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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable S. Phillip Lenski, Administrative Law Judge

Appellate Case No. 2015-000056
Lower Court Docket No. 11-ALJ-07-0575-CC

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center
d/b/a Fort Mill Medical Center Respondent,

v.

South Carolina Department of Health and Environmental Control
and The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill Respondents,

Of whom The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill, is Appellant.

RECORD ON APPEAL - VOLUME III OF XVII

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1 seeing in that part of the county continued to
2 grow as well as the Health Plan itself made a
3 provision that there were 64 beds available to
4 Piedmont to expand.

5 Q: All right. And are you familiar with the Plan?

6 A: Yes.

7 Q: What was your understanding at the time
8 concerning the determination of bed need in the
9 Plan?

10 A: Well, the basic formula they used and language
11 in the Plan, that Piedmont had 64 beds
12 available to it for growth and expansion.

13 Q: All right. Did you meet with the Department
14 officials, DHEC officials concerning the
15 development of your plans?

16 A: I did.

17 Q: And what was the import of that meeting?

18 A: Well, the import of that meeting was to confirm
19 our understanding of the Plan and the formula
20 and the availability of the beds so that there
21 would be no confusion or misunderstanding as
22 basically decisions were being made and I
23 proceeded.

24 Q: And what did you -- did you meet with -- was
25 Mr. Levitt with you?

1 A: Yes.

2 Q: And who did you meet with?

3 A: Mr. Grice.

4 Q: And what did you and Mr. Levitt inform Mr.
5 Grice of at that meeting?

6 A: That we were interested in utilizing the 64
7 beds of expansion for healthcare in York County
8 and that it was our intent to build a hospital
9 in the Fort Mill area with those beds.

10 Q: Okay. Now, did you have any understanding at
11 the time that the beds could be awarded to
12 other parties beyond Piedmont?

13 A: I did not.

14 Q: If you had understood that, would it have
15 affected the plans concerning the establishment
16 of Fort Mill Medical Center?

17 A: Absolutely.

18 Q: How would that have?

19 A: We would have added those beds to Piedmont
20 Medical Center in Rock Hill.

21 Q: And why would you have done that?

22 A: Because it would have avoided placing them at
23 risk for a competing application. It's common
24 practice in South Carolina -- it had been up
25 until there that under the Health Plan that if

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RECORD 000982

1 the existing provider that basically those beds
2 were assigned to wanted to expand their
3 facilities, that's what they did.

4 Q: Okay. All right. Now, let me direct your
5 attention to the issue concerning the 100 beds
6 that were proposed as a result of the October
7 2005 application that was submitted. Were you
8 involved in the decision to complement the 64
9 beds identified in the Plan with 36 transferred
10 beds?

11 A: I was.

12 Q: And why did you decide to do that?

13 A: Basically, what we were looking at was a need
14 of 64 beds as identified in the Plan and also,
15 you know, recognizing what our objectives were
16 in treating the folks in their home community
17 and close to home and we looked at the patient
18 population that we were currently serving from
19 the Fort Mill area at Piedmont Medical Center
20 and we made projections of the beds associated
21 with that and under the goal and assumptions
22 we were using, these people would want to be
23 treated closer to home that we were very
24 quickly finding 64 beds very inadequate.
25 Therefore, if you looked at what basically

1 would be freed up and available at Piedmont,
2 that we could combine with the 64, the
3 efficiencies would be greater and it just made
4 a lot of sense. Do it now versus later.

5 Q: Now, where there -- sorry?

6 A: Do it now versus later.

7 Q: I'm sorry?

8 A: Do it now versus later.

9 Q: Were there any acute-care beds in the hospital
10 that were shuttered at the time and not being
11 used at all?

12 A: We did. I think it was about approximately 19
13 beds or so that were not being utilized in the
14 hospital at the time.

15 Q: Okay. And how did you believe you would
16 protect yourself against the future need for
17 the balance of that 36, the 17 beds?

18 A: Well, I think as Mr. Levitt testified
19 yesterday, we did an analysis on what we
20 believed was the county-wide demand. And you
21 know, particularly as it related to the growth
22 occurring in Rock Hill, the growth patterns in
23 the western side of York County as well, and
24 determined that we were well-equipped to not
25 only transfer beds, but then take care of for

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1 a considerable period of time the needs of the
2 county based on those projections.

3 Q: Okay. All right. Mr. Miller, let me talk with
4 you about the hospital and its medical staff.
5 Start at a high level for me and explain what
6 you believe the relationship is between the
7 medical staff of a facility and it's success.

8 A: Well, I've been in healthcare for 37 years and
9 never admitted a patient, so physicians are
10 critical to the viability and success of a
11 healthcare organization. Particularly
12 specialists, who are the ones who are
13 performing the procedures, surgery and, you
14 know, have a tendency to take care of more
15 patients in the hospital than not. Primary
16 care physicians that are necessary in order to
17 refer patients to the surgeons who ultimately
18 are doing the procedures, but the medical staff
19 is the life blood of the hospital.

20 **THE COURT:** Could you hold on for a second. Could
21 you please turn that off? Thank you.

22 **MR. ANDREWS:** I'm sorry. May we proceed?

23 **THE COURT:** Please.

24 Q: I'm sorry. All right. With that background,
25 what was the medical staff like between the

1 period of time you arrived at Piedmont in late
2 2004 or 2005 when these applications were
3 filed?

4 A: It was a very collegial medical community. You
5 know, a lot of the physicians -- kind of to
6 take you back at the hospital, Piedmont Medical
7 Center moved from York General to the new
8 facility in 1982 with 57 members of the medical
9 staff, they knew each other, their families
10 knew each other, they go to church together,
11 their kids dated each other and still through
12 the early 2000s it was that kind of community.
13 They were very close-knit, socialized together
14 -- and the referral patterns. These were
15 physicians that had known each other for years.
16 They respected their skills, their ability to
17 take care of each other's patients in their
18 respective specialties and, you know, referral
19 patterns as you would find in any other
20 community. Primary care physicians, it didn't
21 matter who owned the practice, it didn't matter
22 who you worked for. Referred to physicians in
23 the community fully, you know, based on your
24 experience and relationships you had developed
25 through the years.

1 Q: Did that kind of collegiality and community
2 continue to exist after the filing of the
3 applications in this case?

4 A: We started to see some change in that. I don't
5 think there's any question that when we filed
6 the application in 2005 there were subsequent
7 competing applications filed. You know, within
8 the medical community the doctors were kind of
9 trying to figure out who was going to win this
10 thing and who wasn't and there was an
11 appreciation, particularly within the various
12 owned practices to kind of circle the wagons
13 around your hospital. We saw Novant-
14 Presbyterian come into the community and begin
15 to aggressively acquire practices which is not,
16 you know, historically their pattern.
17 Carolinas Health System had had practices in
18 the community for a number of years.

19 Q: All right. Let's look at a document that's CHS
20 1383. And just draw that up, if you would, on
21 the screen. Have you looked at this document
22 before Mr. Miller?

23 A: I have.

24 Q: Dan, if you could call out, just highlight it
25 a little bit, pull out the names of the

1 practices or just the whole line concerning the
2 practices. You may not be able to do anything
3 more than highlight it. Just put it in yellow.

4 **MR. MULLER:** Your Honor, I don't mean to interrupt,
5 but if Mr. Andrews could just repeat this
6 Exhibit, I didn't catch it. I heard CHS
7 Exhibit -

8 **MR. ANDREWS:** It's not an Exhibit, Your Honor. It's
9 just a document in discovery and so it's not
10 one we've named an Exhibit and I don't know
11 whether we have a Demonstrative -- Ms. Sackett
12 has informed me that we do. It's a 2008
13 production. I have copies of it here.

14 **THE COURT:** Thank you.

15 **MR. MULLER:** Your Honor, I have no objection to this
16 if we're allowed to do the same thing in terms
17 of making a Demonstrative Exhibits of something
18 that has been produced in discovery. In
19 fairness, believe I probably did that yesterday
20 so I don't have an objection to this as long as
21 we have that opportunity.

22 **THE COURT:** As long as it's a two-way street. Okay.
23 Absolutely, Mr. Muller. And Mr. Andrews.

24 **MR. ANDREWS:** I didn't assume there was anything
25 contrary to the rules of evidence asking

1 questions about it. That's all we intended to
2 do, Your Honor.

3 **THE COURT:** Thank you.

4 Q: All right. Mr. Miller, take a look at this
5 document, if you would please. And walk
6 through here, based on your knowledge, as well
7 as what this document reflects, and identify
8 what this is as of April -- actually, as of
9 2006.

10 A: These are medical practices that are owned and
11 operated by Carolinas Medical System or Health
12 System in York County.

13 Q: All right. And let's take it down to the end,
14 Dan, of the last column. There's some dates
15 provided there related to each. Now, do you
16 see any dates subsequent to 2006?

17 A: I do not.

18 Q: All right. So, at least then current through
19 that period of time, is that right? Okay.
20 Now, Dan, I want to connect the last column
21 with the first, so we can either pull them out
22 or let's just look at the whole document. Mr.
23 Miller, let me give you a copy of this rather
24 than strain your eyes. All right. So, Dan,
25 what you're doing is connecting the first and

1 the last columns to show the name of the
2 practices and the dates they had joined the
3 CPN, CPN is what Mr. Miller?

4 A: Actually, I'm going to assume it's the
5 Carolinas Physician Network.

6 Q: And what is Carolinas Physician Network?

7 A: It's the network owned and operated by
8 Carolinas Health System.

9 Q: A network of physicians?

10 A: Network of physicians, yes.

11 Q: Okay. Now, of these practices you had said
12 just a moment ago that Carolinas had owned and
13 operated practices in the Rock Hill area for
14 some time prior to the filing of any these
15 applications?

16 A: That's correct.

17 Q: Does this document reflect that?

18 A: Yes, I mean Shiland Family Practice goes back
19 to June of 1995. Palmetto Pediatrics, June of
20 1994. Internal Medicine Practice of Medical
21 Associates of Rock Hill, April of 1993.
22 Piedmont GYN/OB, August of 1995, et cetera.

23 Q: All right. And when did Piedmont file its CON
24 application?

25 A: 2005.

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1 Q: You filed one in 2004, didn't you?

2 A: 2004. I'm sorry.

3 Q: Do you remember when?

4 A: I do not. I'm sorry. I believe October.

5 Q: Late year?

6 A: Late year.

7 Q: And you revised it, do you remember when?

8 A: Early 2005.

9 Q: January 2005? The record can stand for itself,
10 but, okay. And what activity here concerning
11 the development of acquisition of practices is
12 reflected on this document?

13 A: Well, you see then in March and April of 2005,
14 the acquisition of Rock Hill Pediatrics and the
15 acquisition of the two local Sanger Clinic
16 operations, the one that was operating in Fort
17 Mill at the time and then Rock Hill.

18 Q: And did Medical Associates of Rock Hill have --
19 previously have an office in Fort Mill?

20 A: No. They opened a satellite facility in 2006
21 and while not reflected on this document,
22 Shiland Medicine also subsequently opened an
23 operation in Fort Mill as well.

24 Q: All right. And let's take a look at what Mr.
25 Levitt testified yesterday, Demonstrative 141,

1 please, Dan, if you could pull that up. All
2 right. Now, let's identify here the -- have
3 you looked at this document previously?

4 A: I have.

5 Q: And what do you understand it to be?

6 A: This is a document showing the total number of
7 referrals, the current list of CPN practices
8 for residents of York County being referred out
9 of York County to others within the CPN
10 network.

11 Q: Let's go down through this list and identify
12 several of the practices. Dan, first let's
13 call out Medical Associates of Fort Mill and
14 Rock Hill and if you'll highlight those two
15 lines. You identified this practice
16 previously, Mr. Miler, on the prior page as
17 being one that had been owned by Carolinas for
18 some time, is that correct?

19 A: Correct.

20 Q: Prior to the filing of the application in 2005,
21 what had been the practice of the physicians of
22 Medical Associates of Rock Hill? Had they been
23 on your medical staff?

24 A: They had been on our medical staff. They
25 utilized specialists within the York County

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1 community who practiced at Piedmont Medical
2 Center.

3 Q: Okay. Let's look at the next two groups.
4 Actually, let's apply Palmetto Pediatrics, the
5 next group. Do you recall seeing that on the
6 prior list?

7 A: Yes.

8 Q: And what had been Palmetto Pediatrics'
9 experience with regard to Piedmont?

10 A: They had utilized Piedmont Medical Center and
11 its physicians, as well, through the support of
12 their patients.

13 Q: And the next group? Piedmont GYN/OB of Rock
14 Hill, what had been the extent to which
15 Piedmont had used -- Piedmont GYN/OB group had
16 used Piedmont hospital?

17 A: Active members of the medical staff, again,
18 seeing their patients at Piedmont and were
19 actively involved in the planning of the
20 women's center that we talked about earlier.

21 Q: Okay. And the next group, Rock Hill Pediatrics
22 Associates and Rock Hill Pediatric, Fort Mill,
23 what's your familiarity with this group?

24 A: Again, active with the medical community and
25 utilization of the hospital for taking care of

1 their patients.

2 Q: And the two Sanger practices? What was their
3 participation in the activities of your medical
4 staff and the use of Piedmont hospital?

5 A: Very active in the use of Piedmont Medical
6 Center particularly of the cardiac
7 catheterization program and support of the open
8 heart surgery program.

9 Q: And finally, Shiland, the two offices that ---

10 A: Significant referral patterns to the
11 specialists in Rock Hill and utilization of
12 Piedmont Medical Center.

13 Q: Okay. Now, after 2005 did the hospital's
14 relationships with the physicians in these
15 practices change?

16 A: We began to see a degradation of the referral
17 patterns from these practices to specialists in
18 the community and a number of them began, over
19 time, to eliminate their medical staff
20 privileges at the hospital completely.

21 Q: Okay. Let's move to Demonstrative 26, please,
22 Dan. Were there members of these practices who
23 were active in the leadership of Piedmont
24 hospital? I'm sorry, Demonstrative, excuse me.
25 Demonstrative 26. Excuse me, my fault.

1 Exhibit 26 rather than Demonstrative. Thank
2 you, Dan. Yes. That's what we're looking for.
3 What is this list, Mr. Miller?

4 A: This is a list going back to 2000 physicians
5 who are employed by Carolinas Health System,
6 through CPN who were active members of the
7 medical staff and held various positions of
8 leadership within the medical staff, either
9 chairmen of departments, chairmen of
10 committees, chief of staff, members of the
11 hospital board. On the quality improvement
12 committee. Utilization review committees,
13 ethics committees a number of different
14 activities.

15 Q: Dan, let's turn to the next page and look at
16 the highlighted section of these. Mr. Miller,
17 have you reviewed Exhibit 26 and made any
18 adjustments to it?

19 A: I have identified -- there were previously on
20 the list some physicians who are not actually
21 employees of Carolinas Health System or CPN
22 that were on the previous list, so what I have
23 done here is highlighted those that are, in
24 fact, CHS-employed, CPN-employed physicians so
25 that we can be clear about who is and who is

1 not. Those that are not highlighted in yellow,
2 were mistakenly identified as CHS-related
3 individuals.

4 Q: And those highlighted have been and are now
5 affiliated with Carolinas?

6 A: That's correct.

7 Q: Okay. Now, from your perspective from working
8 with these physicians who were at various
9 points in time hospital leaders, what's the
10 significance of their now departure from
11 Piedmont Medical Center?

12 A: Well, we've obviously lost a significant number
13 of individuals who were willing to give freely
14 of their time in leadership roles of the
15 organization, particularly relative to the
16 medical staff. These are individuals who in
17 their respective roles were helping drive
18 quality, ethics decisions, utilization reviews,
19 strategic planning, you know, those things that
20 are important to the administrative and medical
21 relationships in the organization.

22 Q: Now, during the time of their leadership
23 position, were these physicians either employed
24 at the time by Carolinas or were they
25 independent prior to their employment or both?

1 A: It would be a combination. For instance, you
2 know, if you start at the top, you've got
3 Martin, Garcia, Cook, Copple, Bale, I believe
4 as identified in a previous Demonstrative,
5 those practices has been owned by Carolinas for
6 a significant period of time, far beyond the
7 2000 date.

8 Q: Okay. And, in fact, did Dr. Bale, who is
9 reflected on that sixth line, did he take any
10 action relative to the application of Piedmont
11 Medical Center?

12 A: Actually, he -- Dr. Bale was serving as
13 chairman of the board of governors at the
14 hospital when we filed and wrote a letter of
15 support for our application.

16 Q: Dan, let's pull out Exhibit 3, Bates 181 and
17 what is this letter, Mr. Miller?

18 A: This is a letter to Joel Grice, if you can go
19 back down to the date, dated November 12, 2004.
20 And it was submitted with the application.

21 Q: Okay. And what does it convey?

22 A: Basically it says it is written with
23 enthusiasm, I would like to endorse Tenet
24 Healthcare Corporation application for a
25 Certificate of Need for the construction of a

1 new hospital facility in Fort Mill, South
2 Carolina.

3 Q: Let's, Dan, pull out the third paragraph, if
4 you would, and read, please, Mr. Miller the
5 second -- beginning with the second sentence
6 from the end of the paragraph.

7 A: Currently many residents within this area are
8 traveling north to secure hospital services
9 often resulting in a fragmentation of their
10 healthcare needs. This new facility will offer
11 an opportunity for the improved continuity of
12 care and additional options for patients and
13 their family. Hopefully, the additional
14 competition will help in managing the rising
15 healthcare costs.

16 Q: All right. Now, at the time he drafted this,
17 what was Dr. Bale's position?

18 A: Chairman of the board of governors of Piedmont
19 Medical Center.

20 Q: And who was he employed by?

21 A: Carolinas Health System, CPN.

22 Q: All right. Dan, if you'll draw up Exhibit 27,
23 please. And what is this document, Mr. Miller?

24 A: This is physicians who had been members of the
25 medical staff who did not renew their

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RECORD 000998

1 privileges after the purchase by CHS at some
2 point.

3 Q: Okay. If we could go through the list, how do
4 the categories, which would be group practices
5 compare to those you previously reviewed?

6 A: They're consistently the same.

7 Q: All right. Now, what were the effects of the
8 resignations when they took place and over what
9 period of time generally did that happen?

10 A: They appear to be happening generally the 2008
11 to '11 period. Their predominantly in late
12 2009 into mid-2011. Excuse me, late 2010 and
13 mid-2011.

14 Q: Now, by the time the resignations occurred, and
15 by the way, is the resignation list complete?
16 Do you have Rock Hill Pediatrics?

17 A: No. Rock Hill Pediatrics is not on this list.

18 Q: And how many physicians do they have?

19 A: They have seven in that practice.

20 Q: And how many of them resigned their privileges?

21 A: All of them.

22 Q: All right. So when you left Piedmont were
23 there any Carolinas physicians who continued to
24 remain on the Piedmont Medical staff who were
25 employed by that system?

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RECORD 000999

1 A: I'm aware of only two.

2 Q: Okay. Now, let me take you back to
3 Demonstrative 141 that you testified about a
4 moment ago. And let's flip to the second page
5 of that Demonstrative, Dan. Now, during the
6 period of time after the changes in practices
7 that you just discussed, did you observe any
8 change in referrals and the referral patterns
9 among physicians affiliated with Carolinas?

10 A: Yes. I mean we had been observing some
11 degradation of referral patterns prior to that
12 but it became really significant as we moved
13 into 2010, particularly 2011 and '12, as noted
14 here.

15 Q: All right. And have you evaluated the effect
16 of those changes on different product lines at
17 Piedmont?

18 A: We have.

19 Q: Dan, let's begin by looking at Demonstrative
20 173. And what does this Demonstrative show,
21 Mr. Miller?

22 A: Basically it shows the market share of Piedmont
23 Medical Center compared to Carolinas Medical
24 Center in years 2005 to 2009 and 2011.

25 Q: And generally, how is it consistent with the

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RECORD 001000

1 observations you were making at the time?

2 A: Well, basically, it is showing the impact that
3 the loss of those referrals within the local
4 medical community and the hospital is having on
5 the market share of the hospital.

6 Q: Okay. And have you analyzed the effect of this
7 impact on complex services as well?

8 A: We did.

9 Q: And let's take a look at that, at Demonstrative
10 81, Dan. And what's being presented here, Mr.
11 Miller?

12 A: These are complex medical cases. Again, it's
13 the total market share for those cases
14 beginning in 2005 to '09 and '11.

15 Q: What's the significance of the changes in the
16 market share of complex cases for Carolinas and
17 Piedmont? What's happened over this period of
18 time?

19 A: Well, obviously over this period of time, these
20 are complex cases that are being referred that
21 had been previously served at Piedmont Medical
22 Center that are now leaving the market place
23 and going to Carolinas Medical Center. Complex
24 cases, you know, represent a high level of
25 reimbursement under Medicare and Medicaid

1 system of DRG reimbursement, so this is a
2 significant financial impact on the hospital.

3 Q: What effect does it have on your medical staff
4 when over 25 percent of the complex procedures
5 are lost to your staff over a six year period?

6 A: It places individual physicians at risk of
7 being able to maintain the high skill levels
8 that they were trained for because these are
9 complex cases. These are the kind of cases
10 that you don't want somebody who has just done
11 one of them over the last year. And so as
12 their frequency goes down over time, it will
13 erode their skill set.

14 Q: Okay. Let's turn to the next -- we're not
15 going to review all of these, Mr. Miller. Mr.
16 Levitt has testified about them at length. But
17 let's look at just a few. Demonstrative 179.2.
18 All right. Now, what's this showing in general
19 terms?

20 A: This is our cardiology program, the one that we
21 invested a significant amount in developing,
22 the open heart center that I spoke of earlier.
23 And you can see that there's been a significant
24 erosion of the market share in that service,
25 particularly over this time period subsequent

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RECORD 001002

1 to 2005.

2 Q: Now, the document that Mr. Levitt testified
3 about yesterday and you will in a moment at
4 Demonstrative 177 shows a 56 percent loss in
5 cath and EP procedures over this same period of
6 time. Do you see that?

7 A: Yes.

8 Q: All right. Now, let's go back to the
9 Demonstrative 179.2. As this loss was
10 occurring, how did you make adjustments to the
11 staff that was available?

12 A: Well, I think Dr. Singhi was absolutely correct
13 in recognizing that we reduced staff. We
14 reduced hours of operation. And there were
15 days we actually closed some of the procedural
16 rooms that were available. We unfortunately,
17 during that period of time, we not able to hold
18 on to some of the experienced and well-trained
19 staff because they were in the position of
20 needing full-time work for their own personal
21 reasons and all. So basically, we rolled back
22 services.

23 Q: And when you rolled back services by reducing
24 staff, how does that affect the compensation of
25 the staff?

1 A: Well, basically, they're not getting their 40
2 hours a week in so their personal paychecks are
3 cut.

4 Q: Why didn't you just keep them on full salary?

5 A: Because I can't afford to.

6 Q: Why?

7 A: Loss of volume.

8 Q: How does that relate to what you pay them?

9 A: Basically, if there's no work, we don't need
10 them to be there putting in hours, and if they
11 don't get hours, they don't get paid.

12 Q: Now, has there been any massive layoff in the
13 hospital or the cardiac unit or other units to
14 make adjustments for the downturn in the loss
15 of services such as in this unit?

16 A: We work hard at trying to avoid your choice of
17 term, massive layoff. A lot of this is done
18 through what's commonly referred to as flexing
19 staff, come in the morning, we assess the
20 schedule, we assess how many admissions we've
21 got, how many procedures we have lined up.
22 Typically, by eight or nine o'clock in the
23 morning we're sending, you know, excess staff
24 home.

25 Q: Why eight or nine in the morning?

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RECORD 001004

1 A: Because they come in at seven in the morning
2 when the shift starts and it gives you a couple
3 of hours to assess the day. And, you know, but
4 they go home and they don't get paid for the
5 hours which they don't work. And also, we did
6 a lot of that, but there are some positions
7 that are eliminated, I describe those, you
8 know, primarily onesies, twosies, but as weeks
9 or months go by they accumulate over the course
10 of the year. And, of course, you know,
11 attrition. Unfortunately attrition doesn't
12 typically happen, unfortunately the highly-
13 skilled people are the most mobile in leaving.

14 Q: Why is that?

15 A: Because they are highly skilled in what they do
16 and they typically have a lot of years of
17 experience and they are the most mobile.

18 Q: Okay. Let's look at the next slide in this
19 series, 179.3. Now, in addition to cardiac
20 services, has there been a downturn in surgery
21 services?

22 A: Yes. In orthopaedics, you know, not only some
23 of the same phenomena that I just spoke about
24 with the cardiology, but in addition to that
25 OrthoCarolina, a Charlotte-based orthopaedic

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RECORD 001005

1 group is now seeing patients, I believe at
2 least one day a week, maybe more, inside the
3 Shiland Family Practice through a contractual
4 relationship they have with Carolinas Health
5 System.

6 Q: And how has that affected your orthopaedic
7 services?

8 A: Well, again, it just continues to support CHS's
9 strategy of driving referrals within an in-
10 network program and to get subsequently the
11 surgical cases into their own facilities.

12 Q: All right. And as we're looking at this flip
13 in market share, where Piedmont had over three
14 times the market share and now has only two-
15 thirds of the market share of Carolinas, how
16 has that affected your ability to maintain the
17 same compliment of staff that you had in 2005
18 in your OR suites?

19 A: Same thing. We're not operating the same
20 number of operating rooms that we did back
21 early in those days and we're dealing with less
22 staff over time.

23 Q: Now, let's finally take a look at the next
24 slide related to neurosurgery. Now, what was
25 the market share in 2005? I'm sorry, let's

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1 move to 180-09. Okay. What does this show,
2 what changes does this show, Mr. Miller?

3 A: Actually, the neurosurgery market share shows,
4 again, decline from 2005 to 2011. This was
5 never -- unlike some of the previous ones we've
6 looked at, if you recall this was a service
7 that we started as part of the sixth addendum.
8 So a relatively new service in the life span of
9 the service area, but we had gotten to a 29
10 percent market share in 2005 and it has
11 likewise gone down to about 16 percent market
12 share in 2011.

13 Q: What effect does it have on their ability to
14 offer a complex service such as neurosurgery
15 when your volume is cut in half and is not
16 substantial to start with?

17 A: I believe that if we continue on this glide
18 path despite the obligation to provide this
19 service, we're not going to have the ability to
20 retain and keep the neurosurgeons themselves
21 into the market place. These are highly-
22 skilled individuals that are used to doing
23 complex cases and a steady stream of them and
24 working with a team of individuals, who, like
25 themselves, have become experienced in working

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1 with these complex cases and they'll migrate
2 away from Piedmont.

3 Q: How will it affect the quality of your nursing
4 staff who have experience in your neurosurgery?

5 A: They'll migrate out as well.

6 Q: And then where would be the neurosurgical
7 services that would be available for York
8 County residents?

9 A: They'd have to go into Charlotte.

10 Q: All right. Okay. Now, let's turn you
11 attention to your communications with the
12 Department through Mr. Levitt related to the
13 effects of the approval of Carolina Medical
14 facility in Fort Mill on the operations and
15 service of Piedmont. Do you recall what you
16 conveyed to the Department concerning what
17 adjustments in services and staff that Piedmont
18 would make if Carolinas were approved?

19 A: Well, we provided them with some examples of
20 some things we would evaluate. I think, we're
21 not going to be in a position to be finite
22 about it, but clearly we would start with that
23 list of additional services that we added
24 subsequent -- that were not part of the system
25 them, but that we added subsequently and we

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1 would probably be looking at the infusion
2 center, wound care center, pain management, you
3 know, we would probably, you know, based on
4 this data look at downsizing the neuro, the
5 cardiology program, there is a significant gap
6 between where we were today with that service
7 and where we are contractually obligated to be
8 with that service. So there's potentially a
9 rolling in that. I think the special care
10 nursery could easily be taken back to a newborn
11 nursery and we would not have neonatology
12 coverage available at the hospital which would
13 put those patients in a position of having to
14 go to Charlotte or here to Columbia.

15 Q: Okay. Before we get into any depth on that,
16 any further embellishment of it, let me ask you
17 instead just to -- help the judge understand
18 what process you have used or you expect based
19 on your experience that the CEO of Piedmont
20 would use in deciding if the volume continued
21 to decline and you lost two to 3,000 additional
22 patients and the revenue associated with the
23 use of their hospital, how you would make
24 judgements of what to cut and where to cut it.

25 A: We would be, as you know, the data continued to

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1 unfold as it has historically, we would be
2 evaluating at the service line level, the
3 impact of those declines of volume were having
4 on us and the revenue stream associated with
5 this and the ability to flex and manage costs
6 associated with those services in order to try
7 to maintain them. At some point, though, we're
8 going to hit a core level of services. Those
9 level of resources that you either can provide
10 the service or you no longer can, so it is off
11 and it would be an ongoing evaluation with a
12 pretty high level of detail.

13 Q: Now, before we look at those services, help the
14 Court understand how you've experienced the
15 loss in services you have. A previous figure
16 that was in your July 11, 2011, report showed
17 a loss of 2200 patients of 2005 to 2010. How
18 did you maintain profitability while at the
19 same time you were losing over 2000 patients?

20 A: Basically by very aggressively managing costs
21 in some cases on almost a daily basis. Flexing
22 staff. Keep in mind human resources represent
23 50 percent of every dollar spent in delivering
24 healthcare. So they become first and foremost
25 an ability to do that. Looking at supply

1 costs, looking at discretionary expenditures
2 and, you know, just focusing on adverse impacts
3 while at the same time you're making effort --
4 in our efforts to reaching other markets which
5 we are trying to do to mitigate the loss but
6 probably predominately through cost management.

7 Q: Okay. All right. Now, Dan, let's go to an
8 Exhibit we developed previously, Mr. Miller, at
9 210. And these are the services you've
10 identified earlier as those being not
11 contractually required to the county. And how
12 would -- you've identified and testified about
13 a number of services on this list. Why have
14 you identified them?

15 A: Because these are, for instance, let's talk
16 about the women's tower, I can close the
17 pediatric unit and migrate what pediatric
18 patients we may still have into a general
19 patient population. I can close the OB/GYN ORs
20 and consolidate those into the main ORs in the
21 core hospital. I can lose the special care
22 nursery, eliminate neonatology and have just a
23 have a well-born nursery and transfer any
24 potential complex cases.

25 Q: Now, if your OB, if your delivery volume

1 dropped below 1200 would you have an option
2 about giving up your special nursery unit?

3 A: No. Probably not. Well, actually under the
4 licensing requirements, I would not be able to
5 maintain my Level II-E nursery status.

6 Q: And now the neonatologist, do you have one or
7 two currently on staff?

8 A: We have two in order to facilitate coverage.

9 Q: Okay. And those are physicians?

10 A: Physicians.

11 Q: Who employs them?

12 A: Actually, it's a contract service through
13 pediatrics, it's a national company.

14 Q: And are they full time contract positions?

15 A: Local. Bariatric surgery is not a program we
16 would need continue. Infusion therapy program
17 is not one.

18 Q: When you say need to continue, do you mean
19 contractually obligated?

20 A: Not contractually obligated. Infusion therapy
21 is a service that helps support our oncologist
22 in the community, some of which are doing
23 infusion therapy in their offices which call on
24 the hospital to assist with that. Wound care
25 center, these are patients who have had surgery

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RECORD 001012

1 or some other incident that's created a wound
2 and allows them to be cared for outside of the
3 hospital setting, the physician office setting.
4 Pain management is a program that we operate.
5 There are alternatives in the community for
6 that. And also, this is probably a
7 representative list of the kinds of areas that
8 we would evaluate very carefully.

9 Q: All right. Let's look at the prior page at
10 209. You had mentioned previously that some of
11 the heart center services that provided more
12 services than may be required under the
13 contract. What were you referring to?

14 A: We operate four cardiac cath units right now.
15 We don't need to have but two.

16 Q: Under the contract?

17 A: Under the contract. The heart dedicated-bed
18 unit is not an obligation. EMS is an area we
19 have significantly -- our response times in EMS
20 are significantly below that we are obligated
21 to have in the contract and we've done that
22 through an expanded investment. What we've
23 done there far exceeds what we're obligated to
24 do there. And so there's flexibility within
25 those even though they are contractual

1 obligations.

2 Q: What's the effect, and based on your operations
3 of hospitals for all the time you've been
4 involved with them, this dwindling down, paring
5 down of the services by product line that the
6 hospital would deliver?

7 A: It's a slow death to be blunt. It's going to
8 have a significant impact on the ability to
9 recruit and maintain quality physicians and
10 it's going to affect the kind of individuals,
11 nursing and technical staff that you're able to
12 attract to your facility as well.

13 Q: All right. Mr. Miller, based on your knowledge
14 of your medical staff and your experience at
15 Piedmont, have you had any concerns related to
16 the ability of the independent members of the
17 medical staff to remain independent?

18 A: Oh, absolutely. I don't think there's any
19 question, if we reflect back on the shift of
20 referrals that are taking place by the
21 Carolinas Health System CPN practices, it's
22 impacting those physicians who have made an
23 effort to remain independent and want to remain
24 independent and by nature like to be
25 independent if they want to, but they are going

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RECORD 001014

1 to be forced into an alignment for their own
2 personal survival.

3 Q: If Dr. Singhi's group, Carolina Cardiology,
4 became affiliated with Carolinas, what effect
5 would it have on the heart center at Piedmont?

6 A: I'm not sure that the hospital wouldn't find
7 itself having a conversation with the county
8 about its ability to even maintain this
9 program. At a minimum we would be faced with
10 the struggle of being able to retain an open
11 heart surgeon who isn't going to be able to
12 continue to maintain his proficiency.

13 Q: If Dr. Taylor's group, Rock Hill GYN, became
14 affiliated with Carolinas and moved their
15 business there as other physicians have, what
16 would be the effect on the operation at
17 Piedmont?

18 A: I've got two OB/GYNs who would be trying to
19 take care of the patient population of York
20 County.

21 Q: Well, you could recruit another OB/GYN?

22 A: I can try.

23 Q: What effect would it have on the patients that
24 have historically sought services there who now
25 see those practitioners?

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RECORD 001015

1 A: They'll leave, they'll have to go to Pineville
2 for their deliveries. They won't deliver with
3 us.

4 Q: Will they also go to CMC-Fort Mill?

5 A: Yes, to the extent they offer those services.

6 Q: Okay. All right. Now, if Carolinas' proposed
7 Fort Mill hospital was approved what effect
8 would it have, based on your experience, on the
9 competition of healthcare in York County?

10 A: I'm not sure that you would still have a
11 competitive model. I think the significant
12 impact that the practices are having and
13 continue to have as well as having that
14 facility available to continue to basically
15 force the independent physicians into non-
16 independent integrated status with Carolinas
17 Health System basically and I think what we
18 would predict to be a significant negative
19 shift in payor mix at Piedmont Medical Center
20 would move it back from where it is today to a
21 hospital comparable to what it was in 1980.

22 Q: Thank you. No further questions, Your Honor.

23 **THE COURT:** All right. Thank you, Mr. Andrews. It
24 is a little after noon. It might be a good
25 time to take a lunch break. What do you think,

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1 hospital?

2 A: It is on the side where Presbyterian was going
3 to build.

4 Q: You were shown a slide showing trend, inpatient
5 volume trends. Was that trend you entire
6 patient volume or was it just York County?

7 A: It's my understanding it is the entire patient
8 population.

9 Q: Dan, could you pull up DHEC's 137? And this is
10 the slide I was referring to. Do you
11 understand that to be your entire patient
12 population or just York County?

13 A: I'm sorry, it's labeled York County inpatient
14 population, so I'm assuming it's York County
15 patient population.

16 Q: If you could go to Demonstrative 211. All
17 right. And these were the things we talked
18 about earlier. These are your obligations
19 under the York County contract. Reasonable
20 pricing, ambulance service, capital
21 reinvestment, annual reports, right?

22 A: Correct. Those are the key elements. There
23 are others.

24 Q: Now, you mentioned that there were various
25 services that you would have to consider

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1 cutting depending on volume, correct?

2 A: I would be in a position to evaluate everything
3 that's available to me to potentially alter,
4 yes.

5 Q: All right. And I asked you in your deposition
6 would you or could you. In other words is it
7 you will cut or that you may cut. How did you
8 respond?

9 A: I believe I told you, I believe the line of
10 questioning we were engaged in was an effort
11 for me to be very specific and I believe my
12 response to you at the time it would be
13 irresponsible of me to be that specific at this
14 point. Basically, we would have to evaluate
15 the impact the various reductions in volumes
16 and all that occurred when they occurred and
17 make decisions accordingly.

18 Q: Have you ever described it as a possibility
19 that you'd cut as opposed to that you would
20 cut?

21 A: I don't think there's any question whatsoever
22 that the -- that if we're impacted as we
23 believe we would be that there would be some
24 alterations in services, potential reductions
25 in the workforce as a result of that.

1 A: Part of it, yes.

2 Q: Your 64-bed application indicated that you had
3 2200 admissions from patients in the Fort Mill,
4 Tega Cay area, those now three zip codes, back
5 then they were two and from the Clover zip
6 code, 29710. And you're proposing to build a
7 64-bed hospital. If you had that level of
8 admissions, meaning you had less than 2200 from
9 the Fort Mill, Tega Cay area, why would you
10 propose to build a 100-bed hospital up there
11 that proposes to serve 5500 patients in year
12 three?

13 A: Because we believe that would be the demand on
14 the facility by year three.

15 Q: All right. Was another concept that it was a
16 defensive strategy?

17 A: No, we believe that we will be serving 5500
18 patients by year three. Those was our basic
19 projection.

20 Q: Did you testify in the previous case that it
21 was a defensive strategy to protect your market
22 share?

23 A: The whole concept of being in Fort Mill
24 starting with Baxter Urgent Care, the imaging
25 center, putting primary care physicians in that

1 market. The hospital and other activities, its
2 stated purpose has been to slow the out-
3 migration of York County residents into the
4 Charlotte area.

5 Q: And was that designed to protect other
6 providers, whether it is Carolinas, whether
7 it's Presbyterian, whether it's any other
8 hospital system from encroaching on your market
9 share?

10 A: The stated goal of our Fort Mill strategy was
11 to curtail the out-migration of York County
12 residents from leaving York County. People
13 are, you know, you own medical practices in
14 York County. Your rival owns medical practices
15 in York County. We're not going to keep that
16 from happening, but we can increase our
17 presence and we believe better serve the folks
18 in that geographic by having a stronger
19 presence there than we have had.

20 Q: Have you previously testified that it was a
21 defensive strategy to protect other systems
22 from encroaching on the market share?

23 A: That is in fact what I just said. In essence,
24 yes.

25 Q: And is protecting market share one of the

1 purposes and needs in the State Health Plan to
2 your knowledge?

3 A: I have no knowledge of that.

4 Q: Those are all the questions I have of Mr.
5 Miller.

6 **THE COURT:** Okay. All right. Ms. Biggers?

7 **MS. BIGGERS:** No questions from the Department.

8 **THE COURT:** All right.

9 (Off the Record)

10 **MR. MILLER - RE-DIRECT EXAMINATION BY MR. ANDREWS:**

11 Q: Dan, please pull up CHS Exhibit 15, go to page
12 two on that. Look at the right-hand square
13 footage of the facility. Mr. Miller, Mr.
14 Muller asked you if you knew the square footage
15 of Piedmont and he drew to your attention the
16 215,000 square feet that existed back in 1980
17 at Piedmont Medical Center. Do you recall it
18 was 215,000?

19 A: Correct.

20 Q: And you weren't certain of the square footage
21 of Piedmont Medical Center. This is an excerpt
22 from the emergency department expansion CON
23 application. Identify the existing square
24 footage without the renovations of Piedmont
25 Medical Center in that graph?

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1 A: 525,000 square feet.

2 Q: About twice the size of the hospital currently?

3 A: Correct.

4 Q: And how has the hospital expanded in the past
5 30 years from 215,000 to over 500,000 square
6 feet?

7 A: The Women's Tower represents about 95,000
8 square feet and I'm not sure what the heart
9 center addition that was done in 1996
10 represents but it's considerably smaller than
11 the Women's Tower.

12 Q: And the balance is?

13 A: Would have been the original core building.

14 Q: Okay. Now, with regard to the examination of
15 Mr. Muller concerning the option that York
16 County exercised, do you know why county
17 officials chose to elect to contract with Tenet
18 in the sixth addendum rather than accept the
19 offer of Carolinas to buy York County Hospital?

20 A: Yes. My understanding from the material I had
21 available to me and all of that, they
22 appreciated the long-standing relationship that
23 our organization had with the county, our
24 responsiveness to the needs of the people that
25 we were serving and our willingness to continue

1 to grow the facility along with the growth in
2 the county as well as the fact that we were a
3 South Carolina, York County-based business.

4 Q: Okay. And as far as you know, did they have
5 free choice to either accept or reject either
6 proposal?

7 A: Absolutely. In fact, it's my understanding
8 that they were offered a rather lucrative
9 opportunity to make the switch.

10 Q: And why didn't they accept it?

11 A: I believe that they firmly believed that what
12 we were doing and what we were proposing doing
13 and our commitment to the community was in the
14 best interest of the people who they were
15 elected to serve.

16 Q: All right. Now, Mr. Muller showed you some
17 excerpts from the York County reports from 2000
18 -- I think it was '10 and '12. Let me take you
19 back, let's look at Demonstrative, Dan, 213.
20 To compare the full-time, part-time and PRN
21 contract staff. What were the changes in those
22 employees as reported in your reports to York
23 County from 2007 to 2012?

24 A: Well, in 2007 it was 2,113 full time employees,
25 1,079 in 2012. Part time dropped from 132 to

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1 77. Almost in half and PRN went up, but again,
2 these are individuals who are called on as-
3 needed basis.

4 **MR. MULLER:** Your Honor, if I could just interject
5 something. And I may have to retract that.
6 This comes from our Exhibit?

7 **MR. ANDREWS:** That's right.

8 **MR. MULLER:** Thank you.

9 Q: And looking at the change between 2007 and
10 2012, Mr. Miller, what information does this
11 provide to you?

12 A: That basically, we were managing the
13 organization and relationship to the declines
14 in volumes and changes in the levels of service
15 that were going on in the organization at the
16 time. I would also offer as I commented on in
17 my testimony, that this is kind of an aggregate
18 number. And I would suspect and offer that if
19 we broke it out, we would find that the
20 hospital numbers are in even sharper decline.
21 We did have one service that we expanding at
22 the time and that was the EMS service as we
23 were expanding and improving response times to
24 the county and added employees to that service.

25 Q: Okay. Now, as you were essentially reducing

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1 the time available to full-time employees, as
2 you testified earlier you did when there wasn't
3 sufficient work for them to do ---

4 A: Correct.

5 Q: Were those nurses and technicians be
6 categorized as full-time or part-time
7 employees?

8 A: They would have been full-time individuals and
9 some part-time. Obviously if you are faced
10 with a day in which business is soft, you would
11 probably hope to go to part-time employees
12 first to be able to float them off. The full-
13 time people are not immune to being floated off
14 on any given day.

15 Q: And so would the information being reported to
16 the county on that full-time line item account
17 for the reduced hours available to full-time
18 employees as a result of the reduction in
19 services?

20 A: Yes, this is not a body count. This are based
21 on actual paid hours for staffing. So, this is
22 a realtime, hourly paycheck impacting
23 reduction.

24 Q: All right. Now, finally, let me ask you to
25 turn to Demonstrative 72, Dan. Mr. Miller, Mr.

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1 Muller had asked you whether or not the peer
2 group reporting to the county and Piedmont's
3 performance in it reflected any adjustment
4 based on the case mix index weighing to your
5 peer hospitals. Do you recall that question?

6 A: I do.

7 Q: And you said it wasn't, what you were reporting
8 to the county wasn't CMI-adjusted, correct?

9 A: Correct.

10 Q: Now, did you ever propose or did you ever
11 address that issue with the county?

12 A: I did. I actually proposed that we use CMI-
13 adjusted data during our discussions on the
14 eighth addendum when we -- again, the primary
15 purpose of the eighth addendum was to basically
16 create clarity and the intent of the parties
17 and we had an extensive discussion about CMI
18 adjusting to the MEDPAR data at that time.

19 Q: And what was the result of your proposal?

20 A: They rejected it. It, by their own admission
21 it in their minds created confusion. It was
22 something they didn't understand how it worked.

23 Q: Okay. Now, have you applied the case mix
24 weighing to the peer group hospitals in your
25 work on this case?

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1 A: Yes.

2 Q: And what's reflected there in that
3 Demonstrative?

4 MR. MULLER: Your Honor, I am going to object to
5 this one because I don't believe this
6 Demonstrative matches up to what I was just
7 looking at in the source. Could I possibly
8 show the Court that?

9 THE COURT: Yes.

10 MR. ANDREWS: Would you show it to me too?

11 MR. MULLER: Yes.

12 MR. ANDREWS: All right. I'm being informed by Mr.
13 Levitt this updates what's in the report.
14 We'll be happy to turn to the report. This is
15 more current information. I wasn't aware of
16 that, Your Honor. Is that all right, Mr.
17 Muller?

18 MR. MULLER: I'm sorry?

19 MR. ANDREWS: Is that all right with you?

20 MR. MULLER: Yes.

21 Q: All right. Thanks. We can just do that. Dan,
22 if you could pull up the end of July 2011
23 report, page 24, figure 10. Thank you. Okay.
24 Now, what is this information before you, Mr.
25 Miller?

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RECORD 001027

1 A: This is the 2010 average MEDPAR inpatient
2 charges of the peer group hospitals. It shows
3 the average charge, the case mix index and
4 basically the charge adjusted for the case mix
5 index.

6 Q: Okay. And what is -- discuss a little more
7 generally, if you would, I don't know if it's
8 been thoroughly explained, the purpose of the
9 CMI adjustment?

10 A: Basically, it is a measure of resources that
11 are consumed in delivering care. The DRG
12 system basically assigns an index to each and
13 every procedure for which it has an assigned
14 code. It's an attempt to indicate -- I guess
15 the best way to describe it, more complex cases
16 have a higher index indicating they consume
17 more resources. A lower index basically
18 reflecting on something that's more simple and
19 less complex and not consume and more resources
20 and all. As an example on here, CMC with a
21 case mix of 2.0372, not surprising, it's a
22 quaternary institution. It's doing organ
23 transplants, level one trauma and it all,
24 compared to Presbyterian, Piedmont, CMC all
25 seen at about 1.6 and some change indicating

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1 that they're delivering services to relatively
2 the same mix of services, cardiology, surgical
3 cases and that kind of thing comparable.

4 Q: And let's just for clarity then, contrast that
5 with Springs, the second one.

6 A: Springs, 1.2. It's a much smaller facility.
7 It does not have a particular capability to
8 provide complex services. It has a pretty, I
9 guess what we would call more traditional
10 community-based kind of hospital

11 Q: All right. And so look at the average column,
12 which is what's reported to the county at their
13 request, how is that information calculated?

14 A: The average charges, it's basically the total
15 of all cases for Medicare inpatients at these
16 facilities divided by the number of total
17 cases. It's a simple average.

18 Q: Without regard to the complexity or the length
19 of stay services?

20 A: Correct. Without regards to any of those
21 influences.

22 Q: All right. And then the CMI then adjusts for
23 the complexity?

24 A: Yes.

25 Q: Understanding that more complex cases are using

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1 more resources, more money and more time.

2 A: Correct.

3 Q: And then based on this, once the adjustment is
4 applied and these facilities are the ones in
5 the peer group that are affiliated in the peer
6 group in the contract, is that correct?

7 A: Correct.

8 Q: Okay. And after the case mix adjustment, which
9 hospitals have the highest CMI adjusted charge?

10 A: Palmetto-Baptist, Springs, Richland, Mary Black
11 Spartanburg.

12 Q: All right. That's enough. And which ones have
13 the lowest?

14 A: Gaston, CMC-Pineville, Piedmont, Presbyterian
15 and CMC. In reverse order.

16 Q: Okay. Thank you. No further questions, Your
17 Honor.

18 **THE COURT:** Thank you.

19 **MR. MULLER:** Nothing further from me.

20 **THE COURT:** All right. Anything from the
21 Department?

22 **MS. BIGGERS:** No, Your Honor.

23 **THE COURT:** All right. I think we're finished with
24 Mr. Miller.

25 **MR. ANDREWS:** We are, Your Honor.

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RECORD 001030

1 **THE COURT:** Sir, thank you very much. You may be
2 excused.

3 **MR. ANDREWS:** Your Honor, before we call Mr. Grice,
4 can we take a short break before we start?

5 **THE COURT:** Ten minutes.

6 (Off the Record)

7 **THE COURT:** Mr. Andrews.

8 **MR. ANDREWS:** Thank you, Your Honor, we would like
9 to call Joel Grice.

10 **THE COURT:** Mr. Grice.

11 **JOEL GRICE,** having been duly sworn, testified as
12 follows:

13 **MR. GRICE - DIRECT EXAMINATION BY MR. ANDREWS:**

14 Q: Good afternoon, Mr. Grice. Please state your
15 name and business address for the record?

16 A: Joel C. Grice. 430 White Falls Drive,
17 Columbia, South Carolina 29212.

18 Q: Mr. Grice, what's your current employment?

19 A: I'm managing partner of Grice & Whiteside, LLC.

20 Q: Have you retired from the state?

21 A: Yes, sir. I retired, technically, in I think
22 March of 2003 as a TERI employee but worked on
23 until December 2007.

24 Q: And what was your last position with the
25 Department?

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RECORD 001031

1 A: I was director of the Bureau of Health
2 Facilities and Services Development.

3 Q: And how long were you with DHEC before you
4 retired?

5 A: I joined DHEC in 1975 and became involved with
6 the Certificate of Need Program in 1978. I was
7 total 32 years, but 29 in the Certificate of
8 Need Program.

9 Q: All right. And what was your title in your
10 last position there, Mr. Grice?

11 A: It was bureau director of the Bureau of Health
12 Facilities and Service Development. And we had
13 four things under us that I supervised,
14 Certificate of Need, the State Health Plan
15 Development, the Medicaid Permit Program and
16 the Certificate of Public Advantage Program.

17 Q: Okay. Let's turn to your resume, which is has
18 been pre-admitted as Exhibit 70. And before
19 one of your four areas of responsibility was
20 supervision of the CON program, is that
21 correct?

22 A: Yes, sir.

23 Q: And how long were you in that position?

24 A: Since December 2000, as the bureau director.
25 But I did supervise the CON program as director

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1 since 1984.

2 Q: Okay. So before becoming director of the
3 bureau, you were director of the Office of
4 Certificate of Need, is that correct?

5 A: Yes, sir.

6 Q: All right. And how long were you in that
7 position?

8 A: A total of 16 years.

9 Q: Okay. And before becoming director of the CON
10 Office, what responsibilities did you have at
11 DHEC?

12 A: Well, just briefly I joined CON in 1978 as a
13 reviewer and was promoted in 1981 to a planner
14 IV, and had some additional responsibilities,
15 the supervision and another new program called
16 The State's Appropriates Review Program.

17 Q: And what's your educational background?

18 A: I have a bachelor's and master's degree in
19 biology from the University of South Carolina.

20 Q: Okay. During the course of your work with the
21 CON program, either as director of the bureau
22 or director of the office or as a reviewer, can
23 you estimate the number of CONs that you've
24 reviewed or supervised during that 29 year
25 period?

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RECORD 001033

1 A: Yes, sir. I would say approximately 2,000.

2 Q: Okay. And would you describe, just in very
3 general terms, the kinds of facilities and
4 services that were subject to your review?

5 A: Well, of course, development of new health care
6 facilities, and replacement facilities like
7 hospitals, nursing homes, ambulatory surgery
8 centers, home health agencies as well as the
9 purchase of sophisticated medical equipment,
10 like MRIs, CT scanners and radiation therapy
11 equipment, et cetera.

12 Q: Okay. For those that you mentioned, the CON
13 applications for new hospitals. Can you
14 estimate how many new hospital CON applications
15 you had the occasion to review?

16 A: I think it's for around, roughly ten or 11. I
17 can't remember. It might be less than that,
18 seven or eight, but these were replacements
19 we're talking about, I believe.

20 Q: All right. What different kind of new hospital
21 applications have you reviewed?

22 A: Well, I've reviewed just everything from a
23 brand new hospital that is being established,
24 replacement hospitals in South Carolina, as
25 well as satellite facilities that were

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RECORD 001034

1 developed from existing hospitals in South
2 Carolina.

3 Q: Okay. And if you've reviewed anywhere from
4 eight to ten replacement hospitals, how many
5 satellite hospital applications have you
6 reviewed?

7 A: I think it was around 14.

8 Q: Okay. And have you testified in CON cases on
9 behalf of DHEC and the decisions it's made?

10 A: Yes, sir.

11 Q: Have you been qualified as an expert witness in
12 those cases?

13 A: I have. Yes, sir.

14 Q: Okay. Were you involved in this case involving
15 Fort Mill during the initial review prior to
16 Judge Matthews' remand?

17 A: Yes, sir. I was.

18 Q: All right. Did you have any involvement in the
19 review of this case subsequent to the remand?

20 A: No, sir.

21 Q: When were you retained by my firm on behalf of
22 Piedmont as an expert witness in this case?

23 A: During the summer of 2012.

24 Q: Did you have any contact with any
25 representatives of Piedmont concerning your

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RECORD 001035

1 retention prior to the summer of 2012?

2 A: No, sir. Not at all.

3 Q: All right. And since being retained to work on
4 this case by Piedmont, what have you done?

5 A: Basically, I have reviewed the applications
6 that I was responsible for in the decision-
7 making process back in 2004, 2005, as well as
8 the revised applications that were submitted, I
9 believe in 2008, '07, '08, '09. I know there
10 was the hearing in 2009.

11 Q: The hearing was in '09?

12 A: Yes, sir.

13 Q: And that subsequent remand was in 2011?

14 A: That's right. I'm sorry. Yes, sir. I
15 reviewed the revised applications that were
16 submitted after Judge Matthews' order.

17 Q: Okay. I would like to move this time to
18 qualify Mr. Grice as an expert in the CON
19 program and healthcare planning.

20 **THE COURT:** Objections?

21 **MR. MULLER:** Without objection, Your Honor.

22 **MS. BIGGERS:** No objection.

23 **THE COURT:** No objection. All right. Then
24 there being no

25 objection Mr. Grice is hereby recognized by the

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1 Court as an expert in the CON program and
2 healthcare Planning.

3 Q: Mr. Grice, you testified that you reviewed
4 about -- something on the order, based on the
5 math I've done, 22 to 25 CON applications
6 involving the construction of new hospitals, is
7 that right?

8 A: Yes, sir.

9 Q: Okay. And you've mentioned two different kind
10 of new hospitals, replacement facilities and
11 satellite hospitals, is that correct?

12 A: That is correct.

13 Q: All right. Let's start with satellite
14 hospitals, what are the reasons, I'm sorry,
15 let's start with replacement facilities first.
16 What are the reasons that hospitals submit CON
17 applications for you for replacement
18 facilities?

19 A: Generally, our experience in South Carolina has
20 been that a lot of our hospitals, particularly
21 county hospitals were very old, built back in
22 the late forties or early fifties and they were
23 antiquated. And they definitely needed to be
24 replaced.

25 Q: All right. Have you developed a Demonstrative

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1 that provides a list of some of those you
2 reviewed?

3 A: Yes, sir.

4 Q: Let's pull up, Dan, Demonstrative 125. And
5 what's on your list here, Mr. Grice?

6 A: Yes, sir. The Medical University of South
7 Carolina, of course, Piedmont Medical Center-
8 Rock Hill.

9 Q: Now, repeat which Piedmont replacement hospital
10 was?

11 A: This is the original, the replacement of the
12 old York General Hospital.

13 Q: Okay.

14 A: And then we've got the Carolinas Hospital in
15 Florence, which was a replacement of actually
16 two facilities in Florence, one being I think
17 called, Florence General and there's one other.
18 I forgot the name of it. It was a very small
19 facility but Carolinas was the replacement.
20 And then we have St. Francis Xavier Hospital in
21 Charleston that was replaced with a new
22 facility over in the, gosh, I forget the name
23 of the area in Charleston. I'm not that
24 familiar with Charleston, but it's in another
25 area.

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RECORD 001038

1 Q: Could it be West Ashley?

2 A: West Ashley, I'm sorry. Yes, sir. And then
3 Coastal Carolina Hospital was a replacement of
4 the old Jasper County Hospital in Jasper
5 County. The Allen Bennett Hospital was owned
6 by the Greenville Hospital System and it's been
7 replaced in Greer, South Carolina. It's now
8 known as Greer Memorial. East Cooper Hospital
9 in Mt. Pleasant was replaced within the last
10 five years to a new site in Mt. Pleasant. And
11 Carolina Pines in Hartsville was a replacement
12 of an old facility located in that town.

13 Q: Now, Mr. Grice you were involved in the review
14 of all of these applications?

15 A: Yes, sir. I was.

16 Q: Now, when you reviewed these applications, what
17 was the Department looking for?

18 A: Well, basically, need. To be sure there's a
19 need for a continued services and certainly
20 there was. And all the important criteria on
21 the Certificate of Need that there would be,
22 you know, a cost effective application and
23 financially feasible and growth and population
24 in those areas.

25 Q: Okay. Now, did you ever deny one of these

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1 applications?

2 A: No, sir, never.

3 Q: All right. Now, let's move to satellite
4 hospitals. How many satellite hospitals,
5 again, did you say you believe you've reviewed?

6 A: My memory, I think it was around 14. I did a
7 list.

8 Q: Have you developed a list of it?

9 A: Yes, sir.

10 Q: All right. Let's take a look at Demonstrative
11 109. And what is this a list of, Mr. Grice?

12 A: This is a list of the first satellites that we
13 did approve, that I was involved in with
14 reviews of the CON applications in South
15 Carolina.

16 Q: Okay. Define for the Court what you would mean
17 by a satellite hospital? What is that?

18 A: Okay. A satellite hospital is one where we
19 have the, I guess we would say, the parent
20 hospital that is there with a bed need, or beds
21 that are probably not properly utilized. In a
22 county where there's some rapidly growing
23 populations in suburban areas. And they
24 realize that they are going to apply for the
25 beds that are shown as needed in the Health

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1 Plan, or beds that aren't properly utilized in
2 the old facility, to build a satellite in that
3 county in a rapidly growing area to benefit the
4 system, their own system there.

5 Q: And up through 2005, did the State Health Plan
6 address a method by which existing hospitals
7 would develop satellite hospitals?

8 A: No, sir. This was something that occurred and
9 we followed our own standard at DHEC. And
10 that's the way it was done.

11 Q: All right. And what was that standard in
12 general terms?

13 A: Well, the standard was if a hospital, you know,
14 could show the need for that satellite and new
15 additions in the county with rapidly growing
16 population. If they could submit that
17 application with their own bed need or transfer
18 of their beds, and if they met all the
19 important criteria in the Certificate of Need
20 regulations, they could be approved.

21 Q: Okay. And in reviewing these hospitals, what
22 you define in your Demonstrative 109 as the
23 first satellite hospital, you mean the first in
24 the state?

25 A: Yes, sir. These are some of the first we had

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1 in South Carolina.

2 Q: What period of time would they generally have
3 been developed?

4 A: It would have been, these are before the year
5 2000.

6 Q: And describe what you have on the list?

7 A: Well, we've got St. Francis Eastside in
8 Greenville. And that was developed by the St.
9 Francis Hospital in Greenville, South Carolina.
10 Now, Trident-Summerville, that hospital was a
11 satellite in Dorchester County.

12 Q: Of what hospital?

13 A: I'm sorry. Trident-Summerville. It's actually
14 called Summerville Medical Center.

15 Q: Okay.

16 A: And just to prevent some confusion here,
17 Trident Medical Center was developed in the
18 North Charleston area in 1975. And they
19 basically served Berkeley and Dorchester
20 County, northern Charleston. But as the growth
21 took place, there was a need for a hospital in
22 Dorchester County. And Trident built the
23 satellite, called Summerville Medical Center.

24 Q: And Providence Northeast?

25 A: That was a satellite of Providence Hospital in

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RECORD 001042

1 Columbia, South Carolina that was developed in
2 the northeastern section.

3 Q: All right. And we've already heard a good bit
4 of testimony about Georgetown-Waccamaw. You
5 don't need to further describe that. Carolina
6 Women's Center is that a speciality facility?

7 A: Yes, sir. It was developed by the Carolinas
8 Hospital System in Florence.

9 Q: That system have any relationship to Carolinas
10 Healthcare System involved in this case?

11 A: No, sir. Not at all.

12 Q: Okay. All right. Now, you've developed a
13 further list of the more recent satellites?

14 A: Yes, sir.

15 Q: Let's look at that, it's Demonstrative 110,
16 please, Dan. And what do we have here Mr.
17 Grice?

18 A: Okay. These are satellite hospitals developed
19 since the year 2000 in South Carolina.

20 Q: As far as you know, is this a complete list of
21 all the satellites developed since 2000?

22 A: Yes, sir. As far as I know, this is the one.
23 The last three on the list are not yet
24 developed. Palmetto-Parkridge is under
25 construction. And the last two are not yet

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1 under construction, just approved.

2 Q: Okay. Describe what you're presenting here in
3 this demonstrative?

4 A: Okay. We've got the AnMed Women's and
5 Children's Hospital in Anderson, South
6 Carolina. That was a satellite of Anderson
7 Medical Center.

8 Q: How many beds?

9 A: It's 72 beds. And that same year 2002, the
10 Greenville -Patewood facility in the Greenville
11 area that's also 72 beds. That was a satellite
12 from beds from the Greenville Hospital System,
13 Greenville Memorial. And then in 2005, out of
14 Loris, the Loris Community Hospital developed a
15 satellite called Seacoast Medical Center and
16 it's 50 beds. And also that same year, we had
17 the Greer Memorial Hospital that was also
18 developed by Greenville Hospital System. There
19 was also a replacement of beds, including the
20 Allen Bennett Hospital. And we have also the
21 Pelham facility in Spartanburg, that was a
22 satellite of Spartanburg Regional Medical
23 Center. And the Roper-Mt. Pleasant is located
24 on Mr. Pleasant that is a satellite of Roper
25 Hospital in downtown Charleston.

1 Q: Is that the Roper Hospital System that's
2 partially owned and managed by Carolinas, the
3 party in this case?

4 A: Yes, sir. It is. I think it's ten percent
5 owned by the Carolinas Hospital System. Okay.
6 And then we have Palmetto-Parkridge, I'm sorry,
7 the Palmetto Baptist-Parkridge. It's currently
8 under construction in the Irmo, South Carolina
9 area. And those beds came from directly from
10 Baptist Medical Center, beds that were not even
11 utilized.

12 Q: Part of the Palmetto System here in Columbia?

13 A: Yes, sir. Palmetto Health. And then the
14 Roper-Berkeley, that is a satellite of the,
15 here again, the Roper Hospital in downtown
16 Charleston. A new hospital of 50 beds in
17 Berkeley County. And also Trident Regional
18 Medical Center in North Charleston also was
19 approved for a satellite in Berkeley County,
20 also for 50 beds.

21 Q: Okay. Now, what I want to do is, let's look at
22 some Demonstrative Maps that you asked me to
23 prepare. Let's begin with Demonstrative 126,
24 Dan, to show the satellites, if you would, the
25 total satellites related to the Greenville

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RECORD 001045

1 Memorial System.

2 A: Yes, sir. There we see the two satellites, the
3 Greenville Memorial and Patewood Memorial that
4 are the two satellites of Greenville Memorial
5 Hospital.

6 Q: Okay. Let's take a look then at Demonstrative
7 128 for the Roper-St. Francis System in
8 Charleston. Now, what are the satellites
9 affiliated with that system in the Charleston
10 area, Mr. Grice?

11 A: Okay. We see the Roper Hospital and here we've
12 got the Roper-Mt. Pleasant and the Roper-
13 Berkeley, they're the satellites there. And
14 Roper-St. Francis, of course, is also
15 affiliated with Roper Hospital and that's also
16 a new facility, relatively new facility.

17 Q: All right. It goes back a few years. Twenty
18 years can seem new.

19 A: It seems like yesterday to me, yes, sir.

20 Q: All right. How many hospitals including, then,
21 the main hospital are in the Tri-County area
22 affiliated with Roper?

23 A: The ones that have been approved, I believe ---

24 Q: The total?

25 A: I believe that are affiliated with Roper,

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RECORD 001046

1 three.

2 Q: All right. And including the center, the main
3 hospital?

4 A: Yes.

5 Q: It would be four?

6 A: Four, that's correct.

7 Q: All right. Let's look at Demonstrative 130,
8 staying in the Tri-County area, are there any
9 other systems with multiple satellites?

10 A: Yes, sir. Trident Medical, Trident Regional
11 Medical Center in North Charleston. Now, it's
12 two satellites, one operational, the
13 Summerville Medical Center in Berkeley County
14 and the, I'm sorry, Summerville Medical Center
15 in Dorchester County and the Berkeley Medical
16 Center that's approved to be in Berkeley
17 County.

18 Q: Okay. And let's look in the Columbia area.
19 What have you identified here, Mr. Grice?

20 A: Here we have Palmetto Health System now
21 consists of the Palmetto-Richland Hospital and
22 Palmetto-Baptist that are in downtown Columbia.
23 And their new satellite that is under
24 construction is the Palmetto-Parkridge.

25 Q: Now, we don't have it on this map, but you

1 identified previously Providence Northeast and,
2 of course, there is Providence downtown, so how
3 many total facilities are there in the
4 Providence System in Columbia?

5 A: All right. In the Providence System it would
6 a total of two hospitals.

7 Q: Okay. Now, Mr. Grice, have you prepared a
8 Demonstrative that identifies what you've
9 previously began testifying about, about the
10 common characteristics that you've identified
11 over the years that are affiliated with
12 satellite hospitals?

13 A: Yes, sir.

14 Q: Okay. Let's pull that up, Dan, Demonstrative
15 129. And what have you prepared here, Mr.
16 Grice?

17 A: Well, what I see is some of the four main
18 patterns that we see with applicants who
19 request approval for satellites. I think a
20 hospital system, if they see in the area, you
21 know, an excess capacity of their own facility
22 where there's an underutilization of beds and
23 perhaps also, new growth areas in the county,
24 suburban areas particularly. They are going to
25 need to be able to protect and gain market

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RECORD 001048

1 share and this is going to strengthen the
2 parent hospital, in my opinion, and, of course,
3 I think the hospitals know this very well. If
4 they do not move in this order, they're going
5 to be damaged. Particularly, they're going to
6 perhaps lose patients to other facilities out
7 of county, et cetera. So it's very important
8 for them, particularly when we have population
9 growth, for them to determine what's the best
10 pattern, advance where I am or build a
11 satellite particularly if an area's growing and
12 it's going to be more convenient for patients
13 to go to a new satellite rather than travel
14 some distance to their parent hospital.

15 Q: Over the last decade, what has been the trend
16 of large hospital systems throughout the state?
17 Has it been to add beds at their main campus or
18 to establish satellites?

19 A: It's mainly satellites.

20 Q: Okay. Dan, let's go back to Demonstrative 110.
21 Mr. Grice, go over the list of hospital
22 satellites developed since 2000 and how many on
23 this list are affiliated with hospitals that
24 are not tertiary facilities, that is not
25 facilities that have open heart programs, and

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1 provide a range of complex services.

2 A: I only see one there, that's the Loris, Loris
3 Community Hospital, which developed Sea Coast.
4 Loris is a smaller primary care hospital in the
5 town of Loris, South Carolina in Horry County.
6 And it's not a tertiary facility.

7 Q: And all the others, how would you characterize
8 them?

9 A: The other satellites, their parent hospitals
10 all have tertiary services, open heart and
11 other sophisticated services.

12 Q: And what relationship exists between the needs
13 and demands of those facilities and their
14 development of satellite hospitals within their
15 system?

16 A: Well, these satellites are going to be able to
17 track patients in the rapid growing areas and
18 when those patients need referral for more
19 complicated services, such as open heart
20 surgery or a therapeutic cardiac
21 catheterization, they can be referred to the
22 parent hospital which has those services. And
23 that helps maintain and substantiate the
24 services of the parent hospital.

25 Q: Okay. Let me take you back to the period, Mr.

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1 Grice, when you were director of the bureau and
2 you had responsibility for the position in
3 which you were involved in this case. Do you
4 remember being first contacted by
5 representatives of Piedmont related to their
6 interest in developing a hospital in Fort Mill?

7 A: Yes, sir. I do. I certainly do. The
8 administrator of the Piedmont Medical Center
9 that testified today, Mr. Levitt, I had an
10 appointment with him. This is the usual
11 situation, we had the open-door policy when I
12 was at DHEC. And I welcomed people to come in
13 and talk about the projects so that they would
14 have some comfort prior to submitting an
15 application.

16 Q: All right. Subsequent to meeting with them,
17 did you also meet with representatives of the
18 other applicants in this matter, Presbyterian,
19 Hospital Partners of America and Carolinas?

20 A: Yes, sir, absolutely.

21 Q: Okay. All right. Now, what do you recall that
22 Mr. Miller and Mr. Levitt informed you about
23 their interest in the Fort Mill Medical Center?

24 A: Well, they were, of course, were aware that the
25 2004-2005 Health Plan showed the need for 64

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1 beds. And they wanted just to let me know that
2 they were working on an application for a
3 satellite in the Fort Mill area that was going
4 to be, you know, a 64-bed facility. And they
5 just wanted us to be aware that the application
6 was under development and would be submitted
7 shortly.

8 Q: All right. Did they discuss with you the
9 options that were available to Piedmont
10 concerning the establishment of a satellite
11 facility or the use of the beds to expand their
12 existing campus in downtown Rock Hill?

13 A: Yes, sir. Certainly, they had an option,
14 anybody would, the bed need was one that was
15 really developed by them in a health plan with
16 their utilization and population growth in the
17 county. And they could have added beds to the
18 existing Piedmont Medical Center or built a
19 satellite. And as we discussed with other
20 satellites in South Carolina, in this
21 particular case with that rapidly growing area,
22 Fort Mill, it would certainly be beneficial to
23 the parent hospital like Piedmont to add that
24 satellite facility.

25 Q: Okay. Now, at this time had you been contacted

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1 by anyone else concerning anyone's interest in
2 the use of those beds?

3 A: No, sir.

4 Q: Okay. Now, the records show that in October of
5 2005, Piedmont withdrew and re-filed their
6 application to build a satellite facility in
7 Fort Mill and to establish a 100-bed facility
8 there. Do you recall that?

9 A: Yes, sir.

10 Q: And how did you review that change?

11 A: It was positive, in my opinion. They had a
12 unique position there because with the rapidly
13 growing population there at Fort Mill, that
14 100-bed facility, I think, was an excellent
15 idea. Particularly to save cost in the future
16 because it's much more cost-effective to build
17 all those beds now, if you can project they
18 will be needed in the future. And basing it on
19 the growth in that area, if they were to build
20 only 64 beds, probably even the second or third
21 year, they would be looking at making an
22 addition. And when you add an addition to an
23 existing hospital, it's very disruptive to the
24 services.

25 Q: How is disruptive?

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RECORD 001053

1 A: Because you've got to start construction and
2 block off areas and the patients are somewhat,
3 you know, distracted and uncomfortable and it's
4 just not a pleasant situation to have a
5 construction project going on.

6 Q: Have you seen that over the years as hospitals
7 have expanded services and added beds?

8 A: I have, yes, sir. I have.

9 Q: Okay. All right. Mr. Grice, let's pull back
10 a little bit and talk more generally about what
11 you do when you're presented with application
12 for a satellite facility like Piedmont's. How
13 do you review that?

14 A: We review it like any application. The
15 regulation required, you know, the standard
16 review process. The number of days for review,
17 ask for additional information. It's reviewed
18 as any application would be. And, of course,
19 we have 30 days to review and request
20 additional information. And if we desire, we
21 can have a project review committee meeting,
22 meet with the applicant, let them go into more
23 detail with the staff.

24 Q: All right. Of all the applications you've
25 received for satellite hospitals during your 29

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1 year career, in particularly those that you've
2 more recently identified. Did you approve
3 them?

4 A: Yes, sir. Everyone of them.

5 Q: Were any of them competing?

6 A: No, sir.

7 Q: Why not?

8 A: I did not review the last two.

9 Q: Other than the last two?

10 A: No, sir. They were not competing.

11 Q: Were those last two competing?

12 A: No, sir. Because there was a need for each of
13 them. One of them transferred beds, the other
14 had a bed need, so basically, you define
15 competing as when there's a limited need and
16 you can only approve one.

17 Q: Okay. Now, did you approve Piedmont's when you
18 had reviewed it and you made a decision for the
19 Department in 2006?

20 A: Yes, sir. I did.

21 Q: Why did you do that?

22 A: I studied that very carefully. That was a
23 long, complicated review process. And my main
24 reason was I felt that there were numerous
25 factors there that were positive for Piedmont.

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1 I saw that project as really protecting that
2 facility that was built in the early 1980s that
3 had developed with tertiary services like open
4 heart, that there was beginning to be out-
5 migration out of the county. And that new
6 satellite I knew was going to benefit the
7 parent hospital, because it would attract
8 patients, a lot of them who currently out-
9 migrate. And then those patients when they
10 needed more sophisticated care like tertiary
11 services would be referred to the parent
12 hospital, Piedmont. It would benefit the
13 county. Piedmont had a great reputation, in my
14 opinion having that contract with the county
15 that had been discussed by Mr. Miller today.
16 And also, I knew with that rapidly growing area
17 with 100 beds, that also was positive. But
18 that wasn't the most important thing, but I
19 knew that if it's really rapidly growing like
20 it is, you're going to need more beds in the
21 future and that was a cost-effective way to do
22 it. Build it now, rather than later when cost
23 go up with inflation.

24 Q: Okay. Let's take a look at Demonstrative 113.
25 I think you prepared this as a list of the

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1 items that you identified in your approval
2 letter, is that right?

3 A: Yes, sir.

4 Q: Okay. And why don't you review just quickly
5 these four bullet points, do these track your
6 letter?

7 A: Yes, sir. The 100 beds, as I mentioned is
8 certainly a benefit and the contract that
9 Piedmont Medical Center System had with York
10 County.

11 Q: Why was that an important issue for them?

12 A: Because it had been there since Piedmont was
13 developed and as it has been discussed today,
14 that left the county to be able to look at the
15 charges and make sure they're reasonable and
16 the other benefits involved. They've already
17 been discussed. That was just very important.
18 And during the review I went over that and that
19 was unique, very unique in this state.

20 Q: All right. And the third bullet point?

21 A: The third bullet point, technically at that
22 time, it was only the applicant that would be
23 approved under the 2004-2005 ---

24 Q: No, I'm sorry. The third, not the fourth.

25 A: I'm sorry. Demonstrate commitment to the

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1 county, yes. You know, I was around and even
2 met the original administrator of the old York
3 General Hospital in 1980. And that hospital
4 needed replacement and it was great that, you
5 know, that AMI came in and built that new
6 facility. And so you think about they
7 developed it as a small facility over the years
8 and added all the services like open heart
9 surgery and so it's a large facility now. And
10 I think it needs to be maintained. I think,
11 you know, that's very important.

12 Q: Okay. And what's the fourth point?

13 A: The fourth point is that it's the only
14 applicant that would be approved under 2004-
15 2005 State Health Plan.

16 Q: That was your finding in the letter?

17 A: It was. I had reviewed them competitively, but
18 I also -- as I'm required, you know, at that
19 time to make findings that relate to the
20 regulations. And I also added that in there,
21 which was true.

22 Q: All right. We're not going to go into your
23 basis for that. That's a statement of fact?
24 Okay. So we'll move beyond that. Now, let me
25 focus on the third bullet point, which is that

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1 with regard to that demonstrated commitment to
2 the county, you were involved in the approval
3 of the first replacement hospital in 1980?

4 A: Yes, sir. That's correct.

5 Q: All right. So you knew about that? Were you
6 involved in the open heart surgery CON
7 application as well?

8 A: Yes, sir. I certainly was.

9 Q: Did you approve that application, Mr. Grice?

10 A: No, sir. The first one I denied.

11 Q: What did you deny?

12 A: Because in reviewing the criteria, I made a
13 mistake, actually. We had opposition from
14 hospitals in Charlotte, North Carolina that had
15 an open heart surgery and I ---

16 Q: Who were they, do you remember?

17 A: I'm sure it was Carolinas Medical Center. It
18 may have been Presbyterian too. It's been so
19 long, that's been probably pushing 20 years ago
20 when we reviewed that. But there was
21 opposition and the concern was that, you know,
22 right now the open heart surgery patients at
23 that time, 20 years ago, were going to
24 Charlotte.

25 Q: From where?

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1 A: From York County, Rock Hill. And I felt it was
2 going to had an adverse effect.

3 Q: On who?

4 A: On North Carolina hospitals.

5 Q: Uh-huh (affirmative response).

6 A: And that was one of my principle reasons for
7 denying it.

8 Q: Okay. Now, were there any border cities in
9 South Carolina during that same period that
10 also filed open heart surgery applications?

11 A: Yes, sir.

12 Q: Who was that?

13 A: Aiken, South Carolina. And we had the same
14 situation occur, Aiken Regional Medical Center
15 applied for open heart and we had opposition
16 from some hospitals in Augusta, Georgia that
17 also had open heart. And I also denied Aiken
18 for the same reason.

19 Q: All right. As a result of those two denials,
20 were those cases appealed?

21 A: Yes, sir, they were.

22 Q: At the time before the establishment of the
23 Administrative Law Court, there were hearing
24 officers, is that correct?

25 A: That's correct.

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RECORD 001060

1 Q: All right. Now, during the pendency of those
2 reviews, was there any legislative action taken
3 concerning DHEC's decision in these two cases?

4 A: Yes, sir. I think the Three M Committee met.

5 Q: The Three M Committee being what?

6 A: The, I think Military, Medical, and ---

7 Q: Municipal.

8 A: Municipal, right. And I was there at the
9 meeting and they were ---

10 Q: You were invited to be present?

11 A: Yes, sir.

12 Q: Did you testify?

13 A: I did.

14 Q: And what was the nature of your testimony?

15 A: Basically, the reason that I denied those was
16 the fact that I saw approval of the facility in
17 South Carolina of open heart as having an
18 adverse impact on the out-of-state facilities.
19 And I was pretty well raked over the coals.

20 Q: In what regard?

21 A: Well, I was told, Mr. Grice, you must, when you
22 make decisions on CON you look at South
23 Carolina citizens. You approve South Carolina,
24 that is your job to focus on South Carolina not
25 out-of-state.

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RECORD 001061

1 Q: What did you understand the message to be with
2 regard to the development of health care
3 facilities in South Carolina?

4 A: The message was that basically, you know, we
5 have to, in making our decisions make sure that
6 we're really benefitting South Carolina. I
7 mean, our program here is part of South
8 Carolina state government. We try to protect
9 and assist South Carolina-licensed hospitals.
10 And that is our main focus, not to make some
11 decision that's going to negatively impact
12 them.

13 Q: Now, as a result of your being summoned before
14 the Senate Three M Committee, what action, if
15 any, was taken concerning the two cases in Rock
16 Hill and Aiken?

17 A: They submitted new applications, each of them,
18 and they were approved.

19 Q: Okay. All right. Now, let's go back to your
20 work on this case. In addition to the four
21 items you've identified in your decision
22 letter, did you also address issues related to
23 this case in the CON summary that was developed
24 around the same time that the decision was
25 made?

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RECORD 001062

1 A: Yes, sir.

2 Q: Okay. And did you have a hand in the
3 preparation of that?

4 A: I did. In my review of this first application,
5 of these first applications for a satellite in
6 York County, I had a lady in our office that
7 did a lot of the work, but basically, we worked
8 together and she.

9 Q: She would appreciate you referring to that.

10 A: But we worked even late at night. We were
11 there until twelve o'clock, midnight. And I
12 was right it out longhand, giving it to her to
13 type and it worked well that way.

14 Q: Who are you referring to?

15 A: Ms. Mary Fechtel.

16 Q: Okay. All right. Now, Dan, let's turn to that
17 CON summary, beginning at page 856 and that
18 being, Joint Exhibit 1(B). All right. And
19 what is this document, Mr. Grice?

20 A: Okay. That is the Certificate of Need summary
21 sheet for the Fort Mill Medical Center. And I
22 believe this is the application that was
23 submitted in 2005.

24 Q: And is this the CON summary sheet that records
25 the Department's analysis of the application?

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RECORD 001063

1 A: Yes, sir. It is.

2 Q: Okay. Now, did you prepare in this analysis a
3 section concerning potential adverse impacts?

4 A: Yes, sir.

5 Q: All right. Let's turn to, Dan, page 898 in the
6 report. And let's go down and pick up, if you
7 would, Mr. Grice. And Dan, if you would draw
8 out and highlight the last paragraph on that
9 page? And Mr. Grice read that into the record,
10 please, those highlighted sections and those
11 paragraphs?

12 A: All right. In contrast should either of the
13 competing three applicants be chosen to
14 construct a new facility, their patient base
15 would be siphoned from the existing utilization
16 of Piedmont Medical Center which must continue
17 to operate under the contract of York County to
18 provide the following services in addition to
19 hospital services whether approved or denied
20 for a satellite facility. If patient
21 utilization should drop drastically at the
22 current facility due to competition from
23 another provider income may be affected and the
24 foregoing services may be compromised.

25 Q: All right. Now, what were you referring to

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1 here, Mr. Grice?

2 A: Well, what we were referring to there is, if we
3 did not have the satellite for Piedmont Medical
4 Center, that, as that last sentence says:
5 Patient utilization would drop and due to
6 competition from another provider -- and it
7 would, it would be a negative situation for the
8 existing provider.

9 Q: Now, that paragraph begins with in contrast,
10 and I probably should have asked initially is
11 that what was your finding in the first
12 paragraph? We don't need to turn back to it,
13 but what was your finding with regard to
14 whether or not the transfer of the 36 beds and
15 the establishment of the Fort Mill Medical
16 Center, the 100-bed facility, would have an
17 adverse impact on operation of Piedmont Medical
18 Center?

19 A: I did not make that finding of that you would
20 have an adverse impact. It would have a
21 positive impact.

22 Q: Why was that?

23 A: Because of the fact that it would actually, it
24 would reduce some of the out-migration in the
25 county. And it would attract patients that

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RECORD 001065

1 would be new residents that would be moving
2 into the rapidly growing area of Fort Mill.
3 And those patients, if they needed
4 sophisticated services would be transferred to
5 the parent hospital, Piedmont Medical Center
6 for those tertiary services.

7 Q: Okay. Dan, let's flip to the next paragraph on
8 the same page 899 and the report. And, Mr.
9 Grice, read into the record this section that's
10 highlighted, please?

11 A: Additionally, there's an issue of critical mass
12 and critical care. For a given population of
13 patients and the physicians who possess the
14 knowledge and skills to offer the required
15 care, utilization of the three diagnostic
16 therapeutic cardiac catheterization
17 laboratories which operate at over a 100
18 percent at Piedmont Medical Center and the
19 willingness of York County residents to stay in
20 York County for this type of critical service
21 attest to the fact that the development of the
22 Fort Mill Medical Center rather than a
23 competing applicant will allow the current
24 provider to expand current services and develop
25 more complex tertiary services as the critical

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RECORD 001066

1 mass of patients reached/served.

2 Q: And what's the purpose of your point concerning
3 the critical mass of patients?

4 A: Well, when I used that term, a lot of times I'm
5 thinking about really a good number of beds
6 available at, you know, the new satellite too.
7 I mean, if that's what you're referring to. I
8 know, let me look at that one more time as you
9 were saying it.

10 Q: Complex tertiary services.

11 A: It's when a critical mass of patients is
12 reached. In other words, that critical mass of
13 patients that you don't want to lose, that you
14 don't want to out-migrate. They may need those
15 type complex services.

16 Q: Okay. Now, let's pick up the last section of
17 the paragraph. Read that if you will, please?

18 A: If a North Carolina-based provider is approved
19 an inevitable dilution of that critical mass
20 would occur as patients choose to stay with
21 and/or are referred to that specific provider's
22 tertiary facility in Charlotte. In the
23 Charlotte scenario, the ability and need would
24 attract highly trained sub-speciality
25 physicians who live, work selectively in York

1 County and South Carolina, would be
2 compromised. Allowing the development of the
3 Fort Mill Medical Center would enable growth of
4 services, expansion of physician staff with
5 critical skills and allow a more equitable
6 comparison to the large providers in North
7 Carolina. It is more important to have more
8 cardiac surgeons, neurosurgeons, infectious
9 disease specialists, oncologists, et cetera,
10 living and working in York Count in South
11 Carolina than to have those positions filled in
12 Charlotte.

13 Q: Why did you believe that to be true?

14 A: Well, I think with the growth of York County
15 and to maintain the high level services of the
16 Piedmont Medical Center that is true. You do
17 not want to lose those type of tertiary-type
18 positions who would move out of state if the
19 existing provider there would continue to lose
20 services.

21 Q: All right. Now, let's move onto the current
22 updated applications that were filed, Mr.
23 Grice, after you left DHEC. You said earlier
24 that you reviewed the updated applications, is
25 that right?

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- 1 A: Yes, sir.
- 2 Q: And have you reviewed the utilization data for
3 the period between 2005 and 2010?
- 4 A: I have.
- 5 Q: And what have you observed about that?
- 6 A: Well, during that period of time there has been
7 more out-migration of patients that are going
8 from York County across state lines.
- 9 Q: Okay. Now, how does your opinion now, that
10 you've developed purposes of this hearing
11 process, compare to the opinion you developed
12 when you were reviewing these applications in
13 2006?
- 14 A: It's much more confirmed and I feel very
15 comfortable with our decision back in 2005,
16 because I think this is the prime example why
17 I saw the need to approve this originally in
18 2005. I think this confirms that decision.
- 19 Q: All right. Now, let me shift your attention to
20 the decision that was made by Ms. Brandt in
21 2011. Have you reviewed her decision?
- 22 A: Yes, sir.
- 23 Q: Have you developed your opinion of it?
- 24 A: Yes, sir.
- 25 Q: All right. You developed a Demonstrative which

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1 outlines that?

2 A: Yes, sir. I have.

3 Q: All right. Dan, let's pull up DHEC's 131. And
4 does this reflect your opinion, Mr. Grice?

5 A: Yes, sir.

6 Q: And review it, if you would for the Court?

7 A: Well, I think the most DHEC decision failed to
8 recognize the connection between the existing
9 Piedmont Medical Center and the Fort Mill
10 Medical Center and the quality of healthcare
11 services in York County. Because I think it's
12 very important that, you know, that Fort Mill
13 Medical Center is going to help the entire
14 system there. It's actual going to maintain
15 the utilization of high quality services and
16 the tertiary services at Piedmont and the
17 quality of healthcare in that county. The
18 second, they failed to recognize the adverse
19 impact of a Charlotte area-based hospital
20 system in Fort Mill. And third, it failed to
21 apply the project review criteria consistently
22 with the Department's historical practice.

23 Q: Okay. Now, are you prepared to offer opinions
24 related to each of those issues?

25 A: Yes, sir.

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1 Q: Okay. Let's begin generally, as you know,
2 section 307.2 of the DHEC regs require the
3 Department to consider competing applications
4 among other things and how they comport with
5 the purposes of the Act. Let's turn to the
6 purposes and look at Demonstrative 92.

7 **THE COURT:** Mr. Muller?

8 **MR. MULLER:** Your Honor, when I took -- this would
9 be another example. When I took Mr. Grice's
10 deposition and I asked him for a list of his
11 opinions, he could not give them to me. As a
12 result, I was forced to go through the review
13 criteria to elicit what opinion he had on the
14 review criteria in the decision letter. And
15 now that we're at trial, he's prepared a list
16 that's far more expansive than that. So my
17 objection to it is, at his deposition he was
18 not prepared to give me any of this
19 information, now he's giving it to the Court.
20 If the Court would like, I can show you that
21 the testimony where he said that.

22 **MR. ANDREWS:** Your Honor, our view is that's the
23 completely the matter of cross examination.
24 This is going to be a general review of the
25 purposes. I can ensure you there was a

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1 complete and thorough review of all the project
2 review criteria. We're not there yet. I don't
3 know that Mr. Muller ever asked about the
4 purposes of the Act. If he did, then Mr. Grice
5 could respond, he's going to be bound by, you
6 know, whatever or subject to cross and whatever
7 his responses are. If he didn't then he
8 didn't. He didn't have a, you know, developed
9 report or written report like the other experts
10 did. And he responded to the questions asked
11 him.

12 **MR. MULLER:** Of these three topics, the only one
13 that he addressed was the last one, I believe.
14 And obviously, adverse impact, but only to the
15 extent of this project review criteria. And he
16 was very vague. In fact, the response, I seem
17 to recall the response he gave me was, you
18 know, whatever they asked me, was the response.
19 As opposed to providing me with this list, so
20 I would have an opportunity to explore these
21 various areas of what is now expanded
22 testimony.

23 **MR. ANDREWS:** Your Honor, we appreciate the ability
24 to go through the examination, it's not
25 expanded at all. That's a summary of the

1 project review criteria. He was examined by
2 Mr. Muller and by Ms. Biggers about the all the
3 project review criteria in which he disagreed
4 with Ms. Brandt. And Ms. Biggers asked him
5 about the others. I think, Mr. Muller's
6 examination actually was limited to those in
7 which there was a finding against Piedmont.
8 Ms. Biggers supplemented that with what about
9 the others. He responded to all of them. And
10 again, he was there as a deponent prepared to
11 respond and give his testimony concerning his
12 opinions and he did that. And, you know, I
13 don't know that it will be fruitful to review
14 several hundred pages of his testimony at
15 deposition for purposes of proving the
16 different elements of this. That's what would
17 be necessary to address the issues now. And I
18 suggest cross examination is the time to do
19 that.

20 **MR. MULLER:** I can show you the exact -- and it's a
21 very short back and forth with Mr. Andrews,
22 where I asked him for a list of the opinions
23 and he said, well, you will get that orally.
24 He doesn't have it in writing, you won't
25 receive it writing and I'm not required to

1 provide it to you in writing. I mean,
2 essentially, here's that he confined it to the
3 review criteria. And, Your Honor -

4 **THE COURT:** At his deposition. Did Mr. Grice
5 confine his opinions at his deposition to the
6 third bullet on that Demonstrative Exhibit?

7 **MR. MULLER:** This is only a matter of three pages,
8 if the Court wants to review it? I can provide
9 the Court with a copy of his deposition. You
10 can see how this issue was addressed at his
11 deposition because he wasn't giving me a list
12 as he's doing here today. He was -- and this
13 is a matter of probably three pages of his
14 deposition, Your Honor. It's not very
15 extensive, but I don't mean to say things that
16 are out of order, but in probably three pages,
17 or maybe even two pages, you can read what the
18 back and forth was between me and Mr. Andrews,
19 with respect to this issue.

20 **MR. ANDREWS:** And I would disagree with that.
21 Because what we need to do is then add Ms.
22 Biggers' examination of it and then some
23 additional work beyond that. So it's not, I
24 don't know even the pages but I can assure you
25 it's beyond that. Let me do, if I could offer

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1 this to you, three lines related to this. On
2 page 18, line 21.

3 **THE COURT:** Of his deposition?

4 **MR. ANDREWS:** Yes. It is his deposition.

5 **MR. COURT:** You're referring to ---

6 **MR. ANDREWS:** Line 18, the question from Mr. Muller
7 to Mr. Grice: Can you just recite the line, it
8 should be at the top of the document, the areas
9 about which you're expected to testify? Mr.
10 Grice's responds: Okay. Mr. Grice will offer
11 opinions in the area of healthcare planning and
12 finance. Mr. Grice will testify that
13 Piedmont's application, as originally filed
14 then is updated, most fully complied with
15 requirements, goals, purposes of the CON Act,
16 the Health Plan, and DHEC regulatory criteria.
17 We identified him -- that was a reference to
18 our pleading response to the interrogatory and
19 the preliminary statement. And which we
20 identified that as the range of matters that
21 Mr. Grice would testify about. And had Mr.
22 Muller asked him about his opinions about the
23 purposes, he would have received a response.
24 He didn't ask him about that. We had already
25 identified that. So for to complaint surprise

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1 about the purposes of that doesn't comport in
2 our view with the representation he made at the
3 outset.

4 **MR. MULLER:** If I can briefly read you -- my
5 question to him was: Mr. Grice I'm trying to
6 understand Mr. Andrews' statement. His
7 statement was basically about the lack of a
8 list. I take it that your intent at trial is
9 to go over DHEC's September 9, 2011, decision
10 letter and explain in what areas you agree with
11 DHEC and what areas you do not agree with them,
12 is that a correct statement? His answer: You
13 know, I will answer whatever questions are
14 given to me during the trial. You know, I
15 don't know exactly how all this is going to be
16 done but I know that you will probably -- Mr.
17 Andrews will have direct questions and you will
18 cross examine. But today, I'll try to answer
19 what you've asked me, you know. And then Mr.
20 Andrews, again, says he's going to offer
21 opinions about the purposes of the program
22 identified in the regs from the CON and then he
23 goes on to say that he doesn't have to give me
24 a list. Which at that point in time that we
25 started going through the project review

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1 criteria because his previous answers were so
2 vague. And then Ms. Biggers asked him the same
3 questions. So we were focused on the decision
4 letter and the review criteria, not on what
5 appears to be expanded testimony.

6 **MR. ANDREWS:** Your Honor, frankly this seems like a
7 lot of to do about nothing for this reason.
8 The purposes of the Act are simply a summary of
9 the project review criteria or the criteria are
10 the embellishment of the purposes of the Act.
11 There's a complete overlap between the two.
12 And the very general statements I intend to
13 elicit at this point concerning the purposes
14 are consistent with and, in fact, I hope you
15 don't find it duplicative but you probably will
16 recognize it entirely overlaps the project
17 review criteria about which he's already
18 testified. This is just essentially a summary
19 as the purposes are a summary of the testimony
20 he'll provide in more detail about the project
21 review criteria.

22 **THE COURT:** All right. Mr. Muller, I'm going to
23 overrule your objection. Mr. Andrews, you may
24 continue.

25 **Q:** All right, sir. Now, let's turn to the

1 purposes of the Act. Mr. Bupp, the
2 Demonstrative is 92. Mr. Grice, you're
3 familiar with these purposes?

4 A: Yes, sir.

5 Q: And review your opinions for the Court related
6 to them in this case based on your review of
7 the updated application?

8 A: Okay. My opinion, the purposes of the CON
9 program, number one, promote cost containment.
10 In my opinion, I would say each application has
11 demonstrated based on their project, you know,
12 they can promote cost containment in building
13 a cost-effective facility. But the other
14 three, when we say prevent unnecessary
15 duplication of healthcare facilities and
16 services, the one that best meets that is the
17 Fort Mill Medical Center. And the reason is,
18 that if we can establish that facility, the
19 Fort Mill Medical Center developed by Piedmont
20 Medical Center, it is going to prevent patients
21 that would go to another facility built there
22 by another provider like Carolinas Hospital
23 System who might refer their patients, their
24 patients any tertiary care services to
25 Charlotte. The Fort Mill Medical Center will

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1 be able to refer their patients, their patients
2 there to the Piedmont Medical Center for the
3 tertiary services. So I would look at the fact
4 that there's a duplication, in my opinion that
5 we would have with not properly utilizing the
6 availability of services at Piedmont, when the
7 patients are going to Fort Mill because of
8 another facility sending the patients over
9 there. Guide the establishing of healthcare
10 facilities and service that best meet public
11 needs. In this case, here again, I see that as
12 the Fort Mill Medical Center best meeting that
13 because of the fact it really, as we've
14 mentioned, it would benefit the York County,
15 the Piedmont Medical Center, that facility
16 that's been built there and the population
17 growth in that county. And also, the last one,
18 ensure that high quality services are provided
19 in health facilities in this state. And here
20 again, it kind of reminds me of what I went
21 through in that senate meeting, we've got to
22 look at that we are planning and ensuring high
23 quality services provided in South Carolina
24 whenever possible. If we can make decisions
25 that would benefit our state facilities.

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RECORD 001079

1 Q: All right. And what's your opinion, Mr. Grice
2 concerning which of the two applicants best
3 then meets the overall purposes of the Act.

4 A: The application by the Fort Mill Medical Center
5 best meets the purposes.

6 Q: All right. Now, let's turn to Ms. Brandt's
7 letter approving Carolinas in the updated
8 applications, which is the Joint Exhibit 1(B),
9 page 1017. All right. Have you reviewed Ms.
10 Brandt's letter?

11 A: Yes, sir. I have.

12 Q: All right. Let's turn to the second page where
13 she identifies the specific issues that she
14 reports in her letter. Let me draw your
15 attention first to the second paragraph. Would
16 you read that into the record?

17 A: Yes, sir. The Department is concerned with the
18 decline in utilization of Piedmont Medical
19 Center. The heavy dependance of recapturing
20 significant lost market share, which would
21 require a significant reversal of market trend.
22 The impact of redirecting existing patients
23 away from Piedmont Health Center and
24 substantial cost of the project and the ability
25 to finance the project.

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1 Q: All right. And what's your opinion of the
2 finding that Ms. Brandt made here?

3 A: I don't agree with that finding at all.

4 Q: Why?

5 A: Well, they say the Department's concerned with
6 the declining utilization of Piedmont Medical
7 Center. Well, there's a reason for that
8 declining utilization, of course, because of
9 the fact that so many patients are being
10 redirected out of state. They say, the heavy
11 dependance of recapturing significant market
12 share, significant lost market share, which
13 would require significant level of reversal of
14 market trend. Well, that, of course, could be
15 repaired, you know, with the development of the
16 Fort Mill Medical Center. And also we're
17 looking at the impact of redirecting existing
18 patients away from Piedmont Medical Center. I
19 don't see that as happening. The Fort Mill
20 Medical Center is not going to redirect
21 patients away Piedmont Medical Center.
22 Ultimately, it's going to really benefit
23 Piedmont Medical Center in redirecting patients
24 to that facilities as well as capturing a lot
25 of the out-migration. The substantial cost of

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RECORD 001081

1 the project, the total project cost is greater
2 for Fort Mill. Well, there's a reason for that
3 and it's actually a very effective plan for
4 building 100 beds, rather than 64. Ability to
5 finance the project, I do not agree with that.
6 Each applicant, in my opinion, meets criteria
7 for the ability to finance.

8 Q: Okay. All right. Let's move to the third
9 paragraph, the next paragraph that is, included
10 in Ms. Brandt's letter. And would you read
11 this into the record?

12 A: If Carolinas Medical Center-Fort Mill, the
13 proposed project demonstrated that it's current
14 significant level of market share and
15 utilization will be sufficient to justify the
16 implementation of the project. Appears to be
17 financially feasible and proposes to shift
18 current market share to a facility in South
19 Carolina, resulting in less adverse impact to
20 existing facilities.

21 Q: Do you agree with that statement?

22 A: No, sir, I do not. Here again, that -- the
23 project by Carolinas Medical Center is not
24 going -- I mean, it could be considered
25 financially feasible but it's not going to

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RECORD 001082

1 shift the current market share to a facility --
2 well it will shift its own market share to a
3 facility in South Carolina. In other words,
4 it's not going to result in less adverse impact
5 for existing facilities like the existing
6 facility in South Carolina, Piedmont Medical
7 Center.

8 Q: In all of your years of working in the CON
9 program, have you ever seen a hospital built
10 that did not attract new market share?

11 A: No, sir. Every new hospital is going to
12 attract new market share.

13 Q: Why is that?

14 A: A new hospital is going to attract existing
15 residents as well as new residents who move to
16 the area. It's just more attractive, it's one
17 that, you know, people want to go to and try
18 even if they're going to have to drive a few
19 extra miles.

20 Q: Okay. Now, let's look quickly at the first of
21 the three paragraphs in Ms. Brandt's decision
22 letter. Do you notice that these refer to
23 project review criteria that Ms. Brandt found
24 that CMC best meets?

25 A: Yes, sir.

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RECORD 001083

1 Q: Okay.

2 A: And she listed the specific ones and I don't
3 agree with that either.

4 Q: All right. We'll go into more detail on that
5 in a moment. So let's move to your review of
6 the CON criteria and did you review these for
7 purposes of developing opinions related to
8 those that Ms. Brandt reached in her review of
9 the application?

10 A: Yes. Yes, I went through all of the criteria,
11 yes.

12 Q: Okay. Have you developed a side-by-side
13 comparison as a Demonstrative?

14 A: Yes, sir.

15 Q: All right. Dan, let's pull up Demonstrative
16 170, please. And, Mr. Grice, describe what's
17 presented in this Demonstrative.

18 A: In this particular one, these are all of the
19 applicable project review criteria.

20 Q: In the left-hand column?

21 A: Yes, sir. They were listed as being most
22 important in the review of these applications.

23 Q: Okay.

24 A: And then, on the right-hand side, we've got the
25 name of the criteria and a brief summary of

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RECORD 001084

1 what it looks to and on the right-hand side, we
2 see as to whether it was considered to be
3 consistent. All -- we were consistent with
4 both Ms. Brandt and ---

5 Q: Sorry, let's just take it one at a time. How
6 about Ms. Brandt's, what do you have there?

7 A: Okay. Ms. Brandt's, we've got whether she
8 considered both projects to be consistent or
9 only one to be consistent with the various
10 criteria.

11 Q: Or what, if she's found, for example on CHS on
12 one could that mean that's the only one or
13 that's the one that best meets the criterion?

14 A: That would be the one that best meets the
15 criteria.

16 Q: Okay. And what have you done in the right-hand
17 column under your name?

18 A: The same thing. For each criteria that's
19 listed, I have put whether I saw it consistent,
20 were both applications consistent or only one
21 and, of course, putting the initials of the one
22 facility I saw to be consistent.

23 Q: And the entries that are not highlighted, are
24 those where you've agreed with Ms. Brandt?

25 A: Yes, sir.

- 1 Q: And the entries where they're green, what do
2 they reflect?
- 3 A: That reflects a disagreement.
- 4 Q: And what's the nature of the disagreement?
- 5 A: It would be that I saw either both met or ---
- 6 Q: No, just the green.
- 7 A: I'm sorry.
- 8 Q: Just the green.
- 9 A: I'm sorry. That's where both met.
- 10 Q: Where you found both met?
- 11 A: Yes, sir.
- 12 Q: And Ms. Brandt found what?
- 13 A: That Carolinas Hospital System met it best.
- 14 Q: Okay. And where you have a red PMC, what does
15 that reflect?
- 16 A: That reflects where I saw that Piedmont Medical
17 Center met it better than Ms. Brandt's
18 determination of Carolinas Hospital System.
- 19 Q: Okay. All right. Now, with that, let's go
20 through these and we'll focus just on the
21 criteria in which there has been, based on your
22 review you disagree with Ms. Brandt's finding,
23 okay?
- 24 A: Yes, sir.
- 25 Q: All right. Let's pick up the first one then,

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1 which appears to be 2(d), would that be
2 correct?

3 A: Yes, sir. That is.

4 Q: All right. Then let's look -- let me take you
5 to the regulation so we can have that fresh in
6 all our minds. We can review what that
7 provision consists of. Dan, if you'll call
8 that up, please. Mr. Grice, if you'll read
9 into the record, which would be regulation
10 section 802.2(d).

11 A: Okay. It says in the case of a reduction,
12 relocation or elimination of a facility of
13 service, the applicant should address the need
14 that the population presently has for the
15 service, the extent for which that need will be
16 met by the proposed relocation or by
17 alternative arrangements and the effect of the
18 reduction or elimination or relocation of the
19 service on the ability of low income persons,
20 racial and ethnic minorities, women, the
21 elderly, handicapped persons and other
22 underserved groups to obtain needed healthcare.

23 Q: Okay. Now, what's the purpose of this section
24 of the criteria, Mr. Grice?

25 A: Well, the purpose of this is if you're going to

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1 have, you know, as it says reduction,
2 relocation, elimination of service, you want to
3 make sure that the applicants address that that
4 change is, is not going -- it's not going to be
5 problematic on the effect of the services to
6 the ability of low income persons, women, the
7 elderly, handicapped and other underserved
8 groups to obtain healthcare services.

9 Q: All right. Based on your review of Piedmont's
10 updated material, do you see any evidence of
11 any medically underserved group would be harmed
12 by the proposed relocation of 36 beds?

13 A: No, sir. I have not.

14 Q: What is your opinion concerning the transfer of
15 the 36 beds?

16 A: I think it's a good move. It's certainly legal
17 and appropriate and I think it is the
18 appropriate move to make in this case with
19 Piedmont developing that satellite hospital.

20 Q: Okay. Now, what would be an example where
21 there would be harm to medically underserved
22 group by the relocation of beds?

23 A: Well, if beds were taken from an area where
24 there was, let's say, a very elderly population
25 or population that met some of the consistent

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RECORD 001088

1 with what's mentioned in that criteria and
2 moved to an area of the county where you're
3 going to serve a different type population,
4 that could be problematic. Where the
5 underserved groups would actually lose access,
6 you know, to needed services and you have moved
7 somewhere them else. And that could be the
8 case, not only of relocation but even
9 elimination.

10 Q: Okay. Now, have you analyzed the transfer of
11 beds in other satellite hospitals?

12 A: Yes, sir.

13 Q: Okay. Now, how often does that happen?

14 A: As far as the?

15 Q: Transfer of beds to establish satellite
16 hospitals?

17 A: In most, most satellite applications there is
18 some transfer of beds.

19 Q: Let's actually take a look back to your
20 Demonstrative 110, of your list of more recent
21 satellite facilities and the last one, and you
22 identified the hospitals that provided the
23 beds. This one has adds the middle column,
24 what does this consist of?

25 A: That is whether the beds were from a transfer

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RECORD 001089

1 or a need in the Health Plan or both.

2 Q: Okay. And what's been your experience and the
3 experience of the Department over the last
4 decade concerning the use of transfers, beds
5 that are transferred from the parent facility
6 to establish satellites?

7 A: It's been -- that's been one of the main ways
8 that satellite hospitals have been developed,
9 from using that method of a transfer.

10 Q: Okay.

11 A: Or need.

12 Q: Now, with regard to the proposed transfer of 36
13 beds by Piedmont to add to the 64 beds
14 identified as needed in the Plan, are you aware
15 of how many beds were available to be
16 transferred to Piedmont?

17 A: Yes, well, I know that I think 19 of the beds
18 may have not been utilized, 17 were
19 understaffed, but if I understand your question
20 correctly, 36 were available up there.

21 Q: Was there a high demand being placed on these
22 beds?

23 A: No, sir. Not at all.

24 Q: And subsequent to the 2005 application, have
25 you reviewed the average use of the beds?

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1 A: Yes. And it was a low utilization.

2 Q: Okay. All right. Now, let me then ask you,
3 you already stated your opinion concerning
4 whether the transfer of the 36 beds would be
5 justified. Which -- what's the number -- which
6 applicant do you believe best meets the need
7 related to the number of beds that would be
8 most helpful to address the out-migration of
9 the area, 64 or 100?

10 A: One hundred.

11 Q: All right. Now, do you agree then with regard
12 to section 2(d), did Piedmont, in your opinion
13 justify the relocation of the beds?

14 A: Yes.

15 Q: Okay. All right. Now, let's then, let me ask
16 you to move to the next section. Section 2(e)
17 of the regs, Dan, if you could pull that out.
18 What's the provision relate to, Mr. Grice?

19 A: Okay. This has to do with the utilization,
20 this is going to relate to a new facility. It
21 says: Current and or projected utilization
22 should be sufficient to justify the expansion
23 or implementation of the proposed service. So,
24 that's, that's looking at utilization, you
25 know, projecting the need, et cetera. It's

1 going to justify the expansion.

2 Q: And do you believe that either or both parties
3 proposed applications would be justified based
4 on the demand for services in the Fort Mill
5 area?

6 A: Yes.

7 Q: Which is it? Either or both?

8 A: Both.

9 Q: Okay. All right. Why is that?

10 A: Well, I mean there is, regardless of which
11 applicant were to build a hospital there, you
12 know, there is certainly a growing population.
13 And so either facility would be financially
14 feasible and, you know, with -- but certainly
15 the Piedmont Medical Center in Fort Mill is
16 better, you know, for the county. But the
17 current projected utilization would be
18 sufficient.

19 Q: Okay. So, Dan, let's go out to Demonstrative
20 117. And look at those last two provisions,
21 2(d) and 2(e) and what's your opinion
22 concerning -- now with regard to those two
23 provisions, how would you assess the
24 application to the two parties?

25 A: I would find both applicants consistent with

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1 those criteria.

2 Q: Okay. All right. Let's move on then to the
3 next section of the regulations, Mr. Grice, and
4 look at section 3. Now, that's got eight sub-
5 parts. Let's focus on, Dan, if you would
6 scroll down and look at the ones that were the
7 subject of any determination by Ms. Brandt
8 where she found that Carolinas best met them.
9 Let's start with section 3(a).

10 A: All right.

11 Q: Now, this one Ms. Brandt found Carolinas best
12 met. You've determined, based on this
13 Demonstrative that Piedmont best met it, is
14 that correct?

15 A: Yes, sir.

16 Q: All right. Let's read the reg and you tell us
17 why.

18 A: Okay. 3(a) Duplication and modernization of
19 services must be justified. Unnecessary
20 duplication of services and unnecessary
21 modernization of services will not be approved.
22 And my reason for saying that Piedmont Medical
23 Center is the only one that will meet this is
24 because I see the development of a satellite by
25 another entity, and out-of-state entity not

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1 Piedmont Medical Center, as being unnecessary
2 duplication of services because of the fact
3 that here again, Piedmont Medical Center has
4 been developed for over 30 years there. The
5 tertiary services there are declining and to
6 maintain and to support and to benefit those
7 services in the future, we're going to need a
8 new hospital and another provider like
9 Carolinas Hospital System, will really be
10 forwarding patients across state lines for
11 those tertiary services which will be a
12 duplication of services currently offered at
13 Piedmont Medical Center.

14 Q: Mr. Grice, if it were instead of Carolinas, if
15 it were Palmetto Health System that were
16 proposing to build a hospital in Fort Mill and
17 to shift patients needing complex care to
18 Columbia instead of to Charlotte, would your
19 analysis about the effect on Piedmont be any
20 different?

21 A: No, sir.

22 Q: Why not?

23 A: Because here again, you have another provider
24 from another area outside of that region, that
25 would be taking the patients away. Removing

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1 patients from the county and they would be
2 getting -- let's say Palmetto here in Columbia
3 had a satellite up there, they would be
4 referring their tertiary patients down to
5 Columbia to Palmetto Health.

6 Q: So, is your principal concern that Carolinas is
7 located out of state or that it's located
8 outside of York County and that is the basis
9 for the opinion you saw from 3(a)?

10 A: It's outside of York County.

11 Q: Okay. And let's move on to 3(b). Read that
12 into the record. Dan, pull that regulation up,
13 please.

14 A: The proposed service should be located so it
15 may serve medically underserved areas or an
16 underserved population such as elderly and
17 should not unnecessarily duplicate existing
18 services or facilities in the proposed service
19 area. And this relates very much to what I
20 just testified to a few moments ago, that
21 should we have this proposed service of a new
22 satellite from a facility that's outside the
23 county, it is going to unnecessarily duplicate
24 some existing services in that service area
25 particularly relating to the tertiary services

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1 that will be really damaged by -- at Piedmont
2 Medical Center.

3 Q: Now, does the 64-bed satellite hospital or free
4 standing hospital in Fort Mill, that would be
5 owned by Carolinas if this application were to
6 be approved in and of itself create an
7 unnecessary duplication?

8 A: No, sir. That would not. I'm looking at
9 unnecessary duplication as a fact that we are
10 going to have -- if that hospital were there,
11 they are going to gain utilization for patients
12 in the Fort Mill area. They are going to refer
13 patients to their main hospital in Charlotte
14 and Piedmont Medical Center is going to lose
15 capacity and there will be excess beds. There
16 will be closed rooms there. That even though
17 right now the utilization is up some, it will
18 be worse, so that will even be unnecessary
19 duplication.

20 Q: Now, aren't referrals already going outside of
21 York County to Charlotte area hospitals?

22 A: Yes, sir.

23 Q: So, why is it unnecessary duplication if it's
24 already happening?

25 A: Well, certainly, this is something we can't

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1 continue. I think we need to have that new
2 Piedmont Medical Center there and because of
3 the fact that -- it's going to really increase
4 the utilization, you know, of the Piedmont
5 Medical Center and it will grow too. I mean it
6 will be a large facility, 100 beds that I think
7 in that rapid growing area will, within five or
8 six years be full.

9 Q: All right. All right. Let's go back, Dan, to
10 Demonstrative 117. And look at the next set of
11 criteria in this section. All right. We just
12 reviewed your opinions concerning 3(a) and
13 3(b), Mr. Grice. On (c), (d), and (e), you and
14 Ms. Brandt apparently agree. So let's then
15 look at 3(f) and (g) and then we'll move to
16 (h). Okay?

17 A: Okay.

18 Q: Now, just in summary, Ms. Brandt found in favor
19 of Carolinas on these two matters and what's
20 your opinion?

21 A: I think both of them meet these two criteria.

22 Q: All right. And let's pull the criteria up and
23 Mr. Grice, read them into the record.

24 A: Okay. (f) states: The applicant should
25 address the extent to which all residents of

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1 the area and particularly the low income
2 persons, racial and ethnic minorities, women,
3 the elderly, handicapped persons and other
4 medically underserved groups are likely to have
5 access to those services being proposed. And
6 (g): The facility providing those services
7 should establish provisions to ensure that
8 individuals in need a treatment as determined
9 by a physician have access to the appropriate
10 service regardless of ability to pay.

11 Q: All right. What are the purposes of these
12 related provisions?

13 A: Well, the purposes are that we want to ensure
14 that medically undeserved groups are -- have
15 access to healthcare. For example, DHEC
16 requires indigent care plans. And that's, you
17 know, each applicant has got to provide that.
18 I don't see these criteria as not being met by
19 either one of the applicants.

20 Q: All right. And do you know the basis, based on
21 her report, why Ms. Brandt awarded the check
22 here to Carolinas?

23 A: I'm not sure.

24 Q: Let me help you with ---

25 A: Okay.

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1 Q: Let's see if I can refresh your memory on this.
2 Do you remember how -- if there was a change in
3 Carolinas' proposed indigent care service in
4 its first application?

5 MR. MULLER: Objection, Your Honor. He's leading
6 the witness and basically suggesting an answer
7 to him.

8 MR. ANDREWS: No, I'm not, Your Honor. It's not
9 leading. Let me finish the question. Does he
10 remember if there was a change was the
11 question. I didn't -- I wasn't going to propose
12 what the change was.

13 MR. MULLER: I believe he was saying exactly what
14 the change was so that the witness would be --
15 know where he was headed.

16 THE COURT: Let's do this. Okay. If you could just
17 re-ask the question and then we'll go from
18 there. And then Mr. Muller, if you still have
19 an objection, please note your objection.

20 MR. ANDREWS: Didn't finish it and I will this time.

21 THE COURT: All right. Thank you, Mr. Andrews.

22 Q: So, do you recall if there was a change in
23 Carolinas' indigent care from its original
24 application to the updated application?

25 THE COURT: All right. You can answer.

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1 **MR. MULLER:** No objection.

2 **THE COURT:** All right. Thank you.

3 A: Yeah, there was. It was, I think the indigent
4 care proposed by Carolinas was approximately
5 double what Piedmont was and I guess one of the
6 reasons I didn't put a lot of emphasis on it
7 was because this was not reasonable at all. I
8 mean, every applicant has to give an indigent
9 care plan and I even remember when that was
10 established in 1984. That was a big issue with
11 the Department of Health and Environmental
12 Control started and I worked applicants to
13 determine what reasonable rates were and every
14 applicant's got to give it, but you want to
15 have a rate that you can live with and not some
16 excessive rate. And so, I think Ms. Brandt at
17 DHEC, she saw the higher indigent care amount
18 being provided by Carolinas as being superior,
19 more for that reason that the criteria. Those
20 two criteria better than Fort Mill Medical
21 Center.

22 Q: Have you looked at Carolinas' and Fort Mill's
23 proposed rates and compared them with the
24 proposed rates of other new hospital
25 applications you've reviewed in the last ten

1 years?

2 A: Yes, sir. I have.

3 Q: Have you developed a Demonstrative on this?

4 A: Yes, sir.

5 Q: Now, let's pull up Demonstrative 118. And
6 what's presented here, Mr. Grice?

7 A: These are satellite hospitals that have been
8 approved in recent years in South Carolina.
9 And in the budgets that they presented, of
10 course they have their percentage of gross
11 revenue allocated to indigent care and we see
12 how much that was, that was allocated and ---

13 Q: Would you be specific and read, state in the
14 record what that is?

15 A: Yes. The indigent care percentage of gross
16 revenue for year three at Carolinas Medical
17 Center-Fort Mill was 6.4 percent.

18 Q: How does that compare to the other applications
19 for new hospitals between 2005 and 2010?

20 A: It is the highest rate.

21 Q: By what margin?

22 A: By, well, let's say the next highest rate is
23 like 4.3 percent, so it's even, let's see --
24 it's 50 percent higher, almost 50 percent
25 higher than the next rate, but it's 100

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RECORD 001101

1 percent, over 100 percent higher than the Fort
2 Mill Medical Center which is 3.1 percent.

3 Q: And how does the Fort Mill Medical Center
4 proposed indigent care load compare with those
5 of other applicants on this Exhibit?

6 A: It's very reasonable. Other applicants have
7 more, some have a little bit higher, but that
8 is a -- the indigent care is a proposed rate.
9 Hospitals really don't know how much indigent
10 care will be provided. They have to have it in
11 their budget and have that money available if
12 it's needed. In many cases they may not
13 actually use that percentage. But in my
14 opinion, that's not a good reason to approve
15 the applicant for the CON based on what their
16 indigent care rate is going to be, if it's
17 reasonable. If it's zero, that would be a
18 problem. If it's too high, you know, that's --
19 they can print that but I think, you know, I
20 don't -- they both provided indigent care, they
21 both meet the criteria and so I would say, you
22 know, I think what Fort Mill gave is
23 reasonable.

24 Q: Do you think what Carolinas did is a reasonable
25 rate based on your view of other new hospital

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1 applications?

2 A: No, sir. I don't. I think it's too high.

3 Q: All right. But your opinion is that they meet
4 this criterion anyway, is that right? These
5 two criteria?

6 A: Yes, I mean they gave indigent care. They gave
7 an amount. I think it's high, but, you know,
8 DHEC certainly has the ability to go in that
9 hospital and monitor to see what it actually
10 was.

11 Q: Okay. All right. Well, let's move on then to
12 the next criterion. Dan, let's go back to
13 DHEC's 117. And that list, you found that both
14 applicants equally meet (f) and (g) and then
15 you have (h).

16 A: Yes, sir.

17 Q: And what is (h) and what have you found?

18 A: Okay. Impact on provider's service and the
19 medically underserved.

20 Q: And you found for Piedmont and we'll pull up
21 that reg and you explain your position.

22 A: Okay. Potential negative impact of the
23 proposed project upon the ability and or
24 resources of existing providers and medically
25 undeserved groups must be considered. Well,

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1 you know, I think Ms. Brandt put that did not
2 apply. That was not applicable, I think, was
3 the determination.

4 Q: Do you believe it should apply?

5 A: Yes, sir. I think so.

6 Q: Why?

7 A: Well, we've got -- let's see, potential
8 negative impact on this proposed project on the
9 ability of services of existing providers and
10 services for medically underserved groups must
11 be considered. I think that's something you do
12 have to consider. This -- let's say for
13 example the Carolinas Medical Center project
14 very well may have a potential negative impact
15 upon existing providers that serve medically
16 underserved groups, particularly if their
17 financial situation is hard as it could be with
18 Piedmont.

19 Q: Who would be the existing provider?

20 A: It would be Piedmont Medical Center.

21 Q: All right. And in what way -- you've offered
22 your opinion that Piedmont meets this better
23 than Carolina. In what way do you believe that
24 potential negative impact would occur?

25 A: Well, what would happen here, the -- because

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1 the Fort Mill Medical Center, which is going to
2 really embellish the system of Piedmont in the
3 county, I think that particular criterion we
4 consider -- I think there would be less
5 potential negative impact, you know, of this
6 project upon the ability of the resources of
7 existing providers like Piedmont Medical Center
8 to be able to serve medically underserved
9 groups.

10 Q: All right. Dan, let's go back and to
11 demonstrative 117. You've offered your opinion
12 concerning this last provision and, Your Honor,
13 can we take a short break before we move onto
14 the next set of criterion?

15 **THE COURT:** Any objection?

16 **MR. MULLER:** No objection.

17 **THE COURT:** Great. Let's take ten minutes in
18 recess.

19 (Off the Record)

20 **THE COURT:** Mr. Andrews?

21 **MR. ANDREWS:** Thank you, Your Honor.

22 Q: All right. Mr. Grice, let's move on to the
23 next criterion. Now, let's begin by going back
24 then to Demonstrative 117. Looking at Ms.
25 Brandt's decision concerning section 22 of 802

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1 and I'm looking at what you believe, how you
2 believe that should be decided. All right.
3 She found for Carolinas and you believe this
4 application, this provision should be applied
5 in favor of Piedmont, is that right?

6 A: Yes, sir. That's correct.

7 Q: All right. Let's read the reg and go forward
8 from there.

9 A: Yes, 22, relating to distribution. The
10 existing distribution of the health service
11 should be identified and the effect of the
12 proposed project upon that distribution should
13 be carefully considered to functionally balance
14 the distribution of the target population.
15 Now, my reasoning for assuming that Piedmont
16 Medical Center best meets that criterion or
17 meets it, you know, best meets it in this case
18 for the Fort Mill Medical Center is because
19 right now what we're seeing in this area is
20 really an out-migration; they're losing. I
21 think what this project is going to do, it will
22 functionally balance the distribution of
23 services to the target population or capture a
24 lot of the out-migration when the new hospital,
25 Fort Mill Medical Center, capture that with

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RECORD 001106

1 referrals to the existing Piedmont Medical
2 Center.

3 Q: And in contrast, how do you believe the
4 application, or how do you believe the
5 Carolinas Fort Mill Medical Center would affect
6 the distribution of services in York County?

7 A: It would not functionally balance of
8 distribution regarding the population, it's
9 going to actually capture patients that live in
10 the Fort Mill area and including existing
11 patients that it currently refers to North
12 Carolina, but also, will refer patients needing
13 more complex services to Charlotte and the
14 facilities up there that it owns.

15 Q: Now, when Ms. Brandt, as you read in your
16 review of her decision letter, in the third
17 paragraph, found that Carolinas would
18 successfully shift market share to its proposed
19 Carolinas Medical Center facility in Fort Mill.
20 How do you believe that finding fits within
21 this criterion?

22 A: I think it, you know, it doesn't fit this
23 criterion. This criterion, I think is really,
24 the Carolinas is inconsistent with this whereas
25 the Fort Mill Medical Center is consistent and

1 better meets it.

2 Q: All right. Now, let's move on to -- actually,
3 Dan, let's move back to 117. And take a look
4 at the next section. Take it all the way
5 through there. All right. Now, this next
6 section of regulations, Ms. Brandt has found
7 that for charges that both parties equally met
8 them, is that correct?

9 A: That's correct.

10 Q: And with regard to all the others that
11 Carolinas best met them and you have that both
12 applicants equally meet them except for the
13 last one, is that correct?

14 A: That is true.

15 Q: All right. Now, in general terms, let's look
16 at Demonstrative 119. Now, this is what we've
17 just discussed and what you've summarized, Mr.
18 Grice. Generally speaking with regard to these
19 criteria that are summarized here, what's the
20 function of these provisions in your
21 experience?

22 A: You know, the function here is to make sure
23 that applicants meet these criteria to be
24 financially feasible where they could develop
25 this project to have, you know, appropriate

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RECORD 001108

1 projection of expenses and utilization, and
2 income that's appropriate. That they are
3 financially feasible. They can identify
4 appropriate methods of financing. And so, you
5 know, most applicants meet this. I mean, if
6 you have an application and require that you've
7 got to demonstrate the method of financing and
8 have an appropriate letter from a lending
9 institution or bank that shows the money is
10 available, it shows financial feasibility, et
11 cetera.

12 Q: Excuse me. In your experience, have CON
13 decisions turned on these issues?

14 A: No, sir. If you have an application, and you
15 know, it's in, those are the ones that
16 definitely you're going to have an application,
17 everybody knows you've got to have information
18 to make that consistent.

19 Q: Okay. Now, after a CON project is awarded,
20 does the Department monitor the implementation
21 of the project?

22 A: Yes, sir. We have the authority, but you know,
23 we don't have the staff to do it. We can
24 monitor the cost, you know, and like
25 particularly the capital cost to make sure it's

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- 1 within the range of what was approved, no, as
2 far as going through and having someone audit,
3 go through the finances, the budget, no, sir.
- 4 Q: All right. Now, there's a process for when a
5 CON project is implemented that when it's
6 complete that the applicant will report to the
7 Department, is that right?
- 8 A: Yes, sir. That's the requirement.
- 9 Q: And what do they report back? What do they
10 include in that report?
- 11 A: They include what all of their capital costs
12 were for the development of the new project.
- 13 Q: Now, after the project is operational is there
14 any report particularly after year two and
15 three when these applications are reviewed that
16 were an applicant reports its operational cost
17 to the Department?
- 18 A: No, sir.
- 19 Q: Doesn't report its charges or expenses?
- 20 A: No, sir.
- 21 Q: Okay. Now, if even when they're reporting on
22 capital costs of projects, when the applicant
23 exceeds those cost, is the CON revoked?
- 24 A: No, sir. Generally, reducing costs overruns,
25 a lot of times, we'll allow up to a ten percent

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1 cost overrun with no penalty. If it's more
2 than ten percent, you know, there will be a
3 fine. A small fine.

4 Q: All right. Now, is that the process the
5 Department applies if the project is
6 competitive or even if it's not competitive?

7 A: Yes, sir. Anyone who receives a Certificate of
8 Need, and develops the project, once it's
9 complete they've got to give the final cost.

10 Q: Now, how does the Department protect itself
11 against an applicant in the competitive process
12 that wants to submit a lowball estimate to win
13 the CON?

14 A: What we have to do in the review process is
15 really compare similar projects that have been
16 reviewed within a recent time frame, make sure
17 that they appear to be reasonable. Just like
18 talking about capital costs of hospitals, they
19 have continued to go up. No doubt. We're
20 looking at a million plus a bed now. But, you
21 know, if a hospital comes in like an average of
22 \$3 million a bed, it kind of raises a red flag.
23 If it comes in a lot less, a million today, you
24 get concerned. Even though I was involved in
25 the program when the average cost was a hundred

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1 thousand dollars a bed, so we've seen a lot of
2 changes. But certainly, we want to make sure
3 it's reasonable.

4 Q: Now, in determining whether or not an applicant
5 in a competing situation, and applicant's
6 proposals are reasonable, do you compare them
7 against each other or do you compare them
8 against projects that the Department has
9 already approved?

10 A: Projects the Department has already approved.
11 In competing applications, no two applicants
12 are going to be exact. You know, in terms of
13 cost per bed -- the costs are wide open, a lot
14 variables that can occur. And it's a
15 projection. You just want to make sure it's
16 reasonable.

17 Q: All right. So is lowest cost necessarily the
18 best cost?

19 A: No, sir. Not at all. Certainly, one of the
20 purposes of the CON is to look at cost
21 effectiveness, cost containment, but a lot of
22 times that is not what you end up with. By
23 approving the lowest cost, there are a number
24 of factors you need to consider and we just
25 want to make sure the cost is reasonable based

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1 on the project for the long term.

2 Q: Now, when a competing application or when an
3 application is submitted and others want to
4 compete with it, is the first application
5 confidential and sealed so that subsequent
6 applicants won't have access to it so they can
7 take that into consideration and slip in below
8 them?

9 A: No, sir. It's not sealed. There's no legal
10 requirement for that. And so, the first
11 applicant -- anyone under the Freedom of
12 Information Act can get a copy of their
13 complete file. And many times in reviewing
14 projects, like nursing homes, for example,
15 years ago, I'd tell the applicant you're not
16 necessarily the smartest to turn in an early
17 application because it will be scrutinized.

18 Q: Why did you advise applicants that it wouldn't
19 be wise to submit it first?

20 A: Well, because if they submitted it early other
21 competitors would get a copy of it and they are
22 gonna to go through it and try to find ways I
23 can beat this applicant in a competitive
24 situation. We'll lower our costs and we'll do
25 a number things that impress the Department.

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1 Q: And what do the regulations provide to protect
2 the Department from the kind of manipulation of
3 the process?

4 A: Well, the regulations allow us to be able to
5 make the best decision based on the criteria
6 and review other files that we have in our
7 department to make sure the information is
8 realistic.

9 Q: And then files being prior approved
10 applications?

11 A: Yes, sir.

12 Q: Okay. All right. Then when was Piedmont's
13 application first submitted to establish a
14 hospital in Fort Mill?

15 A: I believe it was around November 2004.

16 Q: And when was Carolinas' application submitted?

17 A: I think it was around March 2005.

18 Q: So, how much time did Carolinas have to get a
19 copy of it, review it and consider Piedmont's
20 application before submitting its own?

21 A: Four to five months.

22 Q: Okay. All right. Now, all right. Let's go
23 back to the regulations related to the
24 financial criteria. We've already said that
25 Ms. Brandt found with regard to charges that

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1 both applicants equally met that one and let's
2 move to 6(b). Dan, would you pull it up and
3 Mr. Grice would you read that into the record?

4 **THE COURT:** May I offer a suggestion, and Mr.
5 Andrews and Mr. Muller -- and you can handle
6 this in any way -- if it's not necessary to
7 read that entire section into the record, I've
8 got it.

9 **MR. ANDREWS:** You've got it.

10 **THE COURT:** But if that will break up your
11 examination, then please feel free, but I'm
12 just trying to maybe to save a little on the
13 record.

14 **MR. ANDREWS:** Thank you, Your Honor. As long as Mr.
15 Grice - Mr. Grice do you have a copy of the
16 regs with you if you need them?

17 **A:** I don't have it with me, but I can read it up
18 there, is that okay?

19 **Q:** Well, the point of it, I think ---

20 **A:** Oh, I'm sorry.

21 **Q:** --- Judge Lenski was suggesting a way to speed
22 up the process and not having to read.

23 **THE COURT:** I have it. Mr. Muller?

24 **MR. MULLER:** I was just going to say I also noticed
25 on a slide that he has -- that we best met

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1 seven and we did not -- it was equally met, so
2 we can probably skip over seven.

3 **MR. ANDREWS:** Well, Ms. Brandt may have found that,
4 but the others, when you say we, if there's a
5 stipulation that all parties have equally met
6 it from -

7 **MR. MULLER:** Well, just in reading her decision
8 letter, all applicants provided projections -

9 **MR. ANDREWS:** Well, thank you. And Mr. Muller is
10 correctly pointing out that in part of Ms.
11 Brandt's decision letter she says all parties
12 equally met seven, but in numerous places she's
13 critical of Carolinas, you know, Piedmont for
14 having higher capital costs, so that's the
15 reason we're actually having to go into seven.
16 Unless there's a stipulation that we've equally
17 met it, then we're happy to move on.

18 **MR. MULLER:** Well, I don't -- we can address it,
19 Your Honor. I'm not so sure what our position
20 is going to be. I was just trying to shortcut
21 -

22 **THE COURT:** And I appreciate that.

23 **MR. ANDREWS:** It's a good observation. I thought
24 that Ms. Brandt's report was ambiguous in that
25 regard and that's why I felt it needed

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1 addressing.

2 **THE COURT:** Thank you. So how ever you want to
3 handle it, I just wanted to make the
4 suggestion.

5 Q: All right. Now Mr. Grice, let's take it this
6 way, I will ask your opinion and if you need to
7 refer to the regs to remind yourself of the
8 actual language, then let's do that, but
9 otherwise, let's move on, okay?

10 A: Okay.

11 Q: All right. Now, with regard to 6(b), now, how
12 does this regulation relate to financial
13 projections?

14 A: Well, what we were saying there is that the
15 levels of utilization in that service area
16 should be reasonably consistent with those
17 experienced by similar facilities and the
18 projected level should be consistent with the
19 need level. And with this case, both
20 applicants met that as I see. In other words,
21 there is population growth in each one of them.
22 You know, provided need documentation.

23 Q: Okay. Now, 6(b), determine the reasonableness
24 of utilization projections. Does it invite the
25 Department to look at each application's

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RECORD 001117

1 proposal or to look to the reasonableness of
2 their projections and compare them to similar
3 facilities?

4 A: I think to look at the applications and compare
5 them to similar facilities.

6 Q: Okay. And have you done that?

7 A: Yes.

8 Q: And what's your opinion concerning that?

9 A: I think they both, yes.

10 Q: All right. And Mr. Levitt testified about it
11 so I'm not going to pull up the Plan, but have
12 you reviewed the State Health Plan to determine
13 the occupancy rates?

14 A: Yes, sir. I have.

15 Q: And what did you find?

16 A: They are similar. I mean, I didn't see a
17 problem.

18 Q: Okay. All right. Okay. So we'll move on
19 through that. All right. Now next, let's
20 address the issue concerning the expenses that
21 are the subject of section 7, okay?

22 A: Okay.

23 Q: All right. Now, take a look at that. Now,
24 this is consistent with your prior testimony,
25 I believe, but what's the purpose of this

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RECORD 001118

1 section, Mr. Grice? Projected expenses.

2 A: Right.

3 Q: What is the Department directed to look to
4 about determining the reasonableness of
5 projections concerning expenses?

6 A: Here again, we're looking at the projections of
7 all these costs. Construction costs, operating
8 costs, debt service, et cetera, to be
9 consistent with those experienced by similar
10 facilities offering similar types, scope of
11 services. So, there again, both of these
12 applicants.

13 Q: What did Ms. Brandt do?

14 A: She, I believe she said that her -- that
15 Carolinas Medical, Carolinas Hospital System
16 best met this criteria.

17 Q: Do you remember why?

18 A: I think because she saw their construction cost
19 as being less is one thing.

20 Q: Let's just focus on -- yeah, I'm sorry.

21 A: And perhaps even operating costs. I think she
22 went into a lot of detail on this. And so, but
23 that, in my opinion, that's too much going into
24 too much detail, again, you have to look at the
25 broad picture on projected expenses. This is

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RECORD 001119

1 all projected and you just want to make sure
2 it's reasonable.

3 Q: Do you see anything in Ms. Brandt's decision
4 where she followed the regulations and provided
5 evidence concerning what similar facilities
6 incurred in terms of capital and operating
7 expenses?

8 A: No, sir.

9 Q: All right. Did you do that?

10 A: Yes, sir. I did.

11 Q: All right. Now, let's look at Demonstrative
12 151. What does this chart show?

13 A: This shows recent satellite hospitals in South
14 Carolina that have been approved with their
15 total project costs, number of beds and then
16 the calculation of the total budget cost per
17 bed.

18 Q: And how does the proposals of Carolinas and
19 Piedmont compare on total project costs and
20 total project costs per bed with the other
21 satellite hospitals that even were presented
22 prior to in terms of timing of the updated
23 applications to the other facilities?

24 A: Right. They're reasonable in my opinion. We
25 look at -- based on the number of beds the

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1 total project cost is within the range of other
2 applicants as well as the calculation of total
3 budget cost per bed.

4 Q: Okay. And with regard to your comment about
5 the operating cost -- let me actually, Dan, ask
6 you to call up the CON analysis that Ms. Brandt
7 undertook. Joint Exhibit 1(B), page 1029, that
8 Exhibit. All right. All right. Mr. Grice,
9 just read the beginning of the second sentence:
10 However. Do you see that?

11 A: Yes, sir. However, it appears that Piedmont
12 has the highest cost and revenue for adjusted
13 discharge.

14 Q: In your 29 years of work with the Department,
15 Mr. Grice, have you ever seen an application
16 where the Department has made a determination
17 that one of the reasons causing the denial of
18 an application has to do with the determination
19 as to the highest operating cost and revenue
20 per adjusted discharge?

21 A: No, sir. Not at all.

22 Q: Do you see anywhere in the analysis of
23 operating costs where Ms. Brandt compared the
24 reasonableness of Carolinas' proposal with any
25 existing facility that had been approved by the

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RECORD 001121

1 Department?

2 A: I did not.

3 Q: And do you believe there's -- is there any
4 reasonable basis in the regulations for this
5 sort of analysis?

6 A: No, sir.

7 Q: All right. So, what is your determination
8 concerning the application at section 7 for
9 both applicants?

10 A: Not, we're talking about criteria 7?

11 Q: That's right. Yes.

12 A: And I don't memorize them.

13 Q: This is expenses.

14 A: Okay.

15 Q: Which party or which parties best meet that?
16 Projected expenses?

17 A: Yeah, now what I think I put there is ---

18 Q: We can go back to it.

19 A: I'm sorry.

20 Q: No, no. It's getting late.

21 A: Let me go, yeah, let me see. That's sort of,
22 yeah, see, both of them meet that. Both,
23 because even though they can vary, any
24 applicant -- they're -- these were reasonable,
25 they're both of them are reasonable. Both are

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RECORD 001122

1 reasonable. They're not going to be exact,
2 certainly. So they both met it.

3 Q: Okay. Let's move on to the next set of
4 criterion which we'll take up together. The
5 next two in that list are net income and
6 financial feasibility. Now, without reading
7 those, can you summarize what they're about?

8 A: Yes, sir. That's a matter of really analyzing
9 the budget each applicant has provided to
10 determine the net income project for each year.
11 They're require at least a three year projected
12 pro-forma. And then determine whether the
13 project is financially feasible.

14 Q: Okay. So ---

15 A: You know, many projects may take more than
16 three years to show a profit, but these show a
17 profit earlier than that.

18 Q: And have you looked at the net income, the
19 long-term financial feasibility of these
20 applicants' proposals?

21 A: Yes, sir.

22 Q: And what have you found them to be?

23 A: I found them to be reasonable and found both to
24 be consistent with those criteria.

25 Q: Okay. Now, in establishing this analysis, is

1 there -- has it been your experience to look at
2 the performance of other facilities?

3 A: Yes, I mean I based, when I review applications
4 I base knowledge that I have looked at, but I
5 wouldn't necessarily go back to bare budgets of
6 similar applications. These applications, they
7 just need to have reasonable budgets and we're,
8 you know, the income and operational costs are
9 reasonable and with regard to whether it's
10 going to be financially feasible project.
11 Hopefully within three years.

12 Q: Okay. Now, have you in this case compared the
13 proposed net income with the net incomes of
14 other applicants in different CON applications
15 for new hospitals?

16 A: Yes, sir. I have.

17 Q: All right. Let's take a look at Demonstrative
18 150. And what does, describe what this is.
19 First of all, identify, are these from CON
20 applications?

21 A: Yes, sir.

22 Q: Have you reviewed those applications?

23 A: Yes, sir. I have.

24 Q: Okay.

25 A: And these are other satellite hospitals that

1 we've discussed earlier and this is showing
2 their net income for the first three years of
3 operation and what's in red there shows loses.
4 And you see that, you know, all of them are
5 showing income on the third year, but in
6 comparing Fort Mill Medical Center and
7 Carolinas Medical Center-Fort Mill, we see, you
8 know, that Carolinas is showing a profit each
9 year, but, you know, Fort Mill is by the third
10 year, but you look at the others, the other
11 projected ones that, you know, show big losses
12 the first few years. So, I mean, they're all
13 approved. They're all, you know, reasonable.

14 Q: Why do you consider all these reasonable?

15 A: Well, any new hospital that's going to operate,
16 that first year is going to be a very -- the
17 first couple years are going to be very
18 difficult and normally, hiring new staff, it
19 takes time to build up the patient volume,
20 you're going to show loses, that's just the way
21 it is. Of course, they're part of a satellite
22 system, I mean part of a bigger system, and of
23 course, they will, their parent hospital is
24 going to help sustain any losses for the start
25 up. But, when we look at this, that's normally

1 what we see in developing of new hospitals, you
2 know, satellites or any new hospital.

3 Q: All right. Now, let's look at the first two.
4 Those, Roper-Berkeley and Roper-Mt. Pleasant
5 are owned in part and operated by Carolinas, is
6 that right?

7 A: That is correct. Because they are part of the
8 Carolinas system ten percent owned in
9 Charlotte.

10 Q: Now, how does their first year net income of
11 those two projects compare with CMC-Fort Mill
12 projections?

13 A: Tremendous opposite difference. I mean they
14 show a tremendous losses, 11.7 million, 7.7
15 million where Carolinas is showing \$663,000
16 profit the first year.

17 Q: All right. And year two?

18 A: Year two, here again the Roper projects are
19 showing tremendous losses, 3.3 million lost for
20 the Roper-Berkeley; 1.188 loss for Roper-Mt.
21 Pleasant. Of course, Carolinas Medical Center-
22 Fort Mill is showing \$1.6 million profit.

23 Q: All right. And what is in competing
24 application, do you make, has it been your
25 practice to make decisions that one proposal is

1 more financially feasible than another when
2 they all show a positive trend of net income
3 over a three year period?

4 A: No, sir. I would never do that. They're all
5 financially feasible. The numbers are not going
6 to be identical. There are going to be
7 different situations, but if they're all
8 showing a positive trend by the third year,
9 that's very good and they're financially
10 feasible in my opinion.

11 Q: Okay. Is there any doubt in your mind based on
12 the record or your review about the ability of
13 either applicant to be able to afford to build
14 and sustain the development of a new hospital
15 in Fort Mill?

16 A: No, sir. Either applicant would be able to do
17 that.

18 Q: Does that question relate in any way, and how
19 does that question relate, if it does at all,
20 to the purpose of the financial feasibility and
21 net income criteria?

22 A: It relates.

23 Q: Okay. In what way?

24 A: Well, that is, you know, part of the criteria.
25 I mean that's what we talked about in financial

1 feasibility that it's going to be successful in
2 the future.

3 Q: Okay.

4 A: Financially.

5 Q: All right. Let's move on to the next set of
6 criterion related to the financing of the
7 project. And if we can take a look and see
8 what those provisions are. All right. Now,
9 that would be 16(a), is that right?

10 A: Yes, sir.

11 Q: And then there's another provision in the next
12 section related to 13(b), Mr. Grice, let's go
13 ahead and deal with both of those at the same
14 time. You can see 13(b) dealt with the
15 applicant obtaining financing?

16 A: Right.

17 Q: Have you formed an opinion about those
18 provisions?

19 A: Yes. Both applicants are consistent with those
20 criteria, yes.

21 Q: What did Ms. Brandt find?

22 A: She found the cost containment was better met
23 by ---

24 Q: No.

25 A: I'm sorry, I'm sorry.

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RECORD 001128

1 Q: We're talking about it relates to 16(a) and the
2 cost containment provision is actually related
3 to the financing, right?

4 A: Yes, yes.

5 Q: Do you want to take a look at the reg? Would
6 that help you?

7 A: Yes. Yes, sir.

8 Q: Okay. Dan, if you could just bring it up on
9 the board, please. Let's look at 16(a).

10 A: Okay. Okay. I've got it.

11 Q: All right. Now, what does this provision
12 relate to?

13 A: Okay. She's chosen, the one that's, you know,
14 the most feasible one. The most feasible
15 option.

16 Q: For financing?

17 A: For financing, yes.

18 Q: Okay. And what did Ms. Brandt find?

19 A: Okay. I believe she found that Carolinas best
20 met this particular one.

21 Q: Do you remember how Carolinas proposed to
22 finance its project?

23 A: Yes, sir. Cash. I mean no borrowing of funds,
24 it would be paid in cash.

25 Q: All right. And let's take a look at the

1 letter, I don't have the reference here. Do
2 you remember how Piedmont proposed to pay for
3 it?

4 A: Yes, sir. They were going to be -- it was more
5 flexible, it was going to be part financing and
6 part cash.

7 Q: Okay. And how do you evaluate the compliance
8 with the regulation of those two alternative
9 proposals for financing the project?

10 A: Well, I would see either one would be
11 consistent, however, now, you know, I think the
12 option that the Fort Mill Medical Center is
13 going to take is more reasonable. That gives
14 more flexibility. It's impossible to know at
15 this point in time. It may take a year or two
16 to even start construction, how you really want
17 to finance it. What the economy is going to be
18 like. A lot of times applicants will put cash
19 just to reduce the capital costs and have no
20 interest cost for financing. So, it's more
21 reasonable to put, you know, you don't know
22 what its going to be. A combination is a good
23 idea. Cash is rather unusual.

24 Q: Okay. And if cash were used and the project is
25 in part financed in whole or in part,

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RECORD 001130

1 subsequently is there any process for reporting
2 that after the final report is submitted to the
3 Department?

4 A: No, sir. It's not a requirement. Certainly,
5 the Department could ask, but no. That could
6 be changed so much. You know, the Department
7 is really looking at the final capital cost but
8 they may not know the end result on the
9 financing of the project.

10 Q: Okay. All right. So, with regard to the
11 method of financing, what is your determination
12 concerning each applicant?

13 A: Well, you know, I would say each applicant is
14 consistent. I, you know, would favor the one
15 that is owned by Fort Mill, but either one
16 would meet the criteria.

17 Q: Okay. All right. Let's move to efficiency,
18 section 17 and what have you -- first of all,
19 what's the purpose of that regulation?

20 A: You know, I don't memorize ---

21 Q: That's all right. We'll pull it up so you can
22 familiarize yourself with it.

23 A: I wasn't able to do that working at DHEC.

24 Q: Let's see.

25 A: Okay. This one, yes, it's pretty standard.

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1 The project should improve efficiency by
2 avoiding duplication of services, promoting
3 shared services, fostering economy and scales
4 of size.

5 Q: Okay.

6 A: And in my opinion, the Fort Mill Medical Center
7 best meets this criteria, meets it, yes.

8 Q: And why?

9 A: Well, because they're going to avoid the
10 duplication of services like I mentioned before
11 because that duplication is going to really,
12 the duplication is going to be where they do
13 not lose the use of several tertiary services
14 that the home or the parent Piedmont Medical
15 Center and they would promote shared services
16 and fostering the kinds of scale to size, here
17 again, you could make a statement that they're
18 really planning better for the future for a
19 rapidly growing area by being able to do 100
20 beds, which I think in that area, those beds,
21 you would need an addition by the end of three
22 years. Because even if you were building only
23 64, you're probably going to reach about 70
24 percent utilization. That's when you need to
25 start planning for additional beds.

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1 Q: Okay. Mr. Grice, have you reviewed -- you said
2 you reviewed the updated application and
3 related materials of Piedmont that they
4 submitted to the Department. Dan, let's pull
5 up Exhibit 31. Look at slide 37 from the
6 project review materials. Do you recognize
7 this slide, Mr. Grice?

8 A: Yes, sir. I do.

9 Q: What does it show?

10 A: Okay. This is the projected utilization with
11 the average daily census, beds and occupancy
12 rates of the three hospitals, three of the
13 hospitals that were competing originally.
14 Well, it's got Fort Mill Medical Center and
15 Carolinas Medical Center.

16 Q: And PH -- PHY refers to Presbyterian?

17 A: Yes, sir.

18 Q: Okay. Go ahead.

19 A: Okay. So what we've got there are the numbers
20 showing for the first three years the average
21 daily census, the number of beds proposed by
22 each one and their occupancy rate. And we can
23 see in looking at those occupancy rates, it's
24 rather impressive with a new hospital because
25 Carolinas Medical Center will really have, even

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RECORD 001133

1 by the first year, 63.9 -- I'm sorry.

2 Q: No, you're right. Excuse me for interrupting.

3 A: 63.9 for the first year, 65.6 for the second,
4 67.5 for the third. When you reach that
5 utilization right there, that's when you know
6 we're going to need some additional beds.
7 We've got to plan now because to get approval
8 and begin construction will take at least a
9 couple of years.

10 Q: Does the State Health Plan establish occupancy
11 rates that are thresholds for recognizing need
12 in the plan?

13 A: Yes, sir. They do.

14 Q: And as far as a hospital this size, what would
15 those levels be?

16 A: I think we're doing those levels right there,
17 looking at that 60 percent range.

18 Q: And what's the trigger, do you know, for new
19 beds under the Plan?

20 A: I forget right now.

21 Q: Okay.

22 A: I didn't actually do that. Calculate the ---

23 Q: All right. Okay. And so, what does that tell
24 you about Carolinas' proposal with regard to an
25 occupancy rate of its proposed 64-bed facility?

1 A: That it's going to be relatively high in a
2 short period of time.

3 Q: Okay. And in the right-hand column of those
4 three is Presbyterian's proposed occupancy
5 rate, what did they propose for being their 64-
6 bed hospital by year three?

7 A: 74.5 percent.

8 Q: Okay. Now, based on your review of
9 Presbyterian and Carolinas proposals for
10 occupancy of their 64-bed hospitals, what
11 inferences do you make about what number of
12 beds can be effectively used in that area?

13 A: Looking at -- with them both proposing 64 beds
14 and with that occupancy rate proposed by the
15 third year, it very well justifies 100 beds.
16 If you could possibly have 100 beds, you
17 wouldn't have to make that additional
18 construction, begin planning by year three.

19 Q: And in contrast, what proposal by year three is
20 Fort Mill Medical Center making for its
21 occupancy?

22 A: It's already at 58.2 percent, so it's utilizing
23 an average of 58 beds and so probably they're
24 doing well. By five years or six years they
25 will be up there.

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RECORD 001135

1 Q: All right. Should they been in excess under
2 the regulations of 65 percent by three years?

3 A: There's no requirement of that, no, sir.

4 Q: Okay. Now, and therefore which applicant best
5 meets section 17 related to efficiency?

6 A: In my opinion, that would be the Piedmont
7 Medical Center Fort Mill application.

8 Q: Okay. Let's then go to the next series of
9 criteria. Now, you can see here, Mr. Grice,
10 that all of 13 is in indication that you and
11 Ms. Brandt meet those criteria. Those relate
12 to record of the applicant, is that correct?

13 A: Yes, sir.

14 Q: The -- ability to obtain financing, in fact, on
15 13(b), I think probably is mistaken and Ms.
16 Brandt found that Carolinas better met that,
17 would that be correct?

18 A: Yes.

19 Q: Okay. So that'd be 13(b) showed if it
20 accurately reflects Ms. Brandt's decision, that
21 should not say both, it should say CHS?

22 A: Right. Yes, sir. That's correct.

23 Q: Okay. All right. Otherwise, she found the
24 records were -- that all applicants met the
25 record criteria, is that right?

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RECORD 001136

1 A: Yes, sir.

2 Q: Now, acceptability, there was, Ms. Brandt and
3 you both found that all applicants met that.
4 I want to go, just I want to ask you a question
5 about that quickly. Do you recall from your
6 reading of Ms. Brandt's decision the number of
7 letters that were filed by the various parties?

8 A: Yes, sir.

9 Q: In general terms?

10 A: It was in the thousands.

11 Q: Okay.

12 A: Each got letters of support which relates to
13 acceptability.

14 Q: Would it be 10,000 for Presbyterian and many
15 thousands for the others?

16 A: Exactly. I don't know. Five or 6,000 I think
17 for the others.

18 Q: Why do you agree with Ms. Brandt concerning her
19 opinion that all applicants met that criterion?

20 A: Well, when you -- you cannot, you should not
21 base your decision on who has the most letter
22 of support. That's a way -- applicants can
23 always generate letters of support. Numerous
24 ways. I even recall having seen people in
25 front of Wal-Mart for small projects getting

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1 letters of support on Saturdays. I mean if you
2 want to get letters of support, there are ways
3 to do it. And you can hire an organization, a
4 company to go out and get them for you. If you
5 have appropriate support and look at the
6 quality of letters, too, if you have letters of
7 physicians and other people, that's great, but
8 both of them met that criteria. Because they
9 both had appropriate levels of support. You
10 don't count them. You don't weigh them in my
11 opinion.

12 Q: Okay. And let's look at opposition. Ms.
13 Brandt said the opposition expressed in
14 letters, with letters submitted with the
15 Department should be taken into consideration.
16 I'm not quite sure if she meant in clarifying
17 in favor of Carolinas, but what's your
18 recollection?

19 A: Well, I think the Piedmont, the Fort Mill
20 Medical Center had some letters of opposition.
21 Well, there might have been 40 or 50 letters,
22 in that range. And the Carolinas project may
23 have had a few or none, but I think because of
24 that she saw the opposition as being something
25 compelling and she put down that Carolinas best

1 met that. Because they had little if any
2 opposition where the Piedmont project had some.

3 Q: What's your view of that?

4 A: You can get opposition with any project. When
5 you look at the letters of support, that much
6 outweighed the opposition. In my experience in
7 the CON program over the years have been
8 particularly when you have only one facility in
9 the county, people always -- some people have
10 an unpleasant experience. There's only one
11 nursing home, one hospital, it's not a perfect
12 world and somebody is going to have some
13 experience that they thing, you know, is not
14 positive and they don't forget it.

15 Q: Okay. Let's move on to the last two sections,
16 23(a) and (b) related to adverse impact section
17 of the reg based on how those regs are
18 identified. Have you developed your opinion
19 here that Piedmont best meets both the, Ms.
20 Brandt found that Carolinas best met adverse
21 impact on utilization and that it equally, that
22 the applicants equally met the concerns of
23 staffing. What's the basis for your opinion
24 here, Mr. Grice?

25 A: Well, on 23(a) the adverse impact on existing

1 facilities, here again, with the development of
2 Piedmont Medical Center, that is going to have
3 less adverse impact on the existing facility
4 which is the existing Piedmont Medical Center
5 in Rock Hill, so relative of Fort Mill will
6 allow less adverse impact on the existing
7 facility in that county. So, that's why I say
8 that Piedmont Medical Center best meets that.
9 As far as adverse impact on staffing, here
10 again, when you have another provider, it gets
11 to be competition for hiring staff and that is
12 problematic. A new hospital close by, a lot of
13 people that live near there go to work there,
14 to not have to drive further. If it were the
15 Fort Mill Medical Center project, those people
16 would be employed by Piedmont, they could work
17 for both or the new facility but when we have
18 another provider such as Carolinas Hospital
19 System they're going to be working for someone
20 else and it will be an adverse impact on the
21 staffing of the existing Piedmont Medical
22 Center.

23 Q: All right. Have you developed a Demonstrative
24 that summarizes the potential adverse impacts
25 that you've identified?

1 A: Yes, sir.

2 Q: Okay. Dan, let's pull up 122. And what do you
3 have here, Mr. Grice?

4 A: Well, the adverse impact, it would really
5 reduce utilization at the existing facility.
6 Particularly if you look at the specialized
7 services you have at Piedmont Medical Center
8 such as open heart and the neonatal intensive
9 care nursery, it's going to have an impact on
10 medical staff current and future because as our
11 utilization drops and some the people with
12 medical specialities, utilization drops, those
13 physicians are going to be looking for
14 positions somewhere else and leave and it's
15 also going to have an impact on the nursing and
16 technical staff. So, you know, all those
17 things would make a recovery from adverse
18 impacts difficult. So, that's major -- mainly
19 a summary of the adverse impact that would
20 occur if we did not have Fort Mill Medical
21 Center in York County.

22 Q: And what's your opinion of Ms. Brandt's finding
23 concerning adverse impact that Carolinas would
24 only serve its patients and patients from the
25 Carolinas Network?

1 A: Well, I don't agree. I mean it's what is it's
2 obviously going refer many patients to
3 Charlotte. It's going to also be a gathering
4 new patients into that new facility and it's
5 going to cause a continued reduction in
6 utilization and staffing at the existing
7 facility in Rock Hill.

8 Q: Thank you, Mr. Grice.

9 MR. ANDREWS: I have nothing further, Your Honor.

10 THE COURT: All right. Thank you, Mr. Andrews.
11 Unless everybody is just dying to carry on here
12 on a Friday night, I think this is an
13 appropriate time to recess for the weekend.
14 All right. Thank you. Ten o'clock on Monday.

15 (There being nothing further, Day Five recessed at
16 5:25 p.m.)

17 DAY SIX - TUESDAY, APRIL 16, 2013

18 THE COURT: Good morning, everyone. Back on the
19 record. And today is Tuesday the 16th of
20 April. I wanted to put something on the record
21 about matters from yesterday.

22 Yesterday on April 15th the Court was
23 informed by Mr. Muller, counsel for Carolinas,
24 of the very sad news that his father had just
25 passed away in Connecticut. Mr. Muller was

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1 THE COURT: All right, Mr. Westbrook. Good morning. 2 DANIEL SULLIVAN, being duly sworn, testifies as 3 follows: 4 MR. SULLIVAN - DIRECT EXAMINATION BY MR. WESTBROOK: 5 Q: Mr. Sullivan, please state your full name and 6 present address, please. 7 A: Daniel Joseph Sullivan, 2090 Bethany Way, 8 Alpharetta, Georgia. 9 Q: Where were you born and raised, Mr. Sullivan? 10 A: Charleston, South Carolina. 11 Q: Where are you employed now? 12 A: Sullivan Consulting Group, Inc. 13 Q: And what are your duties and -- principal 14 duties and responsibilities with Sullivan 15 Consulting Group? 16 A: Obviously, I'm president of the firm and so 17 I've got administrative duties, but involved in 18 performing consulting work for our healthcare 19 client. Our firm is exclusively focused on the 20 healthcare field. 21 Q: All right. Let's look at Petition's Exhibit 22 11. I believe that's already been admitted. 23 MR. WESTBROOK: Put that up on the screen for us, 24 Dan. 25 Q: Is this your resume, Mr. Sullivan?	1 And at Amhurst, I started as just an entry 2 level consultant and was involved in doing 3 financial feasibility studies in connection 4 with tax-exempt bond issues; doing other types 5 of projection analysis. And that was about the 6 time that certificate of need was just 7 beginning to grow in the country as a program 8 throughout the state. And so I began to do 9 that in addition to other types of health 10 planning work with healthcare organizations; 11 strategic planning, market analysis, product 12 line planning and that sort of thing. 13 I was at Amhurst for eight years. I 14 became a regional vice president with Amhurst. 15 And we merged in 1988 with the firm of actually 16 Ernst & Whinney at the time, which became Ernst 17 & Young. And I was a partner for a couple of 18 years with Ernst & Young. Then I decided to 19 set up on my own and start my own company. And 20 I started Sullivan Consulting Group at that 21 time. 22 Q: Okay. And now that you are with Sullivan 23 Consulting Group, can you tell us what kind of 24 work specifically you do with your company? 25 A: Sure. Again, it broadly falls into two large
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1 A: Yes, it is. 2 Q: Is it current? 3 A: It is. 4 Q: All right. If you would, using your resume if 5 you'd like to jog your memory, tell us a little 6 bit about your educational background; will 7 you? 8 A: Sure. I did my undergraduate degree in 9 economics and public policy studies from Duke 10 University and then a master in health 11 administration from Duke University. 12 Q: All right. And can you summarize your work 13 history for us since your undergraduate degree? 14 A: Sure. Immediately after undergraduate school, 15 I went to work in the Duke University Medical 16 Center, what's called a private diagnostic 17 clinic. It is a group practice with the 18 faculty members at Duke Medical School. I 19 worked there for about six years doing a 20 variety of different administrative roles. The 21 last two years I also attended grad school 22 simultaneous with working. Upon graduation 23 from grad school in 1980, I joined Amhurst 24 Associates, which at the time was a large 25 national healthcare management consulting firm.	1 categories; health planning and healthcare 2 finance. On the health planning side, we are 3 involved in strategic planning for healthcare 4 organizations, market research, projection 5 analysis, preparations; certificate of need 6 applications. On the financial side, we 7 prepare financial projections to various types 8 of healthcare projects; sometimes for use in a 9 certificate of need application, sometimes just 10 for internal use. And then I also analyze 11 financial statements, look at the capacity of 12 organizations and sometimes evaluate 13 opportunities from a financial standpoint for 14 some of our clients. And from time to time I 15 also get involved with providing expert witness 16 testimony in certificate of need matters, as 17 well as other types of litigation. 18 Q: How many states, approximately, have you done 19 CON work in over the years with Sullivan? 20 A: Probably 30 or so over the years. I'm old 21 enough that there were a lot more states that 22 had CON programs when I first started. But, 23 you know, virtually every state on the east of 24 the Mississippi and a few on the west of the 25 Mississippi.

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Page 1173 1 Q: Right. Have you worked in South Carolina 2 before? 3 A: I have. I worked in South Carolina pretty 4 early in my career, and I've been working 5 pretty consistently over the last 30 or 6 something years in South Carolina. 7 Q: Now, just overall, can you estimate for us 8 about how many CON applications that you have 9 had significant involvement in in one way or 10 another? 11 A: You know, somewhere around a thousand. There 12 was a time when, you know, the firm was 13 probably doing 40 or 50 a year. That's slowed 14 down a bit now, but somewhere around a 15 thousand. 16 Q: You've mentioned that you've done some expert 17 witness work before or testimony given as 18 expert witness testimony before. Do you know 19 how many times you have been qualified as an 20 expert? 21 A: Not exactly, but more than a hundred times. 22 Q: And what areas of expertise have you been 23 qualified in particularly? 24 A: Broadly in healthcare planning and healthcare 25 finance. Sometimes it would be specific	Page 1175 1 Francis Hospital in Greenville, South Carolina, 2 we assisted them in developing a new hospital 3 project on the east side of Greenville called 4 St. Francis Women's Hospital, I think, at the 5 time. I think it's a full service hospital 6 now. And I've been involved in assessing the 7 Parkridge Project here in Columbia. 8 Q: Right. 9 A: I was involved in analyzing that project. And 10 while I didn't testify in that case, I was 11 involved in doing a lot of the analytical work 12 on behalf of Lexington Medical Center in the 13 Parkridge case. 14 Q: And the Parkridge, that's a Palmetto Health 15 project, is that right? 16 A: It is, yes. 17 Q: And you worked for Lexington opposing that 18 project? 19 A: I did. And there's probably some more, but 20 those are the ones that come to mind. 21 Q: All right. Have you served on any special 22 committees studying the South Carolina CON 23 programs? 24 A: I have. Last year there was a CON task force, 25 I think at the direction of the governor. I'm
Page 1174 1 proffers for certificate of need analysis, 2 certificate of need programs or certificate of 3 need application preparation; that sort of 4 thing. But generally health planning and 5 healthcare finance. 6 Q: Let's look at a subset of CON applications and 7 that's CON applications from new hospital 8 projects. Have you been involved in those kind 9 of CON matters before? 10 A: I have many, many times. 11 Q: In what states? 12 A: Florida, Georgia, South Carolina, West 13 Virginia, Tennessee, Kentucky, Alabama. 14 Q: Quite a few? 15 A: Yeah. 16 Q: What about -- let's look at some in South 17 Carolina. Can you give us some examples of new 18 hospital projects you've worked on in South 19 Carolina? 20 A: Sure. There was a battle many years ago 21 between Roper and St. Francis Xavier Hospital 22 in Charleston before they got together and both 23 trying to build new hospitals on the West 24 Ashley area of Charleston. And I was involved 25 in working with Roper Hospital on that. St.	Page 1176 1 not quite sure exactly how it came to be. But 2 the task force was put together with 3 representatives of the legislative branch. 4 Various people in the healthcare community; 5 hospital representatives, nursing home, home 6 health agencies. Blue Cross was involved in 7 it. There were a couple of independent 8 consultants who served on that task force, and 9 I was one of those. 10 Q: All right. And how many people all total were 11 on that committee? 12 A: I think about 25 or 27, a fairly large group. 13 Q: And how long did that committee's work go on? 14 A: A long time, probably about seven months, seven 15 or eight months. 16 MR. WESTBROOK: Your Honor, at this time I would 17 like to move to have Mr. Sullivan qualified as 18 an expert in the field of healthcare planning 19 and healthcare finance. 20 MR. GASKINS: No objection. 21 MS. BIGGERS: No objection. 22 THE COURT: All right. There being no objection, 23 the Court recognizes Mr. Sullivan as an expert 24 in the field of healthcare planning and 25 healthcare finance.

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1 Q: Okay, Mr. Sullivan, when were you first 2 retained to work on this case of this matter? 3 A: I believe I was contacted first in July or so 4 of 2012; so a little less than a year ago. 5 Q: All right. So that would have been after 6 DHEC's second decision to award the CON to CHS? 7 A: That's true. 8 Q: Did you have any involvement at all in 9 Piedmont's initial 2005 application? 10 A: I did not. 11 Q: And it sounds like you also did not have any 12 involvement at all in DHEC's -- excuse me, 13 Piedmont's 2010 updated application? 14 A: I did not. 15 Q: And you didn't have any involvement, I guess, 16 in the subsequent submissions after October 17 2010, the subsequent submissions by Piedmont to 18 DHEC? 19 A: That's correct. 20 Q: Okay. Well, what were you asked to do in 21 connection with your engagement in this case? 22 What did you do, I guess, is the better 23 question. 24 A: Sure. Initially I was asked to come in and 25 sort of take a fresh look at this since I	1 additional information that were filed by the 2 various parties involved. And then subsequent 3 to the decision, I reviewed a number of 4 discovery materials that were provided to me 5 from the various parties, Piedmont and 6 Carolinas Health System. And I also had been 7 involved in reviewing exhibits prepared by Mr. 8 Levitt and by experts for the other parties. 9 Q: And how much of this hearing have you sat 10 through so far? 11 A: The entire hearing. 12 Q: Do you have an opinion as to which applicant 13 best meets the purposes of the CON Act, the 14 state health plan, applicable regulatory 15 criteria? 16 A: I do. 17 Q: And what is that? 18 A: I do believe after my analysis that the Fort 19 Mill Medical Center project, I believe, best 20 meets the purposes of the CON Act, the CON 21 review criteria and the state health plan. 22 Q: Do you have an opinion as to how CMC-Fort Mill, 23 if it were to be approved, would affect the 24 availability and quality of healthcare to York 25 County residents?
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1 hadn't been involved in many years of this 2 review process and sort of take a look at the 3 entirety of the record and specifically to 4 focus on the second DHEC decision and to look 5 at that decision from the perspective of 6 whether it was reasonable, whether it was based 7 on sound health planning policies and whether 8 it was supported by data, other analytical 9 information and also asked to undertake any 10 other analyses, investigations that I thought 11 were necessary in order to be able to render 12 those opinions. 13 Q: All right. What -- I'm sure you reviewed a 14 number of documents. What were some of the 15 things -- kinds of things you reviewed besides 16 the DHEC decision? 17 A: When I looked through the records from the 18 first go round, the 2005-2006 applications, 19 though I didn't specifically focus on those as 20 much because I thought that the more recent 21 information would be more relevant. So I 22 reviewed all the submissions by the three 23 parties at that time when Presbyterian was 24 still involved, including the initial 25 applications and the various other bits of	1 A: I do. 2 Q: And what is that? 3 A: I believe that the approval of the CMC-Fort 4 Mill project would be detrimental to the 5 quality and availability of healthcare 6 services to York County residents. 7 Q: Okay. Let's start with Ms. Brandt's decision. 8 You said you reviewed that. And I believe you 9 have a sort of analytical framework that you 10 would like to use in discussing her decision, 11 is that right? 12 A: That's true. I've prepared some demonstrative 13 exhibits. 14 Q: Okay. Let's go to the first one. All right. 15 Now, I see the title to this chart says, "Pivot 16 Points," in quotes, "Pivot Points in Ms. 17 Brandt's Decision." What do you mean by pivot 18 points? 19 A: Well, in reviewing the decision, there were a 20 few significant issues where Ms. Brandt had a 21 choice, either to accept the positions that 22 CMC-Fort Mill were presenting or the positions 23 that FMMC was presenting. And the decision, I 24 believe, really pivoted on these particular 25 choices. You know, had she looked at these in

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1 a different fashion, I think she would have 2 likely reached a different conclusion as to the 3 most appropriate party to pick. 4 Q: All right. Why don't you -- we can go into 5 some detail in these in turn. But to start 6 off, why don't you just read them into the 7 record, which is five that you've identified. 8 A: Sure. The first is adverse impact, and I know 9 there has already been a lot of discussion 10 about that. And I think there is sort of three 11 elements to adverse impact. The first would be 12 with the impact of the CMC-Fort Mill Hospital 13 would be Piedmont Medical Center. Another 14 issue that was raised in the decision would be 15 the impact if Fort Mill Medical Center was 16 approved on Piedmont itself. And then I think 17 probably the most important aspect of that 18 would be the impact of the approval of either 19 applicant on the quality and availability of 20 services in York County. 21 The second issue is mal-distribution. And 22 this was raised by Carolinas Health System and 23 their comments to DHEC. And it really focuses 24 on the issue of 64 beds versus 100 beds and 25 whether 100 beds is too many for the North York	1 but I would just like to get the final numeral 2 of that in the exhibit. It doesn't seem to be 3 on there. 4 MR. WESTBROOK: That I believe that is exhibit -- or 5 demonstrative rather, Exhibit 216. 6 MR. GASKINS: Thank you. 7 Q: Sure. All right. Let's take a first pivot 8 point, adverse impact. And I believe your next 9 demonstrative is 217; is that right? 10 A: That's correct. 11 Q: All right. And I see your question, "Which 12 project will minimize adverse impact on the 13 York County Health system?" And then it says, 14 "CMC-FM will take a significant number of 15 patients from PMC." Now, why did you say that? 16 A: Well, there's a number of different reasons. 17 And let me sort of plot through those. The 18 first is the proximity of the proposed CMC-Fort 19 Mill Hospital to both the Fort Mill population 20 and the Rock Hill population, for that matter. 21 Proximity alone I think is going to result in 22 some redirection of patients. We've already 23 heard some testimony about this. That means 24 the simple fact that if you build a hospital 25 very close to where people live, there's at
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1 County market. 2 Q: All right. 3 A: Unnecessary duplication. That is related to 4 the 100- versus 64-bed issue. Carolinas is the 5 contender, and I think Ms. Brandt adopted their 6 argument that building 36 additional beds over 7 the 64 would result in unnecessary duplication 8 of services. 9 Financial Access, Carolinas had projected 10 6.3. In the second go round, they projected 11 6.3 percent charity care as opposed to 3 12 percent that Fort Mill Medical Center had 13 projected. Ms. Brandt seemed to have focused 14 on that as a favorable consideration, if you 15 will, in evaluating the CMC-Fort Mill 16 application. 17 And then finally there were a number of 18 issues brought up about financing and financial 19 projections, but I think a large derivative of 20 those first four. But I thought I would at 21 least address those because they did pick up a 22 portion of the decision. 23 Q: All right. Well, let's start with the first -- 24 your first pivot point -- 25 MR. GASKINS: Excuse me. I'm sorry to interrupt,	1 least some people who are going to choose to 2 use that hospital. You know, CMC-Fort Mill in 3 its application had taken the position it would 4 only redirect patients from existing CHS 5 facilities in Mecklenburg County. As a 6 practical matter, I don't think you can do 7 that. I mean, if you build a hospital and put 8 it down in an area where there wasn't one 9 before, there is very little way to control 10 which patients are going to come to that 11 hospital. And people don't walk around with 12 visors that say I'm a Piedmont patient or I'm 13 a CMC patient. And so the mere fact of it 14 being there, being proximate and close, in 15 addition to being a shiny new building, I think 16 it's going to attract some new patients there. 17 So I think it would be wholly unrealistic 18 to expect that you would have no impact on 19 existing providers. 20 The second factor, and this has also, I 21 think, been touched on, the emergency 22 department at CMC-Fort Mill is going to serve 23 patients who would have otherwise gone to the 24 PMC. And if we think about it, there are 25 several different ways people get into

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1 emergency departments. One is ambulances bring 2 them there. And oftentimes when a patient is 3 injured or sick, the ambulance will bring them 4 to the closest hospital. Now, in some cases, 5 absent the approval of CMC-Fort Mill, that 6 closest hospital would be Piedmont. With the 7 new hospital there, or at least a portion of 8 that population, that hospital is going to be 9 CMC-Fort Mill. Other patients are going to 10 walk into the hospital, and those patients are 11 going to -- oftentimes want to go to a place 12 that is close to home. And again, this relates 13 to the proximity thing being closer to the 14 population means more people are going to go to 15 the ED. 16 And then finally for patients who go to 17 the ED at CMC-Fort Mill and their diagnosis 18 having a more significant problem. For 19 example, if they come to the hospital and they 20 are diagnosed as having a heart attack, and 21 they need immediate intervention in terms of an 22 angioplasty for example, my understanding is 23 that if those patients need that service, that 24 they are going -- and CMC-Fort Mill is treating 25 that patient, that they would be transferred to	1 will go to the new hospital instead. 2 Q: Now, you said just a moment ago that there was 3 -- from a practical point of view, if you 4 didn't follow to shift, market share I believe 5 is what you said. 6 A: Right. 7 Q: Even if there were a practical way to shift 8 market share, what incentives in your opinion 9 would CHS have to simply shift its current 10 market share from North Carolina to the Fort 11 Mill facility? 12 A: I don't believe from a business standpoint that 13 there is any real incentive for CHS to want to 14 shift patients from North Carolina to York 15 County. Now, I'm not disputing that some 16 patients are going to be shifted. I mean, 17 certainly, some of the patients who go to 18 Pineville, for example, now will choose to go 19 to the new hospital because it is closer to 20 home. But not all of the patients who go to 21 Pineville who live in York County are going to 22 choose to do that. And there is certainly no 23 incentive to CHS to try to give special push to 24 those patients to utilize a hospital in Fort 25 Mill.
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1 the CMC facility for that speciality care. 2 And so there would be sort of a direct 3 impact in terms of the loss of the patients who 4 would come to the ED at CMC-Fort Mill. Then 5 there would also be a loss of these specialty 6 patients who would be transferred to another 7 facility. 8 Q: What impact would CMC-Fort Mill have on 9 physicians in the area? 10 A: Well, I think that is probably the most grave 11 potential impact that it could have. I mean, 12 we -- there were three physicians who testified 13 last week, three independent physicians. And 14 I believe all three of them testified that if 15 CMC-Fort Mill were constructed, they would feel 16 compelled to seek staff privileges there. And 17 that is only good business on their part. They 18 have patients that live in the Fort Mill area. 19 The patients would likely want to go to a 20 proximate hospital. And those doctors right 21 now practice, if not exclusively, a majority of 22 their patients go to Piedmont now. If they 23 were to get staff privileges at CMC-Fort Mill, 24 I think undoubtedly some of those patients who 25 otherwise would have been admitted to Piedmont	1 Q: Why not? 2 A: Well, based on my review of various CON 3 applications and deposition testimony, it 4 appears that CHS has spent about \$300 million 5 over the last decade or so on expanding 6 services at CMC Pineville. And I think we've 7 already talked about this, but it is located 8 right on the York County border. So there is 9 every intention, I think, of trying to justify 10 that significant capital investment by trying 11 to maximize utilization of hospitals. I think 12 that is only rational behavior on the part of 13 CHS. And if we look at the growth, just in the 14 bed complement at CMC Pineville in 2002, it was 15 a 97-bed hospital. Twelve beds were approved 16 to be added in 2002. By 2005, an additional 11 17 beds were added. Then in 2007, it was sort of 18 a big project where CMC Pineville got approval 19 to add 86 additional beds, and in addition to 20 add a number of other specialized services to 21 the hospital and dramatically expand the 22 footprint of hospital as a result of that 23 project. 24 Q: Now, how did CMC Pineville justify its bed 25 expansion with respect to York County?

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1 A: Well, when I reviewed the application, the 2007 2 application, about a quarter of the patients 3 that CMC Pineville was serving at that time 4 came from York County. The application 5 described York County as being in the primary 6 service area of CMC Pineville, which is logical 7 because it is located right on the border of 8 York County. And it indicated that it would 9 expect that the growth in York County would be 10 one of the factors in driving future 11 utilization that would support the increase of 12 86 beds. That wasn't the sole factor. They 13 were also looking at growth, another portion of 14 what they call the southern perimeter of 15 Charlotte. But York County was certainly a 16 significant component and was expected to still 17 represent over 20 percent of the admissions to 18 the expanded CMC Pineville Hospital after 19 development. And so, you know, that's a pretty 20 significant factor. 21 Now, another important thing to think 22 about in just in terms of timing, in 2007 DHEC 23 had approved the Fort Mill Medical Center 24 project. This was before the remand. 25 Q: This was during the first appeal of this	1 Pineville was dramatically greater, 1,500 2 discharges greater. 3 So there is a -- you know, I think what we 4 have here is a situation where CHS, thinking 5 that they had not won the hospital in York 6 County, decided instead from a strategic 7 standpoint to expand its services in Pineville 8 and to try to serve York County from Pineville. 9 And then by happenstance they had another bite 10 of the apple -- 11 Q: Remand, you mean. 12 A: On the remand, yes. They then sort of back 13 tracked a little bit. So actually we are going 14 to shift a whole bunch of patients from 15 Pineville to the new facility. So, you know, 16 I think that CHS has already built to capacity 17 to serve York County patients and that's at 18 Pineville. And for them to now seek approval 19 of this and to say it's only going to come 20 through shifting patients, I think it means 21 that somewhere there is some double counting 22 going on. 23 Q: Now, you mentioned that CMC Pineville, as part 24 of its expansion, added a number of special 25 services, right?
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1 decision? 2 A: Right. And so in the CMC Pineville 3 application, they took into account what the 4 effect of a Fort Mill Medical Center project 5 would have on their Pineville facility. 6 And if I can go to another slide, in 2007 7 they said if CMC Pineville were to be approved 8 with the Fort Mill Medical Center there, that 9 they expected there to be a loss of about 440 10 discharges in, I believe was the third year of 11 operation, as a result of that, Piedmont 12 Medical Center's own facility in York County. 13 Now, in 2010 after the remand when CMC-Fort 14 Mill resubmitted its application, whatever we 15 want to call it, amended or updated or what 16 have you, their projections now in terms of the 17 impact on the Fort Mill Hospital on CMC 18 Pineville would be a shift of 1,923 admissions. 19 So we can see that the assumption was that 20 a Fort Mill Medical Center wasn't going to have 21 much impact on Pineville. But if CMC-Fort Mill 22 were built, because CHS had taken the position 23 in that application that the patients would be 24 shifted from existing CHS facilities, all of 25 a sudden the impact of that hospital on	1 A: It did. 2 Q: And what's the significance of that with 3 respect to the shift? 4 A: Well, I think there are sort of two aspects to 5 that. Among the services they offer; open 6 heart surgery, interventional cardiology, which 7 includes angioplasty, electro physiology 8 studies and so forth that we've discussed 9 before, a neonatal intensive care. In order to 10 support those services, they need to have 11 referrals. I mean, you know, when you have 12 what are often referred to as tertiary 13 services, not all of that business is going to 14 be generated from your in-house population of 15 patients. You have to also rely on transfers 16 from smaller facilities to utilize those 17 services. And so CMC-Pineville, again, 18 projected that those services would be well 19 utilized and relied on the York County 20 population. And I think it is reasonable to 21 assume that if CMC-Fort Mill were constructed 22 and patients are being served at CMC-Fort Mill 23 and they need these specialized services, it is 24 only logical to think that those services would 25 be -- those patients would transfer to CMC-

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1 Pineville. 2 So as I said before, I think in the past, many 3 of those patients would have gone to Piedmont. 4 Q: Now, there has been a good bit of testimony in 5 the hearing so far about out-migration from 6 York County to North Carolina facilities to CHS 7 facilities in North Carolina, specifically, and 8 the effects of CHS physician referrals on that 9 out-migration. With that -- given that 10 context, what effect do you believe CMC-Fort 11 Mill would have on CHS's historical efforts to 12 redirect patients from York County? 13 A: I think that having a hospital in York County 14 is somewhat of a game changer, if you will, for 15 CHS. They've been able to make significant end 16 roads into York County just by building up this 17 physician network. And having a new hospital 18 in York County is going to only increase CHS's 19 ability to expand that physician network. For 20 example, if you have a hospital -- right now 21 CHS doesn't have a hospital. And the testimony 22 I've heard is by and large the Carolinas 23 Physician Network physicians don't practice at 24 Piedmont. Those doctors, if they're located in 25 York County, are having to drive to Pineville	1 the physician component of this, I think, is 2 only going to be exacerbated in terms of the 3 potential for future loss of patients at 4 Piedmont if CHS is successful in getting this 5 hospital. 6 Q: Now, CHS has made an announcement about going 7 into the health insurance business. Can you 8 tell us about that? 9 A: Sure. There was an announcement, I guess a 10 couple of weeks ago, that CHS was entering into 11 a venture with Coventry Health, which is a 12 national health insurance provider. They 13 wanted to begin to offer health insurance 14 products in the Charlotte area. And a number 15 of health systems are taking those steps. But 16 if you think of how you capture patients, how 17 you penetrate a market, there are sort of three 18 legs to the stool, if you will. I mean, one is 19 having facilities in the market where patients 20 can go. Secondly is having physicians in the 21 market where patients can go. And the third is 22 if you don't have a health insurance product, 23 having contracts with health insurance 24 companies that will bring those patients to 25 your facility.
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1 or somewhere else in order to perform either 2 inpatient services or even outpatient surgical 3 services, for example. But by having a 4 hospital there, it would be more attractive to 5 physicians to want to practice in the York 6 County area. It would be more attractive, for 7 example, if orthopedic surgeons, for general 8 surgeons, for gastroenterologists and so forth 9 who would have a hospital based program where 10 they could go and do their procedures. Also a 11 cardiologist, for example, could do certain 12 basic things there and then have the capability 13 of transferring those patients up to Pineville. 14 And so I think that having this capability 15 that a new hospital offers is going to only 16 expand the number of physicians that are in the 17 York County market. And again, when you look 18 at the secondary effect of that, patients who 19 otherwise were going to physicians who practice 20 at Piedmont now, a new doctor moves into your 21 neighborhood, his office is closer to where you 22 live; the likelihood that at least some of 23 those patients are going to choose to use the 24 new physician. And again, it's a ripple 25 effect, you know, through the county. And so	1 If you have your own health insurance 2 product, typically you would be able to require 3 the patients go to facilities that are in the 4 network. With the CHS product, I think it 5 would be logical to assume those in network 6 facilities and those in network physicians 7 would be CHS physicians at those facilities. 8 There would be substantial penalties to go 9 outside the network. And so patients would 10 have a strong incentive to go to CHS 11 facilities. 12 Having a hospital in Fort Mill would 13 facilitate CHS's efforts to sell insurance in 14 York County. It would be if -- let's say, for 15 example, that CHS didn't have a facility in 16 York County and they were trying to sell 17 insurance to a company that was based in Rock 18 Hill, they may not be that excited about 19 signing with CHS if all the patients had to go 20 to Pineville and all of their employees had to 21 go to Pineville for services. But if, instead, 22 CHS had a hospital there, and so they could go 23 to our Fort Mill facility. And if they needed 24 anything more exotic than that, then they can 25 go to Pineville or downtown, that's a more

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1 attractive package to offer to employers. So 2 CHS already has a very large presence in the 3 Charlotte market. And I think through this 4 health insurance effort, I think they can 5 further consolidate some of the market power 6 that they already have. 7 Q: And when you say the Charlotte market, are you 8 including northern York County now? 9 A: I'm including all of York County in that. 10 Q: Now Ms. Brandt, with DHEC accepted CHS's 11 position that if Fort Mill Medical Center were 12 built, it would have an adverse impact on 13 people, that Fort Mill Medical Center would 14 adversely impact Piedmont. What's your 15 reaction to that? 16 A: Well, when I first read that, I was somewhat 17 stunned, quite frankly, by that assertion that 18 somehow allowing the biggest hospital system in 19 the Charlotte market to come in and build a 20 hospital in York County where they didn't have 21 one, would have a lesser impact than an 22 existing provider simply creating a satellite 23 hospital to serve patients in its existing 24 market. That, to me, I just don't see any 25 logical basis for that to, you know, be a	1 away from it because of the hospital in Fort 2 Mill and because of the redirection, especially 3 patients out of York County. 4 And so I think it would be illogical to 5 assume anything other than the fact that 6 allowing Piedmont to shift some of its existing 7 patients and to recapture some of the out- 8 migration that's happening in York County could 9 be a far better outcome for Piedmont than 10 simply the deadweight loss associated with 11 losing patients to CHS. 12 Q: Let me ask you to go back to your second bullet 13 point on your slide for a moment. 14 A: Sure. 15 Q: You were here -- you said you were here for the 16 entire -- for all of the testimony so far in 17 this hearing. I want to ask you to think back 18 to Mr. Masterton's testimony. Do you recall 19 Mr. Masterton talking about a strategy for 20 halting out-migration and recapturing out- 21 migration? 22 A: I do. 23 Q: And did you hear Mr. Masterton testify that 24 while there were three elements of that, the 25 key element was building Fort Mill Medical
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1 reasonable conclusion. You know, we've already 2 heard testimony from Mr. Levitt about the fact 3 that Piedmont has seen its market shares in 4 York County and at Fort Mill specifically 5 decline significantly in the last decade. And 6 so there is a significant amount of impact that 7 has already occurred without having a hospital. 8 Piedmont is going to have no opportunity. I 9 mean, let's assume that CMC-Fort Mill is built. 10 I mean, that in effect is going to create a 11 barrier for Piedmont. Basically it's going to 12 wall off, if you will, the whole northern 13 sector of the county. And it's going to mean 14 that Piedmont is going to have very little 15 opportunity to reverse the out-migration, 16 particularly out-migration from northern York, 17 which is the fastest growing and as we've 18 heard, one of the more affluent portions of 19 York County. And so I think that that's a very 20 real concern. So Piedmont, instead of being 21 able to sort of bounce back from a significant 22 downturn in its market share over the last 23 seven or eight years, it's basically going to 24 be stuck where it is today, with a significant 25 potential for further shift in market share	1 Center. My question is do you agree with that? 2 A: I do. Without Piedmont having a physical 3 presence in the Fort Mill market, I don't see 4 them being able to effectively reverse the out- 5 migration that's occurred over the last seven 6 years or so from northern York County. CHS, 7 as I said, has dramatically expanded Pineville. 8 It offers a broad range of services equivalent 9 to what Piedmont does. They've effectively 10 penetrated the physician market in York County 11 through acquisition and improvement. And so as 12 a result without having a physical presence 13 there that would attract patients to the 14 facility and give Piedmont a base on which to 15 recruit additional physicians, I just -- I 16 don't think that any other strategy is going to 17 have any significant impacts in terms of 18 changing the out-migration pattern. 19 Q: Okay. You've been discussing CMC-Fort Mill if 20 it were to be built, CMC-Fort Mill's adverse 21 impact on Piedmont. Let me ask you now to 22 focus on what kind of impact do you believe 23 CMC-Fort Mill would have on the York County 24 health system and also what do you mean by the 25 York County health system?

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1 A: Let me start with what I mean by the York 2 County health system. 3 Q: All right. 4 A: Now, obviously Piedmont is a big part of York 5 County health system, it's the only hospital in 6 the community. But there is also physicians. 7 There is other types of healthcare 8 professionals that operate in York County. But 9 the county itself, it's in the health business, 10 if you will, the county health department. 11 There is community education programs. There 12 is outreach programs, screening programs and so 13 forth. All of these things are part of the 14 healthcare system. And, you know, in my view 15 approving CMC-Fort Mill is going to adversely 16 affect that for a few different reasons. Let 17 me describe those. 18 Q: Sure. 19 A: I mean, the first is it's going to perpetuate 20 the out-migration of York County residents to 21 North Carolina and for all the reasons we've 22 already talked about. And, you know, you might 23 say, well, what difference does that make if 24 the patient gets service in North Carolina 25 versus South Carolina? Well, I mean, I think	1 speciality programs damages the healthcare 2 system in York County because patients won't 3 have to travel farther to get those services. 4 And in some cases, continued reductions in 5 volume just means that those services can't be 6 as broad and as high quality as they could be 7 if there was a larger patient base. 8 Q: All right. And we're talking about clinical 9 services now. How about some points on that 10 from this adverse impact on the system? 11 A: Well, I think there is certainly the potential 12 for tax revenues for York County and South 13 Carolina to decrease as a result of the 14 approval of CMC-Fort Mill. And we know that 15 Piedmont is a taxpaying entity. And Mr. 16 Miller, I think, described in some detail the 17 types of taxes that are paid and a significant 18 amount of money every year. I'm not saying 19 that you should always approve a taxpaying 20 hospital when we get into a CON fight. I think 21 there is sometimes good reasons to approve for 22 not-for-profits and sometimes good reasons to 23 approve for-profit entities. But when you have 24 an existing for-profit entity that is 25 contributing to the existing infrastructure of
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1 that the focus of the CON Act in South 2 Carolina, and I think just generally good 3 health planning, you would like people to 4 receive needed services as close to home as 5 possible. And I see through the approval of 6 the CMC-Fort Mill project as putting greater 7 pressure on patients leaving the county for 8 care because CHS is a very large network of the 9 hospitals in Mecklenburg County. 10 I think probably equally significant is 11 the fact that the speciality programs that 12 Piedmont offers, and we've heard testimony 13 about some of the things that are done in terms 14 of neonatal services, in terms of cardiac 15 services, in terms of orthopedics and 16 neurosurgery, and the fact that you need a 17 certain volume of patients in order to maintain 18 quality, efficiency in those programs as well 19 as to maintain economic viability. And I think 20 that some of those programs are certainly 21 threatened if there is this continued exodus, 22 especially patients from York County into 23 Mecklenburg County. And I won't go through all 24 the discussion that has already happened on 25 that point, but I think that the loss of those	1 accounting like Piedmont is in York County, if 2 the result of your project is to reduce the 3 number of patients who are getting care in the 4 county and at the same time reduce the county 5 tax base and the county, as I said before, is 6 also involved in activities that have 7 implications for the health of residents, I 8 think that's a negative to the healthcare 9 system. 10 South Carolina, itself, gets revenue from 11 Piedmont. It goes in terms of the income taxes 12 that it pays to the state. And obviously the 13 state is involved in healthcare activities as 14 well. I mean, DHEC is involved in a number of 15 health-related activities. And so you are 16 reducing the revenues that are paid in South 17 Carolina. And I think it goes back again to 18 the purposes of the CON Act, and that is to 19 ensure that quality and accessibility for 20 patients in South Carolina. I mean, if the 21 goal was just to ensure that patients got good 22 quality care, I mean then it would not matter 23 if they were going to Mayo Clinic or Charlotte 24 or wherever. But I think the idea is to try to 25 maximize the services providing within the

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1 state. 2 Q: You mentioned the purposes of the CON Act. 3 You're familiar with those purposes; are you 4 not? 5 A: I am. 6 Q: And you're familiar with the regulatory 7 criteria? 8 A: I am. 9 Q: I know what's set forth in Motion 61-15. Based 10 on your experience and based on health planning 11 principles, do the criteria encompass all 12 aspects of the CON purposes -- CON Act 13 purposes? 14 A: They don't. I think they attempt to flush out 15 those purposes. But healthcare is so complex. 16 It is very difficult to capture on any set of 17 regulations, even though South Carolina has 18 many regulations as it reflects a CON review, 19 to capture all aspects of a determination of 20 which project would best meet the needs of the 21 community. 22 Q: Mr. Sullivan, what effect would approval of 23 CMC-Fort Mill have on the York County 24 Healthcare System with respect to payer mix and 25 the proportionality of who gets served?	1 And so that would be a source of some of these 2 better paying patients for Piedmont. There is 3 certainly a strong potential if CMC-Fort Mill 4 is constructed, that given the payer mix of the 5 physicians who practice there, given the 6 demographics of the area where the Fort Mill 7 facility will be located, that Piedmont will 8 see its payer mix erode even further over time. 9 Q: What do you mean when you say payer mix erode? 10 A: Well, one of the aspects about healthcare that 11 I think it's difficult sometimes for people 12 outside the industry to understand is that not 13 every payer pays the full cost of providing 14 services. Medicaid, for example, is not a 15 particularly generous payer. Oftentimes it is 16 paying below cost. Medicare, depending on the 17 service, can be paying -- you have a small 18 profit or you are actually losing money on 19 Medicare patients, as well. Obviously, people 20 without health insurance, you're not getting 21 paid very much for those people. And so by and 22 large, hospitals make their profits through 23 their managed care commercial insurance 24 patients. That's where there is the greatest 25 margin. And if those patients begin to shrink,
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1 A: Well, you know, we've heard testimony already, 2 which I won't repeat, about the fact that 3 Piedmont has seen erosion in its payer mix in 4 the sense that its percentage of commercial 5 managed care patients has gone down. It's 6 percentage of Medicaid and uninsured patients 7 has gone up. And we've also heard testimony 8 from the physicians about the fact that they 9 see it in their own practices, the free 10 physicians who practice here, they don't see as 11 many of those well-paying patients. We also 12 saw the exhibit and looked at the payer mix of 13 the CPN physicians practicing in York County. 14 We saw that they had -- 15 Q: You're talking about Exhibit 27? 16 A: I'll take your word for that. 17 Q: Okay. I'm sorry. Go ahead. 18 A: That they had relatively low percentages of 19 Medicaid and charity care, self-pay care in 20 their practices. So I think there is certainly 21 a strong concern that if CMC-Fort Mill is 22 approved -- well, let me add one more thing to 23 that. You know, I think there is evidence 24 which we will look at in a minute, that the 25 Fort Mill area has a more affluent population.	1 then you are left increasingly relying upon 2 Medicaid, Medicare and charity self-pay 3 patients. You are going to see your resources 4 shrink as well and your ability to expand 5 services or even to maintain service. 6 Q: Now, we are talking a general topic here I 7 think of this slide is the impact of CMC-Fort 8 Mill, the impact it would have on the York 9 County healthcare system? 10 A: Right. 11 Q: And I think, you know, one more bullet point. 12 What would be the impact on, do you believe, on 13 employment? 14 A: I believe that it would be a net reduction in 15 employment in York County. And, I mean, and I 16 guess granted, whoever builds a hospital in 17 Fort Mill is going to hire employees, you know. 18 And so to some extent, that is somewhat 19 employment neutral, if you will. 20 But if we think about the potential loss 21 of specialty patients going to Mecklenburg 22 County, this certainly, as we've heard 23 testimony from Mr. Masterton and I think from 24 Mr. Miller, there is certainly the potential to 25 have to layoff or reduce the hours of existing

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1 employees who work at Piedmont in those 2 speciality areas. And that's somewhat of a 3 bigger impact because those are sometimes the 4 most highly skilled and most difficult to 5 recruit types of individuals in the healthcare 6 system. And so reducing that employment, I 7 think damages sort of the infrastructure again 8 of the healthcare system in York County. 9 Q: All right. We have been talking about the 10 effect that approval of CMC-Fort Mill would 11 have on the York County healthcare system. 12 Let's move to the topic of the effect that 13 approval of Fort Mill Medical Center would have 14 on the York County healthcare system. 15 A: Sure. In my view, the net effect of approving 16 Fort Mill Medical Center would be to enhance 17 the healthcare system in York County. 18 Q: All right. And why do you say that? 19 A: Well, probably number one is that I believe it 20 would have the biggest impact in terms of 21 reversing out-migration of patients. With the 22 CMC-Fort Mill project it will probably reduce 23 out-migration of some of what I'll call 24 primary/secondary type patients, the patients 25 who have needs but not at the highest level of	1 would be a positive impact in terms of tax 2 revenues, which again filters through the 3 system in terms of the general health of the 4 county which also has an impact on the health 5 of the population. 6 And then finally, for the reasons I think 7 we've already discussed, it would expand 8 employment opportunities in York County, but 9 yet it may well keep more of those patients in 10 the county. There would be greater job 11 opportunities in York County as opposed to 12 those jobs going to Mecklenburg County. 13 Q: All right. On the previous slide, the one 14 talking about focusing on the CMC-Fort Mill's 15 impact on the system, you had a bullet point 16 about payer mix, the proportionality of payer 17 mix. 18 A: Right. 19 Q: What about if Fort Mill Medical Center is 20 approved, what would the effect be on the 21 proportionality of the payer mix? 22 A: I think that again, the presence in Fort Mill 23 will allow Piedmont to be able to maintain a 24 presence in that better demographic market in 25 North York County and also to allow them to
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1 need for treatment. With these tertiary 2 patients, the patients that will need highly 3 specialized services, are not likely to be 4 reversed for CMC-Fort Mill. In contrast, 5 Piedmont would have every incentive to keep 6 those speciality patients in the county. And 7 so I think that would be a positive in terms of 8 trying to build and strengthen the existing 9 speciality services that exist in the county. 10 That's really -- those two points are related, 11 my first and second point. 12 Q: All right. Let's talk about tax revenues. If 13 CMC-Fort Mill is approved, what about Fort Mill 14 Medical Center? 15 A: Well, I think certainly the tax revenues are 16 going to go up in two different ways. First of 17 all, if you have a taxpaying entity in Fort 18 Mill versus a not-for-profit entity in Fort 19 Mill, there is going to be income taxes and 20 business taxes and other types of taxes that 21 will be paid. And specifically, I think there 22 has been some testimony that property tax 23 associated with the proposed Fort Mill Medical 24 Center will be about \$4 million a year that 25 would go directly to York County. So there	1 retain some of those better paying patients who 2 require speciality services that would 3 otherwise be out-migrating into Mecklenburg. 4 So I think that would again be another positive 5 aspect of the approval of Fort Mill Medical 6 Center. 7 Q: Mr. Sullivan, when DHEC evaluates a CON 8 application or is competing to an application, 9 they rank the criteria in order of priority; 10 are you familiar with that? 11 A: I am. 12 Q: In this case where did DHEC rank adverse impact 13 in terms of priority about this? 14 A: Well, they had four tiers, if you will, of 15 priorities. And adverse impact was ranked on 16 the fourth tier -- the last, the lowest tier. 17 Q: All right. And the tiers would contain, in 18 some cases, multiple criteria? 19 A: That's true. 20 Q: All right. And where did -- and so they ranked 21 adverse impact in the fourth tier, you say? 22 A: Yes. 23 Q: Where did Ms. Brandt rank in terms of priority 24 accessibility of that criteria? 25 A: Well, it was in the second tier. But the first

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1 tier, the only criterion was consistency with 2 the state health plan, which I think Judge 3 Matthews addressed in an earlier decision. So 4 really accessibility now is in the second or 5 highest tier of the criteria that we were last 6 discussing. 7 Q: So would you conclude from that that DHEC 8 prioritized -- gave greater priority to 9 accessibility and a number of other criteria 10 than they did to adverse impact? 11 A: Yes. 12 Q: And do you believe from a health planning 13 perspective that was appropriate ranking or 14 not? 15 A: I don't. I mean -- first of all from a general 16 health planning perspective, I think the two 17 key factors in any health planning decision are 18 what's the benefit that's going to derive to 19 the community and what's the negative impact on 20 existing services in the community that would 21 result from approving it. 22 If we only looked at, for example, 23 accessibility, you know, that's often talked 24 about in CON hearings, you'd have a hospital in 25 every corner because that would be the way to	1 what this is before I interrupted you. 2 A: Sure, it's actually page Roman Numeral II-IX, 3 I believe, 2004-2005 State Health Plan. And 4 that's a section on acute care hospital beds. 5 Q: And you've excerpted some language there. 6 A: I have. And just focus on the last sentence. 7 "The benefits have improved accessibility but 8 will be equally weighted with the adverse 9 effects of duplication in evaluating 10 certificate of need applications for these 11 beds." 12 Q: All right. What is the significance of that 13 sentence with respect to this grant ranking or 14 prioritizing criteria? 15 A: Well, I think certainly this is pretty clear. 16 I mean not -- state health plan isn't always 17 this clear in terms of what the priorities are. 18 But in this case, I think it is pretty clear 19 that accessibility should be given the same 20 weight as adverse impact. 21 Q: Now, let's go back to your analytical framework 22 for discussing the pivot points, as you call 23 them, and Ms. Brandt's decision. We've been 24 talking about the first one. Are you done with 25 adverse impact and ready to move on?
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1 maximize accessibility. Now obviously that 2 would have tremendous negative impacts on the 3 existing providers if you started building 4 hospitals on every corner. And so I think 5 there is -- just from a general health planning 6 perspective, I think that there is -- impact 7 always has to be given a very high priority 8 right up there with accessibility and 9 improvements and other aspects of the 10 healthcare system. 11 Q: And health planning principles aside, what 12 about -- how does the state health plan address 13 this, South Carolina State Health Plan? 14 A: Well, there is an exhibit that shows an excerpt 15 from the South Carolina State Health Plan, the 16 section of the health plan that deals with the 17 addition of acute care beds. 18 Q: Well, let me stop you just a second. This is 19 labeled Piedmont Exhibit 8A, and I believe this 20 has been admitted, but I'm not positive. 21 MR. WESTBROOK: Is there objection to 8A? 22 MR. GASKINS: No objection. 23 THE COURT: It's been admitted. 24 MR. WESTBROOK: Thank you. 25 Q: All right. Piedmont Exhibit 8A, tell us again	1 A: I think probably everybody is done with that 2 and ready to move on. 3 Q: Okay. Let's move on to the second pivot point. 4 And tell us what that is. 5 A: It's now distribution, and this goes to the 6 issue of 100 versus 35-64 beds. 7 Q: And I believe you said that this was -- this 8 issue of maldistribution was introduced by CHS, 9 is that right? 10 A: That's correct. 11 Q: Okay. Why don't you elaborate on that. 12 A: CHS in its -- I believe in its July 2011 13 submission to DHEC had set forth an analysis of 14 bed-to-population ratios and divided the county 15 up into three regions; northern York, Rock 16 Hill and western York and then calculated the 17 number of beds per capita that would exist in 18 those regions as a result of one, the approval 19 of 100 beds at Fort Mill and two, with the 20 approval of 64 beds in Fort Mill. 21 MR. WESTBROOK: Let's go to demonstrative 149. 22 Q: And as Dan is doing and calling it out for us, 23 why don't you orient us here, Mr. Sullivan. 24 Let's start with the chart on my left. 25 A: Okay.

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1 Q: It says beginning Platt Exhibit 4; what is 2 that? 3 A: The chart on the left shows what was submitted 4 to DHEC back in July of 2011. 5 Q: All right, who's Platt? 6 A: Kathy Platt is a health planning consultant who 7 was working with CHS on their application. 8 Q: All right. And what is your relationship with 9 Kathy Platt? 10 A: We worked together for 18 years. When I 11 started my firm, she was the first employee I 12 hired. So I know Kathy very well. And so she 13 -- a few years ago we amicably parted ways. 14 And she has her own firm now. 15 Q: Good. All right. Tell us about Ms. Platt's 16 Exhibit 4 here. 17 A: What she did is she defined the population in 18 these three regions that I talked about; 19 northern York, western York and Rock Hill and 20 greater Rock Hill, I guess is the way she said 21 it, and then calculated how many beds would 22 exist per capita. And this is a fairly simple 23 calculation. If you divide the population into 24 the number of beds and then multiply it by a 25 1,000, that will give you the ratio. And based	1 faster there, but she still showed, you know, 2 that it would be almost twice as many beds per 3 capita in northern York than there would be in 4 the remainder of the county. I've got some 5 conceptual difficulties with this approach, but 6 let's kind of focus on her analysis for right 7 now. And I think there are some mechanical 8 issues in terms of how this analysis was 9 presented. 10 Q: Well, explain those mechanical concerns you 11 have. 12 A: Well, if we can go to the right-hand side of 13 this exhibit, and you will see at the top it 14 says Platt Exhibit 4 corrected based on 2012 15 projections. There are actually sort of two 16 corrections that were made to this or updates 17 if you will. I believe in the Platt Exhibit 4, 18 she did not include the population of zip code 19 29707. 20 Q: Is that just an oversight or do you know? 21 A: I don't know, but it wasn't included. I'm sure 22 she will be here to explain it at some point. 23 Q: And is 29704 a part of the Fort Mill primary 24 service area? 25 A: 707.
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1 on her calculation, northern York would have in 2 2010, 2.44 beds per 1,000 population. In 3 comparison, she added together Rock Hill and 4 western York and said that they would have 1.23 5 beds per 1,000. So that would be about twice 6 as many beds per capita in northern York than 7 there would be in the rest of the county. 8 Q: And that's if that was a 100-bed facility in 9 Fort Mill? 10 A: If there was a 100-bed facility. 11 Q: Now the point of this -- I mean, what was Ms. 12 Platt's point in this? 13 A: I mean, her stated point was that the approval 14 of 100 beds was too many. That it would create 15 a maldistribution of resources in York County, 16 and it would potentially restrict access to 17 inpatient healthcare services for residents and 18 other parts of York County if Piedmont were to 19 shift 36 additional beds to northern York. 20 Q: Right. And you just went over her calculations 21 for 2010. She projected that out in 2015, 22 right? 23 A: She did. And as you see, the ratios go down a 24 little bit. They go down faster in northern 25 York County because the population is growing	1 Q: 707 -- I'm sorry. 2 A: Yeah, it is. You know, I believe, it was that 3 zip code that was carved out. It's actually in 4 Lancaster County, but it's located immediately 5 adjacent to the site. And as a result, she 6 understated the population in northern York 7 County. In addition, at the time she did this 8 the census data was not out. And so we didn't 9 know what the actual population counts were 10 going to be in these various components of York 11 County. We now have the luxury of knowing 12 that. And what we see is that the population 13 in northern York is significantly higher. 14 Q: What was it and what did she estimate the 15 population in northern York to be here in her 16 chart here; do you recall? 17 A: Yeah, in 2010 there was about 41,000 and then 18 in 2011 about 48,000. 19 Q: Okay. 20 A: And so what we are looking at here is about 21 26,000 more in 2010 and about 31,000 roughly 22 additional population in 2015. 23 Q: All right. 24 A: So I mean, obviously having a different 25 denominator in the calculation results in

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1 different bed-to-population ratios. 2 Q: All right. 3 A: And so if we look at it now, if we look at the 4 beds of population, and let's look at all three 5 years for northern York, we can see that the 6 ratio in 2010 is 1.51. It goes to 1.25 and 7 then finally to 1.03 in 2020. You might ask me 8 why am I looking at 2020? 9 Q: Yeah. 10 A: The -- where we are today is 2013. Whatever 11 the decision that comes out of this, the 12 likelihood is that there is not going to be a 13 new hospital opening up in northern York County 14 before 2016 or 2017. So the third year of 15 operation could well be 2019 or 2020. And so 16 I think it's important to look at where we're 17 going to be when the new hospital is open. 18 Now, if we contrast these ratios with the 19 ratios for Rock Hill and western York together, 20 we can see there is really not as much 21 difference as Ms. Platt had found in her 22 exhibit. 23 Q: And the difference gets less and less with each 24 year, doesn't it? 25 A: It does. In 2010, the ratio -- it's a little	1 looks at the historical utilization of Piedmont 2 Medical Center and it projects that forward. 3 And there is nothing about the calculation of 4 bed need in the state health plan that has 5 anything to do with how many beds are needed in 6 northern York County. I mean, the 64 beds, 7 it's just an artifact of that methodology. And 8 so somehow I think somewhere along the line, 9 and I don't know where, it became that the need 10 in northern York County was 64 beds. Well, 11 that's not true. The need in northern York 12 County is based on the population of northern 13 York County and what their inpatient 14 utilization statistics and so forth are. And 15 so I think that what Ms. Brandt sort of latched 16 onto this particular analysis of what CHS did 17 and sort of bought into the notion that 18 northern York County only needed 64 beds. 19 Q: Well, let me ask you about that. In her 20 analysis did Ms. Brandt reference this 21 maldistribution analysis. And if so, how did 22 she reference it? 23 A: She did. She referenced the fact that this was 24 raised, and she agreed with that and said that 25 she had concerns, I think is what she said,
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1 bit higher bed-to-population ratio in northern 2 York. By 2015, it's almost equivalent and by 3 2020, the number of beds per capita is actually 4 less in northern York than it is in the rest of 5 the county. So to the extent that this 6 analysis has any meaning, and I think there are 7 some questions about that, this would show that 8 the approval of 100 beds in York County -- in 9 northern York County would not result in a mild 10 distribution of beds based on this framework. 11 Q: All right. So I think you said earlier before 12 you went into detail on this that you are 13 explaining here the concerns you have about the 14 mechanics of the analysis. And I think you 15 also had some reference that the whole 16 underlying analysis was flawed. Can you 17 explain that? 18 A: Sure. Let me go back to my PowerPoint. We 19 just talked about the first point, that it 20 relied on outdated population estimates and 21 projections. It sort of arbitrarily divides 22 the county into three areas. If we look at how 23 the state health plan calculates bed need, it 24 calculates it on a county-wide basis. It looks 25 at the whole population of York County. It	1 that there would be a maldistribution of 2 resources if 100 beds were to be approved in 3 northern York County. 4 Q: Did she ever see the corrected analysis with 5 the revised population on it? 6 A: She did not. 7 Q: Go ahead, I'm sorry, go ahead with where you 8 were. 9 A: And then, I guess finally there is an 10 underlying assumption in here that if the bed- 11 to-population ratio in Rock Hill is 1.25, that 12 is too few. And if it's 2.0 in northern York 13 County, that's too many. But there is no 14 underlying basis for that. You know, bed-to- 15 population ratios really don't tell you 16 anything. They just tell you how many beds 17 you've got in a given geographic area. They 18 don't tell you anything about the needs. If we 19 look at Piedmont Medical Center, they have 288 20 beds today in Rock Hill. 21 Q: Do they need 288 beds in Rock Hill? 22 A: They certainly don't need 288 beds, because 23 they have an average weighted census of about 24 180. So on an average day they have 108 empty 25 beds in Rock Hill. So if you said that -- if

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1 you look at the bed-to-population ratio today 2 in Rock Hill and that number was, let's say 3 1.5, that doesn't mean that there is a need for 4 1.5 beds. That just means that's how many beds 5 there are. 6 And so this bed-to-population ratio I 7 think assumes there is some sort of normative 8 value to a particular ratio, but it's never 9 been established as to what the right ratio 10 would be. In fact, this bed-to-population 11 approach was largely abandoned in the health 12 planning industry sometime in the eighties. 13 And, you know, when the first standards came 14 out one of the standards was there needs to be 15 four beds per thousand in every planning area 16 in the country. I think we've gone well beyond 17 that now and know that that sort of static 18 approach to health planning isn't realistic. 19 Q: Okay. Now, let's go to your next slide, I 20 believe, and what you just testified about the 21 number of empty beds on a given day or an 22 average day at Piedmont, can you elaborate some 23 more on that? 24 A: Sure. And, you know, probably the more 25 important point is what happens if you move 36	1 you look at? 2 A: Well, you know, I think traditionally in 3 certificate of need applications, you are 4 looking at a five-year planning horizon to sort 5 of establish the basic need for the circle. 6 But when you are talking about building a new 7 hospital, I mean, that costs many millions of 8 dollars, you are building a hospital for a 30- 9 or 40-year life, not a five-year life. It's 10 different from buying an MRI unit that might be 11 obsolete in seven years. It's different from, 12 you know, many other types of activities that 13 CONs are required for. So in a hospital, you 14 obviously have to make sure that in the short 15 term it makes sense. But you also have to look 16 at what the long-term needs of the population 17 are going to be in building something that is 18 going to address both the short and long-term 19 needs. 20 Q: When you look at the long-term needs of the 21 Fort Mill area or northern York County, which 22 size hospital better addresses those long-term 23 needs, a 64-bed hospital or 100-bed hospital? 24 A: In my view it would be the 100-bed hospital. 25 Q: Okay.
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1 beds from Piedmont? You know, if we know that 2 they have, on average, 108 empty beds, I mean 3 hospitals have spikes and utilization during 4 the year; flu season, whatever; some unusual 5 occurrence. Let's assume you transfer 36 beds 6 from Piedmont to Fort Mill Medical Center. 7 That would leave 72 empty beds on an average 8 day in the hospital. And right now with a 9 census of 180, let's say that there was a ten- 10 percent spike. That would be 18 additional 11 patients on that day. Let's say it was a 12 really bad day, it was a 20-percent spike. 13 Then that would be 36 additional patients. Or 14 a really significant spike would be 30 percent. 15 And then you would have 54 additional patients. 16 So even with the 36 beds gone you still have 17 significant flexibility in your bed capacity at 18 Piedmont to accommodate fluctuations and 19 utilizations that occur throughout the year. 20 Q: Which better addresses -- I'm sorry, let me 21 back up a second. As a health planner, based 22 on health planning principles, when you are 23 planning for a hospital, do you -- is it more 24 important to plan short term, long term, both? 25 How do you -- what kind of -- how many years do	1 A: You know, as I mentioned earlier, the 64-bed 2 need in the state health plan doesn't have 3 anything to do with the needs in northern York 4 County. Fort Mill is the fastest growing area 5 of York County overall. And if you're looking 6 at a rapidly growing area you've got a 7 population base, we saw, that was going from 8 about 66,000 people up to pushing 100,000 9 people by 2020. That is significant growth in 10 the area. And I think it's important to 11 recognize that when you build a facility there 12 are certain economies associated with building 13 a facility in one fell swoop as opposed to 14 constantly adding on to facilities over time. 15 It's disruptive and more expensive to have to 16 constantly modify and expand facilities in the 17 future. You know, when we look at the 18 projections that were done for CMC-Fort Mill, 19 I believe they are projecting that by the third 20 year they are going to reach 68-percent 21 occupancy in their 64 beds. That's -- 22 Q: I'm sorry, go ahead. What does that tell you? 23 A: Well, that says, you know, that for a facility 24 that size the 64 beds at 68 percent occupancy, 25 you are getting to the point where you have to

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1 think about adding more beds because once you 2 get to about 70-percent occupancy in a facility 3 that size you begin -- those spikes and 4 utilizations that I talked about become more 5 significant because if you've got 64 beds and 6 you are at 70 percent occupancy you've only got 7 an 18-bed cushion. And so the bigger the 8 facility the higher the occupancy rate can be 9 and accommodate, you know, fluctuations and 10 demands. 11 And so, you know, CMC's own projections, 12 and I think Presbyterian, when they were 13 involved, projected even higher utilization. I 14 think they projected 71 percent utilization by 15 the third year. So if you're building a 16 facility that is likely to need to be expanded 17 in the not-distant future, it would seem to be 18 a wiser health planning decision to go ahead 19 and build sufficient capacity now. 20 Q: And while we are on this subject of occupancy 21 rates, Piedmont's third-year occupancy rate is 22 58 percent, is that right? 23 A: That's true. 24 Q: Now, does that suggest to you that Piedmont -- 25 I'm sorry, not Piedmont, Fort Mill Medical	1 percent says we are going to be pretty well 2 utilized by the third year. We are going to be 3 economically justified based on the projections 4 that were in the application. But beyond that 5 we've got the ability to be able to serve the 6 needs of the population for a longer term than 7 just the first three or four years of 8 operation. 9 So I think from a health planning 10 perspective I think that is advantageous. 11 Q: All right. Anything else you would like to say 12 about the maldistribution issue? 13 A: No. 14 Q: All right. Let's go back. What is your next 15 so-called pivot point? 16 A: Unnecessary duplication. 17 Q: All right. 18 A: And this relates, again, to the 36 additional 19 beds that Piedmont was proposing. 20 Q: Why did you believe this was a pivot point in 21 Ms. Brandt's decision? 22 A: Well, because I think there are certainly two 23 aspects of my reasoning. The first is I think 24 she focused way too much on the 36 beds that 25 Piedmont was proposing to transfer. And the
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1 Center -- 2 A: Right. 3 Q: Fort Mill Medical Center's projected third-year 4 occupancy rate is 58 percent. Does that 5 suggest to you that Fort Mill Medical Center is 6 going to be underutilized? 7 A: It does not. 8 Q: And why not? 9 A: Well, first of all, 58 percent is not low 10 utilization in today's world. I looked at some 11 statistics in the South Carolina state health 12 plan, and I can't remember the exact number, 13 but a significant number of hospitals in South 14 Carolina operate well below 58 percent. 15 Hospitals can operate efficiently and 16 financially feasibly at 58-percent occupancy. 17 Let's suppose we were putting this facility 18 into an area that had a static population. You 19 might be more concerned about having 58-percent 20 occupancy because there would be no ability to 21 go beyond that. If we put this facility in a 22 high growth area like northern York County, we 23 know that the population is likely to continue 24 to expand and that there is going to be 25 increased demand in the future. And so 58	1 fact that those were already existing beds in 2 the county, so there were no new beds being 3 created. And secondly, you know, I think that 4 Piedmont demonstrated that at Fort Mill Medical 5 Center, those beds would be well utilized. 6 But secondly, I don't believe Ms. Brandt 7 took a look at the unnecessary duplications 8 that would occur between Fort Mill -- I mean 9 CMC-Fort Mill and CMC-Pineville. For reasons 10 I've already talked about earlier, the 2007 11 CMC-Pineville certificate of need application 12 justified the additional capacity they are 13 adding there based on York County residents. 14 And in my view the CMC-Fort Mill facility will 15 duplicate these facilities at Pineville. 16 So if you are concerned about unnecessary 17 duplication, here is a brand new major 18 expansion project for a hospital located on the 19 border of the county. Now, Ms. Brandt doesn't 20 have any authority to review North Carolina 21 hospitals, but she certainly can look at -- and 22 this issue was raised in the review process. 23 It was raised somewhat prominently by 24 Presbyterian that this would be duplication of 25 resources that existed at Fort Mill -- I mean

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1 at Pineville. And Ms. Brandt gave no 2 consideration of that. 3 Q: Okay. Now, you talked already to some extent 4 about the effect that CMC-Fort Mill would have 5 on Piedmont's specialty programs. How does 6 that relate to the concept of unnecessary 7 duplication? 8 A: Well, we've already heard testimony about all 9 the investments that Piedmont Medical Center 10 has made in the specialty programs over time 11 and the recruitment and the facilities that 12 were constructed. We talked about the fact 13 that CMC-Fort Mill is likely to redirect at 14 least some of these specialty patients to 15 programs in North Carolina. And so the 16 declining utilization of these services at 17 Piedmont that would likely be exacerbated by 18 the CMC-Fort Mill project in my view is another 19 form of unnecessary duplication because it 20 means these services that are already in place 21 are going to be underutilized for the benefit 22 of hospitals in North Carolina. 23 Q: All right. Are we ready to move to your next 24 pivot point? 25 A: I think we are.	1 actually get paid. 2 Q: Okay. All right. That is just by way of 3 context. All right. Why do you think the 6.3 4 percent of their charges that CMC-Fort Mill 5 projects, what do you think that number is? 6 A: Well, first of all, Mr. Levitt, I think, showed 7 an exhibit and showed what the charity care 8 commitments were at other applications that 9 DHEC has approved. And I won't go into that 10 exhibit again. But that shows that this 11 projection was the highest of all the 12 applications by a wide margin. So it is 13 inconsistent with what DHEC has looked at in 14 the past. But sticking with the demographics 15 of northern York County, I believe the exhibits 16 Mr. Levitt introduced showed that York County 17 was one of the more affluent counties in South 18 Carolina and northern York was the most 19 affluent portion of York County. So you 20 wouldn't expect there to be a significant 21 number of indigent patients living in northern 22 York County. So I think that's a concern. 23 It's also inconsistent with data that I've 24 reviewed about the payer mix status of 25 individuals in northern York County. And I've
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1 Q: All right. What is your next pivot point? 2 A: It is financial access. 3 Q: Financial access. All right. With respect to 4 this topic, what is your opinion about CMC-Fort 5 Mill's projection of charity care? 6 A: Well, I mentioned earlier that they projected 7 6.3 percent charity care. 8 Q: And that is 6.3 percent of what? 9 A: Of gross patient revenue. 10 Q: What is gross patient revenue? 11 A: Well, that is the actual charges that are made 12 to patients. I think there has already been 13 some discussion about this, but hospitals 14 charge patients based on a number of factors. 15 But they rarely ever collect what they charge. 16 Medicare and Medicaid have established 17 reimbursement policies, and they pay 18 significantly less than the list charges, if 19 you will. Even commercial carriers, managed 20 care companies, they negotiate deep discounts 21 on charges in their managed care contracts with 22 providers. 23 So, I mean, the charges are -- they serve 24 a purpose, but they don't have a whole lot to 25 do with the amount of money that hospitals	1 got a couple of slides that address that. And 2 the data that we have comes from the South 3 Carolina Office of Research and Statistics and 4 from -- North Carolina has a system called 5 Thompson Reuters. Actually, I think the name 6 has changed now to Nelson or something. But 7 they collect information by zip code. And so 8 we can look at the zip codes. And if you look 9 at the bottom of this chart the three zip codes 10 in northern York County are highlighted. And 11 we can see that in terms of Medicaid services 12 these are people who fall below certain income 13 levels, which would be low income individuals. 14 Only 7.9 percent of the patients served in 15 hospitals from those three zip codes were 16 Medicaid recipients. 17 Q: And Medicaid is not charity care, though, 18 right? 19 A: It's not charity care, but it's an indicator of 20 the level of low income individuals in your 21 area. 22 Q: All right. 23 A: And in the rest of York County the Medicaid 24 population is 16.4 percent. So it's more than 25 double. So you wouldn't expect there to be a

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1 disproportionate amount of Medicaid, for 2 example, in northern York County in looking at 3 these statistics. 4 And then if we look at another measure. 5 And this is self-pay and charity. This is how 6 the data is reported. These are people without 7 insurance. Some of them are what is called 8 self-pay. They might have incomes above 9 poverty levels, you know, that would put them 10 in the charity category, but they don't have 11 health insurance. And then there are also 12 people who are charity patients who would be 13 those who met criteria to qualify for free 14 care. 15 Q: All right. 16 A: And again, Fort Mill, for both self-pay and 17 charity was only 5.5 percent. Now, I don't 18 know what the exact percentage of charity 19 versus self-pay is. But in other measures that 20 I've seen those numbers are generally roughly 21 equivalent. So about half or -- you know, 22 roughly half would be charity and half would be 23 self-pay. 24 Q: All right. And so if that were true here, and 25 I realize you said you don't know, but if that	1 Q: Okay. Let me stop you there for a minute. 2 What are Medicare cost reports? 3 A: The federal government requires that all 4 providers who participate in the Medicare 5 program annually submit a very detailed report. 6 I mean, for hospitals it is literally a report 7 that is very thick, and it has many many 8 schedules. And it breaks down in great detail 9 the revenues and expenses associated with each 10 department, you know, in a hospital. And 11 ultimately -- I mean, at one time it was very 12 very important because you got -- hospitals got 13 paid their actual costs in treating Medicare 14 patients. Now it's more indirectly associated 15 with reimbursement, but it goes -- it is also 16 used by the federal government in calculating 17 reimbursement rates. 18 Q: When a hospital or another provider submits a 19 Medicare cost report, do they have to sign any 20 kind of certifications with the government? 21 A: They do have to certify the accuracy of it. 22 And in fact, there are both civil and criminal 23 penalties associated with falsifying 24 information on cost reports. 25 Q: All right. Go ahead and explain your charts
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1 sort of rule of thumb were to be applied, half 2 of 5.5 percent would be what? 3 A: 2.75 percent. 4 Q: And you would expect the charity care 5 population in the Fort Mill area to be around 6 that level? 7 A: Sure. I mean, that would be a reasonable 8 expectation. When we look at the rest of the 9 county we see that the charity care self-pay 10 levels are 9.5 percent, so not quite double, 11 but significantly higher than they are in 12 northern York. 13 Q: All right. What about Pineville, the 14 experience of CMC-Pineville? 15 A: Well, based on the data I have reviewed, it 16 looks like the charity care experience, and 17 they can put them with Pineville's experience, 18 as well. 19 Q: Do you mean charity care projections? 20 A: Charity care projections are inconsistent with 21 the historical experience at CMC-Pineville. 22 Q: All right. And what is the Demonstrative 200 23 here, what does that say? 24 A: This is information taken from Medicare cost 25 reports.	1 then. 2 A: Okay. There is a table in the cost report that 3 I think is S10 that shows the dollars of 4 charity care, gross revenue dollars of charity 5 care that are provided. It shows the total 6 gross revenue of the facility so you can 7 calculate the percentage of charity care -- of 8 gross revenue for each of the hospitals. And 9 so we looked for each of the CMC facilities and 10 then we also looked at Piedmont. And we see 11 that Mercy-Pineville, and let me qualify this 12 in one respect. Pineville isn't broken out 13 separately from CMC-Mercy downtown. 14 Q: And CMC-Mercy downtown is another hospital? 15 A: It is. It's another hospital, but they operate 16 under a single license, as I understand it. 17 And they file a consolidated cost report. 18 Q: All right. 19 A: Certainly Pineville is a significant component 20 of that dual operation, but I don't have a 21 specific breakdown for Pineville only. But if 22 you look at the combined charity care for 23 Mercy-Pineville, it's 2.6 percent. That is 24 close to that 2.75 we were talking about a 25 minute ago. And even if we assume that

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1 Pineville was a little higher than Mercy 2 downtown, and I don't have any reason to think 3 that is the case. I mean, you would think 4 downtown where there is a higher indigent 5 population it would likely be a little bit 6 higher. But I don't think it's 6.3 percent. 7 And so, you know, Pineville's own experience is 8 2.6 percent. Piedmont, if we look on here, is 9 3.8 percent. So they had a little higher 10 experience. But that's because they serve all 11 of York County, which has somewhat different 12 demographics than the Fort Mill area. And the 13 area across in Southern Mecklenburg County is 14 similar in terms of being sort of a high growth 15 suburban area with somewhat higher income 16 characteristics. 17 Q: Now, you read Ms. Brandt's deposition; did you 18 not? 19 A: I did. 20 Q: And when she was considering the charity care 21 projections at CMC-Fort Mill based on her 22 deposition, what weight did you give historical 23 experience of Mercy and Pineville? 24 A: She gave none. 25 Q: And after a CON facility, like a new hospital	1 Then finally when I look back at the 2005 2 application that was submitted for Fort Mill by 3 CMC, they had, I think, 3.5 percent projected 4 charity care there. And so their projection 5 now is nearly double of what they projected 6 initially. 7 So in sort of taking all that together, if 8 I were DHEC, I might have questioned how much 9 weight would I give to a 6.3 percent projection 10 of charity care in the CMC-Fort Mill 11 application. 12 Q: The updated applications from the -- or updated 13 submissions from the three parties following 14 the remand were in October of 2010, is that 15 right? 16 A: Well, they were for Presbyterian and for 17 Piedmont. For some reason, CMC-Fort Mill did 18 not file. They completely filed their updated 19 application in December. So they had an 20 opportunity to see the changes that were made 21 in the other two applications. 22 Q: And when you say they didn't file their updated 23 application, do you mean they didn't file their 24 charity care projections specifically in 25 October of 2010?
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1 is built, how does DHEC go back -- to what 2 extent does DHEC go at that point and check and 3 make sure that the charity care facility is 4 actually providing, is consistent with 5 projections they gave in their CON application? 6 A: There's no check that goes on. I mean, Mr. 7 Grice testified that was the policy when he was 8 in that position. And I believe Ms. Brandt in 9 her deposition also indicated that she made no 10 check after that, that they did not do 11 anything. 12 Q: Go ahead with where you were. I'm sorry. I 13 interrupted you. 14 A: So if we look at Pineville's experience, which 15 I think would probably be the most directly 16 relevant measure of what the likely charity 17 care percentage would be at a Fort Mill 18 facility, it would be less than half of what 19 was projected for Fort Mill. And then if we 20 look at again, the payer mix of the Carolina 21 Physician's Network Physicians, as I've already 22 discussed, they have relatively low levels of 23 Medicaid and charity care in their practices. 24 So there is nothing there that would indicate 25 that 6.3 percent would be reasonable.	1 A: That's true 2 Q: When did you say they filed? 3 A: In December of 2010. 4 Q: Now, when did Presbyterian file its charity 5 care projections for the second go round? 6 A: October 2010. 7 Q: And Presbyterian -- what did Presbyterian and 8 Carolinas project back in 2005 and what did 9 Presbyterian project in October 2010? 10 A: I believe Carolina's was 3.5 and Presbyterian's 11 was around 3.2 or 3.3. 12 Q: That was back in 2005? 13 A: In 2005. In 2010 in October, Presbyterian 14 projected six percent, which was quite a 15 significant jump in its projection. And then 16 in December of 2010, CMC-Fort Mill projected 17 6.3. 18 Q: Mr. Sullivan, if between 2005 and 2010, if CHS 19 changed its charity care policy to cover a 20 broader range of incomes, would that account, 21 in your opinion, for the charity care 22 projection going from 3.5 percent to 6.3 23 percent? 24 A: I mean, it's possible. And we saw in 2011 that 25 change -- if that change occurred before 2011,

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1 it didn't have the significant impact on the 2 percentage at Mercy Pineville. But if indeed 3 they had a change in policy after 2011, which 4 would have been after they filed their updated 5 application in this case, they -- it wouldn't 6 change the number of people in the community 7 who need charity care. It would change the 8 bookkeeping in terms of how they counted self- 9 pay patient versus charity care patients. So 10 I don't think that's really -- if they are 11 already serving the patients and they're just 12 putting them in a different pot than they were 13 before, I don't see that really being an 14 expansion of assets. 15 Q: What about Piedmont's record on charity care? 16 A: Piedmont has a pretty longstanding record of 17 providing financial access in York County. I 18 think we saw a minute ago that their charity 19 care percentage in 2011 was 3.8 percent. 20 Piedmont has a contract with the county to 21 provide charity care. That contract is going 22 to extend to Fort Mill Medical Center, as we've 23 heard testimony about. Piedmont consistently 24 exceeded the charity care requirements in the 25 contract. I think they've been a pretty	1 A: And -- 2 MR. WESTBROOK: Let's go to that slide, please. 3 A: The first statement I make is that Ms. Brandt 4 made comparative findings regarding these 5 financial aspects of the project, which I don't 6 think the CON criteria really support. I think 7 the CON criteria are asking whether the 8 applicant has presented reasonable projections 9 of financial performance that are consistent 10 with other projects that DHEC has reviewed. I 11 don't think it is necessarily a step that DHEC 12 had to take to say well, I think this applicant 13 was better on this point and this point. I 14 think it is more do these applicants provide 15 sufficient documentation that their financial 16 programs that they've set forth are reasonable. 17 This is one where I think that DHEC could have 18 looked at this sort of broadly and are both 19 applicants consistent or is one of them not 20 consistent with the criteria. And my reading 21 of Ms. Brandt's decision is that both 22 applications were consistent with all the 23 criteria, she just liked CMC-Fort Mill's 24 numbers better. 25 Q: All right. What's your next bullet point to
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1 accessible organization. And Piedmont in 2 preparing the Fort Mill Medical Center 3 application, came up with a projection of 4 charity care. I think it's realistic for the 5 needs of that population consistent with their 6 experience and also consistent with the 7 demographics of that area. 8 Q: That was a 3.5 percent, you said? 9 A: 3 percent, I think. 10 Q: 3 percent -- I'm sorry. 11 A: And so, I mean, as a result, this is one of 12 those where Ms. Brandt gave favorable 13 consideration to CMC-Fort Mill. I think this 14 is one where she should have said both of these 15 projects will provide the same level of 16 financial accessibility. There is no reason to 17 differentiate. 18 Q: All right. Anything else you want to talk 19 about on the issue of financial access? 20 A: I don't think so. 21 Q: All right. What is your next pivot point in 22 this, Mr. Sullivan? 23 A: This gets into the financing -- in financial 24 projection issues. 25 Q: All right.	1 address? 2 A: She -- you know, one issue that I thought was 3 unusually prominent in the decision was where 4 she was talking about the methods of advancing 5 proposed by these applicants, and she gave CMC- 6 Fort Mill favorable consideration because she 7 said they proposed a more definitive form of 8 project financing, in that CMC-Fort Mill said 9 that they were going to use cash reserves to 10 finance their project. 11 Now, Piedmont had a letter for the Fort 12 Mill Medical Center application that stated 13 that they had access to both debt and equity 14 financing and that they would use the 15 appropriate mix of financing at the time the 16 project was developed. I've been putting 17 together CON applications for 30-plus years. 18 That's a pretty common approach to take in 19 presenting financial documentation in CON 20 applications. 21 Q: And why is that a common approach? Why would 22 it be reasonable to present options? 23 A: I mean, market conditions change quite rapidly 24 in the financial world. And, you know, right 25 now we are in a period of very very low

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1 interest rates. Right now it might make sense 2 to say we would use debt financing. But by the 3 time you're ready to go with the project, the 4 feds may have changed its policies and interest 5 rates may be 2 or 3 percent points higher. And 6 you decide at that point to use cash. So, you 7 know, I think it's important to give the 8 applicant the flexibility of being able to use 9 the type of financing that is most appropriate 10 at the time. 11 Q: And, in fact, what kind of financing did 12 Presbyterian propose? 13 A: The same as Fort Mill Medical Center. They 14 proposed to use either debt or equity depending 15 on the circumstances. And so this is one 16 where, again, I think Ms. Brandt gave favorable 17 consideration to the CMC-Fort Mill when I think 18 a more appropriate finding would have been that 19 both have demonstrated the ability to finance 20 their projects. 21 Q: All right. What about project costs? 22 A: This is related to the 100 bed, 36 additional 23 bed issue. She found that CMC was the most 24 favorable because they proposed lower project 25 costs because they're building a smaller	1 patients that would go to other facilities 2 besides CHS facilities. I don't think that has 3 anything to do with the reasonableness of their 4 financial projections. So again, this is -- 5 you know, my bottom line is I think both 6 applicants have presented reasonable financial 7 programs in their applications. And I think 8 the finding should have been that both 9 applicants were consistent with these criteria. 10 Q: All right. Are you finished now going through 11 what you call the pivot points of Ms. Brandt's 12 decision? 13 A: I am. 14 Q: All right. Let me ask you this. With respect 15 to that group of five, I believe it's five 16 pivot points that you just talked about, I 17 believe you identified these as when you 18 consider the pivot points in her analysis. 19 What is, in your analysis, key pivotal point 20 decision making between these two applicants? 21 A: In my analysis, it's adverse impact. 22 Q: And why is that? 23 A: You know, I think that both applicants were 24 proposing to build a new hospital in Fort Mill. 25 So access is somewhat neutral. I think the
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1 facility. But if you look at it in terms of 2 cost per bed, cost per square foot, the Fort 3 Mill Medical Center was actually slightly less 4 than the CMC-Fort Mill project. So this is 5 where the need argument gets tangled up in the 6 financial evaluation argument. But I think 7 that, again, Mr. Levitt showed an exhibit that 8 showed what the project costs for a whole range 9 of different new hospitals that were approved. 10 And these applications are well within the 11 midpoint of that range. So I think, again, a 12 finding should have been that these projects 13 were both consistent with its criteria. 14 Q: All right. Ms. Brandt also gave consideration 15 to what she believed were conservative 16 assumption by CHS, is that right? 17 A: She did. She said that she thought that the 18 projections of revenues and expenses made by 19 CMC-Fort Mill were more reasonable because they 20 were based on a conservative assumption that 21 CMC-Fort Mill would only shift patients from 22 existing CHS facilities. I won't go again into 23 why I don't think that's a conservative 24 assumption or a realistic assumption. I think 25 CMC-Fort Mill is clearly going to serve	1 Fort Mill Medical Center is superior in the 2 sense that it's a larger facility and will meet 3 the longer-term needs. But in terms of access, 4 in terms of cost, in terms of financial 5 projections, financial access, I think all 6 those things are relatively neutral between the 7 two applications. 8 But when we look at adverse impact without 9 going through all my testimony again, I think 10 there is a significant potential for the 11 approval of CMC-Fort Mill to have a negative 12 impact, not just on Piedmont, but on the 13 healthcare system in York County. And I think 14 that should have been giving great weight in 15 the decision because I think that goes directly 16 back to the purposes of the CON. 17 Q: All right. Good. Let's go to an issue that I 18 don't believe Ms. Brandt addressed at all. And 19 that's the issue of competition. In your 20 opinion, would approval of CMC-Fort Mill 21 enhance competition? 22 A: In my opinion, it would not. 23 Q: Why not? 24 A: First of all, competition is already strong in 25 the county. Right now more than 40 percent of

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1 the patients receiving inpatient hospital care 2 are leaving York County to receive that care. 3 So obviously options exist and patients are 4 exercising those options. CHS has made one 5 very convenient by building a large hospital on 6 the border of York County at CMC-Pineville. In 7 the -- if we looked specifically at the Fort 8 Mill area, you know, if there is a question 9 about whether competition exists in the Fort 10 Mill area, I believe that testimony we've heard 11 so far, and I think we will hear from the CHS 12 witnesses, is that CHS is the dominant provider 13 in Fort Mill. They have something like 60 14 percent market share in those zip codes. So 15 they already have a relatively dominant 16 position there. This is not -- 17 Q: What about the larger market outside the Fort 18 Mill area, the larger Charlotte area. Who is 19 the dominant provider? 20 A: Well, if we look at more broadly, I mean -- I 21 think that CHS is by far the largest hospital 22 system in the broader Charlotte market. There 23 was a number of -- there were a number of 24 documents in the submissions to DHEC that 25 talked about the issue of market dominance and	1 having a hospital here is going to allow them 2 to gain even greater leverage in the market 3 than they already have, which is already 4 significant. So from a competitive standpoint 5 Piedmont has hung on for a long time through 6 its efforts. CHS has taken a big step in the 7 last seven years to come in and dilute the 8 level of volume at Piedmont. And giving this 9 hospital to CHS and Fort Mill, I think could be 10 the tipping point, if you will, in terms of 11 significantly destabilizing the healthcare 12 system in York County and resulting in more 13 people leaving the county for care. So I 14 think, if anything, this will just extend the 15 existing dominant position that CHS has further 16 into York County, not to the benefit of York 17 County residents. 18 Q: Thank you, Mr. Sullivan. I don't have any 19 other questions. 20 THE COURT: Thank you, Mr. Westbrook. Any 21 objections to the ten-minute recess? 22 MR. GASKINS: No, Your Honor. 23 (Off the Record) 24 THE COURT: Please be seated. Are you ready? 25 MR. GASKINS: Yes, sir.
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1 so forth. And Presbyterian, I think, pressed 2 this issue. I think there are 21 hospitals in 3 the Charlotte area. Eighteen of them are 4 controlled by either Novant or by CHS. 5 Q: And who is Novant? 6 A: Novant is Presbyterian. That's their parent 7 company. Piedmont is one of the little guys. 8 They are one of the three unaffiliated 9 hospitals in the market. And so they are 10 already facing a significant challenge in 11 trying to compete. I mean, even though they 12 are part of Tenet Healthcare, which is a 13 national company, Tenet doesn't have the 14 resources in this market, doesn't have the 15 reach in this market, it doesn't have the 16 physician network in this market that CHS does. 17 And so they are already struggling to compete 18 and to maintain their services in York County 19 so that they can effectively serve York County 20 patients. And in my view, the CHS project is 21 just going to further weaken that with all the 22 reasons we've already talked about. It's going 23 to allow CHS to strengthen its physician 24 network. And given that CHS is now entering 25 into the payer or the health insurance market,	1 MR. SULLIVAN - CROSS EXAMINATION BY MR. GASKINS: 2 Q: Good morning, Mr. Sullivan. 3 A: Good morning. 4 Q: As I understand it, you were retained by Tenet 5 or Piedmont in the summer of 2012, is that 6 correct? 7 A: True. 8 Q: Okay. I take it you are being paid for your 9 engagement, is that correct? 10 A: I am. 11 Q: And what is your hourly rate? 12 A: \$325. 13 Q: Now, you were engaged by Piedmont back, I 14 think, in late 2004 or early 2005 when they 15 initially submitted their application; were 16 you? 17 A: There may have been a contact at that time, and 18 I think I declined getting involved. 19 Q: So there was a contact from Piedmont? 20 A: My recollection, yes. 21 Q: But they never engaged you at that time? 22 A: Yes, that's correct. 23 Q: Rather you were engaged by CHS; isn't that 24 correct? 25 A: No. CHS had asked me also about getting

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RECORD 001164

1 Q: But you didn't identify those errors when you
2 reviewed it; did you?

3 A: I did not. I had not -- I did not go through
4 and redo the calculations.

5 Q: I believe you got into what you thought the
6 adverse impact would be, not only on Piedmont
7 but also on the healthcare system in York
8 County in general, is that right?

9 A: That's true.

10 Q: Okay. And you said that you had some fears
11 that Piedmont would have to cut some of the
12 services that they currently provide, is that
13 right?

14 A: That's true.

15 Q: And generally speaking that they will have to
16 cut the services when the volume level gets to
17 the point where either the quality decreases
18 and they can't handle it or because it's just
19 not economically feasible, is that right?

20 A: Right. I think that at some point the doctors
21 will not want to perform procedures there if
22 the volumes get too low. And obviously if it
23 is a very expensive service to maintain and
24 there is not sufficient patients, ultimately it
25 probably will have to be discontinued.

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1 MR. SULLIVAN - RE-DIRECT EXAMINATION BY MR.

2 WESTBROOK:

3 Q. Thank you, Your Honor. Just a few. Mr.
4 Sullivan, in the initial application, 2005
5 application for CHS, I believe you said you
6 reviewed that, is that right?

7 A: I didn't -- at the time of my deposition, I
8 didn't recall having done that. I mean, having
9 seen the proposal and so forth, obviously I
10 did.

11 Q: Okay. And of course, you reviewed the updated
12 CHS application, is that right?

13 A: Oh, yeah.

14 Q: And you testified at length today about the
15 updated application, is that correct?

16 A: Yes.

17 Q: Are your opinions based on the updated
18 application or based on the original
19 application primarily?

20 A: The updated application. There were
21 significant changes.

22 Q: All right. And for example, in the original
23 application, did CHS propose to shift all of
24 the patients that would be served at CMC-Fort
25 Mill from their existing facilities? Was that

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1 part of the original application?

2 A: It was not. The original application talked
3 about there being an impact on Piedmont and
4 other North Carolina hospitals.

5 Q: All right. Actually in terms of comparing the
6 original adverse impact of the original
7 projections from where their patients would
8 come from with their updated applications,
9 which were the more recent in your opinion?

10 A: The original application.

11 Q: Mr. Gaskins asked you about some of the South
12 Carolina hospitals that you had done work for.
13 And I believe you testified on direct about
14 some of those. Have you worked with Waccamaw
15 Community Hospital?

16 A: I did.

17 Q: That was a new hospital project; was it not?

18 A: For Georgetown, yes.

19 Q: All right. Now, I believe Mr. Gaskins also
20 asked you about your past work for Tenet
21 Corporation. Did I understand you to say
22 identifying in addition to this project that
23 there had been two or three other projects you
24 had worked on with Tenet in the past?

25 A: I mean, over the course of my whole career

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1 there has been many more. But, I mean, in
2 recent years there is only one other hospital
3 I can recall having worked for in say the last
4 six or seven years.

5 Q: Have you ever been affiliated exclusively with
6 Tenet or primarily with Tenet?

7 A: No.

8 Q: Have you worked with other large hospital
9 systems for profit and nonprofit around the
10 country?

11 A: I've worked with many, yes. Just in the last
12 year I've worked with four or five of the
13 largest hospital corporations.

14 Q: All right. Let me ask you to look back at your
15 deposition in a question or two that Mr.
16 Gaskins was asking about that day.

17 **MR. WESTBROOK:** Dan, can you pull up Mr. Sullivan's
18 deposition, page 55?

19 Q: And let's go over some of the language that Mr.
20 Gaskins had you read on page 55. That
21 paragraph that begins on line 13, I don't think
22 we need for you to read the whole paragraph.
23 But in particular, why don't we start that line
24 halfway through 17 where the sentence begins,
25 "so I knew." Do you see where I'm talking

1 about?

2 A: I do.

3 Q: Would you just start reading "so I knew" down
4 to through the rocket scientist part of that
5 paragraph.

6 A: Sure. "So I knew that they were already in a
7 difficult spot and then putting a competing
8 hospital seven or eight miles away from
9 Piedmont, I mean, I don't think you have to be
10 a rocket scientist to figure out that wouldn't
11 be an ideal situation."

12 Q: All right. Your comment about the rocket
13 scientist there and that they would be -- that
14 Piedmont would be in a heck of a situation. I
15 need for you to clarify that a little bit.
16 Were you saying that you didn't have to be a
17 rocket scientist to know what DHEC was going to
18 do or you didn't have to be a rocket scientist
19 to know that PMC was going to suffer some
20 adverse impact?

21 A: What I meant was the latter. That you wouldn't
22 have to be a rocket scientist to know that
23 putting a new hospital that close to the
24 existing Piedmont Hospital would result in
25 negative impact.

1 Q: And, in fact, in the newspaper interview, you
2 said you didn't know what DHEC was going to do
3 because they hadn't made a decision at that
4 point, is that correct?

5 A: That's correct. You know, and I knew they had
6 a new director. And I didn't know what they
7 were going to do. I mean, my expectation was
8 that just because Piedmont had been approved
9 before and they were the South Carolina based
10 provider, that they would probably get
11 approved.

12 Q: And that new director that you are talking
13 about, that's Ms. Brandt, right?

14 A: Yes.

15 Q: And she had just been appointed a year or two
16 before that newspaper interview?

17 A: Yes.

18 Q: And had you had a lot of experience in working
19 with Ms. Brandt at that point?

20 A: I think I only had maybe one conversation with
21 her.

22 Q: With respect to Mr. Gaskins' questions about
23 physician recruitment and the building of
24 physician networks. I believe there has been
25 testimony by you and others about this. I

1 would like for you to elaborate if you could.
2 Isn't the primary purpose of building a
3 physician network --

4 **MR. GASKINS:** Your Honor, I'm going to object. He
5 is leading the witness.

6 **MR. WESTBROOK:** Okay. I'll rephrase my question.

7 **THE COURT:** Sustained. Go ahead. Will you
8 rephrase, please, Mr. Westbrook?

9 **MR. WESTBROOK:** Sure.

10 **Q:** For building up -- the purposes for building up
11 a physician network, can you relate those
12 purposes to the concept of market share,
13 please?

14 **A:** Sure. If you have a large base of physicians,
15 and the physicians are inclined to use your
16 facilities for their patients, then having more
17 physicians gives you the ability to capture
18 more market share. If you have -- and that's
19 if they are employed or otherwise contractually
20 obligated to, you know, primarily use your
21 services. If you have -- if you recruit
22 physicians who are independent physicians,
23 there is another way of developing a network.
24 That's less effective in developing an
25 increasing market share because let's say a new

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1 hospital were built, those independent
2 physicians would likely seek privileges of that
3 new hospital. And even though you may have
4 recruited them to the area, they were not
5 necessarily going to come to your hospital and
6 wasn't going to make any significant
7 improvement in your market share.

8 Q: All right. Thank you. Now, with respect to
9 another objective, the objective of serving
10 patient needs. Is there an advantage -- that's
11 -- with that purpose in mind, is there an
12 advantage to an independent physician network
13 versus an employed physician network? Is there
14 an advantage, disadvantage or at all?

15 A: Yeah. It's a good question. I mean, it's an
16 intention that's going on in the healthcare
17 industry right now that, you know, and I
18 believe it was Dr. Taylor that said that he
19 thought the system worked better when the
20 physicians were independent. And I don't
21 disagree with that because the physician can be
22 the advocate for the patient. And when they
23 are employed by a healthcare system, their
24 loyalties are a little different. I am not
25 saying that doctors are making bad decisions,

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1 but they make different decisions. But the
2 direction that healthcare is going in is
3 further consolidation of physician practices
4 and hospitals into networks. But I think there
5 is a dilemma in terms of whether the patient's
6 needs somehow get overlooked in that process.

7 Q: All right. Mr. Gaskins referred to utilization
8 leveling out or even an up-tick, I believe was
9 the term he used in the last or recent years.
10 Do you recall that question?

11 A: I do.

12 Q: With respect to utilization at Piedmont
13 leveling out or there being a slight up-tick in
14 a couple of years, how is the -- I mean, how
15 is the payer mix break down on that up-tick?

16 A: I believe the testimony that we heard was that
17 there has been increasing levels of self-pay,
18 Medicaid and Medicare and a decrease in the
19 level of commercial/managed care type of
20 insurance. So as I mentioned in my direct
21 testimony, I view that as an erosion of the
22 payer mix in that it is a less profitable mix
23 of patients.

24 Q: Now, there was some -- you testified about that
25 you would give greater weight to a physician

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1 coming to a courtroom taking an oath and
2 testifying and subjecting himself to cross
3 examination than you would to a physician
4 writing a letter. I assume -- would that be
5 true for any witness, not just physicians?

6 A: Sure. You know, I think it's easy to write a
7 letter. It's harder to come and take your time
8 and put yourself on the line and subject
9 yourself to examination.

10 Q: And you talked about your experience with
11 physicians signing form letters or letters that
12 have been drafted for them. Have you reviewed
13 the support letters submitted for Piedmont by
14 independent physicians in this case?

15 A: I have.

16 Q: Did they appear to you to be form letters?

17 A: They did not. You know, and I had an
18 opportunity to talk individually with a lot of
19 the guys who wrote support letters for
20 Piedmont. And it seemed to me that they had
21 been written independently and not, you know,
22 not basically authored by someone else.

23 Q: Now, with respect to the sixth addendum to the
24 York County contract, Mr. Gaskins has asked you
25 some questions about that, relating that to Mr.

1 Miller's testimony about negotiations with CHS.
2 My question is do you know the extent to which
3 that sixth addendum was the result purely of
4 negotiations with CHS or were there other
5 factors involved; do you know?

6 A: I don't know.

7 Q: I believe you have already testified about the
8 effect of either Fort Mill Medical Center or
9 CMC-Fort Mill on physician recruitment in this
10 area on direct?

11 A: I did.

12 Q: All right. Well, I won't ask you to go through
13 that again. And I believe Mr. Gaskins asked
14 you whether -- whichever applicant gets to
15 build a hospital, I believe you testified would
16 have some impact on out-migration, is that
17 right?

18 A: Yes.

19 Q: Can you quantify or explain what you mean by
20 some impact? Can you be more specific? What
21 level of impact do you think a hospital --
22 well, let's start with CMC-Fort Mill. What
23 level of impact would CMC-Fort Mill, if it were
24 to be built, how about out-migration?

25 A: I think it would bring back some of the out-

1 migration --

2 Q: I'm sorry -- CMC-Fort Mill. Let's start with
3 that one.

4 A: Okay. CMC-Fort Mill. I think some of the
5 patients who are going to Pineville now, I
6 think some of those will stay and go to the
7 Fort Mill facility. I think also some patients
8 who are now going to Piedmont will go to that
9 facility. So, you know, I think it will have
10 some impact. And I haven't -- I can't give you
11 an exact number of patients. Now, if we
12 contrast that with Fort Mill Medical Center, I
13 think their sole focus is going to be on trying
14 to attract patients who are currently leaving
15 the area. That undoubtedly will serve some
16 patients who otherwise would have gone to
17 Piedmont, as well. But I think their effort is
18 going to be in developing a network of
19 physicians and services that would be
20 attractive to patients who right now are
21 choosing to leave the county for care.

22 Q: All right. And will -- Mr. Gaskins asked you
23 a number of questions about competition. And
24 I think you testified about this on direct.
25 Can you summarize again for us in light of his

1 questions, which of these projects would have
2 -- in your opinion, which of these projects
3 would enhance competition more and which would
4 decrease competition and why you say that?

5 A: Sure, I mean, if you look at the broader
6 landscape of the competitive market in the
7 Charlotte area, and that includes York County,
8 CHS is the largest and most powerful competitor
9 now. If Fort Mill Medical Center is approved,
10 there is a greater ability for Piedmont to be
11 able to hang onto its existing market share and
12 also to retain some of the specialty patients
13 who are currently being referred out of the
14 area by the CHS physicians now. If CHS in
15 contrast is awarded the CON, then I think we
16 are going to see a continued out-migration of
17 specialty patients. And I think we are going
18 to see Piedmont be somewhat cut off, if you
19 will, from the ability to refer that out-
20 migration back into the county. So I think
21 that what's going to happen is it's going to
22 weaken Piedmont because it will be dealing with
23 a smaller service area and a less affluent
24 service area. And so the bigger system of the
25 two will get stronger and the smaller player

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1 will get weaker and so sort of the market reach
2 of CHS will be extended.

3 Q: All right. And let me ask you one final
4 question. The term charity care has been used
5 a number of times and a lot of witnesses have
6 used the term charity care. The term indigent
7 care a lot of witnesses --

8 MR. GASKINS: Your Honor, I'm going to object. I
9 don't think I asked him any questions about
10 charity care or indigent care during my cross.
11 So it's beyond the scope of my cross
12 examination.

13 THE COURT: I recall there being a charity care
14 question from Mr. Gaskins. Where we going with
15 this?

16 MR. WESTBROOK: I think where I was going with that,
17 there were questions about payer mix. Well,
18 specifically there were questions that this
19 relates to the up-tick question about, you
20 know, things are looking up at Piedmont in the
21 last couple of years and utilization has
22 stabilized. And I think the testimony has
23 been, and I think Mr. Sullivan just commented
24 that, well yeah, the charity care patients have
25 increased or there has been an up-tick in

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1 charity care patients at Piedmont but not in
2 paying patients, and I wanted to ask a followup
3 on that.

4 **MR. GASKINS:** I didn't address payer mix, either.

5 **MR. WESTBROOK:** Well, he didn't address payer mix,
6 but he addressed utilization. And the point
7 about utilization is not that utilization --
8 there's been an up-tick in utilization; the
9 fact that we are getting -- that Piedmont is
10 getting more patients doesn't mean anything
11 unless it is put in the context of who those
12 patients are. And the payer mix there is
13 really the issue.

14 **THE COURT:** And Mr. Westbrook, you did an excellent
15 job of asking this question of Mr. Sullivan.
16 I took very good notes about the whole -- the
17 Court is very aware of that end, although there
18 is perhaps, an increase in patients and the
19 payer mix between the insured patient versus
20 charity care or Medicare-Medicaid patients has
21 shifted at Piedmont.

22 **MR. WESTBROOK:** And can I just, if Your Honor if you
23 will, and you may sit me down. That's fine.
24 I promise this is my last question. But what
25 I would ask him is really a definition

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1 question. And that is: It relates to when
2 he's talking about charity care, sometimes the
3 term charity care is used. Sometimes the term
4 indigent care is used. I just want to make it
5 clear that we are talking about the same thing.
6 It is not a semantical difference between the
7 two. I'm not sure what he's going to -- I
8 think I know what he's going to answer to that,
9 or I wouldn't ask it. Is charity care and
10 indigent care the same thing? We talking about
11 the same thing? That's my only question there.

12 **MR. GASKINS:** And that certainly was not within the
13 scope of my cross.

14 **THE COURT:** With that limited purpose, I'm going to
15 overrule your objection, Mr. Gaskins. Mr.
16 Westbrook, please go ahead and ask.

17 **MR. WESTBROOK:** Let's hope this is the over and the
18 answer is what I want.

19 **Q:** Mr. Sullivan, we've talked -- you've talked
20 about charity care and indigent care, and a lot
21 of witnesses have. And in your mind, are those
22 the same thing or are we talking about the same
23 thing?

24 **A:** I think the way they are used in common usage,
25 they are the same thing. I mean, there are

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1 some states that differentiate between those
2 two terms where charity care would be people
3 that fell below a certain, you know, income
4 level. And indigent care would be people above
5 that who had other requirements. But, yeah, in
6 general, I think that they are the same.

7 Q: Thank you. No further questions.

8 MR. WESTBROOK: Thank you, Your Honor.

9 THE COURT: Thank you, Mr. Westbrook. Mr. Gaskins?

10 MR. GASKINS: No further questions.

11 THE COURT: Ms. Biggers?

12 MS. BIGGERS: No questions, Your Honor.

13 THE COURT: All right. And are we finished with
14 this witness?

15 MR. WESTBROOK: We are.

16 THE COURT: Mr. Sullivan, thank you very much, sir.

17 MR. SULLIVAN: Thank you.

18 THE COURT: You may be excused. Now, ladies and
19 gentlemen, my understanding is that was all we
20 were going to do today, is that right? Now, do
21 we need to have a brief post off-the-record
22 meeting about just sort of an administrative
23 discussion? Do we want to take a little break
24 here and give everybody a chance to filter out.
25 And then we will perhaps just meet back in this

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1 Q: Well, let's look at the state health plan
2 itself. This is Charleston, CHS Exhibit 12,
3 Page 11.

4 MR. MULLER: If you would just pull up the -- I call
5 it Roman Numeral I.

6 Q: Here is the state health plan. This is from
7 CHS Exhibit 12, which is the 2004, 2005 state
8 health plan. And the language that they use
9 here is that an additional finding has been
10 made in each section as to whether the benefits
11 of improved accessibility to each such type of
12 facility, service and equipment may outweigh
13 the adverse effects caused by the duplication
14 of any existing facility, service or equipment.
15 Do you see that?

16 A: Yes, I do.

17 Q: So the question is whether the benefits of
18 improved accessibility outweigh the adverse
19 effects caused by a duplication. There is no
20 words for "protect market share" in there,
21 correct?

22 A: No, sir. Not those specific words.

23 Q: All right. In terms of increased accessibility
24 certainly with as many patients as CHS has in
25 this area of northern York County, the hospital

1 that they would put there would give improved
2 accessibility to those citizens, correct?

3 A: Well, I think any hospital built in Fort Mill
4 would certainly improve access. But there are
5 some other important reasons here, and that is
6 that we had our existing hospital, as we've
7 mentioned. That's been there for 30 years, and
8 is suffering from out-migration and that
9 rapidly growing area in Fort Mill with a
10 satellite could really benefit the system there
11 at the existing hospitals as satellites have
12 done in other areas of South Carolina and
13 counties. And if we put a competitor there
14 it's going to really further diminish the
15 services of the existing hospital because the
16 competitor such as Carolinas will really be
17 transferring a lot of their patients to their
18 larger hospitals in Charlotte for more
19 sophisticated services when necessary.

20 Q: There is no question, is there, that because
21 Rock Hill is to some degree a veteran community
22 of Charlotte; is it not?

23 A: I'm sorry, a butyrin --

24 Q: A butyrin community.

25 A: Yes, sir. I think probably a lot of people

1 that even work in Charlotte live perhaps in
2 South Carolina.

3 Q: And the same to some degree or to a greater
4 degree in areas north of York County closer to
5 Charlotte.

6 A: Yes sir.

7 Q: You've seen, for example, that one of the
8 doctors who testified for Piedmont actually
9 lives in North Carolina and travels here to
10 work.

11 A: Yes, sir.

12 Q: And did you notice that every single doctor
13 that testified for Piedmont is also licensed in
14 North Carolina?

15 A: I think being so close to the state line; yes,
16 sir, I understand.

17 Q: And there are certain services that would most
18 likely be logically performed in North
19 Carolina, correct?

20 A: Perhaps; yes, sir.

21 Q: For example, CMC Main, Carolina's main hospital
22 has a transplant surgery that no other hospital
23 in Rock Hill could offer.

24 A: That's correct.

25 Q: And they have a Level 1 trauma center that is

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1 some place where trauma patients are taken from
2 anywhere in the area.

3 A: Yes, sir. I understand.

4 Q: but let's look at what you said in the prior
5 review.

6 **MR. MULLER:** This is CHS-4(b), 941-942. Would you
7 go to the bottom there and just enlarge that
8 last paragraph?

9 Q: This was in your CON summary sheet in the prior
10 review. It says York County population is out-
11 migrating to Charlotte facilities for tertiary
12 services but currently there when York County
13 is P&T are doing so out of choice and/or at
14 physician's election since none of the --

15 **MR. MULLER:** Would you go to the next page and
16 enlarge the top.

17 Q: -- of the four competing applicants have opted
18 to offer these type of services, this sudden
19 out-migration will continue and cannot be
20 curbed by any of the four applicants. Only a
21 portion of the out-migration will be affected
22 by a community hospital located in a more
23 convenient location." Do you recall that
24 finding?

25 A: Yes, that was in the 2006 decision, is that

1 correct?

2 Q: And those four were Piedmont, CHS,
3 Presbyterian, HBA. Those are the four
4 applicants.

5 A: That is correct.

6 Q: I take it that your view was that if Piedmont
7 could build in northern York County, then
8 patients -- South Carolina citizens who wanted
9 to go elsewhere could simply go to Charlotte or
10 to Pineville or wherever to CHS Hospital, to be
11 seen at CHS Hospital.

12 A: They would certainly have that ability of
13 choice as they do today, yes. They would have
14 that choice. But I think the hospital -- the
15 Fort Mill Medical Center developed by Piedmont
16 and Fort Mill would be better -- better for the
17 citizens of York County overall in this
18 situation because it would allow the existing
19 hospital in Rock Hill to not lose as many
20 patients in the future. It would help reduce
21 some of the out-migration and help allow more
22 transfers of tertiary -- of patients requiring
23 tertiary services to the Rock Hill facility.

24 Q: I take it that you don't -- I recall your
25 testimony being you only planned for South

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1 Carolina citizens, and you do not plan for
2 North Carolina citizens.

3 A: I try to be fair. But that was what I was told
4 by the 3M committee. So, you know, that would
5 make a big impression. And I do understand the
6 point there. We live in South Carolina. I
7 work for South Carolina state government. My
8 first concern is to make sure that we protect
9 the services we have in South Carolina that we
10 have approved in the past and that we don't
11 make decisions to harm and damage those
12 services.

13 Q: Did you approve the radiation therapy
14 application in Lancaster County that was filed
15 by the Piedmont CHS tri-venture in 2007?

16 A: I don't -- I left the department in December.
17 I don't know what date that decision would have
18 been made. And if the application was received
19 in 2007, I don't know what the decision date
20 would have been on that. I would have if it
21 were made, you know, prior to December 3rd,
22 2007.

23 Q: Do you recall that application?

24 A: I don't recall that right offhand.

25 Q: I want to turn to the state health plan.

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1 utilization had decreased to the point that it
2 was now asking to go from 131 beds to 124 beds,
3 is that correct?

4 A: Yes, if that's what it says, yes.

5 Q: So in effect what happened in this instance is
6 the hospital in a prosperous portion of
7 Georgetown County close to Horry County got
8 bigger and the hospital that was in the steel
9 mill town of Georgetown got smaller and had
10 decreased in utilization. Is that correct?

11 A: Yes, that's correct.

12 Q: Thank you, Mr. Grice.

13 MR. MULLER: I believe those are all the questions I
14 have.

15 THE COURT: All right. Thank you, Mr. Muller.

16 MS. BIGGERS: I don't have any questions.

17 THE COURT: Okay. No questions from the department.
18 Mr. Andrews?

19 MR. ANDREWS: Thank you, Your Honor.

20 MR. GRICE - RE-DIRECT EXAMINATION BY MR. ANDREWS:

21 Q: Mr. Grice, let's pick up where Mr. Muller left
22 you concerning Waccamaw. Based on your
23 familiarity with Georgetown County and
24 historical bed utilization there, what is your
25 opinion concerning the performance of

1 Georgetown Memorial Hospital and the effect
2 that Waccamaw has had on that? Specifically
3 what I would like you to address of how you
4 believe the presence of Waccamaw affected
5 utilization of Georgetown after Waccamaw was
6 established?

7 A: Well, where the existing Georgetown Memorial
8 Hospital is, I don't think -- it is similar to
9 York County with the rapid growth like we're
10 seeing in York County right now. But I think
11 the Waccamaw satellite has really -- you know,
12 that's probably taken a lot of business away
13 from existing Georgetown. Georgetown Hospital,
14 I don't believe, has the tertiary type services
15 that York County has. I may be wrong, but I
16 just don't think it has the size of the
17 hospital that Piedmont Medical Center does or
18 some of the associated services.

19 Q: Are you familiar with the financial performance
20 of Georgetown?

21 A: No sir, not right offhand. I've probably
22 reviewed it, but I imagine, you know, they may
23 be suffering.

24 Q: Are you familiar with the financial performance
25 of Waccamaw?

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1 A: No, sir; not specifically.

2 Q: So you really don't know or have the
3 information one way or the other?

4 A: No, sir, I don't.

5 **MR. ANDREWS:** All right. Dan, turn to Piedmont
6 Exhibit 16 please, Page 79.

7 Q: Mr. Grice, Mr. Muller asked you about your
8 review of the language in the York County
9 contract. Now, did you have -- did the
10 department have copies of all the contracts?
11 Do you remember that?

12 A: Yes, sir. I believe that we did in that
13 decision, the 2006 decision.

14 Q: Okay. And specifically --

15 **MR. ANDREWS:** Dan, let's pull out the language
16 related to the questions.

17 Q: Mr. Grice, I want to ask you about your
18 understanding of the obligations that Piedmont
19 had under the agreement. Specifically, Mr.
20 Muller asked you about the pricing standards
21 that existed in the agreement. Read the
22 highlighted language if you would.

23 A: It says, "AMI agrees to exert every effort to
24 so conduct its operations and finances to
25 maintain prices for services of the hospital at

1 reasonable competitive levels via -- vis-a-vis
2 other hospitals in the peer group as defined in
3 Section 340-13(a)(xii hereof) for which MEDPAR
4 pricing information is provided pursuant to
5 Section 3.13 (a)(xi)."

6 Q: All right. Now based on your review of this
7 term in the sixth addendum, what's your
8 understanding of Piedmont's obligation with
9 respect of assurances it made to the county
10 concerning prices?

11 A: Well, I think what it says here they agree to
12 use every effort possible, you know, to
13 maintain the prices that are competitive and
14 reasonable with others in the peer group.

15 Q: Now, let me take you to another document that
16 Mr. Muller asked you about.

17 **MR. ANDREWS:** Dan, pull up Piedmont Exhibit 3,
18 please, Pages 339-340.

19 Q: You remember that Mr. Muller asked you about
20 the letters from Ms. Fechtel concerning the
21 project review criteria and the other review?

22 A: Yes, sir.

23 Q: And your testimony was that Ms. Fechtel
24 prepared these letters. And while you
25 supervised her you didn't review them, is that

1 right?

2 A: That is correct.

3 Q: All right. Let's look at the second page in
4 the listing. Now, first of all -- before we go
5 there, I'm sorry. Let's go back in to the
6 first page. What is the date of this letter?

7 A: February 8, 2005.

8 Q: Okay. And this is the first complete letter
9 following the January 2005 submission, is that
10 right?

11 A: Yes, sir; that's correct.

12 Q: Now, do you remember whether the January 2005
13 application was submitted with the first or the
14 second application for the 64-bed hospital that
15 Piedmont submitted?

16 A: I believe it was the second, and that is a good
17 point, because basically one of the main things
18 that changed was just the licensee.

19 Q: Okay. And the record will reflect that the
20 date of that first filing was November 2005.
21 Is that your recollection?

22 A: I'm sorry?

23 Q: November 2005 was the very first -- I'm sorry,
24 November 2004?

25 A: Yes, sir; that's correct.

1 Q: Is that right?

2 A: Yes, sir.

3 Q: All right. And do you remember whether there
4 under that November 2004 application, whether
5 there was any request for additional
6 information than Ms. Fechtel submitted to Mr.
7 Levitt who filed the application on behalf of
8 Piedmont?

9 A: I can't recall right now. It may have been.
10 But certainly it was complete. And, therefore,
11 the second submission on February or later --
12 relative to this complete one on February 8,
13 2005, would have been very similar. And it was
14 basically complete when submitted.

15 Q: What are you referring to that would have
16 complete when submitted?

17 A: The application -- the certificate of need
18 application would have been complete for a
19 decision, review of the decision.

20 Q: That is the 64-bed application submitted by
21 Piedmont?

22 A: Yes, sir. That is correct.

23 Q: That would have been the second or first
24 application?

25 A: Second.

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1 Q: Okay, all right. Now, with regard to the
2 request for additional information, Mr. Grice,
3 in your experience of 29 years in the CON
4 office, are the requests for additional
5 information to any degree a reflection of the
6 experience of the healthcare planner who's
7 preparing -- and a planner's experience for
8 South Carolina with your office in preparing
9 the application?

10 A: Yes, sir. It is.

11 Q: In what way?

12 A: Well, generally if an applicant has prepared
13 many other applications, they're more familiar
14 with the type information we need specifically.
15 And, you know, if they are not, we have to
16 sometimes considerable additional information
17 to be able to get the appropriate information
18 we use to make the review. And of course, you
19 know, Tenet Healthcare has hospitals over the
20 state and has submitted numerous applications.
21 So they were familiar with the process.

22 Q: And who was the consultant working on behalf of
23 Piedmont?

24 A: David Levitt.

25 Q: And what was your -- the degree of your

1 experience with Mr. Levitt filing CON
2 application?

3 A: Mr. Levitt had filed applications for many many
4 years and did an excellent job, and he knew
5 exactly what to give us. They were generally
6 complete when submitted.

7 Q: Okay. And who filed the application on behalf
8 of Carolinas? Do you recall?

9 A: Right offhand I don't recall exactly.

10 Q: All right. Was it -- do you recall it being
11 that the application for Carolinas was
12 submitted by anyone who had had considerable
13 experience with the department in filing CON
14 applications?

15 MR. MULLER: Your Honor, I'm going to object to the
16 question. The witness has just testified that
17 he did not recall who had submitted it.

18 MR. ANDREWS: I understood the response, Your Honor.
19 The reason for the question is even if he
20 didn't recall a name, the question is a
21 different one -- whether he recalled whoever
22 submitted that? Whether it was someone he was
23 familiar with based on their experience with
24 the department.

25 MR. MULLER: And I also object to it being leading.

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1 He's trying to lead the witness on redirect.

2 **MR. ANDREWS:** I think it's a question of fact, Your
3 Honor.

4 **THE COURT:** Mr. Muller, I'm going to overrule your
5 objection and let the witness answer the
6 question.

7 A: Would you --

8 Q: Sure, the question is whether you recall, one
9 way or the other, whether the individual
10 responsible for communicating with the
11 department concerning Carolinas' application
12 was one with whom you had had experience in the
13 filing of CON applications?

14 A: No, sir. We had not. I mean, this is the
15 first application we ever got from the
16 Carolinas Medical Center. And so that person
17 had not submitted applications to South
18 Carolina previously.

19 Q: Okay. Now, the letter that's appearing here
20 was prepared by Ms. Fechtel. How many -- well,
21 let's look at the second page, and it's dated
22 February 2005. And the project review criteria
23 that are prepared here, Mr. Grice, at the time
24 that these criteria were identified by Ms.
25 Fechtel, how many applications had been

- 1 submitted to establish a hospital in Fort Mill?
- 2 A: This was the first one, I believe, as I recall.
- 3 Q: I believe in examining you, Mr. Muller said I'm
- 4 going to ask you if you recall March was the
- 5 date -- the month in which the others applied?
- 6 A: Yes, sir.
- 7 Q: So in February, who had filed?
- 8 A: It was just Piedmont Medical Center for the
- 9 Fort Mill Medical Center.
- 10 Q: And among the project review criteria that are
- 11 listed, number six is the adverse affects on
- 12 other facilities. Do you see that?
- 13 A: Yes, sir, I do.
- 14 Q: Why would that be listed last, Mr. Grice?
- 15 A: Well, you know, I guess -- I think in doing
- 16 review I think there has been other
- 17 applications that had been listed higher. But
- 18 one thing, I think Ms. Fechtel, when she was
- 19 listing all this, she probably looked at some
- 20 other very similar type applications for
- 21 hospitals. New hospitals had been done, and
- 22 this is just the way it fell. But it certainly
- 23 could have been higher.
- 24 Q: Well, how many facilities were there in York
- 25 County that could have been adversely affected

1 in February of 2005?

2 A: None. So that could be a reason, you know,
3 that it was -- in this first application when
4 we're talking about adverse effects of other
5 facilities there were no other hospitals in
6 York County. So this would be a low priority
7 -- lower priority than the other criteria.

8 Q: Now, also look at the numbering, the sequence
9 from the first to the last. What's number one?
10 What's the criterion number for number one?

11 A: Number one.

12 Q: And what's the criterion for number two?

13 A: They're all two, A, B, C, D and E.

14 Q: And then three, correct?

15 A: Yes, sir.

16 Q: And for the third criterion, what's the number?

17 A: For the third one, 6, A, B, and 7.

18 Q: And for the next one?

19 A: Also in three, we've got 15.

20 Q: All right. Do you see a pattern that's
21 evolving there, Mr. Grice?

22 A: Yes, sir. I think some people would say
23 they're almost like in chronological order.

24 Q: Or numerical order?

25 A: I meant numerical order, yes.

1 Q: And there are a few that are exceptions. The
2 next one is one, correct?

3 A: That's correct.

4 Q: But by and large, what is the pattern you see
5 of the listing of the order of criteria?

6 A: They appear to be related in numerical order.

7 Q: That they appear where?

8 A: Compared to Section 802 of Regulation 61.15.

9 Q: I have no further questions, thank you.

10 **THE COURT:** Thank you, Mr. Andrews. Mr. Muller.

11 **MR. MULLER:** Very few, Your Honor.

12 **MR. GRICE - RE-CROSS EXAMINATION BY MR. MULLER:**

13 **MR. MULLER:** If we could just go back to Piedmont
14 Exhibit 16, Page 79. If you could enlarge the
15 sentence that starts in the middle, "in the
16 event."

17 Q: This is a sentence after the sentence that Mr.
18 Andrews showed you.

19 A: Yes, sir.

20 Q: Can you read it and tell me whether it was
21 incumbent upon Piedmont to self-report when --

22 A: Would you like me to read aloud or just read
23 it?

24 Q: You're welcome to read it aloud or silently,
25 whatever you prefer.

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1 A: Okay. I graduated high school in 1976. I went
2 to a branch campus of USC in Allendale for two
3 years. And I went on to Columbia and graduated
4 in 1980. I went to work for DHEC. And after
5 I'd been there for a few years I went to
6 graduate school. And I have a masters in
7 Public Health. I went to graduate school part
8 time from 1986 until 1991, and that's when I
9 did get that graduate degree.

10 Q: And when did you begin working for DHEC?

11 A: It was approximately May of 1981.

12 Q: What area of DHEC did you work in to start off
13 with?

14 A: I started off in the Bureau of Radiological
15 Health, and I spent around 22 years with that
16 program.

17 Q: And what program did you work with next?

18 A: I was then a public health preparedness
19 planner, and I was part of the health resources
20 and services administration grant. So I spent
21 five years in that position.

22 Q: And then what did you do after that?

23 A: After that I did get hired on as the bureau
24 chief for the division that oversees the CON
25 program, the Bureau of Health Facilities and

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- 1 Services Development.
- 2 Q: When did you begin in that position?
- 3 A: It was February of 2008.
- 4 Q: And have you retired from the department since
- 5 the time you made this decision?
- 6 A: Yes, I retired this past February.
- 7 Q: Were you involved with the initial decision
- 8 that the department made when the applications
- 9 were first submitted to DHEC?
- 10 A: No, I was not.
- 11 Q: Were you still in your public preparedness
- 12 position at that time?
- 13 A: Yes, I was.
- 14 Q: Okay. And then can you tell us, what was your
- 15 involvement when Judge Matthews remanded this
- 16 matter back to DHEC?
- 17 A: At the time of the remand, I was the bureau
- 18 chief. So I was responsible for responding to
- 19 her decision with the remand.
- 20 Q: In responding to that remand order and
- 21 reviewing the applications, did you rank the
- 22 project review criteria to be applied to the
- 23 review?
- 24 A: Yes, I did.
- 25 Q: What was that?

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1 A: It is focused on the projected utilization,
2 that that is sufficient to justify the
3 expansion or implementation of the proposed
4 service.

5 Q: And did you find that Carolinas' projected
6 utilization justified their application?

7 A: Yes, it did because their projections were
8 based on the high level of their current market
9 share. That is, the South Carolina patients
10 that were leaving South Carolina to be served
11 in North Carolina. So they had some
12 statistical information to support that. And
13 I felt that the need for the project, you know,
14 was based on their current patients that they
15 served, and that they would be able to
16 successfully shift the patients that they --
17 South Carolina patients back to South Carolina.
18 And they had a detailed analysis. And so that
19 is contained in this document. And I felt that
20 their analysis was reasonable.

21 Q: And did you find that Piedmont's projected --
22 current and protected utilization were
23 sufficient to justify its project?

24 A: No, I did not.

25 Q: Why is that?

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- 1 A: Because they had been steadily losing market
2 share and their services -- utilization of
3 their services was substantially declining.
4 And then they felt that, you know, building
5 this hospital that all of a sudden the market
6 share was going to increase substantially and
7 that they would be able to successfully
8 redirect patients from the 29730 and 29732 zip
9 codes. It just didn't seem plausible or
10 reasonable to me.
- 11 Q: Okay. In your analysis of the two applications
12 that we are looking at here, it started on 1309
13 and now we are 1310. It goes on to 1311. The
14 statistics that you cite, are those based on
15 information in the two applications?
- 16 A: Yes, they are.
- 17 Q: Let's look at distribution. What did you find
18 with regard to -- well, first let's look at
19 3(a).
- 20 A: I found that 3(a) only applied to Piedmont.
- 21 Q: And what about -- did you find that Piedmont
22 met it?
- 23 A: I didn't feel that they had adequately
24 justified the duplication of services by
25 transferring the 36 beds.

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1 MR. ANDREWS: Thank you, Your Honor.

2 MS. BRANDT - CROSS EXAMINATION BY MR. ANDREWS:

3 Q: Good afternoon, Ms. Brandt.

4 A: Good afternoon, Mr. Andrews.

5 Q: Ms. Brandt, when you joined the department you
6 had a masters in public health, is that
7 correct?

8 A: I obtained a masters after I started working
9 with DHEC.

10 Q: So you started working in the eighties and then
11 you got your masters degree about ten years
12 later?

13 A: Yes, that was the time I got through that part.

14 Q: Okay. And your master's degree was in
15 environmental and radiological health related
16 construct; wasn't it?

17 A: That was the primary focus for my masters in
18 public health?

19 Q: Right. And you didn't have any advance
20 training in healthcare planning or healthcare
21 finances apart of that process did you?

22 A: No, but I had certainly worked hand-in-hand
23 with healthcare facilities and through my
24 entire tenure with the DHEC in my career.

25 Q: Okay. And when you became bureau director in

1 2008, you had never been involved with CON
2 decisions or CON process before had you?

3 A: I was certainly not involved in decisions. I
4 was on the periphery of the process through
5 *shielding approval letters and their
6 relationship to CON projects.

7 Q: For radiological health imaging concerns, is
8 that right?

9 A: Yes.

10 Q: So relating to MRIs, CAT scans and other
11 medical equipment, you saw the effects of some
12 healthcare facility applications. That is the
13 extent of your exposure to CON at that point;
14 wasn't it?

15 A: Yes, I suppose.

16 Q: And when you took the job, you replaced Mr.
17 Grice, correct?

18 A: Yes, I did.

19 Q: And during that time you hadn't received any
20 additional formal CON training had you?

21 A: No, not at that time.

22 Q: You had a couple of some seminars and some on-
23 line courses concerning healthcare planning and
24 finance that you participated in, is that
25 correct?

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- 1 A: That was more recently, yes.
- 2 Q: And you had a half day of kind of some in-house
3 training related to healthcare reimbursement,
4 right?
- 5 A: It was probably half a day, maybe a full day,
6 I don't --
- 7 Q: But it would be accurate to say that your CON
8 training really consisted of on-the-job
9 training you received after you assumed the
10 position of CON director; would that be fair to
11 say?
- 12 A: Yes, but certainly I brought a lot of skills
13 and experience that transferred to the
14 position. And obviously at a certain point in
15 time I was chosen, you know, over other
16 applicants for the position because of my
17 qualifications.
- 18 Q: Sure. And you had a lot of administrative
19 experience. But you hadn't had any depth in
20 healthcare management and finance; wouldn't
21 that would be fair to say?
- 22 A: Yes, that would be fair.
- 23 Q: And you've never been qualified as an expert
24 witness in healthcare planning or in
25 certificate of need or in healthcare finance?

1 A: No. But that would have been requested by
2 somebody else. I don't believe I would have
3 offered myself as that.

4 Q: All right. And you testified in two previous
5 cases prior to this, is that right?

6 A: Oh, goodness. Certainly the home health case
7 and Berkeley County Hospital cases. I
8 certainly have been deposed more but --

9 Q: Been deposed more but in terms of offering
10 testimony for the benefit while in court, it's
11 been a couple of times that you can think of?

12 A: Yes.

13 Q: Now, when you began your work on this case in
14 2010, you were initially assisted by Lisa
15 Sanders who was a relatively senior reviewer at
16 the time in the department; isn't that right?

17 A: Yes, I was.

18 Q: And she left before you completed the review,
19 correct?

20 A: Yes, she left a few months prior to the
21 decision.

22 Q: And she didn't participate at all in the
23 decision; did she?

24 A: No, she did not.

25 Q: And Mr. Grice had gone. Ms. Fechtel was there,

1 but she had been involved in the previous
2 decision, and you didn't consult with her on
3 this case either; did you?

4 A: Well, Mary served kind as a sounding board for
5 me. And I bounced a lot of things off of her.
6 I was involved in so many projects and so many
7 decisions, it wasn't unusual for me to speak
8 with her.

9 Q: Okay. But you didn't talk with her
10 specifically about the adjustments she needed
11 to make in this case; did you?

12 A: No, I did not.

13 Q: All right. Okay. So Ms. Sanders was gone, Ms.
14 Fechtel wasn't available, and Mr. Grice was
15 gone and you made this decision on your own,
16 right?

17 A: Yes, I did. I certainly did utilize with
18 Shelton in some capacity, as well.

19 Q: But he didn't review the applications or
20 participate in the review; did he?

21 A: He was at the project review meeting, and he
22 performed some analyses under my direction.
23 But no, he was not involved in the decision.

24 Q: Okay. All right. Let's turn to some of the
25 concerns you expressed in your testimony and

1 were reflected in your decision. Now with
2 regard -- let's start with the questions that
3 you raised about Tenets, Piedmont in particular
4 in its ability to finance the project. You
5 never formed an opinion that Piedmont couldn't
6 pay for the construction of the hospital; did
7 you?

8 A: No, because they were owned by Tenet and has a
9 lot of financial means.

10 Q: And Tenet, through their senior vice president,
11 communicated with the department and said Tenet
12 that can stand behind the construction costs
13 and will build and will finance the
14 construction of the new Fort Mill Medical
15 Center; didn't they?

16 A: Yes. I believe there is a letter to that
17 effect.

18 Q: And you didn't have any reason to doubt that;
19 did you?

20 A: No, I did not.

21 Q: And in fact, are you aware that in 2006 Tenet
22 owned the facility called East Cooper Medical
23 Center, built a new replacement hospital that
24 was approximately \$150 million and financed
25 that facility down in the Charleston area?

1 A: I was aware that it was being built. I wasn't
2 aware of how it was financed.

3 Q: You're not aware of budget department -- I
4 mean, that East Cooper, the Tenet facility,
5 would have communicated to the department that
6 they had closed out the project, and they
7 didn't have any trouble, that you're aware of,
8 financing the project did; they?

9 A: I'm just not aware. We got their closeout
10 report, I believe, but they don't have to
11 report anything about financials.

12 Q: Okay. And you're not -- and they built a
13 hospital and as far as you know it's
14 operational and paid for it or certainly being
15 paid for?

16 A: Well, certainly operational, yes.

17 Q: Okay. All right. Now, with regard to the
18 concern that you expressed then. Let's focus
19 -- your concern was not whether not Tenet could
20 build a hospital, your concern was in whether
21 they could finance the construction of the
22 hospital. Your concern was whether or not they
23 identified a definitive approach about how they
24 would finance the construction of it, is that
25 right?

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1 A: Well, that certainly was a concern. They
2 identified several means and chose the one that
3 was resulted in around \$2 million of interest
4 expense.

5 Q: Okay. Now, you had said, I believe, in your
6 testimony that your preference was for a
7 definitive approach. That is an applicant
8 saying this is how we intend to finance it
9 period; end of story. That was your
10 preference; wasn't it?

11 A: Well, my preference was what the regulations
12 stated. And the regulations stated, and this
13 is probably isn't the exact words, but it
14 indicated that they had to chose a method that
15 they were going to utilize.

16 Q: And you referring to the provision in Paragraph
17 16(a), I believe; are you not?

18 **MR. ANDREWS:** Well, let's pull it up. Dan, if you
19 would, let's pull up 802, Section 16(a) in the
20 DHEC reg.

21 Q: Okay. Read that into the record please, Ms.
22 Brandt?

23 A: "The applicant should have identified and
24 sought alternative sources and/or methods of
25 funding and demonstrated that the method chosen

- 1 was the most feasible option."
- 2 Q: Now, in fact, you testified that Carolinas said
- 3 we're going to use cash, correct?
- 4 A0: Yes, from later reserves.
- 5 Q: Cash and cash equivalents is what you put.
- 6 A: Uh-huh (affirmative response).
- 7 Q: They didn't identify alternatives; did they?
- 8 A: (No Response)
- 9 Q: Does the reg say the applicant should have
- 10 identified and sought alternative sources of
- 11 financing?
- 12 A: Yes, it says should not shall.
- 13 Q: That's a meaningful distinction to you?
- 14 A: Well, shall means -- is more of an absolute.
- 15 And they identified something that the cash
- 16 reserve was reasonable, and I felt that was
- 17 sufficient.
- 18 Q: Okay. Did they offer any alternatives? Did
- 19 they identify alternatives that they
- 20 considered?
- 21 A: No.
- 22 Q: And in Tenet's letter, they did identify
- 23 alternatives; did they not?
- 24 A: Yes, they did.
- 25 Q: And it shows one of the alternatives, which was

1 to make themselves -- to allow themselves to
2 form the judgment about which would be most
3 prudent from a business perspective at the time
4 they were ready to build. Isn't that what they
5 did?

6 A: Well, I probably wouldn't have couched it as
7 chosen an alternative. I mean, this has
8 demonstrated the method chosen. And so the
9 method they chose was financing.

10 Q: Well, let's be clear about this. First of all,
11 the department did not have a policy about this
12 issue; did they?

13 A: Could you be more --

14 Q: Sure, yeah, about your definitive approach.
15 You didn't have a policy as to whether or not
16 the applicant should be definitive; that is,
17 express a particular preference and inform the
18 department what it intended to do three to five
19 years in the future when the hospital was
20 built?

21 A: Well, this does say -- demonstrate the method
22 chosen, and it's singular. So if they laid out
23 a variety for future means to finance a
24 project, then we expect them to step up and
25 tell us exactly what they intend to do.

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1 Q: But you didn't tell the applicant that; did
2 you?

3 A: Well, it's mentioned in this. And then I think
4 if we look at some other parts of the
5 regulations, it mentions that as well. No, I
6 did not send back a letter saying, okay,
7 Piedmont, you know, figure it out; if that's
8 what you're asking.

9 Q: Yeah, I'm asking if you communicated to
10 Piedmont that you wanted and expected
11 applicants to make a determination years before
12 they would build a hospital as to which method
13 of financing or any method of financing they
14 would choose?

15 A: Well, I feel that they discussed it
16 sufficiently enough in their application,
17 particularly because they did have a line for
18 interest expense that they had basically
19 declared how they were going to proceed with
20 the project.

21 Q: Now Ms. Brandt, are you aware that in its --
22 originally in its application to the department
23 that Tenet presented the very same alternatives
24 to the department about how it would finance
25 the project?

1 A: No, I'm not aware.

2 **MR. ANDREWS:** Dan, let's pull that up, if you would,
3 and let's look at what would be Exhibit --
4 Petitioner's Exhibit 2, Page 252. Let's pull
5 out the first sentence of the second paragraph.

6 Q: Could you read that sentence into the record,
7 Ms. Brandt?

8 A: "Tenet Healthcare Corporation will fund this
9 project utilizing a mix of debt and cash flow
10 from operations as part of its overall capital
11 investment budget."

12 Q: Now, are you aware that in reviewing Piedmont's
13 application in 2006, Ms. Fechtel found that the
14 presentation or the method of financing for all
15 the applicants was adequate; did not raise any
16 issues with the department?

17 **MS. ROBERTS:** Your Honor, I'm sorry to interrupt. I
18 would like to object to this line of
19 questioning. I think Ms. Brandt has testified
20 that she was not involved in the first review
21 and did not participate in it. That was Ms.
22 Fechtel, Mr. Grice. And Mr. Grice has already
23 testified this witness was not involved in this
24 first review.

25 **THE COURT:** Mr. Andrews.

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1 **MR. ANDREWS:** Your Honor, we're aware that she
2 wasn't involved in the first review. She's
3 also said she conferred with the department and
4 with Ms. Fechtel, in particular; and not about
5 the application but the general principles.
6 And we think as the sole representative of the
7 department that she needs to be able to speak
8 to anything in the department such as to be
9 concerned in this case or other cases, whether
10 she was personally involved or not.

11 **THE COURT:** All right. I'm going to overrule the
12 objection. Thank you, Ms. Robertson. Go
13 ahead, Mr. Andrews.

14 **Q:** All right, sir. So the question for you, Ms.
15 Brandt, is whether or not you were aware that
16 based on the September 30, 2005 letter that you
17 just read an excerpt from Mr. Corbeil, who is
18 senior VP operations for Tenet, that your
19 predecessors in your position found that this
20 form of financing that Tenet presented was
21 acceptable.

22 **A:** Well again, I was not aware of what Mr. Grice
23 decided or what Ms. Fechter decided. I know
24 and I recollect that in general I had
25 conversations with Ms. Fechtel, and she said

1 that the applicants had to be clear about their
2 method of financing.

3 **MR. BIGGERS:** All right. Now, let's look at the
4 next letter. You will see that -- Dan, if you
5 pull up the Joint Exhibit B(1), Page 223. And
6 let's pull out again the second paragraph,
7 first sentence.

8 **Q:** Read that sentence into the record, please, Ms.
9 Brandt.

10 **A:** "Tenet Healthcare Corporation intends to
11 finance the project through the most
12 appropriate and cost effective capital funds
13 available at the time utilizing existing cash
14 reserves, existing lines of credit or the
15 issuance of debt and/or equity."

16 **Q:** Wasn't this basically the same position that
17 Tenet took when they conveyed their willingness
18 and ability to the department in 2005 about how
19 they intended to finance the project then, and
20 they adopted the same position in 2010?

21 **A:** The intent appears to be the same. I mean, I
22 don't believe the wording is identical. And I
23 certainly do appreciate this line of
24 questioning; but this didn't really make or
25 break my decision.

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1 Q: Okay. All right. Now, in your deposition, you
2 testified that the way the department
3 historically had applied 16(a) and 13(b)
4 concerning the financing of the project was to
5 look for definitive methods of financing. I
6 believe I understood that to be your testimony,
7 is that right?

8 A: That sounds correct. I certainly haven't
9 reviewed those. But definitive meaning of it,
10 but they need to state or would certainly know
11 would how they planned to finance the project.

12 Q: But in this case Piedmont, in its first round,
13 expressed they would use a mix of cash or debt
14 and do whatever from a business point of view
15 was prudent at the time. And it would have
16 been reasonable, since there were no objections
17 made to it in the first round, for them to take
18 the same approach in the second; wouldn't it?
19 Wouldn't that make sense to you?

20 A: It would make sense, but I did not review the
21 first round.

22 Q: I know that. But you're the department's
23 representative. And the department did not
24 express any concern that you are aware of
25 toward this mixed approach to financing in its

1 first round. And if you assume that to be the
2 case, wouldn't you believe it would be
3 reasonable for the company to rely on that
4 department maintaining in the same position in
5 the second round with regard to financing?

6 A: I can certainly see your point, Mr. Andrews,
7 but again, you know, I was taught that the
8 applicant had to come up with a means. What
9 they say and what they do, I can't control
10 that.

11 Q: You were taught by Ms. White, Ms. Patricia
12 White?

13 A: I recall raising the issue with Ms. Fechtel.
14 I can't say Ms. White didn't mention it. I
15 just don't specifically recall that.

16 Q: But based on Ms. Fechtel's writing the CON
17 summary approving Piedmont, it doesn't appear
18 that Ms. Fechtel believed it was an issue of
19 any concern, does it?

20 A: Well, I can't speak to what Ms. Fechtel
21 thought, but I can state that she didn't appear
22 to raise that as an issue.

23 Q: All right. And there is no question in your
24 mind, is there, that Tenet has the financial
25 wherewithal to finance the project and to build

1 Fort Mill Medical Center; isn't it?

2 A: Based on the cash reserves that they reported
3 to us, they could certainly financially swing
4 it. But we certainly did look at the project
5 itself as well as the financial capability of
6 the parent.

7 Q: And based on the financial capability of the
8 parent on that specific issue, you can't, as
9 you are sitting here today, express any basis
10 for a concern about whether Tenet could finance
11 the construction of the new hospital at Fort
12 Mill; can you?

13 A: It appears with this \$700 million cash reserve
14 to be able to finance the project.

15 Q: And let me move on to another subject. And
16 that has to do with your statement and your
17 decision letter about annual cost of the
18 project for Piedmont. Let's begin your
19 testimony on this by establishing one of the
20 things that you try to do in reviewing
21 competing applications. And this is the first
22 competing hospital application you've ever
23 reviewed; isn't it?

24 A: I believe you are right.

25 Q: Okay. All right. But generally based on in

1 your -- was it four or five years that you were
2 in your position?

3 A: Five, yes.

4 Q: That you tried to create an apples-to-apples
5 comparison among applicants to make sure when
6 you're measuring them against each other you
7 are doing that on an apples-to-apples basis.
8 That is so you can fairly compare and contrast
9 them. Isn't that one of the things you try to
10 do?

11 A: Yes, I attempt to -- it's much easier said than
12 done.

13 Q: Agree, but that's one of your objectives in
14 this review process; isn't it?

15 A: Well yes, you've got to be able to place them
16 side by side in some capacity.

17 Q: Okay. Now and because you would recognize that
18 different assumptions and different
19 methodologies could produce different results
20 in what's being presented to the department;
21 isn't that right?

22 A: Yes.

23 Q: And if you don't try to understand the basis
24 for their projections and what the underlying
25 assumptions are and the underlying

1 methodologies, then you can't fairly evaluate
2 them against each other; can you?

3 A: No, and we certainly have to have good
4 information to go on.

5 Q: All right. Let's talk about the construction
6 costs and the capital costs.

7 **MR. ANDREWS:** Dan, let's pull up Demonstrative 153-
8 1, please.

9 Q: There's been testimony, Ms. Brandt, prior to
10 your arriving that Piedmont, when it submitted
11 it's application and then reviewed it and the
12 other applications that were presented
13 following it, that it realized there were
14 different assumptions that affected the total
15 project cost; do you remember that?

16 A: Yes.

17 Q: And do you remember then that Piedmont made
18 adjustments to try to get to the point of
19 presenting data used that would allow you to
20 look at the applications for their cost on a
21 fairly equal apples-to-apples basis, is that
22 right?

23 A: Yes.

24 Q: All right. Okay. And these three particular
25 issues were the ones that there has been prior

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1 testimony about. And I just want to review
2 with you to see if you agree with me concerning
3 these; that these were three issues related to
4 the areas that affected the total project cost
5 of the Fort Mill Medical Center, that there
6 were differences between what Piedmont
7 presented and what either or both of the other
8 applicants presented. And those three areas
9 are capitalized interest, the question of
10 whether or not the construction costs were
11 inflated or were then current, and then finally
12 whether or not the projected equipment costs
13 were at list price or reflected a volume
14 discount that the applicants had. Do you
15 remember that?

16 A: Yes.

17 Q: Okay. And you would agree with me that to
18 achieve your apples-to-apples objective, that
19 each of those adjustments were appropriate;
20 wouldn't you?

21 A: Yes, in theory. But I have no issue with
22 updating costs based on more up-to-date
23 information or more accurate information such
24 as the deflation of the construction costs or
25 the discount. However, I didn't feel it was

1 necessarily appropriate to eliminate the
2 capitalized interest because what is more
3 important is to get a realistic picture of the
4 proposed costs for the project. Now, while I
5 certainly appreciated what was attempting to be
6 done, the bottom line is what are your
7 projections.

8 Q: All right. To make sure that we understand
9 each other, so with regard to the adjustment of
10 the construction costs, you didn't have any
11 concerns about that adjustment, correct?

12 A: No.

13 Q: Okay. And with regard to making sure that the
14 assumptions were the same with regard to
15 medical equipment, that is whether they were
16 listed or were using the discounts available to
17 the applicants. That was appropriate, too. So
18 you agree with 2 and 3?

19 A: Yes.

20 Q: All right. Now, with regard to the capitalized
21 interest costs, at the time the applications
22 were filed and you reviewed them, the
23 department had no position, no policy, no
24 practice, no position on whether imputed
25 interest costs should be included or not in

1 their application; isn't that right?

2 A: That's right.

3 Q: Okay. Now, if an applicant, to be conservative
4 to be careful, and that means, doesn't it, that
5 when an applicant is being conservative, that
6 they are overstating their costs, understating
7 their expenses; doesn't it? Would you agree
8 with that?

9 A: Well, yes. They are certainly giving it their
10 best shot for accurate representation.

11 Q: Well, that's always true; isn't it?

12 A: Well, yes.

13 Q: Don't you expect every applicant to do that?

14 A: Well, yes.

15 Q: Okay. When an applicant is being conservative,
16 they are overstating there again, cost because
17 understating it would aggressive, overstating
18 it would be conservative. Would you agree with
19 that?

20 A: Yes.

21 Q: Okay. And on the expense side -- well, on the
22 revenue side, understating revenue would be
23 conservative. That is, they are going to err
24 on the side of projecting less revenue than
25 what they think might come in to be careful.

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1 If they're demonstrating a higher extent of
2 revenue, that's being aggressive, not
3 conservative. Would you agree with that?

4 A: Yes.

5 Q: Okay. Now, with regard to the question about
6 identifying interest costs, the conservative
7 thing to do if an applicant is unsure years
8 before they intend to actually finance the
9 construction, if they include interest costs,
10 that's a conservative approach; isn't it?

11 A: Yes.

12 Q: All right. Even as Tenet has said in their
13 letters, they are unsure. They have the cash.
14 They could put a zero there based on their
15 ability. But a conservative approach is to
16 identify that cost so they won't mislead the
17 department, and they will be conservative in
18 identifying potential costs. Wouldn't that be
19 an accurate way of analyzing what that would
20 yield at the start of that application process?

21 A: Well, yes. I mean, it's ultimately their
22 decision.

23 Q: And as you said, the department doesn't check
24 up on it when the project is completed. It's
25 not even reported as part of the final reports

1 of the department when they complete a project;
2 is it?

3 A: Not the interest expense. We look at the
4 resulting total priority costs.

5 Q: Okay. But at the time that these applications
6 were filed, the department hadn't developed a
7 position about whether an applicant should,
8 even when they don't intend -- when they intend
9 to use cash should identify the cost of having
10 that cash available, which would be imputed
11 interest; wouldn't it?

12 A: Well, to my knowledge, no, there wasn't. And
13 because I got really bombarded so much during
14 my deposition about imputed interest, after my
15 deposition I did go back and talk to Ms.
16 Fechtel about imputed interest specifically.
17 And she told me that they never or she never
18 made a point of specifically asking for imputed
19 interest.

20 Q: Right. And so you didn't ask for it. And if,
21 in fact, interest were incurred later, you
22 wouldn't even have any way of knowing it; would
23 you?

24 A: Not if it didn't affect the total project
25 costs.

1 Q: Right, okay. So if your goal is to compare
2 applications on equal footing, apples to
3 apples. And if one party includes imputed
4 interest to be conservative and another one
5 doesn't, you'd have apples and oranges;
6 wouldn't you?

7 A: Yes. But I believe Piedmont stated it as
8 interest expense and not imputed interest. So
9 I ultimately relied on that to be their best
10 projection of how they calculated their
11 finances.

12 Q: Okay. So your position would be that Piedmont
13 should, even though they said they may use
14 cash, to include an interest expense even
15 though they conservatively incorporated it?

16 A: I'm sorry, Mr. Andrews, can you repeat?

17 Q: Sure, yeah. Your position should be that even
18 if Tenet had not made the decision that it
19 would incur interest, that they should leave
20 the interest in there and not remove it and not
21 impute.

22 A: I'd don't believe Piedmont ever said, oh, you
23 know, we've decided that we are going to fund
24 this from cash reserves. That would have been
25 -- I would have certainly accepted not having

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1 an interest line item. I'm not sure if I'm
2 understanding you.

3 Q: That's fine. But they said they might use
4 cash; didn't they?

5 A: Yes, sir; they said might.

6 Q: And they said, we'll make that decision when it
7 comes because that's the best business
8 decision, not to do it years in advance when we
9 don't know what the market looks like and we
10 don't know what our interest would be.

11 A: Yes, they certainly said that.

12 **MR. ANDREWS:** Well, let's take a look at
13 Demonstrative 151. And Dan, let's pull out the
14 comparison. This is Ms. Brandt's demonstrative
15 about which has been evidence in testimony
16 provided relating to the relevant -- the
17 relative total project costs and total project
18 costs per bed. Dan, pull out the CMC-FM and
19 the FMMC lines just for a moment if you would.
20 We'll just highlight those.

21 Q: Now, I'll represent to you, Ms. Brandt, that
22 the 119 million and some change for FMMC
23 reflects the adjustments for the three
24 different items you've identified that you just
25 testified about. And CMC-Fort Mill represents

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- 1 their total project costs in their application.
2 Do you see that?
- 3 A: Yes.
- 4 Q: Now, if you look at the total project costs per
5 bed, which of the two applicants has the lower
6 total project costs?
- 7 A: Based on this information that is presented, it
8 would be Fort Mill Medical Center.
- 9 Q: And I'm going to hand you a computer.
- 10 **MR. ANDREWS:** Your Honor, if I may approach.
- 11 **THE COURT:** Yes, please.
- 12 Q: I'm sorry, a calculator not a computer. That's
13 about the extent of my technology knowledge and
14 experience. Ms. Brandt, how about do a simple
15 little computation and determine the difference
16 between on a per-bed basis the cost on -- look
17 at that right-hand column. How much more --
18 that's right, each bed at CMC-Fort Mill costs
19 compared to each bed at FMMC?
- 20 A: All right. If I've done this right, I've
21 gotten \$13,354. However, when I did my
22 calculations, I used the figure that included
23 the interest expense to do this.
- 24 Q: And do you know what the interest expense is?
- 25 A: It varied from year to year, but the rough

1 average is around \$10 million.

2 Q: Well, I remember it being less. But even if it
3 were 10 million, and you had 10 million to
4 1,198,000 and what do you get?

5 A: That would be -- I'm sorry, Mr. Andrews, you're
6 talking about the total project cost per bed?

7 Q: That's right.

8 A: I'd have to add it to the total project cost
9 and divide.

10 Q: And multiply -- I mean, divide it by the 100.
11 Well, in any event -- well, why don't you go
12 ahead and do that. Let's just do the quick
13 math. Let me just, for purposes of -- would
14 you accept a correction on the cost of the --
15 the interest cost, interest expense that was
16 identified? Remember it was approximately 8
17 million?

18 A: I think that was year one, and it went up, I
19 think, maybe eight, nine or ten. I'm not sure
20 without looking up the figures.

21 Q: Okay. All right. I can't put my hands on it
22 at this moment.

23 A: But I'll certainly accept that for purposes of
24 what you want me to do.

25 Q: All right. I've got it right here. It's

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1 closer to nine -- 8,962,000. And we're going
2 to pull it right up for you.

3 **MR. ANDREWS:** Dan, if you will, pull up Piedmont
4 Supplemental CON, Page 8. I don't know what
5 that is. It's a different one here. Scroll --
6 there we go, that's the page.

7 Q: All right. Here we go, 8.9 million?

8 A: Now, that's financing cost and construction.

9 Q: Okay, you had something different in mind?

10 A: Yes, sir. It was on their financial statement.

11 Q: Okay. All right. Why don't you add the 10
12 million to the total cost and let's see what
13 we're looking at there.

14 **MR. ANDREWS:** In the meantime, I'm going to ask Mr.
15 Westbrook to find the interest.

16 A: So you said to add the 10 million.

17 Q: Well, first of all, let me just clarify
18 something with you, Ms. Brandt. What's
19 included in the total project cost is the
20 construction interest expense; isn't it?
21 What's included on an operational cost for
22 paying down the interest to the loan would be
23 an operational expense, not a total project
24 capital cost; isn't that right?

25 A: Yes, that's correct.

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1 Q: So it would be that \$8,962,000. That would be
2 the -- part of the total project cost if it
3 were to be included; wouldn't it?

4 A: Yes, you're correct. I see where you're going.

5 Q: All right. Well, why don't you add that.

6 **MR. ANDREWS:** Dan, let's pull that document back up,
7 please. Let's get the precise figure.

8 Q: So Ms. Brandt, we'll cut back 8962851 and ask
9 you to add that to the 119 million and divide
10 by --

11 A: That's approximately, I guess \$1.29 million per
12 bed. I've got exact number right here if you'd
13 like me to read that.

14 Q: Yeah, how about giving me the exact number.

15 A: \$1,287,718.05.

16 Q: All right, good. So even if the interest
17 expense were included, then the cost of --
18 total project bed cost would be about the same;
19 wouldn't it? Would you regard them as being
20 materially different?

21 A: I would have to look at the percentage. But I
22 would say, you know, for the purposes of your
23 questioning, no. But, however, I was choosing
24 which one had specifically I believe in my
25 analysis it was stated which one calculated to

1 be the lowest. So out of the three the lowest
2 or the highest of the three applicants, the
3 cost per bed was what I had stated in my
4 analysis. In other words, Carolinas was less
5 than Fort Mill.

6 Q: Well, in fact, you -- what you characterized as
7 the lower cost for the construction of hospital
8 was one of the reasons you approved Carolinas;
9 wasn't it?

10 A: That was one of many.

11 Q: Yeah, I know. We're going to go over them.
12 But we're talking about that single issue.
13 That was what you -- this differential by
14 including the capitalized interest expense and
15 determining that on a per-bed basis, Carolinas
16 -- there was no material difference as you just
17 testified, but yet that was one of the reasons
18 that you believed that CMC-Fort Mill should be
19 approved; isn't that right?

20 A: I stated for the purposes of your comparison,
21 there was no material difference. But when I
22 aligned all three up, that's when I made the
23 distinction as to who was the higher or the
24 lower.

25 Q: Okay. Well now, the regulations do not support

1 your analysis of the comparison of these
2 expenses at all; do they, Ms. Brandt?

3 A: Well, Mr. Andrews, you would probably have to
4 show me where it doesn't support it. I was
5 charged with determining the best candidate,
6 and my analysis concluded that the cost of
7 Carolinas per bed was less.

8 Q: Let's take a look at the regulation that is
9 intended to provide you guidance on evaluating
10 the reasonableness of project costs.

11 **MR. ANDREWS:** Dan, pull up 8027, please.

12 Q: All right, Ms. Brandt, you've been working with
13 the regulations for five years, right?

14 A: Yes.

15 Q: And you're familiar with them; aren't you?

16 A: Yes.

17 Q: All right. Now, do you know whether or not
18 there are any regulations that address the
19 issue of how the department should evaluate the
20 reasonableness of projected expenses other than
21 this Section 7 -- subsection seven of Section
22 802 in the regulation?

23 A: No, I don't recall anything that specific.

24 Q: This is the reg that addresses how you should
25 evaluate expenses; isn't it?

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1 A: Well, this is the project review criteria which
2 may or may not have been chosen for
3 evaluation.

4 Q: Well, it is chosen. It has been.

5 A: In this case, yes.

6 Q: Right, okay. And whenever there is a question
7 raised, and it's identified as a priority
8 criterion, you try to follow it, right?

9 A: Yes.

10 Q: Okay. Now here, let's take a look at what it
11 says. "Projections of construction costs." Do
12 you see that?

13 A: Yes.

14 Q: And then it identifies other costs. "Should be
15 consistent with those experienced by similar
16 facilities offering a similar level and scope
17 of activities (sic)." That's what it -- or
18 service -- sorry, "scope of services"; isn't
19 that what it says?

20 A: Yes.

21 Q: And where in your CON decision letter or
22 summary have you described how you reviewed the
23 projections of Piedmont and Carolinas against
24 the expenses experienced by similar facilities?
25 It's not in there, is it?

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- 1 A: No, Mr. Andrews. But I would also want to
2 state that this project review criteria can be
3 applied to any type of application. It's not
4 specifically for competing applicants. So in
5 some cases it can be used to compare with
6 existing facilities.
- 7 Q: Well, it always, based on the way it reads, it
8 always would have to be compared with existing
9 facilities or services; wouldn't it? I mean,
10 it doesn't create an option for when it
11 wouldn't apply. I mean, this is the only reg
12 dealing with expenses.
- 13 A: Correct.
- 14 Q: This is the only reg dealing with expenses.
15 And you were looking at expenses, but you never
16 did this; did you?
- 17 A: I certainly looked at what the applicants'
18 proposals.
- 19 Q: That's not there, but the applicants' proposals
20 weren't existing facilities; were they? They
21 were proposed facilities; isn't that right?
- 22 A: Right, but it's also reasonable to assume that
23 if a facility is built 20 or 30 or 40 years ago
24 that there was no way that you could have done
25 an apples-to-apples comparison.

1 Q: Absolutely fair. But you had available at your
2 disposal within the last five years, an
3 extensive list of applications available that
4 you could consult about the proposed project
5 costs; couldn't you?

6 A: Yes. But that doesn't necessarily mean that
7 they had similar demographics. I mean, there
8 is certainly a lot of considerations.

9 Q: Ms. Brandt, demographics had nothing to do with
10 how much it cost to build a hospital; did it?

11 A: Certainly in coastal areas, typically things
12 are more expensive.

13 Q: You're talking then not about demographics, but
14 you're talking about how the market shapes in
15 different locales across the projects. Is that
16 what you mean?

17 A: Well, yes, certainly the costs --

18 Q: All right. But did you even look at the costs
19 to draw a comparison?

20 A: I believe that that information was provided to
21 us by one of the applicants.

22 Q: And that would have been Piedmont, correct?

23 A: Yes, I believe so.

24 **MR. ANDREWS:** All right. Well, let's take a look at
25 Demonstrative 151 that we just got up there.

1 Dan, let's slide back to it.

2 Q: Now, you'll see that from 2005 through 2008,
3 there were no less than eight showing here.
4 Other applications that provided a range of
5 hospital beds from 48 to 150; the same range as
6 these proposed facilities and total project
7 costs; do you see that?

8 A: Yes.

9 Q: And the regulation -- and these would be
10 similar facilities in that they were community
11 facilities or satellite hospitals offering a
12 similar range of services to what was being
13 proposed in Fort Mill; isn't that right?

14 A: Yes.

15 Q: Okay. And you didn't undertake this analysis?

16 A: No, I did not.

17 Q: Now, in fact, isn't it true that the proposed
18 bed cost for both Fort Mil, that is Piedmont's
19 proposed facility and Carolinas' proposed
20 facility fall right down in the middle of this
21 range of other satellite hospitals that the
22 department had approved; don't they?

23 A: Yes, they do.

24 Q: And in fact, you reviewed some of these
25 facilities and approved some of these

1 applications yourself. So you were very
2 familiar with them; weren't you?

3 A: Yes.

4 Q: And let's actually look at the applications
5 that you personally had approved.

6 **MR. ANDREWS:** Dan, let's turn to Demonstrative 266,
7 please.

8 Q: Now Ms. Brandt, you've, I think, reviewed and
9 approved the replacement hospitals. Let's
10 start at the top and go down with Georgetown
11 Memorial Hospital, right?

12 A: Yes.

13 Q: And they had a total project cost of \$154
14 million?

15 A: Yes.

16 **MS. ROBERTSON:** Your Honor, I'm sorry to interrupt.
17 This line of questioning we object to. I think
18 Ms. Brandt found that all applicants met
19 project review criteria number seven. And it
20 seems that Mr. Andrews is continuing to
21 question on that, but she found they equally
22 met.

23 **MR. ANDREWS:** Well, something that was pointed out
24 to me earlier in my prior examination. In
25 fact, Your Honor, I mean, we can go without it.

1 The answer is she -- she said -- it's not
2 clear, but that she made a finding explicitly
3 about Section 7. There is a reference to it,
4 and I'll point that out in a minute. But she
5 said in her decision letter and in three or
6 four places and again in her testimony that the
7 total project costs were a reason that she
8 ruled in favor of Carolinas and against
9 Piedmont. So even though there is a sentence,
10 and I'll read it to you, in Ms. Brandt's letter
11 that addresses Section 7 along with -- it does
12 it together with Section 6(a). And let me
13 point that out to you, and then I can explain
14 the ambiguity. And I'm reading from Page 7 of
15 Ms. Brandt's CON summary, second sentence.
16 "All applicants provided projections of
17 immediate and long-term financial feasibility
18 and comparable projected inpatient charges per
19 patient." There is a parenthetical that says
20 6(a) and 7. 6(a) is the criterion that
21 addresses inpatient charges.

22 **THE COURT:** Yes.

23 **MR. ANDREWS:** And she did find that, and she
24 testified to that. Seven has nothing to do
25 with that subject. It has nothing to do with

1 the subject about immediate or long-term
2 financial feasibility. And in contrast she
3 says in three other places in her decision
4 letter that she is -- and also in the summary
5 decision letter in paragraph two, that one of
6 the reasons she ruled against Piedmont was
7 because of its high -- the high capital costs
8 for its hospital. So that's why we have to go
9 down this path, Your Honor.

10 **THE COURT:** Okay, Ms. Robertson?

11 **MS. ROBERTSON:** Yes, Your Honor. I would submit
12 that she has determined that they all equally
13 met seven. She testified in her testimony
14 earlier today that that was the case. She does
15 not list Carolinas as better meeting criterion
16 seven in her letter. I think the record
17 demonstrates that her findings as to seven was
18 that all were equally met.

19 **MR. ANDREWS:** Your Honor. Let me just address it
20 this way: Paragraph two, she says --

21 **THE COURT:** And you're referring to her letter?

22 **MR. ANDREWS:** I am, yes, sir. I'm sorry. Yes, sir,
23 her cover letter to the CON analysis -- one of
24 the things the department is concerned about is
25 the substantial cost of the project. The costs

1 of the project are addressed based on what she
2 said solely in paragraph seven. And then I
3 could cite several examples of where she says,
4 Piedmont has the highest cost per bed of all
5 the applicants. And then after finding that
6 Carolinas best meets and Presbyterian have
7 total project costs and FTEs per adjusted
8 occupied bed. That they have comparable costs
9 and found that Carolinas best meets that.
10 That's a Section 7 issue, Your Honor. And
11 another page, and I don't intend to stop with
12 construction costs, where she finds that the
13 operating costs for Piedmont are higher yet
14 hasn't performed the only analysis in the
15 project new criteria that addresses. So that
16 is why I'm trying to lay or establish a record.

17 **THE COURT:** Based on this, Ms. Robertson, I see your
18 point. She did clearly state apparently that
19 she found them equal. However, there do appear
20 to be some, what appear to be statements that
21 reflected perhaps she made some considerations
22 and did some comparisons there. I am going to
23 allow Mr. Andrews to go into this. And then if
24 you want to rehabilitate her, please absolutely
25 do so.

- 1 **MS. ANDREWS:** Okay. Now Dan, pull back up
2 Demonstrative 266, please.
- 3 **Q:** Now again, Ms. Brandt, you reviewed each of
4 these applications and approved them, right?
- 5 **A:** Yes, I did.
- 6 **Q:** Georgetown replacement facility, 124 beds at a
7 total project cost of \$1.24 million per bed,
8 \$154 million total, correct?
- 9 **A:** Yes.
- 10 **Q:** All right. And then you approved Millennium,
11 same year?
- 12 **A:** Yes.
- 13 **Q:** At a cost of nearly \$3 million dollars, \$2.9
14 million dollars a bed, right?
- 15 **A:** Yes.
- 16 **Q:** That was a 52-bed hospital at the size of the
17 proposed Fort Mill Medical Center that was
18 approximately \$30 million greater, correct?
- 19 **A:** Yes, but there were very clear in their
20 application as to why the costs were
21 considerably greater to include the green
22 technology. It was a deliberate effort on
23 their part to incorporate some technology that
24 was admittedly expensive.
- 25 **Q:** And two other proposals that you approved were

1 the two competing Berkeley County or the two
2 Berkeley County applications. I believe you
3 found them not competing at the end of the day,
4 is that right?

5 A: Yes.

6 Q: All right. Each \$50 million and -- I'm sorry,
7 50 beds and comparably priced was Fort Mill
8 with, even though half the size, true?

9 A: Yes, that's true. But again, I know this is a
10 comparison, but you have to drill down and look
11 at certainly some of the details. At the time
12 most of these applications came in, there were
13 still some aftereffects from what I recall a
14 post Katrina inflation. And so that would not
15 have been unreasonable for them to have
16 accounted for the increased construction costs
17 and labor costs and steel costs at the time of
18 issue, not the Katrina issue. There are
19 certainly reasons for the total project cost
20 that you have to look at in more detail.

21 Q: All right. The point is that based on the four
22 projects that you approved in 2008, that the
23 costs for construction for the Fort Mill Center
24 was imminently reasonable; wasn't it?

25 A: Yes, according to this chart in comparison.

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1 Q: And the regulations direct you to determine
2 whether or not the proposed project costs and
3 specifically the proposed construction costs
4 are consistent with the costs incurred by
5 similar facilities offering similar services;
6 isn't that right?

7 A: Yes.

8 MS. ANDREWS: All right. Now, let's take a look at
9 -- let's go back to the reg, please Dan.
10 802.7.

11 Q: Now, another cost that the regulations instruct
12 the reviewers to take into consideration is the
13 operating costs, right?

14 A: Yes. And I want to point out that -- I mean,
15 I looked at all of this as a whole. I didn't
16 -- and these things were covered in all the
17 applications. So I did look at those and
18 consider what they were presenting to us.

19 Q: All right. I know you looked at them as a
20 whole. You considered a lot of different
21 project review criteria. We are looking at
22 these related to project expenses. And you've
23 identified one of the reasons, again, in your
24 cover letter that you denied Carolinas was
25 because of their substantial project costs;

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1 that's what you said, right?

2 A: Yes. And if you look at the paragraph, it
3 captures other issues as a whole.

4 Q: Well, do you want us to strike it out and focus
5 on some of those other issues?

6 A: Well, no. They're just all related is my
7 point.

8 Q: All right. Well, we understand that, but the
9 only way we can talk about them is one at a
10 time, okay?

11 A: Okay.

12 Q: So. Now, with regard to projected operating
13 costs. There is no place in these regulations
14 where the regulations approved by the General
15 Assembly say the lowest cost is best; is there?

16 A: No.

17 Q: And you would agree that the lowest cost may
18 not be the best, correct?

19 A: That's correct and certainly you can compare a
20 lot of things about these applications.
21 Carolinas may not have had the lowest cost.
22 Again, I looked at and considered all factors.

23 Q: All right. But the ones you talked about and
24 emphasized in your decision letter and in this
25 analysis had to do with where Piedmont's costs

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1 you've described as higher. And so let's move
2 on to look at the operating costs here. Would
3 you agree that one of the reasons in particular
4 that you are careful about how you compare
5 operating costs is because it's very difficult
6 for the department to understand the
7 assumptions that underlie the proposed pro
8 forma and operating costs of an applicant?

9 A: Mr. Andrews, you said you don't understand what
10 they're saying?

11 Q: That it's very difficult for you to understand
12 when you're reviewing an application for a
13 multi-million dollar hospital to understand all
14 the assumptions related to what goes into the
15 applicant of the pro forma.

16 A: So Mr. Andrews, are you saying individually?
17 I can't -- I'm not able to --

18 Q: No, not individually. I mean anyone in the
19 department that it is difficult to comprehend
20 because they are complex.

21 A: Well, yes they are complex, but the applicants
22 are required to state the assumptions to us.

23 Q: Okay. Do you believe then that it's good or
24 bad if one applicant has more FTEs than
25 another?

1 A: I don't think it's good or bad. We have to
2 look and see are they loaded up on janitors or
3 nurses. I mean, there is a lot to consider.

4 Q: Okay. And it could be a sign that it's better
5 patient service. That would be one potential,
6 wouldn't it, if there were more nurses in a
7 place where the nurses were needed; that could
8 be a good thing, couldn't it?

9 A: Well, yes. I mean, it can go either way. You
10 just want to make sure you have the appropriate
11 staff for your needs; that you are not
12 overstaffed or understaffed.

13 Q: Well, isn't it true in reviewing these
14 applications, Ms. Brandt, that you relied
15 heavily, if not entirely, on what the
16 applicants represented to you about their needs
17 for personnel?

18 A: Yes, I do. In certain cases, I may compare
19 previous applicants for other projects. But,
20 yes, I do rely on the applicants to know what
21 they are doing.

22 Q: And you are relying on them because every one
23 could have a different approach to how -- what
24 services they provide in a hospital versus what
25 they provide in headquarters for backup

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1 services, right?

2 A: Yes.

3 Q: Okay. And they could have different management
4 to front-line ratios; couldn't they?

5 A: Yes.

6 Q: And none of those are necessarily good or bad,
7 but they're just different approaches; aren't
8 they?

9 A: Yes.

10 Q: And others could have more inpatient services
11 or more outpatient services; couldn't they?

12 A: Yes, that would be a decision on their part.

13 Q: Right. Well, it may reflect their own
14 practices and patterns of operating within
15 their different hospitals; wouldn't that be
16 true?

17 A: Yes, it could.

18 Q: And where there are more inpatient services
19 provided than outpatient services as a rule of
20 thumb; wouldn't you expect there to be greater
21 staffing and greater expenses to support the
22 inpatient services and the outpatient services?

23 A: Yes.

24 Q: Okay. And that's going to raise the expense
25 level, isn't it, for those where there is a

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1 higher degree of inpatient services?

2 A: Yes.

3 Q: Okay. Now, let's turn to your analysis and see
4 what you've addressed with regard to operating
5 costs.

6 **MR. ANDREWS:** Dan, if you will pull up Page 7 of Ms.
7 Brandt's analysis. I want to start there. And
8 let's go to the last paragraph. And highlight,
9 Dan, please the sentence beginning, "Both
10 Carolinas and Presbyterian have comparable
11 total project costs."

12 Q: All right. And we've just dealt with total
13 project costs as it relates to capital costs.
14 But let's look at the second element of that
15 statement, Ms. Brandt. It says, "Both
16 Carolinas and Presbyterian have comparable FTEs
17 per adjusted occupied bed." You see that?

18 A: Yes.

19 Q: What does that mean?

20 A: Usually the adjusted occupied beds, if I'm
21 remembering correctly, consider both inpatient
22 and outpatient services. And there is an
23 adjustment made for occupancy.

24 Q: Do you know how to calculate that and
25 reconstruct what your finding was here?

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1 A: I can't say that I know the calculation off the
2 top of my head, and I don't believe that that
3 was part of this analysis. I just made a
4 statement that their costs were comparable. I
5 mean, I'm not sure where you're going, but I
6 did make that statement they were both
7 proposing the same amount in beds.

8 Q: Well, they're both, what you say here is that
9 both -- they have comparable FTEs per adjusted
10 occupied bed.

11 A: Yes.

12 Q: All right. Do you know how to calculate that?

13 A: I would have to look at the figures, and I
14 would also assume that -- or presume that that
15 information is provided to me. I don't recall
16 that I specifically did that calculation
17 myself.

18 Q: Okay. So that would have been a calculation
19 that either or other applicants would have
20 provided to you. And you were making a
21 statement based on that; would that be your
22 recollection?

23 A: I suppose, Mr. Andrews. I'm just trying to
24 think about this so I could appropriately, you
25 know, respond. And perhaps I did look at the

1 total project costs and divide it by FTEs. At
2 this point, I honestly don't remember.

3 Q: Do you ever remember performing that
4 calculation in this case?

5 A: I don't recall, Mr. Andrews.

6 Q: Do you ever recall using that measurement in
7 any case to determine whether an applicant has
8 reasonable expenses?

9 A: I honestly don't remember, Mr. Andrews.

10 Q: Ever having used it before.

11 A: But, I don't believe that I stated that there
12 was a need for this.

13 Q: Well, I think if you look down believe, you
14 said, "Piedmont least meets this criteria,"
15 correct? Do you see that?

16 A: Yes, but that was -- I was talking about the
17 profit in year three.

18 Q: Okay. Well, let's move to the next page where
19 your statement related to Piedmont. It's a
20 little more direct.

21 **MR. ANDREWS:** Dan, highlight the first three lines,
22 please. All right.

23 Q: Now, read the first sentence into the record.

24 A: "The department has received numerous
25 projections or expenses per adjusted discharge

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1 making it difficult to assess impact for
2 adjusted discharge. However, it appears that
3 Piedmont has the highest cost in revenue per
4 adjusted discharge."

5 Q: Now, in the first sentence you acknowledge that
6 you've gotten a lot of data concerning this
7 analysis of expenses per adjusted discharge and
8 that it's difficult to assess?

9 A: Yes.

10 Q: And that would mean hard to figure out; isn't
11 it?

12 A: Well, we kept getting different information,
13 and it was certainly difficult to keep it
14 calculated.

15 Q: Well, it made it hard, but it didn't prevent
16 you from forming the conclusion that you did
17 that Piedmont has the highest cost in revenue
18 per adjusted discharge?

19 A: Well, it says it appears that Piedmont has the
20 highest cost in revenue per adjusted
21 discharge.

22 Q: Well, does that mean you disregarded -- I mean,
23 it's qualified by it here. Does that reflect
24 a conclusion that they did that you took into
25 consideration in making the decision?

1 A: I did not hold that in this ranking. I don't
2 see where I held that against Piedmont. I
3 don't believe it says that Piedmont did not
4 meet.

5 Q: Well, in fact, which -- in fact, the
6 organization of this, Ms. Brandt, would suggest
7 that the expenses under -- which you've
8 discussed under Section 7, or it should be
9 evaluated under Section 16, which has to do and
10 16(a) in particular with the method of
11 financing, right? That's where this is; isn't
12 it?

13 A: Yes, sir. I'm a bit confused by the statement
14 you just made.

15 Q: I'm a bit confused by the placement of an
16 expense analysis in the analysis of the method
17 of financing which is 16(a). So clarify that
18 for me if you would.

19 A: Well, certainly 16(c) deals with the cost of
20 provided services and charges, and that would
21 be figured into the expenses.

22 Q: Well, let's look at 16(c) if you think that
23 provides an answer to you. Ms. Brandt, do you
24 know that 16(c) is in effect an adverse impact
25 analysis wanting to know what the reg invites

1 is your review of the effect of the proposed
2 project costs on existing providers.

3 A: You would have to refresh my memory.

4 **MR. ANDREWS:** All right, let's pull it up. Dan,
5 pull up 16(c) if you would.

6 Q: Okay. Have you had an opportunity to look at
7 it?

8 A: Yes.

9 Q: All right. So this is the impact of the
10 project. "Upon the applicant's cost to provide
11 services and the applicant states the charges
12 to be reasonable. The impact of the project
13 upon the cost of charges of other providers for
14 similar services should be considered as the
15 data are available." So 16(c) really doesn't
16 have anything to do with the calculation of
17 costs and revenue per adjusted discharge; does
18 it?

19 A: Well, it doesn't say that specifically, but it
20 does mention costs to provide services.

21 Q: Well, did you -- did you find that Piedmont's
22 cost of providing services in its application
23 were high, higher than Carolinas, and that
24 would be a basis for deciding against them. If
25 you didn't, we can move on.

1 A: I don't believe I computed that.

2 Q: Did you find anywhere in your analysis and more
3 importantly as you're testifying today, is it
4 your position that the department does not have
5 any concerns about the expenses that Piedmont
6 projected to incur in this project?

7 A: I don't recall having any concerns.

8 Q: All right. Good. Now, let's move to your
9 testimony concerning financial feasibility and
10 net income. Now, let me begin by talking with
11 you about the purpose of this. Isn't this
12 fundamentally through Section 9 of the regs and
13 Section 15 the way the department intends to
14 evaluate whether or not the proposed project is
15 likely to be financially successful and to be
16 able to operate over a long term?

17 A: Yes.

18 Q: And the most concrete way that that's evaluated
19 is if it shows improvement over the three years
20 of its operation; isn't that right?

21 A: Yes.

22 Q: And all of the applicants, including Piedmont
23 and Carolinas application showed that; didn't
24 it?

25 A: Yes.

1 Q: All right. You deemed Piedmont -- you found
2 that they didn't perform as well as Carolinas
3 because they didn't show profitability until
4 year three; isn't that right?

5 A: I believe I identified that as a concern.

6 Q: Well, I mean, is it a mild concern or is it one
7 that was a basis for your ruling in this case?

8 A: It didn't make or break the decision.

9 Q: Meaning it's inconsequential?

10 A: No. I had a specific way to rank the project
11 review criterion. And I don't believe that was
12 the top one.

13 Q: You mean it wasn't particularly important to
14 you but it was on the list so you needed to
15 make a judgment about it, and you made a
16 judgment; is that fair?

17 A: Well, it's certainly important because I was
18 directed to consider it. But it didn't make or
19 break the decision.

20 Q: Okay. Well, I'm not sure what you mean when
21 you say it didn't make or break the decision.
22 It was a factor which you wrote -- was it a
23 factor that you relied on in deciding for
24 Carolinas and against Piedmont?

25 A: It was certainly something that I had to

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1 consider and so I did consider it.

2 Q: Okay. Let me repeat the question. That's not
3 -- I didn't ask whether you considered it. I
4 know you considered it. The question is
5 whether it's a factor that affected your
6 judgment in deciding for Carolinas and against
7 Piedmont?

8 A: Yes, I would say so. At this point, I don't
9 recollect what my decision letter said or even
10 the analysis, but I know I made the statement
11 that the other two applicants showed a positive
12 net income by year two that Piedmont or Fort
13 Mill did not.

14 Q: Well, that's a question of fact, Ms. Brandt.
15 And yes, the records are clear about that. The
16 question is: Is that -- is it a degree of
17 significance, the degree of weight you placed
18 on that in making a decision in this case; was
19 it major factor, was it a minor factor or was
20 it a non-factor?

21 A: I would say that it wasn't a major factor.

22 Q: Was it a minor factor then?

23 A: Yes, as I recollect.

24 Q: Okay. Well, let's take a look at it, in any
25 event, if it was a factor at all. Now, the --

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1 **MR. ANDREWS:** Dan, let's pull up Section 9 of the
2 regs to be sure what we're looking at here.

3 Q: All right. Now, it's the first sentence of
4 Section 9 Ms. Brandt states, "The project
5 should show an improvement in its net revenue
6 position over time, especially the first three
7 years until a steady positive net income trend
8 is attained." Now, Piedmont did that; didn't
9 they?

10 A: Oh yes, they did.

11 Q: The -- and again, the goal here is to
12 demonstrate economic viability and
13 sustainability, correct?

14 A: Yes.

15 Q: Now, in your review of CON applications, there
16 has been a wide range of financial performance
17 demonstrated; wouldn't you say that would be
18 fair?

19 A: Yes.

20 **MR. ANDREWS:** Okay. And let's pull up Demonstrative
21 267, please, Dan.

22 Q: These are the hospital cases you reviewed prior
23 -- well, prior to what you reviewed here. And
24 you had found all of these cases to -- you
25 approved them all. And you found them all to

1 have been financially feasible; haven't you?

2 A: Yes. But I recall that we requested a lot of
3 additional information from Georgetown. And
4 honestly I didn't even remember the year three
5 figure or any of the other figures for their
6 applications. But I know, as a policy, if it
7 doesn't look like a facility is going to
8 increase their debt, that we should get more
9 information from them.

10 Q: Right. And you approved Georgetown, and yet it
11 showed not -- didn't show a positive trend.
12 It's losing more money each of the three years;
13 isn't that right?

14 A: Yes, but --

15 MS. ROBERTSON: If I might just object. I believe,
16 just so the record is clear so there is no
17 confusion, Mr. --

18 MR. ANDREWS: Andrews.

19 MR. ROBERTSON: Yeah, I'm sorry. Thank you. Yes,
20 Mr. Andrews, I know your name.

21 MR. ANDREWS: That's not my --

22 MR. ROBERTSON: I was just going to point out that
23 the Georgetown application that is on this
24 demonstrative, I believe we've heard testimony
25 from Mr. Levitt that it was withdrawn. And Mr.

1 Andrews keeps referring to it as something
2 being approved by Ms. Brandt, and I'm not sure
3 that's accurate.

4 **MR. ANDREWS:** Let me clarify the record. It was
5 approved. It was not implemented. The project
6 was abandoned as Millennium was, too. I was
7 going to go there. Two of the four projects
8 were approved but not implemented.

9 **THE COURT:** Right. Okay. All right. Objection is
10 overruled. Objection is overruled.

11 **MS. ROBERTSON:** That's right, Your Honor. I just
12 wanted it to be clear for the record.

13 **THE COURT:** Yes. And thank you for clarifying that,
14 Ms. Robertson because that's important.

15 **MR. ANDREWS:** Thank you.

16 **Q:** And you approved these, right, Ms. Brandt?

17 **A:** Yes. But again, I'm not disputing the accuracy
18 of this information. But it's merely a
19 snapshot in time and doesn't give a lot of
20 detail about why I was willing to accept the
21 financials for Georgetown, for example.

22 **Q:** Well, do you recall that one of the reasons you
23 were willing to accept the finances for
24 Georgetown is that the operation of the
25 Georgetown hospital system, which included

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1 Waccamaw and Georgetown Memorial, was performed
2 at a viable level as a result of Waccamaw's
3 profit margins and contributions. Do you
4 remember that?

5 A: Yes, sir. I'm sure I also considered the fact
6 that this hospital is located in a real
7 disadvantaged community, and that it was in
8 their best interest to have a new facility, as
9 well. Again, there is other considerations to
10 that.

11 Q: Okay. And ultimately they abandoned the
12 project after you approved it and decided not
13 to go forward, correct?

14 A: Yes.

15 Q: Now, the next project, Millennium, was on the
16 other end of the spectrum with regards to the
17 proposed financial performance, right?

18 A: Yes.

19 Q: They expected to make a lot of money each year?

20 A: Yes.

21 Q: And this was the project that was nearly \$3
22 million a bed, right?

23 A: Yes.

24 Q: And they decided also that it was too expensive
25 and not to go forward?

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1 A: I'm not sure why they decided not to go forward
2 with it, but they decided not to.

3 Q: Okay. And so both of these applications you
4 approved. One at \$3 million a bed, the other
5 showing a total of nearly \$45 million in losses
6 the first three years of operation; but you
7 approved them anyway, right?

8 A: Well, I approved them based on a lot of other
9 information in addition to what's captured in
10 this statement.

11 Q: And then the two Berkeley County projects.
12 They are quite similar, are they not, to the
13 financial progress made from year one, year
14 two, year three with the Fort Mill Medical
15 Center application; aren't they?

16 A: Well, I'd say more so Trident Berkeley for the
17 first two years and Roper Berkeley for the last
18 year, yes.

19 Q: And Roper Berkeley has an enormous loss for
20 year one; doesn't it?

21 A: Yes.

22 Q: And that's the hospital, again affiliated with
23 Roper which is owned in part and managed by
24 Carolinas, correct?

25 A: Yes.

- 1 Q: All right. Now, would you -- have you thought
2 about the relationship between the instructions
3 that the department is given in evaluating the
4 reasonableness of the revenue projections and
5 the reasonableness of the expense projections
6 in forming the proposed net income for various
7 applicants? The question may be a bad one, and
8 if you don't understand me, just tell me, and
9 I'll start over.
- 10 A: Yes, it is. No, I'm having trouble with that,
11 Mr. Andrews.
- 12 Q: Okay. All right. Just a quick review then.
13 Under six -- Section 6(b), the department is
14 instructed to determine the reasonableness of
15 utilization projections, right?
- 16 A: Yes.
- 17 Q: And the way you do that, isn't it true, is that
18 you look to make a determination whether the
19 proposed applications are consistent with
20 similar facilities providing similar services,
21 right?
- 22 A: Well, that's one thing if that information is
23 available, we can do it.
- 24 Q: Well, that's the only thing that is identified,
25 isn't it, in 6(b) as you are determining

1 revenues --

2 **MR. ANDREWS:** Dan, let's go there.

3 A: Yes, thank you.

4 Q: Sorry. Okay. So for purposes of projecting
5 levels of utilization, this regulation says
6 that the department should -- the projected
7 levels of utilization should be reasonable
8 consistent with those experienced by similar
9 facilities in the service area or the state and
10 should be similar and consistent with the need
11 as a second of the target population, the
12 second sentence, right?

13 A: Yes.

14 Q: Now, and so the -- for purposes just like we
15 were talking about earlier, for expenses. What
16 the regulations guide you to review or to do is
17 to determine among other things whether
18 projected levels of utilization is consistent
19 with those experienced by the facilities,
20 similar facilities with similar services,
21 right?

22 A: Well, yes, reasonably services.

23 Q: It doesn't mean exact. It's kind of a baseline
24 measurement that you are taking, right?

25 A: Yes.

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1 Q: Now, the reason you are looking at projected
2 levels of utilization is because that ties to
3 revenues, projected revenues, right?
4 Utilization drives the money that comes into
5 the facility, correct?

6 A: Yes.

7 Q: Okay. And so the guidance that is provided
8 from the regs is looked up at facilities to
9 determine their general levels of utilization
10 as a marker to determine the reasonableness of
11 projected utilization and revenues by the
12 applicant, right?

13 A: Yes.

14 Q: You didn't do that here either; did you?

15 A: Well, I certainly looked at Piedmont Medical
16 Center's reference of utilization.

17 Q: As a guide for determining the reasonableness
18 of Carolinas' projections?

19 A: No, as a guide for determining the
20 reasonableness of the Fort Mill Medical
21 Center's --

22 Q: Well, the regulations say you apply to all
23 applicants, not just one, right?

24 A: Yes, it does. But Carolinas had established
25 what their utilization was.

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1 Q: Well, let me drop a footnote on that. We'll
2 come back to that. I didn't mean to get too
3 far on that radical. But what we're talking
4 about is net income. Would you agree with me
5 that the regs provide guidance for how you are
6 to look at the reasonableness of projected
7 revenue in 6(d) that we just looked at, right?

8 A: Yes.

9 Q: And under 7, it provides guidance as to how you
10 look at the reasonableness of projected
11 expenses; remember that?

12 A: Yes.

13 Q: Okay. And when you put revenue and expenses
14 together, the balance, bottom line is net
15 income, correct?

16 A: Yes.

17 Q: All right. So it would be reasonable, wouldn't
18 it then, that you looked to the performance of
19 other's similar facilities and what their
20 projected net income is and reviewing the net
21 income of a proposed applicant. Doesn't that
22 stand to reason?

23 A: Well yes, as guidance.

24 **MR. ANDREWS:** So as we're -- Dan, let's go back to
25 Demonstrative 267, please.

1 Q: All right. So as we are then looking at the
2 extent to which the proposed net income
3 progression over the three -- first three years
4 of its operation for Fort Mill are, it is
5 comparable to at least three of those, probably
6 two, both Ropers. It's far lower, far better
7 if you want to apply a qualification to it than
8 Georgetown's, right, and not as good as
9 Millennium's in the sense it is not showing as
10 much profitability, right?

11 A: Yes.

12 Q: Okay. And CMC-Fort Mills is more comparable
13 but not as high as Millennium's, right?

14 A: Yes.

15 Q: And it's not showing the losses that the others
16 show, correct?

17 A: Correct.

18 Q: Now, isn't the goal here, Ms. Brandt, as you
19 are reviewing these proposals to determine the
20 consistency with other applications really to
21 determine whether or not the financial
22 projections are reasonable?

23 A: Yes, I would agree with that.

24 Q: It's not a better or worse than. It's just are
25 they reasonable given what they are proposing

1 to do. Isn't that the bottom line?

2 A: Yes, that's true.

3 Q: Okay. And based on your experience in
4 approving these other applications in addition
5 to the one that approved before you arrived,
6 Fort Mill Medical Center's projected financial
7 feasibility is consistent with many of the
8 other satellite hospitals that the departments
9 approved in the five years prior to approving
10 the ones in this case.

11 A: I would have to look at those figures. But
12 again, the figures from Fort Mill Medical
13 Center were predicated upon them recapturing a
14 significant amount of market share. So it's
15 not just a number on a piece of paper but how
16 those projections were derived.

17 Q: But that's not a financial feasibility question
18 as much as it is a projected utilization
19 question; isn't it?

20 A: Well, if you can't obtain your projected
21 utilization, then your project is probably not
22 going to be financially feasible.

23 Q: But your financial feasibility analysis is not
24 based on not showing more profitability but
25 based on questions you raised about whether

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1 they could recapture enough market share.

2 A: Yes, I believe I'm understanding you correctly.

3 Q: Well, in other words, there is nothing
4 inherently inconsistent with the regulations
5 based on the financials that were presented in
6 the financial projections done by Piedmont.
7 Where you have a concern is what the
8 assumptions were that were the basis for their
9 projections?

10 A: Right, right. And you are talking about,
11 again, what was the financial performance over
12 time with this --

13 Q: All right. And so I just want to make sure the
14 record is clear on this. I mean, you've
15 already testified, and we'll examine that a
16 little bit later about what you think may be
17 the questions about whether or not Piedmont
18 reasonably projected the utilization. But
19 again, there is another section in the regs
20 dealing with utilization. This on financial
21 feasibility has to do with forecasting income
22 and the likelihood of economic viability if
23 the assumptions were achieved?

24 A: Yes.

25 Q: All applicants you could say the same thing.

1 If their assumptions aren't achieved, then
2 their financial projections are going to be
3 off, right?

4 A: Yes.

5 Q: Okay. All right. But the purposes of this --
6 question is as they presented their application
7 whether or not looking just at their financial
8 forecasting, there was any probably, in and of
9 itself. And your answer to that is: No, there
10 is not, is that right?

11 A: Correct. I don't recall saying they did not
12 meet that criterion.

13 Q: Okay. All right. Well, let's go back then to
14 the criterion that addresses utilization. And
15 that will lead us into your testimony in that
16 regard. Now, as I understood your testimony
17 and reading your report, Ms. Brandt, my
18 impression, and you tell me if I'm off base on
19 this, that there are really two reasons that
20 you felt that Piedmont's application didn't
21 work for you and that the 100 beds they
22 proposed were not justified. One was because
23 of by transferring the 36 beds, it would create
24 maldistribution of beds in York County. Is
25 that one of the two?

- 1 A: Yes, that was certainly a concern for us.
- 2 Q: And the other was that as you put it, in
3 shifting patients from Piedmont to Fort Mill,
4 patients would have to, as you said, drive by
5 Piedmont, and you didn't think, as you put it,
6 that was logical, right?
- 7 A: Yes, yes. That's correct.
- 8 Q: Now, the idea of this the maldistribution
9 theory, that was not a term that you coined;
10 was it?
- 11 A: No, it was not, but I certainly did look at the
12 beds and the population distribution.
- 13 Q: Okay. Ms. Platt, one of the consultants for
14 Piedmont, did an analysis that presented a per-
15 bed rate. Did I misspeak? I'm sorry. Yeah,
16 they're reminding me that I'm confusing my
17 client -- their names. Ms. Platt, as everybody
18 in the room probably knows, works with
19 Carolinas and not Piedmont. I misspoke. And
20 Ms. Platt provided you an analysis showing that
21 based on a bed-to-population ratio that by
22 moving 36 beds to Fort Mill there would be a
23 shortage of beds available to Rock Hill and to
24 western York County, is that right?
- 25 A: Yes.

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1 Q: And that analysis made sense to you?

2 A: Yes. I mean, certainly she focused on Rock
3 Hill. I honestly don't recall about western
4 York. But I believe you're right.

5 Q: Had you ever performed that analysis before?

6 A: No, not that specific analysis. But I
7 certainly was aware of the population of
8 greater Rock Hill and that it was substantially
9 more than northern York County. And I
10 certainly knew how many beds were proposed to
11 be where and how many were existing and all
12 that at Piedmont.

13 Q: And so -- now, you're aware that in the
14 approval of a lot of satellite hospital
15 applications, there are transfers of unused
16 beds, aren't you, as a basis for the approved
17 creation of satellite hospitals?

18 A: Yes.

19 Q: Roper did that to establish Roper Berkeley;
20 didn't they?

21 A: They did. But again, Mr. Andrews, the
22 specifics of why they did it, I just don't want
23 to say -- blanketly say, you know, without
24 truly knowing. But certainly that's what Roper
25 proposed.

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1 Q: Well, Roper had underused beds in its inventory
2 and used 50 of them to propose the creation of
3 Roper-Berkeley; isn't that true?

4 A: Yes, but I know as far as the population of the
5 peninsula of Charleston, that was a factor, as
6 well.

7 Q: Okay. And Roper also had another 85 beds in
8 its inventory and used that to create Roper
9 Mount Pleasant just a few years before; isn't
10 that also right?

11 A: I believe you're correct.

12 Q: And, in fact, if you are familiar with the
13 creation of satellite hospitals over the last
14 ten years, most of them have been created
15 through the transfer of under utilized beds and
16 the shifting of patients from the underutilized
17 facility to the high growth area; isn't that
18 right?

19 A: Yes.

20 Q: So that's -- in that regard what Fort Mill is
21 proposing to do is consistent with what
22 hospitals, particularly tertiary hospitals,
23 have done throughout the state. Do you know
24 that to be true?

25 A: I guess I would say as a general rule.

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1 Q: Now, and with regard to the transfers of -- the
2 proposed transfer of the beds to the Fort Mill
3 Hospital

4 MR. ANDREWS: Dan pull up, if you would, Carolinas'
5 Exhibit 33. And let's look at Page 4 first of
6 all and call that out.

7 Q: Now, does this look familiar to you, Ms.
8 Brandt?

9 A: Yes, it's been awhile, but I do recall.

10 Q: You can see from the heading it's updated. And
11 so it may be a bit different than the one Ms.
12 Platt would have provided you during the staff
13 review. But what do you understand is the
14 purpose of this document?

15 A: The purpose is to examine where the populations
16 are and where the beds are and correlate the
17 beds to the population per 1,000 population.

18 Q: All right. And has -- now, the state health
19 plan does not use this methodology in
20 determining bed need; does it?

21 A: No, it does not. It certainly uses population
22 projections and utilization projections, but it
23 doesn't drill down to the specific areas of the
24 county.

25 Q: Well, and there is no utilization projection at

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1 all factored into this analysis; is there?

2 A: This is purely based on beds and population.

3 Q: And there is no -- and there is no weighted
4 factor that's applied within the population
5 recognizing that folks over 65 use hospitals
6 with a much greater frequency than those from
7 21 to 50 do, right?

8 A: No, this is purely based on population.

9 Q: So it has limited, if any, reliability from a
10 healthcare planning methodology without any
11 utilization or use data; does it?

12 A: I will say limited. It certainly goes as a
13 reference for comparison.

14 Q: And well, you relied on it, didn't you, in your
15 analysis?

16 A: I certainly looked at this, but I relied on my
17 knowledge of the population of the county and
18 the population trends.

19 Q: Well, in addition to population trends, if
20 that's enough, did you have the utilization
21 trends by region within the state by zip codes
22 within York County?

23 A: I know I had the population by zip code. I'd
24 have to really look to see if I had utilization
25 or not. I know in the broad areas maybe but

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1 not by zip codes. I don't recall.

2 Q: Okay. And you didn't have any use rates by zip
3 code or utilization data by zip code and only
4 had population data by zip code, then this
5 analysis would have limited utility; wouldn't
6 it?

7 A: Again, it would be one of many things that
8 would have been looked at for comparison.

9 Q: Well, I know, but we are talking about your
10 concern about the effect under Section 2(d) of
11 relocating the beds. Now, you remember what
12 Section 2(d) provides; don't you?

13 A: I'm sorry. I would have to look at that.

14 Q: Okay. Let's take a look at 2(d). All right.
15 Now, Section 2(d) asks the fundamental question
16 about whether the relocation of beds causes any
17 harm to medically served groups. Isn't that
18 really what 2(d) gets to?

19 A: Yes.

20 Q: Okay. Now, as you are sitting here right now,
21 you said you didn't know and you applied, as I
22 understood it, and you tell me if I'm wrong,
23 that you didn't give much weight to the western
24 York County factor at all; your concern was
25 Rock Hill, right?

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1 A: I certainly looked at it. It's a sparsely
2 populated area and certainly probably more
3 under-served, but I certainly looked at that
4 and considered that.

5 Q: Well, I thought you said your primary concern
6 was Rock Hill. Did I misunderstand you?

7 A: Well, I know I said that that's where most of
8 the population was.

9 Q: Okay. The question is did you make a finding
10 that there would be an adverse impact on a
11 medically under-served group by Piedmont's
12 transfer of 36 beds at Fort Mill?

13 A: I don't recall with that specificity, but I do
14 know that the Tega Cay, Fort Mill area is known
15 to be an affluent area.

16 Q: Okay. I can see that. But that really didn't
17 relate to my question. You would agree with
18 me, wouldn't you, that Section 2(d) is intended
19 to have the department make a determination
20 about whether the change in a service, in this
21 case the relocation of beds, would create a
22 harm on a medically under-served group? That's
23 where the focus is.

24 A: I believe that's what the last half of it
25 focuses on. I mean, there are other things

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1 within that.

2 Q: Did you find that there would be harm caused to
3 a medically under-served group as a result of
4 the relocation?

5 A: No, I did not specifically.

6 Q: Okay. All right. And, in fact, isn't it true
7 that you raised a concern about whether 2(d)
8 had been met by Piedmont, and then in your
9 deposition said, you know, I guess they met it
10 because I really didn't find that they didn't.
11 Do you remember that?

12 A: I really don't recall what I said in my
13 deposition.

14 Q: Did you find here on this page --

15 **MR. ANDREWS:** Let's turn to Page 3, Dan. And if you
16 call out that middle part of the paragraph in
17 the middle of the page.

18 Q: And in this regard, Ms. Brandt, did you make a
19 finding here that Piedmont did not meet 2(d)?

20 A: No, I just stated that we were concerned that
21 this criterion had been inadequately
22 demonstrated.

23 Q: Now, the -- and that leads to the second
24 question. So the maldistribution issue relied
25 on this plat for -- you recognize a limited

1 utility of looking only at bed-to-population
2 bed ratios. And so let's take a look at the
3 second basis for the concern you raised, which
4 has to do with the shift of patients and beds
5 to Fort Mill Medical Center. First of all, the
6 64 beds -- Your Honor, this might be a good
7 time to take a break. It's been long in the
8 afternoon.

9 **THE COURT:** It has been. Any objection to that?

10 **MS. ROBERTSON:** No, Your Honor.

11 **THE COURT:** Let's take about a 15-minute break. All
12 right. We'll recess.

13 (Off the Record)

14 **THE COURT:** Okay, we're back on the record. Mr.
15 Andrews, sir?

16 **MR. ANDREWS:** Thank you, Your Honor.

17 Q: Ms. Brandt, let me draw your attention to your
18 CON analysis, Page 5 of 10 where you are
19 discussing the relocation of the 36 beds.

20 **MR. ANDREWS:** Dan, if you will call out the bottom
21 paragraph, please.

22 Q: And Ms. Brandt, you say here on the second
23 sentence beginning with relocation, that the
24 relocation replacement of 36 beds in northern
25 York County does not appear to equitably

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1 distribute beds within the county and reduces
2 accessibility to greater Rock Hill and western
3 York. Do you see that?

4 A: Yes.

5 Q: And that was -- the basis for that equitable
6 distribution theory was the maldistribution
7 analysis that Ms. Platt presented; isn't that
8 right?

9 A: Well, I'm sure it certainly contributed, but I
10 also did look at the populations and the
11 greater Rock Hill population was approximately
12 four times greater than that of the northern
13 area.

14 **MR. ANDREWS:** Okay. And the -- let's take a look at
15 -- let's pull back up, Dan, if you would,
16 Carolinas' Exhibit 33, Page 4.

17 Q: This is the analysis based on 100-bed
18 application submitted by Piedmont, right?

19 A: Yes.

20 Q: And it applies to the population that you've
21 identified. Notice that the year that it's
22 presented are 2010 to 2015, correct?

23 A: Yes.

24 Q: And operations third year maybe 2017, the pace
25 we are moving in this case including this cross

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1 examination, we may be at 2020 before we're
2 near through, right?

3 A: Yes.

4 Q: All right. So the point is to make this a fair
5 comparison, you really need to look out into
6 the future not just the first year of operation
7 which Ms. Platt did in her analysis; isn't that
8 fair?

9 A: Yes. And I mean I think the point is that
10 there had been a period of extreme rapid growth
11 in the county. But yeah, I don't recall. I
12 know there is more information submitted by
13 Piedmont, but I don't recall it.

14 Q: And you looked at it at 2017. So let's see
15 what kind of analysis, what this looks like
16 that's dated 2017.

17 **MR. ANDREWS:** Dan, pull up Demonstrative 149.

18 Q: Now, Ms. Platt (sic), this has been the subject
19 of prior testimony from Mr. Sullivan related to
20 a comparison of Ms. Platt's exhibit on the
21 left. And then provide -- you see that?
22 That's what we've just taken a look at, the
23 100-bed -- her breakdown of the population 2010
24 to 2015 and showing the maldistribution of
25 beds. Within northern York, you see in 2015 it

1 would be a little over two beds per 1000. And
2 then for the rest of the county it would be a
3 little over one bed per 1000. Do you see that?

4 A: Yes.

5 Q: And that's part of what led you to conclude
6 that there was a maldistribution in the county,
7 right, if the 36 beds were transferred?

8 A: I'll say that was only part. Again, there was
9 a lot of conflicting, if you will, information.
10 Piedmont had a different point of view and
11 Carolinas had a different point of view. And
12 I'm pretty well tasked with trying to figure
13 out where the truth lies. So I didn't
14 necessary accept either one but formed my own
15 conclusions.

16 Q: You looked at the population, I think you've
17 already testified to. And you identified the
18 year 2017 and looked at the difference in the
19 population, the fact that the Rock Hill area is
20 four times greater than northern York, I
21 believe is what you testified to, right?

22 A: Yes.

23 Q: And you did that for the purposes of
24 determining whether or not the distribution of
25 beds among those two different population

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1 groups would be equitable or not. Wasn't that
2 the reason you did that?

3 A: Yes.

4 Q: Which was consistent with what Ms. Platt
5 presented to you, right?

6 A: Yes.

7 Q: All right.

8 **MR. MR. ANDREWS:** Let's take a look then at the next
9 table in this demonstrative.

10 Q: Now, we are casting out. We are projecting
11 forward the population into 2020. Do you see
12 that?

13 A: Yes.

14 Q: And look at the distribution in northern York
15 County. Do you see the beds per 1000, it's
16 1.03?

17 A: Yes.

18 Q: And look at the beds for Rock Hill and western
19 York County, and you see that as 1.07?

20 A: Yes.

21 Q: So in other words, if there were 100 beds
22 established in Fort Mill, the distribution of
23 the beds for that Fort Mill area or northern
24 York population would be fewer than those
25 available to the rest of the county including

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- 1 Rock Hill and western York. Do you see how
2 that would play out?
- 3 A: Yes. I mean, if you're looking at 1.03 and
4 1.07, they're pretty close.
- 5 Q: And you see the population differences. You
6 had said you projected it in 2017. I don't
7 know what you looked at, but here looking at
8 the zip codes that would constitute northern
9 York, and that would be three, not two. Do you
10 remember whether you included 29715, 29708 and
11 29707 in your analysis or just 708 and 715?
- 12 A: I don't recall. And at this point, I don't
13 know what areas they correlate to.
- 14 Q: Okay. Well, you don't have any reason to
15 believe that these numbers would be inaccurate;
16 do you?
- 17 A: No, not off the top of my head.
- 18 Q: Okay. And so we got here 96,000 -- nearly
19 97,000 would be the projected population for
20 those three zip codes in 2020, and the
21 population of the rest of the county Rock Hill
22 and western York would be 215,000. I'm
23 rounding up to 216; do you see that? So it's
24 just a little over twice; isn't it?
- 25 A: Yes.

1 Q: And there would be 100 beds for northern York
2 and 232 for the rest of the county. And that
3 distributes based on population alone the beds
4 quite equitably; wouldn't it.

5 A: Well yes. But, I mean, the 100 beds weren't
6 solely in to serve northern York because it was
7 -- part of the population was coming from Rock
8 Hill.

9 Q: Right, that's true indeed. Now, let's -- let
10 me turn to the second issue, Ms. Brandt. You'd
11 expressed concern in your testimony and in your
12 analysis about something you referred to as
13 "go-by" or "drive-by," and you didn't find that
14 logical. And again, this is an issue that
15 Carolinas coined for you; didn't they; that
16 Piedmont was proposing to serve patients who
17 would have to drive by Piedmont to get to Fort
18 Mill Medical Center? Isn't that what they said
19 in their criticism of Piedmont's application?

20 A: Yes. But we certainly had information
21 available from Piedmont that identified the zip
22 codes and what zip codes were considering the
23 primary service area. That wasn't something
24 that I would not have considered.

25 Q: And your concern was that there were patients

1 who would be served by Fort Mill Medical Center
2 from zip codes that were south of the river
3 that separated northern York County from the
4 Rock Hill area; isn't that right?

5 A: Well, I would say south of Rock Hill. I don't
6 believe I ever talked about a river. But one
7 zip code was the Rock Hill vicinity and one zip
8 code was south of Rock Hill.

9 Q: All right.

10 **MR. ANDREWS:** Well, let's pull up Demonstrative 38,
11 please, Dan.

12 Q: Now, there has been testimony concerning
13 drive-time studies that were the basis for this
14 demonstrative, Ms. Brandt. And let me just
15 represent to you the testimony in the record
16 shows that Mr. Walsh testified that the pink
17 areas represent areas in which individuals who
18 live there, the residents of the pink area
19 would be able to drive to the Fort Mill Medical
20 Center location, which you will see at the H
21 area, there you go, right where that is, more
22 quickly than they would be able to get to the
23 Piedmont Medical Center which is the H in the
24 center of this map. Do you see that?

25 A: Yes.

- 1 Q: And those in the tannish color, and I don't
2 want to make a representation, but I think it's
3 5 to 10, 0 to 10 minutes; and the blue would be
4 further away, 10 to 20 from Fort Mill Medical
5 Center. And you remember that Piedmont
6 represented to you that there would be
7 individuals living in 730 zip code. And do you
8 see the 730 zip code?
- 9 A: Yes.
- 10 Q: And are you aware enough of the geography of
11 York County to note that zip code continues on
12 over onto the right, the far right, or the
13 eastern border of York County where that --
14 where Mr. Bupp has his arrow. Do you recognize
15 that as being 29730 zip code area?
- 16 A: Yes.
- 17 Q: And then 732 would be the one that's more
18 central in which Piedmont Medical Center is
19 located, right?
- 20 A: Yes.
- 21 Q: All right. Now, when you had expressed
22 concerns about the shifting of patients from
23 Piedmont to the Fort Mill Medical Center, and
24 you said you were concerned about that because
25 that would mean patients would be driving by

1 Piedmont Medical Center to get to Fort Mill.
2 Isn't that what your concern was?

3 A: Yes.

4 Q: Now, you can see by the pink zones that there
5 could be many residents of York County,
6 particularly residents of zip code 29730 and
7 29704 down on the far right and a bit of 29732
8 for whom it would be a faster drive and one
9 simply requiring getting on the interstate to
10 go to the Fort Mill Medical Center. Do you
11 recognize that?

12 A: Yes, I can see that. I'm sure there are more
13 roads.

14 Q: Sure there are, this is background. This is
15 just looking at the major arteries and very few
16 roads. But the point is, is it not, based on
17 your review of this map, you'd recognize,
18 wouldn't you, that Piedmont could shift
19 patients that it has historically served at its
20 inner city hospital to Fort Mill Medical Center
21 for whom it would be a shorter drive for them
22 to get there.

23 A: Yes. But, I mean, I don't know what the
24 population-distribution is in those areas. But
25 I can see in theory what your point is.

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1 Q: Well, that was Piedmont's point that it made
2 during the staff review that there would be
3 many individuals for whom it would be more
4 convenient and certainly not require driving by
5 Piedmont Medical Center in order to get access
6 to Fort Mill; isn't that right?

7 A: I believe that's what they had stated.

8 Q: Okay. And you didn't accept that, but you
9 weren't aware of this population sector. And
10 I understand you don't have any data -- you're
11 sitting here today about the extent of that.
12 But residents who lived there could have been
13 -- well those that Piedmont was intending to
14 encourage the movement up, and expects
15 reasonably the movement up to Fort Mill rather
16 than driving through in-town traffic to get to
17 Piedmont Medical Center, right?

18 A: It could be, but I know that the concentration
19 of the population of Rock Hill is near the
20 hospital as far as the bulk of the population
21 of Rock Hill. You didn't say it was urban. So
22 again, I don't know what the population-
23 distribution is. But I certainly do see what
24 you are trying to demonstrate.

25 Q: Okay. And are you also aware that the patients

1 that would be shifted to address the beds that
2 would be moved would just -- there are 19 beds
3 that are unutilized and un-staffed at Piedmont,
4 right? You are aware of that, correct?

5 A: Yes.

6 Q: And there were 17 that were underutilized that
7 the hospital was proposing to move to
8 accommodate the patients who would be going to
9 Fort Mill rather than Piedmont. Isn't that the
10 way that Piedmont presented it to you?

11 A: Yes, that's the way they presented it.

12 Q: Okay. And that would still leave in the
13 vicinity of well over 100 beds to serve the
14 population of the county; wouldn't it? I mean,
15 that Piedmont could serve the other patients
16 that it would intend?

17 A: Yes. And I know that was brought up. But
18 there was certainly other related issues to
19 include the decrease in utilization through the
20 years. And if the patients aren't going there
21 to Piedmont, they're not going to Piedmont. I
22 mean, you have to look at why is there in this
23 capacity. I mean, there are other factors to
24 consider.

25 Q: And, in fact, Piedmont identified those

1 factors, which was the change in referral
2 patterns and the acquisition of hospitals --
3 excuse me, acquisition by Carolinas of
4 physician practices and the change in those
5 referral patterns among the physicians who
6 historically had served their patients at
7 Piedmont. Do you recollect that?

8 A: I recollect them stating that.

9 Q: Was there any doubt in your mind that was true?

10 A: Well again, there has got to be reasons that
11 patients leave an area. And certainly referral
12 patterns evidently did change, but it's
13 ultimately patient's choice as to whom they go
14 with.

15 Q: Well, it's ultimately patient's choice, but
16 you've testified in depositions that patients
17 often follow the encouragement and the lead of
18 their physicians; isn't that right?

19 A: Yes, I'm sure I did say that.

20 Q: All right.

21 **MR. ANDREWS:** Let's take a look at the regulations
22 again, Section 3(a), Dan.

23 Q: Now Ms. Brandt, as we are pulling this up, I
24 want you to -- if you can do this from memory,
25 fine. If not, we can go back to the document.

1 But for Section 3(a) you stated that this only
2 applies to Piedmont. Do you remember that?

3 A: Yes.

4 Q: Why did you say that?

5 A: Because Piedmont was going to transfer beds, in
6 part, to create Fort Mill Medical Center. So in
7 other words, they were going to create the same
8 services within York County as were already
9 existing with Piedmont Medical Center.

10 Q: Now, Section 2(d) deals with the relocation of
11 36 beds. You've already testified about that,
12 right?

13 A: Yes.

14 Q: Section 3(a) says it requires the department to
15 focus on the question of whether or not there
16 is duplication and to prevent unnecessary
17 duplication, right?

18 A: Right.

19 Q: Now, every applicant that applied needed to be
20 evaluated to determine whether or not their
21 proposal would unnecessarily duplicate existing
22 services in York County; isn't that right?

23 A: Yes. I see your point. But I think that
24 Piedmont even acknowledged that this only
25 applied to them.

1 Q: No. I'll state for the record Piedmont did not
2 acknowledge that.

3 A: But my approach was that Piedmont was
4 duplicating Piedmont.

5 Q: Exactly. You believed that approval of Fort
6 Mill Medical Center would duplicate Piedmont,
7 correct?

8 A: Yes.

9 Q: Because there were two hospitals with the
10 exception of the tertiary services providing
11 similar services, right, in York County?

12 A: Right.

13 Q: Isn't that right? And you believed that the
14 applications by Carolinas and by Hospital
15 Partners of America and by Presbyterian would
16 not duplicate existing services because they
17 weren't proposed by an existing provider of
18 services in that county; isn't that true?

19 A: Well, I'm not familiar with Hospital Partners
20 of America.

21 Q: HBA, I'm sorry, was the third applicant. They
22 dropped out by the time you came into the
23 picture. So I apologize. So those are the
24 two.

25 A: No. I did not believe they would because they

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1 were different institutions, different referral
2 patterns.

3 Q: So the question of duplication of existing
4 facilities and services, you were analyzing
5 based on Piedmont duplicating itself, and you
6 determined they were?

7 A: Yes.

8 Q: And you did not find that Carolinas duplicated
9 itself because it's facilities were in
10 Mecklenburg County, is that right?

11 A: Correct. And again, they were proposing to
12 shift current patients, yes.

13 Q: And so that's how you understood the practice
14 that the department has not to take into
15 consideration the out-of-state entities. You
16 used that against Piedmont to favor the
17 approval of Carolinas and to deny them, deny
18 Piedmont because Carolinas did not have a
19 facility in York County. Isn't that what
20 you're saying?

21 A: That's not what I'm saying.

22 Q: Isn't that the effect of what you're saying?

23 A: Well, Piedmont was established, and they were
24 going to provide the same services. So I did
25 not -- I mean, that's not what I set out to do.

1 I set out to perform an analysis based upon the
2 fact that Piedmont was already offering the
3 services.

4 Q: Ms. Brandt, who trained you on the principle
5 related to the extent to which you should take
6 into consideration out-of-state facilities?

7 A: It was definitely Ms. White, and I am sure Ms.
8 Fechtel actually is probably in here somewhere,
9 too.

10 Q: And do you know how long Ms. White had been
11 with the department in the CON program?

12 A: No, I don't.

13 Q: It wasn't more than several years; was it?

14 A: I don't believe so.

15 Q: Okay. Now, the purpose -- would you agree with
16 me that the purpose of the issue related to the
17 consideration of out-of-state entities was that
18 the department should plan for South Carolina
19 residents, right?

20 A: Yes.

21 Q: The department should not take into
22 consideration the effect on out-of-state
23 facilities the establishment of in-state
24 facilities would have, true?

25 A: Yes. The focus was South Carolina.

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1 Q: Did anyone suggest to you that you should not
2 consider the effect of the existence of out-of-
3 state facilities in their operations on in-
4 state facilities? Do you understand the other
5 side of that?

6 A: So Mr. Andrews, you're asking me if somebody
7 told me I should not?

8 Q: Yes. Did someone tell you that you should not
9 consider the effect, for example, of CMC-
10 Pineville on the operations of a proposed
11 facility by Carolinas in York County?

12 A: Yes.

13 Q: Someone did tell you that?

14 A: I was trained that it's -- you look at what's
15 affecting South Carolina and South Carolina
16 patients.

17 Q: But if your testimony, then, that you believe
18 that Fort Mill Medical Center duplicated
19 Piedmont, which is right beside -- just by --
20 the proposal of another hospital by Piedmont in
21 York County some eight miles, 15 minutes away,
22 duplicated Piedmont; isn't that what your
23 testimony is saying?

24 A: Yes.

25 Q: Now, CMC-Fort Mill would be just about the same

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1 drive time, about 15 minutes away from CMC-
2 Pineville. Are you aware of that?

3 A: Yes, sir.

4 Q: But you didn't regard that as a duplication of
5 the Pineville facility, correct?

6 A: That's correct.

7 Q: And the effect of that is to put at a
8 disadvantage Piedmont because Carolinas doesn't
9 have an existing facility in Rock Hill; does
10 it?

11 A: No, I disagree. I had the applicants before
12 me, and I had to consider what was in
13 existence. I mean, it's beyond my control of
14 about what's located where.

15 Q: But based on that principle, Piedmont could do
16 nothing in your mind to avoid the conclusion
17 that a second hospital within a 15-minute drive
18 time would duplicate itself?

19 A: It did duplicate. And the issue was the
20 justification of the duplication, not the
21 duplication itself.

22 Q: All right. So -- well, you stated that the
23 duplication would be their beds are being
24 transferred, so they're not duplicating those,
25 correct?

1 A: No. The beds themselves, I mean --

2 Q: Would not be duplicated.

3 A: Not the beds but services associated with those
4 beds.

5 Q: Well, anyone who's going to provide the
6 services would be the same services that
7 Piedmont was providing, correct? Carolinas --
8 CMC-Fort Mill services would duplicate the
9 services; wouldn't it?

10 A: Yes. But again, the purpose of the CMC
11 application was to serve existing patients.

12 Q: Well, we're going to deal with the shift issue
13 in a minute. But with regard just to the focus
14 under this section on whether there is a
15 duplication of services, the services that are
16 proposed by CMC-Fort Mill and the services
17 proposed by Fort Mill Medical Center are
18 virtually identical; aren't they?

19 A: Yes.

20 Q: All right. So the services are not being
21 duplicated. They will both be consistent with
22 the services provided by Piedmont with the
23 exception of the tertiary more advanced
24 services; wouldn't they?

25 A: Yes. And again the issue is the justification.

1 Q: All right. So you are referring to the
2 question of who has the established patient
3 base?

4 A: How do they prove that this duplication is
5 necessary.

6 Q: And in fact, Piedmont proposed that it was
7 necessary in order to continue to maintain the
8 base of volume and the quality of services that
9 would be needed to support a tertiary hospital.

10 A: Yes, that's what they proposed.

11 Q: And wouldn't you agree that a core volume of
12 services is necessary to sustain tertiary
13 services?

14 A: Yes.

15 Q: And wouldn't you agree that there is a direct
16 correlation between sustaining that volume and
17 increasing the volume at a level that without
18 which the tertiary services will be in decline?

19 A: Yes. But again, I had to look at the facts
20 before me. I mean, you're making a blanket
21 statement. And yes, that does make sense.

22 Q: Well, weren't you concerned that if Piedmont's
23 decline in utilization continued, that if they
24 were denied what they first planned before any
25 other hospital in the area did, which is

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1 establish a satellite hospital to recapture
2 that lost market share, that Piedmont could
3 possibly not be in a position to recover the
4 volume to support the high quality services
5 that York County had become accustomed to?

6 A: I believe in my analysis reports, that I took
7 that under consideration and looked at that
8 very carefully. In fact, I even made a
9 statement about the impact that Presbyterian
10 would have, and that Carolinas would have a
11 lesser impact on Piedmont. I certainly
12 considered those facts very carefully. The
13 intent of my decision was not to put Piedmont
14 out of business.

15 Q: Piedmont may not go out of business, but if the
16 volume of their open heart services and their
17 cath services and their neurosurgery services
18 and their neonatal services continues to
19 decline, are you aware that those programs
20 would be put in jeopardy?

21 A: I certainly could see where they could be. But
22 again, and this goes to the whole premise of
23 their application is they feel that if they
24 build this hospital, then magically they are
25 going to recover from years and years of

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1 declined utilization. And I just did not
2 accept that.

3 Q: In fact, are you aware, Ms. Brandt, that it's
4 not so many years; that in 2004 and 2005
5 Piedmont was operating at a level which
6 established the benchmark to which they were
7 planning to return?

8 A: Yes, the decline started when --

9 Q: Yeah. So it's not ancient history; is it?

10 A: Well, it's been quite a few years.

11 Q: Well, the effect of the extended application
12 process contributed to that happening?

13 A: Yes, it has.

14 Q: Now, the -- so you are aware that their goal
15 was to achieve a certain historical level. And
16 if they achieved that, they would roughly
17 comparable to where they were at the time they
18 filed the application?

19 A: That makes sense, yeah.

20 Q: Now, and you believed they wouldn't be hurt
21 because you believed that Carolinas would be
22 successful in shifting their patient beds?

23 A: Yes.

24 Q: Isn't that what you believed? And that's what
25 Carolinas represented to you; didn't they?

1 A: Yes.

2 Q: And when Ms. Biggers asked you -- I'm sorry, it
3 may have been Ms. Robertson, I forget which.
4 If you believe that Carolinas would serve the
5 same patients that they served historically,
6 your answer was yes because that is what you
7 believed; isn't it?

8 A: Yes, and that was their intent.

9 Q: Well, you don't know what their intent was; do
10 you? That's what they said to you; isn't that
11 right?

12 A: Yes. And again, I went into the fact that they
13 weren't even proposing to capture 100 percent.
14 You know, they had, based on the areas of the
15 county, different projections for what they
16 intended to capture and that they did consider,
17 I believe it was 10 percent in-migration.

18 Q: And those in-migrating patients could be there,
19 as well; you don't know, do you?

20 A: Well, I believe they specified outside of the
21 county.

22 Q: Well, they could be folks who live outside the
23 county they serve that would come into the
24 county, correct?

25 A: Yes.

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1 Q: From Chester County or Lancaster County,
2 patients they already served who may choose to
3 use that facility; that's certainly possible?

4 A: Yes, that's possible.

5 Q: All right. So the -- but your approval of
6 Carolinas was dependent on their being able to
7 redirect their patients, to shift their
8 patients successfully in a way that they
9 wouldn't have to use, and they wouldn't take
10 from the Piedmont patient basis; isn't that
11 right?

12 A: Yes.

13 Q: Now, you've not studied, have you, as part of
14 this process how patients are admitted in the
15 hospitals; have you?

16 A: Well, I know they are done so by either they
17 enter through the emergency department or
18 through a physician referral. I can't say that
19 I've studied it, but I have knowledge how they
20 enter the system.

21 Q: All right. And do you have any sense of the
22 percentage of admissions that come through the
23 emergency department of a hospital?

24 A: I know I've heard that figure. But I don't
25 believe I can quote with accuracy right now.

1 Q: Would it surprise you if there were well over
2 half?

3 A: I'd -- nothing would really surprise me at this
4 point.

5 Q: Well, wouldn't you recognize -- wouldn't you
6 agree with me that Carolinas has absolutely no
7 control over the patients that show up in their
8 ED at CMC-Fort Mill?

9 A: No, I would agree that Carolinas can't control
10 who shows up.

11 Q: Right. And for that reason, particularly given
12 a hospital immediately adjacent to an
13 interstate exchange, that there could be
14 patients coming to CMC-Fort Mill who for years
15 have used Piedmont or who may not have a doctor
16 and may not have used any hospital and would
17 not be a part of Carolinas' historical mix;
18 isn't that certainly not only possible but
19 likely?

20 A: Well, I agree that it's possible. But
21 historically, you know, patients, if they are
22 going to utilize one healthcare system, they
23 continue to utilize that hospital system unless
24 there's some compelling reason.

25 Q: What are you basing that on?

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1 A: Just information that I've gleaned from CON
2 applications.

3 Q: Well, CON applications all the time talk about
4 shifting -- new hospitals taking market share
5 from others; don't they?

6 A: Oh, yes. But typically, I mean, this was
7 testimony that certainly was hashed out ad
8 nauseum at the Berkeley County Hospital
9 hearings that patients typically stick with
10 their provider.

11 Q: Well, they come through the ED and often based
12 on proximity, don't they? They are going to go
13 to the ED, the emergency department that is
14 closest to them; aren't they?

15 A: Yes, I would think so.

16 **MR. ANDREWS:** Dan, let's pull up Demonstrative 38
17 again.

18 Q: And then look in the area in the pink. And
19 then look in the area in the pink above the
20 dash line, it's white which would, of course,
21 be the northern York County area. Any patient
22 that Piedmont has served historically that has
23 a need to go to the emergency department, it
24 would be a closer drive for them to get to CMC-
25 Fort Mill, which is just above the pink left of

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1 the interstate than it would be to go to
2 Piedmont, correct?

3 A: I see where that could be accurate, yes.

4 Q: And you didn't take into consideration, did
5 you, the extent to which patients who have been
6 part of those -- who have been historically by
7 Piedmont, would, because of proximity if for no
8 other reason, would be admitted into CMC-Fort
9 Mill through there ED because of sheer
10 proximity?

11 A: Well, I took everything into consideration that
12 was before me. And I drew my own conclusions
13 that it was more likely certainly that they
14 would follow the facility that they had
15 typically done business with.

16 Q: Are you -- and your other assumption, Ms.
17 Brandt, is that concerning the admission of
18 patients into CMC-Fort Mill, as they come in
19 through physicians who admit them there, right?
20 That's the other way it's done?

21 A: Yes.

22 Q: All right. And CMC-Fort Mill is not going to
23 be a closed medical staff?

24 A: No.

25 Q: That would be improper under the DHEC regs;

1 wouldn't it?

2 A: Yes.

3 Q: And you don't have any reason to believe, do
4 you, that physicians who are on the medical
5 staff of Piedmont Medical Center who have
6 patients in the Fort Mill area or in eastern
7 York County who want to try the new hospital in
8 town would not get privileges at Carolinas
9 facility in Fort Mill; wouldn't you expect them
10 to do that?

11 A: I would expect them to consider it. I mean,
12 clearly there is a lot of reasons why they may
13 or may not grant privileges, but they would
14 certainly be open to that.

15 Q: I'm talking about why -- I should tell you
16 because everyone -- most folks in the room
17 know, and you didn't have the benefit of being
18 here, that three physicians who are active
19 members of the medical staff at Piedmont,
20 testified saying that if CMC-Fort Mill were
21 built, they would apply for privileges there.
22 And they would admit their patients there
23 because they believe they're patients who live
24 there and even patients who don't live in that
25 area will want to try a new hospital. And they

1 would admit their patients, even though they
2 don't support the approval of that, they would
3 admit their patients there because they don't
4 want to lose their patients. Doesn't that make
5 sense to you?

6 A: Well, it boils down to patient's choice then,
7 in essence.

8 Q: Doesn't it make sense to you that patients
9 would want to try a new facility and use the
10 one that is convenient to them and for that
11 reason, those who had been going to Piedmont
12 historically, not because they want to leave
13 Piedmont but because they want a hospital
14 closer to home, would use the new Carolinas
15 facility in Fort Mill?

16 A: I think it's conceivable. But what it boils
17 down to is patient choice and where they're
18 used to having their services rendered.

19 Q: It would also boil down to the choice of these
20 same physicians and these same patients to use
21 a Fort Mill Medical Center if you gave them the
22 opportunity by approving that. It's not a
23 choice of one provider over another; it's a
24 choice to prefer to use a hospital in their --
25 that's convenient to them and a new facility,

1 which is attractive. Don't you recognize the
2 possibility of those considerations?

3 A: I certainly do recognize the possibility, yes.

4 Q: Finally, Ms. Brandt, let me turn your attention
5 to the indigent care issues. Now, you've
6 testified in your deposition that all the
7 applicants we are talking about and the great
8 things they were doing in the community, and
9 you basically blocked that out and turned your
10 focus to their proposed percentage of indigent
11 care. Did I remember that correctly?

12 A: Well, yes. That's what we're directed to do.

13 Q: And Carolinas' proposal nearly doubled that of
14 Piedmont or more than doubled that of Piedmont.
15 And you found that instructive; didn't you?

16 A: Well, I found it a point of comparison.

17 Q: Right. And did you do anything to evaluate the
18 reasonableness of their projection of 6.3
19 percent of indigent care?

20 A: I know they had provided financial statements,
21 but I don't recall at this point exactly what
22 the figures were. But I know they did provide
23 the information.

24 Q: Do you remember what kind of information?

25 A: Well, if it was financial statements, it would

1 have indicated indigent care figures. I just
2 don't recall what they are.

3 **MR. ANDREWS:** Well, Dan, let's put up Demonstrative
4 118, please.

5 Q: You had already approved several applications,
6 and you had access to others. You knew what
7 new hospitals proposed in the way of indigent
8 care; didn't you?

9 A: Yes.

10 Q: All right. And you were aware that Carolinas'
11 proposal exceeded by more than half the highest
12 among all the other projected indigent care
13 proposals of satellite hospitals; did you know
14 that?

15 A: I know that typically the indigent care is all
16 over the board. And I don't recall if this was
17 presented by Piedmont at any point prior to my
18 decision.

19 Q: Well, you were specifically involved and
20 approved the Roper-Berkeley again and the Roper
21 and Trident-Berkeley, correct?

22 A: Yes.

23 Q: And you believed when you were reviewing those
24 applications, those indigent care proposals to
25 be reasonable, right?

1 A: Yes.

2 Q: And Dorchester County, you are familiar with
3 the demographics of it generally; aren't you?

4 A: Generally.

5 Q: It is not nearly as affluent as York County; is
6 it?

7 A: I would say not.

8 Q: And you are aware, aren't you, that the Fort
9 Mill Medical Center and CMC-Fort Mill are
10 proposed to be located in one of the most
11 affluent of the areas of the county in the
12 state; did you know that? I think testified
13 earlier that they are notable Tega Cay and even
14 Fort Mill are recognized as a highly affluent
15 area?

16 A: Yes. But CMC certainly proposed to serve more
17 than Fort Mill and Tega Cay.

18 Q: Well, but nearly half of their client base was
19 coming out of Fort Mill and Tega Cay; wasn't
20 it?

21 A: I believe that's correct. That certainly
22 leaves the other half.

23 Q: Okay. It does. And these other applications,
24 did you take those into consideration in
25 evaluating the reasonableness of CMC-Fort

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1 Mill's proposal of indigent care?

2 A: No. I relied on the fact that Carolinas had
3 provided what they were currently providing and
4 that they had based their figures on historical
5 experience.

6 Q: But you can't point, just sitting here today,
7 any historical experience that's consistent
8 with 6.3 percent; can you?

9 A: I would have to look at what they've provided
10 in their application.

11 Q: Well, you are here on the stand. Can you
12 identify anything that would be the basis to
13 support 6.3 percent as a projection?

14 A: I don't believe I can really answer that
15 without more information.

16 Q: Well, then you can't do it?

17 A: No.

18 Q: Okay. That was the question, can you do it
19 now?

20 A: No, not right this minute, no.

21 Q: All right.

22 **MR. ANDREWS:** Now, just one moment Your Honor.

23 Q: One final set of questions, Ms. Brandt. Let me
24 take you back to the issue of any consideration
25 you gave to Pineville, CMC-Pineville in this

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1 case. The -- are you aware that Piedmont and
2 Presbyterian alleged or they were presented
3 information to you that they believed that CMC-
4 Pineville added beds and over 100 beds in large
5 part based on their reliance on the historical
6 utilization of Pineville by York County
7 residents; do you remember that?

8 A: Yes. There was reams of information submitted
9 by all applicants about that in Carolinas
10 submitted information that to me clearly
11 indicated that that was not a part. In other
12 words, there were different projects -- that
13 there was a recent Pineville expansion and was
14 not based upon York County residents.

15 Q: Well, I thought you said earlier that you
16 didn't take into consideration anything related
17 to Pineville's performance in determining
18 whether or not CMC-Fort Mill should be
19 approved.

20 A: I did say that. But what I'm saying now is
21 that all the applicants presented me with
22 information. So I read what they presented.
23 That didn't mean I necessarily used it, but I
24 didn't ignore it; the fact that they submitted
25 this.

1 Q: Did you give any consideration to the adverse
2 impact that the operation of CMC-Pineville
3 would have, could have on Piedmont?

4 A: No, no. What I'm saying is the issue was
5 raised, the information was provided and I read
6 that information.

7 Q: All right. Did you recognize anywhere in your
8 review process that as a result of the
9 establishment of Carolinas Hospital in Fort
10 Mill that it would exacerbate the effect on
11 Piedmont by sending more tertiary patients into
12 North Carolina?

13 A: Well, since Piedmont is a tertiary center
14 itself, then I mean, they are already offering
15 their services. Maybe I don't understand -- I
16 mean, clearly if the patients are Carolinas'
17 patients and they are in need of tertiary
18 services, it would stand to reason that they
19 probably would be transferred to Carolinas in
20 Pineville, Charlotte or wherever those services
21 are offered. But again, these are already
22 Carolinas' patients, not Piedmont's patients.

23 Q: Did you give any consideration, Ms. Brandt, to
24 how Carolinas got those patients? Do you think
25 the patients made the choice to use Carolinas

1 Q: And I believe you testified that it was your
2 understanding that Carolinas' percentage was
3 based on its historical experience; is that
4 what you said?

5 A: Yes.

6 Q: No further questions, Your Honor.

7 THE COURT: All right.

8 MR. ANDREWS: Just a short one, Your Honor.

9 THE COURT: Yes, sir.

10 **MS. BRANDT - RE-CROSS EXAMINATION BY MR. ANDREWS:**

11 Q: Ms. Brandt, do you remember then in October
12 2010 that the deadline -- the parties have for
13 submitting information to you to update their
14 application, that Carolinas did not update
15 their application; do you remember that?

16 A: Yes. I recall that we had asked them in the
17 first round of additional information for
18 updating information.

19 Q: All right. But Piedmont provided its
20 projections and its updated application in
21 October of 2010; didn't they?

22 A: Yes.

23 Q: And Presbyterian did, as well; didn't they?

24 A: Yes. But they did later make some changes when
25 the census 2010 data was released.

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1 Q: All right. And in Presbyterian's original
2 application they had proposed, do you remember
3 this, indigent care in the range of 3.5
4 percent?

5 A: I honestly do not, no.

6 Q: But in their 2010 -- their October 2010 filing
7 they projected somewhere in the range of 6 and
8 a half, 6.3 to 6.7; does that sound about
9 right?

10 A: Yes.

11 Q: All right. And that Carolinas had -- do you
12 remember that they had somewhere in the range
13 of 3 and a half percent in their 2005
14 application?

15 A: I absolutely do not remember that. I don't
16 have any recollection of that.

17 Q: And they had two months to review two months to
18 review Presbyterian's application and decide
19 during that period of time to increase their
20 indigent care projections as well; didn't they?

21 A: I really can't testify as to what they thought
22 or did.

23 Q: I know. My question was they had time to do
24 that; didn't they?

25 A: Well, that's reasonable again.

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1 Q: Thank you. Nothing further.

2 THE COURT: All right.

3 MS. ROBERTSON: Just one or two.

4 THE COURT: Yes.

5 MS. BRANDT - RE-CROSS EXAMINATION BY MS. ROBERTSON:

6 Q: Ms. Brandt, when Carolinas submitted their
7 updated application in October, I think Mr.
8 Andrews suggested that there were no updates in
9 that submission. Do you recall, in fact, that
10 they were updated, there was updated
11 information in October?

12 MR. ANDREWS: Objection, leading Your Honor.

13 A: I --

14 THE COURT: Oh, wait. Can you rephrase it?

15 MS. ROBERTSON: I'll rephrase it.

16 THE COURT: Can you rephrase?

17 MS. ROBERTSON: I will. Yes, Your Honor.

18 THE COURT: Thank you.

19 Q: In the submission by Carolinas in October,
20 after the remand, do you recall if there were
21 any updates by Carolinas in that submission to
22 the department?

23 A: Yes. I do recall some sort of table of
24 comments and some comparative information.

25 Q: Okay. And do you recall that the department

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1 The processes are a little different. In
2 North Carolina, when you file your certificate
3 of need application, you know, there is a
4 filing date. And at that date you can't submit
5 any additional documentation to the state in
6 Raleigh.

7 You know, in South Carolina the process is
8 different. You file your application. If the
9 folks at DHEC have questions, the process
10 allows you to communicate with the CON
11 officials and provide additional information.

12 That process is very different. But I
13 would say overall in terms of developing
14 certificate of need applications and developing
15 projects that you want the state to approve, I
16 think they are very similar.

17 Q: What was your role in this particular CON
18 Application that we are about here for this
19 case with the Fort Mill Hospital?

20 A: I was basically the representative of Carolinas
21 Healthcare System to DHEC, the certificate of
22 need department, and I was also responsible for
23 really the totality of our filing and the
24 development of our filing.

25 Q: Okay. Now, I would like to talk about

1 Carolinas Healthcare System and who is
2 Carolinas Healthcare System? Mr. Murphy, have
3 you prepared some demonstratives with respect
4 to describing Carolinas Healthcare System?

5 A: I have.

6 **MS. ROBERTS:** Lynn, would you please.

7 Q: And if you could just first generally describe
8 to us who is CHS, Carolinas Healthcare System?

9 A: Well, a very big picture, Carolinas Healthcare
10 System is a public, not for profit, healthcare
11 system that mostly serves citizens who live in
12 the two Carolinas. And we're headquartered in
13 Charlotte.

14 Q: And I would like to look at the mission, if we
15 could. And I think this is in the record at
16 Joint Exhibit A, CHS, Page 367. I think you've
17 if you've excerpted it into a demonstrative.
18 If you could talk about the mission of CHS.

19 A: Yeah, this demonstrative was actually a part of
20 our record. I think it was in our October 4
21 submission. And we wanted to basically convey
22 to DHEC, you know, what our core mission is,
23 the reason we exist as an organization. And I
24 wanted to take a minute and read it for the
25 Court. "It is to create and operate a

1 the Medical University of South Carolina, and
2 you think about the care that's rendered in a
3 hospital, in general, about 75 percent of the
4 care can be cared for in a community hospital.
5 There is about 25 percent of hospital care that
6 really needs to go to a facility that has, you
7 know, more sub-specialists, more capability to
8 take care of the really significantly injured
9 patient or medically complex. And that's what
10 we refer to as the tertiary quaternary facility
11 versus a community hospital. And CMC-Fort Mill
12 is intended to be a community hospital.

13 **MS. ROBERTSON:** Okay. Let's look at Page 1115 in
14 the record if we could, Lynn, still Joint A,
15 CHS.

16 **Q:** Mr. Murphy, can you talk about this page and
17 what Carolinas experience has been for the
18 inpatient discharges for York County patients?

19 **A:** Sure. This is again a slide that we showed
20 earlier on in our Project Review presentation
21 as evidenced by the people being highlighted
22 under those three points up there in the top
23 right. What it shows is that from 2005, from
24 the year of our first filing, we've had a 69-
25 percent increase in patients that are coming to

1 different type witness.

2 **THE COURT:** Okay.

3 Q: So, Mr. Murphy, if you will try to -- if we
4 can, rather than express opinions beyond that
5 that is reflected in what you've submitted to
6 the department, talk about what you submitted,
7 why and keep it as factual as we can.

8 A: Okay. I can do that. This shows that from
9 2005 to 2010 we had a 69-percent increase in
10 York County citizens discharge -- total
11 inpatient discharges from our Charlotte
12 Hospital.. The purpose of the slide was to
13 demonstrate to DHEC and those at project review
14 that we were the people's choice. We wanted to
15 make it clear to DHEC that we felt we were the
16 people's choice. And this type of information
17 supported that theme.

18 Q: Okay. Thank you. Now, I would like to talk
19 about kind of the key features of the hospital.
20 And if we can look at a record on Page 1112,
21 Mr. Murphy. And before we kind of get into the
22 details of the application and what you
23 submitted, tell us about the key features of
24 CMC-Fort Mill?

25 A: Okay. Just the picture that's inset. That's

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1 determined our market share assumption for CMC-
2 Fort Mill and knowing it was going to be a 64-
3 bed community hospital serving the primary-
4 secondary needs of patients. We evaluated the
5 market share positions of the other four
6 community hospitals that were located in
7 Mecklenburg County and just to look at what
8 type of market share positions they had,
9 because again, they are offering similar
10 services, similar types of settings. So these
11 are the four hospitals that you see listed
12 here; two operated by CM-CHS, CMC-University
13 opened in 1985; CMC-Pineville opened in the mid
14 eighties. Also Presbyterian Matthews opened in
15 the early nineties and Presbyterian
16 Huntersville, all community hospitals similar
17 in service to CMC-Fort Mill. So we looked at
18 those and then we basically targeted our market
19 share for CMC-Fort Mill to be reflective of
20 what a community hospital's market position
21 would be.

22 Q: Okay. and I think you have another
23 demonstrative talking about the home zip codes.
24 Can you please describe this?

25 A: This slide shows -- basically these are the

1 MS. ROBERTSON: Yes, sir.

2 THE COURT: All right. Let's do that -- 15

3 minu
4 tes.

5 (Off the Record)

6 THE COURT: All right, Mr. Westbrook. Oh, I'm
7 sorry. Mr. Murphy, please return to your seat.
8 That would be a difficult cross examination
9 with an empty chair; wouldn't it? They do that
10 in Hollywood, I think.

11 MR. MURPHY - CROSS EXAMINATION BY MR. WESTBROOK:

12 Q: Mr. Murphy, how are you doing?

13 A: Doing well.

14 Q: Good, good to see you. Mr. Murphy, you know,
15 I would like to start off by talking about Dan
16 Sullivan a little bit. Now, my understanding
17 is that early in the development process of
18 your application of your first application,
19 2005 application. Early in that process before
20 you filed that initial application, you had a
21 conference call with Mr. Sullivan, is that
22 right?

23 A: Correct.

24 Q: And during that call you asked him about some
25 of the parameters of the South Carolina CON

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1 process, correct?

2 A: I don't remember really exactly what we talked
3 about on the call. I know generally.

4 Q: Well, and I certainly understand 2005 is a long
5 time ago. So I'm going to ask Dan, my friend
6 Dan, not Dan Sullivan, to put up on the screen
7 your testimony from the 2009 trial because it
8 is a lot closer in time --

9 A: Right.

10 MR. WESTBROOK: -- to the event. And Dan, if you
11 could, pull up Bates Page 1447 of the trial
12 testimony from that 2009 trial where Mr.
13 Murphy's on the stand. And we'll get there in
14 a minute. Let's focus on Page 1447.

15 Q: And Mr. Murphy, I mean, we can read as much of
16 that as you want to. But for me, the relevant
17 part is starting on line 11 where you sort of
18 introduced this topic, you say, "Can I make one
19 comment?" Do you see that?

20 A: Uh-huh (affirmative response).

21 Q: And I'm going to ask, if you would, if you
22 would just read that answer starting at Line
23 11. I will interject my one-word question on
24 Line 12 and let you read the reset of it, okay.
25 So start with, if you don't mind, Line 11,

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1 please, sir?

2 A: Can I make one comment from your prior
3 question?

4 Q: And I say, sure. And then you say what?

5 A: I just remembered, early in our development
6 process, we had a conference call just as a
7 very high-level call with Dan Sullivan in
8 Atlanta who is a CON consultant and just asked
9 him about some of the parameters about the
10 South Carolina CON process. But he was not
11 involved in the development of our application.

12 Q: And then after that, I asked you the question,
13 do you know about what time that call to Mr.
14 Sullivan would have been made, roughly? And
15 you answered what?

16 A: Early February.

17 Q: All right. Does that coincide with your
18 current memory of that involvement with Mr.
19 Sullivan?

20 A: That's what I said at the time. And my only --
21 you know, the only thought I've given it since
22 then was preparing for this trial discovered
23 the proposal from Dan to do the technical
24 review of our application.

25 Q: All right. But again, this would have taken

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1 place you said early in February. Would that
2 have -- is that what you said, yeah, early
3 February there on Line 22? Would that have
4 been February of 2005 or February of 2004?

5 A: 2005.

6 Q: 2005, okay. So that was, what, about four
7 years before your testimony in this trial but
8 about, what, 12 or 13 years ago from today, is
9 that right?

10 A: No, it's not that long.

11 Q: Let me quickly state for the record that I have
12 no expertise in mathematics. Now, would you
13 clarify for us how long that was -- 13 minus 4.

14 A: Well, the question here is about the time. And
15 I said early February. And this was sometime
16 before our March 2005 application,
17 approximately, you know.

18 Q: All right. Thank you. And in fact, when I
19 asked you about the -- on the previous page,
20 if we go to 1446, when I asked you about the
21 question about consultants you've worked with.
22 Initially you didn't remember Mr. Sullivan, is
23 that right?

24 A: Let's see. I think so.

25 Q: Okay. And then as an afterthought, you

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1 interrupted me a little --

2 A: Yeah.

3 Q: -- on the next page and said, oh, yeah, I had

4 --

5 A: Yeah. I just remembered.

6 Q: All right, good.

7 **MR. WESTBROOK:** Now -- that's fine, Dan. Thank you.

8 Q: With respect to the 2005 application and the

9 2010 application, it's not surprising there

10 were differences. Now, there were probably

11 differences in all the applicant's

12 applications. Would that be correct?

13 A: There were.

14 Q: There certainly were differences in yours;

15 isn't that true?

16 A: Yes.

17 Q: And just some of these differences, and I'm not

18 trying to give you a comprehensive list. But

19 I believe in the first application, for

20 example, that the proposal was that 50 percent

21 of the northern York County population would be

22 -- 50 percent of northern York County patients

23 that CMC-Fort Mill would serve would actually

24 be redirected from Piedmont, is that correct?

25 Do you recall?

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1 A: I don't recall specifically.

2 Q: But there was a percentage; would you agree?

3 A: There was, yeah.

4 Q: And in the 2010 application, the assumption was
5 that no patients were going to be redirected to
6 Piedmont, is that correct?

7 A: Correct.

8 Q: And in the 2005 application, CHS projected a
9 first-year net loss of about 1.7 million, is
10 that right?

11 A: Sure. But could I back up just a minute?

12 Q: Sure.

13 A: Just to make one point. In the 2005
14 application, we were basically looking at one
15 point in time, 2003. And we had, you know, six
16 years of history of market share changes. And
17 that's why we selected to keep the market share
18 percentages the way we did in the 2010
19 application. And could I back up even a little
20 bit further?

21 Q: Well --

22 A: Well, similar to my testimony, maybe in the
23 first trial, just something -- I said in the
24 first trial that Dan didn't have anything to do
25 with the development of our application. But

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1 in preparation for this trial, discovered the
2 memo or the proposal from Dan. And we did send
3 him the application, and he did do a review.
4 And that's what the conference call was about.
5 Sorry I didn't say that earlier as I have been
6 sitting here processing your questions. I just
7 want to make that clear for the Court.

8 Q: So it was your understanding Mr. Sullivan
9 reviewed the application the first time?

10 A: He did.

11 Q: All right. And the application he reviewed, of
12 course, was the 2005, not the 2010 application?

13 A: Correct.

14 Q: And that 2005 application, again, had a first-
15 year net loss of 1.7 million, is that right?

16 A: I haven't looked at that application in quite
17 awhile.

18 Q: We can pull that up if we need to. Does that
19 sound about right to you? Would you dispute
20 that or --

21 A: You know, if -- I won't go to the trouble of
22 having you pull it up. If that's what it is,
23 I'll take your word for it.

24 Q: All right. And but there was a loss. you do
25 recall that, I'm sure; or do you?

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1 A: No.

2 **MR. WESTBROOK:** I tell you what -- Dan, why don't we
3 just pull it up just to make sure I'm not
4 confused as I often am. CHS 341, I believe is
5 the Bates Page. And can you identify this as
6 your pro forma from the 2005 application?

7 A: Yes, that does look like it.

8 Q: And does it look like you have a first-year
9 loss of about 1.7 million?

10 A: We do. And again, it was a different
11 application with a different point in time.

12 Q: Different application, different point in time.
13 And your second application, the 2010
14 application, different application, different
15 point in time; there was a first year profit of
16 about over 600,000, is that right?

17 A: I believe so.

18 Q: And in your first application, the 2005
19 application, you projected charity care at
20 about 3.5 percent of gross revenue, right?

21 A: That sounds about right.

22 Q: And in this application, your projection is 6.3
23 percent of the gross revenue, right?

24 A: That's correct. And I did talk about the
25 economic issues we had most recently to this

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1 filing that impacted, you know, those
2 estimates. So lots of contextual factors that
3 I don't know if I should go into.

4 Q: I tell you what, I will ask you a question if
5 I want you to go into them. So let's go then
6 to one other thing. There is also a
7 distinction. You had a different site in 2005.
8 It was close by but it was a different site.

9 **THE COURT:** Mr. Westbrook, if you hold on for a
10 second.

11 **MS. ROBERTSON:** I'm sorry to interject, but I do
12 think the witness ought to have the opportunity
13 to respond and say what he'd like to say
14 without being cutoff.

15 **MR. WESTBROOK:** Sorry to cut off, Your Honor. I
16 think that it was responsive to the question.
17 He could certainly -- you know, he doesn't have
18 to just answer yes or no. He can certainly
19 respond to the question. If it's going down
20 another issue or answering something I haven't
21 asked, I would say we are going to be here all
22 day.

23 **THE COURT:** Let me just clarify this for the
24 proceeding. I do want the witness to be
25 allowed to fully and completely answer any

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1 question asked of him. However, if the witness
2 if going to go off on another subject that
3 wasn't a part of the question, then perhaps
4 that can be something addressed by counsel in
5 redirect or something like that. Yes, let's
6 give the witness and full and complete
7 opportunity to answer fully the question that
8 was asked of him.

9 Q: All right. The last question I believe I
10 asked, and Ms. Robertson can correct me if I am
11 wrong, was about the 6.3 percent. I believe
12 that in 2005 you projected 3.5 percent of gross
13 revenue as your charity care. In 2010, you
14 projected 6.3 percent; isn't that correct?

15 A: That's correct. And I would just add that you
16 can't compare the two directly because many
17 things have transpired or changed over that
18 course of, I would guess about six years.

19 Q: All right. And in 2005, you had a different
20 site than the currently proposed site; isn't
21 that correct?

22 A: We were at Exit 83 in 2005, slightly down the
23 road from Sutton, slightly down the road from
24 our current site. We changed the site because
25 during the review the owner filed bankruptcy.

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1 And so we had a contingency contract and felt
2 we needed to change the site just to secure the
3 land for the hospital.

4 Q: All right.

5 **MR. WESTBROOK:** All right. Dan, let's pull up CHS
6 524 for the first -- no, I guess that's for the
7 second application, please. This showed the
8 two sites, the 2005 site and the 2010 site.

9 Q: Aren't those identified on this page?

10 A: Yes, right. The yellow site closer to 277 is
11 the current site.

12 Q: So the application again, and I'm sure there
13 were other changes made between these two
14 applications. I'm not sure they were with the
15 other applications, Presbyterian and
16 Piedmont's. But the application that Mr.
17 Sullivan reviewed, the 2005 application, not
18 the 2010 application; correct?

19 A: Correct.

20 Q: Now, CHS - Carolinas Healthcare System. The
21 official name is Charlotte Mecklenburg Hospital
22 Authority, right?

23 A: Well, there is a the in there. It's The
24 Charlotte Mecklenburg Hospital Authority.
25 That's the official legal name.

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1 Q: All right, The Charlotte Mecklenburg Hospital
2 Authority. That's a -- and you testified some
3 about that organization. That's a North
4 Carolina Hospital Authority, which is a type of
5 North Carolina public hospital system, is that
6 right?

7 A: That's correct.

8 Q: All right. And it's created by a North
9 Carolina statute; isn't that correct?

10 A: That's correct.

11 Q: And South Carolina, I believe, has hospital --
12 at least one hospital authority; are you
13 familiar with that?

14 A: I don't believe so.

15 Q: Under the North Carolina statute, CHS has power
16 of eminent domain; doesn't it?

17 A: I'm not familiar with all of the parts of that
18 statute.

19 Q: Are you familiar with that particular issue?
20 Do you know whether or not it has the power of
21 eminent domain?

22 A: I don't know that for a fact, no.

23 Q: Do you know that it was created according to
24 the statute to serve North Carolina residents;
25 do you know that?

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1 A: You know, I don't know that for a fact. It's
2 a North Carolina statute. I do understand
3 that.

4 **MR. WESTBROOK:** All right. Let's take a look at,
5 Dan, bear with me a second. Okay 273 -- let's
6 pull up Demonstrative 273.

7 Q: Now, this is a complaint. And the caption
8 says, "The Charlotte Mecklenburg Hospital
9 Authority;" does it not?

10 A: It does.

11 Q: Now, I want to ask you about a statement that
12 made this complaint where Charlotte Mecklenburg
13 Hospital Authority is the Plaintiff and see if
14 you believe they are accurate or not. Now,
15 this is a complaint filed by -- you recognize
16 this as a complaint filed by The Charlotte
17 Mecklenburg Hospital Authority?

18 **MS. ROBERTSON:** Your Honor, sorry to interrupt
19 again. But I believe this is a demonstrative.
20 I just want to make sure I understand what this
21 is. But I don't believe there is anything in
22 the record upon which this demonstrative is
23 made from. I may be wrong, but I don't believe
24 this is in the record.

25 **MR. WESTBROOK:** This is a demonstrative. It's not

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1 an exhibit. It's not part of the record.

2 **THE COURT:** It's not part of the record. Okay --

3 **MR. WESTBROOK:** I want to ask him a question here
4 whether he knows whether it's accurate or not.
5 If he doesn't, he doesn't. If he does; he
6 does.

7 **THE COURT:** Any objection?

8 **MS. ROBERTSON:** Well, demonstratives, as I thought,
9 were to be based on matters and sources within
10 the record. But, you know, I think that is our
11 objection that we are looking at something that
12 is not in the record. And I believe Mr.
13 Westbrook objected earlier to his belief when
14 I was questioning Mr. Murphy of something not
15 being in the record when we placed it up on the
16 screen. So I would make that same suggestion
17 or objection as to this overlying the
18 demonstrative.

19 **MR. WESTBROOK:** I would say this is a public record.
20 It's -- Mr. Murphy has been or clearly is
21 CHS's primary witness or at least fact witness.
22 The -- this is a public document. It is not a
23 hearsay document, therefore. And it and it has
24 some questions on the first page -- excuse me,
25 some statements on the first page about CHS.

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RECORD 001338

1 Mr. Murphy testified at some length about the
2 nature of his organization in what it did and
3 what it was involved in. And these are
4 statements that are certainly not going to be,
5 you know, derogatory in any way because they
6 are made by CHS itself on the first page of its
7 complaint. And I just want to see factually if
8 he knows whether they are true or not.

9 **MS. ROBERTSON:** Well, Your Honor, I think at a
10 minimum he would have to establish a foundation
11 that Mr. Murphy knows anything about this
12 complaint or what's alleged in it and any
13 specifics to be able to talk about it. I don't
14 think we've done that yet.

15 **MR. WESTBROOK:** I think the only way I could do that
16 is by actually showing him the question and
17 then if Ms. Robertson has an objection. I'm
18 not even going to show an allegation. What I'm
19 going to show is you see that first heading as
20 a party as a description of CHS, and I just
21 want to see if that's an accurate description.

22 **MS. ROBERTSON:** One final comment, Your Honor. I
23 think there is an attempt here to get this
24 document into evidence through testimony for an
25 exhibit that is not in the record. This is not

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1 in the record, and he's going to elicit
2 testimony and place it in the record.

3 **MR. WESTBROOK:** I'm not going to -- you know, this
4 is not an exhibit. I'm not going to try and
5 make it an exhibit. But I certainly -- it
6 seems like to me that I can ask him about
7 public documents. He testified a great deal
8 about -- from public documents and non-public
9 documents about the nature of CHS and the
10 nature of that organization and actually a lot
11 of other things, as well. So I'm going to put
12 a public document up there and ask him some
13 questions about if he knows they are true or
14 not. If he doesn't -- if he knows they are
15 true or false, then he can say so. If he
16 doesn't know, then he can say that, as well.
17 But, you know, I mean I think that was a large
18 part of his direct testimony was going into the
19 nature of CHS, describing that organization,
20 what they did, what they didn't do, what kind
21 of organization they are and so --

22 **THE COURT:** And yes, Mr. Westbrook, I do recall him
23 in the initial parts of his testimony talking
24 about the general nature of CHS, its mission
25 statement, what it did. But this appears to be

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1 a matter that isn't -- this isn't a complaint
2 that is any way related to this matter, is that
3 right?

4 **MR. WESTBROOK:** Well, I think it is. But that's not
5 the purpose that I am asking him questions
6 about it; at least not now.

7 **THE COURT:** Maybe we can establish whether he has
8 any knowledge or whether he was involved or has
9 any knowledge of this particular matter first.
10 And then I think maybe that might alleviate --
11 that might answer the question of whether he
12 knows anything about it.

13 **MR. WESTBROOK:** Let me go to another document.
14 Maybe there will be objections to this document
15 or maybe there won't. But let me go to another
16 document that I think I can establish the same
17 thing. So Dan why don't we follow up on that.

18 **Q:** In your early testimony, Mr. Murphy, you were
19 talking about CHS and things that CHS did. It
20 is a North Carolina Hospital Authority, I think
21 you've established. And I believe Ms.
22 Robertson actually asked you some questions
23 relative to MUSC, the Medical University of
24 South Carolina in Charleston. Do you recall
25 that?

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1 A: I do.

2 Q: All right. And I believe the question was
3 something in the nature of were those
4 facilities or those systems comparable. Do you
5 recall that?

6 A: I don't know if she used the word systems. I
7 think -- I do recall her asking something along
8 the lines of is the Medical University of
9 South Carolina similar to Carolinas Medical
10 Center? I think she was inferring that there
11 were, or asking that they were both academic
12 medical centers; you know, large hospitals
13 where there's teaching programs and lots of big
14 trauma services. I think that was the
15 questioning, but that's what I remember.

16 Q: And Medical University of South Carolina is a
17 South Carolina Hospital Authority; isn't it?

18 A: I'm not aware of their legal structure.

19 Q: All right. Medical University of South
20 Carolina has one hospital, correct?

21 A: I don't know. Again, I don't know the details
22 of that system. I know the Medical University
23 is a large academic medical center.

24 Q: You do know that the Medical University of
25 South Carolina doesn't have any hospitals in

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1 North Carolina; isn't that true?

2 A: I don't believe they do.

3 MR. WESTBROOK: Let's look at 6890, CHS. This is a
4 document produced by CHS, CHS 6890.

5 Q: And this is somewhat similar to an exhibit that
6 you put up or that was put up during your
7 testimony. It lists in the margins sort of
8 toward the bottom of that page the various
9 facilities. And I think they are organized --
10 aren't they organized in the same way that they
11 were on the map that you used, Mr. Murphy?

12 A: They look to be very similar.

13 Q: All right. So there's primary enterprise,
14 component facilities and managed facilities.
15 Are those the categories? Am I missing
16 anything? And then future hospitals down at
17 the bottom, is that right?

18 A: Yes.

19 Q: Okay. And looking -- pulling that away, just
20 looking at the map. What does the red indicate
21 on the map?

22 A: It says -- the key here at the bottom, just
23 right inside the bottom right corner is the
24 key. It says, "Those are CHS affiliated
25 hospitals."

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RECORD 001343

1 Q: And so -- and each one of them has a number, is
2 that right?

3 A: Yes.

4 Q: And the number corresponds to the facilities
5 that are listed at the bottom on either side of
6 the page, is that right?

7 A: That's correct.

8 Q: All right. And those do not include -- those
9 are not limited to acute care general hospital,
10 is that right? What kind of facilities do we
11 have represented there?

12 A: I think the majority of these are acute care,
13 licensed acute care hospitals. I'm looking
14 down the list. I see. if you look at Number 9,
15 Carolinas Rehabilitation Mount Holly. That's a
16 rehabilitation. It's a licensed general
17 hospital with only rehabilitation beds. And
18 just below that you see Behavioral Health
19 Center, CMC-Randolph. That's a 66-bed facility
20 that serves behavioral health patients. So
21 there may be -- just looking down the first
22 column, I don't see any other non -- well,
23 there's Carolinas Rehabilitation, Number 8.
24 that's another acute care -- excuse me, a
25 rehabilitation hospital. I think the majority

1 of these are acute care hospitals.

2 **MR. WESTBROOK:** All right. And Dan, if you could
3 focus in just a little tighter on the
4 Charlotte/York County area, please.

5 Q: And these would be the facilities that I guess
6 are closest to proximity to York County, is
7 that right?

8 A: Well, those are facilities that are -- you
9 know, this is clearly not to scale. When you
10 say in proximity to York County, if we go back
11 to the first column most of those facilities
12 are located within a mile or two of each other
13 in the center of Charlotte. They are not all
14 spread out over the Mecklenburg County.

15 Q: You wouldn't have room to put that many red
16 squares in the area that represents Charlotte,
17 right?

18 A: All I'm saying is this is not a geographic
19 depiction of where facilities are located.

20 Q: Right. Do you recognize this is a document CHS
21 created then?

22 A: It looks familiar. I think I've seen it
23 before.

24 Q: And you recognize York County there? In fact,
25 what does Number 35 represent there in the red

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1 square? Isn't that the CMC-Fort Mill proposed
2 site?

3 A: If we could go back to the -- I think it was
4 maybe --

5 **MR. WESTBROOK:** Sure, let's check the -- I think it
6 was blocked in.

7 Q: It would be at the very bottom there?

8 A: Right, that is.

9 Q: All right. Good. Now, you know, I think you
10 testified to this. You're responsible for, is
11 it a 14-county region; is that right, Mr.
12 Murphy?

13 A: Well, we plan -- when we look at the map here,
14 we do -- we work with all of our hospitals and
15 where they're located. But when I talked about
16 market development in the 14-county region,
17 those are natural counties that go together in
18 terms of natural geography and trade patterns
19 and that type of thing.

20 Q: And that 14 counties would include -- one of
21 those is York, right?

22 A: Correct.

23 Q: And then are all -- and then I think that it
24 also includes Chester and Lancaster counties in
25 South Carolina, is that right?

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RECORD 001346

- 1 A: That's right.
- 2 Q: And then, I guess that would be -- I'm
3 delegating the math again, but I think that's
4 11 North Carolina counties then?
- 5 A: I believe so.
- 6 Q: Three South Carolina and 11 North Carolina make
7 14?
- 8 A: Uh-huh (affirmative response).
- 9 Q: Now, in that region, that 14 county region,
10 there -- do you know offhand how many acute
11 care hospitals you have? Is it about ten or
12 11?
- 13 A: I don't know the number right off. I was
14 thinking the acute care was around nine. And
15 then there is some speciality of rehab and the
16 other health facilities.
- 17 Q: And those acute care would include Mercy,
18 Pineville, University, Union?
- 19 A: Correct.
- 20 Q: Among others?
- 21 A: Yes, and some Lincoln.
- 22 Q: All right. And none of those hospitals are
23 unsuccessful in your opinion; are they?
- 24 A: It depends on how you define unsuccessful.
- 25 Q: By any of your definition would they be

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1 unsuccessful?

2 A: No, I don't believe so.

3 Q: And within that 14-county area, there are a lot
4 of competitors; aren't there?

5 A: There are.

6 **MR. WESTBROOK:** Now, let's take a look at
7 Demonstrative 212.

8 Q: I think that's already been admitted through
9 another witness. And I don't know if you've
10 seen this or not. And the source is given
11 there at the bottom, net income of CMC
12 Hospitals 2010 through 2011 based on Medicare
13 Cost Reports. Are you familiar with these cost
14 reports, Mr. Murphy?

15 A: No, I haven't looked at these cost reports.

16 Q: Do you have -- is it any part of your job for
17 you to prepare cost reports?

18 A: No.

19 Q: All right. So do you know then whether the
20 figure of \$241,939,850 net income for 2010 CMC-
21 Main. Do you know whether that's accurate or
22 not?

23 A: I don't believe it's -- I believe it probably
24 ties to the cost report. I don't believe it
25 ties maybe to the net income of Carolinas

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1 Medical Center. And I know that from talking
2 to Gregg Stewart who is going to testify about
3 these cost reports and financial statements.

4 Q: All right. Well, cost reports are -- Medicare
5 cost reports are reports that are submitted to
6 the government, is that right?

7 A: That's right.

8 Q: Now, did I understand you to say that your job
9 doesn't entail filling out cost reports or
10 submitting cost reports?

11 A: Correct, I do not fill out cost reports.

12 Q: Well, if I'm asking you questions that you
13 don't know the answer to, all you have to do is
14 say I do not know. But do you know that
15 Medicare cost reports are submitted to the
16 federal government, and they are certified to
17 be accurate?

18 A: I believe they are certified. Yeah, they are
19 submitted to the government, and they are
20 certified to be accurate. But the way Medicare
21 evaluates certain costs -- they have certain
22 costs that are allowable and not allowable from
23 a Medicare reimbursement perspective. And
24 that's about the extent of my knowledge on the
25 topic. So that's why I don't think you can

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1 make a comparison of what you find in a
2 Medicare cost report to financial statements
3 that are developed for financial reporting
4 reasons. I think there's some methodologies
5 that Medicare has. I'm not familiar with that,
6 I just believe that's the reason they do it.

7 Q: Whatever the net revenue is that CHS Hospital
8 makes -- you know, whatever that amount is,
9 whether it's the cost report amount or
10 financial statement amount, that amount goes
11 back to the CHS system; isn't that correct?

12 A: That's correct. It is.

13 Q: And then the system would distribute it back
14 out to the hospitals based on need, is that
15 correct?

16 A: That's correct.

17 Q: And just -- just because Hospital A, say, makes
18 more money and sends more money back to the
19 system than Hospital B, that doesn't mean that
20 Hospital A is going to get the same
21 distribution back from the system. It doesn't
22 even mean it's going to get more money back
23 from the system than Hospital B; isn't that
24 correct?

25 A: That's correct. I don't think there is a pro

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1 rata of distribution of net income by hospital
2 back to each hospital. The capital is
3 allocated based on where the need is. And the
4 example I gave in my earlier testimony, we
5 allocated \$20 million of capital to Anson
6 Community Hospital, and they have operated a
7 long period of time with no income.

8 Q: Now CHS, I believe you testified on direct, CHS
9 you characterized it as a comprehensive system,
10 right?

11 A: Correct.

12 Q: And I think you discussed and explained a
13 number of financial services and reporting
14 companies, including Standard and Poors; do you
15 recall that?

16 A: I do remember mentioning them.

17 Q: And Standard and Poors is a financial service
18 and a credit rating agency. And I believe we
19 put up -- you actually put up some slides that
20 had been submitted to DHEC about your S&P
21 rating, is that correct?

22 A: I believe the slide I had up as an example was
23 Moody's Investor Service. But I mentioned
24 there were three major rating agencies. And
25 Standard and Poors is one of the three.

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RECORD 001351

1 Q: All right. And you have a good rating with
2 S&P; don't you?

3 A: We do.

4 **MR. WESTBROOK:** All right. Let's look at
5 Demonstrative 235, please.

6 Q: This is a Standard and Poors -- what's the date
7 up there, Mr. Murphy?

8 A: April 23, 2012.

9 Q: All right. I suppose there has been more
10 recent editions than this?

11 A: I don't know.

12 Q: Let's --

13 **MS. ROBERTSON:** Your Honor, I've got to interrupt
14 again. This is the same objection as we had to
15 the earlier demonstrative. Again, we are
16 seeing demonstratives. I think this is not in
17 the record. I'm going to object on the use of
18 the demonstrative that is not in the record.

19 **THE COURT:** Mr. Westbrook?

20 **MR. WESTBROOK:** I don't know why a demonstrative
21 would need to be in the record. A
22 demonstrative is going to help illustrate Mr.
23 Murphy's testimony. This is something that was
24 taken from the CHS website. It is something
25 that he mentioned in his direct testimony. In

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1 his direct testimony he talked about the credit
2 rating.

3 **THE COURT:** He did, I recall. He talks about Moodys
4 or --

5 **MR. WESTBROOK:** Moodys, Standard and Poors.

6 **THE COURT:** And so you are -- the intent of this
7 line of questioning is to pursue what he said
8 -- to pursue more into what he said on direct
9 about the rating?

10 **MR. WESTBROOK:** Well, it's not so much -- no, it's
11 not so -- I didn't want to talk about the
12 rating. I think he's put in plenty of evidence
13 about the rating. But I did want to talk about
14 if he is relying on -- if Standard and Poors is
15 obviously a credible financial services report,
16 to talk about the -- I'm going to ask him some
17 questions in this report that describe
18 Carolinas Healthcare System, and again ask him
19 if they are correct now. I think these are
20 fundamental questions. They are things
21 actually that he testified about. Not the
22 ratings -- some other things he testified. He
23 talked about the different kinds of hospitals
24 that they have in the system, component
25 facilities, the leased facilities, the

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1 management facilities, the owned facilities.
2 And this report talks about those and just
3 gives some very factual descriptions and
4 summaries. I think it's stuff he's going to
5 agree with.

6 **MS. ROBERTSON:** Your Honor, and I think some of the
7 concern is that when we started the trial, we
8 had objections on exhibits. We had a series of
9 exhibits on some Tenet information, public
10 record type information, other things that we
11 had actually marked as exhibits. We received
12 objections on all of those. And this seems to
13 be a kind of back end way to now have exhibits
14 talked about that are not exhibits and coming
15 in through demonstratives. So --

16 **MR. WESTBROOK:** But they're not coming in. I mean,
17 I am not offering this as an exhibit. I just
18 want to ask him a question and say do you know
19 if it's true or not.

20 **MS. ROBERTSON:** Well, and I guess, Your Honor, when
21 you elicit testimony from a document that is
22 not in the record and how he responds or that
23 information then becomes part of the record.
24 So it is seeking to admit information in a
25 document not in the record. It's just doing it

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1 from testimony, but it is still getting in the
2 record.

3 **THE COURT:** Well, but if what Mr. Westbrook is going
4 to do is ask him if he's familiar with this
5 document or with this Standard and Poors
6 research guide. And then ask him questions
7 from that, I mean, he is permitted. I don't
8 see how -- what the objection is to ask him
9 this. The actual document itself isn't going
10 to be marked or come in or at least they
11 haven't marked it and ask that it be entered
12 into the record as an exhibit. And of course,
13 if it is, we can have that discussion at that
14 time. But if the witness is aware of this and
15 can answer questions about it, he certainly --
16 I don't see where -- what's the objection to
17 him doing that?

18 **MS. ROBERTSON:** Well, I guess he could ask him those
19 questions without this information being up
20 before him. And maybe as he starts to do that,
21 we will see if this becomes appropriate. But
22 I still see this as somewhat -- you know, the
23 objections to the similar type of Tenet
24 information as exhibits. And now them seeking
25 to do this through demonstratives, I just want

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1 the Court to appreciate that as we go down the
2 road and seek to have our exhibits considered,
3 as well. But I think it is trying to get
4 information in the record that's not in the
5 record.

6 **THE COURT:** And Ms. Robertson, I do appreciate your
7 concern to the extent that exhibits that
8 haven't been admitted as exhibits are being
9 offered. I am not going to permit that to
10 happen. But at the same time, I am going to
11 permit Mr. Westbrook to at least go down this
12 line a little bit to see if Mr. Murphy has
13 knowledge of this and what's in this document.

14 **MR. WESTBROOK:** Thank you, Your Honor.

15 **THE COURT:** You can proceed, Mr. Westbrook.

16 **MR. WESTBROOK:** I appreciate it. Now, Dan, would
17 you turn to Page 4 of this report, please.

18 Q: And, Mr. Murphy, there is a heading down there
19 that says, Enterprise Profile. I want to start
20 with a couple questions about this. And you
21 can read as much of this as you like for
22 context sake. The only thing I want to ask you
23 is that first file out there it says, "CHS is
24 the larger of two healthcare systems serving
25 the Charlotte region." You testified on direct

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1 about Presbyterian and comparing CHS with
2 Presbyterian or Novant, I guess is
3 Presbyterian's parent company. There were a
4 number of slides. Is CHS the -- is the other
5 large healthcare system serving the Charlotte
6 region, is that Presbyterian or Novant?

7 A: It's Novant Health.

8 Q: Okay. And then the second highlight it says,
9 "CHS's primary enterprise consists of ten
10 hospitals." And then as a parenthetical
11 describes those. Is that accurate? Do you
12 know?

13 A: Well, if I can back up just for a minute. I
14 just want to point out I have not seen this
15 before to my knowledge. And this is
16 information written by a rating analyst. And
17 it says, "CHS is the larger of two healthcare
18 systems serving the Charlotte region." And
19 there are quite a number of other healthcare
20 systems serving the Charlotte region. So
21 there's not just two. So I would not agree
22 with that first statement.

23 Q: All right. Would you agree that CHS in the
24 Charlotte region is the largest healthcare
25 system serving the Charlotte region?

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1 A: I would agree that we are the largest of many
2 healthcare systems serving the Charlotte
3 region.

4 Q: All right.

5 A: Yes, sir.

6 Q: Fine. And does your primary enterprise consist
7 of ten hospitals as it says here? Is that
8 accurate?

9 A: I believe so, yeah.

10 Q: And two long-term care facilities, is that
11 correct?

12 Q: Yes. And then it goes on to say two large-term
13 facilities and 292 licensed beds and a large
14 physician network of primary and specialty
15 physicians and faculty at Carolinas Medical
16 Center. Is that an accurate summary of the CHS
17 system in the Charlotte region?

18 A: The quantitative statistics about our system I
19 think are accurate. I just, you know, didn't
20 agree with that first part.

21 Q: All right. The next paragraph, the first
22 sentence says, "CHS's strategy of broadening
23 its geographic outreach for the network of non-
24 obligated entities including 23 hospitals and
25 eight related nursing homes." Is that -- I

1 know on the chart we looked at earlier on the
2 chart that you showed in your direct
3 examination there was a list of I think the
4 term is component facilities. Is that correct
5 or is this something different?

6 A: I'm not sure it including 23 hospitals. There
7 is likely a page in this report that would show
8 what those 23 hospitals are. So I'm not
9 exactly sure through a network of non-obligated
10 entities. I believe those are referring to our
11 managed hospitals. Now, that I am reading the
12 non-obligated entities, I believe that's mostly
13 the managed hospitals.

14 Q: And that's a term that you are familiar with
15 that you use and that you use; isn't it,
16 obligated entities and non-obligated entities
17 or obligated group and non-obligated group?

18 A: Yes.

19 Q: And the obligated group would be what?

20 A: I believe the naming there refers to a group of
21 hospitals that are obligated to pay on any bond
22 debt.

23 Q: Okay.

24 A: That's the obligation term.

25 Q: And the non-obligated entities obviously would

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1 not?

2 A: Right. Again, those are -- you know, when you
3 contrast our healthcare system against Tenet or
4 Novant we are very different. We have these
5 non-obligated facilities that are simply
6 managed hospitals.

7 Q: All right.

8 A: And many times remote areas from Charlotte.

9 Q: All right. And the third sentence in that
10 paragraph states, "The component units which
11 are separately included in the CHS audit are
12 profitable and generate solid coverage of debt
13 and related lease payments." Would you agree
14 with that?

15 A: Yes. I believe those are the facilities that
16 are listed below the primary enterprise on that
17 list.

18 **MR. WESTBROOK:** Let's go over to the next page,
19 number five.

20 Q: There is a heading that says, "Utilization."
21 And again feel free to read as much of that as
22 you like. The thing I was interested in was
23 the reference to "Continued growth of CHS's
24 physician network which has contributed to
25 greater downstream admissions and outpatient

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RECORD 001360

1 volume." Is that an accurate sentence?

2 A: If you don't mind, I'm just going to read the
3 whole paragraph here.

4 Q: Sure.

5 A: Yeah, I think the -- I think that, you know,
6 part of the sentence that you've highlighted is
7 accurate. I think that there are many things
8 before that that talks about the growth of our
9 system. And as I testified earlier though, it
10 is care coordination percentages when
11 physicians refer to one of our affiliated
12 physicians. There can be growth related to
13 that. But again, the greater value of the
14 physician network is the care coordination.

15 Q: All right. And the last sentence in that
16 paragraph says, "Management reports that CHS
17 volume growth during 2011 outpaced that of
18 other providers of the service area." Is that
19 correct?

20 A: For 2011, that may be correct. And again, our
21 system as you go from the center of Charlotte
22 and go out to the bedroom communities, they are
23 much more densely populated, much higher
24 population growth. So we benefit from that
25 growth versus how providers outside that region

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1 might be growing. So that's likely a large
2 reason for that statement.

3 Q: All right. The next paragraph is headed,
4 "Market Physician Network." And again, you can
5 read as much of it, of course, as you like. My
6 only question, though, about that relates to
7 the final sentence. It says, "CHS competitors
8 have experienced some payer mix erosion because
9 CHS's Medicaid and uncompensated care inpatient
10 market share has decreased in recent years."
11 Is that correct?

12 A: Well, let me just take -- just reading that
13 again to see if it's -- Well, when I was
14 looking at some recent payer mix information
15 for our inpatient hospitals in Charlotte, again
16 this was -- I guess this is referring to 2011
17 because this was dated April 2012. When you
18 look at 2012, I think, and look back, our
19 Medicaid payer mix for inpatient hospital is
20 flat. I think our ED Medicaid is increasing
21 through 2012. And I would say that Novant, a
22 large healthcare system that has a number of
23 hospitals in that region, over the last years
24 they have increased their level of Medicaid and
25 uncompensated care to a degree from this

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1 competition because as we pointed out five
2 years ago there was a huge disparity in our
3 mix. So I think that may be what this is
4 referring to.

5 Q: All right. And then the next paragraph or the
6 next heading on this page, it says, "County
7 Relationship." And again, feel free to read
8 that first sentence if you'd like. But where
9 I wanted to ask you about started with the
10 second sentence. It's highlighted there. It
11 says, "Mecklenburg County has historically
12 funded the operating deficits of Carolinas
13 Medical Centers, Outpatient Indigent Care
14 Clinic as well as other indigent care provided
15 to Mecklenburg County residents."

16 **THE COURT:** Ms. Robertson.

17 **MS. ROBERTSON:** Yes, Your Honor. I'm sorry to
18 interrupt, but I have to renew my objection.
19 Mr. Westbrook is reading into the record this
20 document that's not an exhibit, which is
21 exactly what I thought he was going to do. I
22 do have to object on that basis. And I would
23 also say just on this prior page we were
24 looking at, he was having Mr. Murphy comment on
25 competitors. We went through a long line of

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1 objections on Mr. Murphy having any opinions
2 about competitors or being able to refer to
3 Tenet in its ability to compete and other
4 competitive stuff that he has, on his direct,
5 has mentioned. So I think this is crossing the
6 line for a demonstrative at this point clearly.

7 **MR. WESTBROOK:** Your Honor, I'm not asking to
8 comment on any particular competitor or whether
9 any other competitor has the ability to
10 compete. This is a document that obviously is
11 about CHS. It's about CHS, and I'm asking him
12 questions about CHS. I'm asking whether this
13 document that he mentioned in his direct,
14 whether these statements are accurate or not.
15 And he can say, as he has. Sometimes he's
16 explained it and said, no, I agree with this or
17 I don't agree with this. That's all.

18 **THE COURT:** How much longer is this? I mean, how
19 much more of this document are you planning on
20 going through?

21 **MR. WESTBROOK:** I've got one more question.

22 **THE COURT:** One more question. I am concerned that
23 this document appears to be just becoming a
24 part of the record, a large section of it.

25 **MR. WESTBROOK:** Well, I mean, I can ask him a

1 question without -- I mean, basically I can ask
2 him the same question, I guess, without the
3 document. You know, on the screen or without
4 him looking at it. In other words, if I ask
5 the question: Isn't it true that Mecklenburg
6 County has historically funded indigent care in
7 Mecklenburg County? That would be the same
8 thing but without a point of reference. And
9 then he can say yes or no.

10 **THE COURT:** All right. Ms. Robertson.

11 **MS. ROBERTSON:** And Your Honor, I think if that's
12 what he wants to do, that would be the
13 appropriate way to ask the witness the
14 question, not read the demonstrative into the
15 record. So if he wants to ask the question,
16 ask the question. But I don't think we need to
17 refer to a document that's not in the record
18 and, in fact, place it in the record by doing
19 that.

20 **THE COURT:** Mr. Westbrook, could you ask your
21 question without reading the document into the
22 record?

23 **MR. WESTBROOK:** Yes, Your Honor.

24 **THE COURT:** Please, thank you.

25 **MS. ROBERTSON:** Thank you, Your Honor.

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1 Q: Bear with me just a minute. Mr. Murphy,
2 Mecklenburg County historically has funded
3 indigent care provided by CHS; isn't that
4 correct, to North Carolina residents?

5 A: I believe they have subsidized the losses we've
6 incurred on certain indigent care clinics over
7 the years.

8 MR. WESTBROOK: Over the years. Let me ask Dan to
9 pull up CHS 5991, please. This is a document
10 produced by CHS during the discovery process.

11 Q: Look at the top of the page. You talked on
12 direct about attending project review. You
13 were there as one of CHS's principal speakers;
14 isn't that correct?

15 A: I was there, yes.

16 Q: June 29, 2011; does that sound --

17 A: That sounds about right.

18 Q: -- right? All right. This document, beginning
19 at the top as you see, it says, "Potential
20 Questions." And then number one says, "How
21 much money does Mecklenburg County pay you each
22 cashier indigent care?" And then Del in caps
23 next to it. You're the only Del there and so
24 I'm not --

25 A: That's me, correct. Yeah.

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1 Q: And tell me, Mr. Murphy, I would assume that
2 this is a document sort of prepping you and
3 other participants for the project review in
4 case you got questions from DHEC or anybody
5 else about how to respond to those questions,
6 is that right?

7 A: Yes. We were, you know, again anticipating
8 criticism and wanted to be prepared from our
9 competitor's criticism. And I haven't seen
10 this document in almost two years. But this
11 is, I believe the document we prepared for the
12 project review.

13 Q: And you say you anticipated criticism. I
14 understand that having been through some
15 project reviews myself. But, you are also
16 anticipating questions from DHEC staff, right?

17 A: Not necessarily. It was more, if -- I guess if
18 we did get questions we'd be prepared. But it
19 was just, again, in a broad sense for us to be
20 very knowledgeable about what was going on with
21 Mecklenburg County because I haven't been
22 involved in those. At the time, I wasn't
23 involved in the Mecklenburg County issues over
24 the budget, and I just wanted to learn more
25 about it.

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- 1 Q: In the South Carolina project review meetings
2 that you attended, the applicants don't ask
3 each other questions; isn't that correct?
- 4 A: No, that's correct.
- 5 Q: Even staff intends to have -- usually ask
6 questions of the outcome. Isn't that true?
- 7 A: That's true.
- 8 Q: All right. And in this one, the question is
9 how much money does Mecklenburg County pay you
10 each year for indigent care? And your response
11 was -- just read the first sentence of the
12 response. You can read more if you like to but
13 that was --
- 14 A: "Mecklenburg County provides us about 16-and-a-
15 half million each year for indigent care
16 funding."
- 17 Q: All right. I'm sure that's -- I'm sure that's
18 an accurate response; is it not, or it was at
19 the time?
- 20 A: I believe so. Yeah, at the time.
- 21 Q: Let's go to question number two down there,
22 please. And this questions says, "Why are you
23 having so much trouble with Mecklenburg County
24 at this time?" Dennis -- would that refer to
25 Dennis Phillips?

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RECORD 001368

- 1 A: It would.
- 2 Q: And he's another CHS executive?
- 3 A: He was. And he also was at project review as
- 4 one of our speakers.
- 5 Q: All right. And what's Mr. Phillip -- what was
- 6 he going to say if he received that question?
- 7 A: I don't know what he was going to say if he
- 8 received the question. I can tell you what was
- 9 on the page.
- 10 Q: And the purpose of this page, did we not
- 11 establish, was to prep Mr. Phillips and
- 12 yourself and the other speakers for appropriate
- 13 responses in case you got these questions?
- 14 A: That would be true. And if I could just put a
- 15 little context on this, at least for myself and
- 16 the job I had. Again, I wasn't familiar with
- 17 what was going on with discussion with the
- 18 County and the lawsuit and just wanted to be
- 19 prepared and was working with Dennis to prepare
- 20 for project review like I think our competitors
- 21 would, as well.
- 22 Q: All right. What was the prepared answer for
- 23 Mr. Phillips if he got that question? Can you
- 24 read it?
- 25 A: Sure, I can read it. "We have a wonderful

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1 longstanding relationship with Mecklenburg
2 County. And we have every reason to believe
3 this relationship will extend into the future
4 for many years to come. Quite frankly,
5 Mecklenburg County is in the middle of their
6 budget process. And given the situation, they
7 are just doing their due diligence to ensure
8 their financial house is in order. This has
9 created some stress, but this is really to be
10 expected from time to time."

11 Q: All right. And let's look at question number
12 three: "Why is there a controversy of your
13 proposed behavioral health facility?" It
14 doesn't look like there is a person assigned to
15 that. Do you remember who was assigned to that
16 question?

17 A: No.

18 Q: What's the response?

19 A: "There is no real controversy. It is just a
20 matter of Mecklenburg County sitting down with
21 us and fully understanding the project need.
22 In addition, the county has a concern with how
23 the project could impact their budget given
24 their ownership of CMC-Randolph, their 66-bed
25 behavioral facility. Our discussions are

1 progressing in the right direction." And I
2 guess I would back up. I think this is
3 referring to a behavioral health facility we
4 were proposing to build at the time in north
5 Mecklenburg County. I believe the county was
6 concerned about how that was going to impact
7 their budget. Because I think that all of
8 these discussions, it's my understanding, were
9 primarily about county budget shortfalls and
10 the way they didn't provide us notice to
11 terminate the contract.

12 Q: All right. At the time that the project review
13 was held and at the time these answers were
14 drafted, in fact, the county had put you on
15 notice of a breach of contract; hadn't they?

16 A: That -- I don't know the timing of that. I'd
17 have to -- again, that's not something I work
18 on. I couldn't -- I know the date of project
19 review. And I can't recall specific dates that
20 were related to this issue with the county.

21 Q: All right. But you do know that they put you
22 on -- at some point in time they put you on
23 notice of breach of contract; isn't that
24 correct?

25 A: I believe so. That sounds familiar.

1 **MR. WESTBROOK:** Let's look at -- let's forget that
2 date and try to put it in context of the --
3 let's first back up and see what the date was
4 for the Project review meeting. Well, this
5 was prior to the Project review meeting, so
6 June 29, 2011. Let's put up that demonstrative
7 again, the complaint, Dan. And once again this
8 -- you've seen the cap -- let's turn over to
9 Page 28 of the Complaint just to get a date on
10 this.

11 **Q:** This is the 14th of July 2011 from the Smith
12 Moore Leatherwood firm, is that right?

13 **A:** That's the date I see there.

14 **THE COURT:** Ms. Robertson.

15 **MS. ROBERTSON:** Yes, Your Honor. I think we've
16 talked about this demonstrative earlier. And
17 there's some concern about it obviously not
18 being in the record. And I think, Your Honor,
19 we talked about it not being related to this
20 case. And it's back up on the screen so --

21 **THE COURT:** Mr. Westbrook, again, where --

22 **MR. WESTBROOK:** Where are we going with this?

23 **THE COURT:** Yes, where are we going with this?

24 **MR. WESTBROOK:** There was -- has been a good bit of
25 testimony about the CHS as a nonprofit and its

1 mission, and the things that it does as part of
2 that mission and the charity care that it
3 offers. I think this contract relates to all
4 of that. Excuse me, this complaint, this
5 lawsuit relates to all of that. I think Mr.
6 Murphy will testify that he has some knowledge
7 of this. How much knowledge of this, I don't
8 know. I don't expect him to have detailed
9 knowledge. He just said, for example, that he
10 didn't know the date that the county offered --
11 he had notice of breach. I think we can
12 clarify what that date was, put it in context
13 with the project review date, and I think it's
14 relevant for those reasons. I think it's --
15 there are serious allegations by the county in
16 their notice of breach of contract. There are
17 serious back allegations by CHS against the
18 county in their complaint. And it all relates
19 to -- it's all over indigent care and
20 behavioral health. Those are the two primary
21 issues involved in that. And just seeing a
22 document that showed what they were prepared to
23 tell DHEC about that situation about indigent
24 care and about behavioral health and about
25 their relationship with the county. And so I

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1 think it relates to all that.

2 **THE COURT:** All right.

3 **MS. ROBERTSON:** Your Honor, I don't think it's
4 related. This is not in the record. And if he
5 wants to ask Mr. Murphy questions about what he
6 knows about it, then that's the way to ask
7 these questions. But we are looking at a
8 complaint that is not related to this case.

9 **MR. WESTBROOK:** And the other thing I would say,
10 this and the other document that I am about to
11 go into are public documents and not hearsay.
12 They are not -- the complaint is obviously a
13 part of the record. It was filed by CHS. And
14 the other point I would like to make is that
15 Mr. Murphy is clearly CHS's spokesman in this
16 case. He's their witness they've designated to
17 talk all about their system and about how they
18 operate and their relationship with the county
19 and the county and the good things that they
20 do. And that's what his testimony is all
21 about. I'm not trying to get this admitted
22 into evidence. I think if I ask questions
23 about it, his answers would be limited by his
24 knowledge.

25 **MS. ROBERTSON:** Your Honor, there has been no

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1 foundation laid to question this witness on
2 this. It's hearsay really, and he's not laid
3 any foundation to accept it out of that.

4 **MR. WESTBROOK:** It can't be hearsay. I mean, it's
5 subject to the documents, public records.

6 **MS. ROBERTSON:** And the point I make is there is no
7 foundations, and it's not authenticated through
8 this witness for this witness to know that he
9 knows anything about this. He asks him
10 questions about it, then maybe he gets
11 somewhere. But right now, we don't have any
12 authentication. We don't have any information
13 from this witness on this document.

14 **THE COURT:** Mr. Westbrook, I see where you're -- I
15 see, I think. where you're going. And I don't
16 know that asking questions about the witness'
17 knowledge of this matter or of the lawsuit
18 itself or if he has knowledge of the actual
19 document itself. If he has knowledge of those
20 and can testify about those, I think you can
21 inquire into that and ask him, assuming that
22 it's relevant -- that it bears no relevance to
23 this proceeding. I would -- however, since the
24 document is just a demonstrative exhibit, I
25 would prefer we not read the document into the

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RECORD 001375

1 record, since it hasn't been admitted into the
2 record. But if you want to ask the witness
3 about his knowledge of this lawsuit, about the
4 underlying allegations or about the document
5 itself whether he has any knowledge of it, help
6 prepare it, was involved in it, has seen it, is
7 aware of what it says; I think you are
8 permitted to go down that angle. But as to
9 actually reading it into the record, since it's
10 not been admitted as an exhibit, let's not go
11 there.

12 **MR. WESTBROOK:** All right. I understand. Thank
13 you.

14 **THE COURT:** Thank you.

15 **MS. ROBERTSON:** Okay.

16 **Q:** Okay. I think I asked you this question, but
17 given I was interrupted, I may not have.
18 You're aware, are you not, at some point in
19 time that Mecklenburg County gave a notice that
20 it felt CHS was in breach of the contract
21 between those two parties, is that correct?

22 **A:** I can tell you what I -- maybe the easiest way
23 is for me to tell you what I know about this.

24 **Q:** Well, that's fine. But I want you to first
25 answer the question, yes or no or I don't know

1 and then explain all you want to.

2 A: I have heard -- I recalled the county claim we

3 were in breach of the contract. I've heard

4 that from executives in our system. What I was

5 going to say that I do know about this is that

6 I've been at CHS for 17 years, and I don't

7 recall another situation like this over my 17-

8 year history with CHS where there were issues

9 like this with the county. We work with county

10 governments in North and South Carolina. I

11 don't recall any controversies. We've had

12 great relationships in Mecklenburg. And what

13 I know about this is that the county did not

14 give us proper notice to terminate. That's

15 what my understanding is. And that's about the

16 extent of my knowledge of this. I have not

17 seen this before. And again, I was not

18 involved in the discussion with the county, the

19 lawsuits. And that's about the extent of it.

20 And the project review document preparation

21 was, again, that's not part of my job to be

22 involved in these discussions. We have other

23 folks working on these type matters. And

24 again, we've had a long great relationship with

25 the county, Mecklenburg County. And I think

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1 there were budget constraints. And things just
2 evolved. And that's about the extent I have.

3 **MR. WESTBROOK:** Let me ask Dan to put up on the
4 screen something that is in the record. And
5 that is from the project review submission by
6 Piedmont, and I believe this is slide 19; is
7 that correct, Dan? And that's slide 24. All
8 right, from the project review submission by
9 DHEC. And you see there's an article there of
10 the Charlotte Observer June 12, 2011. And a
11 call out from that article says the June 3
12 letter from Carolinas Healthcare CEO Mike
13 Tarwater, County Manager Harry Jones contended
14 the hospital system has breached the contract
15 by failing to provide requested information
16 about CMC-Randolph's patients and finances.
17 And you were at the project reviews, is that
18 right?

19 A: I was.

20 Q: Do you recall this slide being put up?

21 A: I do recall the slide. And as I read it here
22 today, I mean, it's county managers contending
23 that we breached it.

24 Q: Right, I realize that's --

25 A: I do recall this, if not this exact slide, it

1 was something similar.

2 Q: And the date there, June 3rd, does that ring a
3 bell as the date the county manager put you on
4 notice -- put CHS on notice of a breach?

5 A: You know, I assume this is accurate. Again, I
6 haven't seen the letter, didn't know the date.
7 But if -- it looks like this reporter probably
8 had a copy of the letter. I assume that's the
9 correct date. Again, I'm not familiar with the
10 letter.

11 **MR. WESTBROOK:** Let's look at the next line, Dan;
12 again from the project review.

13 Q: The Charlotte Observer June 12, 2011. CHS
14 doesn't intend to provide immediate details or
15 responses to many of the questions Jones has
16 raised. And Jones is the county manager, is
17 that correct?

18 A: That's correct.

19 Q: Hospital spokeswoman Gail Rosenberg said, "It
20 doesn't feel that there is a lot to be gained
21 by that," she said. Do you recall that
22 response at project review?

23 A: I don't recall this specific response. And I
24 think as a policy we don't discuss issues that
25 are in litigation with the press. It's just

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1 sort of a policy that we have. I don't know if
2 that's a formal policy; it's just my
3 understanding.

4 Q: Now, after to this notice, you are aware that
5 at some point in time the county actually
6 terminated the contract with CHS; isn't that
7 correct?

8 A: I believe so.

9 Q: And then as a result of that, you are aware,
10 are you not, that CHS filed a lawsuit against
11 the county, is that correct?

12 A: My limited understanding is that we did file a
13 lawsuit. And it was because they didn't file
14 the proper termination notice when they ended
15 the contract.

16 Q: And that lawsuit is now over, is that correct?

17 A: I believe so.

18 Q: And as a result of that lawsuit, am I also
19 correct that the county no longer funds that
20 \$16-and-a-half million to CHS for those
21 indigent care programs?

22 A: I don't believe they did.

23 Q: So is the county providing any indigent funding
24 since this 2012 or 2011 or whenever the
25 contract was finally terminated, have they

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1 funded any indigent care for CHS since then?

2 A: I am not sure. I wouldn't know. They may
3 have. I don't know if they terminated funding
4 when those terminations might -- I don't know
5 specific dates.

6 Q: All right. Mr. Murphy, you're aware, are you
7 not, that in 2012, the Charlotte Observer ran
8 a series of articles focused on CHS and other
9 nonprofit hospitals in North Carolina, is that
10 correct?

11 A: That is correct.

12 **MR. WESTBROOK:** And let me -- excuse me, ask Dan to
13 put up the first of those articles and see if
14 this is the site.

15 Q: This article says, "Charlotte Observer."
16 What's the date on this?

17 A: Saturday, April 21, 2012?

18 **THE COURT:** I apologize, Mr. Westbrook. Is this an
19 Exhibit number?

20 **MR. WESTBROOK:** No, it's just a demonstrative.

21 **MS. ROBERTSON:** At the bottom corner.

22 **MR. WESTBROOK:** Is there a demonstrative number on
23 this?

24 **MS. ROBERTSON:** There is something on the corner of
25 the bottom. I couldn't tell what it was.

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1 **MR. WESTBROOK:** Oh, okay. It's from -- I'm sorry.
2 There is the Bates Page. So this is from PMC
3 documents produced, Bates Page
4 11.2013.00030120. Now Dan, if you would go
5 back up to the top. And Dan, if you could
6 highlight where it says the five-part series.

7 **Q:** Is this -- I asked you a question about it,
8 were you familiar with a series of articles by
9 the Charlotte Observer? Is this the series
10 that you were talking about?

11 **A:** Well, you asked me if I was familiar with the
12 series? I assume this is the series that you
13 were referring to, the one I am familiar with.

14 **Q:** Well, and my question I think originally was
15 are you -- something of this nature, are you
16 aware that the Charlotte Observer ran a series
17 of articles that were critical of CHS and other
18 nonprofit hospitals in North Carolina? I
19 believe you said you were, is that right?

20 **A:** Yes. And I would, just for the Court, you
21 know, I don't agree with what was published.
22 And as an example, nonprofit hospitals thrive
23 with profits. I don't agree with that
24 statement. I mean, we have a profit. But we
25 also operate in an industry that has the

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1 highest capital requirements of many
2 industries, if you want to talk about a lot
3 of other industries. So the moneys we make are
4 required to sustain our mission and to replace
5 facilities and build new facilities as
6 populations increase. And I think that, you
7 know, we are responsible fiduciaries of the
8 jobs that we have. And we have to have a
9 viable healthcare system that has a profit so
10 we can fulfill our mission. But I don't think
11 we -- I just don't agree with the headings and,
12 you know, much of these articles. It's my
13 understanding that a lot of the information we
14 gave to the Charlotte Observer didn't get
15 printed.

16 Q: All right.

17 **MS. ROBERTSON:** Your Honor, if I may, and I don't
18 know how we get around that. But we received
19 an objection. And I think you might recall on
20 exhibits and items or newspaper articles and
21 treatises that we had sought to have admitted,
22 this was a demonstrative, but it's the same
23 concept of getting information in the record
24 that's hearsay, and it's not admitted.

25 **MR. WESTBROOK:** My response, Your Honor, is, you

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1 know, I'm not planning on reading into the
2 record. This information is not being offered
3 as an exhibit. I asked him if he was familiar
4 with it. I am going to ask him some questions
5 about his familiarity, his knowledge of some of
6 the issues raised in this series, and I'm not
7 offering it as evidence.

8 **THE COURT:** Okay. Ms. Robertson.

9 **MS. ROBERTSON:** Your Honor, I guess he could ask him
10 the questions about these articles. And, you
11 know, to the extent he ask the questions and
12 we've got it in front of us and we're
13 highlighting sections of it and portions of it
14 are becoming parts of the record in an
15 inappropriate way, I think.

16 **THE COURT:** Mr. Westbrook, you're going to ask him
17 about -- you started down this line of
18 questioning where you asked him if he's
19 familiar with this series of articles done by
20 the Observer. And he has testified that he is
21 somewhat familiar with that. And then he has
22 disagreements with the conclusions drawn, and
23 he has given some of his reasons and rationale
24 for why he's concluded, that he doesn't think
25 those conclusions by the paper with regard to

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1 these issues were proper. You're then -- you
2 want to proceed a little further into this and
3 ask him about some specifics. But then about
4 the article, to ask him if he is familiar with
5 that and if he has an opinion about that; is
6 that where you're going?

7 **MR. WESTBROOK:** Well, something of that nature. I'm
8 going to bear in mind the instruction you gave
9 me previously a few minutes ago not to read
10 from the documents. So I wasn't planning on
11 doing that.

12 **THE COURT:** And because at this point, now we are
13 talking about a newspaper article that is a
14 public document.

15 **MR. WESTBROOK:** So, you know, he said he is familiar
16 with them. I am going to ask him about some of
17 the issues that were raised in this series of
18 articles by the Observer and ask him what he
19 knows about it and some follow-up issues. But
20 I'm not going to read from them.

21 **MS. ROBERTSON:** Your Honor, I would think a
22 newspaper article is an exception to the
23 hearsay rule. It's not an official public
24 document that gets out of hearsay. I think it
25 is hearsay. And I guess when he asks these

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1 questions, we can see where this goes. But we
2 are continuing to look at these on the screen,
3 and we are continuing to refer to them. And it
4 is hearsay and it is not of record.

5 **MR. WESTBROOK:** And I guess -- I mean, I agree with
6 Ms. Robertson that the newspaper article is
7 hearsay. I'm sure that's true. I don't think
8 it is hearsay, though, if I'm asking a
9 question, "Are you aware,?" because I don't
10 think it's offered for the truth of the matter
11 asserted. If I say, "Are you aware that the
12 newspaper criticized you for having excess
13 profits or whatever?"; yeah, I'm aware of
14 that. But that's not being offered for the
15 truth of the matter asserted. It's just
16 something that happened. The newspaper made
17 that accusation.

18 **THE COURT:** Well, but at this point if it is
19 hearsay, what relevance does it have to this
20 proceeding?

21 **MR. WESTBROOK:** Well, I think it is very relevant
22 because it's going to get into the issues that
23 relate to all the criteria. But I think again,
24 we're not -- I'm not going to be reading from
25 the newspaper article. I'm going to ask him if

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1 it's true or not. And then his response will
2 be, I think -- my guess is I think he's already
3 indicated that he disagrees with a lot of these
4 allegations that they are not true.

5 **MS. ROBERTSON:** And I think Mr. Westbrook's
6 description does mean he is offering for the
7 truth of the matter asserted. I think that is
8 what he is trying to do in violation of the
9 hearsay rules.

10 **THE COURT:** Mr. Westbrook, I'm just trying to figure
11 out if we're not -- if it is not being offered
12 for the truth of the matter asserted, and
13 you're just merely asking him are you aware of
14 these series of articles, he's testified he is.
15 He's testified that he disagreed with some of
16 the conclusions drawn. Now, if we go further
17 into that, you're talking about inadmissible
18 hearsay. And you're asking him if he's
19 familiar with the specific allegations where
20 there may apparently be conclusions drawn and
21 the allegations made, whatever, by these
22 newspaper articles, which again are hearsay and
23 therefore not admissible, and then ask him what
24 his opinion of that is. I mean, in essence
25 you're saying, well, do you think it's true

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RECORD 001387

1 what the newspaper article is saying? I don't
2 know -- if we don't -- if this Court isn't
3 going to assume that this is being offered for
4 the truth of the matter asserted, then asking
5 him do you agree or disagree with these
6 assertions, then I'm not sure what other basis
7 this is being offered for. And therefore, I
8 can't get over the fact that it seems to be
9 inadmissible hearsay to pursue this line of
10 questioning.

11 **MR. WESTBROOK:** I'll move on.

12 **THE COURT:** All right. Thank you, sir.

13 **MR. WESTBROOK:** Let's go to Exhibit -- excuse me,
14 114 please. I think this is something that you
15 testified about in your direct. This is the
16 one that is CHS's response to Piedmont's
17 interrogatory.

18 Q: Do you recognize this, Mr. Murphy?

19 A: Yes, I believe this is --

20 Q: The one with the chart that we talked about?

21 A: Right.

22 Q: Let's go on down to what the question is, first
23 of all. Well, that's fine. Let's just go to
24 the chart since you've already talked about the
25 chart. That's fine. And you've already

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RECORD 001388

1 explained the chart. So I think I just want to
2 ask you a couple of questions about the bottom
3 half of the chart. I think you have already
4 testified that the bottom half really
5 summarizes its compilation of the top half,
6 right?

7 A: That's correct.

8 Q: All right. And this gives by year, I take it,
9 the data related to all CHS facilities or CHS
10 facilities in North Carolina or what is this
11 limited to?

12 A: I'm not certain of that, which facilities are
13 included. My assumption would be that it's the
14 primary enterprise that is wholly owned.

15 Q: I thought you testified you prepared the chart,
16 but I assume you meant that somebody under your
17 supervision prepared it, is that correct?

18 A: I actually formatted the chart into this format
19 you see here. Someone else collected the data
20 and sent it to me.

21 Q: All right. And the number of lawsuits by year
22 is in that column, is that correct?

23 A: That is.

24 Q: And I don't think have to go through all these
25 columns but -- skip a column. And then that's

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1 the number of liens that were obtained, is that
2 correct?

3 A: Correct.

4 Q: Now you -- I believe you testified under direct
5 about the number of patient encounters and that
6 this final column indicated a low percentage of
7 patent encounters. Any lawsuits that would be
8 filed by CHS against patients, those would be
9 against patients that didn't pay the bills, is
10 that correct?

11 A: Yeah, that's my understanding.

12 Q: So wouldn't the vast majority of these patients
13 fall into the self-pay category?

14 A: No. I think the lawsuits are filed against --
15 I think our financial counselors evaluate
16 people's ability to pay their bills. And the
17 lawsuits are filed against people who we deem
18 have an ability to pay but aren't. And it is
19 to get a dialogue going to work out a payment
20 plan.

21 Q: I understand that, but you are not suing
22 insured patients; are you, because insured
23 payments would be paying their bills, right,
24 through the insurance company?

25 A: Again, my understanding of this is the folks

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1 who fall into this category and fall into, for
2 instance, in 2011, the 4310, they are folks who
3 have a wherewithal to pay part of their bill.
4 And we are working this process to basically
5 get a dialogue because we deem them able to pay
6 their bill.

7 Q: All right. Let me try this one more time.
8 Wouldn't you anticipate in your position that
9 most of the people who end up being sued,
10 wouldn't you anticipate that the vast majority
11 would either fall in -- would fall into the
12 self-pay category, they would be uninsured;
13 wouldn't you believe that to be true?

14 A: That's an area I'm not familiar with. Again,
15 I have an understanding of this. And there are
16 citizens who are, you know, less fortunate who
17 have no ability to pay. And it's my
18 understanding we don't file lawsuits, judgments
19 or liens against that group because they have
20 no means to pay; therefore, we don't go down
21 that road.

22 Q: But you don't really know that; do you?

23 A: You know, that's my understanding. So, you
24 know --

25 Q: But you don't have first-hand knowledge of

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1 that; do you?

2 A: I don't process the lawsuits, judgments or
3 liens, and I don't work in patient accounting.
4 But from my understanding of working at the
5 healthcare system, again it goes back to what
6 I testified earlier, there is a very small
7 group of patients who have the means to pay,
8 And this is a process and philosophy that I
9 think is -- you know, again it shows that a
10 very small group of patients that fall into
11 that category that have an ability to pay. And
12 we believe, as fiduciaries of Carolinas
13 Healthcare System, we need to have them pay
14 part of their bill.

15 Q: And isn't the definition of self-pay, a person
16 who doesn't fall into the charity
17 classification but who does not have insurance;
18 isn't that correct?

19 A: I'm not -- I can't say specifically how you get
20 categorized into the self-pay from a payer mix.
21 I'm assuming those folks are not sponsored by
22 a federal or state government, Medicare or
23 Medicaid. They are not commercially insured.
24 So those may well be the classic charity
25 patients that have no ability.

- 1 Q: Well, once again, I'm distinguishing -- I'm
2 trying to distinguish my question. And if you
3 don't know the answer to this, that's fine.
4 Between charity patients and self-pay patients,
5 charity patients are patients who qualify for
6 charity care under the policy of the CHS
7 agreement with the hospital; isn't that
8 correct?
- 9 A: Right.
- 10 Q: Self-pay patients are patients who are
11 uninsured but who don't qualify for charity
12 care; isn't that correct?
- 13 A: That seems like the case, yes.
- 14 Q: I mean, you've been working in this business
15 for a long time and that is correct. It
16 doesn't seem correct, it is correct; isn't it?
- 17 A: Well again, I don't get into the details of our
18 billing processes in how we categorize payer
19 mix.
- 20 Q: Mr. Murphy, you've prepared how many CON
21 Applications over the years?
- 22 A: Close to 200 or more.
- 23 Q: And each one of those would have some kind of
24 financial projections, payer mix assumptions in
25 them; wouldn't they?

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1 A: They would.

2 Q: And you tell me you're not sure what self-pay
3 means?

4 A: I'm not telling you what -- self-pay means that
5 you are not sponsored by federal-state
6 government or an insurance program. It means
7 you have no other ability from federal
8 government, state government. Do you have
9 other means to pay? You might.

10 Q: But self-pay would be by definition not
11 insured; isn't that correct?

12 A: That's true.

13 Q: Okay. And wouldn't you agree that the patients
14 -- if you're saying that you're not suing
15 charity patients, wouldn't you agree that you
16 are only suing patients who are not paying
17 their bills; isn't that correct?

18 A: You know, again, I'm not sure I understand your
19 question. I guess I have to stick to what I
20 know and what I understand. And what I
21 understand is the patients who fall into the
22 category of where we will, you know, file a
23 lawsuit or judgment or lien are people we have
24 deemed to have an ability to pay but aren't,
25 for whatever reason in their lives, and we

1 believe we want to work with them to work out
2 a payment plan.

3 **MR. WESTBROOK:** All right. Let's go to Page 44 of
4 Mr. Murphy's deposition, please.

5 Q: Mr. Murphy, I'm just going to hand this up here
6 to you, if that's all right, Your Honor. And
7 if you can just break the seal and just turn to
8 Page 44, please. And Dan will put it on the
9 screen, too.

10 A: (Complies)

11 Q: All right. Where I'm going to ask you to go,
12 Mr. Murphy, is there is a question that begins
13 actually the last line of Page 43; Line 25 of
14 Page 43 and then spills over. And I want to
15 ask you the question from your deposition, I'll
16 read in Ms. Robertson's objection that she
17 makes for the question. And then I would like
18 you to read in your response, okay?

19 A: You're on Page 43, 44?

20 Q: Yeah, I'm going to start Line 25 on Page 43,
21 the very last line on that page.

22 A: Okay.

23 Q: The question says at the bottom of the page if
24 you read the last two paragraphs, I'll just
25 read them into the record. It says, "In a

1 sampling of 100 suits that Carolinas Healthcare
2 filed against Mecklenburg County residents, the
3 newspapers found that 71 of them didn't --
4 either didn't own property in the county or
5 owned houses assessed at less than \$150,000
6 interviews with --"

7 **THE COURT:** Mr. Westbrook, let me stop you for one
8 second. Go ahead, Ms. Robertson.

9 **MS. ROBERTSON:** And, Your Honor, I do need to object
10 to this. And I did object to it at the time of
11 the deposition, too. I think we're going back
12 to referring to newspaper articles through this
13 line of questioning. It is hearsay, it's not
14 in the record, and we're back to that topic
15 again. So I must object to this. And again
16 it's hearsay.

17 **THE COURT:** Okay. Mr. Westbrook.

18 **MR. WESTBROOK:** Your Honor, this goes -- this really
19 is for impeachment purposes. So Mr. Murphy has
20 testified that they see charity care patients.
21 He's testified to that on direct, and he's said
22 it again here on cross. I think that is an
23 emphasis of statement here, and I want to get
24 him to read the reference of the question so I
25 can set up a context of what he's answering to.

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1 **MS. ROBERTSON:** The question, Your Honor, is
2 referring, and again, he is again reading from
3 a newspaper article, which is hearsay. So I do
4 object to the reading of the question in the
5 record. And if it's something else -- I mean,
6 if it's to a response that Mr. Murphy gave,
7 maybe that's different. But this again is
8 reading from a newspaper article into the
9 record.

10 **THE COURT:** Well, this is an impeachment. So I'm
11 just trying to clarify here. You are seeking
12 to impeach some testimony here because you
13 think there's been an inconsistent statement
14 made by the witness. And so there was a set-up
15 question in the deposition which was objected
16 to. And then is it the answer to that question
17 that Mr. Murphy gave that is inconsistent with
18 --

19 **MR. WESTBROOK:** Right.

20 **MS. ROBERTSON:** To get to the answer, you've got to
21 get to the question. And the question is
22 premised on hearsay. And the objection is in
23 the record preserving that -- this discussion
24 here today, Your Honor. So I object to the
25 question that's hearsay. And I do not believe

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1 it should be read into the record or asked of
2 this witness.

3 **MR. WESTBROOK:** Your Honor, and again, maybe this is
4 something you can review for yourself and make
5 that decision. But the point of the question
6 -- really the question, the final question is
7 this: Do you have any way of knowing whether
8 these statements are true or not? That is the
9 question. And his answer is what I'm trying to
10 elicit, the answer that he gave in his
11 deposition. And that's -- so the setup about,
12 you know, reading from the newspaper article
13 here at the deposition is not being offered
14 other than do you know whether it's true or
15 not?

16 **MS. ROBERTSON:** And, Your Honor, I guess for context
17 I'm not sure -- I mean, I think we were back on
18 the answers to interrogatories and what Mr.
19 Murphy did to prepare the answer to
20 interrogatory on the practices of Carolinas.
21 I don't even know if those interrogatories have
22 been responded to, and maybe Mr. Westbrook will
23 correct me, at the time of this line of
24 questioning. So I don't know that this hearsay
25 questioning can be impeachment to something he

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1 subsequently did and has now testified about
2 what he did in that process when he prepared
3 the answers to the interrogatories. I don't
4 believe that is proper impeachment, use of
5 hearsay information.

6 **MR. WESTBROOK:** Well, you know, what I'm impeaching
7 is this, on his direct testimony, Mr. Murphy
8 said we don't sue charity patients. In his
9 deposition, he says, I don't know.

10 **THE COURT:** I kind of see where that's where you're
11 going. And to that, Ms. Robertson, it kind of
12 doesn't seem -- the question that was posed
13 prior to the answer that you objected to, Ms.
14 Robertson, at that time, all that question is
15 whether the truth of those allegations in the
16 question are not at issue here. That question
17 -- if it's -- all that does is set up his
18 answer, which is that I don't have any way of
19 knowing if those statements are true. Whether
20 those statements are true or false or
21 completely made up numbers or right on, spot-on
22 accurate, is irrelevant. It's -- as I
23 understand what Mr. Westbrook is attempting to,
24 at this time do is to get into -- get into at
25 that time Mr. Murphy then responded by saying

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1 that he didn't have any way of knowing what the
2 -- he didn't have any way of knowing whether
3 those statements were true or not. So I don't
4 think that we've got a hearsay problem at this
5 point. I think at this point, what would be
6 your objection to it?

7 **MS. ROBERTSON:** Well, he said he is doing this for
8 purposes of impeachment. I think this
9 deposition predates the work that Mr. Murphy
10 did in responding to the interrogatory and the
11 knowledge that he has about what he did and
12 what's contained in that exhibit in the
13 interrogatory response. So I don't know that
14 you can back up to a previous time and impeach
15 him on something that precedes what he just
16 testified about and the basis for his
17 testimony.

18 **THE COURT:** Okay. I think at that point, that would
19 be something you could rehabilitate him on. So
20 I am going to go ahead and allow Mr. Westbrook
21 ask the question. And then if you wish to
22 rehabilitate your witness or if he could
23 explain his answer, then he can at that point.
24 Go ahead, Mr. Westbrook.

25 **MS. ROBERTSON:** Thank you, Your Honor.

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1 **THE COURT:** Thank you.

2 **Q:** Mr. Murphy, let's go back and start over there
3 at Line 25 on the previous page. I will try to
4 get through this quickly.

5 **MR. WESTBROOK:** Dan, if you could pull up 25.

6 **Q:** All right. At the bottom of the page, if you
7 read the last two paragraphs, I'll just read
8 them into the record. It says, "In a sampling
9 of 100 suits that Carolinas Healthcare filed
10 against Mecklenburg County residents, the
11 newspaper found that 71 of them didn't --
12 either didn't own property in the county or
13 owned houses assessed at less than \$150,000.
14 Interviews with 15 who were sued suggests at
15 least a third of them probably should have
16 qualified for charity care based on the incomes
17 and assets. Do you have any way of knowing
18 whether those statements are true or not?" Ms.
19 Robertson, "object to the form. Go ahead". The
20 witness?"

21 **A:** I said, "I don't have any way of knowing if
22 those statements are true."

23 **Q:** All right. And you go on in your deposition
24 and talk about how you gained some
25 understanding of this from talking with a

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RECORD 001401

1 gentleman named, Steve Burr, is that correct?

2 A: Correct.

3 Q: All right. But Mr. Burr, this is in his area,
4 is that correct?

5 A: That's correct.

6 Q: All right. It's not in your area. I believe
7 you testified already that you're not involved
8 in how collections are run in your
9 organization. Is that correct?

10 A: That's correct. And responding to the
11 discovery request, I've learned more about this
12 area. But again, it's not what I do in my job.

13 Q: All right. Now, the liens that are listed on
14 that chart that you created that we went over
15 a few minutes ago, those are liens on homes, is
16 that correct?

17 A: I assume so.

18 Q: And you -- I believe you testified on direct
19 that you use those liens, you put liens on
20 homes for the purpose of really getting
21 leverage on folks to enter into payment plans,
22 is that correct?

23 A: That's correct.

24 Q: Now, if somebody wanted to refinance their
25 house or put a lien on their home or CHS or

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1 anybody else had a lien on their home, don't
2 you think they'd have some trouble refinancing
3 their house?

4 A: Well, and this is -- I'll tell you what I know.
5 What my understanding is that we have never not
6 allowed a home to be sold or refinancing to
7 take place.

8 Q: But that's based on what Steve Burr tells you?

9 A: That is.

10 Q: All right. And, in fact, if somebody wanted to
11 refinance their house and Carolinas had a lien
12 on it, they went to the bank and the bank said,
13 no, we can't refinance. I mean, Mr. Burr,
14 wouldn't have any way of knowing that; would
15 he?

16 A: If the bank didn't call him, I guess not.

17 MR. WESTBROOK: Now, Your Honor, at this point we
18 have been going for awhile and it's --

19 THE COURT: You'd like to take a break?

20 MR. WESTBROOK: -- which I take responsibility for
21 in large part. Yeah, it might be a good time
22 for a break.

23 THE COURT: Yeah, if this -- yeah, about 15 minutes.

24 MR. WESTBROOK: Yeah.

25 MS. ROBERTSON: Thank you.

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RECORD 001403

(Off the Record)

1
2 **THE COURT:** All right. We're back on the record.

3 And Mr. Westbrook, sir.

4 **MR. WESTBROOK:** Thank you, Your Honor.

5 Q: Mr. Murphy, there's been a good bit of
6 testimony about the expansion at Pineville,
7 CMC-Pineville over the last several years.
8 Just to clarify, the -- I think you said this,
9 but I want to make sure I understand, the
10 service area for CMC-Pineville as articulated
11 in the 2007 application included -- it's larger
12 than York County but it included York County in
13 it; isn't that correct?

14 A: Yes.

15 Q: It includes all of York County, is that right?

16 A: I would think so.

17 Q: And the -- and I think there has been a good
18 bit of testimony about the bed increase. And
19 there were also different kinds of services
20 that were added to Pineville; isn't that
21 correct, that they had a number of speciality
22 tertiary services like open heart, neurosurgery
23 and neonatal and that kind of thing. Is that
24 right?

25 A: That's correct.

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1 Q: Now, currently there are about 70 to 90 CHS
2 employee positions in York County, is that
3 correct?

4 A: That's approximate, I think.

5 Q: And CHS -- excuse me, CMC-Fort Mill, its
6 service area is entirely York County, is that
7 right?

8 A: It's primary and secondary service oriented
9 that cover York County, yes.

10 Q: That's right. So together they cover York
11 County, is that right?

12 A: Right.

13 Q: Now, CHS through Pineville and I guess through
14 other facilities as well have been serving York
15 County since at least 2007 if not before, is
16 that right?

17 A: CHS has been serving York County for, you know,
18 probably since, you know, the 1940's. I would
19 assume the patients travel as long as we needed
20 to assist them, and that dates back to 1943.

21 Q: Now, there was testimony about the, I believe,
22 about the provision of care that CHS has
23 offered in northern York County. And you have
24 some Urgent Care Centers that you have opened
25 up recently in northern York County, is that

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1 correct?

2 A: There is an Urgent Care Center in Fort Mill
3 that was opened a couple of years ago.

4 Q: What's that called; do you recall? Do you have
5 the name of it?

6 A: I'm not positive. It may be CHS-Fort Mill or
7 something to that effect. It has Fort Mill in
8 the name.

9 Q: And you're building another one that is
10 referred to as Ballentine, is that correct? Is
11 that in the process of being build; do you
12 know?

13 A: I'm not aware of an Urgent Care Center being
14 built in Ballentine.

15 Q: Is it a NOB rather than an Urgent Care Center
16 or medical office building?

17 A: I'm not aware of it right now. I may be
18 drawing a blank, but I'm not aware of any
19 construction. There is a construction, I
20 believe, of potentially a children's Urgent
21 Care Center in Blakeney which is close to
22 Ballentine, if that's what you're referring to.

23 Q: Let me ask you, is the Celanese Road exit off
24 I-77, what's being constructed there?

25 A: I'm sorry. That Calanese Road and 77, that is

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RECORD 001406

1 a medical office building where we are
2 consolidating a number of our York County
3 practices. But that is Rock Hill and not
4 Ballentine.

5 Q: Are there plans to provide urgent care services
6 there?

7 A: Not that I'm aware of.

8 Q: Has CHS ever offered to establish an Urgent
9 Care Center in western York County?

10 A: Memory is a little vague on it. I think we may
11 have had one in western York County years ago
12 and closed it. I know there's been discussion
13 about it during this process, but I don't
14 remember exactly what our services were in
15 western York, but that's my recollection.

16 Q: When you say discussion during this process,
17 CHS hasn't proposed to provide urgent care
18 services as a part of this process in western
19 York County; has it?

20 A: No, no; we haven't.

21 Q: And CHS hasn't proposed to the county to offer
22 24/7 ambulance services in York County; have
23 they?

24 A: I'm not familiar with what we may be doing in
25 the emergency services area with the ambulance

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1 services. I know there has been discussions
2 about that. But I don't know with York County
3 or not. I know we have discussions with Tega
4 Cay and whatnot.

5 Q: As part of this, you are in charge of this CMC-
6 Fort Mill CON initiative, is that correct?

7 A: Right.

8 Q: As part of that, I'm going to say initiative or
9 project or whatever the most perfect word would
10 be. As part of that project, there hasn't been
11 any proposals by CHS to offer county-wide free
12 ambulance services; has it?

13 A: No.

14 Q: And there hasn't been any proposal as part of
15 that project to offer quarterly or financial,
16 quarterly or annual financial reports to York
17 County by CHS or CMC-Fort Mill; has there?

18 A: There hasn't been any proposal. And we haven't
19 been required to do that in any county where we
20 operate. So we just haven't been -- unlike
21 Tenet, we haven't been required to do that.

22 Q: And in fact, when going back to the question
23 about the Urgent Care Center, didn't CHS
24 represent to DHEC that an Urgent Care Center in
25 western York County wasn't relevant to these

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1 CON Applications or these CON projects?

2 A: Well, I think I remember a representative from
3 Novant Health basically saying, I believe at
4 the first project review, that if they were
5 awarded the certificate of need application,
6 they would build an Urgent Care Center in
7 western York County. And we may have said
8 something along those lines that there is
9 nothing in the criteria that would require you
10 to build an Urgent Care Center as a part of
11 getting approved for this project.

12 Q: So it was CHS's position, was it not, that that
13 Urgent Care Center in western York County
14 wasn't relevant to the project; isn't that
15 correct?

16 A: You know, I don't think an Urgent Care Center
17 in western York County is relevant to the CMC-
18 Fort Mill proposal that we have. I mean, it's
19 relevant in the sense that both are about
20 meeting healthcare needs. But, you know,
21 western York is not Fort Mill, and it's a
22 different type of service.

23 Q: Now, you talked about CHS. On direct, you
24 talked about CHS being an integrated system I
25 believe, is that right?

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1 A: Correct.

2 Q: And an integrated healthcare system, as I
3 understood you to testify, and I've heard you
4 talk about that before is a system that in
5 which hospitals and physicians and the entire
6 continuum of care is working together towards
7 trying to be bring about high-quality low cost
8 care; is that accurate?

9 A: That's correct, that's right.

10 Q: And an integrated system, if its managed
11 correctly, should increase efficiency; would
12 that be true? Wouldn't that be one of the
13 points of it?

14 A: Yes.

15 Q: And being able to provide tertiary and
16 community services within one system through
17 hospital services and physician services, that
18 would be one aspect or one goal of an
19 integrated system; would it not?

20 A: To -- I'm not sure I understand your question.

21 Q: Let me rephrase that. That's all right. Yeah.
22 In other words, one of the goals of an
23 integrated system would be to provide both
24 community services and tertiary service?

25 A: Right.

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1 Q: And it's possible, I think, you agree; would
2 you not, for a system to be integrated. And
3 you could have a great number of facilities or
4 as few as just two hospitals; wouldn't that be
5 possible?

6 A: That would be possible, yes.

7 Q: Let me ask you about the projections in your
8 updated application. First of all -- and you
9 testified about this. My understanding is it
10 was your understanding, based on your
11 understanding of what was required, CHS
12 submitted its -- really its updated
13 projections, its updated financial projections
14 and utilization projections and cost
15 projections and things of that nature in
16 December of 2010, is that right?

17 A: That is correct. We submitted them following
18 the October -- the first submission I believe
19 it was December the 3rd.

20 Q: Right. And the -- that was -- what was that,
21 two months after Presbyterian and Piedmont
22 submitted their projections, is that correct?

23 A: The initial projections were submitted in March
24 of 2005. So I mean, to be technical about it,
25 it was four years later.

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1 Q: Well, let me put it this way then. Would you
2 agree that updated submissions following the
3 remand, the first submission is following the
4 remand that Presbyterian and Piedmont made were
5 in October 2010; isn't that correct?

6 A: They filed their updated information in
7 October. We filed ours in December. And as I
8 testified, we were uncertain what to file in
9 October. And so we took the course of action
10 that we did and then filed our updated
11 projections in December. And that was based on
12 what was written in Judge Matthew's order, and
13 it was based on -- and I don't know if I can
14 get -- not getting any clarity from DHEC on
15 what to file.

16 Q: Now, going into those utilization projections,
17 it's your position, is it not, or CHS's
18 position in the updated projections that it
19 filed in or submitted to DHEC in December of
20 2010, that the CMC-Fort Mill project would not
21 take any more patients from Piedmont than CHS
22 is currently taking; isn't that your position?

23 A: Yeah. Our position was after looking, you
24 know, again when we initially filed the
25 application, when we looked at the market

1 share changes that had occurred from 2000-2003,
2 and we looked at that. And then we looked at
3 what community hospitals typically maintain in
4 market share. We set our market share for CMC-
5 Fort Mill at approximately 40 percent to be
6 representative of what other community
7 hospitals would maintain. So we didn't, in
8 essence, assume that CHS overall would grow its
9 market share of York County through the
10 development of CMC-Fort Mill.

11 Q: And I appreciate that explanation. And I
12 remember your testifying to that on direct.
13 But going back to my question just to clarify,
14 isn't it your position that CMC-Fort Mill will
15 not take anymore patients from Piedmont than
16 CHS is currently taking; isn't that right?

17 A: We assumed that we would not increase our
18 market share.

19 Q: Well, my question is not about market share.
20 I will get to that in a minute. I understand
21 your testimony about market share, and I
22 understand there is a correlation between
23 market share and patients. But in terms of
24 numbers of patients, that's a slightly
25 different question; isn't it? In terms of

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1 numbers of patients, isn't it true that CHS is
2 not proposing to take anymore patients from
3 York County than it's currently serving; isn't
4 that correct?

5 A: No, that's not really the way I sort of see it.
6 The way I would explain it is if you look at
7 our model, we held our use rate constant and
8 let the market level grow with population
9 growth. So the number of patients from York
10 County increased over our projection period.
11 And we held our market share constant. So we
12 were taking more patients. But again it was
13 relative. It's a relative thing in terms of we
14 maintained that approximate 40 percent market
15 share. And over the course of our projection,
16 the demand -- or for inpatient hospital
17 community service was increasing. So we were
18 taking more patients from York County. But we
19 weren't taking market share from Piedmont. I
20 think that's the way I process your question.

21 Q: All right. Let me ask you to turn to Page 10
22 of your deposition, please, sir.

23 MR. WESTBROOK: And Dan if you would put that on the
24 screen for us please.

25 Q: And I'm going to -- I have a question, Mr.

1 Murphy, that starts at the bottom of Page 10 on
2 Line 20. But to try to just -- it's the first
3 part of the first couple of lines. It's just
4 sort of a setup.. My real question begins on
5 22, Line 22. I'm going to read that and ask
6 you to read your answer. Starting at Line 22.
7 "Is it Carolinas' position that they will not
8 take anymore patients from Piedmont than they
9 are currently taking?" And your answer was
10 what?

11 A: "Correct."

12 Q: So isn't that correct?

13 A: Well, that's what I just said.

14 Q: I'm sorry. I didn't understand you. All
15 right. Now, so going back to market share,
16 your market share, you're proposing that you
17 would shift your market share of York County
18 patients to CMC-Fort Mill. That is -- and when
19 I say your market share, I'm saying CHS's;
20 right?

21 A: That's correct.

22 Q: And so I, believe the projection is that
23 essentially over 3,300 patients would be
24 shifted to CMC-Fort Mill in its first year of
25 operation, is that right?

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1 A: Well, the market share would be shifted,
2 correct. The patients that had typically gone
3 -- or the population in need of healthcare or
4 inpatient community service that had typically
5 gone into Mecklenburg, we assume that the
6 market share would shift from the hospitals in
7 Charlotte to CMC-Fort Mill.

8 Q: And as a result of that shift that you just
9 talked about, would be, would it not -- if CMC-
10 Fort Mill is built, you would not expect there
11 to be any increase in patients from York County
12 going to CHS?

13 A: No. That's again not the way I see it. I
14 mean, if we build CMC-Fort Mill and our
15 projections held true with the use rate plat
16 growing with -- and market demand growing with
17 population, from just the math standpoint, we
18 would be seeing more patients from York County
19 than we are now.

20 Q: All right. Let me ask you to look on Page 18
21 of your application, please. All right, your
22 application -- I mean your deposition. And
23 there on Page 18, Mr. Murphy, my question
24 starts at Line 15. My question on Line 15
25 says, "My understanding is from your earlier

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1 testimony and from the material submitted to
2 DHEC that you don't expect there to be any
3 increase in patients from York County going to
4 CHS if CMC-Fort Mill is built; right?"

5 A: Yeah, and I see your line of question.

6 Q: Just read your answer.

7 A: My answer was, "That's correct."

8 Q: Okay. So since I interrupted you there, once
9 again, my question was -- I'll just read the
10 second half, "you don't expect there to be any
11 increase in patients from York County going to
12 CHS if CMC-Fort Mill is built, right?" And
13 then just read your answer, and then you can
14 explain it if you want to.

15 A: I said, "That's correct." And prior to my
16 deposition, I didn't go back through our model
17 and really evaluate, you know, the implications
18 of our projection. I know -- I remembered how
19 we did it, but when you look at the forecast,
20 we actually are taking more patients. But I
21 think what the focus here is are we taking more
22 market share. You know, that's why I'm sitting
23 here today thinking about that projection. And
24 we are holding market share constant. But
25 because we assumed inpatient demand would grow

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RECORD 001417

1 with population growth, we would be capturing
2 some additional patients. But they wouldn't be
3 coming from Piedmont.

4 Q: All right. And your goal, CHS's goal in this
5 project is not to increase it's market share
6 but simply to maintain its current market
7 share; isn't that right?

8 A: Yeah. Our goal in this project is to serve
9 patients who currently --

10 Q: Let me ask you to answer my question yes or no
11 and then explain it. Okay?

12 A: Okay.

13 Q: So my question again was: CHS's goal in this
14 project is not to increase its market share but
15 to maintain its market share; would you agree
16 with that, yes or no?

17 A: Our goal in this project is not to increase
18 market share. It's to serve patients who are
19 currently leaving York County closer to home.

20 Q: It's actually to maintain your current market
21 share; isn't that part of your goal?

22 A: We would like to, yes.

23 **MR. WESTBROOK:** Okay. All right. Let me ask my
24 friend Dan to put up Demonstrative 155 on the
25 screen, please.

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1 Q: Now, you testified on direct about your
2 observations to proposed sites, is that right?

3 A: I'm sorry. I was looking at your map.

4 Q: That's okay. Over -- on your direct
5 examination you gave some testimony about your
6 personal observations of the two proposed
7 sites, the Fort Mill Medical Center site and
8 the CMC-Fort Mill site; do you remember that?

9 A: Yes.

10 Q: All right. And I don't know if you were here
11 for the testimony of Mr. Walsh earlier, but
12 this is the demonstrative from Mr. Walsh. And
13 I guess my question, you testified about the
14 traffic levels. And I believe you gave some
15 information that had been presented to DHEC
16 about the traffic volume at those two sites, is
17 that right?

18 A: Yes, we did. We went to the Department of
19 Transportation and just got, I think, hours
20 daily of traffic volume.

21 Q: All right. And for the traffic volume of the
22 Fort Mill site, did you check the traffic
23 volume of both Highway 160 and Highway 21 or
24 just 160; do you know?

25 A: I don't recall, no.

1 Q: And did you check the capacity of those two
2 highways for dealing with traffic?

3 A: I don't recall checking the capacity.

4 Q: And do you recall whether you checked the
5 unused capacity or the excess capacity for
6 those two highways?

7 A: No.

8 Q: Do you recall -- moving down to the CMC site,
9 I guess that would be Demonstrative 156,
10 perhaps? Do you recall if you checked with the
11 Department of Transportation about the
12 capacity, current data traffic or the unused
13 capacity at the Sutton Road exit off of I-77?

14 A: You know, when we were responding after project
15 review and we put the information in our
16 submittal after project review, it was in
17 response to the criticism of our site. And as
18 a part of the certificate of need process. I
19 don't select hospital sites. We have a team of
20 people with deep expertise.

21 Q: And so you don't -- do I understand to say that
22 you don't have expertise in selecting hospital
23 sites?

24 A: I don't do that as a part of my job. But I
25 rely on folks. And as I pointed out two

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1 healthcare systems that have a track record for
2 building healthcare facilities, both chose Exit
3 83.

4 Q: And the Presbyterian site is on the other side
5 of the interstate, correct?

6 A: It is.

7 Q: It is not directly across from Love's Truck
8 Stop; is it?

9 A: No.

10 Q: When I say is it, I guess was it would be a
11 better way of saying it.

12 A: Yeah, it's on the other side.

13 **MR. WESTBROOK:** Let's take a look at something that
14 was introduced at project review. Dan, let's
15 go to the videotape.

16 Q: This is a short -- I think it's a minute and a
17 half, something like that, video. See if you
18 remember seeing this at project review. Now,
19 you remember seeing this at project review,
20 don't you, Mr. Murphy?

21 A: I do remember a video like this at project
22 review.

23 Q: And during the project review process after
24 that video was played, didn't you tell DHEC
25 that you had been at the site many times and

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1 had never seen a truck?

2 A: You know, I did. And as I reflect on that,
3 what I probably should have said is that I
4 didn't notice a truck. And it would be
5 tantamount to me asking today when you drove
6 here did you see a Honda Accord? You may have,
7 but your brain didn't, you know, register that
8 you had seen a truck. But I have been to this
9 site many, many times, and I've never seen
10 what's demonstrated in this video, nothing
11 remotely close to it. And that's why I believe
12 I reacted the way I did at project review. And
13 I drive up and down 77 and have never seen
14 anything remotely close to this. And last
15 Thursday when I went home, as I testified
16 earlier, I took the loop going up 21 and came
17 back down Sutton Road. And if you go drive
18 south on Sutton Road, you don't see the truck
19 stop until you're literally there. And, you
20 know, again, I don't know when this video was
21 done. And, again, I've never seen anything
22 remotely close to it.

23 Q: On direct, you testified about the support
24 letters --

25 A: Okay.

- 1 Q: -- that CHS collected and the other applicants
2 collected.
- 3 MR. WESTBROOK: I would like to ask Dan to put on
4 the screen please, Joint Exhibit 1B.
- 5 Q: And this is already into evidence, Mr. Murphy.
6 This is the analysis from Ms. Brandt
7 accompanying her decision letter. And you
8 testified about the number of letters that were
9 submitted.
- 10 MR. WESTBROOK: I want you to highlight the third
11 sentence there, Dan, for me.
- 12 Q: And Mr. Murphy, can you read that sentence,
13 please?
- 14 A: "The current reported totals are 10,004 letters
15 for Presbyterian, 5,053 for Carolinas, and more
16 than 5,400 for Piedmont."
- 17 Q: All right. So according to Ms. Brandt's count,
18 both Piedmont and Carolinas submitted over
19 5,000 letters, is that correct?
- 20 A: Well, I don't believe this accurately reflected
21 all of the letters we had submitted.
- 22 Q: I see.
- 23 A: As I testified earlier, I think our count was
24 over 9,000.
- 25 Q: All right. So what else is inaccurate

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1 factually about Ms. Brandt's report?

2 A: I didn't see anything else other than this.

3 Q: Let's look at the next sentence, please. It
4 says, "The department received -- directly
5 receives 34 letters of opposition to Piedmont
6 from the community." Didn't you testify on
7 direct that you had seen thousands of letters
8 of opposition to Piedmont?

9 A: Well, in our letters of support packages,
10 again, we put all of our letters and internet
11 responses into notebooks. And we would put
12 them all in there. And then we would put in
13 front of the notebook a table with every
14 person's name and their address. And my
15 estimate is that there were thousands of
16 letters that we received that supported us but
17 also mentioned something negative about
18 Piedmont. That's what I meant.

19 Q: Okay. Well, Ms. Brandt counted 34 letters of
20 opposition? Do you think that's another
21 inaccuracy?

22 A: Well, I think here she is referring to letters
23 the department directly received. And I take
24 that to mean someone wrote her a personal
25 letter. And what I'm referring to are letters

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1 that were directed to us.

2 Q: And you didn't submit those letters to DHEC?

3 A: Yes, they are all on file with DHEC.

4 Q: All right. And apparently Ms. Brandt didn't
5 count as an opposition letter to Piedmont, is
6 that right?

7 A: No, I think she is saying here the department
8 directly received 34. I believe she means, and
9 you'd have to ask her obviously, my assumption
10 was these were letters someone addressed
11 directly to her submitted. And what I'm saying
12 is our letters were embedded in our notebooks
13 and mentioned a lack of non-support for
14 Piedmont. So I think they are two different
15 things.

16 **MR. WESTBROOK:** Let me ask Dan to pull up CHS 5908,
17 please. This is a document submitted in
18 discovery by CHS. And just pull it up closer
19 where we can read it.

20 Q: This is a -- it looks like an email from you to
21 Martha Ann McConnell. Who is Martha Ann
22 McConnell?

23 A: She is our vice-president of government
24 relations.

25 Q: All right. What is the date of email?

1 A: June 23, 2011.

2 Q: All right. And at the beginning, how about
3 reading that first paragraph for us, please.

4 A: "I believe Chris may have spoken to you about
5 this a few weeks ago. As you are aware,
6 Governor Haley replaced all but one member of
7 the seven-member DHEC board several months ago.
8 The question I have is this: Could our South
9 Carolina lobbyist visit with each DHEC board
10 member over the next 30 days to educate them
11 about the CHS mission, our role in South
12 Carolina, etcetera. The purpose of the visit
13 is simply to let them know who CHS is and why
14 we need a hospital to serve our South Carolina
15 patients in northern York County. Obviously
16 the board members may have questions about CHS
17 or our proposal."

18 Q: Did the lobbyist or another CHS representative
19 make those contacts with board members?

20 A: I don't believe so. I don't think so.

21 Q: Do you know for sure or just -- you indicate
22 some uncertainty?

23 A: My memory, you know, again; this is a couple of
24 years ago. My memory is that no one from CHS
25 visited those DHEC board members.

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RECORD 001426

- 1 Q: All right. Did you ever get an email, because
2 I don't see one produced by CHS in response to
3 this saying that that did not occur?
- 4 A: No. But my memory is there was conversation
5 after this where it was my belief is that there
6 was no context. I don't recall anything in
7 writing.
- 8 Q: Who was the lobbyist you were referring to
9 there, your South Carolina lobbyist?
- 10 A: I don't know the lobbyist by name.
- 11 Q: Do you have more than one South Carolina
12 lobbyist?
- 13 A: I think we have a firm that has more than one
14 lobbyist that we work with.
- 15 Q: What's the name of the firm?
- 16 A: I couldn't tell you.
- 17 Q: All right. Let me just broaden my question
18 that I asked you a few minutes ago. I think I
19 -- I'm not sure exactly how I worded the
20 question, but it was probably something to the
21 effect: Did anyone from CHS or CHS lobbyist
22 visit board members, to your knowledge? And if
23 you don't know, that's fine. To your
24 knowledge, did anyone, whether employed by CHS
25 or whether a lobbyist or not, did anyone meet

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RECORD 001427

1 with DHEC board members on behalf of CHS
2 related to this project?

3 A: To my knowledge, no one on behalf of CHS met
4 with any DHEC board members to discuss the
5 project.

6 Q: All right. But you proposed that they do, is
7 that correct?

8 A: Well, as I read this -- let me just read it
9 again, because I'm not -- you know, let me just
10 take a minute.

11 Q: All right. While you are taking a minute, I
12 think I'm going to read it, too. I'm going to
13 read it out loud so we can all concentrate on
14 what it says, "Martha Ann, I believe Chris,"
15 and who is Chris, by the way?

16 A: Chris Summer is the administrator of CMC-
17 Pineville.

18 Q: Okay, "Martha Ann, I believe Chris may have
19 spoken to you about this a few weeks ago. As
20 you are aware, Governor Haley replaced all but
21 one member of the seven-member DHEC board
22 several months ago. The question I have is
23 this: Could our South Carolina lobbyist visit
24 with each DHEC board member over the next 30
25 days to educate them about the CHS mission, our

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1 role in South Carolina and so forth? The
2 purpose of the visit is simply to let them know
3 who CHS is and why we need a hospital to serve
4 our South Carolina patients in northern York
5 County. Obviously the board members may have
6 questions about CHS or our proposal." Okay.

7 A: Can I make a comment about that now that I --

8 Q: You certainly can. Let me first, and I think
9 my question was, and you can answer that and
10 then you're free to comment. My question I
11 believe was: To your knowledge, did anyone on
12 behalf of CHS contact a South Carolina board
13 member?

14 A: To my knowledge, no one at CHS contacted a DHEC
15 board member. And as I reflect on this memo,
16 I sent this memo to Martha Ann to give her
17 basically a heads up. I think Chris Hummer had
18 some concern. And again, Chris is not a
19 certificate of need person; but I think he had
20 just concern for some reason that the DHEC
21 board had changed and do we need to educate
22 them about CHS? And I immediately alerted
23 Martha Ann. And I think we concluded that it
24 wouldn't be appropriate for us to do that. And
25 I think that was something Chris was

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1 questioning the process, is this something we
2 should do? And I remember in the first review,
3 you know, something about some county officials
4 becoming involved. And I think Chris was
5 concerned that, you know, how does this process
6 work? And I think after, you know, we
7 contacted Martha Ann, we concluded that it
8 wouldn't be appropriate for us to do that. And
9 I educated Chris on that process.

10 Q: And you have a specific memory of educating
11 Chris on that process?

12 A: Well, my memory --

13 Q: The reason I ask this, Mr. Murphy, I'm not
14 doubting what you're saying, but I'm just
15 saying that you started off responding with
16 something to a degree of uncertainty. And the
17 more you're talking it's even more uncertainty.
18 So I'm trying to ascertain what exactly you
19 know and what your department speculated about.

20 A: Well here's, you know, I'm sitting here and you
21 put a letter in front of me that I haven't seen
22 -- or a memo or email that I haven't seen in a
23 couple of years. And initially it takes a
24 while to remember the context. And my memory
25 is that Chris made me aware of this. And I've

1 asked Martha Ann about this. And we very
2 quickly after this concluded that it wouldn't
3 be appropriate. That's my memory.

4 Q: And your memory that it wouldn't be
5 appropriate, is that because it's against the
6 law?

7 A: I believe so, right.

8 **MR. WESTBROOK:** In fact, let's put up Section 44-7-
9 200 of the South Carolina Code. And let's look
10 just at Section 200. I think it's the bottom
11 half of that page.

12 Q: Mr. Murphy, have you seen this statute before;
13 do you recall? And just take a minute to
14 familiarize yourself with it. It says
15 application for certificate of need notice
16 prohibit communications. Review Section B
17 there, please. All right. It refers to the
18 applicant publishing notification. And then go
19 on to Section C, it says, "Upon publication of
20 this notice until a contested case hearing is
21 requested." And look at Number 2.

22 A: Yeah. I have seen that before. My
23 recollection is, you know, because of what
24 transpired in the first case where some county
25 government officials got involved, one of our

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1 administrators, and I think in his role, you
2 know, suggested to me that we do it. And we
3 quickly concluded that because of this statute,
4 we can't -- we couldn't do that.

5 Q: All right. Mr. Murphy, you testified on direct
6 about Joint Commission Certifications that CHS,
7 Presbyterian and Piedmont had. And I believe
8 you showed a slide that had been presented to
9 that effect. It showed CHS by my notes, and
10 correct me if I'm wrong, had according to the
11 slide presented to DHEC, over 20, I think it
12 was 21, Novant 13 and Piedmont one, is that
13 correct?

14 A: That's correct.

15 Q: Now again, I know we've already established
16 this. But remind me, about how many hospitals
17 are in the CHS system?

18 A: We have, you know, roughly 14 to 15 in that
19 obligated component unit column and another --
20 we have 42 total.

21 Q: And the Novant system has how many hospitals in
22 it?

23 A: Less than us. I'm guessing, you know, maybe
24 ten less than us. And it's a guess, I don't
25 track their numbers.

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1 Q: And the comparison that was made that you made
2 on direct and you made to DHEC was among the
3 CHS system, the Presbyterian system and
4 Piedmont Medical Center, it wasn't with the
5 Tenet system; was it?

6 A: No, it was comparing Piedmont Medical Center.

7 Q: So you're comparing one hospital with two
8 systems, is that correct?

9 A: That would be correct. But I think the point
10 that we were just making is that we made a
11 significant investment in those programs. And
12 I don't think there would be anything
13 prohibiting Piedmont from doing the same thing.

14 Q: I see. But you're point then, and you weren't
15 trying to say that you hadn't -- that you had
16 more Joint Commission Certifications than
17 Piedmont? That wasn't your point?

18 A: No, the point was we had, I think at the time,
19 21 programs certified by the Joint Commission
20 for the clinical quality improvement. And
21 Piedmont had one. And at the time, I -- it
22 wasn't to demonstrate -- I mean I didn't really
23 consider the fact that we had more than one
24 hospital.

25 Q: I see.

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1 A: Because I don't think there is anything
2 prohibiting a single hospital for getting many
3 certifications.

4 Q: So Piedmont could have gotten 21.

5 A: They could have.

6 Q: That's right. And how many of your individual
7 hospitals have 21 Joint Commission
8 Certifications?

9 A: I don't know the answer to that.

10 Q: Yes, you do. It's zero; isn't it?

11 A: I don't know.

12 Q: You don't know? You wouldn't know in your
13 position that one of your hospitals had 21
14 Joint Commission Certifications? Is that what
15 you're saying under oath?

16 A: What I'm saying under oath is when we were
17 preparing this information, contacted the
18 quality department for this information. And
19 they told us our system, to the best of my
20 recollection, we had 21 certified programs from
21 the Joint Commission in clinical quality and
22 Piedmont had one. I don't recall looking at
23 our facility -- I don't recall looking at those
24 numbers by facility. I may have. I just don't
25 recall.

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1 **MR. WESTBROOK:** Let's look at -- Dan, let's pull up
2 Exhibit Joint B, Page 782 and 783.

3 Q: This is a submission from Piedmont to DHEC in
4 July -- excuse me, July of 2011. You testified
5 on direct, you had a number of slides comparing
6 your Medicaid numbers for South Carolina
7 patients to Presbyterian, is that right? Do
8 you recall that?

9 Q: Yes.

10 A: Now, this is something that was submitted to a
11 project review, and you see figure five there
12 shows 2009, which was the most recent data at
13 the time. South Carolina Medicaid Emergency
14 Department's submissions. And then the chart
15 on the right shows 2009 South Carolina Medicaid
16 discharges, which would not be emergency
17 department, obviously hospital discharges. And
18 it confirms your point, does it not, that
19 Carolinas has had a lot more than Presbyterian;
20 isn't that correct?

21 Q: It does.

22 A: But it also shows that Piedmont had a lot more
23 than Carolinas; isn't that correct?

24 Q: But the purpose of my slide wasn't to compare
25 Piedmont to Carolinas because they are not

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1 apples-and-apples comparisons. I think we put
2 our slide together to demonstrate to DHEC,
3 while we were being criticized by Presbyterian,
4 we wanted to show the number of South Carolina
5 patients we serve compared to Presbyterian, not
6 Piedmont. I think Piedmont operates a hospital
7 in York County and received a lot of Medicaid
8 patients through the ED. And their numbers
9 would be larger than ours because we don't
10 operate a hospital there. So I don't think
11 that's real apples and apples.

12 **MR. WESTBROOK:** Let's look at CHS Exhibit 28,
13 please.

14 Q: This is an exhibit, I think, you testified
15 about on your direct. As I understand it, Mr.
16 Murphy, this shows the number of referrals that
17 the CHS practices refer on to other CHS
18 facilities or physicians or providers of any
19 type, is that right?

20 A: It shows the rates of referrals for these four
21 different types of services to physician
22 partners.

23 Q: All right. And I think your point was, at the
24 bottom of the page, that the sort of aggregate
25 number, the average or however you calculated

1 that was, it's actually

2 **MR. WESTBROOK:** Dan if you can pull it up.

3 Q: It's six percent, is that right?

4 A: Right.

5 Q: All right. Now, the lowest -- if you look at
6 that last column.

7 **MR. WESTBROOK:** And Dan, move up so that we can see
8 the last but total column there.

9 Q: That's the one that, you know, totals up all
10 the ancillary diagnostic, medical and surgical,
11 is that right?

12 A: That's correct.

13 Q: And the lowest there is Carolina Cancer
14 Specialist at nine percent, is that correct?

15 A: Right.

16 Q: And that is located in Rock Hill; is it not?

17 A: I believe so.

18 Q: And the second lowest is towards the bottom, I
19 believe, it's Shiland Family Medicine at 36
20 percent, is that right?

21 A: That's correct.

22 Q: And that's also in Rock Hill; is it not?

23 A: Correct.

24 Q: And the third lowest is Medical Associates of
25 Rock Hill, which I would assume from the name

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1 is also located in Rock Hill, is that correct?

2 A: That's correct.

3 Q: And that's 43 percent, the third lowest, is
4 that right?

5 A: Yes.

6 Q: And the others are all located -- well, there's
7 Rock Hill Pediatric Associates in Fort Mill.
8 But the other practices are located in --
9 excuse me, there's Rock Hill Pediatric
10 Associates, which is in Rock Hill; and then
11 Rock Hill Pediatric Associates Fort Mill, which
12 I think is in Fort Mill; correct?

13 A: Right. There is three other practices on that
14 list that are Rock Hill; Palmetto Pediatrics,
15 Piedmont GYN-OB -- well, actually maybe four;
16 Rock Hill Pediatric Associates and Sanger Heart
17 Vascular Institute of Rock Hill. So there are
18 four other ones in Rock Hill in addition to the
19 three you highlighted.

20 Q: But the three lowest on this chart -- in that
21 chart -- the three that are under 45 percent
22 are all in Rock Hill, is that right?

23 A: They are.

24 **MR. WESTBROOK:** Let's look at CHS-27, please.

25 Q: CHS-27. Have you seen this one before?

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1 A: Yes.

2 Q: CPN 2012 payer mix by practice?

3 **MR. WESTBROOK:** Let's go to Page 2, Dan.

4 Q: Now, my question is; and let's look at the
5 Medicaid line there. This shows from 2007 to
6 2012, right?

7 A: That does.

8 Q: And this is a CHS Exhibit, Exhibit 27?

9 A: Yes.

10 Q: And it shows the Medicaid percentage. And just
11 to clarify. We've probably clarified this
12 before, but I don't think we have with you.
13 CPN is the name -- is the acronym for the CHS
14 Physician Network in York County, is that
15 right?

16 A: Yeah, Carolinas Physicians Network.

17 Q: Okay. And Medicaid during that period of time,
18 during that 2007 to 2012 it starts off at 8.4
19 percent. And it actually goes down and then
20 kind it goes up a little bit. But would you
21 characterize that as relatively flat?

22 A: No, I wouldn't. I think you can't just look at
23 that particular line in isolation. That's why
24 I reformatted it and testified to it earlier.
25 I look at a trend from 2009, an upward trend.

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RECORD 001439

1 I think it was about two and half percent a
2 year, but 6.4, 8.7, 10.1, 10.9. And, you know,
3 in light of the testimony from the physicians
4 that I sat here and heard, this doesn't show
5 that we are reducing our Medicaid in volumes
6 while increasing theirs. And then I combined
7 our commercial and managed care to show that
8 actually that had been flat, it hadn't been
9 growing. And again, I think I testified that
10 the economy had a lot to do with these numbers
11 between 2007 and 2009.

12 Q: Right. And the -- from 2007 forward, it goes
13 from 8.4 percent -- it actually decreases into
14 7.6 in 2008 and then decreases again in 2009 to
15 6.4, is that correct?

16 A: That's what these numbers indicate. Yes, it
17 decreased for the most -- from between '07 and
18 '08 and down in '09 and then back up.

19 Q: And then self-pay goes in 2007 from 3.1 and
20 decreases to 2.6. And then is it's at 2.8 in
21 2009, decreases a little bit, 2010 to 2.4 and
22 then goes down to 1.8 percent --

23 A: Right.

24 Q: -- is that correct?

25 A: And then back up.

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- 1 Q: And then back up to 2.2 percent.
- 2 A: Right.
- 3 Q: Again, but you testified about the effect of
- 4 the general recession on these numbers.
- 5 General recession was at its peak in 2008,
- 6 2009, is that correct?
- 7 A: I believe so.
- 8 Q: All right. You testified about the profits
- 9 that CHS hospitals make. I think I asked you
- 10 a question or two about that; and I think you
- 11 testified about that on direct, as well. I'm
- 12 relying on my memory in regard -- it's already
- 13 established that's not very good. So you
- 14 correct me if I'm wrong, but my memory is that
- 15 you testified that it is important for CHS
- 16 hospitals to make profits because to keep up
- 17 with population growth was one reason I believe
- 18 you testified, is that right?
- 19 A: Well, I believe I said that, yeah.
- 20 Q: And another reason I believe you said was so
- 21 that you could maintain -- essentially maintain
- 22 a viable healthcare system.
- 23 A: Right.
- 24 Q: And I'm not sure that's your exact words, but
- 25 was it something to that effect?

1 A: Well, when I go back and start with a mission
2 statement, it is to create a comprehensive
3 healthcare system. And creating that
4 comprehensive system requires us to be
5 financially, you know, good stewards. And
6 that's where the income is required to be able
7 to do that. So that's our mission; that's our
8 purpose.

9 Q: Good, thank you.

10 MR. WESTBROOK: Bear with me a minute, Your Honor,
11 if you don't mind.

12 Q: Mr. Murphy, let me ask you to -- let me ask
13 you, the Medicaid line up there, again, if you
14 will. This is again Page 2 of Exhibit, CHS
15 Exhibit 27.

16 Q: Did I understand you to say that you calculated
17 -- well, let me just ask you; what was the
18 percentage of growth that you calculated for
19 Medicaid? And I think you did it for 2009
20 forward, is that right?

21 A: Yeah. I think what I -- if you compare 2.9 --
22 excuse me, 10.9 in 2012 to 8.4 in 2007, the
23 number I was thinking about was the change. It
24 was 2.5 percent change. I may have said growth
25 rate, but it's -- it's actually the -- I think

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1 what I had on my exhibit were the percentage
2 changes in that far right column. And I think
3 it was -- as I look at 10.9 minus 8.4, it's
4 2.5.

5 Q: What is the growth rate, did you calculate
6 that?

7 A: No, I haven't.

8 Q: Could you do that or is that --

9 A: I don't know that -- you know, I don't think
10 the growth rate from '07 -- again, you know,
11 I think you look at these trends and you look
12 at different points in time.

13 Q: Well, what would it be from '07 to 2012?
14 Whether that's the way you did it or not, I'm
15 just asking what would that --

16 A: It's not a very high growth rate.

17 Q: Well, what would it be?

18 A: I don't know. I would need a calculator.

19 Q: I paid \$10.00 for this.

20 A: Let's see. I'm looking for the on button.
21 That's not the type of calculator I use. Well,
22 can I use my calculator?

23 Q: Certainly.

24 A: It might be a little quicker. It's in my bag
25 back there.

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1 Q: Okay.

2 MS. ROBERTSON: If I may approach --

3 THE COURT: Absolutely.

4 MS. ROBERTSON: Thank you.

5 A: If you just take the number 8.4 percent, and
6 you calculate the number. The percentage
7 change between 8.4 and 10.9, let's see -- and
8 it's not calculating because I don't think this
9 calculator recognizes growth rates between
10 percentages. But I think the point you are
11 trying to make is that it's not a large change
12 between 8.4 and 10.9 over that period of time.
13 And I guess I would just say you have to look
14 at the trend line because again, I put this
15 together in response to the criticism I heard
16 from the physician witnesses from Piedmont that
17 seemed to suggest we were systematically
18 steering the Medicaid patients to their
19 practice and the commercial patients to ours.
20 And I don't think that's the case. I don't
21 think these trends show that.

22 Q: All right. Mr. Murphy, you are -- in the
23 beginning you gave your current job title and
24 responsibilities. Could I ask you to repeat
25 that. What's your -- because I know there's

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1 been a change from the last time we --

2 A: Right. My current job title is Senior Vice-
3 President, Planning and Development, and I was
4 promoted a few weeks ago to that position.

5 Q: Are you an officer of any type with CHS?

6 A: No, I'm not.

7 Q: All right. Are you familiar -- are you aware
8 of an investigation at CHS by Senator Grassley,
9 the United States Senate Judiciary Committee?

10 A: I'm not aware of that, no.

11 Q: You're not aware that an investigation is
12 ongoing? I'm not asking you about the details.
13 I'm asking whether you know whether an
14 investigation, and let me just clarify what my
15 question is. I'm not asking whether you know
16 the details, I am asking do you know whether
17 Senator Grassley, ranking member of the U.S.
18 Senate Judiciary Committee is currently
19 investigating CHS with respect to the 340(b)
20 drug program?

21 **MS. ROBERTSON:** Your Honor, if I may, Mr. Westbrook
22 is in effect testifying with the information he
23 is putting before the witness. He is setting
24 forth the information. He's asking him what he
25 knows, but he's in effect testifying. We have

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RECORD 001445

1 no idea of what he is saying is accurate or not
2 with no foundation for it.

3 **MR. WESTBROOK:** I thought cross examination was
4 where the attorney got to testify. That is the
5 way I was the way I was taught in law school.
6 It's a leading question -- certainly it's a
7 leading question. And I don't think I have to
8 lay a foundation for a question. I just asked
9 the question. He can say yes or no. He either
10 is or he isn't. And then I may or may not
11 follow up.

12 **THE COURT:** Thank you, Mr. Westbrook. I'm going to
13 overrule your objection. Please go ahead and
14 answer that question, Mr. Murphy. Do you know?
15 Are you aware?

16 **A:** Well, I'm not -- what I'm aware of is -- and
17 then my memory here is a little fuzzy. But
18 within the last, it seems like a month, it
19 could have been the last few weeks, I recalled
20 some article in the Charlotte Observer about
21 that topic. And I didn't read the article.
22 And when you mentioned the 340(b) drug pricing,
23 that sort of helped me better -- I recall
24 seeing that in the paper, but I don't know any
25 details about it.

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RECORD 001446

1 Q: The 340(b) drug program is a federal program
2 that provides nonprofit hospitals, the hospital
3 systems with discounts for certain drugs; isn't
4 that correct?

5 A: I believe so.

6 Q: And the idea behind the program is those
7 discounts should be passed on to the citizens
8 who are less financially well off than others,
9 is that correct?

10 A: I believe so.

11 Q: And is the gist of Senator Grassley's
12 investigation that CHS is not passing on those
13 discounts?

14 A: Again, I don't know what his focus is. I just
15 recall seeing an article, and that's about it.

16 Q: Thank you.

17 MR. WESTBROOK: I have no further questions.

18 THE COURT: Okay. Does the department have any
19 questions of witness?

20 MS. BIGGERS: No, Your Honor.

21 THE COURT: Thank you, Ms. Biggers. Any redirect?

22 MS. ROBERTSON: Yes, Your Honor, I do have just a
23 few.

24 THE COURT: All right.

25 MS. ROBERTSON: And I think it will be short, but I

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1 those.

2 Q: Thank you. And in closing, Mr. Stewart, I want
3 to -- let's pull back up Demonstrative 168.1 of
4 the Petitioner. And if you could, remind us of
5 what you believe was Mr. Levitt's assessment of
6 the Carolinas financial criteria or the project
7 review criteria with respect to the financials.

8 A: And as we've gone through all of those sort of
9 demonstratives that were somewhat critical of
10 CHS's financial statements, overall Piedmont's
11 expert agreed with DHEC that CHS met all the
12 financial criteria 6(a)(b) 7, 9, and 15 for the
13 approval of the CON.

14 Q: And those checkmarks are from the Petitioner's
15 Demonstrative Exhibit, is that correct?

16 A: That is correct.

17 Q: Thank you, Mr. Stewart. Please answer any
18 questions Mr. Westbrook may have.

19 **MR. WESTBROOK:** I'm ready, Your Honor.

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

21 **MR. STEWART - CROSS EXAMINATION BY MR. WESTBROOK:**

22 Q: Mr. Stewart, good morning. How are you?

23 A: Good. How are you?

24 Q: Fine, thank you. Mr. Stewart, why don't we
25 just start with just the last -- actually next

1 to the last demonstrative you were looking at,
2 which is the one that was based on the audited
3 financials. That is -- I can't remember the
4 number.

5 **MS. ROBERTSON:** David, do you want us to -- I'd be
6 happy to pull it up.

7 **MR. WESTBROOK:** Well, we could or I could just hand
8 the hard copy. But yeah, if you don't mind
9 doing it, that would be great.

10 **MS. ROBERTSON:** Glad to do it.

11 **MR. WESTBROOK:** Yeah, I'm not going to do too many
12 of those, but I might do a couple of them.
13 Let's look at that -- the one that was based on
14 the approximate percentages.

15 **MS. ROBERTSON:** Is it 2010, 2011.

16 **MR. WESTBROOK:** Great, thanks. And I had a hard
17 time seeing that on my little screen. So I'm
18 going to move up here if I can and try -- as
19 you said, your old man eyes. You are a lot
20 younger man than I am, Mr. Stewart. Mr.
21 Stewart, I know you explained some things about
22 this demonstrative 2.22. This is the -- or the
23 demonstrative based on the 2010-2011 audited
24 financials I think; isn't that correct?

25 **A:** This is from the 2011, 2010 audited financial.

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1 It is from the 2011 audited financial
2 statements which includes results from 2011 and
3 2010.

4 Q: Okay. All right. And the very last line there
5 is the end of year net assets, is that right?
6 The last line item; end of year net assets?

7 A: Yes.

8 Q: Is that what that says?

9 A: Yes.

10 Q: It's hard for me to read it from here, and I
11 can't read it on my monitor. And for 2011, the
12 total reporting -- what does headline -- that
13 heading on that column says total reporting
14 entity; is that what it says?

15 A: I'm not sure which -- it's primary enterprise
16 or are you looking above the primary
17 enterprise?

18 Q: Well, let's start with 2011. At the top of the
19 columns in bold face, each one of them says
20 primary enterprise, the second one says
21 combined component units. And what does the
22 third one say?

23 A: Total reporting entity.

24 Q: Okay. For the total reporting entity column,
25 what's the end of the year net assets? Can you

- 1 read that, please?
- 2 A: Not really. I think it's --
- 3 Q: Is it 3 billion and something.
- 4 A: It's -- yeah, it's 3 point, I think 5 billion.
- 5 Q: All right. And for the combined component
- 6 units, what is it? Can you read that? Is it
- 7 800? I just can't see that.
- 8 A: I'm not sure what number you are looking at.
- 9 Q: I was looking at the combined component units
- 10 end of the year net assets. So it's the very
- 11 bottom of that column.
- 12 A: Oh, yeah, the middle column.
- 13 Q: Yeah, the middle column.
- 14 A: It looks like it's about \$800 million.
- 15 Q: About \$800 million?
- 16 A: Uh-huh (affirmative response).
- 17 Q: And for the primary enterprise, is that 2 point
- 18 something?
- 19 A: Yes, \$2.9 billion.
- 20 Q: \$2.9 billion. Okay, thank you.
- 21 **MR. WESTBROOK:** Now, let's -- Dan, can I ask you to
- 22 pull up, please, CHS-511. This is a -- I think
- 23 you will recognize, Mr. Stewart, this is
- 24 something from the CHS-Application. It says at
- 25 the top "CMC-Fort Mill assumptions for

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1 projected financial statements." And I am
2 going to represent to you this was something
3 produced to us -- produced -- well, not
4 produced to us so much. It was submitted to
5 DHEC. Do these look familiar to you?

6 A: Uh-huh (affirmative response).

7 Q: These the ones for your new current
8 application, is that right?

9 A: I don't know if this is the most recent
10 submission but --

11 Q: Well, take a look. Take a look. For example,
12 does anything like the payer mix. Is that
13 payer mix?

14 A: It looks accurate but --

15 Q: All right. Well, I'm going to ask you to
16 assume that this is your --

17 **MR. WESTBROOK:** And uncross it, if I'm wrong, Ms.
18 Robertson and correct me.

19 **MS. ROBERTSON:** Okay.

20 Q: These assumptions -- these are the assumptions
21 upon which the pro forma projections are based;
22 is that a fair way of saying it?

23 A: Uh-huh (affirmative response). Correct.

24 Q: And you went through and walked through how you
25 created the pro forma budget for this

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- 1 application, right?
- 2 A: Yep.
- 3 Q: So these would be the assumptions that were
- 4 behind those pro formas, is that right?
- 5 A: Uh-huh (affirmative response). Yes.
- 6 Q: All right. Now, the assumptions, themselves,
- 7 I believe you told me were provided to you by
- 8 somebody from Mr. Murphy or someone in working
- 9 his group, is that correct?
- 10 A: Which assumptions are you talking about?
- 11 Q: I'm sorry, the payer mix assumptions?
- 12 A: That is correct.
- 13 Q: All right. The -- the other assumption. Now,
- 14 you got four categories, Medicare, Medicaid,
- 15 managed care and other. And my understanding
- 16 is that the other category is made up largely
- 17 of self-pay and charity care; is that true?
- 18 A: Largely, yes.
- 19 Q: All right. Vast majority, right?
- 20 A: I don't know the exact percentages, but most --
- 21 Q: I wasn't asking for the exact percentages.
- 22 Wouldn't you agree that the big majority is
- 23 made of those two categories?
- 24 A: It is.
- 25 Q: Self-pay and charity. Okay. And there is a

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1 difference between self-pay and charity; isn't
2 there?

3 A: Yes.

4 Q: And that difference is that charity is somebody
5 who qualifies under CHS's policy, or whatever
6 the hospital is for charity care, is that
7 right? So that's written off on the outset, is
8 that right?

9 A: I mean, I would say that there is a bucket of
10 uncompensated care. And in uncompensated care
11 you have bad debt, which are people who can't
12 pay or people who don't pay. You have charity
13 care where people who can't pay. And you then
14 you have charity care discounts which are, you
15 know, people where you may have worked out a
16 payment plan with us, some of the self-pay
17 patients.

18 Q: And a self-pay patient is that -- who -- a
19 self-pay patient who does not pay is what you
20 call bad debt, is that right?

21 A: It depends on if they -- it depends on their
22 financial picture. So there are -- I mean,
23 there are criteria that determine whether that
24 patient would fall into the -- either way, it's
25 uncompensated care. And there is criteria as

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1 to whether or not that patient is classified as
2 charity care or bad debt.

3 Q: All right. Well, before we get to charity --
4 let's make sure of the distinction. You're
5 making a distinction between charity care and
6 bad debt, and I appreciate that distinction.
7 I want you to educate me now on something else;
8 the distinction between charity care and self-
9 pay, okay? Is there a distinction between
10 charity care and self-pay?

11 A: I mean -- I guess I'm not quite sure I
12 understand the question.

13 Q: Is there a distinction between charity care and
14 self-pay?

15 A: Well, I heard the question, but I'm not quite
16 sure I understand the question.

17 Q: All right. I'm sorry. For somebody who
18 doesn't -- for somebody who is uninsured and
19 who does not qualify for charity care, what
20 would you call that person? What
21 classification would that person fall under?
22 If they are uninsured and they don't qualify
23 for charity care?

24 A: They could -- in our financials, they could be
25 under a couple of buckets. They could be

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RECORD 001455

1 either in the bad-debt category or they could
2 be in the sort of category that we classify as
3 self-pay discounts.

4 Q: I'm sorry. I didn't hear you.

5 A: Self-pay discount.

6 Q: Self-pay discount. All right. So those would
7 be the two buckets. Self-pay discount and bad
8 debt, is that right?

9 A: For the folks that don't --

10 Q: That don't qualify for charity care?

11 A: Correct.

12 Q: And most of the time you would get little or no
13 reimbursement from those folks, is that
14 correct?

15 A: I mean, it depends on what you are talking
16 about.

17 Q: Well, I'm talking about, you know,
18 reimbursement, getting paid for a hospital
19 bill.

20 A: Well, I think if you look at self-pay for some
21 of your lower acuity stuff that may occur in
22 the hospital, like an x-ray, the difference in
23 your collection rate may be a little higher
24 than if you are in there from a car accident,
25 and show up in the hospital and you're having

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1 a major trauma, that could be significantly
2 more in cost.

3 **MR. WESTBROOK:** All right. Let me ask Dan to pull
4 up your trial testimony from the last trial.

5 A: Uh-huh.

6 Q: Perhaps you can explain this to me so I can
7 understand it.

8 **MR. WESTBROOK:** And I'm asking -- Dan, how about
9 pulling up Page 1652.

10 Q: Hold on just a minute and I'll give you a line.
11 Page 1652. This is from your direct exam at
12 trial. And let's start on Line 5, I think, and
13 with that word "and." And I'm going to read
14 your attorney's question to you during your
15 direct exam and -- oh, I'm sorry, this is part
16 of the answer. Never mind.

17 So let me go back up to 1651 to get the
18 question. Page 1651, Line 23. That's where
19 your -- the attorney asks the question. And
20 then there is a fairly long response. And
21 maybe if you could just read the answer into
22 the record, Mr. Stewart and then comment on it.
23 So the question on Line 23 of Page 1651 is.
24 "All right. How about the other categories?
25 How do they compare?" And just please read

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1 your answer in.

2 A: Okay, sort of look -- I'm not sure what the
3 other categories mean. Is it alright if I read
4 higher than that before to understand the
5 context?

6 Q: Sure. Uh-huh. In fact, why don't we go on up
7 to -- you take your time to look at it. But
8 let's go to Page 1651. And you see at the top
9 of the page where it says, "Mr. Muller." I
10 think that sort of starts that line of
11 questions. Let's see if there is a -- just for
12 the sake of time, maybe we don't have to go all
13 the way. Let's start at Line 5, okay. I'm
14 going to read the questions, and you just read
15 the answers, okay. And you can comment on the
16 answers or explain the answers. In fact, I'd
17 like you to. But first of all, just for the
18 record, we need to read this in verbatim, okay.
19 Okay? Okay?

20 A: Sure.

21 Q: Okay. I'll be Mr. Muller. Question starting
22 Line 5. "Do you see the category of net
23 operating revenue?" Answer?

24 A: My answer in that testimony was, "yes."

25 Q: Can you just read it, please, verbatim without

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1 commenting until we get through?

2 A: Sort of feels like I'm -- I guess --

3 Q: I'll tell you what, I'll read it in. That's
4 okay. And then after I read it in, you can
5 comment on it. So Line 5,

6 "Question: Do you see the category of net
7 operating revenue?"

8 "Answer: Yes."

9 "Question: All right. Can you -- well,
10 let's start with this. Can you explain to the
11 Court what payer mix means?"

12 "Answer: Sure. What payer mix is, is
13 payer mix represents the number of patients
14 that you have for each one of the categories,
15 so for Medicare, Medicaid, Managed Care,
16 other."

17 "Question: In terms of the category that
18 is most lucrative for a hospital, what category
19 would that be?"

20 "Answer: Typically, the most of your
21 margin occurs in from a managed care pair."

22 "Question: Most of your margin meaning
23 profit margin?"

24 "Answer: Correct."

25 "Question: Okay, so managed care would be

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1 the most lucrative?"

2 "Answer: Correct."

3 "Question: All right. How about the
4 other categories? How do they compare?"

5 "Answer: Typically, Medicare -- typically
6 with Medicare, you know, your goal is to break
7 even. Or sometimes if you are very efficient,
8 you can make some money on Medicare. Medicaid
9 usually pays a rate that is -- does not cover
10 your full expenses. And then self-pay
11 includes, you know, includes your indigent
12 care, your charity care, and your bad debt.
13 And most of the time you are getting very
14 little to no reimbursement for those
15 categories."

16 That's all I want to read into the record.
17 My question before we brought this page up was
18 this. Well, I don't know precisely what my
19 question was. So, let me ask it again and
20 maybe it'll be somewhat close to my question.
21 My question is, isn't from the self-pay bad
22 debt categories, most of the time you get very
23 little to no reimbursement in those categories;
24 wouldn't that be true?

25 A: I would sort of go back to my previous answer.

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1 It depends on what the procedure is. I mean,
2 there are procedures that cost \$100. You have
3 procedures that cost \$100,000. I mean, if it's
4 a safe-pay \$100 account, there is a pretty
5 good chance that we should be able to collect
6 it. If it's \$100,000, probably not.

7 Q: Okay. But -- and I understand that it differs
8 with individual patients and individual
9 amounts. But it seemed to me in your testimony
10 at the trial is that you were making a general
11 statement that most of the time, more than --
12 or most of the time, as you say, you are
13 getting very little to no reimbursement in
14 those categories.

15 A: Our collection rates on self-pay, that whole
16 uncompensated care bucket is lower than what it
17 would be from other payers.

18 Q: Now, the charity care assumption of 6.3 percent
19 of gross revenue, I think you testified that
20 you were the one that came up with that
21 assumption and you explained how you did it,
22 right?

23 A: Uh-huh (affirmative response). That's correct.

24 Q: All right. And you based it, I think, on a
25 weighted average from internal financial

1 statements, a weighted average from CMC-
2 University and CMC-Pineville for 2009, is that
3 right?

4 A: That's correct.

5 Q: Okay. Now, you did not -- when you came up
6 with that 6.3 percent you only looked at those
7 two hospitals, is that right?

8 A: That was what the weighted average was based
9 on. I looked at more than just the two
10 hospitals. But on weighted average, the number
11 that was in our financials was based on those
12 two hospitals.

13 Q: All right. And you based it on one year, 2009,
14 is that right?

15 A: We based it on that year, but we looked at a
16 series of years.

17 Q: All right. And you did not take into account,
18 did you, the demographics of York County, and
19 more specifically northern York County; did
20 you?

21 A: Specifically -- when you say demographics, what
22 do you mean by demographics?

23 Q: Well, I mean you are a health care planner,
24 right?

25 A: Yeah.

1 Q: You know what demographics means. What does
2 demographics mean to you?

3 A: Well, I think we had testimony that was very
4 very different. We had people who talked about
5 demographics in terms of inpatients and
6 inpatient payer mixes. And we had people who
7 talked about demographics in terms of average
8 salary, average wages for people in that
9 market.

10 Q: Well, let me ask you this. Regardless of the
11 definition of demographics, did you -- when you
12 came up with that 6.3 percent, did you factor
13 in any demographics of York County regardless
14 of definition?

15 A: I mean, it included Pineville. Pineville
16 includes and serves a lot of population of the
17 York County population today. So, in part,
18 it's included there. But one of the things
19 that I think is important to note is when you
20 look at payer mix, the public data that is
21 available on payer mix is inpatient. You know,
22 you cannot look at public data on ED's payer
23 mix. You can't look at public data on imaging
24 payer mix. You can't look at public data on
25 ambulatory surgery payer mix. Particularly in

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1 South Carolina, it's not available. So 70 to
2 80 percent of our charity care comes from the
3 outpatient setting. You know, we have drawn on
4 our experience at other hospitals and what we
5 are writing off in the charity care
6 perspective.

7 Q: All right. When you came up with 6.3 percent,
8 and you combined that weighted average, did you
9 look at any employment data, employment data
10 related to York County? Did you specifically
11 take out any data about employment and look at
12 it?

13 A: I did not.

14 Q: Did you look at it in any kind of population
15 statistics specifically, particularly if there
16 were any that were related to age factors. Did
17 you look at that?

18 A: I did not.

19 Q: Did you look at any poverty or income --

20 A: Let me -- the age factors. I'm not sure how
21 age factors would play into charity care. I
22 know how it would play into the Medicare
23 percentages, but I don't know how it would play
24 into charity care.

25 Q: All right. Did you look at any income levels

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1 for York County when you came up with that?

2 A: I didn't. And I think that's one of the things
3 that is often misunderstood with income.
4 Really income is not really reflective of an
5 ability of a patient to pay. You could be a
6 patient, you know, someone who makes \$25,000 a
7 year. But if you work for a company that
8 offers insurance, the payment the hospital is
9 going to get is the same as someone who makes
10 \$150,000 and has that same insurance working
11 for that same company. So income is not always
12 the best benchmark for estimating what charity
13 care would be in a market.

14 Q: So I take it from your answer that you did not
15 look at any specific income data, is that
16 right?

17 A: I did not. That's correct.

18 Q: Okay. Did you look at any CPN or CHS employed
19 physician payer mix data?

20 A: I didn't.

21 Q: Did you look at the percentage of charity care
22 that other satellite hospitals in North or
23 South Carolina provided during their first
24 three years of operation?

25 A: I looked at what other providers were currently

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1 paying. I didn't go through and look at other
2 providers and other markets that were starting
3 up new hospitals. I looked at other hospitals
4 in the market and what they were seeing from
5 a charity care perspective.

6 Q: And you relied on two of those hospitals:
7 Pineville and University, right?

8 A: The assumption was built off of those two. But
9 it was tested against lots of other hospitals.

10 Q: But you didn't -- if I understood your answer,
11 you didn't look at the percentage of care
12 provided by other satellite hospitals in South
13 Carolina; did you?

14 A: We've used this term satellite hospital, and I
15 don't view this as a satellite hospital. I
16 view this as a community hospital. A satellite
17 hospital to me implies is all you're doing is
18 get patients from here and ship them out
19 somewhere else. Our goal is not to ship
20 patients out somewhere else. Our goal is to
21 treat patients at this facility as much as
22 possible.

23 Q: All right. Did you look specifically at any
24 new hospital charity care data or new hospitals
25 in South Carolina that have been started in the

1 last few years?

2 A: I did not look at new hospitals that had been
3 started in the last few years in other markets.
4 Once again, it's not a great benchmark, I
5 don't think for what we would expect here.

6 Q: Okay. And you didn't look at or you didn't
7 factor in the charity care listed on the cost
8 reports. And you've given a number of reasons
9 for that, is that correct?

10 A: That's -- well first, there was not that data
11 available in 2010. It was not included in the
12 cost reports at that point in time.

13 Q: All right. There was a demonstrative cost
14 report income, and it's income is listed on its
15 report to York County; do you recall that?

16 A: I do.

17 Q: It is -- looks like Demonstrative 2.8.

18 **MR. WESTBROOK:** Would it be possible to put that up
19 for us?

20 **MS. ROBERTSON:** Yes, sir. We got it.

21 **MR. WESTBROOK:** Okay.

22 Q: Let's just take a look at that. And the
23 difference is, if I understand the red lines,
24 and you correct me. It appears that on
25 Piedmont's cost report, it reported net income

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1 of \$15,266,000, is that right?

2 A: That's correct.

3 Q: And on it's report to the county, it reported
4 net income of \$9,160,000, is that right?

5 A: That's correct.

6 **MR. WESTBROOK:** I'm going to ask Dan to pull up our
7 cost report, Piedmont's cost report for 2011.
8 Is that an exhibit? Can someone tell me the
9 number of that piece. It's 81? Let's pull up
10 Exhibit 81, Dan; 81(b) to be precise.

11 Q: And let's just look at the top of the page and
12 establish and make sure that's our 2011 --
13 Piedmont's 2011 cost report. Where does it say
14 the year? There it is, okay. All right. Now,
15 let's go to Bates Page 103. And if we go down
16 to line -- looks like Line 26. Let's just take
17 a look and see if that's consistent with the
18 number on your demonstrative \$15,266,176. Is
19 that the net income reported by Piedmont on
20 it's cost report?

21 A: Yeah, I believe that's what I pulled into that
22 demonstrative.

23 Q: Right. So that's consistent with your
24 demonstrative.

25 A: Uh-huh (affirmative response).

1 **MR. WESTBROOK:** Let's look now at the York County
2 report for 2011. And I believe that would be
3 Exhibit 17(c) Dan. Let's try for that.

4 Q: All right. And, yeah, this is the 2011 annual
5 report to York County.

6 A: Uh-huh (affirmative response).

7 **MR. WESTBROOK:** All right. Let's go to Bates Page
8 362. And go down to the after tax income line.
9 Actually, I think it's the third line or maybe
10 the second line from the bottom.

11 Q: Figure \$9,160,000; do you see that, Mr.
12 Stewart?

13 A: I do.

14 Q: And that's in thousands. So that's actually 9
15 million, right?

16 A: That's correct.

17 Q: And that's the number that you had on your
18 demonstrative, right?

19 A: That's correct.

20 Q: I'm showing you a different number from the 15
21 million on the cost report.

22 **MR. WESTBROOK:** Now, let's move up -- Dan, why don't
23 you take that back down. And let's move up a
24 few lines where it says, "listing for federal
25 income taxes."

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- 1 Q: Do you see that line?
- 2 A: I do.
- 3 Q: And that's 5,343,000, is that right?
- 4 A: It's 5,343,000, correct.
- 5 Q: All right. This is what Mr. Andrews calls a
- 6 computer.
- 7 A: Thank you.
- 8 Q: And the next line under the federal income tax
- 9 line is state income taxes, right? And that's
- 10 763,000, is that right?
- 11 A: That's correct.
- 12 Q: Could you add those two together, please?
- 13 A: Sure. 6,106,000.
- 14 Q: And could you add that to the 9,160,000 that's
- 15 the after tax income.
- 16 A: It's 15,266,000.
- 17 Q: And that's the number that's on the cost
- 18 report; isn't it?
- 19 A: That's sort of the point.
- 20 Q: Well, first of all, you can explain why it's
- 21 the point. But first, is that the number on
- 22 the cost report?
- 23 A: That is.
- 24 Q: All right. And so what's the point?
- 25 A: The point is that in the Medicare cost report,