22 started leveling off and then continued to
23 level off or decrease. We treated 74 patients
24 yesterday, 73 the day before.

25 Q: Okay. And how dramatic a difference is that

1 73, 74 patients compared to what you were
2 seeing in 2011?

3 A: In 2011, we were treating over 100 patients a
4 day.

5 Q: Okay. And when a facility is treating -- well,
6 tell me how y'all decide how often you're going
7 to be open.

8 A: It's based on patient volume and patient need.
9 Currently, we're staying open, we're opening I
10 think it's at six in the morning, and we're
11 staying open until 6:30 at night. It's not
12 because of the volume currently because we're
13 only treating 74 patients currently, but we
14 have patients that are wanting to come in
15 before they go to work or come in after they
16 get off of work in the afternoon, so we've
17 elected, since we were staffed to run two
18 shifts, to remain open for the patient's
19 benefit. It also allows the physics staff to
20 do the QA, because we're actually letting the
21 employees to take lunch together during the
22 middle of the day to open the machine up for
23 our physicist so ---

24 Q: Well explain -- I don't think anybody's
25 testified about that. What's is QA?

1 A: It's quality assurance for the patient's
2 treatment.

3 Q: Okay. So what is involved in that?

4 A: The physicist actually runs that quality
5 assurance test, and I can't go into detail
6 about that; I'm not qualified to do that. But
7 it has to be done on the machine, the treatment
8 machine the patient's going to be treated on.

9 Q: Okay.

10 A: Before the patient can actually start
11 treatment.

12 Q: Okay. Is that typically done every day?

13 A: It is not done every day, but it has to be done
14 before the patient can start treatment. So for
15 any new cases.

16 Q: Any new cases, if there's a new patient
17 starting that day, it's got to be done?

18 A: Yes.

19 Q: All right. And if you were running the machine
20 all day with no breaks or very few breaks
21 during the day, when would that typically be
22 done?

23 A: It would be done in the afternoon after
24 everybody was through with treatment.

25 Q: So now you're doing that at lunch?

1 A: Yes.

2 Q: What's the benefit of you being able to be open
3 from say six a.m. to about six or 6:30 p.m.?

4 A: For the patients, it's so they can come in
5 before they go to work or after they get off in
6 the afternoon.

7 Q: Do you have patients who want to do that?

8 A: Yes, we do.

9 Q: Do you have patients who are working while
10 they're getting radiation therapy treatment?

11 A: Yes, we do.

12 Q: We also heard testimony you have patients who
13 like to play golf after they get radiation
14 therapy, right?

15 A: Yes, we do.

16 Q: Okay. And then I assume other patients are
17 much more sick, right?

18 A: Some patients are very sick. And even
19 chemotherapy patients -- radiation patients,
20 they get their treatment every day, so it's a
21 Monday through Friday treatment. Chemotherapy
22 patients, they don't receive chemotherapy the
23 whole time they're getting radiation. So they
24 may go to the medical oncology office like week
25 one and receive a course of chemotherapy, but

1 then not have to return to that medical
2 oncology office until week three or four;
3 whereas, with radiation, they have to come
4 every single day, Monday through Friday. So
5 travel to them is more difficult because it's
6 daily throughout their treatment.

7 Q: And so even somebody -- what's the philosophy
8 of the company even for distance of time in
9 regards to reducing travel for patients?

10 A: It's important. A patient's quality of life,
11 keeping them out of the physician's office and
12 off the road and at home with their families is
13 very important.

14 Q: Okay. Now as the -- in your position, are you
15 aware of any reasons in the center for why the
16 utilization has decreased in 2012 and 2013 from
17 2011?

18 A: The only thing, I have seen a drop in all
19 urology referrals, and that's throughout my
20 centers in all states. And when I talk to
21 managers at any of the centers it's because
22 they tell me that the referrals to the urology
23 offices have decreased. And that's because of
24 the decline in PSAs.

25 Q: So it's not just Myrtle Beach?

1 A: It's not just Myrtle Beach. It's all of my
2 centers.

3 Q: Now, is the -- in the number of treatments that
4 y'all do per day, does it -- I know it
5 fluctuates some I assume, right?

6 A: Yes, it does.

7 Q: Okay. In 2013, did y'all have a period of time
8 where you were busier than you have been at
9 other times during the year?

10 A: Yes. I remember -- I think Mr. Thomas had
11 asked me during my deposition what the hours
12 were, and we had actually increased back up to
13 I think we were treating 102 per day when I did
14 my deposition. That lasted for about a week,
15 and then we dropped back down in the 80s.

16 Q: Okay. And so what happens when it spikes up
17 for a week or two; what do you do?

18 A: We have the staff there. We just extend our
19 hours to take care of the patients.

20 Q: Okay. Now, if the volume in Myrtle Beach
21 decreased by say 20 to 30 patients per day, so
22 instead of being in the 70s or 80, closer to 50
23 on four machines, or less, what would you do --
24 what would you have to do in regards to your
25 staff?

1 A: I hate to admit this, but -- because I always
2 want it to be about patient care and not so
3 much about the money or the revenue, but in
4 reality, you have to have the revenue to be
5 able to pay employees. If we dropped that
6 much, we would have to lay off the employees.
7 And ---

8 Q: Would it affect your -- I'm sorry, go ahead.

9 A: I was just going to say I've never had to do
10 that before and I hope that doesn't happen.

11 Q: Would it affect your ability to kind of flex up
12 a little bit if you had a spot?

13 A: Yes, if we had to reduce our employees, we
14 wouldn't have the employee force that we have
15 today to be able to flex the hours.

16 Q: And would you have the flexibility to be open,
17 say, early in the morning or late at night?

18 A: No, because the hours would be more limited
19 because there would be a less number of staff.

20 Q: Now, did you -- were you part of the team that
21 prepared the certificate of need application
22 for Conway?

23 A: The only input that I had into the certificate
24 of need was for staffing.

25 Q: Okay. And you're comfortable with the staffing

1 projections in the Certificate of Need?

2 A: Yes, I am.

3 Q: And I guess that's something that you do as
4 part of your -- a big part of your job?

5 A: Yes. I look at staffing everywhere.

6 Q: Okay. What about the facility itself; have you
7 actually been there?

8 A: Yes, I went with Sissy to look at the site just
9 to see what it looked like.

10 Q: Was that before the decision had been made that
11 you would go -- that you would put the machine
12 there? Did y'all go and look at it pretty
13 early?

14 A: No, I actually went after -- it was earlier
15 this year that I went to the site.

16 Q: But you've worked -- did you review the
17 schematic drawings and all of the building at
18 the time you looked at the CON?

19 A: I actually had not reviewed anything until
20 after the decision was made as far as the site
21 location. I've worked with the team at 21st
22 Century for many years. I trust them. They've
23 built other sites for us. I know what the sites
24 look like, and I have total confidence that it
25 would be a good site.

1 Q: Well, what was your reaction when you saw it
2 the first time?

3 A: When I first saw it, I told Sissy that there
4 was a lot of potential in that building and
5 that it looked very similar to a couple of
6 other locations that I have in my region.

7 Q: Okay. Do you have any doubt in your mind that
8 you can have an effective center at that square
9 footage?

10 A: I have no doubt in my mind. It's not the size
11 of the building that matters. It's the people
12 that is working inside that building and the
13 equipment. The equipment and the staff is the
14 most important to take care of the patient, and
15 it's the patient that needs taken care of.

16 Q: In regards to the size of the building, not
17 having the physics or dosimetrist in Conway,
18 but doing that at Myrtle Beach, how does that
19 impact the amount of space that you would need
20 in that building?

21 A: It impacts it greatly because there's a lot of
22 planning system for physics. They take up a
23 lot of space. You've got all of that located
24 centrally. We wouldn't need to duplicate that.
25 We do all of our physics and dosimetry planning

1 for eight offices in the Asheville area at one
2 location. Physics, they do travel to the
3 offices to do the QA because that has to be
4 done so patients can start, but they arrange
5 their schedules to do that so there's no delay
6 in anyone's treatment. And again, it's the
7 staff traveling, not the patient.

8 Q: And how does that work in Asheville to have all
9 the physics in a central location? Do you have
10 any problems with that?

11 A: We have no problems with that. Our physicians,
12 because of today's technology, my physicians
13 also travel, so we can look at -- a physician
14 can be in Asheville and they can have a patient
15 -- say like we have two doctors that go to the
16 Asheville office and the Park Ridge office, and
17 one of those physicians may be in Asheville and
18 his patient is in Park Ridge. They can
19 actually pull that patient's plan up in
20 Asheville, look at it on the computer screen,
21 make adjustments as we do the IGRT if there's
22 anything that needs to change in that
23 treatment, and they can do it remotely. They
24 do not have to be onsite to do that, so.

25 Q: Let's assume for a second in my question that

1 Grand Strand has a machine at their facility.

2 If Grand Strand had a machine there and the
3 machine was down for more than say two days,
4 could Grand Strand transfer that patient to
5 CRCC to be treated?

6 A: They could refer that patient to our radiation
7 oncologist, and we would be happy to take care
8 of that patient for them. It wouldn't be an
9 easy transfer though because the machines are
10 not calibrated the same. The patient would
11 have to have a repeat CT scan for planning. A
12 new plan would have to be made before that
13 patient could start treatment on our machine.
14 And it would be a different physician.

15 Q: Why would it be a different physician?

16 A: Because if -- I'm sure the physician that's on
17 at Grand Strand would not be our radiation
18 oncologist, so they're not under our
19 malpractice or anything at our office. They
20 would not be able to treat at our office.

21 Q: And the physicians at 21st Century are employed
22 -- at CRCC are employed by 21st Century, right?

23 A: Correct.

24 Q: And if a physician was at Grand Strand, if they
25 were employed by Grand Strand, you typically

1 wouldn't see ---

2 A: Correct, you wouldn't cross cover like that.

3 Q: Okay. Now, what if the machine at Conway, this
4 machine in Conway, what if that machine went
5 down for say more than two days?

6 A: If the machine in Conway went down for more
7 than two days, we would re-plan the patient
8 very effectively because we would not have to
9 have a repeat CT, the CT is already calibrated
10 to our machines. The patient would just be
11 transferred to another machine and would be
12 treated in Myrtle Beach no extra charge to the
13 patient and no time delay.

14 Q: Same physician?

15 A: Same physician.

16 Q: Okay. Would there be an extra charge to the
17 patient if Grand Strand referred the patient to
18 CRCC?

19 A: Yes, we would have to charge for the new
20 treatment plan.

21 Q: All right. Now, does CRCC treat all patients
22 regardless of their ability to pay?

23 A: Yes, we do. It doesn't matter if a patient can
24 pay or not. We treat everybody -- the indigent
25 patients to get treated. And that's one reason

1 that I really enjoy working with 21C. We don't
2 turn anyone away.

3 MR. LONG: May I have one moment, Your Honor.

4 (Pause)

5 MR. LONG: A few more questions, Your Honor.

6 THE COURT: Okay.

7 Q: You've got a number of different centers that
8 are under your supervision, okay. Did you have
9 a similar situation in Greenville, North
10 Carolina, that you had here in Myrtle Beach,
11 South Carolina?

12 A: Yes, when we took over Greenville, North
13 Carolina, they were treating 23, 25 patients a
14 day. We acquired that center, upgraded one of
15 the machines. And there was a physician there,
16 a radiation oncologist that wasn't getting
17 along in the community. He also retired, but
18 he did not retire until a year after we
19 acquired the center. But once he retired, our
20 numbers picked up and we've been treating in
21 the upper 50s, low 60s since then.

22 Q: So those changes then -- you've seen how
23 changes in physicians being in the community
24 can affect referral patterns?

25 A: Yes, it can.

1 Q: In other locations?

2 A: Yes.

3 Q: Was there a situation in Asheville, North
4 Carolina, that happened at one of your centers
5 that was kind of unusual?

6 A: In Asheville, North Carolina, our main home
7 office on Biltmore Avenue two years ago was
8 closed due to arson. Someone set a fire on the
9 fifth floor of that building. There was a
10 firemen killed, and because of that, there was
11 a long investigation. So the water damage
12 caused mold; the center had to close. That
13 fire happened on a Thursday. That was our main
14 center, our two machines. Our entire team from
15 the corporate office, our physics team, our IT,
16 everyone came to Asheville. They arrived on
17 Friday, re-planned everybody's treatment. I
18 think we had like 60 patients under treatment
19 at that time. Everybody was re-planned and was
20 under treatment again at one of our other
21 satellite offices on that Monday morning. So
22 depending on where the patient lived, they
23 either went to the 15 minutes east of Asheville
24 to our Park Ridge location or 30 minutes the
25 other direction to our Marion location for

1 treatment.

2 Q: How were you able to do that?

3 A: Because of the support of the corporate office.

4 They had the entire IT department and our
5 entire physics team, including Dr. Galmarini,
6 who's our head physicist, he was onsite helping
7 us, and he flew in on that Friday. And these
8 are people that are, you know, we have over 100
9 offices and they heard that we had this need
10 and they arrived the next day.

11 Q: There's been testimony about the drive time
12 between Conway and Myrtle Beach. You go to
13 Myrtle Beach regularly, right? You said you
14 lived there?

15 A: I do. And I kept hearing during the testimony
16 this week that it was a ten-minute drive time
17 from Conway to Myrtle Beach, and I've never
18 been able to make it in ten minutes. So I went
19 back to the hotel and I put in Conway, South
20 Carolina, I just put in Conway, South Carolina,
21 and then I put our office address. And
22 according to MapQuest, it is 17 miles and it's
23 26 minutes one way. So that's significant for
24 the patient, I think. That's almost an hour a
25 day travel time for them.

1 Q: Do you think ten minutes is significant to the
2 patient?

3 A: I think ten minutes is significant. That's 20
4 minutes a day, that's over what, it's over an
5 hour, two hours a week. That's significant.

6 MR. LONG: No further questions, Your Honor.

7 MS. MAYNOR - CROSS-EXAMINATION BY MR. THOMAS:

8 Q: Ms. Maynor, nobody in this trial has said
9 anything that it only takes ten minutes to get
10 to Conway, from Conway to Myrtle Beach, have
11 they? I don't think that's been anybody's
12 testimony, has it?

13 A: It's been on the files. I kept hearing
14 replies, and I'm not sure if it was the
15 witnesses or the attorneys that was saying ten
16 minutes, but I have heard ten minutes
17 throughout the trial.

18 Q: Well, the ten minutes, Ms. Maynor, is what your
19 expert came up with in terms of the drive time
20 savings.

21 A: Okay.

22 Q: As a result of his travel time study, correct?
23 Because I'm going to ask you, are you disputing
24 your expert health planner's drive time study?

25 A: I'm not disputing anyone. I'm just stating

1 what I know and what I looked up.

2 Q: Okay. Ms. Maynor, how many patients are y'all
3 treating today?

4 A: We treated 74 yesterday.

5 Q: Okay. Are you saying there's no longer a need
6 for a fourth linear accelerator in the Horry
7 County market and you guys are ready to
8 withdraw that application?

9 A: No, I'm not saying that.

10 Q: Okay. So you still think there's a need for at
11 least a fourth, right?

12 A: I think there's a need for the fourth.

13 Q: Okay. And you don't know what you're going to
14 be doing in 2017, do you?

15 A: I don't think anyone knows that.

16 Q: Well, some people have made some estimates and
17 gotten paid a lot of money to do that, haven't
18 they?

19 A: They have, but I'm not qualified to say what
20 those estimates were.

21 Q: Okay. Now, when I deposed you, you had never
22 seen the Grand Strand CON application, had you?

23 A: No, I haven't, and I still have not reviewed
24 it.

25 Q: And you had no criticisms of it because you

1 couldn't -- you hadn't seen it, right?

2 A: Correct.

3 Q: And the only input you had on the CRCC CON
4 application was staffing, right?

5 A: Correct.

6 Q: Okay. Now, Mr. Long asked you, I think he
7 mentioned something about the volumes were
8 declining or leveling off at CRCC from 2012, or
9 from 2011 because they were 25,700 and change,
10 right?

11 A: Yes.

12 Q: That's when y'all were the largest volume
13 operator in the state of South Carolina, right?

14 A: Correct.

15 Q: Okay. And then it went down a little bit in
16 2012, right?

17 A: Correct.

18 Q: And then you're saying now, even though I think
19 Grand Strand disagrees with this, but you're
20 saying now that it's even down from last year,
21 correct?

22 A: Correct.

23 Q: And you think that was -- you think that was
24 due to maybe some PSA guidelines or something
25 like that?

1 A: Correct.

2 Q: Okay. Well, isn't the real reason that the
3 urology consults are down so much because a
4 national spotlight was put on them by Bloomberg
5 News for the world to see and that -- and that
6 management told your urologists to cool it to
7 avoid an investigation by the government?

8 A: No, I don't think that's the case at all. And
9 I also agree with what Dr. Francke said, that
10 that report was based on Urorad where the
11 urologist was actually telling the radiation
12 oncologists to order radiation. I think in our
13 practice it's very unique, the radiation
14 oncologist has the autonomy to order what is
15 needed for the patient. The urologist may
16 refer the patient, but the radiation oncologist
17 does not have to treat that patient. And I can
18 tell you, we only treat 75 to 80 percent of the
19 prostate patients that are sent to us. We
20 don't treat all of them.

21 Q: Ms. Maynor, what happened at CRCC, okay, is
22 exactly what happens at every single center
23 where there is a financial incentive with the
24 urologists, isn't it? Isn't that what -- I
25 mean all the studies say what happened at CRCC

1 is what's going to happen when there's a
2 financial relationship, right?

3 A: I can't agree with you.

4 MR. LONG: Your Honor, I mean, I have to object. I
5 mean there's no evidence to that. Plus he's --

6 -

7 MR. THOMAS: Oh, there is evidence. The GA ---

8 THE COURT: Well, let him finish his objection.

9 MR. THOMAS: All right.

10 THE COURT: Or were you through?

11 MR. LONG: She's not familiar with any evidence.

12 That's the problem, he can't lay the foundation
13 with the witness.

14 MR. THOMAS: She just started talking about Urorad
15 and the study, Your Honor. She knows more
16 about it than I do. She's also ---

17 THE COURT: I don't know ---

18 MR. THOMAS: She's also a regional administrator.

19 THE COURT: Well, there's no foundation for that
20 when you say she knows more about it than you
21 do.

22 MR. THOMAS: She just started talking about the
23 Urorad study.

24 THE COURT: Well, I know she started talking about
25 it.

1 Q: You're familiar with the Bloomberg News
2 article, right?

3 A: I never saw that article until you showed it to
4 me during deposition. I did not go back and
5 review it after you showed to me. And what I
6 know about Urorad is what Dr. Francke was
7 saying in his testimony today, and I'm just
8 saying I agree with what he said.

9 Q: Okay.

10 A: It is very different than our organization.

11 Q: Well, so you're not familiar with the General
12 Accounting Office of the United States
13 government and the study that just came out in
14 July of '13? In July of '13?

15 A: No, I'm not.

16 Q: No? That's not something you would read as
17 part of your oversight of a region of a
18 national linear accelerator company?

19 A: No. I think I said earlier, I concentrate more
20 making sure the patients are taken care of when
21 they come into our centers.

22 Q: Okay. Well, let me see if I can get you to
23 admit some things. You're the regional
24 director of operations for the Southeast Region
25 for 21st Oncology, right?

1 A: Yes, I am.

2 Q: Okay. We can agree to that. And so, in that
3 capacity, you're required to know something
4 about the operations of some 31 multi-specialty
5 centers, correct?

6 A: I am available to those centers to make sure
7 that they get all the support that they need
8 from our corporate office.

9 Q: Okay.

10 A: But as far as telling the multi-specialty
11 centers how to run and operate, I have nothing
12 to do that -- to do with that. They are on
13 their own. They have their own practice
14 administrators. Those people run those
15 practices.

16 Q: Well, why did you put it in your resume if you
17 really don't have to -- have anything to do
18 with it? You say that you're in charge of ---

19 A: I am their support person.

20 Q: Okay. That's not what your resume says, right?

21 A: Can I see it?

22 Q: Yeah.

23 MR. THOMAS: Put up Respondent's 18 for me. Blow up
24 just under experience right here.

25 Q: This says Regional Director of Operations,

1 Southeast Region. Currently 31 multi-specialty
2 centers and 17 radiation oncology centers,
3 correct?

4 A: Correct.

5 Q: Okay. So that led me to believe that you're
6 the regional person for those multi-specialty
7 centers; is that ---

8 A: I am the regional person. I support them.

9 Q: Okay. Now, the 31 multi ---

10 A: In their operations.

11 Q: Is there a multi-specialty center in Myrtle
12 Beach?

13 A: There is one. There is a large group of
14 urologists in Myrtle Beach.

15 Q: Okay. That's a single specialty center, right?

16 A: It is a single specialty, correct.

17 Q: Okay. But it could become a multi-specialty
18 center if y'all recruit surgeons or medical
19 oncologists, correct?

20 A: Yes, it can.

21 Q: Okay. And the multi-specialty centers in the
22 21st Century model, those are the physician
23 practices that refer to the radiation therapy
24 centers, correct?

25 A: They can. They're not required to do that.

1 But yes, they can.

2 Q: Okay. But that's actually a business strategy
3 of 21st Century, right? It's in the 10K. We
4 can get that out if we need to.

5 A: Yes, we hire multi-specialty practices. A lot
6 of multi-specialty practices cannot survive on
7 their own. They need the buying power of a
8 larger company to be able to buy their medical
9 supplies. We can get medical supplies 30
10 percent cheaper than private practices that's
11 trying to do it by themselves.

12 Q: But you would agree with me that the primary
13 reason you associate a multi-specialty center
14 group is to get the referrals to the radiation
15 therapy centers, right?

16 A: Yes, we want to support our practice.

17 Q: Okay. Now, another one of your jobs, I think
18 it's right here, it's the third bullet point
19 right here, is try to achieve same store
20 growth, correct?

21 A: Correct.

22 Q: All right. And you did that at Myrtle Beach
23 pretty quickly, didn't you?

24 A: Unfortunately there was a lot of patients that
25 had to come for treatment.

1 Q: Yeah, so you did 65 percent same store growth
2 in two years, right?

3 A: Yes.

4 Q: And you claimed -- the claim was that was done
5 by improving customer service, educating
6 physicians and educating the public, correct?

7 A: Yes.

8 Q: Okay. And you set up health fairs, and
9 essentially, you've had the liaisons go out to
10 the physician office's, correct ---

11 A: Correct.

12 Q: --- and let them know what y'all do; is that
13 right?

14 A: That's correct.

15 Q: Okay. And you would agree with me, Ms. Maynor,
16 that in terms of marketing efforts by 21st
17 Century Oncology, when 21st Century Oncology
18 goes in a competitive market, is there anything
19 that it would do that they wouldn't do if they
20 were in an uncompetitive market?

21 A: No.

22 Q: Okay. And you would agree with me that the
23 centers that you treat in North Carolina, I
24 believe you admitted in your deposition that
25 they're all financially successful, correct?

1 A: Yes, they are.

2 Q: Because you do a good job, don't you?

3 A: I try.

4 Q: Okay. And you would agree with me that some of
5 the practices that you manage, many of them are
6 in the same markets with a hospital operator,
7 correct? When I say a hospital operator, a
8 hospital that operates a radiation therapy
9 center, correct?

10 A: Correct.

11 Q: And 21st Century has, I think you said two
12 centers in Greenville, North Carolina, right?

13 A: We have two machines in Greenville and we have
14 the office at Kinston that serves patients.

15 Q: All right. And in Greenville there's a pretty
16 large hospital system -- this is Greenville,
17 North Carolina. There's a large hospital
18 center called ECU, right? ECU and Pitt?

19 A: It's ECU and Pitt. They have an offsite cancer
20 center.

21 Q: But y'all compete against them, right?

22 A: Yes.

23 Q: And you do so successfully, don't you?

24 A: Correct.

25 Q: Okay. And then in Alabama, you manage some

1 radiation therapy centers that compete with a
2 hospital-based radiation therapy center I
3 believe in Dothan, Alabama; is that right?

4 A: That's correct.

5 Q: Okay. And in Dothan, Alabama, you don't have
6 a supporting multi-specialty practice there,
7 right?

8 A: Correct.

9 Q: Okay. And that center is financially
10 successful, right?

11 A: Yes.

12 Q: And you agree with me that even in this case,
13 CRCC competes with Georgetown to some degree,
14 right?

15 A: Correct.

16 Q: Okay. And Georgetown is a single unit
17 operator, right?

18 A: Yes.

19 Q: Now currently they're 40 miles away, right?
20 From CRCC, maybe give or take?

21 A: Yes.

22 Q: But you still consider that competition, right?

23 A: Yes.

24 Q: I think you told me in your deposition you
25 consider McLeod competition even though they

1 were 80 miles away, right?

2 A: Yes, Georgetown is in the same service area, so

3 it would definitely be competition.

4 Q: Same state-defined service area, right?

5 A: Yes.

6 Q: And you would agree with me, Ms. Maynor, that

7 as part of your job, you do have to review a

8 lot of reports, operations reports, correct?

9 A: Correct.

10 Q: And those reports can show the number of

11 treatments per facility by month, correct?

12 A: Correct.

13 Q: And that's so you can keep up with the

14 productivity at the centers, because that is

15 part of your job, right?

16 A: That is correct. I break it down per day

17 though because it makes more sense to me per

18 day than it does per month,

19 Q: I mean, by the end of the day, at the end of

20 the day, 21st Century is a for profit business

21 and it's a business to make money, correct?

22 A: Correct. As I think HCA is also.

23 Q: I don't think there's been anybody who said

24 different. Now, you would agree with me, Ms.

25 Maynor, that CRCC, in the service area at

1 issue, which you know is Georgetown and Horry
2 and Williamsburg County, correct?

3 A: Correct.

4 Q: Has a lock on the prostate cancer patients and
5 the treatment, correct?

6 A: I'm sorry, can you repeat that?

7 Q: Yeah. Would you agree with me that CRCC has a
8 lock on prostate cancer and prostate cancer
9 treatment?

10 A: I agree that we treat the majority of the
11 prostate patients and prostate treatment
12 patients. We do not treat all of them. We do
13 want the ones that live closer to Georgetown do
14 go to Georgetown because the patient needs to
15 great treated where it's most convenient for
16 the patient.

17 Q: Well, you would agree -- have you seen Mr.
18 Tolbert's, the health planner for CRCC, have
19 you seen his referral analysis that he did
20 recently?

21 A: No, I was not included on that plan and have
22 not reviewed it.

23 Q: So you didn't see that he refer -- that he
24 assumed 100 percent referrals from Atlantic
25 Urology Clinics to CRCC then, right?

1 A: No, I was not included.

2 Q: Now, when I deposed you back in June, you
3 didn't even know that Atlantic Urology Clinics
4 actually owned 100 percent of CRCC, did you?

5 A: I believe 21st Century employs the physicians.
6 I did not know how the corporations were set
7 up, no. But that doesn't really matter to me
8 how the corporations are set up. I'm more
9 concerned with the care that the patient is
10 getting.

11 Q: Fair enough. Now, when I deposed you in June,
12 I did ask you how utilization was doing over
13 2012, and you did say treatments were down,
14 right?

15 A: Yes.

16 Q: Okay. But then you also said, I believe, that
17 y'all were operating at 15 hours a day, right?

18 A: Yes, we were. There was a week or two in the
19 schedule, and I can't remember for what the
20 reason was, but the numbers did go back up
21 about 102. I think we had a lot of metastatic
22 cases, something come in. They were getting
23 fewer treatments, but it did cause the numbers
24 to go up for a couple of weeks.

25 Q: But that was just a flash in the pan?

1 A: It was just a flash.

2 Q: Okay. And you would agree with me, I know
3 there's been a lot of back and forth, but I'm
4 going to ask you this question as well, that
5 prostate cancer patients average 40 to 45
6 treatments when they undergo radiation therapy
7 cancer treatment, correct?

8 A: Yes.

9 Q: That's been your experience, right?

10 A: That has been my experience.

11 Q: And you would agree with me that none of the
12 radiation oncologists at CRCC have ever
13 complained to you about the quality of the
14 utilization of their Clinac iX, right?

15 A: No, they have not.

16 Q: And just so we get this clear for the record,
17 in terms of how many days a year your clinics
18 are open, is it 255?

19 A: Yes.

20 Q: And how many of those are operating more than
21 12 hours a day?

22 A: I'm sorry, just in Myrtle Beach or everywhere?

23 Q: No, just kind of in your region, generally.

24 A: It varies because of units based on the patient
25 need. All of our offices are open eight hours

1 a day, but we will flex up depending on
2 patients.

3 Q: So do you have a -- you have a PRN staff, is
4 that -- that allows you to flex up like that?

5 A: Not everywhere, no.

6 Q: But do you have one in Myrtle Beach ---

7 A: We will pay for time ---

8 Q: Do you have one at Myrtle Beach, a PRN staff
9 that allows you to flex up and down?

10 A: I have because the high numbers that we
11 received when we initially purchased CRCC, we
12 employed additional therapists so that we could
13 run two shifts of employees.

14 Q: Well, what do you assume that your various
15 units can do per hour? Like a Varian Clinac
16 iX, how many -- how many treatments can that
17 unit do per hour?

18 A: Two and a half to four patients.

19 Q: Okay. What about a Tomo?

20 A: A Tomo, three. At least three patients an
21 hour.

22 Q: And what about TrueBeam; do you have that
23 number down yet?

24 A: I don't. I don't have a TrueBeam in any of my
25 area yet.

1 Q: Okay. But is the idea to replace a lot of the
2 existing equipment that y'all do have in your
3 area with TrueBeams and upgrade that equipment?

4 A: I don't know the answer to that. Dr.
5 Galmarini, we would not change something that
6 we just put in a couple years ago.

7 Q: Okay. Now, when I did depose you back in June,
8 I asked you if you were kind of excited about
9 that same store growth I believe we were
10 talking about earlier, and you said -- you said
11 you weren't excited, but you were pleased by
12 it, correct, the same store growth at CRCC-
13 Myrtle Beach?

14 A: Yeah, I think I said I was pleased that
15 patients that needed treatment were getting the
16 treatment that they needed. I'm never pleased
17 that a cancer patient has to come in for a
18 consult.

19 Q: Well, sure. But would you agree with me you
20 were under the impression that maybe all these
21 patients were being sent out -- sent out
22 somewhere, right?

23 A: Correct.

24 Q: Okay. Is that still your understanding today
25 that wherever those patients were, they were

1 going for radiation therapy center outside the
2 area?

3 A: Yes, that's -- I don't know what else could
4 have been happening.

5 Q: Could they maybe have been getting
6 prostatectomies instead of treatment?

7 A: It's possible. Maybe they weren't giving all
8 their treatment choices. Anything is possible,
9 but I don't know the answer to that.

10 Q: And if they weren't given all their treatment
11 choices then that would have been the fault of
12 the urologists because those were the main
13 patients that you saw coming in from 2009 to
14 2010, correct?

15 A: Correct.

16 Q: Okay. I'd like you to -- I might not have to
17 pull up this exhibit, but you would agree with
18 me, and if you don't know, we can look at it,
19 but the Varian Clinac iX is the highest
20 utilized linear accelerator, at least through
21 2012, at CRCC-Myrtle Beach, right?

22 A: I don't know the answer for positive, but I
23 would say that's probably the case because it's
24 the newer equipment and new equipment usually
25 delivers a faster dosage, which would make the

1 throughput faster.

2 Q: Right. And so if you do more throughput, that
3 means more revenue, right?

4 A: It means more patients can be treated. The
5 revenue is going to be same based on
6 treatments. You don't get paid based on the
7 machine, you get paid based on treatment type.
8 So an IMRT patient on a Tomo unit or an IMRT
9 patient on a Clinac 6 or the 2300 are all going
10 to be the same payment.

11 Q: But if you can do more patients on one over the
12 other, that increases your productivity, right?

13 A: It increases your productivity, which is based
14 on the patients. So you'd have to get more
15 patients in to increase that number. As we've
16 said, our patient numbers are decreasing ---

17 Q: Well, in 2012, you did 9,137 treatments on that
18 Clinac iX, didn't you?

19 A: I don't know the number off the top of my head.

20 MR. THOMAS: Pull up Respondent's 22.

21 Q: Let's see if my memory is any good. I was
22 close. 2012, look at the bottom of the page
23 there, the linac one, 23 ix, that's the Clinac
24 iX, correct?

25 A: Yes. 9,437.

1 Q: Okay. So that was the top operator at CRCC in
2 2012, right?

3 A: Correct.

4 Q: And you would agree with me that, as far as you
5 know, that unit's never been down more than a
6 day, has it? It's actually never been down a
7 full day, correct? That's what you testified
8 to back in June.

9 A: As far as I know, it has not.

10 Q: Okay. Now, if that's doing nine -- if that did
11 9,437 treatments in 2012, you would agree with
12 me that that's 37 treatments per day if you're
13 operating 12 hours a day at three treatments
14 per hour, right? That's about how that math
15 works out? Do 9,437 divided by 255, and tell
16 us what you get.

17 A: It's saying 37 treatments a day.

18 Q: Okay. And so three treatments an hour, that
19 would be a 12 hour operating day, right?

20 A: Yes.

21 Q: Okay. Now, I think there's been a lot of back
22 and forth about the size of the facility, okay?
23 CRCC-Conway is one of the smaller facilities in
24 the company, correct?

25 A: Correct.

1 Q: All right. And you would agree with me that
2 the one that y'all building at CRCC-Murrells
3 Inlet is about double the size; is that fair?

4 A: That's correct.

5 Q: And I think you testified that one reason why
6 that facility is going to be a lot larger is
7 that that means that CRCC doesn't have to come
8 back and expand the site if it adds a vault,
9 right?

10 A: Actually, I didn't say that. I said I didn't
11 know what the architect's reason was for
12 expanding the center, and you offered that as
13 a reason, said could that be a possibility, and
14 I agreed with you.

15 Q: Okay. All right. Fair enough. Now, just to
16 make sure, you've had no discussions with Dr.
17 Holt or any medical oncologists at Coastal
18 Cancer Center regarding what they would do in
19 terms of referrals if Grand Strand were
20 approved for a linear accelerator, correct?

21 A: I have not had any conversations with Dr. Holt.

22 Q: Or anybody at Coastal Cancer Center, right?

23 A: No, I haven't talked to anyone at Coastal.

24 Q: And you actually haven't talked to -- and maybe
25 the exception of the urologists, any referral

1 source that may be a potential referral source
2 to Coastal ---

3 A: I haven't.

4 Q: --- I mean CRCC, right?

5 A: I haven't. That is not part of my job. I only
6 go and troubleshoot, so if I had known there
7 was an issue with Dr. Holt, like I have
8 discovered during this hearing this week, I
9 would have talked to Dr. Holt. But I was not
10 aware of that, so I have not.

11 Q: So let me just get this straight for the
12 record. You have not been aware of an -- that
13 there's been some issue with Dr. Holt since the
14 CON application has been filed, correct?

15 A: No, I have not.

16 Q: So it's probably not much of an issue if you
17 hadn't heard about it in your capacity as the
18 senior person for this region, correct?

19 A: I think as everyone heard in the trial, Sissy
20 was even shocked when he signed the letter of
21 support for Grand Strand and he did not sign a
22 letter for us. And I think that implies that
23 he would refer to Grand Strand and not us.

24 Q: But do you think maybe one reason for that was
25 that he wants a hospital-based linear

1 accelerator because there are already
2 freestanding linear accelerators, right? He
3 doesn't support that concept because they
4 already exist, right?

5 A: Maybe there needs to be some education on the
6 inpatient. Mission Hospital is a large
7 tertiary hospital in North Carolina that
8 services several counties. It's huge. They're
9 affiliated with Chapel Hill. They actually
10 moved their inpatient machines to an outpatient
11 site, and they now have to transport all of the
12 inpatients by ambulance to that radiation
13 center for treatment. So if an inpatient
14 facility at a large heart center like the one
15 at Mission saw it feasible to move their
16 patients out to an outpatient site, I don't
17 think having an inpatient facility is crucial.

18 Q: You don't think there's any value to an
19 inpatient or an in hospital linear accelerator
20 facility, that they all should be freestanding;
21 is that your testimony today?

22 A: I think that there is benefit if it's a
23 pediatric center, as Dr. Francke said, because
24 pediatric patients have to have anesthesia. I
25 think if it's a patient that's on a vent, which

1 in my 30 years of experience as a nurse, we
2 have treated one at the cancer center that was
3 adjacent to the hospital that was on a vent.

4 Q: Did you hear Dr. Collins' testimony? You were
5 here that day. He's done 20 in the last five
6 years, correct?

7 A: Yes. And ---

8 Q: That's what he said?

9 A: That's what he said.

10 Q: Okay.

11 MR. THOMAS: Put up Joint 2, page 91 for me.

12 Q: This is the Dr. Holt letter that I think
13 everybody is talking about, right?

14 A: Yes.

15 Q: All right.

16 THE COURT: What's that number again?

17 MR. THOMAS: 891, Your Honor, Joint 2.

18 Q: And let me ask you something. Do you disagree
19 with Dr. Holt's statement here, and I'm going
20 to read it. It says, "Moreover, for those
21 cancer patients who are hospitalized but who
22 also require radiation therapy, a hospital-
23 based program would be of tremendous benefit to
24 the patient and their family members." Do you
25 disagree with a medical oncologist who treats

1 thousands of cancer patients over his career
2 when he says that?

3 A: I have a different opinion than Dr. Holt's.

4 Q: Okay. But you're not a doctor, are you?

5 A: No, I'm not a doctor.

6 Q: Dr. Holt didn't prevent -- I mean, it sounds
7 like what everybody has been talking about is
8 that Dr. Holt is somewhat of the godfather of
9 medical oncology in Horry County, but he never
10 prevented his partners from writing a letter of
11 support for CRCC-Conway, correct?

12 A: Correct.

13 Q: You would agree with me that CRCC can
14 advertise, like they do, like 21st Century does
15 in a lot of markets on print, TV, billboards,
16 radio, all types of media, correct?

17 A: Correct.

18 Q: And they can get the message out that they're
19 still the best in town, correct?

20 A: Correct.

21 Q: When was it that you recall finding out -- was
22 it about August 2010 when you recall
23 communicating with Mr. Lewis about putting a
24 CON application in for CRCC-Conway; does that
25 sound about right?

1 A: I don't remember the exact dates. Part of my
2 job is to look out for the company, so if
3 there's something coming in that could be
4 detrimental to our referrals, then I would
5 report it to corporate. So when I saw the
6 notice, I sent the information in.

7 Q: Well, you didn't see the notice yet, I think --
8 didn't you tell him that the competition was
9 starting to ask questions and that you suspect
10 that they would apply soon; something along
11 those lines?

12 A: I would have communicated that had I heard it,
13 yes.

14 MR. THOMAS: Put up Petitioner's 46 for me, please.

15 Q: Ms. Maynor, this is an email and hopefully I
16 can get it blow up for you here. Some parts of
17 it -- I want to go to the part that you're on.
18 Why don't we get you to pull it out, that right
19 there. I'll get you a notebook for you. Oh,
20 it'll be in here.

21 A: What page?

22 Q: It'll be tab, should be tab 46. And when
23 you're there, if you'd go to CRCC 408. I'm
24 sorry, 409. The email from you to Eduardo
25 Fernandez, Mr. Lewis, Mr. Travis, Dr. Francke,

1 Dr. Dosoretz, correct?

2 A: Correct.

3 Q: Okay. And so about September 30th, is that
4 when you found out that Georgetown was going to
5 move one of their linear -- well, move their
6 linear accelerator from Georgetown to Murrells
7 Inlet?

8 A: Yes.

9 Q: Okay. And then Mr. Travis asked you, are you
10 sure they're not looking to add a new one,
11 correct?

12 A: Correct.

13 Q: All right. And after this point, this is kind
14 of when the move was to get an application in
15 for a relocation of one of the units from CRCC-
16 Myrtle Beach down to Murrells Inlet, correct?
17 Is that a fair statement?

18 A: That's a fair statement. But I would also like
19 to add to that that I knew that a lot of our
20 patients came from the Murrells Inlet area
21 because we had looked at the zip codes to see
22 where they were coming from. I also spoke to
23 the local employees at CRCC, to Sissy to the
24 doctors there, and I was told, you know, if
25 Georgetown moves their center to Murrells

1 Inlet, then those patients that live in
2 Williamsburg County, they're going to have even
3 further to travel than they do currently to
4 Georgetown for treatment. So if Georgetown was
5 allowed to move that vault that's in Georgetown
6 and come to Murrells Inlet, those patients are
7 going to have to travel a great distance. I
8 think it's 20 -- I didn't know at the time of
9 the deposition, but I have found out it's about
10 a 26, 30 minute drive into Murrells Inlet from
11 Georgetown. Then you've got the patients that
12 live past Georgetown from Williamsburg County
13 that are currently getting treated in
14 Georgetown that would no longer have anywhere
15 to go.

16 Q: How well do you know Williamsburg County?

17 A: I don't ---

18 Q: Have you been there once?

19 A: I don't know the county; I don't know the
20 population. I just know there are patients.

21 Q: Can you name one town in Williamsburg County?

22 A: I can't. But I'm sure that ---

23 Q: Okay. Because most people in Williamsburg
24 County live in Kingstree, right?

25 A: I don't know.

1 Q: Okay. You think Florence is closer to
2 Kingstree, or you don't know?

3 A: I don't know. I don't know the answer to that.
4 I just ---

5 Q: Let's talk about Murrells Inlet for a second.
6 Because I think you just said you wanted to
7 move down there, and that one of the reasons
8 CRCC wanted to move down there was because a
9 lot of patients that came from Murrells Inlet.
10 Go to Petitioner's 53 for me. And I want you
11 to go to CRCC 17 and tab 53 there, if you
12 would. Let me know when you get there.

13 A: I'm there.

14 Q: Okay. And so in this email, there's an email
15 from Patricia Price, this is Ms. Price right
16 here in the back, to you and cc'ing Mr. Lewis
17 and Rosa, it says, "Rosa, could you please
18 supply the information the CEO at Grand Strand
19 is requesting." And you say -- what do you
20 say?

21 A: I say there's ten percent, but I think that
22 number's wrong.

23 Q: "It is ten percent of our patients that are
24 coming from Murrells Inlet and I've asked Rich
25 for the address." So on this date at least, on

1 November 16th, 2010, you were under the
2 impression that ten percent of the patients
3 were coming from Murrells Inlet, correct?

4 A: That's what this email says.

5 Q: Okay. And that was enough to basically say
6 let's go down there and meet Georgetown head-
7 on, spend eight million dollars on a center so
8 they don't come up here and take ten percent of
9 our patients, right?

10 A: That's what this says.

11 Q: Go to Petitioner's 63 for me. This is a
12 February 16th, 2011, email, right? And if you
13 turn the page to CRCC 623, when you get to
14 Petitioner's 63.

15 A: Okay.

16 Q: All right. And I believe this one, this is ---

17 A: This is letting them know that Loris/McLeod had
18 applied for a CON.

19 Q: Thank you. And it was Mr. Travis you're
20 looking at, it's very small type, I apologize.
21 It says, Doug/Sam, and that's Doug Bryant and
22 Sam Tolbert, it seems to me that we need to
23 file for Conway CON ASAP, right?

24 A: Correct.

25 Q: So February 16th, that's kind of when the --

1 that was kind of the -- that's what started the
2 application process for Mr. Tolbert, right?
3 And he was able to put together an application
4 very fast.

5 A: I can't say that this is what started that
6 because I don't do the CON applications and I'm
7 not the person that would decide when they are
8 done or started. And I think as Rich
9 testified, he works with the business
10 development team and they had many
11 conversations about where we were going to go.

12 Q: Well, just look at the email right above that,
13 does Mr. Tolbert say, I will need to really
14 pull some magic with my consulting team to get
15 the second one done in the next three weeks if
16 that's what needs to be done?

17 A: That's what the email says. I'm not sure what
18 the interpretation of that would be. You would
19 have to ask Mr. Tolbert what he meant by that.

20 Q: Okay. Thank you. Go to Petitioner's 48 for me
21 please. Actually, I think we already kind of
22 saw this email. That's all right, we don't
23 need to do that one. Petitioner's 60, if you
24 would. And let me know when you get there.

25 A: I'm there. Excuse me, what page.

1 Q: All right. I think it's a one page email.

2 A: Okay.

3 Q: Tolbert 157, I believe is -- and it's from
4 Norton Travis and you're copied on here. And
5 it says, "Jay, in addition to our Murrells
6 Inlet initiative, we are now addressing a
7 competitive CON application to the north from
8 Loris Hospital system. As a result, we may
9 need to file another relocation application to
10 site a linac in North Myrtle Beach in the
11 vicinity of Seacoast Hospital. Please
12 coordinate with Ros and see if we can get an
13 option done." So y'all have just filed a CON
14 application for a relocation to Murrells Inlet,
15 and then a CON application for a brand new CON
16 in Conway, and now you're saying well, gosh, we
17 need to go up to North Myrtle Beach, right?
18 Isn't that what your general counsel is telling
19 you to do?

20 A: Well, I think I told you in our deposition that
21 I did not see this email. I know I'm copied on
22 it, but I did not see it, did not know it
23 existed until you pointed it out in the
24 deposition, so I can't comment on this.

25 Q: No one ever tried to coordinate with you ---

1 A: No. I never talked ---

2 Q: --- about a North Myrtle Beach project?

3 A: --- to Jay about North Myrtle Beach.

4 Q: Have you ever had a conversation with anybody
5 about North Myrtle Beach?

6 A: We've had lots of talks about the different
7 areas, because one of my first comments to
8 Sissy when I was in the center is why did they
9 put three machines in one site instead of
10 moving them out to where the community was. So
11 we've talked about many options. I have not
12 specifically addressed this email.

13 Q: You would agree with me that in terms of the
14 prior ownership of CRCC, you have only heard
15 good things about them, correct?

16 A: Correct.

17 Q: And at least when I deposed you back in June,
18 just a few months ago, it seems like longer
19 than that, but you had no knowledge of the
20 reasons why the urologists had some kind of
21 feud going on with Dr. Bass, correct?

22 A: Correct. I knew there was an issue. I never
23 asked what that issue was because the doctor
24 had left, the issue was resolved, and I had no
25 need to know.

1 Q: And just with respect to -- I think Mr. Long
2 asked you a couple of follow-up questions
3 regarding the fire in Asheville.

4 A: Yes.

5 Q: Okay. Where y'all were able to kind of get
6 everything arranged and got the patients to
7 where they needed to go.

8 A: Yes.

9 Q: There was no sprinkler system in that building,
10 was there?

11 A: No, there wasn't.

12 Q: You would agree with me that -- well, let me
13 ask you this. Does CRCC ever take patients from
14 Georgetown Memorial Hospital, like the Francis
15 Ford Cancer Center when one of their sick
16 machines breaks down?

17 A: No, we do not.

18 Q: Okay. Ms. Maynor, thank you for your time. I
19 know it's never fun. Mr. Long may have some
20 additional follow-up questions for you.

21 MR. LONG: A couple, Your Honor, or just a few.

22 MS. MAYNOR - REDIRECT EXAMINATION BY MR. LONG:

23 Q: Ms. Maynor, if you could, Mr. Thomas asked you
24 some questions about the Clinac iX and he had
25 you do some math. I believe he -- based on the

1 2012 data, you did 37 patients per day on that
2 machine?

3 A: Yes.

4 Q: Do you recall that?

5 A: That's what the calculation came out to.

6 Q: And instead of dividing that number by three,
7 would you divide it by four? You testified
8 three and a half to four ---

9 A: I'm trying to remember the number.

10 Q: It's 37 divided by four, 37 patients a day
11 divided by four.

12 A: Nine and a half hours.

13 Q: Nine and a half hours?

14 A: Yes.

15 Q: Would that be more realistic number for a
16 Clinac iX to treat 37 patients in a day?

17 A: Yes.

18 Q: As far as the time?

19 A: Because the throughput is faster, so it would
20 be four per hour. Yes.

21 Q: Okay. You were here for Dr. Collins'
22 testimony?

23 A: Yes, I was.

24 Q: I think he testified there would be two to
25 three ventilator patients a year?

1 A: Correct.

2 Q: Does that sound right to you?

3 MR. THOMAS: Objection, Your Honor. I mean ---

4 MR. LONG: Well, he did the same thing, Your Honor.

5 MR. THOMAS: He's leading the witness though.

6 THE COURT: Well, you didn't object. Well, it's

7 called pitting the witnesses. Well, no ---

8 MR. THOMAS: No, that's not pitting.

9 THE COURT: Excuse me, that's not pitting. But I'm

10 not going -- well, I allow him -- go back. I'm

11 not sure if that is pitting or not. I'd have

12 to go back and read the case law, but the

13 bottom line is I'm going to sustain the

14 objection.

15 MR. LONG: Thank you.

16 THE COURT: His testimony speaks for itself.

17 MR. LONG: Okay.

18 Q: Well, let me ask this. Would you defer to the

19 testimony in the transcript as to what Dr.

20 Collins testified to about the ventilator

21 patients as opposed to what Mr. Thomas told you

22 his testimony was?

23 A: Yes.

24 Q: Would you be surprised if a center had very

25 many ventilator patient in any of the radiation

1 therapy?

2 A: I would be surprised. I worked in a radiation
3 therapy office, you know, with Saint Joseph's
4 Hospital System for a long time. We had one
5 case in 30 years. But Dr. Francke also
6 testified to the ventilator patients, and he
7 said that he could count in the 20 years that
8 he practiced only two patients.

9 Q: And there was an email that you were shown
10 where you referenced the Murrells Inlet being
11 where you got ten percent of patients, do you
12 recall that, just a minute ago?

13 A: Yes.

14 Q: Okay. When you sent that email, had you done
15 any calculations to determine that number?

16 A: I'm not sure where I got that number. I don't
17 know. I would have to look at that.

18 Q: I think that email was in November 2010. Do
19 you --

20 A: That would have been, we just acquired in
21 April, so I would have had to get the data from
22 the somewhere.

23 Q: Do you think the number is accurate?

24 A: No, I don't.

25 Q: You think it's higher or lower than ten

1 percent?

2 A: I think it's higher than ten percent.

3 Q: That's all I have, ma'am.

4 A: Thank you.

5 THE COURT: You may step down.

6 MS. MAYNOR: Thank you. And they didn't ask me,
7 this is my first time in a courtroom, so.

8 MR. LONG: Your Honor, we have a deposition that we
9 would put in our case that we worked together
10 on that I think we'll probably be ready to give
11 to Your Honor certainly by the close of
12 evidence of Mr. Jamie Thomas, who's an employee
13 of HCA. And we're going to give that to you in
14 a format where you can just read it.

15 THE COURT: All right.

16 MR. LONG: It won't have any objection. Anything
17 that's not been designated will be removed.
18 But I think we're doing the designations, so I
19 think that's completed as far as that goes.

20 MR. THOMAS: Right..

21 THE COURT: You're not going to put somebody up
22 there just to do Q and A? I'm just kidding.

23 MR. LONG: Thank you, Your Honor. We could, but
24 we'd probably rather not.

25 MR. THOMAS: We'd agree not to.

1 MR. LONG: So as far as where we are in the progress
2 of the case, Mr. Tolbert, as we have said, is
3 not available until tomorrow morning. He's our
4 next witness and our final witness, other than
5 this deposition we plan to -- so if it's okay
6 with Your Honor, I guess we will break until
7 nine a.m. tomorrow.

8 THE COURT: Yes, definitely okay. Thank y'all.

9 MR. LONG: Thank you, Your Honor. Your Honor, I do
10 want to clarify one thing on the record if I
11 could. Ms. Maynor and Ms. Price, are they
12 released from their testimony here, so they ---

13 THE COURT: Certainly.

14 MR. LONG: --- can go if they choose?

15 (There being nothing further, the hearing recessed
16 for the day at 3:17 p.m.)

17 DAY 7 - FRIDAY, SEPTEMBER 20, 2013:

18 THE COURT: All right. Ready when y'all are.

19 MR. LONG: Thank you, Your Honor.

20 MS. BIGGERS: Your Honor, before we get started, the
21 Department has submitted and marked Joint
22 Exhibit 1A. Joint Exhibit 1 is the CRCC
23 application file, and I realized there was a
24 separate volume of just the letters of support
25 that wasn't included in Joint 1, so we've

1 marked it as Joint 1A, and the parties have
2 consented to its admission.

3 MR. LONG: Yes, Your Honor, we did.

4 MR. THOMAS: Yes.

5 THE COURT: All right. It's admitted without even
6 being referred to.

7 MR. LONG: Your Honor, we call Sam Tolbert to the
8 stand.

9 SAMUEL H. TOLBERT, being duly sworn, testifies as
10 follows:

11 MR. TOLBERT - DIRECT EXAMINATION BY MR. LONG:.

12 Q: Can you state your full name, please?

13 A: My full name is Samuel Howard Tolbert.

14 Q: And Mr. Tolbert, where do you reside?

15 A: Greenwood, South Carolina. The address is 115
16 Parkwood Road.

17 Q: I guess you have two occupations now at the
18 moment, so ...

19 A: Yes, I -- well, for the last 13-14 years I
20 have.

21 Q: All right. Can you tell the Court what your
22 occupations are?

23 A: I'm a full-time professor at Lander University
24 in Greenwood, South Carolina. I also own and
25 operate a consulting firm called Strategic

1 Directions, Incorporated.

2 Q: All right. Before we get back to your current
3 occupations, can you give the Court your
4 educational background?

5 A: I hold a bachelors of science in industrial
6 management with Honors from Clemson University
7 and a masters of science in industrial
8 management from Georgia Institute of
9 Technology.

10 Q: And can you give the Court an overview of your
11 employment history prior to joining Lander?

12 A: Yes, when I finished my master's degree from
13 Georgia Tech, I was recruited to join the
14 administrative staff at Mayo Clinic in
15 Rochester, Minnesota. In fact, I was the
16 youngest administrator they had ever employed.
17 I was 22 years old and worked there for a
18 little under four years doing planning, and it
19 was called systems and procedures for the Mayo
20 Clinic. I left Minnesota and moved to Chicago
21 where I was a consultant with Carney Management
22 Consultants, also called AT Carney. It's an
23 international consulting firm, and I was in
24 their healthcare division. After I was there
25 a year or two, I was promoted to a manager

1 serving their hospital, primarily their
2 hospital clients throughout the United States
3 providing consulting services and managing
4 public consultants. After about three years of
5 traveling pretty much five days a week, I
6 decided to accept an opportunity to go to work
7 for one of the clients that I had brought to
8 the firm in Albuquerque, New Mexico. So I
9 worked as a corporate division director for
10 Presbyterian Health Services, which then owned
11 and operated 13 hospitals in New Mexico, and we
12 had one in Colorado, and I was in charge of
13 their consulting services for all of their
14 hospitals. I did that for, I think, about four
15 or five years, and I moved back East after my
16 first son was born to join a small consulting
17 firm in Atlanta, Georgia, called Medical
18 Management Associates where I provided,, along
19 with the other consultant, management
20 consultant services to physician practices in
21 the Atlanta area. I did that for about nine
22 months and didn't enjoy it. My partner and I,
23 we were born on the same day at Self Memorial
24 Hospital in Greenwood. It wasn't going to be
25 a long-term relationship, and I was offered the

1 opportunity to move back to Greenwood to my
2 home town to the hospital where I was born and
3 join the administrative staff there where I was
4 vice president and administrative director of
5 planning and marketing for just under 15 years.

6 Q: Okay. What kind of responsibilities -- that's
7 Self Memorial?

8 A: Yes, Self Memorial Hospital. Now it's called
9 Self Regional Healthcare.

10 Q: Okay. What kind of responsibilities did you
11 have when you were at Self?

12 A: My title was planning and marketing, but in
13 that job, the planning included strategic
14 planning, new program development planning. It
15 actually included construction and project
16 management over construction projects. On the
17 marketing side, I did the hospital's marketing
18 research. I planned their marketing campaigns,
19 promotion of services. I was -- supervised the
20 chaplain's program at the hospital. I started
21 and developed the physician recruitment program
22 at that hospital, which is one of the most
23 successful in the country, even still today.
24 So that's kind of a broad range. I did CON
25 applications, was responsible for regulatory

1 liaison with DHEC when I was at the hospital.

2 Q: Is Self a tertiary hospital?

3 A: Yes, it has open heart, neurosurgery, a wide
4 range of tertiary services.

5 Q: And did they obtain those tertiary services
6 while you were there?

7 A: The last CON that I did as a hospital employee
8 was their open heart surgery program CON.

9 Q: Which was granted and then later implemented,
10 right?

11 A: Yes. And in fact, I actually helped implement
12 it when I left the hospital under a consulting
13 agreement.

14 Q: Now, when did you leave Self?

15 A: It was in August of 2000. Lander University,
16 I had taught a couple of adjunct courses for
17 them, and they wanted to expand their business
18 program in healthcare management and asked if
19 I would consider leaving the private sector and
20 becoming a professor.

21 Q: And so you moved to academia?

22 A: I moved to academia.

23 Q: Okay. What courses do you teach at Lander?

24 A: My duties include, I'm qualified under our
25 accreditation standards to teach general

1 business courses and courses in healthcare
2 management or healthcare administration, so
3 I've taught both. On the healthcare side, I've
4 taught Introduction to Health Care in America,
5 Health Care Regulations, Managed Care and
6 Health Care Finance, a senior case study course
7 that we call Health Care Systems. I manage all
8 of our healthcare management internships. We
9 have six specialty courses in healthcare
10 management, and I've taught all of them during
11 my time there.

12 Q: Does it cover the wide range of healthcare
13 issues in those courses.

14 A: It covers a wide range from regulatory to legal
15 to ethical issues in healthcare operational
16 issues. It covers a wide range of delivery
17 modes, from hospitals to nursing homes to
18 assisted living to ambulatory surgery centers.

19 Q: Does it also include reimbursement and finance?

20 A: Yes, the healthcare finance course that I
21 taught includes reimbursement and everything.
22 We teach the students how accounting and
23 finance is applied in the healthcare setting.
24 They take courses in accounting and general
25 finance, but healthcare is a very different

1 setting.

2 Q: Is your work at Lander mostly focused on
3 teaching, or is there some research and
4 publication aspect of it too?

5 A: Well, in academia, the word is publish or
6 perish.

7 Q: Right.

8 A: So you have to -- for our accreditation
9 purposes, all faculty have to do a certain
10 amount of publishing, and my -- their
11 expectation of me when I joined the faculty is
12 I would do the same level of publishing that
13 their PhD faculty would do. So over the now 13
14 full years I've been there, I think I've
15 published and co-authored, I think it's about
16 24 peer reviewed publications based on research
17 that had been conducted, some of it in
18 healthcare, some of it in general business.

19 Q: You're a member of an organization related to
20 healthcare too, right?

21 A: Yes, I'm a member of the American College of
22 Healthcare Executives. It's similar to say a
23 medical professional society. It's considered
24 the premier one in health administration.

25 THE COURT: It's considered what?

1 MR. TOLBERT: A premier, the top one.

2 THE COURT: Oh, okay.

3 MR. TOLBERT: Yeah, I'm sorry, Your Honor.

4 Q: And I'm a Fellow of the American College of
5 Healthcare Executives, and in order to become
6 a Fellow, you have to have a certain level of
7 high level experience in the field, so many
8 years experience, at least a master's degree.
9 You have to pass a written examination. I had
10 to pass an oral examination and about, I think
11 it was about ten years ago, maybe it was eight
12 years ago, I was designated as a Fellow of the
13 American College of Healthcare Executives. The
14 last time I checked, which was a few months
15 ago, there are only 9,500 Fellows of the
16 American College of Healthcare Executives in
17 the world, and so I'm pleased to be one of
18 those.

19 Q: Tell the Court a little bit about your
20 consulting business, Strategic Directions.

21 A: When I was offered a faculty position, it was
22 tenure track. Lander University, the dean and
23 the provost talked with me about they would
24 have wanted me to have gone back to school and
25 get my PhD. To be honest with you, I was 48

1 years old at the time, had three kids that were
2 headed to college and my wife and I didn't
3 think we could afford a fourth set of college
4 tuition, and I told him I really wasn't
5 interested in doing that. I wasn't sure how it
6 would help me teach the courses that they
7 wanted me to teach, and they said that's fine,
8 but if you're going -- under our accreditation
9 standards, for you to be qualified to teach,
10 you have to publish at the same level our PhD
11 faculty do, and you're going to have to stay
12 active in the business world, so you can be an
13 active practitioner and a teacher. So they
14 asked me, would you mind ---

15 THE COURT: And that's why you're here, huh?

16 A: Well, I'm about to tell you why I'm here, yes,
17 Your Honor. I was thinking, I was thinking,
18 they were asking me if I would mind doing some
19 consulting, and I took a 40 percent pay cut to
20 be a faculty member, and I thought, you know,
21 I was thinking to myself, yeah, I'd like to do
22 some consulting to help my family out
23 financially. So I formed this consulting firm
24 and started it in August of 2000.

25 Q: Okay. And what kind of work do you do with the

1 consulting firm?

2 A: The consulting firm, we provide healthcare
3 advisory and management consulting services to
4 healthcare providers primarily in South
5 Carolina. And we do a wide range of services.
6 Most of it has turned out to be in the CON
7 area.

8 Q: Have you -- now, before we talk about CON, you
9 also provide kind of general planning advice to
10 clients?

11 A: Yes. Yes, I will help clients. I've led board
12 retreats to do strategic planning for
13 hospitals. I've helped some of my clients with
14 just broad strategic planning for mapping out
15 the directions of their organizations, both for
16 hospitals and for physician practices and for
17 ambulatory surgery centers and for nursing
18 homes.

19 Q: Do you have somebody -- do you have any people
20 working with you in the consulting business?

21 A: Yes, I do. I'm very proud of the people that
22 work with me. One of my consultants is Lisa
23 Sanders, who I'm pleased is in the courtroom
24 today. I actually have a consultant that I use
25 in Albuquerque, New Mexico, who is one of my

1 former students who helps me. My son, Luke,
2 has worked for me full time for a year. He's
3 an ordained minister now, and he will help me.
4 My wife, who has a bachelors in nursing and is
5 a certified math and science teacher will help
6 me with some clinical things and data analysis.
7 So I have a staff. I think there are four
8 part-time consultants on the payroll.

9 Q: Now, is preparing certificate of need
10 applications a large part of your practice?

11 A: Yes, it is. And it just quite honestly
12 happened to develop that way, because I've not
13 done any marketing in 13 years.

14 Q: Okay. And how many CONs do you -- is most of
15 your CON work in South Carolina?

16 A: I only do CONs in South Carolina. Some of my
17 clients have asked me if I would do one in
18 Georgia or do one in North Carolina. The
19 process, the underlying process is pretty much
20 the same in all states because they were all
21 started under the same federal regulation, you
22 know, 30 plus years ago, and I decline because
23 I have teaching responsibilities. I don't want
24 to travel that far, and I focus on South
25 Carolina. I can be very good at doing one, not

1 multiple states I think.

2 Q: Okay. And how many CONs do you estimate you've
3 prepared in your consulting business?

4 A: In the consulting business since the year 2000,
5 I think it's 78. I know it's between 75 and 80.
6 CON applications. That doesn't include
7 exemption requests and non-applicability
8 determinations. Those are full CON
9 applications.

10 Q: Okay. And you've prepared CONs for most of the
11 services included in the State Health Plan?

12 A: I'd have to look at the list, but I think so.
13 Yeah, I've done nursing homes, ambulatory
14 surgery centers, a wide range of hospital
15 services, CTs, I think that pretty much covers
16 the gamut.

17 Q: And had you worked on a linear accelerator
18 application before the Murrells Inlet
19 application for this client?

20 A: Yes.

21 Q: And you had projects that were appealed to the
22 South Carolina Administrative Law Court other
23 than this one?

24 A: Only a few.

25 Q: Okay.

1 A: Only a few.

2 Q: But you have had some?

3 A: I have.

4 Q: Have you had the opportunity to testify in
5 court as an expert witness?

6 A: Yes, I have.

7 Q: In what courts?

8 A: My first one was state Circuit Court, and that
9 was an issue between MedQuest and InMed over a
10 non-applicability determination. So I
11 testified in the state Circuit Court. And I
12 believe this is my third time with the state
13 Administrative Law Court.

14 Q: Okay. Did you qualify as an expert in those
15 other cases?

16 A: Yes.

17 Q: And the CONs that you've prepared in your
18 career, have you been the person who actually
19 prepared the B-11 need analysis for clients?

20 A: Yes.

21 Q: Wrote that portion yourself?

22 A: Yes, I would write that portion. Of course,
23 some of my staff would help me pull data and
24 assemble data and help with some of the
25 analysis. But actually I write the whole CON

1 applications for my clients from page one to
2 wherever it ends.

3 Q: Okay. And so does that also include the pro
4 formas? Do you do the pro formas for your
5 clients in CONs if they ask you?

6 A: When I meet with a client, I will tell them I
7 can do the financial projections. DHEC
8 requires what they consider to be a qualified
9 accountant to sign a letter attesting to the
10 reasonableness, and I give the clients a
11 choice. I will help prepare the financial
12 projections for the review of their accountant,
13 which could be their CFO or their outside CPA
14 and give them that choice. I think about a
15 third of the CON applications that I've done,
16 I did the financial projections for the
17 client's review. The others, to be honest with
18 you, I tell them how to do it because a lot of
19 finance people and accountants are good at
20 budgeting for next year but projecting out
21 three years or four years is a lot trickier, so
22 in some cases, I'll give them my templates to
23 use and they'll just take them and put their
24 numbers in, so I'm involved with it.

25 Q: And do you also keep apprised of the South

1 Carolina State Health Plan?

2 A: Of course, yes.

3 MR. LONG: Your Honor, we would move Mr. Tolbert as
4 an expert in healthcare planning and healthcare
5 finance.

6 MR. THOMAS: No objection.

7 THE COURT: He's so qualified.

8 MR. LONG: Thank you, Your Honor.

9 Q: Mr. Tolbert, you've been here for most of the
10 trial, right?

11 A: Yes, I've had teaching commitments, so I missed
12 one day and got somebody to cover my classes
13 one of the other days.

14 Q: Let's take a look first at the concept of
15 completing applications.

16 MR. LONG: Can we put the reg up on the screen, 105
17 -- I mean, 61-15(103.6).

18 Q: Can you tell me what this is? Can you see it
19 on the screen?

20 A: Yes, I can. This is of course a part of the,
21 what we all call the CON regulations. DHEC 61-
22 15, if I remember correctly, the section. This
23 is a section that has definitions in it. This
24 defines what competing applicants are.

25 Q: And to be competing applications, you have to

1 show -- you have to have several -- there's
2 several elements to it, right?

3 A: Yes, three or four. I haven't counted them.

4 Q: Okay. Let's walk through them real quick. You
5 have to be two or more facilities offering
6 similar services or facilities, right?

7 A: That's correct.

8 Q: And do we have that in this case?

9 A: We do.

10 Q: Is there any dispute about that?

11 A: No, not in -- no.

12 Q: All right. And they also have to be the same
13 service area, right? The facilities have to be
14 in the same service area ---

15 A: Yes.

16 Q: --- next line down.

17 A: Same service area.

18 Q: Do you have -- are we in the same service area?

19 A: Yes, the department of DHEC defines that at the
20 three counties we've been discussing, same
21 service area.

22 Q: And that's the service area for linear
23 accelerators, right?

24 A: Yes.

25 Q: And also at the bottom of the definition there,

1 the applications have to be filed within a time
2 period and as set out by the Department right?

3 A: That's correct.

4 Q: And was that done in this case, where these two
5 applications filed within the time period
6 prescribed by the Department?

7 A: Yes.

8 Q: Okay. So let's go back to the last element
9 that we haven't talked about, and that is the
10 last part of the definition where it says where
11 the approval of both, whose applications, if
12 approved, would exceed the need for this
13 facility or service.

14 A: Yes.

15 Q: Is that the crux of this lawsuit?

16 A: I think, in my opinion, that will be a key
17 element in the court's decision will be
18 determining if the approval of both would
19 exceed the need.

20 Q: Okay. Where's the first place that you go and
21 look as a healthcare planner to determine need
22 in regards to certificate of need applications?

23 A: Well, you go to the State Health Plan and see
24 what it says in terms of standards and what's
25 approvable or not approvable.

1 Q: Okay. So let's look at Joint Exhibit 4. These
2 applications were filed, it's the 2010-2011
3 Health Plan, right?

4 A: That's correct.

5 Q: Make sure I get my dates right on that. Okay.
6 So let's look at page IX-5. And are these the
7 Standards? Can you tell us what we're looking
8 at here on this page and the next page of the
9 Health Plan?

10 A: Well, certainly. The State Health plan is
11 broken into sections by type of service that
12 the Department's determined require certificate
13 of need. This is a section on radiotherapy
14 services, or what we call radiation therapy;
15 some people call radiation oncology. And this
16 is the section that describes the -- they're
17 called the standards for review of an
18 application.

19 Q: All right. Let's take a look at Standard 6,
20 which I think starts at the bottom of this page
21 and then rolls over to the next page. So what
22 does Standard 6 address?

23 A: Standard 6 says new radiotherapy services will
24 only be approved if the following conditions
25 are met.

1 Q: Okay. Well, first, is Grand Strand applying
2 for new radiation therapy services?

3 A: Yes.

4 Q: All right. Let's look at the -- if the
5 following are met. Are there -- there's
6 basically, are there three parts to this
7 standard or three main concepts?

8 A: I think yes. Yes. We've got an A and a B
9 here.

10 Q: Can you kind of walk me through what -- the
11 analysis of this?

12 A: In order to consider a CON application, I
13 didn't say approve it, just to accept it and
14 consider it, all of the existing units, those
15 would be, we call them linacs, that's kind of
16 the abbreviation we use, in the service area
17 have to have performed at a use rate of 80
18 percent, at least 80 percent for the immediate
19 preceding year.

20 Q: Okay.

21 A: So that's what you might call a trigger. If
22 that's not the case, then it's not approvable.

23 Q: All right. Has that trigger been satisfied?

24 A: Yes.

25 Q: All right. Now, let's look at subsection B.

1 What's the other components?

2 A: That an applicant must project their proposed,
3 in this case it would be a new service, would
4 perform a minimum number of treatments equal to
5 50 percent of the capacity within three years
6 of initiation of services. So typically, you
7 would look at the third year, which if your
8 volume's growing would be your highest year,
9 and that needs -- your volume needs to be at
10 least 50 percent of the capacity that is
11 established for that linear accelerator, and
12 linear accelerators can have different levels
13 of capacity.

14 Q: Was there any question in your mind whether
15 either of the applicants in this case will
16 satisfy the 50 percent?

17 A: They were both satisfying that.

18 Q: And what's the other portion of this
19 subsection?

20 A: You want me to read the rest of this?

21 Q: Well, you can read it or you can explain it.

22 A: Without reducing the utilization of the
23 existing machines in the service area below the
24 80 percent, so the projected service has to, or
25 the new unit has to be at least 50 percent, but

1 its volume cannot impact the existing units to
2 drop them below 80. If it drops them below 80,
3 it's not approvable.

4 Q: Okay. And if the new service drives the
5 existing units back below the 80 percent
6 trigger, is there a need for the service?

7 A: No, no, that's what it's saying here. It's the
8 trigger that's -- it would not be needed.

9 Q: Okay. Now, in your -- let me ask you
10 something. Why does -- what's the -- why does
11 DHEC use the third year? Why is the third year
12 a critical year in regards to analyzing this
13 service and other services?

14 A: Well, the third year should not -- you should
15 not still be in startup. Your operation should
16 be fully going, headed right into maturity, if
17 you will, and it should represent what would be
18 going from there on. So if it didn't, they
19 would ask for three, four or five years of
20 projections. So their third year, I've always
21 interpreted that to be you're well past startup
22 phase.

23 Q: Now, we'll come back to this in a little bit,
24 but just to lay out your position. In this
25 case, what is your opinion as to whether the

1 approval of both of these linear accelerators
2 would drive the existing units below 80
3 percent?

4 A: Following our project review meeting, which is
5 approaching three, two years -- it was in
6 November of 2011, so a few years ago, I put in
7 writing that I felt the approval of the two
8 units that are being discussed here would drive
9 the utilization of existing units below 80
10 percent. My analysis today updated two years
11 later is the same, it would drive the existing
12 units below 80 percent.

13 Q: Okay. Let's take a look at Grand Strand's
14 particular application. I want to talk to you
15 about some of the exhibits that you've prepared
16 for the Court. So let's go first to CRCC
17 Exhibit Number 12, and yeah, it's in that blue
18 book there. And we'll have it on the screen
19 here. All right. First, just give the court
20 an overview of what -- well, let me let you get
21 there first.

22 A: I'm there.

23 Q: Can you just give the Court an overview of what
24 Exhibit 12 represents?

25 A: It's my projection of volumes for our linear

1 accelerator project, and it includes analysis
2 of the other providers.

3 Q: So does it also calculate your projections for
4 Grand Strand's linear accelerator project?

5 A: Well, it includes their projections that I
6 updated since we're two years later.

7 Q: Let me make sure, the exhibit itself is a
8 multi-page exhibit, okay.

9 A: Yes, it's five or six pages. I've not counted.

10 Q: In that particular one, right?

11 A: Yes.

12 THE COURT: Six.

13 Q: All right. Let's actually go to the back of
14 the exhibit, if we would, page 12, we'll use
15 the Tolbert Bates numbers at the bottom of
16 this. Let's take a look at Tolbert 12908,
17 which is the last page of the exhibit.

18 A: Yes.

19 Q: Okay. Can you explain what this page
20 represents to -- can you explain to the Court
21 what this page represents?

22 A: One of the first steps that a planner needs to
23 do in projecting volumes or utilization is to
24 know what's the total need in the service area,
25 and so what I was doing here was projecting

1 into the future how many radiation therapy
2 treatments would be provided within the three-
3 county service area that we're discussing. So
4 in order to do that you look at historically,
5 and this goes back -- I went back, gosh, ten
6 years or so with our volumes, and then you have
7 to project into the future what will the
8 radiation therapy treatment volumes be in the
9 service area. Well, how do you know in the
10 future what's going to happen? Well,
11 population can change, age distribution can
12 change, rates of cancer incident rates can
13 change, and so I believe it's -- what I did
14 here was I used new cancer cases diagnosed,
15 which is a recorded number, and saw how that
16 had changed over that same historical time
17 period to project into the future what
18 radiation therapy would change. I don't want
19 this to get overly complicated, but the ---

20 Q: Well, let's do this first. Let's just jump to
21 the end and give the number, and then we'll
22 come back and explain it.

23 A: Sure.

24 Q: What do you project the total number of
25 treatments will be in the service area in 2017?

1 A: I projected 31,824 radiation therapy
2 treatments.

3 Q: Okay. Why did you choose 2017 ---

4 THE COURT: Wait a second, where ---

5 MR. LONG: Can you blow it up?

6 THE COURT: Oh, I see it now. Tolbert projection.

7 Q: Tolbert projection 31,824, right?

8 A: That's correct.

9 Q: Why did you choose 2017?

10 A: Well, our original CON applications, we
11 projected to 2015. The litigation has delayed
12 everything two years. So I just extended
13 everything an additional two years.

14 Q: All right. I want to ask you one other
15 question, then I want you to kind of explain
16 how you got there. I noticed when you're doing
17 your calculations here that the first two
18 years, 2003 and 2004, there's no number for
19 Georgetown, if you look to the left.

20 A: Yes, I see that.

21 Q: Okay. Why is that?

22 A: It wasn't -- didn't exist in those years.

23 Q: Okay. So Georgetown's first year of operation
24 was 2005?

25 A: The first year that they reported numbers to

1 DHEC was 2005.

2 Q: And so their third year, they had -- so when
3 would you think that they were no longer a
4 startup, looking at their progression of
5 numbers?

6 A: Well, you can see really for them in their
7 second year of operation, they -- it stayed
8 pretty much the same for five years, and then
9 in 2011 went up some and then 2012 went down,
10 back to where they were the previous five years
11 or so.

12 Q: And is Georgetown County's population much
13 smaller than Horry's?

14 A: Oh, I don't have that number memorized, but I
15 think it's about a fourth of the size?

16 Q: Yeah, and we actually saw it earlier in the
17 case.

18 A: Seventy something thousand.

19 Q: And so Georgetown has consistently been over
20 5,400 treatments really since the second year
21 it was operational, right?

22 A: Yes.

23 Q: All right. Now, let's go back and look and see
24 -- can you kind of explain to the Court why the
25 method that you used to determine what the

1 treatments would be in the year 2017?

2 A: Well, first of all, I think the best way to
3 project future radiation therapy cases would be
4 to look at the growth in new cancer cases. New
5 cancer cases, if you look back over, and we've
6 got two, four, six, I guess seven years of
7 data, when it changes from year to year, that
8 change reflects growth in population, more
9 people, more cancer diagnosis. It also factors
10 into it changes in age distribution. As your
11 population ages, you would tend to have more
12 cancer diagnosis. So that would be reflected
13 in the new cancer cases number, and of course
14 then trending over time. What I did was I took
15 those data points and using a mathematical
16 model called linear regression forecasted the
17 future. It's called -- some people call it
18 trend line analysis.

19 Q: Okay.

20 A: So you'll see the actual new cancer cases on
21 the left side of the bottom and the right is
22 projected. That projected or forecasted number
23 is using linear regression. This was done in
24 Excel, which actually has all the calculations
25 built into a formula. It's a fairly complex

1 formula, but it does it for you instead of you
2 having to do it by hand, which I used to do.

3 And those numbers then are the trend that the
4 actuals represent going into the future.

5 Q: Now, did Mr. Sullivan use a different method to
6 project his total cancer cases in 2017?

7 A: Yes, he took the average change per year, the
8 percent average change per year and then
9 calculated what that had averaged over time and
10 forecasted it into the future. In fact, on
11 here I've, for comparison purposes, I wanted to
12 see what his projections were versus mine, and
13 you'll see in the middle on the right, I have
14 -- on the left it says Sullivan projection, and
15 I showed what he projected. And his numbers,
16 as I calculated, it showed about a three
17 percent growth per year in radiation services.
18 My numbers are a little under three percent a
19 year.

20 Q: Can you give the Court an example of why you
21 think linear regression is superior to Mr.
22 Sullivan's method, and I'm going to write the
23 numbers down here on this board for you so we
24 can follow it.

25 THE COURT: What was Sullivan's approach again?

1 What was Sullivan's approach?

2 MR. TOLBERT: Oh, I'm sorry Your Honor. I didn't
3 realize you were asking me. You calculated the
4 percent change per year and then averaged it
5 over the time period that he used. In this
6 case, it looks like three percent was what he
7 used as the average growth per year in
8 radiation therapy services.

9 Q: Can you give us an example of why you think
10 yours is superior for this kind of calculation?

11 A: Yeah, let's take a series of numbers, and I'm
12 going to use nice round numbers. Let's start,
13 say one year you have 100 treatments, say the
14 next year 200, next year 300, next year 400,
15 and next year 500. So that's your actuals.

16 Q: Okay.

17 A: All right. Now, if I was -- I'm putting on my
18 professor hat. I would ask my class, if you're
19 projecting next year, what number would you
20 project? They would figure this out real
21 quickly, 600.

22 Q: Okay.

23 A: Now, if you wanted to look at average change
24 per year, then I would have them do this. I'd
25 say look at year two, that's 200. Divide that

1 by 100. What's the percent change between year
2 one and year two? You can do that in your
3 head. It's 50 percent. All right. Let's look
4 at the change from year two to year three.
5 That's 300 over 200, so that would be a -- no,
6 I'm sorry, the first one is 100 percent.

7 Q: Yeah.

8 A: I'm sorry. That's 100 percent. The next one
9 would be 50 percent. The growth, percentage
10 growth the next year would be, I'm sorry 30 --
11 I can't -- I'm sorry, Mr. Long, I can't see the
12 numbers. It's too bad you're not left handed.
13 The next number would be 33 percent, actually
14 33.333 percent. You just round it to 33.

15 Q: 33?

16 A: 33.

17 MR. THOMAS: I don't mean to interrupt. I just
18 can't see the exhibit.

19 THE COURT: Step on around.

20 A: And the growth from year four to five, you
21 know, and I can explain the math a little. The
22 difference is 100. 100 divided by 400 is 25
23 percent. So that's 25 percent growth.

24 Q: Okay.

25 A: So that's the percent change by year. Now, if

1 you wanted to know, so what's the average over
2 the time period, you would add 100 percent, 50
3 percent, 33 percent, 25 percent, and you would
4 divide it by four to get your average. So the
5 average would be 52 percent. So that's the
6 average change by year for that time period.
7 Now, if you said, well, that's my average
8 change over that time period, what would year
9 six be. If you did it that way, you would
10 multiply 500 times 52 and add it to 500. I
11 hope I'm not going too fast with this
12 calculation. And your projection for next year
13 would be 760 cases.

14 Q: Okay.

15 A: Using compounded average. Using linear
16 regression, it uses what's called the sum of
17 least -- it's a very complicated formula, but
18 it would say the trend line would show you
19 exactly 600, exactly 600 using this example.

20 Q: Now, is there anything wrong with Mr.
21 Sullivan's calculation? I mean, it's not
22 improper, is it, or anything?

23 A: I can tell you a lot of people do it that way
24 because it's easy to explain. People
25 understand compounded growth rate, but it's not

1 necessarily as accurate -- well, it's not ever
2 as accurate as linear regression, but linear
3 regression is hard for some people to explain.
4 I have a hard time explaining it to clients.
5 I have a hard time explaining it to students,
6 but it's more accurate.

7 Q: And the method Mr. Sullivan uses would project
8 a higher number, wouldn't it?

9 A: Yeah, he came up with roughly three to three
10 and a half percent, and mine's two and a half
11 percent.

12 Q: Okay. But your projection for 2017 is 31,824,
13 right?

14 A: That's correct. His projection, I've got it on
15 that page -- I'm sorry, I closed the book here,
16 is slightly higher.

17 Q: Okay. Let's go back to CRCC Exhibit 12.

18 THE COURT: I see Sullivan's projection is three
19 percent. I don't see where your actual
20 percentage is.

21 MR. TOLBERT: I have it on another page Your Honor.
22 I just didn't put it on that page.

23 Q: Is it the page prior that has your, it should
24 be Tolbert 12907?

25 A: Yes.

1 Q: Does that set out your percentage?

2 A: Yes.

3 THE COURT: For 2015 it's 2.47, then it goes below
4 that.

5 MR. TOLBERT: Yes, Your Honor.

6 THE COURT: As we go down one.

7 A: You know, in the end result, his number is
8 slightly higher, and I would have expected that
9 using compounded average. When there's a
10 growth, the trend line is up, not a huge
11 difference in the end.

12 Q: Let's turn over to the first page of Exhibit
13 12, which is Tolbert 12903, and let's kind of
14 blow up the top part of this for everybody, and
15 originally the applications didn't project to
16 2017, did they?

17 A: No, they did not.

18 Q: Okay. And so are these the numbers set out in
19 the -- now where are the Ford Cancer Center
20 numbers from -- that you're using in regards to
21 your exhibits?

22 A: All of these numbers are from the CON
23 application that was submitted to the
24 department.

25 Q: And the Ford Cancer Center numbers would be the

1 Murrells Inlet, their Murrells Inlet
2 application, right?

3 A: That's correct.

4 Q: Okay. And so these were the numbers that were
5 projected for the three applications?

6 A: For those three years.

7 Q: CRC Conway, Grand Strand's linear accelerator
8 and then Georgetown's relocation and Murrells
9 Inlet?

10 A: That's correct.

11 Q: All right. Let's look at the next box.

12 A: Well, I need to explain ---

13 Q: Okay.

14 A: --- the one that's in the middle that was still
15 up

16 Q: Okay. Let's put both of those up together and
17 you can kind of walk through.

18 A: In projecting two additional years, I didn't
19 feel like we could just use the numbers that
20 were projected for '13, '14 and '15 because the
21 market's growing. The population's growing,
22 it's aging, and so I felt all of the
23 applications should be adjusted for growth in
24 the market because they all would be serving
25 the same market, and my projections said the

1 demand for radiation therapy services in the
2 whole market would go up 2.6 percent in the
3 year 2013 versus 2012 and then 2.54 percent in
4 the year 2014. So I basically increased their
5 projections using those percentages to get to
6 these updated projections two more years out in
7 the future.

8 Q: Okay. And did you do that for all three of the
9 applications?

10 A: I treated all three the same.

11 Q: Okay. And so therefore, and that's your
12 adjusted volume there in this box here?

13 A: Based on the population and the market demand.

14 Q: Okay. And so what did you -- based on the CON
15 applications projected forward to 2017, what
16 did the three applicants project for their
17 three projects?

18 A: Well, the Ford Center would be at 7263
19 treatments. Grand Strand, using their
20 projections, would be at 4934 and CRCC's new
21 linear accelerator in Conway would be at 5499.

22 Q: Okay. So CRCC's projection linear accelerator
23 in Conway would actually be higher than Grand
24 Strand's projection at their hospital based ---

25 A: Yes.

1 Q: --- linear accelerator? All right. Let's look
2 at the -- continuing on the page. Now, is this
3 basically that same calculation shown? Tell me
4 what you've got here on the bottom.

5 A: Well, you could go back to the last page in the
6 exhibit, and you can see treatments in the
7 region, 2012 for the actual reported on the
8 JARs, Joint Annual Reports. 2013, I projected
9 by increasing 2012 by 2.6 percent, which ties
10 back into the analysis of the growth in new
11 cancer cases, and the rest of them are the same
12 as we've looked at on the last page in this
13 exhibit, and the 2017 number, I projected for
14 the region there would be within the region a
15 need for 31,824. That number matches the one
16 we had on the previous page, and this is, Your
17 Honor, where I showed the percentages for each
18 year that I was projecting growth.

19 Q: All right. When you say region, is that the
20 same thing as service area?

21 A: I'm sorry, I do use those interchangeable. I
22 apologize if I'm doing that. It's the three-
23 county service area. That's with the State
24 Health Plan. I always tend to call it a
25 region. It's more than one county.

1 Q: All right. So you say regional, we're ---

2 A: Correct me if you will.

3 Q: Okay. I'll try. Let's turn to the next page
4 Tolbert 12904. Now, before we kind of walk
5 through this page a little bit, what occurred
6 to you as you were doing your analysis in this
7 case in regards to projections made by Grand
8 Strand?

9 A: In preparing for this case, you naturally start
10 looking at the numbers and analyzing it and
11 considering things, and what struck me
12 initially when I went back and looked at the
13 numbers and additional information that was
14 provided, and I'm not that familiar with this
15 legal process, but I guess it's called
16 discovery where you exchange information and
17 data, I started seeing some market share
18 numbers that struck me as higher than what I
19 thought Grand Strand was proposing for its
20 linear accelerator. So the first thing I did
21 was column A here, which was to look at their
22 market share of the radiation therapy
23 treatments that they would be doing using their
24 numbers in the CON application adjusted for
25 2017.

1 Q: Okay.

2 A: So the first column here is an analysis of the
3 market and who would be providing what
4 services, the amount of utilization or
5 treatments by provider using the numbers that
6 were in the Grand Strand application for their
7 volumes.

8 Q: All right. Well, let's look at, first I want
9 to ask you about the market share. When you're
10 applying this market share percentage, is that
11 for the entire three-county service area?

12 A: Yes, that's the way I did it. DHEC, the
13 department defines it as three whole counties.
14 The providers in that are supposed to serve the
15 three counties, so it was using all three
16 counties.

17 Q: Does your projection project that the market
18 share for each zip code in the three-county
19 service area would have exactly the same market
20 share?

21 A: No. No.

22 Q: So how do you arrive at the number?

23 A: Well, you take the total demand or the total
24 volume, and here I projected 31,824 treatments.
25 And then you divide what a provider would do

1 into that, and that tells you what percent of
2 the 31,000 they're providing, and that's their
3 market share.

4 Q: Okay. Well, let's just look at one of the maps
5 real quickly if we could just to make sure it's
6 clear. Let's look at CRCC Exhibit 5, which is
7 the CRCC patient origin map. So, when you're
8 looking at the different zip codes, are you
9 participating, are you projecting that each one
10 of these zip codes would have the same market
11 share number?

12 A: No, no, of course not. There would be some
13 much higher, some very low, some in the western
14 side of Williamsburg would probably be zero.

15 Q: Okay. But all together ---

16 A: The whole market area included together.

17 Q: --- would be the numbers on your exhibit?

18 A: That's correct.

19 Q: Okay. When you went to your deposition to be
20 deposed, or prior to your deposition, did you
21 make some assumptions about what -- about
22 market share and certain different -- and
23 different percentages than what had been
24 projected by Grand Strand in the application?

25 A: Yes, I did.

1 Q: All right. And what numbers did you use prior
2 to your deposition?

3 A: I think I looked at volumes assuming Grand
4 Strand had a market share of 20 percent, 25, 30
5 and 35.

6 Q: Okay. And what was the basis of picking those
7 percentages?

8 A: Well, the 30 and 35 was based on some documents
9 I saw in discovery from Grand Strand where they
10 had produced that their market share was, for
11 the hospital overall was 35, and I believe for
12 oncology was 30 percent. So I -- that's where
13 I got those numbers. And then I used 25 and 20
14 just to bracket down from there to provide kind
15 of a range of analysis, basically from 20 to 35
16 percent.

17 Q: So was the 30 and 35 primarily based on, I
18 think in one of these exhibits you had decided,
19 CRCC 97, page 3081.

20 A: Oh, I'm sorry.

21 Q: You want to hold your place there. She's going
22 to put it on the screen too. CRCC Exhibit 97,
23 page 3081. Go back to the first page so we can
24 identify the exhibit. I'm sorry. You remember
25 this document from the testimony and from the

1 discovery of the Eastern Group visit?

2 A: Yes, I do and I -- when I was reading Mr. Doug
3 White's deposition, those numbers jumped out at
4 me and then this was the basis for that.

5 Q: Okay. Let's look over 3081, GSRMC 3081.

6 THE COURT: What's this exhibit again?

7 MR. LONG: This is Exhibit Number 97. We call it
8 the Eastern Group Visit PowerPoint.

9 Q: Was this the page that you were looking at to
10 get the numbers that you used?

11 A: Yes, it was one of the numbers. That's where
12 I picked up the 35 percent market share by
13 service line and this is total.

14 Q: Well, The total is the 35, right, and then
15 oncology is 30?

16 A: Yes, we're looking at the 35, which is total
17 hospital or facility.

18 Q: Okay. Now, what did -- in that number for the
19 30, that's oncology market share, right?

20 A: At the bottom of the page.

21 Q: All right. Now, you'd agree that Grand Strand
22 does not have radiation therapy services at the
23 present time, right?

24 A: No, no.

25 Q: Okay. So what proxies or numbers would you

1 consider to be used to try to project market
2 share for a project like for Grand Strand who
3 is not currently offering this service?

4 A: Well, you would want to use a number that had
5 some solid foundation, if you want to call it
6 that, some underlying hard data, and the best
7 data available is inpatient market share.

8 Q: Okay. And is that a number that's watched very
9 closely by hospitals?

10 A: Every hospital I deal with and administrator I
11 know carefully watches their market share,
12 particularly in South Carolina because the
13 data's collected by the Office of Research and
14 Statistics, and it's published.

15 Q: Okay. Now, Mr. Sullivan used a different proxy
16 in regards to his market share. I think he
17 used oncology inpatient. Is that right?

18 A: Yes.

19 Q: Do you recall that? Now, I think there were,
20 do you recall the testimony, I think there were
21 400, 500 patients in the oncology inpatient?
22 We can look for it.

23 A: I do recall that. I don't remember the exact
24 number.

25 Q: What strikes you about using that particular

1 proxy for market share, inpatient oncology only
2 as opposed to overall inpatient or something
3 else?

4 A: Well, overall inpatient market share is what
5 the hospital's strength in the market to draw
6 all patients to it, whether they're oncology or
7 any type of patient. It really indicates the
8 hospital's or any facility's strength and
9 reputation and medical staff ability to bring
10 patients to the facility regardless of who they
11 are.

12 Q: If Mr. -- if there are 16,000 inpatients in a
13 year at Grand Strand, and there are only 450
14 inpatient oncology, do you have any opinions
15 about using the number 450 out of 16,000 as to
16 whether that's the best proxy to use?

17 A: I wouldn't think so. First of all, it really
18 depends on how you define the diagnosis codes
19 that you call oncology. I've seen different
20 lists that would define what those numbers are.

21 Q: And also -- okay. So what about other -- there
22 are other proxies available too I guess, right?
23 Outpatient and other proxies that could have
24 been used just for market share?

25 A: There can be. Sometimes the data is not as

1 good, not as accurate.

2 Q: Okay. So you feel, in your opinion, what's the
3 best proxy to use if the service doesn't exist
4 for the hospital to determine its market share
5 capability?

6 A: I would use inpatient market share.

7 Q: Okay. Let's go back to this page Tolbert
8 12904. All right. The first column on the far
9 left is Mr. Sullivan's projection from the
10 application?

11 A: Yes.

12 Q: Now, as part of -- will you walk through the
13 next group of each column as we kind of move
14 along with it and you can kind of tell the
15 court what market share number you were be
16 using for each one of those and why? I tell
17 you what let's -- instead of going that way,
18 let's go all the way to the end and let's look
19 at the very last column, column F.

20 MR. LONG: And actually, Bronwyn, if you'll put it
21 back up just like you had it.

22 Q: Let's look at column F. What's the market
23 share percentage you used on the column on the
24 far right?

25 A: Well, it's 35. But if you don't mind, I'd like

1 to explain it.

2 Q: Sure.

3 A: If I could put on my academic researcher hat.
4 I looked at the market share for Grand Strand.
5 I calculated it based on their numbers, 15.5
6 percent. I had the testimony from Mr. White,
7 and it struck me that 15.5 percent looked low.
8 Well, so that's just what struck me. Then as
9 a researcher, you would want to look at that
10 differently using different things to test your
11 hypothesis, if you want to call it that, from
12 a research standpoint. So at the far right, I
13 tested well, what would their actual radiation
14 therapy volumes be if they reached the
15 hospital's inpatient market share as I saw it
16 in the testimony of 35 percent. So if -- given
17 the calculation that in the market there's,
18 say, almost say 32,000 treatment, if Grand
19 Strand reached that market share of 35 percent,
20 they would get 35 percent of those treatments,
21 and that's a number you could calculate..

22 Q: Okay. And what's the number?

23 A: That would be 11,138 treatments.

24 Q: That would be a high number for one year,
25 right?

1 A: That would be a high number for one year.

2 Q: And one unit?

3 A: Yes, excuse me, for one unit for one year.

4 Q: All right. Moving kind of left on the sheet
5 here. Let's look at column E. So what does
6 that projection represent?

7 A: I did the same calculation using what they
8 reported as an oncology market share in the
9 documents that I saw, which was 30 percent.
10 And that would give them 9547 treatments.

11 Q: Okay. And then if you looked at the other two
12 market shares. Let's look at D. What does D
13 represent?

14 A: D's an interesting one because I realized that
15 their claim to market share of 30 and 35
16 percent included some zip codes in North
17 Carolina, I believe. I think that came out in
18 the -- and so it was not exactly the three-
19 county region. So I wanted to say well, so if
20 I just look at the three-county region,
21 excluding what they do for North Carolina or
22 they may get from Marion County, some of the
23 other counties, what would their market share
24 be? That's a number you can calculate. It's
25 published, available from what we call ORS with

1 the State.

2 Q: Let me, if we turn over to 12906, is that the
3 calculation for this particular market share
4 calculation you just did?

5 A: Yes.

6 Q: 12906?

7 A: Yes, it is.

8 Q: Okay.

9 A: So what I did recently was -- I'm sorry, did
10 you want me to explain what the market share --
11 -

12 Q: I'm sorry, I just wanted to -- I thought we'd
13 pull this document up, 12906 if that would help
14 you ---

15 A: Yes.

16 Q: --- explain how you got to this adjusted number
17 and why you adjusted their overall market share
18 to the number you did.

19 A: So what I wanted to do here, we had in their
20 documents what they said their market share was
21 and what they defined as their primary and
22 their secondary market. I wanted to determine
23 what it was for just those three counties, and
24 so I got the data, it's available publically
25 from ORS, and looked at the top page, the top

1 of the page that says Grand Strand, GS patient
2 origin data. And this is really current. I
3 was pleased it was available for last year.
4 Sometimes it's not available even in August.
5 I looked at how many discharges Grand Strand
6 had at its facility from patients who were
7 residents of the three counties that is this
8 service area, and then how many they had from
9 everywhere else. Their total discharges for
10 that year were 15,872, if I'm reading this fine
11 print correctly, and you can see I showed it by
12 county, Horry, Georgetown, Williamsburg, and
13 then I -- everything else I just put,
14 calculated all other. And then also we know
15 what market share they got. So in Horry County
16 their market share for all hospitalizations of
17 residents of Horry county in that year was 39.2
18 percent. That's a very, very impressive number
19 by the way. There are three other hospitals in
20 that county, so they clearly are the major
21 healthcare provider. And then in Georgetown,
22 they received 8.45 percent of all the
23 hospitals. All the residents of Georgetown
24 County that were hospitalized in South Carolina
25 went to Grand Strand, 8.5 percent. And as I

1 pointed out with Williamsburg, not so much.

2 Two reasons, it's not easy to get from
3 Williamsburg up to Myrtle Beach. It's a long
4 drive, and it's a low population, so they got
5 slightly under one percent market share in
6 Williamsburg. Now the right side of this, I
7 said well, I want to know what it is for the
8 whole three regions. So one way I did it was
9 just weighted their market share based on
10 population, so you can see the population in
11 Horry County is very, very large, less in
12 Georgetown and even smaller Williamsburg, and
13 based on the populations, I calculated a
14 weighted market share of 29.9 percent. So
15 round it to three percent -- 30 percent.

16 Q: All right. And did you also make some
17 adjustments for services?

18 A: Well, in the ---

19 THE COURT: The weighted market share was what?

20 MR. TOLBERT: Basically 30 percent for the three
21 counties.

22 THE COURT: Based on, how did you define weighted?

23 MR. TOLBERT: Population.

24 THE COURT: Yeah.

25 MR. TOLBERT: Your Honor.

1 THE COURT: Just wanted to make sure I got that. Go
2 ahead.

3 A: And so what that means is that in that three
4 counties, of all the patients who live in those
5 three counties that were hospitalized in that
6 year, 30 percent of them went to Grand Strand.
7 And then during the depositions that I was
8 reading, and I don't -- I don't recall if it
9 was Doug White's or Mr. Sullivan's, but I
10 remember, it may have been both of them, there
11 was some discussion that our market share at
12 Grand Strand is unusually high because we have,
13 and I don't think they used the words, I'll use
14 it, a center of excellence for cardiac care.
15 And I said, well, okay, so that might be the
16 case. Again trying to test a hypothesis and be
17 objective, I said I wonder what their market
18 share would be if I took out those -- that very
19 specialized service that no one in the region
20 provides. So what I wanted to do was adjust
21 the market share and remove those numbers from
22 it. And then as I thought about it, I said
23 well, and also it's clear in the testimony that
24 Grand Strand isn't going to claim any urology
25 patients for their linear accelerator. So I

1 said well, if I'm taking out that exceptional
2 service, let me take out urology. Well,
3 urology falls into two categories, is the way
4 the published data are available: one is
5 urological surgery, and then there are also
6 some patients that the urologists care for that
7 fall under the category of diseases of the
8 genitourinary tract. Now, I know those are not
9 all urologists, but that's another category of
10 patients that have problems with the
11 genitourological tract. And so I said let me
12 just to be objective here take those out of the
13 market share calculations. So that's what I
14 did in the last half of this page.

15 Q: Okay. Well, what is your -- if we go back to
16 our kind of summary page here, Tolbert 12904.
17 What is the adjusted market share after you do
18 the weighted average and then remove those
19 services?

20 THE COURT: What page are you on now again?

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

22 THE COURT: What page are you on now?

23 MR. LONG: This is back to the summary page, which
24 is Tolbert 12904. It's a couple pages earlier.

25 A: What I did, and actually this part is not

1 weighted. This is based on adding up the
2 totals for all three counties together. When
3 I took out vascular and cardiac surgery, which
4 is a category that's published and was
5 available to me, and when I took out the
6 urological surgery and I took out the diseases
7 of the genitourinary tract, their market share
8 was 27.4 percent.

9 Q: Okay. And if you used the weighted average for
10 population number, it matches closely to the
11 oncology number, right?

12 MR. THOMAS: Objection Your Honor. That's a leading
13 question.

14 Q: I'll rephrase it. Does the oncology number in
15 column E, what's the correlation between that
16 number and the overall oncology market share
17 number?

18 A: Well, first of all, let me -- I was surprised
19 when I took out that specialty service the
20 numbers weren't very -- weren't dramatically
21 different.

22 Q: Okay.

23 A: At the top of the previous exhibit we were
24 looking at, the weighted market share based on
25 the population's about 30 percent. This

1 dropped it to 27.4. Changed it some but not as
2 much as I thought it would before I did the
3 analysis.

4 Q: Okay. What's your projected number of
5 treatments then with the adjusted market share
6 removing those services? What's the total
7 number?

8 A: And we're looking at column D on 12904. I put
9 the number in here, and I didn't show it to the
10 tenth of the percent, but 27.4 percent. If
11 Grand Strand in their radiation therapy service
12 in year three matched their inpatient market
13 share when I made those adjustments for unusual
14 services or services they would not claim, they
15 would, I projected they would have 8719
16 treatments.

17 Q: Is that a realistic number for a single unit
18 provider at a hospital like Grand Strand?

19 A: It's certainly achievable, yes.

20 Q: Take a look at column C. Did you also do after
21 the deposition some additional work in regards
22 to looking at market share?

23 A: Yes.

24 Q: We'll go into more detail on that in a second,
25 but just kind of give an overview of what it

1 is.

2 A: To look at this again another way, I said let
3 me look at the patients that were referred to
4 CRCC in the year 2012 by physician and then say
5 what if Grand Strand was open, what would
6 happen to those referrals, how many of those
7 would likely or maybe or probably shift to
8 Grand Strand on a physician by physician basis?
9 So that's another analysis that I did, again
10 trying to look at what Grand Strand more likely
11 would achieve in market share.

12 Q: And we'll go through that one in a second, but
13 how did that -- what market share number did
14 that give you on the projected referral?

15 A: And that market share number was 26 percent.

16 Q: Okay. Now, are these market share projections
17 on this sheet here, 12904, completely different
18 from what you did in your deposition?

19 A: In the deposition, I did this exact
20 calculation, some of the columns used the same
21 assumptions, and I added I think the two in the
22 middle here, if I recall correctly, based on
23 what I learned after my deposition.

24 Q: If Grand Strand achieved the volumes that you
25 have projected, the market share numbers --

1 well, let me re-ask this. If Grand Strand
2 achieves the market share percentages on any of
3 the columns, B, C, D, E or F, would the
4 approval of both applications drive the
5 existing providers below 80 percent?

6 A: I believe so. We'd have to do that
7 calculation.

8 Q: Is it there on the middle of the page, the
9 capacity and ---

10 A: Oh.

11 Q: --- then the percentages under it?

12 A: Yes.

13 Q: Okay.

14 A: I calculated in the middle of the page the
15 utilization of the existing, and there were
16 four existing linear accelerators. There are
17 four then; there are four now.

18 Q: Right.

19 A: And so the standard says that if the addition
20 of a linear accelerator drops the existings
21 below 80 percent, it shouldn't be approved.

22 Q: Okay. What is the capacity of those four
23 units?

24 A: The capacity of those four units, and I note
25 here is from the State Health Plan, is 26,000

1 treatments.

2 Q: Okay. What would the impact of the approval of
3 both of these projects at these market share
4 percentages, particularly the four to the
5 right, C, D, E and F, what kind of impact would
6 that have on the existing machines at CRCC and
7 Myrtle Beach in regards to its volume? Is that
8 number reflected on here, what the volume would
9 be?

10 A: It's at the top of the page, CRCC existing. It
11 shows what their volumes would be under these
12 different levels of market share for Grand
13 Strand, and it starts out at 14,000 in the far
14 right, their existing volumes and their three
15 machines would be about half, not quite half.

16 Q: So it would be 8,000 treatments for three
17 machines, right?

18 A: That's correct.

19 Q: And even more at Grand Strand. All right.
20 Let's look at the next page just to show,
21 Tolbert 12905. Is this ---

22 THE COURT: Just so the record can be clear, you're
23 doing the utilization of existing machines?

24 MR. LONG: Yes.

25 THE COURT: I'm talking to Tolbert.

1 MR. LONG: Oh, I'm sorry.

2 MR. TOLBERT: I'm sorry, your Honor.

3 THE COURT: You weren't doing it.

4 MR. TOLBERT: I'm sorry, Your Honor.

5 THE COURT: That was based on all, both of the
6 applications being approved?

7 MR. TOLBERT: Yes, sir. This analysis ---

8 THE COURT: Oh, you've got it at the top anyway. I
9 see it.

10 MR. TOLBERT: I'm sorry. Yeah, I try to document
11 things pretty thoroughly, but yes, sir. This
12 assumed Conway would also be a new unit,
13 because it's been approved by the Department,
14 and then I was looking at what would happen if
15 Grand Strand was also approved. And if Grand
16 Strand was approved, basically it's taking
17 volume from the existing units.

18 THE COURT: I just want the record to be clear.

19 MR. TOLBERT: Thank you.

20 Q: Just briefly, Tolbert 12905.

21 A: Well, I just like to -- I always tell my
22 students charts and graphs are very nice to
23 demonstrate what you're doing. So this shows
24 the different levels of market share that I
25 used that we were referring to on the previous

1 page.

2 Q: Okay. Let's move over to CRCC Exhibit 10. Can
3 you identify what this exhibit represents?

4 A: As we were mentioning a few minutes ago, I
5 undertook an analysis of the actual referrals
6 by physician to CRCC using data for the year
7 2012, and --

8 Q: Okay. Let me just stop you here. Let's look
9 at Exhibit 11 really quick, if can pull it up.
10 Tell me what Exhibit 11 is.

11 A: It is a list of referrals, and it is by
12 patient. And these are treatment plans, as I
13 recall. So CRCC produced a list of every
14 patient, of course the patient identifying
15 information was excluded, every patient they
16 did a treatment plan on, and I believe it was
17 produced for two years, 2011, 2012. And so
18 each one of these lines is a separate patient
19 that was referred.

20 Q: Does it also include zip code?

21 A: It included the patient zip code and who the
22 physician was, was the, as I recall, the
23 original data and it -- yes.

24 Q: Okay. So is this kind of, is this the
25 information that -- all right. What was the

1 information that you used? Let's go back to
2 Exhibit 10. If you would, tell me what the
3 information is that you used to do this
4 analysis.

5 A: Well, would you mind going back to the other
6 exhibits so I can explain what I did?

7 Q: Sure. If that would be easier.

8 A: Well, I got a list of physicians, I mean of
9 referrals. Actually, it was an Excel
10 spreadsheet, I have several thousand.

11 Q: I think I actually looked -- we'll show it.
12 It' 25, I think. Take a look at 25, CRCC 25.

13 A: And this one is not quite the original because
14 it has added the group on the right..

15 Q: Well, it's the earlier one right? 25?

16 A: Yeah, it was -- this one was one that we had --
17 the original data did not have the column
18 group. We added that column to indicate of the
19 physicians who was a part of AUC, or the
20 urology practice, who was in Coastal Cancer,
21 and then everybody else was classified as
22 other.

23 Q: Okay. Let's go back to 11 then.

24 A: Then what I did in 11 is I added some more
25 columns so we could see further defined

1 physicians and where their referrals, at least
2 I believed, they would go. So we had -- I
3 created a separate Excel spreadsheet that
4 listed just the doctors in the region and added
5 to that spreadsheet the doctor's name, which is
6 the referring physician here, what practice
7 setting they were, you know, basically what
8 practice they were in, and then another column
9 where I added what I thought their referral
10 pattern might be if Grand Strand had a linear
11 accelerator.

12 Q: Okay.

13 A: And so using -- with and Excel it has a
14 function that's called the look up. So I was
15 able to link those two separate spreadsheets to
16 pull into this one the doctor setting and their
17 likely referral pattern into my original data.

18 Q: All right. What other information did you
19 consider in making your determinations on the
20 -- to the likely referral pattern changes?

21 A: What I was undertaking was looking at in that
22 year and the number -- I'll have to look back
23 at the page -- I think it's almost 900 patients
24 were referred to CRCC and had treatment plans
25 done. And I was saying where those -- who

1 referred those patients, and if Grand Strand
2 was open, how do I think it would impact
3 referrals in the future. In order to do that,
4 I looked at the practice setting of the
5 physician, where they were practicing. I
6 looked at medical staff, where they were on
7 medical staff. That's a little more
8 problematic to look at, and I talked to Dr.
9 Francke and Ms. Price because they know these
10 doctors personally, and discussed with them if
11 Grand Strand had a linear accelerator, how do
12 you think it would impact some of these
13 doctors. I looked at the more higher volume
14 referrals.

15 Q: Okay. Let's go back over to 10 now. You ready
16 to kind of talk about each group?

17 A: So from the spreadsheet we were looking at in
18 11, which was --

19 THE COURT: Y'all just hold on just a second.

20 MR. LONG: We're back to CRCC Exhibit 10.

21 THE COURT: If you could just hold on.

22 MR. LONG: I'm sorry.

23 THE COURT: Try to catch up. All right, go ahead.

24 A: So we have a very lengthy Excel spreadsheet,
25 actually by patient. It would have been,

1 because it included two years worth of data, it
2 would have been almost 2,000 rows of data. In
3 order to summarize that, one of the easiest
4 things you can do is do what's called run a
5 pivot table in Excel. So you can then take
6 that data and summarize it very quickly and
7 very elegantly. So I ran a pivot table and
8 then took that data and formatted it into what
9 we're looking at that's I guess Exhibit 10
10 here.

11 Q: Okay. Kind of if you would just kind of walk
12 us through the top of the exhibit here, the top
13 of the chart first and kind of explain the
14 different columns that you have before we
15 actually look at the numbers and the sums.

16 A: So the column first one says referral source.
17 I categorized these physicians basically into
18 eight groups based on their likely referrals to
19 CRCC or to Grand Strand assuming Grand Strand
20 was open, and we can, I guess, talk about those
21 if you want.

22 Q: We will in a second.

23 A: And then the next column I said based on that
24 categorization as a referral source, here's
25 what I think would happen to their referrals,

1 and I called it referral direction. And then
2 I have a column, I said based on those
3 assumptions, here's how many of -- I guess in
4 this year, there was a total of 886 patients
5 referred. Then I broke them out, how many if
6 Grand Strand was open would likely go to CRCC,
7 how many do I really think would go to Grand
8 Strand, and then how many might go to
9 Georgetown from this population of patients.
10 And then I also showed it by area. I broke the
11 service area, based on my analysis, into six
12 subareas that are shown here, and had to use
13 some of that, particularly when I was looking
14 at the Conway and Loris patients.

15 Q: Okay. So, all right, so you broke it down.
16 Just read, so Conway/Loris and the next column
17 would be?

18 A: Myrtle Beach and North Myrtle Beach, I
19 categorized as kind of one geographic market
20 area.

21 Q: Okay. And then how about Murrells Inlet?

22 A: And Murrells Inlet, which is not just the town
23 of Murrells Inlet, it's how I defined the
24 Murrells Inlet geographic market area, and then
25 Georgetown is the whole county and Williamsburg

1 would be the whole county. Georgetown would
2 exclude that part of Murrells Inlet, those zip
3 codes that are in Georgetown County. So it'd
4 be the rest of Georgetown county, and then it's
5 all of Williamsburg. And then CRCC as well as
6 Grand Strand gets patients from outside of
7 those three counties, so I didn't want to lose
8 those, and I categorized those as all other
9 locations.

10 MR. LONG: Let's pull up the left-hand part if we
11 could.

12 Q: All right. Let's go through each one of these
13 categories here. The first one I see here is
14 AUC. So can you explain to the Court what AUC
15 is and what assumptions you made regarding that
16 row.

17 A: Well, this is ---

18 THE COURT: You're talking about referral source
19 there?

20 MR. LONG: Right. Looking at the referral sources.

21 A: So the -- this first category are referrals to
22 CRCC by we call the urologists that are all
23 practicing in Atlantic Urology, and in that
24 year 2012, they referred to CRCC 263 patients.

25 Q: Okay.

1 A: And I assumed for this analysis they would keep
2 referring 100 percent of those CRCC, even if
3 Grand Strand was open. And so all 263 are
4 shown under the referred to CRCC column.

5 Q: You think it's possible Grand Strand would get
6 some patients from Atlantic Urology if it was
7 open?

8 A: Absolutely. For instance, Grand Strand's
9 employees and covered lives who are family
10 members might refer ---

11 MR. THOMAS: Object, Your Honor, it's assuming facts
12 not in evidence right now.

13 THE COURT: Well, I'll sustain that one unless you
14 can explain it to me. It calls for
15 speculation.

16 Q: Well do you think that there -- did you
17 anticipate, would you expect that the Atlantic
18 Urology, some of Atlantic Urology's patients
19 might be employees of Grand Strand?

20 A: Yes, of course, yes.

21 Q: And how large an employer is Grand Strand in
22 Horry County?

23 A: It's one of the largest employers in Horry
24 County.

25 Q: What's the ---

1 A: Also, I can say when I was an administrator at
2 Self Regional, our benefit plan ----

3 MR. THOMAS: I'm going to object again because he's
4 going to try to compare his Self Regional
5 benefit plan to Grand Strand's benefit plan.
6 That's not in evidence. He knows nothing about
7 it.

8 MR. LONG: He knows the hospital industry. He's a
9 fellow. He's worked at a hospital his entire
10 career, and I think he can give an opinion as
11 to what the employees at Grand Strand, where
12 they would go and get their services if they
13 were, if they needed radiation therapy
14 services. I don't see how he couldn't possibly
15 give his opinion to that.

16 MR. THOMAS: Absolutely not, Your Honor.

17 MR. LONG: He's a healthcare planner and he's been
18 qualified in planning and finance.

19 THE COURT: Well, I think he can give his opinion on
20 it. I think he's very qualified. The problem
21 I have unless there's a foundation laid is that
22 at this point in time, the probative value of
23 comparing Self Hospital to Grand Strand is just
24 not there because there was nothing, there's no
25 nexus that has been established in this case.

1 So I sustain the objection in that regard.

2 Q: Based on your experience as a consultant and
3 working in the healthcare industry and in your
4 entire career, do you have an opinion as to
5 whether it is common for healthcare providers
6 to incentivize, not financially, but to
7 incentivize or even require their employees to
8 use their services.

9 A: In the healthcare industry, my experience in
10 hospitals, if the hospital provides a service
11 and there's another local service available,
12 the hospitals will often provide an incentive
13 for their employees to use their service. For
14 instance, it will -- sometimes it's a negative
15 -- well, the typical one I've seen is they'll
16 waive the deductible. An example could be
17 endoscopy. If you need an endoscopy, hospitals
18 provide endoscopy services, a lot of
19 freestanding centers. The hospital would
20 rather their employees and covered lives use
21 their facility because they already have it
22 open, they've got fixed costs, and they'd
23 rather pay themselves for the service than pay
24 it outside. And so they will often waive their
25 deductible if the employee uses the hospital-

1 based service instead of the outside service,
2 which is cash out. And that's primarily done
3 at the -- hospitals are typically self-insured.
4 So when they write a check, it's coming right
5 out of their cash, and they'd rather pay it to
6 themselves than someone else. So they
7 typically provide that incentive. Also in this
8 case, I'm aware that the urologists are
9 obligated and do tell the patients they have
10 choices for services if they need radiation
11 therapy. And so they would be telling the
12 patients you have a choice of this service of
13 Georgetown, Ford Center, and Grand Strand. A
14 physician would do that and let them know their
15 choices, and they may not all choose as they
16 did in the year 2012 if there was another
17 option available.

18 Q: Okay. So ---

19 A: But in this case I gave ---

20 Q: Your assumption, you gave 100 percent to CRCC
21 from urologist?

22 A: I assumed that would still be the same. I
23 think that is a generous assumption in regards
24 to CRCC, knowing in my mind, my opinion that
25 some of these 263, if Grand Strand had been

1 opened that year, might have opted, from the
2 patient standpoint through a financial
3 incentive or whatever to choose Grand Strand.
4 I just assume none, but likely there would be
5 some.

6 Q: Okay. Let's look at the second column, CRCC -
7 100 percent supportive. What does that column
8 represent?

9 A: These were -- we'd have to look at the list.
10 I think there were a couple of physicians that
11 in my discussions with Dr. Francke and Sissy
12 indicated for several reasons that those two
13 physicians would likely continue to send all of
14 their patients to CRCC, so they got 100
15 percent.

16 Q: Okay. The third column is Coastal, right?
17 What is Coastal?

18 A: That's Coastal Cancer Center, what's been
19 referred to in the trial as Dr. Holt's
20 practice.

21 Q: All right. What did you do with the Coastal
22 Cancer -- how did you allocate the Coastal
23 Cancer referrals?

24 A: Well, I needed to break those in two groups,
25 trying to be very objective and what I think is.

1 very, very fair. We know that three of the
2 Coastal physicians who have some practice
3 presence in Conway provided us with letters of
4 support and indicated they would support our
5 center in Conway. But also we knew there was
6 some close relationship between Grand Strand
7 and Coastal, lots of discussions going on and
8 that they would certainly support Grand
9 Strand's. And so I looked and I broke the
10 Coastal referrals in two groups. The first
11 group is that in that year CRCC received 89
12 patients or did treatment plans on 89 patients
13 who resided in what I classified as the Conway
14 and Loris areas. And I assumed in that group
15 that CRCC would get 75 percent of those
16 patients, 22 percent would go to Grand Strand.

17 Q: Twenty-two patients or 22 percent?

18 A: Excuse me, no, there was 25 percent, 22
19 patients.

20 Q: Okay.

21 A: And that is similar to the assumption I made in
22 our CON application. I assumed that the CRCC
23 patients who we have now who reside in the
24 Loris/Conway area, that 75 percent of them
25 would choose our facility in Conway and 25

1 percent would drive to Myrtle Beach. Why
2 didn't I assume 100 percent? Within that area
3 of Conway and Loris, there's some population
4 centers, Carolina Forest is one of them, that
5 is right between Myrtle Beach and Conway, and
6 I knew some of those patients who work in
7 Myrtle Beach or shop in Myrtle Beach would
8 probably prefer to drive to Myrtle Beach. I
9 also knew there are a variety of other reasons
10 patients might want to go to Myrtle Beach
11 instead of the Conway facility, so I split ours
12 in our original CON application 75/25. So
13 that's how I split that group. The other
14 group, which is all else of Coastal Cancer's
15 referrals, I reversed it and assumed they would
16 send 75 percent of those to Grand Strand and
17 they would still send some to CRCC, primarily
18 in Myrtle Beach that would be the 47 patients
19 there, 25 percent.

20 Q: If you combine those numbers in regards to the
21 Coastal patients, what would the overall
22 breakdown be between Grand Strand and CRCC, if
23 you need to do the calculation ---

24 A: No, yeah, I do.

25 Q: -- if you considered all of the patients

1 instead of breaking it out like you did.

2 A: In this analysis, I did not do that. So you're
3 asking me what percent of Coastal patients
4 would go to ---

5 Q: Grand Strand ---

6 A: --- Grand Strand?

7 Q: --- total if you had not separated it out by
8 geography?

9 A: Is it okay if I write here if I need to -- do
10 you have a slip of paper.

11 MR. LONG: Is that okay, Your Honor?

12 THE COURT: Yeah.

13 A: So I projected if -- the way you look at this,
14 it looks as if Grand Strand linear accelerator
15 was open in 2012, what would happen.

16 Q: Right.

17 A: So I projected that Coastal would send Grand
18 Strand 22 patients from the Conway/Loris area,
19 so that's 22, and then 139 from the rest of the
20 referrals they made. So that total is 161.
21 The total, grand total of all patients referred
22 to CRCC in that year is 89 plus 186, so that's
23 275. So 161 I'm estimating would go to Grand
24 Strand divided by 275 is 58 percent. So I
25 assumed, I had not done this, but I assumed

1 that Grand Strand would get basically 58
2 percent of Coastal's patients that would have
3 otherwise gone to CRCC.

4 Q: Based on the testimony that you've seen and
5 heard in the trial, what do you think about the
6 likelihood that Grand Strand would get 58
7 percent of Dr. Holt's group's patients?

8 A: Based on what I've heard, I think it would
9 exceed 58 percent. My assumptions now that I'm
10 looking at probably were on that -- on the
11 conservative side. It'd probably be a good bit
12 higher than that.

13 Q: Okay. Let's look at the rest of the
14 categories. You've got this category or row
15 four, it says GS committed. What is GS
16 committed?

17 A: Well, we had, and there weren't a lot of
18 physicians, but we had some physicians from the
19 list as we were looking at it that had what I
20 determined to be very, very close working
21 relationships or allegiance to Grand Strand,
22 and I broke them into three categories. One was
23 you'd say described as committed, very high
24 allegiance, and I assumed they would get --
25 send 90 percent of their patients to Grand

1 Strand. As I recall, two of those doctors were
2 neurosurgeons that are employed by Grand
3 Strand. I think the other two were
4 pulmonologists or general surgeons. The next
5 list was not quite as committed, but primarily
6 would support Grand Strand. I don't -- I think
7 maybe four or five, maybe six physicians in
8 that category. The total physician list was
9 about 150. So, and I said those would send
10 Grand Strand 70 percent of their referrals that
11 in the past they would have sent to CRCC, and
12 then there was another small group of
13 physicians that I projected would get 50
14 percent.

15 Q: Okay. And so are those redirect, those
16 redirected patients reflected there in the
17 columns of Grand Strand and CRCC?

18 A: They are, and out of the 886, it's not a huge
19 number, but yes, they are.

20 Q: Okay. And then column -- I mean row number
21 seven, did you also look at Georgetown in
22 regards to these physicians?

23 A: Yes, I did, and again, this was based on some
24 of the physicians that practice at the Waccamaw
25 Hospital, Waccamaw Community Hospital, or

1 based on my analysis, would have very high
2 allegiance to Georgetown and if Georgetown was
3 located or the Ford Center moved to Murrells
4 Inlet would likely in the future send at least
5 69 of the patients to the Murrells Inlet Ford
6 Center. I did not do an extensive analysis of
7 that. That's a different trial I gather on a
8 different date. What I was focusing on this
9 analysis was what would go to Grand Strand.

10 Q: Okay.

11 A: But I put some over that would likely go to
12 Georgetown's facility.

13 Q: All right. And then the last row you said is
14 other?

15 A: It's other. For the most part, it's physicians
16 that -- and that was a long list of physicians
17 that provided one, maybe two referrals. I
18 think there were a couple that were higher
19 volumes that ended up in that category, maybe
20 just two, who sporadically, rarely,
21 occasionally refer to CRCC, and I judge they
22 would not have a strong real allegiance to
23 where to send, and if there were three
24 providers, that they would send 40 percent to
25 CRCC, 40 percent to Grand Strand and 20 percent

1 to Georgetown.

2 Q: All right. Then so by -- after you had done
3 all that redirection, based on the 2012
4 numbers, what is the total number of patients
5 in your opinion that you project would go to
6 Grand Strand based on an analysis of physician
7 referrals?

8 A: Well again, this is looking what if in 2012
9 Grand Strand was open. My projections here,
10 and as we're talking through them, probably are
11 very conservative. Grand Strand would have
12 gotten 290 of the 886 patients that were
13 treated by CRCC.

14 Q: Okay. And if you look at the -- and then at
15 the bottom of that chart, did you make
16 adjustments for 2017?

17 A: Yes. Well, you would need to do that and I
18 used the same percentages I used in all the
19 other calculations to increase it to what the
20 volume would likely be in 2017. So I showed
21 the years and the percentages here and
22 increased it so my projection would be in the
23 year 2017 based on the growth and the demand or
24 need for radiation therapy services, it would
25 be 328 patients.

1 Q: Now then you calculated the total number of
2 treatments for those patients?

3 A: Yes, and I used 25. I believe that was the
4 average treatment per patient for the year
5 2012.

6 Q: Okay. At CRCC?

7 A: I thought it was for the region.

8 Q: For the service area, okay. And then is that
9 the number you used, or is that part of your
10 market share analysis when you looked at the
11 physician referrals that we looked at on
12 Exhibit 12?

13 A: Again, this was one part of my analysis, one of
14 those columns, and I used the 238, the --
15 excuse me, 328 and the 8,195 treatments to add
16 to that other column.

17 Q: Okay. You've also heard testimony in the trial
18 regarding HCA's internal analysis of this
19 project. Do you have some opinions as to
20 whether that is a credible, whether those
21 credible facts for you to look at in
22 determining market share and treatment volume,
23 projected treatment volumes for Grand Strand?

24 A: I'm sorry, could we take a break?

25 MR. LONG: This might be a good time to stop if we

1 could, Your Honor, for a short break.

2 THE COURT: All right. Yeah.

3 MR. LONG: Thank you.

4 (Break from 10:35 a.m. until 10:44 a.m.)

5 THE COURT: Ready.

6 BY MR. LONG:

7 Q: Let's go back before I -- I was going to
8 transition, but I want to pick up one more
9 question here. So on this Exhibit 10, your
10 total treatment number for Grand Strand is
11 8,195, right?

12 A: That's correct.

13 Q: Now let's look over at Exhibit 12 again, the
14 market share exhibit and what would be the
15 second page, Tolbert 12904.

16 A: Yes.

17 MR. LONG: And if you look, bring up the top part of
18 that or at least the first three groups, a
19 little bit further, there you go.

20 Q: Okay. In column C, Tolbert projected shift to
21 Grand Strand from CRCC, that number is 8,210.
22 Can you explain to the Court why those numbers
23 aren't exactly the same?

24 A: The 8,210 is calculated based on what the
25 market share is. And in this case, I'd have to

1 go back and look, but I probably took the
2 market share to a tenth of a decimal place
3 instead of out to three or four and it came
4 out, it just calculated Grand Strand's volume
5 just slightly different.

6 Q: Okay. Less than a patient. It's less than a

7 ---

8 A: Yeah. Well, yes, it would be less than a
9 patient. Looking at it, I wish I had gone
10 ahead and taken it to ten decimal places so the
11 numbers were exact, but that was just how the
12 calculation was done rounding the market share.

13 Q: All right. You have been here listening to the
14 trial. You've also heard some of the testimony
15 regarding HCA, the executives in Nashville,
16 their approval of the program, right? You
17 recall that testimony, some of those exhibits?

18 A: Yes.

19 Q: All right. Can you kind of describe for the
20 Court based on your experience the -- how
21 hospitals go about approving capital projects,
22 in your experience?

23 A: Well my ---

24 Q: Particularly for profit hospitals.

25 A: And I have worked for for profit hospitals as

1 a consultant, but whether it's for profit or
2 not, all of them have some sort of mechanism
3 where they do, it's called an asset, some of
4 them call it a capital investment evaluation
5 system. They have a template that they put
6 numbers in to then calculate how much is it
7 going to cost us to provide this new service or
8 replace this piece of equipment; how much
9 volume will it generate; how much net revenue
10 or cash will it really generate; what it's
11 going to cost us to operate it; basically, how
12 much profit will it make; and is it a sensible
13 thing to do from an economic standpoint? Is it
14 going to be worth our investment? And they all
15 call it, all the ones I've worked with call it
16 different things, but it's similar to what I
17 guess HCA calls it CAMS, and I don't really
18 remember what CAMS stands for, but it's capital
19 asset management system, or something like
20 that.

21 Q: Let's take a look at CRCC Exhibit 122, which is
22 in evidence. Look at the last page of that,
23 okay.

24 MR. LONG: And you can blow up the top of that.

25 Q: Do you recall this email from Mr. Rooker who's

1 ---

2 MR. LONG: If you can catch his name at the bottom,
3 Bronwyn.

4 Q: --- who's the controller in Nashville?

5 A: Yes, I remember that testimony in court.

6 Q: Okay. And of course he says in this email that
7 the current -- for the Grand Strand project
8 that the NPV is 1.54, ROI is how much?

9 A: 32.8.

10 Q: And payback?

11 A: Is 6.3 years.

12 Q: Okay. And you heard the testimony of Mr. Lewis
13 about what those numbers meant?

14 A: Yes.

15 Q: Okay. You disagree with any of that?

16 A: No, he defined what those -- those are called
17 financial ratios, what those numbers mean
18 accurately.

19 Q: Okay. If we could go over to the CRCC Exhibit
20 115. I'm sorry, move over to page 1637, GSRMC
21 1637.

22 THE COURT: What's the exhibit number?

23 MR. LONG: I'm sorry, it's 115. Actually, I wanted
24 to do the page before. I apologize, Your
25 Honor.

1 Q: Let's turn, I'm sorry, to the page before that,
2 GSRMC 1636. Look at the bottom, that box. Do
3 you recall those are the same numbers that we
4 just saw on the email?

5 A: They are the same numbers.

6 Q: Okay. Are those healthy ratios for a project
7 like this?

8 A: I wish I could invest in that project. Yes,
9 they're healthy ratios.

10 Q: Okay. And looking at the tag line, just to
11 clarify for the record, this is the "what if"
12 CAMS right? It says in the tag line, CAMS
13 "what if"?

14 A: Yes. Yes, it is.

15 Q: All right.

16 MR. LONG: Let's look at the next page, GSRMC 1637
17 about the middle of the page, right there.
18 Blow up all that.

19 Q: Okay. You see the treatment projections for
20 the "what if" CAMS?

21 A: Yes.

22 Q: In the top line there.

23 A: It appears those are for five years.

24 Q: Okay. What's the third year o projection for
25 the project in regards to treatments?

1 A: For the linear accelerator, they've got some
2 other volumes on here. It's the top row. It's
3 7,854 treatments in the third year.

4 Q: Do you find that to be fairly close to your
5 calculations?

6 A: Well, my number was about 8,000 using one of
7 the scenarios and several of them were around
8 that number, yes.

9 Q: Okay. And now you didn't know these
10 projections when you were doing your
11 projections, did you?

12 A: I did not know these until it came out in
13 testimony.

14 Q: Okay. All right. If you had a -- now let's
15 look over to Petitioner's 6, Grand Strand
16 Exhibit 6. These are the CAMS that are
17 referred to as the "For Will Thomas CAMS."

18 A: I'm sorry. They're referred to as what?

19 Q: If you look on the tag line on the bottom
20 there. Turn to the third page.

21 A: Yes, I see the tag line.

22 Q: Okay. Can you look on the third page of the
23 exhibit. No, I think we're on -- Petitioner's
24 6. It's 006-003. That's it. If you'll look at
25 that box at the bottom. All right. These are

1 the ratios that are in the CAMS with the lower
2 projections, right? Do you recall?

3 A: Yes, I do.

4 Q: All right. Would the hospital -- is any
5 hospital that you've worked for approve a
6 radiation therapy center with those projected
7 financials?

8 A: A radiation therapy center is an optional
9 service. One is being provided locally in this
10 case. This one, based on these projections, is
11 what we would describe as a money loser. Some
12 people slangily describe it as a dog, in terms
13 of a financial investment.

14 Q: Okay. And what are some of the numbers on here
15 that would cause you to conclude that?

16 A: Well, the net present value index is .85. That
17 indicates that your net present value of your
18 future earnings for the horizon you calculated
19 this, you don't make -- you don't make return
20 what you paid for, invested. It's a negative
21 number, less than 1.0. The internal rate of
22 return and the five year ROI certainly are on
23 the low side of what you would typically want
24 to see. Many, even not for profit hospitals
25 have a ROI threshold of 20 percent. If it's

1 less than 20 percent, they have to ask why
2 would I want to do this service. I know for
3 one of my consultant clients that's a for
4 profit hospital, their threshold is corporate
5 won't even consider a project that's less than
6 20 percent ROI. And then discounted cash
7 payback over the period of time here says
8 never, so you don't in cash make back what the
9 project cost you.

10 Q: Okay. In ---

11 A: Let me add, this is projected apparently over
12 ten years.

13 Q: So it would not pay itself back over that ten
14 years?

15 A: That's what it says. The project life and the
16 formulas that would have been -- should have
17 been used in this, that should have been the
18 ten year horizon.

19 Q: Is radiation therapy ever a loss leader?

20 A: I've been in healthcare now 38 or 40 years.
21 From a hospital standpoint, there are only two
22 services I've ever really heard discussed that
23 are loss leaders in the hospitals. One is an
24 emergency department, which you're for the most
25 part obligated to provide. Also the emergency

1 department is an important community service.

2 The other is a neonatal intensive care unit and
3 some high end maternity services that you
4 generally know are going to lose money.

5 Ancillary services in a hospital, this would
6 fall in the right category, are expected to
7 make money to cover the loss leaders.

8 Radiation therapy is not a loss leader.

9 Q: All right. So looking at those numbers, you
10 projected on your two analysis -- well, at
11 least looking at market share and also
12 supported by position redirection and HCA
13 corporate, where are all those numbers kind of
14 -- what's the kind of common number on that
15 range?

16 A: All -- when I looked at what I thought Grand
17 Strand would likely do, when corporate
18 apparently approved the project, they were all
19 looking at about 8,000 treatments a year.

20 Q: Okay. Now, Mr. Sullivan's number we saw
21 earlier, I guess and we can go back to Exhibit
22 12 I guess. Your projections, Mr. Sullivan's
23 projection -- the CON projection carried
24 forward to 2017 in the middle of the page, if
25 we could, he projected that Grand Strand would

1 achieve how many treatments?

2 A: Well, that's my projection taking his original
3 number and increasing it, moving it out two
4 years was 4,934 treatments.

5 Q: Okay.

6 A: Quite a difference from 8,000.

7 Q: All right. Well, how did -- he used a method
8 to calculate the market share. Do you recall
9 what he called it?

10 A: A draw rate I think is the term he described
11 it.

12 Q: Okay. I think first why don't we take a look
13 at CRCC Number Exhibit 13, and this of course
14 has got a lot of numbers on it, so, but if you
15 can kind of explain to us what work you did in
16 regards to this exhibit and what conclusions
17 you drew.

18 A: Well, I noticed in Mr. Sullivan's analysis that
19 he took by zip code and created a primary and
20 a secondary service area for Grand Strand's
21 radiation therapy, and I saw that in the
22 secondary area, there were some Myrtle Beach
23 zip codes, and I thought that was kind of odd
24 because that's in the shadow of the hospital.
25 And then I said well, let me -- let me look at

1 this kind of draw rate looking at the numbers
2 in terms of not just the number of patients
3 that came from a zip code but also at the
4 population that was in that zip code. For
5 instance, you could have a high number of
6 patients and a very high population and your
7 market share in that zip code might not be that
8 high. You could have a zip code that had a few
9 patients but it's a very small population, and
10 you could be the dominant provider in that
11 market. So I was trying to look at it based on
12 a population analysis too.

13 Q: Okay. And what did you conclude?

14 A: Well, I concluded, and it's hard to read at the
15 bottom right, what I thought that population
16 might generate in terms of projected patients.

17 Q: What criticisms or comments would you have for
18 the Court in regards to Mr. Sullivan's market
19 share projections that he made in the
20 application with his draw rate?

21 A: I think it was on the low -- on the low side in
22 terms of what they would actually be doing.

23 Q: Let me show you, let's look at CRCC Exhibit
24 Number 4, which is, it's actually two maps.

25 Okay. It's two maps. You should have them on

1 the screen there if you'd rather look there.

2 All right. The first map is Mr. Sullivan's
3 projections of the total number of radiation
4 therapy treatments, the total number of
5 radiation therapy treatments that he projects
6 in 2015 in his application by zip code, right?

7 A: Yes.

8 Q: Okay. And then the second map shows his
9 projected patients that he expects Grand Strand
10 to get from in 2015, right?

11 A: Yes.

12 Q: All right. Would you expect that Grand Strand
13 would only get literally a handful, seven
14 patients from these three zip codes, 29527,
15 29526, and 29569?

16 A: I would expect more.

17 Q: And he also -- would you expect that he, that
18 the zip codes closest to the hospital where
19 most of their patients come from that they
20 would get more than 25 percent from those zip
21 codes?

22 A: Yes, in Horry County all the zip codes I
23 thought their inpatient market share was 35
24 percent.

25 Q: We can actually look too at the number of

1 patients by their inpatient discharges and
2 total population. Would you expect -- here's
3 total inpatient discharges by zip code and you
4 see a couple of these zip codes have numbers,
5 what's 29575 total number of inpatients?

6 A: I'm sorry, that's a little small for me to
7 read.

8 Q: I'm sorry, CRCC Exhibit 3. We can blow that up
9 a little bit. I'll bring the map a little
10 closer to you.

11 A: Yeah, I'm sorry.

12 Q: Blow that up a little bit. But if you look at
13 29577, how many patients is that in that zip
14 code?

15 A: In that year, it was 3,276 patients in total.

16 Q: Okay. And based on your analysis of Grand
17 Strand's market share compared to the other
18 hospital providers in the area, how would you
19 describe it?

20 A: Grand Strand is the dominant healthcare
21 provider in the area.

22 Q: Okay. And is it, would you expect it to be
23 particularly dominant in the zip codes with the
24 highest populations?

25 A: Well, yes, there's no other hospital in that

1 zip code area immediately around them other
2 than they.

3 Q: From a mathematical point of view using a
4 fairly small subset of patients like Mr.
5 Sullivan used, I think a few hundred to do his
6 draw rate, does that potentially affect how
7 those numbers come out?

8 A: In doing population analysis, there's a
9 mathematical term that's called the law of
10 large numbers. The larger numbers you have,
11 the more accurately you can predict something
12 because you lose some of the variation. If you
13 deal with a small set of numbers, for instance,
14 you could take one zip code, one year, the
15 number of cancer patients in that zip code.
16 Say it was seven. The next year, it could
17 easily be three times that because you're
18 dealing with a small number. If you did it for
19 the county as a whole, it wouldn't be, you
20 wouldn't have as substantial a variance in your
21 analysis because the law of large numbers makes
22 your statistical analysis more valid. Taking
23 your cancer cases by zip code for one year for
24 small numbers, you could easily -- it might be
25 very wrong.

1 Q: Okay.

2 A: Another point here, when patients are admitted
3 to a hospital, very often they don't know
4 they're a cancer patient. This is on discharge
5 after the diagnosis has been made, so that's
6 why I think you'd use the discharges of all
7 patients to measure what you would potentially
8 have in terms of market share for any service
9 like this.

10 Q: Do you have an opinion as to whether Mr.
11 Sullivan's projections in the CON regarding the
12 projected utilization and Grand Strand's linear
13 accelerator are too high, low, or just right?
14 Mr. Sullivan's projections.

15 A: They're on the low side, which is why I
16 undertook those different levels of analysis to
17 benchmark it and see if I had some data that
18 would indicate that they are low. I think they
19 are low.

20 Q: And in your opinion, their number of treatments
21 at Grand Strand in the third year, can you give
22 the Court a number that you think would be
23 likely thought utilization that they would
24 attain?

25 A: 7,500 to 8,000 treatments.

1 Q: Okay. If you're, let's take the work that
2 we've done so far and ---

3 THE COURT: Is that the third year or 2017? I
4 forgot which one.

5 MR. LONG: Well, I asked him the third year.

6 THE COURT: Okay.

7 MR. LONG: Well, I'll ask it again.

8 Q: Is 2017 the same thing as the third year?

9 A: Yes, yes that's the third year that we're all
10 using in our testimony as far as I know.

11 Q: All right. Let's swing back. At the beginning
12 of your testimony, we talked a little bit about
13 the competing applications and the standards in
14 the Health Plan regarding linear accelerator.
15 You recall that, right?

16 A: Yes.

17 Q: All right. Now, let's see if we can determine
18 for the Court in this particular case -- okay.
19 Let's see if we can determine for the Court
20 what the steps would be to determine how much
21 the utilization would be, need to be for the
22 two projects to where the approval of both
23 would drive the existing units below 80
24 percent. Do you understand the premise?

25 A: Yes, I think I do. The capacity of the four

1 existing units as defined by the Department in
2 the State Health Plan is 26,000 treatments.

3 Q: You want to see that number? It's Joint
4 Exhibit 4, State Health Plan IX-8. About
5 midway down, capacity for the existing units in
6 Georgetown, Horry, and Williamsburg.

7 A: So the capacity of the four existing linear
8 accelerators is 26,000 treatments per year.

9 Q: Right. Okay. So what, how would you calculate
10 the 80 percent threshold?

11 A: Well, you would take 26,000 and multiple it by
12 80 percent.

13 Q: And that number is?

14 A: You're quicker than I am here. 20,800.

15 Q: All right. So if the existing units are below
16 20,800 in the third year, what does that mean
17 in regards to the analysis of whether these two
18 applications can be approved?

19 A: Well, under the regulations in the State Health
20 Plan, if any unit was added, whether it was one
21 or two, and it drove the volumes on the
22 existing four units below 80 -- 20,800, you
23 would be below 80 percent, and the standard
24 says you could not add that unit.

25 Q: And would -- and if there's not a need for the

1 project under the State Health Plan, does the
2 regulations and statute allow the Court to
3 approve more than one on a competing situation?

4 A: No, it would not.

5 Q: In other words, if approval of both
6 applications would exceed the need ---

7 A: If it would drive this below 80 percent, the
8 need would not be there and they both could not
9 be approved.

10 Q: Okay. And before we continue on with this,
11 just talking about competing applications. Why
12 is the concept of competing applications
13 important in healthcare in regards to CON?

14 A: Well, one of the four major purposes or four
15 purposes of the CON Act is to avoid unnecessary
16 duplication. I think the Act says to prevent
17 it, and it would be as the standards are
18 written, a defacto, unnecessary duplication if
19 it drive the existing providers, added another
20 service that drove them below what is
21 determined is an appropriate minimum
22 utilization level.

23 Q: And so if the approval of both of these
24 applications would exceed the need, is the
25 Department permitted to approve both in South

1 Carolina?

2 A: Not under the -- no, not under the regulations.

3 Q: All right. So 20,800 is our number for the
4 existing units?

5 A: Yes.

6 Q: To determine 80 percent. All right. What's
7 the next step that we would do then to
8 determine whether these applications exceed the
9 need?

10 A: Well, you would have to project how many
11 treatments are going to be done in the area in
12 that year, third year 2017. So you have to
13 know what the total need is for radiation
14 therapy treatments.

15 Q: And you've done that calculation in Exhibit 12,
16 correct?

17 A: Yes, it was, you'll have to call it up, it was
18 31,000 --

19 Q: 824?

20 A: Yes.

21 Q: Okay. All right. 31,824 is the total. All
22 right. Now, let's talk about CRCC-Conway.
23 What did you -- let's continue looking at
24 Exhibit 12. It'd be easier for us to get the
25 exact numbers. Probably want to look on the

1 first page, Tolbert 12903, in the middle.

2 MR. LONG: Could we do the first half of the page
3 maybe.

4 Q: Okay. What did you project for CRCC-Conway?

5 A: Now, CRCC-Conway would be a new unit. It's not
6 an existing unit. And I projected in year
7 three, which is year 2017, 5,499 treatments.

8 Q: Has anybody in this trial, have you heard any
9 witness in this case question or call into
10 doubt your projection as to the treatment
11 volumes for CRCC-Conway?

12 A: No.

13 Q: Are you comfortable that your projections in
14 the application for CRCC-Conway are reasonable?

15 A: Yes.

16 Q: And do you -- in your opinion, what would you
17 expect CRCC-Conway's treatment volume to be in
18 2017, the third year?

19 A: 5,499.

20 Q: Okay. Now, if we are -- is there a way that we
21 can kind of calculate, assuming that CRCC-
22 Conway is going to be 5,499 and the total is
23 31,824, what the number would be for Grand
24 Strand where if the approval of Grand Strand
25 would exceed the need, a tipping point, so to

1 speak?

2 A: Well, yeah. A tipping point, you would need to
3 compare that with the 20,800, which is the
4 point at which you would want the existing
5 providers. So if the existing providers were
6 at 20,800, you would subtract that from the
7 31,000, and then you would subtract the Conway
8 projected volume and what's left would be the
9 point at which Grand Strand, if it exceeded
10 that number, would drop the existing four units
11 below 80 percent.

12 Q: Can you do that calculation?

13 A: Let's see. Okay. You take 31,824, and if you
14 assume the existing providers need 20,800 to
15 not drop below 80 percent, let's subtract that.
16 That leaves 11,024. If we accept, and I think
17 it's a very valid number that CRCC-Conway will
18 do 5,499, I would subtract that. And then the
19 point, Grand Strand would be at 5,525
20 treatments. So if Grand Strand is at 5,525,
21 CRCC that we've projected at 5,549 ---

22 Q: 5,499.

23 A: Excuse me, yeah, 5,499, and all the rest, the
24 four existing units would have 20,800. Then
25 all those three added together is 31,824.

1 Q: So if Grand Strand in 2017 exceeds 5,525 and
2 Conway's ---

3 A: That's a given.

4 Q: --- if they exceed 5,525, is there a need to
5 approve both?

6 A: If they exceed 5,525 by one treatment, it would
7 drop it below 80 percent.

8 Q: Okay. And in your opinion, what is the
9 likelihood that Grand Strand will exceed 5,525
10 treatments in 2017?

11 A: Every scenario that I looked at using different
12 ways to project market share, and it appears
13 that HCA corporate also was expecting the unit
14 to be at 8,000 treatments a year, way above
15 5,525.

16 Q: Is there any doubt in your mind about that
17 opinion?

18 A: No, not in my mind.

19 Q: Okay. Now, I'm going to ask you to do another
20 couple of quick calculations if you could.
21 5,525 treatments, can you tell -- can you
22 calculate for the Court how many treatments
23 that would be per day?

24 A: How many operating days a year do you want to
25 assume?

1 Q: Well, I'll let you pick. Which one do you
2 think? We've heard 250, 255. Do you have a --
3 -

4 A: Well, 250 would be more conservative, so let's
5 use 250. That's 22.1.

6 Q: 22.1 patients.

7 A: Or treatments per day.

8 Q: Treatments per -- well, it'd be patients too.
9 Patients per -- treatments per day, okay?

10 A: Yes.

11 Q: All right. Is that a high number or a low
12 number for a world class cancer center
13 connected to the dominant hospital in the
14 service area that's a tertiary hospital?

15 A: I think that would be a low number. I believe
16 Mr. Lewis said his opinion breakeven was 18.

17 Q: Okay.

18 A: And that would not be a busy machine at 22.

19 MR. THOMAS: Your Honor, first of all, I just need
20 to object to that last answer because it does
21 mischaracterize the testimony when he said that
22 some breakeven analysis. That was not for
23 inpatient hospitals. That was for outpatient
24 facilities, so I just want to make sure we've
25 got that on the record.

1 THE COURT: You want to just clarify the record or
2 you wish me to ---

3 MR. THOMAS: Yeah, or if Mr. Long wants to. That's
4 fine to get the witness to clarify. However
5 you want to handle it.

6 THE COURT: I'll take that as a speaking objection
7 which I can't make a ruling on it at this point
8 in time. You've given me the information but
9 do you wish his his testimony to be stricken?

10 MR. THOMAS: Yeah, I do wish it to be stricken
11 because it mischaracterizes Mr. Lewis' own
12 testimony, misstates it.

13 THE COURT: I was speculating on what pitting
14 witnesses were earlier, and I don't think the
15 speculative aspects was pitting the witnesses.
16 This one probably hits that category.

17 MR. LONG: Okay. Well, he ---

18 THE COURT: So I'll sustain it on those grounds.

19 Q: Let's move on to the next calculation. How
20 many patients would 5,525 -- well, let me back
21 up, I do want to ask you one more question. In
22 your opinion, is there any doubt in your mind
23 that Grand Strand will exceed 22 patients per
24 day -- 22 treatments per day in 2017?

25 A: Yes, if they're going to exceed 5,525 total

1 treatments in a year, which I'm absolutely sure
2 they would, it would be a higher number per
3 day.

4 Q: How many patients for the year would 5,525
5 treatments be?

6 A: Well, if we use the 2012 number for the region,
7 I think the average was roughly about 25
8 patients per -- each patient got an average of
9 25 treatments.

10 Q: Okay.

11 A: So that would be 5,525 divided by 25, which is
12 221 patients.

13 Q: Okay. Take a look at, let's pull up Grand
14 Strand's CON Joint Exhibit 2, page 617. Page
15 617.

16 A: Yes.

17 Q: Okay. If you look at the bottom of the page,
18 how many patients did Mr. Sullivan project that
19 Grand Strand would have?

20 A: In this calculation, it's 223, and that's year
21 2015, not adjusted for the growth in the market
22 for the two years lag we've had.

23 Q: So he actually projected more than your
24 calculation of what 5,525 would be?

25 A: Yes.