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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

SC Court of Appeals

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 IV OF XVII

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INDEX

Record Volume I of XVII

ORDERS

Order of Judge Matthews, filed December 9, 2009	1
Order of Supreme Court Order dated April 8, 2010	29
Final Order and Decision of Judge Lenski, filed March 31, 2014.....	34
Order of Judge Lenski Vacating Final Order, May 2, 2014	73
Amended Final Order of Judge Lenski, filed December 15, 2014	74

PLEADINGS

Respondent CHS's Motion in Limine, filed April 2, 2013.....	127
Respondent CHS's Motion for Reconsideration, filed April 9, 2014.....	227
Petitioner's Response in Opposition to Motion for Reconsideration, dated April 21, 2014	250

TRANSCRIPTS

Transcript of Administrative Hearing before the Honorable S. Phillip Lenski, April 8, 2013 – May 7, 2013	271

(pp. 6-66 omitted)

Arun Adlakha, M.D.

Direct Examination by Mr. Andrews	297
Re-Direct Examination by Mr. Andrews	338
Re-Cross Examination by Mr. Muller	341

Bill Masterson

Direct Examination Mr. Westbrook	342
Cross Examination by Mr. Muller.....	394
Re-Direct Examination by Mr. Westbrook	395

Roy Norman Taylor, M.D.

Direct Examination by Mr. Andrews	400
Cross Examination by Mr. Gaskins.....	447
Re-Direct Examination by Mr. Andrews	449

Robert Walsh

Direct Examination by Mr. Westbrook	459

Record Volume II of XVII

Robert Walsh

Cross Examination by Mr. Gaskins.....	534
Re-Direct Examination by Mr. Westbrook	535

David Samuel Levitt

Direct Examination by Mr. Andrews	542

Sushil Singhi, M.D.

Direct Examination by Mr. Andrews	848
Cross Examination by Mr. Gaskins.....	896
Re-Direct Examination by Mr. Andrews	898
Re-Direct Examination by Mr. Andrews	905

David Samuel Levitt (Resumed)

Re-Direct Examination by Mr. Andrews	917

Record Volume III of XVII

Charles Miller

Re- Direct Examination by Mr. Andrews	1021

Joel Grice

Direct Examination by Mr. Andrews	1031

Daniel Sullivan

Direct Examination by Mr. Westbrook	1143
Cross Examination by Mr. Gaskins.....	1164
Re-Direct Examination by Mr. Westbrook	1166

Joel Grice (Resumed)

Re-Direct Examination by Mr. Andrews	1188
Re-Cross Examination by Mr. Muller	1199

Beverly Brandt

Cross Examination by Mr. Andrews	1204
Re-Cross by Mr. Andrews.....	1317
Re-Cross by Ms. Robertson.....	1319

Frank Murphy, Jr.

Cross Examination by Mr. Westbrook	1325

Donald Stewart

Cross Examination by Mr. Westbrook	1448

Record Volume IV of XVII

Donald Stewart

Re-Cross Examination by Mr. Westbrook	1504

Robert Alexander, M.D.

Cross Examination by Mr. Andrews	1511

Re-Direct Examination by Mr. Gaskins	1531

William Revell, M.D.

Cross Examination by Mr. Andrews	1534

Kathryn M.T. Platt

Cross Examination by Mr. Andrews	1585

Dawn Carter

Cross Examination by Mr. Westbrook	1850

Record Volume V of XVII

Dawn Carter

Redirect Examination by Ms. Robertson	2005

David Samuel Levitt

Rebuttal Direct Examination by Mr. Andrews.....	2006
Rebuttal Re-Direct Examination by Mr. Andrews.....	2069
Rebuttal Re-Cross Examination by Mr. Muller	2076

Bill Masterson

Rebuttal Direct Examination by Mr. Westbrook.....	2077
Rebuttal Cross Examination by Mr. Gaskins	2095
Rebuttal Re-Cross Examination by Mr. Gaskins	2096

Daniel Sullivan

Rebuttal Direct Examination by Mr. Westbrook.....	2098

Exhibits

Joint-A-CHS-001

.0009-10, Figures 3-4	2132
.0015-17	2134
.0047-52	2137
.0056-57	2143
.0059-61	2145
.0064.....	2148
.0067.....	2149
.0079-80	2150
.1164-1167	2152

.1174-1182	2156
.1184.....	2165
.1187-1188	2166
.1191.....	2168
.1198.....	2169
.1210-1211	2170
.1215.....	2172
.1303-1315	2173

Joint-B-PMC-001

.0002-0266	2186

Record Volume VI of XVII

Joint-B-PMC-001

0267-0415	2451
.0449-0643	2600
.0690-0835	2795

Record Volume VII of XVII

Joint-B-PMC-001

.0836-0902	2941
.0990-0996	3008
.1000-1014	3015
.1017-1031	3030

CHS

12.....	3045
32, p 1.....	3217

Petitioner

1B.....	3218
2.0032.....	3229
3.0029.....	3230
4.0001.....	3231

Record Volume VIII of XVII

Petitioner Exhibits (Cont'd)

4.0201.....	3431
5.....	3514
6.0001.....	3778

Record Volume IX of XVII

6.0140.....	3917
7.....	3997
8.....	3998
11.....	4170
12.0001.....	4173

Record Volume X of XVII

14.....	4361
15.....	4445
16.....	4449
17A.....	4619
17B.....	4679
17C.....	4740
17D.....	4804

Record Volume XI of XVII

17D.0048.....	4851
18.....	4868
19.....	4885
20.....	4886
21.....	4887
22.....	4889
23.....	4994
24.....	4997
25.....	5010
26.....	5057
27.....	5058
28.....	5060
29.....	5066
30.....	5105
32.....	5106
33.....	5107

34.....	5108
35.....	5109
36A.....	5111
36B.....	5176
37A.....	5244
37B.....	5272
38A.....	5300

Record Volume XII of XVII

38B.....	5335
39A.....	5373
39B.....	5407
40A.....	5440
40B.....	5470
41A.....	5501
41B.....	5530
44A.....	5562
44B.....	5591
45A.....	5594
45B.....	5623
46A.....	5627
46B.....	5656
47A.....	5660
47B.....	5689
48A.....	5693
48B.....	5722
49.....	5726
50.....	5730
51.....	5734
52.....	5738
53.....	5741
54.....	5744
55.....	5748

Record Volume XIII of XVII

55.0070.....	5817
56.....	6181
57.....	6183
58.....	6185
59.....	6187
60.....	6189
61.....	6191
62.....	6193
63.....	6195
64.....	6197

66.....	6205
67.....	6289
69.....	6296
70.....	6300

Record Volume XIV of XVII

71.....	6303
72.....	6308
73.....	6328
74.....	6330
75A.....	6342
75B.....	6452
76A.....	6612

Record Volume XV of XVII

76B.....	6705
77A.....	6800
77B.....	6875
78A.....	6972
78B.....	7047

Record Volume XVI of XVII

79A.....	7147
79B.....	7245
80A.....	7345
80B.....	7421
81A.....	7506
81B.....	7606

Record Volume XVII of XVII

81B.0030.....	7635
82.....	7710
83.....	7730
84.....	7750
88.....	7753
89.....	7754
90.....	7762
91.....	7768
92.....	7774
93.....	7781
94.....	7788
95.....	7794
96.....	7800
97.....	7807

98.....	7808
99.....	7809
100.....	7810
101.....	7811
102A.....	7812
102B.....	7818
102C.....	7819
103.....	7820
104.....	7823
105.....	7824
106.....	7825
107.....	7826
108.....	7827
109.....	7829
110.....	7831
111.....	7832
114.....	7835
115.....	7854
116.....	7856
117.....	7858

DHEC

DHEC Record 000057	7860
DHEC Record 000211 – 000213	7861

1 there are things that are included and there
2 are things that are not. So what CMS used that
3 needs to be included is different than what
4 GAAP assumes that needs to be included. And
5 that's why it's not a great source for data.
6 Q: Okay. Now -- and one of the things that is not
7 included on cost reports are taxes, right?
8 A: That's one of the things, yes..
9 Q: Okay. And first of all, before we get to your
10 point about cost reports, let me just make sure
11 that I understand. So when you add those taxes
12 to the after tax income, it definitely -- that
13 number ties to the cost report number; does it
14 not?
15 A: It ties to the cost report number.
16 Q: All right. And there is no inconsistency,
17 right?
18 A: The bottom line ties. I haven't gone through
19 and tied through all the numbers that --
20 Q: Well, your testimony was just about that. So
21 I mean, and you are certainly welcome to go
22 through and look at it some more if you'd like
23 to. But I just wanted to make sure that we
24 understand that there is no inconsistency
25 between those two reports.

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1 A: Yeah. And I don't think I ever testified that
2 the cost report is wrong or that the financials
3 are wrong. I think I said very clearly that's
4 not to say either of them are wrong. It's just
5 what's included in them are different.

6 Q: And so when you -- the charity care numbers
7 that you looked at for Pineville and University
8 for the year 2009 upon which you used a
9 weighted average to come up with your charity
10 care projection of 6.3 percent, that was based
11 on the internal financial statements of CHS and
12 not on the CMS cost reports to the government,
13 is that correct?

14 A: Well, so first of all, the CMS cost reports did
15 not break out charity care in 2009.

16 Q: Okay.

17 A: So it couldn't have come from there.

18 Q: Okay.

19 A: And second of all, I don't know why you would
20 ever go to a cost report for financial data
21 when you have your internal financial data
22 available. I mean, I've done consulting for
23 six years and was at a lot of different
24 hospitals. And never did I ever use cost
25 report as my source of data.

1 Q: Oh, really. Okay. And have you -- let me ask
2 you this. Is it part of your job, do you
3 complete and submit cost reports?

4 A: I do not.

5 Q: Have you ever done that?

6 A: No.

7 Q: So you've never submitted a cost report
8 yourself?

9 A: No.

10 Q: All right. Are you aware that whoever does
11 submit the cost report has to attest that all
12 the financial information on that cost report
13 is accurate and that attestation goes to the
14 government as a certification?

15 A: And once again, I've never testified that the
16 data was inaccurate. But what I've testified
17 to is the day that CMS requires you to submit
18 is different than what is required to be
19 submitted as part of your audited financials.

20 Q: And I understand that, and I appreciate that
21 distinction. But my question was, are you
22 aware that whoever submits the cost report has
23 to certify that's it accurate to the
24 government? Are you aware of that?

25 A: Yeah, I'm very aware of that.

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1 Q: Okay. What are DISH payments?

2 A: Disproportionate share.

3 Q: Yeah. What does that mean?

4 A: It represents the -- it's a reimbursement that
5 you get to offset the cost of providing
6 indigent care coverage.

7 Q: All right. And that's an important source of
8 income for some hospitals; is it not?

9 A: I don't know if I'd call it a source of income
10 or offset for -- it's a source of revenue. It
11 offsets, you know, the cost of providing
12 uncompensated care.

13 Q: Right. So for some hospitals, that would be an
14 important source of revenue; wouldn't you
15 agree?

16 A: It's a source of revenue, yeah.

17 Q: Yeah. I'm sorry. I couldn't hear your answer.

18 A: It is a source of revenue, correct.

19 Q: It's a source of revenue. My question was is
20 it an important source of revenue for some
21 hospitals?

22 A: I mean, all revenue is important to the
23 hospital.

24 Q: As it is, I guess, to most companies, right?

25 A: Yes.

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- 1 Q: Now, DISH payments are made by the government,
2 right?
- 3 A: Yeah.
- 4 Q: And they are based on cost report data; isn't
5 that correct?
- 6 A: They are.
- 7 Q: Okay. There was another demonstrative that you
8 had, and I'm afraid I don't know the number,
9 that would compare -- well, it showed an
10 inaccuracy in one of our demonstratives about
11 net income. Do you recall that, Mr. Stewart?
- 12 A: There were a few, so --
- 13 Q: That's fine. And we will put it up there once
14 I figure out which one it is. I just wanted to
15 -- I tell you what, while we are looking for
16 that, let's move on to another question.
- 17 A: And I don't think I said anything -- I don't
18 remember there being a net income inaccuracy.
- 19 Q: Okay. Well, that's great if you didn't. But
20 I thought that was a mistake you found on our
21 --
- 22 A: There were several mistakes, but I don't
23 remember anything that was on a net income line
24 item.
- 25 Q: Well, if there is not, there is not. We'll

1 see.

2 **MR. STEWART:** Let's look at Demonstrative 2.11,
3 please, if we could from you guys.

4 Q: All right. This is -- so this is your
5 Demonstrative 2.11, right?

6 A: Correct.

7 Q: And you spent a little time on your direct
8 going over this, correct?

9 A: Yes.

10 Q: All right. Now -- and I believe that the
11 PeopleSoft Report when you started talking
12 about or testifying about this on direct, there
13 was a departmental report. And I think you
14 were explaining that that data in that
15 departmental report was from something called
16 PeopleSoft. Is that correct?

17 A: In a report that was displayed as the original
18 demonstrative exhibit was from a PeopleSoft
19 Report. And I just sort of pulled up the
20 original PeopleSoft Report that it was drawn
21 from.

22 Q: Right. Okay. And but that tied to some data
23 in a departmental report for Pineville that was
24 used; isn't that correct? Do you recall that?

25 A: That's correct.

1 Q: Okay. And so this shows -- you hear the
2 PeopleSoft Report for Pineville and University
3 2009. And I think you explained these various
4 line items and how you came up with the charity
5 care at the bottom half of that chart. The
6 actual results charity care for Pineville was
7 19.4 million and University 31 million, is that
8 right?

9 A: That's correct.

10 Q: Am I reading that correctly? Let's just start
11 focusing on Pineville for the moment. So the
12 19 million number of charity care that you
13 relied on in getting your weighted average,
14 that was based on an allocation from those
15 numbers in the top chart, right? Am I'm saying
16 that correctly -- maybe you can explain.

17 A: Yeah, I call it allocation. There is a process
18 that is gone through in detail to figure out
19 what our charity care reserve should be.

20 Q: Okay. And those various categories up top are
21 Charity Care, Mecklenburg County Inpatient
22 Contractual Adjustments, Bad Debt Expense, Bad
23 Debt Recovery, Bad Debt Total, Self-Pay
24 Discount, and then there is a total.

25 A: And those are direct. Those are what they are

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1 labeled on the PeopleSoft Report.

2 Q: I see. Okay. And so the things that the --
3 the categories that are labeled Bad Debt on the
4 PeopleSoft Report and Inpatient Contractual
5 Adjustments and Self-Pay were reclassified in
6 your process or at least some of them were
7 reclassified or some portions of those amounts
8 were classified as charity care. Is that what
9 I understand that chart to say?

10 A: Yeah. And I guess I don't know that I agree
11 with the term reclassify.

12 Q: What term would you use?

13 A: So, what I would say is this represents our
14 total uncompensated care and then --

15 Q: What represents your total uncompensated care?

16 A: That 39,166,113.

17 Q: Okay. Would that be the same as your other
18 category when you looked at payer mix earlier?

19 A: I don't think it 100 percent ties to what's in
20 the other category.

21 Q: Okay. So it's another category. Okay. Go
22 ahead and explain. I'm sorry.

23 A: So the 39,116,113 represents our uncompensated
24 care. And there is a process that's gone
25 through. It's approved by our auditors. It's

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1 reviewed by our auditors where they go through
2 and test -- do an account test of all the money
3 that is in this uncompensated care bucket and
4 make a determination as to how much of that
5 money belongs in charity care and how much of
6 that money belongs in bad debt.

7 Q: All right.

8 A: And that number feeds into the community
9 benefit numbers that are reported in our audit.

10 Q: Okay. So the first line it says charity care
11 510,847.

12 A: Uh-huh (affirmative response).

13 Q: Right. I assume that all of that would feed
14 into the actual charity care number, the \$19
15 million number that you used, is that correct?

16 A: That would, I believe, be correct.

17 Q: What about the second line item? Mecklenburg
18 County inpatient contractual adjustment.
19 That's 1.1 million. What percentage of that or
20 how much of that would be --

21 A: I'm pretty sure that that all goes into the bad
22 debt bucket.

23 Q: All of it into the bad debt bucket. Okay. Bad
24 debt expense of 35.8 million. How much of that
25 goes into charity care?

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1 A: The majority of the charity care comes from a
2 combination of the bad debt expenses and self-
3 pay discount.

4 Q: Okay. The -- so I take it, then, that a
5 relatively high percentage of that 35.8 million
6 bad debt expense would go into the charity
7 care?

8 A: I mean, half of bad debt is -- half of 35
9 million is 17.5 or 17.9. So, I mean that's 50
10 percent. I mean, it's not much above 50
11 percent.

12 Q: Okay. And then how much of bad debt recovery
13 goes into charity care?

14 A: None of that would feed into charity care.
15 That's actually an offset lowering the number.

16 Q: All right. How much is -- well, then you have
17 a total line, bad debt total. And I think you
18 said self-pay discount was another significant
19 part of the amount that was a charity care
20 total, is that right?

21 A: Yes. Self-pay discount of that 4.7 million in
22 self-pay discount, \$2.9 -- 2,898,000 remains as
23 sort of an uninsured discount. And then the
24 other \$1.9 million of that number is then --
25 there is a determination when they look at that

1 as to whether or not the patients would have
2 met the bad debt or charity care criteria and
3 are allocated as such.

4 Q: All right. The process that you described, I
5 mean who is the processor? Who does that?

6 A: Like a name?

7 Q: Well, is it you?

8 A: It's not me.

9 Q: Is it somebody working under your supervision?

10 A: It's not someone under my supervision.

11 Q: Okay. Do you know that -- do you know the
12 timing of when that process occurs. Is it
13 after patient service has been completed or
14 before or during; do you know?

15 A: It depends.

16 Q: So it's sometimes one, sometimes the other.

17 A: it depends on. There are accounts that are
18 identified as charity care on admission. And
19 there are accounts that later in the process
20 are identified as charity care.

21 Q: You didn't like my term reclassification. But
22 I can't think of a better term. If there is
23 one you prefer, I'll use it. But that when you
24 take that percentage of -- it sounds like it's
25 likely coming from bad debt expense and self-

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1 pay discount, and take a portion of that amount
2 and put it into charity care, do I understand
3 you to say that that process for some patients
4 occurs prior to the outset when they come into
5 the hospital and for some patients it occurs
6 afterwards. Is that what I understood you to
7 say?

8 A: I think -- I think there are sort of two things
9 you are talking to me about here. There is the
10 --

11 Q: Well, answer my question first and then explain
12 the two things I'm talking about. And can you
13 answer my question?

14 A: Well, sort of. And I was going to try to do it
15 through the explanation of it. I think there
16 is sort of two processes.

17 Q: Okay.

18 A: That there is the accounting side of how things
19 are handled, and there is the patient
20 accounting side of how things are handled. On
21 the patient accounting side of how things are
22 handled, you know, the determination of
23 someone's ability to qualify for charity care
24 can occur throughout the process. And, you
25 know, a lot of it just depends on what

1 information we know when. And then from the
2 accounting side of things, you know, the
3 numbers that are reported here are reflective
4 of generally accepted accounting principles
5 approved by our auditors.

6 Q: Okay. Well, I understand that, but I guess my
7 question, I think, is a little simpler than
8 that.

9 A: Okay.

10 Q: At some point in time, these numbers up here,
11 let's just take bad debt expense, just so we
12 can focus on one category. At some point in
13 time, a bad debt expense of \$35.8 million, a
14 portion of that was reclassified, or use some
15 other verb, if you like, into charity care, put
16 into a bucket of charity care that when added
17 to some other things came up to \$19.4 million.
18 And I know there was not one point in time when
19 that happened, is that right?

20 A: Well, first of all, like I said, you're looking
21 at the PeopleSoft report, the departmental
22 performance report. And I don't know that
23 financials are really classified in the bad
24 debt as it shows here. I would say these are
25 classified into uncompensated care. And then

1 there is a process from an accounting side in
2 which they go through and figure out how much
3 of that uncompensated care should be bad debt
4 and how much of it should be charity care.

5 Q: Is PeopleSoft -- is that a contract or a
6 vendor?

7 A: It's a vendor.

8 Q: It's a vendor.

9 A: Yes.

10 Q: And so somebody that CHS uses for this purpose,
11 right, and other purposes, I suppose?

12 A: They don't do the financials. They provide the
13 software.

14 Q: All right. The classifications of bad debt
15 expense, bad debt recovery, charity care, self-
16 pay discounts, and so forth, do you know when
17 those are made for patients?

18 A: It depends on the patient.

19 Q: Okay. So it would depend on individual
20 patient?

21 A: It would depend on the individual patient.

22 Q: And sometimes it would be, again, going back to
23 I think to your earlier testimony, sometimes
24 depending on the patient it might be at the
25 outset; sometimes it might be during the

1 service; sometimes it might be after the
2 service. Is that right?

3 A: Uh-huh (affirmative response).

4 Q: Okay. I'm sorry -- uh-huh.

5 A: Yes.

6 Q: I understand what you're saying, but, you know,
7 the court reporter may not. Thank you. All
8 right. Now, your background, I think you
9 testified that before you became assistant vice
10 president of business development, you were
11 director in a management company, right?

12 A: Yes.

13 Q: Association -- and you explained about the
14 management company. My memory is that your
15 title or one way you describe yourself as
16 you're not only the directory of a management
17 company, but you were director of planning;
18 weren't you?

19 A: Yeah. You could say that. It wasn't an
20 official title. That was just sort of what I
21 did. But there were other people in our group
22 that could have said they were director of
23 planning, as well.

24 Q: I understand. But you worked in the management
25 company. When you worked in the management

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1 company, that was under Murphy's supervision,
2 right?

3 A: In 2005, I did.

4 Q: Yeah, back then. I know you don't now. It's
5 a different area now. And you were essentially
6 a healthcare planner; were you not?

7 A: Sort of. I would say that when I first
8 started, I mean, I was brought in to really
9 help with the financial side of planning. But
10 as I always say, when you do the financial
11 side, you have to understand the operations a
12 little bit, as well.

13 Q: All right.

14 **MR. WESTBROOK:** Bear with me just a minute, Your
15 Honor, and Mr. Stewart.

16 Q: Let's move onto another topic, Mr. Stewart.
17 All right. You explained how you based the
18 charity care projection, 6.3 percent projected,
19 a weighted average of CMC-Pineville and CMC-
20 University. The Medicaid projection in your
21 application was not based on those two
22 hospitals; was it?

23 A: It was not.

24 Q: Okay.

25 A: Let me rephrase.

1 Q: Okay.

2 A: I'm not positive what it was based on. That
3 was something that Mr. Murphy pulled together
4 and provided to me.

5 Q: Okay. But it sounds like what your initial
6 response is, as far as you know, it was not
7 based on those two hospitals. Would that be an
8 accurate way of saying it?

9 A: The only thing I would say that that might
10 change it a little bit is that a lot of the
11 patients that are currently seen at Pineville
12 originated at that Fort Mill market.

13 Q: Let me ask just a few more questions. Let's
14 move onto another topic.

15 A: Sure.

16 **MR. WESTBROOK:** All right. Dan, how about pulling
17 up Bates Page CHS-6879, please.

18 Q: And Mr. Stewart, this is a -- I'm going to
19 represent to you this is a document CHS
20 produced to us during discovery, is that right?

21 A: Okay.

22 Q: And I think this is just --

23 **MR. WESTBROOK:** Can you pull that out where we can
24 see it, Dan?

25 Q: I think is just an email, I believe. It's'

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1 from you; is that correct on September 12,
2 2010 to Debra Godfrey. Is that right?

3 A: Uh-huh (affirmative response).

4 Q: And who is Debra Godfrey?

5 A: She is one of the assistant administrators at
6 CMC-Pineville.

7 Q: All right. And it says, I'm just going to
8 read, and I will ask you a question about it
9 when I get through. Just the beginning. It
10 says, "Hi Debra, we have an updated schedule
11 for Fort Mill. We will be getting volume
12 projections by end of day on Tuesday. At that
13 point, we will forward to you along with an
14 overview of debt complement still finalizing."
15 Now, it says -- that first sentence, "we will
16 be getting volume projections by the end of the
17 day on Tuesday." This email is Sunday
18 September 12th, right? So you were going to
19 get the volume -- at that point, at least, you
20 were expecting volume projections by the
21 following Tuesday. Is that the way I -- do I
22 understand that correctly?

23 A: That's what appears to be.

24 Q: I guess I should start off by asking you -- I
25 know that, like all of us probably, you go

1 through a lot of emails every day. Do you have
2 a particular recollection of this particular
3 email?

4 A: Not of this particular one. I know I had
5 several communications with Debra during that
6 time.

7 Q: And why was that?

8 A: Because she helped me in the development of the
9 staffing projections.

10 Q: Okay. And so you were developing the staffing
11 projections at this time then; is that what I
12 heard you say?

13 A: That's correct.

14 Q: Let's go to the second paragraph. It says,
15 "Unfortunately, our turnaround time is still
16 pretty quick as we need to have finalized by
17 Friday or Monday at the latest so we can have
18 the financial projections completed by
19 Tuesday." I guess that would refer to the
20 following Tuesday, is that right?

21 A: That sounds correct.

22 **MR. WESTBROOK:** Okay. Let's go to 6878, Dan, CHS-
23 6878.

24 Q: There's just a couple of these I want to sort
25 of quickly walk through with you, Mr. Stewart.

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1 This is an email from Debra Godfrey two days
2 later, right; on September 14th?

3 A: Yep.

4 Q: To a number of folks. Do you recognize those
5 names?

6 A: A few of them. Those are, I believe, the
7 department heads that report up to Debra.

8 Q: Okay. And then the first sentence, I think it
9 is consistent with what you just told me. "We
10 have been tasked with developing a staffing
11 plan for the Fort Mill Hospital. Volume
12 projections are not yet available, but I wanted
13 to give you a head start due to the tight time
14 frame. CE mail below from Gregg Stewart." And
15 at that point, so that tight time frame, I
16 guess would that refer back to the email you
17 were talking about, you wanted to get things
18 finalized by the following Tuesday as I recall,
19 is that right?

20 A: That would have been what I meant by tight time
21 frame.

22 **MR. WESTBROOK:** Dan, let's go over to 6865, CHS-
23 6865.

24 Q: And this is another email, I believe, from you.
25 And this is September 24th. So this is, I

1 guess, a week or two later; is that right,
2 again to Debra Godfrey?

3 A: Yep.

4 Q: Okay. And it says, "Hi, Debra. We've pulled
5 the staffing sheet together into a summary
6 page. Our staffing level seems high assuming
7 26 patients." So at this point in time, you
8 were only expecting an average daily census of
9 26, is that right?

10 A: Apparently that was at that point in time.

11 Q: On an FTE per AOB, which I guess is adjusted
12 occupied bed, and you explained that, right.

13 A: Uh-huh (affirmative response).

14 Q: An FTE per adjusted bed basis right now, we're
15 running 4.7 based on the staffing plan
16 provided. Then it says, "a couple of areas
17 where we may look." And you've got several
18 bullet points there. And it looks -- take a
19 moment to look at those. But it looks like to
20 me you're looking for ways to kind of -- well,
21 you say your staffing level seems high. So it
22 looks like to me a couple areas where we may
23 look, you're looking to find places where you
24 might cut some of those staffing? Is that
25 right? Is that what you're doing?

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1 A: I was basically -- you know, we pull numbers
2 together quickly. And there is a little bit of
3 back and forth. So she had her department
4 managers separately pulling together numbers
5 and sending those numbers to me. I
6 consolidated all the numbers and then responded
7 back to her with some questions on those
8 numbers.

9 Q: And so, "there is a couple of areas where we
10 may look." First bullet point, it talks about
11 nursing, a unit nursing, right? Do you see
12 where it says unit nursing there?

13 A: Yeah.

14 Q: And then the last sentence it mentions
15 additionally there are nine nurse aids?

16 A: Uh-huh (affirmative response).

17 Q: And then the second bullet point -- we won't go
18 through all these, but it talks about nurse
19 managers. And then the next bullet point says
20 something else. The fourth bullet point says,
21 "There are six maintenance FTE's. I thought
22 this was done centrally and charged out -- it
23 says, hour through Intercompany." Is that a
24 typo? Should that be out through Intercompany?

25 A: Probably.

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- 1 Q: Okay. And I think you talked about
2 Intercompany expense on your direct. So that
3 would be -- as I understand it, Intercompany
4 expense would be employees or contractors or
5 whoever that provides centralized services to a
6 number of CHS' hospitals, right?
- 7 A: That's correct.
- 8 Q: And they are located off site of where any of
9 those hospitals are --
- 10 A: Right.
- 11 Q: -- is that correct? And they are accounted for
12 -- the expense of those are accounted for in
13 the Intercompany expense line that you talked
14 about on your direct, right?
- 15 A: That's correct.
- 16 Q: Okay. And -- but they are not -- if they are
17 Intercompany expense, those FTEs would not be
18 counted as FTEs on the staffing plan, is that
19 right?
- 20 A: We accounted for the expense through
21 Intercompany, not through the staffing line
22 item in our projection.
- 23 Q: Okay. And then it says, "other thoughts". And
24 you have a number of other thoughts there.
25 Let's bring that down.

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1 **MR. WESTBROOK:** Okay. Let's move onto something
2 else. The next one is CHS-6880, please, Dan.
3 Thank you.

4 **Q:** And I believe there are two emails on this one
5 page. Let's briefly take a look at the top
6 email. The top email is from Debra Godrey to
7 you dated September 26. And it says, "We're
8 missing medical records and coding so there
9 should be an expense allocated in Interco.?" By
10 Interco, is she talking about Intercompany
11 expense?

12 **A:** Yes.

13 **Q:** Okay. And she goes and says, "By the time this
14 hospital is built, all those functions will be
15 off site for efficiency," right?

16 **A:** That's what she says, correct.

17 **Q:** And what she's referring to, I think, and you
18 correct me, is what you were just talking
19 about. If they are Intercompany expense, their
20 expense is accounted for on that Intercompany
21 line. If they are offsite they are not counted
22 as an FTE, is that right?

23 **A:** The expense is captured in the Intercompany
24 line.

25 **Q:** But they are not listed in the FTE compilation,

1 correct?

2 A: That's correct.

3 **MR. WESTBROOK:** And let's look at the bottom half,
4 Dan, of 6880.

5 Q: That's a different email, I think. And that is
6 from Gregg Stewart to Debra Godfrey and Cheryl
7 Atkinson. Who is Cheryl Atkinson?

8 A: Cheryl Atkinson is Debra Godfrey's peer.

9 Q: I'm sorry -- her what?

10 A: Her peer.

11 Q: Her peer?

12 A: So there's two assistant administrators. Some
13 of them have -- the departments are split
14 between the two administrators.

15 Q: Okay. "Hi Debra, it's Cheryl, attached is the
16 latest version of the staffing plan. I've also
17 put together a summary tab which is what we
18 will submit for the CON." This is September
19 24th, right?

20 A: That is September 24th.

21 Q: And then you say, "I think the only change I've
22 made that we didn't discuss is that I dropped
23 lab staffing by .5 FTEs and registration by 1.2
24 FTEs, which gave me an even 250 FTEs in an FTE
25 per adjusted occupied bed of 4.5", right? Now,

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1 that's based still, I guess, on that lower
2 average daily census that you were planning at
3 that point of 26, is that correct?

4 A: I don't know what that was based on. Probably,
5 but I'm not sure.

6 Q: All right. With 250 FTEs, there are only 250
7 FTEs. And you would have a lower number of
8 FTEs if you had lower average daily census;
9 wouldn't you?

10 A: That's correct.

11 **MR. WESTBROOK:** Okay. Let's look at 6882. Well,
12 hang on just a second. Dan, would you put 6880
13 back up for just a moment, please. I just want
14 to make sure I saw that. All right. Yeah, 250
15 FTEs. I got that, and an FTE per AOB of 4.5.
16 Right. Okay. Let's go to 6882 for a minute,
17 Dan.

18 Q: Now, this is one of the spreadsheets. I think
19 you referenced in your direct how you would
20 have detailed FTE spreadsheets that you relied
21 on. Is this an example of one of those?

22 A: It is.

23 Q: And look at the total -- at the last column at
24 the very bottom, doesn't it say 250 FTEs?

25 A: It does.

1 Q: Okay. So that ties to the email that you just
2 have. Would this -- and my question is, does
3 this appear to you to be a draft FTE
4 spreadsheet that you or somebody working with
5 you prepared about that time that you were
6 talking about, you were thinking you would have
7 250?

8 A: It wouldn't be me because I did all the aspects
9 of the financial projection myself.

10 Q: It would have been you?

11 A: It would have been me.

12 Q: Oh, okay. Does this look like something you
13 prepared?

14 A: I mean, like I said, the 26 volumes sounds low
15 to what we would typically include in our
16 application.

17 Q: Sure.

18 A: So this is probably something that was early on
19 in the process. Early on, and I don't know,
20 you know, what that --

21 **MR. WESTBROOK:** Let's go back to the last email,
22 please. I think that was 6880, I believe.

23 Q: And in this one, you're talking about FTEs of
24 250, right?

25 A: Yes.

1 Q: And the date on that is September 24th. So
2 that is early on; isn't it?

3 A: It's early on. And like I said, I would have
4 to see how that 250 -- I don't -- as I recall,
5 I think our FTEs in year one are like 300 and
6 change. So this has to be -- I mean, this is
7 just something that was early on developing a
8 projection based on, you know, the volume
9 projection at that time.

10 Q: But it looked from the earlier emails that you
11 were in -- you had -- you were working on a
12 tight deadline to get this out; wouldn't that
13 be correct?

14 A: A tight -- no, it was a tight time line to get
15 it finished.

16 Q: Oh, okay. Tight time line to get it finished;
17 you're right. And in fact, you didn't present
18 your pro forma budget projections or your FTEs
19 until December 2010; isn't that correct?

20 A: I think there were two submissions. And one
21 was in the December time frame and one was in
22 the March time frame.

23 Q: Okay.

24 A: But I think the March ones are our final
25 submittals that are in the application.

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1 Q: I grant that. I understand. Thank you.

2 MR. WESTBROOK: Let's go back to Demonstrative 2.11,
3 please.

4 MS. ROBERTSON: 211.

5 MR. WESTBROOK: 211, I'm sorry. Yeah, that's okay.

6 MR. ROBERTSON: I didn't know if it was yours our
7 ours?

8 MR. WESTBROOK: I wasn't sure myself. I think it's
9 yours. Thank you very much.

10 Q: Let's go back to this demonstrative, Mr.
11 Stewart, for just a minute. Now, the category
12 of self-pay discount there. I believe you said
13 that that was one of the -- well, I think you
14 said that it ended up that the two major
15 contributors to the charity care total down at
16 the bottom half were self-pay discount and bad
17 debt expense, is that right?

18 A: That's correct.

19 Q: Okay. Let's just look at some of the self-pay
20 discounts for a minute. Now, the process of
21 developing -- I believe you mentioned that the
22 process of developing a patient payment plan
23 for some self-paid patients; isn't that
24 correct?

25 A: Yes. Well, I don't know if I talked about a

1 payment plan. I think we talked about a
2 discount. Discount is different than a payment
3 plan.

4 Q: Right. I would assume that people who get
5 discounts would oftentimes, whether they get
6 discounts or not -- I mean, many patients would
7 get a payment plan from the hospital to pay
8 their bill; wouldn't that be correct?

9 A: That depends on what the procedure is and then
10 what the size of the bill is and what their
11 income is. I mean, what their income is. I
12 mean, there are lots of factors.

13 Q: Okay. Right. Lots of factors. But given
14 those lots of factors, quite a few patients end
15 up on payment plans with hospitals for their
16 bills; wouldn't you agree?

17 A: I don't know if I would say quite a few, but
18 some do, yes.

19 Q: All right. Some do. Thank you. All right.
20 Now, the way that a patient -- under a payment
21 plan, the process would work by a patient
22 reaching an agreement with the hospital to pay
23 some defined amount, is that correct?

24 A: That's correct.

25 Q: On a periodic basis, correct?

1 A: For a payment plan?

2 Q: Yes.

3 A: Yes.

4 Q: All right. And the hospital, if it's a
5 discounted bill, the hospital would discount
6 the charge before those payments were started,
7 is that right?

8 A: Correct.

9 Q: All right. And then the balance after the
10 patient finishes making all his or her payments
11 based on that agreement, based on that
12 discounted rate, there is going to be a
13 balance, right, because it's discounted,
14 correct?

15 A: Well, you would have already written the
16 balance off in your discount.

17 Q: Oh, okay. So you write -- that was going to be
18 my question. You go ahead and write that
19 balance off at the beginning?

20 A: You write that balance off. I think there are
21 sort of two pieces to it. There is the amount
22 that is written off when the agreement is made.
23 But the accounts, you know, the payment plans
24 may or may not be adhered to.

25 Q: Right. And if the payment plan is adhered to,

1 then that balance would be written off. And if
2 the payment plan is not adhered to, I guess you
3 would go to Stage B or something, right?

4 A: It may fall into the bad debt category.

5 Q: Right. Just depending on the circumstances, I
6 guess.

7 A: Uh-huh (affirmative response).

8 Q: But, if the payment plan -- if all the payments
9 are made, the balance is going to be written
10 off, I think is what you said?

11 A: Correct.

12 Q: Now, if an insurance company were paying that
13 amount at a discounted negotiated rate, that --
14 the amount that would be written off would be
15 considered a contractual adjustment. Is that
16 correct, my understanding of contractual
17 adjustments?

18 A: That's correct, yes.

19 Q: Thank you. Now, in charity care, patients who
20 are classified as charity care, are those
21 amounts also written off from the outset, once
22 a person is classified as a charity care?

23 A: I think if I understand your question right,
24 yes.

25 Q: Okay. Thank you. I mean, that's what I

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1 thought. There are no trick questions. I just
2 wanted to make sure I understood the way the
3 process worked. I don't have any other
4 questions. Thank you.

5 **MS. ROBERTSON:** Your Honor, can we take a few
6 minutes, please?

7 **THE COURT:** Sure.

8 **MS. ROBERTSON:** Thank you.

9 **THE COURT:** Actually, you don't want to take a lunch
10 break, do you? I mean, because we just -- do
11 you need that much time or do you want to end
12 this at 12:00. I just don't know.

13 **MS. ROBERTSON:** Just a few minutes if you don't
14 mind. Fifteen is good, thank you.

15 (Off the Record)

16 **THE COURT:** All right. We're back on record. Ms.
17 Robertson.

18 **MS. ROBERTSON:** Yes, Your Honor. Do you want us to
19 try to answer your question first or --

20 **THE COURT:** Maybe that would be best if you just
21 went ahead.

22 **MR. ROBERTSON:** And Mr. Stewart can maybe explain it
23 himself. Well, I'll let him do that first and
24 then I will tell you what we found back here,
25 too.

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RECORD 001503

1 THE COURT: Mr. Westbrook?

2 MR. WESTBROOK: Just a moment, Your Honor. I do
3 have one or two.

4 MR. STEWART - RE-CROSS EXAMINATION BY MR. WESTBROOK:

5 MR. WESTBROOK: All right. Let me ask Dan. If you
6 would pull up CHS-Exhibit 2, please. And Bates
7 Page 57, please.

8 Q: Mr. Stewart, we are pulling up the CHS-64 of
9 that application. This is the 2010
10 application. And it's pulling up 57. This is
11 -- we can go back to the first if you need to.
12 I don't know if you are familiar with this form
13 or not. This is the DHEC form, the application
14 form, Part C of it, programmatic documents.
15 Have you seen this before? Are you familiar
16 with this? Have you reviewed your application?

17 Q: Yeah.

18 MS. ROBERTSON: Your Honor, if I could just for the
19 moment, Mr. Westbrook. I think you referred to
20 this as the 2010 application?

21 MR. WESTBROOK: Yes.

22 MS. ROBERTSON: I believe we're looking at the 2005?

23 MR. WESTBROOK: Oh, okay. I'm sorry. I apologize.

24 MS. ROBERTSON: Clarify that if you could.

25 Q: All right -- it is from the 2005 application.

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1 So I'm really looking at the form -- the
2 questions though rather than the answers. I
3 want you to look at something. This is Part C
4 programmatic documents.

5 **MR. WESTBROOK:** And let's scroll down the page.
6 Scroll down the page, Dan. This is question
7 number one, question C from DHEC.

8 **Q:** It says, "An existing facilities or agencies
9 provide the amounts and dollars in percent of
10 gross revenues that the facility or agency
11 provided in indigent care during the past three
12 fiscal years." Now, that's -- in response to
13 that question in 2005 you gave a number --
14 looks like here 3.4 percent of gross revenue.
15 You may have changed that at some point. But
16 in response to that question in 2010, that's
17 where you gave the 6.3 percent of gross
18 revenue; isn't that correct?

19 **A:** Well, I think in this question it says, if I'm
20 reading the question right, it says, "Existing
21 facilities or agencies provide the amount in
22 dollars and percent of gross revenue that the
23 facility or agency provided in indigent care
24 during the past three fiscal years." So I
25 think the 6.3 percent reflects our projection

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1 of charity care. So I'd have to see what in
2 the 2010 is in here from a historical
3 perspective.

4 Q: All right. Well, that's a good point. And in
5 this question, though, in this -- what's part
6 of this 2005 programmatic document or
7 programmatic section from the application,
8 there -- it says, NOTE in all caps. "Indigent
9 care does not include bad debt, contractual
10 adjustments or care which is reimbursed by our
11 governmental program, Medicare, Medicaid,
12 accounting, indigent program, church or
13 philanthropic -- can't say it, philanthropic
14 organization, correct?

15 A: Correct.

16 Q: Now, let me ask you this. Ms. Robertson got
17 you to read some language from the state health
18 plan and asked you a question about it. I'm
19 asking you to look at this right here, to the
20 extent that this is relevant. Does the -- do
21 the categories that we saw on your
22 Demonstrative 2.11, I believe it was, the
23 categories on there, do they -- and that
24 resulted in a charity care total that you
25 relied on to come up with that 6.3 percent,

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1 does that conform with that definition of
2 indigent care?

3 A: I believe so. I think that sentence is the
4 same. I'm not sure what's different between
5 that and the one that was just put up by Ms.
6 Robertson.

7 Q: Well, on this one it says, "Indigent care does
8 not include bad debt." Now, on your
9 Demonstrative 2.11, I know there was some bad
10 debt categories that were reclassified. And
11 again, that's the word that you objected to,
12 but I don't have a substitute word at the
13 moment, that were portions of those categories
14 were put into the charity care bucket. They
15 went from bad debt to charity care. But
16 originally they were characterized on that
17 demonstrative, that PeopleSoft demonstrative as
18 bad debt. And it says here indigent care does
19 not include bad debt. Can you reconcile that
20 for me?

21 A: I think I have in my testimony. You know, that
22 bucket represents not bad debt but
23 uncompensated care.

24 Q: Is that -- I'm sorry, go ahead.

25 A: And then the uncompensated care includes both

- 1 bad debt and charity care.
- 2 Q: Okay. Just a moment, Mr. Stewart.
- 3 A: Sure.
- 4 Q: Do you ever write off co-payments for private
- 5 insurance?
- 6 A: Write off co-payments in terms of like -- so if
- 7 you are talking about for managed care?
- 8 Q: Yeah, or for any private insurer?
- 9 A: I'm sure we do.
- 10 Q: Okay. And if they are written off, are they
- 11 ever classified as charity care, those
- 12 writeoffs?
- 13 A: I don't believe that would be classified as
- 14 charity care.
- 15 Q: Okay. Do you know or are you just assuming?
- 16 A: I don't know for sure, but I'm pretty sure that
- 17 that's right.
- 18 Q: What about -- Medicare has co-pays, as well,
- 19 don't they?
- 20 A: They do.
- 21 Q: Are those --
- 22 A: And they can depending on what type of co-
- 23 insurance you may or may not have.
- 24 Q: Are Medicare co-pays ever written off?
- 25 A: I'm sure they are.

1 Q: And Medicaid co-pays are written off, I'm sure
2 as well, is that correct?

3 A: I'm sure they are.

4 Q: Are those -- if they are written off, those co-
5 pays for Medicare and Medicaid, does CHS ever
6 classify those as charity care?

7 A: I don't believe so.

8 Q: What about contractual adjustments -- are those
9 -- well, I think we've already talked about
10 contractual adjustments. What about
11 deductibles? Are deductibles ever written off?

12 A: I guess -- I'm a little -- not sure what you
13 mean. I think we talked about co-pays and
14 deductibles.

15 Q: Well, there is a distinction between co-pays
16 and deductibles; is it not? Or is it --

17 A: I mean, I would sort of use those -- I mean,
18 either way that's what the portion of the
19 payment that the patient is responsible for.

20 Q: Okay. So your answers to my questions about
21 co-payments, you were thinking of them as
22 including documents.

23 A: If it had included documents.

24 Q: I don't have any other questions. Thank you.

25 **THE COURT:** Ms. Robertson?

1 probably in 2008. And we used to look at those
2 numbers. But I don't remember percentages
3 until we started getting that type of
4 information, which really didn't happen until
5 sometime in 2009.

6 Q: Well, not so much with regards to percentages
7 but how about volume?

8 A: We're seeing about the same number of Medicaid
9 patients we've always seen; if not more.

10 Q: Now, does -- to your knowledge, does CHS or CPN
11 have a policy regarding the acceptance of
12 Medicaid patients?

13 A: No.

14 Q: And is that determined on a practice basis?

15 A: It is.

16 Q: Now, have you ever declined seeing patients
17 because they were covered by Medicaid?

18 A: No.

19 Q: And I think you testified earlier that's one of
20 the reasons you started your own practice.

21 A: Yeah. I would just as soon not to look at what
22 type of insurance they have.

23 Q: Now, can you tell us, based on your experience,
24 how the payer mix of a physician practice
25 relates to the payer mix of a hospital?

1 A: Because I believe that the level of care
2 delivered and the emphasis on high care, high
3 service and lowered costs that Carolinas
4 Healthcare System now is emphasizing, I think
5 they are going to be able to do a better job of
6 delivering the type of care, keeping care
7 within the county and raising the level of
8 health for the whole community.

9 Q: Thank you very much, Dr. Alexander. That's all
10 I have. Please answer any questions that they
11 other counsel may have.

12 A: Thank you.

13 **DR. ALEXANDER - CROSS EXAMINATION BY MR. ANDREWS:**

14 Q: Good morning, Dr. Alexander.

15 A: Good morning, Stuart.

16 Q: The Court may not know that one of the silver
17 linings in this case is that you and I were
18 brought together again after over 40 years?

19 A: That's true.

20 **MR. ANDREWS:** We were in college together, Your
21 Honor.

22 Q: It's good to see you, Dr. Alexander.

23 A: Thank you. Same here.

24 Q: Now Dr. Alexander, you are here this morning in
25 your role as an employee of the Carolinas

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1 Physician Network; aren't you?

2 **MR. GASKINS:** Objection. That's a
3 mischaracterization of his testimony.

4 **MR. ANDREWS:** It wasn't intending to be a
5 characterization of his testimony, it's just a
6 question.

7 **THE COURT:** I'm going to allow him to answer the
8 question.

9 A: I'm here as a representative supporting
10 Carolinas Healthcare System. But I also happen
11 to be an employee of Carolinas Physicians
12 Network.

13 Q: And as I understand your position, you are
14 about one day a week as a clinician?

15 A: Two days a week.

16 Q: Two days a week, is that right?

17 A: That's correct.

18 Q: The balance of your time as a manager
19 responsible for oversight of the pediatric
20 clinics within Carolinas Physician Network, is
21 that right?

22 A: That has started as of March 1st. Prior to
23 that, I was three days a week -- three and a
24 half days a week in the office.

25 Q: Okay. All right. And in your position when

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1 you were with the -- you were in totally
2 different offices at Piedmont. You were the
3 chief of staff, and you were also head of
4 different committees that were responsible for
5 the oversight of services; weren't you?

6 A: I was at times, yes.

7 Q: Okay. And you believed that the hospital had
8 systems in place to monitor the quality of
9 care; didn't you?

10 A: There were some systems in place to try to
11 monitor quality.

12 Q: Right. And you believed that while you were
13 there in those positions, that the
14 administration was committed to pursuing any
15 issues related to the quality of care as it
16 related to the performance of departments and
17 also individual physicians; didn't you?

18 A: I believe there were people who were interested
19 I delivering high quality care.

20 Q: And you also felt the hospital was committed to
21 improving the quality of care; didn't you?

22 A: I think there were people who were committed to
23 it.

24 Q: Okay. Now, one of the additional reasons that
25 when your practice moved to Carolinas was so

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1 that you could get better access to insurance
2 contracts; wasn't that true?

3 A: That was the result of our move. We didn't
4 know that. But that was the result of our
5 move, that we had more opportunities to
6 contract with different insurance companies.

7 Q: And as a result of that, you ended up having
8 greater access to patients who had private
9 insurance; didn't you?

10 A: We had greater access to patients all over; I
11 would say.

12 Q: Including those who were insured?

13 A: Sure.

14 Q: Right. And as a result of the negotiating
15 strength of Carolinas, you were able to get
16 better rates with those insurance companies
17 too; isn't that true?

18 A: That is correct.

19 Q: Okay. Now, are you familiar with the recent
20 insurance product that Carolinas has invested
21 in called Coventry Hill?

22 A: I do not know anything about that.

23 Q: Not aware of that? Okay. Now, with regard to
24 your Medicaid participation, the degree of the
25 participation that you just talked about at

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1 your Rock Hill office isn't common among all of
2 the clinics -- all the pediatric clinics that
3 you oversee; is it?

4 A: It is actually average.

5 Q: It's average.

6 A: Half of the practices I manage, receive more
7 than 20 percent Medicaid.

8 Q: Right. And half receive -- or at least six of
9 them receive less than ten percent Medicaid;
10 don't they?

11 A: Five.

12 Q: Five to ten percent?

13 A: Five practices receive less than ten percent
14 Medicaid.

15 Q: Okay. Since your deposition, you've gone back
16 and counted to be sure?

17 A: Well, I've gone back and looked at all those
18 figures so that I would be able to answer
19 truthfully today.

20 Q: Good. And at the time of your deposition, you
21 thought it was six, but it's actually five?

22 A: That's right. I did. You're exactly right.
23 I agree with that.

24 Q: Now, and in fact, the -- you had testified
25 earlier and --

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1 **MR. ANDREWS:** Dan, let's just give you as a
2 reference point. Dr. Alexander, let's pull up
3 Carolinas' trial Exhibit 27. That your
4 practice was 50 percent private insurance, 45
5 percent Medicaid. Did I remember that
6 correctly?

7 **A:** Correct.

8 **Q:** In fact, that's the Rock Hill practice. The
9 Fort Mill practice is different than that;
10 isn't it?

11 **A:** It is.

12 **Q:** And that's about 70 percent private insurance
13 and about 26 percent Medicaid; isn't that
14 right?

15 **A:** Between 65 and 70 private and between 25 and 30
16 Medicaid.

17 **Q:** I don't know if you are familiar with this
18 document that is on the screen there in front
19 of you, but this was provided by counsel for
20 Carolinas. And it is identifying the payer mix
21 by practice for the various York County base
22 practices. It's trial Exhibit 27. And this is
23 a 2012 payer mix. And you can see there that
24 if you looked at Rock Hill Associates, Fort
25 Mill, you've got about almost 14 percent

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1 commercial and about 57 percent managed care.
2 It would be about 71 percent. And then
3 Medicaid is closer to 26.5; do you see that?

4 A: I do.

5 Q: Okay. And the third practice in York County is
6 called Palmetto Pediatrics, correct?

7 A: That's correct.

8 Q: You'll see that just a couple of lines above
9 the Rock Hill Pediatric Associates. You can
10 see that this 89 percent of private insurance
11 based patients and just 6.7 percent Medicaid;
12 right?

13 A: That's correct.

14 Q: Now, isn't it true that the high participation
15 of Medicaid in the Rock Hill office is really
16 a reflection of your own personal values and
17 commitments that you testified about at the
18 outset?

19 A: It is.

20 Q: And it's great that you're doing that, not that
21 you need my compliment for it. But it's a good
22 thing. And as your testimony reflected, the
23 decision about the extent to which CPN
24 practices participate in Medicaid or accept
25 indigent patients is a practice by practice

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1 decision; isn't it?

2 A: That's correct.

3 Q: And there's no policy, no directive from
4 Carolinas to encourage physicians to take more
5 or less Medicaid or indigent care; isn't that
6 true?

7 A: That's correct.

8 Q: And isn't it true that there are some
9 compensation models that could create a
10 disincentive for some physicians in the CPN
11 network to accept Medicaid or particularly
12 indigent patients?

13 A: All compensation models, if that's what you
14 base your decision on, would make you not take
15 Medicaid.

16 Q: Now, if we look at -- let's --

17 **MR. ANDREWS:** Dan, hit the Medicaid participation
18 column among the CPN practices.

19 Q: Other than the pediatric practices, there are
20 only two that are in double digits and the rest
21 are all single digits and many are less than a
22 percent or two; isn't that right?

23 A: Yes.

24 Q: And would it be your inference based on your
25 experience as a manager of physician practices

1 that the financial disincentive to individual
2 practitioners could affect what's reported in
3 that column about low percentage of Medicaid
4 participation?

5 A: That's conjecture. I don't know what the
6 reasons for which they make those decisions.

7 Q: So you don't have any basis for knowing that,
8 one way or the other?

9 A: I do not.

10 Q: Now, before you joined Carolinas, your referral
11 pattern to hospitals was broken down about
12 50/50 between Piedmont and CMC main; wasn't it?

13 A: I can't remember the exact numbers. But prior
14 to our joining Carolinas Healthcare System, we
15 took care of patients in the hospital. And so
16 it would be those patients who had a higher
17 level of acuity problems or those patients who
18 had a personal choice of not being taken care
19 of at Piedmont who we would send to Carolinas
20 Healthcare System.

21 Q: Okay. And since joining Carolinas, virtually
22 all of your hospital referrals go to Levine
23 Children's Hospital; isn't that right?

24 A: That's correct.

25 Q: And Levine's was opened about the time you

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1 joined Carolinas; is that about right?

2 A: I can't remember when they were opened. They
3 opened in the fall, and it was after we joined
4 Carolinas Healthcare System. I just don't
5 remember the date that Levine's actually
6 opened.

7 Q: But now you have the opportunity to have a
8 children's speciality hospital available to
9 your patients when they are so serious that
10 they need hospitalization, right?

11 A: That's correct.

12 Q: Okay. All right.

13 **MR. ANDREWS:** Now, Dan, if you will call up SCHS
14 0555 for us, please?

15 Q: Dr. Alexander, we're pulling out here a
16 document that has been produced by Carolinas.
17 And I apologize it's hard to see; but it's an
18 overview -- a summary of services. And the
19 darkened line identifies various Carolinas
20 Hospitals. And all of these are Carolinas
21 Hospitals. And the breakdown among other
22 things in the bottom part of that are different
23 services. And if you look at the service
24 product lines, you will see about the -- it is
25 the fourth one down, a pediatric line. Do you

1 see that?

2 A: Sure.

3 Q: It's been highlighted right there. And if you
4 look at that, if you can see it. With my old
5 eyes it's hard to see it.

6 **MR. ANDREWS:** And maybe, Dan, can you call it out?

7 Q: But you will see the pediatric's line and the
8 percentage of inpatient discharges among these
9 services; and particularly pediatrics. And if
10 you will see there, it is 12.47 percent at CMC.
11 Is that consistent with what you would expect
12 it to be?

13 A: I have no knowledge of what it's supposed to
14 be.

15 Q: Okay. Now, if you look further down the other
16 hospitals in the Carolinas System in the
17 Charlotte area, you will see after CMC Union a
18 percentage of 1.8 percent for Cleveland, .2
19 percent for Mercy, .2 percent for Pineville, .4
20 percent for University and .4 percent for Kings
21 Mountain; do you see that?

22 A: I do see that.

23 Q: And Pineville is the closest Carolinas facility
24 to York County and particularly your Fort Mill
25 and Rock Hill offices; isn't it?

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1 A: It is.

2 Q: But you don't admit pediatric patients there;
3 do you?

4 A: They do not have a pediatrics floor or a place
5 to admit pediatric patients.

6 Q: And that's what you prefer and your patients
7 prefer so that you get that degree of
8 specialized care; isn't that right?

9 A: I do send them to Levine's because of that,
10 yes.

11 Q: All right. Now, let's go to -- actually let's
12 talk about and take a look at the contract
13 terms that you mentioned.

14 **MR. ANDREWS:** Dan, if you pull up Exhibit -- it
15 would be Piedmont's Exhibit 25, the first page
16 of that.

17 Q: Dr. Alexander, do you recognize this as the
18 term that you discussed with Mr. Gaskins that
19 would be in your employment agreement?

20 A: I agree, yes.

21 Q: Okay. And according to this that for
22 consideration provided, that the physician
23 agrees to refer all patients in need of
24 hospitalization, diagnoses or treatments either
25 on an inpatient or outpatient basis to

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1 providers in the Carolina network; isn't that
2 right?

3 A: That's what it says.

4 Q: And you try to comply with this; don't you?

5 A: Within the constraints that are within that
6 statement.

7 Q: It provides you some flexibility?

8 A: Yes, it does.

9 Q: All right. And the flexibility would be if
10 there is patient preference?

11 A: That's correct.

12 Q: Then you can chose to honor that. And I
13 understand it's your practice to do that,
14 right?

15 A: It is.

16 Q: Okay. In the absence of preference by patients
17 or insurance directed course that you would
18 take or where you didn't think it was in the
19 patient's best interest, then you otherwise are
20 -- this agreement, you would agree and you
21 would otherwise comply with terms of this
22 agreement, correct?

23 A: Yes, I would comply with that. If it were a
24 consultant, then it would have to be somebody
25 that I trusted to take care of my patients.

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1 Q: Sure. You'd have to have confidence in their
2 medical capabilities.

3 A: Right. You do.

4 Q: And you'd never make a referral in the absence
5 of that; would you?

6 A: No, I don't.

7 Q: All right. And specifically, though, the
8 general requirement in the absence of an
9 exception is for you to refer to Carolinas' own
10 facilities, correct?

11 A: Yes.

12 Q: All right. And secondly to Carolinas' employed
13 physicians, that is those physicians who are
14 within the Carolina Physician Network, correct?

15 A: That's correct.

16 Q: And in the alternative, if you want to refer to
17 a specialist, for example, a pediatric
18 specialist who may not be within the CPN
19 network, you can chose to do that. And
20 typically the condition, is it not, is that
21 they be CHS friendly?

22 A: You are encouraged to use CHS friendly, but
23 that's no requirement.

24 Q: All right. And CHS friendly means that those
25 physicians who receive the referrals agree to

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1 perform services for those patients in
2 Carolinas' own facilities; isn't that right?

3 A: I think CHS friendly physicians are those
4 physicians who do a portion of their work
5 within the Carolinas Healthcare System. They
6 are not required to send my referral to the
7 hospital or to the lab or to x-ray just because
8 they're coming from my practice, no.

9 Q: Okay. But they are encouraged to do the
10 services performed as a condition over time for
11 receiving them by doing their services --
12 performing their procedures in Carolinas'
13 facilities; isn't that generally the
14 expectation?

15 A: They are -- they are not required to do that.
16 They just happen to do things in the Carolinas
17 Healthcare System. And so Carolinas Healthcare
18 calls them CHS friendly. But they -- they may
19 be required to do some but certainly not all.

20 Q: And they don't have to do all their procedures?

21 A: And just because I send a patient to them does
22 not mean they are going to use the lab, x-ray
23 or the hospital for whatever that patient
24 needs.

25 Q: Okay. Over the time since you have become an

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1 administrator, since 2009, have your referrals
2 within the Carolinas network increased for your
3 practices?

4 A: No.

5 **MR. ANDREWS:** Let's take a look at Demonstrative
6 141-1, please, Dan.

7 Q: Now, Dr. Alexander, this was information that
8 was pulled from material provided by Carolinas
9 through the scope of discovery. And let's take
10 a look at the Rock Hill Pediatric Associates
11 line and the Rock Hill Fort Mill line. You
12 will notice particularly for Rock Hill
13 Pediatric Associates, that's your practice;
14 isn't it?

15 A: It is.

16 Q: That the total referrals captured by the report
17 that was provided show almost a tripling of or
18 greater than a doubling, at least, of the
19 number of referrals; do you see that?

20 A: I do.

21 Q: Were you not aware of that?

22 A: I was not aware that it was of that magnitude.

23 Q: Okay. And if you look at the Fort Mill
24 pediatrics, you see the increase in that, as
25 well?

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1 A: Yes.

2 Q: And let's take a look at the Palmetto
3 Pediatric's increase in referrals. From 2009
4 to 2012, that's increased from 55 to 122. So
5 that's more than doubled, as well; hasn't it?

6 A: Yes.

7 Q: Okay. Now, let me change subjects for you, Dr.
8 Alexander. I believe you testified in response
9 to a question that I asked you during your
10 deposition about the process of letters of
11 support being provided for Carolinas. And you,
12 yourself, submitted a letter of support for
13 Carolinas', didn't you, during the DHEC review?

14 A: Our practice did.

15 Q: And you were one of several physicians who
16 signed that letter?

17 A: I was.

18 Q: Okay. Now, you're not aware that Carolinas
19 representatives were present in any reception
20 area or waiting room of any practices to get a
21 letter from patients or patient's families?

22 A: I was not aware or am not aware of that.

23 Q: And if they were doing that, you don't think it
24 would be right; do you?

25 A: I would not want them doing that in my office.

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1 Q: And in fact, you believed and testified in your
2 deposition that would be unethical; didn't you?

3 A: I didn't think -- yes, I agree with that.

4 Q: Okay. Now Dr. Alexander, you said a moment ago
5 you didn't admit patients into Pineville
6 because they don't have the dedicated
7 pediatrics unit, is that right? Did I
8 understand you correctly?

9 A: That's one of the reasons.

10 Q: Okay. Is that the biggest reason?

11 A: It's the biggest reason, yes.

12 Q: Biggest reason, okay. And you had the benefit
13 of Levine, which is a hospital full of staff
14 trained in and dedicated to caring for
15 children; isn't that right?

16 A: That's correct.

17 Q: And I suspect that's a factor, too?

18 A: It is.

19 Q: Now, if Carolinas proposed facility in Fort
20 Mill is built, you're not aware that they will
21 have a unit dedicated to children; are you?

22 A: I'm not aware of that.

23 Q: And with a 64-bed hospital, that wouldn't be
24 realistic in your experience; would it?

25 A: I don't know what their decision making would

1 be on that.

2 Q: But if they didn't have a unit dedicated to
3 children, your practice generally would be
4 continuing to admit children, your patients
5 into Levine; wouldn't it?

6 A: That's correct.

7 Q: Now, if CMC Fort Mill is built, don't you
8 believe that patients of Piedmont would be
9 shifted from Piedmont to Carolinas Fort Mill
10 and to the Charlotte area hospitals, as well?

11 A: That would totally depend on the patient. I
12 really can't say that for sure.

13 Q: Okay. Let me actually take you to your
14 deposition and read our discussion related to
15 that.

16 **MR. ANDREWS:** Your Honor, may I approach.

17 **THE COURT:** Yes.

18 Q: Dr. Alexander, if you would open that up for
19 me, please.

20 A: Sure.

21 Q: And turn to Page 9.

22 **MR. ANDREWS:** Dan, if you would pull up Page 9 for
23 us; end of Page 9 going on to Page 10.

24 Q: Dr. Alexander, starting on Page 9, Line 24, at
25 the end of that page carrying over to Page 10,

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1 I'm going to read the question. And if you
2 would read your answer to me, I'd appreciate
3 it, okay? All right.

4 "Question: With regard to the concerns
5 expressed by Piedmont Physician witnesses
6 related to the shifting of patients from
7 Piedmont to either CMC-Fort Mill or to other
8 CMC facilities in North Carolina, do you have
9 an opinion about that?" Answer?

10 A: "My opinion would be that that would be an
11 assumed or expected result of people
12 encountering the Carolinas Healthcare
13 physicians."

14 Q: Okay. Now, you also believe that York County
15 patients going to the CMC facilities would
16 increase over where they have been in the past
17 if Carolinas is approved to build the hospital
18 in Fort Mill; don't you?

19 A: I do believe they would.

20 Q: Okay. And you also think, don't you, that CMC-
21 Fort Mill as a hospital in the presence of York
22 County would make it easier for Carolinas to
23 increase their market share in York County;
24 wasn't that your opinion that you gave me
25 during your deposition?

1 A: I don't remember what I said in the deposition
2 about that. My opinion would be that people
3 would choose that because they are already
4 choosing that.

5 Q: And that, in fact, the creation of the Fort
6 Mill Hospital would accelerate that and make it
7 easier for them to increase that market share
8 in York County; wouldn't it?

9 A: It would make it easier for people to go to a
10 CMC Hospital facility if that were present in
11 York County.

12 Q: And that would result in gaining more market
13 share than they have today; wasn't that your
14 opinion?

15 A: I don't know. It may or may not. In thinking
16 about this, I can't say that for sure.

17 Q: At the time of your deposition, you told me
18 that; didn't you?

19 A: I did.

20 Q: Okay. All right. Thank you.

21 **MR. ANDREWS:** No further questions.

22 **THE COURT:** Nothing further?

23 **MR. ANDREWS:** Nothing further, Your Honor.

24 **THE COURT:** Thank you, Mr. Andrews. Mr. Gaskins.

25 **DR. ALEXANDER - RE-DIRECT EXAMINATION BY MR. GASKINS:**

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1 have a relationship with, that you have been
2 able to observe their quality of care and their
3 expertise in their arena. And I always liken
4 it to who I would go to myself or who I would
5 refer my family members to. And since 2007,
6 the physicians that I work with are on staff
7 CMC-Pineville. And that's the only hospital
8 that we deliver. So if a patient does not have
9 a preference, then I use a physician that I
10 have a great deal of respect for at CMC-
11 Pineville when the need arises.

12 Q: Let's talk about payer mix. Are you familiar
13 with that term?

14 A: I am.

15 Q: Okay. And what does it mean?

16 A: It is a breakdown of the various methods of
17 payment that patients have to compensate
18 practice for the services they receive.

19 Q: And what are the categories within the payer
20 mix?

21 A: It would be various private insurance plans.
22 There is Medicare plans, there is Medicaid
23 plans, and there's self-pay.

24 Q: Does Piedmont GYN accept Medicaid patients?

25 A: We do.

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- 1 Q: Okay. To your knowledge, does CHS or CPN have
2 a policy regarding the acceptance of Medicaid
3 patients?
- 4 A: It does not.
- 5 Q: And that's made on a practice-by-practice basis,
6 correct?
- 7 A: Correct.
- 8 Q: Now, Dr. Revell, have you ever dropped a
9 patient because they have become uninsured or
10 become covered by Medicaid?
- 11 A: I have not.
- 12 Q: Dr. Revell, let's talk a little bit about out-
13 migration. Are you familiar with that term?
- 14 A: I am.
- 15 Q: Okay. What do you understand it to mean?
- 16 A: Patients who live in one area and choose their
17 healthcare in a different area, different
18 locality.
- 19 Q: Now, based on you practicing in York County and
20 in North Carolina, have you observed any out-
21 migration occur in York County?
- 22 A: All of our patients go to CMC-Pineville.
- 23 Q: Okay. Well, just generally based on your
24 observations within the medical community, have
25 you observed any other trends regarding out-

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1 receive excellent care.

2 Q: All right. Thank you, Dr. Revell. Please
3 answer any questions that the other counsel may
4 have?

5 **THE COURT:** Thank you, Mr. Gaskins. Mr. Andrews?

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

7 **MR. REVELL - CROSS EXAMINATION BY MR. ANDREWS:**

8 Q: Good afternoon, Dr. Revell.

9 A: Good afternoon.

10 Q: Dr. Revell, you recall when Piedmont undertook
11 the plans to establish its Women's Tower in
12 2002-2003; do you not?

13 A: I do.

14 Q: And Mr. Miller, as CEO, established a committee
15 consisting of members of the medical staff who
16 were OB-GYNs like yourself and nursing leaders
17 to help provide guidance to administration about
18 that. What shape the Women's Tower should
19 take, what designs it needs that the physicians
20 would have. Did you participate in that
21 committee?

22 A: I do not think I was on that committee, no.

23 Q: So you are not aware of the extent, then, with
24 regard to the development of the Women's tower
25 that the hospital administration may have

1 consulted your peers in the development of that
2 service?

3 A: I'm not.

4 Q: But you were aware that such an effort was
5 being undertaken; weren't you?

6 A: I was.

7 Q: Okay. Good. Now, when the Women's Tower
8 opened up, actually many of your patients began
9 using it; didn't they?

10 A: They did.

11 Q: Okay. And then actually you felt it increased
12 Piedmont's market share in OB-GYN services?

13 A: What year was that?

14 Q: 2004.

15 A: 2004, yes.

16 Q: Is that consistent with your memory?

17 A: (Indicates yes)

18 Q: Okay. And it was your impression, wasn't it,
19 that a new facility drew a lot of attention
20 back then, and that facility in particular,
21 right?

22 A: Sure. New facilities always draw a lot of
23 attention.

24 Q: And you testified to that degree just as you
25 said now that a new facility, patients want to

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1 try it out, and it draws attention; isn't that
2 right?

3 A: And as far as -- it really depends on what the
4 facility offers.

5 Q: If the facility offers an institutional
6 healthcare service hasn't it been your
7 testimony, like you just said that patients want
8 to try out the facility and want to satisfy
9 themselves to whether it provides adequate
10 services?

11 A: Right.

12 Q: All right. With regard to referrals, you have
13 said both here today and in your deposition
14 that whenever you get a referral from an
15 existing practice that you try to always send
16 that patient back to the practice. You honor
17 those existing relationships, correct?

18 A: I do.

19 Q: All right. Now, if you get a new patient, you
20 send those -- you keep them in network, don't
21 you and refer them to CPN physicians?

22 A: Well, it really depends on whether the patient
23 requests a physician who is not within CPN.

24 Q: And in the absence of that request, your
25 default would be to keep them within the

1 network; wouldn't it?

2 A: It would be to refer to physicians that I have

3 a relationship with.

4 Q: And those would be principally physicians in the

5 network, correct?

6 A: Correct.

7 Q: Let me actually -- are you aware that Carolinas

8 Physician Networks tracks your referrals and the

9 referrals in your practice?

10 A: I am.

11 Q: All right.

12 **MR. ANDREWS:** Dan, let's pull up Demonstrative 141.

13 Q: Are you aware of the extent to which those

14 referrals have increased over the last several

15 years?

16 A: I am.

17 Q: It's over doubled the number; haven't they?

18 It's the line right there.

19 A: Still a very small number.

20 Q: It is a small number. And it's actually among

21 the smaller among the York County referrals from

22 the CPN practices, correct?

23 A: It is.

24 Q: And largely the OB-GYN practice is relatively

25 self-sufficient in terms of the needs for

1 referrals; would that be fair to say?

2 A: It would be.

3 Q: Now, when we talk about the Piedmont GYN-OB
4 Practice, when you said at the onset you were
5 employed by the practice and you're affiliated
6 with Carolina Physician Network, let's make sure
7 the record is clear on this. Who owns your
8 medical office building?

9 A: A real estate development company.

10 Q: And who pays the rent to that real estate
11 development company?

12 A: The practice.

13 Q: Who actually cuts the check?

14 A: Well, which office are you referring to? The
15 one in Rock Hill?

16 Q: The Rock Hill Office, your Rock Hill.

17 A: In Rock Hill there is a partnership that
18 actually -- a physician partnership that writes
19 the check to the real estate company.

20 Q: Are you an owner of that physician practice --
21 that partnership?

22 A: I am.

23 Q: Okay. All right. And who employs your 60-plus
24 staff members?

25 A: Piedmont GYN-OB works for Carolina Physician

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1 Network which works for Carolinas Healthcare
2 System. Do you want to know who writes my
3 paycheck?

4 Q: Who writes your paycheck?

5 A: Mike Tallwater signs it.

6 Q: And who is Mike Tallwater?

7 A: He is the CEO of Carolinas Healthcare System.

8 Q: And ultimately you are an employee, and all of
9 your staff is an employee of Carolinas
10 Healthcare System, is that correct?

11 A: Correct, right.

12 Q: Okay. All right. Now with regard to these
13 referrals --

14 **MR. ANDREWS:** Actually, Dan, let's turn to Carolinas
15 Exhibit 28, please.

16 Q: And have you seen a document like this before,
17 Dr. Revell, that tracks the extent to which the
18 referrals you make for your patients are
19 captured within the Carolinas Network?

20 A: I have.

21 Q: And you get a monthly report that provides you
22 that information?

23 A: I don't know if it's monthly or quarterly, but
24 yes, I have seen the report.

25 Q: But the report comes out periodically, and it's

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1 made available to you in your position as
2 medical directory, is that correct?

3 A: It is.

4 Q: Sorry, you need to provide an overall answer.

5 A: It is, yes.

6 Q: Thank you. Okay. And here we are seeing that
7 there are -- tell me why there is a blank for
8 ancillary? Are your patients not referred out
9 for any ancillary services? Were they all done
10 in house or what?

11 A: I don't know what that means.

12 Q: Do you order out ancillary services from time
13 to time?

14 A: Give me an example.

15 Q: A lab.

16 A: No, we use Carolinas Physicians Lab within our
17 office in Rock Hill.

18 Q: Okay. All right.

19 A: Wait -- can I clarify?

20 Q: Sure, please.

21 A: Patients who are on Blue Choice or have
22 insurance that cannot use Carolinas Physicians
23 Network, we send them out. So I don't know why
24 that wouldn't show up. But they go to the lab
25 where their insurance will cover services.

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1 Q: Okay. Now, with regard to the referrals for
2 diagnostic testing, 86 percent of those are
3 captured within the Carolinas Network; do you
4 see that?

5 A: I do.

6 Q: And is there a local imaging company or are
7 they sent to Charlotte?

8 A: There is a local imaging company.

9 Q: And is that owned and operated by Carolinas
10 Healthcare System?

11 A: It is not.

12 Q: And who owns it?

13 A: Charlotte Radiology.

14 Q: Okay.

15 A: At this time they're independent.

16 Q: Can you explain then why 86 percent would be
17 showing as being within the services that are
18 coordinated and captured within the network?

19 **MR. GASKINS:** Your Honor, I'm going to object
20 because there's been no foundation laid as to
21 what ancillary means, what diagnostic means,
22 what medical. It is somewhat confusing. And I
23 think we need to lay some foundation about the
24 witnesses' familiarity with this document and
25 the familiarity with what these different terms

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1 mean before we guess or answer questions about
2 them.

3 **MR. ANDREWS:** I'll be happy to ask some additional
4 questions if the Court will find that useful.

5 **THE COURT:** Go ahead, sir.

6 Q: Sure. Dr. Revell, I assume you know what
7 diagnostic services you send your patients out
8 for and your partners do, as well, in general
9 terms. Do you?

10 A: I do. Mammography being the most common in our
11 practice.

12 Q: Okay. And do you -- since you look at these
13 reports since you stated periodically, quarterly
14 or monthly or how often they are presented to
15 you, for what purpose are they provided to you;
16 do you know?

17 A: I really don't. In fact, I've never had a
18 discussion about this paper with anyone.

19 Q: Well, it's high time; isn't it? How long have
20 you been receiving it?

21 A: I can't answer that, either.

22 Q: You know you've been getting them, but you are
23 not sure how long?

24 A: It's not an issue which has been pointed out to
25 me as something I need to address as the

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1 medical director.

2 Q: Okay. And what would you -- based on your
3 experience as the medical director in your
4 office, what would you expect that referrals
5 from medical services to relate to?

6 A: I would say primarily in our office it will be
7 gastroenterology with screening for colonoscopy
8 would be the most likely.

9 Q: Okay. And the surgical services, for what
10 purposes do you refer out your patients for
11 surgical care?

12 A: The most common thing we see is gallbladder
13 disease in women.

14 Q: Now, the -- is there a principal surgery
15 practice to whom you refer your surgeries, you
16 and members of your practice?

17 A: There is a surgical practice that uses CMC-
18 Pineville --

19 Q: And a --

20 A: -- that we have.

21 Q: What's the name of that practice?

22 A: Carolina Surgical Associates, I think. I just
23 know the doctor's name.

24 Q: And they perform their procedures at CMC-
25 Pineville?

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- 1 A: They do.
- 2 Q: And are they located in Rock Hill or in
3 Pineville?
- 4 A: They are located in Pineville.
- 5 Q: Okay. And so your patients served in Rock Hill
6 go to Pineville and are treated at that
7 facility by those physicians?
- 8 A: If they don't have a surgeon at Rock Hill.
- 9 Q: Right, as you testified about earlier, okay.
- 10 A: Right.
- 11 Q: All right. Now, are you familiar with the term
12 CHS friendly physicians?
- 13 A: I am.
- 14 Q: And what does that mean to you?
- 15 A: Physicians that are not in a contractual
16 relationship with Carolinas Healthcare System
17 but who use Carolinas Healthcare System's
18 hospitals or services.
- 19 Q: And they perform their procedures there. For
20 example, in the case of surgeons?
- 21 A: Right.
- 22 Q: And there is a preference, is there not, for
23 members who are employed by Carolinas in the
24 absence of an expressed preference in patients
25 to refer your work to physicians who are CHS

1 friendly and who would perform their services at
2 Carolinas facilities.

3 A: My primary motive is to refer the physicians
4 that I know and the hospital I go to. So
5 that's who I refer to. So I don't -- if I
6 don't know a physician in the system, I don't
7 refer them to somebody I don't know.

8 Q: Well, I would hope not. That wouldn't make
9 much sense; would it?

10 A: Right.

11 Q: But you know a lot of physicians who practice
12 at CMC-Pineville; don't you?

13 A: I do.

14 Q: And you rely heavily on them even if they are
15 not employed by Carolinas, correct?

16 A: Right.

17 Q: All right. Now, with regard to payer mix --

18 **MR. ANDREWS:** Dan, let's take a look at Carolinas
19 Exhibit 27, please.

20 Q: You testified about your knowledge of payer mix
21 and in particular your experience here of your
22 practice.

23 **MR. ANDREWS:** Dan, if you will highlight that.

24 Q: For private insurance, take a look at the first
25 two columns of commercial and managed care,

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1 there is approximately a little over 83 percent
2 of the patients that your practice serves are
3 privately insured; isn't that right?

4 A: That is correct.

5 Q: And a little over 11 percent are Medicaid,
6 true?

7 A: True.

8 Q: Now. And every practice is able to establish
9 its own standard to the extent it takes
10 Medicaid or uninsured patients, correct?

11 A: Correct.

12 Q: Now, with regard to self-pay, you see you go a
13 further down your line, the 2.7 percent?

14 A: Correct.

15 Q: Most of that it consists of actual individuals
16 who are uninsured but who pay for their
17 services at the office out of pocket; isn't
18 that right?

19 A: Correct.

20 Q: Okay. And there is little, if any, completely
21 uninsured patients who don't pay anything who
22 are served at your office there, correct?

23 A: According to this, that is correct. But I'm
24 not sure that's accurate.

25 Q: Okay. You would take issue with your Carolinas

1 Healthcare Systems data?

2 A: Well, we back up a clinic known as Palmetto
3 Volunteers, which is an indigent clinic in Rock
4 Hill. And part of establishing that clinic
5 with Primary Care Physicians to establish that
6 clinic, they came to a sub-specialist and said
7 will you see these patients if we refer them to
8 you? I said, sure, I'll see them. So when
9 they come into our office, I see them. And
10 then it is written off. I just write on there
11 indigent care. So I don't know where that's
12 captured, but I do see them.

13 Q: And occasionally they are referred to you?

14 A: Correct.

15 Q: There's no policy that your practice has adopted
16 related to indigent care. That is sort of an
17 ad hoc arrangement that you've worked out?

18 A: We do not have a policy except my word that we
19 will see them.

20 Q: All right. Let me ask you, during the last
21 decade, the women -- the maternity center at
22 CMC-Pineville has become highly regarded and
23 well known in Mecklenburg County; hasn't it?

24 A: It has.

25 Q: And it also has established a great reputation

1 in York County; isn't that true?

2 A: It has.

3 Q: All right. And that's where you focused all of
4 your work, you and the other physicians in your
5 practice, correct?

6 A: Correct.

7 **MR. ANDREWS:** Let's actually take a look, Dan, at
8 Discovery Document SCHS 555.

9 Q: So I apologize, it's a little hard to read, but
10 Dan has pulled out a line here that looks at
11 Women's health as a percent of inpatient
12 discharges of hospitals within the Carolinas
13 System in Cleveland, Gaston and Mecklenburg and
14 Union Counties. I don't know that you've ever
15 seen -- have you ever seen this before?

16 A: I have not.

17 Q: All right. What I want you to do is take a
18 look at women's health line. And it shows as a
19 percentage of discharges, you will see for CMC
20 and CMC Union are the first two hospitals and
21 then Cleveland. The fourth is Mercy and the
22 fifth is Pineville.

23 **MR. ANDREWS:** And Dan, if you will pull over the
24 Pineville. Take a look, Dr. Revell, if you
25 would of the percentages at CMC, Main and

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1 Union. You see about 17 percent?

2 A: Right.

3 Q: About 16 percent at Cleveland. Small percent,
4 there must be a little OB-GYN Women's Health
5 Service at Mercy, is that right?

6 A: They do not do obstetrics at Mercy.

7 Q: And Pineville is nearly doubled that of the
8 other institutions at 33.2 percent; do you see
9 that?

10 A: I do.

11 Q: And then University has a large women's health
12 service too apparently; is that right, at 34.4
13 percent of its discharges?

14 A: I didn't know that, but they do have a large --

15 Q: But it's clear from this data, is it not, that
16 women's health services line of business at
17 Pineville is their leading service, is that
18 right?

19 A: When Mercy built the hospital, I think in 1990,
20 the maternity center was opened. And it was a
21 vital part of that hospital and has always been
22 an emphasis of CMC-Pineville with an expansion
23 of that maternity center with the labor,
24 delivery, recovery and postpartum all in one,
25 which to my knowledge is the only in

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1 Mecklenburg -- York County that does that. So
2 it has been very attractive to patients who
3 like that concept. So I think that there has
4 always been an emphasis on primarily obstetrics.
5 But also in the GYN surgical arena there has
6 always been a lot of support at the hospital
7 there.

8 Q: Okay. So it's a big line item business. Now,
9 with regard to the LDRP, the labor, delivery,
10 recovery and postpartum services, let's provide
11 a little bit of background for the Court to
12 understand your reference to that. That is a
13 single room that is made available from the
14 point of the woman who has prepared to deliver
15 has provided from labor through the post labor
16 and post delivery, is that correct?

17 A: Correct.

18 Q: Okay. And it's -- are you aware that CMC-Fort
19 Mill is proposing to offer eight LDRP rooms?

20 A: I'm not.

21 Q: Well, I'm going to ask you to accept that the
22 record reflects that. Now, in the -- you're
23 also aware that for busy hospitals that there
24 is a risk in actually having a hospital have
25 LDRP rooms; is there not?

1 A: I'm not aware of that risk. What do you mean
2 by risk?

3 Q: It's a wide open question; fair enough. What I
4 mean by that is there's a possibility that if
5 the hospital is busy that it may run out of
6 delivery rooms. That these are special rooms
7 that are provided for up to three days for a
8 woman who is delivering a child; isn't that
9 right?

10 A: That is correct. But it is no different than
11 having a limited number of labor rooms and run
12 out of labor rooms.

13 Q: Well, the labor rooms turn over a lot more
14 quickly than the LDRP rooms do; don't they?

15 A: They do turn over, but that's why there are
16 more LDRPs than there are labor rooms.

17 Q: And so it hasn't been a problem at Pineville?

18 A: It has not.

19 Q: And how many LDRP rooms do you have at
20 Pineville?

21 A: 20 -- maybe 36.

22 Q: 25 to 30?

23 A: Maybe it's 36 now.

24 Q: A large number.

25 A: A large number.

1 Q: And that service is attractive to your patients
2 because they are able to stay in one room from
3 the time they arrive at the hospital, and they
4 don't have to switch rooms; is that what's
5 attractive?

6 A: Not only that, but it's also very family
7 friendly. There is a program for siblings
8 being involved in the process. There is
9 lactation support within the facility. There is
10 a very nice place for husbands to stay and nice
11 jacuzzis -- yeah, it's really nice.

12 Q: Sounding attractive even for the men, as well.
13 And so the arrangement here is that -- and for
14 all these reasons, the maternity center. This
15 is a free-standing center in Pineville; isn't
16 it?

17 A: It is. It's attached to the hospital, but it's
18 free standing. It was free standing. With the
19 renovation, I don't know if you'd consider it
20 that way. But yes, it's a separate entrance.

21 Q: Well, with the separate entrance and these
22 special inducements that are provided in a
23 positive way to support the facility and to
24 make it attractive to patients, it's going to
25 be difficult for patients to give that up and

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1 move to Carolinas Medical Center in Fort Mill
2 if that small hospital is built; isn't it?

3 A: Well again, it will be very similar to when
4 Mercy began the maternity center back in 1990.
5 At that time we started with eight or nine
6 LDRPs with one C-section room and limited
7 nursery capabilities. And over the last 30
8 years it has expanded its services, expanded its
9 nursery, expanded its anesthesia, expanded its
10 nurse practitioners and pediatrics to a level
11 that can provide services for complicated and
12 high-risk obstetrics. But initially it was very
13 limited, the number of patients who could
14 deliver at the hospital. So at that time our
15 practice -- actually we were on staff at CMC-
16 Main. It had the facility to take care of high
17 risk obstetrics and premature births and those
18 types of things, which we no longer have staff
19 privileges there either.

20 Q: Right. And Carolinas made the decision to make
21 this special investment at CMC-Pineville to
22 really expand the services and step up the
23 grade of that program; didn't they?

24 A: They did.

25 Q: And that's just a 15-minute drive from the

1 proposed site for CMC-Fort Mill; isn't it?

2 A: Yes. Depending on traffic on 485.

3 Q: Right. Yeah. Well, even with the traffic on
4 485, it would be difficult, so difficult that
5 you don't know, do you, whether or not that
6 CMC-Fort Mill actually will be able to pull the
7 patients who've been responding to the strong
8 reputation of CMC-Pineville to come to the Fort
9 Mill facility? You don't know whether that
10 actually will happen or not; do you?

11 A: I don't know. But I think they would if it's
12 the same quality and expertise. With the
13 culture of excellence, I see no reason they
14 wouldn't as long as they meet the criteria for
15 admission.

16 Q: Let me ask you to open your deposition.

17 **MR. ANDREWS:** Your Honor, if I may approach.

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

19 **MR. ANDREWS:** Thank you. And Dan, pull up for me
20 Page 32.

21 Q: Dr. Revell, once you open that nice present,
22 turn to Page 32 for me. And this is -- Dr.
23 Revell, I'm certainly you've had an opportunity
24 to read your deposition or others before if you
25 haven't read this one. And I'm going to begin

1 by asking the questions, and if you then would
2 provide the answer without any comment that you
3 provided during your deposition, okay?

4 A: Sure.

5 Q: All right. Question, line two. "And with
6 regard to your feeling that it won't be much of
7 a hit on Piedmont, do you believe that there
8 would be a sizable percentage of these patients
9 who would now go to Pineville, who would want
10 to instead receive their care at CMC-Fort Mill?"

11 A: "I don't know that exactly -- actually."

12 Q: "Okay, you're not sure whether they'd move or
13 not?"

14 A: "No."

15 Q: "They'd have to give up a center with a great
16 reputation; would they not?"

17 A: "They would."

18 Q: "And you're not sure if that would happen or
19 not?"

20 A: "I am not sure."

21 Q: All right. Thank you, Dr. Revell. No further
22 questions, Your Honor.

23 **THE COURT:** Thank you, Mr. Andrews. Does the
24 department have any questions?

25 **MS. BIGGERS:** No questions, Your Honor.

1 so that it could be looked at in a short, quick
2 way.

3 Q: Okay. And for purposes of today, if we can
4 focus our discussion on where you have a green
5 box or a red box, and if it's been equally met
6 or determined to have been equally met by you
7 we're going to just not have a discussion or
8 focus discussion on those.

9 A: Fine.

10 Q: Okay. If we could start our discussion with
11 criterion 2. I believe that's the first place
12 where you have some red and green boxes. If
13 you could describe please your opinions related
14 to criterion 2 on community need,

15 A: Sure. And I've blown up sections of the
16 summary chart just so that we can focus on a
17 little more detail. And this is sort of a
18 summary page for community need, and we've
19 listed out each criteria in detail just so that
20 it's available for us to look at. So my focus
21 with community need was in terms of criterion
22 2(c), (d), and (e), and this is where there
23 were differentiation between the projects. So
24 in terms of services to meet the need, I found
25 that Carolinas best met this criterion and that

1 Piedmont did not meet this criterion. And I'll
2 go into a little bit more detail, but a lot of
3 my opinion in relation to 2(c) relates to
4 whether we found that it was better or worse to
5 have 100 beds in northern York County versus 64
6 beds in northern York County and the balance of
7 those beds in relation to the needs of the
8 population. Number 2(d), or criterion 2(d)
9 relates to reduction, elimination, or relocation
10 of services. And this did not apply to
11 Carolinas since nothing in their project related
12 to those areas, but it was applied to Piedmont
13 since Piedmont was proposing to replace and
14 relocate 36 beds and move them from Rock Hill
15 to northern York County. And in relation to
16 this criterion, I found that Piedmont did not
17 meet the criteria, again, because I found that
18 there was not 100 beds needed in northern York
19 County and those 36 beds best met the
20 populations' needs remaining in Rock Hill. And
21 then the last piece of criterion 2, community
22 need, related to current and projected
23 utilization, criterion 2(e). And I found that
24 Carolinas best met this criterion, and Piedmont
25 did not meet this criterion. And my findings

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1 were generally related to the reasonability of
2 the projected utilization for each of the
3 applicants and how those projections related to
4 the number of beds that they were proposing.

5 Q: Okay. And let's focus now on criterion 2(c)
6 and talk a little bit more in detail about that
7 criterion. And did you look at the regions
8 that serve as a foundation for the need
9 analysis in the applications?

10 A: Sure. I prepared this map to demonstrate the
11 regions within York County, and our analysis
12 sort of focused on these regions. They were
13 also consistent with the way Carolinas defined
14 their service area within York County. So the
15 green portions of York County we denoted as
16 northern York County, and this is an area in
17 which the proposed hospitals will be located.
18 The blue area is greater Rock Hill and the red,
19 pinkish areas is western York County. And we
20 sort of used these geographic areas to assess
21 where did it make the most sense to put the
22 beds since that was an important comparative
23 factor between Carolinas and Piedmont.

24 Q: And did you look at the population in these
25 geographic areas?

1 A: Yes, I did.

2 Q: Okay. If you will describe that, please, for
3 us.

4 A: So at the time of our July 2011 submission, we
5 looked at Claritas data, which is a generally
6 well accepted population source by zip code, and
7 we looked at the distribution of the population
8 in York County within those three geographic
9 regions. And you can see the little insert of
10 the map of the regions, and this bar graph
11 compares the distribution of the population
12 within those three areas. And this is at the
13 time of the filing, and the data that was
14 available at that time, there was about 22
15 percent of the population in northern York
16 County, a little over 27 percent of the
17 population was in western York County, and over
18 50 percent, the bulk of the population, was in
19 the greater Rock Hill area. And I'll just note
20 that this data does include zip code 29707,
21 which between the 2005/'06 review and the
22 2010/'11 review was split out from another zip
23 code within the county. So the zip code
24 definitions are a little bit different in this
25 review than they were in the last review.

1 Q: Okay. What we're showing on the screen now, I
2 think, is Carolinas Trial Exhibit 33. Do you
3 understand that Mr. Sullivan had issues with
4 your bed population analysis that's reflected in
5 part in this exhibit?

6 A: Yes, that's my understanding.

7 Q: Okay. And have you looked at Mr. Sullivan's
8 purported corrections to your analysis and his
9 demonstratives?

10 A: Yes, I have.

11 Q: What are your comments with respect to Mr.
12 Sullivan's criticisms?

13 A: Well, I understand that he updated the
14 population data source, which, you know,
15 population data is updated from time to time on
16 an ongoing basis. So he used a newer
17 population data source than was available at the
18 time I prepared my report in 2011, and it
19 showed a different distribution of the
20 population and a much more rapid growth rate in
21 really all parts of the county. But then I
22 went to sort of recreate his analysis within
23 the last week or so and pulled new population
24 data, which again has been updated. It appears
25 that they've -- Claritas has incorporated data

1 from the 2010 census. And my even newer
2 population data was different than what Mr.
3 Sullivan used, and I -- so I found a pretty
4 significant difference in the newest population
5 data from what Mr. Sullivan utilized.

6 Q: And do you have a demonstrative to reflect the
7 difference in that population data you found?

8 A: Yes. So this graph is just northern York
9 County. I looked at all three regions, but I
10 thought I would focus on northern York County.
11 The red line depicts the population data and
12 growth trend that was based on the data that
13 Mr. Sullivan analyzed. And it shows that by
14 2020 there will be 96,000 residents of northern
15 York County, the three zip codes. And when I
16 pulled that data just a week or so ago, two
17 weeks ago, the newer data showed that by 2020
18 there would only be 84,000 people in northern
19 York County, so pretty significant difference.
20 It appears that by incorporating the 2010 census
21 the growth rate in northern York County has
22 slowed and really again, the same thing is true
23 for all of the regions; I just pulled out the
24 northern York area for demonstrative purposes.

25 Q: Okay. And if the bed-to-population ratio

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1 analysis that you did is not relevant, assume
2 that that is not relevant, then are there other
3 ways you can look at bed distribution?

4 A: Sure. And, you know, I guess what we see here
5 is that depending on when you pull the
6 population data, at different times you're going
7 to come up with different answers and different
8 results. So, you know, I guess for that
9 reason, and also my understanding is Mr.
10 Sullivan felt that a bed-to-population ratio was
11 not a relevant, you know, sort of planning
12 tool, I did not perform that analysis for
13 demonstrating need, it was really a matter of
14 looking at geographic distribution of services.
15 But if you want to move away from population
16 analysis, another way to look at it would be
17 where are the actual discharges occurring in the
18 area and aligning the beds with the discharges
19 by area of the county.

20 Q: And did you do that?

21 A: Yes, I did.

22 Q: Could you please tell us about that?

23 A: Sure. So I pulled discharge data from, I
24 believe it was Mr. Levitt's Exhibit 104, and
25 this is actual -- my understanding is it's

1 actual discharges for each zip code in the
2 county. And it's discharges that would be
3 appropriate to be served at a community
4 hospital. So it's not the full universe of
5 discharges including tertiary and specialty
6 services, but it's the discharges that have been
7 focused on by the applicants in this case to be
8 appropriate for a community hospital. So I
9 used Mr. Levitt's Exhibit 104 and his actual
10 2011 data, and then his projection of discharges
11 for 2017 and looked at how the discharges
12 aligned within the regions of the county. And
13 you can see that even going out to 2017 there's
14 a little less than 24 percent of the discharges
15 in the county will be in northern York County,
16 28 percent will be in western York County, and
17 48.3 percent will be in the greater Rock Hill
18 area. So I think looking at those discharges
19 is important in terms of how did the proposed
20 beds align with the various regions and in
21 order to ensure that each part of the county
22 has access to the services that they need.

23 Q: And that's reflected on this demonstrative
24 Carolinas 3.8 that's on the screen?

25 A: Yes.

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1 Q: Okay. And did you also prepare a summary of
2 the discharge growth trends in York County?

3 A: Sure. Yes. So again, this is based on Mr.
4 Levitt's Exhibit 10 -- well, it's 104 and 107
5 basically includes the same data. In the
6 greater Rock Hill area, Mr. Levitt projects that
7 there is going to be a net increase of 1,133
8 discharges between 2011 and 2017, and that's a
9 2.4 percent compounded annual growth rate. The
10 western York County zip codes he projects a
11 growth of 693 discharges, and that's a 2.5
12 percent annual growth rate. So the combined
13 total for Rock Hill and western York County is
14 1,826. And comparatively, northern York County,
15 the zip codes in that area, he projects a net
16 growth of 1,030, or a 4.7 percent growth rate.
17 So it is a more rapid growth rate, but the
18 number of net increase in discharges is actually
19 lower than greater Rock Hill and western York
20 County. And I think that's important because
21 the beds that are located today at Piedmont
22 Hospital are more accessible to greater Rock
23 Hill and western York County, and it's important
24 to have enough beds in Rock Hill to continue to
25 meet, which is really a larger net growth in

1 the county than in the northern York County
2 area.

3 Q: Okay. And did you look at how these discharges
4 then align with 100-bed distribution?

5 A: Yes.

6 Q: And let's look at Demonstrative 3.10, and if
7 you could please describe that for us.

8 A: Sure. So this is using, again, the same
9 discharge data. The blue bars represent the
10 percent of discharges in the area, and the red
11 bars represent the percentage of beds in a
12 situation where Piedmont and Fort Mill Medical
13 Center were approved and 36 beds moved away
14 from Rock Hill into northern York County. So
15 what you can see is that there'll be 23.7
16 percent of discharges in northern York County,
17 but 32 percent of the beds, and 76.3 percent of
18 the discharges in Rock Hill and western York
19 County, but only 67.9 or about 70 percent of
20 the beds. So the beds and the discharges don't
21 align that well. And the other thing that's
22 important to consider is these are just
23 community hospital discharges, more primary and
24 secondary level discharges. And when you add
25 to that the tertiary and quaternary level

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1 services and the specialty services offered by
2 Piedmont in Rock Hill, it's important to make
3 sure there are sufficient beds that are going
4 to remain in the Rock Hill area to meet not
5 only this community bed demand or these
6 discharges, but also the higher level tertiary
7 and specialty services.

8 Q: And did you look at the same type comparison
9 with the 64-bed hospital in Fort Mill?

10 A: Yes, I did.

11 Q: And what were your results to this?

12 A: So this is the same sort of graphic
13 representation with the blue, again, as the
14 percentage of discharges, that's the same. But
15 with 64 beds in the Fort Mill area as proposed
16 by Carolinas, the percent of beds aligns much
17 more closely with the percentage of discharges.
18 So there would be 20.5 percent of the beds in
19 northern York County and 79.5 percent of the
20 beds in Rock Hill, which I think is a much more
21 equitable distribution of beds aligning with the
22 actual discharge demand that's anticipated to
23 occur in each of the parts of York County. And
24 again, when you add the tertiary and specialty
25 services in Rock Hill there's even more

1 justification to have the beds in Rock Hill.

2 Q: Okay. And instead of looking at the
3 percentages as you've just been going through,
4 did you also look at the bed-to-discharge
5 ratios?

6 A: Yes, I did.

7 Q: Okay. And let's look at Demonstrative 3.12,
8 and if you could please describe that for us?

9 A: Okay. So this is the sort of beds-to-discharge
10 ratio or beds per 1,000 discharges in a
11 situation where there was 100 beds in Fort
12 Mill, so 36 beds moving from Rock Hill into
13 Fort Mill. And when you perform these
14 calculations, the bed per 1,000 discharges in
15 2017 from northern York County is just a little
16 short of 20, whereas the beds per 1,000
17 discharges in greater Rock Hill and western York
18 County is 13. So there's a good bit of
19 disparity there with a much higher concentration
20 of beds-to-population in northern York County.

21 Q: And that's for the 100 beds?

22 A: That's with the 100 beds, correct.

23 Q: Okay. Did you do the same type of comparison
24 for the 64-bed hospital?

25 A: Yes.

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1 Q: Okay.

2 A: So when you look at this with the 64-bed
3 hospital, the bed-to-discharge ratio is 12.66 in
4 northern York County, and the beds per 1,000
5 discharges in greater Rock Hill and western York
6 County is 15.21. They're not exactly even, but
7 they're closer, the variance is closer than when
8 the beds are put in northern York County. And
9 again, this is only community hospital
10 discharges, so if you were to take the tertiary
11 discharges that can only be served in Rock Hill
12 and specialty discharges and add those in then
13 it would balance it even further. And again, I
14 think there's more need to have the beds in
15 Rock Hill to ensure the needs of that
16 population in addition to the residents --
17 resident demand for Rock Hill and western York
18 County residents.

19 MR. ANDREWS: Your Honor, excuse me for
20 interrupting. Ms. Robertson, if we could have
21 a copy ---

22 MS. ROBERTSON: Yes.

23 MR. ANDREWS: --- of these now before -- instead of
24 waiting until later. There's such detail it
25 would allow us to ---

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1 MS. ROBERTSON: We've got them.

2 MR. ANDREWS: Good.

3 MS. ROBERTSON: I can hand you those. Hold on just
4 a second.

5 MR. ANDREWS: Great.

6 MS. ROBERTSON: This is where we ---

7 MR. ANDREWS: Good. Thanks very much.

8 MS. ROBERTSON: --- and this starts a new topic.

9 MR. ANDREWS: Okay.

10 MS. ROBERTSON: You want me to hand you this as well
11 now too?

12 MR. ANDREWS: Yeah, sure. We'll just take one now.
13 Thank you.

14 Q: Now, Ms. Platt, did you graphically demonstrate
15 what you've been talking about as well?

16 A: Yes.

17 Q: Let's look at that in Demonstrative Carolinas
18 3.14 and if you'll walk us through this graphic
19 demonstration, please.

20 A: Okay. So this is basically a graphic
21 representation of the last two tables with a
22 bed-to-discharge ration. And so the blue bars
23 represent 64 beds in Fort Mill, and the red
24 bars represent 100 beds in Fort Mill, and the
25 northern York County region is on the left and

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1 Rock Hill and western York County region is on
2 the right. And when you look at the 64-bed
3 distribution, the beds per 1,000 discharge is a
4 lot more even, and when you look at the 100
5 beds in Fort Mill the bed-to-discharge
6 distribution is much more disparate. And again,
7 I think that even though in a 64-bed situation
8 there's a little bit higher concentration of
9 beds in Rock Hill and western York County, I
10 think that is more than offset by the fact that
11 that's where the tertiary and specialty services
12 are going to continue to be served.

13 Q: Looking now at Criterion 2(c), can you give us
14 please your conclusions, your opinions with
15 respect to bed alignment?

16 A: Yes. So with respect to Criterion 2(c), and
17 this is services to meet the demands of the
18 population, my finding was that the bed
19 alignment proposed by Carolinas with 64 beds in
20 northern York County best aligned with the needs
21 of the population. And that, you know, I found
22 that at the time in 2011, and I continue to
23 find that today looking at the actual discharge
24 demand in the area, and that the 100-bed
25 project proposed by Piedmont does not align with

1 the needs of the population, that there's more
2 beds than are needed in northern York County,
3 and that, of course, results in a more costly
4 project. And, you know, relocation of 36 beds,
5 that's duplication as well. So within Criterion
6 2(c), I found Carolinas best meets that
7 criterion and that Piedmont did not meet that
8 criterion.

9 Q: And do you have opinions related to the
10 efficiencies of a 100-bed hospital versus a 64-
11 bed hospital in York County?

12 A: I do.

13 Q: And could you, please, describe those opinions
14 for us?

15 A: Sure. Throughout the Fort Mill Medical Center
16 and Piedmont application there was a lot of
17 emphasis on the need to build 100 beds as a
18 more efficient hospital, and you know, I think
19 that was used as, you know, additional
20 justification for why it made more sense to go
21 ahead and build 100 beds in that area. And I
22 did not find that to be the case in reviewing
23 the actual contents of their application. I
24 didn't find that it was more efficient. And I
25 think that they held out that 100 beds as sort

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1 of a minimum size that they would find to be,
2 you know, efficient from an operation
3 standpoint.

4 Q: Okay. And let's look on, if we can, at a
5 record page, I think it's 1181, that was in
6 your analysis submitted to the Department. And
7 if you'll talk a little bit about this for us.

8 A: Sure. This is a page from my report that was
9 filed by Carolinas in July 2011. And what we
10 did was go back and look at other new hospital
11 projects that were approved in South Carolina
12 over the last several years and look at the bed
13 size to see, you know, if they had been large
14 beds or whether smaller bed facilities had been
15 found to be, you know, efficient and approvable
16 by DHEC. And looking across all of these
17 projects, the largest facility that was approved
18 was an 85-bed project in Charleston at Roper
19 Saint Francis, and then all the way down to a
20 31-bed project that was approved at Coastal
21 Carolina. So across all of these projects the
22 average bed size was 57, so much lower than the
23 100 beds proposed by Piedmont. So in DHEC's
24 past practice they have found facilities that
25 are smaller than 100 beds to be efficient and

1 to meet all of the criterion and obviously be
2 approvable. So I think that sort of counters
3 Fort Mill Medical Center's and Piedmont's
4 arguments that they need to build 100 beds for
5 operating efficiencies.

6 Q: And have you also looked at this information in
7 relation to the existing providers in the York
8 County area, and do you see either project as a
9 duplication?

10 A: I don't see either project as a duplication in
11 and of -- in and of the need for a hospital. I
12 believe that the 36 beds and moving those to
13 northern York County as proposed by Piedmont
14 represents a duplication of those beds. The
15 beds are already available in Rock Hill,
16 consistent with my analysis of the demands,
17 there's you know, are demand -- there's demand
18 for those beds in Rock Hill, and so move -- you
19 know, paying to replace and relocate those beds
20 to northern York County I found to be a
21 duplication.

22 Q: Okay. And what we're looking at on the screen,
23 this is part of your comparative analysis for
24 the July submission, is that right?

25 A: Yes, it was.

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1 Q: Okay. And let's look at another page from your
2 comparative review, 1197. If you could tell
3 us, have you looked at the utilization for the
4 two projects?

5 A: Yes, I have. And this is moving on to
6 criterion 2(e) and looking at the utilization
7 projections for each of the projects and whether
8 they're reasonable and consistent with the
9 demands in the area. And you can see that Fort
10 Mill Medical Center projects a significantly
11 higher number of discharges than CMC-Fort Mill.

12 Q: And can you speak to the utilization levels of
13 Fort Mill Medical Center between the 2005 and
14 the 2010 submissions?

15 A: Yes. So interestingly -- and this chart
16 represents the updated projections in year three
17 for Fort Mill Medical Center -- between the
18 2005/'06 submission and the newer submission,
19 the actual utilization projections are lower in
20 the 2010 and 2011 submission. The discharges
21 went down by half a percent, the days went down
22 by 2.48 percent, and I found that really
23 unusual given the passage of six years of time
24 and ongoing population growth, and yet Fort Mill
25 is projected to have lower utilization than it

1 was, you know, five or six years ago. And
2 that's to me, again, inconsistent with the need
3 for 100 beds in the area. If there's a need
4 for so many beds then why would you not have a
5 higher level of utilization for those proposed
6 beds. And you can see that in the new
7 projections, you know, right there, the Fort
8 Mill Medical Center is projected to be 58.24
9 percent occupied, which is a very low level of
10 utilization. It indicates that on any given
11 day on average there's 40 beds that are not
12 being used at Fort Mill Medical Center, and I
13 think that's, again, a very low level of
14 utilization, and to me, does not justify 100-bed
15 hospital in that location.

16 Q: And I think earlier you said you found that
17 Carolinas best met criterion 2(e) and that
18 Amisub Piedmont does not meet 2(c). Can you
19 summarize, please, then for us your findings,
20 your conclusions, on 2(e)?

21 A: Sure. So this is just a summary of my findings
22 and my thoughts on the utilization projections
23 for each of the applicants. Carolinas was able
24 to project utilization based on shifting of its
25 existing market share. It has a much higher

1 existing market share of the northern York
2 County area, and it does not require any
3 incremental market share from any other party in
4 order to meet its projections. And CMC-Fort
5 Mill is projected to be 67.5 percent occupied
6 of 64 beds in year three, which I also found to
7 be a reasonable occupancy level that justified
8 64 beds. In terms of the Piedmont projections,
9 I felt that Piedmont failed to document the
10 need for 100 beds in northern York County. As
11 I showed before, I feel that the distribution
12 of beds does not align with the needs of the
13 community. Piedmont has to capture significant
14 incremental market share at both Piedmont Main
15 Hospital and at Fort Mill Medical Center in
16 order to meet those projections. And one, they
17 would have to take those discharges from another
18 provider; and two, I question their ability to
19 have such significant market share increases and
20 to meet their projections. Fort Mill Medical
21 Center is projected to be only 58.2 percent
22 occupied in the third year, which I found is,
23 in my opinion, not sufficient to justify a 100-
24 bed hospital. And then also I found some
25 inconsistencies in the Fort Mill Medical Center

1 projections between various parts of their
2 filings.

3 Q: Okay. We're looking at Demonstrative 3.19.
4 Did you also do a comparative graph on market
5 share in northern York County and include that
6 in your written comparative analysis?

7 A: Yes, I did.

8 Q: Let's look at that. And I believe that's Joint
9 A-CHS page 1215 in the record.

10 A: So this bar graph simply represents in 2009 at
11 the time when my report was filed with DHEC the
12 most current market share data for the northern
13 York County zip codes. And it shows that
14 Carolinas or CHS had 52.9 percent market share
15 of community hospital discharges in the northern
16 York County region, whereas Piedmont had 28.7
17 percent. So Carolinas' projections of
18 utilization are based on their ability to shift
19 a portion of that 52.9 percent market share to
20 the new hospital and meet their utilization
21 targets without taking market share from other
22 providers. By contrast, Piedmont has a much
23 lower market share of northern York County, and
24 in order to meet their projections for Fort
25 Mill Medical Center they have to take a

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1 significant amount of market share away from
2 other existing providers, both to fill beds at
3 the 100 beds in northern York County and to,
4 essentially, backfill Piedmont Medical Center in
5 order to justify all of their beds. And I did
6 not find that to be reasonable when I prepared
7 my report.

8 Q: And you mentioned, I think, some inconsistencies
9 in Fort Mill Medical Center's utilization
10 projections?

11 A: Yes.

12 Q: Could you, please, talk a little bit more about
13 those. And I believe you've prepared a
14 demonstrative and it's Carolinas 3.21 to reflect
15 those inconsistencies in a little more detail.

16 A: Yes. So I found within the agency file, and
17 these are the filings by Piedmont Medical Center
18 for Fort Mill Medical Center, in the October
19 4th submission on page 36, which was essentially
20 sort of the need section of the application,
21 they projected 5,946 discharges and 21,258
22 patient days. But in the same filing in
23 October, when you get back to page 213, it was
24 one of the attachments where they provided their
25 financial pro forma, the number of discharges

1 that look like they went into the financial pro
2 forma was 6,317 and 22,652 patient days. So
3 there was an internal inconsistency in that
4 filing, which made it difficult to know how
5 many discharges they were really proposing. So
6 then in December of 2010, they updated their
7 submission and responded to some questions from
8 the Department. And on page 432, I believe it
9 was in response to a question from DHEC asking
10 them to confirm their utilization projections
11 and provide departmental utilization detail,
12 they showed that there were 6,317 discharges,
13 but then on page 542 there were revised pro
14 forma financial projections that showed 5,946
15 discharges and 21,258 patient days. So none of
16 the submissions that I saw had a consistent
17 number of discharges. It would be one thing if
18 early in the record, you know, there was a same
19 consistent number and then that was updated
20 later in the record and it was, you know,
21 consistent internally in a later submission,
22 because you are allowed to, you know, change or
23 update or amend your submissions. But the
24 inconsistencies sort of remained throughout the
25 filing. And so from my perspective this caused

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1 concern with regard to relying on the
2 utilization projections within the application.
3 And I pointed this out in our report to DHEC at
4 the time we filed.

5 Q: Okay. Can you now -- let's reflect upon
6 criterion 2 if we can, and if you'll summarize
7 briefly your opinions that relate to criterion
8 2.

9 A: Okay. So again, services to meet the need,
10 this is related to my analysis of where the
11 beds should be located in relation to the
12 discharge demand in each area. And I found
13 that Carolinas with 64 beds in northern York
14 County best aligned with the actual demand for
15 services in the northern York County area, and
16 that Piedmont's proposal to relocate and replace
17 36 beds and move them to northern York County
18 did not align with the demands of the area, and
19 so I found that they did not meet criterion
20 2(c). In terms of 2(d), reduction, elimination,
21 or relocation of services, again, I found that
22 it was not necessary to spend the resources to
23 relocate and replace 36 beds that are currently
24 available in Rock Hill and move those to
25 northern York County, and so I found Piedmont

1 did not meet criterion 2(b). And then the last
2 piece of community need, criterion 2(e), again,
3 I found that Carolinas' projections were
4 reasonable and consistent with their existing
5 market share; they had the ability to meet
6 their utilization projections, again, without
7 taking market share from any other existing
8 provider; and I found that Piedmont's
9 projections were unrealistic in their need to
10 capture significant additional market share to
11 meet both their projections at Fort Mill Medical
12 Center and at Carolinas -- or I'm sorry, and at
13 Piedmont in Rock Hill. And then I found
14 inconsistencies within their utilization
15 projections that also caused me concern. So
16 for those reasons, I found that Piedmont did
17 not meet Criterion 2(e).

18 Q: Okay. And now if we can move to criterion 3
19 and 22, those were also under the rank two of
20 the Department's letter. And if you could tell
21 us do you have opinions related to criterions 3
22 -- criterion 3 and 22?

23 A: Yes.

24 Q: And could you please tell us what those
25 opinions are?

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1 A: So there's various parts of criterion 3, and
2 these relate to distribution of services. And
3 then criterion 22 also relates to distribution.
4 And under distribution, under criterion 3, the
5 subparts look at both sort of geographic
6 distribution and financial accessibility in
7 terms of aligning the services with the needs
8 of the underserved populations and ability to
9 serve the underserved populations, so financial
10 accessibility. So under 3(a), duplication and
11 modernization, that did not apply to Carolinas
12 because they were not proposing to develop or
13 redevelop any existing services. So under
14 duplication and modernization, Piedmont's beds
15 that they were moving and replacing in northern
16 York County, the 36 beds, I found to be a
17 duplication of existing bed capacity. And I
18 found that since those beds were not needed in
19 northern York County and, I believe, best meet
20 the needs of the population in Rock Hill, I
21 found Piedmont non -- inconsistent with
22 criterion 3(a). In terms of location to serve
23 the medically underserved, again, I think the
24 location themselves of the two hospitals are
25 fine geographically, there's very little

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1 difference in those locations, but the alignment
2 of the beds within relation to the needs of the
3 community caused me concern with respect to
4 Piedmont. And then also in terms of medically
5 underserved areas, I believe Carolinas best
6 meets the needs of the underserved or the
7 patients that have less ability to pay. So I
8 found Carolinas best meets criterion 3(b). And
9 similarly, I also found that Carolinas best
10 meets criterion 3(g) which is provision of care
11 with regardless of ability to pay. And then
12 the last piece was distribution of services, and
13 that's criterion 22. I found that Piedmont did
14 not meet criterion 22, again, because I don't
15 believe that locating 100 beds in northern York
16 County is the best distribution of services
17 within the county.

18 Q: Let's look now a little more closely at your
19 opinions that you've just described for us
20 with respect to criterion 3 and 22. Do you
21 have some comments with respect to the
22 geographic locations of these applicants?

23 A: Yes.

24 Q: And I think you included that in your analysis
25 on page 1190. And if you'll comment on this

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1 for us.

2 A: Yes. This is just a map of the two locations
3 for the proposed hospitals in northern York
4 County. The blue dot represents Carolinas
5 HealthCare System, or CMC Fort Mill, the yellow
6 dot represents Fort Mill Medical Center, and the
7 red dot is the existing location of Piedmont
8 Medical Center. And there's about a 1.8 mile
9 straight line distance between the two proposed
10 locations for the new hospitals. And I found,
11 based on that very small difference in location,
12 that the actual location in terms of geographic
13 distribution was, you know, nearly equivalent.
14 I don't think it's the location that's at
15 issue. My concern is the number of beds in
16 that location, and you know, I found that
17 moving beds to Fort Mill Medical Center and
18 having 100 beds in northern York County does
19 not align with the needs of the population.

20 Q: And I think you may have mentioned this, but is
21 distribution a consideration of both geographic
22 and financial access?

23 A: Yes.

24 Q: Have you compared the financial accessibility of
25 these projects?

1 **THE COURT:** Well then let's take a lunch break.
2 Let's reconvene at 12:45.

3 (Lunch break from 11:31 a.m. until 12:58 p.m.)

4 **THE COURT:** Mr. Andrews, are you ready to proceed?

5 **MR. ANDREWS:** Thank you, Your Honor. We are.

6 **MS. PLATT - CROSS EXAMINATION BY MR. ANDREWS:**

7 **Q:** All right. Good afternoon, Ms. Platt.

8 **A:** Good afternoon.

9 **Q:** Ms. Platt, you weren't involved in the
10 preparation for Carolinas' application in the
11 2005 period, were you?

12 **A:** No.

13 **Q:** And you didn't represent Carolinas during their
14 work with DHEC during that first review stage,
15 did you?

16 **A:** No.

17 **Q:** In fact, did I understand your testimony
18 correctly to say in 2010-2011 you didn't
19 communicate with DHEC concerning the
20 application?

21 **A:** Not that I recall.

22 **Q:** Okay. You relied on communications from your
23 office and for Carolinas through Tori Tibshrary,
24 didn't you?

25 **A:** I did. There was very little, but we did have

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- 1 was through Tori.
- 2 Q: All right. Before she joined you, Ms.
- 3 Tibshrary was one of the more senior staff
- 4 members of the CON division, wasn't she?
- 5 A: I don't know comparatively how senior she was,
- 6 but she did work there for a number of years.
- 7 Q: Okay. And she, in fact, was employed by the
- 8 CON division during DHEC's first review of these
- 9 applications, wasn't she?
- 10 A: I think if I'm recalling the timing correctly,
- 11 yes.
- 12 Q: Okay. Now Ms. Tori -- Ms. Tibshrary's
- 13 responsibilities with the office then
- 14 principally were to review exemption requests
- 15 and non-applicability determinations, wasn't
- 16 that what her principal role was?
- 17 A: That's my recollection, yes.
- 18 Q: Okay. Now, and as far as you know, she didn't
- 19 have any formal role in the review of the Fort
- 20 Mill applications?
- 21 A: As far as I know, yes.
- 22 Q: You would have asked her about that before
- 23 working on -- having her work on this case,
- 24 wouldn't you?
- 25 A: I'm sure we would have discussed it if she had

1 been involved, yes.

2 Q: Okay. Now, during that period of time the CON
3 office was a relatively small office; it just
4 had five or six professional reviewers, isn't
5 that right?

6 A: I don't remember the exact number, but it
7 wasn't a large group.

8 Q: Sounds consistent with what you would have
9 expected to have been there at the time?

10 A: Reasonably consistent, yes.

11 Q: Okay. All right. Now, during project review,
12 it's your experience -- you've worked on many
13 different CON applications in South Carolina,
14 right?

15 A: Yes.

16 Q: And during project review, the entire CON
17 division comes -- as a general rule, comes to
18 the CON project review meetings, don't they?

19 A: Yes, from what I recall.

20 Q: Okay. And do you happen to remember whether,
21 or know since you weren't present at the time,
22 whether Ms. Tibshrary was involved in the
23 project review of these first series of Fort
24 Mill application?

25 A: I don't know whether she attended that meeting

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1 or not. We may have talked about that, but I
2 don't remember one way or another.

3 Q: Okay. But it'd be consistent with their
4 practice for her to attend if there wasn't a
5 conflict that prevented her from being there,
6 wouldn't it?

7 A: I believe so. I think she generally attended
8 those meetings when she worked for DHEC.

9 Q: Okay. And are you aware that following the
10 project review meetings, the CON division
11 gathers and talks about and shares ideas about
12 what they've heard at the project review as
13 part of their processing those events?

14 A: You know, I am not -- I'm not fully aware of
15 what they do in terms of discussion, I'm sure
16 they all attend, they all take notes, and I'm
17 sure there is some discussion, but I'm not sure
18 the extent of that or how, you know, how much
19 each person is involved.

20 Q: Okay. And from time to time, other members of
21 the CON division participate in large CON
22 projects, don't they? Based on your experience,
23 do you know that to be true?

24 A: When you say other members you mean other than
25 ---

1 Q: Other than the immediate reviewer and the
2 reviewer's supervisor?

3 A: I guess if there's, you know, maybe a question
4 related to the State Health Plan they might,
5 you know, talk to Les Shelton, but you know, I
6 don't -- I don't really know one way or another
7 who else they might involve in a larger
8 project.

9 Q: Okay. And it could have well been possible
10 that Ms. Tibshrary would have been exposed to
11 internal conversations about the review of that
12 first round of applications; wouldn't that be
13 fair to say?

14 A: It's possible. It did not sound to me in any
15 of our discussions as though she had, you know,
16 any significant role of any kind.

17 Q: How far before you were retained to work on
18 this case had Ms. Tibshrary come to work for
19 you?

20 A: Let's see if I can recall. I think Ms.
21 Tibshrary started working with us in 2009, and
22 then this remand project, you know, that we
23 started working on was probably midway through
24 2010.

25 Q: And no doubt you had, you or others had

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1 communicated with Carolinas that Ms. Tibshrary
2 was working for you and would be working on
3 your project; wouldn't that be true?

4 A: Could you ask that question again?

5 Q: Sure. Sure. Isn't it true that you would have
6 communicated either through others or directly
7 to Carolinas that Ms. Tibshrary was involved in
8 your project and had been employed by DHEC?

9 A: I know that Carolinas was aware that Tori
10 worked with me and that she previously worked
11 for DHEC.

12 Q: All right. And she, during her period of time,
13 got to know the folks well who were involved
14 with the review of the application, with the
15 possible exception of Ms. Brandt; wouldn't that
16 be fair to say?

17 A: I'm sure she knew the people that she worked
18 with well. I think she had very little overlap
19 in timing with Ms. Brandt.

20 Q: Okay. And in particular, Ms. Brandt was
21 assisted by Lisa Sanders, who was one of the
22 reviewers and for a while the principal reviewer
23 along with Ms. Brandt, true?

24 A: I recall that she was, yeah, the principal
25 reviewer.

1 Q: And she would have worked closely with Mary
2 Fechtel, Patricia White, and Les Shelton who all
3 -- whose names also have been mentioned and
4 participating to some degree in the review or
5 supervision or consultation of this file, right?

6 A: I know that Ms. Tibshrary worked with all of
7 them, yes.

8 Q: Okay. And Ms. Tibshrary was based here in
9 Columbia and still is, isn't she?

10 A: Yes.

11 Q: Okay. Now, and she provided -- when there was
12 a need for face-to-face contact with the DHEC
13 staff during this second round of reviews, she
14 provided that, didn't she?

15 A: You know, I'm not sure that she had any face-
16 to-face contact. I believe she attended the
17 project review meeting, but I don't know that
18 she had any other face-to-face contact with DHEC
19 regarding this project, that I can recall.

20 Q: Okay. Well, let's talk about the project
21 review meeting in July of 2011. She attended
22 that meeting, did she not?

23 A: I'm having trouble recalling precisely. I
24 believe I was out of town, and I do think she
25 attended.

1 Q: Okay. Well, Dan, let's pull up a document that
2 was produced, Ms. Platt, in discovery from your
3 files, CHS Platt 0411. Do you recognize this
4 document, Ms. Platt? Yeah. Can you see it
5 well enough? It may be on the screen in front
6 of the monitor.

7 A: Yeah, it's -- it's blurry in front of me.

8 Q: Okay.

9 A: I mean, I was copied on this, yes.

10 Q: And this is a memo from Ms. Tibshirany to Mr.
11 Murphy and you were among those copied on it.
12 It's dated July 5th, 2011, correct?

13 A: Yes.

14 Q: And it says "Project Review Follow Up" in the
15 re: line, right?

16 A: Yes.

17 Q: And Tori is signing the letter to Del and
18 Elizabeth. It says, "It's in preparation for a
19 call on Thursday, and here are the items that I
20 noted during project review to be addressed in
21 our written response to DHEC, is that correct?"

22 A: That's what it looks like it says.

23 Q: Okay. Now, there are six items if you'll look
24 down in the substance of the memo addressed to
25 -- that relate to Piedmont's presentation. Do

1 you see that?

2 A: Yes.

3 Q: And the preface to those items states that
4 issues presented in Piedmont's presentation that
5 should be addressed in the cover letter, right?

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

7 Q: And she's not making recommendations about
8 these, but she's stating as a matter of fact
9 what should be addressed in the follow up,
10 correct?

11 A: I don't know that it's a fact. I think it's
12 her opinion that these items she identified are
13 things that she believes Carolinas should
14 address in their cover letter in their next
15 submission.

16 Q: Okay. And if you'll look down below, she
17 states the same thing with regard to Novant's
18 presentation, there's one item that she
19 identifies that should be addressed in
20 Carolinas' cover letter as well, correct? You
21 see that?

22 A: It looks like it, yes.

23 Q: Okay. And then finally she concludes with
24 directing -- stating that DHEC's follow-up
25 question to CMC that should be further addressed

1 as well. Now, do you know if Ms. Tibshrary
2 talked with any of the CON staff following the
3 project review meeting related to the items that
4 she said should be followed up with?

5 A: I don't believe she did. I don't recall her
6 having any face-to-face conversations or any
7 direct conversations with the DHEC staff about
8 any of these items.

9 Q: But you're not sure one way or the other, are
10 you, whether she had those conversations?

11 A: No, I don't believe that she did. My
12 recollection is that -- I don't know that DHEC
13 staff really wanted to talk to any of the
14 parties during this review. And Tori as a
15 member of my staff would not, you know, speak
16 with them. I mean, again, I don't know that
17 anybody on Carolinas' team spoke outside of the
18 context of project review to anybody from DHEC.

19 Q: Well, she certainly made her statements about
20 what she -- what she believes should be
21 addressed with authority, didn't she?

22 A: I believe these were her opinions.

23 Q: Okay. Now, let's talk about your review, your
24 role in the staff review. You've already
25 clarified you weren't involved in the drafting

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1 of the original CON application in 2005. You
2 didn't have a hand in drafting the update in
3 2010 either, did you?

4 A: I did not draft the update. I reviewed pieces
5 of the update and the cover letter to which my
6 reports were attached, but I did not prepare
7 directly any of those updates.

8 Q: And you did not participate in the development
9 of the assumptions for utilization or for
10 financial projections that were the basis for
11 the update in 2010 either, did you?

12 A: Correct, I did not prepare those.

13 Q: All right. Now, and in fact, it was Carolinas'
14 internal planning team that prepared those
15 projections, both utilization and for financial
16 projections, isn't that true?

17 A: Yes.

18 Q: Okay. Now, with regard to the assumptions for
19 -- that related to the projections for
20 utilization let's begin by taking a look ---

21 **MR. ANDREWS:** Dan, if you'll pull up Carolinas' need
22 methodology, which is -- was an exhibit to your
23 deposition at SCHS 0471.

24 Q: You're familiar with that document, aren't you,
25 Ms. Platt?

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1 A: Yes.

2 Q: Okay. Now, the need methodology presented here
3 on pages 471 through 485 of this document was
4 developed entirely by Mr. Murphy's planning
5 unit, isn't that true?

6 A: Yes. I may have sort of proofread it and
7 looked at it, but it was drafted by Mr. Murphy
8 and his team.

9 Q: And they developed the assumptions on which
10 these projections are based, correct?

11 A: Yes.

12 Q: Okay. Now let's take a look at the service
13 area. Now, the primary service areas you've
14 testified consist of the three zip codes in
15 northern York and the three in Rock Hill, and
16 someone else made the decision to identify that
17 as a primary service area; you didn't do that,
18 did you?

19 A: I did not.

20 Q: And then there was a determination concerning
21 the percent of patients that would assume to be
22 coming from the primary and the secondary
23 service area, and again, you didn't make those
24 assumptions or develop the rationale for the
25 basis for allocating the distribution of

1 patients this way, did you?

2 A: I did not.

3 Q: All right. Now if you'll look at the bottom of
4 the page, there was an assumption related to
5 ten percent of the -- of the projected
6 utilization from the service area would consist
7 of patients in-migrating from outside of York
8 County, correct?

9 A: Yes.

10 Q: Isn't that true? And again, Mr. Murphy's
11 office developed those assumptions as well,
12 true?

13 A: Yes.

14 Q: Okay. All right. Now, and they submitted
15 those and you really weren't consulted on them
16 one way or the other, that was just you were
17 handed a conclusion and that was -- and you
18 just accepted it and then applied it through
19 your analysis that you've testified about,
20 correct?

21 A: Again, I probably reviewed a draft, but they
22 came up with those assumptions and then I
23 reviewed those assumptions and their projections
24 the same way I reviewed Piedmont's information
25 that was submitted in their updates.

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1 Q: Okay. Now let's take a look at -- let's go
2 into the second page or actually the third
3 page, page 473, of this inpatient projection.
4 And let's be clear about this as we work
5 through the different steps in the process.
6 First of all, there is historical York County
7 inpatient discharges that were identified for
8 primary and secondary level services, right?

9 A: Yes.

10 Q: Isn't that what it says? And that was done for
11 both patients York County leaving into North
12 Carolina and elsewhere and those remaining in
13 York County, true? Isn't that right?

14 A: Yes.

15 Q: Okay. Now, in your deposition you testified
16 that you didn't know exactly, while you had a
17 general understanding of what primary, secondary
18 level services are, that again, the Carolinas
19 staff made a line to determine what was
20 included in that and what wasn't and you didn't
21 know exactly how they differentiated between
22 secondary and tertiary services, isn't that
23 right?

24 A: I did not participate in defining what, you
25 know, specific services fell into those

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1 categories. I knew certain services did not.
2 You know, if there were services that were not
3 going to be offered at the Fort Mill Hospital
4 then I knew that they would not be part of that
5 sort of primary and secondary definition, but I
6 did not focus on, you know, sort of the detail
7 is this DRG or this procedure in or out. They
8 made those decisions.

9 Q: And some could be in and some could be out and
10 that could just be a matter of professional
11 judgment; isn't that true?

12 A: Well, there are a variety of ways to look at
13 that, but you know, I think my general
14 understanding of how they did it seemed
15 reasonable. I did not go into detail to assess
16 it one way or the other.

17 Q: But you don't know how they drew that line?

18 A: Not, you know, sort of specific of DRG by DRG
19 or anything like that.

20 Q: Okay. All right. Now the second element of
21 that definition in one and two is that this is
22 a methodology that's intended to project
23 utilization of inpatient discharges, isn't that
24 true?

25 A: Yes.

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1 Q: And there's no discussion within this document
2 of the methodology for projecting outpatient
3 services associated with CMC-Fort Mill, is
4 there?

5 A: From what I recall, there's discussion of
6 outpatient volumes other places in their
7 submissions, not looking at this. This is the
8 discussion of inpatient utilization.

9 Q: And so can you identify anywhere in the
10 application specifically that identifies the
11 methodology for the assumption about the
12 outpatient projections?

13 A: Not without looking at the entire record, I
14 can't recall.

15 Q: Okay. Well, that's a pretty important element
16 since it's in 62 percent of the revenues that
17 are proposed to be generated in year three
18 would be based on outpatient services at CMC-
19 Fort Mill, isn't it?

20 A: I don't remember the percentage.

21 Q: You would accept that it's over 60?

22 A: I'd have to look at it.

23 Q: You don't recall that?

24 A: A good portion of the revenue is certainly
25 based on outpatient services. I don't know the

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1 percentage.

2 Q: Okay. Well, the point is that there -- it
3 would be important to understand, for the
4 Department to understand and for the methodology
5 to be clear about how outpatient services are
6 projected and what the methodology for doing
7 that is, wouldn't it?

8 A: I mean, there would be a presentation of
9 utilization. You know, it's a -- it's a part
10 of the record certainly.

11 Q: But you haven't had any discussions with
12 Carolinas staff about how they did that, have
13 you?

14 A: No. Again, my role was to look at what they
15 prepared and were submitting the way I would
16 look at Piedmont sort of as an external
17 reviewer and then side-by-side, you know,
18 compare the applications and the submissions.

19 Q: Well, in the same way that you made in your
20 direct testimony an adjustment to the
21 depreciation schedule to make sure that you
22 could offer an opinion about the reasonableness
23 and the comparative efficiency of Carolinas'
24 depreciation schedule and Piedmont's, you would
25 want to know to be able to do any assessment

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1 whether the assumptions are consistent, or if
2 they're different, what's the basis for that
3 difference, wouldn't you?

4 A: Yes.

5 Q: Okay.

6 A: I mean, I looked at the overall amount of
7 outpatient volume and amount of gross revenue
8 coming from outpatients. And one of the
9 reasons we used the adjusted discharge figure
10 for a number of the comparisons is because it
11 took into consideration the outpatient volume
12 and the inpatient volume.

13 Q: Okay. What you did is you performed an
14 external analysis, but you didn't, regarding the
15 relationship between inpatient and outpatient
16 services, look behind the assumptions that
17 Carolinas adopted to see and to test the
18 reasonableness and determine on what they were
19 based? You didn't do that, did you?

20 A: I did not look behind the Carolinas assumptions
21 of outpatients, just like I didn't look behind
22 the Piedmont assumptions of outpatient.
23 Whatever was in the record, we evaluated.

24 Q: And to the extent they were based on different
25 assumptions relating to patient service or

1 patient history, those were not things that you
2 explored or determined for purposes of
3 performing your analysis? You just acted on the
4 data that was presented, correct?

5 A: Well, to the extent that there were differences
6 in the service offerings, I, in reviewing the
7 two projects, I didn't find a significant
8 variation in what they proposed service-wise.
9 Again, my approach was to look at it the way I
10 believe DHEC would look at it. They don't have
11 the ability to go behind the numbers, you know,
12 to any great deal. They have a couple of
13 chances to ask questions, but to, you know, dig
14 behind every number, my role was to look at it
15 the way DHEC would and review the information
16 that was submitted, and to the greatest extent
17 possible, compare and evaluate the applications
18 side by side.

19 Q: Okay. Correct. And to the degree that
20 information's been updated through the course of
21 this trial, you're not privy to that
22 information, is that right? You haven't been
23 here and/or had access presumably to a
24 transcript, so your information is based on, and
25 your opinions today, are based on what's in the

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1 DHEC record, true?

2 A: For the most part. I mean ---

3 Q: Except to the degree you've updated it based on
4 information you've testified about; would that
5 be right?

6 A: I guess that would be generally correct. I
7 mean, I've looked at some of Mr. Levitt's
8 exhibits, demonstrative exhibits; I've looked at
9 some of Mr. Sullivan's demonstrative exhibits to
10 the extent they relate to what I presented and
11 testified about on direct.

12 Q: Okay. All right.

13 **MR. ANDREWS:** Let's move to the next page, Dan,
14 please.

15 Q: Look at paragraph eight and the inpatient
16 projection methodology. Now, the key variables
17 in this element of the assumption are the
18 proposed shift of percentage of patients that
19 have consis- -- been a part of Carolinas'
20 market share in 2009, correct?

21 A: Well, this is the -- their assumptions with
22 regard to shift by area, yes.

23 Q: All right. And they were proposing it to
24 summarize it and review it quickly, 75 percent
25 of the patients they've been serving

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1 historically from northern York County would
2 shift to CMC-Fort Mill, correct?

3 A: Yes.

4 Q: And 80 percent of those from the region that
5 you've identified and they identified as Rock
6 Hill, the three zips there, and then 50 percent
7 from the western York County zip codes, correct?

8 A: Yes.

9 Q: All right. And again, these are assumptions
10 they adopted, not you, correct?

11 A: Correct. I did not choose these assumptions.

12 Q: And you don't know why they made these
13 particular assumptions, do you?

14 A: My understand is they looked at other, you
15 know, community hospitals in their market, but
16 it was their choice of assumptions. I, again,
17 evaluated it after they had prepared the
18 projections on a comparative basis.

19 Q: And you don't know if, or do you, whether they
20 tested other assumptions concerning market share
21 before landing on these and settling on these
22 three components, 75, 80, and 50?

23 A: I don't know.

24 Q: All right. And in the -- in this Carolinas
25 utilization model, these market share

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- 1 assumptions really drove the project utilization
2 for CMC-Fort Mill, didn't they?
- 3 A: I mean, they were an important component, yes,
4 because they ---
- 5 Q: They weren't the only -- excuse me for
6 interrupting. Go ahead.
- 7 A: They weren't the only component, but they were
8 a significant component in developing the
9 projections.
- 10 Q: Okay. And if these market share assumptions
11 would have been greater, the occupancy for CMC-
12 Fort Mill would have been greater, correct?
- 13 A: That's true. I think it would be unrealistic
14 for them to be much higher than that, but I
15 guess that would mathematically be the case.
- 16 Q: And if same -- if the flip side's true, if they
17 were less then the occupancy were less -- would
18 be less, and again, unless patients were shifted
19 from another provider such as Piedmont, true?
- 20 A: If they were less, the utilization would be
21 less.
- 22 Q: Unless they were -- the balance was made up for
23 by other existing providers, that'd be a common
24 way to project utilization in new hospitals,
25 some from the parent and some from existing

1 providers, true?

2 A: Well, you sort of asked a two-part question
3 there. If the shift was less and there was an
4 assumed shift from other providers, then the
5 utilization might not be less. As far as
6 whether it's common or not, I mean, there --
7 I've seen it done different ways. Quite often
8 it's primarily a shift driven by sort of the
9 parent hospital or the system when it comes to
10 a new hospital.

11 Q: Okay.

12 **MR. ANDREWS:** Well, let's -- Dan, turn with me in
13 this document to page 41.

14 Q: Let's look at what, in fact, was projected for
15 the occupancy and how this model produced that.

16 **MR. ANDREWS:** Dan, if you'll go down to the last
17 line on these sets of columns. I'm sorry.
18 Let's -- yeah, shift to page 41 on this
19 document. And then let's highlight, if you
20 would, this lefthand column all the way down to
21 the last line and then highlight the last line
22 all the way across, percent occupancy. There
23 we go.

24 Q: And, Ms. Platt, isn't this the methodology, the
25 element of the methodology in which Carolinas

1 calculated what the occupancy would be after
2 applying the shift in the market share that
3 you've just testified about?

4 A: Yes, they would have applied the shift to the
5 projected market discharges and applied the
6 other in-migration factor from outside the
7 service area and calculated the percent
8 occupancy.

9 Q: Okay. And you don't know the basis for their
10 assumption that CMC-Fort Mill would be occupied
11 at 67.5 percent by year three, do you?

12 A: I don't know that that percent occupancy was an
13 assumption. I think it was the assumptions
14 that set up the methodology that resulted in
15 that occupancy rate.

16 Q: Really? So you believe that they chose out of
17 the blue a shift of 75, 80, and 50 percent, and
18 it just happened to land as an occupancy rate
19 of 67.5?

20 A: I mean, the way the model calculates through is
21 that those shifts are applied to the discharges
22 in the area and it flows through the model and
23 calculates 67.5 percent.

24 Q: And 65 percent is the percent that's in the
25 State Health Plan that's identified as a trigger

1 for justifying the approval of additional beds,
2 isn't it, for a hospital this size?

3 A: It's a factor that goes into the bed need
4 methodology for calculating new beds.

5 Q: Well, without exceeding that level, the State
6 Health Plan methodology won't recognize a need
7 for new beds for that particular facility, will
8 it?

9 A: That is a factor in the bed need methodology in
10 the State Health Plan, yes.

11 Q: And again, unless the -- considering all the
12 factors that affect it, unless the bed need
13 exceeds 67.5 percent there -- a bed need would
14 not be recognized in the State Health Plan,
15 isn't that true?

16 A: That's generally the way the methodology works.

17 Q: Okay. All right. Now, if the occupancy
18 assumption -- well, let me ask you to assume
19 that -- well, let me just ask in your
20 experience, have you not participated in the
21 development of utilization projections where
22 there's an assumption about the degree to which
23 a new facility or any service would be occupied
24 and then back into the assumptions for market
25 share that would support that occupancy rate?

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1 A: That's -- that -- generally the way that I
2 develop models, I mean, usually I look at the
3 market share and what's a reasonable level of
4 market share to achieve or to shift and then
5 see how that flows through to the resultant
6 market -- or the resultant utilization.

7 Q: Okay. And if you ---

8 A: It's sort of backwards to pick the occupancy
9 target and go backwards to market share.

10 Q: If you were then, though -- and you don't know
11 whether Carolinas did this based on your
12 testimony, assuming different market shares and
13 they produced an occupancy rate that was too
14 low or one that you didn't -- you believe was
15 too high, then you might want to make changes
16 to the assumptions about market share, wouldn't
17 you?

18 A: I mean, I wasn't involved in developing that
19 model.

20 Q: I know, I'm just asking you generally.

21 A: I mean, if you picked market share assumptions
22 and they ran through and your occupancy rate
23 was higher than you think you could support,
24 then you could reduce the market share and it
25 would be a more conservative model, but I don't

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1 know what they did model-wise.

2 Q: Okay. Well, you said you reviewed and offered
3 opinions on the '05 applications. Do you know
4 why Carolinas changed its methodology and its
5 market share assumptions from its '05 to its
6 '10 application?

7 A: I don't know why they changed their methodology,
8 I did not discuss that with them. They
9 developed their methodology. I know that one
10 of the things that changed between 2005 and
11 2010 was that Carolinas had a greater market
12 share of the service area. So I'm sure that
13 was factored into their projections.

14 Q: Okay. And in that regard, the inconsistencies
15 that you pointed out between Piedmont's
16 application from '05 to '10 also could have
17 reflected changes in their market share. Did
18 you account for that?

19 A: Yes. And I think that is quite likely the
20 reason for the decline, but my point was that
21 with a lower level of utilization, their
22 projections didn't support 100 beds.

23 Q: All right. Well, we'll get to that in a little
24 bit, but let's go back to the question of the
25 occupancy rates. Now, assume for me if you

1 would that Carolinas' proposed occupancy rate of
2 CMC-Fort Mill was not 67.5 percent but 80
3 percent.

4 A: Okay.

5 Q: That would require different assumptions, would
6 it not, to support that degree of occupancy of
7 the market share it would have throughout York
8 County. True?

9 A: Yes, it would have to have higher market share
10 if it were 80 percent occupied.

11 Q: All right. And an 80 percent occupancy
12 reflects a pretty high demand for beds, doesn't
13 it?

14 A: Yes.

15 Q: And, in fact, do you recall that the OB service
16 at CMC-Fort Mill is proposed to be 82 percent?

17 A: I don't remember off the top of my head the
18 varying occupancy levels by unit. I'd have to
19 look at the record to remember exactly.

20 Q: You couldn't disagree with that though? You
21 wouldn't?

22 A: I don't recall the precise percentage. I
23 believe the occupancy of the OB unit was a
24 little bit higher than the acute care beds in
25 total, but I don't recall.

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1 Q: Okay. Well, let's take a look at that. Let's
2 see.

3 MR. ANDREWS: Turn to page 485 of this same
4 document, please, Dan.

5 Q: Let's go down to the lower right-hand column.
6 See percent occupancy for the OB beds at CMC-
7 Fort Mill?

8 A: Yes.

9 Q: And what does that show in year three?

10 A: 81.9 percent.

11 Q: Okay. And, in fact, it's year one, right out
12 of the box, 79.5 percent. Do you see that?

13 A: Yes.

14 Q: There's a high demand for those beds and --
15 isn't that true?

16 A: Those beds would be well utilized.

17 Q: In fact, they justify more beds, couldn't they?

18 A: Well, the occupancy standard is not broken down
19 for OB beds and specific, it's for total acute
20 care beds, but it's a pretty high level of
21 utilization.

22 Q: All right. Now you also participated in the
23 development of the application for the satellite
24 hospital of Georgetown Memorial Hospital, which
25 is Waccamaw Community Hospital, didn't you?

1 A: Yes.

2 Q: And, in fact, that hospital was operating at
3 such a high level of utilization that it had to
4 increase from 40 beds to over 124 in the first
5 five years of its operation, isn't that true?

6 A: I don't remember the exact number of beds, but
7 I do recall that there were multiple expansion
8 projects. Some of those were for rehabilitation
9 beds, not general acute care beds.

10 Q: And you also participated in the development of
11 the application to create satellite facility for
12 Seacoast Hospital, didn't you?

13 A: Yes, the -- you mean, Loris' satellite,
14 Seacoast, yes.

15 Q: Right. And, in fact, the proposed utilization
16 for that facility was over 80 percent, wasn't
17 it? Do you remember that?

18 A: I don't recall off the top of my head. It was
19 a relatively small facility.

20 Q: How many beds was it?

21 A: Again, I don't -- I don't recall. There's too
22 many projects for me to remember every project
23 that ---

24 Q: Fifty-bed hospital, sound about right?

25 A: Sounds about right.

1 Q: And the ...

2 **MR. ANDREWS:** Your Honor, if I may approach?

3 **THE COURT:** Yes.

4 Q: Ms. Platt, if you'd take a look at this and
5 identify what it is on page 44.

6 A: It appears to be a ---

7 **MR. ANDREWS:** Excuse me just a minute, Ms. Platt.

8 **THE COURT:** Thank you.

9 Q: Now, identify what this is, please, Ms. Platt.

10 A: It appears to be sort of the summary table at
11 the end of the presentation of utilization
12 projections for Seacoast Medical Center.

13 Q: Okay. And this is a document you prepared?
14 It's an excerpt from the 800-page, so forgive
15 me, but I thought we all wouldn't want to carry
16 that around. But this is an excerpt from the
17 CON application you prepared to establish the
18 50-bed satellite hospital on behalf of Loris
19 Healthcare System, is that right?

20 A: I did prepare this application. I did not
21 prepare the financial projections. They were
22 derived from a market feasibility study done by
23 Dixon Hughes.

24 **MR. ANDREWS:** Okay. And, Your Honor, I'd like to
25 move to introduce this as Piedmont's next

1 exhibit, which is 118. 118, Your Honor.

2 **THE COURT:** Ms. Robertson?

3 **MS. ROBERTSON:** Your Honor, I'm not sure we've ever
4 seen this identified as an exhibit, nor do I
5 believe we've ever had them produce this to us.

6 **MR. ANDREWS:** Both are true. It's a -- Your Honor,
7 we're operating under the assumption, based on
8 long history of doing this, that exhibits
9 entered through cross-examination of another
10 party do not have to be identified in advance;
11 only those entered in our case in chief. I
12 mean, it defeats the whole purpose of
13 introducing a document which would be the basis
14 for cross-examination to give advance notice of
15 it. We haven't expected that to be applied
16 with regard to our witnesses either. So that
17 would be the basis for why it hasn't been
18 previously identified. And we've laid a
19 foundation for it. It's no surprise to the
20 witness, it's her document.

21 **MS. ROBERTSON:** Your Honor, I guess the assumption
22 we had was that the rules that require you to
23 exchange exhibit lists and witness lists were,
24 in fact, to exchange those that you expected to
25 use in this case. We didn't get any notice of

1 this and, you know, he says it's no prejudice
2 to the witness, but the party certainly has not
3 had an opportunity to look at this or
4 contemplate any questioning with respect to this
5 witness.

6 **MR. ANDREWS:** Well, I also offer another grounds for
7 it, Your Honor, without having to have to make
8 a decision about that, it would be offered for
9 impeachment purposes. In direct a few minutes
10 ago, Ms. Platt stated that when I asked her
11 about the assumptions related to 67.5 percent
12 that much greater than that would be
13 unrealistic, and this is a CON application she
14 prepared where the proposal was in excess of 80
15 percent. That's the basis for the introduction
16 of it. So I think at the very least it would
17 qualify to go in as an exhibit for impeachment
18 purposes.

19 **MR. ROBERTSON:** I'm not sure that was her testimony,
20 Your Honor, so I'm not sure that this is
21 appropriate impeachment. But obviously, we've
22 not had a chance to look at it. I mean, if
23 that is the purpose for which he's going to use
24 it on impeachment, I'm just not sure that, in
25 fact, her testimony was the way he just

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1 characterized it.

2 **THE COURT:** Well, I'm going to allow it on the basis
3 of an impeachment document. And I think you
4 can establish whether that was her testimony or
5 whether this, in fact -- you can rehabilitate
6 the witness if that was not exactly what she
7 said. I'm going to allow it for those
8 purposes, for impeachment purposes.

9 **(Petitioner's Exhibit Number 118 was admitted into**
10 **evidence.)**

11 Q: So, Ms. Platt, based on your experience both
12 with the OB and in Waccamaw and here with
13 Seacoast, it's not uncommon for units or entire
14 satellite facilities that are small to operate
15 at high levels of occupancies such as proposed
16 here for 80 percent at Seacoast, isn't that
17 right?

18 A: Certainly small hospitals can operate at a
19 higher level and so can OB units. I just want
20 to clarify, however, and I've been trying to
21 recall more precisely the situation with Loris
22 and why this application doesn't look like one
23 that I prepared, this -- and it's coming back
24 to me now, I did not prepare this application.
25 It was prepared -- I'm not sure who prepared

1 it. I know that the utilization projections
2 were prepared by Dixon Hughes and Associates,
3 and my role in working with Loris was after the
4 application was filed in preparation for project
5 review and submission of additional information
6 and then assisting them at hearing. So I did
7 not prepare this document. And I also believe
8 what I said earlier is that I thought the
9 percent shift, projecting a much higher
10 percentage of shift in market share than what
11 was projected by Carolinas was not necessarily
12 reasonable. I don't know that I said that a
13 certain level of occupancy was too high or
14 unrealistic.

15 Q: Okay. So you believe that for a small hospital
16 an 80 percent occupancy level would be
17 realistic; would you agree to that?

18 A: It could be achieved. I mean, it could also be
19 less. It's not that -- I don't choose an end
20 result of occupancy. I would pick what I
21 thought were reasonable occupancy or market
22 share percentages and see how that drives the
23 utilization and the ultimate occupancy.

24 Q: Okay. Well, let me then ask you to assume that
25 the occupancy at CMC-Fort Mill would be 80

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1 percent in year three rather than 67 and a half
2 percent. Do you recall that the average daily
3 census for CMC-Fort Mill at 67 and a half
4 percent was somewhere in the range of 83
5 patients a day?

6 A: And say that again.

7 Q: Let's look at page 41. You got a calculator?

8 A: I do.

9 Q: Well, it's calculated for you on page 481.

10 **MR. ANDREWS:** Dan, if we could go back to that.

11 Q: And the question was whether the ADC for a --
12 for CMC-Fort Mill as projected by year three to
13 be 43 patients a day?

14 A: Well, I thought you just said 83 patients a
15 day. Sorry.

16 Q: If I did I misspoke and thank you for
17 correcting me. But 43 is what I meant to say.
18 Is it 43?

19 **MR. ANDREWS:** Dan, actually we're going up two lines
20 for average daily census above percent occupancy
21 on page 481. Take it across. Thank you.
22 There you go.

23 A: Right. The ADC is 43 a day, and that results
24 in an occupancy rate of 67.5 percent.

25 Q: Okay. And I see you had the calculator there

1 for me. Run it if the 80 percent, the
2 occupancy were 80 percent, what the average
3 daily census would be?

4 A: 51.2.

5 Q: So about a difference of about eight patients
6 per day?

7 A: Yes.

8 Q: All right. Now, if we assume the higher
9 occupancy rate of 80 percent then there would
10 need to be an increase in the assumptions about
11 market share in order to achieve that rate of
12 occupancy, right?

13 A: Yes.

14 Q: And as we talked about earlier, there basically
15 are two options available to you to calculate
16 that. You could increase the shift from
17 Carolinas; that would be one way, right?

18 A: Yes.

19 Q: Another would you could have a given shift from
20 Carolinas and then you could move patients, that
21 is, shift them from existing providers; that
22 would be the alternative, right?

23 A: Yes.

24 Q: Now, let's look at the model, Carolinas, to see
25 what they did with respect to that question.

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1 **MR. ANDREWS:** Dan, look at 478, if you would, and
2 look at the left-hand column called market share
3 and take that all the way down to the bottom.
4 Highlight that, please, if you would. And the
5 next to the last line in particular, call that
6 out, where there -- actually, look at the last
7 three lines and highlight those last three
8 lines, please. Yes, that's it, that left-hand
9 corner. And take that all the way across if
10 you would please, Dan.

11 Q: And while he's doing that, Ms. Platt, there are
12 really three issues identified there. First, is
13 the shift in share to CMC-Fort Mill from
14 Carolinas, correct?

15 A: Yes.

16 Q: Isn't that what that ---

17 A: The first piece is shift from, I guess that's
18 75 percent from the Fort Mill area to CMC-Fort
19 Mill.

20 Q: Yeah. All right. And that 75 percent, as you
21 testified earlier, of the Carolinas patient
22 base, correct?

23 A: Yes.

24 Q: And if you take that across, then that is --
25 that 75 percent of 52.9 is 39.7, right?

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1 A: Yes.

2 Q: And that's how the math works. And the
3 assumption in Carolinas' model is that's the
4 basis of their projection of who they'd serve;
5 the patients they've served historically and
6 they'll assume for the northern York County
7 regions 75 percent of those?

8 A: Yes.

9 Q: Now, the next line in their model, it says gain
10 and share by CMC-Fort Mill. Now, one has a
11 line for shift in share from Carolinas. The
12 next is gain in share, and if we look all the
13 way across, that's zeroed out, right?

14 A: Yes.

15 Q: Now, the gain in share as opposed to the shift
16 in share, the gain in share would mean, in this
17 model, gain from other existing providers,
18 wouldn't it?

19 A: Correct, gain from either Piedmont or the Novant
20 System or other providers who are serving the
21 market.

22 Q: Right, and that's zeroed out here. And then,
23 now, are you aware that in developing this
24 model that Carolinas had a value, a figure, a
25 number that reflected the percent of which they

1 would gain from Piedmont or Novant to -- excuse
2 me, Piedmont, the principal provider in York
3 County? Do you know whether that number had
4 been filled, that line had been filled in with
5 something other than zero in prior runs of this
6 model?

7 A: I don't know one way or the other. I was not
8 involved in the development of the model.

9 Q: And in 2005, that -- there was that that blank
10 -- you're familiar because you reviewed the
11 application, right? It was filled in reflecting
12 the extent of the market share that would be
13 taken from Piedmont, true?

14 A: I don't recall what the figure is, but there
15 was some assumption of shift. But at that
16 point in time, as I stated earlier, that
17 Carolinas had a different market share of the
18 area, and they had a significant growth in the
19 market share that occurred between 2005 and
20 2010.

21 Q: Now, in your experience, it's more unusual than
22 not, isn't it, that there would be when a new
23 hospital's built gain from, expected from
24 existing providers?

25 A: That can occur, you know, when -- it depends on

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1 the market situation. But in this instance,
2 Carolinas has a high market share already of
3 the area and they certainly can fill and meet
4 their utilization productions without having to
5 take any market share from other providers.

6 Q: Yeah, but this isn't a theoretical exercise;
7 it's a real world exercise and -- isn't that
8 true?

9 A: Well, it's a real world exercise, but all of us
10 are having to present our theory of how we
11 think this would all play out, so we can only
12 do the best that we can do.

13 Q: Right. And about how not -- how it could play
14 out but how it would play out, and you would
15 agree with me, wouldn't you, that how it will
16 play out or how it's projected to be likely to
17 play out is the important question for the
18 Court to consider?

19 A: Yes, but again, none of us know that. We're
20 all presenting what we think is the most
21 reasonable way for it to play out.

22 Q: Well, and in your experience, Ms. Platt, it
23 would be highly unusual for a hospital to
24 invest \$80 million in the development of a new
25 project and not expect any incremental growth in

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1 market share, not to be getting any new
2 business from that investment; wouldn't that be
3 unusual?

4 A: Well, there will be new business because the
5 market overall is growing, so there's going to
6 more discharges for everyone that's serving that
7 market. So to me, that helps to justify the
8 expenditure. It also -- the other Carolinas
9 facilities are full, and they need to be able
10 to meet their sort of systemwide overall demand.
11 So there's many reasons why this project makes
12 sense as a system.

13 Q: Okay. And that growth would be to the extent
14 they already have market share and are shifting
15 it, that would be growth that would continue to
16 affect their market share? They would continue
17 to gain in Pineville, in CMC-Main, and other
18 Charlotte area hospitals just as they've gained
19 in the past, correct?

20 A: I didn't say that. What I said is that they
21 would gain volume just by simple population
22 growth even with a constant market share.

23 Q: And what my question was, there's no reason to
24 believe they wouldn't continue to gain market
25 share without a hospital in Fort Mill since

1 they've continued to in the past, isn't that
2 true?

3 A: My understanding is the most recent numbers show
4 that market share has sort of leveled off in
5 terms of Piedmont's loss and Carolinas' gain.

6 Q: But we're moving back and forth between market
7 share and growth, and even if the market share
8 were flat, they would continue to grow and
9 experience growth, which I thought was your
10 point?

11 A: Everyone who's serving the market would continue
12 to have growth based on population growth.

13 Q: Okay. All right. Let's go back to the steps
14 in the utilization methodology.

15 **MR. ANDREWS:** And look at number nine, Dan, back on
16 page four.

17 Q: Now the -- in developing the assumption about
18 the ten percent in-migration, do you know
19 whether Carolinas assumed that that ten percent
20 would all be Carolinas patients or whether they
21 would be patients who had been served by
22 Piedmont in the past from Chester and Lancaster
23 counties?

24 A: At least from what's presented here in the
25 application, I don't know that they broke that

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1 ten percent down. But I was not involved in
2 developing that ten percent assumption.

3 Q: And you don't know then whether or not -- and
4 you do recognize that Piedmont historically has
5 served a substantial number of patients from
6 Chester and Lancaster counties? You're aware of
7 that, aren't you?

8 A: I don't know if I would use the term
9 "substantial" because it implies a comparison.
10 I'm not sure where you're comparing to, but
11 yes, certainly patients do travel from those
12 areas to Carolinas.

13 Q: All right. And the methodology isn't clear as
14 to whether or not Carolinas is recognizing that
15 they would take from that in-migration market
16 share from Piedmont? That's not clear, is it?

17 A: I don't know that in this line item it's stated
18 one way or another, but certainly, as you said,
19 they are serving patients from those areas. So
20 it would be closer for those, that same base of
21 patients that is already choosing Carolinas to
22 use a hospital developed by Carolinas in Fort
23 Mill.

24 Q: All right. Now, let me draw your attention to
25 the next paragraph. The one in paragraph on

1 page 474, paragraph ten. Now, this states,
2 does it not, that Carolinas is assuming that
3 inpatient discharges at CMC-Fort Mill will come
4 from York County patients currently seeking care
5 at Carolinas hospitals in North Carolina, right?

6 A: Yes.

7 Q: All right. Now, there's no reference to market
8 share being constant. There's a specific
9 reference to relying on patients who are
10 currently then in 2010 when this information was
11 presented to DHEC, currently seeking care at
12 Carolinas hospitals, right?

13 A: Well, it implies they're a part of Carolinas'
14 existing market share.

15 Q: Well, that would be the necessary implication,
16 wouldn't it?

17 A: They're currently serving, yeah, they're
18 currently choosing Carolinas.

19 Q: All right. And you didn't develop that
20 assumption either, right?

21 A: No.

22 Q: Now, did you understand that to mean that there
23 would be, let's -- first of all, let's take a
24 look at the last sentence in paragraph ten. If
25 you'll look at that. Carolinas does not

1 project any additional market share shift from
2 Piedmont or from Presbyterian facilities; you
3 see that?

4 A: Yes.

5 Q: Now, do you understand that to mean a position
6 that Carolinas is expressing that they will not
7 -- that CMC-Fort Mill will not cause a shift in
8 patients from Piedmont, or that there would be
9 no shift from Piedmont to any Carolinas
10 facility?

11 A: Based on the information that's in the
12 application, it's my understanding that there
13 would be no shift from Piedmont to any
14 Carolinas facility for those zip codes. The
15 presentation is clear that the total Carolinas
16 market share would be the same in the zip code
17 service area.

18 Q: All right. Now, where I'm going to ask you to
19 go is it's clear that's proposed with regard to
20 the utilization of CMC-Fort Mill. Do you know
21 whether in this inpatient projection that there
22 was consideration given to the possibility or
23 the likelihood that CMC-Fort Mill could generate
24 a shift to patients from Piedmont to North
25 Carolina based Carolinas facilities, that is, to

1 Pineville or to Main? Is there any recognition
2 given to that potential?

3 A: I don't recall that in the methodology.

4 Q: What is your position concerning whether or not
5 CMC-Fort Mill will cause further erosion of
6 Piedmont's market share to Carolinas?

7 A: I don't believe it will. I think -- I think
8 Carolinas will focus on shifting their own
9 market share base to the closest facility, which
10 would be Fort Mill Medical Center. And as I
11 mentioned before, they have incentive to do that
12 given that their other hospitals are well
13 utilized.

14 Q: Yeah. Well, with regard to tertiary and
15 complex services, CMC-Fort Mill is not going to
16 provide that care, is it?

17 A: No.

18 Q: And there's every incentive in the world, isn't
19 there, from a service delivery point of view
20 for Carolinas to want to capture as much
21 tertiary business and complex service business
22 as they can for Piedmont in the North Carolina?
23 There's no disincentive to do that from an
24 occupancy or a workload point of view, is
25 there?

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1 A: Well, as I recall, CMC-Downtown, the main
2 tertiary academic medical center, is very highly
3 utilized. I don't -- I don't know that they
4 could accommodate additional tertiary and high
5 level patients.

6 Q: They've moved beds to Pineville and added two
7 open heart surgery suites and cath labs there
8 expressly for the purpose of expanding
9 Carolinas' open heart surgery program, have they
10 not?

11 A: Are you talking about CMC?

12 Q: Yeah.

13 A: You'd have to ask another witness. I'm not
14 involved with all the decisions that are made
15 for CMC-Main campus.

16 Q: I didn't ask about CMC-Main campus. Are you
17 not aware that CMC-Pineville has had an
18 expansion of 86 beds, over \$175 million
19 investment to establish and expand a heart
20 program at CMC-Pineville?

21 A: The way you said it I thought you said CMC-
22 Main, and I asked you CMC-Main and you agreed,
23 so I'm sorry if I misunderstood.

24 Q: Well, I apologize if I've been confusing you.

25 A: I do understand that there's a bed expansion at

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1 Pineville. I don't know the status of the open
2 heart program. I've not been involved in
3 writing CON applications for CMC-Pineville in
4 recent years.

5 Q: And you would not -- so you would not have any
6 reason to believe that Carolinas would not want
7 to capture all the market share they could out
8 of York County at either CMC-Pineville or Main
9 for its open heart program?

10 A: Again, I reviewed the application based on what
11 was presented to DHEC. It was not within the
12 scope of what I was asked to do to go behind
13 all the numbers and look at all the assumptions
14 and how that played out within their system.

15 Q: Did you -- you certainly read the letters
16 provided by the physicians who were concerned
17 about the loss of tertiary services to North
18 Carolina, didn't you?

19 A: I've read some of the letters. There were a
20 huge number of letters submitted by all parties,
21 and I did not review all of them.

22 Q: Did you review the letters from physicians
23 expressing their concerns about the loss of
24 tertiary and other complex services to Carolinas
25 in North Carolina?

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1 A: I'm aware that there were a few letters to that
2 regard.

3 Q: A few? Did you ---

4 A: I don't know the number.

5 Q: Have you read them?

6 A: I think I just said that I have read a few
7 letters, but given the thousands of letters that
8 were submitted by all parties, I did not review
9 all of the letters.

10 Q: I thought my question was clear that I was
11 talking about physician letters, and if it
12 wasn't, let me be clear. Did you read the
13 physician letters in which there were concerns
14 expressed about the loss of tertiary and complex
15 services to Carolinas facilities in North
16 Carolina?

17 A: I have read some letters to that effect. I
18 don't know how many I've looked at, and I'm
19 sure that I've not looked at the full scope of
20 letters for all of that given how many there
21 were.

22 Q: Did you give any weight to that possibility in
23 your analysis of the application?

24 A: My focus was on analyzing the information that
25 was put in the record in terms of the

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1 reasonableness of the projections submitted by
2 the applicants, the assumptions that went into
3 their models. The support letters, my focus
4 was on whether the applicants met the review
5 criteria related to community support or
6 community opposition.

7 Q: We'll deal more with that more in adverse
8 impact, so I'll come back to that. But let me
9 know move on, Ms. Platt, to your opinions
10 related to financial projections in the
11 application, the criteria to them. Again, you
12 weren't involved in the development of the
13 assumptions or projections for the financial
14 components of the application, correct?

15 A: Correct.

16 Q: And the opinions you've offered related to the
17 various components of the slides that you
18 showed in your demonstratives, let me ask you
19 about. Let's actually begin with the ones
20 related to your project review -- your opinions
21 related to expenses. Let's start with section
22 seven of the regulations.

23 **MR. ANDREWS:** Dan, if you'll pull up in the regs
24 Section Seven?

25 Q: You got that? Do you have a copy of the regs

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1 with you, Ms. Platt?

2 A: I don't, but I have a reference to them within
3 my demonstrative exhibits.

4 Q: Okay. Good. Now, read the reg, if you would.
5 I just want to make sure we're on the same
6 page.

7 A: It's criterion 7, projected expenses.
8 Projections of construction costs, start up
9 costs, operating cost, debt service,
10 depreciation, manpower costs, etcetera, should
11 be consistent with those experienced by similar
12 facilities offering a similar level and scope of
13 services with proper consideration given to such
14 factors as inflation and cost of capital,
15 etcetera.

16 Q: Now, this provides guidance to the Department
17 and to the Court about how to evaluate the
18 reasonableness of projected expenses, doesn't
19 it?

20 A: Yes.

21 Q: And you didn't do what's stated here in the
22 regulation, did you?

23 A: I believe I did.

24 Q: Well, let me ask you specifically. Did you
25 develop an opinion that was based on whether or

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1 not the projected costs in these various
2 components was consistent with those costs
3 experienced by similar facilities offering a
4 similar level and scope of services? You
5 didn't do that, did you?

6 A: I compared the two applications that we're here
7 to discuss on the basis of construction costs,
8 startup costs, operating costs, debt service,
9 and a variety of these factors, and that was my
10 understanding of the approach that DHEC takes
11 when they are analyzing applications for new
12 acute care hospitals.

13 Q: Well, you weren't here for Ms. Brandt's
14 testimony, were you?

15 A: I was not.

16 Q: And Ms. Brandt recognized in her testimony that
17 what this meant was a comparison with, as the
18 language says, those costs experienced by
19 similar facilities. Now, experienced by similar
20 facilities would mean existing facilities,
21 wouldn't it?

22 A: Yes, it would.

23 Q: And those costs that have been approved by the
24 agency, correct? That the -- that is the basis
25 for determining the level of reasonableness of

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1 the projections, correct?

2 A: Well, I guess two things along those lines.
3 That is not, in my experience, how DHEC has
4 looked at the expenses. I have not seen them
5 go and pull a variety of different acute care
6 hospitals and necessarily compare those
7 expenses. I think they look to the assumptions
8 that were provided in the applications and the
9 fact that, at least from Carolinas' standpoint,
10 their assumptions were based on other community
11 hospitals of a similar size.

12 Q: Well, let's take a look at what Mr. Levitt did
13 and testified about it in his demonstrative.

14 MR. ANDREWS: Dan, if you'll pull up Demonstrative
15 151.

16 Q: Now, have you seen this demonstrative? Have
17 these been among those that you've been looking
18 at since the case was pending?

19 A: I have not focused on this exhibit.

20 Q: Well, you say you didn't focus on it. You've
21 looked at it, but haven't studied it or gone
22 back behind it; is that what you meant?

23 A: I haven't even studied it.

24 Q: Okay. Well, then let's go through it, and may
25 ask you to accept that the applications approved

1 by the Department for satellite hospitals for
2 new construction are reflected in this
3 demonstrative. Do you see that?

4 A: I mean, that appears to be what's reflected,
5 but I have not checked on any of these numbers
6 or gone behind them, so, I can only state that
7 that's what's on the page and that's what's
8 represented.

9 Q: And based on what's on the page and what's
10 represented here, you would agree with me,
11 wouldn't you, that the construction costs for
12 Carolinas Fort Mill and for the Fort Mill
13 Medical Center are consistent with the
14 construction costs that had been recognized and
15 approved in four other CON applications since
16 2005; wouldn't that be true?

17 A: They're within the range of what's been
18 presented here on this exhibit. Again, I
19 haven't analyzed this information or gone behind
20 the numbers. I'm also not sure how inflation
21 was considered because, obviously, these
22 projects were proposed at different periods of
23 time.

24 Q: Exactly. And if you incorporate the
25 inflationary value and the cost over time, then

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1 Carolinas' and Fort Mill's would be even lower
2 than many, if not all, of the satellite
3 hospitals on a per bed basis that had been
4 approved by the Department. Wouldn't that be
5 true?

6 A: I don't know because I don't know if inflation
7 was taken into consideration or not in these
8 numbers. There's nothing that says anything
9 about an inflation assumption, and I have not
10 evaluated these numbers.

11 Q: Well, the sources identify the exhibits. The
12 exhibits identify the applications that were
13 submitted to the Department and approved by the
14 Department and the numbers, let me represent to
15 you, will tie directly to those without any
16 inflationary investments, okay?

17 A: Okay.

18 Q: So given that, if you wanted to adjust them for
19 inflation, as you raised the point, then it
20 would mean that the 2005 application, those 2005
21 costs would all be higher, correct?

22 A: The older the year, the more inflation, yes.

23 Q: And so again, my question is based on if you
24 wanted to adjust them for inflation to have
25 current figures, then would you agree with me

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1 that Carolinas and Fort Mill facilities would be
2 among the lowest, if not the lowest, on a per
3 bed basis of all the applications approved by
4 the Department for satellite hospitals or
5 community hospitals since 2005?

6 A: They would certainly be within the range.

7 Q: Okay.

8 A: I mean, this is also a different figure than I
9 used for Fort Mill Medical Center for their
10 total project costs. And I guess my point was
11 we're making the assumption that both projects
12 were within this range, then who is the better
13 applicant to meet the criterion.

14 Q: Well, assuming there's a head to head value,
15 but there again, there are variables in the
16 design and variables in patient services that
17 can affect the cost and do affect the cost of
18 every proposed hospital, aren't there?

19 A: Yes.

20 Q: And many of those things improve the experience
21 and improve the quality of services provided by
22 the patients that may cost more, isn't that
23 true?

24 A: They may or may not and they may be as simple
25 as the land is more costly. It's in a more

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1 expensive area to build.

2 Q: That's right. There are unlimited numbers of
3 variables that could affect costs and there's
4 nothing in the Department's regulations related
5 to construction costs that suggest for a minute
6 that the lower cost or the better cost and
7 should -- and that applicant proposing lower
8 costs should be considered the better applicant.
9 These regulations in section seven don't say
10 that at all, do they?

11 A: In my experience, it has been DHEC's practice
12 when they are reviewing comparative applications
13 to analyze the projects side by side and
14 evaluate the more cost effective project.

15 Q: My question was what the regs require, not what
16 your experience is with DHEC. You would agree
17 with me that the regs say nothing about doing
18 anything to determine reasonableness except
19 looking at similar projects that have been
20 approved and what their experience had been;
21 isn't that true?

22 A: If you're analyzing one project alone, then you
23 would certainly looked at that one project alone
24 in relation to projected expenses, project
25 costs, startup costs, operating costs. If

1 you're having to decide between two projects,
2 then you need to go the additional step and
3 compare them with respect to the criteria.

4 Q: Well, that's your opinion, but the regs don't
5 say that, do they?

6 A: The regs tell you what to evaluate, but if
7 you're in a situation and DHEC is supposed to
8 decide between two projects, they have to come
9 up with a way to comparatively decide between
10 the two projects. So they look again to the
11 language of the criteria and comparatively
12 evaluate under the criteria.

13 Q: The project -- well, you would agree with me
14 that the regs don't provide that guidance to
15 the Department and, in fact, with regard to the
16 construction costs and operating costs, the only
17 guidance they provide is compare those costs to
18 existing facilities whether there's a single
19 applicant or competing applicants; you'd have to
20 agree with that, wouldn't you?

21 A: The plain language of the criteria considers
22 comparison to other existing projects, but
23 again, if DHEC is in a position of having to
24 decide between two, they need to have some
25 direction as to how to compare them to

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1 determine which is the better applicant. At
2 the end of the day, they have to choose one
3 better applicant and approve one applicant, and
4 so they look again to the language of the
5 criteria to shape that comparison. And that's
6 been my experience in terms how they evaluate
7 comparative projects.

8 Q: Absolutely. And they must do that for criteria
9 in which there is significant meaningful
10 difference, not ones in which they -- such as
11 construction costs where there's three percent
12 difference that there's an opinion that one
13 favors the public, one application would favor
14 the public more even when there is less costs
15 supporting services to patients; isn't that
16 true?

17 A: I'm not sure I understand your question.

18 Q: Well, then I'll move on for a minute. Okay.
19 Now, you would agree with me that construction
20 costs that are proposed can change, and for
21 that reason, there should be limited weight that
22 the Department puts on it, isn't that right?

23 A: I think the weight that they put on project
24 costs falls within the ranking of the criteria.
25 And so the financial section including project

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1 expenses, number seven, I believe was ranked
2 third, if I'm recalling correctly back at the
3 beginning of my slides. And so that's where
4 they evaluate and rank it.

5 Q: All right. Let's take a look at a document
6 that you produced in discovery, Ms. Platt, 376
7 and 377.

8 A: Okay.

9 Q: Okay. Now, now this particular document ---

10 **MR. ANDREWS:** Dan, let's turn to page 181. I think
11 we can do a better comparison here.

12 Q: You'd want to make sure as you're doing this
13 refined analysis of the costs that you're
14 dealing with apples to apples in the same way
15 that you wanted to make adjustments to the
16 depreciation schedule, correct?

17 A: Yes.

18 Q: And what we're looking at --

19 **MR. ANDREWS:** Dan, if you would, let's begin by
20 looking at capital costs, it's about halfway
21 down on the left-hand column and just the first
22 line looking at construction. That's right.
23 Let's just start with 2005 and then we'll move
24 over and take a look at the comparisons that
25 are offered with 2010.

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1 **MS. ROBERTSON:** Mr. Andrews, could I just ask a
2 question? You stated page, 181, is that a
3 Bates 181 or ---

4 **MR. ANDREWS:** I'm sorry. No, excuse me. It's CHS
5 Platt 181.

6 **MS. ROBERTSON:** Okay. Thank you.

7 Q: Okay. Now, Ms. Platt, if you can track with me
8 here, if you would, for -- and this is a
9 document, did you prepare this, or is this
10 document from provided to you from Carolinas?

11 A: It was provided to me by Carolinas. They had
12 entered the various cost parameters into a
13 spreadsheet and shared that with me.

14 Q: Okay. All right. Let's look at the cost in
15 2005 for the 100-bed facility for what's
16 identified as Tenet or Piedmont's application.
17 Do you see that, 55,687,051?

18 A: Yes.

19 Q: And do you see the Carolinas cost that's
20 identified?

21 A: Yes, 40,920.

22 Q: 40,920,000?

23 A: I'm sorry, 40,920,000.

24 Q: Okay. Now, what I want you to do is track to
25 identify what those construction costs are for

1 under the 2010 update?

2 A: Well, I can't see --

3 Q: I know, we're going to pull them over for you.

4 A: I need to be able to see the headings.

5 Q: And I can ---

6 **MS. ROBERTSON:** I'm not sure, Mr. Andrews, this
7 bottom line that y'all pulling up, I'm not sure
8 that matches up under the columns. The second
9 part is Tenet, but yet we're putting it under
10 the Novant and Carolinas columns. It's a
11 little misleading the way I think it's being
12 pulled out and matched up.

13 **MR. ANDREWS:** Okay.

14 **MR. ROBERTSON:** Not intentionally I don't mean, but
15 it seems to not fall ---

16 **MR. ANDREWS:** Mr. Bupp wouldn't do anything
17 intentional like that to mislead anyone except
18 me occasionally.

19 **MS. ROBERTSON:** No, but I don't think those columns
20 match up.

21 **MR. ANDREWS:** All right. Fair enough.

22 Q: Okay. So we've got two figures, and if we can
23 go forward. There we go, that's works, and
24 look at the 2010 updates and see how they've
25 changed. And I'll represent to you that there

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1 are three different columns for Tenet that are
2 proposed.

3 **MR. ANDREWS:** Let's start there, Dan, if we could in
4 the first three columns or the next three
5 columns under 2010.

6 Q: So there's Tenet October 3, and then Tenet
7 December 3 and then Tenet December 3 with
8 capped interest. Do you see that, Ms. Platt?

9 A: I do.

10 Q: Now, the first 75,631,867 figure, do you recall
11 that that was Tenet's proposed cost at 2014
12 rates that were inflated?

13 A: Generally, yes.

14 Q: And then the next two columns show a reduction
15 in that to 68,160,435. Do you see that?

16 A: Yes.

17 Q: Now, I'm going to ask you to assume that there
18 were no material changes in Tenet's construction
19 design or plans, that would simply -- the
20 changes from 55 million to 68 million
21 represented the cost of, increased cost of money
22 and inflation over that time, okay?

23 A: Well ---

24 Q: And labor assumptions about that as well.

25 A: I believe there -- I mean, I can't say that

1 every single teeny aspect of the project was
2 exactly the same. And I know that at some
3 point in time I believe there was a cath lab
4 included in the project. So I don't know that
5 I could say it is purely just passage of time
6 and inflation.

7 Q: Okay.

8 A: I don't know if there was a change ---

9 Q: I'm talking about increase.

10 A: What's that?

11 Q: You're right. All the parties pulled out a
12 cath lab that was proposed, correct?

13 A: Right.

14 Q: So everyone had a cath lab and everyone
15 proposed taking out the cath lab?

16 A: Right. The assumption you were asking me to
17 make is that there were no design changes
18 whatsoever and --

19 Q: I think I said material changes, but ...

20 A: To me that's a material change, but it's ...

21 Q: Okay. Differentiated from the other part.
22 They all had a cath lab and they all proposed -
23 --

24 A: But you're asking me to compare the cost.

25 Q: Here's what I'm asking you. Let me just go

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1 ahead and make it clear what I'm asking you. I
2 wanted you to compare the increase in the costs
3 from 55 million to 68 million, do the math on
4 that. What's the percent increase?

5 A: From 55 to 75 or to 68?

6 Q: No, 55 to 68 after it was taken down.

7 A: I come up with a 22.4 percent increase.

8 Q: And that works out to about what per year if --
9 to the extent that it's driven by inflation?

10 A: I guess we're going from 2005 to 2010?

11 Q: Correct.

12 A: A little over four percent.

13 Q: All right. Now, do the same calculation with
14 Carolinas, if you would. Look at their \$40.2
15 million 2005 cost and compare that to their
16 2010 cost. What's their -- just for the
17 record, what's their 2010 cost?

18 A: It looks like it's 43,447,925.

19 Q: Okay.

20 A: Well, I don't have the beginning number now.

21 Q: I'm sorry, it's 40,920,000.

22 A: 6.1 percent, 6.2 percent.

23 Q: Over five years. And what does that work out
24 to be in annual inflation rate?

25 A: Roughly around one percent.

1 Q: All right. Now, you're not aware of any
2 material changes other than the dropping of the
3 cath lab in Carolinas proposed project from 2005
4 to 2010, are you?

5 A: I believe they may have changed the number of
6 OB beds and perhaps the observation ER a little
7 bit. I don't recall precisely, but there were
8 a few little changes.

9 Q: Would it be consistent with your memory that
10 they added two OB beds and they reduced their
11 ICU by two beds? There was a net no change?

12 A: I know there was no change in total beds. That
13 sounds -- I know that there was an increase in
14 the OB beds.

15 Q: All right. Now, during the staff review you
16 looked at Presbyterian's costs too, didn't you?

17 A: I did.

18 Q: And you were concerned, weren't you, that their
19 construction costs dropped from 2005, 45 million
20 to 2010 some 40 million? That concerned you,
21 didn't it?

22 A: Yes. I believe that that was one of the things
23 in my report, that their construction costs had
24 dropped over the time period.

25 Q: And one of the reasons you believe that their

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1 costs were understated is because the inflation
2 during this period of time was significant,
3 wasn't it, from 2005 to 2010, and you didn't
4 believe they had reflected that, isn't that
5 true?

6 A: There was inflation during that time and their
7 cost actually went down.

8 Q: And you thought that inflation during that
9 period from 2005 to 2010 was significant, didn't
10 you?

11 A: I mean, it's significant in that it's something
12 that needs to be considered. I's not ---

13 Q: I mean, that it was a lot of inflation during
14 that period. Post Katrina period was a time
15 where the cost of labor and the cost of
16 supplies increased dramatically, isn't that
17 true?

18 A: From what I recall, there was a pretty
19 significant increase around the 2008 time
20 period, but I don't know that that didn't
21 settle back down after that by the time these
22 projections were being made in 2010.

23 Q: But even if it settled back down, you agreed
24 with me in your deposition that the range might
25 be a little less than four to five percent

1 annually of inflation; isn't that right?

2 A: I don't recall what I said during my
3 deposition, but certainly there would be some
4 inflation over that time period.

5 Q: And it would be at a range of three or four
6 percent; you think that would be reasonable?

7 A: You know, I guess it depends on the methods of
8 the construction and the proposed materials, but
9 there certainly would be some inflation. I
10 don't -- at the time, I believe I looked at a
11 means index for inflation rates when I was
12 looking at the Presbyterian project, and that's
13 in my report.

14 Q: Yeah, but it would be true that the inflation
15 for that period of time from 2005 to 2010 would
16 be substantially more, two to three times or
17 greater than the one percent inflation rate
18 that's reflected by Carolinas' proposed change
19 from 2005 to 2010 for its construction cost,
20 wouldn't it?

21 A: I believe the inflation rate would be higher
22 than that one percent, to some degree, maybe a
23 little higher. But I guess the other thing
24 that is taken into consideration is any, you
25 know, design changes, and we've talked about

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1 several small design changes. So it's not just
2 an inflationary factor; there's other factors as
3 well.

4 Q: All right. Now ---

5 A: And that's why, I mean, I looked at it on a
6 cost per square footage basis as well, not just
7 a simple total cost figure.

8 Q: Okay. One of the important considerations
9 related to how much weight DHEC gives and you
10 gave in your opinion to the proposed
11 construction cost and total project cost, is
12 that they can change so much during the many
13 years that it takes from initially filing an
14 application to finally closing out a project,
15 isn't that right?

16 A: Could you say that again.

17 Q: Sure. Isn't one of the reasons that the
18 Department should be careful in assigning too
19 much weight to a proposed total project cost,
20 capital cost, is that those costs can change
21 substantially from the time that an
22 application's first filed to many years later
23 when a project's closed out?

24 A: Well, they can change, but they can't change
25 too much or else it becomes a problem with the

1 proposed -- you know, with the approved dollar
2 amount of the project. I don't know that
3 that's specifically the reason why that's ranked
4 lower. Again, I mean, if they're approving a
5 dollar amount, it has a meaning; it's sort of a
6 bright line that, you know, the Department
7 expects you to come in with your costs close to
8 that figure.

9 Q: Well, in fact, they give a complete blank check
10 to applicants to increase their cost by ten
11 percent, do they not, before any fine or any
12 additional review is applied, right?

13 A: There is a ten percent threshold, that's true.
14 But again, it's -- you know, they approve a
15 dollar amount. Yes, I mean, I guess you could
16 say that that dollar amount always has that ten
17 percent cushion in it. But if it had no
18 meaning and no one was expected to hold to it,
19 then I don't know that it would be something
20 that you wouldn't even have to put in the
21 project. There's a dollar amount that's
22 approved. Yes, it has a ten percent cushion,
23 but I don't think that's why it's necessarily
24 ranked where it's ranked.

25 Q: And even beyond the ten percent, there is just

1 a small fee that DHEC extracts, assuming that
2 the costs beyond ten percent are not within the
3 applicant's control, true?

4 A: There is a mechanism to that approval beyond
5 that ten percent with a fine, yes.

6 Q: Okay. To avoid the fine even if the costs are
7 demonstrated not to be within the applicant's
8 control, true?

9 A: You can ask for yes, for a cost overrun if it's
10 not within your control.

11 Q: Okay. Now, and cost overruns are not uncommon,
12 are they?

13 A: I mean, they happen. I don't -- I couldn't
14 tell you what percentage of the time it
15 happens.

16 Q: Well, let's look at some of the cost overruns
17 that Carolinas has experienced with its
18 projects.

19 MR. ANDREWS: Dan, let me ask you to pull up S-CHS-
20 518. All right. And if you'll call out line
21 24 on the first page of 518 for us. While
22 you're at it, Dan, you might as -- well, no,
23 let's just do one line at a time. That'll be a
24 little easier.

25 Q: Ms. Platt, can you see that well enough?

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1 That's it's a ---

2 A: I can see it, but I can't -- I guess I can't
3 read it all the way across. I don't know what
4 the columns are above it.

5 Q: Okay. Well, I'll represent to you that the
6 first column after the numbering is the year in
7 reviewed, the second is the ID number for the
8 North Carolina CON, the next is the applicant's
9 name, third is description -- or the fourth is
10 a description of a project. The next to the
11 last is the type of service involved, and the
12 final one is the total cost. Okay?

13 A: Okay.

14 Q: And line 24 is CMC project, the addition of
15 four floors to a surgical tower to include ICU
16 beds, progressive care beds, and medical
17 telemetry beds. You see that?

18 A: Yes.

19 Q: And \$70 million cost, you see that?

20 A: Yes.

21 **MR. ANDREWS:** Dan, let's take that to the next page,
22 if yo would, and pull out line 42.

23 Q: And if you -- the tie on this, Ms. Platt, if
24 you'll look at the description. It says -- you
25 with me ---

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- 1 A: Yes.
- 2 Q: --- cost overrun on F, 673903?
- 3 A: Yes.
- 4 Q: And do you remember that being the number ---
- 5 A: I believe so, yes.
- 6 Q: --- for line 24? Okay. All right. And the
- 7 cost overrun is how much?
- 8 A: It looks like it's 13.8 million.
- 9 Q: If you do the math on a \$70 million project,
- 10 what percent increase is that for the project?
- 11 A: 19.7.
- 12 Q: Okay. So a 19.7 percent increase on this
- 13 particular project for Carolinas Medical Center,
- 14 right?
- 15 A: Correct. I mean, but we don't know anything
- 16 else about the reasons for that or anything
- 17 else. I mean, I'm simply doing the math for
- 18 you.
- 19 Q: Thank you. That's what you did in this project
- 20 modifications, given data, did the math, right?
- 21 A: In many cases that's what I did, because that
- 22 is the way DHEC would approach it and that was
- 23 what I was asked to do, to compare side by side
- 24 the information that was put in the DHEC
- 25 record.

1 Q: Okay. Well, let's take a look at ---

2 **MS. ROBERTSON:** Your Honor, if I might object to
3 comparisons with the North Carolina projects.
4 I don't think Mr. Andrews has laid any
5 foundation for this being a comparison that is,
6 in fact, an equivalent comparison. I think
7 North Carolina has different standards with
8 respect to cost overruns versus South Carolina.
9 We have a ten percent standard here, and I
10 don't believe there's any limit in North
11 Carolina. So to the extent he's asking her to
12 compare cost overruns that operate under two
13 different systems, I think he needs to lay a
14 foundation with respect to that comparison with
15 this witness.

16 **MR. ANDREWS:** Your Honor, the purpose of this line
17 of testimony is simply to identify that cost
18 overruns for capital projects are not uncommon
19 and to demonstrate, in particular, Carolinas
20 Medical Center's history in that regard.

21 **THE COURT:** Ms. Robertson, I think I -- and I've got
22 that, Mr. Stuart. I mean, I understand your
23 line of questioning with this witness was to
24 talk about the fact that cost overruns are a
25 factor and that there are -- and that at least

1 with Carolinas they've had that experience. Do
2 we need to go further than that? Because I
3 think the question that Ms. Robertson is getting
4 into is that is the actual degree and the
5 percentage and whether the numbers that are used
6 in the North Carolina CON process, whether they
7 factor in the same things that would be
8 factored in in this state. I think your point
9 is that there are ---

10 **MR. ANDREWS:** To demonstrate that.

11 **THE COURT:** --- and they -- beyond that ...

12 **MS. ROBERTSON:** Well, he's just looking at a history
13 and giving a comparison of different standards,
14 so I think it mischaracterizes kind of the
15 comparison trying to be made. I mean, he's
16 making his point just saying that there's a
17 cost overrun, and I guess to the extent he's
18 trying to compare a historical basis to reflect
19 distinctions between cost overruns in South
20 Carolina with his ten percent that we talked
21 about versus North Carolina then some foundation
22 needs to be laid to show how that comparison is
23 working out.

24 **MR. ANDREWS:** I'm not going to explore this much
25 further, Your Honor. If I may ask a question

1 related to it? Or I'll move on if you want me
2 to.

3 **THE COURT:** Well, I don't -- I understand your
4 objection, and I'm not getting from this
5 particularly that there -- the degree of the
6 percentage of the overrun, but just that there
7 are periodically overruns. Is that the are you
8 going to ask this Court to focus on the actual
9 percent of the overrun and how much they
10 overrun or just the fact that there are kind of
11 overruns?

12 **MR. ANDREWS:** Well the fact they're overruns, they
13 may be considerable, they're far greater than
14 the three percent difference in the total
15 project cost per bed that's proposed here.

16 **THE COURT:** And I think to the extent that we get
17 into the actual percent then I think there
18 would have to be some foundation laid as to how
19 they measure overruns in North Carolina versus
20 if there's -- and if it's different than the
21 way overruns are measured in South Carolina.
22 To the extent that we're going to actually
23 focus on the degree of the overruns, I think
24 you do need to lay more of a foundation. But
25 if you're just going to ask the witness

1 questions about the fact is she aware that
2 there are overruns in projects, I don't think
3 you have to lay any foundation for that. I
4 would overrule the objection to that extent, but
5 to the extent that we're going to get into the
6 actual degree of the overrun, the percentage of
7 the overrun, then I think there would have to
8 be some foundation laid if in fact there is a
9 difference between the way they measure overruns
10 in the state of North Carolina and the way
11 measure it in South Carolina.

12 **MR. ANDREWS:** I would like the record to be clearer
13 than it is presently on that, so I'll ask some
14 questions related to that, if I may?

15 **THE COURT:** Thank you, Mr. Stuart.

16 Q: All right. Ms. Platt, you've got experience in
17 North Carolina and South Carolina with CON
18 applications, don't you?

19 A: Yes.

20 Q: In both states, the applications require the
21 total project cost to be identified by the
22 applicant, true?

23 A: Yes.

24 Q: And in both states, the Department, if it
25 approves an application, approves the

1 application and identifies the total project
2 cost that had been proposed by the applicant,
3 true?

4 A: Yes.

5 Q: And in both states, there is a report expected
6 at the conclusion of the project as to what the
7 total project costs are, right?

8 A: Yes.

9 Q: And the math that's applied to the overrun
10 would be identical in either state, true?

11 A: You mean in terms of how you would calculate a
12 percent of an overrun?

13 Q: That's right.

14 A: You'd calculate a percent the same way.

15 Q: North Carolina and South Carolina math works the
16 same way, right?

17 A: Yes.

18 Q: Now, the issue about the ten percent practice
19 in South Carolina, does it -- is there anything
20 comparable to that in North Carolina that you
21 know of?

22 A: I'm actually not recalling off the top of my
23 head exactly how the standard works in North
24 Carolina. I haven't had a client in North
25 Carolina that I have written a cost overrun

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1 application for in quite some time.

2 Q: Now, DHEC's practice with regard to the ten
3 percent waiver, that's not a regulation or
4 standard that you know of, is it? Not a
5 written standard?

6 A: The ten percent?

7 Q: Yes.

8 A: I think it's more of a practice.

9 Q: It's more of a practice.

10 A: Yes.

11 Q: And if a cost for an application, a cost for an
12 actual project exceeds, let's say, 20 percent,
13 there would be a -- that application, that CON
14 would not be withdrawn, would not be revoked by
15 the Department, would it? Have you ever seen
16 that?

17 A: CON's have been revoked. I don't know, I mean,
18 if you could ask for a cost overrun and explain
19 why the costs have changed.

20 Q: You've never seen a revocation of a CON because
21 of a cost overrun, have you?

22 A: Not that I can recall.

23 Q: And so, at worst, there would be a fine for the
24 overage over ten percent, correct?

25 A: There is a mechanism for a fine over ten

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1 percent.

2 Q: If the reason for the overrun is not explained
3 to the satisfaction of the Department, true?

4 A: Correct.

5 Q: And you're not aware of whether there's anything
6 comparable to North Carolina to address that
7 factor at all, is that right?

8 A: I don't know that there's a fine process the
9 same way, and again, I have not looked at those
10 regs for North Carolina for a while because I
11 have not had a client that's run into a cost
12 overrun situation that required review in quite
13 some time.

14 Q: Okay. Now, generally -- let's move on beyond
15 that. Well, there's one other thing actually
16 on that document that I wanted to draw to your
17 attention and to the Court's.

18 **MR. ANDREWS:** Dan, let's look at the second page of
19 that Exhibit 519. And call out line 38, if you
20 would.

21 Q: Can you read that line, Ms. Platt, from Mercy
22 Hospital?

23 A: Yes. It looks like there's an application for
24 Mercy Hospital to relocate 11 acute care beds
25 from CMC-Mercy to Pineville.

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1 Q: And for a cost of about \$43 million, right?

2 A: Yes.

3 Q: About \$11 million a -- sorry, about four
4 million dollars a bed?

5 A: Roughly.

6 Q: And let's look at line 52. And that was the
7 2005 application, and 2007 is the Mercy project
8 to move more beds to Pineville, correct?

9 A: It says Mercy Hospital Inc., Renovation and
10 Expansion Bed Tower 85 acute care beds relocated
11 from CMC-Mercy to CMC, it looks like University,
12 two ORs, two existing heart lung bypass machines
13 and two cardiac cath labs.

14 Q: For a total project cost of 174 million?

15 A: Yes.

16 Q: Roughly two million dollars a bed?

17 A: Yes.

18 Q: Now, one of the reasons for your opinion, as I
19 understand it, is that Carolinas demonstrates
20 greater commitment to cost containment than
21 Piedmont; has that been the basis for your
22 testimony?

23 A: I think -- I'm not sure that's exactly the way
24 that I put it, and when you're looking at the
25 cost factors, Carolinas' project is less costly,

1 more cost effective when you measure it per bed
2 and look at the expenses in a variety of ways.

3 Q: Let's take a look at how Carolinas presented to
4 the Department its commitment to containing
5 costs on page ---

6 **MR. ANDREWS:** Dan, let's pull up, if you would, S-
7 CHS-456. It's in the record, Your Honor. I'm
8 sorry I don't have the exact Bates record cite
9 that I'm sure Mr. Bupp will provide to us.
10 What's the Bates number on this, Dan? It's
11 Joint A-CHS, there is it, 1.483. Dan, if you'd
12 go back to the body. And let's take it down to
13 the next, just below that, there you go, right
14 there, the bullet points.

15 Q: You'll see in its submission to the Department,
16 Ms. Platt, that Carolinas is identifying that
17 from the period of time from 1996 through 2010
18 that it had 74 CON projects and expended \$1.3
19 billion for those projects, \$100 million a year
20 on its capital costs. And if the Department's
21 principal focus was to -- was the a desire to
22 contain costs, this hardly can be offered as an
23 example of Carolinas' commitment of doing that,
24 spending over a billion dollars during this
25 period of time. Would you agree with that?

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1 A: No, I wouldn't agree with that. First of all,
2 can you zoom it back out so I can look at it in
3 context?

4 Q: Sure.

5 A: What this is being provided for is an example
6 of how Carolinas is invested in the communities
7 that they've served. And your, I guess your
8 proposition that you would like me to agree to
9 assumes that these projects weren't needed to
10 meet the demands of the patients that they're
11 serving in multiple facilities. It doesn't
12 speak to cost containment at all. It speaks to
13 investment in the communities that they're
14 serving and meeting the needs of the patients
15 that they're serving.

16 Q: Exactly. And every construction project is
17 intended to be evaluated by DHEC primarily for
18 the purpose of determining whether that project
19 is meeting the needs of the residents who are
20 the -- who are identified in those applications,
21 correct?

22 A: That is one of the evaluations, yes.

23 Q: And that's one of the purposes of the program,
24 isn't it?

25 A: Yes.

1 MR. ANDREWS: Your Honor, if we could take a short
2 break?

3 THE COURT: Any objection?

4 MR. ROBERTSTON: None, Your Honor.

5 THE COURT: All right. Let's take 15 minutes.

6 (Break from 2:40 p.m. until 3:01 p.m.)

7 THE COURT: Back on the record.

8 MR. ANDREWS: Ready, Your Honor.

9 Q: All right. Ms. Platt, let me draw your
10 attention now to issues related to operating
11 costs.

12 A: Okay.

13 MR. ANDREWS: Again, let's -- Dan, pull up section
14 seven of the regs. Seven.

15 Q: Ms. Platt, criterion 7 identifies operating
16 costs, does it not? That is, startup costs,
17 operating costs, manpower or staffing costs, all
18 costs related to operations are identified in
19 project criterion number 7 as being subject to
20 the same direction that's provided that we just
21 discussed in construction costs, correct?

22 A: Yes.

23 MR. ANDREWS: Now, let's take a look at, Dan,
24 Demonstrative 152.

25 Q: Now, again, this is looking at the experience

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1 of similar facilities at the community hospitals
2 that have been identified by and approved by
3 the Department as a -- as consistent with the
4 language in project criterion 7, isn't it?

5 A: I guess these parameters are consistent, yes,
6 with the language of criterion 7.

7 Q: All right. Because they relate to operating
8 costs and staffing costs and other costs, but
9 particularly focusing on those.

10 A: The indigent care line at the bottom probably
11 is not related to this criterion.

12 Q: Thank you. All right. Now, with regard to the
13 expenses, which would be lines three, four, and
14 five that you addressed in your testimony, you
15 would agree with me, wouldn't you, that the
16 most important thing for the Department is
17 understanding the assumptions on which these
18 proposed costs are based in order for them to
19 make determinations about their reasonableness,
20 correct?

21 A: I believe they do need to look at the
22 assumptions. I don't know that that's the most
23 important thing. I think looking at the
24 assumptions is important, understanding the
25 presentation, understanding how it relates to

1 utilization, and then in this instance where you
2 have more than one application, how the expense
3 parameters compare I believe are all important
4 things to look at.

5 Q: You want to look how the expense parameters
6 compare and you also want to ensure that the
7 proposed expenses are reasonable, do you not?

8 A: Yes.

9 Q: You wouldn't want to have an application that
10 has a labor shortage, would you?

11 A: Correct.

12 Q: And you wouldn't want to have an application
13 that doesn't -- that doesn't identify sufficient
14 expenses that would be necessary to support
15 patient care, true?

16 A: Correct.

17 Q: Now, here if we look at in this same period of
18 time, Roper Berkeley was an application
19 submitted by a company in which Carolinas has
20 an ownership interest in and, in fact, manages,
21 true?

22 A: They do have a relationship with Roper Berkeley.

23 Q: They manage it; do you know that?

24 A: Yes.

25 Q: All right. Now, the -- you'll see here that

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1 their proposed total expenses in the Roper
2 Berkeley application, which was for 50 beds, was
3 nearly twice that of the proposed total expenses
4 for CMC-Fort Mill?

5 A: The total expenses, yes. Yes.

6 Q: And that would be if you look at the difference
7 in the total FTEs per adjusted occupied bed,
8 you can see that Roper Berkeley project is
9 substantially more, if not almost twice as
10 great, you see that?

11 A: Yes, it is -- it is higher, but the -- you have
12 to take into consideration all types of things
13 in terms of, you know, what other services that
14 are proposing to be offered within the 50 beds.
15 In a smaller hospital like Roper Berkeley,
16 you're going to have probably more support
17 personnel that are spread over fewer base of
18 patients. So there's all kinds of things that
19 you need to take into consideration.

20 Q: The difference in those two and the Roper
21 Berkeley satellite hospital and the -- was 50
22 beds and CMC-Fort Mill was 64, correct?

23 A: Yes.

24 Q: And if you compare the Palmetto Parkridge, that
25 is -- that's the Palmetto Baptist Irmo area

1 proposal for a satellite hospital in 2006, you
2 see how those total expenses per adjusted
3 discharge compare?

4 A: Yes.

5 Q: And that's even without the value of inflation,
6 they would be greater than those proposed by
7 Piedmont, wouldn't they?

8 A: They are higher. Again, you'd have to take
9 into consideration the mix of services that were
10 being offered, you'd have to look at how those
11 align bed category services.

12 Q: Now, a 76-bed facility was what Palmetto
13 proposed. Smaller than that which Piedmont
14 proposed. And so the analysis that you just
15 applied to Roper Berkeley and Carolinas Fort
16 Mill wouldn't explain the difference, would it?

17 A: It's -- as far as the FTEs? I mean, that's
18 what I was looking at, the FTEs in terms of the
19 size and the support personnel.

20 Q: Okay. Well, I was actually talking about the
21 same line I'd asked you a question about
22 earlier, so my apologies for not being clear.
23 Total expenses per adjusted discharge appear to
24 be comparable without considering of the value
25 of inflation between 2006 and 2010; do you see

1 that?

2 A: Yes. They're similar, but again, you'd have to
3 take into consideration the mix of service
4 offerings.

5 Q: Well, for -- it's a community hospital,
6 generally providing services as would be
7 proposed to provide by both Fort Mill Medical
8 Center and CMC-Fort Mill. Community services,
9 non-tertiary services, no specialty services.
10 You don't have any reason to believe the range
11 of services in these proposed satellite
12 hospitals are different, do you?

13 A: I mean, I haven't studied it side by side. You
14 know, there could be a greater level of
15 outpatient services. They could have a cath
16 lab, for example. I mean, without knowing the
17 background, I can't tell you that it's
18 completely apples to apples.

19 Q: Well, let me ask you ---

20 A: It's similar. Yes, they're both community
21 hospitals.

22 Q: And there's no -- assume there's no cath lab.
23 And the whole purpose of applying the adjusted
24 discharge is to eliminate any differences
25 between outpatient and inpatient assumptions,

1 correct?

2 A: That does take it into consideration.

3 Q: Does it eliminate the difference?

4 A: It would sort of eliminate the percentage of
5 inpatient/outpatient. It might not take into
6 consideration all the mix of services. Again,
7 I don't know what the mix of services in detail
8 that were proposed by Palmetto Parkridge are,
9 and I don't know how that exactly compares with
10 Fort Mill Medical Center.

11 Q: But you would accept that for general purposes
12 they're both proposed to be community satellite
13 hospitals and the general range of services
14 being the same?

15 A: I understand they are both to be community
16 hospitals.

17 Q: And the FTEs per adjusted occupied bed are
18 almost identical between Fort Mill and Palmetto,
19 correct?

20 A: They are similar, yes.

21 Q: And the real outliers in this selection would
22 be CMC-Fort Mill and Roper Berkeley, one being
23 very low in comparison, 75 percent of those
24 offered by Fort Mill and by Palmetto, and then
25 Berkeley being a good bit higher, correct, than

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1 that Roper facility?

2 A: Are you talking about just the expense lines?

3 Q: No, I'm sorry. I thought we were just talking
4 about the FTEs per adjusted occupied bed?

5 A: Oh, okay. I thought you were just asking me
6 about the expenses. In terms of FTEs per
7 adjusted occupied bed, CMC-Fort Mill is the
8 lowest. What I think you need to look at there
9 then is to sort of go beneath that superficial
10 level and look the level of clinical FTEs,
11 which I did do for Fort Mill and CMC-Fort Mill
12 to ensure that there's sufficient clinical
13 staffing. And I think the area that brings
14 CMC-Fort Mill down lower is that there's less
15 overall sort of administrative and support
16 personnel because a lot of sort of
17 administrative level functions are handled at
18 the system level for Carolinas.

19 Q: Well, and you don't know exactly to what degree
20 Piedmont is making -- providing support
21 personnel from its hospital in Rock Hill or
22 either support personnel from its regional
23 offices in Atlanta or in Dallas, do you?

24 A: Correct, I don't. But again, when you look at
25 the breakdown of the clinical FTEs, the clinical

1 FTEs proposed by CMC-Fort Mill are actually, I
2 believe, even slightly higher, at least
3 comparable. So in terms of having sufficient
4 staff for clinical services, I think that CMC-
5 Fort Mill has that staff and where the
6 efficiencies are being achieved are on the non-
7 clinical side.

8 Q: But when comparing the Carolinas and the Fort
9 Mill applications, you don't know when you're
10 looking head to head at those what assumptions
11 that either the Carolina planning staff made or
12 that Piedmont made concerning their basis for
13 projections about personnel costs, do you?

14 A: I know what is contained in the application,
15 the staffing plan and the FTEs by position
16 that's presented in the application, so I'm able
17 to break out the clinical FTEs from the support
18 FTEs and look at it that way. As far as
19 exactly how every sort of support function is
20 staffed, I don't have that level of detail for
21 either project.

22 Q: And so while they're -- to the degree there are
23 differences in assumptions about, for example,
24 relying on contract personnel then instead of
25 employees, you don't know which applicant may

1 have assumed what with regard to that
2 distinction, do you?

3 A: Only to the extent that it's stated in the
4 application, and again, to the extent that
5 there's variation of use of contract personnel,
6 I think that would show up in other areas of
7 expenses. So, for example, if Carolinas had a
8 lower level of FTEs because they were relying
9 on more contract staffing, you should see that
10 reflected in other areas of expenses. But what
11 we're seeing is that Carolinas' expenses are
12 lower overall when you look at all the
13 categories. So I didn't find that to be a
14 meaningful exercise.

15 Q: Well, the point is when you're relating to
16 expenses, what you want to make sure is you're
17 comparing some projections that are reasonable.
18 Section 7 provides a methodology for doing that
19 by looking at the experience of applicants the
20 Department has already approved, correct?

21 A: Criterion 7 does indicate comparison to
22 applications that are actually existing. I
23 don't believe it says approved. So this
24 exercise in comparing to other approvals is not
25 exactly what is stated in criterion 7.

1 Q: Well, you didn't do that comparison for
2 applications in hospitals that have been
3 approved or for those that have been operating,
4 did you?

5 A: I did not compare it to those that have been
6 approved or those that have been operating. I
7 evaluated the assumptions stated by both
8 applicants. Carolinas in their assumptions made
9 it clear that they were looking at other
10 facilities that they operated as a basis for
11 their expenses, and then I compare across the
12 two projects, because at the end of the day
13 DHEC has to pick one of the two projects, which
14 is the reason for the comparison.

15 Q: Sure. And that doesn't mean though on each and
16 every criterion that there is a meaningful
17 difference; you would agree with that, wouldn't
18 you?

19 A: There is varying degrees. I mean, some have a
20 bigger difference and some have a smaller
21 difference. If there were sort of negligible
22 differences then I actually considered those to
23 be equally met.

24 Q: All right. With regard to the assumptions
25 about the extent to which the applicants are

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1 relying on contract services or onsite services,
2 again, you took the -- you didn't test out, you
3 didn't look behind those numbers, isn't that
4 true, to determine whether the assumptions were
5 reasonable with regards to FTEs, for example?

6 A: As I said before, the approach that I took in
7 my evaluation was to look at the information
8 that was put in the record by each of the two
9 parties so that I could compare them in the way
10 that DHEC would compare them based on the
11 information that DHEC has available to it. So
12 if there's assumptions available, then I
13 reviewed those assumptions for reasonability,
14 but I did not have material to go behind there
15 to evaluate sort of the information behind those
16 assumptions.

17 Q: Okay. Well, let's create an opportunity that
18 this Court has to do that in a way that DHEC
19 did not.

20 **MR. ANDREWS:** Dan, let's pull up, if you would, a
21 document. So let's begin with S-CHS-6874.

22 Q: Now, Ms. Platt, this is ---

23 **MR. ANDREWS:** Dan, highlight the first paragraph if
24 you would.

25 Q: This is a document that's been the subject in

1 Mr. Stewart's testimony and has been produced in
2 discovery. This is an email from Mr. Craig
3 Stewart to Ms. Debra Godfrey. Now, and read
4 the first paragraph into the record if you
5 would.

6 A: "We pulled the staffing sheet together into a
7 summary page; however, our staffing level seems
8 high assuming 26 patients on an FTE per AOB
9 bases. Right now, we're running 4.7 based on
10 the staffing plan provided."

11 Q: Now, DHEC wouldn't have had any way to know
12 that in September, we'll look at another email
13 in a minute that is dated in September, that
14 before the filing of Carolinas' application that
15 they were looking at a staffing model that
16 instead of putting it at 3.1 FTEs per adjusted
17 occupied bed, they were looking at a 4.7? They
18 wouldn't have had any way to know that, would
19 they?

20 A: They would not have had any way to know that.

21 Q: And the record doesn't reflect this, does it?

22 A: No, it doesn't reflect this, but ---

23 Q: Did you know it?

24 A: No. Again, I mean, I looked at it the way DHEC
25 did. DHEC does not have the ability to go back

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1 behind either what Carolinas did and look at
2 the various assumptions they tested, various
3 assumptions that Piedmont may have tested. They
4 look at the record as it's presented to them
5 and evaluate based on the assumptions and the
6 information in the record. And that's what I
7 was asked to do, and that's what I did.

8 Q: Let's take a look at the closing paragraph.

9 MR. ANDREWS: Well, first of all, the last two
10 bullet points, please, Dean. You see the
11 bullet point related to six maintenance FTEs?
12 I'm sorry, Dan, the last two bullet, the last
13 two dark bullet points. Yes, there you go.

14 Q: Read the -- well, I'll read it for you, Ms.
15 Platt. There are six maintenance FTEs, I
16 thought this was done centrally and charged out
17 through intercompany. You understand that to be
18 a reference as to whether or not the cost
19 related to those FTEs would be reflected within
20 CMC-Fort Mill's staffing model or instead be
21 part of the percentage that was paid for the
22 intercompany expense?

23 A: It looks like it's a discussion of how to
24 handle those FTEs.

25 Q: And as you've testified earlier, there would be

1 assumptions that can be made for both applicants
2 about the extent of their reliance on their
3 central office to provide support services for
4 them, right?

5 A: Yes. Each of them had to make their
6 assumptions in preparing their financial
7 projections.

8 Q: And again, you don't know how they may have
9 made them differently, do you?

10 A: I don't know how they made them differently.
11 I'm sure Mr. Stewart spoke to his assumptions
12 on his staffing plan. Again, I evaluated the
13 information that was submitted to the record by
14 both of the applicants and evaluated them based
15 on what was in the record the same way DHEC
16 would evaluate them.

17 **MR. ANDREWS:** Let's take a look at the, down in that
18 last three bullet points, Dan.

19 Q: The first sub-point into other thoughts says
20 imagining, are there any opportunities for
21 cross-utilization of staff (ultrasound,
22 diagnostic and CT). Each have someone 24/7 and
23 there is an additional tech 24/7. Do you
24 understand the gist of these are there any
25 opportunities to cross-utilization, meaning is

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1 there any way that we can get our staff per
2 adjusted occupied bed assumption down lower than
3 it is because we want to get a lower -- we want
4 to submit a lower proposed staffing level to
5 DHEC. Does that appear to be Mr. Stewart's
6 goal, based on your review of this?

7 A: I think that's reading intent into it. It's
8 obviously a discussion of how to plan an
9 efficient staffing model, a realistic staffing
10 model, and Mr. Stewart was obviously asking
11 questions about that. I don't know about
12 intent one way or another.

13 Q: Let's take a look the last bullet point of that
14 series and see if this helps clarify it in your
15 mind. Registration 20.4 FTEs, no idea on this
16 one (just looking everywhere possible for
17 opportunities). That would be opportunities to
18 keep -- to lower the staffing proposal, wouldn't
19 it, Ms. Platt?

20 A: To plan the most efficient staffing possible,
21 yes.

22 Q: To get their proposal as low as they can for
23 approval by the Department, right?

24 A: I mean, you'll have to ask Mr. Stewart what his
25 intention was. I mean, maybe it's to ensure

1 that the project's feasible. It says what it
2 says. I was not privy to this at the time I
3 was doing my evaluation, and I was not asked to
4 review this information.

5 Q: If you had known that the Department was
6 turning over every leaf looking for every
7 opportunity to drive down its proposed staffing
8 model and its labor needs, would that have made
9 a difference to you in your analysis?

10 A: You mean Carolinas? You said the Department.

11 Q: Yes, I'm sorry. Carolinas, thank you.

12 A: Not necessarily because, for all I know,
13 Piedmont was going through the very same
14 exercise on their end trying to ensure that
15 they had the most reasonable staffing projected
16 in their application. And they had really even
17 more reason to do so because their project has
18 a far narrower net income at the end of the
19 day. They have a loss for the first two years
20 of operation and a small profit in the third
21 year. so they had even more incentive to
22 evaluate their staffing, and they very well may
23 have gone through the same exercise.

24 Q: If their intent was to produce a competitive --
25 the most competitive application instead of the

1 most realistic one; wouldn't that be fair?

2 A: Not necessarily. I mean, I'm sure both parties
3 spent time trying to prepare the best
4 application that they could.

5 Q: And by best, don't you believe that the goal
6 should be to present the most realistic
7 application that they could?

8 A: Yes.

9 Q: And in that regard, again, it would be useful
10 for any reviewer then to determine the
11 reasonableness of the proposals. And so let's
12 take a look at the assumption about that
13 Carolinas made that it would have 3.1 FTEs per
14 adjusted occupied bed and Piedmont's assumption
15 of 4.0. Have you looked at any -- we've taken
16 a look at two other satellite hospital proposals
17 that had enough detail so that that number
18 could be extracted and they both were either
19 comparable to Piedmont's or much greater,
20 correct, that is, Palmetto Parkridge and Roper
21 Berkeley, true?

22 A: There were multiple applications in that
23 comparison, the two -- you're pulling two out
24 of there, yes.

25 Q: Have you looked at any other to determine what

1 their adjusted occupied beds FTE rate is?

2 A: I did not. I compared the two applications
3 before DHEC in this matter.

4 Q: And have you looked at any databases to
5 determine what is the norm for FTEs per
6 adjusted occupied bed?

7 A: I have not looked at any other sources. I
8 evaluated the information that was presented to
9 DHEC.

10 Q: Well, let me ask you to do that. Are you
11 familiar with Healthcare Management Partners?

12 A: Generally.

13 Q: Okay.

14 **MR. ANDREWS:** Dan, let's pull up Demonstrative
15 286.1.

16 Q: And look at the cover page if you would, Ms.
17 Platt. This is a report dated October 2010,
18 and let's turn to page three in this exhibit?

19 **MS. ROBERTSON:** Your Honor, I would object. I know
20 Mr. Andrews has stated this is a demonstrative,
21 but this is another document or exhibit that I
22 don't believe we've ever been provided or that
23 was provided in discovery. On that basis, I'd
24 object.

25 **MR. ANDREWS:** It's offered for impeachment purposes,

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1 your Honor. Ms. Platt has testified concerning
2 the reasonableness of Carolinas' projection of
3 3.1 FTEs per adjusted occupied bed. This is a
4 report reflecting national experience among
5 varying different hospital groups on that same
6 issue, and I want to offer it for purposes of
7 impeachment.

8 **MS. ROBERTSON:** Your Honor, I would just like to
9 point out Rule 27 in the Administrative Law
10 Court rules. It speaks very clear to the
11 exchange of lists of exhibits and witnesses, and
12 it clearly states that you exchange a final
13 list of all exhibits expected to be offered at
14 the hearing. It goes on to say that any
15 exhibit not exchanged prior to the hearing may
16 be excluded from the admission into evidence.
17 I think again we're looking at a back end way
18 to put up demonstratives that are not in the
19 record. This witness has been a witness in
20 this case for some time. They've deposed her.
21 They've known her opinions relative to this
22 comparative analysis, and I'm not sure these
23 exhibits that we are now seeing are really for
24 impeachment purposes.

25 **THE COURT:** Mr. Stuart, you don't intend to offer

1 this into evidence?

2 **MR. ANDREWS:** No, sir.

3 **THE COURT:** You're just going to ask her if she's
4 aware of this and what it says?

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

6 **THE COURT:** I'm going to allow you to -- I'm going
7 to allow Mr. Stuart to do that. Objection --
8 for purposes of -- limited purposes of
9 impeachment, it's not going to be admitted into
10 evidence, you can ask her if she's aware of
11 this and what it says and if she is she is and
12 if she's not, she can certainly testify to
13 that.

14 **Q:** All right. Ms. Platt, just so we can make sure
15 that what I ask you about, we have an
16 understanding that's consistent with your
17 understanding.

18 **MR. ANDREWS:** Dan, turn to page 286.5. This is an
19 executive summary of the hospital performance
20 metrics, and the fourth row, Dan, if you --
21 that's it. Highlight that.

22 **Q:** This is definition of FTEs per adjusted occupied
23 bed. Do you see that, Ms. Platt?

24 **A:** Yes.

25 **Q:** And it states that it measures the number of

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1 FTEs employees used for each occupied bed
2 similar to the previous ratio a higher
3 percentage compared to its peers indicates that
4 a hospital uses more labor to treat its
5 patients. Is that consistent with your
6 understanding of the definition of FTE per
7 adjusted occupied bed?

8 A: Yes.

9 MR. ANDREWS: And Dan, let me ask you to turn to
10 page 13 in this exhibit.

11 Q: And you'll see here, Ms. Platt, that there are
12 six years of data provided from 2004 to 2009
13 that reflect FTEs per adjusted occupied bed
14 looking at full group of hospitals or then by
15 hospital category. That includes investor owned
16 such as CMC-Fort Mill and includes state or
17 local government owned such as Carolinas. Do
18 you see that?

19 A: Yes.

20 Q: And look -- the averages describe what you see
21 in all overall for all the hospitals? What's
22 the range of average FTEs per adjusted occupied
23 bed?

24 A: For what year?

25 Q: For all across the spectrum, from -- what's the

1 range for this six year period?

2 A: For all it ranges from it looks like a high of
3 4.86 to a low of 4.77.

4 Q: And for investor owned facilities, what's the
5 range?

6 A: 4.4 looks like it's the highest and 4.28 the
7 lowest.

8 Q: And for state and local government-owned
9 facilities?

10 A: Looks like 4.2 is the lowest, or sorry, 4.92 is
11 the lowest and 4.99 is the highest.

12 Q: Now, and are these as averages for these
13 facilities and for all hospitals generally
14 consistent with your experience in all the years
15 you've worked in identifying FTEs per adjusted
16 occupied bed?

17 A: I wouldn't say they look unusual but remember
18 these are averages, so you're certainly going to
19 have facilities that are at the high end of the
20 range and facilities that are at the low end of
21 the range, and it doesn't mean they can't
22 operate within those parameters and the whole
23 point is to measure efficiency. This is an
24 average.

25 Q: Let's take a look then at ---

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1 **MS. ROBERTSON:** Your Honor, if I could, I'm sorry to
2 interrupt again, but because Mr. Andrews is
3 reading from this, if we're going to do it
4 under the learned treatise exception to hearsay,
5 the witness can be asked about it, I assume
6 that's what he's doing it for, if it's a
7 reliable authority and established as a reliable
8 authority. And I don't think he's established
9 that and maybe it is, but if he can lay that
10 foundation with this witness, I'd appreciate it.

11 **THE COURT:** Mr. Andrews.

12 **MR. ANDREWS:** Well, Your Honor, if that were coming
13 under the hearsay exception that would be the
14 way I'd do it, but I'm using it for
15 impeachment, it's not necessary. I don't mind
16 making that effort but that doesn't limit the
17 utilization for purposes of impeachment.

18 **MS. ROBERTSON:** Well, the rule does speak to the
19 extent which it's called to the attention of an
20 expert witness upon cross-examination, not just
21 upon direct. So otherwise, it is hearsay, but
22 I think still the foundation and whether this
23 is a reliable source that we're even referring
24 to needs to be laid for foundation to ask her
25 questions about this document.

1 **THE COURT:** And Mr. Stuart, we do seem to be once
2 again reading this document into the record,
3 which is a concern. With some previous
4 demonstrative exhibits it sort of just gets --
5 or we basically read en toto into the record.
6 My understanding of your intention here was for
7 you to go to certain sections of this
8 particular exhibit and ask her if she was
9 familiar with this, which is apparently some
10 kind of a report, and ask her if this is
11 consistent with her experience, I think was the
12 question you went with regard to the FTE issue
13 and whether she was familiar with that and if
14 that was consistent with her experience. But
15 it seems like you're reading the document that
16 is not admitted as an exhibit; we're reading
17 that document into evidence and making it an
18 exhibit. Is there any way you can focus your
19 questions without reading the entire document
20 into the record of the entire section?

21 **MR. ANDREWS:** I will make a better attempt, Your
22 Honor.

23 **THE COURT:** Yes, sir. Thank you.

24 **MS. ROBERTSON:** I'll try not to interrupt again, but
25 can we please get a copy of this demonstrative.

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1 I don't believe we've been provided a copy
2 previously. Thank you.

3 **MR. ANDREWS:** We certainly will. Your Honor, I'm
4 sorry. If you'll just give us a moment.

5 **THE COURT:** No, that's fine. That's fine.

6 **MS. ROBERTSON:** Thank you.

7 **Q:** All right. Ms. Platt, let me draw your
8 attention to 286.6.

9 **MR. ANDREWS:** Dan, if you'll --

10 **Q:** I'll give you a hard copy of that, as well.
11 Might be a little easier to review.

12 **MR. ANDREWS:** Your Honor, if I may approach?

13 **THE COURT:** Yes.

14 **Q:** I'm sorry, I wanted to take you to a different
15 page. Yeah, it's page nine of the exhibit.
16 Now, Ms. Platt, you've just said that what you
17 were identifying earlier was the ranges that
18 were averages. This is the page that
19 identifies the peer quartiles.

20 **A:** Yes.

21 **Q:** Do you see any quartile that's as low as the
22 3.1 FTEs per adjusted occupied bed on page
23 nine?

24 **A:** The lowest quartile that I see is 3.21 in the
25 investor-owned category, which is an average of

1 the facilities in that first quartile. So
2 it's, again, an average of a smaller portion of
3 the facilities, but it's an average. But I
4 guess the other thing is that this breaks down
5 these facilities into various types in terms of
6 all investor owned not for profit, you know, so
7 ownership, and it's got a couple of categories
8 that might distinguish some types of hospitals
9 with children's and teaching hospitals. It
10 doesn't have anything to do with bed size. It
11 doesn't have anything to do with whether the
12 facilities are, you know, part of a larger
13 local system that may support the facility.
14 So, I mean, these are averages, and that's all
15 they are. So I don't know that they're really
16 relevant to the comparison that I made, which
17 is of the two applicants that are before the
18 court today.

19 Q: So your point is that there are always many
20 variables that affect the FTE per adjusted
21 occupied bed analysis, aren't there?

22 A: There are variables, and again, the purpose of
23 my analysis was to compare the information and
24 the assumptions that were provided by each of
25 the applicants, which is the information that

1 was before DHEC and to compare them for the
2 purposes of determining which was the better
3 applicant.

4 Q: And you didn't do anything to determine whether
5 3.1 as an assumption for CMC was reasonable,
6 did you?

7 A: I did. I looked at the assumptions. I also
8 broke it down into FTEs clinical versus not
9 clinical, which I felt was an important
10 consideration. And when I did that, there were
11 plenty of clinical FTEs in the Carolinas
12 application, and I believe there were more
13 clinical FTEs per adjusted occupied bed than the
14 Piedmont facility. I mean, again, I compared
15 what I was asked to compare and came up with
16 the results that I came up with.

17 Q: Okay. Based on what's in the record, not based
18 on what the internal assumptions were that were
19 not conveyed to the Department, such as the
20 memos from Mr. Stewart that we just reviewed,
21 correct?

22 A: Correct. The information that was in the
23 record, that was what I was asked to review.

24 Q: And that's what your testimony is limited to
25 here today?

1 A: Yes. I was asked to testify about the
2 information in my report that was a reflection
3 of the comparative projects that were before
4 DHEC.

5 Q: Okay. Let's move on to the area of charges
6 under 6.a. You've offered an assumption here
7 that again, Piedmont, excuse me, Carolinas
8 better meets this criterion than Piedmont's
9 application. With regard to charges, you would
10 agree me that they have little or no impact on
11 net revenue, correct?

12 A: They have a little bit of impact to the extent
13 that a commercial payor may negotiate a discount
14 from charges, but most payors are not
15 necessarily affected by charges.

16 Q: And you've never seen a CON decision based on
17 charges alone, have you?

18 A: No.

19 Q: And 6.A like seven and like 6.B, also charges
20 the Department with the review to determine
21 consistency with other existing providers,
22 doesn't it?

23 A: Yes.

24 Q: And you didn't do that, did you?

25 A: I did not. Again, I compared the two projects.

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1 I reviewed the assumptions as the basis for the
2 development of the charges and of the net
3 revenue. And then again, at the end of the
4 day, DHEC has to decide between the two
5 applicants and decide which best meets the
6 comparable charges criterion, and that's what I
7 did. That's what I evaluated.

8 **MR. ANDREWS:** Let's take a look for determining
9 consistency with others at Demonstrative 15
10 please, Dan. 1-5, not -- well, that's 1-5.
11 Your Honor, I'm off in what I need here, so
12 I'll just move on to the next step. Dan,
13 actually how about pull up S-CHS-4082.

14 Q: Now, in terms of your head-to-head comparison,
15 the -- you analyzed and made a determination
16 that Carolinas' proposed charges were lower than
17 Piedmont's, didn't you?

18 A: Yes, based on adjusted occupied bed.

19 Q: And that was affected also by -- I mean,
20 affected fundamentally by their proposed
21 charges, right, for each party? I mean, that's
22 what drives that analysis, correct?

23 A: The charges create the gross revenue and it
24 then it, right, flows through to the calculation
25 of gross revenue per adjusted occupied bed.

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1 Q: Okay. And one of the important variables in
2 the projections for both parties were their
3 annual -- their assumptions about annual
4 inflation adjustments, true?

5 A: Inflation would have a function in terms of
6 charges.

7 Q: And do you remember what those inflationary
8 adjustments were for each party?

9 A: I don't remember off the top of my head.

10 Q: Would three percent for Carolinas and four
11 percent Piedmont be consistent with your memory?

12 A: Those sound like they're within the range of
13 what I recall. They don't sound out of line.

14 Q: And if you made adjustments so they were based
15 on the same assumptions, such as you made for
16 the depreciation schedule, so you can do an
17 apples to apples comparison, it would affect the
18 analysis, wouldn't it?

19 A: It would change the math, but I mean, I can't
20 adjust every assumption that both parties make,
21 otherwise it's not a meaningful comparison. The
22 depreciation is a completely different
23 adjustment, because if you -- if you look at
24 the depreciation expense, you have Piedmont with
25 a much more expensive project, millions and

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1 millions of dollars more. But because of their
2 depreciation assumption, their -- the term of
3 the depreciation they assumed, the depreciation
4 expense that flows through into the financial
5 model is roughly the same as Carolinas Medical
6 Center. So they've chosen a very different
7 method of applying depreciation. So I simply
8 used the same term to look at both projects,
9 which to me is a more accurate reflection of
10 the two projects and reflects the fact that
11 Piedmont's project is much more capital
12 intensive. It's a much more costly project.
13 So when the depreciation translates into a
14 depreciation expense, it needs to be reflective
15 of the project costs.

16 Q: And it's a much more expensive project because
17 it has 36 beds that it intends to provide and
18 has the capability of future growth to meet the
19 needs of York County residents that the
20 Carolinas facility does not have, that's the
21 reason that it's so much more expensive, isn't
22 it?

23 A: The reason it's more expensive is because it's
24 a larger facility.

25 Q: Right. Okay. All right. Now, with regard to

1 the assumptions, you would want to satisfy
2 yourself that the three percent assumption
3 concerning increase charges over time for
4 Carolinas was reasonable, wouldn't you?

5 A: I didn't look at Carolinas' data, but three
6 percent is very consistent with what I've been
7 using in my financial models over the last
8 several years. I found it very reasonable.

9 Q: Let's take a look at this document and
10 determine what their actual experience is in the
11 years prior to this application.

12 MR. ANDREWS: Dan, if you'll look at the last row of
13 that category. It's CMI adjusted charges
14 percent change of them.

15 Q: And if you'll look at Pineville and University.
16 And look at that period from particularly from
17 2006 to 2010, last four years.

18 A: Okay.

19 Q: Now, during this period of time, if you look at
20 each year, Ms. Platt, that there was -- in 2006
21 there was a 6.2 percent growth, do you see
22 that, in charges for Pineville and a 10.5
23 percent for University?

24 A: Yes.

25 Q: And taking it to the next year, there was an

1 eight percent reduction for Pineville, an eight
2 percent growth for University, right?

3 A: Yes.

4 Q: '08 increases of 6.2 for Pineville and 7.9
5 percent for University, correct?

6 A: I mean, the calculations are there on the page.
7 I didn't do the analysis.

8 Q: Fair enough.

9 A: I agree that the numbers are those numbers on
10 the page.

11 Q: All right. And it carries on out for increases
12 for '09 and '10 for Pineville of over eight
13 percent and for University of 7.3 and then four
14 percent. Do you see that?

15 A: Yes.

16 Q: All right. And if you look at ---

17 **MR. ANDREWS:** Dan, let's take it up to look at the
18 compounded annual growth rate of those two
19 facilities for the period of time reflected on
20 this document, from 2000 through 2010. We're
21 going the row up, Dan, looking at Pineville and
22 University and the CMI adjusted charges per
23 discharge. That's right.

24 Q: And if you look at that, the compounded annual
25 growth rate for those two facilities for that

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1 decade, it's six percent a year for Pineville
2 and 9.2 for University; you see that?

3 A: Yes.

4 Q: All of those are two to three times, those are
5 two to three times greater than the assumptions
6 that Carolinas presented for Fort Mill
7 concerning annual increase in charges, aren't
8 they?

9 A: They are higher. I don't -- I don't know that
10 that's necessarily relevant because this is a
11 forward-looking projection and that doesn't
12 necessarily mean that going forward charges are
13 going to increase at the rate that they have in
14 the past. In fact, recently I've been doing
15 projections for people where they've held their
16 charges completely constant because they're
17 anticipating declines in reimbursement, so why
18 increase your charges. So, I mean, they are
19 what they are in the past. The numbers are on
20 the page, but that doesn't necessarily mean that
21 that's the level that should be used going
22 forward.

23 Q: There was nothing produced in the application or
24 in the record, was there, explaining the
25 reasonableness for Carolinas' projections other

1 than -- well, at all, was there? It was just
2 this is our assumption, true?

3 A: I believe that was the statement that was made,
4 and I think a similar statement was made in the
5 Piedmont application. They both stated what
6 their assumptions were. I don't know that
7 either of them provided information as to why
8 that was their assumption. I found both the
9 three percent and the four percent to be
10 reasonable based on my experience developing
11 models for similar healthcare facilities.

12 Q: But the difference in the three and four
13 percent assumption rates, if you held them
14 constant, treated them the same, the
15 differential then charges between CMC-Fort Mill
16 and Fort Mill Medical Center would be
17 eliminated, wouldn't it?

18 A: I have not done that math to know if it would
19 be eliminated. It would certainly come closer
20 together.

21 Q: All right. Now, you also testified that you
22 believe that Carolinas best met project review
23 criterion 4(a) related to letters of support?

24 A: Yes.

25 Q: And I believe you said that you believe that

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1 Carolinas had, in fact, more letters as
2 substantially greater volume and that was one of
3 the reasons, in addition to the opposition, that
4 you gave that criterion to Carolinas, right?

5 A: I believe at the time it was my understanding
6 that they had more letters. Now, my report was
7 prepared in June and submitted in early July,
8 so I don't know that my report took into
9 consideration letters that may have come in
10 after that. But at that time, it was my
11 understanding that Carolinas had more letters.

12 Q: Well, you testified today that they should be
13 recognized as better meeting that criterion,
14 didn't you?

15 A: Well, a combination of letters, positive letters
16 and also the negative letters.

17 Q: All right. Well, let's ---

18 A: The negative letters were the most critical
19 factor in my mind for both 13(a) and (b).

20 Q: All right. Well, let's take a look at the
21 volume since you testified about Carolinas
22 having more volume. Let's determine whether,
23 based on Ms. Brandt's letter, you regard that
24 difference as material.

25 MR. ANDREWS: Dan, pull up if you would, Ms.

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1 Brandt's letter, Joint Exhibit A-1306 and let's
2 go to page nine of ten in her CON analysis,
3 please. All right. Now, and Dan, if you'll
4 look to paragraph 4(a) and highlight the first
5 three lines.

6 Q: Now, the Department determined that the total
7 letters for Presbyterian were over 10,000 and
8 that for Carolinas, 5,753, and Piedmont more
9 than 5,400, correct?

10 A: That's what the agency determined or DHEC
11 determined.

12 Q: And she found that all applicants equally met
13 this criterion for acceptability, didn't she?

14 A: She did.

15 Q: Now, quite a number of times, Ms. Platt, you've
16 testified today that you believe the Department
17 interpreted a regulation or applied a regulation
18 in a particular way and used that as a basis
19 for the action you took, didn't you? Do you
20 remember testifying to that effect?

21 A: Yes, and my understanding of how they've looked
22 at criterion in the past.

23 Q: And in this regard, the Department did not find
24 any material differences in the letters of
25 support offered for any parties, including

1 Presbyterian, who had almost two to one for
2 what was submitted for the other applicants,
3 correct?

4 A: They did not find, I guess, a significant
5 variance in that they found all parties met
6 this criterion. What I'm not sure that the
7 agency took into consideration is that some of
8 the letters that were counted as support letters
9 and where Carolinas' letters actually contained
10 opposition statements or negative statements
11 about -- about Piedmont. And I don't know that
12 she took that into consideration. I don't know
13 how many of the letters she was able to look
14 at, and I don't know if she evaluated
15 Carolinas' letters for the purposes of
16 opposition to Piedmont.

17 Q: Well, first of all, let's -- 4(a) doesn't say
18 anything about opposition; 4(a) talks about
19 letters of support, correct?

20 A: Correct, but they sort of go hand in hand ---

21 Q: Well, I'm sorry for interrupting, but (b)
22 addresses opposition, doesn't it?

23 A: Correct, but there's also different kinds of
24 opposition. There's opposition where a party
25 formally enters into a review process as an

1 opponent, and then there's letters that are in
2 opposition, and these letters came in the form
3 of letters of support for Carolinas but really
4 also against Piedmont. They were in the volume
5 of letters of support that came into the
6 agency. It was not a formal party submitting
7 their name as an opponent to the project.

8 Q: I think you've said, have you not, Ms. Platt,
9 that anyone can develop a marketing campaign and
10 influence people to submit letters?

11 A: I may have said that.

12 Q: Would that sound like something you'd want -- a
13 statement you'd want to own?

14 A: Certainly. I mean, people can do that.

15 Q: And all applicants did that here, didn't they?

16 A: All applicants sought community support from the
17 York County area.

18 Q: And let's take a look at the extent to which
19 Carolinas did that.

20 **MR. ANDREWS:** Dan, pull up if you would S-CHS-4106.
21 All right. And what we have here is kind of an
22 email string that, let's begin at page 4107,
23 please, Dan. And just call out the first
24 quarter of the letter down through one, two,
25 three. And I'm sorry, but I didn't -- pull

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1 back out of that.

2 Q: I want to make sure, you don't have a copy of
3 this in front you, Ms. Platt, that you can
4 confirm that this is an email from Mr. Murphy.

5 A: It looks likes down at the bottom it says it's
6 from Mr. Murphy.

7 Q: Okay. Can you see it?

8 A: Yes.

9 Q: All right. Good.

10 A: I can't tell on that page who it's to, but.

11 Q: Well, and it's just an attachment that says
12 team.

13 A: Okay.

14 Q: We'll scroll forward and you can see who's
15 listed there on the "to" line.

16 A: Okay.

17 Q: And this is a statement that's saying from Mr.
18 Murphy to the team, I have attached our initial
19 target contact list of employers and civic
20 community organizations for CMC-Fort Mill's
21 support, including sample letters and
22 instructions. You've been included on this
23 email distribution for at least one of the
24 following reasons. And you see there that
25 there are a number of individuals who are

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1 identified as having responsibilities to lead
2 the support initiative?

3 A: Yes.

4 Q: Okay. And it identifies that they were
5 involved in helping to get letters in the past.
6 And let's take a look at the next page.

7 **MR. ANDREWS:** Dan, let's move on back through that
8 4109.

9 Q: And do you see here a list of employers and the
10 number of employees for each employer that are
11 listed?

12 A: Yes.

13 Q: On this page that are -- that's being
14 distributed?

15 A: Yes.

16 **MR. ANDREWS:** Dan, go to quickly 410.

17 Q: You'll see some more of these employers. Do
18 you see that, Ms. Platt?

19 A: Yes.

20 Q: Now let's take a look at the next page, 4111.
21 It has a target list of Fort Mill area
22 community organizations?

23 A: Yes.

24 Q: All right.

25 **MR. ANDREWS:** Now, let's go back if you would to the

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1 front page, 4106, Dan.

2 Q: And do you see at the bottom of the page, it
3 says 'from Mr. Murphy and the recipients that
4 were identified, see that?

5 A: Yes.

6 Q: Then if you'll scroll up, Mr. Murphy receives
7 an email from Mr. Lordo, and then Mr. Murphy
8 responds, or let's say to summarize, would you
9 agree with that Mr. Lordo says essentially is
10 information Piedmont Tenet's placed a full ad in
11 today's "Rock Hill Herald" and has distributed
12 yard signs showing support for Piedmont facility
13 to many businesses and civic leaders throughout
14 the Fort Mill Township; you see that?

15 A: Yes.

16 Q: And what's Mr. Murphy's response in the email
17 just above that?

18 A: It says, Rod, all I can think to say this
19 Sunday evening is that desperate times calls for
20 desperate measures, talk to you tomorrow, Del.

21 Q: Okay. Now, let's take a look at some of what
22 those measures were from the public support
23 plan.

24 **MR. ANDREWS:** Dan, turn to 3989, in that same CHS
25 series.

1 **MS. ROBERTSON:** Your Honor, I object to Mr. Andrews'
2 characterization of what he just said. He's
3 reflecting what he thinks the intent of the
4 email is. It's not at all the intent of the
5 email. He doesn't have the witness on the
6 stand who in fact wrote the email, but yet he's
7 suggesting intent and reading it in and asking
8 this witness about it.

9 **MR. ANDREWS:** I'd say that's what redirect is for,
10 Your Honor.

11 **MS. ROBERTSON:** In regards to the email.

12 **THE COURT:** Mr. Andrews, let's try to not ---

13 **MR. ANDREWS:** I'm sorry. I withdraw that
14 internalizing.

15 **THE COURT:** --- suggest the intent of the message.
16 I'll figure out what I think the intent of the
17 message is.

18 **MR. ANDREWS:** I certainly -- I will do that, Your
19 Honor.

20 **THE COURT:** Thank you, sir.

21 **MR. ANDREWS:** All right. On page, Dan do we have
22 this, if you'll call this up, 3989, and Dan, if
23 you'll -- what I'd like for you to do is call
24 out the physician practice plan under the
25 first segment. There you go.

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1 Q: And do you see that this particular document
2 has a series of directed actions concerning its
3 public support plan, Ms. Platt?

4 A: I'm reading it. It looks like a list of ways
5 in which they have to obtain support.

6 Q: And the first of which relates to physician
7 practices, correct?

8 A: Yes..

9 Q: And among those is they're providing a new
10 script to registration staff; they're asking
11 staff to visit web sites; they're asking
12 physicians to send letters to patients to
13 request support letters. Do you see that?

14 A: Yes.

15 Q: They're asking physicians to ask their spouses
16 to visit the web site and provide support too;
17 they're asking practice managers to solicit
18 support as well. Do you see that?

19 A: Yes.

20 **MR. ANDREWS:** Now, let's actually turn to the next
21 page, Dan. It's actually the prior page to
22 this exhibit, 3988.

23 Q: And, Ms. Platt, do you see that this is said
24 script for CMC-Fort Mill support only for
25 patients who live in York County; you see that?

1 A: Yes.

2 Q: And who is it intended, who is it identified to
3 be used by?

4 A: Registration personnel and physician practices
5 in York County and the emergency department of
6 CMC-Pineville and CMC-Steele Creek.

7 Q: Were you aware that registration personnel and
8 physician offices and emergency departments were
9 asked to have patients prepare and submit
10 letters of support?

11 A: I was not aware of the specifics of Carolinas'
12 plans in terms of how they generated support,
13 but I was sure that it included a variety of
14 ways.

15 Q: Were you aware that they asked, Carolinas asked
16 its Carolinas physician network physicians to
17 write letters to their patients asking for
18 letters of support?

19 A: I wasn't aware, but I'm not necessarily
20 surprised.

21 Q: Do you think it's ethical and appropriate for
22 patients who come to see a physician for
23 medical purposes to be asked while they're there
24 to provide letters of support?

25 A: I've heard of it done in many, many CON

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1 instances. I don't have a problem with it.
2 The patient can say they don't want to, or they
3 can say, you know, let me take it home and
4 think about it. It's not anything that I see
5 as tremendously unusual. I mean, the volume
6 for this project, for all the projects was
7 unusual, but I have seen that done before in
8 other projects.

9 Q: What would you think of a physician who comment
10 that characterized that practice as unethical?

11 A: They may not be familiar with what happens in a
12 CON context, but again, I've seen this happen
13 in other CON projects before.

14 **MS. ROBERTSON:** And Your Honor, I would object to
15 the characterization. I think that misstates
16 witness testimony in this case, Mr. Andrews'
17 question.

18 **MR. ANDREWS:** I don't think it does, Your Honor, but
19 I'm moving on.

20 **THE COURT:** Well, all right, let's move on.

21 **MR. ANDREWS:** All right.

22 **THE COURT:** Thank you.

23 Q: Now, with regard to --

24 **MR. ANDREWS:** Dan, pull up -- pull up S-CHS-4114.

25 Q: Now, do you see that this is -- has handwritten

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1 in the upper right-hand corner "independent
2 physicians"?

3 A: Yes.

4 Q: And what does this appear to be to you, Ms.
5 Platt?

6 A: Instructions on how to go about writing a
7 letter of support for the CHS hospital in Fort
8 Mill and how you should address it and not to
9 mail it because I'm sure they wanted to have
10 them come in as a group.

11 Q: And who would that be intended, who was that
12 stated to be for?

13 A: It looks like based on the handwritten note
14 that at least this one particular page was for
15 an independent physician.

16 **MR. ANDREWS:** All right. Dan, let's turn to the
17 next page at 4115. Your Honor, if you'll give
18 us just a moment.

19 **THE COURT:** Certainly.

20 **MR. ANDREWS:** We're having technical difficulties.
21 There you go.

22 Q: All right. Ms. Platt, what does this document
23 appear to be?

24 A: A sample support letter from a physician
25 regarding Carolinas' plans for a 64-bed hospital

1 in York County.

2 Q: And the second paragraph states that as a
3 physician practicing in York County, and I'm
4 very familiar with the growth of the community
5 and the need for expanded healthcare services.
6 Currently, there is only one hospital in the
7 county and many residents seek inpatient care in
8 other areas. The addition of a new alternative
9 in York County will give my patients a choice
10 to receive care closer to home. I am
11 supportive of CHS' proposal and I intend to
12 refer patients to the new hospital. That's
13 what it says, isn't it?

14 A: Yes.

15 Q: Do you know how many letters of support that
16 Carolinas received from physicians that it did
17 not employ who practice in York County?

18 A: I'm not familiar with the breakdown of
19 independent versus employed physicians.

20 Q: Well, let's take a look at that.

21 **MR. ANDREWS:** Dan, turn to Exhibit 31, please, Bates
22 654.

23 Q: Now, what does this reflect in terms of
24 independent, that is, non-employed physician
25 support for Carolinas' project?

- 1 A: Well, it says here that Carolinas received --
2 just had one independent physician, but I didn't
3 prepare this so I don't who prepared it.
- 4 Q: You haven't reviewed the letters of support from
5 physicians to determine the extent to which
6 Carolinas received support from them?
- 7 A: I did not go through the 5,000 letters, the
8 5,700 letters and try to determine whether they
9 were independent or employed physicians.
- 10 Q: There weren't 5,000 letters from physicians now
11 were there, Ms. Platt?
- 12 A: No, there were not.
- 13 Q: It looks like there was something in the order
14 of 150.
- 15 A: And I didn't go through all of those to
16 determine whether they were employed or
17 independent.
- 18 Q: Well, it looks like Carolinas made a request
19 for physicians who are independent in York
20 County to support their application and only one
21 did that, if this is an accurate representation,
22 right?
- 23 A: If this an accurate representation, then that
24 would be the case. But it's also my
25 understanding that Carolinas has more employed

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1 physicians, whereas Piedmont has more
2 independent physicians on their medical staff,
3 so perhaps distribution is in relation to the
4 status of their medical staff.

5 Q: Meaning members of the medical staff of
6 Carolinas -- I mean ...

7 **MS. ROBERTSON:** Your Honor, we've been going now for
8 a number of questions with matters and documents
9 and letters for which this witness was not
10 involved in, does not have any personal
11 knowledge, and I'm going to object to continuing
12 that line of questioning based on Rule 602 in
13 the Rules of Evidence, where a witness who does
14 not have personal knowledge really cannot
15 comment on matters for which they don't.
16 Unless there's some basis or he establishes that
17 she does have personal knowledge, then really
18 these matters should not be gone into with this
19 witness.

20 **MR. ANDREWS:** Your Honor, this is a document in the
21 record.

22 **MS. ROBERTSON:** Well, it's ---

23 **MR. ANDREWS:** And so are all the letters, so it's
24 hardly -- and Ms. Platt is here to testify
25 about her opinions related to the record.

1 **MS. ROBERTSON:** That is not accurate to a number of
2 things she has been shown. A number of these
3 documents were discovery documents. They are
4 not part of the Department's record for which
5 Ms. Platt has said that's what she reviewed.
6 We've had thousands of pages of discovery
7 material exchanged between these parties. Those
8 are not materials necessarily that this witness
9 has seen or reviewed. It's not part of the
10 Department's record. And we've gone through now
11 a number of those. And to the extent we
12 continue down this line, I think it's time to
13 object based on her lack of personal knowledge
14 of any of this information and him just seeking
15 to elicit a comment for which she has not had
16 any personal involvement in.

17 **THE COURT:** At this point what you're asking the
18 witness about is the letters that were received
19 by physicians, and specifically, we're talking
20 about physicians that are not affiliated with
21 one of the networks. They're independent
22 practicing physicians and the number of letter
23 that were received by the Department?

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

25 **THE COURT:** And this is demonstrative exhibit of

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1 those letters?

2 **MR. ANDREWS:** This is a copy of a slide that was
3 presented to the Department.

4 **MS. ROBERTSON:** And is it a demonstrative or is it?

5 **MR. ANDREWS:** No, it's an exhibit in this case.
6 It's Exhibit 31, and which is, contains the
7 project review slides presented in July of 2011
8 to the Department.

9 **MR. ROBERTSON:** If he's now on matters within the
10 record, then my objection may not relate. It
11 relates to those that we've been going through,
12 and I thought we were continuing to go through
13 that. So if he is asking her about matters
14 within the Department's record, then I won't
15 object on the basis of 602.

16 **THE COURT:** Thank you, Ms. Robertson. Mr. Andrews,
17 and perhaps the whole confusion here was just
18 simply that, and I didn't catch it either,
19 whether this was an exhibit in the record, and
20 maybe if you could just make sure that that's
21 clear when you move on to the next item, and
22 that way then if Ms. Robertson has any
23 objection she can lodge that. Otherwise, if
24 it's a document in the record, then ---

25 **MR. ANDREWS:** Absolutely.

1 **THE COURT:** --- we can proceed. Thank you.

2 **MR. ANDREWS:** I'll try to do a better job of that,
3 Your Honor. Thank you. All right. In fact,
4 I've concluded with that line of examination.
5 Your Honor, we've been at it about an hour
6 plus, an hour and a half. I probably have
7 something a little less than an hour to go, but
8 if we could take a short break now before I
9 assume this would be the conclusion.

10 **THE COURT:** How about ten minutes? Could we do ten
11 minutes..

12 **(Break from 4:09 p.m. until 4:25 p.m.)**

13 **THE COURT:** We're back on the record, Mr. Andrews.

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

15 Q: Ms. Platt, let's talk a little bit about
16 indigent care and your opinions related to that.

17 A: Okay.

18 **MR. ANDREWS:** If we could, Trudy, Ms. Robertson, if
19 I could ask your staff to pull up what was
20 Joint A, or actually it's part of -- it's one
21 of your exhibits, so we should be able to get
22 it. Dan, if you would, pull up page 25 of
23 Carolinas Exhibit 12, which reflects apparently
24 a table that's already in the record. Let's
25 just go directly to 1193 of Joint Exhibit A and

1 the table at the top of the page. I think that
2 will do it for us. Now, you testified in your
3 direct about this exhibit, didn't you, Ms.
4 Platt?

5 A: Yes. I mean, it was a similar version to this
6 exhibit. Yes, without Presbyterian.

7 Q: Okay. Yeah, and you've essentially modified
8 this for purposes of the trial exhibit, correct?

9 A: Yes.

10 Q: Okay. And this supports your testimony that
11 you believe that CMC-Fort Mill would be more
12 financially accessible than Fort Mill Medical
13 Center, correct?

14 A: Yes.

15 Q: Now, first of all with regard to the percentage
16 of charity care as a -- that's reflected
17 percentages of gross revenues, and you're aware
18 that Carolinas nearly doubled their projections
19 of charity care from 3.5 in their 2005
20 application to 6.3 in the 2010 update, correct?

21 A: I know that it was increased. I don't -- I
22 don't know the exact percentage, but yes, I
23 know it did increase.

24 Q: Now, you don't know the eligibility criteria
25 that Carolinas applies to its patients, do you,

1 for financial charity care?

2 A: I have looked at their policies related to
3 charity care for the purpose of including it in
4 the CON applications, but I have not spent a
5 significant amount of time evaluating those
6 policies and the guidelines.

7 Q: And you don't know, do you, about how Carolinas
8 classifies charity care, do you? How they make
9 that judgment as to who should be considered in
10 the charity care category and who falls outside
11 it?

12 A: I don't know the details on a day-to-day basis
13 of that process. I've looked at their policies
14 and procedures in the context of putting them
15 into applications, but I've not spent time on a
16 day-to-day basis looking at how they evaluate
17 that.

18 Q: And would it be fair to say you didn't look
19 behind these projections to determine the
20 accuracy or reasonableness of Carolinas' 6.3
21 percent projection, did you?

22 A: Only in that it's my understanding that they
23 derived the 6.3 percent from their experience
24 with other similar community hospitals that they
25 operate.

- 1 Q: And that's what you read or is what they told
2 you? You didn't determine how they
3 categorized charity care at any of those
4 community hospitals, did you?
- 5 A: I did not.
- 6 Q: Now let's take a look at the next row, charity
7 and bad debt as a percentage of charges. You
8 would agree with me, wouldn't you, that the
9 Department's definition of charity expressly
10 excludes bad debt?
- 11 A: Yes, and that's why we looked at charity alone.
- 12 Q: And bad debt wouldn't have any bearing on
13 financial accessibility, would it?
- 14 A: It may or it may not. I really don't know that
15 that's the most important evaluation in this
16 table.
- 17 Q: Well, in fact, the record here has established
18 that Carolinas files lawsuits and places liens
19 on folks' homes who have bad debt if they're
20 not eligible for charity care. So that
21 wouldn't relate to financial accessibility at
22 all, would it?
- 23 A: I was not here for that testimony, so I can't
24 speak to it one way or another.
- 25 Q: All right. So let's just -- well, would you

1 agree with me then that that row on your
2 analysis doesn't really relate to the
3 Department's definition of financial access?

4 A: DHEC does not include bad debt in their
5 evaluation of charity care.

6 Q: All right. Now, with regards to the projected
7 Medicaid mix. In terms of medically underserved
8 groups, the Department's definition of that term
9 looks at Medicaid, Medicare and uninsured or
10 underinsured groups, does it not?

11 A: Yes.

12 Q: And, in fact, did you compare the projected
13 Medicare mix of CMC-Fort Mill and Fort Mill
14 Medical Center?

15 A: I'm sure that I did. I don't recall what the
16 percentages were. To me, the Medicaid and the
17 charity were the most relevant because, at this
18 point in time, Medicare is typically looked as
19 a good payer and most hospitals want Medicare
20 patients. So, I don't that in my opinion as an
21 underserved population. My focus was on
22 Medicaid and charity that I think are more
23 truly the underserved populations.

24 Q: Well, if you're trying to do this as DHEC does
25 it, DHEC looks at Medicare and Medicaid as well

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1 as indigent care, don't they?

2 A: They do also look at Medicare.

3 Q: The Medicare, let me ask if this is familiar to
4 you, that Carolinas' proposal was for 30.7
5 percent and Piedmont's was 42 percent Medicare
6 mix. So 12 percentage points greater. Is that
7 consistent with your memory?

8 A: I don't recall. I didn't focus on that.
9 Again, in my mind, Medicare is a good payer,
10 most hospitals want to serve Medicare patients,
11 and the real focus in terms of being concerned
12 about underserved populations is charity care
13 and Medicaid.

14 Q: The charity care adjustment adjusted discharges
15 is driven solely by the application and your
16 assumption that Fort Mill, in fact, would serve
17 6.3 percent of its patients, or at least 6.3
18 percent of its gross revenue would be applied
19 to indigent patients, isn't that right?

20 A: The calculation of charity adjusted discharges
21 of 646 for Carolinas or for CMC-Fort Mill is
22 based on the assumption that 6.3 percent of
23 charges would be charity care.

24 Q: Right. And so you simply look at the
25 difference between the charity care proposals of

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1 each party and that's what's going to drive
2 that bottom row, isn't it?

3 A: Yes, but I think the reason I broke that out is
4 it was interesting to me that the variation in
5 charity care percentage between Carolinas and
6 Piedmont or Amisub was significant enough even
7 though Amisub is a larger facility with higher
8 utilization, CMC-Fort Mill or Carolinas actually
9 projects to serve more overall charity adjusted
10 discharges.

11 Q: And that would be driven by the 60 percent of
12 outpatient services that Carolinas proposed to
13 offer in contrast to a much smaller percentage
14 for Fort Mill, wouldn't it?

15 A: Well, the adjusted discharges sort of takes that
16 into consideration, so it makes it an apples to
17 apples when you're comparing. It's a function
18 of the 6.3 percent charity care.

19 Q: Again, you're just doing the math here, aren't
20 you?

21 A: I am doing the math to calculate what I think
22 is relevant for comparative purposes.

23 Q: All right. Now, you would agree with me that
24 after full implementation of the Affordable Care
25 Act, the federal act that is intended to and

1 plans to provide insurance to those who are
2 uninsured, that there will be fewer uninsured
3 individuals that these hospitals would serve.
4 Isn't that true?

5 A: There should be a smaller percentage of charity
6 care, and those patients ideally would be in
7 another payer category. At the time that this
8 was filed and reviewed by the Department, it
9 wasn't clear whether the Affordable Care Act was
10 going to go through or not. Again, I evaluated
11 what was presented by each applicant.

12 Q: At the time of the -- at the staff review of
13 the applications?

14 A: Yes.

15 Q: All right. Now, let's move on to your
16 testimony concerning your opinions related to
17 the need for 100 beds ---

18 A: Okay.

19 Q: --- in Fort Mill. First of all, your opinion
20 was driven largely by, no matter which
21 methodology you applied, your creation or
22 application of these regions, the three regions
23 within York County, correct?

24 A: I used the three regions as a basis for
25 determining where it made the most sense to put

1 more beds, whether it made more sense to put
2 more beds in northern York County, relocating
3 the 36 beds as proposed by Piedmont, or to
4 leave those beds in the greater Rock Hill area.
5 And they did align with Carolinas' service area
6 breakdown, but in my opinion, they also made
7 sense in terms of the geographic areas that
8 were most proximate to the proposed beds so
9 that patients would have the most convenient
10 access in terms of travel within their community
11 to the beds at each hospital.

12 Q: All right.

13 **MR. ANDREWS:** Actually, Ms. Robertson, I am going to
14 need your help on this one, if y'all could be
15 so kind to pull up demonstrative, your
16 Demonstrative 3.12?

17 **MS. ROBERTSON:** Sure.

18 Q: Okay. Now, Ms. Platt, in your updated analysis
19 you have -- there's some things that caught my
20 eye that I wanted to ask you about. First of
21 all, the number of beds that are showing for --
22 in northern York County, this is would be
23 applying the 100 beds in Fort Mill in your
24 analysis of the bed discharge ratio, right?

25 A: Correct.

1 Q: And you've got 100 beds in northern York County
2 that would reflect Fort Mill Medical Center's
3 presence there. Now, the beds available to
4 greater Rock Hill and to western York would
5 represent the balance of the beds available
6 after the 64 beds is applied to the 288 beds
7 currently, right?

8 A: You mean, in other words, after the 36 is
9 relocated?

10 Q: Yeah. Yeah.

11 A: Well, and I also took our psychiatric beds
12 because psychiatric beds were really not
13 relevant to this project, and also psychiatric
14 patients, from what I understand, were not
15 included in the community hospital discharges
16 that were evaluated in Exhibit 104, 107 that
17 Piedmont's witness prepared, at least that's my
18 understanding.

19 Q: And what's your understanding of the number of
20 beds at Piedmont including the psych beds?

21 A: I think the number is 288.

22 Q: That's consistent with my understanding, so we
23 agree on that. And how many psych beds are
24 there?

25 A: I believe there are 20 beds.

- 1 Q: Right. And then that would leave a balance of
2 268, right?
- 3 A: And then 36.
- 4 Q: Thirty-six, and what's the balance? 232 isn't
5 it?
- 6 A: I guess. I'm not sure whether the 32 were --
7 or I'm sorry, whether the 20 were taken out
8 prior to the 28 -- or the 288 or not.
- 9 Q: Well, it looks like the 20 may have been taken
10 out twice because 20 from 232 would be 212,
11 right?
- 12 A: That's correct.
- 13 Q: And I mean, should I go forward, or are you
14 willing to accept that apparent based on your
15 review of this?
- 16 A: Let me look back.
- 17 **MR. ANDREWS:** If we could do a quick override, Dan,
18 we can just cut to the chase on this a little
19 more quickly if you're unclear. Dan, if you'd
20 pull up demonstrative, our Demonstrative 149.1.
- 21 Q: What I can do here, Ms. Platt, is show you a
22 copy of your original analysis and you can look
23 at that line and see what you have there under
24 beds for the greater Rock Hill area.
- 25 A: That's 232. I, at that time, I thought that

1 that did still include the psychiatric beds.

2 It may not have.

3 Q: And if you look down below in that total of the
4 beds, there's 232. I mean, 332, do you see
5 that?

6 A: Yes, yes.

7 Q: And if you would add into that 332 the 20 psych
8 beds, you get 342, correct?

9 A: If you add 20 to 332?

10 Q: I'm sorry, excuse me, no never mind, never
11 mind. So take 64 beds from the 332, and what
12 do you have?

13 A: 268.

14 Q: Okay. So you just weren't sure whether or not
15 the original 332 already had the psych beds
16 excluded?

17 A: I believe that I thought the original 332
18 included the psych beds.

19 Q: Well, the total excluding the psych beds should
20 be how many beds?

21 A: You mean the total for the county?

22 Q: That's right.

23 A: With or without the 100 beds?

24 Q: With the 100 beds. It's the same number, isn't
25 it? You add 64 to the 268 of acute beds.

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1 A: Okay. Right.

2 Q: Right?

3 A: Right. So you're adding either 64 -- okay.

4 That makes sense.

5 Q: And what's that number?

6 A: Without the psych beds?

7 Q: Yes.

8 A: 332.

9 Q: Okay. So it would appear to be originally your
10 332 did not include the psych beds, right?

11 A: It looks like it did not. I thought it had.

12 **MR. ANDREWS:** Okay. So let's go back, Trudy, if we
13 could, to 3.12.

14 Q: And if we look down at that number of total
15 beds which is 312, then would you agree that
16 that total should be 332?

17 A: If you include -- yes.

18 Q: Without psych?

19 A: Without psych.

20 Q: 332 without psych. And that the number above
21 the second red box that reflects 13 should then
22 be what?

23 A: 232.

24 Q: Okay. And if you do the math, that would cause
25 a change in the beds per 1,000 discharges for

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- 1 greater Rock Hill, wouldn't it?
- 2 A: Yes, it would.
- 3 Q: And well for the whole region, I mean, Rock
- 4 Hill and western York. You want to do the
- 5 calculation?
- 6 A: Sure. I'll just check it again. 7.2, or I'm
- 7 sorry 7.02. I'm not sure if that's right. Are
- 8 you doing Rock Hill or which area do you want
- 9 me to do?
- 10 Q: Well, you're doing beds per 1000 discharge ---
- 11 A: In which area?
- 12 Q: --- instead of 13-0.
- 13 A: You're asking me to do the total for Rock Hill
- 14 and western York combined.
- 15 Q: Yes. Well, what you've done. The calculation
- 16 you've done that represents 13 beds per 1,000
- 17 discharges, you see that?
- 18 A: Uh-huh (affirmative response).
- 19 Q: That's the number that would change, wouldn't
- 20 it, if you had 232 beds?
- 21 A: 7.0
- 22 Q: I had 14.2. How are you calculating that?
- 23 A: Are you asking, which year are you asking me to
- 24 do?
- 25 Q: Well, I was focused on '17. You'd need to do

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- 1 it for both years, though, wouldn't you?
- 2 A: Okay. Yeah, I mean, yes.
- 3 Q: Okay. Neither would be seven, though, would
- 4 they? Beds per 1,000 discharges, it would be a
- 5 larger number?
- 6 A: Yes, it would be. It would be 14.
- 7 Q: For 2017, would that be 14.2?
- 8 A: Yes.
- 9 Q: Is that what you got?
- 10 A: Yes.
- 11 Q: And for 2011? You're just dividing the number
- 12 of beds into the number of discharges, aren't
- 13 you?
- 14 A: Correct.
- 15 Q: What do you get for 2011?
- 16 A: 12.4.
- 17 Q: And that's more beds?
- 18 A: I'm doing the discharges per bed.
- 19 Q: Okay.
- 20 A: Let's see.
- 21 Q: Well, the ---
- 22 A: Right, right.
- 23 Q: --- your column says beds per 1,000 discharges?
- 24 A: It is. You're right. Sixteen.
- 25 Q: Okay. And again, I don't want to be tedious

1 about this, but -- so let's just focus on 2017,
2 because we're focused going forward, but the
3 calculation would need to be corrected as well
4 down below for the total York County beds,
5 would it not?

6 A: Yes.

7 Q: And why don't you do that math for us?

8 A: Okay. 15.5.

9 Q: Okay. That's what I have as well. And just so
10 that the record won't include an incorrect
11 computation, I'm sure you'd want to correct the
12 16.86, too. So do that match quickly and let's
13 get that right.

14 A: 17.9.

15 Q: Okay. Good.

16 **MR. ANDREWS:** Now on the next page, which is --
17 Trudy, if you could pull that up for us please,
18 313.

19 Q: Was your application of bed discharge ratio for
20 the Carolinas 64-bed facility?

21 A: Yes.

22 Q: And if you look at the beds for the Rock Hill
23 and western York area, you'll see 248?

24 A: Right.

25 Q: Now, as we discussed, that should be 264,

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1 should it not?

2 A: It should be -- well, if you're adding 20 back
3 in, it would be 268.

4 Q: Excuse me. I'm falling into the trap. 268,
5 you're right.

6 A: Correct.

7 Q: Okay. And let's just focus on the correction
8 for 2017. What would the corrected number be?

9 A: 16.44.

10 Q: That's what I have. And the totals would be
11 consistent with what they were on the prior
12 page, wouldn't they?

13 A: Correct.

14 Q: So they don't need to be changed. And just
15 for, can't help myself, for purposes of
16 completion, then let's go ahead because we've
17 corrected all the others. What would be the
18 2011 calculation?

19 A: 18.5.

20 Q: Okay. All right. Now, your testimony is, as I
21 understand it, that the -- in Mr. Sullivan's
22 exhibit, he relied on some census data that had
23 been updated as it is every year, is that
24 correct?

25 A: Correct.

1 Q: And you just got the most recent update in
2 March?

3 A: April.

4 Q: Or it was published in March or April? Okay.
5 And but your conclusion was the same, and you
6 moved to a discharge bed to ratio -- bed to
7 discharge ratio analysis to get there. I want
8 to ask you, though, about -- and just looking
9 at what you have up on the screen, in doing
10 that, that's really driven by the assumption
11 that the populations within these different
12 regions of the county, particularly in the lower
13 part of the county have greater access to
14 Piedmont and its beds than they would to either
15 of the hospitals that are proposed in Fort
16 Mill, right? Otherwise, this analysis just
17 doesn't work at all?

18 A: It's based on my assumption that the people in
19 western York County and the zip codes that
20 comprise greater Rock Hill have more access,
21 greater access to the beds if they're in Rock
22 Hill than in northern York County. They would
23 have to, most of those patients, a good number
24 of those patients would have to drive past
25 Piedmont Medical Center to get services in

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1 northern York County, which would not make
2 sense.

3 Q: And you advocated that position to the
4 Department and Ms. Brand in her letter repeated
5 it more than once. So, let's take a look at
6 your map.

7 MR. ANDREWS: Ms. Robertson, if you wouldn't mind,
8 help me one more time on Demonstrative 3.5.

9 MS. ROBERTSON: Sure.

10 Q: And looking at the regions, and you've
11 identified of course the green as the northern
12 York County region, correct?

13 A: Yes.

14 Q: And the blue is the greater Rock Hill region,
15 right?

16 A: Yes.

17 Q: And the blue incorporates three zip codes, 932,
18 I'm sorry, 732, my eyes are failing me, 730 and
19 704, right?

20 A: Yes, correct.

21 Q: Now, and your position is that this analysis
22 makes sense that the population that you've
23 identified in 732, 730, and 704 have greater
24 access to Piedmont than they do -- Piedmont
25 Medical Center than they would to Fort Mill

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1 Medical Center or to Carolinas Medical Center in
2 the Fort Mill area?

3 A: That the majority of the population in those
4 areas would have greater access to Piedmont Rock
5 Hill.

6 Q: Yeah, but we're not --

7 **MR. ANDREWS:** Let's take a look at, Dan -- thank
8 you, Ms. Robertson. Let's pull our document
9 up, Demonstrative 38, please, Dan.

10 Q: Now, Ms. Platt, I don't know if you've seen
11 this in your review of the trial materials, but
12 this is demonstrative that is prepared by Mr.
13 Rob Walsh, who is a traffic study engineer, who
14 testified at the trial and his testimony is
15 that in the white -- in the pink zone that
16 those individuals who are residents of these
17 same three greater Rock Hill zip codes, 732,
18 730 and 704, where they're in the pink zone,
19 they would have greater access, that is, shorter
20 drive times to Fort Mill Medical Center than
21 they would to Piedmont. Now, you've had an
22 opportunity to look at these, have you -- have
23 you?

24 A: I have. You showed this to me at my
25 deposition.

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1 Q: Okay. Good. Have you attempted to calculate
2 the population that resides in the pink zone?

3 A: I've not actually calculated the population.
4 I've looked at it in terms of density, and the
5 population density in this area is far greater
6 towards the Piedmont hospital side of I-77.
7 The population is pretty sparse when you look
8 at the pink area zip code 29704. It's pretty
9 rural, very few people live there, and again,
10 the population is denser as you move to the
11 west side of I-77.

12 Q: Well, we're not talking about the majority of
13 the population, but we're, in fact, talking
14 about your very precise mathematical calculation
15 that is affected by certainly by a few
16 thousands and certainly by potentially tens of
17 thousands of residents who live in the pink
18 zone, wasn't that true?

19 A: Again, my understanding is that the population
20 is more dense to the west moving into the areas
21 that are not more necessarily more accessible to
22 Fort Medical Center or to -- and this study was
23 done just for Fort Mill Medical Center, not for
24 the location of CMC-Fort Mill. But the pink
25 areas are less dense in terms of their

1 population, and therefore, their demand for
2 services.

3 Q: Well, I wouldn't disagree with you that, but
4 would you accept the proposition that if your
5 intent was to evaluate the extent to which beds
6 are accessible to residents of different regions
7 of the county, that what's important is where
8 the residents live and where there's greater
9 geographic proximity to the hospitals rather
10 than what zip codes they may happen to live in?

11 A: I agree with the premise that they attempted to
12 analyze where patients are closer and have more
13 access. I chose to do it at a zip code level,
14 that was the data that was readily and easily
15 available to do it. To attempt to do it in
16 these sort of travel contours would be much
17 more difficult, and they don't even align
18 necessarily with census track, so it would be
19 difficult to do. So using the zip code level
20 data, which is -- I mean, occasionally you go
21 below that level in health planning, but it's
22 pretty commonly accepted planning measure. The
23 zip code definition that I used I felt were a
24 reasonable surrogate for proximity to the
25 hospital in terms of access.

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1 Q: And you didn't use census track population data
2 that would allowed you to make some more
3 precise determinations about the number of
4 residents in the 730 and certainly in 704 for
5 whom it would be a shorter drive time to either
6 proposed Fort Mill location, did you?

7 A: I did not use census track because I don't even
8 that census tracks would get you down to a
9 level where you could break up the population
10 into these colored drive time contours. So,
11 you know, I looked at the density of the
12 population. You know, it doesn't necessarily
13 change my opinion. It would be very difficult,
14 I believe, to come up with a calculation of
15 exactly how many people resided in each of
16 those colored areas. It doesn't align with
17 census tracks exactly, so you'd have to go even
18 below that level.

19 Q: And so you believe that would be more reliable
20 to lump everyone, whether or not they have a
21 shorter drive to the Fort Mill hospital in
22 these larger zip code categories you've created?
23 That was what you did, wasn't it?

24 A: I evaluated it in terms of zip codes. I found
25 that to be a reasonable planning measure for

1 analysis of geographic accessibility.

2 Q: Okay. Now let's take a look at actually the
3 analysis that you haven't spoken much about in
4 your direct, but that you presented to the
5 Department concerning -- to support your
6 maldistribution theory that beds were not
7 equitably distributed if Carolinas -- if Fort
8 Mill -- if Piedmont placed 100 beds in the Fort
9 Mill area. Let me start by doing that.

10 MR. ANDREWS: And I'm sorry, Ms. Robertson, one more
11 time, if you could help me with Demonstrative
12 3.7.

13 Q: Ms. Platt, you'll recognize this as the exhibit
14 that reflected your testimony that showed, I
15 think you testified, that 96,752, the red line
16 and the top figure was what the -- that was
17 reflected in Mr. Sullivan's demonstrative, and
18 you determined that, according to the current
19 census data, the population instead for northern
20 York County was 84,144, right?

21 A: Yes.

22 Q: Now, you've described these as post, the blue
23 as post 2010 census and the red as pre 2010
24 census. In fact, both could be post 2010
25 census and just be reflecting the updates that's

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1 provided, isn't that true?

2 A: Well, Claritas does update its data each year,
3 and but the reason I believe that Mr.
4 Sullivan's data is pre 2010 census incorporation
5 into the data is when you look at that, the
6 data source he used, it actually doesn't
7 identify a 2010 census number for each zip
8 code. It identifies a 2000 census number, and
9 then I believe a 2012 number and a 2017 number;
10 whereas, the data that I pulled shows a 2000
11 census number, a 2010 census number 2013
12 projection and a 2018 projection. So that
13 would be my basis for the assertion that his
14 data did not yet encompass the 2010 census
15 data.

16 Q: But you don't know that for a fact, do you?

17 A: I think it's pretty clear in the way that it's
18 presented. It would seem unusual to me that
19 Claritas would publish a number and not have
20 actual 2010 census data shown on the very same
21 report if it was available and incorporated
22 into, fully incorporated into the projections.

23 Q: All right. Let me take you back to a
24 demonstrative that, in fact, you reviewed that
25 Mr. Sullivan did present.

1 **MR. ANDREWS:** Dan, please pull up Demonstrative
2 149.1.

3 **Q:** Now, Ms. Platt, you'll see on the left your
4 original analysis before you incorporated zip
5 code 707 into the -- this represents your
6 original analysis that you presented to the
7 Department, correct?

8 **A:** Yes.

9 **Q:** All right. And it shows the differential of
10 over two beds per 1,000 for northern York and
11 just a little over one bed per 1,000 for the
12 balance of the county, right?

13 **A:** Yes.

14 **Q:** So almost a two to one ratio, which caused you
15 to take the position you did to the Department,
16 correct?

17 **A:** Yes.

18 **Q:** All right. And then Mr. Sullivan produced the
19 document to the right on more recent data
20 that's identified as Claritas 2013 and shows
21 with the growth of the population in northern
22 York County over time that those ratios become
23 almost identical, and in fact, there are fewer
24 beds per person for northern York than for the
25 rest of the county, correct?

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1 A: Well ---

2 Q: Isn't that what it shows?

3 A: Fractionally smaller, but ---

4 Q: Okay. Fractionally smaller, but very similar?

5 A: Very similar, I would agree.

6 Q: All right. And if it indeed were very similar
7 then it would reflect an equitable population
8 base distribution of beds, wouldn't it?

9 A: It would. Other than -- well, first of all, I
10 don't -- I don't agree with Mr. Sullivan's
11 population projections. I don't dispute that
12 they are incorrect at the time he pulled them,
13 but newer data shows a much lower rate of
14 growth, particularly in northern York County, a
15 very different rate of growth. But the other
16 thing, to balance that, if it was truly sort of
17 an equal distribution is the fact that beds
18 will continue to be needed in greater Rock Hill
19 at Piedmont Hospital to serve tertiary and
20 special needs services that are not going to be
21 offered by a community hospital in northern York
22 County. So if it was truly a balanced
23 comparison like this and if, you know, except
24 that Mr. Sullivan's math was correct, then I
25 would still give the nod to spending less money

1 and keeping the 36 beds in greater Rock Hill to
2 ensure access to patients who are going to need
3 those tertiary and specialized services.

4 Q: Well, in fact, let's just -- in looking at the
5 more recent data, you didn't stop with the
6 review of what was reflected for northern York
7 County, did you?

8 A: I'm not sure I know what you mean.

9 Q: Well, you had just presented the data in your -
10 - the prior slide we'd looked at that showed
11 that based on the most recent Claritas report
12 that the population for northern York County
13 didn't grow at the rate expected?

14 A: Correct.

15 Q: And I said, you didn't stop there in analyzing
16 the beds per person in the county, the
17 distribution of those, did you?

18 A: No, I just did the population comparison, and I
19 found across all of the areas of population
20 that the growth rate had slowed for all areas
21 of York County.

22 Q: And did you apply that slowed growth rate
23 according to your model in the same way you had
24 originally to determine how it affected the
25 distribution of the beds?

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1 A: I did.

2 Q: All right. Well, actually we can just take a
3 look at that. We did that as well since your
4 direct.

5 **MR. ANDREWS:** Dan, would you pull that up, please.

6 Q: All right. Now, what we're pulling up here,
7 Ms. Platt, incorporates the population data.
8 And what I want to do is just make sure we're
9 tying to what you've just testified to, which
10 is that the population in northern York was not
11 96,752 as reflected earlier, but more recent
12 Claritas data show that it was projected to be
13 in 2020, 84,151. And that ties within seven to
14 the number reflected on your demonstrative that
15 we just looked at, right?

16 A: Yes.

17 Q: Okay. And if you then complete that process
18 and look at the beds per 1,000 population, it
19 falls to 1.19, doesn't it?

20 A: Yes, it does.

21 Q: And the population in -- for the rest of the
22 county that's reflected there is 195,398. Is
23 that consistent with what you'd found as you
24 undertook this analysis?

25 A: That looks about right.

1 Q: All right. And the beds per population for
2 1,000 population are 1.19, right?

3 A: Yes.

4 Q: And that's identical to the bed to population
5 ratio for the northern York County area, isn't
6 it?

7 A: Yes.

8 Q: And the -- and that would make it true that the
9 total beds for the total service area, the
10 entire York County would be the same, correct?

11 A: Yes.

12 Q: Now let's take a look at -- what effect will
13 this have on if there were only 64 beds in Fort
14 Mill under your bed population ratio? Let's go
15 ahead and show that based on -- we've analyzed
16 this as well, Ms. Platt. Did you analyze it?

17 A: I did.

18 Q: And you changed your mind about the value of
19 the model after analyzing it?

20 A: No, I did not. I was responding to Mr.
21 Sullivan's criticism in terms of whether the bed
22 population ratio was a meaningful tool. I
23 think it is. I moved to also look at the
24 distribution of the discharges, which is what I
25 presented based on Mr. Levitt's calculation. And

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1 what I determined was that the population of
2 northern York County appears to be, I guess in
3 some regards, a younger and healthier population
4 that has a lower demand in terms of discharges.
5 So I felt that was relevant to the
6 presentation.

7 Q: The beds per 1,000 population if there were
8 only 64 beds under the Carolinas model in
9 northern York County would be .76 per bed,
10 correct?

11 A: Yes.

12 Q: I mean, I'm sorry, it would be .76 beds per
13 1,000?

14 A: Yes.

15 Q: And in the balance of the county there would
16 be, according to the characterization you gave
17 it, an inequitable distribution based on
18 population alone of 1.37 beds per same
19 population group, right?

20 A: If you go out to 2020 that's the math, yes.

21 Q: In 2020, if you assume a couple years for
22 appeal of this case, it's probably going to be
23 year three of this operation of this hospital
24 for either one, wouldn't you agree?

25 A: I still think the 2017 projection is reasonable.

1 I don't know that it's necessary to go to 2020.

2 Q: If you assume two years for an appeal and two
3 years before the opening of a hospital, the
4 first year of operation is likely to be 2017,
5 isn't it?

6 A: If you assume that this appeal is going to go
7 on for two more years, yes.

8 Q: All right. But I promise you the cross-
9 examination won't. All right. Okay, let's
10 move on. Now, let me take you to your
11 testimony about the assumption that there would
12 be -- one of the reasons that Carolinas would
13 want to build CMC-Fort Mill was to shift
14 patients from Mecklenburg County to the Fort
15 Mill area. Did I understand your testimony
16 correct that that was what you understood to be
17 one of their incentives for proposing this
18 hospital?

19 A: Yes, to decompress the very highly utilized
20 facility at CMC-Downtown.

21 **MR. ANDREWS:** Dan, let me pull up Demonstrative 243,
22 please.

23 Q: Now, Ms. Platt, given what your testimony is
24 about Carolinas' interest in decompressing the
25 utilization of its facilities in North Carolina,

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1 let me ask you to review this data concerning
2 the occupancy rates in 2009 and 2011.

3 A: Okay.

4 Q: You see those?

5 A: Yes.

6 Q: All right. And as I understood your testimony
7 is that not only Main but all of the Carolinas
8 facilities were full, and that was the incentive
9 that Carolinas had to shift patients to York
10 County. Did I understand you correctly?

11 A: I don't know that I said they were all full. I
12 think my focus was on CMC and the need to
13 decompress beds at that facility.

14 **MS. ROBERTSON:** Your Honor, if I may, sorry to
15 interrupt, but I'm looking at this demonstrative
16 and I believe it's based on a source that was
17 not admitted into the record on the 2013 North
18 Carolina Medical Facilities Plan. I may be
19 wrong, but I don't believe that was ever
20 admitted as an exhibit and this demonstrative
21 seems to based upon that.

22 **MR. ANDREWS:** It's true, it wasn't admitted or --
23 yet, Your Honor. I mean it's one of the things
24 you said you'd wait until -- take it up as we
25 presented it. So and it's still not being

1 admitted.

2 **MS. ROBERTSON:** Actually I thought you had ruled on
3 that, that this was not -- this was not an
4 admissible exhibit.

5 **THE COURT:** Which exhibit was this?

6 **MR. ANDREWS:** Thirteen I believe, but I'm not sure.
7 Thirteen, Your Honor. And our notes reflect
8 that you didn't rule on it. That was my
9 recollection.

10 **MS. ROBERTSON:** Actually, my notes reflect something
11 otherwise. Imagine that. It says that you, in
12 fact, had granted our objection on that and you
13 excluded it.

14 **THE COURT:** On grounds of relevance.

15 **MS. ROBERTSON:** Your ruling, and then you -- yes,
16 sir, I thought you had, in fact, excluded it
17 and granted that. And if you said you --
18 something about revisiting, but I thought you,
19 in fact, had ruled on it at the outset.

20 **THE COURT:** I believe -- yeah, that's what -- my
21 note says that I granted the motion and said
22 that if you wanted to revisit it at a later
23 time, we would do that, but that 9, 10, 12, and
24 13 I granted that motion on the grounds of
25 relevance, I think was your objection.

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1 **MR. ANDREWS:** Well, Your Honor, I'm not moving to
2 introduce it, although I'm happy to do that. I
3 think this demonstrates the relevance issue in
4 part that it, first of all, was an -- simply
5 provides an opportunity in this regard to update
6 the data that's already in the record, that
7 data that Carolinas provided. And it clearly
8 relates to this witness' testimony concerning
9 the effects of the occupancy of the North
10 Carolina facilities on their interest in the
11 Fort Mill hospital.

12 **MS. ROBERTSON:** Your Honor, to the extent we're
13 still sourcing a North Carolina Medical
14 Facilities Plan, I think we stand by our
15 objection that that's not relevant. And it
16 does underlie this exhibit, so I think we still
17 question the relevance of that document in this
18 case.

19 **MR. ANDREWS:** Your Honor, frankly, it's not an
20 important issue. I'm happy to go with 2009, my
21 guess is they'd want to update it. But if not,
22 then we can just focus on 2009, which was still
23 available.

24 **MS. ROBERTSON:** Yes, the footnote from the source
25 for one is in fact the 2013 North Carolina

1 Medical Facilities Plan, so he's got it sourcing
2 that 2009 line. And Your Honor, if we could
3 get a copy of this demonstrative as well, I
4 don't think we've seen this one prior to.

5 **MR. ANDREWS:** Your Honor, with regard to this
6 demonstrative and this data, again, I'm
7 satisfied that it's just -- that the 2011
8 information provided for consistency. If it
9 allows things to go forward, we don't need it.
10 The 2009 information we do need. I'm not
11 proposing to withdraw that. That's already in
12 the record frankly. It's a document about
13 which there's already been evidence elicited. We
14 believe that -- we'd like to revisit the issue
15 with you concerning other matters concerning the
16 relevance and the need for the admissibility of
17 North Carolina Medical Facilities Plan, but we
18 don't need it for this. I mean, the experience
19 is relatively consistent.

20 **MS. ROBERTSON:** And, Your Honor, I guess my question
21 remains that the source for the footnote one
22 he's referring to 2009 ---

23 **THE COURT:** Right, and I was going to ask ---

24 **MR. ANDREWS:** I was going -- I'm sorry. I should
25 have offered that. The footnotes are reversed.

1 That's mistake. 2009 is sourced to Carolinas
2 document 555. And it's the '11 data that ties
3 to the 2013 North Carolina Medical Facilities
4 Plan.

5 **MS. ROBERTSON:** And, Your Honor, we haven't seen this
6 demonstrative, so we've not had a chance to
7 check that. I guess if Mr. Andrew says that's
8 the case, that's the case. On here, it
9 certainly reflects otherwise.

10 **THE COURT:** And I see that. Do you want to take a
11 minute to do that?

12 **MS. ROBERTSON:** Yes, sir.

13 **THE COURT:** I'm inclined to at least let him proceed
14 along the 2009 lines. Do you want to take five
15 minutes and do that?

16 **MS. ROBERTSON:** Yes, sir. And if the 2009 is
17 sourced as he has reflected and we can confirm
18 that, then the 2009 may be okay.

19 **THE COURT:** All right. Let's take a five minute
20 recess. All right.

21 **MR. ANDREWS:** We can pull that document up if you'd
22 rather avoid a recess. If you want to take a
23 recess, that's fine.

24 **THE COURT:** Let's take a five minute recess. I
25 appreciate it, Mr. Andrews.

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1 (Break from 5:15 p.m. until 5:22 p.m.)

2 **MS. ROBERTSON:** Your Honor, we're going to withdraw
3 our objection to the reference to the North
4 Carolina Medical Facilities Plan.

5 **THE COURT:** Completely -- I mean, completely?

6 **MS. ROBERTSON:** Yes.

7 **MR. MULLER:** It might be helpful to fill you in a
8 little bit, Your Honor. We discovered that in
9 fact the North Carolina Medical Facilities Plan
10 was sourced in a footnote to one of Ms Carter's
11 exhibits and is now already in evidence.

12 **MS. ROBERTSON:** So that being in evidence, we will
13 withdraw our objection.

14 **THE COURT:** Well, I was just thinking about all of
15 this, but that just resolves everything, doesn't
16 it? So that was Exhibit 12, right?

17 **MR. ANDREWS:** Thirteen, I believe.

18 **THE COURT:** Thirteen. I beg -- I keep -- all right,
19 Exhibit 13. All right. Therefore, -- well,
20 I'll let you if you want to offer it at the
21 appropriate time into evidence, you may. Do
22 you want to do that or do you want to ---

23 **MR. ANDREWS:** Yes, I'll do that at this point, Your
24 Honor.

25 **THE COURT:** All right. Thank you. And without

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1 objection then?

2 **MS. ROBERTSON:** That's correct.

3 **THE COURT:** And any objection from the Department?

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

5 **THE COURT:** All right. Without objection, Exhibit
6 13 which was previously -- which I previously
7 ruled was not admissible is admitted. And Mr.
8 Andrews --

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

10 Q: All right. Ms Platt ---

11 **MR. ANDREWS:** Dan, if you'd pull up back
12 Demonstrative 243, please. Let's go back to
13 this document. And again, Your Honor, for the
14 record, I'm sorry that we had crossed our
15 footnotes here and 2009 should be referenced to
16 the South Carolina 555. Did Mr. Bupp already
17 correct it? Thank you, Dan. All right. So,
18 as always, you're way ahead of me. And so
19 we've made an adjustment to the footnotes for
20 2009 and 2011 sourcing.

21 Q: All right. Now, with that, Ms. Platt, I'm
22 going to take you back to the subject that this
23 -- I intend this to relate to, which is
24 Carolinas desire to move patients to York County
25 to address the high occupancy of its Mecklenburg

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1 County or North Carolina facility. Now, this
2 is a demonstrative based on -- let's look at
3 2009 -- the utilization of the Carolinas
4 facilities. This is taken, as I said, from one
5 of Carolinas' own documents, and if you look at
6 the total column, you'll see that 65.3 percent
7 of the beds are occupied, and if you'll look at
8 the total ADC, you compare that to the total
9 beds, you'll see that there are nearly 600 beds
10 available in 2009 in the Carolinas system,
11 right?

12 A: Six hundred beds comparing those -- I mean,
13 that's assuming that there are not swings in
14 capacity levels. I mean, if you're looking at
15 the bed need driven by the average daily
16 census, you know, I think you'd probably end up
17 with a similar number of beds needed.

18 Q: All right. Well the -- looking at the average
19 daily census, and over time that takes into
20 account the swings in beds, doesn't it? The
21 increases and the troughs in utilization?

22 A: It does, but I don't think I could say that
23 there are hundreds of beds not needed because
24 of the swings in census from day to day.

25 Q: All right. And in fact ---

1 **MR. ANDREWS:** Dan, let's take a look at the next
2 demonstrative that looks at this.

3 **Q:** If we're -- if Carolinas were interested in
4 relieving the demand on CMC-Main, which as you
5 recall was a showing an occupancy over 83
6 percent, and they want -- they were able to and
7 wanted to shift patients, these are the
8 facilities into which those patients could be
9 moved for non-tertiary and quaternary services,
10 aren't they?

11 **A:** Well, it doesn't work exactly like that. The
12 patients have to be able to go somewhere else
13 proximate to their home. So you're assuming
14 that they're -- that the sort of full beds at
15 downtown CMC are filled by patients that live
16 closer to Kings Mountain or Cleveland Regional
17 or Union Regional. And that may or may not be
18 the situation. What we do know is that there
19 are a lot of patients from York County that go
20 into Charlotte Main, and those patients could be
21 served more proximately with a facility in Fort
22 Mill.

23 **Q:** CMC-Main provides services to individuals in the
24 communities represented by every one of these
25 hospitals, does it not, for non tertiary and

1 quaternary services?

2 A: Yes, but to varying degrees by area, and you
3 have break out -- certainly for tertiary
4 services, they serve all these areas. But what
5 you're trying to sort of shift back and to
6 relieve the capacity constraints are the-non
7 tertiary patients.

8 Q: That's what I asked you about. And do you know
9 for a fact that Carolinas today and in 2011,
10 when it showed an 88 percent occupancy, provided
11 non-tertiary, non- quaternary services to many
12 patients who reside in the very communities
13 where these hospitals in the Carolinas system
14 are located, didn't they?

15 A: I don't know if I could say many. I think it's
16 varying degrees by area. So, you know, it
17 doesn't mean that necessarily there are as many
18 people coming from Union County to use those
19 beds that are non-tertiary as there are from
20 York County. So they're not all sort of
21 equivalent opportunities to offload patients and
22 move them out of CMC.

23 Q: Now, there may not be equivalent opportunities,
24 those same limitations about the difficulty that
25 Carolinas has apparently had in moving patients

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1 for community services to its community
2 hospitals would be a factor affecting their
3 ability to move patients out of -- out of CMC-
4 Main back to Fort Mill, wouldn't it? Same
5 factors in play?

6 A: No, I don't think so. I didn't say it was
7 difficult. I said there are varying degrees to
8 which non-tertiary patients are coming from
9 these communities.

10 Q: And you don't -- but you don't know what they
11 are?

12 A: I haven't analyzed that in detail, but they're
13 not all the same, it doesn't represent all
14 exactly the same situations as York County.
15 And these patients, or these beds, even if
16 they're available, they don't help alleviate the
17 number of patients coming from York County to
18 CMC because they're not in a -- in an
19 approximate area to meet that demand.

20 Q: Well, in fact, this data doesn't represent the
21 86 beds added to Pineville, does it? They
22 would be on top of the 294 of 2011, wouldn't
23 it?

24 A: They would be in addition to ---

25 Q: In addition to?

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- 1 A: --- the Pineville beds. Not your -- the 294 is
2 Mercy and Pineville combined.
- 3 Q: Yeah, I understand ---
- 4 A: They were added at Pineville not at Mercy.
- 5 Q: Right. But they would be added to the 294
6 looking at the combined number of beds available
7 for those facilities in that system, right?
- 8 A: Yes.
- 9 Q: And, in fact, Mercy added 230 -- I mean, excuse
10 me, 38 beds as well, didn't they, to help cover
11 the beds that they transferred to Pineville;
12 isn't that true?
- 13 A: I'm not the witness to go back through all the
14 bed derivations for Carolinas. I believe
15 there's other witnesses that would know that in
16 more detail than me.
- 17 Q: So you don't know whether Pineville, in addition
18 to the 86 beds at Pineville, Mercy added 38?
- 19 A: I don't know all the beds that have been added
20 at Mercy or all the other Carolinas facilities.
21 That's not something that I've studied.
- 22 Q: All right. Okay. Now, the record that was
23 presented to the Department that was the basis
24 for the opinions you've offered as well, since
25 that's what you said you tried to focus on, did

1 not include an analysis by Carolinas of the
2 adverse impact they would have on Piedmont, did
3 it?

4 A: I think it had a discussion of the adverse
5 impact that they would have on Piedmont and the
6 fact that they expected their utilization to be
7 based on their current market share, and as a
8 result, they would not have an adverse impact
9 on Piedmont.

10 Q: So right, they had a discussion. They didn't
11 attempt to quantify the analysis, did they,
12 other than say zero?

13 A: Their isn't any analysis to be done if the
14 market share all comes from a shift of existing
15 market share. There's no math to be done.

16 Q: Isn't common in your experience, Ms. Platt, that
17 there is an assumption that when a new provider
18 moves into a new market that there would be an
19 adverse impact on the existing providers
20 proportionally based on their then existing
21 market share?

22 A: That is one way to look at adverse impact. And
23 that distribution sort of based on historical
24 market share assumes that there's not going to
25 be a shift from existing providers. So I don't

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1 know that when you're -- when you're building a
2 satellite facility and you have existing market
3 share in an area and you expect patients to be
4 served closer to home, I don't know that you
5 necessarily make the same exact assumption with
6 regard to impact being distributed based on
7 market share.

8 Q: All right. Now, the most common way to -- for
9 health care planners to undertake that adverse
10 impact analysis is to measure how an existing
11 facility would perform with a proposed facility
12 and compare that to how it would perform in the
13 absence of that facility, right?

14 A: Typically, I would look at the way that a
15 facility would perform with, you know, a new
16 provider in the market compared to how they are
17 performing today.

18 Q: That's not the most common way you do that in
19 your years of experience, is it?

20 A: It's been done a variety of ways, but yes,
21 quite often it's looked at how they're doing
22 today. Because if the facility is feasible
23 today and you look at the impact on the way it
24 operates today, you can determine whether it
25 would still be feasible in the future. No

1 hospitable or facility is guaranteed growth out
2 into the future necessarily. So to me, if
3 they're feasible today and you add the impact,
4 then you can determine whether they would still
5 be feasible with the introduction of a new
6 facility in the market.

7 Q: That's not what I asked you, Ms. Platt. I
8 asked you, in your experience, if the most
9 common adverse impact analysis that you've
10 applied is comparing what the facility would be
11 like with the -- what existing providers would
12 be like with the proposed facility and without
13 it, not the look back. We'll talk about that,
14 but the question is simple. Is that the
15 analysis that you most commonly apply as you've
16 done your work over the last 20 years or not?

17 A: And I would say I don't think that's the most
18 common way. I have done it that way. But I've
19 also looked at comparing the facility today to
20 how they would operate with the facility in
21 the future.

22 Q: All right. Let's talk about each of those.
23 Let's start with the one that compares the
24 performance with the proposed facility and
25 without it. Now that, and I'll refer to that

1 as the with and without analysis. You
2 understand what I mean by that, don't you?

3 A: Yes.

4 Q: All right. Now, that analysis takes into
5 account growth and inflation, right?

6 A: Growth in population?

7 Q: Yes.

8 A: Yes.

9 Q: And the -- well, let's just say and that -- the
10 effect of that is the existing facility gets
11 the benefit of that expected growth, doesn't it?

12 A: In a status quo scenario, they would have the
13 benefit of that -- that growth.

14 Q: And the -- what you discussed as looking to the
15 current performance, that would be a measure
16 that I'm going to refer to as looking back
17 about how an existing facility, let's say
18 Piedmont, as performing at some point in the
19 past compared with how we would perform in the
20 presence of the proposed facility in the future.

21 Is that ---

22 A: I don't know if I'd necessarily say past. I
23 mean, I think the point is to look at it as
24 current as possible. I mean, you have to use
25 whatever data is available, so it might be

1 slightly in the past, but sort of an attempt to
2 look at the current status compared to what
3 would happen in the future with a proposed
4 facility.

5 Q: And that look back method does not take into
6 account growth, does it?

7 A: Actually it does because it assumes that that
8 incremental growth in many instances is served
9 by the new provider. And that growth is sort
10 of what justifies the need for the project.

11 Q: Well, and that growth though is -- is something
12 which you're measuring against the past -- the
13 place of operation in the past to the provider,
14 right, of the existing provider?

15 A: You're looking at the incremental growth overall
16 of the market, which is the reason that there's
17 a need. But again, I don't know that any
18 provider is necessarily entitled to retain that
19 growth.

20 Q: Okay. Now, in this analysis, let's actually --
21 you don't have in the application, do you, a --
22 either the look back or the analysis of the
23 with and without? It's not in the record, is
24 it, that the Carolinas performed?

25 A: You mean in Carolinas ---

1 Q: Yes.

2 A: --- record? No, they did not perform that
3 analysis because their assumption is that the
4 utilization for the proposed facility will come
5 from existing market share. And under that
6 assumption, there is no impact.

7 Q: All right.

8 A: nd Piedmont would benefit from the growth in
9 population, as would Carolinas with respect to
10 their current levels of market share.

11 Q: Now, in that -- Carolinas' analysis that's in
12 the record, they rely strictly on an analysis
13 based on discharges, don't they?

14 A: I'm not sure I understand. Strictly discharges
15 as compared to what?

16 Q: Yeah. Well, there are other factors that any
17 adverse impact analysis you take into
18 consideration other than just utilization, isn't
19 that right?

20 A: Staffing is one and that's, you know, one of
21 the criterion, the project review criteria. But
22 I mean typically measures of utilization are the
23 fundamental basis for calculating adverse
24 impact.

25 Q: Okay. Well, you'd also take into consideration

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1 a change in and a shift in medical staff
2 alignment; wouldn't that be a relevant
3 consideration?

4 A: I mean usually that would be a function of
5 market share. If you were to shift medical
6 staff then you would shift market share. And
7 the assumption that Carolinas presented was that
8 they would not -- they would not shift market
9 share to meet their projections.

10 Q: And I understand that was their assumption.
11 What I'm talking about is in a normal review of
12 adverse impact, you'd take into consideration
13 the reasonableness of that assumption and
14 whether it would be reasonable for physician
15 alignment to change, and that would -- have you
16 looked at that factor here?

17 A: I looked at it in terms of market share, which
18 I think is the ultimate reflection of whether a
19 physician alignment would change.

20 Q: And that was Carolinas' assumption that no
21 market share would change. That's wasn't yours,
22 was it?

23 A: That was their assumption. As I stated
24 earlier, I was asked to look at what Carolinas
25 put in the record and what Piedmont looked in

1 the record -- put in the record and analyze
2 them for what they were in the record the way
3 DHEC would look at them.

4 Q: Now, when Piedmont put in the record letters
5 from physicians saying that there would be a
6 change in physician alignment, you didn't even
7 read those letters, did you?

8 A: I looked at some of the letters. I did not
9 look at every record in the file.

10 Q: No. But you haven't taken into consideration
11 the extent that there may be a shift in
12 physician and physician practice that could
13 affect whether there would be an adverse impact
14 on Piedmont; you have not incorporated that into
15 your analysis as you're sitting here, have you?

16 A: I have not because shift in physician alignment
17 would result in a shift in market share, and my
18 analysis is based on no shift in market share,
19 which was the assumption for Carolinas. Just
20 like I accepted and reviewed Piedmont's market
21 share assumptions and evaluated those, I
22 evaluated the record for what it was, the way
23 DHEC would look at the record.

24 Q: All right. In addition to the potential for
25 physician shift, there could be change in payer

1 mix as a result of the introduction of CMC-Fort
2 Mill into York County, couldn't there?

3 A: There could be.

4 Q: And that could produce an adverse effect in and
5 of itself without regard to changes in market
6 share, couldn't it?

7 A: Well, again, if you're assuming that market
8 share is remaining constant for Carolinas and
9 the same base of patients that they're serving
10 today are the ones that they're going to serve
11 in Fort Mill, then it wouldn't have any impact
12 on payer source.

13 Q: Again, if that assumption proves to be true?

14 A: If that assumption assumes to be true, which
15 was what was in the record and what I reviewed.

16 Q: All right. Now, another consideration related
17 to the adverse impact that could result for
18 existing providers is the health of that
19 provider, that is, how well they're doing of
20 their -- isn't that a relevant consideration?

21 A: You mean sort of the financial health?

22 Q: No, the general operational health, and
23 financial would be an element of it, but it
24 wouldn't be limited to that, would it?

25 A: Of the provider that's coming into the market

1 or the existing provider?

2 Q: Of the existing provider? Talking about adverse
3 effect on the existing provider, an important
4 consideration is how the existing provider is
5 doing?

6 A: That's not really something that, you know, the
7 new proposed provider can control, nor is that
8 really something that DHEC can control.

9 Q: All right. Not talking, but it's a -- the
10 control is not the question. The question is
11 the potential adverse impact and how that should
12 be evaluated. You've testified before that the
13 health or size of an existing provider is a
14 relevant consideration in evaluating adverse
15 impact, haven't you?

16 A: I don't know if I've used the word health. I
17 mean I think financial, the financial status of
18 the existing provider, if you've got one, I
19 think that's -- I mean, the financial health
20 would be relevant. I don't know what other
21 measures ---

22 Q: Okay.

23 A: --- you would look at.

24 **MR. ANDREWS:** Your Honor, if I may approach, I want
25 to show Ms. Platt a copy of her deposition in

1 another case.

2 **THE COURT:** Yes, sir,

3 **MR. ANDREWS:** All right. I apologize for the size
4 of this, Your Honor, and Ms. Platt but it's --
5 I knew if I just provided a page there would be
6 issues about that. So here's the entire
7 document.

8 **THE COURT:** I understand. It's quite a deposition.

9 Q: All right. Ms. Platt, open the first page, the
10 cover page, please.

11 A: Okay.

12 Q: And tell me if you recognize this document?

13 A: Yes.

14 Q: What is it?

15 A: It appears to be a transcript of my deposition
16 in a Wake County acute care hospital case.

17 Q: And you provided the deposition, and did you
18 testify in this case?

19 A: It sort of settled, or there was some parts of
20 summary judgment before it went to hearing, so
21 I did not testify in court, just deposition.

22 Q: All right. Let me turn your attention to page
23 77.

24 A: Okay.

25 Q: And ---

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1 A: Okay.

2 Q: All right. I'm going to -- the question I'll
3 read and you can just read the answer. "Is
4 there a particular level that -- that you think
5 is a market share impact that you think is of
6 a particular concern in general?" And your
7 answer? Go ahead and read it.

8 A: "There really isn't a set level. It's
9 partially a measure measured against the health
10 or the size of the existing provider. For
11 example, if you have a smaller provider with
12 thin margins, then you know a smaller percentage
13 impact could be devastating financially, whereas
14 as if you have a very large hospital or health
15 system, you know, a few percentage --
16 percentages of impact is, you know, barely going
17 to be a dent." Do you want me to keep going,
18 or?

19 Q: No that's enough.

20 A: Okay.

21 Q: All right. Are you aware of the extent to
22 which Piedmont has lost market share since
23 filing its application in 2005?

24 A: I'm aware that it has lost market share. And I
25 would just like to clarify that in this

1 instance here, I was referring to financial
2 health. And that's specifically the example
3 that I gave in terms of financial health. What
4 you just asked me about was other types of
5 health in terms of operations.

6 Q: Uh-huh, that's right. And do you believe that
7 operational performance is a relevant
8 consideration?

9 A: Ultimately, its impact is usually measured in
10 terms of financial impact. And what I was
11 speaking to here was financial health of an
12 organization.

13 Q: And to the extent that you're dealing with a
14 tertiary facility whose -- whose volumes are
15 recognized as a matter of law or as a matter of
16 the State Health Plan to be related to quality,
17 then the effect on market share would be an
18 important consideration, wouldn't it?

19 A: If it's market share of those tertiary services.
20 What we're talking about here is community
21 services, and we're talking about no shift in
22 market share because Carolinas has sufficient
23 market share to meet their utilization
24 projections without impacting any other
25 provider.

1 Q: All right. Well, you believe in reality that
2 some patients would, in fact, shift and the
3 representation that Carolinas made is not what
4 would reasonably be expected, don't you?

5 A: Well, there's -- no one has a crystal ball, and
6 certainly we can't prevent patients who
7 previously have gone to Piedmont from going to
8 Carolinas. But, in my opinion, the fact that
9 Carolinas already has a significant market share
10 in northern York County to me shows that they
11 have the ability to fill the hospital without
12 taking any market share. They've had market
13 share increases in the past, but it -- my
14 understanding is that those have stabilized.

15 Q: Ms. Platt, my question was whether you would
16 agree that, in fact, some Piedmont patients
17 would shift to Carolinas if that facility was
18 built in Fort Mill, and your answer is yes or
19 no?

20 A: There may be some patients that shift.

21 Q: All right. Now, Carolinas' first goal would be
22 to, before shifting patients, would be to ensure
23 that its North Carolina facilities are fully
24 utilized, wouldn't it? Wouldn't that be its
25 primary goal?

1 A: I think you'd have to ask a Carolinas witness
2 that question.

3 Q: All right.

4 **MR. ANDREWS:** Let's actually, if I could have your
5 exhibit, please, Ms. Sackett. I'm sorry, not
6 exhibit, deposition transcript. Oh, did you
7 already give it to me? Pardon me. Your Honor,
8 if I may approach?

9 **THE COURT:** Yes.

10 Q: If you would open that for me, Ms. Platt.

11 A: Don't know if I can. Okay.

12 Q: All right. And turn to page 77, please. All
13 right. Let's take that down through line 18.
14 My question is, "Isn't in their best interest,
15 first of all, to ensure the hospitals in which
16 they've made an investment are fully utilized?"
17 Your answer?

18 A: "Well, I mean, I certainly think that would be
19 a goal."

20 Q: "And that would be Pineville, would it not?"

21 A: "That would be Pineville and yes, they -- they
22 invest in all their facilities."

23 Q: Okay. Now, you testified that even though
24 there was not an adverse impact analysis,
25 assuming that there would be a loss of market

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1 share proportionate to the market share that the
2 existing providers had, that you didn't see that
3 in the application, but isn't true that you
4 prepared one yourself?

5 A: I did do one prior to my deposition.

6 Q: Okay. And let's take a look at that, please.

7 **MR. ANDREWS:** Dan, if you'd pull up Ms. Platt's
8 Exhibit 10 to her deposition.

9 Q: And it should be if you want to look at a hard
10 copy attached as an exhibit, Ms. Platt. And
11 what we have here in your demonstrative is an
12 example of what the with and without analysis
13 that you've seen used in many, many cases,
14 isn't that right?

15 A: Yes.

16 Q: All right. And, in effect, what you've done
17 here is you've applied some of Mr. Levitt's
18 assumptions and analysis, correct?

19 A: I used Mr. Levitt's sort of format and his
20 projection of overall market demand, and then
21 applied actual market shares as the basis for
22 the potential loss and for shift in market
23 share. And the way I believe I characterized
24 this in my deposition was that this would sort
25 of be a worst case scenario, that if providers

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1 all lost in relation to their existing market
2 share, which I don't expect to be the case
3 because Carolinas has a very significant market
4 share in northern York County and in York
5 County, and I believe they will have the
6 ability to shift their patient base to the new
7 facility. So I did this exercise as what I
8 call a worst case scenario.

9 Q: All right. But, in fact, it's typically not
10 done as a worst case scenario, but the way
11 planners begin their analysis and then make
12 adjustments from it as to their assumption about
13 adverse impact, isn't that right?

14 A: Not ---

15 Q: As a general rule?

16 A: Not necessarily because, I mean, this is, to
17 me, the best starting point if your -- you have
18 a new entrant coming into the market that
19 doesn't necessarily have a market presence, then
20 your assumption would have to be based on
21 shifts within existing market share. But when
22 you have an existing provider that has a large
23 market share and has the ability to ensure that
24 their patients are served closer to home, then
25 you don't necessarily start with this.

1 Q: All right. Let's turn to the second page of
2 this analysis to determine what your -- how
3 your application of this model, what it
4 resulted in. And the bottom line on this page
5 ---

6 **MR. ANDREWS:** Dan, if you'd highlight it, please.

7 Q: -- is that applying the proportionality adverse
8 impact test to the effect on Piedmont is that
9 in 2017 Piedmont would be projected to lose
10 1,628 cases, isn't that right?

11 A: It is. But if you look at the net growth
12 that's offsetting it and you look at the --
13 where Piedmont would be looking at them today
14 versus 2017, there's almost no impact
15 whatsoever. Piedmont would lose 67 cases, which
16 is on the prior page.

17 Q: All right. Let's go back to that page and so
18 we can just follow how you have -- how your
19 math works on that.

20 **MR. ANDREWS:** Dan, if you'll highlight the last
21 three rows and the headings for them on that
22 page.

23 Q: Now, you'll see here that Ms. Levitt -- excuse
24 me, Ms. Platt -- let the crowd enjoy that for a
25 moment -- that Mr. Levitt applied -- did a

1 computation that you've then adjusted and
2 applied the 1,628 cases to. But explain to the
3 Court, if you would, how you've derived the
4 10,048 cases -- 10,418 cases.

5 A: Okay. The starting point was the 2009 actual
6 discharges for PMC, CMC, other North Carolina
7 providers and then total. So that's sort of
8 the first block. And then Mr. Levitt grew
9 those cases out to, or those discharges out to
10 2017 with constant market share to see sort of
11 the status quo in 2017. And so applying
12 constant market share, Piedmont grows from
13 10,485 cases in the first block to 12,046 in
14 the second block, which would be a net increase
15 of 1,561 cases. The total incremental growth
16 in the market, and again, my understanding of
17 Mr. Levitt's information here is that these are
18 community hospital discharges, so this doesn't
19 take into consideration growth and demand for
20 tertiary and specialty services, but that there
21 would be a net increase of 3,000 cases between
22 2009 and 2017 that would be available for the
23 various hospitals to serve.

24 Q: And the distribution of those would work out in
25 a way that Piedmont would have taken a little

1 over half of those 1,561 correct?

2 A: Right, based on their market share across the
3 whole county. Yes.

4 Q: All right. And then the 10,418 would be where
5 they would find themselves with CMC-Fort Mill
6 rather than the 12,046, correct?

7 A: Correct. So they would be at 10,418, which is
8 just 67 cases lower than they are -- they were
9 in 2009.

10 Q: All right.

11 A: So if you're comparing ---

12 Q: Excuse me.

13 A: -- their financial feasibility or looking at
14 their operations in 2009, and we know that they
15 were feasible in 2009 and they're feasible
16 today, then, you know, the net impact of 67
17 cases to me is not going to change the
18 feasibility of their hospital.

19 Q: Well, again, there are two different forms of
20 this adverse impact analysis. The first would
21 look at performance that's projected with and
22 without in 2017, correct? And that's the loss
23 of 1,628 cases?

24 A: Correct.

25 Q: A different analysis is that you then look back

1 to how that performance of 10,418 would have
2 compared to Piedmont's performance at a prior
3 point in time, and you're looking as to what
4 their performance was in 2009 and they were
5 only 67 more than 10,418, right?

6 A: Right.

7 Q: All right.

8 A: And I believe that's the relevant analysis
9 because I believe that it's been bound in
10 looking at adverse impact in South Carolina CON
11 cases that the measure of impact is whether an
12 existing facility can take the hit. And so
13 looking at it this way measure whether Piedmont
14 can, based on their current level of
15 feasibility, take a hit in terms of a loss of
16 67 cases.

17 Q: Well, you're referring ---

18 A: And this does not ---

19 Q: Excuse me. I'm sorry, go ahead.

20 A: This doesn't even take into consideration that
21 there's continued growth and demand for tertiary
22 and other specialized services that are not
23 going to be served by a Fort Mill hospital that
24 Piedmont can continue to serve. And again this
25 is -- I'm considering the worst case scenario

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1 because this assumes that Carolinas' patients
2 are not going to return to be served in York
3 County when there's a Carolinas facility
4 available. And I don't agree with that. I
5 think it makes sense for those patients, that
6 market share base to shift to the new hospital
7 when Carolinas has a facility in York County.

8 Q: The analysis you performed, you're rejecting the
9 with and the without, you believe that the
10 look back analysis is more accurate and more
11 relevant to your opinion, is that right?

12 A: Yes.

13 Q: All right. And let's take a look at your
14 exhibit, which you didn't testify about on your
15 direct, but I'm going to ask you questions
16 about it anyway. Exhibit 33, Page 11.

17 A: Okay.

18 Q: Now, this is your workup, again, with some
19 slight differences in the numbers, which I'm
20 sure you can reconcile, that reflects what you
21 just reviewed from your two different forms of
22 adverse impact analysis. Doesn't it? And then
23 applies a contribution margin too?

24 A: It looks at the impact, yes, taking the
25 difference between 2009 and 2017, applying the

1 contribution margin per case that Mr. Levitt
2 had previously used and looking at what would
3 the lost contribution margin and the impacts of
4 pre-tax income.

5 Q: All right. And so what you're doing on the
6 first large category across the large first row,
7 is your look back analysis?

8 A: Yes.

9 Q: You're comparing performance that's projected in
10 2017 to 2011 and applying the -- and then
11 comparing where Piedmont would be in 2017 to
12 where it was in 2009, and find that it's just
13 62 cases rather now 67 short of where it was,
14 right?

15 A: Right.

16 Q: And then you apply the contribution margin to
17 that and show a net loss of \$252,359?

18 A: Yes.

19 Q: All right. Now, the second part of your table
20 shows the with and without analysis as is
21 stated there, right?

22 A: Correct.

23 Q: And here you're applying the loss over the
24 three year, I mean, sorry, over the three
25 regions of 1,623 cases rather than 28. Is that

1 a function of rounding or why is the number
2 different ---

3 A: It's a function of rounding.

4 Q: Okay. And then applying the contribution margin
5 to that, you show a loss to Piedmont that would
6 suffer a six point -- \$6,565,043, correct?

7 A: Right, but that's a loss sort of opportunity.
8 You wouldn't compare that to their current
9 level of operations because that would be, you'd
10 have to essentially grow their financial
11 performance out to 2017 and then subtract that.

12 Q: All right. Now, the calculation of the loss of
13 1,623 patients ---

14 **MR. ANDREWS:** Let's go back, Dan, if you would to
15 Exhibit 10 to Ms. Platt's deposition that we
16 just visited.

17 Q: And if you show the loss of the 1,623 cases
18 against the projected 12,046 cases, do the math
19 for me, Ms. Platt, and tell me what that is?

20 A: What are you -- tell me what you want me to do
21 again? The 1,628 ---

22 Q: 1,623 loss from the projection of 12,046.

23 A: Okay.

24 Q: What percentage of cases is that would be lost?

25 A: From what starting point?

1 Q: Well, this is the with and without analysis.

2 A: Right.

3 Q: So?

4 A: So you have to take that variance and you're
5 really dividing it by the with, the 12,046.

6 Q: Right.

7 A: 13.4 percent.

8 Q: Okay. Now, that loss that would be projected
9 is a function of also the -- your analysis
10 assumes, does it not, the occupancy of CMC-Fort
11 Mill would be at 67.5 percent?

12 A: Yes.

13 Q: And if, in fact, that CMC-Fort Mill were
14 occupied instead at 80 percent, busy hospital
15 with 53 average daily census instead of -- or
16 51 instead of 43, then that the adverse effect
17 applying the same proportionality methodology on
18 Piedmont would be considerably greater, wouldn't
19 it?

20 A: I don't agree because, first of all, again, I
21 believe this is a worst case scenario. I don't
22 believe this is how the market shares are going
23 to play out. Carolinas has a significant level
24 of market share. I believe they have the
25 ability to shift market share because Carolinas'

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1 patients will want to be served closer to home
2 in northern York County. But if you're going
3 to go the next step and assume that they're
4 going to be occupied higher than what they put
5 in their application, then I would assume that
6 that increase in utilization would come as a
7 result of shifting of patients, and I don't
8 know that it would have any impact whatsoever
9 on Piedmont or change these numbers.

10 Q: Well, in fact ---

11 A: You would have to assume that all of that
12 incremental growth -- you're asking me to assume
13 that all of that incremental growth would come
14 at the expense of Piedmont, and I don't think
15 that's reasonable.

16 Q: No, I'm asking you to assume that it would be
17 split evenly, or it would be split to some
18 degree between both Piedmont and Carolinas.
19 That's -- and asking you even to apply your
20 assumption that it would be applied
21 proportionate to their existing market share,
22 that's the common way to perform the adverse
23 impact analysis, true?

24 A: I disagree. I think that is one way to look at
25 adverse impact. I did it for the exercise of

1 showing a worst case scenario. I don't believe
2 that's what's going to happen. I believe that
3 Carolinas has significant market share and they
4 have the ability to redirect those patients and
5 that people who are choosing the Carolinas
6 system are going to choose to be served closer
7 to home in northern York County.

8 Q: Well, in fact, you commented in your review of
9 the various applications on the adverse impact
10 that you projected Presbyterian would have on
11 several different existing providers, didn't
12 you?

13 A: Yes.

14 MR. ANDREWS: Dan, let's take a look at that. Let's
15 go to the record and look at S-CHS-981 and 82.

16 Q: And this is part of your July 2011 submission
17 to the Department, isn't it, Ms. Platt?

18 A: It appears to be, yes.

19 Q: Okay. And if ---

20 MR. ANDREWS: Let's pull out, Dan, the paragraph
21 under Use of Erroneous and Incongruent Data
22 under the analysis related to Presbyterian.

23 Q: And, Ms. Platt, if -- or what you've done here
24 is you've applied your critique of
25 Presbyterian's own adverse impact analysis,

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1 haven't you?

2 A: I looked at their adverse impact analysis and
3 yes, I evaluated it.

4 Q: All right. And what you say here is that
5 Presbyterian's starting point for its impact,
6 that is, its adverse impact study is 2008,
7 however utilization data from calendar year 2009
8 should have been used as the impact analysis
9 was performed near the end of 2010, this
10 information was available at the time. By
11 using the 2008 data, Presbyterian fails to
12 account for a growth in utilization of least
13 two percent between '08 and '09 experienced by
14 most of the hospitals in the study, isn't that
15 right? That's what you say here?

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

17 Q: And it says that, Further, that Presbyterian's
18 flawed analysis does not consider this growth
19 and underestimates the impact as a result.
20 Now, you'll just remember ---

21 **MR. ANDREWS:** Dan, would you pull up real quickly,
22 cut back to Ms. Platt's Exhibit 10 to her
23 deposition.

24 Q: And this shows that 2009 data was used as a
25 starting point rather than 2010 data because you

1 prepared this in July of 2011, and that's the
2 same criticism that you had just applied to Mr.
3 Lutz's analysis to Presbyterian, isn't it?

4 A: No, it's not because in this instance I'm
5 looking at Mr. Levitt's analysis and it's his
6 data. I don't have the ability necessarily to
7 update his data and put it into the categories
8 that he used for community hospital discharges.
9 So I'm using his data for the purposes of
10 adverse impact. What I was criticizing
11 Presbyterian for is that their own consultants
12 did not use the most updated data in presenting
13 their adverse impact analysis. Certainly, Mr.
14 Levitt's analysis could be updated, but this is
15 his analysis and his data source, not mine.

16 Q: But, in fact, what's critical about your
17 analysis and your conclusion that there would be
18 the growth would cover in the look back
19 analysis the change over time, you were looking
20 back at 2009 saying there were 67 cases short
21 of where they were, and therefore, there's
22 little to no impact at all, and in fact, the
23 measurement wouldn't be against 2009, it would
24 be, at this point in time, against 2011 or
25 2012, wouldn't it?

1 A: But then you'd have to update every other
2 factor. So you certainly could do that, but
3 for the purposes of this analysis, the data
4 that I had available to me was 2009 data and
5 Mr. Levitt's 2017 projections.

6 Q: Right.

7 A: So I certainly could update it, but again, this
8 was the data that was available to me.

9 Q: But to show the true impact of the proposed
10 project on the existing providers, you would
11 need to use the more current data so that it
12 would give Piedmont the benefit of the growth
13 that it's actually experienced, isn't that
14 right?

15 A: You certainly could give them that growth. I
16 mean, this project could go on and on and on
17 and we can keep updating every year and
18 certainly if the data's available, that could be
19 done.

20 Q: All right.

21 **MR. ANDREWS:** Now, let me go on and ask you to look
22 further at your analysis of Presbyterian's
23 impact by turning Dan, to page 986.

24 Q: Now, and you identify here what you describe as
25 the correct -- the updated and corrected impact,

1 haven't you?

2 A: Yes, they had some flaws in their actual
3 mechanical calculations when they were aligning
4 their census tracks with their zip codes and
5 performing their analysis.

6 Q: Now, what you were critical of Presbyterian
7 previously doing was applying -- the way they
8 applied the look back analysis, they were
9 looking back too far and that was your
10 criticism and the flaw in their methodology,
11 isn't that right?

12 A: Because they were going further back than
13 current data was available.

14 Q: Okay. And here you're identifying what you
15 believe should be the correct way to analyze
16 the impact. And what you say here on ---

17 **MR. ANDREWS:** Dan, let's pull out the bottom part of
18 the page.

19 Q: Your finding is that Presbyterian would
20 significantly impact both Piedmont and CMC,
21 didn't you?

22 A: Yes, because Presbyterian had the lowest market
23 share of all the providers in this review and
24 they would have to take tremendous market share
25 from all existing providers in order to meet

1 their projections.

2 **MR. ANDREWS:** Well, let's look at the next page,
3 Dan, on 987 to see the extent to which
4 Presbyterian proposed to impact existing
5 providers.

6 Q: Presbyterian didn't describe that impact as
7 significant did they? That was your
8 characterization of it, right?

9 A: I'm sure they did not.

10 Q: Okay. And you did, correct?

11 A: I did.

12 Q: All right. Let's look at what they proposed
13 the impact be. You'll see in your Figure 33
14 that there would be a loss of Piedmont of 2,165
15 cases and that would represent a loss of 15.5
16 percent, correct?

17 A: Correct.

18 Q: And the significant loss on up to CMC would be
19 a total of 8.8 percent for 1,230 cases?

20 A: Yes.

21 Q: And split roughly evenly between CMC-Pineville
22 and other CMC facilities, right?

23 A: Yes.

24 **MR. ANDREWS:** Now, let's take a look, Dan, if you'll
25 call out the first paragraph under that table

1 and highlight the last three lines.

2 Q: What you say here, Ms. Platt, is that, All of
3 Presbyterian Hospital York's primary service
4 area overlaps with that of CMC-Pineville. As a
5 result, the proposed facility will definitely
6 have an impact on CMC-Pineville's acute care
7 discharges. Now, isn't true here that CMC-
8 Pineville's, as well as CMC-Fort Mill's,
9 proposed service areas completely overlap with
10 Piedmont's proposed service area?

11 A: Yes. The difference is that Prebyterian had to
12 gain a tremendous amount of market share in
13 order to meet their projections. They had the
14 lowest market share of all the providers in the
15 review, as opposed to Carolinas that has the
16 highest market share in terms of Fort Mill and
17 has the ability to fill their hospital and meet
18 their utilization projections within their
19 current market share base. So, I mean, the
20 overlap is the same, but the assessment of
21 adverse impact is not the same at all.
22 Carolinas and Presbyterian were in completely
23 different situations in going into this review
24 based on their current market share.

25 Q: All right. Well, let's look at how you

1 characterized the effect of that impact.

2 **MR. ANDREWS:** Dan, let's pull out the last
3 paragraph, if you would, and the last -- the
4 first three lines.

5 Q: In particular doesn't -- don't you find here,
6 Ms. Platt, that Presbyterian will have what you
7 characterize as a serious adverse effect on
8 these two facilities, meaning CMC-Pineville and
9 CMC-Mercy?

10 A: Yes. And again, the market share issue here is
11 Presbyterian is taking tremendous market share
12 from other providers. The other issue is that
13 Presbyterian -- this was an impact based on
14 current utilization, whereas the impact that
15 you're trying to analogize to, the one from my
16 deposition that you've quantified or I
17 quantified 1,600 cases, that was a difference
18 with and with out going out into the future.
19 The impact that Presbyterian would have would be
20 an impact that would knock the providers well
21 below their current utilization. Again, they
22 had to capture tremendous market share to meet
23 their projected utilization.

24 **MR. ANDREWS:** Your Honor, I can see we're past six
25 o'clock. I'm sorry for having gone long. I was

1 hoping to finish but since the lateness of the
2 hour, I'm happy to pick it up and wrap up
3 tomorrow morning.

4 **THE COURT:** Well, how much later do you think you're
5 going to be?

6 **MR. ANDREWS:** Not much.

7 **THE COURT:** My preference would be if you think you
8 can finish, we could go ahead and at least
9 finish your cross-examination.

10 **MR. ANDREWS:** All right.

11 **THE COURT:** I don't mind staying if everybody else --
12 does anybody have any place they absolute need
13 to be? All right.

14 Q: All right. Now, Ms. Platt, let's take a look
15 at the next page, actually two pages forward,
16 989. Now, this is your full page analysis of
17 the with and without adverse impact methodology,
18 isn't it?

19 A: Yes..

20 Q: All right. You didn't do a full analysis of
21 the look back adverse impact method, did you?

22 A: I believe I did look at it both ways.

23 Q: Okay. But on page 989 this is where you
24 presented your with and without scenario,
25 correct?

- 1 A: Yes.
- 2 Q: And if we ---
- 3 **MR. ANDREWS:** Dan, you'll highlight the last row of
- 4 that first table.
- 5 Q: This reflects the total number of cases lost at
- 6 CMC-Pineville and the patient days associated
- 7 with those, correct?
- 8 A: Yes.
- 9 Q: And that's 614 cases and 2,398 days, right?
- 10 A: Yes.
- 11 Q: And then the table below in Exhibit 36, you
- 12 have identified the effect of that. It would
- 13 be the loss of 6.8 percent discharges and the
- 14 same percent for lost days?
- 15 A: Yes.
- 16 Q: And that's at Pineville. And you've described
- 17 that impact as being serious, haven't you?
- 18 A: Yes.
- 19 Q: And on the next page, let's take a look at how
- 20 you've analyzed the impact on Piedmont.
- 21 A: Okay.
- 22 Q: Here you identify a 19.5 percent hit on
- 23 Piedmont in the third year of operation, is
- 24 that correct?
- 25 A: Yes.

1 **MR. ANDREWS:** And, Dan, pull out that top paragraph
2 if you would.

3 **Q:** And the last sentence here, Ms. Platt, says --
4 why don't you read it into the record.

5 **A:** Sure. As shown -- "As time progresses, the
6 more residents utilize the proposed hospital
7 services the impact will only grow more
8 adverse."

9 **Q:** As time progresses, more residents will utilize
10 the proposed hospital services, meaning
11 Presbyterian's proposed hospital, the impact to
12 Piedmont will only grow more adverse, right?

13 **A:** Right. And I think you're comparing apples to
14 oranges here because this is -- Presbyterian's
15 utilization assumptions and their need to
16 capture significant market share in order to
17 meet their projections. And you're comparing
18 that to a hypothetical that I did of Carolinas'
19 impact on Piedmont that I don't believe is
20 going to be the case. I put it out as a
21 hypothetical worst case scenario. I don't
22 believe that that's going to be the case
23 because Carolinas has significantly more
24 existing market share, and I believe they have
25 the ability to redirect those patients. Those

1 patients who have historically chosen to have
2 their services from Carolinas are going to want
3 to be served in northern York County at a more
4 convenient facility. So you're comparing
5 Piedmont's actual assumptions and their need to
6 increase market share with a hypothetical that
7 I don't believe to be the case for Carolinas.

8 Q: And you don't have any doubt do you, Ms. Platt,
9 that residents of Fort Mill and Tega Cay would
10 -- whether they've used Piedmont or used
11 Carolinas would want to use the new hospital in
12 Fort Mill, do you?

13 A: They may or they may not. But what's very
14 clear is that the patients who have chosen
15 Carolinas are going to be able to be served
16 closer to home. And there's no reason to think
17 that patients who've historically chosen
18 Piedmont, especially if they're up in Tega Cay,
19 they are so close to Charlotte, if they've
20 chosen Piedmont in the past, I have no reason
21 to think that they would not continue to use
22 Piedmont.

23 Q: Well, and the physicians at Piedmont may want
24 to get privileges there, or they may go to the
25 emergency department at Carolinas medical

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1 facility. There are unlimited number of way
2 for residents of Fort Mill and Tega Cay and
3 eastern York County to use the CMC-Fort Mill
4 facility, aren't there? And all of that would
5 result in a potential adverse effect on
6 Piedmont?

7 A: There's nothing that would preclude a patient
8 from using CMC, but in my opinion, the fact
9 that Carolinas has a very significant market
10 share of northern York County, that market share
11 would form the basis for the utilization of the
12 proposed hospital.

13 Q: Now, Ms. Platt, looking at your Exhibit 37,
14 19.5 percent hit that Presbyterian's identified
15 that you described as significant is, in fact,
16 you know, if you apply your loss of 1,623 cases
17 in this with and without scenario that's here,
18 I don't know if you've run the numbers, but
19 it's about a 10.3 percent reduction in
20 Piedmont's utilization that would be experienced
21 with Fort Mill that otherwise would have without
22 it. Does that sound about ---

23 A: Yes.

24 Q: --- like the math that would work for you?

25 A: Yes, that --

1 Q: You have run it?

2 A: Yes.

3 Q: Okay.

4 **MR. ANDREWS:** All right. Now let's take a look at
5 the next page, Dan, please, 991.

6 Q: Now, you've performed, in the bottom half of
7 this page, you have concluded that Presbyterian
8 would have a significant impact on Pineville as
9 well as on Piedmont, and if you look down at
10 the bottom of the page, you conclude that that
11 significant impact would be created just with
12 the loss of 6.3 percent of its patients and
13 patient days; isn't that what's reflected by
14 your exhibit?

15 A: That's the calculation I projected, a 6.3
16 percent impact resulting from loss of market
17 share because Presbyterian does not currently
18 have the market share it needs in the area to
19 meet its projections.

20 Q: Ms. Platt, I didn't ask you, did I, about why
21 they were losing. I'm just asking about your
22 characterization of that extent of the loss.
23 And you called it significant, didn't you?

24 A: I did. But again, you're comparing a
25 hypothetical to Presbyterian's actual projected

1 shift in market share.

2 Q: Let's take a look at the next page and see how
3 you characterize the loss that Springs would
4 suffer at page 992. Top of the page, Springs
5 Memorial Hospital will also be severely impacted
6 by Presbyterian. And what percentage ---

7 MR. ANDREWS: Dan, if you'll call out that table.

8 Q: --- of cases did Presbyterian project that
9 Springs would lose? Is it 9.9 percent?

10 A: Yes, it is.

11 Q: Okay. And now your conclusion, Ms. Platt, and
12 down lower on that page, is that Presbyterian
13 would have a serious impact because it would
14 take some 20 percent of market share, and that
15 it would -- what you say here is Presbyterian
16 will steal over 20 percent market share from
17 existing providers that will result in adverse
18 impact?

19 A: That's their own assumption. In order to meet
20 their own projections, they make an assumption
21 that they have to take 20 percent market share
22 from other existing providers. Carolinas does
23 not have to do that. And I don't believe that
24 they will. They have sufficient market share
25 to meet their projected utilization from within

1 their current base of patients.

2 Q: And the fact they have significant market share
3 does not in any way prevent physicians who are
4 at Piedmont from getting medical staff
5 privileges there or from patients who've
6 historically have been served by Piedmont
7 choosing to go there because it's the new
8 hospital in town, does it?

9 A: There are no patients that are precluded from
10 going to any hospital.

11 Q: Thank you. No further questions.

12 **THE COURT:** Thank you, Mr. Andrews. Ms. Robertson,
13 if you want to try to get redirect in, I'm
14 willing to sit here and wait. I mean, I don't
15 what Ms. Platt's schedule is like, whether she's
16 planning on being here tomorrow, or.

17 **MS. ROBERTSON:** Your Honor, given the hour of the day
18 and how long we have been going, all afternoon,
19 I may not have that much for her, but I really
20 would suggest we just do it in the morning. I
21 think we can probably do it quickly and then
22 move right on in to our next witness.

23 **THE COURT:** All right. Any objections to that?

24 **MR. HARRIS:** No objections, Your Honor.

25 **THE COURT:** All right. Then let's do that. We'll

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1 in my opinion, does not meet or best meet all
2 of the criteria.

3 Q: Okay. And let's start with your opinion number
4 one, that Piedmont failed to demonstrate a need
5 for 100 beds at Fort Mill Medical Center. And
6 let's start with your subpart A, Piedmont's
7 projections for Fort Mill Medical Center aren't
8 reasonable. Do these opinions reflecting on
9 these topics relate to specific criteria?

10 A: Yes, they do.

11 Q: Could you please tell us which ones?

12 A: Specifically, it relates to 2(c) 2(e), and in
13 my opinion, 4(b). And I would just highlight
14 that 2(c) indicates that the project has to
15 provide services that meet an identified need of
16 the target population, and that's where, I
17 believe, the Fort Mill Medical Center fails to
18 do that. And also I believe 4(b), which is
19 related to opposition and the opposition in this
20 case that Piedmont Medical Center has a direct
21 impact on their ability to -- the ability of
22 the -- to demonstrate need for the 100 beds by
23 that target population.

24 Q: And under this opinion one, part A, you've
25 indicated the Fort Mill Medical Centers volumes

1 or their volume projections are unreasonable.
2 Do you have a demonstrative to illustrate this
3 opinion?

4 A: Yes, I do.

5 Q: Let's look at Demonstrative 4.16.

6 A: First of all, as the map at the bottom shows,
7 this demonstrative focuses on those four Zip
8 codes in northern York County. And what the
9 chart indicates is by zip code, it shows the
10 number of patients that Piedmont served per day
11 in 2009 from those three zip codes, and that
12 totals 13. I can't get an arrow as hard as I
13 try. That totals 13. And then the next
14 section illustrates Piedmont's projections for
15 both the Fort Mill Medical Center and Piedmont
16 in Rock Hill, and then the total number of
17 patients that it projects in 2017 for the two
18 hospitals combined. And what that shows in
19 total is that they're projecting to serve more
20 than 40 -- well, 41 patients a day in 2017
21 compared to the 13 patients per day that they
22 served at Piedmont in 2009. And overall,
23 that's over a 200 percent increase in patient
24 volume.

25 Q: Is this based on the 2009 data?

1 A: It is. This was based on the 2009 data that
2 was part of Piedmont's submission to DHEC, but
3 I would also note that their need methodology
4 in their submission to DHEC as noted on the
5 bottom of this includes only med/surg and
6 obstetric patients, so it's not -- it's not
7 total patients, but only med/surg and obstetric
8 patients.

9 Q: Okay. And do you recall that Mr. Levitt
10 provided an updated data for 2011 as part of
11 this trial?

12 A: Yes, he did.

13 Q: And did you -- have you examined that data?

14 A: I have. And what this next slide shows is that
15 the same chart with the updated data from 2011.
16 And I would note a couple things. First of
17 all, this includes all discharges except normal
18 newborns. And the number of patients that
19 Piedmont served in 2011 were a couple less,
20 down to 11. And again, it just shows an even
21 greater increase that they would have to achieve
22 to reach their projections of 41 patients in
23 2017.

24 Q: And what does this data mean in terms of market
25 share?

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1 A: Well, I think that's an important thing to look
2 at, particularly given the small number of
3 patients we're talking about here. And what
4 Piedmont and Fort Mill Medical Center combined,
5 their projections rely on a 40 to 60 shift. A
6 40 to 60 points of share from other providers
7 within the first three years that Fort Mill
8 Medical Center opens. And that in some zip
9 codes, particularly the 29707, is a point gain
10 of about 20 points a year. And what this chart
11 shows is in the first section, Piedmont's share
12 by zip code in 2011 and the North Carolina
13 provider share in 2011, which was largely CHS,
14 but there was some Presbyterian share in there
15 too. The second section shows Piedmont and
16 Fort Mill Medical Center's combined share in
17 2017. So, for example, in 29707, they had 7.9
18 percent share in 2011. They project to have
19 68.3 percent share in 2017. And then you can
20 see in the far right column, that means a net
21 gain of 60.4 points of share, again, within the
22 first three years that Fort Mill Medical Center
23 opens. And I would note another piece of this
24 is that if we pull out Fort Mill Medical's
25 share alone and separate that from the combined

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1 share with Piedmont, in 29707, Fort Mill Medical
2 Center projects that it will have 47.3 percent
3 share. So the remainder of that 68.3 percent
4 share would be going to Piedmont. And so
5 Piedmont already exists today to serve zip code
6 29707. But as a result of Fort Mill Medical
7 Center, Piedmont is projecting that it is going
8 to gain points of share not only at Fort Mill
9 Medical Center but at Piedmont.

10 Q: Have you compared this shift with other market
11 share shifts?

12 A: I have. In particular, the first analysis I
13 did is compared it with what the North Carolina
14 providers, the share that they have gained over
15 the last six years. And we've heard a lot of
16 testimony about physician alignment and
17 physicians driving share to North Carolina and
18 what the impact that has been on Piedmont.
19 What this chart examines is the share in 2005.
20 And as you may recall, 29707 was not a separate
21 zip code in 2005, which is why we have these
22 brackets for those years. But in 2005, you can
23 see the share that Piedmont had, the share that
24 the North Carolina providers had, and then how
25 that's changed in 2011. And what the last

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1 column shows is that the North Carolina
2 providers gained about 20 points of share over
3 the course of six years. And that was with the
4 physician alignment and with the physician
5 direction of patients that Piedmont claims has
6 occurred in this case.

7 Q: And are those factors likely to change even if
8 Piedmont builds?

9 A: In my opinion, no, they will not.

10 Q: Let's look at Piedmont's Demonstrative 106.1.

11 A: This is the second analysis that I did relative
12 to the reasonableness of Piedmont's market share
13 changes. And this was, I believe, a
14 demonstrative that Mr. Levitt testified about
15 which shows the change year to -- or excuse me,
16 it shows the actual market share that Piedmont
17 held by zip code each year from 2003 to 2011.
18 And I took this data and looked at the change
19 from year to year. And for purposes of my
20 analysis, I looked at the absolute value. So
21 regardless of plus or minus, I was just trying
22 to determine the magnitude of change in each
23 year. And so that's what I have done on this
24 exhibit and then rank ordered based on that
25 average annual change in market share in the

1 far column to the right. And as you can see,
2 in most every zip code the market share change
3 has been -- the market share change per year
4 has been five percent or less. There have been
5 three exceptions, and there are two reasons, in
6 my opinion, for those exceptions. The first is
7 that the top two zip codes, 743 and 726, are
8 two of the least populated and smallest zip
9 codes in western York County. And they only
10 had, I think, as I recall, about 150
11 hospitalized patients in any given year. And
12 so the change in just a few patients could make
13 the percentage be higher. And I think that's
14 the phenomenon that's occurring there. Relative
15 to 29710, which is a larger western York zip, I
16 looked back at that data, and I think there's a
17 problem with the reporting or the data in that
18 zip code specifically because what it showed is
19 that in certain years, particularly those years
20 with the big changes, in one year Piedmont's
21 volume would drop significantly, but you didn't
22 see other providers volume going up by that
23 amount. The total market also dropped. And so
24 if it had been a pure share change, then you
25 would have expected Piedmont's volume to go

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- 1 down, and another providers volume to go up,
2 but the total market volume to stay the same.
3 And based on my review of that data, that's not
4 what happened. It was a reflection of some
5 anomaly in Piedmont's data. So when I looked
6 at this data in looking at the more populated
7 zips and in looking at that year by year, what
8 I concluded is that overall, the average annual
9 change over these years in market share has
10 been only about two percent. And again, I
11 think that's another factor that demonstrates
12 the unreasonableness of Piedmont assuming that
13 it would have a 60 percent, a 40 to 60 percent
14 share point change in three years.
- 15 Q: And that's how much times the historical
16 percentage?
- 17 A: Well, in the case of -- I mean, two percent a
18 year versus their 20 percent a year would be
19 ten times.
- 20 Q: And again, is the fact that Fort Mill Medical
21 Center, they get to build a hospital in
22 northern York County, do you believe that that
23 will make these share gains possible?
- 24 A: No, I don't.
- 25 Q: And will they gain some patients?

1 it just mentioned here, the only Fort Mill
2 Medical Center.

3 Q: Okay. Now, did you hear Mr. Sullivan testify
4 that he thought there would be a need for 100
5 beds at Fort Mill Medical Center?

6 A: Yes.

7 Q: And do you agree with this?

8 A: No, I don't.

9 Q: Would you please describe that?

10 A: Well, first of all, as I said, I don't believe
11 that Piedmont demonstrated that their
12 projections were reasonable. And I also think
13 that Mr. Sullivan's testimony is not consistent
14 with testimony that he gave in a case that he
15 and I both were involved in in North Carolina.

16 Q: And which case is that?

17 A: That would be a case for -- that involved new
18 beds in Wake County, which is the seat of the
19 capital Raleigh.

20 Q: And could you briefly describe for us the
21 circumstances of that Wake County case?

22 A: Yes.

23 Q: I think we have a Demonstrative 4.27. Give us
24 just a second.

25 A: Yes. This is just a map to very briefly talk

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1 about how the two cases are somewhat analogous.
2 As I said, this is Wake County, home of the
3 capital of Raleigh. This was a review for beds
4 that had been determined as needed in the State
5 Health Plan, just like in this Fort Mill
6 review. One difference in the Wake County
7 review, there were applicants both for new
8 hospitals as well as existing hospitals that
9 proposed to add beds to their existing campuses.
10 But in -- particularly relevant to my opinion
11 about this is the -- there were two applicants,
12 including the one Mr. Sullivan was questioned
13 about by Novant to build a new hospital in that
14 purple shaded area of the county. And similar
15 to northern York, this is an area of Wake
16 County that is growing, and as you can see,
17 there are two proposed hospitals down there, but
18 doesn't currently have a hospital in that
19 region. And Mr. Sullivan was representing the
20 WakeMed Hospital system. They were an applicant
21 that -- they have two existing hospitals in the
22 county, and had projected to add beds to their
23 existing hospital, and so were opposed to the
24 new hospitals in the southern part of the
25 county. And Mr. Sullivan gave two opinions in

1 that case that I believe are somewhat
2 inconsistent with his opinions here. And the
3 first is that he acknowledged that in the Wake
4 County situation, Novant coming in as a new
5 provider would have a difficult time gaining
6 patients as a result of the physician
7 allegiances and that already existed in Wake
8 County. I will note that in the Wake County
9 situation, Novant does not have a hospital in
10 Wake County, and it doesn't have a hospital in
11 a nearby county. They do have physician
12 practices in that -- in the general Triangle
13 region. But unlike CHS having a hospital in
14 Mecklenburg County, they would be a new hospital
15 provider in that county and in that area.
16 However, I would also point out that as we
17 talked about a moment ago, relative to northern
18 York, Carolinas is -- excuse me -- Piedmont has
19 a fairly small market share, in some Zip codes
20 less than ten percent. Their highest market
21 share is 30 percent. So even though they're
22 not a new provider, they would be -- they're
23 not the dominant provider in northern York
24 County, and I think that's somewhat similar to
25 this Wake County situation.

1 Q: Okay. And how do you believe Mr. Sullivan's
2 testimony is inconsistent with this case?

3 A: Well, as I recall on direct, his direct
4 testimony, he said that Fort Mill Medical Center
5 was really a critical part of the strategy and
6 the only way that Piedmont could reverse out-
7 migration going to North Carolina, and that also
8 100 beds was wise health planning because of
9 the population growth, and they needed to build
10 the beds. I also recall on cross-examination
11 that he acknowledged that Piedmont would have to
12 do more than just build the hospital, that if
13 there were -- if there were patients who didn't
14 like Piedmont for various reasons, they would
15 have to overcome that and that they would be
16 operating in a competitive environment.

17 Q: And if we could, let's look at Mr. Sullivan's
18 specific testimony in the Wake County case.
19 And if you could point us to those portions of
20 his testimony that is relevant to your opinions
21 in this Fort Mill case.

22 A: Well, first of all, this is from a deposition
23 that was taken on Monday, March the 5th, 2012.
24 And from page 190, and and I'll pull out the
25 relevant section. Starting on line 8, and he

1 was again talking about what a reasonable market
2 share assumption for Novant would have been.
3 And he says that, "You're going to be fighting
4 an uphill battle. You will get some benefit
5 from the improved geographic proximity. But
6 even if Novant wanted to recruit doctors into
7 the area, patients still have --" it says
8 exiting, I think it meant existing "-- loyalties
9 with physicians in Wake County, and they aren't
10 necessarily going to change their allegiances
11 overnight to use a new physician. So those
12 physician practices will grow over time, and
13 it's just a general recognition of the -- of
14 the, you know, difficult competitive environment
15 in which you would be operating."

16 Q: How do you believe this testimony of Mr.
17 Sullivan in the Wake County case is relevant to
18 the Fort Mill case we're here about today?

19 A: Again, I think it is -- it's more consistent
20 with his testimony under cross-examination that
21 Piedmont's -- it's not just the Fort Mill
22 Medical Center that they need, but I also think
23 it supports my opinion that the reasonableness
24 of Piedmont being able to achieve 40 to 60
25 percent points of share in the first three

1 years the hospital was open is unrealistic in
2 part because of the varied physician
3 relationships we've been hearing about in this
4 case, and that patients are associated with the
5 Carolinas physicians and as -- and those
6 relationships are likely to continue in the
7 future, which will affect their choice of
8 hospitals.

9 Q: Thank you. And let's now move, if we can, to
10 your second part of your opinion under number
11 one.

12 MS. ROBERTSON: And Your Honor, we've still got
13 probably 30 or so minutes on this line of
14 questioning under opinion one. I don't know if
15 you want to pause for a lunch, or do you want
16 us to try to wrap up the second part of one?

17 THE COURT: I'm fine going either way. Do you want
18 a -- is this the appropriate time to take a
19 lunch break, or do you want to go forward, and
20 we can finish it up?

21 MR. WESTBROOK: You know ---

22 THE COURT: What would be better?

23 MR. WESTBROOK: --- I would prefer that they go
24 forward and finish.

25 MS. ROBERTSON: That's good.

1 MR. WESTBROOK: So I can ---

2 MS. ROBERTSON: That's fine.

3 MR. WESTBROOK: --- frankly, so I can work on their
4 cross during lunch. But ---

5 THE COURT: Well, let's do it.

6 MR. WESTBROOK: --- that's a selfish reason. But
7 that's ---

8 THE COURT: That's a perfectly good reason.

9 MS. ROBERTSON: That's perfectly fine, Your Honor.
10 I didn't want to go on if others wanted to
11 stop.

12 THE COURT: Thank you very much. Let's just go
13 ahead and proceed through this.

14 MS. ROBERTSON: Certainly, certainly.

15 THE COURT: Thank you.

16 Q: Let's move, Ms. Carter, to the second part of
17 your opinion under number one, that is that
18 Piedmont's own projections for Fort Mill Medical
19 Center do not demonstrate a need for 100 beds.
20 And can you please explain this portion of your
21 opinion?

22 A: Yes. Despite everything I just said about why
23 I think their projections are not reasonable, if
24 you look at their own projections, in my mind,
25 even accepting their numbers for the sake of

1 argument, they do not demonstrate a need for
2 100 beds. And specifically what I've looked at
3 on this map are the number of patients that
4 Piedmont projects to serve at the new Fort Mill
5 Medical Center in year three that it operates,
6 in 2017. And as you can see, the patients that
7 they project to serve from northern York County,
8 they project an average of 28 patients a day
9 from those three zip codes. And in my opinion,
10 those three zip codes are the ones that
11 Piedmont could argue need greater geographic
12 access to a Piedmont facility. And so those
13 are the patients that if a Fort Mill Medical
14 Center is built would have greater access than
15 they do coming to Piedmont and Rock Hill. And
16 those 28 patients a day, again, these are their
17 own projections, those 28 patients a day at 65
18 percent occupancy, which is the target in the
19 State Health Plan, those 28 patients would need
20 43 beds.

21 Q: And do you recall testimony from Piedmont's
22 traffic engineer that parts of zip code 29730
23 were closer to the Fort Mill Medical Center
24 site than Piedmont Center Hospital?

25 A: Yes, I do. And I looked at that study and that

1 exhibit as it relates to this map. And what I
2 did to account for that is if you consider the
3 geographic area of zip code 29730, I believe
4 that less than half of it is east of I-77,
5 which is roughly the pink shaded area on that
6 traffic map. But to be conservative, I -- and
7 also, I think the western portions appear on
8 Google Maps to be more densely congested in the
9 western portions of that zip code. But I took
10 half of the patients per day that they project
11 to serve at the Fort Mill Medical Center from
12 that zip code, and then I also took the one
13 down here, 29704, which I believe their traffic
14 engineer said was closer, and when you add
15 those to the 28, that brings you to an average
16 daily census of 34 patients that would arguably
17 be closer to a Fort Mill Medical Center, and
18 those 47 patients at 65 percent occupancy would
19 only need 52 beds.

20 Q: Do you agree that northern York County is
21 growing?

22 A: Yes.

23 Q: Do you believe there is a need to go ahead and
24 build 100 beds now?

25 A: No.

1 Q: And could you please elaborate?

2 A: Well, I think they're -- I have three reasons
3 for that. First of all, to my recollection, I
4 don't think anywhere in the seven years of this
5 case, in my opinion, has Piedmont ever said,
6 this is when we're going to need these 100
7 beds. They have -- I would characterize their
8 argument as the population is growing, just
9 trust us. We need to -- we'll need these 100
10 beds at some point, and it's better to build
11 them now. But they've never demonstrated, in
12 my mind, a need for -- a need for the 100 beds.

13 Q: And what is it that Fort Mill Medical Center
14 has projected? Let's look at Demonstrative
15 4.32.

16 A: Well, what this demonstrative shows is that in
17 the 2005 submission to DHEC, Fort Mill Medical
18 Center was projected to be operational in 2009,
19 2010, and 2011 as it's first three years. And
20 in 2010, the projections had year one, two, and
21 three as 2015, '16, and '17. And what you can
22 see here is that in the 2010 submission, Fort
23 Mill Medical Center projects fewer patients per
24 day than they did in 2005, and that was even on
25 top of this population growth, and six more

1 years of the population growth that they argue
2 is leading toward a need for 100 beds.

3 Q: And I think you started saying that the three
4 reasons or three issues that you had. Let's
5 look at the second. What's your second reason?

6 A: Well, the second reason is based on the
7 language in the State Health Plan. And I've
8 alluded a couple times to the variable occupancy
9 rates that the State Plan uses in its planning
10 methodology for more beds. And I would note
11 that the South Carolina State Health Plan
12 doesn't have a requirement for hospitals to meet
13 or be at these occupancy levels like other
14 states do. But as indicated in the highlighted
15 area here, the State Plan does say, "Use of
16 these planning factors is not intended to stem
17 initiative or to suggest that facilities cannot
18 operate at more efficient levels than used in
19 the calculations without additional beds." And
20 what that means to me is that these are targets
21 that the State Plan uses to determine when
22 additional beds may be needed, but it certainly
23 suggests that hospitals can operate at above
24 those occupancy rates, which the Fort Mill
25 Medical Center is not projected to do even by

1 year three of its operation.

2 Q: And have you examined the occupancy rates
3 projected by the other satellite hospital
4 applications, I believe as they were cited by
5 Mr. Grice in his testimony?

6 A: Yes, I have.

7 Q: All right. And could you please discuss that,
8 and is this your third reason?

9 A: Yes. What I've done is taken from Mr. Grice's
10 diagnostic -- Demonstrative Exhibit 150, and
11 took the satellite hospitals that he had listed
12 and then added CMC-Fort Mill and Fort Mill
13 Medical Center to those. And what you see in
14 the far left column is the hospital in the year
15 that the applications were submitted, the number
16 of beds that each projected and then the number
17 of patients per day they were projected to have
18 in years one, two, and three, and then I went
19 out to year five for Fort Mill Medical Center.
20 And on the far right I've listed the State
21 Health Plan occupancy planning factor, which for
22 all these sized hospitals is 65 percent. And
23 then the last column shows the difference
24 between the hospitals last projected year and
25 the State Health Plan occupancy factor. So in

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1 the case of Roper Berkeley, the first one, they
2 projected to be at 70 percent occupancy in year
3 three. The State Plan occupancy target for
4 them for that size hospital is 65 percent. So
5 they were projected to be operating five percent
6 above the State Plan target. And as you can
7 see, going all the way down this list on the
8 far right side, that all of the hospitals, all
9 the satellite hospitals that Mr. Grice discussed
10 and CMC-Fort Mill project to operate above that
11 target occupancy rate by the third year, whereas
12 Fort Mill Medical Center even by year five is
13 only projected to be at 62 percent occupancy
14 versus the 65 percent occup- -- excuse me, the
15 65 percent planning factor for it's size
16 facility. So in my mind, if we are looking at
17 those other satellite hospital applications,
18 they documented that they would need their beds
19 based on their projected utilization. Fort Mill
20 Medical Center has, in my opinion, has not
21 projected that it needs all the beds that it's
22 proposing to build.

23 Q: And if a hospital does project to operate above
24 the occupancy factor in the State Health Plan,
25 does that trigger the need for bed need?

- 1 A: Yes. It would trigger a bed need. Just as it
2 did in the 2004/2005 plan when Piedmont
3 triggered a bed need that is at issue in this
4 case today. At the same time, Piedmont has
5 said they had 19 unused beds then. And then
6 just as in the 2012/2013 State Health Plan,
7 which has also shown a need for beds at
8 Piedmont, and Piedmont currently claims that
9 they have 100 unused beds. So just because --
10 so the bottom line is that, yes, if you reach
11 these target -- if you reach these occupancy
12 rates, a bed need will be generated in the plan
13 that you have the option to apply for.
- 14 Q: And is it your understanding that Mr. Grice
15 approved the applications in this demonstrative?
- 16 A: It's my understanding that Mr. Grice approved
17 Roper Mt. Pleasant, Parkridge, Greer, and the
18 Village at Pelham. He did not approve the two
19 Berkeley applications.
- 20 Q: Okay. Those were approved by someone else
21 within the Department?
- 22 A: I understand those were approved by Ms. Brandt.
- 23 Q: And did you hear the Piedmont testimony that
24 compared to other hospitals in the region
25 Piedmont's projected occupancy means that both

1 Piedmont and Fort Mill Medical Center will be
2 well utilized? Did you hear testimony with
3 respect to that in this case?

4 A: Yes, I did. But I think what, in my opinion,
5 what that testimony failed to consider is the
6 second part of criterion 6(b), and that
7 indicates that projected levels of utilization
8 have to be consistent with the need of the
9 target population. And so what I heard the
10 Piedmont witnesses indicate is that because
11 there were other hospitals operating in the
12 region at 55 percent occupancy, that they met
13 this criterion because that was the experience
14 of other providers. But you could have a
15 situation where other providers in the region
16 were operating at 20 percent occupancy and that
17 wouldn't mean that you needed to build 100 beds
18 for -- to serve 20 patients a day. So you have
19 to look at not only what other facilities have
20 experienced, but also what is the projected need
21 of the target population. And I would also add
22 to that is just because those other hospitals
23 are operating at 55 percent currently doesn't
24 mean that in years past they weren't operating
25 at higher occupancy rates or that they simply

1 have overbuilt facilities. But there's no
2 indication that 55 percent is a target level
3 that's supported by the need of the target
4 population.

5 Q: And I think you indicated a moment ago that
6 Piedmont had generated a bed need, but it also
7 had unused beds and lower occupancy levels than
8 what they said they needed beds. Do you have a
9 demonstrative that illustrates this?

10 A: Yes, I do. And I think this is, to me,
11 demonstrates that their testimony has been
12 somewhat inconsistent. On the far right, the
13 far right two bars show the projected occupancy
14 rate based on Piedmont's projections for
15 Piedmont and Rock Hill in 2017, 66.2 percent,
16 and for Fort Mill Medical Center at 58.2
17 percent. Again, these are their projections for
18 the third year that Fort Mill Medical Center is
19 opened. And they have said that at 66 percent
20 occupancy at Piedmont and 58 percent at Fort
21 Mill, they are well utilized. Yet they've also
22 said that when Piedmont was operating at 73.6
23 percent occupancy in 2005, it had 19 unused and
24 available beds, and that was why they could
25 move 36 beds to the Fort Mill Medical Center.

1 Similarly, based on an occupancy rate of 62
2 percent in 2011, they're saying they have over
3 100 unused beds, and that's the reason that
4 they can move that -- those 36 beds to Fort
5 Mill. So in my opinion, it's not consistent to
6 say at similar or lower occupancy rates, we're
7 well utilized, but at similar or in the case of
8 2005 higher occupancy rates, we have unused and
9 available beds.

10 Q: Do you believe that the population growth in
11 northern York County will lead to a need for
12 100 beds in the future?

13 A: I don't believe that Piedmont has demonstrated
14 anywhere that I've seen that at what point in
15 time the population will need 100 beds. And as
16 I said a moment ago, yes, the population is
17 growing, but there are also factors at play
18 relative to inpatient hospitalization that are
19 going against that population growth. Some of
20 the industry trends I've talked about and the
21 fact that we had, you know, Medicare is already
22 not paying for readmissions, and that's
23 affecting how many patients are readmitted to
24 the hospital. SG2, which is a well-known
25 health care intelligence company has estimated

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1 that 25 to 30 percent of hospital admissions to
2 a community hospital are not going to be
3 admissions in the future. We have some of
4 these other pilot projects that I mentioned,
5 like Geisinger and others that are showing
6 evidence of reducing hospital admissions by
7 anywhere from 10 to 20 percent. So I think
8 those factors are at play in conjunction with
9 the population growth. And, to me, the bottom
10 line is Piedmont has not demonstrated that they
11 need these 100 beds in Fort Mill.

12 Q: Do you agree with Piedmont's experts, and I
13 think it was Mr. Sullivan who commented on
14 this, that it's wiser health planning to build
15 100 bed capacity now.

16 A: I don't agree if you haven't demonstrated a
17 need for those beds within some reasonable time
18 frame that you should build beds that you
19 haven't demonstrated are needed. And again, I
20 think that is not consistent with the testimony
21 that Mr. Sullivan gave in the Wake County case
22 we referenced a moment ago.

23 Q: And how is that?

24 A: Well, in that case, the purple area that I
25 showed on the map, Holly Springs has a pop- --

1 or was projected to have a population of about
2 133,000 in 2017. And Mr. Sullivan had opined
3 that that was not sufficient for a 50 -- to
4 support a 50-bed hospital. And if you look at
5 the population of northern York, those three zip
6 codes are about 86,000 in 2017. And yet, he
7 says that population, that makes wise health
8 planning to build 100 beds in that scenario.

9 Q: And let's look at Demonstrative 4.37. If you
10 could comment on this demonstrative.

11 A: Yes. This is -- shows the population of Holly
12 Springs, as I was just talking about, that the
13 133,000 that was part of that service area,
14 which Mr. Sullivan said was insufficient to
15 support a 50-bed hospital, compared to the
16 northern York 2017 population of 86,000 where,
17 again, in my opinion, the hospital in Fort Mill
18 is needed geographically to serve northern York
19 patients, not -- it isn't needed for improved
20 geographic access for the rest of York County,
21 and so that 86,000, Mr. Sullivan thought was
22 wise health planning to build 100 beds. I
23 would also note that in his testimony, if he
24 didn't mean the entire Holly Springs service
25 area but just meant the town of Holly Springs,

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1 that was projected to still be at about 60,000
2 residents in 2017. And again, he said the
3 60,000 was insufficient for 50 beds, but yet
4 86,000 is sufficient for 100 beds.

5 Q: Okay. And let's look at this testimony that
6 you were referencing in the Wake County case.
7 Can you show us the specific portions of Mr.
8 Sullivan's testimony that you're relying on?

9 A: Sure. And again, this would come from page 48,
10 and I'll -- I'm sorry. And I think a couple
11 things here. He was talking about what I had
12 alluded to a moment ago, and that is the
13 overall factors affecting inpatient utilization.
14 And he says starting on line 4 -- well, the
15 question is, "None of us as we sit here today
16 can know if what -- what future utilization
17 patterns may bring." And he answers starting
18 on line 4, "Right. And -- and, you know, I
19 think that, you know, health planning decisions
20 need to be based on the most recent and
21 accurate information that you can use. And,
22 you know, if this were, you know, if we were in
23 an economic situation where we're still having,
24 you know, substantial economic growth, and there
25 was a one year blip in utilization, I think you

1 could write it off as, you know, as -- as an
2 anomaly. But when you see nationwide -- you
3 see declines in hospital utilization, and then
4 you see a Wake County, albeit a little bit
5 later in time than some other parts of the
6 country, I think you have to be concerned that
7 maybe there is a little bit of a change in the
8 demand curve and how that's going to play out
9 in the future. And I could be wrong, I mean,
10 in 2012, the numbers could -- could be up
11 higher. But, you know, what we're seeing in
12 other parts of the country is the numbers have
13 -- have stayed relatively flat over a period of
14 time." And just by way of background here, I
15 say to explain that in the course of the Wake
16 County litigation, Mr. Sullivan and his client
17 had decided that there wasn't a bed need after
18 all and the beds that they had applied for
19 shouldn't have been approved. And so that was
20 why he was arguing the -- about the -- about
21 the utilization here.

22 Q: Okay. We can look on the next page, our
23 Demonstrative 4.39. I think you have another
24 reference to Mr. Sullivan's testimony in the
25 Wake County case.

1 A: Yes. And this is from page 208, and I'll pull
2 out the relevant portion. And this was
3 referencing the population base issue that I was
4 just discussing, and he was being asked how
5 high does the population base have to be to
6 support that 50-bed hospital. And he begins to
7 answer on line 9 and talks about the four beds
8 per 1,000, which I think he testified to here.
9 But the relevant portion starts on line 13. He
10 says, "So if you can capture 100 percent market
11 share, in theory, you could probably support a
12 50-bed hospital with a population of only 25,000
13 or 30,000 people. But in the real world, a
14 small hospital competing against larger
15 community and tertiary hospitals, you probably
16 need a relative large population base in order
17 to support it. You know, in this case, I think
18 the population would have to be substantially
19 larger than Holly Springs in order to be able
20 to achieve a sufficient volume to support the
21 hospital."

22 Q: Okay. Does Fort Mill Medical Center here
23 propose to serve patients from outside of
24 northern York County?

25 A: Yes, they do.

1 Q: Do you have any opinions relative to whether
2 they need a new hospital or not to do that?

3 A: Yes. Again, the proposed to serve patients
4 throughout York County, although a very small
5 portion from western York zip codes, but as
6 I've -- as I said, I think that in my opinion,
7 the accessibility issue that is Piedmont's
8 reason for needing to serve -- needing to build
9 a Fort Mill Medical Center is based largely on
10 the three zip codes in northern York County and
11 possibly on that portion of zip code 27230 and
12 then the very southern York zip code that we
13 talked about at most. Otherwise, everybody else
14 that they're proposing to serve has sufficient
15 access to a Piedmont hospital bed at Piedmont
16 Medical Center in Rock Hill.

17 Q: Okay. Well, turn to Demonstrative 4.40. Ms.
18 Carter, I think that brings us up to your
19 second opinion. And before we go there, can
20 you just give us a conclusion, if you can, on
21 your first opinion that we've just been
22 discussing this morning.

23 A: It is that, essentially, Piedmont did not
24 demonstrate a need for its project. It didn't
25 demonstrate that it needed to build 100 beds at

1 Fort Mill Medical Center. Their projections for
2 that facility are unreasonable and, I think,
3 highly unlikely to be achieved, and there's no
4 reasonable assumption to believe that they would
5 be achieved, and their own projections, if you
6 accept their own projections, do not demonstrate
7 that their facility is needed in Fort Mill.

8 Q: Okay. And we can move now to your second
9 opinion. It is that Fort Mill Medical Center
10 is 100 beds or an unnecessary duplication and
11 maldistribution.

12 A: Yes, that's correct.

13 Q: So do your opinions on this subject relate to
14 specific review criteria?

15 A: Yes, they do.

16 Q: And which ones are those?

17 A: Criteria 2(d), 3(a), 3(b), and 22. And I would
18 highlight in particular 2(d), which says that in
19 the case of relocation, which is what Piedmont
20 is proposing to do with the 36 beds, the
21 applicant should address the need that the
22 population presently has for the service the
23 extent to which that need will be met by the
24 proposed relocation. So to me, that says that
25 if you're proposing to relocate, in this case

1 beds, you have to address the population that
2 is currently utilizing those beds and the degree
3 to which the need of that population will be
4 met by the relocation.

5 Q: And what are the reasons that you believe
6 Piedmont Medical Center does not comply with
7 these criteria that you just listed?

8 A: Well, first of all, I don't believe that
9 Piedmont demonstrated that the 36 beds that it's
10 proposing to move to Fort Mill Medical Center
11 would not be needed by the population that
12 they're presently serving. And specifically, as
13 I said a moment ago, the 2012/2013 State Health
14 Plan shows that Piedmont, it actually indicates
15 that Piedmont will have a bed need for 16
16 patients in 2018. And I would point out that
17 this is based on the 2011 patients and patient
18 days that were served by Piedmont. So those
19 patients that Piedmont served in 2011, if we
20 apply a population growth factor to those
21 patients, those are the patients that are going
22 to need the 16 additional beds in 2018,
23 according to the State Health Plan.

24 Q: And where do these patients that PMC or
25 Piedmont Medical Center now serves, where do

1 they reside?

2 A: The York County patients that they serve reside
3 largely in Rock Hill and western York. Of
4 their York County patients, 90 percent reside in
5 the Rock Hill zip codes or the western York zip
6 codes. Again, in 2011, only 11 patients a day
7 resided from -- resided in the three northern
8 York zip codes. And so it's this predominantly
9 Rock Hill and western York population and that
10 utilization that is driving the bed need for 16
11 additional beds at Piedmont in 2018.

12 Q: Well, let's look if we can at Piedmont's
13 Demonstrative 178 that we've seen in this case.
14 I think we've got it on a slide up on the
15 screen. Have Piedmont witnesses testified that
16 they currently have an excess of 100 beds per
17 day?

18 A: Yes, they have.

19 Q: Would you comment on this?

20 A: Well, I think they failed to consider three
21 things when they looked at this demonstrative.
22 And, first of all, that demonstrative includes
23 psychiatric beds and patients, and you certainly
24 couldn't put general acute care patients in
25 psychiatric beds. They also did not factor in

1 an occupancy rate as the State Plan methodology
2 does as you do when you're planning for beds.
3 And that occupancy rate factors in not only the
4 seasonal fluctuation and volume that you have,
5 but the volume you have based on days of the
6 week, and even specific hours of the day are
7 more heavily utilized. So you need to factor
8 in that occupancy rate in order to ensure that
9 there are beds at Piedmont. And secondly -- or
10 excuse me, thirdly, they considered only their
11 2011 volume and didn't look to the future 2018
12 volume to determine the bed need at Piedmont.

13 Q: Have you calculated the impact of those changes?

14 A: I have.

15 Q: Would you please walk us through that.

16 A: First of all, I adjusted for the first two. I
17 deleted the psychiatric beds and counted only
18 the licensed acute beds and also the acute
19 average daily census from the State Plan, and
20 then adjusted for the occupancy factor that's
21 applied to a hospital the size of Piedmont.
22 And that's 70 percent, according to the State
23 Health Plan. And if you do that math, that
24 means that based on the 2011 data, there would
25 be 31 available beds in 2011. If they relocate

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1 36 beds to Fort Mill Medical Center, then there
2 would be a five bed deficit at Piedmont.

3 Q: And have you applied the same formula to 2018?

4 A: I did.

5 Q: If you could please describe that for us.

6 A: Again, I looked at the acute average daily
7 census from the State Health Plan, adjusted that
8 for the 70 percent occupancy, and that showed,
9 as it does in the State Plan, a 16 be deficit
10 at Piedmont. If we then relocate, if they
11 relocate 36 beds to Fort Mill Medical Center,
12 that would create an even bigger bed deficit at
13 Piedmont of 52 beds in 2018.

14 Q: Okay. And does this conclude your opinion
15 number two?

16 A: No. Actually, I have one more factor here.
17 Because in addition to relocating beds, Fort
18 Mill Medical Center also indicated that they
19 were going to shift patients that are currently
20 served at Piedmont to Fort Mill Medical Center,
21 so I made a final adjustment and took the 230 -
22 - or excuse me, the 36 beds that they're going
23 to relocate to Fort Mill, which left -- leaves
24 them with 232 beds at Piedmont, and I also
25 subtracted the patients that they're going to

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1 shift to Fort Mill from Piedmont, and they
2 still would then result in 2018 with an eight
3 bed deficit at Piedmont. But I think the other
4 important thing to point out about this, in
5 addition to the bed deficit at Piedmont, is the
6 fact that they are shifting 36 beds to Fort
7 Mill and 31 patients per day from Piedmont to
8 Fort Mill, in my opinion, is the very
9 definition to unnecessary duplication. Because
10 except for those 11 patients that are in
11 northern York County, arguably the rest of those
12 patients have access to those beds, and in
13 fact, they're utilizing those beds now at
14 Piedmont, and in my opinion, is unnecessary
15 duplication for them to then move those beds,
16 spend the capital to move beds that they
17 already have to Fort Mill and move the patients
18 along with them.

19 Q: Thank you. And does that bring us now to your
20 third opinion?

21 A: Yes, it does.

22 **MS. ROBERTSON:** Your Honor, I think this is probably
23 a reasonable spot to stop. If you want to stop
24 for a lunch break because the third one is a
25 little lengthy.

1 the contribution margin impact would be 12
2 million.

3 Q: Okay. Let's look at that slide. I think it's
4 Demonstrative 4.75. Is that reflected in this
5 demonstrative?

6 A: Yes. Again, I made the same adjustment to pre-
7 tax income for that \$12 million reduction in
8 contribution margin and the -- that would adjust
9 their net income in 2011 to a margin of 2.1
10 percent, and based on 2012 performance, a margin
11 of 4.6 percent.

12 Q: Okay. Let's now move to your next subpart
13 under your opinion three. Let's look at
14 subpart C. If you can tell us what this
15 opinion is.

16 A: In my opinion, and based on the analysis I've
17 done, I believe actually Fort Mill Medical
18 Center will have a greater impact on Piedmont
19 than a CMC-Fort Mill Hospital.

20 Q: And did you hear Mr. Grice testify, I believe
21 it was Mr. Grice, that in his opinion, Fort
22 Mill Medical Center could repair the volume
23 declines at Piedmont Medical Center?

24 A: Yes, I did hear him say that.

25 Q: And could you please comment on that?

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1 A: Well, first of all, in order to do that they
2 would have to achieve their projections, and
3 I've already talked about my opinions about the
4 difficulty I thought that they would have in
5 doing that. And in addition to that, their
6 inability to do that, I think it would not put
7 them in a better financial position.

8 Q: What supports your opinion here?

9 A: Well, I examined the information submitted to
10 DHEC in this review, the projected financial
11 statements for both Fort Mill Medical Center
12 itself, as well as Piedmont Medical Center with
13 the development of Fort Mill Medical Center, and
14 if you look at the year five, I took this all
15 the way out to year five, they project in 2019
16 that Fort Mill Medical Center itself will have
17 a net income of about 2.9 million, and then at
18 the same time, they project that Piedmont
19 Medical Center will have a net income of about
20 7.3 million. Those two combined is a total
21 combined net income of 10.3 million, which based
22 on their revenue at those two facilities results
23 in -- their projected revenue results in a 2.5
24 percent margin.

25 Q: And did you compare that against their 2012

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1 actual margins?

2 A: Yes, I did.

3 Q: Okay. Let's look at a demonstrative on that
4 and have you comment, 4.78.

5 A: If you take their, again, projected combined net
6 income in 2019 of 10.3 million and a 2.5
7 percent margin and compare that to what they
8 reported to York County for 2012, that was a
9 \$16.4 million after tax net income and that
10 represented a seven percent margin. Again,
11 based on a difference from their current
12 position today, what they're projecting with
13 Fort Mill Medical Center would be a reduction
14 from their current position.

15 Q: Now, have you created a chart that summarizes
16 your discussion here?

17 A: Yes.

18 Q: Okay. Let's look at that on Demonstrative
19 4.79.

20 A: I tried to bring this together because I know
21 there have been a lot of numbers and a lot of
22 margin numbers that I've been discussing, but
23 looking at this in three segments, first of
24 all, this summarizes Piedmont's actual margins
25 from 2005 to 2012 during this time that they

1 were losing share to Carolinas and feeling the
2 impact of that as they have testified to. And
3 as you can see here, as I stated earlier, other
4 than the one year where they had a margin of
5 1.2 percent, every other year their margins have
6 been three percent or considerably higher than
7 three percent. Then the analyses that we just
8 -- the various analyses that I walked through,
9 my analysis of the impact at 677 patients or
10 two million in contribution margin, Mr. Levitt's
11 analysis of the 2044 patients or eight million
12 dollar contribution margin, or his other
13 analysis at over 3,000 patients and a \$12
14 million contribution margin, if you look at all
15 of those, again, the only one that has a margin
16 well below three percent is Mr. Levitt's \$12
17 million contribution margin impact, and that
18 results in a 2.1 percent overall margin for
19 Piedmont. And I would point out a couple of
20 things, again, for that -- for that to occur,
21 to going back to the very first demonstrative I
22 had with the arrows and the map, you have to
23 believe their assumptions about what patients
24 are going to do and that the vast majority of
25 patients now going to North Carolina for care

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1 are going to continue to go to North Carolina
2 for care. If that doesn't happen, then there's
3 no way that adverse impact comes about. And
4 then lastly, I looked at this compared to
5 Piedmont's own projections that we just talked
6 about with Piedmont and Fort Mill combined, and
7 that's a -- and they project a combined margin
8 of 2.5 percent, which aside from these two I
9 have highlighted here, that's actually the
10 lowest margin of any of the either actual or
11 the various scenarios that I've discussed.

12 Q: Let's go back to your summary of opinions. I
13 think we're up to the subparagraph D under your
14 third opinion, and that opinion is the CMC-Fort
15 Mill will not jeopardize Piedmont's services to
16 York County. We've been talking a lot about
17 the financial components of Piedmont's adverse
18 impact. Do you also recall testimony in this
19 case about services that would diminish at
20 Piedmont as a result of CMC-Fort Mill?

21 A: Yes, I do.

22 Q: And I think those were services like open
23 heart, emergency, neonatal and intensive care;
24 do you recall that?

25 A: I believe those were some of the services that

1 Thursday.

2 **MR. WESTBROOK:** Yes, that would be good.

3 **MR. MULLER:** This was one of the exhibits that was
4 missing pages and we just -- we needed to go
5 back and check it. And so Mr. Westbrook and I
6 will try to resolve that by Thursday.

7 **THE COURT:** If you could, yes. Great. All right.
8 Was there anything else we needed to take up
9 now?

10 **MS. ROBERTSON:** No, Your Honor.

11 **THE COURT:** All right. If not, then we're at recess
12 until Thursday.

13 (There being nothing further, Day Twelve recessed at
14 4:05 p.m.)

15 DAY THIRTEEN - THURSDAY, MAY 2, 2013

16 **THE COURT:** Okay. We're back on the record. And I
17 believe we are ready to start the cross-
18 examination of Ms. Carter, is that right?

19 **MR. WESTBROOK:** Yes, Your Honor.

20 **THE COURT:** All right. Ready to go, Mr. Westbrook?

21 **MR. WESTBROOK:** I am. Thank you.

22 **MS. CARTER - CROSS EXAMINATION BY MR. WESTBROOK:**

23 Q: I am. Good morning, Ms. Carter.

24 A: Good morning.

25 Q: Ms. Carter, I would like to start today with

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1 your Demonstrative 4.2.

2 **MR. WESTBROOK:** And if I could ask Dan to put that
3 up on the screen, please.

4 Q: This is the one that's on the screen now. It's
5 entitled, No adverse impact on PMC from CMC-Fort
6 Mill. And I want to ask you about that second
7 paragraph under the arrows over there. It
8 says, "But if CMC-FM is approved, PMC's adverse
9 impact assumes that 60 to 80 percent of
10 northern York patients now going to North
11 Carolina hospitals will continue to travel to
12 North Carolina hospitals and a much smaller
13 percentage will stay in their home community."
14 Is that right?

15 A: Yes.

16 Q: Okay. I just want to clarify that I understand
17 the basis for the 60 to 80 percent. I think I
18 understand.

19 **MR. WESTBROOK:** But I want to ask Dan to put --
20 well, the source there is Piedmont Exhibit 104
21 at CHS's Exhibit 32. Let me ask Dan, put up
22 Piedmont's Exhibit 104 on the screen, please.
23 And that's hard to read. We will isolate it.

24 Q: I just want to focus on those northern York
25 County zip codes, and those I believe are

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1 29707, 708 and 715, right?

2 A: Yes.

3 Q: All right. Let's start, let's just focus on
4 707 to start off with since it's the first one.
5 And just by way of explanation, the first --
6 this of course, is Mr. Levitt's adverse impact
7 analysis up here, but that first part, what I'm
8 going to say, see where's labeled at the top
9 2011, I think of this sort of in thirds. That
10 first big block from 2011 down to the next
11 heading, 2017, that first block is Mr. Levitt's,
12 what he says are the 2011 numbers and market
13 shares, number of discharges and market shares
14 for Piedmont and all North Carolina hospitals,
15 is that right?

16 A: Yes.

17 Q: Okay. And then the second block, that middle
18 block where it says 2017, those are Mr.
19 Levitt's projections for 2017 if there is no
20 hospital at all in Fort Mill, is that right?

21 A: That's my understanding, yes.

22 Q: Okay. And the bottom block, which also is
23 labeled 2017, that's -- those are his
24 projections if there is, it says a proposed
25 North Carolina provider in Fort Mill, but since

1 right now the only possibility for that would
2 be CMC-Fort Mill, right? So those are
3 essentially his projections if CMC-Fort Mill is
4 approved, is that right?

5 A: That's correct.

6 Q: Okay. Let's just look at -- as I said, let's
7 start out on the top with the 2011 data with
8 29707.

9 **MR. WESTBROOK:** And I want you -- Dan, if you would
10 highlight about four lines down to 84.7 percent.

11 Q: Ms. Carter, is it your understanding that that
12 is the current market share for that zip code
13 for all of North Carolina hospitals?

14 A: That's correct. That is what that number
15 represents.

16 Q: Right. That was what I thought. And the --
17 let's go down, work our way down 29707 to the
18 middle part, and we see 84.7 percent again,
19 fourth line down. And is it your understanding
20 that is what Mr. Levitt would project the
21 market share would be for North Carolina
22 providers if there's no hospital in Fort Mill
23 in 2017?

24 A: Yes. My understanding is for 2017, without a
25 hospital in Fort Mill, Mr. Levitt assumed that

1 market share would stay the same and the only
2 change would be the growth and discharges
3 resulting from population.

4 Q: Okay. Thank you. And let's go down to the
5 bottom third, the bottom part of this chart.
6 And again, looking at 29707, let's go down to
7 about four lines down, it says 51.5 percent,
8 see that?

9 A: Yes.

10 Q: And is it your understanding that that is Mr.
11 Levitt's projection for North Carolina
12 providers, that is, providers obviously in North
13 Carolina, if CMC-Fort Mill is approved? Is
14 that your understanding?

15 A: That is the market share that would remain in
16 North Carolina if CMC-Fort Mill is approved.

17 Q: Okay. And, Ms. Carter, you may not need it for
18 this question, but you're going to need it
19 sooner or later. Do you have your calculator
20 with you by chance?

21 A: There is a calculator up here.

22 Q: Okay. If you would, that 51.5 percent that we
23 see there, his projected market share for North
24 Carolina providers if CMC-Fort Mill is approved,
25 would you divide that by that 84.7 that is in

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1 the middle block, which is what the market
2 share for North Carolina providers would be if
3 there is no Fort Mill hospital. Just divide
4 51.5 by 84.7.

5 A: That's 61 percent.

6 Q: Okay. And going back -- we you don't have to -
7 --

8 **MR. WESTBROOK:** Dan, you can stay where you are.

9 Q: But going back to your Demonstrative 4.2, I
10 think you said in that middle paragraph that I
11 read out it was 60 to 80 percent, is that
12 right?

13 A: That's correct.

14 Q: Is that the -- where you got the 60 percent
15 from?

16 A: Yes.

17 Q: Is that how you got the 60 percent?

18 A: Yes.

19 Q: Okay. That's what I thought. I just wanted to
20 make sure I understood that. And I don't want
21 to take too long to do this, but let's just go
22 over --

23 **MR. WESTBROOK:** You don't need to go to the top of
24 the page, Dan. Let's just go over 29708.

25 Q: And if you'll see for 29708, it's 78 percent,

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1 excuse me, 78.6 percent is his projected market
2 share if there's no Fort Mill hospital, and if
3 you go down, 56.6 percent if CMC-Fort Mill is
4 built, right?

5 A: Yes.

6 Q: And so if you divide 56.6 by 78.6, it would
7 fall somewhere between 60 and 80, wouldn't it?

8 A: It's 72 percent.

9 Q: Seventy-two percent. And finally, go over and
10 let's do the same thing quickly for 29715. It
11 would be 64.7 percent and the corresponding
12 number for 2017 would be that 50.7 percent and
13 you make that division and it still falls in
14 that range?

15 A: Yes.

16 Q: How much is that?

17 A: That's -- I believe that's 78 percent.

18 Q: Seventy-eight percent. So that's where you got
19 your range of 60 to 80, I just wanted to
20 confirm that and make sure I understood that,
21 would be dividing those projections for the
22 North Carolina providers in 2017 if CMC-Fort
23 Mill is approved, divide those percentages by
24 the percentage if there's no Fort Mill hospital
25 in 2017, is that right?

1 A: Yes.

2 Q: Did I say that right?

3 A: Well, let me make sure. It is the percentage
4 of share that would remain going to North
5 Carolina providers divided by the current
6 percent of share going to North Carolina
7 providers.

8 Q: All right. So again, it would be those numbers
9 that we have highlighted there on the screen
10 and that range I believe is like 61 to 78
11 percent. Is that what you came up with?

12 A: I believe so, yes.

13 Q: All right. Thank you for clarifying that. Now
14 let's just look at the bottom part.

15 **MR. WESTBROOK:** Let's go back to 29707, Dan, and why
16 don't we just call out the bottom part I think
17 now and make it a little bit larger. And,
18 yeah, let's just look at 29707.

19 Q: Now, in 29707, what he projects, if you see
20 down there, there's a line item that says
21 "total." He projects there is going to be
22 1,332 -- 1,332 patients from that zip code in
23 2017, right?

24 A: Yes, going to some provider somewhere.

25 Q: Going to some provider somewhere. And he

1 divies those up, does he not, by saying we've
2 already established he believes that 51.5
3 percent are going to go to North Carolina
4 providers, right?

5 A: Well, as I recall his testimony and how it
6 worked, that wasn't the first one. He first
7 established that he thought that 40 percent
8 would go to the North Carolina Fort Mill
9 hospital and then he determined of that, the --
10 which one, he determined where it shows in that
11 zip code the percent from Piedmont and from
12 North Carolina providers, the 17 percent and 83
13 percent, he then determined what that was going
14 to be and then the math worked out between
15 Piedmont and North Carolina providers.

16 Q: All right. But where he ended up was
17 projecting that 51.5 percent of that 1,332 would
18 go to North Carolina providers. That's where
19 he ended up on this chart, right?

20 A: Yes.

21 Q: And that 51.5 percent of 1,332 is presumably,
22 or at least by Mr. Levitt's calculation, you
23 can check him if you want to, but it's 686 is
24 what he's got up there, right? So 686 patients
25 out of those 1,332 would go to North Carolina

1 providers. Is that his projection?

2 A: Yes.

3 Q: And he's projecting, where he ended up with was
4 that Fort Mill Medical Center would get 40
5 percent of that 1,332, correct?

6 A: Yes.

7 Q: And that's 533?

8 A: Yes.

9 Q: And that Piedmont would get 2.4 percent of that
10 1,332, which is 33 patients, is that right?

11 A: Yes.

12 Q: All right. And we can do that for 29708 and
13 297 -- yeah, 29715, but it's the same, it's the
14 same formula, right, that he ended up doing for
15 each one of those zips, is that right?

16 A: Yes.

17 Q: Now, so again, just focusing on 29707, one of
18 those three zips, Mr. Levitt's projection, if I
19 understand it, is that of the 1,332 total
20 patients from that zip code in 2017, 51.5
21 percent would go to North Carolina hospitals and
22 40 percent would go to CMC-Fort Mill and a
23 little over two percent would go to Piedmont;
24 is that his projection?

25 A: Yes.

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1 Q: Okay. Thank you. Now, let's go to the Rock
2 Hill zip codes. The two Rock Hill zip codes
3 are 29730 and 29732, right?

4 A: Yes.

5 MR. WESTBROOK: And actually, Dan, if you don't
6 mind, let's take us back to Ms. Carter's
7 Demonstrative 4.2, I believe it is.

8 Q: And 4.2, let's look at that last paragraph at
9 the bottom that says, And 80 to 90 percent of
10 patients from Rock Hill will drive past a CMC-
11 Fort Mill hospital to continue to go to North
12 Carolina for care, right?

13 A: Yes.

14 Q: And again, I just want to clarify that 80 to 90
15 percent, and I think I understand where you get
16 that, but I want to make sure I understand it
17 right.

18 MR. WESTBROOK: Let's go back to Exhibit 104 Dan.
19 Let's take a look at 29730 I guess is the first
20 one. And 29730 for that -- let's go to that,
21 well, where's 29730, would you highlight that
22 for us, Dan. Okay. It's those two at the end.

23 Q: Again, about -- for 2-9 -- about four lines
24 down, there's there 22.4 percent, and again,
25 that is the current, according to Mr. Levitt,

1 that's the current market share that North
2 Carolina hospitals have for that zip code, is
3 that correct?

4 A: Yes.

5 Q: And if we go down to the middle part, I've
6 decided to challenge Mr. Bupp this morning. If
7 we could go down to the middle part of this
8 chart. Again, let's look at 29730 and about
9 four lines down, there is that 22.4 percent,
10 which he's projecting essentially wouldn't
11 change, right, if there's no Fort Mill hospital?

12 A: That's correct.

13 Q: Okay. And then if we go down to the bottom
14 part -- well, I'm sorry -- yeah, let's go down
15 to the bottom part, the bottom part of the
16 chart, 29730, and we've got there what he's
17 projecting for that zip code for 2017. If
18 there's a Fort Mill hospital there, he is
19 projecting 19.4 percent for North Carolina
20 hospitals, right?

21 A: That's correct.

22 Q: And if you divide the 19.4 by the 22.4 earlier,
23 you are going to get something between 80 and
24 90 percent, is that correct?

25 A: It's 87 percent.

1 Q: Eighty-seven percent. Okay. Thank you. And
2 again, just quickly the same thing with 29732,
3 you've got -- for 29732, you've got his 2017 --
4 we don't even need to go to the top. Let's
5 look at the 2017 projection for North Carolina
6 hospitals without a Fort Mill hospital is 29.1.
7 His projection if there is a Fort Mill hospital
8 for North Carolina providers is, is it 23.3?
9 No. Yeah, that's the middle, it's 29.1 if
10 there is none, no Fort Mill hospital, but if
11 there is a Fort Mill hospital, you go down to
12 the bottom part and for 29732, it's 23.3,
13 right?

14 A: Yes.

15 Q: Okay. And you divide 23.3 divided by that 29.1
16 and you get?

17 A: Eighty percent.

18 Q: Eighty percent. So that's where you get your
19 80 to 90 percent, one is 80 and one is 87, is
20 that right?

21 A: That's correct.

22 Q: And that is where you got that 80 to 90
23 percent, correct?

24 A: Yer.

25 Q: I'm right on that?

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1 A: Yes.

2 Q: All right. And again, just to clarify his
3 projections.

4 **MR. WESTBROOK:** Let's stay on the bottom part, Dan,
5 for those two zip codes. He -- well let's just
6 look at the first zip code, 29730.

7 Q: For 29730, he's got a total number of patients
8 from that zip code that he projects in 2017 of
9 5,429, 5,429, is that right?

10 A: Yes.

11 Q: And he's projecting that 19.4 of those are
12 going to go to a North Carolina hospital, I
13 think we've already looked at that number, and
14 he's projecting that 20 percent -- when I say
15 19.4, I should have said 19.4 percent of those,
16 and 19.4 percent of 5,429 is 1,053, is that
17 correct?

18 A: I assume so.

19 Q: Unless he's calculated wrong.

20 A: Yes. 1,053.

21 Q: Okay. And then 20 percent, he's projecting 20
22 percent of that 5,429 would go to CMC-Fort
23 Mill, and he says, he calculates that as 1,086,
24 is that correct?

25 A: Yes.

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1 Q: And he's projecting that 56 percent of that zip
2 code would go to Piedmont, and that's 3,041, is
3 that right?

4 A: Yes.

5 Q: So Mr. Levitt's projection for 2017 is at least
6 for that zip code of the 5,429 patients, 20
7 percent would go to CMC-Fort Mill, 19.4 percent
8 would go to North Carolina and 56 percent would
9 go to Piedmont, right?

10 A: Yes.

11 Q: And you could do -- we won't take the time to
12 go through 2973 whatever the other one is too,
13 but it would be the same calculation, wouldn't
14 it?

15 A: Yes.

16 Q: Set of calculations? Okay. Thanks. Thank
17 you, Ms. Carter. Okay, let's go ---

18 **MR. WESTBROOK:** I think we can take that off the
19 board now or off the screen now, Dan. Thank
20 you.

21 Q: Now, it's clear, it's been made clear I think
22 throughout this hearing and before this hearing
23 that CHS's position is in this case and that
24 your opinion is that CMC-Fort Mill is not going
25 to shift any market share from PMC if it's

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1 approved, is that right?

2 A: No additional market share, that's right.

3 Q: No additional market share, right. Okay.

4 Thank you. And just to be clear on that, CHS
5 projects that CMC-Fort Mill is going to shift
6 zero discharges from Piedmont after CMC-Fort
7 Mill is built, is that correct?

8 A: Well, I think the way I explained it in my
9 direct testimony is that the assumption that
10 there is no shift from any hospital other than
11 the CHS hospitals is based on a pattern of
12 utilization. And so, you know, there are a
13 variety of circumstances that patients would
14 make up that pattern of utilization, but that
15 pattern of utilization would remain the same as
16 represented by the CHS market share, current
17 market share.

18 Q: But the result of that pattern of utilization
19 would be, in your opinion and CHS's position,
20 that zero discharges would shift from Piedmont
21 to CMC-Fort Mill?

22 A: The equivalent effect of that is that if you
23 look at market share and you translate that to
24 discharges, it wouldn't be any additional
25 discharges shifting from Piedmont.

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1 Q: None, right?

2 A: That's correct.

3 Q: All right. And another way of saying that is
4 that CMC-Fort Mill will not take any more
5 patients from Piedmont than they've already
6 taken, is that right?

7 A: Again, I think to, as I said on Tuesday, if
8 you're thinking about this in terms of a
9 pattern of utilization, there are going to be
10 patients of the CMC-Fort Mill hospital who have
11 previously been inpatients at a CHS facility.
12 That pattern of utilization, there's going to be
13 a component of that pattern of utilization that
14 consists of patients who have been patients at
15 CHS hospitals before and now go to the CMC-Fort
16 Mill hospital. Within that, there is going to
17 be a set of patients who've never been an
18 inpatient before, but again, are representative
19 of that pattern of patients that historically go
20 to CHS hospitals and that pattern is still
21 going -- is going to shift to CMC-Fort Mill.
22 So to try to isolate it down to patients number
23 one through number 5,000, that set of patients
24 is different every year. But it is what, it is
25 the set of patients in the aggregate represented

1 by the market share that is representative of
2 what I'm discussing in my testimony.

3 Q: Okay. I think I understand what you're saying
4 but just to help, again, help me clarify your
5 position on that.

6 **MR. WESTBROOK:** Dan, would you put up Ms. Carter's
7 deposition, please.

8 Q: And let me get a copy of it, Ms. Carter for you
9 to take a look at. Ms. Carter, you've got
10 multiple depositions here. Let's see if I can
11 help guide you so you don't have to turn to --
12 where I'm going to be looking, Ms. Carter, is
13 where I'm asking Dan to put on the screen and
14 ask you to look at is the deposition dated
15 February 14th, 2013.

16 A: Okay. I have that.

17 Q: All right. Good. Let's turn to page 104,
18 please.

19 A: 1-0?

20 Q: 104.

21 A: Four.

22 **MR. WESTBROOK:** And I'm going to ask Dan to
23 highlight lines one through six, please.

24 Q: And let's just publish it. I'll read the
25 question and you read the answer, and then feel

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1 free to explain. The question starts mid
2 sentence on line 1, "Is it your understanding,"
3 I'm going to read from here. "Is it your
4 understanding, is it CHS's position and your
5 opinion that CHS by shifting that volume to
6 CMC-Fort Mill, that CMC-Fort Mill is not going
7 to take any more patients from Piedmont?" And
8 what's your answer?

9 A: "Yes, that is the basis of the projection in
10 the application."

11 Q: Okay. Now, is that the same thing that you
12 were just saying? It may have been. I just
13 wasn't sure.

14 A: As I said on Tuesday, and I believe I
15 specifically said on Tuesday that both in the
16 course of the deposition and in my testimony on
17 Tuesday, I was, as a planner, I tend to think
18 of share and patients and use those terms
19 interchangeably. And so, again, in the sense
20 that patients is represented by the pattern of
21 utilization and by the current market share that
22 CHS has, then that is correct, that there would
23 be no more share shifted, there would be no
24 more pattern, there would be no more pattern
25 changes shifted from Piedmont.

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1 Q: All right. Ms. Carter, the emergency department
2 is a source -- let me see if I can phrase this
3 better. For CHS hospitals, and I assume all
4 hospitals, you can tell me if you disagree, a
5 high percentage of inpatient admissions come
6 through the emergency department, isn't that
7 correct?

8 A: Generally, usually a majority of inpatient
9 admissions come through the emergency
10 department.

11 Q: All right. Good. And CHS, there's been a good
12 bit of testimony in this case about CHS's
13 acquisition of physician practices in York
14 County in the last several years, and you've
15 been here for most or all of the testimony,
16 haven't you?

17 A: Yes.

18 Q: And CHS, in your opinion, is not going to stop
19 acquiring physician practices in York County if
20 CMC-Fort Mill is built?

21 A: Well, as I believe I have said in this same
22 deposition, I think that -- I think that what's
23 happened in York County, in my opinion, is
24 similar to other markets, there has been a lot
25 of activity that tends to get concentrated in a

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1 few years, and that seems based on the data,
2 and I think even reflected by Mr. Levitt's, I
3 know at least in his deposition, he said that
4 he thought Piedmont's market share had gone up
5 and their volume had gone up in 2012, that
6 would seem to bear out that some of the
7 activity over the last several years has settled
8 down. That doesn't mean that CHS won't acquire
9 physician practices in the future; it doesn't
10 mean that Piedmont won't acquire physician
11 practices in the future or Novant continue to
12 acquire physician practices in the future.

13 Q: All right. So I think what you said there,
14 again, just responsive to my question was you
15 would expect CHS to continue to acquire
16 physician practices in York County in the future
17 if CMC-Fort Mill is built, right?

18 A: I would expect based on where I believe the
19 healthcare industry is going that all of the
20 providers, CHS, Novant, and Piedmont included
21 would continue to acquire physician practices in
22 York County.

23 Q: All right. And you mentioned the last year or
24 two, I'm not sure exactly sure how you put it a
25 moment ago, but utilization of Piedmont did you

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1 say had leveled off or gone -- been a slight
2 increase or something of that nature?

3 A: I believe I recall Mr. Levitt, again he may
4 have testified to it in his trial, but I
5 specifically recall in his deposition he
6 indicated in 2011 and 2012, he thought the
7 Piedmont utilization had gone up and their
8 market share had gone up.

9 Q: Right. But the increase in Piedmont's
10 utilization in the last few years has been from
11 uninsured patients, hasn't it?

12 A: I haven't -- I know I've heard testimony that,
13 as I said on Tuesday, my experience with
14 clients in about every market I serve, their
15 commercial patients have gone down, their
16 charity care uninsured patients have gone up,
17 their Medicaid patients have gone up, and I
18 recall testimony that Piedmont's mix of patients
19 have shifted, like the industry has shifted to
20 more uninsured, more Medicaid, fewer commercial
21 payments. In terms of actually looking at the
22 patients that are driving the increase, I
23 haven't analyzed those specific patients in
24 terms of what their payer mix is. But
25 Piedmont's payer mix has changed, as I just

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1 said, such that commercial has gone down,
2 Medicaid and uninsured have gone up as with
3 just about every other client I work with.

4 Q: All right.

5 **MR. WESTBROOK:** Dan, let's look at Piedmont's
6 Demonstrative 159, please.

7 Q: Do you recall seeing this demonstrative earlier
8 during the testimony I think of Mr. Masterton?

9 A: Yes, I do believe I recall seeing this.

10 Q: All right. Now, I recall at the time Mr.
11 Muller has some objections to this because the
12 scales on either side, there are different
13 scales, aren't there, the one from managed
14 commercial and the one for self-pay charity,
15 right?

16 A: Yes.

17 Q: But it says there, sort of the I guess the
18 point there, according to this chart, it says
19 it's sourced in the ORS, and that's the South
20 Carolina Office of Research and Statistics, is
21 that right?

22 A: Yes.

23 Q: Is that self-pay charity admissions at Piedmont
24 during this period of time have increased 175
25 percent and managed commercials down negative

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1 23, is that right? Is that what it says?

2 A: That's correct.

3 Q: Now, again to overcome, so I don't want to
4 mislead and Mr. Muller felt this was misleading
5 demonstrative. Let's go to another
6 demonstrative that takes those two sort of
7 bottom line figures.

8 **MR. WESTBROOK:** And Dan, this would be
9 Demonstrative, I believe, it is 282. Yeah.

10 Q: Now, that shows, again, doesn't that show what
11 the previous chart showed that during this
12 period of time a 23 percent decrease at
13 Piedmont in managed care commercial admissions
14 and a 175 percent increase?

15 A: It shows those two percentages, and I would
16 make two comments. Again, this is -- this is -
17 - this trend is very consistent within the
18 industry, consistent with the clients that --
19 consistent with the experience of my clients.
20 And the other thing I would note relative to
21 the testimony I gave a moment ago, what I have
22 not analyzed is to determine whether the
23 historical share that Piedmont has had, whether
24 the payer mix within that population has changed
25 or the increase, or what is the payer mix of

1 the increase that specifically Piedmont has
2 gained.

3 Q: So, I'm sorry, I wasn't sure I quite followed
4 what you just said. You said you had not
5 looked at the payer mix in York County to see
6 if it's changed for the last few years?

7 A: No, I did not say that.

8 Q: And have you seen anything that would suggest
9 that CHS as a whole or any CHS facility, as far
10 as that goes, has experienced a 175 percent
11 increase in self-pay charity admissions in the
12 last six or seven years?

13 A: I have not looked at, to the best of my
14 recollection, I haven't looked at the percentage
15 increase.

16 Q: Have you looked at anything that would indicate
17 that CHS or any CHS facilities experienced a 23
18 percent drop in managed care commercial in the
19 last six to seven years?

20 A: I have not calculated the percentage increase
21 for CHS in terms of payer mix from 2005 to
22 2011.

23 Q: Okay. Now, if CMC-Fort Mill is approved, CHS
24 physicians in York County are going to continue
25 to refer their patients to CHS facilities.

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1 Wouldn't you expect that to be true?

2 A: That would be my expectation.

3 Q: That would be consistent with the industry
4 trends, the testimony you gave the other day,
5 wouldn't it?

6 A: Yes.

7 Q: All right. And the most important factor in
8 determining where a patient goes for specialty
9 physician services is referral by their primary
10 care physician, isn't that right?

11 A: That's my opinion, yes.

12 Q: All right.

13 **MR. WESTBROOK:** Let's look, Dan let's look at, pull
14 up CHS 9692.

15 Q: This is the New England Journal of Medicine
16 article that you read into the record, parts of
17 it yesterday, correct?

18 A: Yes.

19 Q: And just to give the title, it says, Hospitals
20 race to employ physicians, the logic behind a
21 money losing proposition by Dr., how do you
22 pronounce that fellow's name, do you know?

23 A: I do not know.

24 Q: K-O-C-H-E-R and Dr. Sahni, S-A-H-N-I, is that
25 right?

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1 A: Yes, although I think Mr. Sahni is just a
2 mister, not a doctor.

3 Q: You're right, BS. All right. I'm going to ask
4 you to read part of this into the record,
5 please.

6 **MR. WESTBROOK:** Let's go down and, Dan, would you
7 highlight the portion that I gave to you
8 earlier and why don't -- well, let's just read
9 that and then we'll go, because it spills over
10 to the next page. Dan, why don't we -- okay,
11 Dan, I'm sorry, you know what you're doing a
12 lot better than I do. You go ahead and
13 highlight it and then we'll get Ms. Carter to
14 read it.

15 Q: Okay. Why don't you just read that into the
16 record, Ms. Carter, starting just the
17 highlighted portions and then I'll ask you a
18 question or two about that.

19 A: "For hospitals to break even, newly hired PCPs
20 must generate at least 30 percent more visits
21 and --" ---

22 Q: Let me stop you right there and ask you, PCPs
23 stands for what?

24 A: Primary care physicians.

25 Q: Okay. Thanks. Go ahead. I'm sorry.

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1 A: --- "at least 30 percent more visits and new
2 specialists 25 percent more referrals than they
3 do at the outset. After three years, hospitals
4 expect to begin making money on employed
5 physicians when they account for the value of
6 all care, tests, and referrals. Skeptics note
7 that often they already capture this value from
8 physicians without employing them through stable
9 referral networks and hospital practice choices.
10 Outpatient office practices of employed
11 physicians seldom turn a profit for hospitals.
12 Hospitals are willing to take a loss employing
13 PCPs in order to influence the flow of
14 referrals to specialists who use their
15 facilities."

16 Q: Okay. Do you agree with those statements?

17 A: Yes.

18 Q: All right.

19 **MR. WESTBROOK:** And let's go down to the next
20 highlighted portion, Dan.

21 A: And let me just say that I don't, I haven't
22 done any of my own research relative to the
23 percentages that they specifically quote in this
24 article. I have no reason to disagree with
25 them, but I think in my experience, many

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1 hospitals do lose money on primary care
2 physicians, and they -- from a financial
3 perspective they make it up on the volume of
4 patients referred to specialists and/or things
5 that are performed in their hospitals.

6 Q: All right. And would you read that sentence
7 into the record, please?

8 A: Yes, I believe this was what I read yesterday.

9 Q: Oh, really? Okay.

10 A: Yes.

11 Q: Read it again, please.

12 A: "Hospital employed PCPs generally direct
13 patients to their own hospitals and specialists
14 affiliated with them."

15 Q: All right. Good. And since you read it into
16 the record yesterday, I assume you agree with
17 that as well, right?

18 A: Yes.

19 Q: All right. Now, Ms. Carter, you gave a good
20 bit of testimony about your background,
21 introduced your resume into evidence and so
22 forth. You've done a good bit of CON work
23 over the years and that's clear. The majority
24 of that work, in fact, the vast majority of
25 your CON work has been in North Carolina, is

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1 that right?

2 A: Yes, it has.

3 Q: And in North Carolina, you were explaining this
4 to me, there's a legal standard that involves
5 where the party would be substantially
6 prejudiced by a CON, a new CON or CON applied,
7 is that right?

8 A: Yes.

9 Q: And that's sort of -- and that substantial
10 prejudice analysis is not a, as I understand
11 it, it's not a CON criteria but it's a legal
12 standard, I believe is the way you described
13 it, that is somewhat similar to an adverse
14 impact analysis, is that right?

15 A: Let's see if I can explain this. It is not a
16 CON standard. It is not applied in certificate
17 of need reviews in any way. Where it has come
18 into play in CON, it's come into play in the
19 CON appeal process and that's whereby I mean
20 it's a legal standard, as I understand it, as
21 to whether or not a party to an appeal can
22 prove legally, whether or not they even had an
23 application in, that they would be substantially
24 prejudiced by the outcome of the CON case.

25 Q: All right. And I think that you could

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1 specifically recall testifying about substantial
2 prejudice on one occasion. There was a
3 deposition involving a freestanding ER case, is
4 that right?

5 A: Yes.

6 Q: All right. And other than this case right
7 here, and when I say this case, I mean this
8 trial and the updated applications and the one
9 back in 2009, the Fort Mill Medical Center
10 case, other than this case, you can't recall
11 another case you've worked on where adverse
12 impact was a major issue, is that correct?

13 A: To the best of my recollection, no.

14 Q: And you yourself have never done, you yourself
15 personally have never done an adverse impact
16 analysis for a client who is concerned about
17 the adverse impact, is that correct?

18 A: As I recall, I think I couldn't recall any at
19 my deposition. I don't want to say that I've
20 never done one, but I can't recall one.

21 Q: Okay. Let's go to the demonstrative, I'd like
22 to go, Ms. Carter, to your Demonstrative 4.69,
23 please, Dan. And this is a demonstrative you
24 testified about yesterday, right?

25 A: Yes.

1 Q: And this says, the heading is "PMC's projected
2 impact not adverse," right?

3 A: Yes.

4 Q: And you've got -- just to, just to, I know you
5 went over this yesterday, but just to refresh
6 our memories, I think what you've got there is
7 a column that says Actual 2009 PMC Experience,
8 right?

9 A: Yes.

10 Q: And is the source for that -- you've got your
11 sources at the bottom. Would the source for
12 those numbers be Piedmont Supp. CON.487?

13 A: I believe that's correct.

14 Q: And then the second column is Mr. Levitt's
15 projected 2020 PMC experience with CMC-Fort
16 Mill, is that right?

17 **MS. ROBERTSON:** Your Honor, if I could just clarify
18 for the record. Mr. Westbrook, you referred to
19 yesterday, Tuesday.

20 **MR. WESTBROOK:** Tuesday, you're right.

21 **THE COURT:** That's right.

22 **MR. WESTBROOK:** Seems like only yesterday.

23 **MS. ROBERTSON:** It does.

24 **THE COURT:** Any references referring to yesterday,
25 we're actually referring to the last time we

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1 were in this hearing, which was Tuesday.

2 **MR. WESTBROOK:** Thank you very much.

3 **THE COURT:** Thank you, Mr. Westbrook.

4 Q: So that second column, the one that's projected
5 2020 PMC experience, those are Mr. Levitt's 2020
6 projections if CMC-Fort Mill is built, is that
7 right?

8 A: Yes, but just to clarify, at the time he made
9 those projections, they were if either of the
10 North Carolina providers was approved, but at
11 this point yes, CMC-Fort Mill.

12 Q: Right. Thank you. And the source for that
13 would be, again, looking down at the bottom it
14 would be Piedmont Supp. CON 545?

15 A: I believe those -- yes, those two pages
16 correspond.

17 Q: Okay. And then your final column has the
18 difference, percentage difference between those
19 numbers line item by line item, right?

20 A: Yes.

21 Q: And now in the margins of either side, in the
22 big font are two numbers, and the one on my
23 right is hard to read, but I believe is that 23
24 million and something?

25 A: Yes. I believe it's 23.5 million.

1 Q: And that's bad debt ---

2 A: Yes.

3 Q: --- did I understand you to say? And the one
4 on my left is clearer to read and that's
5 24,914,730, right?

6 A: Yes.

7 Q: And that's bad debt too?

8 A: Yes.

9 Q: Now, the 24,914,730 number, that would represent
10 the bad debt that is did I understand you to
11 say would be included in those actual 2009 PMC
12 experience; is that what that is?

13 A: That was my recollection, yes.

14 Q: All right. I would like to go, just remember
15 that number -- well, it's 24.9 million, so
16 let's everybody just keep that in our heads for
17 a minute because I couldn't find that number,
18 and I wanted to see if I'm missing something
19 here. Let's go to Piedmont Supp. CON.487. Now
20 this is the, one of the annual reports from
21 Piedmont to York County, is that right?

22 A: Yes.

23 Q: This is one of the reports that they make on a
24 -- yeah, it says annual, yeah, and this is the
25 one for fiscal year 2009 ending May 31st, 2009,

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1 right?

2 A: Yes.

3 Q: All right. Now, I don't see a \$24 million
4 number on that page. Am I -- was that through
5 a calculation, or am I just missing something?

6 A: Well, there is a \$26.2 million number for those
7 unwilling to pay, and I'm not sure whether I
8 just -- or I may have pulled -- there was a
9 subsequent, there were subsequent pages I
10 believe to the York County report that gave
11 more detail about bad debt, and it may be that
12 that's where I pulled that number because I ...

13 Q: Let's look at one of the subsequent pages.
14 Now, first of all, this says for those
15 unwilling to pay, I know that doesn't
16 specifically say bad debt. Does that sort of
17 sound like it might be bad debt to you?

18 A: Generally, I would assume that that was bad
19 debt.

20 Q: Okay. Let's go over to Bates page 492, which
21 is just a few pages, and this is 487, this is
22 part, so 492 I'm going to represent to you is
23 part of the same report. Look at 492, and it's
24 sort of in the middle of the page there. You
25 see other uncompensated care right there?

1 A: Yes.

2 Q: And it says in paren, bad debt division, right?

3 A: Yes.

4 Q: And that's that 26.2 number, isn't it?

5 A: Yes.

6 Q: Okay. So that, would that confirm to you that
7 that number on that first page that we looked
8 at is the actual bad debt number for the 26.2?

9 A: Yes.

10 Q: Okay.

11 **MR. WESTBROOK:** Let's go back, Dan, to that, to 487,
12 please.

13 Q: So the 24.9 number is just a clerical error,
14 would that be the best way to describe it, or -
15 --

16 A: It would appear that way, yes.

17 Q: Okay. So the actual number that should be for
18 bad debt is 26.2? Okay, good. All right.
19 Bear with me for just a second, Ms. Carter.

20 **MR. WESTBROOK:** I am going to go low tech for a
21 minute, and I apologize to everybody, especially
22 you because I only have one -- I don't know of
23 a better way to do this, I'm afraid, and Ms.
24 Robertson, I'm going to put this over here and
25 I'm going to block Ms. Biggers' view, but let's

1 see here. Can I lean it right here, Your
2 Honor?

3 **THE COURT:** That would be fine. That might be the
4 easiest way..

5 **MR. WESTBROOK:** Okay. Good. We'll see how this
6 works. All right.

7 **THE COURT:** Don't sneeze.

8 **MR. WESTBROOK:** I know I won't.

9 Q: I think we're going to be juxtaposing two
10 things, and so I think it might be easier to
11 write something down. Now, from this 487,
12 again, I mean Bates page 487. This is the 2009
13 York County report and I want to focus on those
14 expenses, and expenses would be under that
15 category "Funds Applied"; would they not?

16 A: That's how they've -- the format of this report
17 to York County is a little different from most
18 financial statements in terms of the words that
19 they use, but yes, that would essentially be
20 their expenses.

21 Q: And if you'll see the total expenses, it says
22 207, and that's supposed to be 207 million,
23 right?

24 A: That's correct.

25 Q: Two hundred seven million 286. And that's the

1 number on your demonstrative. We can go back
2 if you need to refresh your memory. Isn't that
3 the total number on your demonstrative?

4 A: Yes.

5 Q: And it's got, the first line items says, To pay
6 full and part-time employees 68,310,000 and the
7 next line item to provide employee benefits
8 15,278,000. Would you mind using your
9 calculator and adding those two numbers, please?
10 What is that number?

11 A: Eighty-three five eighty-eight.

12 Q: Eighty-three five eighty-eight. All right. And
13 then let's go -- I want to skip that line.
14 I'll come back to the purchase supplies in a
15 minute, but let's go down to something a little
16 simpler. Depreciation and amortization, what is
17 that?

18 A: Ten million three sixteen.

19 Q: Okay. I'm just going to write down here the
20 abbreviation for depreciation, and I'm sorry, 10
21 million what?

22 A: Three sixteen.

23 Q: Okay. And then the one under that is interest,
24 right?

25 A: Yes.

1 Q: How much is interest?

2 A: 16,287

3 Q: 16,287. And then the one we skipped over is to
4 purchase supplies, utilities, insurance and
5 other expenses, is that right?

6 A: Yes.

7 Q: And that is what?

8 A: 97,094.

9 Q: And I'm going to call that "supplies and
10 other." Okay. Is that good enough since I'm
11 afraid this thing is going to fall over any
12 minute so I'm going to write as little as
13 possible. All right. And what's the total
14 again, please?

15 A: 207,286.

16 Q: 207,286.

17 **MR. WESTBROOK:** Okay. Let's go back to the
18 demonstrative please Dan.

19 Q: All right. And this is again, Demonstrative
20 469, and let's look at your column about the
21 2009 experience.

22 **MR. WESTBROOK:** And just kind of go down to the
23 expense detail Dan, please.

24 Q: Salaries and benefits 83,588, that checks off,
25 doesn't it?

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1 A: Yes.

2 Q: All right. And the 10,316 for depreciation

3 checks off?

4 A: Yes.

5 Q: 16,287 for interest checks off?

6 A: Yes.

7 Q: 97,094 checks off?

8 A: Yes.

9 Q: And the 207,286 checks off, right?

10 A: Rounding, considering rounding, yes.

11 Q: Considering rounding, right. Thank you. And

12 so that \$26 million of bad debt is not included

13 there, is it?

14 A: In the report to York County, the 26 million in

15 bad debt would have been included or taken into

16 account in the net revenue calculation.

17 Q: Uh-huh (affirmative response).

18 A: But at the end of the day, in my -- it doesn't

19 change my opinion about the difference in the

20 bottom line.

21 Q: Okay. But the \$26 million is not part of that

22 207, right?

23 A: It is not, that is correct.

24 Q: Okay. And if we added that 26, what was that

25 number again, do you recall or do we need to go

1 back, it was 26 something, 26 ---

2 **MR. WESTBROOK:** Dan, how about just run it back
3 quickly to 487 just so we can get it right.

4 Q: And that, what they call "those unwilling to
5 pay" which I think we established as bad debt
6 is 26,292, is that right?

7 A: Yes.

8 Q: Why don't you add 26,292 and the 207,286 and
9 what do you come up with?

10 A: 233,578.

11 Q: 233,578. Okay. All right. Good. Let's go
12 back to the demonstrative for a second, I keep
13 forgetting the number of it, but I think it's
14 4.69. Yeah. And let's focus on the 2020
15 column, and again, I would you look down at the
16 expense, the bottom half where it says expense
17 details and we've got those same categories.
18 Let's see if I can flip this over without doing
19 any damage. And on 2020, what are salaries and
20 benefits?

21 A: 88,184.

22 Q: I tell you what, you know what I think it's
23 going to work easier is if we go the other way.
24 Let's go to the source of this 545, kind of
25 like we did the way, and I'm going to write

1 down what that has and then we'll check it off
2 again.

3 **MR. WESTBROOK:** So let's go, Dan, to Piedmont Bates
4 page 545, please.

5 Q: And here are Mr. Levitt's projections, right?

6 A: Yes.

7 Q: Okay. Let's go to the last column 2020 is what
8 we're focused on here, and if we'll go down to
9 I think operating expenses. You see where that
10 is, Dan, and Ms. Carter?

11 A: Yes.

12 Q: And the first line item is Salaries, Wages and
13 Benefits, right?

14 A: Yes.

15 Q: So would you read that off for me, please?

16 A: 88,184.

17 Q: 88,184. Let's find depreciation on here.
18 Where is depreciation?

19 A: It's below the line, I believe.

20 Q: All right. Yes. For some reason, it's -- I'm
21 sure it's a good reason, but for some reason
22 it's down there. Depreciation and amortization,
23 last -- go over to 2020, what is it?

24 A: 12,328.

25 Q: Depreciation 12,328?

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- 1 A: Yes.
- 2 Q: Okay. What about interest?
- 3 A: 15,195.
- 4 Q: 151, oops, 195. All right. And is bad debt
- 5 singled out on there?
- 6 A: It is. It's listed in Mr. Levitt's projection
- 7 here as an expense, whereas in the York County
- 8 that we were just looking at, it was a
- 9 deduction from revenue.
- 10 Q: Gotcha. And how much is that bad debt?
- 11 A: 23,508.
- 12 Q: 23,508. And I believe that's the same number,
- 13 is it not, that was hard to read in the margin
- 14 of your demonstrative over on the right side,
- 15 right?
- 16 A: Yes.
- 17 Q: That was that same number. That's where you
- 18 got that from, right? Okay. And now what are
- 19 -- we also have up there supplies, other
- 20 controllable expenses and non-controllable
- 21 expenses/corporate overhead, right?
- 22 A: Yes.
- 23 Q: Can you add those three numbers for me?
- 24 A: 121,001.
- 25 Q: 121,001?

- 1 A: Yes.
- 2 Q: All right. And what does this all add up to?
- 3 A: 260,216.
- 4 Q: 260,216. And that's the total that you had on
- 5 your demonstrative, right?
- 6 A: With some rounding, yes.
- 7 Q: With some rounding, yes. Let's go back to the
- 8 Demonstrative 4.69 and just kind of confirm.
- 9 You had salaries and benefits of how much?
- 10 A: 88,184.
- 11 Q: So we got that checked off. Depreciation, what
- 12 was your depreciation?
- 13 A: 12,328.
- 14 Q: What was your interest?
- 15 A: 15,195.
- 16 Q: What was your bad debt? Well, you didn't have
- 17 bad debt singled out, right? But you had it in
- 18 the margin it was 23.
- 19 A: Yes, it was included with the ---
- 20 Q: It was included with the other.
- 21 A: --- the other.
- 22 Q: So if you add these two together, does it come
- 23 up to that number 144,511 that you have?
- 24 A: Yes.
- 25 Q: So that, you just added the bad debt into the

1 other. I mean, that's included in the other,
2 right?

3 A: That's correct.

4 Q: Okay. So it appears, isn't this true, that on
5 the 2020 column, you included bad debt of about
6 20, a little over \$23 million, and on the 2009,
7 that did not include bad debt of about \$26
8 million, is that right?

9 A: To be clear, bad debt was -- in the 2009
10 experience, bad debt was not included in the
11 York County report as an expense detail, but
12 that column includes bad debt. It just treats
13 it as a deduction from revenue, and so it's
14 factored into the net revenue line item.

15 Q: All right.

16 **MR. WESTBROOK:** Let's look at demonstrative 289,
17 Dan.

18 Q: All right. Now, Demonstrative 289 has these
19 two sets of numbers, and if you'll see, it's
20 got -- on both of them it's got bad debt broken
21 out as a separate line item, right?

22 A: Yes.

23 Q: And then we totaled both of them, and the 2009
24 is 233,577,000 and the 2020 remains the same at
25 260,218,000, is that right?

1 A: Yes.

2 Q: Now, wouldn't you agree that this is a more
3 complete and really a fairer way of comparing
4 the 2009 expenses and the projected 2020
5 expenses?

6 A: Well, to fully do this with my analysis, you
7 have to then adjust the net revenue impact of
8 switching how you're looking at bad debt,
9 because the focal point of my Demonstrative 4.69
10 was the difference in the bottom line and what
11 was driving that difference. And so the fact
12 that bad debt is treated differently as whether
13 it's an adjustment to revenue or an expense, it
14 falls out the same on the bottom line, and so
15 in order to -- if you're going to treat it the
16 same in both, then you also need to make the
17 adjustment on the revenue side.

18 Q: All right. But I do remember your testifying
19 ...

20 **MR. WESTBROOK:** Dan, I'm going to rely on your quick
21 hands here. Let's go back to 4.69 for a
22 minute.

23 Q: I do remember your testifying, isn't this
24 correct, and that your testimony focused on the
25 total, just on the expenses at the bottom.

1 **MR. WESTBROOK:** Just focus on that bottom part, Dan.

2 Q: That the difference, the percentage difference
3 in the total expense between 2009 and 2020 was
4 25.5 percent. Didn't you testify about that?

5 A: I believe I did, and the point was I was trying
6 to determine in my analysis what was driving
7 the difference between Piedmont's actual 2009
8 experience resulting in an after tax income of
9 10.8 million and a five percent margin and
10 virtually the same volume resulting in a net
11 loss in year 2020. And so I looked at the
12 expense items in more detail. You are correct
13 that the expense items, the expense detail on
14 the 2009 side does not include bad debt
15 because, as we've been talking about, that was
16 taken into account with revenue on that report.

17 Q: All right. And the way that 25.5 percent was
18 derived, was it not, was by dividing \$207
19 million, and I'm just going to round up to \$207
20 million by \$260 million. Wasn't that way you
21 got the 25.5 percent increase?

22 A: Well it's ---

23 Q: Well, it's not quite that simple, I'm sorry.
24 You would do a couple more steps to that, but
25 that's -- those are the two factors?

1 A: It represents the difference between those two
2 factors.

3 Q: Right.

4 MR. WESTBROOK: Let's go back to our demonstrative,
5 Dan, 289.

6 Q: And if you include the bad debt, what would the
7 -- and so 25.5 percent, what would the
8 increased interest be between 233 million and
9 260 million? And why don't you just walk us
10 through the steps for the record. I think you
11 would start off, would you not, by subtracting
12 the 233 from the 260, is that correct?

13 A: Yes, and that difference is 26.641.

14 Q: And then you would divide that by what?

15 A: The 233,577, and that difference is 11.4
16 percent.

17 Q: 11.4 percent. Now, this is a period of time
18 from 2009 to 2020, so that is -- is that 11
19 time periods? In other words, 2009 to 2010
20 would be one; 2010 to 2011 would be two ---

21 A: Yes, it's 11 years.

22 Q: --- something like that. Isn't that 11? Are
23 you able with your calculator to calculate what
24 the compound annual growth rate would be over
25 that 11 period from 233 million to 260 million?

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1 A: No. I can't calculate like that on this
2 calculator.

3 Q: But just looking at it, it's -- we're talking
4 about 11 years, and I believe you said the
5 total was 11.4 percent change, is that right?

6 A: Yes.

7 Q: So wouldn't that be about one percent or maybe
8 a little over one percent a year?

9 A: Somewhere in that ballpark, yes.

10 Q: Okay.

11 **MR. WESTBROOK:** Let's go to CHS Exhibit 32, page 15,
12 Dan.

13 Q: Now, this is something you've prepared, is that
14 right?

15 A: Yes.

16 Q: And, in fact, that was a demonstrative that you
17 testified about yesterday that was based on, it
18 may have even been identical to this but, I'm
19 not sure, Demonstrative I believe it's 4.81, is
20 that right?

21 A: Yes.

22 Q: Okay. And again, the print's a little hard to
23 read but I think we can -- I'm not going to go
24 into a whole lot of detail on this so. I think
25 what you did here, you correct me if I'm wrong,

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1 is you compared -- you selected some South
2 Carolina counties and compared them, their
3 situation in terms of healthcare and so forth
4 and hospital services and so forth to York
5 County and you also grouped some counties and
6 made comparisons, is that right?

7 A: I took the counties that were closest in size
8 to York County plus or -- well, all the
9 counties plus or minus 50,000 population in
10 South Carolina, and those are the individual
11 counties. And then I grouped the urban regions
12 around those counties, and I think specifically
13 Berkeley, those three Berkeley counties are
14 actually grouped that way in the State Health
15 Plan.

16 Q: Those three Berkeley -- oh, I see, Berkeley,
17 Charleston ---

18 A: The Berkeley Charleston, and Dorchester. Yeah.

19 Q: --- and Dorchester. All right. I want to ask
20 you about some of these. One of the counties,
21 and I'm not going in any particular order but
22 just, well, let's see -- because one of the
23 counties that you compared York to was Anderson
24 County, right?

25 A: Yes.

1 Q: And in Anderson county, I think you have listed
2 that there are two hospitals in Anderson, but
3 actually both those hospitals are owned by the
4 same company, right?

5 A: That's why I have only one hospital system
6 listed.

7 Q: Right. And that one hospital system, that's --
8 I'm not exactly sure of the full name for it,
9 but it's something that's commonly called AnMed,
10 is that right?

11 A: Yes.

12 Q: And AnMed actually is managed by CHS, right?

13 A: Yes, they are.

14 Q: Coincidentally, right? I guess coincidentally.
15 So AnMed, so there are two hospitals in
16 Anderson county. They're both AnMed hospitals,
17 and one of them is a specialty hospital, right?
18 It's not a general acute care hospital; it's a
19 women's and children's hospital, right?

20 A: Well, I think -- I mean, it is a women's and
21 children's hospital, but women's and children's
22 services are provided. I mean, the women's and
23 children's services are traditionally included
24 in general acute care.

25 Q: All right. But these two hospitals, one is a

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1 women's and children's hospital and one is a
2 more general hospital, both owned by AnMed, both
3 owned by CHS. They're not competing with each
4 other, are they?

5 A: Both managed by CHS.

6 Q: Did I say -- did I say something different?

7 A: You said owned by CHS.

8 Q: I'm sorry. Both managed by CHS. They're not
9 competing with each other, are they?

10 A: No.

11 **MR. WESTBROOK:** And let's go to Piedmont's Exhibit
12 15 for a minute, please. And Dan, I'm not sure
13 what page this is but there's a page on the
14 Anderson County here.

15 Q: Anderson County's out-migration, you see that
16 over on the left under ---

17 **MR. WESTBROOK:** Dan, would you highlight 23.9
18 percent. That out-migration rate for Anderson
19 County is a good bit lower than the out-
20 migration rate for York County, isn't that true?

21 A: Yes.

22 Q: I mean York County's out-migration is the 40s,
23 isn't it? Forty-six, does that sound right?

24 A: Somewhere in that neighborhood, yes.

25 Q: Somewhere in that neighborhood. And this is

1 about 24 percent. And the out-migration,
2 actually this is an interesting chart because it
3 shows where the out-migration is going.

4 **MR. WESTBROOK:** And if you will scroll down, Dan, I
5 think there is a percentage that shows that 17
6 percent of the out-migration is going to
7 Greenville County, which is of course I guess
8 not too surprising being right next door to
9 Anderson County, right?

10 A: That's correct.

11 Q: And there are a number of hospitals in
12 Greenville County, but none of those hospitals
13 in Greenville County have an extensive physician
14 network in Anderson County, isn't that correct?

15 A: I do not know the extent of the physician
16 networks by the Greenville hospital systems in
17 Anderson County.

18 Q: All right. So you don't know whether the
19 Greenville Hospital System or any other
20 Greenville hospital has a physician network in
21 Anderson County that's comparable to the
22 presence that CHS has in York County?

23 A: I don't know the comparability of that.

24 Q: And it is true that neither Greenville Hospital
25 System or any other Greenville hospital is

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1 attempting or has attempted to build a hospital
2 in Anderson County, is that correct?

3 A: To the best of my knowledge, nobody has
4 submitted a certificate of need to build a
5 hospital in Anderson County.

6 Q: All right. Now, Lexington County is another
7 county that you actually seemed to kind of
8 focus on, and I know you found some real
9 analogies between Lexington County and York
10 County, right, in your testimony, I was about
11 to say yesterday again, but day before
12 yesterday?

13 A: Yes.

14 Q: All right.

15 **MR. WESTBROOK:** And let's go back, Dan, to -- well,
16 that's okay, I don't think we need to go back.
17 That's fine.

18 Q: But again, and I think this is one of the
19 analogies, just like in York County, there's
20 only hospital in Lexington County, Lexington
21 Medical Center, right?

22 A: That's correct.

23 Q: And there are two hospital systems, I believe,
24 in Richland; there's Palmetto Health and there's
25 Providence, correct?

1 A: That's correct.

2 Q: And again, wouldn't you agree that neither
3 Palmetto Health nor Providence have extensive
4 physician networks with employed physicians in
5 Lexington County anywhere near comparable to
6 what CHS has in York County?

7 A: Again, I don't know the comparability of those.

8 Q: All right. And Parkridge, which of course is
9 under construction right now, and that's not
10 open, right?

11 A: That's correct.

12 Q: And it's out there by Columbiana Mall, correct?

13 A: Yes.

14 Q: And it's close to the Lexington County line,
15 but it's in Richland County, right?

16 A: Yes.

17 Q: Lexington, I mean excuse me, neither Palmetto
18 Health nor Providence is attempting to build a
19 hospital or has attempted to build a hospital
20 or get a CON to build a hospital in Lexington
21 County, is that correct?

22 A: That's correct. As I said on Tuesday, that was
23 one of the differences, though I thought slight,
24 because Parkridge virtually does sit on the
25 county -- on the county line. The other thing

1 going back to the point that I would just add
2 relative to the physicians in Lexington County,
3 I do not know, as I said a moment ago, I don't
4 know the comparability of the employed
5 physicians. I do know that there are
6 physicians, particularly specialists, who are on
7 the medical staff of both Lexington and the
8 Palmetto Hospitals.

9 Q: All right. But I believe Mr. Murphy testified,
10 I may be getting these numbers slightly wrong,
11 but I think he testified that currently CHS had
12 somewhere between 70 and 90, and you correct me
13 if I'm getting my numbers wrong but that's my
14 memory of employed physicians currently in York
15 County. Neither Palmetto nor Providence had
16 anywhere near that number of employed physicians
17 with offices in Lexington County; isn't that
18 true, or do you know?

19 A: I don't know the comparability.

20 Q: All right. And another county that you
21 compared on your chart was Spartanburg County,
22 right?

23 A: Yes.

24 Q: Now, there are two hospital systems in
25 Spartanburg County, there's Spartanburg Regional

1 and there's Mary Black, right?

2 A: That's correct.

3 Q: And both of them have been there for a long
4 time, haven't they?

5 A: That's correct.

6 **MR. WESTBROOK:** And let's go, Dan, to the State
7 Health Plan, the current State Health Plan 2012-
8 2013. What exhibit number is that?

9 Q: Exhibit 12. Piedmont's Exhibit 12, I believe.
10 And going to page III-18.

11 **MR. WESTBROOK:** And Dan, can you find Mary Black on
12 there? It's in Region I, I believe. And let's
13 highlight Mary Black.

14 Q: Now, this shows the occupancy rates for the
15 last three years for data that they had from
16 2009 through 2011, right, Ms. Carter?

17 A: Yes.

18 Q: And Mary Black's occupancy rate for those three
19 years, for each of those three years if you
20 round them is 42 percent, is that correct?

21 A: Yes.

22 Q: Now, 42 percent occupancy rate, would you
23 consider that underutilized?

24 A: I would consider that less than-- less than
25 well utilized.

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1 Q: Less than well utilized. Is that the same
2 thing as saying underutilized? Or is there a
3 difference?

4 A: From, as I believe I testified in my
5 deposition, that there are times when hospitals
6 who have a current lower occupancy rate and
7 lower than ideal occupancy rate may be -- may
8 have historically operated at higher occupancy
9 rates, which is why they needed the beds at
10 some point in time. But what I would say is
11 they are at 42 percent occupancy, again,
12 assuming that is over some sustained period of
13 time. They wouldn't need all the beds that
14 they have currently.

15 Q: And so they're not really -- would you agree
16 then that Mary Black is really not thriving
17 right now in competition with Spartanburg
18 Regional; would you agree with that?

19 A: Not necessarily. I don't think you can -- you
20 can determine that just purely based on
21 inpatient occupancy rates.

22 Q: And are you aware of any hospital system,
23 hospital or hospital system headquartered
24 outside of Spartanburg County that has an
25 extension -- extensive physician network in

1 Spartanburg County the way that CHS has in York
2 County?

3 A: Again, I have not looked at the comparability
4 of the physician networks with Spartanburg
5 County.

6 Q: Are you aware of any hospital system outside
7 Spartanburg County that has announced its
8 intention to try to build a hospital in
9 Spartanburg County?

10 A: I'm not aware of anybody having submitted a CON
11 application to build a hospital in Spartanburg
12 County.

13 Q: Now, one county you didn't check out, you
14 didn't look at was Aiken County, and I'm going
15 to ask Dan to go back to Piedmont Exhibit 15
16 and ask you a couple of questions about Aiken
17 County. Now, you're originally from Greenville,
18 I believe, is that right?

19 A: That's correct.

20 Q: So, I mean, you're generally familiar I guess
21 with Aiken County; you've been there before,
22 haven't you?

23 A: Yes.

24 Q: Okay. Now, Aiken County is on a state border
25 just like York County is, right? York County

1 borders North Carolina; Aiken County borders
2 Georgia, correct?

3 A: That's correct.

4 Q: Augusta is right across the -- right across the
5 state line, right?

6 A: Yes.

7 Q: And there's only one hospital in Aiken County,
8 and that's Aiken Regional Medical Center, right?

9 A: I believe that's correct.

10 Q: And let's go back to that page on the State
11 Health Plan exhibit, Exhibit 12, Piedmont's
12 Exhibit 12, Bates, or not Bates page but page
13 III-18 and let's look at Aiken County occupancy
14 rate. It's going to be I think a little bit
15 better than Mary Black's. It's in the low 60s,
16 right?

17 A: Yes.

18 Q: All right. So, and I think there's been
19 testimony that Piedmont's current occupancy rate
20 is around 62, is that right? Do you recall
21 that?

22 A: I believe that's correct, yes.

23 Q: So they have similar occupancy rates, right?

24 A: Yes.

25 Q: Now, let's go to Piedmont Exhibit 15, please.

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1 Let's find Aiken County in this chart. Aiken
2 County, let's go down to the out-migration rate
3 for Georgia. That's a 64 percent out-migration
4 to Georgia. So that's even higher out-migration
5 to Georgia than York County out-migration to
6 North Carolina, isn't it?

7 A: Yes.

8 Q: And there are a number of hospitals in Augusta,
9 right?

10 A: Yes.

11 Q: But none of those hospitals have extensive
12 physician networks in Aiken County comparable to
13 the extensive physician network that CHS has in
14 York County, isn't that true?

15 A: I don't know the comparability of the physician
16 networks.

17 Q: And no Georgia hospital, to your knowledge, has
18 attempted to build a hospital in Aiken County,
19 isn't that correct?

20 A: Not to my knowledge.

21 Q: And wouldn't you agree that if an Augusta
22 hospital were to try to build a hospital in
23 Aiken County, that's it's likely that Aiken
24 Regional would oppose that vigorously?

25 A: I don't know what Aiken General would do.

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1 Q: Let's go back to CHS exhibit.

2 **MS. ROBERTSON:** Your Honor, if I might just
3 interpose an objection to the questioning with
4 respect to the comparability of the physician
5 network systems that Mr. Westbrook -- he's
6 stating it in the record. Ms. Carter has not
7 done any comparisons, but yet he was
8 questioning, he is suggesting that
9 comparability, and there's nothing in the record
10 to lay a foundation for the comparability of
11 those other physician networks.

12 **THE COURT:** Mr. Westbrook?

13 **MR. WESTBROOK:** I think I've asked the last question
14 I'm going to ask on this topic. I would simply
15 say in response to that I asked her if she
16 knew, and she said she didn't know. I think
17 there has been plenty of evidence over the
18 extensiveness of the physician -- of CHS's
19 physician network in York County. She may, and
20 I will simply say this, she opened the door by
21 saying these counties were comparable. She said
22 these counties that she selected, Anderson and
23 the others, Lexington and Spartanburg and the
24 others were comparable to York county, and she
25 gave some ways in which they were comparable

1 and analogous ---

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

3 **MR. WESTBROOK:** --- and I'm trying to suggest that
4 maybe there are some ways they're not all that
5 comparable.

6 **THE COURT:** Right. And I think that what Ms.
7 Robertson suggesting is that your questions are
8 not -- Ms. Carter is testifying that she is not
9 aware of the physician networks and what's going
10 on in these counties that she did make the
11 comparison with. And Ms. Robertson, I do
12 understand that there's been no evidence
13 introduced into the record at this time about
14 the physician networks in these counties outside
15 of York County. Certainly there are plenty of
16 evidence of -- and not aware of that and I
17 understand that Mr. Westbrook's questions were
18 asking about that, but there has been no
19 evidence introduced into the record.

20 **MS. ROBERTSON:** Right. His questions are suggestive
21 that there had been but there has not been so I
22 wanted the record to be clear that that's not
23 in the record.

24 **THE COURT:** Thank you, Ms. Robertson. I'm aware of
25 that and you are about ready to move on, is

1 that true, Mr. Westbrook?

2 **MR. WESTBROOK:** I am.

3 **THE COURT:** Thank you.

4 **MR. WESTBROOK:** Thank you Your Honor.

5 Q: Let's go back to CHS Exhibit 32, page 15. And
6 there's a column there that has systems per
7 100,000, right?

8 A: Yes.

9 Q: That's I guess pretty obvious what that means,
10 is how many hospital systems per 100,000's
11 populations in each of these counties and county
12 groupings, correct?

13 A: That's correct.

14 Q: And York, there's a line item about halfway
15 down that says York as approved, so that means
16 would be York with assuming that CMC-Fort Mill
17 -- well, right now CMC-Fort Mill has the nod
18 from DHEC, so that would include the 64 beds --
19 -

20 A: Yes.

21 Q: --- for CMC-Fort Mill? And the systems per
22 100,000 ---

23 **MR. WESTBROOK:** Dan, if you'd just isolate that
24 column for a moment. What's that number for
25 York county as approved, .87?

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1 A: Yes.

2 Q: .87 per 100,000, right?

3 A: Yes.

4 Q: That's the highest number in that column, right?

5 A: As I testified on Tuesday, it is the highest
6 number there similar to Spartanburg, and it's
7 actually, I did not calculate the Berkeley
8 number because when I originated this, I think
9 the, and I'm not sure if the Berkeley situation
10 had been resolved, but nevertheless, the
11 Berkeley number will be one point something with
12 the approval of those two hospitals in Berkeley
13 County.

14 Q: All right. Let's go to demonstrative, your
15 Demonstrative 4.77, please. And this a
16 demonstrative you testified about yesterday,
17 correct?

18 A: On Tuesday, yes.

19 Q: Sorry, Tuesday, yeah. And it's titled FFMC
20 Greater Impact, and you've got a number from
21 2019 over there at the bottom, 7,374,043, and
22 then a number from year five of 2019 there that
23 says 2,961,062, right?

24 A: I'm sorry, I thought you were ---

25 Q: No, I'm sorry. Well, I was kind of mumbling

1 through that. So the thing I want to focus on
2 is that number, that 2,961,000 number, you see
3 that?

4 A: Yes.

5 Q: Now, what you end up doing on some later pages
6 is comparing those numbers, Is that correct?

7 A: I compared the combined net income that you can
8 see on the bottom of this chart ---

9 Q: Right.

10 A: --- and that margin of 2.5, combined margin of
11 2.5 percent to other calculations I made.

12 Q: Okay. You've got your sources listed down
13 there at the bottom. The source for the 2-9,
14 for the stuff on my left hand, that set of
15 projections on the left-hand side of the screen
16 would be Petitioner's Exhibit 1 page 519?

17 A: Yes.

18 Q: All right. Again, I just can't find that \$2.9
19 million number. It may be on there, but I
20 wanted to see if I'm just missing something.

21 **MR. WESTBROOK:** Can we go, Dan, to Bates page 519?

22 Q: And this is for -- this is for 2019, so we can
23 just focus on the 2019 column, right, Ms.
24 Carter?

25 A: Yes.

1 Q: And once again, I -- unless is that -- I see
2 the \$2.8 million, which is a pretty high number
3 and it's not that far off from the \$2.9
4 million, but I was just wondering where you got
5 the \$2.9 million from.

6 A: Unless there's a wrong page reference, because
7 I mean I highlighted directly from the document,
8 but what you've pulled up is not the same
9 number.

10 Q: Right.

11 A: It's a lower number.

12 Q: This is Mr. Levitt's projections for 2019,
13 right?

14 A: Yes.

15 Q: And it's the -- the Bates number is the same
16 that you've listed as the source on your
17 demonstrative, right?

18 A: It's the same Bates number, yes.

19 Q: And that \$2.8 million, what line item is that?
20 It's the net income, right?

21 A: Yes, the after tax income.

22 Q: Okay. And that's what you were going after,
23 right?

24 A: Yes.

25 Q: So is this just a clerical error, is that what

1 this is, or do you ...

2 A: I'm not sure it's that either.

3 Q: So that \$2.9 million number is not rounded off
4 or anything; it's a very precise number? It
5 carries all the way out, doesn't it? So I mean
6 it looks like it came from somewhere, right?

7 A: Well, and the reason I say I'm not sure it's a
8 clerical error is because you can, if you
9 understand how I put together Demonstrative
10 4.77, just as you all are doing here, I mean, I
11 directly pulled from this same source and pulled
12 that number. So, and it's overlaid so I can't
13 see if it was in fact the number below it.

14 Q: Well, let's go back out. Dan, take it out ---

15 A: So, in other words, just to be clear. I didn't
16 type in the 2,961,062. I extracted it from.

17 Q: You extracted it from somewhere?

18 A: From this document or ...

19 Q: Just take a minute or a couple of minutes. I
20 mean, it's not that big an issue really, but I
21 just wanted to understand where that number came
22 from.

23 A: It's looks like what I'm looking -- I'm looking
24 at the other numbers on the page, and it may be
25 just an incorrect page reference because when I

1 look at the document in my Demonstrative 4.77,
2 the other line items are slightly off as well.

3 Q: Okay. Are there -- all right. Okay. Well, so
4 at this point, it sounds like you're just not
5 sure about that number, right, where that came
6 from, at least where it derived?

7 A: Well, I think it came from this document that I
8 have on the left side of Demonstrative 4.77.
9 What it -- if you have on the screen page 519,
10 then perhaps it was a different, it was a
11 different page number.

12 Q: Okay. All right. But obviously, you're not
13 sure what that page number is right now, right?

14 A: That's correct, not without going back and
15 looking through that material.

16 Q: All right. Okay. Let's move on then. Now,
17 let me ask you a hypothetical. If Presbyterian
18 had stayed in the case and ended up winning the
19 CON and Presbyterian ended up building its
20 hospital in Fort Mill, and I believe it's your
21 opinion that Presbyterian's hospital in Fort
22 Mill would have definitely taken patients away
23 and adversely impacted Piedmont, right?

24 A: In order for -- in my opinion, in order for
25 Presbyterian to meet its projections, that's the

1 only way it could have met its projections
2 because Presbyterian has so little market share
3 in York County now. It would have to have
4 taken the volume from somebody else if it were
5 going to meet its projections.

6 Q: Okay. And if Presbyterian had built, again
7 hypothetically speaking, if Presbyterian had
8 ended up getting the CON and building that
9 hospital in Fort Mill, and if, just
10 hypothetically speaking, if it had taken
11 patients away from CMC-Pineville or other CHS
12 facilities, but Pineville being the closest one,
13 if it had taken patients away from Pineville,
14 that -- in a significant fashion that would
15 have hurt Pineville? It would have been an
16 adverse impact on Pineville, right?

17 A: I haven't looked at any adverse impact on North
18 Carolina facilities as a result of whatever
19 might happen in York County.

20 Q: Well, I understand that, and I know you haven't
21 done that analysis, but I'm just asking you to
22 sort of again hypothetically and as a matter of
23 principle, if Presbyterian or we could pick some
24 other or any hospital had built a hospital in
25 Fort Mill and taken a significant number of

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1 patients away from CMC-Pineville, that would
2 have been an adverse impact on Pineville? It
3 would have hurt Pineville, right, if you take
4 volume away from them?

5 A: If volume was to be taken away from CMC-
6 Pineville in your hypothetical, it would have an
7 impact on Pineville. Whether that would be
8 adverse or not, I don't know. It would not
9 necessarily be adverse.

10 Q: Let's look at your trial testimony from 2009.

11 MR. WESTBROOK: Dan, I'm going to ask you to put
12 page 1931 up on the screen, please.

13 Q: And Ms. Carter, if you need a hard copy, let me
14 know, but I think it's only a line or two I
15 want you to look at. I was hoping it would be
16 clearer on the screen.

17 MR. WESTBROOK: From the 2009 trial, page 1931, Dan,
18 if you could zoom that in.

19 Q: And what I want you to look at is -- bear with
20 me for a second, page 1931, right? 1931 ---

21 MS. ROBERTSON: Do you have a copy to give her, or
22 something just a page ---

23 MR. WESTBROOK: Sure.

24 MS. ROBERTSON: --- she might need to look at it in
25 context.

1 **MR. WESTBROOK:** Sure. I do.

2 **Q:** I can give you the whole thing, but since it's
3 kind of bulky, I'll just start with this and if
4 you want more, let me know.

5 **A:** Okay.

6 **MR. WESTBROOK:** I'm sorry. Is it okay if I approach
7 the witness, Your Honor?

8 **THE COURT:** Yes, you may approach the witness.

9 **Q:** All right. And what I want you to do, Ms.
10 Carter, is let's start on ---

11 **MR. WESTBROOK:** And Dan, how about just highlighting
12 starting with page 8 -- it's not page 8, line
13 8, line 8, and we're going to go down through
14 line 21, okay?

15 **Q:** And I'll read the question and you read the
16 answer, okay? Question starting on line 8,
17 "Right, but if in fact Presbyterian, for
18 example, were to build that hospital in Fort
19 Mill and if Presbyterian, and you may think
20 that this is not going to happen, but if they
21 were able to redirect out-migrating patients who
22 are currently going to Pineville or CMC or
23 Mercy and redirect those patients to
24 Presbyterian's facility in Fort Mill, that would
25 hurt Carolina's Healthcare System, would it

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1 not?" And what was your answer?

2 A: "As you said, assuming they were able to
3 accomplish that."

4 Q: Question, "Yeah."

5 A: "And that would certainly take volume away from
6 Carolinas."

7 Q: It would certainly take volume away from
8 Carolinas. And did I understand you to say
9 that wouldn't necessarily -- that taking volume
10 away would not necessarily be an adverse impact?

11 A: What I said was anytime a -- anytime you take
12 volume away from a provider, that's an impact.
13 Whether it is adverse in terms of the -- that
14 it adversely affects the provider, just because
15 you take volume away doesn't necessarily mean
16 that there's an adverse impact on the provider.
17 The provider may be able to continue to move
18 forward.

19 Q: All right. Now, if CMC-Fort Mill is built and
20 if it takes patients away from CMC-Pineville,
21 your opinion is that would definitely not be an
22 adverse impact on CMC-Pineville, correct?

23 A: What I think I demonstrated on Tuesday is that
24 Pineville was, in its 2007 application, it was
25 projected to be above its targeted occupancy

1 rate by the third year that that expansion
2 project was developed and is growing faster than
3 projected in that application, and the
4 subsequent projections that were presented to
5 DHEC that showed the shift of patients from
6 Pineville to CMC-Fort Mill showed that there
7 would be fewer patients going to Pineville than
8 originally projected, but again, that -- yes,
9 there's less volume, but that impact is not
10 adverse to Pineville.

11 Q: All right. And, in fact, I mean the idea of
12 shifting volume from Pineville to CMC-Fort Mill
13 is basically part of the strategy, part of the
14 plan that CHS has in this case, isn't that
15 correct?

16 A: Yes.

17 Q: All right. So you wouldn't consider it adverse
18 impact if it's part of the strategy, would you?
19 Part of the plan?

20 A: Particularly if as projected for Pineville,
21 they're going to continue to be utilized at the
22 level that they were projected to be in the
23 materials submitted to DHEC.

24 Q: Now, Fort Mill Medical Center projects a third
25 year occupancy of 58 patients, right?

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1 A: Yes.

2 Q: And that projects for 100 beds, that's a 58
3 percent occupancy rate that it's projecting,
4 correct?

5 A: That's correct.

6 Q: Now, obviously, if it was a smaller hospital,
7 if it was say a 64-bed hospital, 58 patients in
8 a 64-bed hospital would be a lot higher
9 occupancy rate? It would be 90 something,
10 right?

11 A: Yes. It would be 91 percent.

12 Q: But it's not a 64-bed hospital. It's 100-bed
13 hospital, or at least that's what's proposed.
14 And so the occupancy rate projected is 58
15 percent, and I believe you've testified that
16 that is too low to justify the need for a 100-
17 bed hospital?

18 A: What I have testified to is that I'm not aware,
19 in my opinion, of Piedmont ever demonstrating a
20 need to have all 100 beds, and that is assuming
21 that you believe Piedmont's projections, which
22 I don't believe are reasonable.

23 Q: Well, I understand that and I appreciate that
24 clarification. But didn't you also testify, and
25 if you didn't that's great, it will cut out --

1 it'll make cross-exam a lot shorter. Didn't
2 you also testify that 58 percent occupancy rate
3 is, in your opinion, too low to justify a 100-
4 bed hospital?

5 A: What I said was that you -- my recollection of
6 Piedmont's testimony is that the 58 percent was
7 reasonable because they compared it to other
8 existing facilities in the region which were
9 operating at similar levels. And my testimony
10 was that you have to -- you can't look just at
11 existing facilities because either they could
12 have overbuilt the facilities or they could have
13 operated at higher occupancy rates at some time
14 in the past when there was greater inpatient
15 utilization. But since their occupancy would
16 have been reduced, you also have to compare it
17 with the target need of the population, and
18 that is what in my opinion they failed to do.
19 And so the bottom line is if they're going --
20 in my opinion, if they're going to be occupied
21 at 58 percent, they don't need all 100 beds
22 they have.

23 Q: All right. Okay. Thank you.

24 **MR. WESTBROOK:** Let's look at, Dan, how about
25 pulling up again Exhibit 12, please, the current

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1 State Health Plan 2012-2013 State Health Plan,
2 and go to I think that same page we've looked
3 at before, page III-18.

4 Q: Let's just take it region by region. Region I
5 for this three year period, it gives the
6 occupancy rates for all the hospitals in Region
7 I, right?

8 A: That's correct, yes.

9 Q: And the average in 2009 was 53.5 percent
10 occupancy rate, is that right?

11 A: 53.5 in 2009.

12 Q: I'm sorry 53.5 percent, I'm sorry, yes. And in
13 2010, 52.1 and in 2011 52.6 percent, is that
14 correct?

15 A: Yes.

16 **MR. WESTBROOK:** Now, let's go to Region II, Dan.

17 Q: And the average for those three years in Region
18 II is all 57, 55 to 57, right?

19 A: Yes.

20 Q: And for Region III? All the hospitals in South
21 Carolina Region III, 54 through 57, is that
22 right?

23 A: Yes.

24 Q: And for Region IV, all the hospitals in Region
25 IV for that three year period is 54.9, 56.7, Is

1 that correct?

2 A: Yes.

3 Q: And there are only four regions in South
4 Carolina, is that correct?

5 A: I believe that's correct.

6 Q: So the four regions that we just looked at
7 would contain all the hospitals in South
8 Carolina?

9 A: Yes.

10 Q: Let's look at Joint Exhibit 1A, please, page
11 593. Now, I think we've -- somebody's looked
12 at this before and it's -- one of the problems
13 with this one is that the headings are hard to
14 read, but I think we can try to manage that.
15 The headings at the top, it says at the top
16 "Summary of Services Carolinas Hospitals in Four
17 County Region," correct?

18 A: Yes.

19 Q: And those four counties are Cleveland, Gaston,
20 Mecklenburg, and Union, right?

21 A: That's correct.

22 Q: All right.

23 **MR. WESTBROOK:** Let's go to -- Dan, see if you can
24 find, we'll just take several of these. See if
25 you can find Cleveland.

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- 1 Q: And I know you talked about Cleveland yesterday.
2 That's not -- obviously it's not in Mecklenburg
3 County, is it?
- 4 A: No, it's in Cleveland County.
- 5 Q: It's in Cleveland County. And the total
6 licensed beds for Cleveland are 241, is that
7 correct?
- 8 A: That's what this chart represents. I haven't
9 verified that that's the current correct number.
- 10 Q: All right. This chart, by the way, I'm just
11 going to represent to you is produced by CHS to
12 us in discovery, and in fact, it's got a Bates
13 number on there of CHS 555 in addition to the
14 exhibit number I just called out. And the
15 average daily census acute is 91, is that
16 correct?
- 17 A: That's what this chart says.
- 18 Q: And this CHS chart says average daily census
19 specialty is zero, right?
- 20 A: That's what it says, yes.
- 21 Q: So to get the occupancy rate, would you divide
22 the 91 by 241?
- 23 A: Yes.
- 24 Q: And what is that?
- 25 A: Thirty-eight percent.

1 Q: All right. Let's go to Mercy Hospital.

2 **MR. WESTBROOK:** Is that the next one, Dan?

3 Q: Again, hard to read but can you tell that's
4 CMC-Mercy?

5 A: Yes, I can see that.

6 Q: All right. Again, let's -- at the time, and I
7 guess, you know what we should do, I believe
8 somewhere on this chart it says that this is
9 2009 data.

10 **MR. WESTBROOK:** Dan, can you find that and see if
11 I'm right about that?

12 Q: So just to be clear, we're looking at 2009
13 data.

14 A: Okay.

15 Q: There's more recent data, of course. But in
16 2009, at least, Mercy had -- how many beds did
17 it have listed there? 196?

18 A: 185 if you take out the -- I don't -- I'm not
19 sure the 11 are acute care beds. I can't see
20 what ---

21 **MR. WESTBROOK:** Let's take a look. Dan, what does
22 that 11 represent?

23 A: Those are psych, psych beds.

24 Q: Psych chemical dependency? Okay. so take
25 those out and it's got what?

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- 1 A: 185.
- 2 Q: 185. All right. And what's the average daily
3 census for Mercy?
- 4 A: It was 86.
- 5 Q: Eighty-six. And then that nine would be the
6 specialty. Would that -- if we took out the
7 psych beds, those 11 psych, would be it be fair
8 to take out those nine, too?
- 9 A: Yes, I would think so.
- 10 Q: Okay. Let's divide 86 into 185 and what's
11 that?
- 12 A: It's 46 percent.
- 13 Q: Forty-six percent. And then the next one is
14 Pineville, is that right?
- 15 A: Yes.
- 16 Q: All right. And we've got, at this point in
17 time in 2009, 110 beds at Pineville?
- 18 A: Yes.
- 19 Q: An 81 average daily census. What's that
20 occupancy rate?
- 21 A: Seventy-four percent.
- 22 Q: Seventy-four percent. Now, Pineville, there's
23 been a good bit of testimony about the
24 expansion at Pineville. I've actually heard a
25 couple of different things, and maybe you can

1 clarify this for me. Maybe I misheard or maybe
2 this is just somebody was mistaken of the
3 testimony, but were there 86 or 96 beds added
4 in the most recent expansion of Pineville?

5 A: There were 86 beds that were moved from CMC-
6 Mercy and CMC-University to Pineville. And so
7 that, a couple of points I would make on those
8 calculations you've had me make. Since 2009,
9 CMC-Mercy has, as I just said, they have
10 shifted beds to Pineville. They have also
11 since shifted programs, specialty surgery
12 programs from CMC to CMC-Mercy, which has
13 affected CMC-Mercy's utilization in a positive
14 way. And then the last thing I would say
15 relative to Cleveland is, to me, Cleveland is
16 one of the examples of they have, you know, a
17 number of licensed beds from their history and
18 -- but that would not, I would not look at
19 Cleveland and say today, based on the current
20 volume that they have, that if they were
21 contemplating building 241 beds that they needed
22 to build 241 beds.

23 Q: All right. Thank you. And this, of course, is
24 just a snapshot in time, right? We're looking
25 at 2009 and some things have changed since

1 2009, right?

2 A: That's correct.

3 Q: But since 2009, CMC-Pineville has added in the
4 way you just explained, 86 beds, not 96, right?

5 A: That's -- well, there were a couple of
6 different projects and this -- this bed count
7 intervenes with various phases of shifting that.
8 The bottom line is when the -- maybe the most
9 accurate way to say it is when the Pineville
10 expansion project is complete, it will have 206
11 beds.

12 Q: Two hundred and six beds. And I believe you've
13 told me that that 206 beds become operational
14 sometime in 2013, was it, or have they already
15 become ---

16 A: They were projected to become operational in
17 July of 2013, and I don't know the current
18 update. At some point in time, I believe Mr.
19 Hummer indicated that they might be available,
20 might be fully available sometime this spring.

21 Q: This spring. And Mr. Hummer is the CE -- not
22 CEO, but essentially --

23 A: The president.

24 Q: --- the CEO, the president or administrator or
25 whatever the title is.

1 A: Of Pineville.

2 Q: Of Pineville. Thanks. All right. So that 110
3 beds that Pineville had in 2009, that's going
4 to move up to 206 sometime in 2013, if it
5 hasn't already. Let's go -- what's the next
6 column over there? Is that University?

7 A: Yes. And I would just say along with the
8 increase of 206 beds to Pineville, again, there
9 were tertiary programs that were being shifted
10 to Pineville, so the average daily census would
11 be expected to go up along with those beds as
12 the patients are shifted to Pineville as well.

13 Q: All right. And University in 2009 had a 130
14 beds, is that right?

15 A: That's correct.

16 Q: And 61 average daily census? What's that
17 occupancy rate?

18 A: That is 47 percent, and again, that would be
19 prior to the shift of beds from CMC-Mercy to
20 Pineville.

21 Q: All right. And the last column there, is that
22 King's Mountain?

23 A: Yes.

24 Q: Actually, it's not the last column I see; it's
25 the next to the last column. King's Mountain

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1 had what, 92 beds of which -- what's that 20
2 represent, though?

3 A: I think those are psychiatric beds.

4 Q: Okay. Well, let's just look at the 72 beds,
5 and then the average daily census of 20 acute
6 care patients. Is that the way you read that?

7 A: Yes.

8 Q: And what would that occupancy rate be?

9 A: Twenty-eight.

10 Q: All right. Let's go to -- well, let me just
11 ask you this. Again, realizing this is in
12 2009; there have been changes made since then.
13 You were here for Mr. Murphy's testimony, right?

14 A: Yes.

15 Q: And I believe Mr. Murphy said that -- I asked
16 him did he have any hospitals in the -- in that
17 11 county region, I believe it was an 11 county
18 region or a 13 county region, whatever it was
19 that he works in, that were unsuccessful and he
20 asked me to define it, and I said, well,
21 however you define it. And I think he said
22 that he felt they were all successful. Would
23 you agree with that?

24 A: Yes.

25 Q: Okay. Let's look at Exhibit 38B, please. This

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1 is Piedmont's Exhibit 38B. This is a 2012
2 hospital license renewal application, Ms.
3 Carter.

4 A: And can I -- can I just ---

5 Q: Certainly.

6 A: --- let me clarify something about what I just
7 said?. Yes, I would agree that, to the best of
8 my knowledge, those are successful hospitals,
9 and I can't recall if Mr. Murphy said this or
10 not, but it is in part based on not only their
11 inpatient volume but their outpatient volume.
12 And again, my point relative to the 100 beds is
13 that Piedmont is proposing for Fort Mill Medical
14 Center is all other things being equal and
15 assuming they could make their projections, it's
16 not that they couldn't be a successful hospital
17 there, it is the fact that they don't need to
18 spend the capital to build the beds that they
19 don't need. So, could they be, if they could
20 achieve their projections, which I don't believe
21 they could, but if they achieve their
22 projections, could they be successful at an
23 occupancy rate of 58 percent. I'm not saying
24 that they couldn't be. I'm saying that the
25 very criteria required under the CON regulations

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1 is that you do not unnecessarily duplicate
2 facilities that exist, and that would be exactly
3 what they were doing if they built all 100 beds
4 and didn't need all of those beds.

5 Q: All right. Thank you. Let's look at 38B.
6 This is the 2012 hospital license renewal
7 application. I don't think we have quite this
8 -- something quite like this in South Carolina,
9 but this is a form that every hospital in North
10 Carolina has to fill out on an annual basis, is
11 that correct?

12 A: Yes. And it's the equivalent, in my mind
13 anyway, of the JARs reports in South Carolina.

14 Q: And the JARs reports of South Carolina, that's
15 the acronym for Joint Annual Reports?

16 A: That's correct.

17 Q: And so the -- what we have here is the 2012
18 application for CMC-University, is that correct?

19 A: Yes.

20 MR. WESTBROOK: And let's go to page 9. Dan, if you
21 could go there. I think page 9 is where I want
22 to go.

23 Q: And it's got -- this has actually been filled
24 in. You see it in handwriting, average daily
25 census. They've put it in as 57.94. Is that

1 right?

2 A: Yes.

3 Q: And beds for this --

4 **MR. WESTBROOK:** Dan, let's go to that page with
5 beds. Which page is that? Page 8.

6 Q: At 8 it says, again at the time of this report
7 was filled out, 130 beds, is that right?

8 A: Yes. Again, and I'm not positive, but I
9 believe that's prior to beds shifting to CMC-
10 Pineville.

11 Q: Okay. So this may have been prior to the shift
12 to Pineville, right?

13 A: It may have been. I'm not positive, but it may
14 have been.

15 Q: I gotcha. Now, at this point in time though,
16 when this application was filled out, it was
17 130 beds, an average daily census of 57.94.
18 Can you calculate what that occupancy rate was
19 at that point in time, please?

20 A: It would be 45 percent.

21 Q: Okay. Let's go to Exhibit, Piedmont Exhibit
22 36B, please. Again, this is the 2012 renewal
23 application, license renewal application for
24 Mercy/Pineville. And, Ms. Carter, I think
25 there's been some testimony to this before, but

1 for some purposes, Mercy and Pineville compile
2 and submit their information jointly, is that
3 right?

4 A: They -- as you can see here, they share the
5 same license, but actually this report separates
6 their utilization.

7 Q: It does.

8 A: To get them separate.

9 Q: It does. So even though it's one report, I
10 think you can look at separate, information
11 separated as you just said, right?

12 A: Yes.

13 Q: Okay. Let's look at, go over to page 9 on this
14 one. And what's the average daily census
15 listed there? 102.75, is that right?

16 A: And this is for I think the top said CMC-Mercy.

17 Q: Yeah, good point. CMC-Mercy, right?

18 A: Yes.

19 Q: Okay. So for Mercy in this application, it was
20 average daily census of 102.75. And how many
21 beds at this point in time did Mercy have?
22 179?

23 A: Yes.

24 Q: And what's that occupancy rate?

25 A: Fifty-seven percent.

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1 Q: Fifty-seven percent, okay. And if we'll go
2 over to page 10, I believe we'll see this same
3 kind of information broken out for CMC-
4 Pineville, correct?

5 A: Yes.

6 Q: And again, Pineville 90.94 average daily census,
7 is that right?

8 A: Yes.

9 Q: And at this point in time, 126 beds, so the
10 occupancy rate would be what?

11 A: Seventy-two percent.

12 Q: Seventy-two percent, okay. And okay, all right.
13 Now, CMC-Fort Mill projects a third year
14 occupancy rate of 68 percent, is that right?

15 A: I believe that's correct.

16 Q: Okay.

17 **MR. WESTBROOK:** Let's just, just to be sure, Dan
18 would you pull up ---

19 Q: I know it's 60 something percent, but I don't
20 want to misquote and it didn't sound like you
21 were positive about that so let's just check.
22 CHS 481, what's that third year occupancy rate,
23 does it say it on there?

24 A: 67.5 percent.

25 Q: 67.5 percent. So, all right. And now, I

1 believe you've said you haven't done an analysis
2 of when in the future CMC-Fort Mill may or may
3 not need to expand beyond 64 beds, have you?

4 A: I have not, and I think I may have been asked
5 if at some point in time if I knew what the
6 plans were, and I don't have any knowledge of
7 any plans ---

8 Q: Okay. You don't have. I'm sorry.

9 A: --- regard to an expansion.

10 Q: I didn't mean to cut you off. But you haven't
11 done that analysis and you're not aware of any
12 plans, right?

13 A: That's correct.

14 Q: Okay. Now, under the South Carolina State
15 Health Plan, there's a 65 percent target
16 occupancy rate that's been talked about. I
17 think you talked it and other witnesses have as
18 well. My understanding is that at a 65 percent
19 occupancy rate, that's the trigger for possible
20 expansion or possible bed need expansion by a
21 hospital in South Carolina, is that correct?

22 A: Well, the way the State Plan works is, and
23 specifically relative to a future CMC-Fort Mill
24 hospital is it will take its utilization, it
25 will be benchmarked against a 65 percent

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1 occupancy rate because that's the rate for a
2 64-bed facility, and if future utilization based
3 on population growth is expected -- is expected
4 to need more beds based on that occupancy
5 factor than a bed need would be shown in the
6 State Plan that someone could apply for.

7 Q: All right. And you were here for Mr. Sullivan's
8 testimony, right?

9 A: Yes.

10 Q: And do you remember Mr. Sullivan testifying that
11 at 68 percent or 67.5 percent rounded up to 68
12 percent, that would be an occupancy rate at
13 which a hospital would be -- would be ready to
14 start thinking about an expansion. Do you
15 recall him saying something to that nature?

16 A: He very well may have, yes.

17 Q: Would you agree with him on that?

18 A: I think as I mentioned to you in my deposition,
19 I think that it is -- it's certainly
20 conceivable that a hospital at that rate would
21 begin thinking about that, and as I said a --
22 at that level the State Health Plan is likely
23 to trigger a need for more beds. Depending on
24 how a hospital configures its beds, because not
25 every patient can go in every kind of bed, but

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1 depending on how they configure their bed, their
2 beds, some can operate at higher levels, as
3 again, contemplated by the State Health Plan
4 that hospitals can operate at higher levels than
5 those targeted occupancy rates and -- but yes,
6 they may be thinking about this. But I think
7 the second point that I would make relative to
8 this is that, in my opinion, the need for CMC,
9 a CMC-Fort Mill hospital to add beds in the
10 future is a very different scenario than the
11 need for Fort Mill Medical Center to build 100
12 beds because, as I've opined about already,
13 there's more to it than just whoever -- than
14 just a building being there with a certain
15 number of beds, and therefore, patients are
16 going to come. So it's based on the physicians
17 associated with that facility, the patients
18 associated with those physicians and the
19 patient's choice about which organization or
20 which system they want to be a patient of. And
21 so in the future if there's a need for CMC-Fort
22 Mill to add beds, that does not necessarily
23 equate to a Fort Mill Medical Center needing
24 those same or a similar number of beds.

25 Q: All right.

1 **THE COURT:** Mr. Westbrook, perhaps this is a good
2 time to take a -- we've been going at it for a
3 little while.

4 **MR. WESTBROOK:** That's great. Your Honor, I am
5 actually like three or four questions away from
6 being done with this topic if you would give me
7 about five more minutes, I think I'll be
8 through.

9 **THE COURT:** All right. Well, then when we reach
10 that point, if you could let us know and we
11 will take a quick break.

12 **MR. WESTBROOK:** I sure will.

13 **THE COURT:** Thank you, sir.

14 Q: Ms. Carter, what is -- the term "shell space"
15 or "shelled-in space" in a hospital, what does
16 that mean?

17 A: To me, generally that means that the outside
18 walls are already constructed, but there's
19 nothing other than outside walls.

20 Q: All right. So there's outside walls
21 constructed, but it's empty inside to be used
22 for something in the future, is that right?

23 A: Yeah, to be -- the build-out to be finished at
24 some point in the future.

25 Q: Okay. Good. Thank you. And there is no shell

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1 space in the CMC-Fort Mill design, is there?

2 A: To the best of my recollection and knowledge, I
3 don't believe so.

4 Q: Now, if you were to add additional beds at any
5 hospital, if you're adding additional beds at
6 any hospital, but including CMC-Fort Mill, that
7 would require new construction, would it not?

8 A: Generally it does unless you have some space.
9 I mean, some hospitals can add beds either by
10 converting observation bed space or other things
11 like that. But many times, it requires new
12 construction.

13 Q: Many times. And in particular if there is no
14 shell space, right?

15 A: Or if there -- if there's no shell space or if
16 there is no other space that can be converted,
17 it would require new construction.

18 Q: All right. And also, if you add beds in the
19 future, it's -- you would have to get a CON in
20 South Carolina, would you not, to add additional
21 beds?

22 A: Yes.

23 Q: And a CON can -- a CON process can be time
24 consuming, can't it?

25 A: It can take a while.

1 Q: It can take a while, can't it? It can be
2 expensive for the clients, can't it?

3 A: I assume so.

4 Q: Now, CMC-Fort Mill, for medical surgical beds --
5 -

6 A: And let me just add to that last point. Yes,
7 it can take a while as evidenced by this case,
8 but I would say that in my experience that this
9 is case is unusual, and I think it's fairly
10 unusual in South Carolina too.

11 Q: All right. Conceded. But in any event, in any
12 case, CON, CON cases, particularly contested CON
13 cases, even if this is an outlier case, can be
14 time consuming and are often time consuming and
15 expensive, wouldn't you agree?

16 A: And it certainly adds to the process, which is
17 part of the reason why the -- that along with
18 construction and everything else is part of the
19 reason why the occupancy factors are what they
20 are, is to allow -- allow for that time lapse
21 between when something might be needed and when
22 it can be developed.

23 Q: Ms. Carter, have you read -- you know who Bo
24 Sellers is?

25 A: Yes.

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1 Q: Mr. Sellers is a CHS employed architect, is
2 that correct?

3 A: That's correct.

4 Q: And have you read his deposition?

5 A: I may have. I don't recall specifically. I
6 may have.

7 Q: All right. Do you know, and if you don't know
8 this is fine, but do you know that or would you
9 agree rather that CMC-Fort Mill's design, except
10 for OB beds and ICU beds only has room for
11 another 18 to 20 med/surg beds that they can
12 add at that current design; is that your
13 understanding?

14 A: I don't know.

15 **MR. WESTBROOK:** Your Honor, I think this is a good
16 time to break.

17 **THE COURT:** All right. Let's take a 15-minute
18 recess..

19 **(Lunch break from 12:07 p.m. until 1:20 p.m.)**

20 **THE COURT:** Okay. We're back on the record. Mr.
21 Westbrook.

22 **MR. WESTBROOK:** Thank you, Your Honor.

23 Q: Ms. Carter, an important factor affecting the
24 level of Medicaid care the hospital provides is
25 the degree to which its employed physicians

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1 accept Medicaid patients; would you agree with
2 that?

3 A: I would say that that can be a factor. There
4 are certainly other factors that are -- well,
5 there are a couple of things that influence
6 that. First of all, it depends on -- by and
7 large in any market, typically a physician
8 practice payer mix is different from a hospital
9 payer mix. If you think about it just in terms
10 of a physician practice is going to see
11 patients when they are well, and so they have
12 more visits associated with patients who are
13 well, which frequently are, you know,
14 commercially insured patients. On the Medicaid
15 side it might be, you know, some well children
16 visits, but then hospitals see people at least
17 on the inpatient side only generally when they
18 are sick. And so it doesn't have a payer mix
19 typically for the more well patients, and so
20 that affects the payer mix. In addition to
21 that, admissions to a hospital may not be, may
22 not come exclusively from physicians who are
23 employed by the hospital, and so the payer mix
24 of whoever the physicians are that admit to the
25 hospital, again, well, physician practice and

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RECORD 001947

1 hospital payer mix are not parallel. You would
2 have those patients as well, as well as
3 patients who may not even have a physician in
4 the community and may come directly to the
5 emergency room.

6 Q: All right. And thank you for that answer, but
7 going back to my question. I think my question
8 was, isn't it true that an important factor,
9 one important factor in determining the level of
10 Medicaid care the hospital provides would be the
11 receptivity of the degree to which its employed
12 physicians accept Medicaid patients?

13 A: I recall that you said a very important factor.
14 I would say it is a factor among others that
15 influences ultimately what a hospital's payer
16 mix is going to be.

17 Q: Is it an important factor?

18 A: It's a -- I mean it's a factor. It depends on
19 -- again, for a given hospital it's going to
20 depend on, number one, how many employee
21 physicians they have, the mix of patients that
22 they get from employed versus non-employed
23 physicians as to its degree of influences on
24 that number.

25 Q: What about with CHS Hospitals, or CHS -- for

- 1 example, CHS or CMC-Pineville or CMC-Main where
2 there are a lot of employed physicians?
3 Wouldn't you think that would be an important
4 factor with CHS hospitals? Don't you think it
5 would be an important factor with CMC-Fort Mill?
- 6 A: Okay. Are you asking me about all three
7 hospitals, or?
- 8 Q: Well, let's take it -- let's start with CMC-
9 Fort Mill.
- 10 A: Again, it is, it will -- it's going to depend
11 on those factors that I mentioned as to whether
12 or not -- which factor ends up influencing one
13 way or another. It depends on how many
14 employed physicians practice there versus how
15 many non-employed physicians admit their
16 patients there.
- 17 Q: All right. Is it an important factor with
18 respect to why CHS facilities in Charlotte
19 providing more medicaid than Presbyterian
20 facilities in Charlotte?
- 21 A: Again, I don't know. There are several very
22 large independent physician groups in Charlotte
23 who also admit patients to CHS Hospitals in
24 Charlotte. I don't know to what degree the
25 amount of Medicaid that CHS facilities serve in

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1 Charlotte, which is significant on a statewide
2 comparative basis. I don't know to what degree
3 that is influenced by their employed physicians
4 versus the independent physicians who admit
5 there.

6 Q: All right. Let me ask you to look, or ask Dan
7 to pull up your trial testimony from 2009, and
8 I'll hand you the page again I'm going to ask
9 you to read from, please. This is page 1867
10 from the 2009 trial testimony, Ms. Carter. I'm
11 going to get set up with 1867, and we're going
12 to go into 1868 as well. I want to ask you to
13 start, let's look at my question starts around
14 line 18, and I'll just read it. I'm going to
15 read the question if you will read your answer
16 please. Question: "Your experience in Charlotte
17 or your understanding of Carolina's experience
18 in Charlotte is that they provide, Carolinas
19 provides a great deal more Medicaid than
20 Presbyterian in that area, isn't that correct?"
21 Answer?

22 A: "Of the analyses that I've seen, yes, that's my
23 understanding."

24 Q: Question: "And the reason for that would be
25 related," and we'll go over to the next page,

1 "to employee physicians and their receptivity to
2 Medicaid patients; is that one of the reasons?"

3 Answer?

4 A: "That is certainly part of it. In my
5 experience even beyond Charlotte is whether or
6 not physicians are going to accept Medicaid."

7 Q: Okay. Thank you. And so, as you say, it's a
8 factor and as you say, that's certainly part of
9 it in your trial testimony but that's the
10 factor that you testified about in that trial.
11 You said, "In my experience even beyond
12 Charlotte is whether or not physicians are going
13 to accept Medicaid." That sounds a little more
14 definite ---

15 A: Well ---

16 Q: --- what you testified a moment ago.

17 A: --- I would disagree with that.

18 Q: Okay. You would disagree with my
19 characterization of what you said?

20 A: Yes.

21 Q: Okay.

22 A: Because you, in the prior trial testimony you
23 specifically asked the question if the reason
24 for that would be related to employed
25 physicians, and I said, as I've said here,

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RECORD 001951

1 that's part of it, and then my answer went on
2 to say it's whether or not physicians are going
3 to accept Medicaid. And again, it is -- it's
4 not just whether or not employed physicians or
5 non-employed physicians are going to accept
6 Medicaid. Physicians, as I believe one of the
7 Piedmont physicians testified in this hearing
8 that they had had to limit their Medicaid, it's
9 difficult for physicians to -- well, let me put
10 it this way, many of them manage the amount of
11 Medicaid that they accept in their practices.
12 And so that's why I say it is a factor of any
13 physician, whether employed or not, whether or
14 not they accept Medicaid. And also as this
15 goes on to indicate, part of the reason some of
16 the free clinics that CHS provides in Charlotte,
17 which is where many of the Medicaid patients
18 receive their physician-related services, and
19 Medicaid patients accessing care sometimes it is
20 primary care that they're accessing in the
21 emergency department rather than in a
22 physician's office.

23 Q: By the way, are you aware of any free clinics
24 that CHS runs in northern York County?

25 A: I don't know one way or the other.

1 Q: So the answer is you're not aware of any, is
2 that correct?

3 A: I don't know whether they do or I don't know
4 whether they don't.

5 Q: So you are not aware of them, right?

6 A: If they exist, I'm not aware of them.

7 Q: Now, under the Affordable Care Act even in
8 states that choose not to expand Medicaid, the
9 state insurance exchanges should at least
10 theoretically lower the number of uninsured
11 patients; is that your understanding?

12 A: I believe as I testified in my deposition in
13 this case, theoretically it should. A lot will
14 depend on where the uninsured in any given
15 state are in terms of on the poverty scale how
16 that relates to the state health insurance
17 exchanges and subsidies and whether or not they
18 can afford the state -- whether or not they can
19 -- excuse me, afford insurance through the state
20 health exchange.

21 Q: Back in 2005, in the 2005 application CHS
22 projected, was it 3.5 percent charity care? It
23 was three point something, right?

24 A: It was three point something. I can't recall
25 the exact number.

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1 Q: And Presbyterian projected three point
2 something, right?

3 A: I believe that was correct.

4 Q: And Piedmont projected 3.0, I believe, is that
5 right?

6 A: I believe that's correct.

7 Q: Now, Mr. Murphy was in charge of CHS's
8 application back in 2005 and he's in charge in
9 the updated applications of 2010, right?

10 A: That's my understanding.

11 Q: And at one point in time on the updated
12 applications, you and your firm were charged
13 with the primary responsibilities for preparing
14 the updated application, isn't that correct?

15 A: As I testified in my deposition, there were --
16 there was a period of time where things went
17 back and forth in terms of whether or not our
18 firm was going to prepare the updated
19 information and what parts of it versus at what
20 point in time the CHS management company was
21 going to do that.

22 Q: And that point in time when it looked like you
23 and your firm were going to be preparing the
24 updated application, or parts of the updated
25 application, was back when the submission date

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1 from DHEC was in February of 2010. It was
2 later extended, right?

3 A: That's -- I believe that's correct.

4 Q: And then when that deadline was changed, that's
5 when the decision to submit what you were
6 working on was also changed, is that right?

7 A: That was one of the decisions. In other words,
8 it became more of a fluid process after
9 February in terms of what we worked on versus
10 what CHS management company worked on versus
11 what CHS management company worked on and what
12 was -- maybe the easiest way to say it is, to
13 the best of my knowledge, the bulk of what was
14 submitted to DHEC originated with the CHS
15 management company. There were a couple of
16 analyses that we did that they folded in, and I
17 believe that there were some utilization
18 projections that we discussed between the two
19 organizations as they were finalized.

20 Q: But after February of 2010, the CHS management
21 company, that's Mr. Murphy's division, right?

22 A: Yes.

23 Q: The CHS management company under Mr. Murphy made
24 a decision to submit different information than
25 some of the information you were working on,

1 isn't that right?

2 A: No.

3 Q: Let's look at your deposition page 35, please.
4 And this would be -- yeah, so this would be the
5 earliest of your depositions. Ms. Carter, I'm
6 going to ask you to look at page 35. This is
7 line 16, and this is part of a long answer
8 you're giving to a question of mine. You're
9 certainly welcome to read anything you want to
10 for context, but I want to read line 16 through
11 18. If you can just read that sentence out
12 loud, please.

13 A: "And then that did not, the decision to submit
14 that change and there was a decision to submit
15 different information."

16 Q: And the decision to submit different information
17 was a decision made by CHS management company,
18 Mr. Murphy; wouldn't that be correct?

19 A: It was, but what I would say is that my prior
20 answer on that page talks about updating the
21 models so that they could feed into the
22 utilization model specifically. I guess I want
23 to make sure this is characterized correctly, is
24 it is not as though we were preparing
25 information that the CHS management company

1 completely disregarded and substituted
2 completely different information.

3 Q: Uh-huh (affirmative response).

4 A: My -- the characterization is that we were
5 preparing information including updating models
6 that would potentially feed into a utilization
7 model, and once it was determined that that
8 wasn't going to be filed in February, the
9 actual documents themselves were different in
10 terms of what CHS submitted to DHEC. It
11 doesn't necessarily mean that the base
12 information was different.

13 Q: Okay. Well, I understand that and I'm not
14 suggesting that what you did was disregarded,
15 but it doesn't say on that sentence, it doesn't
16 say "documents"; it says different information,
17 doesn't it; isn't that what it says? Isn't
18 that what you said?

19 A: Those are the words I said, and what I'm trying
20 to explain is in the context -- if you read the
21 context of my entire answer ...

22 Q: Well, let's do that. Let's do that. Let's
23 start, I think at the bottom of page 34 is
24 where this line of questions start. I have a
25 question that starts on line 25 at page 34, and

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1 I'll read the questions and you've got a long
2 answer and you can read the entire answer into
3 the record. Line 25 my question is, "Okay. In
4 your role you said very, but the role that you
5 and your firm had, tell me how that varied over
6 time. And again just from, you know, the
7 updated start after the trial, in other words."
8 Answer?

9 A: "Right. As I believe Ms. Platt mentioned
10 yesterday, there was a little bit of uncertainty
11 as to what the timing was going to be on
12 updated information. And so at one point in
13 time earlier on when we thought the submissions
14 were going to be in February, we were charged
15 with updating models so that they could feed
16 into utilization model. And then, of course,
17 that stopped because we learned that we weren't
18 filing updated information in February, and I
19 may not be remembering the timing correctly, but
20 at one point in time, we were charged with the
21 primary responsibility for preparing an updated
22 application in the application format, and we
23 did work on that. And then that did not -- the
24 decision to submit that change and there was a
25 decision to submit different information. And

1 then I would say that maybe to characterize it
2 as our role relative to what was submitted to
3 DHEC in both October and December was providing
4 some supporting information and then in
5 reviewing some of the documents. We did not
6 review everything before it was submitted, but
7 reviewed some of the documents."

8 Q: Okay. Thank you. So your role after February
9 changed to a role of being over reviewing some
10 documents and providing some feedback?

11 A: Yes and no. Ultimately, that was our role with
12 what was submitted to DHEC. As I explained
13 here, there was some -- there was going, and it
14 may not be in this place of my deposition, but
15 somewhere in my deposition there was between --
16 my recollection between the February filing and
17 at some point later on in the year, it
18 fluctuated back and forth depending on when we
19 thought the submission date was and my
20 interpretation of what the capacity was at the
21 management company as to what we were charged
22 with doing versus what the management company
23 was charged with doing. But ultimately, what
24 was submitted to the management company, there
25 were parts of it that we reviewed, there were

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1 pieces of it that we had direct input on. I
2 think that's the best way to characterize what
3 occurred.

4 Q: All right. And the materials actually submitted
5 in October 2010 and December of 2010, that
6 would have been primarily from Mr. Murphy's
7 group, is that right?

8 A: Yes, they compiled that information.

9 Q: And in October 2010, Presbyterian submitted a
10 new charity care projection of about six percent
11 or maybe it was six something percent of
12 charity care, is that right?

13 A: I don't recall that one way or the other.

14 Q: All right. And CHS did not submit a revised
15 charity care projection until December of 2010,
16 do you recall that?

17 A: I recall, as I believe Mr. Murphy testified and
18 I understood at the time, that in fact, we had
19 discussions about what was appropriate to submit
20 in October given the wording of Judge Matthews'
21 Order, and Mr. Murphy made the decision to
22 follow how he read the Order, and it made sense
23 to me, to rely on the application that had been
24 submitted in 2005. And then DHEC came back and
25 said we do want updated information, and that