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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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

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

v.

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

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

RECORD ON APPEAL - VOLUME III OF XVII

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

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

A: Yes.

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

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

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

A: I did.

Q: And what was the import of that meeting?

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

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

A: Yes.
Q: And who did you meet with?
A: Mr. Grice.
Q: And what did you and Mr. Levitt inform Mr. Grice of at that meeting?
A: That we were interested in utilizing the 64 beds of expansion for healthcare in York County and that it was our intent to build a hospital in the Fort Mill area with those beds.
Q: Okay. Now, did you have any understanding at the time that the beds could be awarded to other parties beyond Piedmont?
A: I did not.
Q: If you had understood that, would it have affected the plans concerning the establishment of Fort Mill Medical Center?
A: Absolutely.
Q: How would that have?
A: We would have added those beds to Piedmont Medical Center in Rock Hill.
Q: And why would you have done that?
A: Because it would have avoided placing them at risk for a competing application. It's common practice in South Carolina -- it had been up until there that under the Health Plan that if

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

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

A: I was.

Q: And why did you decide to do that?

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

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

Q: Now, where there -- sorry?

A: Do it now versus later.

Q: I'm sorry?

A: Do it now versus later.

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

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

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

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

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

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

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

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

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

THE COURT: Please.

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

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

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

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

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

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

A: I have.

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

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

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

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

THE COURT: Thank you.

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

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

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

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

THE COURT: Thank you.

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

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

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

A: I do not.

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

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

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

Q: And what is Carolinas Physician Network?

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

Q: A network of physicians?

A: Network of physicians, yes.

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

A: That's correct.

Q: Does this document reflect that?

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

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

A: 2005.

Q: You filed one in 2004, didn't you?
A: 2004. I'm sorry.
Q: Do you remember when?
A: I do not. I'm sorry. I believe October.
Q: Late year?
A: Late year.
Q: And you revised it, do you remember when?
A: Early 2005.
Q: January 2005? The record can stand for itself, but, okay. And what activity here concerning the development of acquisition of practices is reflected on this document?
A: Well, you see then in March and April of 2005, the acquisition of Rock Hill Pediatrics and the acquisition of the two local Sanger Clinic operations, the one that was operating in Fort Mill at the time and then Rock Hill.
Q: And did Medical Associates of Rock Hill have -- previously have an office in Fort Mill?
A: No. They opened a satellite facility in 2006 and while not reflected on this document, Shiland Medicine also subsequently opened an operation in Fort Mill as well.
Q: All right. And let's take a look at what Mr. Levitt testified yesterday, Demonstrative 141,

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

A: I have.

Q: And what do you understand it to be?

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

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

A: Correct.

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

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

community who practiced at Piedmont Medical Center.

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

A: Yes.

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

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

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

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

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

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

their patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

A: That's correct.

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

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

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

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

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

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

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

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

Q: Okay. And what does it convey?

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

new hospital facility in Fort Mill, South Carolina.

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

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

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

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

Q: And who was he employed by?

A: Carolinas Health System, CPN.

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

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

privileges after the purchase by CHS at some point.

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

A: They're consistently the same.

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

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

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

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

Q: And how many physicians do they have?

A: They have seven in that practice.

Q: And how many of them resigned their privileges?

A: All of them.

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

A: I'm aware of only two.
Q: Okay. Now, let me take you back to Demonstrative 141 that you testified about a moment ago. And let's flip to the second page of that Demonstrative, Dan. Now, during the period of time after the changes in practices that you just discussed, did you observe any change in referrals and the referral patterns among physicians affiliated with Carolinas?
A: Yes. I mean we had been observing some degradation of referral patterns prior to that but it became really significant as we moved into 2010, particularly 2011 and '12, as noted here.
Q: All right. And have you evaluated the effect of those changes on different product lines at Piedmont?
A: We have.
Q: Dan, let's begin by looking at Demonstrative 173. And what does this Demonstrative show, Mr. Miller?
A: Basically it shows the market share of Piedmont Medical Center compared to Carolinas Medical Center in years 2005 to 2009 and 2011.
Q: And generally, how is it consistent with the

observations you were making at the time?

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

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

A: We did.

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

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

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

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

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

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

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

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

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

to 2005.

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

A: Yes.

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

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

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

A: Well, basically, they're not getting their 40 hours a week in so their personal paychecks are cut.
Q: Why didn't you just keep them on full salary?
A: Because I can't afford to.
Q: Why?
A: Loss of volume.
Q: How does that relate to what you pay them?
A: Basically, if there's no work, we don't need them to be there putting in hours, and if they don't get hours, they don't get paid.
Q: Now, has there been any massive layoff in the hospital or the cardiac unit or other units to make adjustments for the downturn in the loss of services such as in this unit?
A: We work hard at trying to avoid your choice of term, massive layoff. A lot of this is done through what's commonly referred to as flexing staff, come in the morning, we assess the schedule, we assess how many admissions we've got, how many procedures we have lined up. Typically, by eight or nine o'clock in the morning we're sending, you know, excess staff home.
Q: Why eight or nine in the morning?

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

Q: Why is that?

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

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

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

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

Q: And how has that affected your orthopaedic services?

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

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

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

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

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

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

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

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

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

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

A: They'll migrate out as well.

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

A: They'd have to go into Charlotte.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A: We have two in order to facilitate coverage.

Q: Okay. And those are physicians?

A: Physicians.

Q: Who employs them?

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

Q: And are they full time contract positions?

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

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

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

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

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

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

Q: Under the contract?

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

obligations.

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

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

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

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

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

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

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

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

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

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

A: I can try.

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

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

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

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

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

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

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

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

hospital?
A: It is on the side where Presbyterian was going to build.
Q: You were shown a slide showing trend, inpatient volume trends. Was that trend you entire patient volume or was it just York County?
A: It's my understanding it is the entire patient population.
Q: Dan, could you pull up DHEC's 137? And this is the slide I was referring to. Do you understand that to be your entire patient population or just York County?
A: I'm sorry, it's labeled York County inpatient population, so I'm assuming it's York County patient population.
Q: If you could go to Demonstrative 211. All right. And these were the things we talked about earlier. These are your obligations under the York County contract. Reasonable pricing, ambulance service, capital reinvestment, annual reports, right?
A: Correct. Those are the key elements. There are others.
Q: Now, you mentioned that there were various services that you would have to consider

cutting depending on volume, correct?

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

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

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

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

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

A: Part of it, yes.
Q: Your 64-bed application indicated that you had 2200 admissions from patients in the Fort Mill, Tega Cay area, those now three zip codes, back then they were two and from the Clover zip code, 29710. And you're proposing to build a 64-bed hospital. If you had that level of admissions, meaning you had less than 2200 from the Fort Mill, Tega Cay area, why would you propose to build a 100-bed hospital up there that proposes to serve 5500 patients in year three?
A: Because we believe that would be the demand on the facility by year three.
Q: All right. Was another concept that it was a defensive strategy?
A: No, we believe that we will be serving 5500 patients by year three. Those was our basic projection.
Q: Did you testify in the previous case that it was a defensive strategy to protect your market share?
A: The whole concept of being in Fort Mill starting with Baxter Urgent Care, the imaging center, putting primary care physicians in that

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

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

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

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

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

Q: And is protecting market share one of the

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

A: I have no knowledge of that.

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

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

MS. BIGGERS: No questions from the Department.

THE COURT: All right.

(Off the Record)

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

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

A: Correct.

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

A: 525,000 square feet.
Q: About twice the size of the hospital currently?
A: Correct.
Q: And how has the hospital expanded in the past 30 years from 215,000 to over 500,000 square feet?
A: The Women's Tower represents about 95,000 square feet and I'm not sure what the heart center addition that was done in 1996 represents but it's considerably smaller than the Women's Tower.
Q: And the balance is?
A: Would have been the original core building.
Q: Okay. Now, with regard to the examination of Mr. Muller concerning the option that York County exercised, do you know why county officials chose to elect to contract with Tenet in the sixth addendum rather than accept the offer of Carolinas to buy York County Hospital?
A: Yes. My understanding from the material I had available to me and all of that, they appreciated the long-standing relationship that our organization had with the county, our responsiveness to the needs of the people that we were serving and our willingness to continue

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

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

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

Q: And why didn't they accept it?

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

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

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

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

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

MR. ANDREWS: That's right.

MR. MULLER: Thank you.

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

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

Q: Okay. Now, as you were essentially reducing

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

A: Correct.

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

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

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

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

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

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

A: I do.

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

A: Correct.

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

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

Q: And what was the result of your proposal?

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

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

A: Yes.
Q: And what's reflected there in that Demonstrative?
MR. MULLER: Your Honor, I am going to object to this one because I don't believe this Demonstrative matches up to what I was just looking at in the source. Could I possibly show the Court that?
THE COURT: Yes.
MR. ANDREWS: Would you show it to me too?
MR. MULLER: Yes.
MR. ANDREWS: All right. I'm being informed by Mr. Levitt this updates what's in the report. We'll be happy to turn to the report. This is more current information. I wasn't aware of that, Your Honor. Is that all right, Mr. Muller?
MR. MULLER: I'm sorry?
MR. ANDREWS: Is that all right with you?
MR. MULLER: Yes.
Q: All right. Thanks. We can just do that. Dan, if you could pull up the end of July 2011 report, page 24, figure 10. Thank you. Okay. Now, what is this information before you, Mr. Miller?

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

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

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

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

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

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

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

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

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

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

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

A: Yes.

Q: Understanding that more complex cases are using

more resources, more money and more time.

A: Correct.

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

A: Correct.

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

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

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

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

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

THE COURT: Thank you.

MR. MULLER: Nothing further from me.

THE COURT: All right. Anything from the Department?

MS. BIGGERS: No, Your Honor.

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

MR. ANDREWS: We are, Your Honor.

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

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

THE COURT: Ten minutes.

(Off the Record)

THE COURT: Mr. Andrews.

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

THE COURT: Mr. Grice.

JOEL GRICE, having been duly sworn, testified as follows:

MR. GRICE - DIRECT EXAMINATION BY MR. ANDREWS:

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

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

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

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

Q: Have you retired from the state?

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

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

A: I was director of the Bureau of Health Facilities and Services Development.
Q: And how long were you with DHEC before you retired?
A: I joined DHEC in 1975 and became involved with the Certificate of Need Program in 1978. I was total 32 years, but 29 in the Certificate of Need Program.
Q: All right. And what was your title in your last position there, Mr. Grice?
A: It was bureau director of the Bureau of Health Facilities and Service Development. And we had four things under us that I supervised, Certificate of Need, the State Health Plan Development, the Medicaid Permit Program and the Certificate of Public Advantage Program.
Q: Okay. Let's turn to your resume, which is has been pre-admitted as Exhibit 70. And before one of your four areas of responsibility was supervision of the CON program, is that correct?
A: Yes, sir.
Q: And how long were you in that position?
A: Since December 2000, as the bureau director. But I did supervise the CON program as director

since 1984.

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

A: Yes, sir.

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

A: A total of 16 years.

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

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

Q: And what's your educational background?

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

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

A: Yes, sir. I would say approximately 2,000.
Q: Okay. And would you describe, just in very general terms, the kinds of facilities and services that were subject to your review?
A: Well, of course, development of new health care facilities, and replacement facilities like hospitals, nursing homes, ambulatory surgery centers, home health agencies as well as the purchase of sophisticated medical equipment, like MRIs, CT scanners and radiation therapy equipment, et cetera.
Q: Okay. For those that you mentioned, the CON applications for new hospitals. Can you estimate how many new hospital CON applications you had the occasion to review?
A: I think it's for around, roughly ten or 11. I can't remember. It might be less than that, seven or eight, but these were replacements we're talking about, I believe.
Q: All right. What different kind of new hospital applications have you reviewed?
A: Well, I've reviewed just everything from a brand new hospital that is being established, replacement hospitals in South Carolina, as well as satellite facilities that were

developed from existing hospitals in South Carolina.

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

A: I think it was around 14.

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

A: Yes, sir.

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

A: I have. Yes, sir.

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

A: Yes, sir. I was.

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

A: No, sir.

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

A: During the summer of 2012.

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

retention prior to the summer of 2012?

A: No, sir. Not at all.

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

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

Q: The hearing was in '09?

A: Yes, sir.

Q: And that subsequent remand was in 2011?

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

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

THE COURT: Objections?

MR. MULLER: Without objection, Your Honor.

MS. BIGGERS: No objection.

THE COURT: No objection. All right. Then there being no objection Mr. Grice is hereby recognized by the

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

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

A: Yes, sir.

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

A: That is correct.

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

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

Q: All right. Have you developed a Demonstrative

that provides a list of some of those you reviewed?

A: Yes, sir.

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

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

Q: Now, repeat which Piedmont replacement hospital was?

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

Q: Okay.

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

Q: Could it be West Ashley?
A: West Ashley, I'm sorry. Yes, sir. And then Coastal Carolina Hospital was a replacement of the old Jasper County Hospital in Jasper County. The Allen Bennett Hospital was owned by the Greenville Hospital System and it's been replaced in Greer, South Carolina. It's now known as Greer Memorial. East Cooper Hospital in Mt. Pleasant was replaced within the last five years to a new site in Mt. Pleasant. And Carolina Pines in Hartsville was a replacement of an old facility located in that town.
Q: Now, Mr. Grice you were involved in the review of all of these applications?
A: Yes, sir. I was.
Q: Now, when you reviewed these applications, what was the Department looking for?
A: Well, basically, need. To be sure there's a need for a continued services and certainly there was. And all the important criteria on the Certificate of Need that there would be, you know, a cost effective application and financially feasible and growth and population in those areas.
Q: Okay. Now, did you ever deny one of these

applications?
A: No, sir, never.
Q: All right. Now, let's move to satellite hospitals. How many satellite hospitals, again, did you say you believe you've reviewed?
A: My memory, I think it was around 14. I did a list.
Q: Have you developed a list of it?
A: Yes, sir.
Q: All right. Let's take a look at Demonstrative 109. And what is this a list of, Mr. Grice?
A: This is a list of the first satellites that we did approve, that I was involved in with reviews of the CON applications in South Carolina.
Q: Okay. Define for the Court what you would mean by a satellite hospital? What is that?
A: Okay. A satellite hospital is one where we have the, I guess we would say, the parent hospital that is there with a bed need, or beds that are probably not properly utilized. In a county where there's some rapidly growing populations in suburban areas. And they realize that they are going to apply for the beds that are shown as needed in the Health

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

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

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

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

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

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

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

in South Carolina.
Q: What period of time would they generally have been developed?
A: It would have been, these are before the year 2000.
Q: And describe what you have on the list?
A: Well, we've got St. Francis Eastside in Greenville. And that was developed by the St. Francis Hospital in Greenville, South Carolina. Now, Trident-Summerville, that hospital was a satellite in Dorchester County.
Q: Of what hospital?
A: I'm sorry. Trident-Summerville. It's actually called Summerville Medical Center.
Q: Okay.
A: And just to prevent some confusion here, Trident Medical Center was developed in the North Charleston area in 1975. And they basically served Berkeley and Dorchester County, northern Charleston. But as the growth took place, there was a need for a hospital in Dorchester County. And Trident built the satellite, called Summerville Medical Center.
Q: And Providence Northeast?
A: That was a satellite of Providence Hospital in

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

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

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

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

A: No, sir. Not at all.

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

A: Yes, sir.

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

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

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

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

under construction, just approved.

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

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

Q: How many beds?

A: It's 72 beds. And that same year 2002, the Greenville -Patewood facility in the Greenville area that's also 72 beds. That was a satellite from beds from the Greenville Hospital System, Greenville Memorial. And then in 2005, out of Loris, the Loris Community Hospital developed a satellite called Seacoast Medical Center and it's 50 beds. And also that same year, we had the Greer Memorial Hospital that was also developed by Greenville Hospital System. There was also a replacement of beds, including the Allen Bennett Hospital. And we have also the Pelham facility in Spartanburg, that was a satellite of Spartanburg Regional Medical Center. And the Roper-Mt. Pleasant is located on Mr. Pleasant that is a satellite of Roper Hospital in downtown Charleston.

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

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

Q: Part of the Palmetto System here in Columbia?

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

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

Memorial System.

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

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

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

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

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

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

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

Q: The total?

A: I believe that are affiliated with Roper,

three.

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

A: Yes.

Q: It would be four?

A: Four, that's correct.

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

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

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

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

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

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

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

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

A: Yes, sir.

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

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

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

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

A: It's mainly satellites.

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

provide a range of complex services.
A: I only see one there, that's the Loris, Loris Community Hospital, which developed Sea Coast. Loris is a smaller primary care hospital in the town of Loris, South Carolina in Horry County. And it's not a tertiary facility.
Q: And all the others, how would you characterize them?
A: The other satellites, their parent hospitals all have tertiary services, open heart and other sophisticated services.
Q: And what relationship exists between the needs and demands of those facilities and their development of satellite hospitals within their system?
A: Well, these satellites are going to be able to track patients in the rapid growing areas and when those patients need referral for more complicated services, such as open heart surgery or a therapeutic cardiac catheterization, they can be referred to the parent hospital which has those services. And that helps maintain and substantiate the services of the parent hospital.
Q: Okay. Let me take you back to the period, Mr.

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

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

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

A: Yes, sir, absolutely.

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

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

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

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

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

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

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

A: No, sir.

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

A: Yes, sir.

Q: And how did you review that change?

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

Q: How is disruptive?

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

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

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

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

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

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

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

A: Yes, sir. Everyone of them.

Q: Were any of them competing?

A: No, sir.

Q: Why not?

A: I did not review the last two.

Q: Other than the last two?

A: No, sir. They were not competing.

Q: Were those last two competing?

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

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

A: Yes, sir. I did.

Q: Why did you do that?

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

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

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

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

A: Yes, sir.

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

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

Q: Why was that an important issue for them?

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

Q: All right. And the third bullet point?

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

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

A: I'm sorry. Demonstrate commitment to the

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

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

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

Q: That was your finding in the letter?

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

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

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

A: Yes, sir. That's correct.

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

A: Yes, sir. I certainly was.

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

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

Q: What did you deny?

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

Q: Who were they, do you remember?

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

Q: From where?

A: From York County, Rock Hill. And I felt it was going to had an adverse effect.
Q: On who?
A: On North Carolina hospitals.
Q: Uh-huh (affirmative response).
A: And that was one of my principle reasons for denying it.
Q: Okay. Now, were there any border cities in South Carolina during that same period that also filed open heart surgery applications?
A: Yes, sir.
Q: Who was that?
A: Aiken, South Carolina. And we had the same situation occur, Aiken Regional Medical Center applied for open heart and we had opposition from some hospitals in Augusta, Georgia that also had open heart. And I also denied Aiken for the same reason.
Q: All right. As a result of those two denials, were those cases appealed?
A: Yes, sir, they were.
Q: At the time before the establishment of the Administrative Law Court, there were hearing officers, is that correct?
A: That's correct.

Q: All right. Now, during the pendency of those reviews, was there any legislative action taken concerning DHEC's decision in these two cases?
A: Yes, sir. I think the Three M Committee met.
Q: The Three M Committee being what?
A: The, I think Military, Medical, and ---
Q: Municipal.
A: Municipal, right. And I was there at the meeting and they were ---
Q: You were invited to be present?
A: Yes, sir.
Q: Did you testify?
A: I did.
Q: And what was the nature of your testimony?
A: Basically, the reason that I denied those was the fact that I saw approval of the facility in South Carolina of open heart as having an adverse impact on the out-of-state facilities. And I was pretty well raked over the coals.
Q: In what regard?
A: Well, I was told, Mr. Grice, you must, when you make decisions on CON you look at South Carolina citizens. You approve South Carolina, that is your job to focus on South Carolina not out-of-state.

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

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

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

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

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

A: Yes, sir.
Q: Okay. And did you have a hand in the preparation of that?
A: I did. In my review of this first application, of these first applications for a satellite in York County, I had a lady in our office that did a lot of the work, but basically, we worked together and she.
Q: She would appreciate you referring to that.
A: But we worked even late at night. We were there until twelve o'clock, midnight. And I was right it out longhand; giving it to her to type and it worked well that way.
Q: Who are you referring to?
A: Ms. Mary Fechtel.
Q: Okay. All right. Now, Dan, let's turn to that CON summary, beginning at page 856 and that being, Joint Exhibit 1(B). All right. And what is this document, Mr. Grice?
A: Okay. That is the Certificate of Need summary sheet for the Fort Mill Medical Center. And I believe this is the application that was submitted in 2005.
Q: And is this the CON summary sheet that records the Department's analysis of the application?

A: Yes, sir. It is.
Q: Okay. Now, did you prepare in this analysis a section concerning potential adverse impacts?
A: Yes, sir.
Q: All right. Let's turn to, Dan, page 898 in the report. And let's go down and pick up, if you would, Mr. Grice. And Dan, if you would draw out and highlight the last paragraph on that page? And Mr. Grice read that into the record, please, those highlighted sections and those paragraphs?
A: All right. In contrast should either of the competing three applicants be chosen to construct a new facility, their patient base would be siphoned from the existing utilization of Piedmont Medical Center which must continue to operate under the contract of York County to provide the following services in addition to hospital services whether approved or denied for a satellite facility. If patient utilization should drop drastically at the current facility due to competition from another provider income may be affected and the foregoing services may be compromised.
Q: All right. Now, what were you referring to

here, Mr. Grice?

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

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

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

Q: Why was that?

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

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

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

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

mass of patients reached/served.

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

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

Q: Complex tertiary services.

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

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

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

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

Q: Why did you believe that to be true?

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

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

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

outlines that?
A: Yes, sir. I have.
Q: All right. Dan, let's pull up DHEC's 131. And does this reflect your opinion, Mr. Grice?
A: Yes, sir.
Q: And review it, if you would for the Court?
A: Well, I think the most DHEC decision failed to recognize the connection between the existing Piedmont Medical Center and the Fort Mill Medical Center and the quality of healthcare services in York County. Because I think it's very important that, you know, that Fort Mill Medical Center is going to help the entire system there. It's actual going to maintain the utilization of high quality services and the tertiary services at Piedmont and the quality of healthcare in that county. The second, they failed to recognize the adverse impact of a Charlotte area-based hospital system in Fort Mill. And third, it failed to apply the project review criteria consistently with the Department's historical practice.
Q: Okay. Now, are you prepared to offer opinions related to each of those issues?
A: Yes, sir.

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

THE COURT: Mr. Muller?

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: Of his deposition?

MR. ANDREWS: Yes. It is his deposition.

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

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

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

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

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

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

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

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

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

A: Yes, sir.

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

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

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

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

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

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

A: Yes, sir. I have.

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

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

Q: All right. And what's your opinion of the finding that Ms. Brandt made here?
A: I don't agree with that finding at all.
Q: Why?
A: Well, they say the Department's concerned with the declining utilization of Piedmont Medical Center. Well, there's a reason for that declining utilization, of course, because of the fact that so many patients are being redirected out of state. They say, the heavy dependance of recapturing significant market share, significant lost market share, which would require significant level of reversal of market trend. Well, that, of course, could be repaired, you know, with the development of the Fort Mill Medical Center. And also we're looking at the impact of redirecting existing patients away from Piedmont Medical Center. I don't see that as happening. The Fort Mill Medical Center is not going to redirect patients away Piedmont Medical Center. Ultimately, it's going to really benefit Piedmont Medical Center in redirecting patients to that facilities as well as capturing a lot of the out-migration. The substantial cost of

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

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

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

Q: Do you agree with that statement?

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

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

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

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

Q: Why is that?

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

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

A: Yes, sir.

Q: Okay.
A: And she listed the specific ones and I don't agree with that either.
Q: All right. We'll go into more detail on that in a moment. So let's move to your review of the CON criteria and did you review these for purposes of developing opinions related to those that Ms. Brandt reached in her review of the application?
A: Yes. Yes, I went through all of the criteria, yes.
Q: Okay. Have you developed a side-by-side comparison as a Demonstrative?
A: Yes, sir.
Q: All right. Dan, let's pull up Demonstrative 170, please. And, Mr. Grice, describe what's presented in this Demonstrative.
A: In this particular one, these are all of the applicable project review criteria.
Q: In the left-hand column?
A: Yes, sir. They were listed as being most important in the review of these applications.
Q: Okay.
A: And then, on the right-hand side, we've got the name of the criteria and a brief summary of

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

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

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

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

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

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

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

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

A: Yes, sir.

Q: And the entries where they're green, what do they reflect?
A: That reflects a disagreement.
Q: And what's the nature of the disagreement?
A: It would be that I saw either both met or ---
Q: No, just the green.
A: I'm sorry.
Q: Just the green.
A: I'm sorry. That's where both met.
Q: Where you found both met?
A: Yes, sir.
Q: And Ms. Brandt found what?
A: That Carolinas Hospital System met it best.
Q: Okay. And where you have a red PMC, what does that reflect?
A: That reflects where I saw that Piedmont Medical Center met it better than Ms. Brandt's determination of Carolinas Hospital System.
Q: Okay. All right. Now, with that, let's go through these and we'll focus just on the criteria in which there has been, based on your review you disagree with Ms. Brandt's finding, okay?
A: Yes, sir.
Q: All right. Let's pick up the first one then,

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

A: Yes, sir. That is.

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

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

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

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

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

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

A: No, sir. I have not.

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

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

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

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

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

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

A: Yes, sir.

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

A: As far as the?

Q: Transfer of beds to establish satellite hospitals?

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

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

A: That is whether the beds were from a transfer

or a need in the Health Plan or both.

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

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

Q: Okay.

A: Or need.

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

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

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

A: No, sir. Not at all.

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

A: Yes. And it was a low utilization.
Q: Okay. All right. Now, let me then ask you, you already stated your opinion concerning whether the transfer of the 36 beds would be justified. Which -- what's the number -- which applicant do you believe best meets the need related to the number of beds that would be most helpful to address the out-migration of the area, 64 or 100?
A: One hundred.
Q: All right. Now, do you agree then with regard to section 2(d), did Piedmont, in your opinion justify the relocation of the beds?
A: Yes.
Q: Okay. All right. Now, let's then, let me ask you to move to the next section. Section 2(e) of the regs, Dan, if you could pull that out. What's the provision relate to, Mr. Grice?
A: Okay. This has to do with the utilization, this is going to relate to a new facility. It says: Current and or projected utilization should be sufficient to justify the expansion or implementation of the proposed service. So, that's, that's looking at utilization, you know, projecting the need, et cetera. It's

going to justify the expansion.
Q: And do you believe that either or both parties proposed applications would be justified based on the demand for services in the Fort Mill area?
A: Yes.
Q: Which is it? Either or both?
A: Both.
Q: Okay. All right. Why is that?
A: Well, I mean there is, regardless of which applicant were to build a hospital there, you know, there is certainly a growing population. And so either facility would be financially feasible and, you know, with -- but certainly the Piedmont Medical Center in Fort Mill is better, you know, for the county. But the current projected utilization would be sufficient.
Q: Okay. So, Dan, let's go out to Demonstrative 117. And look at those last two provisions, 2(d) and 2(e) and what's your opinion concerning -- now with regard to those two provisions, how would you assess the application to the two parties?
A: I would find both applicants consistent with

those criteria.

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

A: All right.

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

A: Yes, sir.

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

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

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

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

A: No, sir.

Q: Why not?

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

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

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

A: It's outside of York County.

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

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

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

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

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

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

A: Yes, sir.

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

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

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

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

A: Okay.

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

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

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

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

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

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

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

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

A: I'm not sure.

Q: Let me help you with ---

A: Okay.

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

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

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

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

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

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

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

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

THE COURT: All right. You can answer.

MR. MULLER: No objection.

THE COURT: All right. Thank you.

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

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

years?
A: Yes, sir. I have.
Q: Have you developed a Demonstrative on this?
A: Yes, sir.
Q: Now, let's pull up Demonstrative 118. And what's presented here, Mr. Grice?
A: These are satellite hospitals that have been approved in recent years in South Carolina. And in the budgets that they presented, of course they have their percentage of gross revenue allocated to indigent care and we see how much that was, that was allocated and ---
Q: Would you be specific and read, state in the record what that is?
A: Yes. The indigent care percentage of gross revenue for year three at Carolinas Medical Center-Fort Mill was 6.4 percent.
Q: How does that compare to the other applications for new hospitals between 2005 and 2010?
A: It is the highest rate.
Q: By what margin?
A: By, well, let's say the next highest rate is like 4.3 percent, so it's even, let's see -- it's 50 percent higher, almost 50 percent higher than the next rate, but it's 100

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

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

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

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

applications?
A: No, sir. I don't. I think it's too high.
Q: All right. But your opinion is that they meet this criterion anyway, is that right? These two criteria?
A: Yes, I mean they gave indigent care. They gave an amount. I think it's high, but, you know, DHEC certainly has the ability to go in that hospital and monitor to see what it actually was.
Q: Okay. All right. Well, let's move on then to the next criterion. Dan, let's go back to DHEC's 117. And that list, you found that both applicants equally meet (f) and (g) and then you have (h).
A: Yes, sir.
Q: And what is (h) and what have you found?
A: Okay. Impact on provider's service and the medically underserved.
Q: And you found for Piedmont and we'll pull up that reg and you explain your position.
A: Okay. Potential negative impact of the proposed project upon the ability and or resources of existing providers and medically undeserved groups must be considered. Well,

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

Q: Do you believe it should apply?

A: Yes, sir. I think so.

Q: Why?

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

Q: Who would be the existing provider?

A: It would be Piedmont Medical Center.

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

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

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

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

THE COURT: Any objection?

MR. MULLER: No objection.

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

(Off the Record)

THE COURT: Mr. Andrews?

MR. ANDREWS: Thank you, Your Honor.

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

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

A: Yes, sir. That's correct.

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

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

referrals to the existing Piedmont Medical Center.

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

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

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

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

better meets it.
Q: All right. Now, let's move on to -- actually, Dan, let's move back to 117. And take a look at the next section. Take it all the way through there. All right. Now, this next section of regulations, Ms. Brandt has found that for charges that both parties equally met them, is that correct?
A: That's correct.
Q: And with regard to all the others that Carolinas best met them and you have that both applicants equally meet them except for the last one, is that correct?
A: That is true.
Q: All right. Now, in general terms, let's look at Demonstrative 119. Now, this is what we've just discussed and what you've summarized, Mr. Grice. Generally speaking with regard to these criteria that are summarized here, what's the function of these provisions in your experience?
A: You know, the function here is to make sure that applicants meet these criteria to be financially feasible where they could develop this project to have, you know, appropriate

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

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

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

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

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

within the range of what was approved, no, as far as going through and having someone audit, go through the finances, the budget, no, sir.

Q: All right. Now, there's a process for when a CON project is implemented that when it's complete that the applicant will report to the Department, is that right?

A: Yes, sir. That's the requirement.

Q: And what do they report back? What do they include in that report?

A: They include what all of their capital costs were for the development of the new project.

Q: Now, after the project is operational is there any report particularly after year two and three when these applications are reviewed that were an applicant reports its operational cost to the Department?

A: No, sir.

Q: Doesn't report its charges or expenses?

A: No, sir.

Q: Okay. Now, if even when they're reporting on capital costs of projects, when the applicant exceeds those cost, is the CON revoked?

A: No, sir. Generally, reducing costs overruns, a lot of times, we'll allow up to a ten percent

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

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

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

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

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

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

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

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

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

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

on the project for the long term.

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

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

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

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

Q: And what do the regulations provide to protect the Department from the kind of manipulation of the process?
A: Well, the regulations allow us to be able to make the best decision based on the criteria and review other files that we have in our department to make sure the information is realistic.
Q: And the files being prior approved applications?
A: Yes, sir.
Q: Okay. All right. Then when was Piedmont's application first submitted to establish a hospital in Fort Mill?
A: I believe it was around November 2004.
Q: And when was Carolinas' application submitted?
A: I think it was around March 2005.
Q: So, how much time did Carolinas have to get a copy of it, review it and consider Piedmont's application before submitting its own?
A: Four to five months.
Q: Okay. All right. Now, all right. Let's go back to the regulations related to the financial criteria. We've already said that Ms. Brandt found with regard to charges that

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

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

MR. ANDREWS: You've got it.

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

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

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

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

A: Oh, I'm sorry.

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

THE COURT: I have it. Mr. Muller?

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

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

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

MR. MULLER: Well, just in reading her decision letter, all applicants provided projections –

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

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

THE COURT: And I appreciate that.

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

addressing.

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

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

A: Okay.

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

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

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

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

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

Q: Okay. And have you done that?

A: Yes.

Q: And what's your opinion concerning that?

A: I think they both, yes.

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

A: Yes, sir. I have.

Q: And what did you find?

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

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

A: Okay.

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

section, Mr. Grice? Projected expenses.
A: Right.
Q: What is the Department directed to look to about determining the reasonableness of projections concerning expenses?
A: Here again, we're looking at the projections of all these costs. Construction costs, operating costs, debt service, et cetera, to be consistent with those experienced by similar facilities offering similar types, scope of services. So, there again, both of these applicants.
Q: What did Ms. Brandt do?
A: She, I believe she said that her -- that Carolinas Medical, Carolinas Hospital System best met this criteria.
Q: Do you remember why?
A: I think because she saw their construction cost as being less is one thing.
Q: Let's just focus on -- yeah, I'm sorry.
A: And perhaps even operating costs. I think she went into a lot of detail on this. And so, but that, in my opinion, that's too much going into too much detail, again, you have to look at the broad picture on projected expenses. This is

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

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

A: No, sir.

Q: All right. Did you do that?

A: Yes, sir. I did.

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

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

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

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

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

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

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

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

A: No, sir. Not at all.

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

Department?
A: I did not.
Q: And do you believe there's -- is there any reasonable basis in the regulations for this sort of analysis?
A: No, sir.
Q: All right. So, what is your determination concerning the application at section 7 for both applicants?
A: Not, we're talking about criteria 7?
Q: That's right. Yes.
A: And I don't memorize them.
Q: This is expenses.
A: Okay.
Q: Which party or which parties best meet that? Projected expenses?
A: Yeah, now what I think I put there is ---
Q: We can go back to it.
A: I'm sorry.
Q: No, no. It's getting late.
A: Let me go, yeah, let me see. That's sort of, yeah, see, both of them meet that. Both, because even though they can vary, any applicant -- they're -- these were reasonable, they're both of them are reasonable. Both are

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

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

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

Q: Okay. So ---

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

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

A: Yes, sir.

Q: And what have you found them to be?

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

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

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

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

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

A: Yes, sir. I have.

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

A: Yes, sir.

Q: Have you reviewed those applications?

A: Yes, sir. I have.

Q: Okay.

A: And these are other satellite hospitals that

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

Q: Why do you consider all these reasonable?

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

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

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

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

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

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

Q: All right. And year two?

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

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

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

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

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

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

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

A: It relates.

Q: Okay. In what way?

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

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

Q: Okay.

A: Financially.

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

A: Yes, sir.

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

A: Right.

Q: Have you formed an opinion about those provisions?

A: Yes. Both applicants are consistent with those criteria, yes.

Q: What did Ms. Brandt find?

A: She found the cost containment was better met by ---

Q: No.

A: I'm sorry, I'm sorry.

Q: We're talking about it relates to 16(a) and the cost containment provision is actually related to the financing, right?
A: Yes, yes.
Q: Do you want to take a look at the reg? Would that help you?
A: Yes. Yes, sir.
Q: Okay. Dan, if you could just bring it up on the board, please. Let's look at 16(a).
A: Okay. Okay. I've got it.
Q: All right. Now, what does this provision relate to?
A: Okay. She's chosen, the one that's, you know, the most feasible one. The most feasible option.
Q: For financing?
A: For financing, yes.
Q: Okay. And what did Ms. Brandt find?
A: Okay. I believe she found that Carolinas best met this particular one.
Q: Do you remember how Carolinas proposed to finance its project?
A: Yes, sir. Cash. I mean no borrowing of funds, it would be paid in cash.
Q: All right. And let's take a look at the

letter, I don't have the reference here. Do you remember how Piedmont proposed to pay for it?

A: Yes, sir. They were going to be -- it was more flexible, it was going to be part financing and part cash.

Q: Okay. And how do you evaluate the compliance with the regulation of those two alternative proposals for financing the project?

A: Well, I would see either one would be consistent, however, now, you know, I think the option that the Fort Mill Medical Center is going to take is more reasonable. That gives more flexibility. It's impossible to know at this point in time. It may take a year or two to even start construction, how you really want to finance it. What the economy is going to be like. A lot of times applicants will put cash just to reduce the capital costs and have no interest cost for financing. So, it's more reasonable to put, you know, you don't know what its going to be. A combination is a good idea. Cash is rather unusual.

Q: Okay. And if cash were used and the project is in part financed in whole or in part,

subsequently is there any process for reporting that after the final report is submitted to the Department?

A: No, sir. It's not a requirement. Certainly, the Department could ask, but no. That could be changed so much. You know, the Department is really looking at the final capital cost but they may not know the end result on the financing of the project.

Q: Okay. All right. So, with regard to the method of financing, what is your determination concerning each applicant?

A: Well, you know, I would say each applicant is consistent. I, you know, would favor the one that is owned by Fort Mill, but either one would meet the criteria.

Q: Okay. All right. Let's move to efficiency, section 17 and what have you -- first of all, what's the purpose of that regulation?

A: You know, I don't memorize ---

Q: That's all right. We'll pull it up so you can familiarize yourself with it.

A: I wasn't able to do that working at DHEC.

Q: Let's see.

A: Okay. This one, yes, it's pretty standard.

The project should improve efficiency by avoiding duplication of services, promoting shared services, fostering economy and scales of size.

Q: Okay.

A: And in my opinion, the Fort Mill Medical Center best meets this criteria, meets it, yes.

Q: And why?

A: Well, because they're going to avoid the duplication of services like I mentioned before because that duplication is going to really, the duplication is going to be where they do not lose the use of several tertiary services that the home or the parent Piedmont Medical Center and they would promote shared services and fostering the kinds of scale to size, here again, you could make a statement that they're really planning better for the future for a rapidly growing area by being able to do 100 beds, which I think in that area, those beds, you would need an addition by the end of three years. Because even if you were building only 64, you're probably going to reach about 70 percent utilization. That's when you need to start planning for additional beds.

Q: Okay. Mr. Grice, have you reviewed -- you said you reviewed the updated application and related materials of Piedmont that they submitted to the Department. Dan, let's pull up Exhibit 31. Look at slide 37 from the project review materials. Do you recognize this slide, Mr. Grice?

A: Yes, sir. I do.

Q: What does it show?

A: Okay. This is the projected utilization with the average daily census, beds and occupancy rates of the three hospitals, three of the hospitals that were competing originally. Well, it's got Fort Mill Medical Center and Carolinas Medical Center.

Q: And PH -- PHY refers to Presbyterian?

A: Yes, sir.

Q: Okay. Go ahead.

A: Okay. So what we've got there are the numbers showing for the first three years the average daily census, the number of beds proposed by each one and their occupancy rate. And we can see in looking at those occupancy rates, it's rather impressive with a new hospital because Carolinas Medical Center will really have, even

by the first year, 63.9 -- I'm sorry.
Q: No, you're right. Excuse me for interrupting.
A: 63.9 for the first year, 65.6 for the second, 67.5 for the third. When you reach that utilization right there, that's when you know we're going to need some additional beds. We've got to plan now because to get approval and begin construction will take at least a couple of years.
Q: Does the State Health Plan establish occupancy rates that are thresholds for recognizing need in the plan?
A: Yes, sir. They do.
Q: And as far as a hospital this size, what would those levels be?
A: I think we're doing those levels right there, looking at that 60 percent range.
Q: And what's the trigger, do you know, for new beds under the Plan?
A: I forget right now.
Q: Okay.
A: I didn't actually do that. Calculate the ---
Q: All right. Okay. And so, what does that tell you about Carolinas' proposal with regard to an occupancy rate of its proposed 64-bed facility?

A: That it's going to be relatively high in a short period of time.
Q: Okay. And in the right-hand column of those three is Presbyterian's proposed occupancy rate, what did they propose for being their 64-bed hospital by year three?
A: 74.5 percent.
Q: Okay. Now, based on your review of Presbyterian and Carolinas proposals for occupancy of their 64-bed hospitals, what inferences do you make about what number of beds can be effectively used in that area?
A: Looking at -- with them both proposing 64 beds and with that occupancy rate proposed by the third year, it very well justifies 100 beds. If you could possibly have 100 beds, you wouldn't have to make that additional construction, begin planning by year three.
Q: And in contrast, what proposal by year three is Fort Mill Medical Center making for its occupancy?
A: It's already at 58.2 percent, so it's utilizing an average of 58 beds and so probably they're doing well. By five years or six years they will be up there.

Q: All right. Should they been in excess under the regulations of 65 percent by three years?
A: There's no requirement of that, no, sir.
Q: Okay. Now, and therefore which applicant best meets section 17 related to efficiency?
A: In my opinion, that would be the Piedmont Medical Center Fort Mill application.
Q: Okay. Let's then go to the next series of criteria. Now, you can see here, Mr. Grice, that all of 13 is in indication that you and Ms. Brandt meet those criteria. Those relate to record of the applicant, is that correct?
A: Yes, sir.
Q: The -- ability to obtain financing, in fact, on 13(b), I think probably is mistaken and Ms. Brandt found that Carolinas better met that, would that be correct?
A: Yes.
Q: Okay. So that'd be 13(b) showed if it accurately reflects Ms. Brandt's decision, that should not say both, it should say CHS?
A: Right. Yes, sir. That's correct.
Q: Okay. All right. Otherwise, she found the records were -- that all applicants met the record criteria, is that right?

A: Yes, sir.
Q: Now, acceptability, there was, Ms. Brandt and you both found that all applicants met that. I want to go, just I want to ask you a question about that quickly. Do you recall from your reading of Ms. Brandt's decision the number of letters that were filed by the various parties?
A: Yes, sir.
Q: In general terms?
A: It was in the thousands.
Q: Okay.
A: Each got letters of support which relates to acceptability.
Q: Would it be 10,000 for Presbyterian and many thousands for the others?
A: Exactly. I don't know. Five or 6,000 I think for the others.
Q: Why do you agree with Ms. Brandt concerning her opinion that all applicants met that criterion?
A: Well, when you -- you cannot, you should not base your decision on who has the most letter of support. That's a way -- applicants can always generate letters of support. Numerous ways. I even recall having seen people in front of Wal-Mart for small projects getting

letters of support on Saturdays. I mean if you want to get letters of support, there are ways to do it. And you can hire an organization, a company to go out and get them for you. If you have appropriate support and look at the quality of letters, too, if you have letters of physicians and other people, that's great, but both of them met that criteria. Because they both had appropriate levels of support. You don't count them. You don't weigh them in my opinion.

Q: Okay. And let's look at opposition. Ms. Brandt said the opposition expressed in letters, with letters submitted with the Department should be taken into consideration. I'm not quite sure if she meant in clarifying in favor of Carolinas, but what's your recollection?

A: Well, I think the Piedmont, the Fort Mill Medical Center had some letters of opposition. Well, there might have been 40 or 50 letters, in that range. And the Carolinas project may have had a few or none, but I think because of that she saw the opposition as being something compelling and she put down that Carolinas best

met that. Because they had little if any opposition where the Piedmont project had some.

Q: What's your view of that?

A: You can get opposition with any project. When you look at the letters of support, that much outweighed the opposition. In my experience in the CON program over the years have been particularly when you have only one facility in the county, people always -- some people have an unpleasant experience. There's only one nursing home, one hospital, it's not a perfect world and somebody is going to have some experience that they thing, you know, is not positive and they don't forget it.

Q: Okay. Let's move on to the last two sections, 23(a) and (b) related to adverse impact section of the reg based on how those regs are identified. Have you developed your opinion here that Piedmont best meets both the, Ms. Brandt found that Carolinas best met adverse impact on utilization and that it equally, that the applicants equally met the concerns of staffing. What's the basis for your opinion here, Mr. Grice?

A: Well, on 23(a) the adverse impact on existing

facilities, here again, with the development of Piedmont Medical Center, that is going to have less adverse impact on the existing facility which is the existing Piedmont Medical Center in Rock Hill, so relative of Fort Mill will allow less adverse impact on the existing facility in that county. So, that's why I say that Piedmont Medical Center best meets that. As far as adverse impact on staffing, here again, when you have another provider, it gets to be competition for hiring staff and that is problematic. A new hospital close by, a lot of people that live near there go to work there, to not have to drive further. If it were the Fort Mill Medical Center project, those people would be employed by Piedmont, they could work for both or the new facility but when we have another provider such as Carolinas Hospital System they're going to be working for someone else and it will be an adverse impact on the staffing of the existing Piedmont Medical Center.

Q: All right. Have you developed a Demonstrative that summarizes the potential adverse impacts that you've identified?

A: Yes, sir.
Q: Okay. Dan, let's pull up 122. And what do you have here, Mr. Grice?
A: Well, the adverse impact, it would really reduce utilization at the existing facility. Particularly if you look at the specialized services you have at Piedmont Medical Center such as open heart and the neonatal intensive care nursery, it's going to have an impact on medical staff current and future because as our utilization drops and some the people with medical specialities, utilization drops, those physicians are going to be looking for positions somewhere else and leave and it's also going to have an impact on the nursing and technical staff. So, you know, all those things would make a recovery from adverse impacts difficult. So, that's major -- mainly a summary of the adverse impact that would occur if we did not have Fort Mill Medical Center in York County.
Q: And what's your opinion of Ms. Brandt's finding concerning adverse impact that Carolinas would only serve its patients and patients from the Carolinas Network?

A: Well, I don't agree. I mean it's what is it's obviously going refer many patients to Charlotte. It's going to also be a gathering new patients into that new facility and it's going to cause a continued reduction in utilization and staffing at the existing facility in Rock Hill.

Q: Thank you, Mr. Grice.

MR. ANDREWS: I have nothing further, Your Honor.

THE COURT: All right. Thank you, Mr. Andrews. Unless everybody is just dying to carry on here on a Friday night, I think this is an appropriate time to recess for the weekend. All right. Thank you. Ten o'clock on Monday.

(There being nothing further, Day Five recessed at 5:25 p.m.)

DAY SIX - TUESDAY, APRIL 16, 2013

THE COURT: Good morning, everyone. Back on the record. And today is Tuesday the 16th of April. I wanted to put something on the record about matters from yesterday.

Yesterday on April 15th the Court was informed by Mr. Muller, counsel for Carolinas, of the very sad news that his father had just passed away in Connecticut. Mr. Muller was

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THE COURT: All right, Mr. Westbrook. Good morning.
DANIEL SULLIVAN, being duly sworn, testifies as follows:
MR. SULLIVAN - DIRECT EXAMINATION BY MR. WESTBROOK:
Q: Mr. Sullivan, please state your full name and present address, please.
A: Daniel Joseph Sullivan, 2090 Bethany Way, Alpharetta, Georgia.
Q: Where were you born and raised, Mr. Sullivan?
A: Charleston, South Carolina.
Q: Where are you employed now?
A: Sullivan Consulting Group, Inc.
Q: And what are your duties and -- principal duties and responsibilities with Sullivan Consulting Group?
A: Obviously, I'm president of the firm and so I've got administrative duties, but involved in performing consulting work for our healthcare client. Our firm is exclusively focused on the healthcare field.
Q: All right. Let's look at Petition's Exhibit 11. I believe that's already been admitted.
MR. WESTBROOK: Put that up on the screen for us, Dan.
Q: Is this your resume, Mr. Sullivan?

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A: Yes, it is.
Q: Is it current?
A: It is.
Q: All right. If you would, using your resume if you'd like to jog your memory, tell us a little bit about your educational background; will you?
A: Sure. I did my undergraduate degree in economics and public policy studies from Duke University and then a master in health administration from Duke University.
Q: All right. And can you summarize your work history for us since your undergraduate degree?
A: Sure. Immediately after undergraduate school, I went to work in the Duke University Medical Center, what's called a private diagnostic clinic. It is a group practice with the faculty members at Duke Medical School. I worked there for about six years doing a variety of different administrative roles. The last two years I also attended grad school simultaneous with working. Upon graduation from grad school in 1980, I joined Amhurst Associates, which at the time was a large national healthcare management consulting firm.

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And at Amhurst, I started as just an entry level consultant and was involved in doing financial feasibility studies in connection with tax-exempt bond issues; doing other types of projection analysis. And that was about the time that certificate of need was just beginning to grow in the country as a program throughout the state. And so I began to do that in addition to other types of health planning work with healthcare organizations; strategic planning, market analysis, product line planning and that sort of thing.

I was at Amhurst for eight years. I became a regional vice president with Amhurst. And we merged in 1988 with the firm of actually Ernst & Whinney at the time, which became Ernst & Young. And I was a partner for a couple of years with Ernst & Young. Then I decided to set up on my own and start my own company. And I started Sullivan Consulting Group at that time.

Q: Okay. And now that you are with Sullivan Consulting Group, can you tell us what kind of work specifically you do with your company?
A: Sure. Again, it broadly falls into two large

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categories; health planning and healthcare finance. On the health planning side, we are involved in strategic planning for healthcare organizations, market research, projection analysis, preparations; certificate of need applications. On the financial side, we prepare financial projections to various types of healthcare projects; sometimes for use in a certificate of need application, sometimes just for internal use. And then I also analyze financial statements, look at the capacity of organizations and sometimes evaluate opportunities from a financial standpoint for some of our clients. And from time to time I also get involved with providing expert witness testimony in certificate of need matters, as well as other types of litigation.
Q: How many states, approximately, have you done CON work in over the years with Sullivan?
A: Probably 30 or so over the years. I'm old enough that there were a lot more states that had CON programs when I first started. But, you know, virtually every state on the east of the Mississippi and a few on the west of the Mississippi.

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Q: Right. Have you worked in South Carolina before?
A: I have. I worked in South Carolina pretty early in my career, and I've been working pretty consistently over the last 30 or something years in South Carolina.
Q: Now, just overall, can you estimate for us about how many CON applications that you have had significant involvement in in one way or another?
A: You know, somewhere around a thousand. There was a time when, you know, the firm was probably doing 40 or 50 a year. That's slowed down a bit now, but somewhere around a thousand.
Q: You've mentioned that you've done some expert witness work before or testimony given as expert witness testimony before. Do you know how many times you have been qualified as an expert?
A: Not exactly, but more than a hundred times.
Q: And what areas of expertise have you been qualified in particularly?
A: Broadly in healthcare planning and healthcare finance. Sometimes it would be specific

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proffers for certificate of need analysis, certificate of need programs or certificate of need application preparation; that sort of thing. But generally health planning and healthcare finance.
Q: Let's look at a subset of CON applications and that's CON applications from new hospital projects. Have you been involved in those kind of CON matters before?
A: I have many, many times.
Q: In what states?
A: Florida, Georgia, South Carolina, West Virginia, Tennessee, Kentucky, Alabama.
Q: Quite a few?
A: Yeah.
Q: What about -- let's look at some in South Carolina. Can you give us some examples of new hospital projects you've worked on in South Carolina?
A: Sure. There was a battle many years ago between Roper and St. Francis Xavier Hospital in Charleston before they got together and both trying to build new hospitals on the West Ashley area of Charleston. And I was involved in working with Roper Hospital on that. St.

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Francis Hospital in Greenville, South Carolina, we assisted them in developing a new hospital project on the east side of Greenville called St. Francis Women's Hospital, I think, at the time. I think it's a full service hospital now. And I've been involved in assessing the Parkridge Project here in Columbia.
Q: Right.
A: I was involved in analyzing that project. And while I didn't testify in that case, I was involved in doing a lot of the analytical work on behalf of Lexington Medical Center in the Parkridge case.
Q: And the Parkridge, that's a Palmetto Health project, is that right?
A: It is, yes.
Q: And you worked for Lexington opposing that project?
A: I did. And there's probably some more, but those are the ones that come to mind.
Q: All right. Have you served on any special committees studying the South Carolina CON programs?
A: I have. Last year there was a CON task force, I think at the direction of the governor. I'm

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not quite sure exactly how it came to be. But the task force was put together with representatives of the legislative branch. Various people in the healthcare community; hospital representatives, nursing home, home health agencies. Blue Cross was involved in it. There were a couple of independent consultants who served on that task force, and I was one of those.
Q: All right. And how many people all total were on that committee?
A: I think about 25 or 27, a fairly large group.
Q: And how long did that committee's work go on?
A: A long time, probably about seven months, seven or eight months.
MR. WESTBROOK: Your Honor, at this time I would like to move to have Mr. Sullivan qualified as an expert in the field of healthcare planning and healthcare finance.
MR. GASKINS: No objection.
MS. BIGGERS: No objection.
THE COURT: All right. There being no objection, the Court recognizes Mr. Sullivan as an expert in the field of healthcare planning and healthcare finance.

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Q: Okay, Mr. Sullivan, when were you first retained to work on this case of this matter?
A: I believe I was contacted first in July or so of 2012; so a little less than a year ago.
Q: All right. So that would have been after DHEC's second decision to award the CON to CHS?
A: That's true.
Q: Did you have any involvement at all in Piedmont's initial 2005 application?
A: I did not.
Q: And it sounds like you also did not have any involvement at all in DHEC's -- excuse me, Piedmont's 2010 updated application?
A: I did not.
Q: And you didn't have any involvement, I guess, in the subsequent submissions after October 2010, the subsequent submissions by Piedmont to DHEC?
A: That's correct.
Q: Okay. Well, what were you asked to do in connection with your engagement in this case? What did you do, I guess, is the better question.
A: Sure. Initially I was asked to come in and sort of take a fresh look at this since I

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hadn't been involved in many years of this review process and sort of take a look at the entirety of the record and specifically to focus on the second DHEC decision and to look at that decision from the perspective of whether it was reasonable, whether it was based on sound health planning policies and whether it was supported by data, other analytical information and also asked to undertake any other analyses, investigations that I thought were necessary in order to be able to render those opinions.
Q: All right. What -- I'm sure you reviewed a number of documents. What were some of the things -- kinds of things you reviewed besides the DHEC decision?
A: When I looked through the records from the first go round, the 2005-2006 applications, though I didn't specifically focus on those as much because I thought that the more recent information would be more relevant. So I reviewed all the submissions by the three parties at that time when Presbyterian was still involved, including the initial applications and the various other bits of

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additional information that were filed by the various parties involved. And then subsequent to the decision, I reviewed a number of discovery materials that were provided to me from the various parties, Piedmont and Carolinas Health System. And I also had been involved in reviewing exhibits prepared by Mr. Levitt and by experts for the other parties.
Q: And how much of this hearing have you sat through so far?
A: The entire hearing.
Q: Do you have an opinion as to which applicant best meets the purposes of the CON Act, the state health plan, applicable regulatory criteria?
A: I do.
Q: And what is that?
A: I do believe after my analysis that the Fort Mill Medical Center project, I believe, best meets the purposes of the CON Act, the CON review criteria and the state health plan.
Q: Do you have an opinion as to how CMC-Fort Mill, if it were to be approved, would affect the availability and quality of healthcare to York County residents?

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A: I do.
Q: And what is that?
A: I believe that the approval of the CMC-Fort Mill project would be detrimental to the quality and availability of healthcare services to York County residents.
Q: Okay. Let's start with Ms. Brandt's decision. You said you reviewed that. And I believe you have a sort of analytical framework that you would like to use in discussing her decision, is that right?
A: That's true. I've prepared some demonstrative exhibits.
Q: Okay. Let's go to the first one. All right. Now, I see the title to this chart says, "Pivot Points," in quotes, "Pivot Points in Ms. Brandt's Decision." What do you mean by pivot points?
A: Well, in reviewing the decision, there were a few significant issues where Ms. Brandt had a choice, either to accept the positions that CMC-Fort Mill were presenting or the positions that FMMC was presenting. And the decision, I believe, really pivoted on these particular choices. You know, had she looked at these in

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a different fashion, I think she would have likely reached a different conclusion as to the most appropriate party to pick.

Q: All right. Why don't you -- we can go into some detail in these in turn. But to start off, why don't you just read them into the record, which is five that you've identified.

A: Sure. The first is adverse impact, and I know there has already been a lot of discussion about that. And I think there is sort of three elements to adverse impact. The first would be with the impact of the CMC-Fort Mill Hospital would be Piedmont Medical Center. Another issue that was raised in the decision would be the impact if Fort Mill Medical Center was approved on Piedmont itself. And then I think probably the most important aspect of that would be the impact of the approval of either applicant on the quality and availability of services in York County.

The second issue is mal-distribution. And this was raised by Carolinas Health System and their comments to DHEC. And it really focuses on the issue of 64 beds versus 100 beds and whether 100 beds is too many for the North York

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County market.

Q: All right.

A: Unnecessary duplication. That is related to the 100- versus 64-bed issue. Carolinas is the contender, and I think Ms. Brandt adopted their argument that building 36 additional beds over the 64 would result in unnecessary duplication of services.

Financial Access, Carolinas had projected 6.3. In the second go round, they projected 6.3 percent charity care as opposed to 3 percent that Fort Mill Medical Center had projected. Ms. Brandt seemed to have focused on that as a favorable consideration, if you will, in evaluating the CMC-Fort Mill application.

And then finally there were a number of issues brought up about financing and financial projections, but I think a large derivative of those first four. But I thought I would at least address those because they did pick up a portion of the decision.

Q: All right. Well, let's start with the first -- your first pivot point --

MR. GASKINS: Excuse me. I'm sorry to interrupt,

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but I would just like to get the final numeral of that in the exhibit. It doesn't seem to be on there.

MR. WESTBROOK: That I believe that is exhibit -- or demonstrative rather, Exhibit 216.

MR. GASKINS: Thank you.

Q: Sure. All right. Let's take a first pivot point, adverse impact. And I believe your next demonstrative is 217; is that right?

A: That's correct.

Q: All right. And I see your question, "Which project will minimize adverse impact on the York County Health system?" And then it says, "CMC-FM will take a significant number of patients from PMC." Now, why did you say that?

A: Well, there's a number of different reasons. And let me sort of plot through those. The first is the proximity of the proposed CMC-Fort Mill Hospital to both the Fort Mill population and the Rock Hill population, for that matter. Proximity alone I think is going to result in some redirection of patients. We've already heard some testimony about this. That means the simple fact that if you build a hospital very close to where people live, there's at

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least some people who are going to choose to use that hospital. You know, CMC-Fort Mill in its application had taken the position it would only redirect patients from existing CHS facilities in Mecklenburg County. As a practical matter, I don't think you can do that. I mean, if you build a hospital and put it down in an area where there wasn't one before, there is very little way to control which patients are going to come to that hospital. And people don't walk around with visors that say I'm a Piedmont patient or I'm a CMC patient. And so the mere fact of it being there, being proximate and close, in addition to being a shiny new building, I think it's going to attract some new patients there.

So I think it would be wholly unrealistic to expect that you would have no impact on existing providers.

The second factor, and this has also, I think, been touched on, the emergency department at CMC-Fort Mill is going to serve patients who would have otherwise gone to the PMC. And if we think about it, there are several different ways people get into

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emergency departments. One is ambulances bring them there. And oftentimes when a patient is injured or sick, the ambulance will bring them to the closest hospital. Now, in some cases, absent the approval of CMC-Fort Mill, that closest hospital would be Piedmont. With the new hospital there, or at least a portion of that population, that hospital is going to be CMC-Fort Mill. Other patients are going to walk into the hospital, and those patients are going to -- oftentimes want to go to a place that is close to home. And again, this relates to the proximity thing being closer to the population means more people are going to go to the ED.

And then finally for patients who go to the ED at CMC-Fort Mill and their diagnosis having a more significant problem. For example, if they come to the hospital and they are diagnosed as having a heart attack, and they need immediate intervention in terms of an angioplasty for example, my understanding is that if those patients need that service, that they are going -- and CMC-Fort Mill is treating that patient, that they would be transferred to

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the CMC facility for that speciality care.

And so there would be sort of a direct impact in terms of the loss of the patients who would come to the ED at CMC-Fort Mill. Then there would also be a loss of these specialty patients who would be transferred to another facility.

Q: What impact would CMC-Fort Mill have on physicians in the area?

A: Well, I think that is probably the most grave potential impact that it could have. I mean, we -- there were three physicians who testified last week, three independent physicians. And I believe all three of them testified that if CMC-Fort Mill were constructed, they would feel compelled to seek staff privileges there. And that is only good business on their part. They have patients that live in the Fort Mill area. The patients would likely want to go to a proximate hospital. And those doctors right now practice, if not exclusively, a majority of their patients go to Piedmont now. If they were to get staff privileges at CMC-Fort Mill, I think undoubtedly some of those patients who otherwise would have been admitted to Piedmont

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will go to the new hospital instead.

Q: Now, you said just a moment ago that there was -- from a practical point of view, if you didn't follow to shift, market share I believe is what you said.

A: Right.

Q: Even if there were a practical way to shift market share, what incentives in your opinion would CHS have to simply shift its current market share from North Carolina to the Fort Mill facility?

A: I don't believe from a business standpoint that there is any real incentive for CHS to want to shift patients from North Carolina to York County. Now, I'm not disputing that some patients are going to be shifted. I mean, certainly, some of the patients who go to Pineville, for example, now will choose to go to the new hospital because it is closer to home. But not all of the patients who go to Pineville who live in York County are going to choose to do that. And there is certainly no incentive to CHS to try to give special push to those patients to utilize a hospital in Fort Mill.

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Q: Why not?

A: Well, based on my review of various CON applications and deposition testimony, it appears that CHS has spent about $300 million over the last decade or so on expanding services at CMC Pineville. And I think we've already talked about this, but it is located right on the York County border. So there is every intention, I think, of trying to justify that significant capital investment by trying to maximize utilization of hospitals. I think that is only rational behavior on the part of CHS. And if we look at the growth, just in the bed complement at CMC Pineville in 2002, it was a 97-bed hospital. Twelve beds were approved to be added in 2002. By 2005, an additional 11 beds were added. Then in 2007, it was sort of a big project where CMC Pineville got approval to add 86 additional beds, and in addition to add a number of other specialized services to the hospital and dramatically expand the footprint of hospital as a result of that project.

Q: Now, how did CMC Pineville justify its bed expansion with respect to York County?

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A: Well, when I reviewed the application, the 2007 application, about a quarter of the patients that CMC Pineville was serving at that time came from York County. The application described York County as being in the primary service area of CMC Pineville, which is logical because it is located right on the border of York County. And it indicated that it would expect that the growth in York County would be one of the factors in driving future utilization that would support the increase of 86 beds. That wasn't the sole factor. They were also looking at growth, another portion of what they call the southern perimeter of Charlotte. But York County was certainly a significant component and was expected to still represent over 20 percent of the admissions to the expanded CMC Pineville Hospital after development. And so, you know, that's a pretty significant factor.

Now, another important thing to think about in just in terms of timing, in 2007 DHEC had approved the Fort Mill Medical Center project. This was before the remand.

Q: This was during the first appeal of this

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decision?

A: Right. And so in the CMC Pineville application, they took into account what the effect of a Fort Mill Medical Center project would have on their Pineville facility.

And if I can go to another slide, in 2007 they said if CMC Pineville were to be approved with the Fort Mill Medical Center there, that they expected there to be a loss of about 440 discharges in, I believe was the third year of operation, as a result of that, Piedmont Medical Center's own facility in York County. Now, in 2010 after the remand when CMC-Fort Mill resubmitted its application, whatever we want to call it, amended or updated or what have you, their projections now in terms of the impact on the Fort Mill Hospital on CMC Pineville would be a shift of 1,923 admissions.

So we can see that the assumption was that a Fort Mill Medical Center wasn't going to have much impact on Pineville. But if CMC-Fort Mill were built, because CHS had taken the position in that application that the patients would be shifted from existing CHS facilities, all of a sudden the impact of that hospital on

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Pineville was dramatically greater, 1,500 discharges greater.

So there is a -- you know, I think what we have here is a situation where CHS, thinking that they had not won the hospital in York County, decided instead from a strategic standpoint to expand its services in Pineville and to try to serve York County from Pineville. And then by happenstance they had another bite of the apple --

Q: Remand, you mean.

A: On the remand, yes. They then sort of back tracked a little bit. So actually we are going to shift a whole bunch of patients from Pineville to the new facility. So, you know, I think that CHS has already built to capacity to serve York County patients and that's at Pineville. And for them to now seek approval of this and to say it's only going to come through shifting patients, I think it means that somewhere there is some double counting going on.

Q: Now, you mentioned that CMC Pineville, as part of its expansion, added a number of special services, right?

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A: It did.

Q: And what's the significance of that with respect to the shift?

A: Well, I think there are sort of two aspects to that. Among the services they offer; open heart surgery, interventional cardiology, which includes angioplasty, electro physiology studies and so forth that we've discussed before, a neonatal intensive care. In order to support those services, they need to have referrals. I mean, you know, when you have what are often referred to as tertiary services, not all of that business is going to be generated from your in-house population of patients. You have to also rely on transfers from smaller facilities to utilize those services. And so CMC-Pineville, again, projected that those services would be well utilized and relied on the York County population. And I think it is reasonable to assume that if CMC-Fort Mill were constructed and patients are being served at CMC-Fort Mill and they need these specialized services, it is only logical to think that those services would be -- those patients would transfer to CMC-

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Pineville.
So as I said before, I think in the past, many of those patients would have gone to Piedmont.
Q: Now, there has been a good bit of testimony in the hearing so far about out-migration from York County to North Carolina facilities to CHS facilities in North Carolina, specifically, and the effects of CHS physician referrals on that out-migration. With that -- given that context, what effect do you believe CMC-Fort Mill would have on CHS's historical efforts to redirect patients from York County?
A: I think that having a hospital in York County is somewhat of a game changer, if you will, for CHS. They've been able to make significant end roads into York County just by building up this physician network. And having a new hospital in York County is going to only increase CHS's ability to expand that physician network. For example, if you have a hospital -- right now CHS doesn't have a hospital. And the testimony I've heard is by and large the Carolinas Physician Network physicians don't practice at Piedmont. Those doctors, if they're located in York County, are having to drive to Pineville

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or somewhere else in order to perform either inpatient services or even outpatient surgical services, for example. But by having a hospital there, it would be more attractive to physicians to want to practice in the York County area. It would be more attractive, for example, if orthopedic surgeons, for general surgeons, for gastroenterologists and so forth who would have a hospital based program where they could go and do their procedures. Also a cardiologist, for example, could do certain basic things there and then have the capability of transferring those patients up to Pineville.
And so I think that having this capability that a new hospital offers is going to only expand the number of physicians that are in the York County market. And again, when you look at the secondary effect of that, patients who otherwise were going to physicians who practice at Piedmont now, a new doctor moves into your neighborhood, his office is closer to where you live; the likelihood that at least some of those patients are going to choose to use the new physician. And again, it's a ripple effect, you know, through the county. And so

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the physician component of this, I think, is only going to be exacerbated in terms of the potential for future loss of patients at Piedmont if CHS is successful in getting this hospital.
Q: Now, CHS has made an announcement about going into the health insurance business. Can you tell us about that?
A: Sure. There was an announcement, I guess a couple of weeks ago, that CHS was entering into a venture with Coventry Health, which is a national health insurance provider. They wanted to begin to offer health insurance products in the Charlotte area. And a number of health systems are taking those steps. But if you think of how you capture patients, how you penetrate a market, there are sort of three legs to the stool, if you will. I mean, one is having facilities in the market where patients can go. Secondly is having physicians in the market where patients can go. And the third is if you don't have a health insurance product, having contracts with health insurance companies that will bring those patients to your facility.

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If you have your own health insurance product, typically you would be able to require the patients go to facilities that are in the network. With the CHS product, I think it would be logical to assume those in network facilities and those in network physicians would be CHS physicians at those facilities. There would be substantial penalties to go outside the network. And so patients would have a strong incentive to go to CHS facilities.
Having a hospital in Fort Mill would facilitate CHS's efforts to sell insurance in York County. It would be if -- let's say, for example, that CHS didn't have a facility in York County and they were trying to sell insurance to a company that was based in Rock Hill, they may not be that excited about signing with CHS if all the patients had to go to Pineville and all of their employees had to go to Pineville for services. But if, instead, CHS had a hospital there, and so they could go to our Fort Mill facility. And if they needed anything more exotic than that, then they can go to Pineville or downtown, that's a more

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attractive package to offer to employers. So CHS already has a very large presence in the Charlotte market. And I think through this health insurance effort, I think they can further consolidate some of the market power that they already have.

Q: And when you say the Charlotte market, are you including northern York County now?

A: I'm including all of York County in that.

Q: Now Ms. Brandt, with DHEC accepted CHS's position that if Fort Mill Medical Center were built, it would have an adverse impact on people, that Fort Mill Medical Center would adversely impact Piedmont. What's your reaction to that?

A: Well, when I first read that, I was somewhat stunned, quite frankly, by that assertion that somehow allowing the biggest hospital system in the Charlotte market to come in and build a hospital in York County where they didn't have one, would have a lesser impact than an existing provider simply creating a satellite hospital to serve patients in its existing market. That, to me, I just don't see any logical basis for that to, you know, be a

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reasonable conclusion. You know, we've already heard testimony from Mr. Levitt about the fact that Piedmont has seen its market shares in York County and at Fort Mill specifically decline significantly in the last decade. And so there is a significant amount of impact that has already occurred without having a hospital. Piedmont is going to have no opportunity. I mean, let's assume that CMC-Fort Mill is built. I mean, that in effect is going to create a barrier for Piedmont. Basically it's going to wall off, if you will, the whole northern sector of the county. And it's going to mean that Piedmont is going to have very little opportunity to reverse the out-migration, particularly out-migration from northern York, which is the fastest growing and as we've heard, one of the more affluent portions of York County. And so I think that that's a very real concern. So Piedmont, instead of being able to sort of bounce back from a significant downturn in its market share over the last seven or eight years, it's basically going to be stuck where it is today, with a significant potential for further shift in market share

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away from it because of the hospital in Fort Mill and because of the redirection, especially patients out of York County.

And so I think it would be illogical to assume anything other than the fact that allowing Piedmont to shift some of its existing patients and to recapture some of the out-migration that's happening in York County could be a far better outcome for Piedmont than simply the deadweight loss associated with losing patients to CHS.

Q: Let me ask you to go back to your second bullet point on your slide for a moment.

A: Sure.

Q: You were here -- you said you were here for the entire -- for all of the testimony so far in this hearing. I want to ask you to think back to Mr. Masterton's testimony. Do you recall Mr. Masterton talking about a strategy for halting out-migration and recapturing out-migration?

A: I do.

Q: And did you hear Mr. Masterton testify that while there were three elements of that, the key element was building Fort Mill Medical

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Center. My question is do you agree with that?

A: I do. Without Piedmont having a physical presence in the Fort Mill market, I don't see them being able to effectively reverse the out-migration that's occurred over the last seven years or so from northern York County. CHS, as I said, has dramatically expanded Pineville. It offers a broad range of services equivalent to what Piedmont does. They've effectively penetrated the physician market in York County through acquisition and improvement. And so as a result without having a physical presence there that would attract patients to the facility and give Piedmont a base on which to recruit additional physicians, I just -- I don't think that any other strategy is going to have any significant impacts in terms of changing the out-migration pattern.

Q: Okay. You've been discussing CMC-Fort Mill if it were to be built, CMC-Fort Mill's adverse impact on Piedmont. Let me ask you now to focus on what kind of impact do you believe CMC-Fort Mill would have on the York County health system and also what do you mean by the York County health system?

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A: Let me start with what I mean by the York County health system.
Q: All right.
A: Now, obviously Piedmont is a big part of York County health system, it's the only hospital in the community. But there is also physicians. There is other types of healthcare professionals that operate in York County. But the county itself, it's in the health business, if you will, the county health department. There is community education programs. There is outreach programs, screening programs and so forth. All of these things are part of the healthcare system. And, you know, in my view approving CMC-Fort Mill is going to adversely affect that for a few different reasons. Let me describe those.
Q: Sure.
A: I mean, the first is it's going to perpetuate the out-migration of York County residents to North Carolina and for all the reasons we've already talked about. And, you know, you might say, well, what difference does that make if the patient gets service in North Carolina versus South Carolina? Well, I mean, I think

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that the focus of the CON Act in South Carolina, and I think just generally good health planning, you would like people to receive needed services as close to home as possible. And I see through the approval of the CMC-Fort Mill project as putting greater pressure on patients leaving the county for care because CHS is a very large network of the hospitals in Mecklenburg County.

I think probably equally significant is the fact that the speciality programs that Piedmont offers, and we've heard testimony about some of the things that are done in terms of neonatal services, in terms of cardiac services, in terms of orthopedics and neurosurgery, and the fact that you need a certain volume of patients in order to maintain quality, efficiency in those programs as well as to maintain economic viability. And I think that some of those programs are certainly threatened if there is this continued exodus, especially patients from York County into Mecklenburg County. And I won't go through all the discussion that has already happened on that point, but I think that the loss of those

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speciality programs damages the healthcare system in York County because patients won't have to travel farther to get those services. And in some cases, continued reductions in volume just means that those services can't be as broad and as high quality as they could be if there was a larger patient base.
Q: All right. And we're talking about clinical services now. How about some points on that from this adverse impact on the system?
A: Well, I think there is certainly the potential for tax revenues for York County and South Carolina to decrease as a result of the approval of CMC-Fort Mill. And we know that Piedmont is a taxpaying entity. And Mr. Miller, I think, described in some detail the types of taxes that are paid and a significant amount of money every year. I'm not saying that you should always approve a taxpaying hospital when we get into a CON fight. I think there is sometimes good reasons to approve for not-for-profits and sometimes good reasons to approve for-profit entities. But when you have an existing for-profit entity that is contributing to the existing infrastructure of

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accounting like Piedmont is in York County, if the result of your project is to reduce the number of patients who are getting care in the county and at the same time reduce the county tax base and the county, as I said before, is also involved in activities that have implications for the health of residents, I think that's a negative to the healthcare system.

South Carolina, itself, gets revenue from Piedmont. It goes in terms of the income taxes that it pays to the state. And obviously the state is involved in healthcare activities as well. I mean, DHEC is involved in a number of health-related activities. And so you are reducing the revenues that are paid in South Carolina. And I think it goes back again to the purposes of the CON Act, and that is to ensure that quality and accessibility for patients in South Carolina. I mean, if the goal was just to ensure that patients got good quality care, I mean then it would not matter if they were going to Mayo Clinic or Charlotte or wherever. But I think the idea is to try to maximize the services providing within the

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state.
Q: You mentioned the purposes of the CON Act. You're familiar with those purposes; are you not?
A: I am.
Q: And you're familiar with the regulatory criteria?
A: I am.
Q: I know what's set forth in Motion 61-15. Based on your experience and based on health planning principles, do the criteria encompass all aspects of the CON purposes -- CON Act purposes?
A: They don't. I think they attempt to flush out those purposes. But healthcare is so complex. It is very difficult to capture on any set of regulations, even though South Carolina has many regulations as it reflects a CON review, to capture all aspects of a determination of which project would best meet the needs of the community.
Q: Mr. Sullivan, what effect would approval of CMC-Fort Mill have on the York County Healthcare System with respect to payer mix and the proportionality of who gets served?

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A: Well, you know, we've heard testimony already, which I won't repeat, about the fact that Piedmont has seen erosion in it's payer mix in the sense that its percentage of commercial managed care patients has gone down. It's percentage of Medicaid and uninsured patients has gone up. And we've also heard testimony from the physicians about the fact that they see it in their own practices, the free physicians who practice here, they don't see as many of those well-paying patients. We also saw the exhibit and looked at the payer mix of the CPN physicians practicing in York County. We saw that they had --
Q: You're talking about Exhibit 27?
A: I'll take your word for that.
Q: Okay. I'm sorry. Go ahead.
A: That they had relatively low percentages of Medicaid and charity care, self-pay care in their practices. So I think there is certainly a strong concern that if CMC-Fort Mill is approved -- well, let me add one more thing to that. You know, I think there is evidence which we will look at in a minute, that the Fort Mill area has a more affluent population.

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And so that would be a source of some of these better paying patients for Piedmont. There is certainly a strong potential if CMC-Fort Mill is constructed, that given the payer mix of the physicians who practice there, given the demographics of the area where the Fort Mill facility will be located, that Piedmont will see its payer mix erode even further over time.
Q: What do you mean when you say payer mix erode?
A: Well, one of the aspects about healthcare that I think it's difficult sometimes for people outside the industry to understand is that not every payer pays the full cost of providing services. Medicaid, for example, is not a particularly generous payer. Oftentimes it is paying below cost. Medicare, depending on the service, can be paying -- you have a small profit or you are actually losing money on Medicare patients, as well. Obviously, people without health insurance, you're not getting paid very much for those people. And so by and large, hospitals make their profits through their managed care commercial insurance patients. That's where there is the greatest margin. And if those patients begin to shrink,

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then you are left increasingly relying upon Medicaid, Medicare and charity self-pay patients. You are going to see your resources shrink as well and your ability to expand services or even to maintain service.
Q: Now, we are talking a general topic here I think of this slide is the impact of CMC-Fort Mill, the impact it would have on the York County healthcare system?
A: Right.
Q: And I think, you know, one more bullet point. What would be the impact on, do you believe, on employment?
A: I believe that it would be a net reduction in employment in York County. And, I mean, and I guess granted, whoever builds a hospital in Fort Mill is going to hire employees, you know. And so to some extent, that is somewhat employment neutral, if you will.
But if we think about the potential loss of specialty patients going to Mecklenburg County, this certainly, as we've heard testimony from Mr. Masterton and I think from Mr. Miller, there is certainly the potential to have to layoff or reduce the hours of existing

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employees who work at Piedmont in those speciality areas. And that's somewhat of a bigger impact because those are sometimes the most highly skilled and most difficult to recruit types of individuals in the healthcare system. And so reducing that employment, I think damages sort of the infrastructure again of the healthcare system in York County.

Q: All right. We have been talking about the effect that approval of CMC-Fort Mill would have on the York County healthcare system. Let's move to the topic of the effect that approval of Fort Mill Medical Center would have on the York County healthcare system.

A: Sure. In my view, the net effect of approving Fort Mill Medical Center would be to enhance the healthcare system in York County.

Q: All right. And why do you say that?

A: Well, probably number one is that I believe it would have the biggest impact in terms of reversing out-migration of patients. With the CMC-Fort Mill project it will probably reduce out-migration of some of what I'll call primary/secondary type patients, the patients who have needs but not at the highest level of

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need for treatment. With these tertiary patients, the patients that will need highly specialized services, are not likely to be reversed for CMC-Fort Mill. In contrast, Piedmont would have every incentive to keep those speciality patients in the county. And so I think that would be a positive in terms of trying to build and strengthen the existing speciality services that exist in the county. That's really -- those two points are related, my first and second point.

Q: All right. Let's talk about tax revenues. If CMC-Fort Mill is approved, what about Fort Mill Medical Center?

A: Well, I think certainly the tax revenues are going to go up in two different ways. First of all, if you have a taxpaying entity in Fort Mill versus a not-for-profit entity in Fort Mill, there is going to be income taxes and business taxes and other types of taxes that will be paid. And specifically, I think there has been some testimony that property tax associated with the proposed Fort Mill Medical Center will be about $4 million a year that would go directly to York County. So there

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would be a positive impact in terms of tax revenues, which again filters through the system in terms of the general health of the county which also has an impact on the health of the population.

And then finally, for the reasons I think we've already discussed, it would expand employment opportunities in York County, but yet it may well keep more of those patients in the county. There would be greater job opportunities in York County as opposed to those jobs going to Mecklenburg County.

Q: All right. On the previous slide, the one talking about focusing on the CMC-Fort Mill's impact on the system, you had a bullet point about payer mix, the proportionality of payer mix.

A: Right.

Q: What about if Fort Mill Medical Center is approved, what would the effect be on the proportionality of the payer mix?

A: I think that again, the presence in Fort Mill will allow Piedmont to be able to maintain a presence in that better demographic market in North York County and also to allow them to

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retain some of those better paying patients who require speciality services that would otherwise be out-migrating into Mecklenburg. So I think that would again be another positive aspect of the approval of Fort Mill Medical Center.

Q: Mr. Sullivan, when DHEC evaluates a CON application or is competing to an application, they rank the criteria in order of priority; are you familiar with that?

A: I am.

Q: In this case where did DHEC rank adverse impact in terms of priority about this?

A: Well, they had four tiers, if you will, of priorities. And adverse impact was ranked on the fourth tier -- the last, the lowest tier.

Q: All right. And the tiers would contain, in some cases, multiple criteria?

A: That's true.

Q: All right. And where did -- and so they ranked adverse impact in the fourth tier, you say?

A: Yes.

Q: Where did Ms. Brandt rank in terms of priority accessibility of that criteria?

A: Well, it was in the second tier. But the first

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tier, the only criterion was consistency with the state health plan, which I think Judge Matthews addressed in an earlier decision. So really accessibility now is in the second or highest tier of the criteria that we were last discussing.

Q: So would you conclude from that that DHEC prioritized -- gave greater priority to accessibility and a number of other criteria than they did to adverse impact?

A: Yes.

Q: And do you believe from a health planning perspective that was appropriate ranking or not?

A: I don't. I mean -- first of all from a general health planning perspective, I think the two key factors in any health planning decision are what's the benefit that's going to derive to the community and what's the negative impact on existing services in the community that would result from approving it.

If we only looked at, for example, accessibility, you know, that's often talked about in CON hearings, you'd have a hospital in every corner because that would be the way to

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maximize accessibility. Now obviously that would have tremendous negative impacts on the existing providers if you started building hospitals on every corner. And so I think there is -- just from a general health planning perspective, I think that there is -- impact always has to be given a very high priority right up there with accessibility and improvements and other aspects of the healthcare system.

Q: And health planning principles aside, what about -- how does the state health plan address this, South Carolina State Health Plan?

A: Well, there is an exhibit that shows an excerpt from the South Carolina State Health Plan, the section of the health plan that deals with the addition of acute care beds.

Q: Well, let me stop you just a second. This is labeled Piedmont Exhibit 8A, and I believe this has been admitted, but I'm not positive.

MR. WESTBROOK: Is there objection to 8A?

MR. GASKINS: No objection.

THE COURT: It's been admitted.

MR. WESTBROOK: Thank you.

Q: All right. Piedmont Exhibit 8A, tell us again

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what this is before I interrupted you.

A: Sure, it's actually page Roman Numeral II-IX, I believe, 2004-2005 State Health Plan. And that's a section on acute care hospital beds.

Q: And you've excerpted some language there.

A: I have. And just focus on the last sentence. "The benefits have improved accessibility but will be equally weighted with the adverse effects of duplication in evaluating certificate of need applications for these beds."

Q: All right. What is the significance of that sentence with respect to this grant ranking or prioritizing criteria?

A: Well, I think certainly this is pretty clear. I mean not -- state health plan isn't always this clear in terms of what the priorities are. But in this case, I think it is pretty clear that accessibility should be given the same weight as adverse impact.

Q: Now, let's go back to your analytical framework for discussing the pivot points, as you call them, and Ms. Brandt's decision. We've been talking about the first one. Are you done with adverse impact and ready to move on?

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A: I think probably everybody is done with that and ready to move on.

Q: Okay. Let's move on to the second pivot point. And tell us what that is.

A: It's now distribution, and this goes to the issue of 100 versus 35-64 beds.

Q: And I believe you said that this was -- this issue of maldistribution was introduced by CHS, is that right?

A: That's correct.

Q: Okay. Why don't you elaborate on that.

A: CHS in its -- I believe in its July 2011 submission to DHEC had set forth an analysis of bed-to-population ratios and divided the county up into three regions; northern York, Rock Hill and western York and then calculated the number of beds per capita that would exist in those regions as a result of one, the approval of 100 beds at Fort Mill and two, with the approval of 64 beds in Fort Mill.

MR. WESTBROOK: Let's go to demonstrative 149.

Q: And as Dan is doing and calling it out for us, why don't you orient us here, Mr. Sullivan. Let's start with the chart on my left.

A: Okay.

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Q: It says beginning Platt Exhibit 4; what is that?
A: The chart on the left shows what was submitted to DHEC back in July of 2011.
Q: All right, who's Platt?
A: Kathy Platt is a health planning consultant who was working with CHS on their application.
Q: All right. And what is your relationship with Kathy Platt?
A: We worked together for 18 years. When I started my firm, she was the first employee I hired. So I know Kathy very well. And so she -- a few years ago we amicably parted ways. And she has her own firm now.
Q: Good. All right. Tell us about Ms. Platt's Exhibit 4 here.
A: What she did is she defined the population in these three regions that I talked about; northern York, western York and Rock Hill and greater Rock Hill, I guess is the way she said it, and then calculated how many beds would exist per capita. And this is a fairly simple calculation. If you divide the population into the number of beds and then multiply it by a 1,000, that will give you the ratio. And based

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on her calculation, northern York would have in 2010, 2.44 beds per 1,000 population. In comparison, she added together Rock Hill and western York and said that they would have 1.23 beds per 1,000. So that would be about twice as many beds per capita in northern York than there would be in the rest of the county.
Q: And that's if that was a 100-bed facility in Fort Mill?
A: If there was a 100-bed facility.
Q: Now the point of this -- I mean, what was Ms. Platt's point in this?
A: I mean, her stated point was that the approval of 100 beds was too many. That it would create a maldistribution of resources in York County, and it would potentially restrict access to inpatient healthcare services for residents and other parts of York County if Piedmont were to shift 36 additional beds to northern York.
Q: Right. And you just went over her calculations for 2010. She projected that out in 2015, right?
A: She did. And as you see, the ratios go down a little bit. They go down faster in northern York County because the population is growing

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faster there, but she still showed, you know, that it would be almost twice as many beds per capita in northern York than there would be in the remainder of the county. I've got some conceptual difficulties with this approach, but let's kind of focus on her analysis for right now. And I think there are some mechanical issues in terms of how this analysis was presented.
Q: Well, explain those mechanical concerns you have.
A: Well, if we can go to the right-hand side of this exhibit, and you will see at the top it says Platt Exhibit 4 corrected based on 2012 projections. There are actually sort of two corrections that were made to this or updates if you will. I believe in the Platt Exhibit 4, she did not include the population of zip code 29707.
Q: Is that just an oversight or do you know?
A: I don't know, but it wasn't included. I'm sure she will be here to explain it at some point.
Q: And is 29704 a part of the Fort Mill primary service area?
A: 707.

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Q: 707 -- I'm sorry.
A: Yeah, it is. You know, I believe, it was that zip code that was carved out. It's actually in Lancaster County, but it's located immediately adjacent to the site. And as a result, she understated the population in northern York County. In addition, at the time she did this the census data was not out. And so we didn't know what the actual population counts were going to be in these various components of York County. We now have the luxury of knowing that. And what we see is that the population in northern York is significantly higher.
Q: What was it and what did she estimate the population in northern York to be here in her chart here; do you recall?
A: Yeah, in 2010 there was about 41,000 and then in 2011 about 48,000.
Q: Okay.
A: And so what we are looking at here is about 26,000 more in 2010 and about 31,000 roughly additional population in 2015.
Q: All right.
A: So I mean, obviously having a different denominator in the calculation results in

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different bed-to-population ratios.
Q: All right.
A: And so if we look at it now, if we look at the beds of population, and let's look at all three years for northern York, we can see that the ratio in 2010 is 1.51. It goes to 1.25 and then finally to 1.03 in 2020. You might ask me why am I looking at 2020?
Q: Yeah.
A: The -- where we are today is 2013. Whatever the decision that comes out of this, the likelihood is that there is not going to be a new hospital opening up in northern York County before 2016 or 2017. So the third year of operation could well be 2019 or 2020. And so I think it's important to look at where we're going to be when the new hospital is open. Now, if we contrast these ratios with the ratios for Rock Hill and western York together, we can see there is really not as much difference as Ms. Platt had found in her exhibit.
Q: And the difference gets less and less with each year; doesn't it?
A: It does. In 2010, the ratio -- it's a little

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bit higher bed-to-population ratio in northern York. By 2015, it's almost equivalent and by 2020, the number of beds per capita is actually less in northern York than it is in the rest of the county. So to the extent that this analysis has any meaning, and I think there are some questions about that, this would show that the approval of 100 beds in York County -- in northern York County would not result in a mild distribution of beds based on this framework.
Q: All right. So I think you said earlier before you went into detail on this that you are explaining here the concerns you have about the mechanics of the analysis. And I think you also had some reference that the whole underlying analysis was flawed. Can you explain that?
A: Sure. Let me go back to my PowerPoint. We just talked about the first point, that it relied on outdated population estimates and projections. It sort of arbitrarily divides the county into three areas. If we look at how the state health plan calculates bed need, it calculates it on a county-wide basis. It looks at the whole population of York County. It

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looks at the historical utilization of Piedmont Medical Center and it projects that forward. And there is nothing about the calculation of bed need in the state health plan that has anything to do with how many beds are needed in northern York County. I mean, the 64 beds, it's just an artifact of that methodology. And so somehow I think somewhere along the line, and I don't know where, it became that the need in northern York County was 64 beds. Well, that's not true. The need in northern York County is based on the population of northern York County and what their inpatient utilization statistics and so forth are. And so I think that what Ms. Brandt sort of latched onto this particular analysis of what CHS did and sort of bought into the notion that northern York County only needed 64 beds.
Q: Well, let me ask you about that. In her analysis did Ms. Brandt reference this maldistribution analysis. And if so, how did she reference it?
A: She did. She referenced the fact that this was raised, and she agreed with that and said that she had concerns, I think is what she said,

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that there would be a maldistribution of resources if 100 beds were to be approved in northern York County.
Q: Did she ever see the corrected analysis with the revised population on it?
A: She did not.
Q: Go ahead, I'm sorry, go ahead with where you were.
A: And then, I guess finally there is an underlying assumption in here that if the bed-to-population ratio in Rock Hill is 1.25, that is too few. And if it's 2.0 in northern York County, that's too many. But there is no underlying basis for that. You know, bed-to-population ratios really don't tell you anything. They just tell you how many beds you've got in a given geographic area. They don't tell you anything about the needs. If we look at Piedmont Medical Center, they have 288 beds today in Rock Hill.
Q: Do they need 288 beds in Rock Hill?
A: They certainly don't need 288 beds, because they have an average weighted census of about 180. So on an average day they have 108 empty beds in Rock Hill. So if you said that -- if

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you look at the bed-to-population ratio today in Rock Hill and that number was, let's say 1.5, that doesn't mean that there is a need for 1.5 beds. That just means that's how many beds there are.

And so this bed-to-population ratio I think assumes there is some sort of normative value to a particular ratio, but it's never been established as to what the right ratio would be. In fact, this bed-to-population approach was largely abandoned in the health planning industry sometime in the eighties. And, you know, when the first standards came out one of the standards was there needs to be four beds per thousand in every planning area in the country. I think we've gone well beyond that now and know that that sort of static approach to health planning isn't realistic.

Q: Okay. Now, let's go to your next slide, I believe, and what you just testified about the number of empty beds on a given day or an average day at Piedmont, can you elaborate some more on that?

A: Sure. And, you know, probably the more important point is what happens if you move 36

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beds from Piedmont? You know, if we know that they have, on average, 108 empty beds, I mean hospitals have spikes and utilization during the year; flu season, whatever; some unusual occurrence. Let's assume you transfer 36 beds from Piedmont to Fort Mill Medical Center. That would leave 72 empty beds on an average day in the hospital. And right now with a census of 180, let's say that there was a ten-percent spike. That would be 18 additional patients on that day. Let's say it was a really bad day, it was a 20-percent spike. Then that would be 36 additional patients. Or a really significant spike would be 30 percent. And then you would have 54 additional patients. So even with the 36 beds gone you still have significant flexibility in your bed capacity at Piedmont to accommodate fluctuations and utilizations that occur throughout the year.

Q: Which better addresses -- I'm sorry, let me back up a second. As a health planner, based on health planning principles, when you are planning for a hospital, do you -- is it more important to plan short term, long term, both? How do you -- what kind of -- how many years do

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you look at?

A: Well, you know, I think traditionally in certificate of need applications, you are looking at a five-year planning horizon to sort of establish the basic need for the circle. But when you are talking about building a new hospital, I mean, that costs many millions of dollars, you are building a hospital for a 30- or 40-year life, not a five-year life. It's different from buying an MRI unit that might be obsolete in seven years. It's different from, you know, many other types of activities that CONs are required for. So in a hospital, you obviously have to make sure that in the short term it makes sense. But you also have to look at what the long-term needs of the population are going to be in building something that is going to address both the short and long-term needs.

Q: When you look at the long-term needs of the Fort Mill area or northern York County, which size hospital better addresses those long-term needs, a 64-bed hospital or 100-bed hospital?

A: In my view it would be the 100-bed hospital.

Q: Okay.

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A: You know, as I mentioned earlier, the 64-bed need in the state health plan doesn't have anything to do with the needs in northern York County. Fort Mill is the fastest growing area of York County overall. And if you're looking at a rapidly growing area you've got a population base, we saw, that was going from about 66,000 people up to pushing 100,000 people by 2020. That is significant growth in the area. And I think it's important to recognize that when you build a facility there are certain economies associated with building a facility in one fell swoop as opposed to constantly adding on to facilities over time. It's disruptive and more expensive to have to constantly modify and expand facilities in the future. You know, when we look at the projections that were done for CMC-Fort Mill, I believe they are projecting that by the third year they are going to reach 68-percent occupancy in their 64 beds. That's --

Q: I'm sorry, go ahead. What does that tell you?

A: Well, that says, you know, that for a facility that size the 64 beds at 68 percent occupancy, you are getting to the point where you have to

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think about adding more beds because once you get to about 70-percent occupancy in a facility that size you begin -- those spikes and utilizations that I talked about become more significant because if you've got 64 beds and you are at 70 percent occupancy you've only got an 18-bed cushion. And so the bigger the facility the higher the occupancy rate can be and accommodate, you know, fluctuations and demands.

And so, you know, CMC's own projections, and I think Presbyterian, when they were involved, projected even higher utilization. I think they projected 71 percent utilization by the third year. So if you're building a facility that is likely to need to be expanded in the not-distant future, it would seem to be a wiser health planning decision to go ahead and build sufficient capacity now.

Q: And while we are on this subject of occupancy rates, Piedmont's third-year occupancy rate is 58 percent, is that right?

A: That's true.

Q: Now, does that suggest to you that Piedmont -- I'm sorry, not Piedmont, Fort Mill Medical

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Center --

A: Right.

Q: Fort Mill Medical Center's projected third-year occupancy rate is 58 percent. Does that suggest to you that Fort Mill Medical Center is going to be underutilized?

A: It does not.

Q: And why not?

A: Well, first of all, 58 percent is not low utilization in today's world. I looked at some statistics in the South Carolina state health plan, and I can't remember the exact number, but a significant number of hospitals in South Carolina operate well below 58 percent. Hospitals can operate efficiently and financially feasibly at 58-percent occupancy. Let's suppose we were putting this facility into an area that had a static population. You might be more concerned about having 58-percent occupancy because there would be no ability to go beyond that. If we put this facility in a high growth area like northern York County, we know that the population is likely to continue to expand and that there is going to be increased demand in the future. And so 58

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percent says we are going to be pretty well utilized by the third year. We are going to be economically justified based on the projections that were in the application. But beyond that we've got the ability to be able to serve the needs of the population for a longer term than just the first three or four years of operation.

So I think from a health planning perspective I think that is advantageous.

Q: All right. Anything else you would like to say about the maldistribution issue?

A: No.

Q: All right. Let's go back. What is your next so-called pivot point?

A: Unnecessary duplication.

Q: All right.

A: And this relates, again, to the 36 additional beds that Piedmont was proposing.

Q: Why did you believe this was a pivot point in Ms. Brandt's decision?

A: Well, because I think there are certainly two aspects of my reasoning. The first is I think she focused way too much on the 36 beds that Piedmont was proposing to transfer. And the

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fact that those were already existing beds in the county, so there were no new beds being created. And secondly, you know, I think that Piedmont demonstrated that at Fort Mill Medical Center, those beds would be well utilized.

But secondly, I don't believe Ms. Brandt took a look at the unnecessary duplications that would occur between Fort Mill -- I mean CMC-Fort Mill and CMC-Pineville. For reasons I've already talked about earlier, the 2007 CMC-Pineville certificate of need application justified the additional capacity they are adding there based on York County residents. And in my view the CMC-Fort Mill facility will duplicate these facilities at Pineville.

So if you are concerned about unnecessary duplication, here is a brand new major expansion project for a hospital located on the border of the county. Now, Ms. Brandt doesn't have any authority to review North Carolina hospitals, but she certainly can look at -- and this issue was raised in the review process. It was raised somewhat prominently by Presbyterian that this would be duplication of resources that existed at Fort Mill -- I mean

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at Pineville. And Ms. Brandt gave no consideration of that.
Q: Okay. Now, you talked already to some extent about the effect that CMC-Fort Mill would have on Piedmont's specialty programs. How does that relate to the concept of unnecessary duplication?
A: Well, we've already heard testimony about all the investments that Piedmont Medical Center has made in the specialty programs over time and the recruitment and the facilities that were constructed. We talked about the fact that CMC-Fort Mill is likely to redirect at least some of these specialty patients to programs in North Carolina. And so the declining utilization of these services at Piedmont that would likely be exacerbated by the CMC-Fort Mill project in my view is another form of unnecessary duplication because it means these services that are already in place are going to be underutilized for the benefit of hospitals in North Carolina.
Q: All right. Are we ready to move to your next pivot point?
A: I think we are.

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Q: All right. What is your next pivot point?
A: It is financial access.
Q: Financial access. All right. With respect to this topic, what is your opinion about CMC-Fort Mill's projection of charity care?
A: Well, I mentioned earlier that they projected 6.3 percent charity care.
Q: And that is 6.3 percent of what?
A: Of gross patient revenue.
Q: What is gross patient revenue?
A: Well, that is the actual charges that are made to patients. I think there has already been some discussion about this, but hospitals charge patients based on a number of factors. But they rarely ever collect what they charge. Medicare and Medicaid have established reimbursement policies, and they pay significantly less than the list charges, if you will. Even commercial carriers, managed care companies, they negotiate deep discounts on charges in their managed care contracts with providers.
So, I mean, the charges are -- they serve a purpose, but they don't have a whole lot to do with the amount of money that hospitals

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actually get paid.
Q: Okay. All right. That is just by way of context. All right. Why do you think the 6.3 percent of their charges that CMC-Fort Mill projects, what do you think that number is?
A: Well, first of all, Mr. Levitt, I think, showed an exhibit and showed what the charity care commitments were at other applications that DHEC has approved. And I won't go into that exhibit again. But that shows that this projection was the highest of all the applications by a wide margin. So it is inconsistent with what DHEC has looked at in the past. But sticking with the demographics of northern York County, I believe the exhibits Mr. Levitt introduced showed that York County was one of the more affluent counties in South Carolina and northern York was the most affluent portion of York County. So you wouldn't expect there to be a significant number of indigent patients living in northern York County. So I think that's a concern.
It's also inconsistent with data that I've reviewed about the payer mix status of individuals in northern York County. And I've

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got a couple of slides that address that. And the data that we have comes from the South Carolina Office of Research and Statistics and from -- North Carolina has a system called Thompson Reuters. Actually, I think the name has changed now to Nelson or something. But they collect information by zip code. And so we can look at the zip codes. And if you look at the bottom of this chart the three zip codes in northern York County are highlighted. And we can see that in terms of Medicaid services these are people who fall below certain income levels, which would be low income individuals. Only 7.9 percent of the patients served in hospitals from those three zip codes were Medicaid recipients.
Q: And Medicaid is not charity care, though, right?
A: It's not charity care, but it's an indicator of the level of low income individuals in your area.
Q: All right.
A: And in the rest of York County the Medicaid population is 16.4 percent. So it's more than double. So you wouldn't expect there to be a

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disproportionate amount of Medicaid, for example, in northern York County in looking at these statistics.

And then if we look at another measure. And this is self-pay and charity. This is how the data is reported. These are people without insurance. Some of them are what is called self-pay. They might have incomes above poverty levels, you know, that would put them in the charity category, but they don't have health insurance. And then there are also people who are charity patients who would be those who met criteria to qualify for free care.

Q: All right.

A: And again, Fort Mill, for both self-pay and charity was only 5.5 percent. Now, I don't know what the exact percentage of charity versus self-pay is. But in other measures that I've seen those numbers are generally roughly equivalent. So about half or -- you know, roughly half would be charity and half would be self-pay.

Q: All right. And so if that were true here, and I realize you said you don't know, but if that

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sort of rule of thumb were to be applied, half of 5.5 percent would be what?

A: 2.75 percent.

Q: And you would expect the charity care population in the Fort Mill area to be around that level?

A: Sure. I mean, that would be a reasonable expectation. When we look at the rest of the county we see that the charity care self-pay levels are 9.5 percent, so not quite double, but significantly higher than they are in northern York.

Q: All right. What about Pineville, the experience of CMC-Pineville?

A: Well, based on the data I have reviewed, it looks like the charity care experience, and they can put them with Pineville's experience, as well.

Q: Do you mean charity care projections?

A: Charity care projections are inconsistent with the historical experience at CMC-Pineville.

Q: All right. And what is the Demonstrative 200 here, what does that say?

A: This is information taken from Medicare cost reports.

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Q: Okay. Let me stop you there for a minute. What are Medicare cost reports?

A: The federal government requires that all providers who participate in the Medicare program annually submit a very detailed report. I mean, for hospitals it is literally a report that is very thick, and it has many many schedules. And it breaks down in great detail the revenues and expenses associated with each department, you know, in a hospital. And ultimately -- I mean, at one time it was very very important because you got -- hospitals got paid their actual costs in treating Medicare patients. Now it's more indirectly associated with reimbursement, but it goes -- it is also used by the federal government in calculating reimbursement rates.

Q: When a hospital or another provider submits a Medicare cost report, do they have to sign any kind of certifications with the government?

A: They do have to certify the accuracy of it. And in fact, there are both civil and criminal penalties associated with falsifying information on cost reports.

Q: All right. Go ahead and explain your charts

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then.

A: Okay. There is a table in the cost report that I think is S10 that shows the dollars of charity care, gross revenue dollars of charity care that are provided. It shows the total gross revenue of the facility so you can calculate the percentage of charity care -- of gross revenue for each of the hospitals. And so we looked for each of the CMC facilities and then we also looked at Piedmont. And we see that Mercy-Pineville, and let me qualify this in one respect. Pineville isn't broken out separately from CMC-Mercy downtown.

Q: And CMC-Mercy downtown is another hospital?

A: It is. It's another hospital, but they operate under a single license, as I understand it. And they file a consolidated cost report.

Q: All right.

A: Certainly Pineville is a significant component of that dual operation, but I don't have a specific breakdown for Pineville only. But if you look at the combined charity care for Mercy-Pineville, it's 2.6 percent. That is close to that 2.75 we were talking about a minute ago. And even if we assume that

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Pineville was a little higher than Mercy downtown, and I don't have any reason to think that is the case. I mean, you would think downtown where there is a higher indigent population it would likely be a little bit higher. But I don't think it's 6.3 percent. And so, you know, Pineville's own experience is 2.6 percent. Piedmont, if we look on here, is 3.8 percent. So they had a little higher experience. But that's because they serve all of York County, which has somewhat different demographics than the Fort Mill area. And the area across in Southern Mecklenburg County is similar in terms of being sort of a high growth suburban area with somewhat higher income characteristics.

Q: Now, you read Ms. Brandt's deposition; did you not?

A: I did.

Q: And when she was considering the charity care projections at CMC-Fort Mill based on her deposition, what weight did you give historical experience of Mercy and Pineville?

A She gave none.

Q: And after a CON facility, like a new hospital

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is built, how does DHEC go back -- to what extent does DHEC go at that point and check and make sure that the charity care facility is actually providing, is consistent with projections they gave in their CON application?

A: There's no check that goes on. I mean, Mr. Grice testified that was the policy when he was in that position. And I believe Ms. Brandt in her deposition also indicated that she made no check after that, that they did not do anything.

Q: Go ahead with where you were. I'm sorry. I interrupted you.

A: So if we look at Pineville's experience, which I think would probably be the most directly relevant measure of what the likely charity care percentage would be at a Fort Mill facility, it would be less than half of what was projected for Fort Mill. And then if we look at again, the payer mix of the Carolina Physician's Network Physicians, as I've already discussed, they have relatively low levels of Medicaid and charity care in their practices. So there is nothing there that would indicate that 6.3 percent would be reasonable.

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Then finally when I look back at the 2005 application that was submitted for Fort Mill by CMC, they had, I think, 3.5 percent projected charity care there. And so their projection now is nearly double of what they projected initially.

So in sort of taking all that together, if I were DHEC, I might have questioned how much weight would I give to a 6.3 percent projection of charity care in the CMC-Fort Mill application.

Q: The updated applications from the -- or updated submissions from the three parties following the remand were in October of 2010, is that right?

A: Well, they were for Presbyterian and for Piedmont. For some reason, CMC-Fort Mill did not file. They completely filed their updated application in December. So they had an opportunity to see the changes that were made in the other two applications.

Q: And when you say they didn't file their updated application, do you mean they didn't file their charity care projections specifically in October of 2010?

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A: That's true

Q: When did you say they filed?

A: In December of 2010.

Q: Now, when did Presbyterian file its charity care projections for the second go round?

A: October 2010.

Q: And Presbyterian -- what did Presbyterian and Carolinas project back in 2005 and what did Presbyterian project in October 2010?

A: I believe Carolina's was 3.5 and Presbyterian's was around 3.2 or 3.3.

Q: That was back in 2005?

A: In 2005. In 2010 in October, Presbyterian projected six percent, which was quite a significant jump in its projection. And then in December of 2010, CMC-Fort Mill projected 6.3.

Q: Mr. Sullivan, if between 2005 and 2010, if CHS changed its charity care policy to cover a broader range of incomes, would that account, in your opinion, for the charity care projection going from 3.5 percent to 6.3 percent?

A: I mean, it's possible. And we saw in 2011 that change -- if that change occurred before 2011,

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it didn't have the significant impact on the percentage at Mercy Pineville. But if indeed they had a change in policy after 2011, which would have been after they filed their updated application in this case, they -- it wouldn't change the number of people in the community who need charity care. It would change the bookkeeping in terms of how they counted self-pay patient versus charity care patients. So I don't think that's really -- if they are already serving the patients and they're just putting them in a different pot than they were before, I don't see that really being an expansion of assets.

Q: What about Piedmont's record on charity care?

A: Piedmont has a pretty longstanding record of providing financial access in York County. I think we saw a minute ago that their charity care percentage in 2011 was 3.8 percent. Piedmont has a contract with the county to provide charity care. That contract is going to extend to Fort Mill Medical Center, as we've heard testimony about. Piedmont consistently exceeded the charity care requirements in the contract. I think they've been a pretty

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accessible organization. And Piedmont in preparing the Fort Mill Medical Center application, came up with a projection of charity care. I think it's realistic for the needs of that population consistent with their experience and also consistent with the demographics of that area.

Q: That was a 3.5 percent, you said?

A: 3 percent, I think.

Q: 3 percent -- I'm sorry.

A: And so, I mean, as a result, this is one of those where Ms. Brandt gave favorable consideration to CMC-Fort Mill. I think this is one where she should have said both of these projects will provide the same level of financial accessibility. There is no reason to differentiate.

Q: All right. Anything else you want to talk about on the issue of financial access?

A: I don't think so.

Q: All right. What is your next pivot point in this, Mr. Sullivan?

A: This gets into the financing -- in financial projection issues.

Q: All right.

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A: And --

MR. WESTBROOK: Let's go to that slide, please.

A: The first statement I make is that Ms. Brandt made comparative findings regarding these financial aspects of the project, which I don't think the CON criteria really support. I think the CON criteria are asking whether the applicant has presented reasonable projections of financial performance that are consistent with other projects that DHEC has reviewed. I don't think it is necessarily a step that DHEC had to take to say well, I think this applicant was better on this point and this point. I think it is more do these applicants provide sufficient documentation that their financial programs that they've set forth are reasonable. This is one where I think that DHEC could have looked at this sort of broadly and are both applicants consistent or is one of them not consistent with the criteria. And my reading of Ms. Brandt's decision is that both applications were consistent with all the criteria, she just liked CMC-Fort Mill's numbers better.

Q: All right. What's your next bullet point to

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address?

A: She -- you know, one issue that I thought was unusually prominent in the decision was where she was talking about the methods of advancing proposed by these applicants, and she gave CMC-Fort Mill favorable consideration because she said they proposed a more definitive form of project financing, in that CMC-Fort Mill said that they were going to use cash reserves to finance their project.

Now, Piedmont had a letter for the Fort Mill Medical Center application that stated that they had access to both debt and equity financing and that they would use the appropriate mix of financing at the time the project was developed. I've been putting together CON applications for 30-plus years. That's a pretty common approach to take in presenting financial documentation in CON applications.

Q: And why is that a common approach? Why would it be reasonable to present options?

A: I mean, market conditions change quite rapidly in the financial world. And, you know, right now we are in a period of very very low

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interest rates. Right now it might make sense to say we would use debt financing. But by the time you're ready to go with the project, the feds may have changed its policies and interest rates may be 2 or 3 percent points higher. And you decide at that point to use cash. So, you know, I think it's important to give the applicant the flexibility of being able to use the type of financing that is most appropriate at the time.

Q: And, in fact, what kind of financing did Presbyterian propose?

A: The same as Fort Mill Medical Center. They proposed to use either debt or equity depending on the circumstances. And so this is one where, again, I think Ms. Brandt gave favorable consideration to the CMC-Fort Mill when I think a more appropriate finding would have been that both have demonstrated the ability to finance their projects.

Q: All right. What about project costs?

A: This is related to the 100 bed, 36 additional bed issue. She found that CMC was the most favorable because they proposed lower project costs because they're building a smaller

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facility. But if you look at it in terms of cost per bed, cost per square foot, the Fort Mill Medical Center was actually slightly less than the CMC-Fort Mill project. So this is where the need argument gets tangled up in the financial evaluation argument. But I think that, again, Mr. Levitt showed an exhibit that showed what the project costs for a whole range of different new hospitals that were approved. And these applications are well within the midpoint of that range. So I think, again, a finding should have been that these projects were both consistent with its criteria.

Q: All right. Ms. Brandt also gave consideration to what she believed were conservative assumption by CHS, is that right?

A: She did. She said that she thought that the projections of revenues and expenses made by CMC-Fort Mill were more reasonable because they were based on a conservative assumption that CMC-Fort Mill would only shift patients from existing CHS facilities. I won't go again into why I don't think that's a conservative assumption or a realistic assumption. I think CMC-Fort Mill is clearly going to serve

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patients that would go to other facilities besides CHS facilities. I don't think that has anything to do with the reasonableness of their financial projections. So again, this is -- you know, my bottom line is I think both applicants have presented reasonable financial programs in their applications. And I think the finding should have been that both applicants were consistent with these criteria.

Q: All right. Are you finished now going through what you call the pivot points of Ms. Brandt's decision?

A: I am.

Q: All right. Let me ask you this. With respect to that group of five, I believe it's five pivot points that you just talked about, I believe you identified these as when you consider the pivot points in her analysis. What is, in your analysis, key pivotal point decision making between these two applicants?

A: In my analysis, it's adverse impact.

Q: And why is that?

A: You know, I think that both applicants were proposing to build a new hospital in Fort Mill. So access is somewhat neutral. I think the

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Fort Mill Medical Center is superior in the sense that it's a larger facility and will meet the longer-term needs. But in terms of access, in terms of cost, in terms of financial projections, financial access, I think all those things are relatively neutral between the two applications.

But when we look at adverse impact without going through all my testimony again, I think there is a significant potential for the approval of CMC-Fort Mill to have a negative impact, not just on Piedmont, but on the healthcare system in York County. And I think that should have been giving great weight in the decision because I think that goes directly back to the purposes of the CON.

Q: All right. Good. Let's go to an issue that I don't believe Ms. Brandt addressed at all. And that's the issue of competition. In your opinion, would approval of CMC-Fort Mill enhance competition?

A: In my opinion, it would not.

Q: Why not?

A: First of all, competition is already strong in the county. Right now more than 40 percent of

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the patients receiving inpatient hospital care are leaving York County to receive that care. So obviously options exist and patients are exercising those options. CHS has made one very convenient by building a large hospital on the border of York County at CMC-Pineville. In the -- if we looked specifically at the Fort Mill area, you know, if there is a question about whether competition exists in the Fort Mill area, I believe that testimony we've heard so far, and I think we will hear from the CHS witnesses, is that CHS is the dominant provider in Fort Mill. They have something like 60 percent market share in those zip codes. So they already have a relatively dominant position there. This is not --

Q: What about the larger market outside the Fort Mill area, the larger Charlotte area. Who is the dominant provider?

A: Well, if we look at more broadly, I mean -- I think that CHS is by far the largest hospital system in the broader Charlotte market. There was a number of -- there were a number of documents in the submissions to DHEC that talked about the issue of market dominance and

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so forth. And Presbyterian, I think, pressed this issue. I think there are 21 hospitals in the Charlotte area. Eighteen of them are controlled by either Novant or by CHS.

Q: And who is Novant?

A: Novant is Presbyterian. That's their parent company. Piedmont is one of the little guys. They are one of the three unaffiliated hospitals in the market. And so they are already facing a significant challenge in trying to compete. I mean, even though they are part of Tenet Healthcare, which is a national company, Tenet doesn't have the resources in this market, doesn't have the reach in this market, it doesn't have the physician network in this market that CHS does. And so they are already struggling to compete and to maintain their services in York County so that they can effectively serve York County patients. And in my view, the CHS project is just going to further weaken that with all the reasons we've already talked about. It's going to allow CHS to strengthen its physician network. And given that CHS is now entering into the payer or the health insurance market,

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having a hospital here is going to allow them to gain even greater leverage in the market than they already have, which is already significant. So from a competitive standpoint Piedmont has hung on for a long time through its efforts. CHS has taken a big step in the last seven years to come in and dilute the level of volume at Piedmont. And giving this hospital to CHS and Fort Mill, I think could be the tipping point, if you will, in terms of significantly destabilizing the healthcare system in York County and resulting in more people leaving the county for care. So I think, if anything, this will just extend the existing dominant position that CHS has further into York County, not to the benefit of York County residents.

Q: Thank you, Mr. Sullivan. I don't have any other questions.

THE COURT: Thank you, Mr. Westbrook. Any objections to the ten-minute recess?

MR. GASKINS: No, Your Honor.

(Off the Record)

THE COURT: Please be seated. Are you ready?

MR. GASKINS: Yes, sir.

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MR. SULLIVAN - CROSS EXAMINATION BY MR. GASKINS:

Q: Good morning, Mr. Sullivan.

A: Good morning.

Q: As I understand it, you were retained by Tenet or Piedmont in the summer of 2012, is that correct?

A: True.

Q: Okay. I take it you are being paid for your engagement, is that correct?

A: I am.

Q: And what is your hourly rate?

A: $325.

Q: Now, you were engaged by Piedmont back, I think, in late 2004 or early 2005 when they initially submitted their application; were you?

A: There may have been a contact at that time, and I think I declined getting involved.

Q: So there was a contact from Piedmont?

A: My recollection, yes.

Q: But they never engaged you at that time?

A: Yes, that's correct.

Q: Rather you were engaged by CHS; isn't that correct?

A: No. CHS had asked me also about getting

Q: But you didn't identify those errors when you reviewed it; did you?
A: I did not. I had not -- I did not go through and redo the calculations.
Q: I believe you got into what you thought the adverse impact would be, not only on Piedmont but also on the healthcare system in York County in general, is that right?
A: That's true.
Q: Okay. And you said that you had some fears that Piedmont would have to cut some of the services that they currently provide, is that right?
A: That's true.
Q: And generally speaking that they will have to cut the services when the volume level gets to the point where either the quality decreases and they can't handle it or because it's just not economically feasible, is that right?
A: Right. I think that at some point the doctors will not want to perform procedures there if the volumes get too low. And obviously if it is a very expensive service to maintain and there is not sufficient patients, ultimately it probably will have to be discontinued.

MR. SULLIVAN - RE-DIRECT EXAMINATION BY MR. WESTBROOK:

Q. Thank you, Your Honor. Just a few. Mr. Sullivan, in the initial application, 2005 application for CHS, I believe you said you reviewed that, is that right?

A: I didn't -- at the time of my deposition, I didn't recall having done that. I mean, having seen the proposal and so forth, obviously I did.

Q: Okay. And of course, you reviewed the updated CHS application, is that right?

A: Oh, yeah.

Q: And you testified at length today about the updated application, is that correct?

A: Yes.

Q: Are your opinions based on the updated application or based on the original application primarily?

A: The updated application. There were significant changes.

Q: All right. And for example, in the original application, did CHS propose to shift all of the patients that would be served at CMC-Fort Mill from their existing facilities? Was that

part of the original application?
A: It was not. The original application talked about there being an impact on Piedmont and other North Carolina hospitals.
Q: All right. Actually in terms of comparing the original adverse impact of the original projections from where their patients would come from with their updated applications, which were the more recent in your opinion?
A: The original application.
Q: Mr. Gaskins asked you about some of the South Carolina hospitals that you had done work for. And I believe you testified on direct about some of those. Have you worked with Waccamaw Community Hospital?
A: I did.
Q: That was a new hospital project; was it not?
A: For Georgetown, yes.
Q: All right. Now, I believe Mr. Gaskins also asked you about your past work for Tenet Corporation. Did I understand you to say identifying in addition to this project that there had been two or three other projects you had worked on with Tenet in the past?
A: I mean, over the course of my whole career

there has been many more. But, I mean, in recent years there is only one other hospital I can recall having worked for in say the last six or seven years.

Q: Have you ever been affiliated exclusively with Tenet or primarily with Tenet?

A: No.

Q: Have you worked with other large hospital systems for profit and nonprofit around the country?

A: I've worked with many, yes. Just in the last year I've worked with four or five of the largest hospital corporations.

Q: All right. Let me ask you to look back at your deposition in a question or two that Mr. Gaskins was asking about that day.

MR. WESTBROOK: Dan, can you pull up Mr. Sullivan's deposition, page 55?

Q: And let's go over some of the language that Mr. Gaskins had you read on page 55. That paragraph that begins on line 13, I don't think we need for you to read the whole paragraph. But in particular, why don't we start that line halfway through 17 where the sentence begins, "so I knew." Do you see where I'm talking

about?

A: I do.

Q: Would you just start reading "so I knew" down to through the rocket scientist part of that paragraph.

A: Sure. "So I knew that they were already in a difficult spot and then putting a competing hospital seven or eight miles away from Piedmont, I mean, I don't think you have to be a rocket scientist to figure out that wouldn't be an ideal situation."

Q: All right. Your comment about the rocket scientist there and that they would be -- that Piedmont would be in a heck of a situation. I need for you to clarify that a little bit. Were you saying that you didn't have to be a rocket scientist to know what DHEC was going to do or you didn't have to be a rocket scientist to know that PMC was going to suffer some adverse impact?

A: What I meant was the latter. That you wouldn't have to be a rocket scientist to know that putting a new hospital that close to the existing Piedmont Hospital would result in negative impact.

Q: And, in fact, in the newspaper interview, you said you didn't know what DHEC was going to do because they hadn't made a decision at that point, is that correct?
A: That's correct. You know, and I knew they had a new director. And I didn't know what they were going to do. I mean, my expectation was that just because Piedmont had been approved before and they were the South Carolina based provider, that they would probably get approved.
Q: And that new director that you are talking about, that's Ms. Brandt, right?
A: Yes.
Q: And she had just been appointed a year or two before that newspaper interview?
A: Yes.
Q: And had you had a lot of experience in working with Ms. Brandt at that point?
A: I think I only had maybe one conversation with her.
Q: With respect to Mr. Gaskins' questions about physician recruitment and the building of physician networks. I believe there has been testimony by you and others about this. I

would like for you to elaborate if you could. Isn't the primary purpose of building a physician network --

MR. GASKINS: Your Honor, I'm going to object. He is leading the witness.

MR. WESTBROOK: Okay. I'll rephrase my question.

THE COURT: Sustained. Go ahead. Will you rephrase, please, Mr. Westbrook?

MR. WESTBROOK: Sure.

Q: For building up -- the purposes for building up a physician network, can you relate those purposes to the concept of market share, please?

A: Sure. If you have a large base of physicians, and the physicians are inclined to use your facilities for their patients, then having more physicians gives you the ability to capture more market share. If you have -- and that's if they are employed or otherwise contractually obligated to, you know, primarily use your services. If you have -- if you recruit physicians who are independent physicians, there is another way of developing a network. That's less effective in developing an increasing market share because let's say a new

hospital were built, those independent physicians would likely seek privileges of that new hospital. And even though you may have recruited them to the area, they were not necessarily going to come to your hospital and wasn't going to make any significant improvement in your market share.

Q: All right. Thank you. Now, with respect to another objective, the objective of serving patient needs. Is there an advantage -- that's -- with that purpose in mind, is there an advantage to an independent physician network versus an employed physician network? Is there an advantage, disadvantage or at all?

A: Yeah. It's a good question. I mean, it's an intention that's going on in the healthcare industry right now that, you know, and I believe it was Dr. Taylor that said that he thought the system worked better when the physicians were independent. And I don't disagree with that because the physician can be the advocate for the patient. And when they are employed by a healthcare system, their loyalties are a little different. I am not saying that doctors are making bad decisions,

but they make different decisions. But the direction that healthcare is going in is further consolidation of physician practices and hospitals into networks. But I think there is a dilemma in terms of whether the patient's needs somehow get overlooked in that process.

Q: All right. Mr. Gaskins referred to utilization leveling out or even an up-tick, I believe was the term he used in the last or recent years. Do you recall that question?

A: I do.

Q: With respect to utilization at Piedmont leveling out or there being a slight up-tick in a couple of years, how is the -- I mean, how is the payer mix break down on that up-tick?

A: I believe the testimony that we heard was that there has been increasing levels of self-pay, Medicaid and Medicare and a decrease in the level of commercial/managed care type of insurance. So as I mentioned in my direct testimony, I view that as an erosion of the payer mix in that it is a less profitable mix of patients.

Q: Now, there was some -- you testified about that you would give greater weight to a physician

coming to a courtroom taking an oath and testifying and subjecting himself to cross examination than you would to a physician writing a letter. I assume -- would that be true for any witness, not just physicians?

A: Sure. You know, I think it's easy to write a letter. It's harder to come and take your time and put yourself on the line and subject yourself to examination.

Q: And you talked about your experience with physicians signing form letters or letters that have been drafted for them. Have you reviewed the support letters submitted for Piedmont by independent physicians in this case?

A: I have.

Q: Did they appear to you to be form letters?

A: They did not. You know, and I had an opportunity to talk individually with a lot of the guys who wrote support letters for Piedmont. And it seemed to me that they had been written independently and not, you know, not basically authored by someone else.

Q: Now, with respect to the sixth addendum to the York County contract, Mr. Gaskins has asked you some questions about that, relating that to Mr.

Miller's testimony about negotiations with CHS. My question is do you know the extent to which that sixth addendum was the result purely of negotiations with CHS or were there other factors involved; do you know?

A: I don't know.

Q: I believe you have already testified about the effect of either Fort Mill Medical Center or CMC-Fort Mill on physician recruitment in this area on direct?

A: I did.

Q: All right. Well, I won't ask you to go through that again. And I believe Mr. Gaskins asked you whether -- whichever applicant gets to build a hospital, I believe you testified would have some impact on out-migration, is that right?

A: Yes.

Q: Can you quantify or explain what you mean by some impact? Can you be more specific? What level of impact do you think a hospital -- well, let's start with CMC-Fort Mill. What level of impact would CMC-Fort Mill, if it were to be built, how about out-migration?

A: I think it would bring back some of the out-

migration --

Q: I'm sorry -- CMC-Fort Mill. Let's start with that one.

A: Okay. CMC-Fort Mill. I think some of the patients who are going to Pineville now, I think some of those will stay and go to the Fort Mill facility. I think also some patients who are now going to Piedmont will go to that facility. So, you know, I think it will have some impact. And I haven't -- I can't give you an exact number of patients. Now, if we contrast that with Fort Mill Medical Center, I think their sole focus is going to be on trying to attract patients who are currently leaving the area. That undoubtedly will serve some patients who otherwise would have gone to Piedmont, as well. But I think their effort is going to be in developing a network of physicians and services that would be attractive to patients who right now are choosing to leave the county for care.

Q: All right. And will -- Mr. Gaskins asked you a number of questions about competition. And I think you testified about this on direct. Can you summarize again for us in light of his

questions, which of these projects would have -- in your opinion, which of these projects would enhance competition more and which would decrease competition and why you say that?

A: Sure, I mean, if you look at the broader landscape of the competitive market in the Charlotte area, and that includes York County, CHS is the largest and most powerful competitor now. If Fort Mill Medical Center is approved, there is a greater ability for Piedmont to be able to hang onto its existing market share and also to retain some of the specialty patients who are currently being referred out of the area by the CHS physicians now. If CHS in contrast is awarded the CON, then I think we are going to see a continued out-migration of specialty patients. And I think we are going to see Piedmont be somewhat cut off, if you will, from the ability to refer that out-migration back into the county. So I think that what's going to happen is it's going to weaken Piedmont because it will be dealing with a smaller service area and a less affluent service area. And so the bigger system of the two will get stronger and the smaller player

will get weaker and so sort of the market reach of CHS will be extended.

Q: All right. And let me ask you one final question. The term charity care has been used a number of times and a lot of witnesses have used the term charity care. The term indigent care a lot of witnesses --

MR. GASKINS: Your Honor, I'm going to object. I don't think I asked him any questions about charity care or indigent care during my cross. So it's beyond the scope of my cross examination.

THE COURT: I recall there being a charity care question from Mr. Gaskins. Where we going with this?

MR. WESTBROOK: I think where I was going with that, there were questions about payer mix. Well, specifically there were questions that this relates to the up-tick question about, you know, things are looking up at Piedmont in the last couple of years and utilization has stabilized. And I think the testimony has been, and I think Mr. Sullivan just commented that, well yeah, the charity care patients have increased or there has been an up-tick in

charity care patients at Piedmont but not in paying patients, and I wanted to ask a followup on that.

MR. GASKINS: I didn't address payer mix, either.

MR. WESTBROOK: Well, he didn't address payer mix, but he addressed utilization. And the point about utilization is not that utilization -- there's been an up-tick in utilization; the fact that we are getting -- that Piedmont is getting more patients doesn't mean anything unless it is put in the context of who those patients are. And the payer mix there is really the issue.

THE COURT: And Mr. Westbrook, you did an excellent job of asking this question of Mr. Sullivan. I took very good notes about the whole -- the Court is very aware of that end, although there is perhaps, an increase in patients and the payer mix between the insured patient versus charity care or Medicare-Medicaid patients has shifted at Piedmont.

MR. WESTBROOK: And can I just, if Your Honor if you will, and you may sit me down. That's fine. I promise this is my last question. But what I would ask him is really a definition

question. And that is: It relates to when he's talking about charity care, sometimes the term charity care is used. Sometimes the term indigent care is used. I just want to make it clear that we are talking about the same thing. It is not a semantical difference between the two. I'm not sure what he's going to -- I think I know what he's going to answer to that, or I wouldn't ask it. Is charity care and indigent care the same thing? We talking about the same thing? That's my only question there.

MR. GASKINS: And that certainly was not within the scope of my cross.

THE COURT: With that limited purpose, I'm going to overrule your objection, Mr. Gaskins. Mr. Westbrook, please go ahead and ask.

MR. WESTBROOK: Let's hope this is the over and the answer is what I want.

Q: Mr. Sullivan, we've talked -- you've talked about charity care and indigent care, and a lot of witnesses have. And in your mind, are those the same thing or are we talking about the same thing?

A: I think the way they are used in common usage, they are the same thing. I mean, there are

some states that differentiate between those two terms where charity care would be people that fell below a certain, you know, income level. And indigent care would be people above that who had other requirements. But, yeah, in general, I think that they are the same.

Q: Thank you. No further questions.

MR. WESTBROOK: Thank you, Your Honor.

THE COURT: Thank you, Mr. Westbrook. Mr. Gaskins?

MR. GASKINS: No further questions.

THE COURT: Ms. Biggers?

MS. BIGGERS: No questions, Your Honor.

THE COURT: All right. And are we finished with this witness?

MR. WESTBROOK: We are.

THE COURT: Mr. Sullivan, thank you very much, sir.

MR. SULLIVAN: Thank you.

THE COURT: You may be excused. Now, ladies and gentlemen, my understanding is that was all we were going to do today, is that right? Now, do we need to have a brief post off-the-record meeting about just sort of an administrative discussion? Do we want to take a little break here and give everybody a chance to filter out. And then we will perhaps just meet back in this

Q: Well, let's look at the state health plan itself. This is Charleston, CHS Exhibit 12, Page 11.

MR. MULLER: If you would just pull up the -- I call it Roman Numeral I.

Q: Here is the state health plan. This is from CHS Exhibit 12, which is the 2004, 2005 state health plan. And the language that they use here is that an additional finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment. Do you see that?

A: Yes, I do.

Q: So the question is whether the benefits of improved accessibility outweigh the adverse effects caused by a duplication. There is no words for "protect market share" in there, correct?

A: No, sir. Not those specific words.

Q: All right. In terms of increased accessibility certainly with as many patients as CHS has in this area of northern York County, the hospital

that they would put there would give improved accessibility to those citizens, correct?

A: Well, I think any hospital built in Fort Mill would certainly improve access. But there are some other important reasons here, and that is that we had our existing hospital, as we've mentioned. That's been there for 30 years, and is suffering from out-migration and that rapidly growing area in Fort Mill with a satellite could really benefit the system there at the existing hospitals as satellites have done in other areas of South Carolina and counties. And if we put a competitor there it's going to really further diminish the services of the existing hospital because the competitor such as Carolinas will really be transferring a lot of their patients to their larger hospitals in Charlotte for more sophisticated services when necessary.

Q: There is no question, is there, that because Rock Hill is to some degree a veteran community of Charlotte; is it not?

A: I'm sorry, a butyrin --

Q: A butyrin community.

A: Yes, sir. I think probably a lot of people

that even work in Charlotte live perhaps in South Carolina.

Q: And the same to some degree or to a greater degree in areas north of York County closer to Charlotte.

A: Yes sir.

Q: You've seen, for example, that one of the doctors who testified for Piedmont actually lives in North Carolina and travels here to work.

A: Yes, sir.

Q: And did you notice that every single doctor that testified for Piedmont is also licensed in North Carolina?

A: I think being so close to the state line; yes, sir, I understand.

Q: And there are certain services that would most likely be logically performed in North Carolina, correct?

A: Perhaps; yes, sir.

Q: For example, CMC Main, Carolina's main hospital has a transplant surgery that no other hospital in Rock Hill could offer.

A: That's correct.

Q: And they have a Level 1 trauma center that is

some place where trauma patients are taken from anywhere in the area.

A: Yes, sir. I understand.

Q: but let's look at what you said in the prior review.

MR. MULLER: This is CHS-4(b), 941-942. Would you go to the bottom there and just enlarge that last paragraph?

Q: This was in your CON summary sheet in the prior review. It says York County population is out-migrating to Charlotte facilities for tertiary services but currently there when York County is P&T are doing so out of choice and/or at physician's election since none of the --

MR. MULLER: Would you go to the next page and enlarge the top.

Q: -- of the four competing applicants have opted to offer these type of services, this sudden out-migration will continue and cannot be curbed by any of the four applicants. Only a portion of the out-migration will be affected by a community hospital located in a more convenient location." Do you recall that finding?

A: Yes, that was in the 2006 decision, is that

correct?

Q: And those four were Piedmont, CHS, Presbyterian, HBA. Those are the four applicants.

A: That is correct.

Q: I take it that your view was that if Piedmont could build in northern York County, then patients -- South Carolina citizens who wanted to go elsewhere could simply go to Charlotte or to Pineville or wherever to CHS Hospital, to be seen at CHS Hospital.

A: They would certainly have that ability of choice as they do today, yes. They would have that choice. But I think the hospital -- the Fort Mill Medical Center developed by Piedmont and Fort Mill would be better -- better for the citizens of York County overall in this situation because it would allow the existing hospital in Rock Hill to not lose as many patients in the future. It would help reduce some of the out-migration and help allow more transfers of tertiary -- of patients requiring tertiary services to the Rock Hill facility.

Q: I take it that you don't -- I recall your testimony being you only planned for South

Carolina citizens, and you do not plan for North Carolina citizens.

A: I try to be fair. But that was what I was told by the 3M committee. So, you know, that would make a big impression. And I do understand the point there. We live in South Carolina. I work for South Carolina state government. My first concern is to make sure that we protect the services we have in South Carolina that we have approved in the past and that we don't make decisions to harm and damage those services.

Q: Did you approve the radiation therapy application in Lancaster County that was filed by the Piedmont CHS tri-venture in 2007?

A: I don't -- I left the department in December. I don't know what date that decision would have been made. And if the application was received in 2007, I don't know what the decision date would have been on that. I would have if it were made, you know, prior to December 3rd, 2007.

Q: Do you recall that application?

A: I don't recall that right offhand.

Q: I want to turn to the state health plan.

utilization had decreased to the point that it was now asking to go from 131 beds to 124 beds, is that correct?

A: Yes, if that's what it says, yes.

Q: So in effect what happened in this instance is the hospital in a prosperous portion of Georgetown County close to Horry County got bigger and the hospital that was in the steel mill town of Georgetown got smaller and had decreased in utilization. Is that correct?

A: Yes, that's correct.

Q: Thank you, Mr. Grice.

MR. MULLER: I believe those are all the questions I have.

THE COURT: All right. Thank you, Mr. Muller.

MS. BIGGERS: I don't have any questions.

THE COURT: Okay. No questions from the department. Mr. Andrews?

MR. ANDREWS: Thank you, Your Honor.

MR. GRICE - RE-DIRECT EXAMINATION BY MR. ANDREWS:

Q: Mr. Grice, let's pick up where Mr. Muller left you concerning Waccamaw. Based on your familiarity with Georgetown County and historical bed utilization there, what is your opinion concerning the performance of

Georgetown Memorial Hospital and the effect that Waccamaw has had on that? Specifically what I would like you to address of how you believe the presence of Waccamaw affected utilization of Georgetown after Waccamaw was established?

A: Well, where the existing Georgetown Memorial Hospital is, I don't think -- it is similar to York County with the rapid growth like we're seeing in York County right now. But I think the Waccamaw satellite has really -- you know, that's probably taken a lot of business away from existing Georgetown. Georgetown Hospital, I don't believe, has the tertiary type services that York County has. I may be wrong, but I just don't think it has the size of the hospital that Piedmont Medical Center does or some of the associated services.

Q: Are you familiar with the financial performance of Georgetown?

A: No sir, not right offhand. I've probably reviewed it, but I imagine, you know, they may be suffering.

Q: Are you familiar with the financial performance of Waccamaw?

A: No, sir; not specifically.
Q: So you really don't know or have the information one way or the other?
A: No, sir, I don't.
MR. ANDREWS: All right. Dan, turn to Piedmont Exhibit 16 please, Page 79.
Q: Mr. Grice, Mr. Muller asked you about your review of the language in the York County contract. Now, did you have -- did the department have copies of all the contracts? Do you remember that?
A: Yes, sir. I believe that we did in that decision, the 2006 decision.
Q: Okay. And specifically --
MR. ANDREWS: Dan, let's pull out the language related to the questions.
Q: Mr. Grice, I want to ask you about your understanding of the obligations that Piedmont had under the agreement. Specifically, Mr. Muller asked you about the pricing standards that existed in the agreement. Read the highlighted language if you would.
A: It says, "AMI agrees to exert every effort to so conduct its operations and finances to maintain prices for services of the hospital at

reasonable competitive levels via -- vis-a-vis other hospitals in the peer group as defined in Section 340-13(a)(xii hereof) for which MEDPAR pricing information is provided pursuant to Section 3.13 (a)(xi)."

Q: All right. Now based on your review of this term in the sixth addendum, what's your understanding of Piedmont's obligation with respect of assurances it made to the county concerning prices?

A: Well, I think what it says here they agree to use every effort possible, you know, to maintain the prices that are competitive and reasonable with others in the peer group.

Q: Now, let me take you to another document that Mr. Muller asked you about.

MR. ANDREWS: Dan, pull up Piedmont Exhibit 3, please, Pages 339-340.

Q: You remember that Mr. Muller asked you about the letters from Ms. Fechtel concerning the project review criteria and the other review?

A: Yes, sir.

Q: And your testimony was that Ms. Fechtel prepared these letters. And while you supervised her you didn't review them, is that

right?
A: That is correct.
Q: All right. Let's look at the second page in the listing. Now, first of all -- before we go there, I'm sorry. Let's go back in to the first page. What is the date of this letter?
A: February 8, 2005.
Q: Okay. And this is the first complete letter following the January 2005 submission, is that right?
A: Yes, sir; that's correct.
Q: Now, do you remember whether the January 2005 application was submitted with the first or the second application for the 64-bed hospital that Piedmont submitted?
A: I believe it was the second, and that is a good point, because basically one of the main things that changed was just the licensee.
Q: Okay. And the record will reflect that the date of that first filing was November 2005. Is that your recollection?
A: I'm sorry?
Q: November 2005 was the very first -- I'm sorry, November 2004?
A: Yes, sir; that's correct.

Q: Is that right?
A: Yes, sir.
Q: All right. And do you remember whether there under that November 2004 application, whether there was any request for additional information than Ms. Fechtel submitted to Mr. Levitt who filed the application on behalf of Piedmont?
A: I can't recall right now. It may have been. But certainly it was complete. And, therefore, the second submission on February or later -- relative to this complete one on February 8, 2005, would have been very similar. And it was basically complete when submitted.
Q: What are you referring to that would have complete when submitted?
A: The application -- the certificate of need application would have been complete for a decision, review of the decision.
Q: That is the 64-bed application submitted by Piedmont?
A: Yes, sir. That is correct.
Q: That would have been the second or first application?
A: Second.

Q: Okay, all right. Now, with regard to the request for additional information, Mr. Grice, in your experience of 29 years in the CON office, are the requests for additional information to any degree a reflection of the experience of the healthcare planner who's preparing -- and a planner's experience for South Carolina with your office in preparing the application?

A: Yes, sir. It is.

Q: In what way?

A: Well, generally if an applicant has prepared many other applications, they're more familiar with the type information we need specifically. And, you know, if they are not, we have to sometimes considerable additional information to be able to get the appropriate information we use to make the review. And of course, you know, Tenet Healthcare has hospitals over the state and has submitted numerous applications. So they were familiar with the process.

Q: And who was the consultant working on behalf of Piedmont?

A: David Levitt.

Q: And what was your -- the degree of your

experience with Mr. Levitt filing CON application?

A: Mr. Levitt had filed applications for many many years and did an excellent job, and he knew exactly what to give us. They were generally complete when submitted.

Q: Okay. And who filed the application on behalf of Carolinas? Do you recall?

A: Right offhand I don't recall exactly.

Q: All right. Was it -- do you recall it being that the application for Carolinas was submitted by anyone who had had considerable experience with the department in filing CON applications?

MR. MULLER: Your Honor, I'm going to object to the question. The witness has just testified that he did not recall who had submitted it.

MR. ANDREWS: I understood the response, Your Honor. The reason for the question is even if he didn't recall a name, the question is a different one -- whether he recalled whoever submitted that? Whether it was someone he was familiar with based on their experience with the department.

MR. MULLER: And I also object to it being leading.

He's trying to lead the witness on redirect.

MR. ANDREWS: I think it's a question of fact, Your Honor.

THE COURT: Mr. Muller, I'm going to overrule your objection and let the witness answer the question.

A: Would you --

Q: Sure, the question is whether you recall, one way or the other, whether the individual responsible for communicating with the department concerning Carolinas' application was one with whom you had had experience in the filing of CON applications?

A: No, sir. We had not. I mean, this is the first application we ever got from the Carolinas Medical Center. And so that person had not submitted applications to South Carolina previously.

Q: Okay. Now, the letter that's appearing here was prepared by Ms. Fechtel. How many -- well, let's look at the second page, and it's dated February 2005. And the project review criteria that are prepared here, Mr. Grice, at the time that these criteria were identified by Ms. Fechtel, how many applications had been

submitted to establish a hospital in Fort Mill?
A: This was the first one, I believe, as I recall.
Q: I believe in examining you, Mr. Muller said I'm going to ask you if you recall March was the date -- the month in which the others applied?
A: Yes, sir.
Q: So in February, who had filed?
A: It was just Piedmont Medical Center for the Fort Mill Medical Center.
Q: And among the project review criteria that are listed, number six is the adverse affects on other facilities. Do you see that?
A: Yes, sir, I do.
Q: Why would that be listed last, Mr. Grice?
A: Well, you know, I guess -- I think in doing review I think there has been other applications that had been listed higher. But one thing, I think Ms. Fechtel, when she was listing all this, she probably looked at some other very similar type applications for hospitals. New hospitals had been done, and this is just the way it fell. But it certainly could have been higher.
Q: Well, how many facilities were there in York County that could have been adversely affected

in February of 2005?
A: None. So that could be a reason, you know, that it was -- in this first application when we're talking about adverse effects of other facilities there were no other hospitals in York County. So this would be a low priority -- lower priority than the other criteria.
Q: Now, also look at the numbering, the sequence from the first to the last. What's number one? What's the criterion number for number one?
A: Number one.
Q: And what's the criterion for number two?
A: They're all two, A, B, C, D and E.
Q: And then three, correct?
A: Yes, sir.
Q: And for the third criterion, what's the number?
A: For the third one, 6, A, B, and 7.
Q: And for the next one?
A: Also in three, we've got 15.
Q: All right. Do you see a pattern that's evolving there, Mr. Grice?
A: Yes, sir. I think some people would say they're almost like in chronological order.
Q: Or numerical order?
A: I meant numerical order, yes.

Q: And there are a few that are exceptions. The next one is one, correct?
A: That's correct.
Q: But by and large, what is the pattern you see of the listing of the order of criteria?
A: They appear to be related in numerical order.
Q: That they appear where?
A: Compared to Section 802 of Regulation 61.15.
Q: I have no further questions, thank you.

THE COURT: Thank you, Mr. Andrews. Mr. Muller.

MR. MULLER: Very few, Your Honor.

MR. GRICE - RE-CROSS EXAMINATION BY MR. MULLER:

MR. MULLER: If we could just go back to Piedmont Exhibit 16, Page 79. If you could enlarge the sentence that starts in the middle, "in the event."
Q: This is a sentence after the sentence that Mr. Andrews showed you.
A: Yes, sir.
Q: Can you read it and tell me whether it was incumbent upon Piedmont to self-report when --
A: Would you like me to read aloud or just read it?
Q: You're welcome to read it aloud or silently, whatever you prefer.

A: Okay. I graduated high school in 1976. I went to a branch campus of USC in Allendale for two years. And I went on to Columbia and graduated in 1980. I went to work for DHEC. And after I'd been there for a few years I went to graduate school. And I have a masters in Public Health. I went to graduate school part time from 1986 until 1991, and that's when I did get that graduate degree.

Q: And when did you begin working for DHEC?

A: It was approximately May of 1981.

Q: What area of DHEC did you work in to start off with?

A: I started off in the Bureau of Radiological Health, and I spent around 22 years with that program.

Q: And what program did you work with next?

A: I was then a public health preparedness planner, and I was part of the health resources and services administration grant. So I spent five years in that position.

Q: And then what did you do after that?

A: After that I did get hired on as the bureau chief for the division that oversees the CON program, the Bureau of Health Facilities and

Services Development.
Q: When did you begin in that position?
A: It was February of 2008.
Q: And have you retired from the department since the time you made this decision?
A: Yes, I retired this past February.
Q: Were you involved with the initial decision that the department made when the applications were first submitted to DHEC?
A: No, I was not.
Q: Were you still in your public preparedness position at that time?
A: Yes, I was.
Q: Okay. And then can you tell us, what was your involvement when Judge Matthews remanded this matter back to DHEC?
A: At the time of the remand, I was the bureau chief. So I was responsible for responding to her decision with the remand.
Q: In responding to that remand order and reviewing the applications, did you rank the project review criteria to be applied to the review?
A: Yes, I did.
Q: What was that?

A: It is focused on the projected utilization, that that is sufficient to justify the expansion or implementation of the proposed service.

Q: And did you find that Carolinas' projected utilization justified their application?

A: Yes, it did because their projections were based on the high level of their current market share. That is, the South Carolina patients that were leaving South Carolina to be served in North Carolina. So they had some statistical information to support that. And I felt that the need for the project, you know, was based on their current patients that they served, and that they would be able to successfully shift the patients that they -- South Carolina patients back to South Carolina. And they had a detailed analysis. And so that is contained in this document. And I felt that their analysis was reasonable.

Q: And did you find that Piedmont's projected -- current and protected utilization were sufficient to justify its project?

A: No, I did not.

Q: Why is that?

A: Because they had been steadily losing market share and their services -- utilization of their services was substantially declining. And then they felt that, you know, building this hospital that all of a sudden the market share was going to increase substantially and that they would be able to successfully redirect patients from the 29730 and 29732 zip codes. It just didn't seem plausible or reasonable to me.

Q: Okay. In your analysis of the two applications that we are looking at here, it started on 1309 and now we are 1310. It goes on to 1311. The statistics that you cite, are those based on information in the two applications?

A: Yes, they are.

Q: Let's look at distribution. What did you find with regard to -- well, first let's look at 3(a).

A: I found that 3(a) only applied to Piedmont.

Q: And what about -- did you find that Piedmont met it?

A: I didn't feel that they had adequately justified the duplication of services by transferring the 36 beds.

MR. ANDREWS: Thank you, Your Honor.

MS. BRANDT - CROSS EXAMINATION BY MR. ANDREWS:

Q: Good afternoon, Ms. Brandt.

A: Good afternoon, Mr. Andrews.

Q: Ms. Brandt, when you joined the department you had a masters in public health, is that correct?

A: I obtained a masters after I started working with DHEC.

Q: So you started working in the eighties and then you got your masters degree about ten years later?

A: Yes, that was the time I got through that part.

Q: Okay. And your master's degree was in environmental and radiological health related construct; wasn't it?

A: That was the primary focus for my masters in public health?

Q: Right. And you didn't have any advance training in healthcare planning or healthcare finances apart of that process did you?

A: No, but I had certainly worked hand-in-hand with healthcare facilities and through my entire tenure with the DHEC in my career.

Q: Okay. And when you became bureau director in

2008, you had never been involved with CON decisions or CON process before had you?

A: I was certainly not involved in decisions. I was on the periphery of the process through *shielding approval letters and their relationship to CON projects.

Q: For radiological health imaging concerns, is that right?

A: Yes.

Q: So relating to MRIs, CAT scans and other medical equipment, you saw the effects of some healthcare facility applications. That is the extent of your exposure to CON at that point; wasn't it?

A: Yes, I suppose.

Q: And when you took the job, you replaced Mr. Grice, correct?

A: Yes, I did.

Q: And during that time you hadn't received any additional formal CON training had you?

A: No, not at that time.

Q: You had a couple of some seminars and some on-line courses concerning healthcare planning and finance that you participated in, is that correct?

A: That was more recently, yes.
Q: And you had a half day of kind of some in-house training related to healthcare reimbursement, right?
A: It was probably half a day, maybe a full day, I don't --
Q: But it would be accurate to say that your CON training really consisted of on-the-job training you received after you assumed the position of CON director; would that be fair to say?
A: Yes, but certainly I brought a lot of skills and experience that transferred to the position. And obviously at a certain point in time I was chosen, you know, over other applicants for the position because of my qualifications.
Q: Sure. And you had a lot of administrative experience. But you hadn't had any depth in healthcare management and finance; wouldn't that would be fair to say?
A: Yes, that would be fair.
Q: And you've never been qualified as an expert witness in healthcare planning or in certificate of need or in healthcare finance?

A: No. But that would have been requested by somebody else. I don't believe I would have offered myself as that.
Q: All right. And you testified in two previous cases prior to this, is that right?
A: Oh, goodness. Certainly the home health case and Berkeley County Hospital cases. I certainly have been deposed more but --
Q: Been deposed more but in terms of offering testimony for the benefit while in court, it's been a couple of times that you can think of?
A: Yes.
Q: Now, when you began your work on this case in 2010, you were initially assisted by Lisa Sanders who was a relatively senior reviewer at the time in the department; isn't that right?
A: Yes, I was.
Q: And she left before you completed the review, correct?
A: Yes, she left a few months prior to the decision.
Q: And she didn't participate at all in the decision; did she?
A: No, she did not.
Q: And Mr. Grice had gone. Ms. Fechtel was there,

but she had been involved in the previous decision, and you didn't consult with her on this case either; did you?

A: Well, Mary served kind as a sounding board for me. And I bounced a lot of things off of her. I was involved in so many projects and so many decisions, it wasn't unusual for me to speak with her.

Q: Okay. But you didn't talk with her specifically about the adjustments she needed to make in this case; did you?

A: No, I did not.

Q: All right. Okay. So Ms. Sanders was gone, Ms. Fechtel wasn't available, and Mr. Grice was gone and you made this decision on your own, right?

A: Yes, I did. I certainly did utilize with Shelton in some capacity, as well.

Q: But he didn't review the applications or participate in the review; did he?

A: He was at the project review meeting, and he performed some analyses under my direction. But no, he was not involved in the decision.

Q: Okay. All right. Let's turn to some of the concerns you expressed in your testimony and

were reflected in your decision. Now with regard -- let's start with the questions that you raised about Tenets, Piedmont in particular in its ability to finance the project. You never formed an opinion that Piedmont couldn't pay for the construction of the hospital; did you?

A: No, because they were owned by Tenet and has a lot of financial means.

Q: And Tenet, through their senior vice president, communicated with the department and said Tenet that can stand behind the construction costs and will build and will finance the construction of the new Fort Mill Medical Center; didn't they?

A: Yes. I believe there is a letter to that effect.

Q: And you didn't have any reason to doubt that; did you?

A: No, I did not.

Q: And in fact, are you aware that in 2006 Tenet owned the facility called East Cooper Medical Center, built a new replacement hospital that was approximately $150 million and financed that facility down in the Charleston area?

A: I was aware that it was being built. I wasn't aware of how it was financed.
Q: You're not aware of budget department -- I mean, that East Cooper, the Tenet facility, would have communicated to the department that they had closed out the project, and they didn't have any trouble, that you're aware of, financing the project did; they?
A: I'm just not aware. We got their closeout report, I believe, but they don't have to report anything about financials.
Q: Okay. And you're not -- and they built a hospital and as far as you know it's operational and paid for it or certainly being paid for?
A: Well, certainly operational, yes.
Q: Okay. All right. Now, with regard to the concern that you expressed then. Let's focus -- your concern was not whether not Tenet could build a hospital, your concern was in whether they could finance the construction of the hospital. Your concern was whether or not they identified a definitive approach about how they would finance the construction of it, is that right?

A: Well, that certainly was a concern. They identified several means and chose the one that was resulted in around $2 million of interest expense.

Q: Okay. Now, you had said, I believe, in your testimony that your preference was for a definitive approach. That is an applicant saying this is how we intend to finance it period; end of story. That was your preference; wasn't it?

A: Well, my preference was what the regulations stated. And the regulations stated, and this is probably isn't the exact words, but it indicated that they had to chose a method that they were going to utilize.

Q: And you referring to the provision in Paragraph 16(a), I believe; are you not?

MR. ANDREWS: Well, let's pull it up. Dan, if you would, let's pull up 802, Section 16(a) in the DHEC reg.

Q: Okay. Read that into the record please, Ms. Brandt?

A: "The applicant should have identified and sought alternative sources and/or methods of funding and demonstrated that the method chosen

was the most feasible option."
Q: Now, in fact, you testified that Carolinas said we're going to use cash, correct?
A0: Yes, from later reserves.
Q: Cash and cash equivalents is what you put.
A: Uh-huh (affirmative response).
Q: They didn't identify alternatives; did they?
A: (No Response)
Q: Does the reg say the applicant should have identified and sought alternative sources of financing?
A: Yes, it says should not shall.
Q: That's a meaningful distinction to you?
A: Well, shall means -- is more of an absolute. And they identified something that the cash reserve was reasonable, and I felt that was sufficient.
Q: Okay. Did they offer any alternatives? Did they identify alternatives that they considered?
A: No.
Q: And in Tenet's letter, they did identify alternatives; did they not?
A: Yes, they did.
Q: And it shows one of the alternatives, which was

to make themselves -- to allow themselves to form the judgment about which would be most prudent from a business perspective at the time they were ready to build. Isn't that what they did?

A: Well, I probably wouldn't have couched it as chosen an alternative. I mean, this has demonstrated the method chosen. And so the method they chose was financing.

Q: Well, let's be clear about this. First of all, the department did not have a policy about this issue; did they?

A: Could you be more --

Q: Sure, yeah, about your definitive approach. You didn't have a policy as to whether or not the applicant should be definitive; that is, express a particular preference and inform the department what it intended to do three to five years in the future when the hospital was built?

A: Well, this does say -- demonstrate the method chosen, and it's singular. So if they laid out a variety for future means to finance a project, then we expect them to step up and tell us exactly what they intend to do.

Q: But you didn't tell the applicant that; did you?
A: Well, it's mentioned in this. And then I think if we look at some other parts of the regulations, it mentions that as well. No, I did not send back a letter saying, okay, Piedmont, you know, figure it out; if that's what you're asking.
Q: Yeah, I'm asking if you communicated to Piedmont that you wanted and expected applicants to make a determination years before they would build a hospital as to which method of financing or any method of financing they would choose?
A: Well, I feel that they discussed it sufficiently enough in their application, particularly because they did have a line for interest expense that they had basically declared how they were going to proceed with the project.
Q: Now Ms. Brandt, are you aware that in its -- originally in its application to the department that Tenet presented the very same alternatives to the department about how it would finance the project?

A: No, I'm not aware.

MR. ANDREWS: Dan, let's pull that up, if you would, and let's look at what would be Exhibit -- Petitioner's Exhibit 2, Page 252. Let's pull out the first sentence of the second paragraph.

Q: Could you read that sentence into the record, Ms. Brandt?

A: "Tenet Healthcare Corporation will fund this project utilizing a mix of debt and cash flow from operations as part of its overall capital investment budget."

Q: Now, are you aware that in reviewing Piedmont's application in 2006, Ms. Fechtel found that the presentation or the method of financing for all the applicants was adequate; did not raise any issues with the department?

MS. ROBERTS: Your Honor, I'm sorry to interrupt. I would like to object to this line of questioning. I think Ms. Brandt has testified that she was not involved in the first review and did not participate in it. That was Ms. Fechtel, Mr. Grice. And Mr. Grice has already testified this witness was not involved in this first review.

THE COURT: Mr. Andrews.

MR. ANDREWS: Your Honor, we're aware that she wasn't involved in the first review. She's also said she conferred with the department and with Ms. Fechtel, in particular; and not about the application but the general principles. And we think as the sole representative of the department that she needs to be able to speak to anything in the department such as to be concerned in this case or other cases, whether she was personally involved or not.

THE COURT: All right. I'm going to overrule the objection. Thank you, Ms. Robertson. Go ahead, Mr. Andrews.

Q: All right, sir. So the question for you, Ms. Brandt, is whether or not you were aware that based on the September 30, 2005 letter that you just read an excerpt from Mr. Corbeil, who is senior VP operations for Tenet, that your predecessors in your position found that this form of financing that Tenet presented was acceptable.

A: Well again, I was not aware of what Mr. Grice decided or what Ms. Fechter decided. I know and I recollect that in general I had conversations with Ms. Fechtel, and she said

that the applicants had to be clear about their method of financing.

MR. BIGGERS: All right. Now, let's look at the next letter. You will see that -- Dan, if you pull up the Joint Exhibit B(1), Page 223. And let's pull out again the second paragraph, first sentence.

Q: Read that sentence into the record, please, Ms. Brandt.

A: "Tenet Healthcare Corporation intends to finance the project through the most appropriate and cost effective capital funds available at the time utilizing existing cash reserves, existing lines of credit or the issuance of debt and/or equity."

Q: Wasn't this basically the same position that Tenet took when they conveyed their willingness and ability to the department in 2005 about how they intended to finance the project then, and they adopted the same position in 2010?

A: The intent appears to be the same. I mean, I don't believe the wording is identical. And I certainly do appreciate this line of questioning; but this didn't really make or break my decision.

Q: Okay. All right. Now, in your deposition, you testified that the way the department historically had applied 16(a) and 13(b) concerning the financing of the project was to look for definitive methods of financing. I believe I understood that to be your testimony, is that right?

A: That sounds correct. I certainly haven't reviewed those. But definitive meaning of it, but they need to state or would certainly know would how they planned to finance the project.

Q: But in this case Piedmont, in its first round, expressed they would use a mix of cash or debt and do whatever from a business point of view was prudent at the time. And it would have been reasonable, since there were no objections made to it in the first round, for them to take the same approach in the second; wouldn't it? Wouldn't that make sense to you?

A: It would make sense, but I did not review the first round.

Q: I know that. But you're the department's representative. And the department did not express any concern that you are aware of toward this mixed approach to financing in its

first round. And if you assume that to be the case, wouldn't you believe it would be reasonable for the company to rely on that department maintaining in the same position in the second round with regard to financing?

A: I can certainly see your point, Mr. Andrews, but again, you know, I was taught that the applicant had to come up with a means. What they say and what they do, I can't control that.

Q: You were taught by Ms. White, Ms. Patricia White?

A: I recall raising the issue with Ms. Fechtel. I can't say Ms. White didn't mention it. I just don't specifically recall that.

Q: But based on Ms. Fechtel's writing the CON summary approving Piedmont, it doesn't appear that Ms. Fechtel believed it was an issue of any concern, does it?

A: Well, I can't speak to what Ms. Fechtel thought, but I can state that she didn't appear to raise that as an issue.

Q: All right. And there is no question in your mind, is there, that Tenet has the financial wherewithal to finance the project and to build

Fort Mill Medical Center; isn't it?

A: Based on the cash reserves that they reported to us, they could certainly financially swing it. But we certainly did look at the project itself as well as the financial capability of the parent.

Q: And based on the financial capability of the parent on that specific issue, you can't, as you are sitting here today, express any basis for a concern about whether Tenet could finance the construction of the new hospital at Fort Mill; can you?

A: It appears with this $700 million cash reserve to be able to finance the project.

Q: And let me move on to another subject. And that has to do with your statement and your decision letter about annual cost of the project for Piedmont. Let's begin your testimony on this by establishing one of the things that you try to do in reviewing competing applications. And this is the first competing hospital application you've ever reviewed; isn't it?

A: I believe you are right.

Q: Okay. All right. But generally based on in

your -- was it four or five years that you were in your position?

A: Five, yes.

Q: That you tried to create an apples-to-apples comparison among applicants to make sure when you're measuring them against each other you are doing that on an apples-to-apples basis. That is so you can fairly compare and contrast them. Isn't that one of the things you try to do?

A: Yes, I attempt to -- it's much easier said that done.

Q: Agree, but that's one of your objectives in this review process; isn't it?

A: Well yes, you've got to be able to place them side by side in some capacity.

Q: Okay. Now and because you would recognize that different assumptions and different methodologies could produce different results in what's being presented to the department; isn't that right?

A: Yes.

Q: And if you don't try to understand the basis for their projections and what the underlying assumptions are and the underlying

methodologies, then you can't fairly evaluate them against each other; can you?

A: No, and we certainly have to have good information to go on.

Q: All right. Let's talk about the construction costs and the capital costs.

MR. ANDREWS: Dan, let's pull up Demonstrative 153-1, please.

Q: There's been testimony, Ms. Brandt, prior to your arriving that Piedmont, when it submitted it's application and then reviewed it and the other applications that were presented following it, that it realized there were different assumptions that affected the total project cost; do you remember that?

A: Yes.

Q: And do you remember then that Piedmont made adjustments to try to get to the point of presenting data used that would allow you to look at the applications for their cost on a fairly equal apples-to-apples basis, is that right?

A: Yes.

Q: All right. Okay. And these three particular issues were the ones that there has been prior

testimony about. And I just want to review with you to see if you agree with me concerning these; that these were three issues related to the areas that affected the total project cost of the Fort Mill Medical Center, that there were differences between what Piedmont presented and what either or both of the other applicants presented. And those three areas are capitalized interest, the question of whether or not the construction costs were inflated or were then current, and then finally whether or not the projected equipment costs were at list price or reflected a volume discount that the applicants had. Do you remember that?

A: Yes.

Q: Okay. And you would agree with me that to achieve your apples-to-apples objective, that each of those adjustments were appropriate; wouldn't you?

A: Yes, in theory. But I have no issue with updating costs based on more up-to-date information or more accurate information such as the deflation of the construction costs or the discount. However, I didn't feel it was

necessarily appropriate to eliminate the capitalized interest because what is more important is to get a realistic picture of the proposed costs for the project. Now, while I certainly appreciated what was attempting to be done, the bottom line is what are your projections.

Q: All right. To make sure that we understand each other, so with regard to the adjustment of the construction costs, you didn't have any concerns about that adjustment, correct?

A: No.

Q: Okay. And with regard to making sure that the assumptions were the same with regard to medical equipment, that is whether they were listed or were using the discounts available to the applicants. That was appropriate, too. So you agree with 2 and 3?

A: Yes.

Q: All right. Now, with regard to the capitalized interest costs, at the time the applications were filed and you reviewed them, the department had no position, no policy, no practice, no position on whether imputed interest costs should be included or not in

their application; isn't that right?
A: That's right.
Q: Okay. Now, if an applicant, to be conservative to be careful, and that means, doesn't it, that when an applicant is being conservative, that they are overstating their costs, understating their expenses; doesn't it? Would you agree with that?
A: Well, yes. They are certainly giving it their best shot for accurate representation.
Q: Well, that's always true; isn't it?
A: Well, yes.
Q: Don't you expect every applicant to do that?
A: Well, yes.
Q: Okay. When an applicant is being conservative, they are overstating there again, cost because understating it would aggressive, overstating it would be conservative. Would you agree with that?
A: Yes.
Q: Okay. And on the expense side -- well, on the revenue side, understating revenue would be conservative. That is, they are going to err on the side of projecting less revenue than what they think might come in to be careful.

If they're demonstrating a higher extent of revenue, that's being aggressive, not conservative. Would you agree with that?

A: Yes.

Q: Okay. Now, with regard to the question about identifying interest costs, the conservative thing to do if an applicant is unsure years before they intend to actually finance the construction, if they include interest costs, that's a conservative approach; isn't it?

A: Yes.

Q: All right. Even as Tenet has said in their letters, they are unsure. They have the cash. They could put a zero there based on their ability. But a conservative approach is to identify that cost so they won't mislead the department, and they will be conservative in identifying potential costs. Wouldn't that be an accurate way of analyzing what that would yield at the start of that application process?

A: Well, yes. I mean, it's ultimately their decision.

Q: And as you said, the department doesn't check up on it when the project is completed. It's not even reported as part of the final reports

of the department when they complete a project; is it?

A: Not the interest expense. We look at the resulting total priority costs.

Q: Okay. But at the time that these applications were filed, the department hadn't developed a position about whether an applicant should, even when they don't intend -- when they intend to use cash should identify the cost of having that cash available, which would be imputed interest; wouldn't it?

A: Well, to my knowledge, no, there wasn't. And because I got really bombarded so much during my deposition about imputed interest, after my deposition I did go back and talk to Ms. Fechtel about imputed interest specifically. And she told me that they never or she never made a point of specifically asking for imputed interest.

Q: Right. And so you didn't ask for it. And if, in fact, interest were incurred later, you wouldn't even have any way of knowing it; would you?

A: Not if it didn't affect the total project costs.

Q: Right, okay. So if your goal is to compare applications on equal footing, apples to apples. And if one party includes imputed interest to be conservative and another one doesn't, you'd have apples and oranges; wouldn't you?

A: Yes. But I believe Piedmont stated it as interest expense and not imputed interest. So I ultimately relied on that to be their best projection of how they calculated their finances.

Q: Okay. So your position would be that Piedmont should, even though they said they may use cash, to include an interest expense even though they conservatively incorporated it?

A: I'm sorry, Mr. Andrews, can you repeat?

Q: Sure, yeah. Your position should be that even if Tenet had not made the decision that it would incur interest, that they should leave the interest in there and not remove it and not impute.

A: I'd don't believe Piedmont ever said, oh, you know, we've decided that we are going to fund this from cash reserves. That would have been -- I would have certainly accepted not having

an interest line item. I'm not sure if I'm understanding you.

Q: That's fine. But they said they might use cash; didn't they?

A: Yes, sir; they said might.

Q: And they said, we'll make that decision when it comes because that's the best business decision, not to do it years in advance when we don't know what the market looks like and we don't know what our interest would be.

A: Yes, they certainly said that.

MR. ANDREWS: Well, let's take a look at Demonstrative 151. And Dan, let's pull out the comparison. This is Ms. Brandt's demonstrative about which has been evidence in testimony provided relating to the relevant -- the relative total project costs and total project costs per bed. Dan, pull out the CMC-FM and the FMMC lines just for a moment if you would. We'll just highlight those.

Q: Now, I'll represent to you, Ms. Brandt, that the 119 million and some change for FMMC reflects the adjustments for the three different items you've identified that you just testified about. And CMC-Fort Mill represents

their total project costs in their application. Do you see that?

A: Yes.

Q: Now, if you look at the total project costs per bed, which of the two applicants has the lower total project costs?

A: Based on this information that is presented, it would be Fort Mill Medical Center.

Q: And I'm going to hand you a computer.

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

THE COURT: Yes, please.

Q: I'm sorry, a calculator not a computer. That's about the extent of my technology knowledge and experience. Ms. Brandt, how about do a simple little computation and determine the difference between on a per-bed basis the cost on -- look at that right-hand column. How much more -- that's right, each bed at CMC-Fort Mill costs compared to each bed at FMMC?

A: All right. If I've done this right, I've gotten $13,354. However, when I did my calculations, I used the figure that included the interest expense to do this.

Q: And do you know what the interest expense is?

A: It varied from year to year, but the rough

average is around $10 million.
Q: Well, I remember it being less. But even if it were 10 million, and you had 10 million to 1,198,000 and what do you get?
A: That would be -- I'm sorry, Mr. Andrews, you're talking about the total project cost per bed?
Q: That's right.
A: I'd have to add it to the total project cost and divide.
Q: And multiply -- I mean, divide it by the 100. Well, in any event -- well, why don't you go ahead and do that. Let's just do the quick math. Let me just, for purposes of -- would you accept a correction on the cost of the -- the interest cost, interest expense that was identified? Remember it was approximately 8 million?
A: I think that was year one, and it went up, I think, maybe eight, nine or ten. I'm not sure without looking up the figures.
Q: Okay. All right. I can't put my hands on it at this moment.
A: But I'll certainly accept that for purposes of what you want me to do.
Q: All right. I've got it right here. It's

closer to nine -- 8,962,000. And we're going to pull it right up for you.

MR. ANDREWS: Dan, if you will, pull up Piedmont Supplemental CON, Page 8. I don't know what that is. It's a different on here. Scroll -- there we go, that's the page.

Q: All right. Here we go, 8.9 million?

A: Now, that's financing cost and construction.

Q: Okay, you had something different in mind?

A: Yes, sir. It was on their financial statement.

Q: Okay. All right. Why don't you add the 10 million to the total cost and let's see what we're looking at there.

MR. ANDREWS: In the meantime, I'm going to ask Mr. Westbrook to find the interest.

A: So you said to add the 10 million.

Q: Well, first of all, let me just clarify something with you, Ms. Brandt. What's included in the total project cost is the construction interest expense; isn't it? What's included on an operational cost for paying down the interest to the loan would be an operational expense, not a total project capital cost; isn't that right?

A: Yes, that's correct.

Q: So it would be that $8,962,000. That would be the -- part of the total project cost if it were to be included; wouldn't it?
A: Yes, you're correct. I see where you're going.
Q: All right. Well, why don't you add that.
MR. ANDREWS: Dan, let's pull that document back up, please. Let's get the precise figure.
Q: So Ms. Brandt, we'll cut back 8962851 and ask you to add that to the 119 million and divide by --
A: That's approximately, I guess $1.29 million per bed. I've got exact number right here if you'd like me to read that.
Q: Yeah, how about giving me the exact number.
A: $1,287,718.05.
Q: All right, good. So even if the interest expense were included, then the cost of -- total project bed cost would be about the same; wouldn't it? Would you regard them as being materially different?
A: I would have to look at the percentage. But I would say, you know, for the purposes of your questioning, no. But, however, I was choosing which one had specifically I believe in my analysis it was stated which one calculated to

be the lowest. So out of the three the lowest or the highest of the three applicants, the cost per bed was what I had stated in my analysis. In other words, Carolinas was less than Fort Mill.

Q: Well, in fact, you -- what you characterized as the lower cost for the construction of hospital was one of the reasons you approved Carolinas; wasn't it?

A: That was one of many.

Q: Yeah, I know. We're going to go over them. But we're talking about that single issue. That was what you -- this differential by including the capitalized interest expense and determining that on a per-bed basis, Carolinas -- there was no material difference as you just testified, but yet that was one of the reasons that you believed that CMC-Fort Mill should be approved; isn't that right?

A: I stated for the purposes of your comparison, there was no material difference. But when I aligned all three up, that's when I made the distinction as to who was the higher or the lower.

Q: Okay. Well now, the regulations do not support

your analysis of the comparison of these expenses at all; do they, Ms. Brandt?

A: Well, Mr. Andrews, you would probably have to show me where it doesn't support it. I was charged with determining the best candidate, and my analysis concluded that the cost of Carolinas per bed was less.

Q: Let's take a look at the regulation that is intended to provide you guidance on evaluating the reasonableness of project costs.

MR. ANDREWS: Dan, pull up 8027, please.

Q: All right, Ms. Brandt, you've been working with the regulations for five years, right?

A: Yes.

Q: And you're familiar with them; aren't you?

A: Yes.

Q: All right. Now, do you know whether or not there are any regulations that address the issue of how the department should evaluate the reasonableness of projected expenses other than this Section 7 -- subsection seven of Section 802 in the regulation?

A: No, I don't recall anything that specific.

Q: This is the reg that addresses how you should evaluate expenses; isn't it?

A: Well, this is the project review criteria which may or may not have been chosen for evaluation.
Q: Well, it is chosen. It has been.
A: In this case, yes.
Q: Right, okay. And whenever there is a question raised, and it's identified as a priority criterion, you try to follow it, right?
A: Yes.
Q: Okay. Now here, let's take a look at what it says. "Projections of construction costs." Do you see that?
A: Yes.
Q: And then it identifies other costs. "Should be consistent with those experienced by similar facilities offering a similar level and scope of activities (sic)." That's what it -- or service -- sorry, "scope of services"; isn't that what it says?
A: Yes.
Q: And where in your CON decision letter or summary have you described how you reviewed the projections of Piedmont and Carolinas against the expenses experienced by similar facilities? It's not in there, is it?

A: No, Mr. Andrews. But I would also want to state that this project review criteria can be applied to any type of application. It's not specifically for competing applicants. So in some cases it can be used to compare with existing facilities.

Q: Well, it always, based on the way it reads, it always would have to be compared with existing facilities or services; wouldn't it? I mean, it doesn't create an option for when it wouldn't apply. I mean, this is the only reg dealing with expenses.

A: Correct.

Q: This is the only reg dealing with expenses. And you were looking at expenses, but you never did this; did you?

A: I certainly looked at what the applicants' proposals.

Q: That's not there, but the applicants' proposals weren't existing facilities; were they? They were proposed facilities; isn't that right?

A: Right, but it's also reasonable to assume that if a facility is built 20 or 30 or 40 years ago that there was no way that you could have done an apples-to-apples comparison.

Q: Absolutely fair. But you had available at your disposal within the last five years, an extensive list of applications available that you could consult about the proposed project costs; couldn't you?

A: Yes. But that doesn't necessarily mean that they had similar demographics. I mean, there is certainly a lot of considerations.

Q: Ms. Brandt, demographics had nothing to do with how much it cost to build a hospital; did it?

A: Certainly in coastal areas, typically things are more expensive.

Q: You're talking then not about demographics, but you're talking about how the market shapes in different locales across the projects. Is that what you mean?

A: Well, yes, certainly the costs --

Q: All right. But did you even look at the costs to draw a comparison?

A: I believe that that information was provided to us by one of the applicants.

Q: And that would have been Piedmont, correct?

A: Yes, I believe so.

MR. ANDREWS: All right. Well, let's take a look at Demonstrative 151 that we just got up there.

Dan, let's slide back to it.

Q: Now, you'll see that from 2005 through 2008, there were no less than eight showing here. Other applications that provided a range of hospital beds from 48 to 150, the same range as these proposed facilities and total project costs; do you see that?

A: Yes.

Q: And the regulation -- and these would be similar facilities in that they were community facilities or satellite hospitals offering a similar range of services to what was being proposed in Fort Mill; isn't that right?

A: Yes.

Q: Okay. And you didn't undertake this analysis?

A: No, I did not.

Q: Now, in fact, isn't it true that the proposed bed cost for both Fort Mil, that is Piedmont's proposed facility and Carolinas' proposed facility fall right down in the middle of this range of other satellite hospitals that the department had approved; don't they?

A: Yes, they do.

Q: And in fact, you reviewed some of these facilities and approved some of these

applications yourself. So you were very familiar with them; weren't you?

A: Yes.

Q: And let's actually look at the applications that you personally had approved.

MR. ANDREWS: Dan, let's turn to Demonstrative 266, please.

Q: Now Ms. Brandt, you've, I think, reviewed and approved the replacement hospitals. Let's start at the top and go down with Georgetown Memorial Hospital, right?

A: Yes.

Q: And they had a total project cost of $154 million?

A: Yes.

MS. ROBERTSON: Your Honor, I'm sorry to interrupt. This line of questioning we object to. I think Ms. Brandt found that all applicants met project review criteria number seven. And it seems that Mr. Andrews is continuing to question on that, but she found they equally met.

MR. ANDREWS: Well, something that was pointed out to me earlier in my prior examination. In fact, Your Honor, I mean, we can go without it.

The answer is she -- she said -- it's not clear, but that she made a finding explicitly about Section 7. There is a reference to it, and I'll point that out in a minute. But she said in her decision letter and in three or four places and again in her testimony that the total project costs were a reason that she ruled in favor of Carolinas and against Piedmont. So even though there is a sentence, and I'll read it to you, in Ms. Brandt's letter that addresses Section 7 along with -- it does it together with Section 6(a). And let me point that out to you, and then I can explain the ambiguity. And I'm reading from Page 7 of Ms. Brandt's CON summary, second sentence. "All applicants provided projections of immediate and long-term financial feasibility and comparable projected inpatient charges per patient." There is a parenthetical that says 6(a) and 7. 6(a) is the criterion that addresses inpatient charges.

THE COURT: Yes.

MR. ANDREWS: And she did find that, and she testified to that. Seven has nothing to do with that subject. It has nothing to do with

the subject about immediate or long-term financial feasibility. And in contrast she says in three other places in her decision letter that she is -- and also in the summary decision letter in paragraph two, that one of the reasons she ruled against Piedmont was because of its high -- the high capital costs for its hospital. So that's why we have to go down this path, Your Honor.

THE COURT: Okay, Ms. Robertson?

MS. ROBERTSON: Yes, Your Honor. I would submit that she has determined that they all equally met seven. She testified in her testimony earlier today that that was the case. She does not list Carolinas as better meeting criterion seven in her letter. I think the record demonstrates that her findings as to seven was that all were equally met.

MR. ANDREWS: Your Honor. Let me just address it this way: Paragraph two, she says --

THE COURT: And you're referring to her letter?

MR. ANDREWS: I am, yes, sir. I'm sorry. Yes, sir, her cover letter to the CON analysis -- one of the things the department is concerned about is the substantial cost of the project. The costs

of the project are addressed based on what she said solely in paragraph seven. And then I could cite several examples of where she says, Piedmont has the highest cost per bed of all the applicants. And then after finding that Carolinas best meets and Presbyterian have total project costs and FTEs per adjusted occupied bed. That they have comparable costs and found that Carolinas best meets that. That's a Section 7 issue, Your Honor. And another page, and I don't intend to stop with construction costs, where she finds that the operating costs for Piedmont are higher yet hasn't performed the only analysis in the project new criteria that addresses. So that is why I'm trying to lay or establish a record.

THE COURT: Based on this, Ms. Robertson, I see your point. She did clearly state apparently that she found them equal. However, there do appear to be some, what appear to be statements that reflected perhaps she made some considerations and did some comparisons there. I am going to allow Mr. Andrews to go into this. And then if you want to rehabilitate her, please absolutely do so.

MS. ANDREWS: Okay. Now Dan, pull back up Demonstrative 266, please.

Q: Now again, Ms. Brandt, you reviewed each of these applications and approved them, right?

A: Yes, I did.

Q: Georgetown replacement facility, 124 beds at a total project cost of $1.24 million per bed, $154 million total, correct?

A: Yes.

Q: All right. And then you approved Millennium, same year?

A: Yes.

Q: At a cost of nearly $3 million dollars, $2.9 million dollars a bed, right?

A: Yes.

Q: That was a 52-bed hospital at the size of the proposed Fort Mill Medical Center that was approximately $30 million greater, correct?

A: Yes, but there were very clear in their application as to why the costs were considerably greater to include the green technology. It was a deliberate effort on their part to incorporate some technology that was admittedly expensive.

Q: And two other proposals that you approved were

the two competing Berkeley County or the two Berkeley County applications. I believe you found them not competing at the end of the day, is that right?

A: Yes.

Q: All right. Each $50 million and -- I'm sorry, 50 beds and comparably priced was Fort Mill with, even though half the size, true?

A: Yes, that's true. But again, I know this is a comparison, but you have to drill down and look at certainly some of the details. At the time most of these applications came in, there were still some aftereffects from what I recall a post Katrina inflation. And so that would not have been unreasonable for them to have accounted for the increased construction costs and labor costs and steel costs at the time of issue, not the Katrina issue. There are certainly reasons for the total project cost that you have to look at in more detail.

Q: All right. The point is that based on the four projects that you approved in 2008, that the costs for construction for the Fort Mill Center was imminently reasonable; wasn't it?

A: Yes, according to this chart in comparison.

Q: And the regulations direct you to determine whether or not the proposed project costs and specifically the proposed construction costs are consistent with the costs incurred by similar facilities offering similar services; isn't that right?

A: Yes.

MS. ANDREWS: All right. Now, let's take a look at -- let's go back to the reg, please Dan. 802.7.

Q: Now, another cost that the regulations instruct the reviewers to take into consideration is the operating costs, right?

A: Yes. And I want to point out that -- I mean, I looked at all of this as a whole. I didn't -- and these things were covered in all the applications. So I did look at those and consider what they were presenting to us.

Q: All right. I know you looked at them as a whole. You considered a lot of different project review criteria. We are looking at these related to project expenses. And you've identified one of the reasons, again, in your cover letter that you denied Carolinas was because of their substantial project costs;

that's what you said, right?
A: Yes. And if you look at the paragraph, it captures other issues as a whole.
Q: Well, do you want us to strike it out and focus on some of those other issues?
A: Well, no. They're just all related is my point.
Q: All right. Well, we understand that, but the only way we can talk about them is one at a time, okay?
A: Okay.
Q: So. Now, with regard to projected operating costs. There is no place in these regulations where the regulations approved by the General Assembly say the lowest cost is best; is there?
A: No.
Q: And you would agree that the lowest cost may not be the best, correct?
A: That's correct and certainly you can compare a lot of things about these applications. Carolinas may not have had the lowest cost. Again, I looked at and considered all factors.
Q: All right. But the ones you talked about and emphasized in your decision letter and in this analysis had to do with where Piedmont's costs

you've described as higher. And so let's move on to look at the operating costs here. Would you agree that one of the reasons in particular that you are careful about how you compare operating costs is because it's very difficult for the department to understand the assumptions that underlie the proposed pro forma and operating costs of an applicant?

A: Mr. Andrews, you said you don't understand what they're saying?

Q: That it's very difficult for you to understand when you're reviewing an application for a multi-million dollar hospital to understand all the assumptions related to what goes into the applicant of the pro forma.

A: So Mr. Andrews, are you saying individually? I can't -- I'm not able to --

Q: No, not individually. I mean anyone in the department that it is difficult to comprehend because they are complex.

A: Well, yes they are complex, but the applicants are required to state the assumptions to us.

Q: Okay. Do you believe then that it's good or bad if one applicant has more FTEs than another?

A: I don't think it's good or bad. We have to look and see are they loaded up on janitors or nurses. I mean, there is a lot to consider.

Q: Okay. And it could be a sign that it's better patient service. That would be one potential, wouldn't it, if there were more nurses in a place where the nurses were needed; that could be a good thing, couldn't it?

A: Well, yes. I mean, it can go either way. You just want to make sure you have the appropriate staff for your needs; that you are not overstaffed or understaffed.

Q: Well, isn't it true in reviewing these applications, Ms. Brandt, that you relied heavily, if not entirely, on what the applicants represented to you about their needs for personnel?

A: Yes, I do. In certain cases, I may compare previous applicants for other projects. But, yes, I do rely on the applicants to know what they are doing.

Q: And you are relying on them because every one could have a different approach to how -- what services they provide in a hospital versus what they provide in headquarters for backup

services, right?
A: Yes.
Q: Okay. And they could have different management to front-line ratios; couldn't they?
A: Yes.
Q: And none of those are necessarily good or bad, but they're just different approaches; aren't they?
A: Yes.
Q: And others could have more inpatient services or more outpatient services; couldn't they?
A: Yes, that would be a decision on their part.
Q: Right. Well, it may reflect their own practices and patterns of operating within their different hospitals; wouldn't that be true?
A: Yes, it could.
Q: And where there are more inpatient services provided than outpatient services as a rule of thumb; wouldn't you expect there to be greater staffing and greater expenses to support the inpatient services and the outpatient services?
A: Yes.
Q: Okay. And that's going to raise the expense level, isn't it, for those where there is a

higher degree of inpatient services?

A: Yes.

Q: Okay. Now, let's turn to your analysis and see what you've addressed with regard to operating costs.

MR. ANDREWS: Dan, if you will pull up Page 7 of Ms. Brandt's analysis. I want to start there. And let's go to the last paragraph. And highlight, Dan, please the sentence beginning, "Both Carolinas and Presbyterian have comparable total project costs."

Q: All right. And we've just dealt with total project costs as it relates to capital costs. But let's look at the second element of that statement, Ms. Brandt. It says, "Both Carolinas and Presbyterian have comparable FTEs per adjusted occupied bed." You see that?

A: Yes.

Q: What does that mean?

A: Usually the adjusted occupied beds, if I'm remembering correctly, consider both inpatient and outpatient services. And there is an adjustment made for occupancy.

Q: Do you know how to calculate that and reconstruct what your finding was here?

A: I can't say that I know the calculation off the top of my head, and I don't believe that that was part of this analysis. I just made a statement that their costs were comparable. I mean, I'm not sure where you're going, but I did make that statement they were both proposing the same amount in beds.

Q: Well, they're both, what you say here is that both -- they have comparable FTEs per adjusted occupied bed.

A: Yes.

Q: All right. Do you know how to calculate that?

A: I would have to look at the figures, and I would also assume that -- or presume that that information is provided to me. I don't recall that I specifically did that calculation myself.

Q: Okay. So that would have been a calculation that either or other applicants would have provided to you. And you were making a statement based on that; would that be your recollection?

A: I suppose, Mr. Andrews. I'm just trying to think about this so I could appropriately, you know, respond. And perhaps I did look at the

total project costs and divide it by FTEs. At this point, I honestly don't remember.

Q: Do you ever remember performing that calculation in this case?

A: I don't recall, Mr. Andrews.

Q: Do you ever recall using that measurement in any case to determine whether an applicant has reasonable expenses?

A: I honestly don't remember, Mr. Andrews.

Q: Ever having used it before.

A: But, I don't believe that I stated that there was a need for this.

Q: Well, I think if you look down believe, you said, "Piedmont least meets this criteria," correct? Do you see that?

A: Yes, but that was -- I was talking about the profit in year three.

Q: Okay. Well, let's move to the next page where your statement related to Piedmont. It's a little more direct.

MR. ANDREWS: Dan, highlight the first three lines, please. All right.

Q: Now, read the first sentence into the record.

A: "The department has received numerous projections or expenses per adjusted discharge

making it difficult to assess impact for adjusted discharge. However, it appears that Piedmont has the highest cost in revenue per adjusted discharge."

Q: Now, in the first sentence you acknowledge that you've gotten a lot of data concerning this analysis of expenses per adjusted discharge and that it's difficult to assess?

A: Yes.

Q: And that would mean hard to figure out; isn't it?

A: Well, we kept getting different information, and it was certainly difficult to keep it calculated.

Q: Well, it made it hard, but it didn't prevent you from forming the conclusion that you did that Piedmont has the highest cost in revenue per adjusted discharge?

A: Well, it says it appears that Piedmont has the highest cost in revenue per adjusted discharge.

Q: Well, does that mean you disregarded -- I mean, it's qualified by it here. Does that reflect a conclusion that they did that you took into consideration in making the decision?

A: I did not hold that in this ranking. I don't see where I held that against Piedmont. I don't believe it says that Piedmont did not meet.

Q: Well, in fact, which -- in fact, the organization of this, Ms. Brandt, would suggest that the expenses under -- which you've discussed under Section 7, or it should be evaluated under Section 16, which has to do and 16(a) in particular with the method of financing, right? That's where this is; isn't it?

A: Yes, sir. I'm a bit confused by the statement you just made.

Q: I'm a bit confused by the placement of an expense analysis in the analysis of the method of financing which is 16(a). So clarify that for me if you would.

A: Well, certainly 16(c) deals with the cost of provided services and charges, and that would be figured into the expenses.

Q: Well, let's look at 16(c) if you think that provides an answer to you. Ms. Brandt, do you know that 16(c) is in effect an adverse impact analysis wanting to know what the reg invites

is your review of the effect of the proposed project costs on existing providers.

A: You would have to refresh my memory.

MR. ANDREWS: All right, let's pull it up. Dan, pull up 16(c) if you would.

Q: Okay. Have you had an opportunity to look at it?

A: Yes.

Q: All right. So this is the impact of the project. "Upon the applicant's cost to provide services and the applicant states the charges to be reasonable. The impact of the project upon the cost of charges of other providers for similar services should be considered as the data are available." So 16(c) really doesn't have anything to do with the calculation of costs and revenue per adjusted discharge; does it?

A: Well, it doesn't say that specifically, but it does mention costs to provide services.

Q: Well, did you -- did you find that Piedmont's cost of providing services in its application were high, higher than Carolinas, and that would be a basis for deciding against them. If you didn't, we can move on.

A: I don't believe I computed that.
Q: Did you find anywhere in your analysis and more importantly as you're testifying today, is it your position that the department does not have any concerns about the expenses that Piedmont projected to incur in this project?
A: I don't recall having any concerns.
Q: All right. Good. Now, let's move to your testimony concerning financial feasibility and net income. Now, let me begin by talking with you about the purpose of this. Isn't this fundamentally through Section 9 of the regs and Section 15 the way the department intends to evaluate whether or not the proposed project is likely to be financially successful and to be able to operate over a long term?
A: Yes.
Q: And the most concrete way that that's evaluated is if it shows improvement over the three years of its operation; isn't that right?
A: Yes.
Q: And all of the applicants, including Piedmont and Carolinas application showed that; didn't it?
A: Yes.

Q: All right. You deemed Piedmont -- you found that they didn't perform as well as Carolinas because they didn't show profitability until year three; isn't that right?
A: I believe I identified that as a concern.
Q: Well, I mean, is it a mild concern or is it one that was a basis for your ruling in this case?
A: It didn't make or break the decision.
Q: Meaning it's inconsequential?
A: No. I had a specific way to rank the project review criterion. And I don't believe that was the top one.
Q: You mean it wasn't particularly important to you but it was on the list so you needed to make a judgment about it, and you made a judgment; is that fair?
A: Well, it's certainly important because I was directed to consider it. But it didn't make or break the decision.
Q: Okay. Well, I'm not sure what you mean when you say it didn't make or break the decision. It was a factor which you wrote -- was it a factor that you relied on in deciding for Carolinas and against Piedmont?
A: It was certainly something that I had to

consider and so I did consider it.

Q: Okay. Let me repeat the question. That's not -- I didn't ask whether you considered it. I know you considered it. The question is whether it's a factor that affected your judgment in deciding for Carolinas and against Piedmont?

A: Yes, I would say so. At this point, I don't recollect what my decision letter said or even the analysis, but I know I made the statement that the other two applicants showed a positive net income by year two that Piedmont or Fort Mill did not.

Q: Well, that's a question of fact, Ms. Brandt. And yes, the records are clear about that. The question is: Is that -- is it a degree of significance, the degree of weight you placed on that in making a decision in this case; was it major factor, was it a minor factor or was it a non-factor?

A: I would say that it wasn't a major factor.

Q: Was it a minor factor then?

A: Yes, as I recollect.

Q: Okay. Well, let's take a look at it, in any event, if it was a factor at all. Now, the --

MR. ANDREWS: Dan, let's pull up Section 9 of the regs to be sure what we're looking at here.

Q: All right. Now, it's the first sentence of Section 9 Ms. Brandt states, "The project should show an improvement in its net revenue position over time, especially the first three years until a steady positive net income trend is attained." Now, Piedmont did that; didn't they?

A: Oh yes, they did.

Q: The -- and again, the goal here is to demonstrate economic viability and sustainability, correct?

A: Yes.

Q: Now, in your review of CON applications, there has been a wide range of financial performance demonstrated; wouldn't you say that would be fair?

A: Yes.

MR. ANDREWS: Okay. And let's pull up Demonstrative 267, please, Dan.

Q: These are the hospital cases you reviewed prior -- well, prior to what you reviewed here. And you had found all of these cases to -- you approved them all. And you found them all to

have been financially feasible; haven't you?

A: Yes. But I recall that we requested a lot of additional information from Georgetown. And honestly I didn't even remember the year three figure or any of the other figures for their applications. But I know, as a policy, if it doesn't look like a facility is going to increase their debt, that we should get more information from them.

Q: Right. And you approved Georgetown, and yet it showed not -- didn't show a positive trend. It's losing more money each of the three years; isn't that right?

A: Yes, but --

MS. ROBERTSON: If I might just object. I believe, just so the record is clear so there is no confusion, Mr. --

MR. ANDREWS: Andrews.

MR. ROBERTSON: Yeah, I'm sorry. Thank you. Yes, Mr. Andrews, I know your name.

MR. ANDREWS: That's not my --

MR. ROBERTSON: I was just going to point out that the Georgetown application that is on this demonstrative, I believe we've heard testimony from Mr. Levitt that it was withdrawn. And Mr.

Andrews keeps referring to it as something being approved by Ms. Brandt, and I'm not sure that's accurate.

MR. ANDREWS: Let me clarify the record. It was approved. It was not implemented. The project was abandoned as Millennium was, too. I was going to go there. Two of the four projects were approved but not implemented.

THE COURT: Right. Okay. All right. Objection is overruled. Objection is overruled.

MS. ROBERTSON: That's right, Your Honor. I just wanted it to be clear for the record.

THE COURT: Yes. And thank you for clarifying that, Ms. Robertson because that's important.

MR. ANDREWS: Thank you.

Q: And you approved these, right, Ms. Brandt?

A: Yes. But again, I'm not disputing the accuracy of this information. But it's merely a snapshot in time and doesn't give a lot of detail about why I was willing to accept the financials for Georgetown, for example.

Q: Well, do you recall that one of the reasons you were willing to accept the finances for Georgetown is that the operation of the Georgetown hospital system, which included

Waccamaw and Georgetown Memorial, was performed at a viable level as a result of Waccamaw's profit margins and contributions. Do you remember that?

A: Yes, sir. I'm sure I also considered the fact that this hospital is located in a real disadvantaged community, and that it was in their best interest to have a new facility, as well. Again, there is other considerations to that.

Q: Okay. And ultimately they abandoned the project after you approved it and decided not to go forward, correct?

A: Yes.

Q: Now, the next project, Millennium, was on the other end of the spectrum with regards to the proposed financial performance, right?

A: Yes.

Q: They expected to make a lot of money each year?

A: Yes.

Q: And this was the project that was nearly $3 million a bed, right?

A: Yes.

Q: And they decided also that it was too expensive and not to go forward?

A: I'm not sure why they decided not to go forward with it, but they decided not to.
Q: Okay. And so both of these applications you approved. One at $3 million a bed, the other showing a total of nearly $45 million in losses the first three years of operation; but you approved them anyway, right?
A: Well, I approved them based on a lot of other information in addition to what's captured in this statement.
Q: And then the two Berkeley County projects. They are quite similar, are they not, to the financial progress made from year one, year two, year three with the Fort Mill Medical Center application; aren't they?
A: Well, I'd say more so Trident Berkeley for the first two years and Roper Berkeley for the last year, yes.
Q: And Roper Berkeley has an enormous loss for year one; doesn't it?
A: Yes.
Q: And that's the hospital, again affiliated with Roper which is owned in part and managed by Carolinas, correct?
A: Yes.

Q: All right. Now, would you -- have you thought about the relationship between the instructions that the department is given in evaluating the reasonableness of the revenue projections and the reasonableness of the expense projections in forming the proposed net income for various applicants? The question may be a bad one, and if you don't understand me, just tell me, and I'll start over.

A: Yes, it is. No, I'm having trouble with that, Mr. Andrews.

Q: Okay. All right. Just a quick review then. Under six -- Section 6(b), the department is instructed to determine the reasonableness of utilization projections, right?

A: Yes.

Q: And the way you do that, isn't it true, is that you look to make a determination whether the proposed applications are consistent with similar facilities providing similar services, right?

A: Well, that's one thing if that information is available, we can do it.

Q: Well, that's the only thing that is identified, isn't it, in 6(b) as you are determining

revenues --

MR. ANDREWS: Dan, let's go there.

A: Yes, thank you.

Q: Sorry. Okay. So for purposes of projecting levels of utilization, this regulation says that the department should -- the projected levels of utilization should be reasonable consistent with those experienced by similar facilities in the service area or the state and should be similar and consistent with the need as a second of the target population, the second sentence, right?

A: Yes.

Q: Now, and so the -- for purposes just like we were talking about earlier, for expenses. What the regulations guide you to review or to do is to determine among other things whether projected levels of utilization is consistent with those experienced by the facilities, similar facilities with similar services, right?

A: Well, yes, reasonably services.

Q: It doesn't mean exact. It's kind of a baseline measurement that you are taking, right?

A: Yes.

Q: Now, the reason you are looking at projected levels of utilization is because that ties to revenues, projected revenues, right? Utilization drives the money that comes into the facility, correct?
A: Yes.
Q: Okay. And so the guidance that is provided from the regs is looked up at facilities to determine their general levels of utilization as a marker to determine the reasonableness of projected utilization and revenues by the applicant, right?
A: Yes.
Q: You didn't do that here either; did you?
A: Well, I certainly looked at Piedmont Medical Center's reference of utilization.
Q: As a guide for determining the reasonableness of Carolinas' projections?
A: No, as a guide for determining the reasonableness of the Fort Mill Medical Center's --
Q: Well, the regulations say you apply to all applicants, not just one, right?
A: Yes, it does. But Carolinas had established what their utilization was.

Q: Well, let me drop a footnote on that. We'll come back to that. I didn't mean to get too far on that radical. But what we're talking about is net income. Would you agree with me that the regs provide guidance for how you are to look at the reasonableness of projected revenue in 6(d) that we just looked at, right?

A: Yes.

Q: And under 7, it provides guidance as to how you look at the reasonableness of projected expenses; remember that?

A: Yes.

Q: Okay. And when you put revenue and expenses together, the balance, bottom line is net income, correct?

A: Yes.

Q: All right. So it would be reasonable, wouldn't it then, that you looked to the performance of other's similar facilities and what their projected net income is and reviewing the net income of a proposed applicant. Doesn't that stand to reason?

A: Well yes, as guidance.

MR. ANDREWS: So as we're -- Dan, let's go back to Demonstrative 267, please.

Q: All right. So as we are then looking at the extent to which the proposed net income progression over the three -- first three years of its operation for Fort Mill are, it is comparable to at least three of those, probably two, both Ropers. It's far lower, far better if you want to apply a qualification to it than Georgetown's, right, and not as good as Millennium's in the sense it is not showing as much profitability, right?

A: Yes.

Q: Okay. And CMC-Fort Mills is more comparable but not as high as Millennium's, right?

A: Yes.

Q: And it's not showing the losses that the others show, correct?

A: Correct.

Q: Now, isn't the goal here, Ms. Brandt, as you are reviewing these proposals to determine the consistency with other applications really to determine whether or not the financial projections are reasonable?

A: Yes, I would agree with that.

Q: It's not a better or worse than. It's just are they reasonable given what they are proposing

to do. Isn't that the bottom line?

A: Yes, that's true.

Q: Okay. And based on your experience in approving these other applications in addition to the one that approved before you arrived, Fort Mill Medical Center's projected financial feasibility is consistent with many of the other satellite hospitals that the departments approved in the five years prior to approving the ones in this case.

A: I would have to look at those figures. But again, the figures from Fort Mill Medical Center were predicated upon them recapturing a significant amount of market share. So it's not just a number on a piece of paper but how those projections were derived.

Q: But that's not a financial feasibility question as much as it is a projected utilization question; isn't it?

A: Well, if you can't obtain your projected utilization, then your project is probably not going to be financially feasible.

Q: But your financial feasibility analysis is not based on not showing more profitability but based on questions you raised about whether

they could recapture enough market share.
A: Yes, I believe I'm understanding you correctly.
Q: Well, in other words, there is nothing inherently inconsistent with the regulations based on the financials that were presented in the financial projections done by Piedmont. Where you have a concern is what the assumptions were that were the basis for their projections?
A: Right, right. And you are talking about, again, what was the financial performance over time with this --
Q: All right. And so I just want to make sure the record is clear on this. I mean, you've already testified, and we'll examine that a little bit later about what you think may be the questions about whether or not Piedmont reasonably projected the utilization. But again, there is another section in the regs dealing with utilization. This on financial feasibility has to do with forecasting income and the likelihood of economic viability if the assumptions were achieved?
A: Yes.
Q: All applicants you could say the same thing.

If their assumptions aren't achieved, then their financial projections are going to be off, right?

A: Yes.

Q: Okay. All right. But the purposes of this -- question is as they presented their application whether or not looking just at their financial forecasting, there was any probably, in and of itself. And your answer to that is: No, there is not, is that right?

A: Correct. I don't recall saying they did not meet that criterion.

Q: Okay. All right. Well, let's go back then to the criterion that addresses utilization. And that will lead us into your testimony in that regard. Now, as I understood your testimony and reading your report, Ms. Brandt, my impression, and you tell me if I'm off base on this, that there are really two reasons that you felt that Piedmont's application didn't work for you and that the 100 beds they proposed were not justified. One was because of by transferring the 36 beds, it would create maldistribution of beds in York County. Is that one of the two?

A: Yes, that was certainly a concern for us.
Q: And the other was that as you put it, in shifting patients from Piedmont to Fort Mill, patients would have to, as you said, drive by Piedmont, and you didn't think, as you put it, that was logical, right?
A: Yes, yes. That's correct.
Q: Now, the idea of this the maldistribution theory, that was not a term that you coined; was it?
A: No, it was not, but I certainly did look at the beds and the population distribution.
Q: Okay. Ms. Platt, one of the consultants for Piedmont, did an analysis that presented a per-bed rate. Did I misspeak? I'm sorry. Yeah, they're reminding me that I'm confusing my client -- their names. Ms. Platt, as everybody in the room probably knows, works with Carolinas and not Piedmont. I misspoke. And Ms. Platt provided you an analysis showing that based on a bed-to-population ratio that by moving 36 beds to Fort Mill there would be a shortage of beds available to Rock Hill and to western York County, is that right?
A: Yes.

Q: And that analysis made sense to you?
A: Yes. I mean, certainly she focused on Rock Hill. I honestly don't recall about western York. But I believe you're right.
Q: Had you ever performed that analysis before?
A: No, not that specific analysis. But I certainly was aware of the population of greater Rock Hill and that it was substantially more than northern York County. And I certainly knew how many beds were proposed to be where and how many were existing and all that at Piedmont.
Q: And so -- now, you're aware that in the approval of a lot of satellite hospital applications, there are transfers of unused beds, aren't you, as a basis for the approved creation of satellite hospitals?
A: Yes.
Q: Roper did that to establish Roper Berkeley; didn't they?
A: They did. But again, Mr. Andrews, the specifics of why they did it, I just don't want to say -- blanketly say, you know, without truly knowing. But certainly that's what Roper proposed.

Q: Well, Roper had underused beds in its inventory and used 50 of them to propose the creation of Roper-Berkeley; isn't that true?

A: Yes, but I know as far as the population of the peninsula of Charleston, that was a factor, as well.

Q: Okay. And Roper also had another 85 beds in its inventory and used that to create Roper Mount Pleasant just a few years before; isn't that also right?

A: I believe you're correct.

Q: And, in fact, if you are familiar with the creation of satellite hospitals over the last ten years, most of them have been created through the transfer of under utilized beds and the shifting of patients from the underutilized facility to the high growth area; isn't that right?

A: Yes.

Q: So that's -- in that regard what Fort Mill is proposing to do is consistent with what hospitals, particularly tertiary hospitals, have done throughout the state. Do you know that to be true?

A: I guess I would say as a general rule.

Q: Now, and with regard to the transfers of -- the proposed transfer of the beds to the Fort Mill Hospital

MR. ANDREWS: Dan pull up, if you would, Carolinas' Exhibit 33. And let's look at Page 4 first of all and call that out.

Q: Now, does this look familiar to you, Ms. Brandt?

A: Yes, it's been awhile, but I do recall.

Q: You can see from the heading it's updated. And so it may be a bit different than the one Ms. Platt would have provided you during the staff review. But what do you understand is the purpose of this document?

A: The purpose is to examine where the populations are and where the beds are and correlate the beds to the population per 1,000 population.

Q: All right. And has -- now, the state health plan does not use this methodology in determining bed need; does it?

A: No, it does not. It certainly uses population projections and utilization projections, but it doesn't drill down to the specific areas of the county.

Q: Well, and there is no utilization projection at

all factored into this analysis; is there?
A: This is purely based on beds and population.
Q: And there is no -- and there is no weighted factor that's applied within the population recognizing that folks over 65 use hospitals with a much greater frequency than those from 21 to 50 do, right?
A: No, this is purely based on population.
Q: So it has limited, if any, reliability from a healthcare planning methodology without any utilization or use data; does it?
A: I will say limited. It certainly goes as a reference for comparison.
Q: And well, you relied on it, didn't you, in your analysis?
A: I certainly looked at this, but I relied on my knowledge of the population of the county and the population trends.
Q: Well, in addition to population trends, if that's enough, did you have the utilization trends by region within the state by zip codes within York County?
A: I know I had the population by zip code. I'd have to really look to see if I had utilization or not. I know in the broad areas maybe but

not by zip codes. I don't recall.

Q: Okay. And you didn't have any use rates by zip code or utilization data by zip code and only had population data by zip code, then this analysis would have limited utility; wouldn't it?

A: Again, it would be one of many things that would have been looked at for comparison.

Q: Well, I know, but we are talking about your concern about the effect under Section 2(d) of relocating the beds. Now, you remember what Section 2(d) provides; don't you?

A: I'm sorry. I would have to look at that.

Q: Okay. Let's take a look at 2(d). All right. Now, Section 2(d) asks the fundamental question about whether the relocation of beds causes any harm to medically served groups. Isn't that really what 2(d) gets to?

A: Yes.

Q: Okay. Now, as you are sitting here right now, you said you didn't know and you applied, as I understood it, and you tell me if I'm wrong, that you didn't give much weight to the western York County factor at all; your concern was Rock Hill, right?

A: I certainly looked at it. It's a sparsely populated area and certainly probably more under-served, but I certainly looked at that and considered that.

Q: Well, I thought you said your primary concern was Rock Hill. Did I misunderstand you?

A: Well, I know I said that that's where most of the population was.

Q: Okay. The question is did you make a finding that there would be an adverse impact on a medically under-served group by Piedmont's transfer of 36 beds at Fort Mill?

A: I don't recall with that specificity, but I do know that the Tega Cay, Fort Mill area is known to be an affluent area.

Q: Okay. I can see that. But that really didn't relate to my question. You would agree with me, wouldn't you, that Section 2(d) is intended to have the department make a determination about whether the change in a service, in this case the relocation of beds, would create a harm on a medically under-served group? That's where the focus is.

A: I believe that's what the last half of it focuses on. I mean, there are other things

within that.

Q: Did you find that there would be harm caused to a medically under-served group as a result of the relocation?

A: No, I did not specifically.

Q: Okay. All right. And, in fact, isn't it true that you raised a concern about whether 2(d) had been met by Piedmont, and then in your deposition said, you know, I guess they met it because I really didn't find that they didn't. Do you remember that?

A: I really don't recall what I said in my deposition.

Q: Did you find here on this page --

MR. ANDREWS: Let's turn to Page 3, Dan. And if you call out that middle part of the paragraph in the middle of the page.

Q: And in this regard, Ms. Brandt, did you make a finding here that Piedmont did not meet 2(d)?

A: No, I just stated that we were concerned that this criterion had been inadequately demonstrated.

Q: Now, the -- and that leads to the second question. So the maldistribution issue relied on this plat for -- you recognize a limited

utility of looking only at bed-to-population bed ratios. And so let's take a look at the second basis for the concern you raised, which has to do with the shift of patients and beds to Fort Mill Medical Center. First of all, the 64 beds -- Your Honor, this might be a good time to take a break. It's been long in the afternoon.

THE COURT: It has been. Any objection to that?

MS. ROBERTSON: No, Your Honor.

THE COURT: Let's take about a 15-minute break. All right. We'll recess.

(Off the Record)

THE COURT: Okay, we're back on the record. Mr. Andrews, sir?

MR. ANDREWS: Thank you, Your Honor.

Q: Ms. Brandt, let me draw your attention to your CON analysis, Page 5 of 10 where you are discussing the relocation of the 36 beds.

MR. ANDREWS: Dan, if you will call out the bottom paragraph, please.

Q: And Ms. Brandt, you say here on the second sentence beginning with relocation, that the relocation replacement of 36 beds in northern York County does not appear to equitably

distribute beds within the county and reduces accessibility to greater Rock Hill and western York. Do you see that?

A: Yes.

Q: And that was -- the basis for that equitable distribution theory was the maldistribution analysis that Ms. Platt presented; isn't that right?

A: Well, I'm sure it certainly contributed, but I also did look at the populations and the greater Rock Hill population was approximately four times greater than that of the northern area.

MR. ANDREWS: Okay. And the -- let's take a look at -- let's pull back up, Dan, if you would, Carolinas' Exhibit 33, Page 4.

Q: This is the analysis based on 100-bed application submitted by Piedmont, right?

A: Yes.

Q: And it applies to the population that you've identified. Notice that the year that it's presented are 2010 to 2015, correct?

A: Yes.

Q: And operations third year maybe 2017, the pace we are moving in this case including this cross

examination, we may be at 2020 before we're near through, right?

A: Yes.

Q: All right. So the point is to make this a fair comparison, you really need to look out into the future not just the first year of operation which Ms. Platt did in her analysis; isn't that fair?

A: Yes. And I mean I think the point is that there had been a period of extreme rapid growth in the county. But yeah, I don't recall. I know there is more information submitted by Piedmont, but I don't recall it.

Q: And you looked at it at 2017. So let's see what kind of analysis, what this looks like that's dated 2017.

MR. ANDREWS: Dan, pull up Demonstrative 149.

Q: Now, Ms. Platt (sic), this has been the subject of prior testimony from Mr. Sullivan related to a comparison of Ms. Platt's exhibit on the left. And then provide -- you see that? That's what we've just taken a look at, the 100-bed -- her breakdown of the population 2010 to 2015 and showing the maldistribution of beds. Within northern York, you see in 2015 it

would be a little over two beds per 1000. And then for the rest of the county it would be a little over one bed per 1000. Do you see that?

A: Yes.

Q: And that's part of what led you to conclude that there was a maldistribution in the county, right, if the 36 beds were transferred?

A: I'll say that was only part. Again, there was a lot of conflicting, if you will, information. Piedmont had a different point of view and Carolinas had a different point of view. And I'm pretty well tasked with trying to figure out where the truth lies. So I didn't necessary accept either one but formed my own conclusions.

Q: You looked at the population, I think you've already testified to. And you identified the year 2017 and looked at the difference in the population, the fact that the Rock Hill area is four times greater than northern York, I believe is what you testified to, right?

A: Yes.

Q: And you did that for the purposes of determining whether or not the distribution of beds among those two different population

groups would be equitable or not. Wasn't that the reason you did that?

A: Yes.

Q: Which was consistent with what Ms. Platt presented to you, right?

A: Yes.

Q: All right.

MR. MR. ANDREWS: Let's take a look then at the next table in this demonstrative.

Q: Now, we are casting out. We are projecting forward the population into 2020. Do you see that?

A: Yes.

Q: And look at the distribution in northern York County. Do you see the beds per 1000, it's 1.03?

A: Yes.

Q: And look at the beds for Rock Hill and western York County, and you see that as 1.07?

A: Yes.

Q: So in other words, if there were 100 beds established in Fort Mill, the distribution of the beds for that Fort Mill area or northern York population would be fewer than those available to the rest of the county including

Rock Hill and western York. Do you see how that would play out?

A: Yes. I mean, if you're looking at 1.03 and 1.07, they're pretty close.

Q: And you see the population differences. You had said you projected it in 2017. I don't know what you looked at, but here looking at the zip codes that would constitute northern York, and that would be three, not two. Do you remember whether you included 29715, 29708 and 29707 in your analysis or just 708 and 715?

A: I don't recall. And at this point, I don't know what areas they correlate to.

Q: Okay. Well, you don't have any reason to believe that these numbers would be inaccurate; do you?

A: No, not off the top of my head.

Q: Okay. And so we got here 96,000 -- nearly 97,000 would be the projected population for those three zip codes in 2020, and the population of the rest of the county Rock Hill and western York would be 215,000. I'm rounding up to 216; do you see that? So it's just a little over twice; isn't it?

A: Yes.

Q: And there would be 100 beds for northern York and 232 for the rest of the county. And that distributes based on population alone the beds quite equitably; wouldn't it.

A: Well yes. But, I mean, the 100 beds weren't solely in to serve northern York because it was -- part of the population was coming from Rock Hill.

Q: Right, that's true indeed. Now, let's -- let me turn to the second issue, Ms. Brandt. You'd expressed concern in your testimony and in your analysis about something you referred to as "go-by" or "drive-by," and you didn't find that logical. And again, this is an issue that Carolinas coined for you; didn't they; that Piedmont was proposing to serve patients who would have to drive by Piedmont to get to Fort Mill Medical Center? Isn't that what they said in their criticism of Piedmont's application?

A: Yes. But we certainly had information available from Piedmont that identified the zip codes and what zip codes were considering the primary service area. That wasn't something that I would not have considered.

Q: And your concern was that there were patients

who would be served by Fort Mill Medical Center from zip codes that were south of the river that separated northern York County from the Rock Hill area; isn't that right?

A: Well, I would say south of Rock Hill. I don't believe I ever talked about a river. But one zip code was the Rock Hill vicinity and one zip code was south of Rock Hill.

Q: All right.

MR. ANDREWS: Well, let's pull up Demonstrative 38, please, Dan.

Q: Now, there has been testimony concerning drive-time studies that were the basis for this demonstrative, Ms. Brandt. And let me just represent to you the testimony in the record shows that Mr. Walsh testified that the pink areas represent areas in which individuals who live there, the residents of the pink area would be able to drive to the Fort Mill Medical Center location, which you will see at the H area, there you go, right where that is, more quickly than they would be able to get to the Piedmont Medical Center which is the H in the center of this map. Do you see that?

A: Yes.

Q: And those in the tannish color, and I don't want to make a representation, but I think it's 5 to 10, 0 to 10 minutes; and the blue would be further away, 10 to 20 from Fort Mill Medical Center. And you remember that Piedmont represented to you that there would be individuals living in 730 zip code. And do you see the 730 zip code?

A: Yes.

Q: And are you aware enough of the geography of York County to note that zip code continues on over onto the right, the far right, or the eastern border of York County where that -- where Mr. Bupp has his arrow. Do you recognize that as being 29730 zip code area?

A: Yes.

Q: And then 732 would be the one that's more central in which Piedmont Medical Center is located, right?

A: Yes.

Q: All right. Now, when you had expressed concerns about the shifting of patients from Piedmont to the Fort Mill Medical Center, and you said you were concerned about that because that would mean patients would be driving by

Piedmont Medical Center to get to Fort Mill. Isn't that what your concern was?

A: Yes.

Q: Now, you can see by the pink zones that there could be many residents of York County, particularly residents of zip code 29730 and 29704 down on the far right and a bit of 29732 for whom it would be a faster drive and one simply requiring getting on the interstate to go to the Fort Mill Medical Center. Do you recognize that?

A: Yes, I can see that. I'm sure there are more roads.

Q: Sure there are, this is background. This is just looking at the major arteries and very few roads. But the point is, is it not, based on your review of this map, you'd recognize, wouldn't you, that Piedmont could shift patients that it has historically served at its inner city hospital to Fort Mill Medical Center for whom it would be a shorter drive for them to get there.

A: Yes. But, I mean, I don't know what the population-distribution is in those areas. But I can see in theory what your point is.

Q: Well, that was Piedmont's point that it made during the staff review that there would be many individuals for whom it would be more convenient and certainly not require driving by Piedmont Medical Center in order to get access to Fort Mill; isn't that right?

A: I believe that's what they had stated.

Q: Okay. And you didn't accept that, but you weren't aware of this population sector. And I understand you don't have any data -- you're sitting here today about the extent of that. But residents who lived there could have been -- well those that Piedmont was intending to encourage the movement up, and expects reasonably the movement up to Fort Mill rather than driving through in-town traffic to get to Piedmont Medical Center, right?

A: It could be, but I know that the concentration of the population of Rock Hill is near the hospital as far as the bulk of the population of Rock Hill. You didn't say it was urban. So again, I don't know what the population-distribution is. But I certainly do see what you are trying to demonstrate.

Q: Okay. And are you also aware that the patients

that would be shifted to address the beds that would be moved would just -- there are 19 beds that are unutilized and un-staffed at Piedmont, right? You are aware of that, correct?

A: Yes.

Q: And there were 17 that were underutilized that the hospital was proposing to move to accommodate the patients who would be going to Fort Mill rather than Piedmont. Isn't that the way that Piedmont presented it to you?

A: Yes, that's the way they presented it.

Q: Okay. And that would still leave in the vicinity of well over 100 beds to serve the population of the county; wouldn't it? I mean, that Piedmont could serve the other patients that it would intend?

A: Yes. And I know that was brought up. But there was certainly other related issues to include the decrease in utilization through the years. And if the patients aren't going there to Piedmont, they're not going to Piedmont. I mean, you have to look at why is there in this capacity. I mean, there are other factors to consider.

Q: And, in fact, Piedmont identified those

factors, which was the change in referral patterns and the acquisition of hospitals -- excuse me, acquisition by Carolinas of physician practices and the change in those referral patterns among the physicians who historically had served their patients at Piedmont. Do you recollect that?

A: I recollect them stating that.

Q: Was there any doubt in your mind that was true?

A: Well again, there has got to be reasons that patients leave an area. And certainly referral patterns evidently did change, but it's ultimately patient's choice as to whom they go with.

Q: Well, it's ultimately patient's choice, but you've testified in depositions that patients often follow the encouragement and the lead of their physicians; isn't that right?

A: Yes, I'm sure I did say that.

Q: All right.

MR. ANDREWS: Let's take a look at the regulations again, Section 3(a), Dan.

Q: Now Ms. Brandt, as we are pulling this up, I want you to -- if you can do this from memory, fine. If not, we can go back to the document.

But for Section 3(a) you stated that this only applies to Piedmont. Do you remember that?

A: Yes.

Q: Why did you say that?

A: Because Piedmont was going to transfer beds, in part, to create Fort Mill Medical Center. So in other words, they were going to create the same services within York County as were already existing with Piedmont Medical Center.

Q: Now, Section 2(d) deals with the relocation of 36 beds. You've already testified about that, right?

A: Yes.

Q: Section 3(a) says it requires the department to focus on the question of whether or not there is duplication and to prevent unnecessary duplication, right?

A: Right.

Q: Now, every applicant that applied needed to be evaluated to determine whether or not their proposal would unnecessarily duplicate existing services in York County; isn't that right?

A: Yes. I see your point. But I think that Piedmont even acknowledged that this only applied to them.

Q: No. I'll state for the record Piedmont did not acknowledge that.

A: But my approach was that Piedmont was duplicating Piedmont.

Q: Exactly. You believed that approval of Fort Mill Medical Center would duplicate Piedmont, correct?

A: Yes.

Q: Because there were two hospitals with the exception of the tertiary services providing similar services, right, in York County?

A: Right.

Q: Isn't that right? And you believed that the applications by Carolinas and by Hospital Partners of America and by Presbyterian would not duplicate existing services because they weren't proposed by an existing provider of services in that county; isn't that true?

A: Well, I'm not familiar with Hospital Partners of America.

Q: HBA, I'm sorry, was the third applicant. They dropped out by the time you came into the picture. So I apologize. So those are the two.

A: No. I did not believe they would because they

were different institutions, different referral patterns.

Q: So the question of duplication of existing facilities and services, you were analyzing based on Piedmont duplicating itself, and you determined they were?

A: Yes.

Q: And you did not find that Carolinas duplicated itself because it's facilities were in Mecklenburg County, is that right?

A: Correct. And again, they were proposing to shift current patients, yes.

Q: And so that's how you understood the practice that the department has not to take into consideration the out-of-state entities. You used that against Piedmont to favor the approval of Carolinas and to deny them, deny Piedmont because Carolinas did not have a facility in York County. Isn't that what you're saying?

A: That's not what I'm saying.

Q: Isn't that the effect of what you're saying?

A: Well, Piedmont was established, and they were going to provide the same services. So I did not -- I mean, that's not what I set out to do.

I set out to perform an analysis based upon the fact that Piedmont was already offering the services.

Q: Ms. Brandt, who trained you on the principle related to the extent to which you should take into consideration out-of-state facilities?

A: It was definitely Ms. White, and I am sure Ms. Fechtel actually is probably in here somewhere, too.

Q: And do you know how long Ms. White had been with the department in the CON program?

A: No, I don't.

Q: It wasn't more than several years; was it?

A: I don't believe so.

Q: Okay. Now, the purpose -- would you agree with me that the purpose of the issue related to the consideration of out-of-state entities was that the department should plan for South Carolina residents, right?

A: Yes.

Q: The department should not take into consideration the effect on out-of-state facilities the establishment of in-state facilities would have, true?

A: Yes. The focus was South Carolina.

Q: Did anyone suggest to you that you should not consider the effect of the existence of out-of-state facilities in their operations on in-state facilities? Do you understand the other side of that?

A: So Mr. Andrews, you're asking me if somebody told me I should not?

Q: Yes. Did someone tell you that you should not consider the effect, for example, of CMC-Pineville on the operations of a proposed facility by Carolinas in York County?

A: Yes.

Q: Someone did tell you that?

A: I was trained that it's -- you look at what's affecting South Carolina and South Carolina patients.

Q: But if your testimony, then, that you believe that Fort Mill Medical Center duplicated Piedmont, which is right beside -- just by -- the proposal of another hospital by Piedmont in York County some eight miles, 15 minutes away, duplicated Piedmont; isn't that what your testimony is saying?

A: Yes.

Q: Now, CMC-Fort Mill would be just about the same

drive time, about 15 minutes away from CMC-Pineville. Are you aware of that?

A: Yes, sir.

Q: But you didn't regard that as a duplication of the Pineville facility, correct?

A: That's correct.

Q: And the effect of that is to put at a disadvantage Piedmont because Carolinas doesn't have an existing facility in Rock Hill; does it?

A: No, I disagree. I had the applicants before me, and I had to consider what was in existence. I mean, it's beyond my control of about what's located where.

Q: But based on that principle, Piedmont could do nothing in your mind to avoid the conclusion that a second hospital within a 15-minute drive time would duplicate itself?

A: It did duplicate. And the issue was the justification of the duplication, not the duplication itself.

Q: All right. So -- well, you stated that the duplication would be their beds are being transferred, so they're not duplicating those, correct?

A: No. The beds themselves, I mean --
Q: Would not be duplicated.
A: Not the beds but services associated with those beds.
Q: Well, anyone who's going to provide the services would be the same services that Piedmont was providing, correct? Carolinas -- CMC-Fort Mill services would duplicate the services; wouldn't it?
A: Yes. But again, the purpose of the CMC application was to serve existing patients.
Q: Well, we're going to deal with the shift issue in a minute. But with regard just to the focus under this section on whether there is a duplication of services, the services that are proposed by CMC-Fort Mill and the services proposed by Fort Mill Medical Center are virtually identical; aren't they?
A: Yes.
Q: All right. So the services are not being duplicated. They will both be consistent with the services provided by Piedmont with the exception of the tertiary more advanced services; wouldn't they?
A: Yes. And again the issue is the justification.

Q: All right. So you are referring to the question of who has the established patient base?
A: How do they prove that this duplication is necessary.
Q: And in fact, Piedmont proposed that it was necessary in order to continue to maintain the base of volume and the quality of services that would be needed to support a tertiary hospital.
A: Yes, that's what they proposed.
Q: And wouldn't you agree that a core volume of services is necessary to sustain tertiary services?
A: Yes.
Q: And wouldn't you agree that there is a direct correlation between sustaining that volume and increasing the volume at a level that without which the tertiary services will be in decline?
A: Yes. But again, I had to look at the facts before me. I mean, you're making a blanket statement. And yes, that does make sense.
Q: Well, weren't you concerned that if Piedmont's decline in utilization continued, that if they were denied what they first planned before any other hospital in the area did, which is

establish a satellite hospital to recapture that lost market share, that Piedmont could possibly not be in a position to recover the volume to support the high quality services that York County had become accustomed to?

A: I believe in my analysis reports, that I took that under consideration and looked at that very carefully. In fact, I even made a statement about the impact that Presbyterian would have, and that Carolinas would have a lesser impact on Piedmont. I certainly considered those facts very carefully. The intent of my decision was not to put Piedmont out of business.

Q: Piedmont may not go out of business, but if the volume of their open heart services and their cath services and their neurosurgery services and their neonatal services continues to decline, are you aware that those programs would be put in jeopardy?

A: I certainly could see where they could be. But again, and this goes to the whole premise of their application is they feel that if they build this hospital, then magically they are going to recover from years and years of

declined utilization. And I just did not accept that.

Q: In fact, are you aware, Ms. Brandt, that it's not so many years; that in 2004 and 2005 Piedmont was operating at a level which established the benchmark to which they were planning to return?

A: Yes, the decline started when --

Q: Yeah. So it's not ancient history; is it?

A: Well, it's been quite a few years.

Q: Well, the effect of the extended application process contributed to that happening?

A: Yes, it has.

Q: Now, the -- so you are aware that their goal was to achieve a certain historical level. And if they achieved that, they would roughly comparable to where they were at the time they filed the application?

A: That makes sense, yeah.

Q: Now, and you believed they wouldn't be hurt because you believed that Carolinas would be successful in shifting their patient beds?

A: Yes.

Q: Isn't that what you believed? And that's what Carolinas represented to you; didn't they?

A: Yes.
Q: And when Ms. Biggers asked you -- I'm sorry, it may have been Ms. Robertson, I forget which. If you believe that Carolinas would serve the same patients that they served historically, your answer was yes because that is what you believed; isn't it?
A: Yes, and that was their intent.
Q: Well, you don't know what their intent was; do you? That's what they said to you; isn't that right?
A: Yes. And again, I went into the fact that they weren't even proposing to capture 100 percent. You know, they had, based on the areas of the county, different projections for what they intended to capture and that they did consider, I believe it was 10 percent in-migration.
Q: And those in-migrating patients could be there, as well; you don't know, do you?
A: Well, I believe they specified outside of the county.
Q: Well, they could be folks who live outside the county they serve that would come into the county, correct?
A: Yes.

Q: From Chester County or Lancaster County, patients they already served who may choose to use that facility; that's certainly possible?
A: Yes, that's possible.
Q: All right. So the -- but your approval of Carolinas was dependent on their being able to redirect their patients, to shift their patients successfully in a way that they wouldn't have to use, and they wouldn't take from the Piedmont patient basis; isn't that right?
A: Yes.
Q: Now, you've not studied, have you, as part of this process how patients are admitted in the hospitals; have you?
A: Well, I know they are done so by either they enter through the emergency department or through a physician referral. I can't say that I've studied it, but I have knowledge how they enter the system.
Q: All right. And do you have any sense of the percentage of admissions that come through the emergency department of a hospital?
A: I know I've heard that figure. But I don't believe I can quote with accuracy right now.

Q: Would it surprise you if there were well over half?
A: I'd -- nothing would really surprise me at this point.
Q: Well, wouldn't you recognize -- wouldn't you agree with me that Carolinas has absolutely no control over the patients that show up in their ED at CMC-Fort Mill?
A: No, I would agree that Carolinas can't control who shows up.
Q: Right. And for that reason, particularly given a hospital immediately adjacent to an interstate exchange, that there could be patients coming to CMC-Fort Mill who for years have used Piedmont or who may not have a doctor and may not have used any hospital and would not be a part of Carolinas' historical mix; isn't that certainly not only possible but likely?
A: Well, I agree that it's possible. But historically, you know, patients, if they are going to utilize one healthcare system, they continue to utilize that hospital system unless there's some compelling reason.
Q: What are you basing that on?

A: Just information that I've gleaned from CON applications.

Q: Well, CON applications all the time talk about shifting -- new hospitals taking market share from others; don't they?

A: Oh, yes. But typically, I mean, this was testimony that certainly was hashed out ad nauseum at the Berkeley County Hospital hearings that patients typically stick with their provider.

Q: Well, they come through the ED and often based on proximity, don't they? They are going to go to the ED, the emergency department that is closest to them; aren't they?

A: Yes, I would think so.

MR. ANDREWS: Dan, let's pull up Demonstrative 38 again.

Q: And then look in the area in the pink. And then look in the area in the pink above the dash line, it's white which would, of course, be the northern York County area. Any patient that Piedmont has served historically that has a need to go to the emergency department, it would be a closer drive for them to get to CMC-Fort Mill, which is just above the pink left of

the interstate than it would be to go to Piedmont, correct?

A: I see where that could be accurate, yes.

Q: And you didn't take into consideration, did you, the extent to which patients who have been part of those -- who have been historically by Piedmont, would, because of proximity if for no other reason, would be admitted into CMC-Fort Mill through there ED because of sheer proximity?

A: Well, I took everything into consideration that was before me. And I drew my own conclusions that it was more likely certainly that they would follow the facility that they had typically done business with.

Q: Are you -- and your other assumption, Ms. Brandt, is that concerning the admission of patients into CMC-Fort Mill, as they come in through physicians who admit them there, right? That's the other way it's done?

A: Yes.

Q: All right. And CMC-Fort Mill is not going to be a closed medical staff?

A: No.

Q: That would be improper under the DHEC regs;

wouldn't it?
A: Yes.
Q: And you don't have any reason to believe, do you, that physicians who are on the medical staff of Piedmont Medical Center who have patients in the Fort Mill area or in eastern York County who want to try the new hospital in town would not get privileges at Carolinas facility in Fort Mill; wouldn't you expect them to do that?
A: I would expect them to consider it. I mean, clearly there is a lot of reasons why they may or may not grant privileges, but they would certainly be open to that.
Q: I'm talking about why -- I should tell you because everyone -- most folks in the room know, and you didn't have the benefit of being here, that three physicians who are active members of the medical staff at Piedmont, testified saying that if CMC-Fort Mill were built, they would apply for privileges there. And they would admit their patients there because they believe they're patients who live there and even patients who don't live in that area will want to try a new hospital. And they

would admit their patients, even though they don't support the approval of that, they would admit their patients there because they don't want to lose their patients. Doesn't that make sense to you?

A: Well, it boils down to patient's choice then, in essence.

Q: Doesn't it make sense to you that patients would want to try a new facility and use the one that is convenient to them and for that reason, those who had been going to Piedmont historically, not because they want to leave Piedmont but because they want a hospital closer to home, would use the new Carolinas facility in Fort Mill?

A: I think it's conceivable. But what it boils down to is patient choice and where they're used to having their services rendered.

Q: It would also boil down to the choice of these same physicians and these same patients to use a Fort Mill Medical Center if you gave them the opportunity by approving that. It's not a choice of one provider over another; it's a choice to prefer to use a hospital in their -- that's convenient to them and a new facility,

which is attractive. Don't you recognize the possibility of those considerations?

A: I certainly do recognize the possibility, yes.

Q: Finally, Ms. Brandt, let me turn your attention to the indigent care issues. Now, you've testified in your deposition that all the applicants we are talking about and the great things they were doing in the community, and you basically blocked that out and turned your focus to their proposed percentage of indigent care. Did I remember that correctly?

A: Well, yes. That's what we're directed to do.

Q: And Carolinas' proposal nearly doubled that of Piedmont or more than doubled that of Piedmont. And you found that instructive; didn't you?

A: Well, I found it a point of comparison.

Q: Right. And did you do anything to evaluate the reasonableness of their projection of 6.3 percent of indigent care?

A: I know they had provided financial statements, but I don't recall at this point exactly what the figures were. But I know they did provide the information.

Q: Do you remember what kind of information?

A: Well, if it was financial statements, it would

have indicated indigent care figures. I just don't recall what they are.

MR. ANDREWS: Well, Dan, let's put up Demonstrative 118, please.

Q: You had already approved several applications, and you had access to others. You knew what new hospitals proposed in the way of indigent care; didn't you?

A: Yes.

Q: All right. And you were aware that Carolinas' proposal exceeded by more than half the highest among all the other projected indigent care proposals of satellite hospitals; did you know that?

A: I know that typically the indigent care is all over the board. And I don't recall if this was presented by Piedmont at any point prior to my decision.

Q: Well, you were specifically involved and approved the Roper-Berkeley again and the Roper and Trident-Berkeley, correct?

A: Yes.

Q: And you believed when you were reviewing those applications, those indigent care proposals to be reasonable, right?

A: Yes.
Q: And Dorchester County, you are familiar with the demographics of it generally; aren't you?
A: Generally.
Q: It is not nearly as affluent as York County; is it?
A: I would say not.
Q: And you are aware, aren't you, that the Fort Mill Medical Center and CMC-Fort Mill are proposed to be located in one of the most affluent of the areas of the county in the state; did you know that? I think testified earlier that they are notable Tega Cay and even Fort Mill are recognized as a highly affluent area?
A: Yes. But CMC certainly proposed to serve more than Fort Mill and Tega Cay.
Q: Well, but nearly half of their client base was coming out of Fort Mill and Tega Cay; wasn't it?
A: I believe that's correct. That certainly leaves the other half.
Q: Okay. It does. And these other applications, did you take those into consideration in evaluating the reasonableness of CMC-Fort

Mill's proposal of indigent care?
A: No. I relied on the fact that Carolinas had provided what they were currently providing and that they had based their figures on historical experience.
Q: But you can't point, just sitting here today, any historical experience that's consistent with 6.3 percent; can you?
A: I would have to look at what they've provided in their application.
Q: Well, you are here on the stand. Can you identify anything that would be the basis to support 6.3 percent as a projection?
A: I don't believe I can really answer that without more information.
Q: Well, then you can't do it?
A: No.
Q: Okay. That was the question, can you do it now?
A: No, not right this minute, no.
Q: All right.
MR. ANDREWS: Now, just one moment Your Honor.
Q: One final set of questions, Ms. Brandt. Let me take you back to the issue of any consideration you gave to Pineville, CMC-Pineville in this

case. The -- are you aware that Piedmont and Presbyterian alleged or they were presented information to you that they believed that CMC-Pineville added beds and over 100 beds in large part based on their reliance on the historical utilization of Pineville by York County residents; do you remember that?

A: Yes. There was reams of information submitted by all applicants about that in Carolinas submitted information that to me clearly indicated that that was not a part. In other words, there were different projects -- that there was a recent Pineville expansion and was not based upon York County residents.

Q: Well, I thought you said earlier that you didn't take into consideration anything related to Pineville's performance in determining whether or not CMC-Fort Mill should be approved.

A: I did say that. But what I'm saying now is that all the applicants presented me with information. So I read what they presented. That didn't mean I necessarily used it, but I didn't ignore it; the fact that they submitted this.

Q: Did you give any consideration to the adverse impact that the operation of CMC-Pineville would have, could have on Piedmont?

A: No, no. What I'm saying is the issue was raised, the information was provided and I read that information.

Q: All right. Did you recognize anywhere in your review process that as a result of the establishment of Carolinas Hospital in Fort Mill that it would exacerbate the effect on Piedmont by sending more tertiary patients into North Carolina?

A: Well, since Piedmont is a tertiary center itself, then I mean, they are already offering their services. Maybe I don't understand -- I mean, clearly if the patients are Carolinas' patients and they are in need of tertiary services, it would stand to reason that they probably would be transferred to Carolinas in Pineville, Charlotte or wherever those services are offered. But again, these are already Carolinas' patients, not Piedmont's patients.

Q: Did you give any consideration, Ms. Brandt, to how Carolinas got those patients? Do you think the patients made the choice to use Carolinas

Q: And I believe you testified that it was your understanding that Carolinas' percentage was based on its historical experience; is that what you said?

A: Yes.

Q: No further questions, Your Honor.

THE COURT: All right.

MR. ANDREWS: Just a short one, Your Honor.

THE COURT: Yes, sir.

MS. BRANDT - RE-CROSS EXAMINATION BY MR. ANDREWS:

Q: Ms. Brandt, do you remember then in October 2010 that the deadline -- the parties have for submitting information to you to update their application, that Carolinas did not update their application; do you remember that?

A: Yes. I recall that we had asked them in the first round of additional information for updating information.

Q: All right. But Piedmont provided its projections and its updated application in October of 2010; didn't they?

A: Yes.

Q: And Presbyterian did, as well; didn't they?

A: Yes. But they did later make some changes when the census 2010 data was released.

Q: All right. And in Presbyterian's original application they had proposed, do you remember this, indigent care in the range of 3.5 percent?
A: I honestly do not, no.
Q: But in their 2010 -- their October 2010 filing they projected somewhere in the range of 6 and a half, 6.3 to 6.7; does that sound about right?
A: Yes.
Q: All right. And that Carolinas had -- do you remember that they had somewhere in the range of 3 and a half percent in their 2005 application?
A: I absolutely do not remember that. I don't have any recollection of that.
Q: And they had two months to review two months to review Presbyterian's application and decide during that period of time to increase their indigent care projections as well; didn't they?
A: I really can't testify as to what they thought or did.
Q: I know. My question was they had time to do that; didn't they?
A: Well, that's reasonable again.

Q: Thank you. Nothing further.

THE COURT: All right.

MS. ROBERTSON: Just one or two.

THE COURT: Yes.

MS. BRANDT - RE-CROSS EXAMINATION BY MS. ROBERTSON:

Q: Ms. Brandt, when Carolinas submitted their updated application in October, I think Mr. Andrews suggested that there were no updates in that submission. Do you recall, in fact, that they were updated, there was updated information in October?

MR. ANDREWS: Objection, leading Your Honor.

A: I --

THE COURT: Oh, wait. Can you rephrase it?

MS. ROBERTSON: I'll rephrase it.

THE COURT: Can you rephrase?

MS. ROBERTSON: I will. Yes, Your Honor.

THE COURT: Thank you.

Q: In the submission by Carolinas in October, after the remand, do you recall if there were any updates by Carolinas in that submission to the department?

A: Yes. I do recall some sort of table of comments and some comparative information.

Q: Okay. And do you recall that the department

The processes are a little different. In North Carolina, when you file your certificate of need application, you know, there is a filing date. And at that date you can't submit any additional documentation to the state in Raleigh.

You know, in South Carolina the process is different. You file your application. If the folks at DHEC have questions, the process allows you to communicate with the CON officials and provide additional information.

That process is very different. But I would say overall in terms of developing certificate of need applications and developing projects that you want the state to approve, I think they are very similar.

Q: What was your role in this particular CON Application that we are about here for this case with the Fort Mill Hospital?

A: I was basically the representative of Carolinas Healthcare System to DHEC, the certificate of need department, and I was also responsible for really the totality of our filing and the development of our filing.

Q: Okay. Now, I would like to talk about

Carolinas Healthcare System and who is Carolinas Healthcare System? Mr. Murphy, have you prepared some demonstratives with respect to describing Carolinas Healthcare System?

A: I have.

MS. ROBERTS: Lynn, would you please.

Q: And if you could just first generally describe to us who is CHS, Carolinas Healthcare System?

A: Well, a very big picture, Carolinas Healthcare System is a public, not for profit, healthcare system that mostly serves citizens who live in the two Carolinas. And we're headquartered in Charlotte.

Q: And I would like to look at the mission, if we could. And I think this is in the record at Joint Exhibit A, CHS, Page 367. I think you've if you've excerpted it into a demonstrative. If you could talk about the mission of CHS.

A: Yeah, this demonstrative was actually a part of our record. I think it was in our October 4 submission. And we wanted to basically convey to DHEC, you know, what our core mission is, the reason we exist as an organization. And I wanted to take a minute and read it for the Court. "It is to create and operate a

the Medical University of South Carolina, and you think about the care that's rendered in a hospital, in general, about 75 percent of the care can be cared for in a community hospital. There is about 25 percent of hospital care that really needs to go to a facility that has, you know, more sub-specialists, more capability to take care of the really significantly injured patient or medically complex. And that's what we refer to as the tertiary quaternary facility versus a community hospital. And CMC-Fort Mill is intended to be a community hospital.

MS. ROBERTSON: Okay. Let's look at Page 1115 in the record if we could, Lynn, still Joint A, CHS.

Q: Mr. Murphy, can you talk about this page and what Carolinas experience has been for the inpatient discharges for York County patients?

A: Sure. This is again a slide that we showed earlier on in our Project Review presentation as evidenced by the people being highlighted under those three points up there in the top right. What it shows is that from 2005, from the year of our first filing, we've had a 69-percent increase in patients that are coming to

different type witness.

THE COURT: Okay.

Q: So, Mr. Murphy, if you will try to -- if we can, rather than express opinions beyond that that is reflected in what you've submitted to the department, talk about what you submitted, why and keep it as factual as we can.

A: Okay. I can do that. This shows that from 2005 to 2010 we had a 69-percent increase in York County citizens discharge -- total inpatient discharges from our Charlotte Hospital. The purpose of the slide was to demonstrate to DHEC and those at project review that we were the people's choice. We wanted to make it clear to DHEC that we felt we were the people's choice. And this type of information supported that theme.

Q: Okay. Thank you. Now, I would like to talk about kind of the key features of the hospital. And if we can look at a record on Page 1112, Mr. Murphy. And before we kind of get into the details of the application and what you submitted, tell us about the key features of CMC-Fort Mill?

A: Okay. Just the picture that's inset. That's

determined our market share assumption for CMC-Fort Mill and knowing it was going to be a 64-bed community hospital serving the primary-secondary needs of patients. We evaluated the market share positions of the other four community hospitals that were located in Mecklenburg County and just to look at what type of market share positions they had, because again, they are offering similar services, similar types of settings. So these are the four hospitals that you see listed here; two operated by CM-CHS, CMC-University opened in 1985; CMC-Pineville opened in the mid eighties. Also Presbyterian Matthews opened in the early nineties and Presbyterian Huntersville, all community hospitals similar in service to CMC-Fort Mill. So we looked at those and then we basically targeted our market share for CMC-Fort Mill to be reflective of what a community hospital's market position would be.

Q: Okay. and I think you have another demonstrative talking about the home zip codes. Can you please describe this?

A: This slide shows -- basically these are the

MS. ROBERTSON: Yes, sir.

THE COURT: All right. Let's do that -- 15 minutes.

(Off the Record)

THE COURT: All right, Mr. Westbrook. Oh, I'm sorry. Mr. Murphy, please return to your seat. That would be a difficult cross examination with an empty chair; wouldn't it? They do that in Hollywood, I think.

MR. MURPHY - CROSS EXAMINATION BY MR. WESTBROOK:

Q: Mr. Murphy, how are you doing?

A: Doing well.

Q: Good, good to see you. Mr. Murphy, you know, I would like to start off by talking about Dan Sullivan a little bit. Now, my understanding is that early in the development process of your application of your first application, 2005 application. Early in that process before you filed that initial application, you had a conference call with Mr. Sullivan, is that right?

A: Correct.

Q: And during that call you asked him about some of the parameters of the South Carolina CON

process, correct?
A: I don't remember really exactly what we talked about on the call. I know generally.
Q: Well, and I certainly understand 2005 is a long time ago. So I'm going to ask Dan, my friend Dan, not Dan Sullivan, to put up on the screen your testimony from the 2009 trial because it is a lot closer in time --
A: Right.
MR. WESTBROOK: -- to the event. And Dan, if you could, pull up Bates Page 1447 of the trial testimony from that 2009 trial where Mr. Murphy's on the stand. And we'll get there in a minute. Let's focus on Page 1447.
Q: And Mr. Murphy, I mean, we can read as much of that as you want to. But for me, the relevant part is starting on line 11 where you sort of introduced this topic, you say, "Can I make one comment?" Do you see that?
A: Uh-huh (affirmative response).
Q: And I'm going to ask, if you would, if you would just read that answer starting at Line 11. I will interject my one-word question on Line 12 and let you read the reset of it, okay. So start with, if you don't mind, Line 11,

please, sir?
A: Can I make one comment from your prior question?
Q: And I say, sure. And then you say what?
A: I just remembered, early in our development process, we had a conference call just as a very high-level call with Dan Sullivan in Atlanta who is a CON consultant and just asked him about some of the parameters about the South Carolina CON process. But he was not involved in the development of our application.
Q: And then after that, I asked you the question, do you know about what time that call to Mr. Sullivan would have been made, roughly? And you answered what?
A: Early February.
Q: All right. Does that coincide with your current memory of that involvement with Mr. Sullivan?
A: That's what I said at the time. And my only -- you know, the only thought I've given it since then was preparing for this trial discovered the proposal from Dan to do the technical review of our application.
Q: All right. But again, this would have taken

place you said early in February. Would that have -- is that what you said, yeah, early February there on Line 22? Would that have been February of 2005 or February of 2004?

A: 2005.

Q: 2005, okay. So that was, what, about four years before your testimony in this trial but about, what, 12 or 13 years ago from today, is that right?

A: No, it's not that long.

Q: Let me quickly state for the record that I have no expertise in mathematics. Now, would you clarify for us how long that was -- 13 minus 4.

A: Well, the question here is about the time. And I said early February. And this was sometime before our March 2005 application, approximately, you know.

Q: All right. Thank you. And in fact, when I asked you about the -- on the previous page, if we go to 1446, when I asked you about the question about consultants you've worked with. Initially you didn't remember Mr. Sullivan, is that right?

A: Let's see. I think so.

Q: Okay. And then as an afterthought, you

interrupted me a little --

A: Yeah.

Q: -- on the next page and said, oh, yeah, I had --

A: Yeah. I just remembered.

Q: All right, good.

MR. WESTBROOK: Now -- that's fine, Dan. Thank you.

Q: With respect to the 2005 application and the 2010 application, it's not surprising there were differences. Now, there were probably differences in all the applicant's applications. Would that be correct?

A: There were.

Q: There certainly were differences in yours; isn't that true?

A: Yes.

Q: And just some of these differences, and I'm not trying to give you a comprehensive list. But I believe in the first application, for example, that the proposal was that 50 percent of the northern York County population would be -- 50 percent of northern York County patients that CMC-Fort Mill would serve would actually be redirected from Piedmont, is that correct? Do you recall?

A: I don't recall specifically.
Q: But there was a percentage; would you agree?
A: There was, yeah.
Q: And in the 2010 application, the assumption was that no patients were going to be redirected to Piedmont, is that correct?
A: Correct.
Q: And in the 2005 application, CHS projected a first-year net loss of about 1.7 million, is that right?
A: Sure. But could I back up just a minute?
Q: Sure.
A: Just to make one point. In the 2005 application, we were basically looking at one point in time, 2003. And we had, you know, six years of history of market share changes. And that's why we selected to keep the market share percentages the way we did in the 2010 application. And could I back up even a little bit further?
Q: Well --
A: Well, similar to my testimony, maybe in the first trial, just something -- I said in the first trial that Dan didn't have anything to do with the development of our application. But

in preparation for this trial, discovered the memo or the proposal from Dan. And we did send him the application, and he did do a review. And that's what the conference call was about. Sorry I didn't say that earlier as I have been sitting here processing your questions. I just want to make that clear for the Court.

Q: So it was your understanding Mr. Sullivan reviewed the application the first time?

A: He did.

Q: All right. And the application he reviewed, of course, was the 2005, not the 2010 application?

A: Correct.

Q: And that 2005 application, again, had a first-year net loss of 1.7 million, is that right?

A: I haven't looked at that application in quite awhile.

Q: We can pull that up if we need to. Does that sound about right to you? Would you dispute that or --

A: You know, if -- I won't go to the trouble of having you pull it up. If that's what it is, I'll take your word for it.

Q: All right. And but there was a loss. you do recall that, I'm sure; or do you?

A: No.

MR. WESTBROOK: I tell you what -- Dan, why don't we just pull it up just to make sure I'm not confused as I often am. CHS 341, I believe is the Bates Page. And can you identify this as your pro forma from the 2005 application?

A: Yes, that does look like it.

Q: And does it look like you have a first-year loss of about 1.7 million?

A: We do. And again, it was a different application with a different point in time.

Q: Different application, different point in time. And your second application, the 2010 application, different application, different point in time; there was a first year profit of about over 600,000, is that right?

A: I believe so.

Q: And in your first application, the 2005 application, you projected charity care at about 3.5 percent of gross revenue, right?

A: That sounds about right.

Q: And in this application, your projection is 6.3 percent of the gross revenue, right?

A: That's correct. And I did talk about the economic issues we had most recently to this

filing that impacted, you know, those estimates. So lots of contextual factors that I don't know if I should go into.

Q: I tell you what, I will ask you a question if I want you to go into them. So let's go then to one other thing. There is also a distinction. You had a different site in 2005. It was close by but it was a different site.

THE COURT: Mr. Westbrook, if you hold on for a second.

MS. ROBERTSON: I'm sorry to interject, but I do think the witness ought to have the opportunity to respond and say what he'd like to say without being cutoff.

MR. WESTBROOK: Sorry to cut off, Your Honor. I think that it was responsive to the question. He could certainly -- you know, he doesn't have to just answer yes or no. He can certainly respond to the question. If it's going down another issue or answering something I haven't asked, I would say we are going to be here all day.

THE COURT: Let me just clarify this for the proceeding. I do want the witness to be allowed to fully and completely answer any

question asked of him. However, if the witness if going to go off on another subject that wasn't a part of the question, then perhaps that can be something addressed by counsel in redirect or something like that. Yes, let's give the witness and full and complete opportunity to answer fully the question that was asked of him.

Q: All right. The last question I believe I asked, and Ms. Robertson can correct me if I am wrong, was about the 6.3 percent. I believe that in 2005 you projected 3.5 percent of gross revenue as your charity care. In 2010, you projected 6.3 percent; isn't that correct?

A: That's correct. And I would just add that you can't compare the two directly because many things have transpired or changed over that course of, I would guess about six years.

Q: All right. And in 2005, you had a different site than the currently proposed site; isn't that correct?

A: We were at Exit 83 in 2005, slightly down the road from Sutton, slightly down the road from our current site. We changed the site because during the review the owner filed bankruptcy.

And so we had a contingency contract and felt we needed to change the site just to secure the land for the hospital.

Q: All right.

MR. WESTBROOK: All right. Dan, let's pull up CHS 524 for the first -- no, I guess that's for the second application, please. This showed the two sites, the 2005 site and the 2010 site.

Q: Aren't those identified on this page?

A: Yes, right. The yellow site closer to 277 is the current site.

Q: So the application again, and I'm sure there were other changes made between these two applications. I'm not sure they were with the other applications, Presbyterian and Piedmont's. But the application that Mr. Sullivan reviewed, the 2005 application, not the 2010 application; correct?

A: Correct.

Q: Now, CHS - Carolinas Healthcare System. The official name is Charlotte Mecklenburg Hospital Authority, right?

A: Well, there is a the in there. It's The Charlotte Mecklenburg Hospital Authority. That's the official legal name.

Q: All right, The Charlotte Mecklenburg Hospital Authority. That's a -- and you testified some about that organization. That's a North Carolina Hospital Authority, which is a type of North Carolina public hospital system, is that right?
A: That's correct.
Q: All right. And it's created by a North Carolina statute; isn't that correct?
A: That's correct.
Q: And South Carolina, I believe, has hospital -- at least one hospital authority; are you familiar with that?
A: I don't believe so.
Q: Under the North Carolina statute, CHS has power of eminent domain; doesn't it?
A: I'm not familiar with all of the parts of that statute.
Q: Are you familiar with that particular issue? Do you know whether or not it has the power of eminent domain?
A: I don't know that for a fact, no.
Q: Do you know that it was created according to the statute to serve North Carolina residents; do you know that?

A: You know, I don't know that for a fact. It's a North Carolina statute. I do understand that.

MR. WESTBROOK: All right. Let's take a look at, Dan, bear with me a second. Okay 273 -- let's pull up Demonstrative 273.

Q: Now, this is a complaint. And the caption says, "The Charlotte Mecklenburg Hospital Authority;" does it not?

A: It does.

Q: Now, I want to ask you about a statement that made this complaint where Charlotte Mecklenburg Hospital Authority is the Plaintiff and see if you believe they are accurate or not. Now, this is a complaint filed by -- you recognize this as a complaint filed by The Charlotte Mecklenburg Hospital Authority?

MS. ROBERTSON: Your Honor, sorry to interrupt again. But I believe this is a demonstrative. I just want to make sure I understand what this is. But I don't believe there is anything in the record upon which this demonstrative is made from. I may be wrong, but I don't believe this is in the record.

MR. WESTBROOK: This is a demonstrative. It's not

an exhibit. It's not part of the record.

THE COURT: It's not part of the record. Okay --

MR. WESTBROOK: I want to ask him a question here whether he knows whether it's accurate or not. If he doesn't, he doesn't. If he does; he does.

THE COURT: Any objection?

MS. ROBERTSON: Well, demonstratives, as I thought, were to be based on matters and sources within the record. But, you know, I think that is our objection that we are looking at something that is not in the record. And I believe Mr. Westbrook objected earlier to his belief when I was questioning Mr. Murphy of something not being in the record when we placed it up on the screen. So I would make that same suggestion or objection as to this overlying the demonstrative.

MR. WESTBROOK: I would say this is a public record. It's -- Mr. Murphy has been or clearly is CHS's primary witness or at least fact witness. The -- this is a public document. It is not a hearsay document, therefore. And it and it has some questions on the first page -- excuse me, some statements on the first page about CHS.

Mr. Murphy testified at some length about the nature of his organization in what it did and what it was involved in. And these are statements that are certainly not going to be, you know, derogatory in any way because they are made by CHS itself on the first page of its complaint. And I just want to see factually if he knows whether they are true or not.

MS. ROBERTSON: Well, Your Honor, I think at a minimum he would have to establish a foundation that Mr. Murphy knows anything about this complaint or what's alleged in it and any specifics to be able to talk about it. I don't think we've done that yet.

MR. WESTBROOK: I think the only way I could do that is by actually showing him the question and then if Ms. Robertson has an objection. I'm not even going to show an allegation. What I'm going to show is you see that first heading as a party as a description of CHS, and I just want to see if that's an accurate description.

MS. ROBERTSON: One final comment, Your Honor. I think there is an attempt here to get this document into evidence through testimony for an exhibit that is not in the record. This is not

in the record, and he's going to elicit testimony and place it in the record.

MR. WESTBROOK: I'm not going to -- you know, this is not an exhibit. I'm not going to try and make it an exhibit. But I certainly -- it seems like to me that I can ask him about public documents. He testified a great deal about -- from public documents and non-public documents about the nature of CHS and the nature of that organization and actually a lot of other things, as well. So I'm going to put a public document up there and ask him some questions about if he knows they are true or not. If he doesn't -- if he knows they are true or false, then he can say so. If he doesn't know, then he can say that, as well. But, you know, I mean I think that was a large part of his direct testimony was going into the nature of CHS, describing that organization, what they did, what they didn't do, what kind of organization they are and so --

THE COURT: And yes, Mr. Westbrook, I do recall him in the initial parts of his testimony talking about the general nature of CHS, its mission statement, what it did. But this appears to be

a matter that isn't -- this isn't a complaint that is any way related to this matter, is that right?

MR. WESTBROOK: Well, I think it is. But that's not the purpose that I am asking him questions about it; at least not now.

THE COURT: Maybe we can establish whether he has any knowledge or whether he was involved or has any knowledge of this particular matter first. And then I think maybe that might alleviate -- that might answer the question of whether he knows anything about it.

MR. WESTBROOK: Let me go to another document. Maybe there will be objections to this document or maybe there won't. But let me go to another document that I think I can establish the same thing. So Dan why don't we follow up on that.

Q: In your early testimony, Mr. Murphy, you were talking about CHS and things that CHS did. It is a North Carolina Hospital Authority, I think you've established. And I believe Ms. Robertson actually asked you some questions relative to MUSC, the Medical University of South Carolina in Charleston. Do you recall that?

A: I do.
Q: All right. And I believe the question was something in the nature of were those facilities or those systems comparable. Do you recall that?
A: I don't know if she used the word systems. I think -- I do recall her asking something along the lines of is the Medical University of South Carolina similar to Carolinas Medical Center? I think she was inferring that there were, or asking that they were both academic medical centers; you know, large hospitals where there's teaching programs and lots of big trauma services. I think that was the questioning, but that's what I remember.
Q: And Medical University of South Carolina is a South Carolina Hospital Authority; isn't it?
A: I'm not aware of their legal structure.
Q: All right. Medical University of South Carolina has one hospital, correct?
A: I don't know. Again, I don't know the details of that system. I know the Medical University is a large academic medical center.
Q: You do know that the Medical University of South Carolina doesn't have any hospitals in

North Carolina; isn't that true?

A: I don't believe they do.

MR. WESTBROOK: Let's look at 6890, CHS. This is a document produced by CHS, CHS 6890.

Q: And this is somewhat similar to an exhibit that you put up or that was put up during your testimony. It lists in the margins sort of toward the bottom of that page the various facilities. And I think they are organized -- aren't they organized in the same way that they were on the map that you used, Mr. Murphy?

A: They look to be very similar.

Q: All right. So there's primary enterprise, component facilities and managed facilities. Are those the categories? Am I missing anything? And then future hospitals down at the bottom, is that right?

A: Yes.

Q: Okay. And looking -- pulling that away, just looking at the map. What does the red indicate on the map?

A: It says -- the key here at the bottom, just right inside the bottom right corner is the key. It says, "Those are CHS affiliated hospitals."

Q: And so -- and each one of them has a number, is that right?
A: Yes.
Q: And the number corresponds to the facilities that are listed at the bottom on either side of the page, is that right?
A: That's correct.
Q: All right. And those do not include -- those are not limited to acute care general hospital, is that right? What kind of facilities do we have represented there?
A: I think the majority of these are acute care, licensed acute care hospitals. I'm looking down the list. I see. if you look at Number 9, Carolinas Rehabilitation Mount Holly. That's a rehabilitation. It's a licensed general hospital with only rehabilitation beds. And just below that you see Behavioral Health Center, CMC-Randolph. That's a 66-bed facility that serves behavioral health patients. So there may be -- just looking down the first column, I don't see any other non -- well, there's Carolinas Rehabilitation, Number 8. that's another acute care -- excuse me, a rehabilitation hospital. I think the majority

of these are acute care hospitals.

MR. WESTBROOK: All right. And Dan, if you could focus in just a little tighter on the Charlotte/York County area, please.

Q: And these would be the facilities that I guess are closest to proximity to York County, is that right?

A: Well, those are facilities that are -- you know, this is clearly not to scale. When you say in proximity to York County, if we go back to the first column most of those facilities are located within a mile or two of each other in the center of Charlotte. They are not all spread out over the Mecklenburg County.

Q: You wouldn't have room to put that many red squares in the area that represents Charlotte, right?

A: All I'm saying is this is not a geographic depiction of where facilities are located.

Q: Right. Do you recognize this is a document CHS created then?

A: It looks familiar. I think I've seen it before.

Q: And you recognize York County there? In fact, what does Number 35 represent there in the red

square? Isn't that the CMC-Fort Mill proposed site?

A: If we could go back to the -- I think it was maybe --

MR. WESTBROOK: Sure, let's check the -- I think it was blocked in.

Q: It would be at the very bottom there?

A: Right, that is.

Q: All right. Good. Now, you know, I think you testified to this. You're responsible for, is it a 14-county region; is that right, Mr. Murphy?

A: Well, we plan -- when we look at the map here, we do -- we work with all of our hospitals and where they're located. But when I talked about market development in the 14-county region, those are natural counties that go together in terms of natural geography and trade patterns and that type of thing.

Q: And that 14 counties would include -- one of those is York, right?

A: Correct.

Q: And then are all -- and then I think that it also includes Chester and Lancaster counties in South Carolina, is that right?

A: That's right.
Q: And then, I guess that would be -- I'm delegating the math again, but I think that's 11 North Carolina counties then?
A: I believe so.
Q: Three South Carolina and 11 North Carolina make 14?
A: Uh-huh (affirmative response).
Q: Now, in that region, that 14 county region, there -- do you know offhand how many acute care hospitals you have? Is it about ten or 11?
A: I don't know the number right off. I was thinking the acute care was around nine. And then there is some speciality of rehab and the other health facilities.
Q: And those acute care would include Mercy, Pineville, University, Union?
A: Correct.
Q: Among others?
A: Yes, and some Lincoln.
Q: All right. And none of those hospitals are unsuccessful in your opinion; are they?
A: It depends on how you define unsuccessful.
Q: By any of your definition would they be

unsuccessful?
A: No, I don't believe so.
Q: And within that 14-county area, there are a lot of competitors; aren't there?
A: There are.
MR. WESTBROOK: Now, let's take a look at Demonstrative 212.
Q: I think that's already been admitted through another witness. And I don't know if you've seen this or not. And the source is given there at the bottom, net income of CMC Hospitals 2010 through 2011 based on Medicare Cost Reports. Are you familiar with these cost reports, Mr. Murphy?
A: No, I haven't looked at these cost reports.
Q: Do you have -- is it any part of your job for you to prepare cost reports?
A: No.
Q: All right. So do you know then whether the figure of $241,939,850 net income for 2010 CMC-Main. Do you know whether that's accurate or not?
A: I don't believe it's -- I believe it probably ties to the cost report. I don't believe it ties maybe to the net income of Carolinas

Medical Center. And I know that from talking to Gregg Stewart who is going to testify about these cost reports and financial statements.

Q: All right. Well, cost reports are -- Medicare cost reports are reports that are submitted to the government, is that right?

A: That's right.

Q: Now, did I understand you to say that your job doesn't entail filling out cost reports or submitting cost reports?

A: Correct, I do not fill out cost reports.

Q: Well, if I'm asking you questions that you don't know the answer to, all you have to do is say I do not know. But do you know that Medicare cost reports are submitted to the federal government, and they are certified to be accurate?

A: I believe they are certified. Yeah, they are submitted to the government, and they are certified to be accurate. But the way Medicare evaluates certain costs -- they have certain costs that are allowable and not allowable from a Medicare reimbursement perspective. And that's about the extent of my knowledge on the topic. So that's why I don't think you can

make a comparison of what you find in a Medicare cost report to financial statements that are developed for financial reporting reasons. I think there's some methodologies that Medicare has. I'm not familiar with that, I just believe that's the reason they do it.

Q: Whatever the net revenue is that CHS Hospital makes -- you know, whatever that amount is, whether it's the cost report amount or financial statement amount, that amount goes back to the CHS system; isn't that correct?

A: That's correct. It is.

Q: And then the system would distribute it back out to the hospitals based on need, is that correct?

A: That's correct.

Q: And just -- just because Hospital A, say, makes more money and sends more money back to the system than Hospital B, that doesn't mean that Hospital A is going to get the same distribution back from the system. It doesn't even mean it's going to get more money back from the system than Hospital B; isn't that correct?

A: That's correct. I don't think there is a pro

rata of distribution of net income by hospital back to each hospital. The capital is allocated based on where the need is. And the example I gave in my earlier testimony, we allocated $20 million of capital to Anson Community Hospital, and they have operated a long period of time with no income.

Q: Now CHS, I believe you testified on direct, CHS you characterized it as a comprehensive system, right?

A: Correct.

Q: And I think you discussed and explained a number of financial services and reporting companies, including Standard and Poors; do you recall that?

A: I do remember mentioning them.

Q: And Standard and Poors is a financial service and a credit rating agency. And I believe we put up -- you actually put up some slides that had been submitted to DHEC about your S&P rating, is that correct?

A: I believe the slide I had up as an example was Moody's Investor Service. But I mentioned there were three major rating agencies. And Standard and Poors is one of the three.

Q: All right. And you have a good rating with S&P; don't you?

A: We do.

MR. WESTBROOK: All right. Let's look at Demonstrative 235, please.

Q: This is a Standard and Poors -- what's the date up there, Mr. Murphy?

A: April 23, 2012.

Q: All right. I suppose there has been more recent editions than this?

A: I don't know.

Q: Let's --

MS. ROBERTSON: Your Honor, I've got to interrupt again. This is the same objection as we had to the earlier demonstrative. Again, we are seeing demonstratives. I think this is not in the record. I'm going to object on the use of the demonstrative that is not in the record.

THE COURT: Mr. Westbrook?

MR. WESTBROOK: I don't know why a demonstrative would need to be in the record. A demonstrative is going to help illustrate Mr. Murphy's testimony. This is something that was taken from the CHS website. It is something that he mentioned in his direct testimony. In

his direct testimony he talked about the credit rating.

THE COURT: He did, I recall. He talks about Moodys or --

MR. WESTBROOK: Moodys, Standard and Poors.

THE COURT: And so you are -- the intent of this line of questioning is to pursue what he said -- to pursue more into what he said on direct about the rating?

MR. WESTBROOK: Well, it's not so much -- no, it's not so -- I didn't want to talk about the rating. I think he's put in plenty of evidence about the rating. But I did want to talk about if he is relying on -- if Standard and Poors is obviously a credible financial services report, to talk about the -- I'm going to ask him some questions in this report that describe Carolinas Healthcare System, and again ask him if they are correct now. I think these are fundamental questions. They are things actually that he testified about. Not the ratings -- some other things he testified. He talked about the different kinds of hospitals that they have in the system, component facilities, the leased facilities, the

management facilities, the owned facilities. And this report talks about those and just gives some very factual descriptions and summaries. I think it's stuff he's going to agree with.

MS. ROBERTSON: Your Honor, and I think some of the concern is that when we started the trial, we had objections on exhibits. We had a series of exhibits on some Tenet information, public record type information, other things that we had actually marked as exhibits. We received objections on all of those. And this seems to be a kind of back end way to now have exhibits talked about that are not exhibits and coming in through demonstratives. So --

MR. WESTBROOK: But they're not coming in. I mean, I am not offering this as an exhibit. I just want to ask him a question and say do you know if it's true or not.

MS. ROBERTSON: Well, and I guess, Your Honor, when you elicit testimony from a document that is not in the record and how he responds or that information then becomes part of the record. So it is seeking to admit information in a document not in the record. It's just doing it

from testimony, but it is still getting in the record.

THE COURT: Well, but if what Mr. Westbrook is going to do is ask him if he's familiar with this document or with this Standard and Poors research guide. And then ask him questions from that, I mean, he is permitted. I don't see how -- what the objection is to ask him this. The actual document itself isn't going to be marked or come in or at least they haven't marked it and ask that it be entered into the record as an exhibit. And of course, if it is, we can have that discussion at that time. But if the witness is aware of this and can answer questions about it, he certainly -- I don't see where -- what's the objection to him doing that?

MS. ROBERTSON: Well, I guess he could ask him those questions without this information being up before him. And maybe as he starts to do that, we will see if this becomes appropriate. But I still see this as somewhat -- you know, the objections to the similar type of Tenet information as exhibits. And now them seeking to do this through demonstratives, I just want

the Court to appreciate that as we go down the road and seek to have our exhibits considered, as well. But I think it is trying to get information in the record that's not in the record.

THE COURT: And Ms. Robertson, I do appreciate your concern to the extent that exhibits that haven't been admitted as exhibits are being offered. I am not going to permit that to happen. But at the same time, I am going to permit Mr. Westbrook to at least go down this line a little bit to see if Mr. Murphy has knowledge of this and what's in this document.

MR. WESTBROOK: Thank you, Your Honor.

THE COURT: You can proceed, Mr. Westbrook.

MR. WESTBROOK: I appreciate it. Now, Dan, would you turn to Page 4 of this report, please.

Q: And, Mr. Murphy, there is a heading down there that says, Enterprise Profile. I want to start with a couple questions about this. And you can read as much of this as you like for context sake. The only thing I want to ask you is that first file out there it says, "CHS is the larger of two healthcare systems serving the Charlotte region." You testified on direct

about Presbyterian and comparing CHS with Presbyterian or Novant, I guess is Presbyterian's parent company. There were a number of slides. Is CHS the -- is the other large healthcare system serving the Charlotte region, is that Presbyterian or Novant?

A: It's Novant Health.

Q: Okay. And then the second highlight it says, "CHS's primary enterprise consists of ten hospitals." And then as a parenthetical describes those. Is that accurate? Do you know?

A: Well, if I can back up just for a minute. I just want to point out I have not seen this before to my knowledge. And this is information written by a rating analyst. And it says, "CHS is the larger of two healthcare systems serving the Charlotte region." And there are quite a number of other healthcare systems serving the Charlotte region. So there's not just two. So I would not agree with that first statement.

Q: All right. Would you agree that CHS in the Charlotte region is the largest healthcare system serving the Charlotte region?

A: I would agree that we are the largest of many healthcare systems serving the Charlotte region.
Q: All right.
A: Yes, sir.
Q: Fine. And does your primary enterprise consist of ten hospitals as it says here? Is that accurate?
A: I believe so, yeah.
Q: And two long-term care facilities, is that correct?
Q: Yes. And then it goes on to say two large-term facilities and 292 licensed beds and a large physician network of primary and specialty physicians and faculty at Carolinas Medical Center. Is that an accurate summary of the CHS system in the Charlotte region?
A: The quantitative statistics about our system I think are accurate. I just, you know, didn't agree with that first part.
Q: All right. The next paragraph, the first sentence says, "CHS's strategy of broadening its geographic outreach for the network of non-obligated entities including 23 hospitals and eight related nursing homes." Is that -- I

know on the chart we looked at earlier on the chart that you showed in your direct examination there was a list of I think the term is component facilities. Is that correct or is this something different?

A: I'm not sure it including 23 hospitals. There is likely a page in this report that would show what those 23 hospitals are. So I'm not exactly sure through a network of non-obligated entities. I believe those are referring to our managed hospitals. Now, that I am reading the non-obligated entities, I believe that's mostly the managed hospitals.

Q: And that's a term that you are familiar with that you use and that you use; isn't it, obligated entities and non-obligated entities or obligated group and non-obligated group?

A: Yes.

Q: And the obligated group would be what?

A: I believe the naming there refers to a group of hospitals that are obligated to pay on any bond debt.

Q: Okay.

A: That's the obligation term.

Q: And the non-obligated entities obviously would

not?

A: Right. Again, those are -- you know, when you contrast our healthcare system against Tenet or Novant we are very different. We have these non-obligated facilities that are simply managed hospitals.

Q: All right.

A: And many times remote areas from Charlotte.

Q: All right. And the third sentence in that paragraph states, "The component units which are separately included in the CHS audit are profitable and generate solid coverage of debt and related lease payments." Would you agree with that?

A: Yes. I believe those are the facilities that are listed below the primary enterprise on that list.

MR. WESTBROOK: Let's go over to the next page, number five.

Q: There is a heading that says, "Utilization." And again feel free to read as much of that as you like. The thing I was interested in was the reference to "Continued growth of CHS's physician network which has contributed to greater downstream admissions and outpatient

volume." Is that an accurate sentence?

A: If you don't mind, I'm just going to read the whole paragraph here.

Q: Sure.

A: Yeah, I think the -- I think that, you know, part of the sentence that you've highlighted is accurate. I think that there are many things before that that talks about the growth of our system. And as I testified earlier though, it is care coordination percentages when physicians refer to one of our affiliated physicians. There can be growth related to that. But again, the greater value of the physician network is the care coordination.

Q: All right. And the last sentence in that paragraph says, "Management reports that CHS volume growth during 2011 outpaced that of other providers of the service area." Is that correct?

A: For 2011, that may be correct. And again, our system as you go from the center of Charlotte and go out to the bedroom communities, they are much more densely populated, much higher population growth. So we benefit from that growth versus how providers outside that region

might be growing. So that's likely a large reason for that statement.

Q: All right. The next paragraph is headed, "Market Physician Network." And again, you can read as much of it, of course, as you like. My only question, though, about that relates to the final sentence. It says, "CHS competitors have experienced some payer mix erosion because CHS's Medicaid and uncompensated care inpatient market share has decreased in recent years." Is that correct?

A: Well, let me just take -- just reading that again to see if it's -- Well, when I was looking at some recent payer mix information for our inpatient hospitals in Charlotte, again this was -- I guess this is referring to 2011 because this was dated April 2012. When you look at 2012, I think, and look back, our Medicaid payer mix for inpatient hospital is flat. I think our ED Medicaid is increasing through 2012. And I would say that Novant, a large healthcare system that has a number of hospitals in that region, over the last years they have increased their level of Medicaid and uncompensated care to a degree from this

competition because as we pointed out five years ago there was a huge disparity in our mix. So I think that may be what this is referring to.

Q: All right. And then the next paragraph or the next heading on this page, it says, "County Relationship." And again, feel free to read that first sentence if you'd like. But where I wanted to ask you about started with the second sentence. It's highlighted there. It says, "Mecklenburg County has historically funded the operating deficits of Carolinas Medical Centers, Outpatient Indigent Care Clinic as well as other indigent care provided to Mecklenburg County residents."

THE COURT: Ms. Robertson.

MS. ROBERTSON: Yes, Your Honor. I'm sorry to interrupt, but I have to renew my objection. Mr. Westbrook is reading into the record this document that's not an exhibit, which is exactly what I thought he was going to do. I do have to object on that basis. And I would also say just on this prior page we were looking at, he was having Mr. Murphy comment on competitors. We went through a long line of

objections on Mr. Murphy having any opinions about competitors or being able to refer to Tenet in its ability to compete and other competitive stuff that he has, on his direct, has mentioned. So I think this is crossing the line for a demonstrative at this point clearly.

MR. WESTBROOK: Your Honor, I'm not asking to comment on any particular competitor or whether any other competitor has the ability to compete. This is a document that obviously is about CHS. It's about CHS, and I'm asking him questions about CHS. I'm asking whether this document that he mentioned in his direct, whether these statements are accurate or not. And he can say, as he has. Sometimes he's explained it and said, no, I agree with this or I don't agree with this. That's all.

THE COURT: How much longer is this? I mean, how much more of this document are you planning on going through?

MR. WESTBROOK: I've got one more question.

THE COURT: One more question. I am concerned that this document appears to be just becoming a part of the record, a large section of it.

MR. WESTBROOK: Well, I mean, I can ask him a

question without -- I mean, basically I can ask him the same question, I guess, without the document. You know, on the screen or without him looking at it. In other words, if I ask the question: Isn't it true that Mecklenburg County has historically funded indigent care in Mecklenburg County? That would be the same thing but without a point of reference. And then he can say yes or no.

THE COURT: All right. Ms. Robertson.

MS. ROBERTSON: And Your Honor, I think if that's what he wants to do, that would be the appropriate way to ask the witness the question, not read the demonstrative into the record. So if he wants to ask the question, ask the question. But I don't think we need to refer to a document that's not in the record and, in fact, place it in the record by doing that.

THE COURT: Mr. Westbrook, could you ask your question without reading the document into the record?

MR. WESTBROOK: Yes, Your Honor.

THE COURT: Please, thank you.

MS. ROBERTSON: Thank you, Your Honor.

Q: Bear with me just a minute. Mr. Murphy, Mecklenburg County historically has funded indigent care provided by CHS; isn't that correct, to North Carolina residents?

A: I believe they have subsidized the losses we've incurred on certain indigent care clinics over the years.

MR. WESTBROOK: Over the years. Let me ask Dan to pull up CHS 5991, please. This is a document produced by CHS during the discovery process.

Q: Look at the top of the page. You talked on direct about attending project review. You were there as one of CHS's principal speakers; isn't that correct?

A: I was there, yes.

Q: June 29, 2011; does that sound --

A: That sounds about right.

Q: -- right? All right. This document, beginning at the top as you see, it says, "Potential Questions." And then number one says, "How much money does Mecklenburg County pay you each cashier indigent care?" And then Del in caps next to it. You're the only Del there and so I'm not --

A: That's me, correct. Yeah.

Q: And tell me, Mr. Murphy, I would assume that this is a document sort of prepping you and other participants for the project review in case you got questions from DHEC or anybody else about how to respond to those questions, is that right?

A: Yes. We were, you know, again anticipating criticism and wanted to be prepared from our competitor's criticism. And I haven't seen this document in almost two years. But this is, I believe the document we prepared for the project review.

Q: And you say you anticipated criticism. I understand that having been through some project reviews myself. But, you are also anticipating questions from DHEC staff, right?

A: Not necessarily. It was more, if -- I guess if we did get questions we'd be prepared. But it was just, again, in a broad sense for us to be very knowledgeable about what was going on with Mecklenburg County because I haven't been involved in those. At the time, I wasn't involved in the Mecklenburg County issues over the budget, and I just wanted to learn more about it.

Q: In the South Carolina project review meetings that you attended, the applicants don't ask each other questions; isn't that correct?
A: No, that's correct.
Q: Even staff intends to have -- usually ask questions of the outcome. Isn't that true?
A: That's true.
Q: All right. And in this one, the question is how much money does Mecklenburg County pay you each year for indigent care? And your response was -- just read the first sentence of the response. You can read more if you like to but that was --
A: "Mecklenburg County provides us about 16-and-a-half million each year for indigent care funding."
Q: All right. I'm sure that's -- I'm sure that's an accurate response; is it not, or it was at the time?
A: I believe so. Yeah, at the time.
Q: Let's go to question number two down there, please. And this questions says, "Why are you having so much trouble with Mecklenburg County at this time?" Dennis -- would that refer to Dennis Phillips?

A: It would.
Q: And he's another CHS executive?
A: He was. And he also was at project review as one of our speakers.
Q: All right. And what's Mr. Phillip -- what was he going to say if he received that question?
A: I don't know what he was going to say if he received the question. I can tell you what was on the page.
Q: And the purpose of this page, did we not establish, was to prep Mr. Phillips and yourself and the other speakers for appropriate responses in case you got these questions?
A: That would be true. And if I could just put a little context on this, at least for myself and the job I had. Again, I wasn't familiar with what was going on with discussion with the County and the lawsuit and just wanted to be prepared and was working with Dennis to prepare for project review like I think our competitors would, as well.
Q: All right. What was the prepared answer for Mr. Phillips if he got that question? Can you read it?
A: Sure, I can read it. "We have a wonderful

longstanding relationship with Mecklenburg County. And we have every reason to believe this relationship will extend into the future for many years to come. Quite frankly, Mecklenburg County is in the middle of their budget process. And given the situation, they are just doing their due diligence to ensure their financial house is in order. This has created some stress, but this is really to be expected from time to time."

Q: All right. And let's look at question number three: "Why is there a controversy of your proposed behavioral health facility?" It doesn't look like there is a person assigned to that. Do you remember who was assigned to that question?

A: No.

Q: What's the response?

A: "There is no real controversy. It is just a matter of Mecklenburg County sitting down with us and fully understanding the project need. In addition, the county has a concern with how the project could impact their budget given their ownership of CMC-Randolph, their 66-bed behavioral facility. Our discussions are

progressing in the right direction." And I guess I would back up. I think this is referring to a behavioral health facility we were proposing to build at the time in north Mecklenburg County. I believe the county was concerned about how that was going to impact their budget. Because I think that all of these discussions, it's my understanding, were primarily about county budget shortfalls and the way they didn't provide us notice to terminate the contract.

Q: All right. At the time that the project review was held and at the time these answers were drafted, in fact, the county had put you on notice of a breach of contract; hadn't they?

A: That -- I don't know the timing of that. I'd have to -- again, that's not something I work on. I couldn't -- I know the date of project review. And I can't recall specific dates that were related to this issue with the county.

Q: All right. But you do know that they put you on -- at some point in time they put you on notice of breach of contract; isn't that correct?

A: I believe so. That sounds familiar.

MR. WESTBROOK: Let's look at -- let's forget that date and try to put it in context of the -- let's first back up and see what the date was for the Project review meeting. Well, this was prior to the Project review meeting, so June 29, 2011. Let's put up that demonstrative again, the complaint, Dan. And once again this -- you've seen the cap -- let's turn over to Page 28 of the Complaint just to get a date on this.

Q: This is the 14th of July 2011 from the Smith Moore Leatherwood firm, is that right?

A: That's the date I see there.

THE COURT: Ms. Robertson.

MS. ROBERTSON: Yes, Your Honor. I think we've talked about this demonstrative earlier. And there's some concern about it obviously not being in the record. And I think, Your Honor, we talked about it not being related to this case. And it's back up on the screen so --

THE COURT: Mr. Westbrook, again, where --

MR. WESTBROOK: Where are we going with this?

THE COURT: Yes, where are we going with this?

MR. WESTBROOK: There was -- has been a good bit of testimony about the CHS as a nonprofit and its

mission, and the things that it does as part of that mission and the charity care that it offers. I think this contract relates to all of that. Excuse me, this complaint, this lawsuit relates to all of that. I think Mr. Murphy will testify that he has some knowledge of this. How much knowledge of this, I don't know. I don't expect him to have detailed knowledge. He just said, for example, that he didn't know the date that the county offered -- he had notice of breach. I think we can clarify what that date was, put it in context with the project review date, and I think it's relevant for those reasons. I think it's -- there are serious allegations by the county in their notice of breach of contract. There are serious back allegations by CHS against the county in their complaint. And it all relates to -- it's all over indigent care and behavioral health. Those are the two primary issues involved in that. And just seeing a document that showed what they were prepared to tell DHEC about that situation about indigent care and about behavioral health and about their relationship with the county. And so I

think it relates to all that.

THE COURT: All right.

MS. ROBERTSON: Your Honor, I don't think it's related. This is not in the record. And if he wants to ask Mr. Murphy questions about what he knows about it, then that's the way to ask these questions. But we are looking at a complaint that is not related to this case.

MR. WESTBROOK: And the other thing I would say, this and the other document that I am about to go into are public documents and not hearsay. They are not -- the complaint is obviously a part of the record. It was filed by CHS. And the other point I would like to make is that Mr. Murphy is clearly CHS's spokesman in this case. He's their witness they've designated to talk all about their system and about how they operate and their relationship with the county and the county and the good things that they do. And that's what his testimony is all about. I'm not trying to get this admitted into evidence. I think if I ask questions about it, his answers would be limited by his knowledge.

MS. ROBERTSON: Your Honor, there has been no

foundation laid to question this witness on this. It's hearsay really, and he's not laid any foundation to accept it out of that.

MR. WESTBROOK: It can't be hearsay. I mean, it's subject to the documents, public records.

MS. ROBERTSON: And the point I make is there is no foundations, and it's not authenticated through this witness for this witness to know that he knows anything about this. He asks him questions about it, then maybe he gets somewhere. But right now, we don't have any authentication. We don't have any information from this witness on this document.

THE COURT: Mr. Westbrook, I see where you're -- I see, I think. where you're going. And I don't know that asking questions about the witness' knowledge of this matter or of the lawsuit itself or if he has knowledge of the actual document itself. If he has knowledge of those and can testify about those, I think you can inquire into that and ask him, assuming that it's relevant -- that it bears no relevance to this proceeding. I would -- however, since the document is just a demonstrative exhibit, I would prefer we not read the document into the

record, since it hasn't been admitted into the record. But if you want to ask the witness about his knowledge of this lawsuit, about the underlying allegations or about the document itself whether he has any knowledge of it, help prepare it, was involved in it, has seen it, is aware of what it says; I think you are permitted to go down that angle. But as to actually reading it into the record, since it's not been admitted as an exhibit, let's not go there.

MR. WESTBROOK: All right. I understand. Thank you.

THE COURT: Thank you.

MS. ROBERTSON: Okay.

Q: Okay. I think I asked you this question, but given I was interrupted, I may not have. You're aware, are you not, at some point in time that Mecklenburg County gave a notice that it felt CHS was in breach of the contract between those two parties, is that correct?

A: I can tell you what I -- maybe the easiest way is for me to tell you what I know about this.

Q: Well, that's fine. But I want you to first answer the question, yes or no or I don't know

and then explain all you want to.

A: I have heard -- I recalled the county claim we were in breach of the contract. I've heard that from executives in our system. What I was going to say that I do know about this is that I've been at CHS for 17 years, and I don't recall another situation like this over my 17-year history with CHS where there were issues like this with the county. We work with county governments in North and South Carolina. I don't recall any controversies. We've had great relationships in Mecklenburg. And what I know about this is that the county did not give us proper notice to terminate. That's what my understanding is. And that's about the extent of my knowledge of this. I have not seen this before. And again, I was not involved in the discussion with the county, the lawsuits. And that's about the extent of it. And the project review document preparation was, again, that's not part of my job to be involved in these discussions. We have other folks working on these type matters. And again, we've had a long great relationship with the county, Mecklenburg County. And I think

there were budget constraints. And things just evolved. And that's about the extent I have.

MR. WESTBROOK: Let me ask Dan to put up on the screen something that is in the record. And that is from the project review submission by Piedmont, and I believe this is slide 19; is that correct, Dan? And that's slide 24. All right, from the project review submission by DHEC. And you see there's an article there of the Charlotte Observer June 12, 2011. And a call out from that article says the June 3 letter from Carolinas Healthcare CEO Mike Tarwater, County Manager Harry Jones contended the hospital system has breached the contract by failing to provide requested information about CMC-Randolph's patients and finances. And you were at the project reviews, is that right?

A: I was.

Q: Do you recall this slide being put up?

A: I do recall the slide. And as I read it here today, I mean, it's county managers contending that we breached it.

Q: Right, I realize that's --

A: I do recall this, if not this exact slide, it

was something similar.

Q: And the date there, June 3rd, does that ring a bell as the date the county manager put you on notice -- put CHS on notice of a breach?

A: You know, I assume this is accurate. Again, I haven't seen the letter, didn't know the date. But if -- it looks like this reporter probably had a copy of the letter. I assume that's the correct date. Again, I'm not familiar with the letter.

MR. WESTBROOK: Let's look at the next line, Dan; again from the project review.

Q: The Charlotte Observer June 12, 2011. CHS doesn't intend to provide immediate details or responses to many of the questions Jones has raised. And Jones is the county manager, is that correct?

A: That's correct.

Q: Hospital spokeswoman Gail Rosenburg said, "It doesn't feel that there is a lot to be gained by that," she said. Do you recall that response at project review?

A: I don't recall this specific response. And I think as a policy we don't discuss issues that are in litigation with the press. It's just

sort of a policy that we have. I don't know if that's a formal policy; it's just my understanding.

Q: Now, after to this notice, you are aware that at some point in time the county actually terminated the contract with CHS; isn't that correct?

A: I believe so.

Q: And then as a result of that, you are aware, are you not, that CHS filed a lawsuit against the county, is that correct?

A: My limited understanding is that we did file a lawsuit. And it was because they didn't file the proper termination notice when they ended the contract.

Q: And that lawsuit is now over, is that correct?

A: I believe so.

Q: And as a result of that lawsuit, am I also correct that the county no longer funds that $16-and-a-half million to CHS for those indigent care programs?

A: I don't believe they did.

Q: So is the county providing any indigent funding since this 2012 or 2011 or whenever the contract was finally terminated, have they

funded any indigent care for CHS since then?

A: I am not sure. I wouldn't know. They may have. I don't know if they terminated funding when those terminations might -- I don't know specific dates.

Q: All right. Mr. Murphy, you're aware, are you not, that in 2012, the Charlotte Observer ran a series of articles focused on CHS and other nonprofit hospitals in North Carolina, is that correct?

A: That is correct.

MR. WESTBROOK: And let me -- excuse me, ask Dan to put up the first of those articles and see if this is the site.

Q: This article says, "Charlotte Observer." What's the date on this?

A: Saturday, April 21, 2012?

THE COURT: I apologize, Mr. Westbrook. Is this an Exhibit number?

MR. WESTBROOK: No, it's just a demonstrative.

MS. ROBERTSON: At the bottom corner.

MR. WESTBROOK: Is there a demonstrative number on this?

MS. ROBERTSON: There is something on the corner of the bottom. I couldn't tell what it was.

MR. WESTBROOK: Oh, okay. It's from -- I'm sorry. There is the Bates Page. So this is from PMC documents produced, Bates Page 11.2013.00030120. Now Dan, if you would go back up to the top. And Dan, if you could highlight where it says the five-part series.

Q: Is this -- I asked you a question about it, were you familiar with a series of articles by the Charlotte Observer? Is this the series that you were talking about?

A: Well, you asked me if I was familiar with the series? I assume this is the series that you were referring to, the one I am familiar with.

Q: Well, and my question I think originally was are you -- something of this nature, are you aware that the Charlotte Observer ran a series of articles that were critical of CHS and other nonprofit hospitals in North Carolina? I believe you said you were, is that right?

A: Yes. And I would, just for the Court, you know, I don't agree with what was published. And as an example, nonprofit hospitals thrive with profits. I don't agree with that statement. I mean, we have a profit. But we also operate in an industry that has the

highest capital requirements of many industries, if you want to talk about a lot of other industries. So the moneys we make are required to sustain our mission and to replace facilities and build new facilities as populations increase. And I think that, you know, we are responsible fiduciaries of the jobs that we have. And we have to have a viable healthcare system that has a profit so we can fulfill our mission. But I don't think we -- I just don't agree with the headings and, you know, much of these articles. It's my understanding that a lot of the information we gave to the Charlotte Observer didn't get printed.

Q: All right.

MS. ROBERTSON: Your Honor, if I may, and I don't know how we get around that. But we received an objection. And I think you might recall on exhibits and items or newspaper articles and treatises that we had sought to have admitted, this was a demonstrative, but it's the same concept of getting information in the record that's hearsay, and it's not admitted.

MR. WESTBROOK: My response, Your Honor, is, you

know, I'm not planning on reading into the record. This information is not being offered as an exhibit. I asked him if he was familiar with it. I am going to ask him some questions about his familiarity, his knowledge of some of the issues raised in this series, and I'm not offering it as evidence.

THE COURT: Okay. Ms. Robertson.

MS. ROBERTSON: Your Honor, I guess he could ask him the questions about these articles. And, you know, to the extent he ask the questions and we've got it in front of us and we're highlighting sections of it and portions of it are becoming parts of the record in an inappropriate way, I think.

THE COURT: Mr. Westbrook, you're going to ask him about -- you started down this line of questioning where you asked him if he's familiar with this series of articles done by the Observer. And he has testified that he is somewhat familiar with that. And then he has disagreements with the conclusions drawn, and he has given some of his reasons and rationale for why he's concluded, that he doesn't think those conclusions by the paper with regard to

these issues were proper. You're then -- you want to proceed a little further into this and ask him about some specifics. But then about the article, to ask him if he is familiar with that and if he has an opinion about that; is that where you're going?

MR. WESTBROOK: Well, something of that nature. I'm going to bear in mind the instruction you gave me previously a few minutes ago not to read from the documents. So I wasn't planning on doing that.

THE COURT: And because at this point, now we are talking about a newspaper article that is a pubic document.

MR. WESTBROOK: So, you know, he said he is familiar with them. I am going to ask him about some of the issues that were raised in this series of articles by the Observer and ask him what he knows about it and some follow-up issues. But I'm not going to read from them.

MS. ROBERTSON: Your Honor, I would think a newspaper article is an exception to the hearsay rule. It's not an official public document that gets out of hearsay. I think it is hearsay. And I guess when he asks these

questions, we can see where this goes. But we are continuing to look at these on the screen, and we are continuing to refer to them. And it is hearsay and it is not of record.

MR. WESTBROOK: And I guess -- I mean, I agree with Ms. Robertson that the newspaper article is hearsay. I'm sure that's true. I don't think it is hearsay, though, if I'm asking a question, "Are you aware,?" because I don't think it's offered for the truth of the matter asserted. If I say, "Are you aware that the newspaper criticized you for having excess profits or whatever?"; yeah, I'm aware of that. But that's not being offered for the truth of the matter asserted. It's just something that happened. The newspaper made that accusation.

THE COURT: Well, but at this point if it is hearsay, what relevance does it have to this proceeding?

MR. WESTBROOK: Well, I think it is very relevant because it's going to get into the issues that relate to all the criteria. But I think again, we're not -- I'm not going to be reading from the newspaper article. I'm going to ask him if

it's true or not. And then his response will be, I think -- my guess is I think he's already indicated that he disagrees with a lot of these allegations that they are not true.

MS. ROBERTSON: And I think Mr. Westbrook's description does mean he is offering for the truth of the matter asserted. I think that is what he is trying to do in violation of the hearsay rules.

THE COURT: Mr. Westbrook, I'm just trying to figure out if we're not -- if it is not being offered for the truth of the matter asserted, and you're just merely asking him are you aware of these series of articles, he's testified he is. He's testified that he disagreed with some of the conclusions drawn. Now, if we go further into that, you're talking about inadmissible hearsay. And you're asking him if he's familiar with the specific allegations where there may apparently be conclusions drawn and the allegations made, whatever, by these newspaper articles, which again are hearsay and therefore not admissible, and then ask him what his opinion of that is. I mean, in essence you're saying, well, do you think it's true

what the newspaper article is saying? I don't know -- if we don't -- if this Court isn't going to assume that this is being offered for the truth of the matter asserted, then asking him do you agree or disagree with these assertions, then I'm not sure what other basis this is being offered for. And therefore, I can't get over the fact that it seems to be inadmissible hearsay to pursue this line of questioning.

MR. WESTBROOK: I'll move on.

THE COURT: All right. Thank you, sir.

MR. WESTBROOK: Let's go to Exhibit -- excuse me, 114 please. I think this is something that you testified about in your direct. This is the one that is CHS's response to Piedmont's interrogatory.

Q: Do you recognize this, Mr. Murphy?

A: Yes, I believe this is --

Q: The one with the chart that we talked about?

A: Right.

Q: Let's go on down to what the question is, first of all. Well, that's fine. Let's just go to the chart since you've already talked about the chart. That's fine. And you've already

explained the chart. So I think I just want to ask you a couple of questions about the bottom half of the chart. I think you have already testified that the bottom half really summarizes its compilation of the top half, right?

A: That's correct.

Q: All right. And this gives by year, I take it, the data related to all CHS facilities or CHS facilities in North Carolina or what is this limited to?

A: I'm not certain of that, which facilities are included. My assumption would be that it's the primary enterprise that is wholly owned.

Q: I thought you testified you prepared the chart, but I assume you meant that somebody under your supervision prepared it, is that correct?

A: I actually formatted the chart into this format you see here. Someone else collected the data and sent it to me.

Q: All right. And the number of lawsuits by year is in that column, is that correct?

A: That is.

Q: And I don't think have to go through all these columns but -- skip a column. And then that's

the number of liens that were obtained, is that correct?

A: Correct.

Q: Now you -- I believe you testified under direct about the number of patient encounters and that this final column indicated a low percentage of patent encounters. Any lawsuits that would be filed by CHS against patients, those would be against patients that didn't pay the bills, is that correct?

A: Yeah, that's my understanding.

Q: So wouldn't the vast majority of these patients fall into the self-pay category?

A: No. I think the lawsuits are filed against -- I think our financial counselors evaluate people's ability to pay their bills. And the lawsuits are filed against people who we deem have an ability to pay but aren't. And it is to get a dialogue going to work out a payment plan.

Q: I understand that, but you are not suing insured patients; are you, because insured payments would be paying their bills, right, through the insurance company?

A: Again, my understanding of this is the folks

who fall into this category and fall into, for instance, in 2011, the 4310, they are folks who have a wherewithal to pay part of their bill. And we are working this process to basically get a dialogue because we deem them able to pay their bill.

Q: All right. Let me try this one more time. Wouldn't you anticipate in your position that most of the people who end up being sued, wouldn't you anticipate that the vast majority would either fall in -- would fall into the self-pay category, they would be uninsured; wouldn't you believe that to be true?

A: That's an area I'm not familiar with. Again, I have an understanding of this. And there are citizens who are, you know, less fortunate who have no ability to pay. And it's my understanding we don't file lawsuits, judgments or liens against that group because they have no means to pay; therefore, we don't go down that road.

Q: But you don't really know that; do you?

A: You know, that's my understanding. So, you know --

Q: But you don't have first-hand knowledge of

that; do you?

A: I don't process the lawsuits, judgments or liens, and I don't work in patient accounting. But from my understanding of working at the healthcare system, again it goes back to what I testified earlier, there is a very small group of patients who have the means to pay, And this is a process and philosophy that I think is -- you know, again it shows that a very small group of patients that fall into that category that have an ability to pay. And we believe, as fiduciaries of Carolinas Healthcare System, we need to have them pay part of their bill.

Q: And isn't the definition of self-pay, a person who doesn't fall into the charity classification but who does not have insurance; isn't that correct?

A: I'm not -- I can't say specifically how you get categorized into the self-pay from a payer mix. I'm assuming those folks are not sponsored by a federal or state government, Medicare or Medicaid. They are not commercially insured. So those may well be the classic charity patients that have no ability.

Q: Well, once again, I'm distinguishing -- I'm trying to distinguish my question. And if you don't know the answer to this, that's fine. Between charity patients and self-pay patients, charity patients are patients who qualify for charity care under the policy of the CHS agreement with the hospital; isn't that correct?

A: Right.

Q: Self-pay patients are patients who are uninsured but who don't qualify for charity care; isn't that correct?

A: That seems like the case, yes.

Q: I mean, you've been working in this business for a long time and that is correct. It doesn't seem correct, it is correct; isn't it?

A: Well again, I don't get into the details of our billing processes in how we categorize payer mix.

Q: Mr. Murphy, you've prepared how many CON Applications over the years?

A: Close to 200 or more.

Q: And each one of those would have some kind of financial projections, payer mix assumptions in them; wouldn't they?

A: They would.
Q: And you tell me you're not sure what self-pay means?
A: I'm not telling you what -- self-pay means that you are not sponsored by federal-state government or an insurance program. It means you have no other ability from federal government, state government. Do you have other means to pay? You might.
Q: But self-pay would be by definition not insured; isn't that correct?
A: That's true.
Q: Okay. And wouldn't you agree that the patients -- if you're saying that you're not suing charity patients, wouldn't you agree that you are only suing patients who are not paying their bills; isn't that correct?
A: You know, again, I'm not sure I understand your question. I guess I have to stick to what I know and what I understand. And what I understand is the patients who fall into the category of where we will, you know, file a lawsuit or judgment or lien are people we have deemed to have an ability to pay but aren't, for whatever reason in their lives, and we

believe we want to work with them to work out a payment plan.

MR. WESTBROOK: All right. Let's go to Page 44 of Mr. Murphy's deposition, please.

Q: Mr. Murphy, I'm just going to hand this up here to you, if that's all right, Your Honor. And if you can just break the seal and just turn to Page 44, please. And Dan will put it on the screen, too.

A: (Complies)

Q: All right. Where I'm going to ask you to go, Mr. Murphy, is there is a question that begins actually the last line of Page 43; Line 25 of Page 43 and then spills over. And I want to ask you the question from your deposition, I'll read in Ms. Robertson's objection that she makes for the question. And then I would like you to read in your response, okay?

A: You're on Page 43, 44?

Q: Yeah, I'm going to start Line 25 on Page 43, the very last line on that page.

A: Okay.

Q: The question says at the bottom of the page if you read the last two paragraphs, I'll just read them into the record. It says, "In a

sampling of 100 suits that Carolinas Healthcare filed against Mecklenburg County residents, the newspapers found that 71 of them didn't -- either didn't own property in the county or owned houses assessed at less than $150,000 interviews with --"

THE COURT: Mr. Westbrook, let me stop you for one second. Go ahead, Ms. Robertson.

MS. ROBERTSON: And, Your Honor, I do need to object to this. And I did object to it at the time of the deposition, too. I think we're going back to referring to newspaper articles through this line of questioning. It is hearsay, it's not in the record, and we're back to that topic again. So I must object to this. And again it's hearsay.

THE COURT: Okay. Mr. Westbrook.

MR. WESTBROOK: Your Honor, this goes -- this really is for impeachment purposes. So Mr. Murphy has testified that they see charity care patients. He's testified to that on direct, and he's said it again here on cross. I think that is an emphasis of statement here, and I want to get him to read the reference of the question so I can set up a context of what he's answering to.

MS. ROBERTSON: The question, Your Honor, is referring, and again, he is again reading from a newspaper article, which is hearsay. So I do object to the reading of the question in the record. And if it's something else -- I mean, if it's to a response that Mr. Murphy gave, maybe that's different. But this again is reading from a newspaper article into the record.

THE COURT: Well, this is an impeachment. So I'm just trying to clarify here. You are seeking to impeach some testimony here because you think there's been an inconsistent statement made by the witness. And so there was a set-up question in the deposition which was objected to. And then is it the answer to that question that Mr. Murphy gave that is inconsistent with --

MR. WESTBROOK: Right.

MS. ROBERTSON: To get to the answer, you've got to get to the question. And the question is premised on hearsay. And the objection is in the record preserving that -- this discussion here today, Your Honor. So I object to the question that's hearsay. And I do not believe

it should be read into the record or asked of this witness.

MR. WESTBROOK: Your Honor, and again, maybe this is something you can review for yourself and make that decision. But the point of the question -- really the question, the final question is this: Do you have any way of knowing whether these statements are true or not? That is the question. And his answer is what I'm trying to elicit, the answer that he gave in his deposition. And that's -- so the setup about, you know, reading from the newspaper article here at the deposition is not being offered other than do you know whether it's true or not?

MS. ROBERTSON: And, Your Honor, I guess for context I'm not sure -- I mean, I think we were back on the answers to interrogatories and what Mr. Murphy did to prepare the answer to interrogatory on the practices of Carolinas. I don't even know if those interrogatories have been responded to, and maybe Mr. Westbrook will correct me, at the time of this line of questioning. So I don't know that this hearsay questioning can be impeachment to something he

subsequently did and has now testified about what he did in that process when he prepared the answers to the interrogatories. I don't believe that is proper impeachment, use of hearsay information.

MR. WESTBROOK: Well, you know, what I'm impeaching is this, on his direct testimony, Mr. Murphy said we don't sue charity patients. In his deposition, he says, I don't know.

THE COURT: I kind of see where that's where you're going. And to that, Ms. Robertson, it kind of doesn't seem -- the question that was posed prior to the answer that you objected to, Ms. Robertson, at that time, all that question is whether the truth of those allegations in the question are not at issue here. That question -- if it's -- all that does is set up his answer, which is that I don't have any way of knowing if those statements are true. Whether those statements are true or false or completely made up numbers or right on, spot-on accurate, is irrelevant. It's -- as I understand what Mr. Westbrook is attempting to, at this time do is to get into -- get into at that time Mr. Murphy then responded by saying

that he didn't have any way of knowing what the -- he didn't have any way of knowing whether those statements were true or not. So I don't think that we've got a hearsay problem at this point. I think at this point, what would be your objection to it?

MS. ROBERTSON: Well, he said he is doing this for purposes of impeachment. I think this deposition predates the work that Mr. Murphy did in responding to the interrogatory and the knowledge that he has about what he did and what's contained in that exhibit in the interrogatory response. So I don't know that you can back up to a previous time and impeach him on something that precedes what he just testified about and the basis for his testimony.

THE COURT: Okay. I think at that point, that would be something you could rehabilitate him on. So I am going to go ahead and allow Mr. Westbrook ask the question. And then if you wish to rehabilitate your witness or if he could explain his answer, then he can at that point. Go ahead, Mr. Westbrook.

MS. ROBERTSON: Thank you, Your Honor.

THE COURT: Thank you.

Q: Mr. Murphy, let's go back and start over there at Line 25 on the previous page. I will try to get through this quickly.

MR. WESTBROOK: Dan, if you could pull up 25.

Q: All right. At the bottom of the page, if you read the last two paragraphs, I'll just read them into the record. It says, "In a sampling of 100 suits that Carolinas Healthcare filed against Mecklenburg County residents, the newspaper found that 71 of them didn't -- either didn't own property in the county or owned houses assessed at less than $150,000. Interviews with 15 who were sued suggests at least a third of them probably should have qualified for charity care based on the incomes and assets. Do you have any way of knowing whether those statements are true or not?" Ms. Robertson, "object to the form. Go ahead". The witness?"

A: I said, "I don't have any way of knowing if those statements are true."

Q: All right. And you go on in your deposition and talk about how you gained some understanding of this from talking with a

gentleman named, Steve Burr, is that correct?
A: Correct.
Q: All right. But Mr. Burr, this is in his area, is that correct?
A: That's correct.
Q: All right. It's not in your area. I believe you testified already that you're not involved in how collections are run in your organization. Is that correct?
A: That's correct. And responding to the discovery request, I've learned more about this area. But again, it's not what I do in my job.
Q: All right. Now, the liens that are listed on that chart that you created that we went over a few minutes ago, those are liens on homes, is that correct?
A: I assume so.
Q: And you -- I believe you testified on direct that you use those liens, you put liens on homes for the purpose of really getting leverage on folks to enter into payment plans, is that correct?
A: That's correct.
Q: Now, if somebody wanted to refinance their house or put a lien on their home or CHS or

anybody else had a lien on their home, don't you think they'd have some trouble refinancing their house?

A: Well, and this is -- I'll tell you what I know. What my understanding is that we have never not allowed a home to be sold or refinancing to take place.

Q: But that's based on what Steve Burr tells you?

A: That is.

Q: All right. And, in fact, if somebody wanted to refinance their house and Carolinas had a lien on it, they went to the bank and the bank said, no, we can't refinance. I mean, Mr. Burr, wouldn't have any way of knowing that; would he?

A: If the bank didn't call him, I guess not.

MR. WESTBROOK: Now, Your Honor, at this point we have been going for awhile and it's --

THE COURT: You'd like to take a break?

MR. WESTBROOK: -- which I take responsibility for in large part. Yeah, it might be a good time for a break.

THE COURT: Yeah, if this -- yeah, about 15 minutes.

MR. WESTBROOK: Yeah.

MS. ROBERTSON: Thank you.

(Off the Record)

THE COURT: All right. We're back on the record. And Mr. Westbrook, sir.

MR. WESTBROOK: Thank you, Your Honor.

Q: Mr. Murphy, there's been a good bit of testimony about the expansion at Pineville, CMC-Pineville over the last several years. Just to clarify, the -- I think you said this, but I want to make sure I understand, the service area for CMC-Pineville as articulated in the 2007 application included -- it's larger than York County but it included York County in it; isn't that correct?

A: Yes.

Q: It includes all of York County, is that right?

A: I would think so.

Q: And the -- and I think there has been a good bit of testimony about the bed increase. And there were also different kinds of services that were added to Pineville; isn't that correct, that they had a number of speciality tertiary services like open heart, neurosurgery and neonatal and that kind of thing. Is that right?

A: That's correct.

Q: Now, currently there are about 70 to 90 CHS employee positions in York County, is that correct?
A: That's approximate, I think.
Q: And CHS -- excuse me, CMC-Fort Mill, its service area is entirely York County, is that right?
A: It's primary and secondary service oriented that cover York County, yes.
Q: That's right. So together they cover York County, is that right?
A: Right.
Q: Now, CHS through Pineville and I guess through other facilities as well have been serving York County since at least 2007 if not before, is that right?
A: CHS has been serving York County for, you know, probably since, you know, the 1940's. I would assume the patients travel as long as we needed to assist them, and that dates back to 1943.
Q: Now, there was testimony about the, I believe, about the provision of care that CHS has offered in northern York County. And you have some Urgent Care Centers that you have opened up recently in northern York County, is that

correct?

A: There is an Urgent Care Center in Fort Mill that was opened a couple of years ago.

Q: What's that called; do you recall? Do you have the name of it?

A: I'm not positive. It may be CHS-Fort Mill or something to that effect. It has Fort Mill in the name.

Q: And you're building another one that is referred to as Ballentine, is that correct? Is that in the process of being build; do you know?

A: I'm not aware of an Urgent Care Center being built in Ballentine.

Q: Is it a NOB rather than an Urgent Care Center or medical office building?

A: I'm not aware of it right now. I may be drawing a blank, but I'm not aware of any construction. There is a construction, I believe, of potentially a children's Urgent Care Center in Blakeney which is close to Ballentine, if that's what you're referring to.

Q: Let me ask you, is the Celanese Road exit off I-77, what's being constructed there?

A: I'm sorry. That Calanese Road and 77, that is

a medical office building where we are consolidating a number of our York County practices. But that is Rock Hill and not Ballentine.

Q: Are there plans to provide urgent care services there?

A: Not that I'm aware of.

Q: Has CHS ever offered to establish an Urgent Care Center in western York County?

A: Memory is a little vague on it. I think we may have had one in western York County years ago and closed it. I know there's been discussion about it during this process, but I don't remember exactly what our services were in western York, but that's my recollection.

Q: When you say discussion during this process, CHS hasn't proposed to provide urgent care services as a part of this process in western York County; has it?

A: No, no; we haven't.

Q: And CHS hasn't proposed to the county to offer 24/7 ambulance services in York County; have they?

A: I'm not familiar with what we may be doing in the emergency services area with the ambulance

services. I know there has been discussions about that. But I don't know with York County or not. I know we have discussions with Tega Cay and whatnot.

Q: As part of this, you are in charge of this CMC-Fort Mill CON initiative, is that correct?

A: Right.

Q: As part of that, I'm going to say initiative or project or whatever the most perfect word would be. As part of that project, there hasn't been any proposals by CHS to offer county-wide free ambulance services; has it?

A: No.

Q: And there hasn't been any proposal as part of that project to offer quarterly or financial, quarterly or annual financial reports to York County by CHS or CMC-Fort Mill; has there?

A: There hasn't been any proposal. And we haven't been required to do that in any county where we operate. So we just haven't been -- unlike Tenet, we haven't been required to do that.

Q: And in fact, when going back to the question about the Urgent Care Center, didn't CHS represent to DHEC that an Urgent Care Center in western York County wasn't relevant to these

CON Applications or these CON projects?

A: Well, I think I remember a representative from Novant Health basically saying, I believe at the first project review, that if they were awarded the certificate of need application, they would build an Urgent Care Center in western York County. And we may have said something along those lines that there is nothing in the criteria that would require you to build an Urgent Care Center as a part of getting approved for this project.

Q: So it was CHS's position, was it not, that that Urgent Care Center in western York County wasn't relevant to the project; isn't that correct?

A: You know, I don't think an Urgent Care Center in western York County is relevant to the CMC-Fort Mill proposal that we have. I mean, it's relevant in the sense that both are about meeting healthcare needs. But, you know, western York is not Fort Mill, and it's a different type of service.

Q: Now, you talked about CHS. On direct, you talked about CHS being an integrated system I believe, is that right?

A: Correct.
Q: And an integrated healthcare system, as I understood you to testify, and I've heard you talk about that before is a system that in which hospitals and physicians and the entire continuum of care is working together towards trying to be bring about high-quality low cost care; is that accurate?
A: That's correct, that's right.
Q: And an integrated system, if its managed correctly, should increase efficiency; would that be true? Wouldn't that be one of the points of it?
A: Yes.
Q: And being able to provide tertiary and community services within one system through hospital services and physician services, that would be one aspect or one goal of an integrated system; would it not?
A: To -- I'm not sure I understand your question.
Q: Let me rephrase that. That's all right. Yeah. In other words, one of the goals of an integrated system would be to provide both community services and tertiary service?
A: Right.

Q: And it's possible, I think, you agree; would you not, for a system to be integrated. And you could have a great number of facilities or as few as just two hospitals; wouldn't that be possible?

A: That would be possible, yes.

Q: Let me ask you about the projections in your updated application. First of all -- and you testified about this. My understanding is it was your understanding, based on your understanding of what was required, CHS submitted its -- really its updated projections, its updated financial projections and utilization projections and cost projections and things of that nature in December of 2010, is that right?

A: That is correct. We submitted them following the October -- the first submission I believe it was December the 3rd.

Q: Right. And the -- that was -- what was that, two months after Presbyterian and Piedmont submitted their projections, is that correct?

A: The initial projections were submitted in March of 2005. So I mean, to be technical about it, it was four years later.

Q: Well, let me put it this way then. Would you agree that updated submissions following the remand, the first submission is following the remand that Presbyterian and Piedmont made were in October 2010; isn't that correct?

A: They filed their updated information in October. We filed ours in December. And as I testified, we were uncertain what to file in October. And so we took the course of action that we did and then filed our updated projections in December. And that was based on what was written in Judge Matthew's order, and it was based on -- and I don't know if I can get -- not getting any clarity from DHEC on what to file.

Q: Now, going into those utilization projections, it's your position, is it not, or CHS's position in the updated projections that it filed in or submitted to DHEC in December of 2010, that the CMC-Fort Mill project would not take any more patients from Piedmont than CHS is currently taking; isn't that your position?

A: Yeah. Our position was after looking, you know, again when we initially filed the application, when we looked at the market

share changes that had occurred from 2000-2003, and we looked at that. And then we looked at what community hospitals typically maintain in market share. We set our market share for CMC-Fort Mill at approximately 40 percent to be representative of what other community hospitals would maintain. So we didn't, in essence, assume that CHS overall would grow its market share of York County through the development of CMC-Fort Mill.

Q: And I appreciate that explanation. And I remember your testifying to that on direct. But going back to my question just to clarify, isn't it your position that CMC-Fort Mill will not take anymore patients from Piedmont than CHS is currently taking; isn't that right?

A: We assumed that we would not increase our market share.

Q: Well, my question is not about market share. I will get to that in a minute. I understand your testimony about market share, and I understand there is a correlation between market share and patients. But in terms of numbers of patients, that's a slightly different question; isn't it? In terms of

numbers of patients, isn't it true that CHS is not proposing to take anymore patients from York County than it's currently serving; isn't that correct?

A: No, that's not really the way I sort of see it. The way I would explain it is if you look at our model, we held our use rate constant and let the market level grow with population growth. So the number of patients from York County increased over our projection period. And we held our market share constant. So we were taking more patients. But again it was relative. It's a relative thing in terms of we maintained that approximate 40 percent market share. And over the course of our projection, the demand -- or for inpatient hospital community service was increasing. So we were taking more patients from York County. But we weren't taking market share from Piedmont. I think that's the way I process your question.

Q: All right. Let me ask you to turn to Page 10 of your deposition, please, sir.

MR. WESTBROOK: And Dan if you would put that on the screen for us please.

Q: And I'm going to -- I have a question, Mr.

Murphy, that starts at the bottom of Page 10 on Line 20. But to try to just -- it's the first part of the first couple of lines. It's just sort of a setup. My real question begins on 22, Line 22. I'm going to read that and ask you to read your answer. Starting at Line 22. "Is it Carolinas' position that they will not take anymore patients from Piedmont than they are currently taking?" And your answer was what?

A: "Correct."

Q: So isn't that correct?

A: Well, that's what I just said.

Q: I'm sorry. I didn't understand you. All right. Now, so going back to market share, your market share, you're proposing that you would shift your market share of York County patients to CMC-Fort Mill. That is -- and when I say your market share, I'm saying CHS's; right?

A: That's correct.

Q: And so I believe the projection is that essentially over 3,300 patients would be shifted to CMC-Fort Mill in its first year of operation, is that right?

A: Well, the market share would be shifted, correct. The patients that had typically gone -- or the population in need of healthcare or inpatient community service that had typically gone into Mecklenburg, we assume that the market share would shift from the hospitals in Charlotte to CMC-Fort Mill.

Q: And as a result of that shift that you just talked about, would be, would it not -- if CMC-Fort Mill is built, you would not expect there to be any increase in patients from York County going to CHS?

A: No. That's again not the way I see it. I mean, if we build CMC-Fort Mill and our projections held true with the use rate plat growing with -- and market demand growing with population, from just the math standpoint, we would be seeing more patients from York County than we are now.

Q: All right. Let me ask you to look on Page 18 of your application, please. All right, your application -- I mean your deposition. And there on Page 18, Mr. Murphy, my question starts at Line 15. My question on Line 15 says, "My understanding is from your earlier

testimony and from the material submitted to DHEC that you don't expect there to be any increase in patients from York County going to CHS if CMC-Fort Mill is built; right?"

A: Yeah, and I see your line of question.

Q: Just read your answer.

A: My answer was, "That's correct."

Q: Okay. So since I interrupted you there, once again, my question was -- I'll just read the second half, "you don't expect there to be any increase in patients from York County going to CHS if CMC-Fort Mill is built, right?" And then just read your answer, and then you can explain it if you want to.

A: I said, "That's correct." And prior to my deposition, I didn't go back through our model and really evaluate, you know, the implications of our projection. I know -- I remembered how we did it, but when you look at the forecast, we actually are taking more patients. But I think what the focus here is are we taking more market share. You know, that's why I'm sitting here today thinking about that projection. And we are holding market share constant. But because we assumed inpatient demand would grow

with population growth, we would be capturing some additional patients. But they wouldn't be coming from Piedmont.

Q: All right. And your goal, CHS's goal in this project is not to increase it's market share but simply to maintain its current market share; isn't that right?

A: Yeah. Our goal in this project is to serve patients who currently --

Q: Let me ask you to answer my question yes or no and then explain it. Okay?

A: Okay.

Q: So my question again was: CHS's goal in this project is not to increase its market share but to maintain its market share; would you agree with that, yes or no?

A: Our goal in this project is not to increase market share. It's to serve patients who are currently leaving York County closer to home.

Q: It's actually to maintain your current market share; isn't that part of your goal?

A: We would like to, yes.

MR. WESTBROOK: Okay. All right. Let me ask my friend Dan to put up Demonstrative 155 on the screen, please.

Q: Now, you testified on direct about your observations to proposed sites, is that right?
A: I'm sorry. I was looking at your map.
Q: That's okay. Over -- on your direct examination you gave some testimony about your personal observations of the two proposed sites, the Fort Mill Medical Center site and the CMC-Fort Mill site; do you remember that?
A: Yes.
Q: All right. And I don't know if you were here for the testimony of Mr. Walsh earlier, but this is the demonstrative from Mr. Walsh. And I guess my question, you testified about the traffic levels. And I believe you gave some information that had been presented to DHEC about the traffic volume at those two sites, is that right?
A: Yes, we did. We went to the Department of Transportation and just got, I think, hours daily of traffic volume.
Q: All right. And for the traffic volume of the Fort Mill site, did you check the traffic volume of both Highway 160 and Highway 21 or just 160; do you know?
A: I don't recall, no.

Q: And did you check the capacity of those two highways for dealing with traffic?
A: I don't recall checking the capacity.
Q: And do you recall whether you checked the unused capacity or the excess capacity for those two highways?
A: No.
Q: Do you recall -- moving down to the CMC site, I guess that would be Demonstrative 156, perhaps? Do you recall if you checked with the Department of Transportation about the capacity, current data traffic or the unused capacity at the Sutton Road exit off of I-77?
A: You know, when we were responding after project review and we put the information in our submittal after project review, it was in response to the criticism of our site. And as a part of the certificate of need process. I don't select hospital sites. We have a team of people with deep expertise.
Q: And so you don't -- do I understand to say that you don't have expertise in selecting hospital sites?
A: I don't do that as a part of my job. But I rely on folks. And as I pointed out two

healthcare systems that have a track record for building healthcare facilities, both chose Exit 83.

Q: And the Presbyterian site is on the other side of the interstate, correct?

A: It is.

Q: It is not directly across from Love's Truck Stop; is it?

A: No.

Q: When I say is it, I guess was it would be a better way of saying it.

A: Yeah, it's on the other side.

MR. WESTBROOK: Let's take a look at something that was introduced at project review. Dan, let's go to the videotape.

Q: This is a short -- I think it's a minute and a half, something like that, video. See if you remember seeing this at project review. Now, you remember seeing this at project review, don't you, Mr. Murphy?

A: I do remember a video like this at project review.

Q: And during the project review process after that video was played, didn't you tell DHEC that you had been at the site many times and

had never seen a truck?

A: You know, I did. And as I reflect on that, what I probably should have said is that I didn't notice a truck. And it would be tantamount to me asking today when you drove here did you see a Honda Accord? You may have, but your brain didn't, you know, register that you had seen a truck. But I have been to this site many, many times, and I've never seen what's demonstrated in this video, nothing remotely close to it. And that's why I believe I reacted the way I did at project review. And I drive up and down 77 and have never seen anything remotely close to this. And last Thursday when I went home, as I testified earlier, I took the loop going up 21 and came back down Sutton Road. And if you go drive south on Sutton Road, you don't see the truck stop until you're literally there. And, you know, again, I don't know when this video was done. And, again, I've never seen anything remotely close to it.

Q: On direct, you testified about the support letters --

A: Okay.

Q: -- that CHS collected and the other applicants collected.

MR. WESTBROOK: I would like to ask Dan to put on the screen please, Joint Exhibit 1B.

Q: And this is already into evidence, Mr. Murphy. This is the analysis from Ms. Brandt accompanying her decision letter. And you testified about the number of letters that were submitted.

MR. WESTBROOK: I want you to highlight the third sentence there, Dan, for me.

Q: And Mr. Murphy, can you read that sentence, please?

A: "The current reported totals are 10,004 letters for Presbyterian, 5,053 for Carolinas, and more than 5,400 for Piedmont."

Q: All right. So according to Ms. Brandt's count, both Piedmont and Carolinas submitted over 5,000 letters, is that correct?

A: Well, I don't believe this accurately reflected all of the letters we had submitted.

Q: I see.

A: As I testified earlier, I think our count was over 9,000.

Q: All right. So what else is inaccurate

factually about Ms. Brandt's report?

A: I didn't see anything else other than this.

Q: Let's look at the next sentence, please. It says, "The department received -- directly receives 34 letters of opposition to Piedmont from the community." Didn't you testify on direct that you had seen thousands of letters of opposition to Piedmont?

A: Well, in our letters of support packages, again, we put all of our letters and internet responses into notebooks. And we would put them all in there. And then we would put in front of the notebook a table with every person's name and their address. And my estimate is that there were thousands of letters that we received that supported us but also mentioned something negative about Piedmont. That's what I meant.

Q: Okay. Well, Ms. Brandt counted 34 letters of opposition? Do you think that's another inaccuracy?

A: Well, I think here she is referring to letters the department directly received. And I take that to mean someone wrote her a personal letter. And what I'm referring to are letters

that were directed to us.

Q: And you didn't submit those letters to DHEC?

A: Yes, they are all on file with DHEC.

Q: All right. And apparently Ms. Brandt didn't count as an opposition letter to Piedmont, is that right?

A: No, I think she is saying here the department directly received 34. I believe she means, and you'd have to ask her obviously, my assumption was these were letters someone addressed directly to her submitted. And what I'm saying is our letters were embedded in our notebooks and mentioned a lack of non-support for Piedmont. So I think they are two different things.

MR. WESTBROOK: Let me ask Dan to pull up CHS 5908, please. This is a document submitted in discovery by CHS. And just pull it up closer where we can read it.

Q: This is a -- it looks like an email from you to Martha Ann McConnell. Who is Martha Ann McConnell?

A: She is our vice-president of government relations.

Q: All right. What is the date of email?

A: June 23, 2011.
Q: All right. And at the beginning, how about reading that first paragraph for us, please.
A: "I believe Chris may have spoken to you about this a few weeks ago. As you are aware, Governor Haley replaced all but one member of the seven-member DHEC board several months ago. The question I have is this: Could our South Carolina lobbyist visit with each DHEC board member over the next 30 days to educate them about the CHS mission, our role in South Carolina, etcetera. The purpose of the visit is simply to let them know who CHS is and why we need a hospital to serve our South Carolina patients in northern York County. Obviously the board members may have questions about CHS or our proposal."
Q: Did the lobbyist or another CHS representative make those contacts with board members?
A: I don't believe so. I don't think so.
Q: Do you know for sure or just -- you indicate some uncertainty?
A: My memory, you know, again; this is a couple of years ago. My memory is that no one from CHS visited those DHEC board members.

Q: All right. Did you ever get an email, because I don't see one produced by CHS in response to this saying that that did not occur?

A: No. But my memory is there was conversation after this where it was my belief is that there was no context. I don't recall anything in writing.

Q: Who was the lobbyist you were referring to there, your South Carolina lobbyist?

A: I don't know the lobbyist by name.

Q: Do you have more than one South Carolina lobbyist?

A: I think we have a firm that has more than one lobbyist that we work with.

Q: What's the name of the firm?

A: I couldn't tell you.

Q: All right. Let me just broaden my question that I asked you a few minutes ago. I think I -- I'm not sure exactly how I worded the question, but it was probably something to the effect: Did anyone from CHS or CHS lobbyist visit board members, to your knowledge? And if you don't know, that's fine. To your knowledge, did anyone, whether employed by CHS or whether a lobbyist or not, did anyone meet

with DHEC board members on behalf of CHS related to this project?

A: To my knowledge, no one on behalf of CHS met with any DHEC board members to discuss the project.

Q: All right. But you proposed that they do, is that correct?

A: Well, as I read this -- let me just read it again, because I'm not -- you know, let me just take a minute.

Q: All right. While you are taking a minute, I think I'm going to read it, too. I'm going to read it out loud so we can all concentrate on what it says, "Martha Ann, I believe Chris," and who is Chris, by the way?

A: Chris Summer is the administrator of CMC-Pineville.

Q: Okay, "Martha Ann, I believe Chris may have spoken to you about this a few weeks ago. As you are aware, Governor Haley replaced all but one member of the seven- member DHEC board several months ago. The question I have is this: Could our South Carolina lobbyist visit with each DHEC board member over the next 30 days to educate them about the CHS mission, our

role in South Carolina and so forth? The purpose of the visit is simply to let them know who CHS is and why we need a hospital to serve our South Carolina patients in northern York County. Obviously the board members may have questions about CHS or our proposal." Okay.

A: Can I make a comment about that now that I --

Q: You certainly can. Let me first, and I think my question was, and you can answer that and then you're free to comment. My question I believe was: To your knowledge, did anyone on behalf of CHS contact a South Carolina board member?

A: To my knowledge, no one at CHS contacted a DHEC board member. And as I reflect on this memo, I sent this memo to Martha Ann to give her basically a heads up. I think Chris Hummer had some concern. And again, Chris is not a certificate of need person; but I think he had just concern for some reason that the DHEC board had changed and do we need to educate them about CHS? And I immediately alerted Martha Ann. And I think we concluded that it wouldn't be appropriate for us to do that. And I think that was something Chris was

questioning the process, is this something we should do? And I remember in the first review, you know, something about some county officials becoming involved. And I think Chris was concerned that, you know, how does this process work? And I think after, you know, we contacted Martha Ann, we concluded that it wouldn't be appropriate for us to do that. And I educated Chris on that process.

Q: And you have a specific memory of educating Chris on that process?

A: Well, my memory --

Q: The reason I ask this, Mr. Murphy, I'm not doubting what you're saying, but I'm just saying that you started off responding with something to a degree of uncertainty. And the more you're talking it's even more uncertainty. So I'm trying to ascertain what exactly you know and what your department speculated about.

A: Well here's, you know, I'm sitting here and you put a letter in front of me that I haven't seen -- or a memo or email that I haven't seen in a couple of years. And initially it takes a while to remember the context. And my memory is that Chris made me aware of this. And I've

asked Martha Ann about this. And we very quickly after this concluded that it wouldn't be appropriate. That's my memory.

Q: And your memory that it wouldn't be appropriate, is that because it's against the law?

A: I believe so, right.

MR. WESTBROOK: In fact, let's put up Section 44-7-200 of the South Carolina Code. And let's look just at Section 200. I think it's the bottom half of that page.

Q: Mr. Murphy, have you seen this statute before; do you recall? And just take a minute to familiarize yourself with it. It says application for certificate of need notice prohibit communications. Review Section B there, please. All right. It refers to the applicant publishing notification. And then go on to Section C, it says, "Upon publication of this notice until a contested case hearing is requested." And look at Number 2.

A: Yeah. I have seen that before. My recollection is, you know, because of what transpired in the first case where some county government officials got involved, one of our

administrators, and I think in his role, you know, suggested to me that we do it. And we quickly concluded that because of this statute, we can't -- we couldn't do that.

Q: All right. Mr. Murphy, you testified on direct about Joint Commission Certifications that CHS, Presbyterian and Piedmont had. And I believe you showed a slide that had been presented to that effect. It showed CHS by my notes, and correct me if I'm wrong, had according to the slide presented to DHEC, over 20, I think it was 21, Novant 13 and Piedmont one, is that correct?

A: That's correct.

Q: Now again, I know we've already established this. But remind me, about how many hospitals are in the CHS system?

A: We have, you know, roughly 14 to 15 in that obligated component unit column and another -- we have 42 total.

Q: And the Novant system has how many hospitals in it?

A: Less than us. I'm guessing, you know, maybe ten less than us. And it's a guess, I don't track their numbers.

Q: And the comparison that was made that you made on direct and you made to DHEC was among the CHS system, the Presbyterian system and Piedmont Medical Center, it wasn't with the Tenet system; was it?

A: No, it was comparing Piedmont Medical Center.

Q: So you're comparing one hospital with two systems, is that correct?

A: That would be correct. But I think the point that we were just making is that we made a significant investment in those programs. And I don't think there would be anything prohibiting Piedmont from doing the same thing.

Q: I see. But you're point then, and you weren't trying to say that you hadn't -- that you had more Joint Commission Certifications than Piedmont? That wasn't your point?

A: No, the point was we had, I think at the time, 21 programs certified by the Joint Commission for the clinical quality improvement. And Piedmont had one. And at the time, I -- it wasn't to demonstrate -- I mean I didn't really consider the fact that we had more than one hospital.

Q: I see.

A: Because I don't think there is anything prohibiting a single hospital for getting many certifications.
Q: So Piedmont could have gotten 21.
A: They could have.
Q: That's right. And how many of your individual hospitals have 21 Joint Commission Certifications?
A: I don't know the answer to that.
Q: Yes, you do. It's zero; isn't it?
A: I don't know.
Q: You don't know? You wouldn't know in your position that one of your hospitals had 21 Joint Commission Certifications? Is that what you're saying under oath?
A: What I'm saying under oath is when we were preparing this information, contacted the quality department for this information. And they told us our system, to the best of my recollection, we had 21 certified programs from the Joint Commission in clinical quality and Piedmont had one. I don't recall looking at our facility -- I don't recall looking at those numbers by facility. I may have. I just don't recall.

MR. WESTBROOK: Let's look at -- Dan, let's pull up Exhibit Joint B, Page 782 and 783.

Q: This is a submission from Piedmont to DHEC in July -- excuse me, July of 2011. You testified on direct, you had a number of slides comparing your Medicaid numbers for South Carolina patients to Presbyterian, is that right? Do you recall that?

Q: Yes.

A: Now, this is something that was submitted to a project review, and you see figure five there shows 2009, which was the most recent data at the time. South Carolina Medicaid Emergency Department's submissions. And then the chart on the right shows 2009 South Carolina Medicaid discharges, which would not be emergency department, obviously hospital discharges. And it confirms your point, does it not, that Carolinas has had a lot more than Presbyterian; isn't that correct?

Q: It does.

A: But it also shows that Piedmont had a lot more than Carolinas; isn't that correct?

Q: But the purpose of my slide wasn't to compare Piedmont to Carolinas because they are not

apples-and-apples comparisons. I think we put our slide together to demonstrate to DHEC, while we were being criticized by Presbyterian, we wanted to show the number of South Carolina patients we serve compared to Presbyterian, not Piedmont. I think Piedmont operates a hospital in York County and received a lot of Medicaid patients through the ED. And their numbers would be larger than ours because we don't operate a hospital there. So I don't think that's real apples and apples.

MR. WESTBROOK: Let's look at CHS Exhibit 28, please.

Q: This is an exhibit, I think, you testified about on your direct. As I understand it, Mr. Murphy, this shows the number of referrals that the CHS practices refer on to other CHS facilities or physicians or providers of any type, is that right?

A: It shows the rates of referrals for these four different types of services to physician partners.

Q: All right. And I think your point was, at the bottom of the page, that the sort of aggregate number, the average or however you calculated

that was, it's actually

MR. WESTBROOK: Dan if you can pull it up.

Q: It's six percent, is that right?

A: Right.

Q: All right. Now, the lowest -- if you look at that last column.

MR. WESTBROOK: And Dan, move up so that we can see the last but total column there.

Q: That's the one that, you know, totals up all the ancillary diagnostic, medical and surgical, is that right?

A: That's correct.

Q: And the lowest there is Carolina Cancer Specialist at nine percent, is that correct?

A: Right.

Q: And that is located in Rock Hill; is it not?

A: I believe so.

Q: And the second lowest is towards the bottom, I believe, it's Shiland Family Medicine at 36 percent, is that right?

A: That's correct.

Q: And that's also in Rock Hill; is it not?

A: Correct.

Q: And the third lowest is Medical Associates of Rock Hill, which I would assume from the name

is also located in Rock Hill, is that correct?
A: That's correct.
Q: And that's 43 percent, the third lowest, is that right?
A: Yes.
Q: And the others are all located -- well, there's Rock Hill Pediatric Associates in Fort Mill. But the other practices are located in -- excuse me, there's Rock Hill Pediatric Associates, which is in Rock Hill; and then Rock Hill Pediatric Associates Fort Mill, which I think is in Fort Mill; correct?
A: Right. There is three other practices on that list that are Rock Hill; Palmetto Pediatrics, Piedmont GYN-OB -- well, actually maybe four; Rock Hill Pediatric Associates and Sanger Heart Vascular Institute of Rock Hill. So there are four other ones in Rock Hill in addition to the three you highlighted.
Q: But the three lowest on this chart -- in that chart -- the three that are under 45 percent are all in Rock Hill, is that right?
A: They are.
MR. WESTBROOK: Let's look at CHS-27, please.
Q: CHS-27. Have you seen this one before?

A: Yes.
Q: CPN 2012 payer mix by practice?
MR. WESTBROOK: Let's go to Page 2, Dan.
Q: Now, my question is; and let's look at the Medicaid line there. This shows from 2007 to 2012, right?
A: That does.
Q: And this is a CHS Exhibit, Exhibit 27?
A: Yes.
Q: And it shows the Medicaid percentage. And just to clarify. We've probably clarified this before, but I don't think we have with you. CPN is the name -- is the acronym for the CHS Physician Network in York County, is that right?
A: Yeah, Carolinas Physicians Network.
Q: Okay. And Medicaid during that period of time, during that 2007 to 2012 it starts off at 8.4 percent. And it actually goes down and then kind it goes up a little bit. But would you characterize that as relatively flat?
A: No, I wouldn't. I think you can't just look at that particular line in isolation. That's why I reformatted it and testified to it earlier. I look at a trend from 2009, an upward trend.

I think it was about two and half percent a year, but 6.4, 8.7, 10.1, 10.9. And, you know, in light of the testimony from the physicians that I sat here and heard, this doesn't show that we are reducing our Medicaid in volumes while increasing theirs. And then I combined our commercial and managed care to show that actually that had been flat, it hadn't been growing. And again, I think I testified that the economy had a lot to do with these numbers between 2007 and 2009.

Q: Right. And the -- from 2007 forward, it goes from 8.4 percent -- it actually decreases into 7.6 in 2008 and then decreases again in 2009 to 6.4, is that correct?

A: That's what these numbers indicate. Yes, it decreased for the most -- from between '07 and '08 and down in '09 and then back up.

Q: And then self-pay goes in 2007 from 3.1 and decreases to 2.6. And then is it's at 2.8 in 2009, decreases a little bit, 2010 to 2.4 and then goes down to 1.8 percent --

A: Right.

Q: -- is that correct?

A: And then back up.

Q: And then back up to 2.2 percent.
A: Right.
Q: Again, but you testified about the effect of the general recession on these numbers. General recession was at its peak in 2008, 2009, is that correct?
A: I believe so.
Q: All right. You testified about the profits that CHS hospitals make. I think I asked you a question or two about that; and I think you testified about that on direct, as well. I'm relying on my memory in regard -- it's already established that's not very good. So you correct me if I'm wrong, but my memory is that you testified that it is important for CHS hospitals to make profits because to keep up with population growth was one reason I believe you testified, is that right?
A: Well, I believe I said that, yeah.
Q: And another reason I believe you said was so that you could maintain -- essentially maintain a viable healthcare system.
A: Right.
Q: And I'm not sure that's your exact words, but was it something to that effect?

A: Well, when I go back and start with a mission statement, it is to create a comprehensive healthcare system. And creating that comprehensive system requires us to be financially, you know, good stewards. And that's where the income is required to be able to do that. So that's our mission; that's our purpose.

Q: Good, thank you.

MR. WESTBROOK: Bear with me a minute, Your Honor, if you don't mind.

Q: Mr. Murphy, let me ask you to -- let me ask you, the Medicaid line up there, again, if you will. This is again Page 2 of Exhibit, CHS Exhibit 27.

Q: Did I understand you to say that you calculated -- well, let me just ask you; what was the percentage of growth that you calculated for Medicaid? And I think you did it for 2009 forward, is that right?

A: Yeah. I think what I -- if you compare 2.9 -- excuse me, 10.9 in 2012 to 8.4 in 2007, the number I was thinking about was the change. It was 2.5 percent change. I may have said growth rate, but it's -- it's actually the -- I think

what I had on my exhibit were the percentage changes in that far right column. And I think it was -- as I look at 10.9 minus 8.4, it's 2.5.

Q: What is the growth rate, did you calculate that?

A: No, I haven't.

Q: Could you do that or is that --

A: I don't know that -- you know, I don't think the growth rate from '07 -- again, you know, I think you look at these trends and you look at different points in time.

Q: Well, what would it be from '07 to 2012? Whether that's the way you did it or not, I'm just asking what would that --

A: It's not a very high growth rate.

Q: Well, what would it be?

A: I don't know. I would need a calculator.

Q: I paid $10.00 for this.

A: Let's see. I'm looking for the on button. That's not the type of calculator I use. Well, can I use my calculator?

Q: Certainly.

A: It might be a little quicker. It's in my bag back there.

Q: Okay.

MS. ROBERTSON: If I may approach --

THE COURT: Absolutely.

MS. ROBERTSON: Thank you.

A: If you just take the number 8.4 percent, and you calculate the number. The percentage change between 8.4 and 10.9, let's see -- and it's not calculating because I don't think this calculator recognizes growth rates between percentages. But I think the point you are trying to make is that it's not a large change between 8.4 and 10.9 over that period of time. And I guess I would just say you have to look at the trend line because again, I put this together in response to the criticism I heard from the physician witnesses from Piedmont that seemed to suggest we were systematically steering the Medicaid patients to their practice and the commercial patients to ours. And I don't think that's the case. I don't think these trends show that.

Q: All right. Mr. Murphy, you are -- in the beginning you gave your current job title and responsibilities. Could I ask you to repeat that. What's your -- because I know there's

been a change from the last time we --

A: Right. My current job title is Senior Vice-President, Planning and Development, and I was promoted a few weeks ago to that position.

Q: Are you an officer of any type with CHS?

A: No, I'm not.

Q: All right. Are you familiar -- are you aware of an investigation at CHS by Senator Grassley, the United States Senate Judiciary Committee?

A: I'm not aware of that, no.

Q: You're not aware that an investigation is ongoing? I'm not asking you about the details. I'm asking whether you know whether an investigation, and let me just clarify what my question is. I'm not asking whether you know the details, I am asking do you know whether Senator Grassley, ranking member of the U.S. Senate Judiciary Committee is currently investigating CHS with respect to the 340(b) drug program?

MS. ROBERTSON: Your Honor, if I may, Mr. Westbrook is in effect testifying with the information he is putting before the witness. He is setting forth the information. He's asking him what he knows, but he's in effect testifying. We have

no idea of what he is saying is accurate or not with no foundation for it.

MR. WESTBROOK: I thought cross examination was where the attorney got to testify. That is the way I was the way I was taught in law school. It's a leading question -- certainly it's a leading question. And I don't think I have to lay a foundation for a question. I just asked the question. He can say yes or no. He either is or he isn't. And then I may or may not follow up.

THE COURT: Thank you, Mr. Westbrook. I'm going to overrule your objection. Please go ahead and answer that question, Mr. Murphy. Do you know? Are you aware?

A: Well, I'm not -- what I'm aware of is -- and then my memory here is a little fuzzy. But within the last, it seems like a month, it could have been the last few weeks, I recalled some article in the Charlotte Observer about that topic. And I didn't read the article. And when you mentioned the 340(b) drug pricing, that sort of helped me better -- I recall seeing that in the paper, but I don't know any details about it.

Q: The 340(b) drug program is a federal program that provides nonprofit hospitals, the hospital systems with discounts for certain drugs; isn't that correct?

A: I believe so.

Q: And the idea behind the program is those discounts should be passed on to the citizens who are less financially well off than others, is that correct?

A: I believe so.

Q: And is the gist of Senator Grassley's investigation that CHS is not passing on those discounts?

A: Again, I don't know what his focus is. I just recall seeing an article, and that's about it.

Q: Thank you.

MR. WESTBROOK: I have no further questions.

THE COURT: Okay. Does the department have any questions of witness?

MS. BIGGERS: No, Your Honor.

THE COURT: Thank you, Ms. Biggers. Any redirect?

MS. ROBERTSON: Yes, Your Honor, I do have just a few.

THE COURT: All right.

MS. ROBERTSON: And I think it will be short, but I

those.

Q: Thank you. And in closing, Mr. Stewart, I want to -- let's pull back up Demonstrative 168.1 of the Petitioner. And if you could, remind us of what you believe was Mr. Levitt's assessment of the Carolinas financial criteria or the project review criteria with respect to the financials.

A: And as we've gone through all of those sort of demonstratives that were somewhat critical of CHS's financial statements, overall Piedmont's expert agreed with DHEC that CHS met all the financial criteria 6(a)(b) 7, 9, and 15 for the approval of the CON.

Q: And those checkmarks are from the Petitioner's Demonstrative Exhibit, is that correct?

A: That is correct.

Q: Thank you, Mr. Stewart. Please answer any questions Mr. Westbrook may have.

MR. WESTBROOK: I'm ready, Your Honor.

THE COURT: Yes, sir.

MR. STEWART - CROSS EXAMINATION BY MR. WESTBROOK:

Q: Mr. Stewart, good morning. How are you?

A: Good. How are you?

Q: Fine, thank you. Mr. Stewart, why don't we just start with just the last -- actually next

to the last demonstrative you were looking at, which is the one that was based on the audited financials. That is -- I can't remember the number.

MS. ROBERTSON: David, do you want us to -- I'd be happy to pull it up.

MR. WESTBROOK: Well, we could or I could just hand the hard copy. But yeah, if you don't mind doing it, that would be great.

MS. ROBERTSON: Glad to do it.

MR. WESTBROOK: Yeah, I'm not going to do too many of those, but I might do a couple of them. Let's look at that -- the one that was based on the approximate percentages.

MS. ROBERTSON: Is it 2010, 2011.

MR. WESTBROOK: Great, thanks. And I had a hard time seeing that on my little screen. So I'm going to move up here if I can and try -- as you said, your old man eyes. You are a lot younger man than I am, Mr. Stewart. Mr. Stewart, I know you explained some things about this demonstrative 2.22. This is the -- or the demonstrative based on the 2010-2011 audited financials I think; isn't that correct?

A: This is from the 2011, 2010 audited financial.

It is from the 2011 audited financial statements which includes results from 2011 and 2010.

Q: Okay. All right. And the very last line there is the end of year net assets, is that right? The last line item; end of year net assets?

A: Yes.

Q: Is that what that says?

A: Yes.

Q: It's hard for me to read it from here, and I can't read it on my monitor. And for 2011, the total reporting -- what does headline -- that heading on that column says total reporting entity; is that what it says?

A: I'm not sure which -- it's primary enterprise or are you looking above the primary enterprise?

Q: Well, let's start with 2011. At the top of the columns in bold face, each one of them says primary enterprise, the second one says combined component units. And what does the third one say?

A: Total reporting entity.

Q: Okay. For the total reporting entity column, what's the end of the year net assets? Can you

read that, please?
A: Not really. I think it's --
Q: Is it 3 billion and something.
A: It's -- yeah, it's 3 point, I think 5 billion.
Q: All right. And for the combined component units, what is it? Can you read that? Is it 800? I just can't see that.
A: I'm not sure what number you are looking at.
Q: I was looking at the combined component units end of the year net assets. So it's the very bottom of that column.
A: Oh, yeah, the middle column.
Q: Yeah, the middle column.
A: It looks like it's about $800 million.
Q: About $800 million?
A: Uh-huh (affirmative response).
Q: And for the primary enterprise, is that 2 point something?
A: Yes, $2.9 billion.
Q: $2.9 billion. Okay, thank you.
MR. WESTBROOK: Now, let's -- Dan, can I ask you to pull up, please, CHS-511. This is a -- I think you will recognize, Mr. Stewart, this is something from the CHS-Application. It says at the top "CMC-Fort Mill assumptions for

projected financial statements." And I am going to represent to you this was something produced to us -- produced -- well, not produced to us so much. It was submitted to DHEC. Do these look familiar to you?

A: Uh-huh (affirmative response).

Q: These the ones for your new current application, is that right?

A: I don't know if this is the most recent submission but --

Q: Well, take a look. Take a look. For example, does anything like the payer mix. Is that payer mix?

A: It looks accurate but --

Q: All right. Well, I'm going to ask you to assume that this is your --

MR. WESTBROOK: And uncross it, if I'm wrong, Ms. Robertson and correct me.

MS. ROBERTSON: Okay.

Q: These assumptions -- these are the assumptions upon which the pro forma projections are based; is that a fair way of saying it?

A: Uh-huh (affirmative response). Correct.

Q: And you went through and walked through how you created the pro forma budget for this

application, right?
A: Yep.
Q: So these would be the assumptions that were behind those pro formas, is that right?
A: Uh-huh (affirmative response). Yes.
Q: All right. Now, the assumptions, themselves, I believe you told me were provided to you by somebody from Mr. Murphy or someone in working his group, is that correct?
A: Which assumptions are you talking about?
Q: I'm sorry, the payer mix assumptions?
A: That is correct.
Q: All right. The -- the other assumption. Now, you got four categories, Medicare, Medicaid, managed care and other. And my understanding is that the other category is made up largely of self-pay and charity care; is that true?
A: Largely, yes.
Q: All right. Vast majority, right?
A: I don't know the exact percentages, but most --
Q: I wasn't asking for the exact percentages. Wouldn't you agree that the big majority is made of those two categories?
A: It is.
Q: Self-pay and charity. Okay. And there is a

difference between self-pay and charity; isn't there?

A: Yes.

Q: And that difference is that charity is somebody who qualifies under CHS's policy, or whatever the hospital is for charity care, is that right? So that's written off on the outset, is that right?

A: I mean, I would say that there is a bucket of uncompensated care. And in uncompensated care you have bad debt, which are people who can't pay or people who don't pay. You have charity care where people who can't pay. And you then you have charity care discounts which are, you know, people where you may have worked out a payment plan with us, some of the self-pay patients.

Q: And a self-pay patient is that -- who -- a self-pay patient who does not pay is what you call bad debt, is that right?

A: It depends on if they -- it depends on their financial picture. So there are -- I mean, there are criteria that determine whether that patient would fall into the -- either way, it's uncompensated care. And there is criteria as

to whether or not that patient is classified as charity care or bad debt.

Q: All right. Well, before we get to charity -- let's make sure of the distinction. You're making a distinction between charity care and bad debt, and I appreciate that distinction. I want you to educate me now on something else; the distinction between charity care and self-pay, okay? Is there a distinction between charity care and self-pay?

A: I mean -- I guess I'm not quite sure I understand the question.

Q: Is there a distinction between charity care and self-pay?

A: Well, I heard the question, but I'm not quite sure I understand the question.

Q: All right. I'm sorry. For somebody who doesn't -- for somebody who is uninsured and who does not qualify for charity care, what would you call that person? What classification would that person fall under? If they are uninsured and they don't qualify for charity care?

A: They could -- in our financials, they could be under a couple of buckets. They could be

either in the bad-debt category or they could be in the sort of category that we classify as self-pay discounts.

Q: I'm sorry. I didn't hear you.

A: Self-pay discount.

Q: Self-pay discount. All right. So those would be the two buckets. Self-pay discount and bad debt, is that right?

A: For the folks that don't --

Q: That don't qualify for charity care?

A: Correct.

Q: And most of the time you would get little or no reimbursement from those folks, is that correct?

A: I mean, it depends on what you are talking about.

Q: Well, I'm talking about, you know, reimbursement, getting paid for a hospital bill.

A: Well, I think if you look at self-pay for some of your lower acuity stuff that may occur in the hospital, like an x-ray, the difference in your collection rate may be a little higher than if you are in there from a car accident, and show up in the hospital and you're having

a major trauma, that could be significantly more in cost.

MR. WESTBROOK: All right. Let me ask Dan to pull up your trial testimony from the last trial.

A: Uh-huh.

Q: Perhaps you can explain this to me so I can understand it.

MR. WESTBROOK: And I'm asking -- Dan, how about pulling up Page 1652.

Q: Hold on just a minute and I'll give you a line. Page 1652. This is from your direct exam at trial. And let's start on Line 5, I think, and with that word "and." And I'm going to read your attorney's question to you during your direct exam and -- oh, I'm sorry, this is part of the answer. Never mind.

So let me go back up to 1651 to get the question. Page 1651, Line 23. That's where your -- the attorney asks the question. And then there is a fairly long response. And maybe if you could just read the answer into the record, Mr. Stewart and then comment on it. So the question on Line 23 of Page 1651 is. "All right. How about the other categories? How do they compare?" And just please read

your answer in.

A: Okay, sort of look -- I'm not sure what the other categories mean. Is it alright if I read higher than that before to understand the context?

Q: Sure. Uh-huh. In fact, why don't we go on up to -- you take your time to look at it. But let's go to Page 1651. And you see at the top of the page where it says, "Mr. Muller." I think that sort of starts that line of questions. Let's see if there is a -- just for the sake of time, maybe we don't have to go all the way. Let's start at Line 5, okay. I'm going to read the questions, and you just read the answers, okay. And you can comment on the answers or explain the answers. In fact, I'd like you to. But first of all, just for the record, we need to read this in verbatim, okay. Okay? Okay?

A: Sure.

Q: Okay. I'll be Mr. Muller. Question starting Line 5. "Do you see the category of net operating revenue?" Answer?

A: My answer in that testimony was, "yes."

Q: Can you just read it, please, verbatim without

commenting until we get through?

A: Sort of feels like I'm -- I guess --

Q: I'll tell you what, I'll read it in. That's okay. And then after I read it in, you can comment on it. So Line 5,

"Question: Do you see the category of net operating revenue?"

"Answer: Yes."

"Question: All right. Can you -- well, let's start with this. Can you explain to the Court what payer mix means?"

"Answer: Sure. What payer mix is, is payer mix represents the number of patients that you have for each one of the categories, so for Medicare, Medicaid, Managed Care, other."

"Question: In terms of the category that is most lucrative for a hospital, what category would that be?"

"Answer: Typically, the most of your margin occurs in from a managed care pair."

"Question: Most of your margin meaning profit margin?"

"Answer: Correct."

"Question: Okay, so managed care would be

the most lucrative?"

"Answer: Correct."

"Question: All right. How about the other categories? How do they compare?"

"Answer: Typically, Medicare -- typically with Medicare, you know, your goal is to break even. Or sometimes if you are very efficient, you can make some money on Medicare. Medicaid usually pays a rate that is -- does not cover your full expenses. And then self-pay includes, you know, includes your indigent care, your charity care, and your bad debt. And most of the time you are getting very little to no reimbursement for those categories."

That's all I want to read into the record. My question before we brought this page up was this. Well, I don't know precisely what my question was. So, let me ask it again and maybe it'll be somewhat close to my question. My question is, isn't from the self-pay bad debt categories, most of the time you get very little to no reimbursement in those categories; wouldn't that be true?

A: I would sort of go back to my previous answer.

It depends on what the procedure is. I mean, there are procedures that cost $100. You have procedures that cost $100,000. I mean, if it's a safe-pay $100 account, there is a pretty good chance that we should be able to collect it. If it's $100,000, probably not.

Q: Okay. But -- and I understand that it differs with individual patients and individual amounts. But it seemed to me in your testimony at the trial is that you were making a general statement that most of the time, more than -- or most of the time, as you say, you are getting very little to no reimbursement in those categories.

A: Our collection rates on self-pay, that whole uncompensated care bucket is lower than what it would be from other payers.

Q: Now, the charity care assumption of 6.3 percent of gross revenue, I think you testified that you were the one that came up with that assumption and you explained how you did it, right?

A: Uh-huh (affirmative response). That's correct.

Q: All right. And you based it, I think, on a weighted average from internal financial

statements, a weighted average from CMC-University and CMC-Pineville for 2009, is that right?

A: That's correct.

Q: Okay. Now, you did not -- when you came up with that 6.3 percent you only looked at those two hospitals, is that right?

A: That was what the weighted average was based on. I looked at more than just the two hospitals. But on weighted average, the number that was in our financials was based on those two hospitals.

Q: All right. And you based it on one year, 2009, is that right?

A: We based it on that year, but we looked at a series of years.

Q: All right. And you did not take into account, did you, the demographics of York County, and more specifically northern York County; did you?

A: Specifically -- when you say demographics, what do you mean by demographics?

Q: Well, I mean you are a health care planner, right?

A: Yeah.

Q: You know what demographics means. What does demographics mean to you?

A: Well, I think we had testimony that was very very different. We had people who talked about demographics in terms of inpatients and inpatient payer mixes. And we had people who talked about demographics in terms of average salary, average wages for people in that market.

Q: Well, let me ask you this. Regardless of the definition of demographics, did you -- when you came up with that 6.3 percent, did you factor in any demographics of York County regardless of definition?

A: I mean, it included Pineville. Pineville includes and serves a lot of population of the York County population today. So, in part, it's included there. But one of the things that I think is important to note is when you look at payer mix, the public data that is available on payer mix is inpatient. You know, you cannot look at public data on ED's payer mix. You can't look at public data on imaging payer mix. You can't look at public data on ambulatory surgery payer mix. Particularly in

South Carolina, it's not available. So 70 to 80 percent of our charity care comes from the outpatient setting. You know, we have drawn on our experience at other hospitals and what we are writing off in the charity care perspective.

Q: All right. When you came up with 6.3 percent, and you combined that weighted average, did you look at any employment data, employment date related to York County? Did you specifically take out any data about employment and look at it?

A: I did not.

Q: Did you look at it in any kind of population statistics specifically, particularly if there were any that were related to age factors. Did you look at that?

A: I did not.

Q: Did you look at any poverty or income --

A: Let me -- the age factors. I'm not sure how age factors would play into charity care. I know how it would play into the Medicare percentages, but I don't know how it would play into charity care.

Q: All right. Did you look at any income levels

for York County when you came up with that?
A: I didn't. And I think that's one of the things that is often misunderstood with income. Really income is not really reflective of an ability of a patient to pay. You could be a patient, you know, someone who makes $25,000 a year. But if you work for a company that offers insurance, the payment the hospital is going to get is the same as someone who makes $150,000 and has that same insurance working for that same company. So income is not always the best benchmark for estimating what charity care would be in a market.
Q: So I take it from your answer that you did not look at any specific income data, is that right?
A: I did not. That's correct.
Q: Okay. Did you look at any CPN or CHS employed physician payer mix data?
A: I didn't.
Q: Did you look at the percentage of charity care that other satellite hospitals in North or South Carolina provided during their first three years of operation?
A: I looked at what other providers were currently

paying. I didn't go through and look at other providers and other markets that were starting up new hospitals. I looked at other hospitals in the market and what they were seeing from a charity care perspective.

Q: And you relied on two of those hospitals: Pineville and University, right?

A: The assumption was built off of those two. But it was tested against lots of other hospitals.

Q: But you didn't -- if I understood your answer, you didn't look at the percentage of care provided by other satellite hospitals in South Carolina; did you?

A: We've used this term satellite hospital, and I don't view this as a satellite hospital. I view this as a community hospital. A satellite hospital to me implies is all you're doing is get patients from here and ship them out somewhere else. Our goal is not to ship patients out somewhere else. Our goal is to treat patients at this facility as much as possible.

Q: All right. Did you look specifically at any new hospital charity care data or new hospitals in South Carolina that have been started in the

last few years?

A: I did not look at new hospitals that had been started in the last few years in other markets. Once again, it's not a great benchmark, I don't think for what we would expect here.

Q: Okay. And you didn't look at or you didn't factor in the charity care listed on the cost reports. And you've given a number of reasons for that, is that correct?

A: That's -- well first, there was not that data available in 2010. It was not included in the cost reports at that point in time.

Q: All right. There was a demonstrative cost report income, and it's income is listed on its report to York County; do you recall that?

A: I do.

Q: It is -- looks like Demonstrative 2.8.

MR. WESTBROOK: Would it be possible to put that up for us?

MS. ROBERTSON: Yes, sir. We got it.

MR. WESTBROOK: Okay.

Q: Let's just take a look at that. And the difference is, if I understand the red lines, and you correct me. It appears that on Piedmont's cost report, it reported net income

of $15,266,000, is that right?

A: That's correct.

Q: And on it's report to the county, it reported net income of $9,160,000, is that right?

A: That's correct.

MR. WESTBROOK: I'm going to ask Dan to pull up our cost report, Piedmont's cost report for 2011. Is that an exhibit? Can someone tell me the number of that piece. It's 81? Let's pull up Exhibit 81, Dan; 81(b) to be precise.

Q: And let's just look at the top of the page and establish and make sure that's our 2011 -- Piedmont's 2011 cost report. Where does it say the year? There it is, okay. All right. Now, let's go to Bates Page 103. And if we go down to line -- looks like Line 26. Let's just take a look and see if that's consistent with the number on your demonstrative $15,266,176. Is that the net income reported by Piedmont on it's cost report?

A: Yeah, I believe that's what I pulled into that demonstrative.

Q: Right. So that's consistent with your demonstrative.

A: Uh-huh (affirmative response).

MR. WESTBROOK: Let's look now at the York County report for 2011. And I believe that would be Exhibit 17(c) Dan. Let's try for that.

Q: All right. And, yeah, this is the 2011 annual report to York County.

A: Uh-huh (affirmative response).

MR. WESTBROOK: All right. Let's go to Bates Page 362. And go down to the after tax income line. Actually, I think it's the third line or maybe the second line from the bottom.

Q: Figure $9,160,000; do you see that, Mr. Stewart?

A: I do.

Q: And that's in thousands. So that's actually 9 million, right?

A: That's correct.

Q: And that's the number that you had on your demonstrative, right?

A: That's correct.

Q: I'm showing you a different number from the 15 million on the cost report.

MR. WESTBROOK: Now, let's move up -- Dan, why don't you take that back down. And let's move up a few lines where it says, "listing for federal income taxes."

Q: Do you see that line?
A: I do.
Q: And that's 5,343,000, is that right?
A: It's 5,343,000, correct.
Q: All right. This is what Mr. Andrews calls a computer.
A: Thank you.
Q: And the next line under the federal income tax line is state income taxes, right? And that's 763,000, is that right?
A: That's correct.
Q: Could you add those two together, please?
A: Sure. 6,106,000.
Q: And could you add that to the 9,160,000 that's the after tax income.
A: It's 15,266,000.
Q: And that's the number that's on the cost report; isn't it?
A: That's sort of the point.
Q: Well, first of all, you can explain why it's the point. But first, is that the number on the cost report?
A: That is.
Q: All right. And so what's the point?
A: The point is that in the Medicare cost report,