

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

SC Court of Appeals

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

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APR 21 2017

S.C. SUPREME COURT

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.

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- 1 line separating opposing directions of traffic.
2 The white lines on the outside show that
3 there's a paved shoulder, a fairly wide paved
4 shoulder. And you can see the grass shoulders
5 beyond there with the undeveloped areas beyond
6 the shoulders. Pretty wide open stretch of
7 road. It's flat and straight, pretty flat.
- 8 Q: Okay. And as we're moving down, let us know
9 when we get close to the hospital site?
- 10 A: Okay. Both sides of the road here are peach
11 groves and you can see a sign on the right side
12 of the road, which is the sign for the future
13 Fort Mill Medical Center.
- 14 Q: All right. And if you turn to look to the
15 right, what do you see? Where is that in
16 relation to the hospital site?
- 17 A: That shows the portion of the hospital site
18 where you see the peach groves.
- 19 Q: All right. Now, have you seen the site plans
20 for FMMC, Fort Mill Medical Center?
- 21 A: I have. Yes.
- 22 Q: And how many entrances off US 21 are there
23 proposed in the site plan for the hospital?
- 24 A: The site plan shows three separate driveway
25 entrances from US 21 into the hospital center.

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RECORD 000491

1 Q: All right. Let's keep on going then down
2 towards the intersection with State 160,
3 please? And when we get to that intersection,
4 Dan, let's turn right onto South Carolina 160.
5 All right. What is this building on the right
6 that we're coming up to, Mr. Walsh?

7 A: That is the produce stand that sells peaches
8 and I believe they sell some other produce
9 also.

10 Q: All right. Is that the stand that you were
11 talking about you had been to before?

12 A: Yes.

13 Q: All right. What's going to happen to that
14 stand if the hospitals built?

15 A: My understanding is that it will remain in
16 operation and still sell produce.

17 Q: All right. Let's pan out to the right so we
18 can look behind that peach stand Dan, okay?
19 All right. Let's go back the way we were and
20 go down here and turn right.

21 A: Okay. As we approach the SC 160 intersection,
22 you can see the left-turn lane developed. You
23 can see the traffic light here and the traffic
24 moving through the intersection.

25 Q: All right. I'm sorry, go on up just a tad,

- 1 Dan. Now, what's over to the left?
- 2 A: Over to the left is a convenience store, gas
3 station and a convenience store.
- 4 Q: All right. Is it a truck stop?
- 5 A: It is not.
- 6 Q: Okay. Let's look over to the right. All
7 right. Is that the same building we looked at
8 a minute ago?
- 9 A: Yes.
- 10 Q: All right. Dan, let's drive on down South
11 Carolina 160 for a ways. And Mr. Walsh, what
12 do you see?
- 13 A: Okay. This is representative of -- fairly
14 typical of what SC 160 looks like. As you can
15 see, this is again, the multi-lane, four-lane
16 highway, two lanes in each direction. You can
17 see the grass median that separates the
18 directions of traffic which provides some
19 safety improvement as opposed to a double
20 yellow line. And just on up the road here, you
21 can see this dash line opening up to provide a
22 left-turn lane at the upcoming intersection.
- 23 Q: All right. And what does this turn left into?
- 24 A: That turns into Peach Lane.
- 25 Q: Okay. And that's a street, right?

- 1 A: That's a street that serves some residential
2 properties. I believe there's a few commercial
3 properties closer to the roadway.
- 4 Q: All right. Let's turn and look over to the
5 right now towards the hospital site, take a
6 look and see what we see over there. Anything
7 remarkable?
- 8 A: You can see just off the left edge of the
9 photograph there, you can see the sign for the
10 future Fort Mill Medical Center site..
- 11 Q: All right.
- 12 A: And a fairly flat piece of property where the
13 hospital site would be located.
- 14 Q: Okay. Good. Dan, let's go back to 160, keep
15 on going west, northwest. There's another
16 left-turn lane I see, what's that going to?
- 17 A: That's going into the next street, I believe
18 the street name will come up as you get close
19 to it.
- 20 Q: All right. Now, I asked you a minute ago about
21 entrances to the hospital site from US 21. How
22 many entrances to the hospital site from State
23 160?
- 24 A: There's one entrance onto 160 to the hospital
25 site. So the site plan has a total of four

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- 1 different access points shown.
- 2 Q: Okay. Let's keep on going. And I don't think
- 3 we need to go on out to the interstate. Mr.
- 4 Walsh, is anything else that you want to
- 5 comment about this highway? Do we need to go
- 6 any further at this point?
- 7 A: No, I think that is pretty good representation
- 8 of what's out there.
- 9 Q: All right. It looked like, you said you went
- 10 several different times of day and several
- 11 times to this site. What you're seeing here
- 12 representative or typical of what you saw?
- 13 A: Fairly representative.
- 14 Q: All right. What's the capacity on US 160, I'm
- 15 sorry, US 21, the one that goes north-south,
- 16 the two-lane road?
- 17 A: Well, from a planning perspective in the very
- 18 initial stage, when we look at a two-lane
- 19 roadway, we generally consider the capacity on
- 20 a daily basis that a two-lane roadway can
- 21 handle up just over 12,000 vehicles per day.
- 22 Q: All right. And do you how many cars or
- 23 vehicles actually travel on a daily now on US
- 24 21?
- 25 A: The most recent traffic count on 21 is just

1 over 6,000.

2 Q: All right. So what percentage of that is the
3 capacity of that?

4 A: Just about 50 percent capacity.

5 Q: What's the capacity on the four-lane, South
6 Carolina 160?

7 A: Four-lane roadway would typically be able to
8 handle about 28,000 vehicles per day.

9 Q: All right. And what's the current vehicular
10 use on that?

11 A: The current traffic volume is just over 17,000
12 vehicles per day.

13 Q: All right. Okay. Good. Well, let me ask you
14 before we go anywhere. No, I'm sorry. Let's
15 go the aerial view again, Dan. And let's go to
16 that intersection. Good. Now, where is the
17 CMC-Fort Mill site geographically in relation
18 to this site?

19 A: It's at the next exit south of SC 160 and I-77.

20 Q: All right. Dan, let's drive up to the
21 interstate and then let's head south on the
22 interstate. And Mr. Walsh, you stop us when we
23 get to the right place.

24 A: This is the interchange with Sutton Road here.

25 Q: Okay. What's the name of the road, I'm sorry?

1 A: Sutton Road.

2 Q: Okay. All right. Now, we see the interstate,
3 where do you understand the proposed CMC-Fort
4 Mill site is located?

5 A: The site that I've seen is right here in the
6 southwest quadrant of the interchange.

7 **MR. GASKINS:** Your Honor, I'm going to object to
8 this testimony to the extent that it relates to
9 the CHS site which as of yesterday has not been
10 reviewed by Mr. Walsh prior to his deposition.
11 Also, as we argued yesterday, his opinions
12 regarding the site are limited to the access
13 points and the proximity to the truck stop. So
14 I believe his testimony should be limited to
15 those areas which we would have the chance to
16 depose him on. Since his deposition they've
17 had no supplemental production or anything to
18 lead us to believe that they have developed any
19 further and/or reviewed any further
20 information.

21 **THE COURT:** Mr. Westbrook?

22 **MR. WESTBROOK:** As we discussed yesterday, his
23 opinions related to the CHS site have to do
24 with access points. His opinions relate to the
25 proximity of the site to the interstate and to

1 the truck stop. That's what he's about to do,
2 is to explain the bases for those opinions
3 which as I said yesterday are largely not based
4 on documents. To some extent, they're based on
5 documents but they're largely based on his
6 observations and his knowledge and experience
7 as a transportation engineer. He's going to
8 explain that in just a minute. And I would say
9 that Mr. Gaskins' objections, I would have the
10 same response as I did yesterday. They would
11 go the weight, he's welcome to cross-exam Mr.
12 Walsh about his opinions, the bases for those
13 opinions. They haven't changed since his
14 deposition, Your Honor. He wasn't asked
15 everything that he based his opinions on. He
16 was asked what his two main opinions were and
17 he gave them. He said the site in his opinion,
18 is too close to the interstate and too close to
19 the truck stop. And there's a lot of sort of,
20 you know, bases for those opinions, but they're
21 not based on, you know, some traffic impact
22 study or anything like that, so that's what I'm
23 saying.

24 **MR. GASKINS:** Well, Your Honor, to the extent that
25 it's limited to his prior opinions, I see no

1 objection. But, I believe, from what I'm
2 hearing I believe it's going to go beyond, much
3 further than what he testified to during his
4 deposition. And I would reserve my objections
5 until then, if need be.

6 **THE COURT:** I'm going to overrule your objection.
7 And let you proceed with the question.

8 **MR. WESTBROOK:** Thank you, Your Honor.

9 Q: All right. So that sort of big circle area is
10 roughly where the proposed CHS site is, is that
11 correct?

12 A: Correct.

13 Q: All right. Now, what is the development across
14 Sutton Road? And Sutton Road is the name of
15 that road there that's heading, it looks like
16 almost north-south, but to some extent east-
17 west, is that right?

18 A: Sutton Road runs kind around this way.

19 Q: All right. What's the development on the other
20 side of the hospital site?

21 A: This development here is Love's Plaza; it's a
22 truck stop.

23 Q: Now, have you been to this site before?

24 A: I have.

25 Q: And let's take off the markings, if you will,

1 Mr. Walsh. And how many times have you been to
2 this site? Well, let me start off by asking you
3 at the time of your deposition how many times
4 had you been to that site?

5 A: I had been to the site one time.

6 Q: Okay. Was it once or twice?

7 A: I guess it was twice.

8 Q: Would you rely on whatever you said in your
9 deposition?

10 A: Yes.

11 Q: All right. How many times have you been since
12 then?

13 A: I've been there a total of six times now.

14 Q: All right. Have you familiarized yourself in
15 any way with the history of Love's Truck Stop
16 and the way it's grown over the years?

17 A: Yes. We've evaluated using Google Earth aerial
18 photographs at different time periods from 2005
19 to present to evaluate construction and growth
20 of that site.

21 Q: And is that relevant to your opinion?

22 **MR. GASKINS:** Your Honor, I'm going to object. He
23 was asked during his deposition what Google
24 Earth photos he looked at and he admitted to
25 one; it was a 2013 photo. Now, he's talking

1 about photos going back to 2005, clearly this
2 is opinions that he has developed since that
3 time. So I would renew my objection at this
4 time.

5 **MR. WESTBROOK:** I'm about to ask him how's that
6 relevant to his opinion which is related to
7 access points which is what he testified more
8 of his opinions in the deposition. So I've
9 laid a foundation for that.

10 **THE COURT:** I understand. Mr. Gaskins, your
11 objection is that apparently he's going to be
12 talking these access points which he was asked
13 about it in his deposition, is that right?

14 **MR. GASKINS:** Yes, Your Honor.

15 **THE COURT:** But your objection is that you think
16 he's going to talk about the basis other than
17 what he told you was the basis of his opinion
18 at the time of his objection.

19 **MR. GASKINS:** Exactly, Your Honor. And we heard
20 similar arguments yesterday from the other side
21 prior to starting the trial, that they objected
22 to any testimony that had not been produced and
23 we would rely on our witnesses. So the extent
24 that, you know, it's good for their -- our
25 experts can't rely on new information, develop

1 new opinions. I think the same should apply to
2 them.

3 **MR. WESTBROOK:** Your Honor, I think the principle
4 here is - well, I'll tell you the first one --
5 I don't think -- I think it's important in a
6 deposition that an expert be able to give his,
7 what his opinions are and what his major
8 sources or bases for those opinions are. So we
9 don't sandbag or surprise, which I think is a
10 violation of the rules of discovery. I don't
11 think that an expert is prohibited after his
12 deposition from finding new sources of
13 information, if they come up. Sometimes in a
14 response to what other people say in other
15 depositions on the other side or as long as his
16 opinions don't change in a significant way and
17 as long as the sources for those opinions don't
18 change in a significant way. Now, what's he
19 going to testify about is that the access
20 points to this proposed site are too close to
21 the interstate and too close to the truck stop.
22 That's what he said at his deposition. When he
23 was asked what he had reviewed at the time of
24 the deposition, he said I reviewed -- I can't
25 remember exactly what he said, I'm sure Mr.

1 Gaskins will point it out to us. And he can
2 point that out on cross if he wants to. If he
3 wants to impeach, you know, what Mr. Walsh
4 says, I mean, cross is the time to do that. I
5 know he referenced to Google Earth, I don't
6 know how specifically. I don't remember him
7 saying I looked at one Google Earth photograph,
8 maybe he did. Mr. Gaskins said he did and I'll
9 take his word for it. But I don't think he's
10 prohibited from looking at other Google Earth
11 photos once the deposition is over with. So
12 that's my position. I think this is relevant
13 to his opinion. It supports his opinion. It
14 shouldn't be a surprise that he would be
15 looking at Google Earth photographs once he's
16 made that statement at his deposition. And,
17 you know, again, it goes to the issue of
18 whether this is a good site or not. And it
19 goes to his opinion as to whether this is a
20 good site.

21 **THE COURT:** All right. Mr. Gaskins?

22 **MR. GASKINS:** Yes, just briefly, Your Honor. The
23 fact is we subpoenaed Mr. Walsh to provide all
24 the documents he relied on. He hasn't provided
25 any of these. I asked him during the

1 deposition what he looked at. He said Google
2 Earth, he said it was a 2013 photo. So to
3 argue that there's no surprise or no prejudice
4 is just not the case. He's going to testify
5 about what he looked at and I don't have that
6 to cross-examine him. And if they would have
7 produced it, yes, then I think they had a
8 better argument. But the fact is, we haven't
9 seen these documents. We don't know what he's
10 going to testify about. And I don't have it
11 here to cross-examine him or impeach him.

12 **MR. WESTBROOK:** If I can respond briefly, Your
13 Honor. This is not evidence. This is Google
14 Earth, it's a Demonstrative to better
15 illustrate his testimony. It is not something
16 that Mr. Walsh created; it's an illustration,
17 not an opinion.

18 **THE COURT:** At this time, Mr. Gaskins, I'm going to
19 overrule your objection. I'm going to give you
20 every opportunity to examine Mr. Walsh to the
21 bases of his opinion. I'll allow you to ask
22 him what, if anything, he looked at after his
23 deposition that changed his opinion, bolstered
24 his opinion, or anything of that nature. At
25 that time, if you feel -- we'll explore, if you

1 feel that this information left you at some
2 disadvantage, we'll explore remedies that you
3 can use to bring information in, if you feel
4 that's necessary to support your position at
5 that time. But at this time, I'm going to go
6 ahead and overrule the objection and allow him
7 to testify as to that.

8 **MR. GASKINS:** Thank you, Your Honor.

9 **MR. WESTBROOK:** Thank you, Your Honor.

10 **THE COURT:** Go ahead, Mr. Westbrook.

11 Q: Mr. Walsh, have you looked at Google Earth
12 material that would illustrate the growth of
13 Love's Truck Stop over the years?

14 A: Yes.

15 Q: All right. Is that helpful to you in
16 explaining your opinions on this case?

17 A: Yes.

18 Q: All right. Dan, let's go back to the earliest
19 view of Love's Truck Stop we have? All right.
20 Mr. Walsh, what's the date on this?

21 A: I believe it's 2005, but I'm having trouble
22 seeing the date.

23 Q: Dan, is there anything you can do to bring that
24 date out, highlight it or anything? Anything
25 clearer on your monitor?

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1 A: Yes, it looks like a date. I'm still having
2 trouble reading it but I think it says 2005.
3 I can see it now. It's come up on my screen.
4 It's June 14, 2005.

5 Q: All right. Thank you. And what do you see
6 there?

7 A: You see a street and cul-de-sac and the site
8 area that is now occupied by the truck stop but
9 it's been cleared but it's not developed yet.

10 Q: All right. Let's go to the next one, Dan. All
11 right. Can you see the date on this?

12 A: This is dated June 13, 2005.

13 Q: Okay. Let's see if we can move a little beyond
14 2005. What's the next one?

15 A: Okay. This is June of 2006. And you can see
16 the site has been paved. You can see the truck
17 stop as being constructed up to just before you
18 get to the cul-de-sac at the end of the street.

19 Q: All right. Let's move on, Dan.

20 A: This is a clear image dated November of 2006.

21 Q: All right. Let's keep going, Dan. All right.
22 What's the date?

23 A: Okay. This is dated 2010.

24 Q: Okay. 2010?

25 A: That's correct.

1 Q: What's the next one, Dan?

2 A: And this is date June of 2011, where you can
3 see at the end of the cul-de-sac where the
4 parking areas for the truck stop before there's
5 a new auxiliary parking lot here that was built
6 between 2010 and 2011.

7 Q: Okay.

8 A: It showed the expansion of the site.

9 Q: All right. Is there another one or is that it?
10 Is there one that's up-to-date?

11 A: There should be one that's up-to-date. This
12 one's dated 2012.

13 Q: Okay. Take your circle off, if you don't mind?
14 That's dated what?

15 A: 2012.

16 Q: Okay. Good. All right. Now, let's go back
17 out to -- we're looking at the aerial view of
18 Sutton Road there with the truck stop. Show us
19 the principle entrance to the truck stop, Mr.
20 Walsh?

21 A: It's located right where the hand was. This is
22 the driveway into the truck stop at Sutton
23 Road.

24 Q: All right. And directly across from that
25 driveway, do you remember the name of that

- 1 little street or driveway?
- 2 A: The truck stop drive?
- 3 Q: Yeah.
- 4 A: It's Sutton Ridge Lane.
- 5 Q: Sutton Ridge Lane, directly across from Sutton
- 6 Ridge Lane, do you see something over there?
- 7 A: There's a frontage road entrance and you can
- 8 barely see it through the trees. It comes in
- 9 and turns and runs down into here.
- 10 Q: All right. So when I say frontage road, that's
- 11 what I'm going to be referring to, okay, Mr.
- 12 Walsh?
- 13 A: Yes.
- 14 Q: All right. Now, let's take off your purple
- 15 marks for a minute. And Dan, can you pull us
- 16 out a little higher up. Okay. Mr. Walsh, what
- 17 does the Kanawha site refer to?
- 18 A: The Kanawha site is a development that's been
- 19 proposed encompassing the proposed hospital
- 20 site, as well as a larger area of land that you
- 21 can see on this drawing here.
- 22 Q: All right. Can you kind of just roughly give
- 23 us, again, just a rough approximation of the
- 24 boundaries of the Kanawha site?
- 25 A: Yes, it's bounded by the interstate, the

- 1 Catawba River, and I don't know the exact
2 boundary of the property up here but it does
3 encompass some of these local streets here and
4 Sutton Road.
- 5 Q: All right. And what is your involvement been
6 with the Kanawha site?
- 7 A: I was involved -- approximately in 2008 we were
8 enlisted, our services were enlisted to
9 evaluate the traffic generated by the site.
- 10 Q: All right. And who enlisted, when you say
11 enlisted your services, what do you mean?
- 12 A: We were employed by a firm by the name of Land
13 Design.
- 14 Q: Okay. Land Design?
- 15 A: Land Design.
- 16 Q: Where are they headquartered?
- 17 A: They're headquartered in Charlotte.
- 18 Q: All right. Who is the person in charge of that
19 project for Land Design?
- 20 A: His name is Theron Pickens.
- 21 Q: All right. And the Kanawha site development,
22 do you know what the current status of that is?
- 23 A: I don't know what the current status of it is.
- 24 Q: All right. Your involvement ended in 2008, is
25 that correct?

- 1 A: That's correct.
- 2 Q: All right. At the time that you were involved,
3 were you aware that there was a hospital being
4 proposed as part of the site?
- 5 A: No, sir. The site plan that we did our study
6 work on did not include a hospital.
- 7 Q: All right. Let's take a look Dan, at CHS, I
8 guess this would be CHS Exhibit 1, Bates page
9 524. And would you take off your purple
10 circle, please, sir? Thank you. All right.
11 What is this, Mr. Walsh?
- 12 A: This plan shows the proposed CHS site.
- 13 Q: All right. And it also shows, I believe, a
14 2005, something that's identified as a 2005 CHS
15 site, but we won't worry about that one. Let
16 me just ask you to focus on what's been labeled
17 as a 2010 CHS site in that yellow geometrical
18 figure, that's sort of like a triangle but I'm
19 not sure it's exactly a triangle. Now, orient
20 us a little bit. It's obviously easy the
21 interstate, where is Love's Truck Stop?
- 22 A: It's inside this pink circle here.
- 23 Q: All right. Where is the frontage road that you
24 were referring to a minute ago?
- 25 A: Right here.

1 Q: All right. And that goes back to what CHS has
2 identified as its site, is that correct?

3 A: That's correct. This lighter area that you see
4 extending from the end of the pink line I drew
5 was the site plan's extension of the frontage
6 road, down and across the frontage to the
7 hospital site.

8 Q: All right. Now, let's take a look at CHS 163.
9 Now, you testified at your deposition you had
10 not looked at the site plan, is that correct?

11 A: That's correct.

12 Q: After you were asked that at your deposition,
13 did you look at the site plan?

14 A: Yes.

15 Q: All right. Now, the site plan that's there, is
16 that the same roughly the same geometrical
17 figure that we looked at a minute ago?

18 A: It is.

19 Q: It's just oriented directionally differently
20 though, isn't it?

21 A: Correct.

22 Q: All right. Show us where the interstate is and
23 Sutton Road is?

24 A: Okay. You can see up here the north arrow
25 pointing towards the bottom left of the screen.

1 This is Interstate 77 that's heading northbound
2 in this direction. This is Sutton Road.

3 Q: Okay. Where's the truck stop?

4 A: The truck stop is in the bottom right corner of
5 the screen.

6 Q: Is that where that arrow is, is that Sutton
7 Ridge Lane?

8 A: That's Sutton Ridge Lane.

9 Q: All right. Where's the frontage road?

10 A: And the frontage road and the development
11 access drive which will become the development
12 access drive is built this way, it's located
13 here.

14 Q: All right. And the front part of that
15 geometrical figure is, in fact, a triangle.
16 And what's labeled there in the middle?

17 A: It's labeled medical office building.

18 Q: Okay. What's in the back portion of that
19 figure there is something labeled hospital,
20 right?

21 A: Here is the label for hospital.

22 Q: And how many entrances are proposed to the
23 hospital?

24 A: There are three driveways connecting the
25 development access road to the hospital.

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- 1 Q: Now, those three driveways, you weren't aware
2 of where those were located until you saw the
3 site plan after the deposition, is that
4 correct?
- 5 A: That's correct.
- 6 Q: Do those three driveways, entrances into the
7 hospital site, have any bearing on your
8 opinions in this case?
- 9 A: No, we did not evaluate those driveways.
- 10 Q: All right. Does the location of Sutton Ridge
11 Lane and the frontage road have something to
12 do, any relevance to your opinions?
- 13 A: Yes.
- 14 Q: All right. Let's go back out, Dan, to Google
15 Earth. And let's go down to the street view of
16 Google Earth, and let's go on the other side of
17 the interstate so we get a kind of head start
18 on things, there at River Crossing Drive, I
19 believe. Is that where River Crossing Drive
20 is, Mr. Walsh?
- 21 A: Yes.
- 22 Q: Okay. So that's on eastern side of the
23 interstate, is that correct?
- 24 A: That's correct.
- 25 Q: And let's drive towards the interstate and

1 towards the hospital site and towards Love's
2 Truck Stop and tell us what you see?

3 A: Okay. As you're heading towards the interstate
4 you can see a right-turn lane on the side of
5 the road over here toward traffic to turn right
6 on the northbound 77. These are the ramps,
7 this is the northbound off-ramp, this is the
8 northbound on-ramp to Interstate 77.

9 Q: All right. So you turn right, you're heading
10 towards Charlotte, right?

11 A: If you turn right here, you're headed to
12 Charlotte.

13 Q: And if you're coming off the off-ramp, you've
14 been coming from the south, like from Columbia?

15 A: That's correct.

16 Q: Okay. Keep going.

17 A: Okay.

18 Q: All right. What do you see Mr. Walsh?

19 A: Okay. Right here you can see a truck heading
20 towards us, heading away from the west side of
21 the interstate where the Love's Plaza is,
22 heading towards the interstate. It looks like
23 he's getting ready to turn left and go
24 northbound. He's in the left-turn lane.

25 Q: Keep going, Dan. All right. What are we

1 approaching here?

2 A: We're approaching the bridge over the
3 interstate at this point. On your left you can
4 see a concrete median that separates the
5 westbound traffic from the eastbound traffic.

6 Q: All right.

7 A: Okay. This is crossing over the interstate at
8 this point. And you can see the concrete
9 median pushing away from the direction of
10 traffic that we're tracking in here to make
11 room for a left-turn lane that would allow for
12 traffic to turn left and head southbound on
13 Interstate 77.

14 Q: All right.

15 A: Now, here we're approaching the southbound
16 ramps. On the right is the southbound off-
17 ramp. And you can see a heavy vehicle, a truck
18 getting ready to turn off of the interstate.
19 He's coming from the north, from Charlotte
20 direction heading southbound and taking this
21 exit.

22 Q: All right.

23 A: And here we are at the ramps. The truck is
24 making his turn in front of the vehicle taking
25 the photographs. And here you can see the

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1 entrance to Love's Plaza and there's another
2 truck you can see just behind the pink dot
3 turning from Love's Plaza and making a left
4 onto Sutton Road heading back towards the
5 interstate.

6 Q: Now, is that truck coming out of Sutton Ridge
7 Lane?

8 A: He is.

9 Q: Okay. Let's look to the right, Dan. Mr.
10 Walsh, what's that over there?

11 A: This is the Sutton Ridge Land and the truck
12 stop. You see another truck heading up towards
13 the stop sign. And then off in the horizon,
14 you can see the trucks lined up at the fueling
15 stations.

16 Q: Okay. Can you take your purple dot off now,
17 Mr. Walsh? Thank you. All right. Dan, let's
18 go a little bit further. One more time, look
19 to the right, please Dan. All right. And
20 what's on the left across the street from
21 Love's. I don't know if the truck cleared.
22 What's that?

23 A: Okay. You can see a little gravel shoulder
24 area and a gate. This is the entrance into the
25 frontage road.

- 1 Q: And that's the frontage road that's the way to
2 get back to the hospital site?
- 3 A: Correct.
- 4 Q: Okay. All right. Let's continuing heading
5 west or northwest on Sutton Road. All right.
6 Describe for us what's that?
- 7 A: You can see Sutton Road left, the arrow in the
8 pavements for a left turn lane for vehicles
9 turning left into Sutton Ridge Lane and into
10 the truck stop area.
- 11 Q: All right.
- 12 A: You can also see that the shoulders are not as
13 wide as US 21 with the tree line, they're
14 pretty up close to the road there.
- 15 Q: Okay. Is there a street coming up here?
- 16 A: Yes, we're approaching the intersection with
17 Frances Circle is on the left and Country Lodge
18 Road on the right. And you can see off to the
19 right some residences that are ---
- 20 Q: What kind of area is this on either side of the
21 street here?
- 22 A: It's kind of an older residential community,
23 typical fairly small to medium-size ranch style
24 homes.
- 25 Q: All right.

- 1 A: Probably 30 or 40 years old. I don't really
2 know.
- 3 Q: Okay. Do we have any further need for Google
4 Earth?
- 5 A: No, I don't think so.
- 6 Q: Okay. Let's go, Dan, I think we can go to
7 Demonstrative 41. Is this another chart that
8 you prepared?
- 9 A: It is.
- 10 Q: All right. And this is not drawn to scale or
11 anything is it?
- 12 A: No.
- 13 Q: Okay. Now, does this help explain your
14 opinions with respect to the proposed CMC-Fort
15 Mill site?
- 16 A: Yes, it does. The distance you can see shown
17 between Sutton Ridge Lane and Interstate 77
18 southbound ramps is shown as 300 feet.
- 19 Q: How do you know it's 300 feet?
- 20 A: I measured it.
- 21 Q: All right. And that's the distance you said
22 from Sutton Ridge Lane, is that also the
23 distance from the frontage road?
- 24 A: Yes.
- 25 Q: All right. Now, what's the significance of 300

1 feet?

2 A: Well, 300 feet to interstate ramps is, first of
3 all, it's below the guideline for distance
4 separating intersections from interstate ramps.
5 The DOT manual shows a minimum of 750 feet for
6 a full access intersection.

7 Q: All right. Now, why is in your opinion, why is
8 that an issue here?

9 A: Well, my opinion has always been revolving
10 around two basic issues, safety and operation.

11 Q: So how does that affect safety and operations?

12 A: Well, first of all, the separation between
13 intersections is necessary to allow a driver to
14 navigate through one intersection and deal with
15 the conflicts of turning vehicles, making
16 decisions and getting through there and back
17 onto the open road before they identify and
18 come into contact with another conflict point.
19 So a driver needs to take all of that driving
20 through an intersection, get that behind them
21 and have time to focus on the next intersection
22 while their driving and then make a decision at
23 the next decision point.

24 Q: All right. And I understand that is a sort of
25 conceptual framework, but how does that apply

1 to this site?

2 A: Well, in this site in particular, you have an
3 interchange with a interstate which is
4 typically -- arterials along the interstate are
5 one of the most heavily congested locations in
6 a transportation system. As these areas
7 develop we continue to have problems with them.
8 The arterials we have that are already
9 developed and we have a number of them in this
10 location through Rock Hill. The next one to
11 the south, exit 82, has a similar situation
12 where the nearest side road is 300 or 400 feet
13 away. That particular interchange, the
14 congestion that's caused on the arterial by
15 traffic volumes and by the nearest
16 intersection, it backs traffic up on the
17 southbound ramp all the way up onto the
18 interstate sometimes and blocks traffic on the
19 interstate.

20 Q: There are no hospitals at those interchanges,
21 right?

22 A: There are not.

23 Q: Okay. Let's take a look at Petitioner's
24 Exhibit 1, Bates page 862. You referenced a
25 DOT manual a moment ago. What is this?

- 1 A: This is DOT's ARMS manual. That's an acronym
2 for Access and Roadside Management Standards.
- 3 Q: All right. Is that a manual that you've had
4 occasion to work with?
- 5 A: Yes, we use it on a regular basis.
- 6 Q: All right. Let's go to Bates page 863, Dan.
7 And is this a page from that manual?
- 8 A: Yes, it is.
- 9 Q: Dan, how about highlighting or bringing up that
10 first paragraph, please? All right. Mr.
11 Walsh, I'm going to ask you to read the first
12 couple of sentences in that paragraph and then
13 comment on that, how those sentences relate to
14 the CMC-Fort Mill site?
- 15 A: Sure. This particular paragraph introduces the
16 Department's guidelines on access placement and
17 interchange areas as it's labeled. This
18 specifically relates to intersections near the
19 interstate system. The opening paragraph
20 states: Adequate spacing and design of access
21 points near freeway interchanges is important
22 to avoid traffic queues and conflicts near
23 interchange ramp turns. When access points are
24 too close to the ramp turn line, heavy weaving
25 volumes, complex signal traffic operations,

1 frequent accidents and recurrent congestion
2 generally results.

3 Q: All right. What is the reference to heavy
4 weaving volumes, what does that mean from a
5 engineering perspective?

6 A: Well, when you have closely spaced
7 intersections and you have traffic, for
8 instance, you have traffic on the right side of
9 the road that's trying to turn left, and the
10 traffic on the left side of the road that wants
11 to turn right, you end up with traffic trying
12 to cross, pass each other, which creates a
13 weave.

14 Q: All right. And then right after that phrase,
15 there's another phrase, complex traffic signal
16 operations, what is that?

17 A: Well, again, when we have intersections that
18 are placed too closely, less than a 1,000 feet
19 typically, the backups from one signal, when
20 the light is red, the backups can backup and
21 restrict the flow of traffic through the next
22 nearest traffic signal. So generally, what we
23 look for to produce good arterial traffic
24 movement is traffic signals spaced no closer
25 than 1,000 feet or quarter mile.

- 1 Q: Okay. Now, let's take a look at the bottom
2 half of this page, please? All right. And
3 there's a little chart down there, Mr. Walsh,
4 you see that? What's the reference to 750
5 feet? How is that relevant to what you're
6 saying?
- 7 A: That, again, the description through 750 feet
8 is the distance from the closest interchange
9 ramp to the first full access location.
- 10 Q: All right. Is that a recommended distance or
11 a minimum distance or how would you
12 characterize that?
- 13 A: I would call that a minimum distance.
- 14 Q: All right. And remind us again, what's the
15 distance between the frontage road and the
16 interstate ramp?
- 17 A: 300 feet.
- 18 Q: All right. Now, does DOT have the authority in
19 your experience to waive that requirement, that
20 750 foot requirement?
- 21 A: Yes, they can.
- 22 Q: All right. Have you seen any documentation in
23 this case related to this site from the
24 Department of Transportation waiving or
25 permitting the frontage road as a hospital

1 entrance here?

2 A: No.

3 Q: All right. Let's take a look at Petitioner's
4 Exhibit 115, please? And, again, I believe
5 that's already been admitted without objection.
6 All right. This has DOT letterhead on the
7 front. Who's this letter from specifically at
8 DOT?

9 A: The letter is from the district engineering
10 administrator, John McCarter, and signed for
11 him by Greg Shaw, who is the district traffic
12 engineer.

13 Q: All right. Do you know these two gentlemen?

14 A: I know both of them very well.

15 Q: All right. And have you worked with them over
16 the years?

17 A: I've worked with them consistently throughout
18 my career.

19 Q: All right. Let's go back to the top of the
20 front page, the first page. Who's the letter
21 to?

22 A: The letter is addressed to Theron Pickens at
23 Land Design.

24 Q: All right. And I believe you've already
25 mentioned Mr. Pickens, remind us who he is?

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1 A: He works for Land Design and they were the
2 planning firm involved with the Kanawah project
3 and the design of the development of that
4 piece of land.

5 Q: And is he the person, is that firm that
6 retained you and your firm?

7 A: That's correct.

8 Q: All right. What's the date of this letter?

9 A: February 9, 2011.

10 Q: Okay. And, again, the subject matter of this
11 letter I forgot to go over a moment ago. Dan,
12 could you pull that out again, please?

13 A: Yes, the subject matter of this letter is
14 regarding the Kanawha site.

15 Q: All right. Now, this letter, of course,
16 involves you just said the Kanawha site. In
17 your opinion, though, does it have some
18 relevance to the hospital site, which
19 encompasses, which is part of the larger
20 Kanawha site?

21 A: It does, because it references the one entrance
22 located across from the Love's Plaza entrance
23 on Sutton Ridge Lane.

24 Q: All right. I believe you've highlighted two or
25 three relevant bullet points in this letter.

1 Let's go those highlights and you explain why
2 you've highlighted them please? What's the
3 first highlight or bullet point?

4 A: Okay. The first bullet point that's
5 highlighted reads: The current frontage road
6 drive is an overgrown two-way lane, 20 to 24
7 feet wide. We understand the development's
8 desire to match the Love's plaza drive but in
9 that process this should remain a minor roadway
10 and/or drive.

11 Q: Okay. Now, let's go to the next bullet point
12 that's highlighted. What does that say?

13 A: The next bullet point states: SCDOT currently
14 does not have any plans to signalize the
15 easternmost drive at Love's Plaza now or in the
16 future.

17 Q: All right. The term, signalize, does that mean
18 traffic signals?

19 A: That means traffic signals.

20 Q: Okay. Red light, green light?

21 A: That's correct.

22 Q: Okay. I'm going to keep that in your head and
23 ask you about that in a minute. But first, let
24 me go to the last bullet point you've
25 highlighted on the next page.

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1 A: Okay. This last bullet point reads: Traffic
2 impact analysis of the large scale development
3 for this site calls for traffic signals at each
4 I-77 exit ramp -- that means northbound ramps
5 and the southbound ramps. We feel that these
6 signals should be included in the scope of
7 traffic mitigation for future phases of this
8 development.

9 Q: All right. Now I'm going to ask you about this
10 bullet point and the just previous to this.
11 This one indicates that signals, refers to
12 signals at the exit ramps. What's the
13 significance of that?

14 A: Well, what this is saying is the DOT is
15 directing Mr. Pickens and his client that the
16 development of the Kanawha site will require
17 signalization of the ramps. So at some point
18 in the development, when they develop enough
19 traffic to warrant signalization, both of those
20 ramps will have to be signalized at the cost of
21 the developer.

22 Q: All right. And what does this letter say about
23 the traffic signal at the frontage road-Sutton
24 Ridge Lane intersection?

25 A: That's somewhat tied together because what

1 they're saying is that they're going to
2 signalize the ramps at the interstate. And
3 with Sutton Ridge Lane and the entrance into
4 the hospital site being only 300 feet away that
5 would preclude any opportunity to signalize
6 that entrance. And that's the reason for their
7 first bullet point on the other page is that
8 they're going to have to signalize the
9 interstate ramps. So there's no way that
10 signalization of Sutton Ridge Lane could ever
11 occur.

12 Q: Okay. Now, with respect to your opinion about
13 access to this site and the proximity of the
14 frontage road to the interstate ramp, how do
15 these bullet points -- well let's just take
16 them one at a time. If there are no traffic
17 signals at the intersection of the frontage
18 road and Sutton Road, how does that affect your
19 opinion with respect to safety and congestion?

20 A: Well, when you look at current operations at
21 Sutton Ridge Lane, there's already some
22 difficulties in making traffic movements to and
23 from that stop sign-controlled intersection.
24 As you're coming down Sutton Ridge Lane, you've
25 got to come from a stop sign and make your turn

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1 from a stop. Traffic is free-flowing.

2 Q: You're talking a truck?

3 A: On Sutton Road. I'm just talking about traffic
4 in general. Developing the other side is going
5 to now take a three-way intersection and make
6 it four ways. You're still going to have stop
7 signs. You're never going to signalize it.
8 And as the traffic growth continues or this
9 Kanawha development or whatever happens to all
10 that land as it develops, the development will
11 bring additional traffic. Traffic growth
12 continues on Sutton Road, makes it more and
13 more difficult and less safe to make those
14 maneuvers.

15 Q: All right.

16 A: The other thing that happens is once you
17 signalize the ramps, the eastbound traffic is
18 going to be stopped at the red light at Sutton
19 at the southbound off ramps. You've only got
20 300 feet to this entrance. So as traffic grows
21 and those queues or the line of traffic
22 increases, 300 feet is not a very long ways for
23 traffic to back up. There's certainly huge
24 potential for that traffic to back up all the
25 way to the entrance to the hospital site.

- 1 Q: All right. What does the term queuing mean to
2 a transportation engineer?
- 3 A: Queuing is, you know, maybe layman's term
4 congestion or traffic is stopped and backed up
5 and you're waiting. You might have a signal
6 and you might have 20 cars in front of you,
7 that's the queue of traffic in front of you
8 waiting for an opportunity to move through the
9 intersection.
- 10 Q: All right. Do you know what the capacity is,
11 traffic capacity is for Sutton Road?
- 12 A: Again, as I said about US 21, a two-lane road
13 the general daily capacity would be considered
14 about 12,000 vehicles per day.
- 15 Q: All right. And do you know what the current
16 volume is there?
- 17 A: Traffic on Sutton Road is also about 6,000.
18 It's very similar to US 21.
- 19 Q: About 50 percent capacity?
- 20 A: About 50 percent, yes.
- 21 Q: All right. The fact that it's only at 50
22 percent capacity, does that alleviate your
23 concerns about traffic congestion?
- 24 A: No.
- 25 Q: Why not?

1 A: First of all, the first point that I have is
2 that the proximity between those two locations,
3 the frontage road, Sutton Ridge Lane and the
4 interstates, it's just too close. And as we
5 see that the real difference here is that this
6 area has not been developed yet. And we're
7 going to see, if we hadn't had the downturn,
8 the economic downturn of 2008 when this project
9 stopped, the Kanawha site would probably
10 already be under development. So as this area
11 develops and grows, we've already got developed
12 interchanges north and south of here that have
13 the same issues. Whereas the arterial grows in
14 traffic and the congestion occurs, the nearest
15 intersections that are only 300-400 feet have
16 operational problems. They have safety issues
17 and, you know, everyone of them is a fight with
18 the development community to keep it from
19 happening.

20 Q: Now, you've testified a good bit about the
21 proximity to the interstate and your opinions
22 about that. What's the relevance of the
23 proximity of the frontage to the Love's Truck
24 Stop entrance?

25 A: Concerns with the things I've already talked

1 about are increase with the Love's Plaza
2 entrance because we have a truck stop there.
3 We have slow-moving, heavy vehicles moving in
4 and out of Love's Plaza. And the problem there
5 is first-out when they're coming out of Love's
6 Plaza from that stop sign and moving very
7 slowly it takes them a long time to clear the
8 intersection. Traffic moving even 35 miles an
9 hour is coming down pretty quickly, so you have
10 a bigger concern with safety there because of
11 that slow-moving traffic. The other issue is
12 visibility. Those trucks are big and you can't
13 see what's behind them.

14 Q: And why is that a problem?

15 A: Visibility and sight distance are one of the
16 biggest things. You want to have your drivers
17 on a transportation system have the time to
18 identify issues and makes their decisions to
19 come to a stop to avoid some kind of conflict.
20 And when you have visibility issues, whether
21 it's trees on the side of the road and you
22 can't see far enough down the road to see an
23 object coming or it's a heavy vehicle in front
24 of you, you don't know what's behind it. You
25 don't know what decision to make.

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1 Q: Now, let me ask you to go back to the first
2 site we looked at with the proposed Fort Mill
3 Medical Center site up US 21 and South Carolina
4 160. Do you have any opinions about traffic
5 congestion or danger at that site?

6 A: Well, at that site you don't have either of the
7 issues. We have well-spaced intersections.
8 There's nothing on the site side of the road.
9 US 21 has no driveways on either side of the
10 road to restrict the decisions on where to
11 appropriately space those intersections. It's
12 fairly flat and straight section of the
13 roadway. SC 160 is already developed on the
14 other side of the road with well-spaced
15 intersections. So the opportunities to come up
16 with acceptable and appropriate locations for
17 the intersections in and out of the site are
18 available.

19 Q: All right. Now, at this point you've only seen
20 and are aware of one entrance back towards the
21 CMC site. At least, you've only identified
22 one, that's the frontage road, is that right?

23 A: That's correct.

24 Q: How many entrances did you say are planned for
25 the Fort Mill Medical Center site?

1 A: Fort Mill Medical Center site, as I said
2 before, there's three on US 21 and another one
3 on 160, which is very important because you
4 have multiple access points and drivers can
5 make decisions. You've got a better way to
6 distribute the traffic to and from the site.

7 Q: All right. Mr. Walsh, do you have an opinion
8 to a reasonable degree of scientific certainty
9 which is the better site for a hospital?

10 A: There's no doubt in my mind that the 160 site
11 for the Fort Mill Medical Center is a better
12 site location from a traffic engineering
13 perspective.

14 Q: All right. Answer any questions opposing
15 counsel may ask.

16 **THE COURT:** Mr. Gaskins?

17 **MR. GASKINS:** Yes, Your Honor.

18 **MR. WALSH - CROSS EXAMINATION BY MR. GASKINS:**

19 Q: Mr. Walsh, earlier you testified about DOT's
20 access and roadside management standards?

21 A: Correct.

22 Q: And you mentioned there is a waiver process,
23 correct?

24 A: That is correct.

25 Q: And it's your understanding that the DOT is

1 Q: Okay. Did you do anything besides jump in your
2 car and drive around?

3 MR. WESTBROOK: I object to the characterization of
4 jumping in the car and driving around.

5 THE COURT: Let's rephrase that question.

6 MR. GASKINS: Okay.

7 Q: The point is that the higher number of test
8 runs you have the more accurate data that
9 you're going to have, correct?

10 A: Correct.

11 Q: Okay. And you had a very small sample size for
12 this study, correct?

13 A: Correct.

14 Q: That's all I have.

15 THE COURT: Nothing further, Mr. Gaskins?

16 MR. GASKINS: Not right now, Your Honor.

17 THE COURT: Okay. All right. Mr. Westbrook?

18 MR. WESTBROOK: Does DHEC have questions?

19 THE COURT: I'm sorry, Ms. Biggers.

20 MS. BIGGERS: No questions.

21 THE COURT: I figured that. I didn't mean to forget
22 you. No questions. Okay. Now, Mr. Westbrook.

23 MR. WESTBROOK: I've got a few questions.

24 MR. WALSH - RE-DIRECT EXAMINATION BY MR. WESTBROOK:

25 Q: Mr. Walsh, one of the very first questions Mr.

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1 Gaskins asked you was about a waiver. And I'm
2 not sure I understood the question or the
3 answer so I'm just asking for clarification
4 here. Have you seen any documentation from the
5 Department of Transportation that a waiver or
6 a permit or anything official like that has
7 been granted or will be granted for the
8 frontage road entrance to the hospital site
9 there at Sutton Ridge Lane?

10 A: No, sir.

11 Q: All right. Have you been presented by anybody
12 with any evidence, any documentation or any
13 testimony that you've heard or read about any
14 other entrance off Sutton Road that's
15 specifically planned, it's been planned, it's
16 been designed, it's been identified to go back
17 to that hospital site, other than the frontage
18 road?

19 A: No, sir.

20 Q: And if, in fact, another entrance off Sutton
21 Road were to be designated or identified or
22 developed to go back to the hospital site,
23 would that involve, would you have some
24 concerns about it? I guess it depends on where
25 it is?

- 1 A: It depends on where it is.
- 2 Q: All right. And since it hasn't been
3 identified, we don't know where it is?
- 4 A: That's right.
- 5 Q: Well, would there be -- if someone wanted to do
6 that, would it be as simple as identifying it?
7 What kind of areas are on either side of Sutton
8 Road as you go west and north? You know, we
9 can go back to Google Earth, but I'm sure you
10 can remember this. What kind of areas are on
11 either side of that road after the truck stop?
- 12 A: Once you get past the truck stop, you've got a
13 residential community on both sides of the
14 road.
- 15 Q: All right. Have you seen anything that the
16 people who own those residences are willing to
17 donate their homes and land and property to CHS
18 to develop their hospital site?
- 19 A: I have no knowledge of that.
- 20 Q: Would that cost something, do you think?
- 21 A: Certainly.
- 22 Q: Have you seen any evidence that CHS has
23 presented those costs to DHEC and calculated
24 their total project cost related to this case?
- 25 A: No, sir.

1 Q: Now, Mr. Gaskins asked you if you had taken any
2 notes when you went to the site observations.
3 Did you need any notes?

4 A: No, sir.

5 Q: And you didn't take any photos. Did you need
6 to take any photos, would that have helped you?

7 A: No, I don't think so.

8 Q: And you talked about your visual observation
9 but in your direct examination you also
10 referred to -- we looked at some documents,
11 didn't we? We looked at the DOT letter from
12 Theron Pickens, didn't we?

13 A: That's right.

14 Q: You relied on that to some extent in your
15 opinions, didn't you?

16 A: That's right.

17 Q: We looked at the DOT ARMS, DOT ARMS manual.
18 You relied on that to some extent, didn't you?

19 A: That's right.

20 Q: All right. Now, Mr. Gaskins also asked you a
21 good bit about holiday traffic. Let me ask you
22 this, he was asking with respect to the travel
23 time. I want to ask you about holiday traffic
24 with respect to the sites. What's the effect
25 of holiday traffic going to be on the

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1 congestion safety issues that you raised with
2 respect to the CMC-Fort Mill site?

3 A: I'm sorry, can you repeat the question?

4 Q: Sure. What would be the effect -- well, let me
5 back up for a second. It's my understanding
6 that traffic on the interstate tends to be
7 heavier during holidays such as Memorial Day,
8 than otherwise is that correct?

9 A: Correct. It's a little bit different, because
10 on your normal weekday you have commuter
11 traffic in the morning and the evening peaks.
12 The holiday traffic, you've got a heavier
13 volume of traffic throughout the day. So it's
14 a little bit different. I don't know that I
15 can say it's heavier at one time than the
16 other, but, yes, there's significantly
17 different peaking characteristics and volume
18 characteristics.

19 Q: All right. Well, let me try and simplify my
20 question. The heavier the traffic is on
21 Interstate 77 for whatever reason, whether it's
22 due to a peak hour or holiday or whatever, the
23 heavier the traffic is, how is that going to
24 affect safety and congestion concerns that you
25 raised with respect to the CMC-Fort Mill site?

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1 A: You're going to have heavier traffic on the
2 ramps coming off the interstate as well. So
3 you're going to see more traffic there at the
4 Sutton Ridge Road intersection with the
5 interstate ramps.

6 Q: Okay. Now, with respect to the travel time
7 studies that you conducted, it sounds like you
8 took some of your trips on Monday, is that
9 right?

10 A: That's correct.

11 Q: And you took some of your trips in May, is that
12 correct?

13 A: That's correct.

14 Q: It wasn't clear from Mr. Gaskins questions, and
15 I don't know if you remember this and I don't
16 know the answer to this, maybe you do, maybe
17 you don't. Did you do any of your trips on
18 Memorial Day?

19 A: Not on Memorial Day, itself.

20 Q: You just did them in May?

21 A: Correct.

22 Q: Is it your opinion that -- I'm sorry, let's go
23 to the Demonstrative simplified version of
24 Exhibit 111. I can't remember what
25 Demonstrative number it is, 38. Let's go to

1 Demonstrative 38. We looked at this on direct,
2 do you remember this one?

3 A: Yes.

4 Q: And you created this one, right?

5 A: We did.

6 Q: All right.

7 A: My staff and I.

8 Q: Is it your opinion as a transportation engineer
9 that the pink area identified on there that -

10 **MR. GASKINS:** Objection, Your Honor, he's leading
11 the witness.

12 **MR. WESTBROOK:** I am leading the witness, Your
13 Honor, he's absolutely right. But I would
14 think at this point I'm given a little
15 latitude. I'll try to rephrase that.

16 **THE COURT:** Maybe not leading quite so much, Mr.
17 Westbrook.

18 Q: Mr. Walsh, tell me again your opinion with
19 respect to the pink area identified on that?

20 A: In spite of the issues that have been
21 discussed, the small sample size and so forth
22 and collecting traffic data on a Monday. Those
23 issues, in my opinion would be insignificant,
24 to the results that are shown on the screen
25 here.

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1 Q: Thank you. No further questions.

2 THE COURT: Mr. Gaskins?

3 MR. GASKINS: Nothing further, Your Honor.

4 MS. BIGGERS: Nothing, Your Honor.

5 THE COURT: All right. Thank you. Are we finished
6 with Mr. Walsh?

7 MR. WESTBROOK: We are finished with Mr. Walsh.

8 THE COURT: All right. Mr. Walsh, thank you very
9 much, sir.

10 MR. WALSH: Thank you.

11 THE COURT: You may be excused.

12 MR. WESTBROOK: Can we take a break now, Your Honor?

13 THE COURT: Absolutely. Let's break for ten
14 minutes. We are at recess.

15 (Off the Record)

16 THE COURT: Please be seated. Okay. We're back on
17 the record.

18 MR. ANDREWS: Your Honor, Piedmont's ready to call
19 our next witness.

20 THE COURT: Excellent.

21 MR. ANDREWS: David Levitt, please.

22 THE COURT: Mr. Levitt.

23 DAVID LEVITT, being duly sworn, testifies as follows:

24 MR. LEVITT - DIRECT EXAMINATION BY MR. ANDREWS:

25 Q: Good afternoon, Mr. Levitt. Please state your

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1 full name and business address for the record?

2 A: It's David Samuel Levitt and the business
3 address is two addresses, one is 1778 Emory
4 Ridge Drive, Atlanta 30329 and the other is 9
5 River Place, Beaufort, South Carolina 29906.

6 Q: Mr. Levitt, what's your occupation?

7 A: I'm a healthcare consultant.

8 Q: All right. And have you been retained to work
9 on this matter that's before the Court today?

10 A: Yes.

11 Q: All right. You've provided a copy of your
12 resume to counsel and the other parties?

13 A: Yes.

14 Q: All right. Dan, let's pull up Exhibit 69, if
15 we could. And Mr. Levitt will work through
16 that. Let's begin with your education on page
17 three of your resume. Would you review that
18 please, for the Court?

19 A: Sure. I earned a bachelor's of science from
20 Virginia Tech. I guess the major was
21 industrial psychology and I've got a master's
22 in health services and administration from the
23 George Washington University.

24 Q: All right. And if we turn to the next page,
25 identify publications and seminars of which you

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1 made presentations. Is that a current list of
2 those?

3 A: I believe so. I've made a number of different
4 presentations, publications and different
5 educational seminars over the last 20 years.

6 Q: Okay. And after obtaining your master's, let's
7 turn to the page three, back to page three,
8 please, Dan. What did you do?

9 A: Well, as part of the master's program a 12-
10 month residency, administrative residency is
11 required. So when I finished the didactic
12 portion I went to Potomac Hospital as
13 administrative resident. Because of the
14 situation and the timing, it worked out well
15 for me. That residency ended very early, I
16 think, after three months and they gave me
17 administrative responsibilities. So I worked
18 in administration at the Potomac Hospital and
19 I stayed on several months, I guess four months
20 after my residency, and then I left Potomac
21 Hospital.

22 Q: And have you been doing healthcare planning
23 ever since.

24 A: After I left Potomac Hospital, I went into
25 healthcare consulting, yes.

1 Q: Okay. Dan, let's turn to the first page of the
2 resume. And who are you currently affiliated,
3 Mr. Levitt?

4 A: Levitt Healthcare Affiliates.

5 Q: And what's your position there?

6 A: I'm the managing partner of the practice.

7 Q: All right. And have you worked for yourself
8 your career or have you been with other
9 practices?

10 A: When I first started consulting, I worked at a
11 firm called Fowler Healthcare Affiliates. And
12 when I left Fowler, I was there a couple of
13 years. We left Fowler and started our firm.
14 So after that, I was an owner of a consulting
15 firm.

16 Q: Okay. All right. Let's roll through your
17 first page and identify different areas that
18 are noted on your resume. The first relates to
19 your providing healthcare strategic planning
20 services to acute and post-acute healthcare
21 facilities. Could you explain that a little
22 bit, please, sir?

23 A: Sure. In addition, to general consulting
24 services, strategic planning, we do market
25 analysis, competitor analysis, marketing

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1 strategies, demographic analysis, looking at
2 market opportunities for hospitals, either at
3 service line level or product line level. What
4 sorts of services should a hospital pursuing or
5 not pursuing. How to best achieve those. How
6 to respond to competition and things like that.

7 Q: Okay. And the second category of services
8 relates to a financial modeling and
9 reimbursement analysis, specifically related to
10 financial feasibility, is that right?

11 A: Part of that would be financial feasibility,
12 looking at the financial aspects of some of the
13 strategic initiatives we identify as well as
14 acquisition analysis, evaluations, things like
15 that.

16 Q: Okay. And the third category relates to
17 inpatient and outpatient utilization
18 projections and financial forecasting. Who
19 have you done that for and what does that
20 typically involve?

21 A: That can include, well, you can see from the
22 list sort of the full spectrum of healthcare
23 services from acute care services to post-acute
24 services, long-term care, skilled nursing, home
25 health. Speciality services including

1 psychiatric and rehabilitation, hospice,
2 specialized women's services, oncology, things
3 like that.

4 Q: Okay. And the next page outlines services
5 you've performed for the state of Tennessee.
6 When was that and what did they involve in
7 general terms?

8 A: The date was probably the late nineties, '98,
9 somewhere around there. And I was contracted
10 by the state to perform the functions of the
11 Certificate of Need Division. To review
12 Certificate of Need applications for post-acute
13 CON applications for a period of one year.

14 Q: And the next category identifies your CON
15 services, in particular. What is your estimate
16 of CONs in which you have provided or otherwise
17 provided, services related to?

18 A: I have been involved in -- the resume says 450.
19 I've done several since then, so, you know,
20 close to 460, 470.

21 Q: Okay. And how many states have you worked, in
22 providing CON-related services?

23 A: I've done probably about a dozen states.
24 Mostly the Northeast and the Southeast.

25 Q: And where do you tend to concentrate over the

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1 last five or ten years of your practice?

2 A: Well, since I have a 4 year old and a 6 year
3 old now, I tend to focus closer to home and
4 that would be in the Southeast, Tennessee,
5 Georgia, South Carolina.

6 Q: Okay. All right. Now, let's move to South
7 Carolina and explain to the Court, if you
8 would, your experience in working with South
9 Carolina hospitals?

10 A: I've worked with a variety of South Carolina
11 hospitals over the years. I've worked with
12 small community hospitals, large community
13 hospitals, academic medical centers, healthcare
14 systems, a variety of different acute-care
15 hospitals systems.

16 Q: Okay. Well, in the Beaufort area, Beaufort
17 County, where you live, you represent any
18 facilities there?

19 A: I've done work with Hilton Head, just outside
20 of Beaufort. I've done work with Coastal
21 Carolina. Going up the coast, I've worked in
22 Charleston. I've worked for East Cooper. I've
23 worked for MUSC. I've worked for Roper. I've
24 worked for Georgetown Hospital System. Worked
25 for Conway. I've worked for hospitals in

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1 Florence, McLeod and Carolinas. Columbia, I've
2 worked for Providence and Palmetto and
3 Lexington.

4 Q: Greenville area?

5 A: In Greenville, I've worked for St. Francis.
6 I've worked Oconee. I've worked for
7 Spartanburg Regional. I've worked for the
8 hospital in Cherokee County. Worked for South
9 Memorial. Worked for Kershaw. Worked with a
10 lot of hospitals.

11 Q: Are there many that are not on your resume.

12 A: There are a few I haven't worked with.

13 Q: Okay. Good. Now, with regard to new
14 hospitals, what's your experience related to
15 those in your developments of CONS for your
16 clients, related to the new facilities?

17 A: I've worked on about five or six new hospital
18 projects. I've worked on two in Georgia, I
19 worked on the John's Creek Hospital and Sumter
20 Regional, two replacement hospitals. In South
21 Carolina I worked on the Patewood Hospital, the
22 Village Hospital, well, this hospital, Fort
23 Mill Medical Center, Georgetown replacement.

24 Q: Were you involved with the Palmetto facility.
25 Palmetto Heart?

1 A: Yeah, I assisted them in their original
2 Parkridge application.

3 Q: All right. And there's been an issue raised
4 concerning services you may have provided to
5 Roper and the development of the Roper-Berkeley
6 facility. Were you retained to provide any
7 assistance in that regard?

8 A: For the Roper-Berkeley Hospital, I was retained
9 by legal counsel after the applications were
10 submitted, very close to the decision date to
11 review both applications, the Roper-Berkeley
12 and the Roper-Trident CON applications. And I
13 calculated a bed need for Berkeley County and
14 then meet with DHEC to present that
15 calculation.

16 Q: Were you provided any information in the
17 services you performed, other than what was
18 available to the public?

19 A: No. They sent me the two CON applications.
20 And I don't believe I even met with anyone from
21 Roper. I just met with legal counsel.

22 Q: All right. And have you been qualified as an
23 expert in healthcare planning and the
24 Certificate of Need Programs previously, Mr.
25 Levitt?

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1 A: Yes.

2 Q: Your Honor, I would like to move to qualify Mr.
3 Levitt as an expert in Healthcare Planning and
4 in Certificate of Need Programs.

5 MR. MULLER: Without objection, Your Honor.

6 MS. BIGGERS: Without objection.

7 THE COURT: All right. Without objection, Mr.
8 Levitt is qualified as an expert in the fields
9 of Healthcare Planning and Certificate of Need
10 applications.

11 MR. ANDREWS: Thank you, sir.

12 Q: Mr. Levitt, when did you first become involved
13 with Piedmont Medical Center?

14 A: I believe I started working on projects for
15 them shortly after I started consulting, so the
16 early nineties.

17 Q: Okay. And were you involved with Piedmont in
18 the consideration of their plans to establish
19 a new hospital in Fort Mill?

20 A: Yes. As I said, I had done some preliminary
21 work on some of their CON applications in the
22 early mid-nineties. And continued to so some
23 planning assistance throughout that period even
24 until today.

25 Q: All right. For purposes of background

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1 describe, if you would, the services that were
2 being developed. Have you prepared a
3 Demonstrative related to the identifications of
4 it?

5 A: Yes..

6 Q: Okay. Dan, show Demonstrative 133. And what
7 were the services that Piedmont was developing
8 during that period of time that you were
9 beginning to work with them, Mr. Levitt?

10 A: Well, we developed a number of services. They
11 expanded some services and I think these six
12 represent, sort of represent those that were
13 the focus of their attention. The open heart
14 surgery, they developed that with a therapeutic
15 cardiocatheterization. They did a Women's
16 Tower project, an expansion of women's
17 services. Neonatal intensive care, the Level
18 II-E, you heard the discussion about they
19 developed that. The emergency department
20 renovation they did and then developing
21 neurosurgery services.

22 Q: All right. And during this period of time,
23 let's say from the late nineties up through the
24 time of the filing of the application, did you
25 monitor the utilization of the hospital?

1 A: Yes. We monitored the utilization of the
2 hospital, market conditions and activities and
3 the Health Plan.

4 Q: Okay. And based on your work, have you
5 prepared a graph that would show how their
6 discharges evolved over that period of time?

7 A: Yes.

8 Q: Dan, let's pull up Demonstrative 134, please?
9 What is this, Mr. Levitt?

10 A: This is a figure that shows from 1997 to 2005
11 utilization at Piedmont Medical Center, York
12 County utilization of Piedmont Medical Center.
13 In '97, you can see it was slightly less than
14 10,000 discharges, by 2005, it was close to
15 14,000 discharges. Also, shown on the graph
16 are the experience of the Charlotte, North
17 Carolina hospitals. And you can see those
18 utilizations are fairly flat, right around --
19 for Mercy-Pineville and for Carolinas Medical
20 Center, right around 2,000 discharges. And the
21 Presbyterian Hospital around 1,000 discharges
22 throughout that time period.

23 Q: All right. Now, and you're also familiar with
24 the market share during this period of time?

25 A: Correct.

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1 Q: All right. Dan, let's pull up Demonstrative
2 135, please. And describe what is it this
3 exhibit, Mr. Levitt?

4 A: This is an exhibit that shows from 2000 and
5 2005, the market share or the percentage of
6 total patients. And we talked about how many
7 patients they treated. This is sort of
8 dividing that by the total number of patients
9 in the market at that time. And you can see it
10 was fairly flat. It went down a little bit
11 from 2002 and 2005, 66, 67 percent, down to
12 about 64 percent in 2005.

13 Q: Now, what would explain the chart that we just
14 looked at, which showed an increase in
15 discharges in a relatively flat market share?

16 A: It would say that the utilization increased
17 proportionately for them and others.

18 Q: Okay. Now, and what was the slight decline in
19 market share between 2002 and 2005 represented?

20 A: That was a shift in the market. Again, it was
21 a very small percentage but that was just a
22 shift in utilization of market share for
23 Piedmont.

24 Q: Okay. And during that period of time between
25 1999 and 2000, was Piedmont, based on your

1 knowledge and information related to them,
2 involved with any conversations with third
3 parties related to the development of a
4 hospital in Fort Mill?

5 A: Yes.

6 Q: And to what degree?

7 A: They were in discussions with the developer of
8 that area to provide healthcare services to the
9 development.

10 Q: Okay. And have you reviewed the materials and
11 records related to those communications?

12 A: Yes. And as part of the, I guess, preparation
13 for the last trial, I also spoke with some of
14 the individuals at the development firm.

15 Q: All right. Dan, pull up Demonstrative 86,
16 please? And Mr. Levitt, have you prepared this
17 outline?

18 A: Yes.

19 Q: And what is it?

20 A: This summarizes the sort of time line for the
21 development of services in the northern York
22 County area. In April of 1999, an RFP to
23 develop Fort Mill medical services went out by
24 the developer. In October of '99, Piedmont was
25 selected as the preferred provider to develop

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1 the healthcare services in that area in
2 affiliation with the developer of the real
3 estate. And by August of 2008, they entered
4 into that agreement to develop those services.
5 And those services included placement of
6 physician practices and urgent care services,
7 developing an imaging center, and ultimately a
8 hospital.

9 Q: Okay. Now, let's pull up, Dan, if you would
10 what's been pre-admitted as Exhibit 19. What
11 is this document, Mr. Levitt?

12 A: This is the Baxter Medical Campus is
13 referencing the northern York-Fort Mill area,
14 the northern York area facility phasing
15 comparison. And this was the analysis by the
16 developer comparing the two providers that
17 responded to the RFP.

18 Q: And who are they?

19 A: Piedmont Medical Center and Presbyterian.

20 Q: Okay.

21 A: The timing of when they were planning on
22 developing certain services and the extent to
23 which those services, the scope of those
24 services.

25 Q: And did those proposed services include a

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1 hospital?

2 A: They did. Item G, you can see acute-care
3 hospital, that's the hospital.

4 Q: And both parties proposed to develop a hospital
5 for the Fort Mill Baxter Medical Campus?

6 A: Correct. Piedmont, you can see, had a shorter
7 time frame, ten years versus the 15 to 20 years
8 for Presbyterian.

9 Q: Okay. Now, based on your investigation and
10 research, did you determine whether Carolinas
11 was part of this process?

12 A: Yes.

13 Q: And were they?

14 A: No. They did not participate. They were
15 invited and they -- it appears they attended
16 meetings, conducted meetings, did site visits,
17 but they declined to respond to the RFP.

18 Q: All right. Now, let's look at Exhibit 20, if
19 you would? And this is a letter from Clear
20 Springs Development Company addressed to Mr.
21 Charles Miller as CEO of the hospital. And
22 what does it communicate?

23 A: It is the ---

24 Q: Excuse me. Dan, if you could highlight the
25 second paragraph. There we go.

1 A: Basically, it identifies Piedmont as the
2 selected candidate and it asks that Mr. Miller
3 sign the agreement to initiate developing the
4 services.

5 Q: Okay. And what's the date of this letter?

6 A: October 1999.

7 Q: All right. Now, at some point following this
8 letter, apparently there was a decision made to
9 file the CON application by Piedmont, is that
10 right?

11 A: I'm sorry.

12 Q: After this letter?

13 A: Yes.

14 Q: Piedmont made a decision to file the
15 application that we're here today to talk
16 about?

17 A: Correct.

18 Q: And were you involved in the development of
19 that decision?

20 A: Yes.

21 Q: Okay. Dan, let's look at Demonstrative 87,
22 please? And are you aware of the decisions, the
23 basis for that decision?

24 A: Yes.

25 Q: And what are they?

1 A: We summarized them here. The four general
2 areas that the hospital, the satellite hospital
3 in Fort Mill would represent a centerpiece for
4 a long-term plan. And we talked about the
5 areas and services that would be developed in
6 the Fort Mill area by Piedmont for the
7 developer. It would present a presence in the
8 northern part of York County to prevent out-
9 migration looking at the market utilization and
10 where our patients were receiving services.
11 Piedmont knew that that area, the population
12 was growing and they were not increasing their
13 utilization from that area. So obviously,
14 those residents were seeking care elsewhere
15 outside the state. It strengthens the services
16 to York County residents by increasing the
17 critical mass of patients treated by Piedmont,
18 expands the scope of services in Fort Mill. We
19 talked about the physician practices, the
20 urgent care and imaging center. This would
21 compliment those. And then ultimately, the
22 publication of the need and the State Health
23 Plan allowed for the hospital CON to be
24 developed.

25 Q: Okay. Now, what were the goals of the

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1 application. Have you identified those?

2 A: Yes, we have.

3 Q: Let's look at Demonstrative 88 please, Dan.
4 And what are they?

5 A: The three general goals for the application
6 were to increase services to the residents of
7 York County in York County. Stop the erosion
8 or out-migration of York County residents to
9 the Charlotte area. And to treat those people
10 from York County in York County. And to assure
11 the continued viability of Piedmont Medical
12 Center and the medical staff that supports
13 Piedmont Medical Center by keeping the patients
14 in the county and having those available
15 services.

16 Q: Okay. Now, you said a moment ago that -- you
17 have some water there?

18 A: Yes.

19 Q: Okay. That one of the factors that affected
20 Piedmont's decision to file was the publication
21 of the 2004-2005 State Health Plan. What's
22 your experience, generally, and during that
23 period of time with regard to the review of
24 State Health Plans?

25 A: The process is statutorily required every two

1 years that the plan be developed, often it's
2 every year. So as a consultant with a long-
3 standing relationship with a number of clients,
4 I typically review the health Plan as it's
5 developed, the draft Health Plan, the process
6 and monitor areas that our clients are
7 interested in to keep them apprised of
8 opportunities.

9 Q: Okay. Now, during this period of time from
10 1999 to the filing of the application, were you
11 reviewing the Plans related to the need for new
12 hospital beds in York County?

13 A: Yes. That would be one of the areas of
14 opportunity that I was monitoring for a long-
15 standing client.

16 Q: Okay. And have you developed a Demonstrative
17 showing the progression of need in York County
18 during those years?

19 A: Yes.

20 Q: Dan, let's turn to Demonstrative 89, please?
21 And what's reflected here, Mr. Levitt?

22 A: This shows in the four actual State Health
23 Plans, including one draft of 2004, the
24 calculated bed need for Piedmont Medical
25 Center. You can see in 1999 there was a

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1 surplus of 18 beds. In 2001, there was a need
2 for one bed. In 2003, there was a surplus of
3 five beds. And suddenly when the draft 2004
4 Plan came out, it showed a need of 22 beds. We
5 sort of looked at that, analyzed that and
6 sought to determine if that was an opportunity
7 for us to build a hospital. And when the final
8 Plan came out in 2004-2005, the need jumped
9 from 22 to 64 and that's when we decided it was
10 time to file the application.

11 Q: Okay. Let's take this point to explain to the
12 Court how need is determined in the State
13 Health Plans. And let's -- since the '04-'05
14 Plan was the Plan under which the application
15 of Piedmont was filed, explain how that need
16 for 64 beds was derived?

17 A: Sure. In the Plan, the utilization of Piedmont
18 Medical Center by age cohort is analyzed,
19 looking at patient days by age cohort. They
20 apply use rates. In other words, they divide
21 that by the population of that time period,
22 apply that to the projected population to come
23 up with an average daily census or as many
24 number of people in the beds. They divide by
25 an occupancy rate to determine the bed need.

1 They subtract that from the existing beds to
2 determine whether it's a surplus or a deficit.

3 Q: It might be a little more helpful to actually
4 look at a Plan and you can work through it as
5 well. And then you can work through that.
6 Dan, let's turn to Exhibit 8(a), please, the
7 2004-2005 Plan. I think that's on page 25,
8 Roman numeral II-XIV. And Mr. Levitt, explain
9 what's represented here and those excerpts from
10 2004-5 State Health Plans?

11 A: Sure. This sort of puts numbers to what I just
12 said, that the three age cohorts, the less than
13 18 to 64, 65 plus takes the, in this point, it
14 takes the 2000 population by those cohorts,
15 also shows the projected 2010 population by
16 those cohorts. It takes the patient days in
17 2003, divides that by the 2003 population,
18 multiplies that by the 2010 population and
19 divides by the number of days in the year. In
20 this case, it would 365 to get an average daily
21 census of 233 patients basically. This bottom
22 line here of 233.

23 Q: Dan, could we highlight that? You may not be
24 able to draw it out. Okay. Sorry, Mr. Levitt,
25 go ahead.

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1 A: And then applies the 70 percent occupancy rate
2 to that to show a need of 332 beds, 268
3 existing beds, so you subtract the two and that
4 totals 64 beds.

5 Q: That is the difference?

6 A: Correct.

7 Q: Between the number of the beds identified as
8 being needed based on the mathematical
9 calculation you just identified and the
10 existing beds?

11 A: Correct. There are 268 existing beds at
12 Piedmont, there is a need for 332, so a
13 difference of 64.

14 Q: Okay. Now, the two variables that are
15 incorporated into the calculation you
16 identified the population as one, and the
17 differences in the population, is that right?

18 A: Correct. The factors that drive the
19 calculation would be the population, the growth
20 of the population, and then the utilization of
21 Piedmont Medical Center.

22 Q: Okay. All right. Now, Dan, turn and kind of
23 look back at the existing bed compliment. Just
24 so we can be clear going forward, 268 beds
25 represents 268 beds of what sort?

1 A: Those are the acute-care beds. Mr. Masterton
2 talked about 288 beds at the hospital, that's
3 their licensed capacity. The 20 difference is
4 the psychiatric beds that they operate. So
5 this is just the acute beds less the
6 psychiatric beds.

7 Q: An acute beds, is that general hospital beds?

8 A: That's all other beds in the hospital, the med-
9 surg beds, the ICU beds, the OB beds, all of
10 the beds besides psychiatric beds.

11 Q: Okay. Now, after the publication of the bed
12 need and the final 2004-2005 State Health Plan,
13 what do you recall doing for Piedmont related
14 to that?

15 A: Well, we had discussions and meetings. And we
16 decided it was the appropriate time to submit
17 the application for Fort Mill Medical Center.
18 So we scheduled a meeting with DHEC to talk
19 about the application.

20 Q: And relate that meeting, who you met with and
21 what the focus of the conversation?

22 A: We met with Joel Grice, who at the time was the
23 director of the Certificate of Need Division.
24 He was the individual who would ultimately make
25 the decision on the CON application. We talked

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1 to him about the need and the Plan, our long
2 term plans. The affiliation with the developer
3 of that area, our goals, about some of the
4 trends in the market. We talked to him about
5 the out-migration, the number of people that
6 were leaving the state for services. And asked
7 him the best way to approach getting a hospital
8 in northern York County.

9 Q: Now, let's back up a little bit. Why would you
10 meet with the CON director before filing the
11 application?

12 A: Well, we wanted to file the application in a
13 manner that would be approved or at least
14 approvable. So we wanted to talk to him about
15 some of the options or nuances of the
16 application and see if he had any issues or any
17 suggestions or approaches that would make him
18 more comfortable or if, in fact, it was at
19 possible to develop an application for a new
20 hospital.

21 Q: Was it an unusual thing to do, to meet with the
22 CON director concerning a proposed application?

23 A: No, I would say that most, if not all, of the
24 applications, well, all of the applications I
25 developed in South Carolina at that time, I

1 would either call or meet with Mr. Grice before
2 I submitted them to make sure that it was in a
3 format or manner that was consistent with the
4 regs and would be reviewed.

5 Q: All right. Now, let's focus on the content of
6 the conversation concerning -- you said you
7 wanted to explore the options. What options
8 were available to Piedmont?

9 A: Well, the need for 64 beds at Piedmont, we
10 wanted to use that need to develop the Fort
11 Mill Medical Center. So the first option was,
12 do we need to file an application, add the beds
13 at Piedmont and then move them. Letting him
14 know that our intent is to never operate the
15 beds at Piedmont, we want an acute-care
16 location in northern York County. And we
17 explained why we did not want to do that
18 option. Why it didn't make sense, why it
19 wasn't consistent with the goals and intent of
20 the Plan and he agreed. And he also identified
21 precedent where other hospitals had done the
22 same thing. So we agreed the best approach
23 would be our preferred approach, would be to
24 submit a CON application for a new hospital in
25 York County using the bed need from Piedmont

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1 Medical Center.

2 Q: Why might have Piedmont have considered placing
3 the beds at the Piedmont site and then moving
4 them to another location?

5 A: Because the need in the Plan was for Piedmont
6 Medical Center. So we didn't know if that
7 meant we had to put it at Piedmont Medical
8 Center or it could be placed at another
9 location.

10 Q: And what did Mr. Grice advise you?

11 A: That another location was perfectly okay.

12 Q: Okay. All right. Now, let's move to the stage
13 in which the application was filed. Have you
14 developed a time line related to the filing of
15 that and the subsequent applications?

16 A: Yes.

17 Q: Okay. Dan, let's pull up Demonstrative 90,
18 please? And what does this Demonstrative show,
19 Mr. Levitt?

20 A: This shows the time frame of applications
21 submitted for a York County hospital. The
22 three Piedmont applications and then the
23 competitors.

24 Q: All right. And let's read each one of them, if
25 you would, and explain the development?

1 A: Sure. In November of 2004, very shortly after
2 the Health Plan was adopted, we submitted the
3 64-bed application for the Fort Mill Medical
4 Center. The applicant was an affiliated
5 company. I believe it was a new entity that
6 was created for the applicant. We decided in
7 January, just a few months later, to withdraw
8 that application and resubmit it with Amisub as
9 the applicant. The entire application was
10 identical with the exception of that. So we
11 withdrew and resubmitted the application.
12 Several months later, in April of 2005, three
13 other competitor applications were submitted.
14 The Carolinas Hospital, Presbyterian Hospital
15 and Health Partners of America submitted a 64-
16 bed application. In October of 2005, we
17 withdrew the 64-bed application and resubmitted
18 a 100-bed application.

19 Q: And why did you do that?

20 A: After further analysis of the market and
21 looking at the needs and the projected needs
22 and the future needs, 64 beds wasn't going to
23 be enough to meet the needs. And 100 beds
24 better met the needs in the area.

25 Q: Okay. Now, subsequent to the filing of the

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1 October of 2005 application, DHEC reached a
2 decision in 2006, correct?

3 A: Correct.

4 Q: And that decision was in Piedmont's favor the
5 record shows?

6 A: Correct. Piedmont was approved.

7 Q: And there was the appeal and remand that's a
8 matter of record. So let's move onto the point
9 in which the applications were remanded back to
10 the Department for consideration. Did you work
11 on that updated application process?

12 A: I did. I developed the remand CON application.

13 Q: All right. Now, were there any changes in any
14 way that you regard is significant from the
15 time from 2005 to 2010?

16 A: Yes. There were a number of changes in the
17 market.

18 Q: Have you identified those for us?

19 A: Yes.

20 Q: All right. Dan, let's turn to Demonstrative
21 172, please? All right. What you have here is
22 an overview, Mr. Levitt?

23 A: This shows, as I said, the changes in the
24 market from 2005 to 2010. The first being
25 decreased utilization of Piedmont. So unlike

1 when we had submitted the 2005 application and
2 utilization was increasing, it had decreased
3 since that time. Our market share had gone
4 down since the 2005 submission. And physician
5 networks and medical staff had changed in the
6 market. CHS had developed additional physician
7 ownerships. And then the referral patterns had
8 changed as well.

9 Q: All right. Well, let's spend a moment looking
10 in more detail at each. Let's begin with the
11 decreased utilization that Piedmont was
12 experiencing. Dan, if you will pull up Exhibit
13 136, please? And what does this show, Mr.
14 Levitt?

15 A: So this shows -- unlike the period prior to
16 submitting this CON application, after the CON
17 application was submitted in 2005, utilization
18 at Piedmont declined from 2005 to 2009. From
19 2009 to 2010 showed a modest uptick, but we
20 went from about 14,000 York County discharges
21 to around 11,000 York County discharges.
22 During that same time period Mercy-Pineville
23 and Carolinas Medical Center showed an
24 increase. They went from about 2,000 in 2005
25 discharges to over 3,000 by 2010.

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1 Q: Now, are you referring to the graph lines at
2 the bottom of this chart?

3 A: Correct. The green line is the Piedmont
4 Medical Center, the purple and red lines are
5 Mercy-Pineville and Carolinas Medical Center.

6 Q: And what do the other lines at the very bottom
7 of the chart at 1,000 discharges and below
8 represent?

9 A: Those represent -- Gaston is the black line and
10 Presbyterian is the yellow line and
11 Presbyterian Orthopaedic is the brown line.
12 And those were flat throughout that time
13 period.

14 Q: Okay. Now, let's take a look at the next
15 Exhibit, 137, is this a chart that you also
16 prepared?

17 A: Correct. This puts those two charts together.
18 So from '97 to 2010 on one graph, you can see
19 the line is when we submitted the CON
20 application and you can see the decline
21 together. So ours was trending up, everyone
22 else's was flat. We submitted the application,
23 ours trended down pretty dramatically and
24 Pineville-Mercy and Carolinas Medical Center
25 trended up, while everyone else stayed pretty

1 flat.

2 Q: And what relationship does Mercy-Pineville have
3 to Carolinas Medical Center?

4 A: The data at Mercy-Pineville is the two-location
5 hospital. Mercy Hospital and Pineville Medical
6 Center, they report their data together, I
7 believe, and they have one provider number, so
8 they don't separate their information in the
9 data that we have access to. So those are the
10 two Carolinas Medical Center hospitals. The
11 Pineville Hospital is the one just over the
12 border. And the Mercy one is downtown
13 Charlotte. But those are both Carolinas
14 Medical Center hospitals.

15 Q: Okay. Let's also take a look at how market
16 share changed, you identified that following
17 the filing of the 2005 application.
18 Demonstrative 139, please, Dan. Is this your
19 graph, Mr. Levitt?

20 A: It is. And it shows sort of, as I said, we had
21 shown the line, from the blue line to the left,
22 before where our market share was about 66, 67
23 percent, went down to about 64 percent by 2005.
24 Then you can see the drop off from 2005 to
25 2011, went down to about 55 percent. So from

1 64 percent to 55 percent over that same time
2 period. And that's consistent with the
3 utilization we just showed that CMC and
4 Pineville-Mercy were increasing their market
5 share. They were getting more discharges, more
6 of the percentage of discharges, and we were
7 getting less.

8 Q: Okay. Now, let's actually pull up a chart that
9 was in the DHEC record, Exhibit 1, page 767,
10 figure 3. What is this table, Mr. Levitt?

11 A: This shows the trend we looked at, as I said,
12 we had a decline from 2005 to 2010 in York
13 County discharges of about 2200. So the
14 decline was about 2200 and you look at the
15 other providers, Carolinas Medical Center and
16 Mercy-Pineville showed an increase of about
17 1800. So we went down by 2200, they went up a
18 combined 1800. And Presbyterian was pretty
19 flat with 80 more admissions during that same
20 time period. Presbyterian Orthopaedic declined
21 a little bit. The other North Carolina
22 hospitals were absolutely flat, no change at
23 all. And then other South Carolina hospitals
24 showed a slight increase of 158 patients. And
25 that includes MUSC and Columbia hospitals, as

1 well as any other hospital in South Carolina.

2 Q: All right. And so of the 2200 cases that
3 Piedmont lost in the five years between 2005
4 and 2010, what percentage of them in general
5 terms, or if you can do the calculation there,
6 did Carolinas grow by York County discharges in
7 that same period?

8 A: Over 80 percent of our decline went to those
9 two providers.

10 Q: All right. And what inferences did you draw at
11 the time you submitted this to the Department
12 of this data?

13 A: That because CMC or Carolinas Health System,
14 CHS, had submitted a competing application
15 that changes in the market referrals were due
16 to that fact that they were directing patients
17 away from Piedmont into their North Carolina
18 hospitals.

19 Q: Okay. Now, next on your list of changes or
20 developments in the market was changes in the
21 physicians networks. Have you analyzed the
22 changes in the numbers of Carolinas physicians
23 in the market during that period?

24 Q: Yes. All right. Dan, let's pull up
25 Demonstrative 140. And what does this reflect,

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1 Mr. Levitt?

2 A: This shows the number of employed physicians in
3 York County, employed by CHS, or the CPN
4 network, showed in February of 2005, there were
5 25 employed physicians. A few months later, by
6 April, they had 37, so they were up by 12
7 physicians in a very short period of time.
8 Forty-six physicians by 2008. And then by
9 2012, 66 physicians. So the change from
10 February of 2005 to 2012, 164 percent growth in
11 the number of physicians in York County
12 employed by CHS.

13 Q: All right. And you also had access information
14 concerning the referral practices of the
15 Carolinas physicians?

16 A: Yes, I reviewed that.

17 Q: All right. Let's begin by reviewing the first
18 page of Exhibit 25. What is this, Mr. Levitt?

19 A: This was an attachment, I believe, to Dr.
20 Wiens' deposition. And it shows a policy
21 about referring CMHA to CMHA facilities.

22 Q: And what is your understanding, based on your
23 reading of the policy? What does it provide?

24 A: It's a preference to send to CMHA facilities by
25 the physicians.

1 Q: Okay. Yeah, let's look at the next page that
2 you have highlighted, does it show what the
3 physicians agreed to?

4 A: Yes.

5 Q: And what, in fact, does that provide?

6 A: It talks about the physicians agree to refer
7 all patients to facilities owned, operated or
8 managed directly or indirectly by CMHA and/or
9 to a practitioner who is a member of the
10 medical staff of any such facility, unless, and
11 they're three exceptions to that. And those
12 exceptions are (a) the patient expresses a
13 preference for a different facility or
14 practitioner, (b) the patient insurer
15 determines the facility or practitioner, or (c)
16 the referrals not in the patient's best medical
17 interest according to the physician's
18 judgement.

19 Q: Okay. Now, have you, in fact, had access to
20 documents produced by Carolinas that showed the
21 extent to which referrals were identified and
22 changed over the same period of time?

23 A: Yes.

24 Q: All right. Let's pull up Demonstrative 141,
25 please, Dan? And what do you have here?

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1 A: This is a summary. We tallied the numbers that
2 were provided in a number of pages by medical
3 practice, the number of York.

4 **MR. MULLER:** Your Honor, let me stop the witness. I
5 understand the using of Demonstrative Exhibits
6 and we probably intend to, too. But it seems
7 that the practice has been to throw up a
8 Demonstrative Exhibit that may not be
9 admissible and allow the witness to read it
10 into the record. So what I'm seeing is an
11 Exhibit without any source documents to tell us
12 where it came from. This witness is going to
13 read into the record and make it admissible
14 evidence. I don't mind the witness referring
15 to an Exhibit that is admitted into evidence,
16 but to take various unknown sources, put it
17 into a document and then read it into the
18 records, seems to me to be beyond what a
19 Demonstrative Exhibit is intended to show. If
20 Mr. Andrews would like to question that
21 document that is in evidence, I don't have any
22 problem with that. But instead we're making
23 the inadmissible admissible.

24 **MR. ANDREWS:** Your Honor, fair objection in this one
25 sense, it's not a footnote, my mistake. This

1 is directly out of an Exhibit of Carolinas and
2 we'll be happy to lay the proper foundation for
3 that. It's from Exhibit 25.

4 **MR. MULLER:** If that's the case, I don't have any
5 problem with it, Your Honor. I just want to
6 make sure that we're not getting in through
7 another route something that might not be
8 admissible, Your Honor.

9 **MR. ANDREWS:** Let me point out, generally, Your
10 Honor. And I think there's been an exception
11 to this and if there is, let Mr. Muller correct
12 me. But it's certainly the intention to
13 identify materials, the sources of materials,
14 particularly when we're using data. And nearly
15 all of that ties to Exhibits. And where it
16 doesn't we need to lay a proper foundation for
17 that. I'll do that in this instance and we'll
18 go forward.

19 **MR. MULLER:** And while we're on this subject, Your
20 Honor. I've not been provided with any of
21 these Demonstrative Exhibits. And I understand
22 that maybe something that Mr. Andrews does not
23 want to do. But for the purposes of my cross
24 examination, I would like a copy of these
25 Demonstrative Exhibits that they're referring

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1 to.

2 **MR. ANDREWS:** Fair enough. There hadn't been a
3 request for them and now that you're making a
4 request, we'll give them to you. And I assume
5 you would do the same.

6 **MR. MULLER:** We will do the same, Your Honor.

7 **MR. ANDREWS:** Okay. Fair enough.

8 **THE COURT:** So you'll lay the foundation for this.
9 And in the future, if that's not clear then.

10 **MR. ANDREWS:** I will do that, Your Honor.

11 **THE COURT:** Thank you very much.

12 **MR. ANDREWS:** The way we'll do this, Your Honor, if
13 it's acceptable to you and Mr. Muller doesn't
14 have any objections, ask Ms. Sackett to provide
15 Mr. Muller and Ms. Biggers with copies of the
16 Demonstratives as we refer to them. That work?

17 **MR. MULLER:** And that's fine, Your Honor, I think we
18 can probably do the same thing after we use a
19 Demonstrative Exhibit, we will obtain a copy
20 and provide it to them.

21 **THE COURT:** And if that's acceptable to you, Mr.
22 Muller, then that -

23 **MR. ANDREWS:** I'm sorry, I didn't hear what he said.

24 **THE COURT:** Mr. Muller just said they'll do the same
25 thing basically. So they'll provide you with

1 copies of their Demonstrative Exhibits as
2 they're moving through.

3 **MR. ANDREWS:** All right. So let's begin by
4 providing Ms. Biggers and Mr. Muller a copy of
5 141.

6 Q: Dan, in order to lay the foundation for this,
7 let's look to the last page and then scroll
8 forward from Demonstrative 25, excuse me, from
9 Exhibit 25. All right. Forty-six, go to 2009,
10 if you would, please, Dan? Mr. Levitt, as Mr.
11 Bupp's making the transition to the start of
12 this series of pages, would you explain to the
13 Court what we're looking at?

14 A: Yes. This was information provided by
15 Carolinas that was referrals by zip code, by
16 practice for different time periods.

17 Q: And what were those time periods?

18 A: 2009 through 2011, I believe.

19 Q: If we look to the end of this, Dan, if you
20 could cut to the last page and if you can get
21 the last page showing there?

22 A: 2012, I'm sorry.

23 Q: 2012. And Demonstrative 141.1, what's
24 reflected here?

25 A: This is a summary of that data, is this.

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1 Q: And what's in the left-hand column?

2 A: The name of the practice, the various
3 practices. So this summarizes by practice, it
4 collapses all the zip code information by year
5 from 2009 to 2012 total referrals.

6 Q: Okay. In general terms -- well, why did you do
7 this in the first place?

8 A: To look at the trend, as I said, from 2009 to
9 2012 we experienced a decline in the
10 utilization. Piedmont wanted to see the
11 relationship between the Carolinas physicians,
12 the referral patterns. And what it showed was
13 that the total went from 1200 referrals in 2009
14 to CHS to over 5,000 by 2012. The biggest jump
15 though, was that Sanger-Rock Hill, went from
16 zero basically, to 2300.

17 Q: And what is the Sanger group?

18 A: Sanger is the cardiac group. So we took out
19 Sanger to look at the totals without Sanger.
20 Because, again, the Sanger-Rock Hill went from
21 zero to 2,100, Sanger-Fort Mill from zero to
22 500. So sort of look at a better trend we took
23 those out and you can see it went from 1200
24 cases in 2009 to nearly double, 2400 cases by
25 2012.

1 Q: Okay. And let's take a look at the second page
2 of this Demonstrative. What's reflected here?

3 A: This shows the majority of those cases, those
4 four medical practices, the primary care
5 physicians, the Medical Associates of Rock Hill
6 and Fort Mill and the Shiland Family Medicine
7 of Fort Mill and Rock Hill. Those four groups
8 represent over 80 percent of the total. So you
9 can see of the 1200 in 2009, a 1,000 of those
10 were attributable to those groups were 83
11 percent and that number is pretty consistent.
12 In 2012, it's nearly doubled, went from 1,000,
13 almost 2,000, and went from 1200 total to 2400.
14 But still, about 82 percent of those patients
15 were associated with those four groups.

16 Q: Now, are there four groups or two groups?

17 A: Well, it's two groups, four locations.

18 Q: Okay. And are many of the observations
19 concerning the changes at the various
20 locations?

21 A: You can see the growth, predominately Fort
22 Mill. The Medical Associates of Fort Mill went
23 from 160 to 542, almost a 240 percent growth
24 compared to a 34 percent growth for Rock Hill.
25 Family Medicine Group, same thing. Fort Mill

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1 increased by 163 percent compared to a 20
2 percent increase in Rock Hill.

3 Q: All right. Now, in addition to the changes in
4 referral practices, did you notice any changes
5 during this period of time in the Piedmont
6 Medical Center medical staff?

7 A: Yes.

8 Q: And did you identify those? Let's actually,
9 Dan, pull up Exhibit 26? And what is this a
10 list of, Mr. Levitt?

11 A: This is the list of CHS physicians who were
12 formerly in a leadership position from a period
13 of 2000 to 2012.

14 Q: And is this what you requested of the medical
15 staff from Piedmont?

16 A: It is. We asked for them to pull this list so
17 we could look at just what it says, the
18 leadership and who was affiliated with CHS.

19 Q: Have you discussed this list with Mr. Miller?

20 A: Yes, Mr. Miller reviewed the list after it was
21 compiled and had some adds to it.

22 Q: Okay. Have you prepared a Demonstrative
23 showing those?

24 A: I have.

25 Q: Or just highlighting, Dan, how about show that

1 to us? There we go. All right. And what does
2 this highlighting reflect, Mr. Levitt?

3 A: The highlighted ones are the actual CHS
4 physicians. There were some on the list that
5 weren't CHS physicians.

6 Q: Now, are these all separate, then? The
7 highlighted area, they're separate physicians
8 or does it include physicians who had multiple
9 positions?

10 A: It includes physicians that have multiple
11 positions. So, I believe, there are nine
12 unique physicians identified on here, but
13 they're listed multiple times.

14 Q: And if you go down to as late as 2010, what was
15 the position that Dr. Nathaniel Edwards had at
16 Piedmont?

17 A: He was the chief of staff and the chairman of
18 the medical executive committee and he was also
19 the chairman of the peer review committee.

20 Q: All right.

21 A: And he's a CHS physician.

22 Q: Now, let's turn to Exhibit 27. Dan, if you'll
23 pull that up? What does this list show, Mr.
24 Levitt?

25 A: This shows those physicians that practiced at

1 Piedmont Medical Center who did not renew their
2 privileges after they purchased by CHS.

3 Q: All right. Why did you ask for this document
4 to be prepared?

5 A: To see the trends. Again, we noticed the
6 utilization shift. We wanted to see what the
7 results were and the impact were on the medical
8 staff compliment at Piedmont Medical Center, as
9 CHS acquired additional physician practices.

10 Q: All right. And among the others, the second
11 group it says, Shiland Family Medicine. Is
12 that one of the groups you identified earlier
13 that had a major increase in referrals?

14 A: Correct..

15 Q: And did they resign their privileges at
16 different times or at one period?

17 A: No, they all resigned on the same day, August
18 25th of 2010.

19 Q: Okay. Let's go down a couple and look at the
20 Sanger Clinic. Do you know who those
21 physicians are?

22 A: Those are the cardiology physicians.

23 Q: And what does this document reflect concerning
24 their resignations?

25 A: That they all, well, a large number of them, I

1 would say, they all resigned within, I guess,
2 about a week of each other. So late June,
3 early July of 2011, they all resigned their
4 privileges at Piedmont Medical Center.

5 Q: Okay. And the last group on this page. Who is
6 that?

7 A: That's the Medical Associates of Rock Hill.

8 Q: And have you analyzed their referral pattern to
9 this period of time?

10 A: Yes. That was the other primary care physician
11 group that we looked at.

12 Q: And what does this reflect?

13 A: This shows that they also resigned their
14 privileges. The one physician in 2009 but the
15 other three in 2011.

16 Q: Now, do you know, in general terms, whether
17 these practices were acquired and the
18 physicians employed immediately before they
19 resigned or had they been in the Carolinas
20 System for some time before they resigned?

21 A: They had been owned by Carolinas for a period
22 of time before they resigned.

23 Q: Okay. Now, in general terms -- Dan, let's go
24 back to take a look at the issues that affected
25 the application. And Mr. Levitt, just let me

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1 draw your attention back to the changes and
2 discharges and utilizations and physician
3 ownership and referral patterns and the medical
4 staff, how did these developments that you just
5 reviewed affect Piedmont's position that was
6 reflected by your application?

7 A: Well, in 2005 when we submitted the application
8 we said that in the absence of a hospital
9 presence in northern York County the out-
10 migration would increase. Piedmont would
11 experience lower utilization, decreased patient
12 days and admissions and that's what happened.
13 That we did not get approved, we weren't able
14 to develop, we were approved but we weren't
15 able to develop the Fort Mill hospital and out-
16 migration multiplied and more patients left
17 York County for services in North Carolina.

18 Q: Okay. All right. Now, let's move forward to
19 the Department's decision in September of 2011.
20 Have you reviewed that decision?

21 A: Yes.

22 Q: All right. Have you analyzed it?

23 A: I reviewed and analyzed it.

24 Q: Okay. Have you developed a Demonstrative that
25 reflects your opinions about it?

- 1 A: I have several Demonstratives.
- 2 Q: Dan, let's begin with taking a look at
- 3 Demonstrative 91. And go through this, if you
- 4 would, Mr. Levitt?
- 5 A: Sure. This summarizes what DHEC, in their
- 6 decision, how they analyzed it, what they
- 7 accepted and what they rejected. You can see
- 8 they accepted the need to address out-migration
- 9 to the Carolinas Medical Center, proposed to
- 10 treat only their patients that were going to
- 11 North Carolina for services. They asserted
- 12 that it would have no impact on any providers,
- 13 because they were only treating their patients,
- 14 weren't going to treat anyone else's patients.
- 15 And their analysis of the financial projections
- 16 contained a number of flawed basis and we'll
- 17 talk about those in detail in a minute. From
- 18 the other column, the rejected column, they did
- 19 not accept Fort Mill's argument that there was
- 20 a need to strengthen the existing services in
- 21 York County. That there would be a tremendous
- 22 adverse impact on Piedmont if CMC were approved
- 23 or at the time, Presbyterian were approved.
- 24 And they misapplied the regulatory standards
- 25 related to the financial projections.

1 Q: Okay. Now, what I'm going to ask you to do,
2 Mr. Levitt, is began the process of introducing
3 the framework that's established through the
4 Department's regulations related to the review
5 and approval of competing applications, okay?

6 A: Yes.

7 Q: And you're familiar with that?

8 A: Yes.

9 Q: All right. Let's begin by pulling up the
10 regulation that addresses that issue. Dan, if
11 you'll pull up Exhibit 29, which is the Agency
12 regulations on page 22? And is that found at
13 regulation 61-15.307.2, Mr. Levitt?

14 A: No. Yes.

15 Q: Okay. And what does this section of the regs
16 provide?

17 A: Instructs DHEC how to analyze competing
18 applications.

19 Q: Would you read that into the record, please?
20 How should they do that?

21 A: In the case competing applicants, the
22 Department shall award a Certificate of Need,
23 if appropriate, on the basis of which, if any,
24 most fully complies with the requirements,
25 goals, purposes of a Certificate of Need

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1 Program, South Carolina Health Plan Project
2 Review criteria, and any regulation developed
3 by the Department.

4 Q: Okay. Let's start with this process by
5 identifying the purposes of the program. Dan,
6 if you'll pull up Demonstrative 92, please?
7 And what are they, Mr. Levitt?

8 A: The four purposes are: (1) to prevent cost
9 containment (2) to prevent unnecessary
10 duplication of healthcare facilities and
11 services, (3) is to guide the establishment of
12 health facilities and services that best meet
13 the public's needs, and, finally, to ensure
14 high quality services are provided in health
15 facilities in this state.

16 Q: Now, you've been working on this case nearly 15
17 years on the outside, is that right?

18 A: I suppose, yes.

19 Q: A long period of time. All right. Well, based
20 on your experience and your perspective, what
21 do you think are the key questions related to
22 this? Have you identified those?

23 A: Yes, we've identified the framework and key
24 questions.

25 Q: Dan, let's look at Demonstrative 94. And what

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1 are they?

2 A: Pull it down and look at the analysis. It's
3 what health planning needs are being addressed
4 by each applicant and what are the likely
5 benefits and risks associated with each project
6 to the residents of York County.

7 Q: Okay. All right. So we'll return to those at
8 the end of the case. But let's lay those out
9 -- or at the end of your testimony, as well.
10 And let's begin by working through the purposes
11 of the program that you just recently
12 identified. Let's start with the first goal is
13 cost containment, promoting cost containment.
14 In general terms, what's the purpose of that?

15 A: The purpose of cost containment is to assure
16 that capital expenditure is necessary and
17 there's a need for that before it's approved.

18 Q: Okay. And have you identified what those
19 principals are related to the application of
20 that purpose for the program?

21 A: Uh-huh (affirmative response).

22 Q: Dan, let's pull up Demonstrative 97. And
23 explain what they are if you will?

24 A: Well, again, to sort of put a little more flesh
25 on that, capital expenditures should not be

1 incurred unless there's a need demonstrated for
2 those. The cost containment principal serves
3 to authorize only those expenditures that are
4 valid health planning objectives that meet an
5 objective that is related to a valid health
6 planning concept. The reasonableness of the
7 expenditure compared to previously approved
8 projects should be analyzed. This is the area
9 that I alluded to you about the DHEC analysis,
10 rather than looking at the applicant that has
11 the lowest cost, it should be a reasonable
12 cost, it should be a needed cost and it should
13 be comparable to other services. And because
14 those numbers are easily manipulated, you can
15 put whatever number you want in the CON
16 application. If it's the lowest, it's the
17 lowest. And if DHEC were to say I'm going to
18 give it to the lowest applicant then everyone
19 with unreasonable numbers or questionable
20 numbers in and there's little monitoring of
21 that. So DHEC doesn't come back and say what
22 were your staffing costs in year three compared
23 to what you projected it to be in your CON
24 application and monitor that in any degree. So
25 the real test is is it reasonable as a

1 comparable to previous projects.

2 Q: Okay. All right. Let's begin by actually
3 applying these principals to your accounting
4 related to York County needs. So with regard
5 to the first one, that whether there is a need
6 for an expenditure of a major capital project.
7 How would you access that?

8 A: Yes, there's a need for an additional at least
9 64 additional beds in York County. There's a
10 demonstration of the Plan that there's a need
11 for more beds. So there is a need for
12 additional services.

13 Q: Okay. And with regard to the second principal,
14 the advancing of valid healthcare planning
15 objectives. What are the valid healthcare
16 planning objectives related to the needs of
17 York County?

18 A: That by spending the money to provide those
19 services, out-migration would be reduced and
20 the health delivery system and the providers in
21 York County would be strengthened.

22 Q: Okay. So there are two parts to that?

23 A: Correct.

24 Q: Okay. All right. Now, let's apply that second
25 principal to begin by looking at the extent to

1 which Carolinas meets it. With regard to the
2 first element of that, addressing the needs of
3 the county with regards to the residents you're
4 leaving. Does Carolinas proposal for purposes
5 of cost containment meet that need?

6 A: They proposed to treat residents that were
7 historically leaving to go to their facility,
8 no other residents, but those residents, yes.

9 Q: Okay. And with regard to the second objective,
10 to strengthen the healthcare infrastructure in
11 York County. Does Carolinas proposal address
12 that need?

13 A: No, they would have the opposite effect. They
14 would weaken the healthcare system in York
15 County.

16 Q: All right. Now, let's look at Piedmont's
17 proposal. Does Piedmont's proposal to
18 establish its hospital in Fort Mill address the
19 first need with regard to addressing the
20 residents who are leaving the county?

21 A: Yes, particularly in the remanded application.
22 The goal was to get the patients back that we
23 had in the past. Those patients that you saw
24 in the utilization go down at Piedmont from
25 2005 to 2010. So yes, the goal of the Fort

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1 Mill Medical Center was to reverse out-
2 migration and to treat residents of York County
3 in York County.

4 Q: And with regard to the second objective, which
5 is addressing the broader needs of residents of
6 York County. How does Piedmont's proposal
7 address those?

8 A: Yes, as we said in the application, both
9 applications, by having a presence in northern
10 York, we would be able to treat more York
11 County residents in York County and that would
12 have a positive impact on Piedmont. You heard
13 some testimony today and yesterday about the
14 volume and quality by having higher volume of
15 patients at Piedmont, it would increase the
16 strength and the services available at Piedmont
17 as well as the medical staff. You heard the
18 concerns of the physicians today and yesterday
19 about declining volumes and the impact on them.
20 So, yes, it would have an overall impact of an
21 overall positive impact on the health delivery
22 system in York County.

23 Q: All right. Now, with regard to the third test
24 under your principals relating to the
25 reasonableness of the expenditures. How do you

1 evaluate each applicants, the extent to which
2 they've met those?

3 A: You compare their level of expenditures
4 compared to similar projects. And both
5 applicants have capital expenditures comparable
6 to existing similar projects.

7 Q: Okay. Now, taking all of those three
8 considerations into account, how would you best
9 assess which of the two applicants meets and
10 best meets the goals and purposes and
11 requirements of promoting cost containment?

12 A: As I said, the Fort Mill application meets all
13 of those. There's a need. There is a valid
14 health planning objective. It reduces out-
15 migration and it strengthens the healthcare
16 delivery system in York County and the costs
17 are reasonable. The CMC application does not
18 strengthen the healthcare delivery care system
19 in York County, so it does not meet it. Fort
20 Mill Medical Center does meet those cost
21 containment principals.

22 Q: Okay. As we go through these, just to be able
23 to keep up with them, Dan, let's bring up
24 Demonstrative 167?

25 **THE COURT:** Mr. Andrews, I've been advised there are

1 some people that need to take a comfort break.

2 **MR. ANDREWS:** Absolutely, Your Honor.

3 **THE COURT:** Is this an appropriate time for us just
4 to break for ten minutes?

5 **MR. ANDREWS:** Certainly.

6 **THE COURT:** All right. We're at recess.

7 **(Off the Record)**

8 **THE COURT:** Please be seated. All right. We're
9 back on the record.

10 **MR. ANDREWS:** Before we resume, I thought it would
11 be helpful for you to be aware that we will go
12 into tomorrow with Mr. Levitt. He is one of
13 our principal experts.

14 **THE COURT:** I thought maybe you were.

15 **MR. ANDREWS:** So at anytime you want to break, just
16 let us know.

17 **THE COURT:** I would like to go as close to 6:00 or
18 so as we can. But if there's an appropriate
19 time before that, then that's fine.

20 **MR. ANDREWS:** Okay. Great.

21 Q: All right. Before we broke, Mr. Levitt, I was
22 asking you if you had prepared a grid that kind
23 of outlines the four purposes of the CON
24 program and I just asked you whether Piedmont
25 or Carolinas best meets the first, which is to

1 promote cost containment.

2 A: Yes, and this would be that grid and Piedmont
3 best meets the cost containment.

4 Q: Okay. Let's move to the second purpose then,
5 which is what?

6 A: To prevent unnecessary duplication.

7 Q: Okay. And what's the goal of this purpose in
8 the program?

9 A: Again, to ensure that resources that are
10 approved on your Certificate of Need are
11 necessary and the existing resources are
12 considered when that determination is made.

13 Q: Okay. And have you prepared Demonstratives as
14 you did with cost containment that weighs out
15 the principals related to this goal?

16 A: Yes.

17 Q: All right. Dan, let's pull up Demonstrative
18 99, please? And would you review those
19 principals for us, Mr. Levitt?

20 A: Sure. Again, certainly, the two principals
21 are, does the proposed project cause
22 unnecessary duplication, either directly or
23 indirectly, on existing providers in the
24 service area. And the second is, if it does,
25 is there a superior alternative that avoids

1 that adverse impact to the existing provider.

2 Q: Okay. All right. Well, let's apply these
3 questions to first, let's begin with Carolinas
4 application. With regard to Carolinas is there
5 a necessary duplication of proposed services
6 that's affected by their application?

7 A: Yes. That there's a need for additional acute-
8 care beds, existing acute-care beds, there are
9 existing acute-care beds in York County, so
10 from that perspective it's a duplication and
11 it's necessary. There's a need for additional
12 beds.

13 Q: All right. Under this principal is there any
14 wrong with duplication?

15 A: As long as it's necessary, no.

16 Q: Okay. It's unnecessary duplication that's the
17 issue?

18 A: Correct.

19 Q: All right. And your position is that a 64-bed
20 application, in of itself, is necessary or
21 unnecessary?

22 A: It is necessary in that there's a need for
23 additional beds.

24 Q: All right. That's the direct application of
25 the principal, how you evaluate the indirect

1 affect of Carolinas application?

2 A: Indirectly, if the CMC application were
3 approved, it would negatively impact the
4 resources at Piedmont Medical Center. We
5 talked about those speciality services that
6 Piedmont offers, the open heart surgery, the
7 cardiac cath, the level II-E neonatal intensive
8 care services. To the extent that CMC takes
9 patients away from Piedmont, those volumes go
10 down and the ability to offer those services
11 are negatively impacted.

12 Q: All right. Let's take a look, first of all, at
13 what the need is to address York County
14 residents that are leaving the county. Dan, if
15 you'll pull up Exhibit 99? This has been pre-
16 admitted into evidence. Mr. Levitt, what does
17 this table reflect?

18 A: This is a calculation that I performed. It
19 sort of duplicates the acute-care bed need
20 methodology in the Health Plan, but it also
21 adds in all York County residents.

22 Q: Tell us how it works?

23 A: So looking at York County residents, the total
24 patient days in 2005 were 93,415 and by 2011
25 that number had increased to 105,296 for an

1 average daily census of almost 289 patients.

2 Q: Tell us how the average daily census
3 calculation works?

4 A: Again, it's the patient days divided by the
5 number of days in the year. So in 2011, it's
6 365, so 288.5 is an estimate on the average
7 number of patients in a bed on any given day.

8 Q: And that's what you're reflecting there is,
9 what's the source of the patient days? Let me
10 ask you that.

11 A: The patient days is a database that everybody's
12 been using in all CON applications. It's the
13 South Carolina ROS data and the North Carolina
14 Thompson-Reuters data combined. So those
15 residents that were treated in South Carolina
16 are in the South Carolina database, those
17 residents that were treated in North Carolina
18 are in the North Carolina database. And we
19 extracted out the York County residents from
20 both of those the patient days for those
21 residents. And that's where we got the 93,000
22 and 105,000 patient days.

23 Q: Okay. Now, the total patient days, it's for
24 York County residents who receive hospital
25 care, is that right?

- 1 A: Correct. Regardless, of where they received
2 that, North Carolina or South Carolina. And
3 Georgia, I believe, is in there too, because
4 South Carolina data includes Georgia data as
5 well.
- 6 Q: So York County residents who receive services
7 at Piedmont would be a subset of those patient
8 day totals, would that be right?
- 9 A: Correct. Some of the patients were treated at
10 Piedmont, some were treated in North Carolina,
11 some were treated in Columbia, some were
12 treated in Charleston. So this is the total of
13 all patients, regardless of where they were
14 treated.
- 15 Q: Okay. And the average daily census would
16 reflect what?
- 17 A: Again, that's the patient days divided by 365
18 and that reflects the average number of
19 patients in a bed on an average day. So we had
20 289 patients by 2011 and we used that
21 population in 2011, divide the two, multiply by
22 the 2018 population to get an estimated 116,000
23 patient days, divide that by 365 to get 319
24 average daily census, assuming 65 percent
25 occupancy rate results in a need for 491 beds.

1 Again, we had 288 total beds, the 268 acute,
2 plus the psych. This includes all psychiatric
3 days as well.

4 Q: And you're referring into 288 being at
5 Piedmont?

6 A: At Piedmont in York County, those are the only
7 beds in York County for a difference of 203
8 beds. So in order to treat all of York County
9 residents in York County in 2018, based off of
10 2011 utilization we need about 200 beds, 200
11 additional beds.

12 Q: All right. Now, in that regard to what degree
13 does Carolinas meet that need to provide
14 services to the average daily number of York
15 County residents hospitalized out of the
16 county?

17 A: They only proposed 64 beds, so it's a fraction
18 of that.

19 Q: Okay. All right. Let's move to what you've
20 identified as the other indirect element which
21 is the effect on the services available to all
22 York County residents. How have you evaluated
23 that issue? Did you develop any Exhibits that
24 show the extent to which York County services
25 have been affected?

1 A: Yes. We looked at the utilization by product
2 line of various services for York County
3 residents at Piedmont Medical Center and to the
4 North Carolina products.

5 Q: And let's look at Exhibit 108. Is this an
6 Exhibit that you've prepared, Mr. Levitt?

7 A: It is.

8 Q: And what is it?

9 A: Again, from that same database, the North
10 Carolina and South Carolina combined databases.
11 We looked at the 2005, 2009, 2011 utilization
12 by year, by provider, by product line. So
13 going down the first left column is the product
14 line. We looked at the various product lines,
15 burns, cardiovascular medicine, cardiac cath
16 and EP, on down the line. And the categories
17 we looked at were the CHS Charlotte Hospitals.
18 And those are those four hospitals that CHS
19 identified would be the source of redirected
20 patients to their Fort Mill facility, CMC-Main,
21 CMC-Pineville, CMC-Mercy, and CMC-University.
22 We looked at those in total. We looked at the
23 other CHS hospitals. We looked at other
24 hospitals. And then we looked at Piedmont.
25 And obviously, if you add all those together,

1 you get the total. So we looked at the trends
2 from 2005 to 2009 to 2011.

3 Q: Okay. And have you prepared a Demonstrative
4 that shows the total market share comparison of
5 those services and how they evolved over that
6 secure period?

7 A: Yes.

8 Q: Dan, let's pull up Demonstrative 173, please?
9 And what is this reflect, Mr. Levitt?

10 A: This shows that in 2005 overall Piedmont, the
11 red, had about a 63 percent market share and
12 the Carolinas Charlotte hospitals had about 20
13 percent market share. You can see Piedmont's
14 lost market share went from 63 percent to 52
15 percent by 2011. At the same time, Carolinas
16 Charlotte went up by 11 percentage points,
17 almost 50 percent increase from 2005, and 20
18 percent to 32 percent.

19 Q: And we're comparing, again, market share of
20 what?

21 A: This is total market share of all discharges
22 for York County residents.

23 Q: Okay. All right. And did you look at a subset
24 of this data?

25 A: I did. Again, the data we showed looked at it

1 by product line and we graphed a number of
2 those product lines.

3 Q: Okay. And let's begin with an overview on
4 Demonstrative 81, please, Dan? And what does
5 this show, Mr. Levitt?

6 A: Well, the last graph showed all patients, all
7 York County residents regardless of their
8 severity of illness. We also wanted to look at
9 the sicker patients, the higher acuity
10 patients, the graph identifies in shorthand,
11 CMI or case mix index greater than two. Those
12 patients that have a higher acuity or sicker
13 patients and what was market share trends for
14 those patients. And as demonstrated from 2005
15 to 2011 had about a 50 percent market share,
16 those more severe patients stopped going to
17 Piedmont or were redirected to North Carolina.
18 So we went down to a 36 percent market share.
19 During that same time period CMC-Charlotte had
20 about a 30 percent share and they exceeded
21 Piedmont by 2011 and a 42 percent market share
22 for more patients. More of the higher acuity
23 patients were leaving York County than were
24 staying.

25 Q: All right. And so based on this overview of

1. the shift of the product lines and total
2 discharges, does either of the projects create
3 an unnecessary duplication on Piedmont, which
4 is the existing provider in the service area?

5 A: Yes. That the resources at Piedmont for those
6 higher acuity, tertiary level, sometimes,
7 patients are available and were used in 2005.
8 Half of the patients stayed, 30 percent left
9 and another 20 percent were treated in other
10 places in South Carolina. And that changed, so
11 we have resources that were historically
12 utilized that are no longer utilized. And, as
13 we said, as you heard from the physicians, the
14 direct relationship between quality and volume
15 and the ability to continue to offer these
16 services are negatively impacted as the volume
17 goes down.

18 Q: Okay. Now, the second part of your analysis
19 under this purpose of the program was to
20 evaluate whether there's a superior alternative
21 that avoids adverse impacts to existing
22 providers?

23 A: Correct.

24 Q: Is there one?

25 A: Yes.

1 Q: What is it?

2 A: The Fort Mill Medical Center. By approving the
3 Fort Mill Medical Center, reversing the out-
4 migration, the acute care patients would be
5 treated in York County. And not just the
6 primary care patients at Fort Mill Medical
7 Center, but also those requiring tertiary
8 services or the higher acuity services, case
9 mix greater than two, would then be referred to
10 Piedmont for services. The CMC-Fort Mill
11 patients, if treated at CMC-Fort Mill and
12 required a level of care beyond that offered at
13 Fort Mill Hospital would be sent to Charlotte,
14 not to Piedmont.

15 Q: Okay. And given your testimony, which of the
16 applicants best meets the purpose of the second
17 goal of the program to prevent unnecessary
18 duplication?

19 A: Piedmont's application for the Fort Mill
20 Medical Center.

21 Q: All right. Let's move to the third purpose,
22 which is to guide the establishment of
23 facilities that would best serve public needs.
24 What's the purpose of this particular goal of
25 the program?

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1 A: This is a broad goal that allows DHEC to
2 consider other factors that aren't specifically
3 outlined in the project review criteria.

4 Q: All right. And have you analyzed the
5 applications to determine which of the
6 applicants best meets this objective?

7 A: Yes.

8 Q: All right. And have you identified the issues
9 that you have addressed related to it?

10 A: Yes. We've identified three issues.

11 Q: Okay. Let's take a look at Demonstrative 174,
12 Dan? And what are they, Mr. Levitt?

13 A: Those three issues of the contract with York
14 County, the taxes paid and the issues
15 identified at the site.

16 Q: Sorry.

17 A: Sites, plural.

18 Q: Okay. All right. Let's begin with the first
19 one. There's already been some testimony about
20 the contract between Piedmont Medical Center
21 and York County. Have you reviewed the
22 contracts?

23 A: Yes. I've reviewed the contracts and the
24 addendum and all the addendums, so I'm familiar
25 with them.

1 Q: You're familiar with them?

2 A: Yes.

3 Q: All right. And have you prepared a
4 Demonstrative that addresses your opinions
5 concerning that?

6 A: Yes.

7 Q: All right. Let's pull up Demonstrative 100,
8 please, Dan? What does this show, Mr. Levitt?

9 A: This shows the benefits that are afforded from
10 the York County contract with Piedmont Medical
11 Center. Their transparency, you heard Mr.
12 Masterton talk about the quarterly and annual
13 reports provided to the county was public
14 information available. And then the
15 obligations in the contract, things that the
16 hospital's required to provide, the reasonable
17 pricing provision, the ambulance services that
18 are operated at a substantial loss to the
19 hospital. Then annual investments in capital
20 and then the charitable contributions and
21 educational scholarships and things like that
22 are required in the contract.

23 Q: All the hospitals you've represented, and there
24 have been many based on your testimony, have
25 any had any comparable contractual

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1 responsibilities to the counties in which there
2 are located?

3 A: Not that I'm aware of, no.

4 Q: Okay. Does Carolinas Medical Center have any
5 contractual, similar or any contractual
6 relationship at all with Mecklenburg County to
7 your knowledge?

8 A: They had one in the past but they no longer
9 have a contract with the county.

10 Q: All right. Was there a lawsuit related to that
11 contract?

12 A: There was.

13 Q: Okay. The second issue you identified was
14 taxes. Let's pull up Exhibit 30, Dan? While
15 it's coming up, Mr. Levitt, what's the
16 significance, your opinion, related to taxes
17 that have been identified as an issue in this
18 case?

19 A: Well, there's a public benefit to the residents
20 of York County by the payment of taxes,
21 property taxes in this case, to the various
22 municipalities that can then use the tax money
23 for benefit of the residents.

24 Q: Okay. Let's identify on the upper left-hand
25 box, Dan, what the sources of the taxation are?

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1 A: Yes. For the Fort Mill project there are four,
2 York County, the town of Fort Mill, the Fort
3 Mill school district and then the other county
4 schools.

5 Q: Okay. And have you reviewed these documents
6 and submitted them to the Department during its
7 review?

8 A: Yes.

9 Q: Okay. And let's look in the right-hand corner
10 of this lower right-hand box, what's the extent
11 of the taxes that are projected to be paid by
12 Fort Mill Medical Center, Mr. Levitt?

13 A: Approximately, a little over \$4 million in
14 total annually for the Fort Mill Medical Center
15 and property taxes.

16 Q: Okay. Now, how should in your view, the taxes
17 be taken into consideration in consideration of
18 these applications?

19 A: Well, from the framework that we've been
20 talking about from the purpose of the Act, that
21 the fact that \$4 million additional dollars
22 every year are available to the residents of
23 the area, it's positive and beneficial.

24 Q: Okay. All right. Now, let's move to the third
25 issue that you've identified, which is Exhibit

1 31. This relates to the site, I believe, or
2 the sites?

3 A: Correct.

4 Q: During the Department's review of the
5 applications, did you make your presentation to
6 the Department through a video presentation
7 about the sites?

8 A: I did, during the project review presentation
9 I presented a video that showed the proposed
10 CMC site.

11 Q: Okay. Let's take a look at that. And as this
12 is coming up, explain what we're looking at.

13 A: Okay. This is from the Google Earth, you
14 remember this is standing on the bridge,
15 basically over 77 facing the site. The car
16 just passed the sign there.

17 Q: Which site?

18 A: The CMC-Fort Mill site. The car that just
19 passed the sign there is the sign for the, I
20 believe, Mr. Westbrook referred to that as the
21 frontage road entrance. You can see the truck
22 turning to the right there into Love's Truck
23 Stop. The other truck coming towards us, I
24 believe, is going to turn right onto 77 south.
25 It might continue forward actually, yeah, it's

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1 continued forward. You can see the traffic
2 going, another truck came out of the Love's
3 Truck Stop. Again, if it had gone straight, it
4 would have gone onto the frontage road entrance
5 into the CMC-Fort Mill proposed hospital site.
6 And again, I guess this would be looking
7 northwest and there, that truck's turning left,
8 that's the entrance ramp onto 77. And then
9 again, this truck is turning right onto 77
10 south.

11 Q: And what are we looking at here?

12 A: This is from the road further down, that's
13 looking into the Love Truck Stop parking lot.

14 Q: All right. What's the significance of what
15 you've just shown and the presence of the truck
16 stop across the street from the proposed
17 entrance to the hospital site?

18 A: Well, you can see it from the video, the heavy
19 truck traffic, the parking lot you could see a
20 number of trucks. I think you can see the one
21 here with the giant tires on it was one of the
22 ones that drove by it during the filming, it's
23 parked there. And you heard Mr. Walsh talk
24 about some of the access issues, the two-lane
25 road and the issues with the traffic lights.

1 You know, entering into a hospital,
2 particularly for an ambulance, even though it
3 has lights and sirens, if there's an 18-wheeler
4 in the way, they have a lot more trouble
5 pulling off to the side of the road than a car.
6 So for an emergency entrance for an ambulances,
7 things like that makes it much more difficult
8 to get to a hospital when there's a lot of 18-
9 wheelers around.

10 Q: All right. Based on your considerations of
11 these three factors, which of the applicants
12 best meets the public needs?

13 A: The Fort Mill Medical Center.

14 Q: Okay. All right. Let's pull up Exhibit 167
15 and have that reflected on the grid. Okay.
16 And the final purpose is identified there, Mr.
17 Levitt, relating to the ensuring high quality
18 services in this state. What is the purpose of
19 this goal of the program?

20 A: The purpose of that is to assure that, again,
21 approval of the CON application wouldn't
22 detract from the quality of existing providers
23 in the state.

24 Q: All right. And what effect would approval of
25 Fort Mill Medical Center have on the quality of

- 1 services in York County?
- 2 A: It would have a negative impact. As we talked
3 about to the degree that volume is reduced at
4 Piedmont Medical Center, the ability to offer
5 speciality services available there. The
6 volume of those services would all be
7 negatively impacted. And it could have a
8 negative impact on quality.
- 9 Q: That's on Carolinas development of the ---
- 10 A: Approval of the Carolinas Medical Center at
11 Fort Mill, yes.
- 12 Q: Have you developed a Demonstrative that
13 identifies the quality concerns that you have?
- 14 A: Yes.
- 15 Q: All right. Dan, pull up 167, please? I'm
16 sorry, it's actually 101 or is it 167? All
17 right. And what do you have here, Mr. Levitt?
- 18 A: These are the areas that we talked about,
19 reduce the quality of open heart and
20 cardiovascular services by reducing volume,
21 physician availability, and access to
22 resources, other complex services, including
23 neurosurgery, women's services, neonatal and
24 speciality care, the level II-E that they
25 provide at the hospital would all be impacted

1 by reduced volume and physician availability,
2 quality of the payor mix. I guess it was Dr.
3 Taylor spoke a lot about the impact of payor
4 mix by redirecting patients. The payor mix at
5 Piedmont's negatively impacted to the extent
6 that managed care and commercial patients are
7 treated either at the CMC-Fort Mill or in North
8 Carolina. And then the medical staff, the
9 ability to retain and recruit quality medical
10 staff as volume goes down is negatively
11 impacted. And finally, to the extent that
12 nursing staff leave, either from the perception
13 that volumes and quality and financial
14 liability are going to be decreased or from
15 reality that they're offered jobs at the new
16 CMC-Fort Mill Medical Center will have a
17 negative impact on Piedmont Medical Center.

18 Q: Okay. All right. As a result of that, what do
19 you think that approval of Fort Mill Medical
20 Center by Piedmont would have on the quality of
21 services in York County?

22 A: Well, again, it would have the opposite effect.
23 It would increase the volumes in York County
24 provided by Piedmont Medical Center at both
25 locations, increasing the volume also of

1 tertiary services or higher level services,
2 increasing open heart referrals by having a
3 larger base, of acute-care of patients.
4 Assuring that the level II-Es services are at
5 a volume that maintains that quality.
6 Additional staffing, nurse staffing, rather
7 than losing staff we hire additional staff.
8 And the medical staff, again, would grow, both
9 at Piedmont and at the Fort Mill Medical
10 Center. So it would all, taken in total, would
11 have a positive impact on quality.

12 Q: All right. Dan, let's pull up the
13 Demonstrative 167? Mr. Levitt, which of the two
14 applicants, Fort Mill Medical Center or
15 Carolinas-Fort Mill would best ensure a
16 continued delivery of high quality services in
17 York County?

18 A: Piedmont's application for Fort Mill Medical
19 Center.

20 Q: Okay. All right. Let's turn, Mr. Levitt, to
21 the project review criteria. First of all,
22 what's your relationship between the purposes
23 of the program and the more detailed criteria?

24 A: Well, just that. That the project review
25 criteria provides more detailed analysis or

1 direction as far as how to analyze the CON
2 application relative to the purposes of the
3 Act.

4 Q: How many criteria are there, do you know?

5 A: I think there's 30 some odd criteria in total.

6 Q: Okay. And are they all equally applied to
7 applications presented to the Department?

8 A: No. The Department identifies those criteria
9 that are most appropriate, most applicable and
10 of the highest weight.

11 Q: Did that happen in this case?

12 A: Yes.

13 Q: Okay. All right. Dan, let's take a look at
14 Exhibit 2, page 479? And what is this, Mr.
15 Levitt?

16 A: This is the complete letter for CON
17 application.

18 Q: What does a complete letter mean?

19 A: This is the letter that notifies the applicant
20 that the information submitted to the
21 Department is sufficient to start the review
22 process and it identifies the project review
23 criteria and the relative importance of those
24 criteria that are going to be used to review
25 the CON application.

- 1 Q: Okay. And are they set forth there in the
2 center of the letter?
- 3 A: They are.
- 4 Q: Okay. And have you applied those to a separate
5 Exhibit?
- 6 A: Yes, we developed a grid based on that.
- 7 Q: Okay. Now, before we move to that grid, the
8 first criterion and identified in this letter
9 is what?
- 10 A: Complies with the State Health Plan.
- 11 Q: And is that unusual?
- 12 A: That's always the first criterion of every CON
13 application I've ever seen in South Carolina.
- 14 Q: All right. And then there are different
15 categories of criteria that were identified in
16 this case by the CON staffer who sent the
17 letter to you, Ms. Fechtel, is that right?
- 18 A: Correct.
- 19 Q: Okay. And let's look at Demonstrative 102.
20 And what are we looking at here?
- 21 A: This shows those, other than the first one that
22 complied with the Health Plan, shows those
23 other criteria in order of groupings of those
24 three rankings. The second category, the third
25 category, and the fourth category.

- 1 Q: And why is the first ranking missing?
- 2 A: Because Judge Matthews on the remand indicated
3 that all applicants had met that.
- 4 Q: Okay. And these other rankings -- and how in
5 your experience, has the Department applied the
6 criteria identified by the various rankings?
- 7 A: They generally look at the language in the
8 regulations that are specifically identified
9 under each of these criteria.
- 10 Q: Okay. All right. Now, there are a lot of
11 criteria here that are referenced. And we'll
12 work through each of them. But with regard to
13 the issues that are emerged from the criteria,
14 have you identified them?
- 15 A: I have, yes.
- 16 Q: Okay. Now, let's take a look at that on
17 Demonstrative 103, please, Dan? And what does
18 this show, Mr. Levitt?
- 19 A: The three general areas that those criteria fit
20 under are need, adverse impact, and financial-
21 related issues. From a need perspective, the
22 question is what needs based on valid health
23 planning objectives are demonstrated and who
24 best demonstrates those. From an adverse
25 impact perspective, what would be the impact of

- 1 either applicant if approved on the existing
2 health services. And finally, from a financial
3 perspective what are the material differences
4 in the financial information we compared to
5 similar facilities.
- 6 Q: Okay. All right. Let's begin by beginning at
7 the top and working through these different
8 project review criteria. And let's start with
9 section 2, that is the community need
10 documentation. Let's begin by actually turning
11 to the regulations themselves, Mr. Levitt and
12 read for the record the paragraph 802.2(a) it's
13 on page 25 on Exhibit 29?
- 14 A: Community documentation 2(a) target population
15 should be clearly identified as the size,
16 location, distribution and socially economic
17 status if applicable.
- 18 Q: Okay. Now, the Department found that in terms
19 of target population, that all the applicants
20 equally met this. What's your opinion?
- 21 A: Yes. They both identify in the same target
22 area, which is York County.
- 23 Q: Okay. And let's move onto the second
24 criterion, which is paragraph (b). What does
25 this address?

- 1 A: 2(b) says: Projections of anticipated
2 population changes should be reasonable and
3 based on accepted demographic statistical
4 methodologies with assumptions and
5 methodologies clearly presented in the
6 application. The applicant must use the
7 population statistics consisted with those
8 generated by the state demographer, State
9 Budget and Control Board.
- 10 Q: And again, the Department here identified or
11 concluded that both applicants met this
12 provision. What's your opinion?
- 13 A: I agree, both applicants met that.
- 14 Q: Okay. Let's go ahead and begin a grid. And
15 let's focus it, Dan, let's look at
16 Demonstrative 168.2, which identifies the
17 subpoints of section 2. Is that what this
18 shows, Mr. Levitt?
- 19 A: Yes, 2(a) through (e).
- 20 Q: Okay. And then what are the findings under
21 2(a) and 2(b)?
- 22 A: They both equally meet.
- 23 Q: And so each get a check?
- 24 A: Correct.
- 25 Q: That would be under (a) and (b)?

- 1 A: Yes, (a) and (b), correct.
- 2 Q: All right. Now, let's move onto the third
- 3 provision withing the section 2(c). Dan, if
- 4 you'll pull up that again? And Mr. Levitt,
- 5 please read that section.
- 6 A: The proposed project should provide services
- 7 that meet and identify need (documented) need
- 8 of the targeted population. And the
- 9 assumptions and methods used to determine the
- 10 level of need should be specified in the
- 11 application, based on a reasonable approach and
- 12 judged the reviewing body. Any deviation from
- 13 the population projections used in the South
- 14 Carolina Health Plan should be explained.
- 15 Q: Okay. Now, generally, what's the purpose of
- 16 this provision?
- 17 A: Again, this is the documentation of the need,
- 18 while there may be a need identified in the
- 19 Plan, the applicant is still incumbent upon the
- 20 applicant to demonstrate the need and document
- 21 the need and identify the target population.
- 22 Q: And who is the target population here?
- 23 A: Residents of York County.
- 24 Q: Okay. And have you identified in a
- 25 Demonstrative the needs related to this

1 section?

2 A: Yes.

3 Q: All right. Dan, pull up Exhibit 202, please?
4 And what are they, Mr. Levitt?

5 A: The population of York County obviously is the
6 target population as we said. And the two
7 areas to look at are, do the applicants address
8 out-migration and the services for York County
9 residents.

10 Q: Okay. All right. Let's go back, with regard
11 to the first issue of addressing the out-
12 migration. What's your basis for identifying
13 what the need is for out-migration? You've
14 earlier testified about Exhibit 99. Dan, let's
15 pull that up? What is this?

16 A: This is the utilization of all York County
17 residents. So those patients not treated in
18 York County are those out-migrating. So if all
19 York County residents were treated in York
20 County there would be a need for about 200 more
21 beds than are currently available.

22 Q: Okay. All right. Let's take a look at the
23 second part of the two-part test that you
24 presented related to strengthening the county
25 healthcare system. Now, previously you had an

1 overview the product line changes. Do you
2 remember that?

3 A: Yes.

4 Q: All right. Now, did you further analyze that
5 data?

6 A: Oh, yes.

7 Q: All right. It's a lot to work with, isn't it?

8 A: Yes, it was a lot of data.

9 Q: Okay. All right. Let's take a look at, Dan,
10 Demonstrative 182. And what have you done
11 here? And let's talked about what you've
12 analyzed specifically, Mr. Levitt, with regard
13 to specific product lines.

14 A: So looking at those product lines that
15 experienced the greatest shift from 2005 to
16 2011, we looked at the change in market share
17 for those specific product lines. And just as
18 we graphed the change for Piedmont and for
19 Carolinas Medical Center-Charlotte, we looked
20 at the same change by product lines that have
21 been totaled.

22 Q: Okay. And which product lines have you
23 identified here?

24 A: We looked at the ten that were identified as
25 having the largest change from 2005 to 2011.

1 Q: And what's showing on this particular
2 Demonstrative, which is 180.1?

3 A: 180-01 shows the cardiac cath and EP market
4 share from 2005 to 2011. It shows Piedmont had
5 about an 80 percent market share in 2005, down
6 to about a 56 percent market share by 2011. At
7 the same time CMC-Charlotte, the four hospitals
8 went from 11 percent market share to a 29
9 percent market share.

10 Q: Okay. And let's continue to move forward
11 through this set of Demonstratives. And 180-
12 02?

13 A: This is for the open heart surgery product
14 line. Again, similar trend, Piedmont declined
15 while CMC-Charlotte went up. From 50 percent
16 for Piedmont in 2005 to about 40 percent and
17 CMC-Charlotte went from about 28 percent to 39,
18 40 percent in the same time period. So they
19 had about the same market share in 2011 for
20 open heart surgery.

21 Q: All right. And have you further analyzed the
22 cardiovascular medicine changes in market share
23 in 180-03?

24 A: Yes. And this is the medical side of
25 cardiovascular services and it shows the same

- 1 trend, decrease from Piedmont from 67 to 54
2 percent with a doubling of the CMC-Charlotte
3 market share from 16 to 30 percent.
- 4 Q: All right. Let's move to a different service,
5 looking at changes in the OB market on 180-04.
6 What do you have here?
- 7 A: Again, similar trend, not as dramatic, but a
8 decrease in OB market shares, 63 percent to 55
9 percent for Piedmont with an increase at CMC-
10 Charlotte from 25 to 32 percent.
- 11 Q: Okay. Let's take a look at some product line
12 changes related to surgery. Particularly, the
13 next slide at 180-05, what does this show?
- 14 A: This shows the plastic surgery market share.
15 This shows basically a flip, so we were at 55
16 percent, Piedmont was at 55 percent in 2005,
17 went down to 25 percent by 2011. CMC-Charlotte
18 was at 26 percent in 2005, they went to 58
19 percent by 2011. So a complete reversal of
20 market for that service line.
- 21 Q: All right. Let's look at the next one in
22 vascular surgery at 180-06. What's showing
23 here?
- 24 A: Again, consistent with cardiac 70 percent
25 market share in 2005 at Piedmont, down to 46

1 percent by 2011. And then, basically a
2 doubling of the CMC-Charlotte market share of
3 17 to 33, 34 percent by 2011.

4 Q: And the next one related to orthopaedic
5 surgery?

6 A: Orthopaedic surgery, similar to plastics, a
7 reversal of 51 percent for Piedmont down to 33
8 percent and a doubling for CMC-Charlotte from
9 22 percent to 44 percent. So now, CMC-
10 Charlotte had the larger market share for
11 orthopaedic surgery than Piedmont does of York
12 County residents.

13 Q: Okay. And the general surgery market
14 comparison and 180-08?

15 A: Again, similar trend, 64 percent down to 46
16 percent for Piedmont, 20 percent to 37 percent
17 for CMC-Charlotte.

18 Q: Let's take a look at the next one for
19 neurosurgery. How has the market share for
20 Piedmont and Carolinas changed over that same
21 period of time?

22 A: Again, this is one where CMC had a larger
23 market share in 2005 than Piedmont did. They
24 had about 50 percent market share in 2005,
25 they're up to a 63 percent market share while

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1 the volumes at Piedmont have dropped off
2 dramatically, 30 percent down to 16 percent by
3 2011. And we talked about the county contract,
4 that is one of the services that's identified
5 as being mandated to be offered at Piedmont
6 through the county contract.

7 Q: Okay. And we also heard from -- let's look at
8 the next one, in 180-10. We heard earlier
9 today from or yesterday from Dr. Adlakha.
10 What's reflected in this pulmonary medicine
11 market share comparison?

12 A: This is consistent with what Dr. Adlakha had
13 said. The volumes are down at Piedmont. The
14 market share is down 73 percent, a strong
15 market share in 2005 down to 60 percent by
16 2011. And CMC-Charlotte up nearly tripled, 13
17 percent or doubled, 13 to 26 percent.

18 Q: Okay. Now, have you also looked at the trends
19 within certain service areas?

20 A: Yes.

21 Q: All right. Dan, let's pull up Demonstrative
22 179? And what does this reflect, Mr. Levitt?

23 A: This is the complex plastic surgery. So these
24 are the plastic surgery product line with a
25 case mix greater than two. And what it shows

1 is, again, a dramatic drop, 63 percent market
2 share in 2005 to about an 18 percent market
3 share, a 19 percent market share by 2011 at
4 Piedmont. And reversal again, 16 to 63
5 percent.

6 Q: Now, when you identified this earlier as being
7 cases with a case mix index or acuity rating of
8 over 2.0, are these the kind of cases that
9 would be commonly done at a small hospital like
10 CMC-Fort Mill or Fort Mill Medical Center?

11 A: No, generally, these would be done at a larger
12 hospital.

13 Q: Okay. All right. Then beyond a complex
14 plastic surgery, what you have analyzed at
15 179.2?

16 A: Again, these are what we labeled as complex
17 cath and EP patients. Those are those with
18 the case mix greater than two. And similar to
19 what we had shown on most of these graphs, the
20 market share for Piedmont's declined pretty
21 dramatically, 76 percent to 42 percent, while
22 CMCs doubled from 15 to 40 percent.

23 Q: What would be involved in these cath and EP
24 services?

25 A: These are the sicker, higher acuity cardiac

1 cath patients. And this is one of those
2 speciality services we talked about at Piedmont
3 that's offered. And there's a tremendous body
4 of literature that correlates volume and
5 quality for cardiac services.

6 Q: Okay. Let's look at the next one at 179.3.
7 What does this reflect?

8 A: These are the complex orthopaedic surgery
9 cases. Again, showing the same trend.
10 Piedmont declining while CMC increased to a
11 point where in 2011, CMC-Charlotte had a higher
12 market share than Piedmont for the complex
13 orthopaedic surgery cases of York County
14 residents.

15 Q: All right. Then, 179.4 addresses complex
16 vascular surgery. What have you observed here?

17 A: Again, similar trend. Piedmont declined while
18 CMC has grown.

19 Q: Okay. Now, have you grouped the services into
20 various categories?

21 A: Yes.

22 Q: Let's take a look at 175. What does this
23 relate to, Mr. Levitt?

24 A: This combines cardiovascular medicine, cath/EP,
25 and open heart surgeries as sort of cardiac,

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1 heart-related procedures with a case mix
2 greater than two. Again, went from 60 percent
3 market share compared to a 21 percent market
4 share at CMC. So in 2005, Piedmont had three
5 times the market share that CMC had and by
6 2010, they are the same. I think that should
7 say 2011.

8 Q: In the bottom right-hand?

9 A: Yes.

10 Q: Instead of 2010, it should be 2011?

11 A: I believe so.

12 Q: And that's the database that you had
13 identified?

14 A: Correct.

15 Q: Okay. Thank you for that correction. All
16 right. Have you analyzed any other groupings
17 of services?

18 A: Yes.

19 Q: All right. Demonstrative 176, what does this
20 include, Mr. Levitt?

21 A: This is sort of compilation of all the complex
22 surgery cases. These are the case mix index
23 greater than two. But the high acuity patients
24 includes orthopaedic surgery, general surgery,
25 vascular surgery, plastic surgery, urology,

1 neurosurgery, oncology, spinal fusion, and ENT.

2 Q: And why have you compiled the data and looked
3 at them as a whole like this?

4 A: To look at the overall service lines. This
5 would be the impact on the surgical services,
6 all surgical services at Piedmont. And you can
7 see, again, in 2005 we had almost double the
8 market share that CMC-Charlotte had, 50 percent
9 market share at Piedmont versus 28 percent.
10 The lines crossed and by, again, I think that
11 should say 2011, Piedmont had a lower market
12 share than CMC for the surgical cases.

13 Q: And let's let the record be clear that the
14 change in market share for Piedmont and
15 Carolinas was for York County?

16 A: These are all York County residents, correct.

17 Q: All right. Okay. All right. Did you in
18 reviewing this data, did you make a
19 determination of the extent to which the
20 services Piedmont provided at its hospital were
21 reduced?

22 A: Yes.

23 Q: All right. And have you prepared a
24 Demonstrative that demonstrates that?

25 A: Yes.

1 Q: Okay. Let's look at that. Dan, Demonstrative
2 177.

3 A: The slides we had just looked at showed the
4 changes in market share. Now, this shows a
5 relative impact of those changes. So plastic
6 surgery, while we showed the market share
7 changing this gives a better idea of the volume
8 impact. So plastic surgery, the volume's down
9 from 2005 to 2011 down by 57 cases. But that's
10 74 percent of the total plastic surgery volume
11 at Piedmont. You can see that's a big
12 percentage of the total. Again, going down the
13 line, cath/EP, 60 percent decline.
14 Neurosurgery, 52 percent decline.

15 Q: Sorry, what did you say the cath/EP decline
16 was?

17 A: 56 percent.

18 Q: Okay.

19 A: Neurosurgery, 52 percent decline. Vascular
20 surgery, 52 percent. ENT surgery, 50 percent
21 decline. GYN surgery, 50 percent decline in
22 volume, and down the line. So you can see down
23 to cardiovascular medicine, these are in order
24 of impact. Cardiovascular medicine, about 300
25 case loss or about 25 percent of the volume at

1 Piedmont.

2 Q: Now, when a hospital loses anywhere from a
3 quarter to three quarters as is reflected in
4 this Exhibit of its volume in a particular
5 service line, what generally is the effect of
6 that?

7 A: Well, it can have a dramatic impact on ability
8 to offer those services. The hospital may need
9 to cease offering those sort of speciality
10 services. Staff may be laid off. Service
11 lines closed. Patients wouldn't have access to
12 those services. And some physicians may leave.

13 Q: All right. Let's apply the findings that
14 you've made to concerning the need to address
15 the out-migration and the need to address the
16 effects of the volume reduction that both
17 Carolinas applications and Piedmont
18 applications would have on the needs you've
19 identified. Let's start with Carolinas. To
20 what degree would that facility at CMC-Fort
21 Mill address the need for what exists to serve
22 the over 200 individuals on any given day
23 leaving York County?

24 A: They would add 64 additional beds and it would
25 be some of the need, yes.

1 Q: All right. Now, how did Carolinas propose to
2 use, make use of the 64 beds that it identified
3 in its application? What was the source of the
4 patients that they were going to, they
5 identified who would use that facility?

6 A: They assumed that the patients that had
7 historically been treated at their four North
8 Carolina hospitals would be redirected to the
9 Fort Mill Hospital.

10 Q: Okay. Do you believe that would occur? That
11 was a reasonable assumption?

12 A: I believe some of that would occur. I think
13 what was unreasonable was that was their sole
14 source of patients. They said that they would
15 not impact anybody because they wouldn't take
16 any other patients. It would be solely to
17 serve those patients that had historically gone
18 to those four hospitals, would then be treated
19 at their Fort Mill Hospital.

20 Q: All right. Let's deal with the question of the
21 reasonableness of Carolinas' assumption that it
22 would fill up CMC-Fort Mill with its existing
23 patient base. Do you believe that to be a
24 reasonable assumption?

25 A: No.

1 Q: Why?

2 A: Because from an economic standpoint, it doesn't
3 make sense to the extent that they would have
4 no incremental utilization associated with a
5 \$70 million expenditure. It doesn't make a lot
6 of health planning sense either. The goal of
7 that expansion would be to increase incremental
8 utilization. So, in other words, they would
9 not want to treat the same patients they've
10 been treating. They would want to treat new
11 patients. And those new patients would come
12 from predominately Piedmont Medical Center.

13 Q: In your experience in working with hospitals,
14 why would they not be content to build a
15 hospital to serve patients from an area that
16 they were already providing services to?

17 A: I guess there could be a scenario where that
18 would happen but the trends in this market it
19 appears to be a dramatic shift in a very short
20 period of time of patients that have
21 historically been treated by CHS physicians at
22 Piedmont no longer being treated there, are
23 being sent to North Carolina for services. I
24 think to the extent that they could continue to
25 do that and that's what they would do.

1 Q: All right. Now, by representing to the
2 Department that they would shift the patients
3 they were serving in North Carolina to their
4 CMC-Fort Mill facility, how would patients, as
5 a practical matter, be shifted? How would they
6 get into the hospital?

7 A: Well, in the CON application they were never
8 clear on that. They never identified their
9 mechanism. But generally, there are several
10 mechanisms for admission of patients to a
11 hospital.

12 Q: Well, if they're saying they're going to admit
13 their patients, who is serving their patients
14 currently?

15 A: I think the assumption or the implied
16 assumption would be that the physicians would
17 redirect the patients from North Carolina to
18 their CMC-Fort Mill facility.

19 Q: And those would be the Carolinas physicians
20 having practices in York County?

21 A: Yes. Those that had historically sent the
22 patients to North Carolina would then send them
23 to Fort Mill.

24 Q: So that would be one source of admissions into
25 CMC-Fort Mill, is that right?

- 1 A: Correct.
- 2 Q: All right. Are there any others?
- 3 A: Yes.
- 4 Q: All right. Have you identified those others?
- 5 A: Yes.
- 6 Q: All right. Dan, let's pull up Demonstrative
7 104 related to that. All right. So what other
8 ways would patients, in your opinion, be
9 admitted into CMC-Fort Mill other than through
10 the Carolinas physicians?
- 11 A: Well, the three other sources, general sources,
12 would be through the emergency room. Those
13 patients that show up at the emergency room
14 that then require inpatient admission would be
15 admitted by non-CMC physicians. Those
16 physicians that aren't owned by CMC who get
17 privileges at the new hospital who had
18 historically treated patients at Piedmont would
19 admit patients. And then other independent
20 physicians who then align with CMC. So there
21 are a number of other sources of patient
22 admissions to their proposed facility that they
23 did not address or didn't identify.
- 24 Q: Okay. Let's begin by analyzing each of these.
25 And let's start with the emergency room

1 admissions. Generally, to what extent are
2 patients who are admitted into the hospital are
3 admitted through an ER visit?

4 A: The numbers range by facility and over time.
5 But increasingly hospitals are relying on EDs
6 for sources of admissions.

7 Q: Have you examined this issue with respect to
8 CMC facilities' admissions through their ER?

9 A: Yes.

10 Q: Okay. And Dan, pull up Demonstrative 85,
11 please. What's the source of this Exhibit, Mr.
12 Levitt?

13 A: This is from the North Carolina hospital
14 license or renewal applications. And what it
15 shows ---

16 Q: Excuse me for interrupting. Those are Exhibits
17 36 through 41 that have already been admitted
18 into evidence?

19 A: Correct.

20 Q: Okay. And what does it show?

21 A: As I said, it varies by hospital and has
22 changed a bit overtime. But you can see from
23 Mercy, about 45 percent of their admissions
24 come from the ED. Pineville, 50 percent.

25 Q: Sorry. But you're referring to 2012 admission

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1 experience, is that right?

2 A: Correct. In 2012, about 45 percent of the
3 admissions at Mercy were admitted from the ED
4 or the emergency department. That number
5 increased, these are in rank order from lowest
6 to highest but the highest, at Lincoln, about
7 80 percent of their admissions came through the
8 ED. Pineville about 50 percent in 2012. And
9 CMC, it's identified as CMC-Center for Mental
10 Health, but that's the CMC facility. And about
11 50 percent of their cases were admitted through
12 the ED or the source of the admissions were
13 from the ED. And 64 and 60 percent at Union
14 and University. So with the exception of Mercy
15 in 2012, 45 percent, at least half, to almost
16 80 percent of the patients at these CMC
17 facilities in North Carolina were admitted from
18 the ED.

19 Q: And what's the significance of this data and
20 this experience at Carolinas to you?

21 A: That they can't control who shows up at their
22 ED, whether they're historical CHS patients or
23 historical Piedmont patients. So to the extent
24 that someone goes to their ED and is admitted
25 to the hospital, they have no control of

1 whether that was a historical CMC patient or
2 not.

3 Q: Okay. All right. What are the factors that
4 affect whether someone uses an ED?

5 A: There are several factors that influence the
6 selection of an ED.

7 Q: Okay. Beyond that, the second item on your
8 list was the admissions that would be made non-
9 Carolinas physicians. Why do you think that
10 would occur?

11 A: Well, speaking with the physicians and hearing
12 their testimony, they will seek privileges at
13 the new facility in Fort Mill regardless of
14 who's approved. If CMC's approved, they will
15 get privileges there. And those were
16 historical patients who had gone to Piedmont
17 and would then go to the new CMC facility.

18 Q: Okay. Did you hear any physicians that have
19 already testified in this case address that
20 question?

21 A: Yes.

22 Q: And what positions did they take?

23 A: That they would seek privileges and they would
24 use the facility.

25 Q: All right. And would those patients, where

1 would they have historically received services?

2 A: They would have generally, historically
3 received them at Piedmont.

4 Q: Okay. Now, the third item that you identified
5 was the alignment of physicians who had been
6 independent physicians with Carolinas Medical
7 Center and their physician network. Why do you
8 believe that could affect the utilization of
9 CMC-Fort Mill?

10 A: To the extent that independent physicians,
11 either align or are acquired by or seek
12 employment by CHS, again, that would have the
13 same effect as an independent physician getting
14 privileges, probably to a greater degree, have
15 an effect on where they refer their patient.

16 Q: Okay. Now, with regard to the data that you've
17 reviewed, how does that affect your opinion as
18 to whether Carolinas Medical Center at Fort
19 Mill would address the need of those patients
20 who have been historically leaving the county
21 and out-migrating?

22 A: They would partially address that need. They
23 would serve some patients, but they would also
24 serve some patients who would have historically
25 stayed in the county and were treated at

1 Piedmont Medical Center.

2 Q: Okay. With respect to the second need that you
3 identified, which is to strengthen the
4 healthcare delivery system in York County, how
5 would CMC-Fort Mill address that need?

6 A: I think we've talked about that in another
7 criteria, but they would have a negative
8 impact. They would reduce the volumes at
9 Piedmont and have a negative impact. They
10 would not strengthen, they would weaken the
11 healthcare delivery system, both the hospital
12 and the physician network.

13 Q: Okay. And with regard to Piedmont, how would
14 they and, just in summary, how does their
15 application address those two needs?

16 A: They seek to reverse the out-migration. So
17 they want to continue to treat those patients
18 that stayed at Piedmont in addition to those
19 that have left to go to North Carolina for
20 care. So they would address the out-migration
21 to a better degree.

22 Q: And the issue with regard to the strengthening
23 of the system?

24 A: They would have a positive impact by, as we've
25 said, by increasing volume and keeping the

1 patients in York County within the Piedmont
2 System has a positive impact on the Piedmont as
3 well as the independent physicians that
4 practice at Piedmont.

5 Q: All right. Then in summary, with regard to
6 802.2(c), the question of meeting the needs of
7 the target population, which applicant best
8 meets that provision?

9 A: Piedmont Fort Mill Medical Center application.

10 Q: Okay. Dan, let's pull up that, and so does
11 that check and X accurately reflect your
12 opinion?

13 A: Correct.

14 Q: Okay. Let's move to the next section of the
15 regulations, which is 2(d), 802.2(d). Dan, if
16 you'll pull this up in the regs in Exhibit 29.

17 I believe it's on page 25. What does this
18 section address, Mr. Levitt?

19 A: 2(d) says: That in the case of reduction,
20 relocation, or elimination of the facility of
21 service, the applicant shall address the need
22 that the population presently has for the
23 service, the extent to which that need will be
24 met by the proposed relocation or alternative
25 arrangement and the effects of the reduction,

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1 elimination, or relocation of the service on
2 the ability of low-income persons, racial and
3 ethnic minorities, women and elderly,
4 handicapped persons and other underserved
5 populations -- underserved groups to obtain
6 needed health services -- healthcare.

7 Q: Okay. Now, the Department found that Piedmont
8 did not demonstrate justification for the
9 transfer of the 36 beds that would be added to
10 the 64 to form the 100-bed facility. How've
11 you evaluated this issue?

12 A: I disagree with that.

13 Q: Why?

14 A: I think that the relocation was, is needed.
15 It's consistent with the Plan and the goals.
16 And we've identified and addressed the areas
17 that are outlined in this criteria.

18 Q: Okay. And first of all, to what degree does
19 the 100-bed facility address the needs of the
20 203 patients out, leaving the county on an
21 average day?

22 A: Well, it redeploys -- not only does it add the
23 64 additional beds but it also redeploys
24 resources that are currently at Piedmont to a
25 growing area and an area that is going to have

1 needs for more services and would present them
2 to be better utilized in the future than where
3 they are at Piedmont.

4 Q: Okay. Have you identified those beds ---

5 A: Yes.

6 Q: --- at Piedmont? Dan, let's pull up
7 Demonstrative 178, please. And what does this
8 Exhibit show, Mr. Levitt?

9 A: This shows the inventory beds, the 288 licensed
10 beds. The 2011 average daily census, 182, I
11 believe that was taken, if not sourced by, I
12 believe that was taken from the Joint Annual
13 Report. That shows the 288 beds minus the 182
14 daily average daily census shows 106 available
15 beds. Again, we were going to relocate 36 of
16 those to the Fort Mill Medical Center. That
17 still leaves 70 available beds at Piedmont
18 Medical Center.

19 Q: Okay. Now, the available beds, the 106
20 available beds, are all of those currently
21 staffed and available for patients?

22 A: No.

23 Q: And how many are not?

24 A: I believe 19 beds are not set up and staffed.

25 Q: Okay. And those would be among the 106 that

1 are available and unused in Piedmont on a given
2 day?

3 A: Correct.

4 Q: All right. And then among the balance of the
5 beds that would be relocated what's the purpose
6 of the deployment to move them from Rock Hill
7 to Fort Mill?

8 A: To position them for better utilization. That
9 by having a presence in Fort Mill, as we said
10 in both the 2005 and the 2010 CON application,
11 we will be able to reverse out-migration,
12 increase utilization at both locations, at the
13 Fort Mill Medical Center and at Piedmont
14 Medical Center. So by moving them it's going
15 to put them in a position that will be better
16 utilized and also help Piedmont.

17 Q: All right. If the beds weren't moved and
18 Carolinas was permitted to build the facility
19 in Fort Mill, how would those 106 unused beds
20 be used?

21 A: Well, that number, I think, would grow. Those
22 106 beds would increase because the average
23 daily census at Piedmont would decline and
24 there would be more unused beds at Piedmont
25 Medical Center.

- 1 Q: Okay. All right. Then given that analysis, do
2 you believe that Piedmont met the test that's
3 required of applicants to demonstrate
4 justification for locating beds?
- 5 A: Yes.
- 6 Q: All right. Now, Dan, let's take a look at
7 168.2 and pull that up? Would there be any
8 reason to apply that provision to Carolinas
9 application?
- 10 A: No, they're not relocating any beds.
- 11 Q: Okay.
- 12 A: Or services.
- 13 Q: So there would be a check for PMC?
- 14 A: And a dash for CHS.
- 15 Q: Okay. All right. Let's move on to the next
16 section. Dan, if you'll pull that up in the
17 regs which is 802.2 paragraph (e)? And read
18 what that addresses, if you would, Mr. Levitt?
- 19 A: Current and/or projected utilization should be
20 sufficient the expansion or implementation of
21 the proposed project.
- 22 Q: Okay. And how have you analyzed this
23 particular provision?
- 24 A: We looked at the historical occupancy of
25 providers, as well as, the projected

1 utilization of the two Fort Mill hospitals.

2 Q: Okay. And Dan, let's pull up Exhibit 1(b),
3 page 36, figures 24 and 25? In the application
4 and the updated material, Mr. Levitt, did you
5 project the utilization at Fort Mill Medical
6 Center and Piedmont Medical Center?

7 A: I did. I did this at both the original
8 application and the updated application and we
9 projected, based on our assumed market share
10 and calculations, about 58 percent occupancy by
11 year three at the Fort Mill Medical Center and
12 resulting occupancy at Piedmont of 66 percent
13 by the third year on the reduced beds at
14 Piedmont.

15 Q: Why are you connecting the utilization at both
16 Piedmont and Fort Mill?

17 A: Well, for a number of reasons. The first
18 reason was to show the impact of moving the
19 beds, relocating the 36 beds. I wanted to show
20 what the resulting occupancy and utilization
21 would be at Piedmont on those 232 remaining
22 beds. But then, as well as to give effect to
23 the Fort Mill -- they were going to be
24 operating as a hospital. So Mr. Masterton
25 talked about he would be the CEO of both

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1 facilities. They're going to be operated
2 collectively, so those two facilities will
3 impact one another. * And the increase in
4 utilization would occur at both facilities and
5 we wanted to show that even with an increase
6 utilization, both facilities have sufficient
7 beds.

8 Q: Okay. Your Honor, I'm about to move into a
9 section that will take time. Would this be an
10 appropriate time?

11 **THE COURT:** I was just about to say, I think having
12 gone through that. I was going to ask you if
13 you felt this might be a good time to stop. It
14 looks like it would be the best time.

15 **MR. ANDREWS:** It would be a good time. Thank you.

16 **THE COURT:** We will recess until tomorrow morning.
17 Thank you.

18 (There being nothing further, Day Two recessed at
19 5:46 p.m.)
20
21
22
23
24
25

DAY THREE - WEDNESDAY, APRIL 10, 2013

1 **THE COURT:** Please be seated. All right. We're
2 back on the record. Good morning, everyone.
3 Day three. Here we go. And Mr. Andrews, are
4 you ready to go?

5 **MR. ANDREWS:** I am, sir. Thank you.

6 **THE COURT:** All right.

7 Q: Good morning, Mr. Levitt.

8 A: Good morning.

9 Q: Mr. Levitt you were present and in the
10 courtroom during the cross examination of Mr.
11 Masterton, were you not?

12 A: Yes

13 Q: And let's call up Carolinas Exhibit 15, which
14 is an excerpt from the Piedmont's Emergency
15 Department application. Did you have any
16 involvement with that application?

17 A: Yes, I developed that CON application.

18 Q: All right. And let's pull out figure one if we
19 could, which is entitled Emergency Department
20 Utilization. Do you see that?

21 A: I do.

22 Q: And what's reflected here?

23 A: This shows the historical utilization from 2007
24 to 2011 for the Piedmont Medical Center
25

1 emergency department. It shows the emergency
2 visits, the admissions, the total ED volume and
3 the total hospital admissions from that same
4 time period and then the last row calculates
5 the percentage of the ED admissions as a
6 percent of the total admissions to the
7 hospital.

8 Q: All right. And are these ED admissions, do
9 they count the York County residents who
10 received services through the Piedmont
11 Emergency Department or do they include York
12 County and others?

13 A: This is both. The York County residents as
14 well as residents from all counties.

15 Q: Okay. And that's the total utilization, for
16 example, in calendar year 2011 would be 15,693?

17 A: Correct. That's the total number of admissions
18 at the hospital regardless of what county they
19 lived in, not just York County but from all
20 counties.

21 Q: And let's, Dan, pull up if you would
22 Demonstrative 199. Are you familiar with this
23 Demonstrative, Mr. Levitt?

24 A: Yes.

25 Q: And if you'll track the -- and this is intended

1 to show what from admissions point of view?

2 A: This shows that while the population of the
3 yellow line is increasing, it shows the
4 population increasing through a time period of
5 2005 to 2011, while the admissions were
6 decreasing. The purple line showing from 2005
7 about 12,500 admissions going down to less than
8 12,000 admissions by 2011.

9 Q: Okay. Now how would you reconcile the over
10 14,500 admissions showing in 2011 and the
11 document we just reviewed from your application
12 to expand the emergency department with the
13 admissions reflected in Demonstrative 199?

14 A: Well, 199 is just for York County. The
15 population is the York County population. The
16 admissions are the York County resident
17 admissions. The figure we just saw was the
18 total for all patients regardless of what
19 county they lived in.

20 Q: Are there any inconsistencies between those two
21 data sets?

22 A: No, they're not inconsistent. They're
23 different.

24 Q: Okay. All right. Thank you very much. Now,
25 Mr. Levitt, let me take you back to where we

1 concluded the line of examination yesterday.
2 You'll recall, and let's pull it up again, Dan,
3 looking at figures 24 and 25 of Exhibit 1,
4 Bates page 36. You were looking at two
5 different figures showing the utilization of
6 Piedmont Medical Center and Fort Mill Medical
7 Center. Do you remember that?

8 A: Yes.

9 Q: And why did you present to the Department the
10 relationship between the two?

11 A: Well, as I said yesterday, the projections for
12 Fort Mill assume out-migration is reversed,
13 more patients are treated in York County both
14 at Fort Mill and at Piedmont, and this
15 demonstrates that the bed compliment at both
16 locations are adequate and sufficient and
17 consistent with experience of other providers.
18 The 58 percent at Fort Mill by year three and
19 66 percent on the 232 remaining beds at
20 Piedmont justify the project.

21 Q: Okay. Now, in your qualifications you
22 identified a number of new hospital
23 applications that you had worked on and you had
24 mentioned there were a number of satellite
25 hospital applications. Describe for the judge,

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1 if you would, in general terms what the purpose
2 of satellite hospitals are and how they relate
3 in experience to the main hospital to which
4 they are a satellite.

5 A: Well, there are a number of goals pertaining to
6 the market and the situation. But generally,
7 the satellite hospital is developed to
8 collaborate, serve as a collaborative hospital,
9 a collaborative location for the main hospital
10 to address some issues in the market, maybe the
11 population is perhaps growing in that area.
12 Changes in utilization, shifts in utilization,
13 out-migration, loss of market share. To remedy
14 some situations in the market to keep the main
15 hospital competitive.

16 Q: Okay. And are you familiar with the
17 development of satellite hospitals in South
18 Carolina?

19 A: Yes.

20 Q: Okay. And have you developed a Demonstrative
21 that shows the common characteristics related
22 to the development of new satellite hospitals?

23 A: Yes.

24 Q: All right. Dan, let's pull up Demonstrative
25 105, please. And review these if you would.

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1 What are we looking at here?

2 A: Generally from the projects in South Carolina,
3 these are the four common themes or
4 characteristics of the satellite hospitals.
5 They're in generally high growth areas, either
6 in a suburban area or a separate county in the
7 service area. Generally there is excess
8 capacity of the main hospital or strong
9 utilization at the main hospital to address a
10 need for a satellite hospital. And there's a
11 desire to either recover or for growth in the
12 market share through the satellite hospital.
13 Sort of having the physical presence as we
14 outlined in the Fort Mill application, having
15 a physical presence in the area where there is
16 a lower utilization than in other areas. To
17 remedy that and they involve either transfer of
18 existing beds, either alone or in combination
19 with need identified in the Plan.

20 Q: Okay. Now, based on your familiarity with
21 hospitals in South Carolina that developed
22 satellites, have you developed any Exhibits
23 concerning any of what you believe are
24 particular analogous?

25 A: Yes.

1 Q: And what have you developed in that regard?

2 A: Well, looking at the various satellite
3 hospitals that were developed in the last
4 several years, the market situation most
5 analogous to the Fort Mill Medical Center would
6 be the Waccamaw satellite hospital for the
7 Georgetown Hospital System.

8 Q: And have you developed a set of Exhibits to
9 demonstrate why you think that's the case?

10 A: Yes.

11 Q: And why did you do that?

12 A: To illustrate from an actual experience what
13 happens when a satellite hospital is developed,
14 what the implications are and what the impact
15 are on both the proposed hospital, the
16 satellite hospital and the main hospital.

17 Q: Okay. And I understand, Your Honor, there are
18 objections pending related to this and you
19 reserved your ruling for Exhibit 64 related to
20 the admissibility of that. If we can pull it
21 up and I can have Mr. Levitt go through it in
22 whatever detail to lay a foundation for the
23 admission, I'd be happy to do that.

24 **THE COURT:** Okay.

25 Q: All right. Dan, if you will pull up Exhibit

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1 64, please? And let's move to page three of
2 this Exhibit. And just begin, Mr. Levitt,
3 before you talk about what your findings are
4 and your opinions related to them because at
5 this point we're just laying the foundation to
6 move for the admission, what the source of this
7 data is.

8 A: Well, I do a substantial amount of work for the
9 Georgetown Hospital System which includes
10 Waccamaw Community Hospital and Georgetown
11 Memorial Hospital. In order to get publically
12 available information rather than using
13 information that I have from my work with them,
14 I looked at the Medicare cost reports. Those
15 are publicly available. You can order them or
16 buy them from a variety of sources to get the
17 Medicare cost reports and we looked at the 2002
18 through 2007 information from those cost
19 reports.

20 Q: Okay. And have you developed Exhibits showing
21 the relationship among these different data
22 points?

23 A: Yes, what I pulled from those six cost reports,
24 the 2002, 2003, 4, 5, 6, and 7 cost reports
25 were the net income, net operating income from

1 those two facilities, the Waccamaw Community
2 Hospital and the Georgetown Community Hospital
3 and that's what shown in this Exhibit.

4 Q: And how were these Exhibits, how do these
5 Exhibits relate to the testimony and to your
6 opinions concerning the Fort Mill Medical
7 Center application?

8 A: Well, from a financial feasibility stand point
9 and from the reasonability of the projections
10 contained in the CON applications, this show
11 the actual experience of a system that
12 developed a hospital, shows the financial
13 performance of the new satellite hospital and
14 it shows the resulting utilization and the
15 financial performance of the main hospital.

16 Q: Were there issues concerning out-migration
17 related to this application?

18 A: Yes. That was the impetus similar to Fort Mill
19 Medical Center for placing the Waccamaw
20 hospital in the northernmost portion of
21 Georgetown County was to address out-migration
22 and market share shift.

23 Q: Your Honor, with that, we'd like to move
24 admission of Exhibit 64.

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

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1 **MR. MULLER:** Your Honor, I think our original
2 objection to this was simply a recycled Exhibit
3 from the last trial to which we objected. As
4 you can see, the source says Medicare cost
5 reports, no 2008 data is not available. It has
6 not been updated. They have not done anything
7 with it in terms of present day numbers. As
8 you can see, it ends in 2007. But we can ask
9 on cross exam why he has not done that and fill
10 us in on what he intends to do with it. He
11 even testified about it in his deposition. The
12 fact that he said the Court has the ability to
13 judge it for what it is, so I'm happy to waive
14 our objection if he would like to answer
15 questions about it.

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

17 **MR. ANDREWS:** Well, if Mr. Muller is prepared to
18 withdraw the objection, I'd like to move
19 forward, but I can respond to the points he
20 made particularly concerning the update, Your
21 Honor, I was going to elicit testimony and I
22 probably should have prior to moving, related
23 to the dating of it. I mean I'll ask Mr.
24 Levitt rather than tell you what the issues are
25 related to that. I'll be happy to elicit

1 testimony concerning that if that's of interest
2 to you. But the short of it is there was no
3 need related to the intent of the updated
4 dated. It was intended to look at the early
5 period following the establishment of the
6 facility.

7 **MR. MULLER:** And that's fine, Your Honor. I
8 withdraw the objection and can ask questions of
9 him.

10 **THE COURT:** Mr. Muller, if you withdraw the
11 objection, please go ahead.

12 **MR. ANDREWS:** Thank you, sir.

13 **Q:** All right. Mr. Levitt, let's begin with the
14 point Mr. Muller has raised which concerns the
15 applicable period of time that you've chosen to
16 examine here in this Exhibit. What did you
17 chose the years from 2002 to 2007?

18 **A:** We chose 2002 because that was the year prior
19 to Waccamaw opening and then we chose 3 through
20 7 to show the first five years of operation of
21 the Waccamaw hospital.

22 **Q:** Why didn't you continue that out through 2013?

23 **A:** Well, this was to really illustrate the
24 experience of the initial opening of the
25 satellite hospital. How it performed compared

- 1 to the main hospital and all probable impacts.
- 2 Q: Okay. All right. Well, given that, identify
- 3 what you've found as a result of the
- 4 comparisons to the operating income and
- 5 financial performance of Waccamaw and
- 6 Georgetown during this period of time?
- 7 A: Well, prior to opening Georgetown Memorial
- 8 Hospital, which was the sole hospital in the
- 9 Georgetown Hospital System, it was operating at
- 10 a loss. It was ---
- 11 Q: Which hospital was operating at a loss?
- 12 A: Georgetown Memorial Hospital.
- 13 Q: Okay.
- 14 A: Was operating at a loss prior to opening the
- 15 Waccamaw hospital.
- 16 Q: Now, was Georgetown a new hospital?
- 17 A: No, Georgetown was a long-standing, very old
- 18 county hospital in Georgetown.
- 19 Q: Okay. And where is it located?
- 20 A: It's located in the south central part of the
- 21 county.
- 22 Q: In the town of Georgetown?
- 23 A: In the town of Georgetown.
- 24 Q: All right.
- 25 A: And the operation and utilization and payor mix

1 at Georgetown were such that it was operating
2 at a loss. They identified the growth area,
3 the more desirable payor mix area to the north
4 in the Waccamaw area, just in the northernmost
5 area of Georgetown County, adjacent to Horry
6 County, which is where Myrtle Beach is, where
7 the population was growing and where a
8 tremendous threat was being presented by the
9 Horry County Hospital just over the border in
10 Horry County, they were staging health services
11 and facilities to capture greater market share
12 which included northern Georgetown County.

13 Q: Was there anything located in southern Horry
14 County near the Georgetown border comparable to
15 the facility like Steele Creek?

16 A: Yes, there was an outpatient center that
17 offered outpatient services, urgent care,
18 emergency services, physician offices, things
19 like that. So, in response to that Georgetown
20 filed the Waccamaw application and built the
21 Waccamaw Community Hospital and initiated
22 operations in 2003.

23 Q: All right. And what was the effect over time
24 after Waccamaw became operational on
25 Georgetown?

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- 1 A: It was positive. Overall, on the system, on
2 Georgetown Hospital System it had tremendous
3 positive impact. The Waccamaw Hospital
4 experienced substantial loses the first year of
5 operation. Almost a \$6 million loss. By the
6 second year they were making money, they were
7 well-utilized, making money and you can see by
8 the forth year they had operating income of
9 over \$4 million. It went down slightly in
10 2007. And I believe that was due to capital
11 costs associated with expanding. So, in the
12 period of time they opened, they expanded, they
13 were well-utilized and they showed positive
14 financial impact on the Georgetown System.
- 15 Q: Now, you're familiar with Georgetown's
16 operations?
- 17 A: Very familiar, yes.
- 18 Q: All right. Now, how would Waccamaw have
19 affected the financial performance of
20 Georgetown?
- 21 A: Similar to the Fort Mill and the Piedmont
22 Hospital proposal, Waccamaw offered basic
23 hospital services. Georgetown offered some
24 services that weren't available at Waccamaw, so
25 overall the system experienced increased

1 utilization, positive impact on payor mix and
2 it had an overall positive impact on the
3 system.

4 Q: Now, when Waccamaw was established, was it
5 anticipated that Waccamaw would take or there
6 would be a shift in some of Georgetown's
7 patients to Waccamaw?

8 A: Yes. Initially, the initial application was
9 actually a transfer of beds, all the beds, the
10 40 beds at Waccamaw were from Georgetown
11 Memorial Hospital. At the time, I believe
12 right after that application was approved ---

13 Q: Now, how many, excuse me for interrupting, but
14 how many beds was it approved for?

15 A: Forty.

16 Q: Forty?

17 A: Yes. They amended the application because
18 there was room in the Plan for additional beds.
19 So, rather transfer all 40 beds, a portion of
20 those, I believe 11 beds were transferred from
21 Georgetown to Waccamaw with the remaining
22 coming out of the need in the Plan.

23 Q: And did the total change?

24 A: No. That bed complement of both facilities was
25 still the same, just instead of transferring

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1 from Georgetown, some were transferred and some
2 came out of the need.

3 Q: Okay. So there was a transfer and a need that
4 was recognized in the Plan, that was what
5 established the basis for the creation of
6 Waccamaw?

7 A: Correct.

8 Q: And how does that compare to Piedmont?

9 A: Very analogous. There's a need in the Plan for
10 the 64 beds; Piedmont's applying for those.
11 Transferring 36 of the beds from Piedmont
12 Medical Center is similar to the transfer of
13 beds from Georgetown to Waccamaw.

14 Q: Okay. Now, explain why Georgetown's financial
15 performance improved over the years as Waccamaw
16 became established.

17 A: Well, again, the utilization at Georgetown
18 increased. The types of patients transferred
19 to Georgetown changed. And overall, the system
20 was positively impacted.

21 Q: Now, when you say the system was positively
22 impacted, what are you referring to?

23 A: Georgetown Hospital System is the two hospitals
24 combined. They operate together. They
25 consolidate their resources and financial

1 information and from that perspective, even
2 today, Waccamaw has a positive impact on the
3 system.

4 Q: By having patients Georgetown shift to
5 Waccamaw, was there any adverse impact on
6 Georgetown that was experienced?

7 A: No, it was a positive impact.

8 Q: Okay. And why -- and how does the comparison
9 of resources and assets of Georgetown and
10 Waccamaw compare with what's being proposed
11 between Piedmont and Fort Mill?

12 A: Again, very similar. The Waccamaw area is a
13 more affluent area, faster growing area. The
14 northern portion is closer to a much larger,
15 also growing area. And so it is very
16 analogous.

17 Q: And where, in fact, is Waccamaw Community
18 Hospital located?

19 A: It is in Murrell's Inlet which is literally on
20 the border of Georgetown and Horry County.

21 Q: All right. Let's take a look at the next page
22 of your exhibit.

23 **THE COURT:** And let me just stop for a minute for an
24 administrative, housekeeping measure. Subject
25 to the withdraw of Respondent Carolinas'

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1 objection to Petitioner's Exhibit 64,
2 Petitioner's Exhibit 64 is now being admitted
3 into the record.

4 **MR. ANDREWS:** Thank you, sir.

5 Q: What is this page of the Exhibit? This is page
6 four of Exhibit 64 reflect Mr. Levitt?

7 A: This just graphically shows that information.
8 The -- what's supposed to be kind of red is the
9 Georgetown hospital and the blue is the
10 Waccamaw Community Hospital graphed together.
11 So, 2003, this line here would be zero
12 basically.

13 Q: Right here?

14 A: Yes. So you can see in 2002 that the operating
15 income was negative, below the line for
16 Georgetown the only operational hospital that
17 year. 2003, when they're both operational,
18 they've both lost money so you can see the
19 nearly \$12 million combined loss for the two
20 hospitals. And then things started going
21 positive. So while Georgetown in 2004 still
22 showed a loss, Waccamaw showed a positive. In
23 2005, again, sort of trending up and you can
24 see combined 2006, which was sort of the peak
25 year, where combined they were nearly a \$6

1 million operating income. Again, then they
2 added, actually they added beds during that
3 time. And they added beds again in 2007.

4 Q: Who is they?

5 A: The Georgetown Hospital System, so they added
6 beds at the Waccamaw Community Hospital. They
7 have not added beds at Georgetown since I don't
8 know when, but since 2002, they reduced beds by
9 11 and they've maintained that same bed
10 complement until today.

11 Q: All right. Let's take a look at the next
12 Exhibit. And what does Exhibit 64-5 look like?

13 A: 64-5 shows the Georgetown Memorial Hospital
14 historical utilization for that same time
15 period. You can see, 2004, the beds went from
16 142 in 2002 and 2003 down to 131 in 2004. That
17 was the transfer of the 11 beds.

18 Q: We're looking at Georgetown's beds, right?

19 A: Correct. Georgetown transferred 11 beds to
20 create the 40-bed Waccamaw Hospital. You can
21 see the admissions slightly decline from 2002
22 to 2003 and they continued to drop off a little
23 bit during that time period they went from
24 9,000 to about 7500 and then down to about
25 6,000 by 2008. Patient days declined as well

1 and the average daily census is down, but still
2 well-utilized with about 55 percent occupancy
3 in 2008.

4 Q: All right. And the ADC at Georgetown during
5 that period from 115 to 73?

6 A: Correct.

7 Q: Is that a problem?

8 A: No, because again, you'll see the next slide
9 what happened at Waccamaw.

10 Q: All right. Let's move to that slide please,
11 Dan, 64-6, and what does this slide show in
12 general terms? It shows the utilization at
13 Waccamaw, is that right?

14 A: That's right. This is the Waccamaw Hospital in
15 2003 when it opened with 40 beds. The very
16 next year on the anniversary, they submitted an
17 application to expand to 54 beds. They added
18 14 beds. Then from 2004 to 2005, they added
19 additional beds. From 2005 to 2007 they were
20 operating 82 beds and then in 2008 they brought
21 online an additional 42 beds for a total
22 complement of 124 acute-care beds.

23 Q: Tripling their bed compliment in this time of
24 five years, correct?

25 A: Correct. Yes.

1 Q: Okay.

2 A: And during that same time period, their average
3 daily census, as you can see, went from 30
4 which was a 76 percent occupancy up to 71 and
5 even with the additional beds, 124 additional
6 acute beds, their occupancy was still nearly 60
7 percent.

8 Q: 57.6?

9 A: 57.6 percent. I'm sorry, I may have said -- I
10 meant 60 percent. 57.6 percent occupancy on
11 124 beds.

12 Q: And how does 57.6 percent occupancy in year
13 five operation of Waccamaw compare to what
14 you've projected for year three in Piedmont?

15 A: It's consistent. We, I believe 58 percent is
16 what we've projected for Fort Mill Medical
17 Center.

18 Q: Okay. Let's take a look at the next slide.
19 And what does this slide show, Mr. Levitt?

20 A: Again, this shows the average daily census of
21 the two facilities and while it's not labeled,
22 the third line is the Georgetown Hospital
23 System, so adding the two together. So in
24 2002, the system with only one hospital had an
25 average daily census of about 115. Then you

1 can see the steady increase, peaking in 2005
2 with a slight decline by 2008, but still higher
3 than it was in 2002, 144 patients versus 115
4 patients.

5 Q: And how does this relate to your opinion in
6 this case?

7 A: That by having that northern satellite hospital
8 in a growing area and preventing out-migration
9 from Georgetown County to Horry County,
10 Georgetown Hospital System was able to treat
11 more Georgetown residents, to treat more
12 residents in total and to be in a stronger
13 position.

14 Q: Okay. And let's look at the last Exhibit in
15 this series and what does this reflect?

16 A: This is again, just graphically that same
17 information showing the Georgetown Hospital
18 System combined, the red being Georgetown, the
19 blue being Waccamaw and showing the graphically
20 the trend of the average daily census
21 increasing over time and remaining fairly flat
22 from 2005 to 2008.

23 Q: Now, Mr. Levitt, summarize that and based on
24 your review of the effect on the operating
25 income and utilization of Georgetown and that

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1 it's satellite Waccamaw had, how you believe
2 this relates to your opinions concerning
3 Piedmont and Fort Mill?

4 A: Well again, as I said, they're very analogous
5 that Georgetown recognized a threat, just as
6 Piedmont did in 2005 by not having a presence
7 in the northern area of their county. There
8 was a threat to the north that had a hospital
9 even not in Georgetown, if a hospital had been
10 built, I think it's called South Strand, at the
11 South Strand site, would have been devastating
12 to Georgetown Hospital System. They were
13 already in a position where they were having
14 negative financial performance, that the threat
15 of the northern provider taking patients out of
16 Georgetown County was negative. They addressed
17 that by building the Waccamaw hospital just as
18 Fort Mill, just as Piedmont is proposing to
19 build Fort Mill hospital and overall
20 strengthened the system and they're in a very
21 positive position today.

22 Q: If, and is there a tertiary hospital that
23 provides open heart and other complex services
24 in Horry County north of Georgetown County?

25 A: Yes, that would be Grand Strand Memorial

1 Hospital which owns the South Strand outpatient
2 location.

3 Q: And if Grand Strand had established a satellite
4 hospital in Murrels Inlet instead of
5 Georgetown, what effect would it have had on
6 the operation of Georgetown Memorial Hospital?

7 A: Well, as I said, if they had, either in Murrels
8 Inlet or at the South Strand location just over
9 the line in Horry County -- and that may
10 actually be considered Murrels Inlet as well.
11 It would have been tremendously negative. They
12 would have taken patients out of Georgetown
13 County, they would have left Georgetown and the
14 town of Georgetown to serve what was leftover
15 which would be the lower income, lower payor
16 mix, less desirable payor mix and they would
17 not have been able to consolidate positive
18 financial performance.

19 Q: Now, prior to the establishment of the Waccamaw
20 hospital, were there residents of the greater
21 Murrels Inlet, northern Georgetown County area
22 who were leaving the county?

23 A: Yes, they were traveling north. Again,
24 Georgetown while an older town, doesn't have
25 the economic resources of Horry County, of

1 Myrtle Beach or the restaurants, shopping,
2 things like that. So people tend to travel
3 north, just as they do in Fort Mill.

4 Q: Okay. All right. Now, let's return your focus
5 to Piedmont and what it proposes to do and what
6 it hopes to establish through the construction
7 of the Fort Mill Medical Center.

8 Q: How does Piedmont propose to establish a base
9 of patients at Fort Mill Medical Center? Have
10 you developed a Demonstrative to walk us
11 through those steps?

12 A: Yes.

13 Q: All right. Dan, let's pull up Demonstrative
14 181, please. And what does this show Mr.
15 Levitt?

16 A: Well, as we outlined in the CON application,
17 both the 2005 and the 2010 applications, that
18 the goal of Fort Mill Medical Center is to
19 provide services to northern York County to
20 address the out-migration. Those people
21 leaving York County for services could stay in
22 York County. Improve access to patients
23 treated at Piedmont to ensure that those future
24 patients aren't being transferred to North
25 Carolina or out of state for other services.

1 And ultimately to meet the needs of the growing
2 population of that area of the county as well.

3 Q: Okay. Now, in developing this application did
4 you have a specific goal with regard to the
5 market share that Piedmont hoped to capture?

6 A: Yes.

7 Q: And what was that?

8 A: We hoped that by having a presence in northern.
9 York County that the market shares for combined
10 Piedmont and Fort Mill would get back close to
11 what we had had, what we had experienced
12 historically just at Piedmont Medical Center.
13 Obviously with an increase in that area. That
14 was one of the areas of the county where while
15 the overall market share of the county was
16 still strong, the Fort Mill, Tega Cay was not.
17 So, by having a presence in that market, those
18 would go up and then we would be back close to
19 where we were historically.

20 Q: Have you developed a Demonstrative that
21 analyzes the market share throughout the county
22 that you hope to achieve?

23 A: Yes, we looked at it by zip code historically
24 and what we have projected in the Fort Mill
25 Medical Center application.

- 1 Q: All right. Dan, let's pull up Demonstrative
2 106. And what does it show Mr. Levitt?
- 3 A: This shows the market share for Piedmont
4 Medical Center in York County, the various zip
5 codes in York County including the 29707. You
6 can see in 2003, 29707 through 2006, 2003 to
7 2006, which is not applicable. That's a new
8 zip code. I think someone talked about that.
9 That's a new zip code that was created in 2007
10 part of 29715, I think, split off, that's the
11 Lancaster County portion of that zip code. So
12 it's a new zip code but it was in with the
13 data.
- 14 Q: Let's just take this slowly. Since it's a lot
15 of data. And begin with the identification in
16 the left-hand column. You've got the zip codes
17 and are they the zip codes for all of York
18 County in addition to 707?
- 19 A: Yes, those are the zip codes comprised of York
20 County. Some of those extend beyond York
21 County, but those are the York County zip codes
22 and then 707 to address the splitting out of
23 that information. So, we looked at each zip
24 code by year.
- 25 Q: Over what period of time?

- 1 A: From 2003 through 2011 and when you compare
2 that, excuse me, to the 2017, the third year of
3 operation at the Fort Mill Medical Center, that
4 2017 combined shows the combined market share
5 of York County in each of those zip codes for
6 both Piedmont Medical Center and Fort Mill
7 Medical Center.
- 8 Q: All right. Let's start by identifying what the
9 goal was and what your projections are with
10 regard to the market share that you're
11 projecting that would be obtained by 2017.
- 12 A: So by 2017 overall, in total we projected for
13 those zip codes an average of 71.2 percent
14 market share.
- 15 Q: And that would be again, for Fort Mill alone?
- 16 A: No, that's for all zip codes in York County
17 plus the Lancaster County zip code.
- 18 Q: Excuse me, I wasn't clear with my question,
19 Fort Mill Medical Center or for Piedmont and
20 Fort Mill?
- 21 A: No, that's for Piedmont and Fort Mill.
- 22 Q: This would be the system market share?
- 23 A: Correct.
- 24 Q: Okay.
- 25 A: And that compares to in 2004 for all the zip

1 codes combined, we have a 68 percent market
2 share. So you can see, it's just a few
3 percentage points higher than where we were
4 historically at the peak in 2004.

5 Q: All right. Let's go to the next Exhibit and we
6 can kind of track the different points in which
7 there's been a historic market share that's
8 been comparable to what you're projecting.
9 That's 106-2. All right. Let's call that out.
10 It might help to track the data points a little
11 more effectively. Mr. Levitt, what do we have
12 here? Would you walk through this for us?

13 A: Yeah. This shows that in, by zip code to get
14 to those totals, you know, basically the totals
15 sum up those, but for the first zip code,
16 29704, in 2004, we had a peak of 82.4 percent
17 market share. By 2017, we're projecting 72.3
18 or 72.6, I'm sorry, 72.6 percent market share.
19 And that represents 9.7 percentage points less
20 than what we had out our peak.

21 Q: All right. And so as you work through those,
22 and I want you to do that, what the highlight
23 shows is the historical high from since 2003
24 compared with what you're projecting in 2017,
25 is that right?

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1 A: That's correct.

2 Q: And the last column shows the difference
3 between the two?

4 A: Correct.

5 Q: Okay. All right. Well, work through each of
6 the York County zip codes and identify what
7 you're projecting.

8 A: So for each of the zip codes, as we said, we
9 gave the example of 29704 projecting a 72.6
10 percent market share compared to an 82.4 market
11 share at Piedmont alone. A high from 2004,
12 29707, about a 65 percent market share. Now,
13 29707, 29708 and 29715, those are the three
14 that show a dramatic jump from where we were
15 historically.

16 Q: Why is that?

17 A: Those are the three northernmost zip codes in
18 York County where historically, Piedmont did
19 not have a large market share. So, you can see
20 in the first one, 29707, we only have five
21 years of data, but in 2008, we had a ten
22 percent market share. That's going to be
23 adjacent to where Fort Mill Medical Center is
24 located. We assume, just as we had
25 historically and even as late as 2011 in Rock

1 Hill, 29730 and 29732, we had 70 percent market
2 share and 64 percent market share because
3 that's where Piedmont Medical Center is
4 located. So, the zip codes adjacent to the
5 hospital generally have a higher market share,
6 so the zip codes adjacent to the Fort Mill
7 Medical Center would have market share
8 consistent with those, 64, 69 and 72 percent
9 market share.

10 Q: Good. Just to be clear, the period from 2003
11 to 2011 is the market share at Piedmont alone,
12 correct?

13 A: Correct. Just one location at that time
14 Piedmont Medical Center in Rock Hill.

15 Q: And the projected market share in 2017 reflects
16 the combined market share of both Piedmont and
17 the new Fort Mill Medical Center, is that
18 right?

19 A: That's correct. So, that was the assumption.
20 That having a presence in northern York at Fort
21 Mill Medical Center we would experience a
22 larger market share for those three zips than
23 we had historically. The rest of them were
24 showing lower than our historical peak at one
25 location, at two locations. So, I think these

1 are reasonable market share assumptions and
2 achievable.

3 Q: All right. And then, what would be the total
4 difference from the Piedmont only high point of
5 market share in 2004, with the projected market
6 share when both hospitals would be operating?

7 A: Our peak in 2004 at Piedmont was 68.1 compared
8 to 71.2 at both Piedmont and Fort Mill combined
9 for a difference of 4.1 percentage points.

10 Q: Okay. All right. And how did this
11 Demonstrative affect your judgement in this
12 case and how does it demonstrate it?

13 A: Well, I think it shows it's reasonable that we
14 will get back to where we had been in
15 historical by having a new hospital, new
16 physical presence in northern York County. And
17 it would reverse out-migration and allow
18 patients in York County to be treated in York
19 County.

20 Q: All right. Now, were you assisted in this
21 analysis by reviewing any maps that Mr. Walsh
22 has previously testified about?

23 A: I'm sorry, could you repeat that?

24 Q: Sure. Were you assisted in this analysis or
25 did you consider any of the maps that Mr. Walsh

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1 testified about reflecting the drive time
2 studies that he had done?

3 A: Yeah, obviously I didn't have those maps at the
4 time developing the information, but I looked
5 at those and considered those and it supports
6 this information.

7 Q: All right. Let's draw your attention to
8 Demonstrative 38, please. Now, as you've just
9 testified, you did not have access to this map
10 or any drive time study maps from Mr. Walsh at
11 the time you developed your projections, is
12 that right?

13 A: Correct.

14 Q: What assumptions did you make about the
15 accessibility of Fort Mill Medical Center to
16 individuals not only in the northeast of York
17 County, but on the eastern side of the county?

18 A: Well, we assumed that portions of the residents
19 in portions of 29732 and 29730, and even, I
20 guess, to some degree 29704 would access the
21 Fort Mill Medical Center due to proximity. You
22 can see from Mr. Walsh's map, all of those
23 residents of 29730 that live east of 77 are
24 much more -- have easier access to the Fort
25 Mill Medical Center and a portion of those

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1 living to the west have easier access. The
2 brown area shows five to ten minutes, I think,
3 is what Mr. Walsh said. A difference going to
4 Piedmont and Fort Mill, so the same for 29732,
5 perhaps not to the same degree, but portions of
6 that zip code would be accessible to Fort Mill
7 Medical Center versus Rock Hill so we assume
8 that residents of those areas would access Fort
9 Mill that had historically gone to Piedmont.

10 Q: All right. Based on your experience working
11 with hospitals, Mr. Levitt, including market
12 share analysis, does a drive time difference of
13 five or ten minutes have a material effect on
14 the judgement of patients as to which hospital
15 they would want to use?

16 A: No, not materially, no.

17 Q: All right. Now, let's take a look at
18 Carolinas' trial Exhibit, actually, Number 5.
19 Do you recognize this, Mr. Levitt?

20 A: Yes, from my deposition; I believe Mr. Muller
21 showed that to me.

22 Q: Okay. What is it?

23 A: It is the service area map for the 64-bed CON
24 application by Amisub.

25 Q: So, it's a map or Exhibit that you prepared for

1 the CON application that was initially filed on
2 behalf of Piedmont?

3 A: Yeah, I believe this was in the CON
4 application, yes.

5 Q: Okay. And what does it show?

6 A: This shows the three zip codes, 29708, 29715
7 and 29710, the third zip code as the primary
8 service area for the proposed 64-bed hospital.

9 Q: All right. And why were these zip code areas
10 identified as the service area under the
11 original 64-bed application?

12 A: The assumption was that having a presence in
13 northern York would allow patients in that area
14 better access to a hospital. Those were the
15 three zip codes identified as the three
16 northernmost zip codes and that's why they were
17 identified as the primary service area.

18 Q: Okay. Now, did this remain the service area of
19 the proposed Fort Mill Medical Center?

20 A: No. When we submitted the 100-bed application,
21 we had looked at this, looked at travel times
22 and consistent with what Mr. Walsh testified to
23 yesterday, access for 29710 would require --
24 there aren't any bridges across the lake.
25 Going around to the north at the time we

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1 submitted the application we thought that made
2 sense, but looking at travel times, residents
3 of that zip code would not have as much access
4 to the Fort Mill area as we had previously
5 understood, so we modified the service area to
6 show 29708, 29715 and then, as we talked about,
7 portions of 29730 and 32.

8 Q: Let's take a look at that next Exhibit, next
9 page in Carolinas' Exhibit 5. And what does
10 this reflect?

11 A: This reflects the revised service area. This
12 is actually the remanded CON that adds the
13 29707 zip code which was just a portion of
14 29715 at the time, but the original 2005 100-
15 bed application shows the same as this, but
16 there was no 29707 zip code, shifting 29710 to
17 the secondary service area while still in the
18 service area and, in fact, identifying the
19 secondary service area. In the 64-bed
20 application we didn't identify in the map the
21 rest of York County as a secondary service
22 area. I believe we described it, but we didn't
23 show it on the map. This illustrates that and
24 shows the entire York County, all the zip codes
25 in York County either primary or secondary

1 service area for the 100-bed application.

2 Q: All right. You mentioned as part of the
3 process looking at some drive times. Did you
4 undertake or retain any drive time analysis
5 such as Mr. Walsh performed?

6 A: No.

7 Q: All right. Then what did you look at in
8 considering the question of access of residents
9 on the southern and eastern side of York
10 County?

11 A: We looked at internet resources, Google Maps,
12 and things like that as well as software,
13 mapping software we have. And then also
14 discussions with Mr. Miller who has very
15 detailed knowledge of the York County market,
16 travel times and travel patterns.

17 Q: Okay. All right. With that Mr. Levitt, let me
18 ask you to, let me ask your opinion concerning
19 who best meets paragraph 2(e). Let me take you
20 back to that so you have a chance to read that
21 again since we first did that yesterday. If
22 you'd draw up Exhibit 29, please, Dan? Page
23 25, paragraph 2(e). What does this paragraph
24 mean to you, Mr. Levitt?

25 A: 2(e) says: The current annual projected

1 utilization should be sufficient to justify the
2 expansion and implementation of the service.

3 Q: And which of the applicants best meets that
4 provision?

5 A: Based on everything we've talked about,
6 Piedmont's application for Fort Mill Medical
7 Center best meets that. CHS does not.

8 Q: Okay. Dan, let's go ahead and provide the
9 appropriate check. All right. Let's take
10 that, Dan, if you would to the overview, the
11 overview grid at 168.1. Now, with regard to
12 the full community need analysis under section
13 2, Mr. Levitt, summarize your opinion
14 concerning which applicant best meets that.

15 A: Yes, taking in total (a) through (e), Piedmont
16 Medical Center best meets the review criteria.

17 Q: All right. Well, let's move then to section 3.
18 And let's begin with section (a) and let's pull
19 that out with the regs and define what that
20 addresses, please.

21 A: 3(a) is the distribution accessibility criteria
22 that talks about duplication and modernization
23 of services must be justified. Unnecessary
24 duplication of services and unnecessary
25 modernization of services will not be approved.

1 So, it's looking at the duplication,
2 modernization and basically determining whether
3 or not that has been justified in the CON
4 application.

5 Q: All right. And how do you apply this section
6 of the regs to Carolinas' application?

7 A: Again, as we talked about under the purposes of
8 the Act, both direct and indirect duplication
9 of services should be analyzed.

10 Q: And apply that -- is there any direct
11 unnecessary duplication that Carolinas' Fort
12 Mill Medical Center would present?

13 A: No, that the 64 beds are needed in the market,
14 additional beds are definitely needed in the
15 market. So, from the direct perspective, no.
16 But from an indirect perspective for all the
17 reasons we've talked about that their
18 duplication of specialized services and higher
19 level services that would be treated in North
20 Carolina, they would transfer those patients to
21 North Carolina versus transferring them to the
22 resources that are available at Piedmont,
23 that's duplication.

24 Q: All right. Now, should this section be applied
25 to both Carolinas' and Piedmont's applications?

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1 A: Yes.

2 Q: Now, did the Department do that?

3 A: No.

4 Q: All right. Would you then apply it to
5 Piedmont's application? Did they meet this
6 provision?

7 A: Yes. Again, as we said when we talked about
8 duplication in the context, the purpose of the
9 Act, the need for the additional beds has been
10 demonstrated, both in the Plan and in the CON
11 application. And then rather than duplicate
12 the other services that are available at
13 Piedmont, we are strengthening healthcare
14 services.

15 Q: And is the transfer of the 36 beds from
16 Piedmont to Fort Mill an unnecessary
17 duplication of existing services?

18 A: No. In order to increase utilization of both
19 facilities, the transferred beds to Fort Mill
20 is positive and results in positive impact.

21 Q: And which applicant best meets the tests under
22 3(a)?

23 A: Piedmont's application for Fort Mill Medical
24 Center.

25 Q: Okay. Let's look at the grid that focuses on

1 3 specifically. And pull that up if you would,
2 Dan, 168.3 and do those checks comport with
3 your opinion?

4 A: Yes.

5 Q: All right. And let's move on to paragraph (b)
6 and (c). We'll take these in one fell swoop,
7 Mr. Levitt. Do you agree with the Department's
8 position that both applicants equally meet
9 provisions of (b) and (c) of Paragraph 3?

10 A: Yes.

11 Q: Okay. All right. Then let me draw your
12 attention to Paragraph (d). Dan, if you would
13 pull (d) up so Mr. Levitt can publish that.

14 A: 3(d) says: The proposed facility should not
15 restrict admissions. If any restrictions are
16 applied, their nature should be fully
17 explained.

18 Q: All right. Now, what's the purpose of this
19 provision?

20 A: To assure that the services are available to
21 all residents in the area and that they're not
22 identifying certain patient populations that
23 are more desirable than others to treat.

24 Q: All right. Now, first of all, let's begin with
25 DHEC's position on this. There has been

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1 testimony, and you stated as well, there's a
2 representation from Carolinas that they would
3 shift their patients to the Carolinas Medical
4 Center, is that right?

5 A: Yes.

6 Q: All right. And what position did DHEC take
7 with regard to that assumption?

8 A: DHEC accepted and agreed with that position.

9 Q: Okay. And have you identified two places in
10 the record that reflect that?

11 A: Yes.

12 Q: All right. Let's pull them up. Dan, let's
13 begin with Joint Exhibit 1(B), page 1025. All
14 right. And would you highlight the section of
15 this page that reflects that position? All
16 right. And what does this show, Mr. Levitt?

17 A: This is from the analysis attached to the
18 decision to approve Carolinas Medical Center
19 and what it says is the projections for
20 Carolinas Medical Center-Fort Mill are based on
21 a high level of current market share and is the
22 only applicant that projects no increase in
23 market share as a result of the proposed
24 project. Carolinas proposes to serve only its
25 existing patient base of patients.

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1 Q: And what's your view of that position?

2 A: It doesn't make sound health planning sense.
3 They're not going to serve only their patients.

4 Q: All right. Let's look at the prior page. For
5 the any other such representations and
6 reflecting the Department's position on this
7 issue. What does this portion of the sentence
8 state?

9 A: The analysis goes on to say Carolinas proposes
10 to serve only its existing base of patients at
11 CMC-Fort Mill, Carolinas captured 56.8 percent
12 market share from northern York County in 2010
13 as compared to 44.3 percent in 2005.

14 Q: Did Carolinas, based on your review of the
15 material they submitted to the Department,
16 express positions consistent with the
17 Department's findings?

18 A: Yes, they also indicated they would only treat
19 their patients.

20 Q: All right. Let's look at Joint Exhibit 18,
21 Dan, page 502. Pull out that paragraph 10.
22 And read that into the record, if you would,
23 Mr. Levitt where a statement is made by
24 Carolinas. The last sentence.

25 A: This is from their assumptions for their

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1 inpatient methodology and the last sentence
2 states: Carolinas does not project any
3 additional market share shift from Piedmont
4 Medical Center or from Presbyterian-Mecklenburg
5 facilities. Meaning their only going to be
6 treating their patients.

7 Q: And let's look at the first sentence of that
8 paragraph. What does that reflect?

9 A: It says: Assumed patient discharges at CMC-
10 Fort Mill hospital would be derived from York
11 County patients currently seeking care at
12 Carolinas hospital in North Carolina. (Now
13 given a choice to receive care at Carolinas
14 facility closer to home). Again, these two
15 taken together indicate they're only going to
16 be treating their patients.

17 Q: All right. Now, if indeed this were to occur,
18 what are the implications concerning the use of
19 physicians on the medical staff of Carolinas
20 Medical Center?

21 A: Well, I think their implied assumption is that
22 only their physicians will be admitting
23 patients and will only be admitting patients
24 they had historically sent to North Carolina.
25 So only CPN physicians would be using CMC-Fort

1 Mill and for all intents and purposes, it would
2 be a closed medical center.

3 Q: Now, could it be a closed medical center so
4 that only Carolinas physicians could practice
5 in it?

6 A: I suppose they could do that but it would be
7 inconsistent with the standards in the Health
8 Plan.

9 Q: So it would violate the standards in the Health
10 Plan for them to close the medical center?

11 MR. MULLER: Your Honor, I want to object. He's
12 asking for a legal interpretation from this
13 witness.

14 MR. ANDREWS: Fair enough. I'll withdraw the
15 question.

16 THE COURT: I sustain the objection. Well, you've
17 withdrawn it, so that's -

18 MR. ANDREWS: Sure.

19 Q: As a health planner who studies the State
20 Health Plan, would it be consistent with the
21 Plan for Carolinas to close the medical center?

22 A: No. And as we said, the number one criteria,
23 number one importance in the project review
24 criteria was compliance with the State Health
25 Plan. So, if the application had a closed

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1 medical staff, that would be inconsistent with
2 the State Health Plan and the regulations say
3 that an applicant that's not consistent with
4 the State Health Plan can't be approved.

5 Q: All right. Is there, you've read Carolinas'
6 application and its submission to the
7 Department?

8 A: Yes.

9 Q: Have they stated the medical staff would be
10 closed?

11 A: No.

12 Q: Okay. Now, have you, in your work on this
13 case, Mr. Levitt, analyzed the extent to which
14 the Carolinas employed physicians who are
15 affiliated with the Carolinas Physician
16 Network, accept patients on governmental
17 programs like Medicaid or uninsured and
18 indigent?

19 A: Yes.

20 Q: Have you developed a Demonstrative to identify
21 those various sources of information you've
22 reviewed?

23 A: Yes, we've done a number of different analyses
24 and I've summarized those in an Exhibit.

25 Q: Dan, let's look at Demonstrative 203, please.

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1 What's reflected here, Mr. Levitt?

2 A: This shows the four areas that we looked at to
3 look at what we call payor mix research for the
4 CPN physicians. The first one was included in
5 submission to DHEC and I believe was submitted
6 in July of 2011, so prior to submission we
7 conducted a telephone survey.

8 Q: Let's pull -- I'm sorry, go ahead.

9 A: Kim Clayton is an employee at Piedmont Medical
10 Center, works in medical staff services for
11 Piedmont Medical Center and we asked her to
12 conduct some surveys. I had called one
13 facility at the time, one provider, one of the
14 physician practices at the time and in the
15 interest of time, I asked her to duplicate what
16 we had done and call the CPN physicians in York
17 County to determine whether or not they were
18 accepting Medicaid and indigent patients.

19 Q: All right. Let's take a look at what's in the
20 record concerning that survey. I'm sorry, it's
21 Joint Exhibit 1(B), page 782. And what's
22 reflected here, Mr. Levitt.

23 A: Again, this is the summary. We had done the
24 same thing for the Presbyterian physicians, but
25 this shows the CHS physicians, the Shiland

1 Family Medical Practices both Fort Mill and
2 Rock Hill, and then the Medical Associates of
3 Fort Mill and Rock Hill, the two primary care
4 physician practices at the four locations, we
5 looked at some data yesterday about the order
6 of magnitude that those physicians represent
7 for York County referrals and they were 80
8 percent of the referrals, so the vast majority
9 of those practices in York County that refer to
10 CHS facilities. What it showed for Shiland
11 Family Practice was that no new uninsured
12 patients were being accepted and no new
13 Medicare or Medicaid patients were being
14 accepted. Medical Associates of Fort Mill and
15 Rock Hill both indicated that no uninsured
16 patients would be accepted unless they paid in
17 advance and they were to pay 70 percent of a
18 new patient charge which averaged \$290 to \$800
19 prior to being able to schedule an appointment
20 to see a physician.

21 Q: Okay. Let's then go back to Demonstrative 203,
22 please, Dan? In addition to that survey in
23 2011, did you learn anything else that
24 supported your opinions?

25 A: Yes, the second on the list, the interview and

1 meetings that Mr. Sullivan and I had with the
2 medical staff prior to my deposition in July of
3 2013, very recently, we talked to the
4 physicians about trends in the market, what
5 they were experiencing, what they were hearing
6 from their patients and what they were
7 experiencing in the market as far as referring
8 patients and what practices were taking what
9 types of patients.

10 Q: And what did you learn in that regard?

11 A: It confirmed what we had found out in 2011,
12 that nothing had changed as far as accepting of
13 Medicaid patients at the primary care
14 physicians in Rock Hill.

15 MR. MULLER: You know, we are now getting into the
16 area we raised earlier in the objection. Mr.
17 Andrews has not pointed it out, but he's asking
18 him a hearsay question from the exact document
19 we're objecting to. And that is a document
20 that is replete with written notes that Mr.
21 Levitt took of multiple doctors who are on the
22 Piedmont Medical Center staff, on the governing
23 board of the applicant. We would not have had
24 an opportunity to depose all of them. So that
25 document is hearsay and his repeating of in his

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1 testimony is hearsay and that's the basis of
2 our objection.

3 **MR. ANDREWS:** Your Honor, we don't need Exhibit 65,
4 so I wasn't going to use that, Mr. Levitt's
5 particular notes contain a lot of different
6 issues. Don't object to them and I understand
7 there's an objection so I was going to move
8 through that. Of course, experts can, where
9 it's consistent with what they do in this
10 field, rely on hearsay, information otherwise
11 inadmissible. That's the nature of what he's
12 learned from a broad group and it's not a
13 matter, in our opinion, of whether it's
14 admissible concerning quite a number of members
15 of the board, but we're don't believe that's
16 factually true. But in any event, we believe
17 it is admissible.

18 **THE COURT:** All right.

19 **MR. MULLER:** Your Honor, Mr. Andrews has pointed out
20 that an expert can in some instances rely on
21 hearsay. It has to be reliable. And our
22 contention and we thoroughly briefed this in
23 the motion in limine, is that information is
24 not reliable, it's anecdotal. It's coming from
25 various sources that can't be repeated. It is

1 the worst type of hearsay imaginable that he is
2 now relying. Doctors telling him what they've
3 heard from other CPN physicians or what they
4 heard from unidentified patients. We have
5 absolutely no way to refute that, of course,
6 other than calling witnesses, which we will do,
7 but it is the worst kind of rank hearsay you
8 could possibly imagine and that's what he's
9 getting ready to testify -- he's getting ready
10 to repeat unreliable hearsay.

11 **MR. ANDREWS:** Frankly, Your Honor, he's finished.
12 It would be a matter of striking it. I don't
13 intend to go in any further depth. It's
14 confirmative of a variety of sources and
15 actually confirmed by Carolinas own documents
16 that we're going to in just a minute, in fact,
17 next. So -

18 **THE COURT:** Well, in light of the fact that that is
19 the extent of what you're going to ask, I'm
20 going to overrule your objection. I'm going to
21 not strike what's been entered into the record.
22 But don't -- you're not going to pursue this
23 any further?

24 **MR. ANDREWS:** No, I'm not.

25 **THE COURT:** And so -- of course, you'll have the

1 opportunity to bring forth your position of
2 this, the basis of this hearsay evidence upon
3 which Mr. Levitt relied upon for opinion in
4 this matter, the degree of reliability that and
5 the verifiability of that.

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

7 **THE COURT:** Thank you.

8 Q: Mr. Levitt, let's go to your third point on
9 your research related to CPN's acceptability of
10 these patients.

11 A: Yes, again, prior to my deposition, Ms. Clayton
12 and I did a similar analysis that we did in
13 2011. We called the physician practices, asked
14 if they accepted Medicaid and self-pay patients
15 and we had similar responses. They didn't.

16 Q: Okay. And subsequent to the calls before your
17 deposition, have you made any further calls to
18 Carolinas Physician Network offices?

19 A: I did.

20 Q: What are those?

21 A: Yesterday morning I called.

22 Q: And what did you learn?

23 **MR. MULLER:** Your Honor, let me just -- he is
24 repeating information he did not provide during
25 his deposition. Apparently he's done further

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1 research that I didn't have the opportunity to
2 depose him on and how he's expected to testify
3 about it. So, I really, our position is that
4 we're severely prejudiced by all this last
5 minute information. You can see what's on your
6 screen, this update was done apparently in
7 February of 2013.

8 **MR. ANDREWS:** Your Honor, let me be clear for the
9 record because apparently it's not. The
10 February 13th calls were made before the
11 deposition.

12 **COURT REPORTER:** One at a time, please.

13 **THE COURT:** Let's let Mr. Muller complete his
14 objection.

15 **MR. ANDREWS:** I'm sorry.

16 **THE COURT:** And Mr. Andrews I'll let you fully
17 explain. Thank you, sir.

18 **MR. MULLER:** The deposition date is February 11,
19 2013. He never mentioned any kind of updated
20 survey and I asked him specifically about the
21 survey that he had taken. So, this is the
22 concern we had earlier is that some of these
23 witness, their work has been much more expanded
24 after the deposition is taken and this is a
25 perfect example of that. I mean it is

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1 prejudicing us because we didn't have an
2 opportunity to depose him on these subjects.

3 **THE COURT:** All right. Now, Mr. Andrews?

4 **MR. ANDREWS:** I apologize, Your Honor. Your Honor,
5 several points. First, the calls had been
6 made. Mr. Levitt, to the best of my
7 recollections, was not asked if it was updated.
8 He doesn't have any obligation to volunteer
9 that information and it certainly was related
10 to the same subject. He was just updating the
11 survey that had been conducted two years
12 before. And frankly, Your Honor, he did the
13 same thing yesterday. Just to gather the
14 information. There is nothing, as I understand
15 the rules of discovery and the rules of
16 evidence, that would exclude information that's
17 directly related to opinions that have been
18 previously identified and the subject matter on
19 which there's been opportunity to explore fully
20 that would prevent any witness from continuing
21 to gather information as long as it is
22 consistent as long as it doesn't change
23 opinions. All of which would be true related
24 to his calls that Mr. Levitt made just to
25 confirm the practice. And that's the issue, is

1 what's occurring as is a screen at the initial
2 attempt for a patient to establish services.
3 And then -

4 **THE COURT:** And I think Mr. Muller's position on
5 this matter, Carolinas' position on this matter
6 is that -- and I realize what you're basically
7 offering is this subsequent to deposition
8 testimony updates by your expert that bolster,
9 in essence, the opinion that is given during
10 the deposition. Not changing that opinion, but
11 rather bolstering it. But at the same time
12 there is an issue, in essence, of the inability
13 of Carolinas in this situation to verify that
14 or research that because it didn't come up in
15 the deposition. And so, there is a certain
16 degree of fairness here and the inability of
17 Carolinas to be able to research what this
18 basis was that bolsters the opinion after the
19 deposition. I wasn't -- I did brief research
20 on this last night. I wasn't able -- I agree
21 with you. I can't find anything that prohibits
22 this. On the other hand, I am concerned about
23 the degree of fairness to Carolinas and their
24 ability to prove this. Mr. Muller, can you
25 determine from the deposition whether Mr.

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1 Levitt was asked the question?

2 **MR. MULLER:** I asked him on two separate occasions
3 to relay to me what it is that he did. And he
4 never told me that there was a second updated
5 survey that he had done. He said -- and a lot
6 of this, and lot of these deposition excerpts,
7 I believe, are in our memorandum with the
8 motion of limine.

9 **THE COURT:** With the motion.

10 **MR. MULLER:** And I asked him, actually asked him
11 once and he had some difficulty identifying who
12 he had spoken to and then I asked him again and
13 went into this, well basically I called and
14 acted like I was a new patient and asked them
15 if they accept Medicare or Medicaid. They said
16 no, no. Not identified who he was speaking to.
17 If the Court will give me a minute, I can
18 probably identify the exact pages of the
19 deposition where I asked him those questions,
20 if it will help the Court to decide the issue.

21 **MR. ANDREWS:** May I respond just to something more
22 generally related to the prejudice question?

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

24 **MR. ANDREWS:** Which is, Piedmont has no access other
25 than through the standard depositions to issues

1 of practice of Carolinas Physician Network.
2 And the practices vary. We could have done
3 30(b)(6) of someone at Carolinas, but we didn't
4 do that. Carolinas has the ability to call
5 anyone from those practices and refute this.
6 We have -- we would not be in a position to
7 object to exceeding the witnesses if it relates
8 to their need to respond to this. And that's
9 the way to manage the prejudice is whether in
10 fact it's done. I would think the Court would
11 have an interest in whether or not this was a
12 practice in 2011, which they denied before the
13 Department in project review, and whether it
14 continues to be. We believe there are multiple
15 sources of evidence that suggest this indeed is
16 a practice and we believe it's reliable. I
17 mean it can certainly be subject to cross
18 examination, but not to exclusion what Mr.
19 Levitt has learned and how we intend to use it.

20 **MR. MULLER:** Your Honor, that's the crux of the
21 matter. He identified in very vague terms in
22 his deposition what he had done and it was so
23 vague and so unscientific that we objected to
24 it our motion of limine. The Court reserved
25 that objection to wait to hear how that was

1 going to be offered. Then in open court he
2 said in addition to that, we've done this
3 updated information. We've not made a test of
4 the deposition of the veracity and reliability
5 of this method that's he's used. We're hearing
6 it for the first time on the stand so we are
7 prejudiced in terms of how he's approaching
8 this. And, you know, the reason we take
9 depositions is because very often the story
10 changes. We would have like to have known how
11 he did it then if he had indeed done it prior
12 to the deposition as he testified. He did not
13 reveal that, so that's the worst kind of
14 prejudice. You know, it's the basic tenet of
15 cross examination, you generally don't want to
16 ask a question you're not sure you know the
17 answer to. I have no idea what he's going to
18 say. And nor will Mr. Andrews solicit that
19 from him because it is unfavorable to his case.
20 So that's the prejudice part of this particular
21 testimony and I understand Mr. Andrews has
22 already pointed out he has a letter on the
23 record that has addressed this issue. I
24 believe if I ask questions about what he did it
25 will be objected to, we do not believe it's

1 relevant. We don't believe the kind of
2 information he got was reliable in the way he
3 approached it by pretending he's a patient. He
4 didn't identify who he spoke to at CHS. This
5 is compounding that issue with a new updated
6 survey he never disclosed to us.

7 **MR. ANDREWS:** Your Honor, just finally, again, this
8 is fundamentally a question of fact. The
9 ability to refute it is solely in Carolinas'
10 hands. They cannot be unfairly prejudiced if
11 they have the ability to call as witnesses
12 those individuals who would be in a position to
13 know what receptionist, back clerk, staff at
14 their practices -- and it has too been
15 identified. Saying to potential patients when
16 they call and say do you take Medicaid, what
17 does it cost if I don't have insurance? In
18 fact, I'll elicit everything that -- despite
19 what Mr. Muller says, what Mr. Levitt knows and
20 said and who he talked with. He got a name
21 this last time. That was an objection before.
22 So they can verify that if they want at the
23 practice. So, we're happy to put all that
24 information on the record and go from there.

25 **MR. MULLER:** And Mr. Andrews has just outlined that

1 this information is factual. It is not the
2 need of expert testimony to provide factual
3 information. He took a 30(b)(6) deposition of
4 our witness on these very issues. He's not
5 sought to introduce that evidence. So that is
6 part of my objection. He's simply trying to
7 get through the backdoor of this expert witness
8 some factual information that apparently he
9 cannot obtain through a 30(b)(6) deposition of
10 our witness.

11 **MR. ANDREWS:** And the reason for that, Your Honor,
12 is that the 30(b)(6) witness didn't know,
13 couldn't provide that level of detail. It was
14 a senior official in Carolinas Network
15 Physician System. Didn't have the knowledge.

16 **MR. MULLER:** And he denied that would have occurred.
17 So, Your Honor, I maintain my objection as to
18 the scope of this testimony, especially
19 considering that what is now being offered as
20 very likely post-deposition until the time of
21 trial.

22 **MR. ANDREWS:** Your Honor, let me say in closing, if
23 I could, that we identified this issue in 2011.
24 It could have been checked out. Could have
25 been specifically responded to saying, no, we

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1 have checked with all of our York County
2 practices and they don't do this. And verify
3 that. That never occurred. And so we felt the
4 issue was still live and still was the subject
5 of research and that's why I asked Mr. Levitt
6 to do it.

7 **THE COURT:** Mr. Andrews, let me see if can get
8 clarification here and Mr. Muller, if you would
9 be kind enough to help me here, in essence what
10 we're talking about here is this initial
11 calling interview study that was done by Mr.
12 Levitt in order to attempt to verify or
13 determine whether these certain physician
14 groups were accepting uninsured patients.

15 **MR. ANDREWS:** And Medicaid.

16 **THE COURT:** And Medicaid patients. And there was an
17 initial study done and that had formed the
18 basis of Mr. Levitt's opinion. Subsequent to
19 his deposition, this matter, he updated that
20 survey and made some additional phone calls to
21 some numbers. He made them to the same
22 physicians.

23 **MR. ANDREWS:** Same practices, that's correct.

24 **THE COURT:** Same practices and received in essence,
25 I guess, the same information.

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

2 **THE COURT:** And Mr. Muller, your position is that
3 because you weren't aware of the basis for this
4 testimony that this all occurred after the
5 deposition that this is prejudicing you and
6 your ability to refute what he's testifying to?

7 **MR. MULLER:** Well ---

8 **THE COURT:** In addition to the reliability issue.

9 **MR. MULLER:** As Mr. Andrews said, we knew what he
10 contended in the letter he submitted to DHEC.
11 We asked him questions about that and he
12 responded to those questions and that was the
13 basis of our objection. It was a very un-
14 thorough way to survey and it was deceptive in
15 the way he did it and there's no way for us to
16 even determine who he spoke to. You know, and
17 Mr. Levitt has a tendency of doing this, when
18 you point out deficiencies during his
19 deposition, he then tries to bolster before
20 trial and that is exactly what he has done. He
21 has tried to go back and do a more thorough
22 approach to that but I suspect he's not going
23 to tell us who he spoke to by name. I don't
24 know any of the details of what he's saying
25 because he didn't reveal them during his

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1 deposition and it's a game of hide and seek,
2 frankly. And this is a pattern of Mr. Levitt
3 during these depositions.

4 **MR. ANDREWS:** Objection to the second time for that,
5 Your Honor. The characterization of Mr.
6 Levitt's practice and his testimony is really
7 out of bounds.

8 **MR. MULLER:** Well, I think I can bring some of that
9 out on cross.

10 **THE COURT:** All right. And let's not disparage
11 anybody's character here. Let's just get this
12 done. I'm going to tell you what. It's 11:30.
13 We haven't had a break. What I -- how much
14 longer do you anticipate you're going to be
15 with Mr. Levitt? Assuming we get through this.

16 **MR. ANDREWS:** Other than this 30 minute delay, I
17 think it's likely to go beyond lunch, but not
18 a lot beyond lunch.

19 **THE COURT:** All right. And then you'll have, of
20 course, some, I'm sure, a substantial amount of
21 questioning to do. What I'm thinking is, it
22 might be a perfect time to take an early lunch
23 break. It's 11:30. We'll reconvene at one and
24 that will give me an opportunity to review this
25 and your objection, we'll come back on the

1 record, I will rule on this and then move
2 forward. Gentlemen, thank you. Ladies and
3 gentlemen, thank you. We're in recess.

4 (Off the Record)

5 **THE COURT:** Please be seated. Okay. We're back on
6 the record. And I do apologize to the parties.
7 That took a little longer than I anticipated.
8 I hope y'all had an enjoyable lunch and relaxed
9 a little bit. Mr. Andrews, I have a question
10 for Mr. Levitt.

11 **MR. ANDREWS:** Yes, sir.

12 **THE COURT:** Mr. Levitt, sir, is this -- and when I
13 refer to this thing, I'm talking about the
14 surveys ---

15 A: Yes.

16 **THE COURT:** --- in question here, that you took, the
17 telephonic surveys. Are these surveys, this
18 type of thing, is that something you've
19 reasonably relied upon or that is reasonably
20 relied upon by experts in your field of
21 healthcare planning in a Certificate of Need
22 application in formulating your opinions or
23 inferences?

24 A: Yes.

25 **THE COURT:** All right. Ladies and gentleman, based

1 on this answer, I conclude that the telephone
2 surveys conducted by Mr. Levitt in February of
3 2013 and the prior survey were of the type of
4 data that is reasonably relied upon by experts
5 in this field of healthcare planning and
6 Certificate of Need application and is proper
7 as a basis for the formulation of his opinion
8 on the subject. Which in this case, is the
9 out-migration of payor, insured patients from
10 Petitioner Piedmont's hospital is in part due
11 to the practice of Respondent's affiliated
12 physicians not taking uninsured, Medicare or
13 Medicaid patients. The Court will consider the
14 testimony elicited from Mr. Levitt regarding
15 the February 13th survey and the prior survey
16 conducted before that, that he and the unnamed
17 Piedmont employee conducted, and which were
18 known to Respondent Carolinas at the time of
19 Mr. Levitt's deposition. However, because of
20 the limited size of the survey group, the fact
21 that Mr. Levitt did not conduct all the
22 surveys, the very limited nature of the survey
23 questions asked and the lack of identity of
24 parties answering Mr. Levitt and the other
25 employee's questions at the various practices,

1 the Court finds that this evidence is of
2 limited probative value and that any evidence
3 of the subsequent survey that was conducted
4 this week by Mr. Levitt is outweighed by the
5 prejudice to the Respondent Carolinas and
6 therefore the Court will not consider any
7 evidence regarding the most recent survey on
8 permitting the questioning of Mr. Levitt on
9 that survey other than cross examination
10 questions -- well, at all on that matter, but
11 of course cross examination questions as to the
12 crux.

13 **MR. ANDREWS:** All right, sir. Thank you, Your
14 Honor. All right. With that, shall I proceed?

15 **THE COURT:** Yes, sir. Please.

16 **Q:** Mr. Levitt, then if you would, please explain
17 to the Court the nature of your calls, what you
18 did to place the calls in February of 2013.
19 Why you conducted them.

20 **A:** Simply -- and perhaps the calling it a survey
21 is a bit much. I just simply called the
22 physician practices, called the primary care
23 physicians practices in York County owned by
24 CHS. When an individual answered the phone --
25 I believe, I believe it was automated, press

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1 two for an appointment. I pressed two. An
2 individual answered the phone. I said you
3 know, I have a family member that would like to
4 make an appointment -- or one I asked, I said
5 that to the other, that I would like to make an
6 appointment. Asked if they were accepting new
7 Medicaid patients and they said no. On -- I
8 believe on the first call before I said if they
9 were accepting new Medicaid patients, they
10 asked what my insurer was. They said what
11 insurance do they have. I said if they have
12 Medicaid can I make an appointment and they
13 said no. They weren't taking any Medicaid
14 patients. One of them I asked if they were
15 taking Medicare, they said no new Medicare
16 patients either. And self pay? If they paid
17 in advance, they could come. So, it wasn't a
18 scientific survey. It was to confirm what the
19 physicians had told me prior to that in those
20 interviews I conducted.

21 Q: Let's don't get into any more detail on that.

22 A: Okay. To confirm what I had heard, that the
23 CPN physicians weren't accepting Medicaid and
24 Medicare patients and self pay, so I called to
25 confirm that and that's what I found out.

- 1 Q: Okay. And let's be specific about which
2 practices you called. Do you remember?
- 3 A: I called the two Shiland - no, then I called
4 the -- not the Shiland practices, the ---
- 5 Q: Dan, if you would, put up Demonstrative 27
6 which includes a list of all the practices so
7 you'll have them in front of you and you can
8 identify which ones. I'm sorry. I said
9 Demonstrative, I mean Carolinas Exhibit 26.
- 10 A: I called Medical Associates, the two Medical
11 Associates locations, Fort Mill and Rock Hill.
- 12 Q: Okay. And why did you elect to call those two
13 offices?
- 14 A: They were the primary care practices in York
15 County owned by CPN.
- 16 Q: Okay. And why didn't you say this is David
17 Levitt the healthcare planner working for
18 Piedmont Medical Center? Why didn't you
19 introduce yourself that way?
- 20 A: Well, frankly it didn't occur to me. I wanted
21 to find out if they were accepting new
22 patients. Not if they were accepting new
23 patients if they were asked by me for Piedmont
24 Medical Center.
- 25 Q: Okay. Now, the individual that participated in

1 the calls that were recorded in your July 11,
2 2011, letter to DHEC for Piedmont, what was her
3 name?

4 A: Her name was Kim Clayton.

5 Q: Okay.

6 A: I couldn't remember that at time of the
7 deposition.

8 Q: And based on the report that's in the record,
9 what offices did she call? We can pull those
10 up if it would be helpful.

11 A: Yes, I believe she called those as well as the
12 Shiland Family Practice, both locations.

13 Q: Okay. And how did the information she obtained
14 in those calls compare to what you learned in
15 yours?

16 A: They were consistent. They weren't accepting
17 new Medicaid patients. Shiland wasn't
18 accepting Medicare patients and Medical
19 Associates required an advance payment for self
20 pay.

21 Q: Okay. All right. Now, let's move on and let's
22 go back, Dan, to Carolinas Exhibit 27. In
23 addition to the telephone calls that were made,
24 Mr. Levitt, have you considered any other
25 information that affects your opinion about

1 whether the Carolinas Physicians restrict the
2 services they provide to their patients?

3 A: Yes.

4 Q: And what did you learn through this document?

5 A: This document shows the payor mix by practice
6 that they provided. And it, we talked about
7 yesterday, I think it was, where we showed that
8 Shiland Family Medicine and Medical Associates,
9 those four locations, represent about 80
10 percent of the total and you can see the payor
11 mix of those four locations, the percentage
12 Medicaid for Medical Associates of Fort Mill is
13 a fraction of a percent, .3 percent. Medical
14 Associates of Rock Hill is 0.1 percent.

15 Q: Excuse me a minute. Dan, could you draw those
16 out so we could see them a little better,
17 please? I think that's pretty clear. And what
18 are, I'm sorry, Dan, can you draw out the
19 practice name and then the Medicaid
20 participation for each of those offices? We'll
21 begin with Medical Associates of Fort Mill.
22 And what's the source of this document, Mr.
23 Levitt?

24 A: This was provided by Carolinas Medical Center
25 in discovery.

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1 Q: All right. And for 2012, what was the Medicaid
2 participation reported by Carolinas of the
3 Medical Associates of Fort Mill?

4 A: It is 0.3 percent of the patients are Medicaid
5 patients.

6 Q: All right. And for the Medical Associates of
7 Rock Hill office?

8 A: 0.1 percent.

9 Q: Okay. And Shiland Family Medicine?

10 A: That's the location in Rock Hill and it's 1.0
11 percent Medicaid.

12 Q: And what's the Medicaid participation for
13 Shiland Family Medicine Fort Mill?

14 A: 0.6 percent.

15 Q: Okay. And do you remember from your review of
16 the referral data yesterday the total
17 percentage in general terms, referrals that
18 these four offices made of all the York County
19 CPN offices?

20 A: They represent with the exception of, taking
21 out the cardiac --

22 Q: The Sanger Clinic?

23 A: The Sanger Clinic, they represented about 80
24 percent.

25 Q: Okay. And in the -- Dan, let's go back to the

1 document, if you would. And you can drop those
2 highlights. Thank you. And actually, I'd like
3 for you to pull out the Sanger Heart and
4 Vascular Institute at Fort Mill and the Sanger
5 Heart and Vascular Institute of Rock Hill. And
6 pull out their Medicaid participation as well
7 for 2012.

8 A: Above that.

9 Q: All right. And what is the Medicaid
10 participation of these two clinics that provide
11 cardiac services to York County residents?

12 A: Fort Mill is about, is 1.5 percent and Rock
13 Hill is 1.6 percent.

14 Q: And do you remember the general order of
15 magnitude of the number of referrals that came
16 out of the two Sanger Clinics in 2012 based on
17 the data you looked at?

18 A: 2012 was a very large number, a very large
19 percent.

20 Q: Around 3,000 between the two offices?

21 A: Between the two combined, yes.

22 Q: All right. Okay. Let's take a look -- thank
23 you, Dan -- at the bottom practices, Sanger
24 Heart and Vascular Institute and Rock Hill
25 Pediatrics just to be clear about what that is.

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1 There's a footnote. Dan, if you'll just
2 highlight the left hand corner of that document
3 so we can just call -- well, first of all,
4 sorry. Let's call out the whole corner so we
5 pick up the Sanger and pediatric office down
6 through the Medicaid and the footnote. There
7 you go. All right. Now, there's a Sanger
8 Heart and Vascular Institute line item that
9 says and has a slash Rock Hill Pediatrics.
10 Dan, would you take that all the way through
11 Medicare? I'm sorry. One more. All right.
12 There we go. So we pick up the footnote. And
13 Mr. Levitt, we see that there's a third Sanger
14 office, it has a name and shares it with Rock
15 Hill Pediatric Center and do you see the fourth
16 column that has zero?

17 A: Yes.

18 Q: That's in the Medicare column and then read the
19 footnote, if you would.

20 A: It indicates that pediatric practice does not
21 see Medicare patients.

22 Q: So, what inference would you draw concerning
23 that line item as to what kind of office is
24 reflected there?

25 A: That it's a pediatric office.

- 1 Q: All right. So then if you look at the internal
2 medicine practice operated by Carolinas York
3 County, the family medicine practice and the
4 cardiac, cardiology practice, what is your
5 conclusion concerning their participation of
6 those six offices in the Medicaid program?
- 7 A: That they have a very limited degree of
8 Medicaid participation. A fraction of a
9 percent to a high of 1.6 percent.
- 10 Q: Based on your knowledge of demand for services
11 in this county and your experience in this
12 field, what's your opinion concerning the
13 likelihood that these offices providing those
14 services would have that percentage of Medicaid
15 practice if they were not restricting their
16 Medicaid new patients?
- 17 A: Well, it wouldn't make any sense. If they're
18 accepting all patients regardless of payor,
19 they would have a normal distribution of payor
20 patients and that's not what's shown.
- 21 Q: What is a normal distribution in York County
22 and particularly in Rock Hill and Fort Mill of
23 Medicaid patients?
- 24 A: It's in the teens for hospital patients. In
25 the teens, so I mean less than one percent is

- 1 substantially lower than the county average.
- 2 Q: Than the county average?
- 3 A: Yes.
- 4 Q: That's for hospitals and based on the testimony
- 5 you've heard from Dr. Taylor and Dr. Adlakha
- 6 and otherwise looking at the data that
- 7 Carolinas provided in Exhibit 27, do you have
- 8 an opinion about what the general range for
- 9 physician practices would be of Medicaid?
- 10 A: Yeah, some of them -- I heard Dr. Taylor say 50
- 11 percent of his OB practice, so substantially
- 12 higher than less than one percent and single
- 13 digits.
- 14 Q: All right. And let's look at the top line for
- 15 this document for Carolinas Cancer Specialist.
- 16 What is the Medicaid participation of that
- 17 practice?
- 18 A: 14.3 percent.
- 19 Q: And who are the owners of the cancer center and
- 20 where is the Carolina Cancer Specialist
- 21 practice?
- 22 A: That's the joint venture between Piedmont and
- 23 Carolinas Health System.
- 24 Q: Okay. All right. Now, based on your review of
- 25 the data that you've testified about and the

1 telephone calls, the review of your meetings
2 with physicians, your review of the data in
3 Exhibit 27, Mr. Levitt, what is your opinion
4 concerning which party, whether either party
5 imposes restrictions or would impose
6 restrictions either directly or indirectly on
7 their admissions at their respective hospitals?

8 A: Well, based on what we've talked about, that
9 the Piedmont Medical Center proposal does not
10 and with the CHS proposal does.

11 Q: Okay. And what --

12 **THE COURT:** I'm sorry, I didn't hear that Mr.
13 Levitt, could you repeat that?

14 A: I'm sorry, that the Piedmont proposal for Fort
15 Mill does not propose any restrictions and the
16 CHS proposal does.

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

18 Q: And let me again ask you to explain how the
19 limitations on the practices of the Carolinas
20 medical practices in York County would impose
21 a restriction on the admissions of CMC-Fort
22 Mill?

23 A: Well, if the primary care practices aren't
24 accepting Medicaid patients and don't have a
25 history of having any Medicaid or very limited

1 Medicaid patients, they would then not be --
2 those patients would not have access to primary
3 care physicians that would refer them to
4 specialist to take them to the hospital. So
5 they sort of act as a gatekeeper to prevent
6 those admissions from occurring.

7 Q: What if you assumed that some Medicaid patients
8 would come in through the ER. What effect
9 would that have on the restrictions that you've
10 identified?

11 A: Well, obviously they can't control who shows up
12 at the ER and what their payor sources are, but
13 those would not be CPN patients if they had
14 Medicaid because they wouldn't be in the pool.
15 If they have Medicaid, they're not seeing the
16 CPN patient, the CPN physician, so they would
17 be patients that had historically been treated
18 at Piedmont.

19 Q: And which patients was it that Carolinas in
20 their application have represented that they
21 would shift?

22 A: The CHS patients that are treated by CPN
23 physicians.

24 Q: And what Medicaid participation is reflected in
25 those? In that patient population?

1 A: In the CPN physicians?

2 Q: Yes.

3 A: It is very little. That's what we've been
4 talking about.

5 Q: Okay. All right. And based on that, what's
6 your opinion about which applicant best meets
7 these terms of 3(d)?

8 A: The Piedmont application.

9 Q: Okay. And Dan, let's cut to the grid at 168.2
10 looking at the components of Section 3. And
11 so, I think previously you testified that both
12 parties equally met Paragraphs 3(b) and 3(c).
13 Do I remember that correctly?

14 A: Correct. And 3(d) we just said Piedmont meets
15 and CHS does not.

16 Q: Okay. All right. Let's move to the next
17 section of the regulations. Which is at 3(e)
18 and documenting the needs of access. Do you
19 agree with the Department's position that both
20 parties equally meet that?

21 A: Yes.

22 Q: Okay. And then let's move to paragraphs (f)
23 and (g). Would you, Dan, if you'd pull up
24 Exhibit 29, page 26. And Dan, if you'd
25 highlight both of those and Mr. Levitt, if

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1 you'll read each of those into the record,
2 please.

3 A: (f) states: That the applicant should address
4 the extent to which all residents of the area
5 and in particular low income persons, racial
6 and ethnic minorities, women, the elderly,
7 handicapped persons and other medically
8 underserved groups are likely to have access to
9 those services being proposed and (g) states:
10 The facility providing the proposed services
11 should establish provisions to ensure that
12 individuals who need a treatment as determined
13 by a physician have access to the appropriate
14 services regardless of the ability to pay.

15 Q: All right. And what's the relationship between
16 (f) and (g)?

17 A: They're interrelated that they both address
18 individual access to the facility based off of
19 certain criteria including ability to pay as
20 well as other minority identifications.

21 Q: Okay. All right. Let's begin by looking at
22 the projected levels of indigent care that each
23 of the parties offered. Have you identified
24 those?

25 A: Yes.

1 Q: Dan, let's pull up Demonstrative 182, please.
2 And what does this information contain, Mr.
3 Levitt?

4 A: This is a summary from the two CON
5 applications, or the four CON applications,
6 actually, the 2002 applications for both
7 applicants and the 2010 information submitted
8 shows the Piedmont proposal, both 2005 and 2010
9 propose three percent of gross revenue to be
10 indigent care. Carolinas, in the original 2005
11 application projected 3.5 percent. They raised
12 that to 6.3 percent in the most recent
13 application.

14 Q: Do you believe that increase in their projected
15 indigent care volume was justified?

16 A: No.

17 Q: Why not?

18 A: Based on their patients that they're sending to
19 North Carolina from York County, the experience
20 in their North Carolina facilities, and then
21 from -- most recently, the mix of their
22 physician practices, it's unreasonable.

23 Q: All right. Did you look at any internal
24 information in the Carolinas application to
25 determine whether the projection of 6.3 percent

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1 was consistent with their application?

2 A: Yes.

3 Q: All right. Dan, let's look at Demonstrative
4 183. And did you prepare this Mr. Levitt?

5 A: Yes.

6 Q: And what's the purpose of it?

7 A: This is to show, we raised this issue in the
8 July 11 submission to DHEC that their payor
9 mix, there aren't enough patients in the payor
10 mix to justify the 6.3 indigent care. So in
11 their initial application, the other category
12 was eight and a half percent of total. So,
13 eight and a half percent total patients in the
14 2005 application would be other than commercial
15 managed care patients, Medicare and Medicaid
16 patients. So that's the source of the indigent
17 care. Those people that don't have insurance.

18 Q: But is indigent care showing on that?

19 A: No. Well, indigent care is a separate line
20 item at the bottom, three and a half percent.
21 And that three and a half percent would come
22 out of the eight and a half percent.

23 Q: In their initial application?

24 A: In their initial application. In their revised
25 application, they projected that their other

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1 category would be reduced to three and a half
2 percent. So their managed care went up
3 substantially from 36 percent to 50 percent.
4 Again, the totals have to add up to 100. So it
5 came out of other. And a little bit of
6 Medicaid, so their other went down to three and
7 a half percent, but their indigent care went up
8 to 6.3 percent. So, they're saying that for
9 three and a half percent of their patients,
10 they're going to provide 6.3 percent charity
11 care. So the math just doesn't work. There's
12 not enough uninsured patients to get to that
13 level of charity care.

14 Q: All right. So, let's break down the components
15 of the payor mix chart that you prepared. You
16 testified earlier about what managed care and
17 commercial are. That's Medicare and Medicaid.
18 Now, what in the presentation of financial
19 information of the hospitals would be included
20 in the other or miscellaneous category?

21 A: That would be -- given these four categories,
22 that would be self pay, uninsured individuals.
23 It could also include workers' compensation,
24 auto insurance, sometimes that's in commercial
25 but generally that would be in the other

1 category. VA, CHAMPUS. Sort of the other
2 small, other identified payors.

3 Q: Now, are all self-pay patients always indigent?

4 A: No.

5 Q: And explain how that's the case.

6 A: No. Self pay just means they don't have either
7 insurance or Medicare or Medicaid. So, an
8 individual could have a job, chose not to buy
9 health insurance, goes to the hospital and that
10 would be in that category.

11 Q: Because that individual did not meet the
12 hospital's eligibility, charity care
13 eligibility guidelines, would that be true?

14 A: That could be a category, yes, that they would
15 have sufficient funds to pay their bill and
16 they don't have health insurance and they pay
17 for it.

18 Q: Okay. And so that other, that miscellaneous
19 category in the initial application was 8.5 and
20 would there have been any justification for
21 reducing that miscellaneous category by over
22 two times, down to 3.5?

23 A: They didn't identify any, no. And that's
24 inconsistent with doubling of their indigent
25 care.

- 1 Q: Okay. All right. Now, the percentage
2 presented are percentages of what did you say?
- 3 A: I believe these are percentages of revenue.
- 4 Q: Okay. Now, could it be the 6.3 percent are
5 percentages of patients instead of revenue?
6 Would that be a reasonable or plausible
7 interpretation of this data?
- 8 A: No, because generally they would have lower.
9 The self pay would have lower charges than
10 average, so then that would be worse.
- 11 Q: Okay. Why is it generally true in your
12 experience that self pay would have lower
13 charges?
- 14 A: Because they're paying for it. So, if ---
- 15 Q: Because -- sorry, go ahead.
- 16 A: Because they're aware of what they have to pay
17 for and it becomes very expensive and that's
18 sort of one of the issues that's been
19 identified with healthcare, if you don't have
20 to pay for it then you get lots of things
21 provided to you, so the, the charge is
22 generally lower.
- 23 Q: All right. Now, okay. Did you look at any
24 other data beyond the application concerning
25 the reasonableness that led you to an opinion

1 concerning the reasonableness of the Carolinas
2 projection?

3 A: Yes.

4 Q: All right. Let's take a look at Demonstrative
5 200. And what does this reflect, Mr. Levitt?

6 A: We looked from the Medicare cost reports for
7 the most recent year available, 2010 or 2011
8 depending on the facility. The amount of
9 charity care they reported on the charity care
10 schedule compared to their total gross revenue
11 to calculate the percentage of charity care for
12 the CMC facilities in Charlotte and then
13 compared that to Piedmont.

14 Q: All right. And you pulled this from the
15 Exhibits 75 through 78 and then 81 for
16 Piedmont, is that right?

17 A: Correct. And those Exhibits were the Medicare
18 cost reports.

19 Q: All right. Now was this data you had to
20 calculate or was it identified in the cost
21 reports?

22 A: Well, the two numbers were identified in the
23 cost reports. For instance, for CMC,
24 \$188,131,392 was a line item in the cost
25 report. Gross revenues of \$3,739 -- 739,648

1 was in the cost report and then I did the math.
2 I divided the two to get the five percent.

3 Q: Okay.

4 A: And I did that for all the facilities. And you
5 can see the range for the CMC North Carolina
6 facilities, five percent for CMC, 2.6 percent
7 for Mercy-Pineville, 4.8 percent for CMC-
8 University. And those are the four facilities
9 they identified as the source of patients for
10 the CMC-Fort Mill hospital. So, looking at the
11 average of those, four and a half percent is
12 their charity care experience in 2011. Again,
13 they projected 6.3 percent at the Fort Mill
14 hospital. CMC-Union, another facility just
15 over the border in North Carolina from South
16 Carolina, they had a three and a half percent
17 charity care percentage, so an average of all
18 five of those hospitals, 4.4 percent. And that
19 compares to the 3.8 percent at Piedmont and
20 Piedmont projected three percent. So, it shows
21 that Piedmont was consistent and the CMC-Fort
22 Mill was inconsistent with their experience.

23 Q: All right. Did you look at any of the York
24 County data, the extent to which charity care
25 was provided to York County residents from

1 Piedmont and Carolinas?

2 A: Yes.

3 Q: All right. Let's take a look at that.
4 Demonstrative 186, Dan. And what did you find
5 here?

6 A: Well, we couldn't isolate ---

7 Q: First of all, I'm sorry, identify if you would
8 just for the record, the source of the
9 information too.

10 A: This is from -- it's identified as Piedmont
11 Exhibit 14 and I believe that is the database,
12 the North Carolina South Carolina data with the
13 IRS and the Thompson-Reuters information.

14 Q: You say you believe because you're not certain
15 where the data comes from or you're not certain
16 which Exhibit it was?

17 A: I'm not certain what Exhibit 14 is.

18 Q: That's the pivot table of the database and is
19 that where this information came from?

20 A: Correct.

21 Q: Okay. And the CHS includes what?

22 A: CHS, again, that's the four facilities they
23 identified as the source of CMC-Fort Mill
24 patients. The CMC-Main, CMC-Mercy/Pineville
25 and CMC-University hospitals combined, so all

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1 York County residents that were treated in
2 North Carolina in 2011, this is the payor mix
3 for those patients treated at the CHS
4 hospitals.

5 Q: Okay.

6 A: Also shown is the York County Piedmont payor
7 mix that shows their mix of patients for York
8 County by payor. Now, we couldn't identify
9 charity alone because it's not a category in
10 the two databases. There is the self
11 pay/charity category. So that includes both
12 those patients that pay out-of-pocket as well
13 as those patients that don't pay out-of-pocket
14 would be the charity. And you can see CHS had
15 about a six percent of their patients were self
16 pay/charity and Piedmont had 10.7 percent of
17 patients as self pay/charity.

18 Q: Okay. Now, while we're on this document, let's
19 look at the Medicaid line item since we've
20 given so much attention to that previously.
21 What have you found here and what are the
22 implications of the finding?

23 A: The Medicaid mix for CHS, the four facilities
24 is 11 percent. Piedmont is 18 percent. In
25 their CON application, I believe they projected

1 15 percent Medicaid so they projected higher
2 Medicaid than they actual experience. Same
3 with the self pay/charity. They had six
4 percent self pay/charity, so that included
5 people that did pay their bill as well as
6 people that didn't pay the bill and they
7 projected higher than that for charity care at
8 the CMC-Fort Mill location which is a much more
9 affluent part of York County.

10 Q: All right. Let's -- before you leave that,
11 look at the difference between the managed care
12 experience of the two systems. What do you
13 observe there?

14 A: That the CHS facilities transfer or treat more
15 managed care patients in North Carolina than
16 Piedmont gets out of York County at their
17 facility in Rock Hill.

18 Q: Okay. All right. Did you look at any
19 documents of particular CHS hospitals
20 concerning their indigent care experience?

21 A: To the best that I could find, yes, I did.

22 Q: All right. Dan, let's pull up Demonstrative --
23 well, before we move to the Demonstrative, I
24 think it's the Bates document is SCHS-1205.
25 And highlight the header on this if you would,

1 Dan. What is this document, Mr. Levitt?

2 A: This is the generalized health system,
3 Carolinas Healthcare System departmental
4 performance report for period 12/31/2009, if
5 you scroll back out and go over to the left at
6 the top, I believe it is for business unit
7 Carolinas Medical Center-Pineville.

8 Q: And why did you look at this?

9 A: To look at the experience of Pineville. This
10 is the only data I could find that isolated out
11 Pineville from Mercy.

12 Q: Why is it important to look at Pineville and/or
13 the Pineville Mercy system?

14 A: Well, based off of their need methodology where
15 they said they're redirecting their patients
16 that went to North Carolina, the majority of
17 those patients went to Pineville.

18 Q: Let's actually, Dan, cut that back, if you
19 would, to Demonstrative -

20 MR. MULLER: May I ask the source of that document
21 they just showed?

22 Q: Sure, it's your document, SCHS-1205. I'm
23 coming back to it.

24 MR. MULLER: I guess my question is, is it an
25 Exhibit that's been admitted into evidence?

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1 MR. ANDREWS: It's a demonstrative.

2 MR. MULLER: It's a demonstrative?

3 MR. ANDREWS: Yes.

4 MR. MULLER: Because we did have -- this is an
5 incomplete document and we did label
6 confidential in discovery. There's a protocol
7 for using that. I just want to make sure
8 they're following that. I really had no idea
9 they were going to use this document. We had
10 a consent protective order in place ---

11 THE COURT: Yeah.

12 MR. MULLER: --- that was designed so that Mr.
13 Andrews was supposed to alert me if he was
14 going to use a document like this. When I
15 looked at it initially, I just thought it was
16 an Exhibit. He's now using a demonstrative
17 without notice.

18 THE COURT: Mr. Andrews?

19 MR. ANDREWS: We're not intending to introduce the
20 document into evidence, Your Honor. I thought
21 it would be, or if I intended to do that and
22 put it into the record would be the need to
23 notify counsel and protect it, which I
24 appreciate, but I didn't think it was necessary
25 when we were eliciting limited testimony.

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1 **THE COURT:** I realize you're just using it as a
2 demonstrative, but it is a confidential
3 document that's sitting up here on the screen
4 and that's your concern.

5 **MR. MULLER:** Frankly, if he is using this we would
6 object to it because it is an incomplete
7 document. Now, in all honesty I think we can
8 address it through our witnesses if it not
9 offered as an Exhibit. It is a confidential
10 document. I feel like I need to preserve that.
11 That aspect of the protective order that we
12 mutually agreed to and entered into.

13 **THE COURT:** But you're not objecting to Mr. Levitt's
14 testimony from the information, but you're
15 saying you don't want that -- you're objecting
16 to this document being flashed up here?

17 **MR. MULLER:** I think that, and I can recall during
18 his -- I just want to be completely honest with
19 the Court.

20 **THE COURT:** Yes.

21 **MR. MULLER:** I'm nor surprised by this document
22 because Mr. Levitt referenced it in his
23 deposition, I think the only thing that
24 surprised me is, relates to my objection
25 yesterday, Mr. Andrews keeps trying to get

1 information in the record that might not be
2 admissible through these Demonstrative
3 Exhibits. That is not a document that Mr.
4 Levitt created, it's a document they pulled out
5 of discovery materials that we labeled
6 confidential and now are trying to introduce
7 through this testimony. That's the basis of my
8 objection.

9 **MR. ANDREWS:** And in fact, Your Honor, Mr. Westbrook
10 just corrected me, I had forgotten that we had
11 indeed identified this as a potential Exhibit.
12 There was no objection to it. Exhibit 60,
13 chart 83.

14 **MR. MULLER:** I stand corrected, but, Your Honor, I
15 just -

16 **THE COURT:** That's okay. I was just going to
17 suggest if it was a confidential document you
18 could still have the witness talk about it.

19 **MR. ANDREWS:** And I'm frankly, without getting into
20 this, that fact passed me by. I'll be willing
21 to withdraw it as an Exhibit and just use it
22 for limited demonstrative purposes.

23 **MR. MULLER:** And I frankly did not realize it was an
24 Exhibit. That's why I asked when it was put up
25 because he indicated it was a Demonstrative, I

1 simply did not mark it -

2 **THE COURT:** Yes, sir. I understand.

3 **MR. MULLER:** We did not object to it, I believe.

4 **THE COURT:** Right.

5 **MR. MULLER:** Is that right?

6 **MS. ROBERTSON:** We did not object to that.

7 **THE COURT:** So therefore it is an Exhibit -

8 **MR. MULLER:** It is. I apologize to the Court, when
9 he said it was a demonstrative -

10 **THE COURT:** I'm glad you clarified that. Thank you
11 Mr. Muller and Mr. Andrews, you may proceed.

12 Q: All right. Mr. Levitt, actually, I was --
13 before we -- I elicit further testimony about
14 this document, I want to take you back to
15 Demonstrative 200. To specifically look at
16 based on the cost reports, the indigent care
17 experience reported by the Mercy Pineville
18 system. What percent did you find there based
19 on what you identified in the cost reports?

20 A: It was about 2.6 percent and a little less than
21 \$31 million in total charity care.

22 Q: And to what degree, based on your view of
23 Carolinas' applications would the patient base
24 that Carolinas intends to serve with CMC-Fort
25 Mill be derived from their services at Mercy

1 and Pineville?

2 A: The majority of the patients. Those two
3 facilities represent, particularly Pineville,
4 the single largest source for patients for the
5 CMC-Fort Mill facility.

6 Q: And then what inferences did you make about
7 their historical experience at those two
8 facilities at 2.6 percent and how that compares
9 to the 6.3?

10 A: That's the source of patients but yet they're
11 projecting nearly three times higher percentage
12 of charity care at their Fort Mill location.

13 Q: Okay. And with that, let's go back to what
14 I'll refer to as Demonstrative 187.

15 **MR. MULLER:** Your Honor, we don't have any objection
16 to withdrawing our Exhibit 83 and just going
17 with a Demonstrative. I'm sorry, never mind.
18 Let me, I stand corrected.

19 **THE COURT:** It had been admitted without objection.

20 Q: It was already admitted, all right. Okay.
21 Let's go back to this document then, Mr. Levitt
22 and let's look at Demonstrative 187, Dan, if
23 you could pull that out. And what does this
24 show?

25 A: This shows for that for line item provision for

1 charity care, that they -- their actual
2 experience for the year was \$510,847 out of
3 \$385,034,797 in gross revenue. And as a
4 percentage that represents a fraction of a
5 percent, 0.13 percent.

6 Q: Okay. Now, just so the record is clear, you
7 said they. Who are you talking about here?

8 A: This is the Pineville location. So the
9 Pineville hospital, this was their -- according
10 to this document, this was the amount of
11 charity care they provided in 2010, I think it
12 was.

13 Q: Okay. And there's an actual line item and
14 there's a budget line item. And are you
15 referring to the actual or the budget as the
16 charity care that was identified in this
17 document?

18 A: That was the actual amount. I think Ms.
19 Carter, in her deposition said that they
20 reclassify a lot of that charity care and I
21 wouldn't understand why you would reclassify
22 it, and that could be, but I don't understand
23 why you would reclassify it in your budget
24 though. And that was their budget amount was
25 \$355,000 out of \$375 million or less than one

1 percent. Or less than .1 percent. So that's
2 what they budgeted and that's what their actual
3 experience was.

4 Q: Now, what was their actual experience? Have
5 you calculated that?

6 A: Yeah, that was the .13 percent, I believe.

7 Q: And their budgeted allocation of charity care
8 was what?

9 A: .09 percent.

10 Q: Okay. Thank you. Now, let's actually -- did
11 you do any further review of the Mercy
12 Pineville indigent care experience?

13 A: I did. The cost report, again, is combined for
14 the two locations. This identified -- we had
15 also identified the Mercy location separately
16 in another document.

17 Q: Okay. Let's pull that document up. Dan,
18 Demonstrative 20. And what does this document
19 reflect?

20 A: So, the first column is the Mercy information
21 pulled out and that we got from a North
22 Carolina CON application where they presented
23 their Mercy-only information. It showed \$551
24 million in gross revenue, \$199 million in net
25 revenue. The charity identified was

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1 \$28,108,000. That represented 5.1 percent of
2 their gross revenue and 14.1 percent of their
3 net revenue.

4 Q: And what do you have as in the Pineville?

5 A: Now, in Pineville, there's a difference. We
6 had a Medicare cost report at about \$31 million
7 in charity care. And the gross revenue was in
8 there as well. Subtracting those out gives you
9 \$661 million in gross revenue at Pineville,
10 \$215 million of net revenue at Pineville and
11 the difference between the total charity care
12 at both facilities and the Mercy facility of
13 \$2.2 million at Pineville for a 0.3 percent of
14 gross revenue of their indigent care which is
15 consistent, higher, but consistent with their
16 information in the budget and their actual
17 experience.

18 Q: All right. Now, Mr. Levitt, did you attempt to
19 determine whether or not Carolinas' projection
20 of 6.3 percent was consistent with the indigent
21 care that was projected in CON applications in
22 South Carolina for new hospitals?

23 A: Yes.

24 Q: And did you prepare a Demonstrative reflecting
25 that?

1 A: Yes.

2 Q: All right. Dan, let's pull up Demonstrative
3 118, please. What does this show?

4 A: This shows the information pulled from various
5 CON applications for satellite hospitals since
6 2005 ---

7 Q: The Exhibit is identified in the footnote?

8 A: Correct. There was all the Exhibits we've been
9 provided as Exhibits. I pulled the information
10 from those. What it shows is by the third year
11 of operation for these facilities from highest
12 to lowest, the CMC-Fort Mill at 6.3 percent is
13 by far the highest projected indigent care
14 amount. Going down, Greer-Greenville was the
15 next at 4.13. Two percentage points lower. At
16 the bottom the Trident-Berkeley and the Roper-
17 Mt. Pleasant facilities at less than two
18 percent, 1.9 and 1.8 percent of gross revenue
19 was their charity care percentage. The Fort
20 Mill Medical Center at three percent fell in
21 the middle of the pack.

22 Q: All right. Now, does Carolinas own and or
23 manage of the hospitals reflected on this list?

24 A: Yeah, the two Roper hospitals.

25 Q: And what was the indigent care that those

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1 hospitals projected?

2 A: Roper-Berkeley in 2008 projected 2.2 percent
3 and Mt. Pleasant, Roper-Mt. Pleasant in 2005
4 projected 1.9 percent. So, substantially lower
5 than the 6.3 percent projected at CMC-Fort
6 Mill.

7 Q: And how does the information you extracted from
8 these applications affect your opinion
9 concerning the reasonableness of the 6.3
10 percent?

11 A: I find it to be unreasonable. It's just too
12 high. It's not based off their experience.
13 It's not consistent with other projections.
14 It's not consistent with their cost report
15 experience in any of their facilities. I find
16 it unreasonable.

17 Q: To what degree do the demographics of an area
18 that a hospital serves affect the indigent care
19 of those facilities?

20 A: Well, I think very directly. To the extent
21 that an area that is obviously more affluent
22 than the number of individuals that would fall
23 below the guidelines for their charity care
24 would be less.

25 Q: All right. And looking at the counties and the

1 service areas reflected in the applications on
2 your Demonstrative 118, which of the areas are
3 the most in -- well, how does the Fort Mill
4 area compare in terms of affluence and average
5 incomes to those other areas served by the
6 other hospitals?

7 A: Well, York County has one of the highest median
8 household incomes in the state. I think it
9 sort of battles back and forth year by year
10 with Beaufort. Beaufort and York are the two
11 most affluent counties in South Carolina. And
12 Fort Mill is the most affluent area within York
13 County based on median household income.

14 Q: And how would that affect the comparative data
15 compared to the demand or need for indigent
16 care?

17 A: Generally, if it's in the most affluent area of
18 one of the most affluent counties, it would
19 have a lower percentage of charity care not the
20 highest.

21 Q: Did you in fact prepare a demonstrative that
22 shows the median household income that you have
23 researched?

24 A: Yes.

25 Q: Dan, let's turn to Demonstrative 188, please.

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1 And what is this and where did you get it Mr.
2 Levitt?

3 A: This is the median household income by zip code
4 for 2012 and 2017. And there's an error on
5 here.

6 Q: What's that?

7 A: The source is not ORS.

8 Q: What is it?

9 A: It's Claritas.

10 Q: Okay. And what's Claritas?

11 A: Claritas is a data source that I don't
12 typically use, but CHS used it so we used it.
13 Planners use it for the most part to get
14 population demographic information. The office
15 of research and statistics generally doesn't
16 project population by zip code, so it's
17 commonly accepted to use that as a source for
18 zip code level information. And what it shows
19 is the 2012 and the projected 2017 median
20 household income by zip code -- and you can see
21 with the highest median household income in
22 2017, \$71,000 is 29708, which is the Fort Mill
23 zip code. The next highest is \$61,577, which
24 is the other Fort Mill zip code, 715, and then
25 the portion of Lancaster County is higher than

1 average, but still 46, 47,000. So, the two
2 highest zip codes in the market are the Fort
3 Mill area. Which is where the proposed
4 hospital is going.

5 Q: Okay. Now, what effect does the location, and
6 again, the income data have on the
7 reasonableness of the 6.3 percent projection?

8 A: Well, it's an affluent area with high median
9 household income. There isn't a sufficient
10 pool of indigent patients in that area to
11 justify a 6.3 percent projection by CMC-Fort
12 Mill.

13 Q: Okay. Are there any other considerations that
14 you took into account in forming an opinion
15 concerning the indigent care projections?

16 A: Yes.

17 Q: What's that?

18 A: Generally, as I said, the experience of the
19 applicant, the demographics of the area, the
20 socioeconomics of the area and the experience
21 of the physicians in the area led to the
22 conclusion that the 6.3 percent is not
23 reasonable.

24 Q: Okay. Mr. Levitt, are you familiar with the
25 Affordable Care Act?

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- 1 A: Yes.
- 2 Q: What's the, in general terms, with regard to
- 3 availability of insurance, what would be in
- 4 your judgment the effect of the full
- 5 implementation of the Affordable Care Act?
- 6 A: Well, the goal of the Affordable Care Act is to
- 7 assure that individuals have insurance
- 8 coverage. So, to the extent there are less
- 9 individuals without insurance, then there would
- 10 be less of a need for indigent care assumptions
- 11 and the percentage would be lower.
- 12 Q: Okay. All right. Based on all of the research
- 13 and the testimony you just provided, which
- 14 applicant would best meet the purposes of
- 15 803.3(f) and (g) to serve the medically
- 16 underserved?
- 17 A: The Piedmont application for Fort Mill Medical
- 18 Center.
- 19 Q: All right. Dan, if you'd pull that up. We
- 20 want to complete that portion of the grid.
- 21 That would be (e), let's double check, is that
- 22 right Mr. Levitt?
- 23 A: Yeah, (e) was already double checked. (F)
- 24 would be a check for PMC and an X for CHS.
- 25 Q: And (g)?

- 1 A: A check for PMC and an X for CHS.
- 2 Q: Now, there is one more section that's showing,
3 a subsection of Paragraph 3. What is that?
- 4 A: That's 3(h) and that's the impact on existing
5 resources.
- 6 Q: Now, Dan, let's turn to the regs and Mr. Levitt
7 if you would read that section, please.
8 Paragraph (h).
- 9 A: Paragraph (h) says: Potential negative impact
10 of the proposed project on the availability and
11 or resources of existing providers to serve
12 medically underserved groups must be
13 considered.
- 14 Q: Did the Department consider this?
- 15 A: No.
- 16 Q: All right. Do you believe they should have?
- 17 A: Yes.
- 18 Q: Do you believe it should be considered now that
19 you're testifying?
- 20 A: Yes.
- 21 Q: Why?
- 22 A: Because it involves an implementation of the
23 service that could potentially have a negative,
24 potentially have an impact on the resources of
25 an existing Piedmont Medical Center provider.

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1 They neglected to consider that.

2 Q: All right. And have you examined the payor mix
3 in York County and how it's changed?

4 A: Yes.

5 Q: On existing providers? All right. Let's take
6 a look at Demonstrative 189, please, Dan. And
7 what is this and what is the source of it, Mr.
8 Levitt?

9 A: This is from Piedmont Exhibit 14, which I think
10 we just talked about being the North
11 Carolina/South Carolina database and it shows
12 the 2005, 2011 payor mix for York County
13 residents at Piedmont Medical Center. You can
14 see from 2005 to 2011 the percent declined in
15 managed care. Went from 38 to 31 percent or a
16 16 percent decrease. Medicare went down as
17 well, ten percent. Medicaid went up from 14.8
18 to 18 percent, a 22 percent increase. The
19 other, again that's over the CHAMPUS, VA, other
20 categories, it went down a little bit, 4.4
21 percent and you can see self pay/charity went
22 from 3.6 to 10.7 percent. Almost a 200 percent
23 increase.

24 Q: All right. And this relates to all York County
25 patients served anywhere or just served at

1 Piedmont?

2 A: These are the York County residents served at
3 Piedmont Medical Center.

4 Q: Okay. Now, just to discuss the effects of this
5 and whether it be negative, to what degree does
6 managed care and commercial coverage relate to
7 the cost of the services that a hospital
8 provides?

9 A: Well, as I believe it was Dr. Taylor talked
10 about, that's the cost shifting or maybe Mr.
11 Masterton talked about that. That the ability
12 to cover those patients that are under other
13 payors that provide less reimbursement, managed
14 care and commercial patients that provide
15 better paying resources use that money,
16 providers use that money to offset the loss on
17 the other patients. So, it's pretty critical
18 that the facility have a strong pool of those
19 patients to offset the Medicaid and self-pay
20 patients.

21 Q: Okay. And let's -- and so managed care is down
22 16.6 percent and Medicare is down 9.6 and
23 Medicaid is up 22.5. Charity is up nearly
24 twice. What's the cumulative or aggregate
25 effect on these changes in the payor mix over

1 that six year period?

2 A: Their negative. For Piedmont Medical Center
3 there's less, as I said, the pool of managed
4 care patients to offset those other patients.

5 Q: Now, in Paragraph 3(h), if the question is how
6 would Carolinas' proposed new hospital in Fort
7 Mill affect the ability of existing providers,
8 that is Piedmont to serve medically underserved
9 patients, how would you apply this data to that
10 question?

11 A: Well, this data combined with the data that
12 we've talked about, that if the CHS-Fort Mill
13 facility were to be approved and those
14 patients, if the patients are treated at that
15 facility are those that have historically gone
16 to North Carolina, what would be left would be
17 treated at Piedmont would be much more Medicaid
18 patients or much more Medicare patients and
19 much less managed care patients.

20 Q: Okay. All right. And now, Mr. Levitt, have
21 you developed a Demonstrative that shows the
22 effect of the change in payor mix of the
23 hospital?

24 A: Yes.

25 Q: All right. Let's take a look at it. Dan, if

1 you would pull up Demonstrative 67 please. And
2 what is this, Mr. Levitt?

3 A: This shows, on the left side it shows baseline
4 calculation, can you zoom in on that left side?

5 Q: Discuss generally what you've prepared. Is
6 this an actual experience that you're proposing
7 in the first two columns or is this a
8 hypothetical?

9 A: This is a hypothetical that shows the
10 experience of a facility based on a series of
11 assumptions. If there are 34,000 patient days
12 with a payor mix provided here, the different
13 mix of Medicare, Medicaid, managed care and
14 self pay, their contractual adjustments.

15 Q: And what are contractual adjustments?

16 A: Contractual adjustments are the difference from
17 what the facility charges and what they get
18 paid. It shows that the net revenue, while
19 they charged \$552 million, they would get \$200
20 million. They have \$173 million in expenses
21 for a net income of \$26 million.

22 Q: And is that unreasonable distribution of the
23 payor mix and net income for a hospital?

24 A: No. Actually, this was taken from the Mercy
25 CON application, so this is from what they

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1 projected in the Mercy application.

2 Q: The one you were referring to earlier in 2010?

3 A: Correct.

4 Q: All right. What have you done as a comparison
5 based on?

6 A: If you can zoom in on the next column, I held
7 the patient base the same, so I said the same
8 utilization, I assumed that the gross revenue
9 would be the same by payor. I adjusted the
10 mix, assumed that the percentage of payment by
11 payor would be the same, so the \$551 million in
12 gross revenue, assumed that the percentage for
13 change, so that they would have a lower net
14 revenue, \$171 million in net revenue because of
15 the change in payor mix and they had
16 historically made \$22 million, I believe it
17 was. They would make \$23 million. So, Dan, if
18 you could zoom back out and highlight the top,
19 yeah, all the way across, down to the, yeah,
20 gross revenue. You can see, and zoom it in,
21 you can see the mix of before they had 42
22 percent Medicare ---

23 Q: Could you highlight those please, Dan?

24 A: So 42 percent Medicare, I took up to 55 percent
25 Medicare. The ten percent Medicaid I doubled

1 to 20 percent Medicaid, so they had more
2 Medicaid and Medicare left over, just as
3 Piedmont would have at the main hospital.
4 Managed care went from 40 percent to 15 percent
5 so they would have less managed care and self
6 pay I held pretty constant. I rounded it up to
7 ten percent. So, you can see gross revenue is
8 the same at \$551 million. The change happens
9 with what they get paid for that. So then on
10 the next section, the adjustments, that's where
11 the issue happens is they have more
12 adjustments, they get less of the net revenue.
13 They would, you know, the Medicare contractual
14 went from \$170 million to \$225 million and then
15 you take those away and go down to the net
16 income or net revenue, net revenue and you can
17 see a decline in \$28 million from \$199 million
18 to \$171 million. Again, this is just from a
19 shift in payor. All other assumptions remain
20 the same. So, just by shifting the payor mix,
21 they would be paid \$28 million less than they
22 would have been otherwise.

23 Q: Okay. Has the volume changed?

24 A: No, volume remains the same. Just -- and
25 charges are the same. The percentage

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1 adjustments are the same by payor, it's just
2 the pie is split differently. Those payors
3 that pay more is smaller, those payors that pay
4 less is the bigger and the net result is
5 negative impact.

6 Q: So, is it possible for a hospital not to lose
7 any patients but to lose money as a result in
8 the change of the insurance coverage available
9 for those patients?

10 A: Yes. Simply a shift in payor mix can have a
11 dramatic impact on the bottom line.

12 Q: And how does this hypothetical that you've
13 prepared relate to your opinion concerning the
14 exposure that Piedmont may have if the
15 Carolinas-Fort Mill hospital is approved?

16 A: Well, again, as I said to the extent that payor
17 mix of those patients remained in York County
18 treated at Piedmont which is substantially
19 different, which it would be because we showed
20 the CPN physicians have a small Medicare and
21 Medicaid percentage of patients. Then the
22 resulting payor mix at Piedmont would shift
23 similar to this. More Medicare, more Medicaid
24 and you would have negative impact.

25 Q: All right. And so let's then reach the bottom

1 line question on Section 3(h). Which applicant
2 best meets this provision?

3 A: Piedmont Medical Center.

4 Q: All right. Then let's, Dan, if you can take it
5 to the overview grid for all the review
6 criterion and look at section 3. In section 3
7 relating to duplication and medically
8 underserved groups, Mr. Levitt, does Piedmont
9 or Carolinas best meet the requirements of
10 these subsections within section 3?

11 A: Taken in a total, while CHS met a few of those,
12 Piedmont best meets those criteria.

13 Q: All right. Now, let's move on to the next set
14 of criteria and, Mr. Levitt, let me ask you,
15 let's just move to issues concerning adverse
16 impacts and adverse effects and the regulations
17 and the statutory language related to those.
18 Have you developed an Exhibit that provides an
19 overview of those authorities?

20 A: Yes.

21 Q: All right. Dan, let's pull up Demonstrative
22 190 please. And what's on this chart, Mr.
23 Levitt?

24 A: This shows the framework for looking at adverse
25 impact, how to consider it, which of those

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1 standards that were left, fit sort of into
2 adverse impact category. The first being
3 802.22 and distribution of existing healthcare
4 services, 802.3(h) dealing with existing
5 providers to serve indigent groups, 802.16(c)
6 costs and charges of existing providers, 23(a)
7 utilization and staffing of existing facilities
8 and then in the statute, the balancing of
9 improving accessibility against the adverse
10 implications.

11 Q: Okay. Well, let's work through each one of
12 those. And then we'll identify, actually, the
13 language with respect to each when we get to
14 it. Let's begin though, with an overview of
15 your opinions concerning adverse impact. Have
16 you developed a Demonstrative to show that?

17 A: Yes, I have.

18 Q: Dan, if you'll pull up Demonstrative 181,
19 please. And how does this reflect your
20 opinions, Mr. Levitt?

21 A: Well, this is the basis that we determined the
22 adverse impact, that the Piedmont patients
23 would be treated at CMC-Fort Mill, so in the
24 CON application for CMC-Fort Mill, they talked
25 about redirecting patients that went to North

1 Carolina and not changing the market share and
2 not taking any patients from Piedmont. Well,
3 obviously that's not going to be the case.
4 Those patients will be redirected. They're not
5 going to limit their patients to those going to
6 North Carolina. And the reason they're going
7 to do that -- for a number of reasons, we
8 talked about the inability to control that, but
9 more importantly, their investment in the CMC-
10 Fort Mill facility and the North Carolina
11 facilities, they want to maintain occupancy
12 levels at those facilities, utilization at
13 those facilities. They will continue to
14 attract as many patients as they can and those
15 patients will come from Piedmont Medical
16 Center. And Piedmont will be negatively
17 impacted by that loss in patients, in volume
18 and in revenue and the adverse impact will
19 cause a negative impact on their ability to
20 offer services, both basic and complex as well
21 as it's going to have a negative impact on
22 personnel.

23 Q: And have you attempted to quantify that impact?

24 A: Yes.

25 Q: All right. Have you developed a methodology to

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1 do that?

2 A: Yes.

3 Q: All right. Let's explain that to the Court, if
4 you will. Let's start by looking at
5 Demonstrative 192. What is this?

6 A: This describes the way we addressed the adverse
7 impact. We provided this in the remanded CON
8 application in 2010. We addressed it during
9 project review meeting and this sort of
10 outlines the methodology. It assumes that, you
11 know, just as in the CMC application and in the
12 Fort Mill Medical Center application, patients
13 from all areas of York County would use the
14 facility. The CMC facility in particular, they
15 identified the entire York County as the
16 service area, obviously those further away
17 would use it to a lesser degree than those
18 immediately in the vicinity. We looked at all
19 zip codes in York County. Calculated the
20 historical utilization for Piedmont and North
21 Carolina hospitals. We projected CMC-Fort
22 Mill's market share by zip code. We assumed
23 that the patients would come from both Piedmont
24 and North Carolina based on proximity and
25 market experience. We talked about -- Mr.

1 Miller and I talked about that and the
2 assumptions at the end of the day resulted in
3 about 67 percent of the patients that would be
4 treated at CMC would come from Piedmont. In
5 order to quantify that from a financial
6 perspective, we looked at the contribution
7 margin, applied that to the lost cases to get
8 the financial impact.

9 Q: Okay. All right. Let's begin by looking at an
10 overview of the results of your analysis. Dan,
11 let's pick it up at Demonstrative 18.3. All
12 right. And is this a document that reflects
13 your work and methodology, Mr. Levitt?

14 A: Yes.

15 Q: And walk us through it if you will.

16 A: Again, this is the summary of the detailed
17 model that we did that shows the market share
18 in 2011 of 55 percent in total.

19 Q: I'm sorry, but let's just kind of lay out the
20 basics here. What is PSA and SSA?

21 A: PSA is primary service area. SSA is secondary
22 service area.

23 Q: And remind us again what zip codes are in the
24 primary service area?

25 A: Primary service area would be the three

1 northern zip codes, 707, 29707, 29708 and 29715
2 and portions of -- and also the Rock Hill zip
3 codes 29730 and 732. The secondary service
4 area is the rest of York County.

5 Q: And the one in the lower southeast corner of
6 the county, 704?

7 A: I believe that was in the secondary service
8 area.

9 Q: Okay.

10 A: And you can see, historically in 2011 Piedmont
11 had about a 55 percent market share overall, 55
12 and 53 percent between the two service areas.
13 Projected cases, using the 2011 use rate,
14 applying it to the 2017 projected population,
15 about 11,536 cases in the market. Projected
16 cases for the North Carolina Fort Mill hospital
17 would be lower in total. About 8,461 or a
18 difference of about 3,000 cases. Applying the
19 contribution margin to that shows a \$12 million
20 loss.

21 Q: Okay. And explain again what the contribution
22 margin is?

23 MR. MULLER: Your Honor, I just object. I'm a
24 little hesitant to object because this slide is
25 actually favorable to us, but I am looking at

1 Petitioner's Trial Exhibit and it does not have
2 these numbers in it.

3 **THE COURT:** All right.

4 **MR. ANDREWS:** It seems like, well first of all, it's
5 my fault again, I'm sorry this slipped through
6 without a source identified in this Exhibit.
7 We have several Exhibits that -- I'm not sure
8 which one Mr. Muller is referring to. If I can
9 elicit some information from the witness. He
10 can identify the source of it.

11 **THE COURT:** Let's do that. Let's do that first, Mr.
12 Muller and we'll go back to the objection you
13 might have. Go ahead.

14 Q: All right. Your Honor. Mr. Levitt, what's the
15 source of this information?

16 A: This was an Exhibit we provided. We did
17 several different scenarios and this was one of
18 the scenarios.

19 Q: Okay. And let's just go through them since I
20 don't want to guess and identify which ones
21 they are. Let's start with Exhibit 104.

22 **MR. MULLER:** Just for clarity, I've got 103 as the
23 first adverse impact analysis. There may be
24 others after it?

25 **MR. ANDREWS:** Well, actually, there are several.

1 But Your Honor, so that I can get oriented
2 there are actually about four or five Exhibits
3 related to this data. Can we take a break now
4 and I can figure that out.

5 **THE COURT:** Recessed for ten minutes.

6 (Off the Record)

7 **THE COURT:** Please be seated.

8 **MR. ANDREWS:** Thank you for the break, Your Honor,
9 so I could determine the source of this
10 Demonstrative is Exhibit 104. And we are going
11 to go over that in some detail in a moment.

12 **THE COURT:** All right. Mr. Muller, do you have any
13 objection to that?

14 **MR. MULLER:** No, I don't Your Honor, I was just
15 looking at Exhibit 103 which was the first one
16 and it didn't match up.

17 **THE COURT:** Makes sense, so it's 104. Thank you.

18 **Q:** All right. Mr. Levitt, please again describe
19 what Demonstrative 183 does and how it supports
20 your opinions.

21 **A:** It summarizes the calculated adverse impact on
22 Piedmont Medical Center with the CMC-Fort Mill
23 hospital. Again, it summarized the impact on
24 market share would be in total from a 55
25 percent market share in 2011 to about 40

1 percent market share in 2017 or a loss of about
2 a little over 3,000 patients. Multiplying that
3 out by the contribution margin of about \$4,000
4 per patient results in a negative net impact of
5 about \$12 million.

6 Q: Okay. And I think at the break I had asked you
7 to explain what contribution margin is.

8 A: Contribution margin is a measure to determine
9 the impact of lost patients. Generally, it's
10 the -- if you don't treat a patient there's
11 lost revenue associated with that patient; you
12 don't get paid for that patient. But there's
13 also an assumption that there's some expenses
14 that you wouldn't incur if you weren't treating
15 that patient either. So, the contribution
16 margin is the difference between the lost
17 revenue and the foregone costs incurred to
18 treat that patient. Piedmont Medical Center in
19 total is about a \$4,000 per patient.

20 Q: Okay. All right. Now, let's, let's go to the
21 Exhibit on which this Demonstrative is based.
22 Which is Exhibit 104. It looks a little
23 intimidating, but I'm sure you can explain it
24 in a way that makes it all understandable with
25 all of this being on one page. Help us work

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- 1 through this please.
- 2 A: I did just explain it, but we'll go through the
- 3 details.
- 4 Q: Details please.
- 5 A: What it shows is, again, we looked at every zip
- 6 code.
- 7 Q: I'm sorry, why don't we start with the header
- 8 and explain what that caption on the document
- 9 is as a starting point.
- 10 A: Yeah, this is slightly different than what we
- 11 had submitted in the July 11th, I think it was,
- 12 CON application. And what it is, is it assumes
- 13 that the CMC-Fort Mill facility will be at 80
- 14 percent occupancy. That 67 percent of the
- 15 impact would come from Piedmont, 33 percent of
- 16 the impact would come from North Carolina
- 17 patients being redirected and we limited it to
- 18 the pool of patients with a case mix index less
- 19 than 2.0. So this is the non-complex patients
- 20 that would be treated at the CMC-Fort Mill
- 21 facility.
- 22 Q: And why did you establish an assumption that
- 23 there would be an 80 percent occupancy at CMC-
- 24 Fort Mill?
- 25 A: Because we think that's what it would be by the

1 third year of operation. They projected a
2 lower occupancy. But again, they were assuming
3 they would only treat their patients. Did they
4 didn't give any effect to redirected patients,
5 so it would be additional -- in this case, a
6 majority of patients would be redirected
7 patients.

8 Q: Okay. All right. Now, and you said that you
9 prepared other methodologies. We'll get into
10 those in a little bit. But how was this
11 different than what you submitted to the
12 Department in 2011?

13 A: All right. This, we eliminated the case mix
14 less than two. We didn't do that in the
15 original submission. And we had a higher
16 occupancy at the proposed Fort Mill Hospital.
17 We lowered it a little bit. And then there was
18 a math error in the model and we corrected that
19 math error.

20 Q: Okay. All right. And then work through this
21 analysis to show how your methodology works.

22 A: And also, I believe you asked the difference
23 between this one and what we provided to the
24 Department?

25 Q: Yes.

1 A: And also this updates it for 2011 information
2 compared to what was submitted, I think in 2009
3 at the time of the remand application.

4 Q: Okay.

5 A: Okay. So, zooming in on the first column. You
6 can see 2011 and the methodology works the same
7 across. So we'll just look at the first one.
8 The 2011 in 29074, that zip code, Piedmont had
9 199 patients. Which represented 61 percent of
10 the total. You can see the total of 325, no,
11 I'm sorry, 326. So if you divide 199 by 326
12 you get 61 percent. So, 61 percent of total
13 patients in that zip code were treated at
14 Piedmont, 30.4 percent or 99 of those patients,
15 were treated at North Carolina hospitals. So
16 the subtotal of those two, the 99 and the 199,
17 298 patients were those treated at either
18 Piedmont or the North Carolina hospital, so the
19 difference between those, you know, the eight
20 percent of the patients not identified there
21 were treated elsewhere. Likely South Carolina.

22 Q: In Columbia or other facilities in South
23 Carolina outside of York County?

24 A: Correct. MUSC, Columbia, exactly. So this
25 showed the baseline of 2011. Going down to

1 2017, the next section, that same zip code,
2 29074, we projected at the bottom 367 cases, so
3 the number of cases would go up because the
4 population is expected to grow, so the 2011
5 cases divided by the 2011 population and apply
6 that to the 2017 population gives us 367 cases.
7 We assume the same market share, that 61
8 percent, so you multiply the 367 times 61
9 percent gives you the 224 cases at Piedmont
10 Medical Center. We held the North Carolina at
11 the same, 30.6, 30.4 percent for 112 patients
12 at the North Carolina hospitals. So, that
13 shows the 2017 projected Piedmont utilization
14 if there's no North Carolina hospital in Fort
15 Mill. Zoom back out and go across ---

16 Q: Before you leave that, Mr. Levitt, just to be
17 clear, what's the basis for your projected
18 increase of hospitalizations in 2011 to 2017?

19 A: That's the population growth. The population
20 is going to grow and generate more discharges
21 in this instance, in this zip code.

22 Q: More hospitalizations?

23 A: Correct.

24 Q: All right. Okay.

25 A: So if you highlight, yes, cross, yes, the

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1 total, you do that for each of the zip codes.
2 We add that up. In 2017 there's a projected
3 total at Piedmont of 11,536 for a weighted
4 average market share of 54 percent.

5 Q: That's for 2017?

6 A: For 2017. So that basically assumes the market
7 share is held constant. Okay. If you go down
8 to the next section, what we assumed was --
9 what we started was the proposed North Carolina
10 provider Fort Mill hospital would have 25
11 percent market share of that zip code.

12 Q: And what is the basis for that assumption?

13 A: That was based off the geographic proximity,
14 where that was located relative to the hospital
15 and based on the experience of other providers.
16 So we assumed the 25 percent market share for
17 the new hospital, multiply that again by the
18 same number of projected cases, we have 367
19 cases. That gives them 92 patients. And the
20 question was, where are those 92 patients going
21 to come from. Well, we made the assumption
22 again based off of geographic proximity for
23 that zip code, half the patients would come
24 from Piedmont, half the patients would come
25 from the North Carolina providers. So,

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1 assuming half of the 25 percent is 12 and a
2 half percent, remember the Piedmont market
3 share was 61 percent in that zip code, so 61
4 percent minus 12 and a half percent equals 48
5 and a half percent. So 48 and a half percent
6 times the 367 equals 178 cases. So, if we did
7 that for each of the zip codes, subtotaled or
8 totaled across to the right and adding all of
9 those up resulted in 8,461 cases by 2017 with
10 4,671 cases at the CMC-Fort Mill facility.

11 Q: And that's 8,461 would be the remaining cases
12 at Piedmont?

13 A: Correct. Piedmont's market share would have
14 gone down from 54 percent, I think it was, down
15 to 40 percent, 39.6 percent. And the
16 difference between the 11,000 patients in 2017
17 without a Fort Mill provider and the 2017 with
18 a Fort Mill provider is 3,076. And that was
19 from the summary table multiply that by the
20 contribution margin gives us the slightly over
21 \$12 million negative financial impact.

22 Q: All right. Why don't we, let's go back and
23 take a look at the assumptions you made that
24 support the result you just identified. What
25 are the drivers in this methodology and key

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1 assumptions you've made?

2 A: Well, the first assumption is where they would
3 be in 2017, they being Piedmont, would be in
4 2017 without a provider in Fort Mill. And we
5 held the market share constant. Market share
6 had been fairly constant. When we submitted
7 the first application, it had declined a bit,
8 pretty substantially, actually, from 2005 to
9 2009; 2010 data looked like it was leveling
10 off. 2011 showed that so in an abundance of
11 caution, we held constant. And the next -- so
12 that tells us where we would be in the future
13 without a provider.

14 Q: And you held a constant through what period of
15 time?

16 A: 2017.

17 Q: 2011 to 2017?

18 A: 2011 to 2017, which is the third year of
19 operation by both applicants.

20 Q: Okay. Now, does that assumption take into
21 consideration the effect of the establishment
22 of CMC-Fort Mill?

23 A: No, that assumes that the market share would
24 stay the same because there is not a CMC-Fort
25 Mill hospital located there. So then to

- 1 determine the impact of putting a hospital
2 there, we assumed a market share for that
3 facility. And as I said, in that first zip
4 code, 29704, I assumed 25 percent market share.
5 Going across, you can see those numbers ---
6 Q: Dan, why don't you pull out half of that and
7 we'll look at the other half.
8 A: Well, in those zip codes you can see the range
9 is -- no, not there.
10 Q: Pull out above that. Down below that actually.
11 A: Down below that.
12 Q: Down below that.
13 A: The proposed North Carolina proposed -- yes.
14 That area there.
15 Q: Sorry, Dan, start on the left. There you go.
16 Take it all the way through. That's good.
17 Okay. Now, there is your assumption you've
18 testified about. Dan, if you could highlight
19 that and make it a little more legible. The
20 first assumption for the 25 percent in 704 is
21 what you've testified about, correct?
22 A: Correct.
23 Q: And that's the market share of the CMC-Fort
24 Mill?
25 A: Correct. In that zip code.

1 Q: Now, before you go further, the document says
2 proposed North Carolina provider for Fort Mill
3 hospital. Did you make this same assumption
4 when the Department was reviewing the
5 applications for either Carolinas or
6 Presbyterian should be awarded?

7 A: Yes.

8 Q: Why?

9 A: Because both facilities would take a market
10 share in that market. In order to be
11 successful and operational, a hospital located
12 in that area would have a market share of each
13 of the various zip codes. They -- both
14 providers would take from Piedmont and the out-
15 migration to North Carolina.

16 Q: Now, how does, how did it at this time,
17 Presbyterian's market share and how does it
18 today compare to Carolinas in York County?

19 A: Very small.

20 Q: All right. And why then did you treat them and
21 why do you believe they should be treated the
22 same in terms of the assumption you're making?

23 A: Because they both will take patients. CMC will
24 take patients from Piedmont and itself.
25 Presbyterian will take patients from Piedmont

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1 itself and CMC. And I guess CMC would take
2 from Presbyterian as well.

3 Q: All right. Now, and as an overview, in general
4 terms what is the assumption that you've made
5 in Exhibit 104 concerning the market share of
6 North Carolina or what percentage of CMC-Fort
7 Mill's cases would be taken from North Carolina
8 hospitals?

9 A: We would have to look at that.

10 Q: No, I mean total. Is it not the 6,733
11 assumption?

12 A: Yes, in total 33 percent of the patients from
13 North Carolina, 33 percent of the patients at
14 the CMC-Fort Mill hospital would come from
15 North Carolina.

16 Q: Okay. And you're reflecting this by this
17 analysis?

18 A: To start with.

19 Q: Okay. All right.

20 A: And let me clarify..

21 Q: Sure.

22 A: When I say coming from North Carolina, it would
23 be York County residents that historically have
24 been treated in North Carolina. They're from
25 South Carolina but they have historically have

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1 been in North Carolina.

2 Q: And so the market share of CMC-Fort Mill in 704
3 would be 25 percent. And go through these zip
4 codes and identify the categories of market
5 share you've assumed for the others.

6 A: Obviously, for the ---

7 Q: Stay on that same line, Dan.

8 A: Yeah.

9 Q: Thank you.

10 A: For 29707 and 29708, those zip codes in Fort
11 Mill, a 40 percent market share. For 29701,
12 which is western York, I guess that's the
13 northern, western York, north central York,
14 further away from Fort Mill, they'd only have
15 five percent market share of that zip code.

16 Q: Now, before we move on, why have you assumed a
17 40 percent market share, a higher market share
18 for 707 and 707 and 715 and a lower market
19 share for 701?

20 A: Again, because of the geographic proximity.
21 You know, the 707, 708 and 715, you can see on
22 this view, all three are at 40 percent. That's
23 the -- those are the three zip codes
24 immediately adjacent to where the hospital is
25 going to located, so that's where they would

1 have the highest market share. Just as
2 Piedmont has the highest market share of the
3 two zip codes it's immediately adjacent to.

4 Q: Okay.

5 A: And further out, the further away you go, the
6 less market share you have, so 29717, 29726 a
7 much lower market share of three percent. They
8 will get a few patients, four patients from
9 those areas, but not a lot. And then moving
10 over, 30 and 32, 29730 and 29732, 20 percent
11 and 25 percent. Those are the Rock Hill zip
12 codes. Again, Piedmont has a very strong
13 market share of those zip codes. Some of those
14 would go to the new facility, so a smaller
15 percentage or in between the home zip codes and
16 the distant zip codes of 20 and 25 percent and
17 then, again, the last three on the list, last
18 two on the list, 742, 743 are the western York,
19 three percent, a few patients and seven
20 percent, a little more at 745, which is closer.

21 Q: All right. And then what was the total market
22 share of York County patients that you assumed
23 CMC-Fort Mill would have?

24 A: So sort of the weighted average of all the
25 results in 21.9 market share of York County for

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1 the CMC-Fort Mill facility or 4,671 patients
2 which comes out to be about a 80 percent
3 occupancy on their 64 beds.

4 Q: All right. Now, Mr. Levitt, did you conduct --
5 at the time when you first undertook the study
6 and developed methodology, did you do anything
7 else to confirm the reliability of your
8 assumptions?

9 A: Yes.

10 Q: What did you do?

11 A: Well, I looked at a number of other facilities
12 in the market share, but in order to determine
13 the range of impact if these numbers were too
14 high or too low, I did a sensitivity. So, I
15 said if it were lower, instead of 67 percent of
16 the patients coming from Piedmont, if it were
17 50 percent of the patients. And I also went to
18 the other side and said well, if more come from
19 Piedmont, if 80 percent of the patients come
20 from Piedmont, so I looked at the range of
21 those and calculated that out to see what the
22 impact would be, sort of on a high side and a
23 low side, what I call a sensitivity analysis.

24 Q: Okay. And did you provide that to the
25 Department during it's review?

1 A: I did.

2 Q: Okay. And let's look at then. Dan, Joint
3 Exhibit One Bates 43. Exhibit -- figure E, I
4 believe it is. All right. Mr. Levitt, what
5 have you done here?

6 A: This summarizes what we have done in the past.
7 Again, this is a little different than what
8 we've just looked at. The numbers are
9 comparable and consistent, but what it shows is
10 the sensitivity. This is based off of 2009
11 instead of 2011. This has the math error in it
12 we talked about. And this, it shows a higher
13 utilization at the CMC or the North Carolina
14 Fort Mill hospital, but what it shows is
15 assuming that 50 percent of the cases instead
16 of 67 percent of the cases. Fifty percent of
17 the cases come from Piedmont, it would have
18 about a \$10 million negative impact, 10.4
19 million, lower obviously because less would
20 come from Piedmont more would come from North
21 Carolina. And then sensitivity two is a higher
22 assumption. That if 80 percent of the patients
23 came from Piedmont instead of 67 percent,
24 obviously it has a higher impact or \$16.5
25 million negative impact. More patients, more

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1 dollars.

2 Q: Okay. Now, what's the market share data that's
3 presented here?

4 A: This shows the -- the historical input is the
5 2009 projected with 2017 based off the 2009
6 experience, so it shows Piedmont coming from a
7 50 -- in the first scenario, 53 percent market
8 share to 41.5 percent market share. And the
9 second scenario shows a more dramatic drop from
10 53.4 down to 33.7 percent market share.

11 Q: Now, these sensitivity analyses were conducted
12 to support the methodology and analysis that
13 you prepared for the Department, is that
14 correct?

15 A: Correct. This was submitted to the Department.

16 Q: All right. And let's actually take a look at
17 Exhibit 103. Now, what you submitted to the
18 Department is in the record. Pull up Exhibit
19 103 please, Dan. Not Demonstrative, but
20 Exhibit and what is this document, Mr. Levitt?

21 A: This is that original analysis, corrected for
22 that math error.

23 Q: Okay. And you identified the math error before
24 and otherwise is there any differences in the
25 assumptions?

1 A: No, it was -- the math error, it was reading
2 off the wrong cell. It was reading off of the
3 subtotal instead of the total.

4 Q: Okay. And you corrected that ---

5 A: That's what this reflects, yes.

6 Q: --- in Exhibit 103, okay. Did you conduct
7 additional sensitivity analyses?

8 A: Yes.

9 Q: Okay. And did you do that the same way you did
10 it originally or did you undertake a different
11 way to analyze the liability of the project?

12 A: I did it a little differently. Instead of
13 looking at the 50 percent, 67 percent, 80
14 percent assumption, I looked at it a little
15 differently.

16 Q: Okay. And have you prepared a Demonstrative to
17 show that?

18 A: Yes.

19 Q: All right. Dan, let's look at 18.5, please.
20 Now, this summarizes Exhibit 105, is that
21 correct, Mr. Levitt?

22 A: Yes.

23 Q: And let's turn, just quickly before you go
24 ahead and detail this at Exhibit 105 and tell
25 us what you have there.

- 1 A: Again, that's the same model and analysis that
2 we did. You can zoom in on the title there.
- 3 Q: You mean that you just reviewed in Exhibit 104?
- 4 A: Correct. And we changed the assumptions. So,
5 this assumes that the CMC-Fort Mill facility is
6 80 percent occupancy, same assumption, but
7 instead of 67 percent of the patients coming
8 from Piedmont, we took a proportional impact of
9 the patients.
- 10 Q: Why did you do that?
- 11 A: To look at what would be the impact if the
12 market share shifted proportionally based off
13 of the historical market shares of the existing
14 providers, Piedmont and the North Carolina
15 providers.
- 16 Q: Okay. And then let's move back to
17 Demonstrative 18.5 rather than go through the
18 detail of this document. Does the methodology
19 work the same way as the one you just testified
20 about?
- 21 A: It does. With the exception of where the
22 patients would come from. So, as I said,
23 rather than assuming for instance in 29704 we
24 said 50 percent would come from Piedmont, 50
25 percent would come from North Carolina, we used

1 the actual percentage. The percentage of
2 market share Piedmont had at that zip code
3 compared to the actual market share of North
4 Carolina providers had. So you will remember
5 Piedmont had a 61 percent market share of 29704
6 so we assumed 61 percent of the patients from
7 that zip code would come from Piedmont. We did
8 that across the board to come up with a lower
9 impact, about \$8.8 million dollars or 2,250
10 patients less at Piedmont with a CMC-Fort Mill
11 provider if the patients were redirected
12 proportionally to the historical market share.
13 And then this is pretty consistent with the
14 lower scenario of 50 percent. If 50 percent of
15 the patients came from Piedmont, it was very
16 consistent with that.

17 Q: And you mean one of the two sensitivity
18 analyses you performed?

19 A: Correct. The lower sensitivity.

20 Q: Okay. All right. And did you also prepare any
21 other analyses of the adverse impact?

22 A: Yes.

23 Q: And what did you do in general terms?

24 A: I did a third sensitivity that looked at the
25 effect of using the CHS methodology presented

1 in their remanded application.

2 Q: And what was that? What was the methodology?

3 A: Where they assumed a percentage of the
4 historical patients would be treated at CMC-
5 Fort Mill. I believe it was 80 percent of the
6 northern York area patients that had
7 historically gone to North Carolina for care
8 would go to CMC-Fort Mill, 75 percent of the
9 Rock Hill, greater Rock Hill we called it,
10 would go, and 50 percent of the rest of York
11 County would go to the CMC-Fort Mill facility.

12 Q: All right. Let's take a look at that. Let's
13 look at the Exhibit 106 please, Dan. Is this
14 the document that reflects the market share
15 methodology?

16 A: No.

17 Q: I thought I might have gotten it wrong. Then
18 let's look at 107. Now, before we go there,
19 what is this? What does 106 do? I'm sorry.

20 A: This assumes the market share methodology -- so
21 that uses their methodology to project the
22 utilization at the CMC-Fort Mill, so before I
23 said I assumed 80 percent occupancy or 80
24 percent utilization, this uses their
25 methodology to get the patient days at CMC-Fort

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1 Mill and it assumes a 67 percent impact at
2 Piedmont and a 33 percent impact to North
3 Carolina.

4 Q: And what's the effect of that?

5 A: Well, the effect is, if you look at the
6 utilization proposed facility, if you do their
7 math across the board based off 2011, what they
8 submitted in the CON application is 2009, I
9 think, information. If you update that to
10 2011, assume the exact same assumption that
11 they had, the number of patient days at the
12 CMC-Fort Mill facility in 2017 would be 4,650
13 which is very consistent with the 80 percent
14 occupancy that I assumed.

15 Q: All right. And then let's look at Exhibit 107.
16 And what have you done here?

17 A: This uses their assumption, again, this is the
18 proportional impact. So, I used their
19 assumptions to get their occupancy at their
20 CMC-Fort Mill facility and I assumed the impact
21 would be proportional to the historical market
22 share. The example there again in 29704, 61
23 percent of that market share was Piedmont's.
24 So 61 percent of that impact would come from
25 Piedmont and I tallied that across to get this

1 impact.

2 Q: And what results did you determine?

3 A: You can see at the bottom it's consistent with
4 the lower scenario or about \$8 million negative
5 impact.

6 Q: Okay. All right. Under any of these analyses
7 that you've performed, Mr. Levitt, what is your
8 bottom line opinion concerning the effect of
9 the proposed Carolinas facility in Fort Mill on
10 Piedmont's operation?

11 A: That it would have negative impact. From a
12 contribution margin perspective, from a
13 occupancy/utilization perspective patients are
14 going to be redirected. Those redirected
15 patients have a value both from a utilization
16 standpoint and from a financial stand point and
17 its in the millions of dollars. The low
18 scenario of \$8 million is substantial, \$12
19 million, even worse. So and then the high
20 scenario, even higher. These are very large
21 numbers. These are just the inpatient numbers
22 and it's tremendous.

23 Q: All right. Now, have you analyzed the effect
24 on utilization as well?

25 A: I did.

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- 1 Q: The -- before we go there, with regard to this
2 analysis, is this a one year, one-time hit?
3 The \$8 to 12 million dollar inpatient, not
4 including outpatient loss of revenue?
- 5 A: It's a one year, but not a one time. It's
6 every year. So they would lose that volume
7 with perpetuity. So every year that would be
8 the lost revenue that they would experience.
- 9 Q: Okay.
- 10 A: Inpatient.
- 11 Q: All right. Let's look at your analysis about
12 the impact on specific utilization
13 considerations in addition to the financial.
14 Have you prepared a Demonstrative that reflects
15 that?
- 16 A: Yes.
- 17 Q: Dan, let's look at 18.4. And what is this
18 slide, Mr. Levitt?
- 19 A: This shows the impact on utilization. That in
20 2011 Piedmont was 63 percent utilized. In 2017
21 with the 2011 market share, Piedmont would be
22 about 70 percent utilized, but with the CMC-
23 Fort Mill facility in 2017 Piedmont would be
24 only 51 percent utilized or 23 percent less, or
25 27 percent less than they would be without CMC

1 facility.

2 Q: Okay. And what effect would that have on
3 Piedmont?

4 A: Well, it would have a negative utilization,
5 we'd have excess capacity and we'd go down from
6 63 percent to 51 percent in occupancy.

7 Q: How many beds would be in Piedmont would be
8 unused?

9 A: Over 140.

10 Q: All right. Let's move to consideration of how
11 DHEC and Carolinas analyzed this issue. Mr.
12 Levitt, let's first turn to Joint Exhibit 1(B),
13 1018. And let's actually identify where we
14 are. Dan, if you would, pull out of that and
15 put the prior page so we can identify what this
16 document is. And what is this Mr. Levitt?

17 A: This is the remanded decision letter from
18 Beverly Brandt on the Fort Mill Medical Center
19 application.

20 Q: Okay. And then let's go to the second page.
21 Look at paragraph three. Concerning adverse
22 impact, what finding did Ms. Brandt make?

23 A: That the facility would not adversely impact.
24 She made no finding there would be adverse
25 impact.

1 Q: And specifically concerning Carolinas, what did
2 she find? Dan, if you would highlight the last
3 two lines, please.

4 A: The end of the -- the sentence states: That
5 proposed CMC-Fort Mill proposes to shift
6 current market share to a facility in South
7 Carolina resulting in less adverse impact to
8 existing facilities.

9 Q: Less adverse impact to whom?

10 A: The other applicants. Fort Mill Medical Center
11 and at the time, Presbyterian.

12 Q: Now, let's also look at Joint Exhibit 1A. Page
13 474 paragraph 10, Dan. Now, let's Mr. Levitt,
14 do you recall this document or do you want us
15 to pull it out?

16 A: Yes. No.

17 Q: All right. What is it?

18 A: This is the analysis attached to the decision.

19 Q: All right. And what statement -- is that Ms.
20 Brandt's analysis?

21 A: This is Ms. Brandt's analysis.

22 Q: All right. And what does she say there?

23 A: It is assumed inpatient discharges as CMC-Fort
24 Mill hospital will be derived from York County
25 patients currently seeking care at Carolina's

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- 1 hospital in North Carolina. (Now given the
2 choice to receive care at Carolina's facility
3 closer to home.) The end of it goes on to say:
4 Carolinas does not project any additional
5 market share shift from Piedmont Medical Center
6 or from Presbyterian-Mecklenburg facilities.
- 7 Q: Okay. And what's your opinion of Ms. Brandt's
8 conclusions?
- 9 A: They're incorrect. That they said that, CMC
10 said that, but that's not what's going to
11 happen.
- 12 Q: Now, the -- at any point did you in
13 representing Piedmont, Piedmont take the
14 position that the adverse impact would put
15 Piedmont Medical Center out of business?
- 16 A: I don't think we ever presented that we would
17 be out of business, no.
- 18 Q: All right. What effect, then, do you believe
19 that the adverse impact has on Piedmont's
20 operations, its utilization and its long term
21 revenue?
- 22 A: Well, it would all be negative. That the
23 utilization would be negatively impacted, the
24 resulting financial impact would be negative.
25 We talked about the ability to offer specialty

1 services with lower volumes, their inability to
2 do that and, overall, it would just be negative
3 impact to the hospital.

4 Q: And have you done any independent research in
5 addition to what you've presented related to
6 what the views of practitioners at Piedmont
7 were about the potential for adverse impact?

8 A: Yes.

9 Q: Okay. Now, did you review the letters that
10 were presented to the Department from
11 physicians on medical staff at Piedmont?

12 A: Yes.

13 Q: Let's Dan, actually pull up Exhibit 31. Did
14 you make a presentation from summaries of those
15 letters to the Department during the project
16 review presentation?

17 A: We did and then subsequent to that we put some
18 of that in the July submission to DHEC as well.

19 Q: Okay. Let's go through this document in the
20 record and show for the Court a summary of what
21 the positions were that you've identified from
22 physicians who submitted letters to the
23 Department in support of Piedmont's
24 application. Let's take a look at the first
25 one, Dan. First of all, the overview of these

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1 letters, have you reviewed and analyzed these
2 letters?

3 A: Yes. Uh-huh (affirmative response). We did.
4 And we presented this at project review as
5 well. We looked at the independent physicians
6 in York County that supported the various
7 projects and as you can see, over 75 percent of
8 the independent physicians supported the
9 Piedmont project, 45 letters in support for
10 Piedmont, one for CHS and 11 for Presbyterian.

11 Q: Is that 13?

12 A: I'm sorry, 13. Yes.

13 Q: All right. And then there were employed docs
14 who submitted letters?

15 A: There were. 22 Piedmont-employed physicians,
16 55 CHS-employed physicians and 20 Presbyterian-
17 employed physicians.

18 Q: Okay. And let's move on to the next slide.
19 Before we leave that, why have you highlighted
20 independent physicians there?

21 A: Well, obviously, if you're employed then you're
22 going to be writing a letter in support of your
23 facility. So, those independent physicians are
24 the ones that we were focusing on to look at
25 their positions and which applicant they chose

1 to support.

2 Q: Okay. And let's take a look at some of those
3 statements in the record. And what does this
4 particular excerpt -- these are all in the
5 record? These letters are in the record?

6 A: They are. This comes from the project review
7 presentation as well.

8 Q: Okay.

9 A: This is Dr. Pennington, a gastroenterologist,
10 states: There will be a drop in patients who
11 use the Rock Hill facility and thus a
12 subsequent drop in the funds available to
13 continue technological advances people in the
14 community have come to enjoy.

15 Q: All right. Let's move on to the next. And
16 what do you have here?

17 A: This is from Dr. Fletcher, an orthopaedic
18 surgeon and he states: These past few years
19 have shown that not only Presbyterian but also
20 Carolinas Medical, by their actions, have
21 proven they do not support York County. They
22 routinely continue to encourage their York
23 County practitioners to refer patients to
24 physicians who practice in the Charlotte
25 network facilities.

- 1 Q: Okay. Next page.
- 2 A: This is a letter from Dr. Powell. Neal Powell,
- 3 Jr., he states: To allow the migration of
- 4 Charlotte-based hospitals to York County would
- 5 contribute to the erosion of overall healthcare
- 6 delivery in York County.
- 7 Q: All right.
- 8 A: This is from Dr. Robert Wilson. He states: My
- 9 main worry is that if another entity builds a
- 10 hospital in Fort Mill, Rock Hill would become
- 11 a less attractive place to practice medicine.
- 12 End result is that fewer top level physicians
- 13 will want to come to and practice in Rock Hill.
- 14 This means less good care for Rock Hill
- 15 patients.
- 16 Q: Okay. Is that it? All right. Now, based on
- 17 your review of these letters or conversations
- 18 that you've had with physicians on the medical
- 19 staff, Mr. Levitt, have you identified the
- 20 themes that have been communicated by the
- 21 members of the Piedmont medical staff
- 22 concerning the proposed Fort Mill project?
- 23 A: Yes.
- 24 Q: All right. Have you prepared a Demonstrative
- 25 that reflects those?

1 A: I have.

2 Q: All right. Let's turn to that. Demonstrative
3 194, please, Dan. All right. And what do you
4 have here, Mr. Levitt?

5 A: These are the general themes, the five themes.
6 The concerns, I guess, of what would happen if
7 the CMC-Fort Mill facility were to be approved.
8 The ability to maintain competent quality would
9 be compromised. That the CMC facility would
10 send, continue to send patients to Charlotte,
11 not Piedmont as we talked about for some of
12 those higher level specialty services that are
13 available at Piedmont and then have been
14 historically used by CMC physicians at
15 Piedmont. Physicians, CHS Physicians would
16 refer from within their system so the
17 independent physicians wouldn't get the
18 referrals from those physicians. They would
19 refer to other CHS physicians and to other
20 physicians that would perform at other CMC
21 facilities. It would have an impact on
22 Piedmont's medical staff and the payor mix.
23 And overall the impact would be to weaken the
24 delivery system in York County, both the
25 hospital as well as the medical staff with

1 physicians in the area.

2 Q: Okay. Now, let's then, go back to the original
3 analytical framework for adverse impact that
4 you pulled together as Demonstrative 168.4.
5 And let's identify and apply the various
6 criteria to your analysis unless you otherwise
7 identify it. So let's actually, what I'd like
8 to do, if you have a set of the regs with you,
9 so we don't need to leave this screen, if you
10 could read from them. Read, if you would the
11 section 802.22 relating to distribution of
12 existing health services.

13 A: Twenty-two states: The existing distribution
14 of health services should be identified in the
15 effect of the proposed project on the
16 distribution shall be carefully considered to
17 functionally balance the distribution of the
18 target population.

19 Q: And how have you analyzed that?

20 A: Well, as we talked about looking at the
21 distribution of health facilities, the impact
22 on the existing resources and what the proposed
23 effects would be, the proposed CMC facility
24 would have negative impact on Piedmont's
25 resources.

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1 Q: And the 3(h), and then, Dan, go ahead and --
2 who best meets 22?

3 A: Piedmont.

4 Q: And 3(h) you've already analyzed and offered
5 your opinion on so Dan, let's check that as
6 well, 16(c), read that into the record, Mr.
7 Levitt.

8 A: So 16(c) is cost containment. The impact of
9 the project upon the applicant's cost to
10 provide services and the applicant's patient
11 charges should be reasonable. The impact of
12 the project on the cost of the charges of other
13 providers of similar services should be
14 considered if the data are available.

15 Q: All right. And what is your opinion concerning
16 the impact of the establishment of CMC-Fort
17 Mill on the cost of charges at Piedmont Medical
18 Center?

19 A: Well, to the extent that the volume goes down
20 at Piedmont, which it would, the cost per unit
21 of service would go up. We have fixed costs
22 that are difficult to control. And the cost of
23 per unit service would go up at Piedmont as a
24 result of the lower utilization.

25 Q: All right. And then who best meets that?

1 A: Piedmont.

2 Q: Okay. And 802.23 (a) and (b). Let's read that
3 into the record.

4 A: Twenty-three is adverse effects on other
5 facilities, 23(a) states: The impact on the
6 current projected occupancy rates or use rates
7 of existing facilities and services should be
8 weighed against the increased accessibility
9 offered by the services and (b) states staffing
10 of proposed services should be provided by
11 unnecessarily depleting the staff of existing
12 facilities or services or causing an excessive
13 rise in the staffing costs due to increased
14 competition.

15 Q: Okay. And what's your analysis concerning (a),
16 effects on utilization?

17 A: Well, we talked about the negative impact, the
18 reduction in Piedmont's utilization. So, it
19 would be negative. But the impact would be
20 negative on Piedmont on utilization.

21 Q: All right. And let's go to the second part of
22 that, before eliciting your opinion related to
23 compliance with section. And what's your
24 opinion concerning staffing?

25 A: That the approval of CMC-Fort Mill facility

1 will have a negative impact on staffing as
2 well.

3 Q: Now, let's pull up Dan, Demonstrative 15. Mr.
4 Masterton testified concerning nurses and his
5 concerns related to the potential approval of
6 CMC-Fort Mill, Mr. Levitt. I'm going to ask
7 your opinion concerning this data.

8 A: That as Mr. Masterton identified, 23 percent of
9 the nursing staff live in Fort Mill, Tega Cay
10 or Mecklenburg County and those would be the
11 direct nurses at risk for leaving Piedmont if
12 CMC-Fort Mill were approved since it would be
13 closer to where they lived. So the potential
14 negative impact would be to taking staff away
15 from Piedmont Medical Center.

16 Q: And is that something that's considered in the
17 regulations?

18 A: Yes. That's what 23(b) talks about. The
19 impact of the proposed project on staffing at
20 the existing facilities.

21 Q: Why would that be an important consideration
22 for the Department in evaluating adverse
23 impact?

24 A: Because that's the largest part of, largest
25 expense of a hospital is staffing. The ability

1 to provide the services is dependant on the
2 particular clinical staff to the extent that
3 the staff are taken away or encouraged to leave
4 or leave on their own volition. It's negative
5 to the hospital.

6 Q: Okay. Now, Dan, let's go back to 168.4 and
7 look at the fifth factor, and sorry, let me ask
8 you as we are on 23 (a) and (b), Mr. Levitt,
9 which applicant best meets these terms?

10 A: Piedmont.

11 Q: Okay. And finally, what is 44-7-180(B)(4)
12 relate to?

13 A: That's the regulation ---

14 Q: Statute?

15 A: I'm sorry, statute that requires the
16 determination of the creating of -- improving
17 accessibility relative to the adverse impact.

18 Q: Okay. And what's your opinion concerning that
19 balancing test?

20 A: That the improved accessibility of CMC-Fort
21 Mill Hospital to residents of northern York
22 County is not outweighed by the negative impact
23 it would have on -- the negative impact
24 outweighs that increased accessibility.

25 Q: Does Piedmont offering a hospital placement in

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- 1 Fort Mill address the issue of accessibility?
- 2 A: It does. The Fort Mill Medical Center would
- 3 provide access to residents in that area.
- 4 Q: All right. Do they, would the Fort Mill
- 5 Medical Center produce an adverse effect on the
- 6 operation at Piedmont Medical Center?
- 7 A: No, no. A positive impact on the operation at
- 8 Piedmont Medical Center.
- 9 Q: All right. And given your opinions concerning
- 10 those matters, what determination have you made
- 11 about which applicant most improves
- 12 accessibility and avoids adverse effects?
- 13 A: Piedmont Medical Center.
- 14 Q: All right. Now, let's move at this point, if
- 15 you would, Dan, if we could convert those
- 16 checks and Xs to the grid, 168.1. The overview
- 17 of the project review criteria related to
- 18 distribution and accessibility should be the
- 19 next one. And then related to cost adverse
- 20 impact, bottom, related to cost containment,
- 21 the two considerations there. So, we'll hold
- 22 that open until you address 6(a), okay?
- 23 A: Okay.
- 24 Q: And (h) has already been addressed under
- 25 section 3. All right. So, I think that takes

1 us to the third issue you've identified, Mr.
2 Levitt, as you began your testimony concerning
3 project review criteria, you've identified
4 three buckets in which the criteria fell. One
5 was need. You've addressed that. The second
6 was adverse impact. We've concluded that. And
7 the third was financial considerations, is that
8 right?

9 A: Correct.

10 Q: All right. So, have you prepared a
11 Demonstrative that identifies the various
12 financial considerations and provides an
13 overview for them?

14 A: Yes.

15 Q: All right. Let's take a look at that,
16 Demonstrative 195. And what do you have here?

17 A: This shows the criteria that are the financial
18 considerations. 802.6(a), gross charges;
19 802.6(b), projected utilization; 802.7
20 projected expenses. 802.9.15, net income and
21 financial feasibility, 802.16(a) cost
22 containment related to funding; 16(c) charges
23 and 803.17, efficiency.

24 Q: Okay. Now, let's go ahead and begin, dive into
25 these. The first one is an easy start. The

1 Department found that all parties equally met
2 the criterion related to projected charges. Do
3 you agree with that?

4 A: Yes.

5 Q: Okay. And then let's move to the second part
6 of section 6. Which relates to projected
7 utilization. Would you read from that section
8 of the regs, please? And Dan, let's go ahead
9 and cut to the regs on that.

10 A: The projected levels of utilization should be
11 reasonably consistent with those experienced by
12 similar facilities in the service area and or
13 state. In addition the projected levels of
14 utilization be consistent with the need level
15 of the target population.

16 Q: All right. Now, in general terms, why is a
17 utilization being addressed in this financial
18 section of the regs?

19 A: Because the utilization will drive the
20 financial pro-forma. So, one is directed
21 related to the financials.

22 Q: And the revenue?

23 A: And the revenue.

24 Q: Okay. All right. And what does the regulation
25 require?

- 1 A: That the levels are consistent with similar
2 facilities in the service area and the state.
- 3 Q: And have you analyzed the utilization of
4 similar facilities in the service area and or
5 state?
- 6 A: Yes.
- 7 Q: Okay. And let's actually, Dan, go to Exhibit
8 12, page 37 of this. But let's do the cover
9 page first. So we can identify what the source
10 is, Mr. Levitt.
- 11 A: This is the current State Health Plan.
- 12 Q: All right. And let's then look page to 37 on
13 this. And why are you using the current State
14 Health Plan to look at this criterion, Mr.
15 Levitt?
- 16 A: Because it shows the most recent occupancy
17 experience of the hospitals.
- 18 Q: Okay. And which is the region that, there are
19 four regions in the state, is that right?
- 20 A: Yes, there are four regions in the state.
- 21 Q: Okay. And which is the one that Piedmont and
22 York County is located in?
- 23 A: Region 2. Bottom left corner.
- 24 Q: Dan, pull that up, please. Okay. And the
25 focus of the regulation as you testified to,

1 Mr. Levitt, is consistent with similar
2 facilities. So, what have you highlighted
3 here?

4 A: Well, the first thing highlighted is the total
5 regional average of Region 2 is 55 percent in
6 the most recent year. Last three years was 57,
7 55, I'm sorry, 57.4, 55.7, 55.0 for the ---

8 Q: Again, these are statements of the occupancy
9 rates?

10 A: Occupancy rates of those hospitals in Region 2.

11 Q: Okay.

12 A: Well, we also highlighted what were comparable
13 facilities, community hospitals and the only
14 hospital located the service area of York
15 County, Piedmont Medical Center. You can see
16 Piedmont at 57, 58, 62 percent occupancy.
17 Providence Northeast in 2011, I think was their
18 third year, 53 percent. Lexington, 58 percent.
19 Springs, 44 percent and Kershaw at 57 percent.

20 Q: And we could look at the top of the page, but
21 do you happen to know what years these three
22 columns reflect?

23 A: I believe it is '09, '10 and '11; 2009, 2010
24 and 2011.

25 Q: And what is the proposed occupancy rate, that

1 is, the percentage of beds that would be
2 occupied at Fort Mill Medical Center?

3 A: Fifty-eight.

4 Q: Okay. And then what's your opinion concerning,
5 related to the consistency of Piedmont's
6 proposed occupancy with similar facilities in
7 the region?

8 A: That it's consistent.

9 Q: Okay. And how would you evaluate that against
10 Carolinas' projected occupancy?

11 A: Their occupancy was higher. There were 67
12 percent, I think.

13 Q: Year three?

14 A: Year three, 67 percent, so, much higher, much
15 more well-utilized, again because they had the
16 smaller facility.

17 Q: All right. Is that consistent with these
18 facilities?

19 A: It's higher, but consistent.

20 Q: Okay. Now, there are two parts of the test
21 under 6(b), aren't there?

22 A: Yes.

23 Q: And the second one, do you want to look at it
24 again? Relates to, again, I think you've read
25 it, related to the need level of the target

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1 population?

2 A: Yes.

3 Q: All right. Now, you -- I'll take the time to
4 do this, do you recall Exhibit 99, your
5 projection of 203 patients leaving the county?

6 A: Yes.

7 Q: All right. And how, do the proposed projects
8 relate to that need level of the target
9 population?

10 A: Again, the 64 additional beds at CMC is a lower
11 percentage of that but still helps to address
12 the needs of the market.

13 Q: And how does Piedmont's?

14 A: Again, they are adding 64 new beds and
15 transferring 36 other beds to be better
16 utilized, so it also addresses the needs,
17 perhaps even in a better manner.

18 Q: Okay. So, then, Dan, let's go back to the grid
19 at 168. Mr. Levitt, which, how would you
20 evaluate the extent to which the applicants
21 meet the projected revenue criterion in 6(a)
22 and (b)?

23 A: Well, I think, because of 6(b) Piedmont might
24 better meet it, but they both meet it.

25 Q: Okay. All right. Let's move to the next

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- 1 section, which is section 7, 802.7 that looks
2 at projected expenses of the applicants.
3 Actually, look, Dan, pull up the reg again.
4 And, Mr. Levitt, please read that into the
5 record.
- 6 A: On seven, projected expenses. Projections of
7 construction costs, start up costs, operating
8 costs, debt service, depreciation, manpower
9 costs, et cetera, should be considered with
10 those experienced by similar facilities
11 offering a similar level and scope of service
12 (with proper consideration given to such
13 factors such as inflation, cost of capital, et
14 cetera).
- 15 Q: All right. Now, what's the purpose of this
16 provision?
- 17 A: To determine if the expenses are reasonable.
- 18 Q: All right. Now, in competing applications for
19 the Department to make that determination look
20 at the projected expenses and compare them head
21 to head, is that what the regulation provides
22 for?
- 23 A: No. They can, but they need to compare those
24 to other facilities offering similar services.
- 25 Q: What does the regulation state?

1 A: That they -- the projection should be
2 consistent with those experienced by similar
3 facilities offering a similar level of service
4 and scope.

5 Q: Okay. Did Ms. Brandt do that in her analysis?

6 A: No.

7 Q: All right. Now, have you done that?

8 A: Yes.

9 Q: All right. So, first category of expenses
10 identified are construction costs. Did you
11 compare the construction costs proposed by
12 Carolinas and by Piedmont against those of
13 similar facilities?

14 A: Yes.

15 Q: How did you do that?

16 A: I looked at the CON applications for comparable
17 facilities and compared that to the projections
18 in the CON application.

19 Q: Okay. Before we look at that, let's pull out
20 Demonstrative 153. Now, at any point during
21 the review of the costs, the review of these
22 applications, Mr. Levitt, did you communicate
23 with the Department concerning the comparisons
24 that they were undertaking or appeared to be
25 undertaking with regard to the capital costs

1 for -- that each of the applicants would incur?

2 A: Yes.

3 Q: All right. And why did you do that?

4 A: To make them aware that the capital costs
5 couldn't just be compared across the board
6 looking at what was in the applications. They
7 contained different elements just as the
8 regulation says, proper consideration should be
9 given to -- as an example it gives cost of
10 capital. So, if one applicant includes cost of
11 capital and capitalized interest, then they
12 need to be able to compare that. If one did
13 include it and one didn't include it, it's not
14 a fair comparison to look at the total. So,
15 for that reason, and several others, if there
16 were inflation, again the reg talks about
17 adjusting for inflation. So, you want to make
18 sure the inflations were comparable. The
19 assumptions were comparable, so we adjusted our
20 numbers to make them, as you called it, apples
21 to apples comparison.

22 Q: Did Carolinas include in their projected
23 capital costs capitalized interest?

24 A: They did not.

25 Q: In the application you prepared originally did

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1 you present that?

2 A: We did.

3 Q: Okay. And so these were one of the three
4 reasons for adjustments that you present to the
5 Department in your capital costs, is that
6 right?

7 A: Correct.

8 Q: All right. Let's look at the second one. What
9 does that relate to?

10 A: The information submitted by the applicants, we
11 submitted a complete, revised and updated
12 application in 2010; CHS didn't. They
13 ultimately updated their information, but they
14 inflated their construction costs to a
15 different time period than we did. So, in
16 order to compare the numbers, we identified it
17 as deflation, but we adjusted the inflation to
18 be consistent for consistent time periods. So,
19 we adjusted our inflation to the time period
20 that they identified and I think it was 2010
21 inflated construction costs.

22 Q: All right. And what is the third issue related
23 to?

24 A: We included our medical equipment at sort of
25 list price. What the, quote, the list price

1 would be. Piedmont, as a group purchased, as
2 a member of a group purchase organization we
3 received a 22 percent discount on medical
4 equipment, so we knew that that wasn't what the
5 equipment would cost. It would be 22 percent
6 less, so we adjusted that to reflect the out-
7 of-pocket cost.

8 Q: All right. And let's look at the next
9 demonstrative, 153.2, Dan, as to how those
10 adjustments were applied. Would you review
11 this please?

12 A: Sure. You can see the land costs wouldn't be
13 adjusted because none of those factors impact
14 land costs. So, 4.6 million would remain
15 constant. Construction costs were, as we
16 called it deflated from 75 million to 68
17 million to be comparable to the time period for
18 the CHS application. The equipment costs that
19 reflects the 22 percent discount. A and E
20 costs or the architect and engineering fees,
21 those are a factor, a percentage of the
22 construction costs, so as those go down, as the
23 construction costs go down, the A and E fees
24 will go down and we eliminated the capitalized
25 interest expense. So, taking all those

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1 adjustments into account, the miscellaneous,
2 other expenses remained constant but the
3 overall impact \$146 million went down to \$118.8
4 million.

5 Q: Okay. Now, applying the \$118.8 million capital
6 costs figure and Carolinas' proposed capital
7 costs, did you analyze those in accordance
8 with the regulation against other total project
9 costs for other satellite hospitals?

10 A: Yes.

11 Q: All right. And let's take a look at that. At
12 Demonstrative 151, please. And what does this
13 one show?

14 A: This shows for the CON applications filed and
15 approved since 2005 --

16 Q: Now, are these the CON applications that have
17 been made Exhibits of Piedmont?

18 A: Yes, these are, as it shows at the bottom,
19 Joint Exhibit 1A, 1B and Piedmont Exhibits 56
20 through 63.

21 Q: Okay.

22 A: This shows the number of beds and the CON
23 application, the total cost, TPC, total project
24 costs. And the total project costs per bed.
25 You can see that the blue numbers boxed are the

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1 CMC-Fort Mill and the Fort Mill Medical Center
2 CON applications, \$77 million for CMC and \$118
3 million we just showed for Fort Mill, divided
4 by the number of beds and they're comparable,
5 1.2 million versus 1.2 million, basically. And
6 you can see there in the middle of the pack,
7 Trident-Berkeley, Roper-Berkeley were the
8 highest, 2.3 million dollars per bed and the
9 lowest was Greer in Pelham in 2005, \$700,000
10 per bed and a little over a million dollars a
11 bed.

12 Q: Now, are any of the hospitals identified this
13 Exhibit, and they're not all satellite
14 hospitals by the way, are they?

15 A: No, some of them are replacement hospitals.
16 Some are satellite hospitals.

17 Q: Okay. Now, among these, are there any
18 facilities other than CMC-Fort Mill associated
19 with Carolinas?

20 A: Yes.

21 Q: And which are they?

22 A: The Roper-Berkeley and Roper-Mt. Pleasant which
23 are the, two of the three highest total cost
24 per bed at 2.2 and 2.5, or 1.5 million dollars
25 per bed.

1 Q: Okay. And the years are identified there. Is
2 there any significance related to these cost
3 projections and the years that they were
4 offered?

5 A: Yes. With the exception of Roper-Mt. Pleasant
6 in 2005, obviously the older the facility, the
7 lower the cost. So, the 2005 facilities at the
8 bottom, Greer, East Cooper, The Village,
9 Pelham, are the lower cost per bed because that
10 was before inflation was applied to them. So,
11 if you were to inflate those all to the same
12 year, then they would be comparable.

13 Q: And they would be comparable, the ones from
14 '05?

15 A: Perhaps. You know, if you were to increase it
16 depending on the assumption, but even without
17 increasing in the proposed projects fall into
18 the middle of the pack.

19 Q: Okay. And what does that cause you to conclude
20 related to the extent to which these two
21 proposed projects would meet the standard under
22 the projected capital expenses under section 7?

23 A: That they would both meet it.

24 Q: All right. Now, did you evaluate anything else
25 under section 7 other than capital costs?

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- 1 A: Yes, operating costs.
- 2 Q: All right. Dan, let's look at Demonstrative
- 3 196. And what's the source of this, Mr.
- 4 Levitt?
- 5 A: These are the Medicare costs reports and CON
- 6 applications. Oh, I'm sorry. These are the
- 7 CON applications for the various hospitals.
- 8 Fort Mill Medical Center, CMC-Fort Mill, Roper-
- 9 Berkeley, Palmetto-Parkridge and Roper-Mt.
- 10 Pleasant.
- 11 Q: From the CON applications?
- 12 A: From the CON applications.
- 13 Q: Okay. And what have you done there?
- 14 A: Looking at the operating expenses, the total
- 15 expenses per adjusted discharge, the Fort Mill
- 16 Medical Center, the \$9500, 9558 with CMC lower
- 17 at 7500 comparing that to the other applicants,
- 18 Roper-Berkeley at 14,000, Palmetto-Parkridge at
- 19 9500 consistent with Fort Mill and Roper-Mt.
- 20 Pleasant in 2005 at 7100 would be, I guess,
- 21 comparable to the CMC-Fort Mill in 2010. The
- 22 same with personnel expenses per adjusted
- 23 discharge. Again that 3300 for Fort Mill,
- 24 3,000 for CMC, 5600 for Berkeley, Roper
- 25 Berkeley, 4,000 for Parkridge and 3100 for Mt.

1 Pleasant.

2 Q: Okay. Let's go through them as you're going
3 through them, evaluate the comparability of
4 Fort Mill and Carolinas to the three
5 applications you've identified.

6 A: Sure. That they -- because as I said the total
7 expenses per adjusted discharge and the
8 personnel expenses per adjusted discharge, they
9 are comparable to the various facilities.
10 Roper-Berkeley is the highest in 2008. And
11 then the CMC-Fort Mill and Fort Mill Medical
12 Center are comparable to the other two
13 facilities.

14 Q: Now, the Roper-Berkeley, that's a Carolinas-
15 managed project, is that right?

16 A: Yes.

17 Q: And it's nearly twice the total expenses per
18 adjusted discharge?

19 A: Correct.

20 Q: Okay.

21 A: The salaries, I'm sorry, supplies and other
22 expenses, again, the CMC-Fort Mill at 1500 per
23 adjusted discharge is a little more than the
24 Roper-Mt. Pleasant in 2005. The Fort Mill
25 Medical Center 2300 is slightly higher than

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1 that and comparable to the Parkridge and then
2 Berkeley again, higher at 3300. Total FTEs per
3 adjusted bed, this was raised during project
4 review. Fort Mill is at 4.2 CMC-Fort Mill was
5 at 3.1, which in my mind was low and that's
6 what the data showed. Roper-Berkeley was at
7 5.6, almost double CMC-Fort Mill, Palmetto-
8 Parkridge 4.0, consistent with Piedmont's 4.2.
9 Roper-Mt. Pleasant didn't provide enough
10 information to calculate the FTEs per adjusted
11 occupied bed. And then the indigent care
12 percentage assumptions that CMC-Fort Mill,
13 again, we talked detailed about the 6.3 percent
14 assumption that compares to the three percent
15 at Fort Mill, 2.2 percent at Berkeley, Roper-
16 Berkeley, 4 percent at Parkridge and 1.9 at
17 Roper-Mt. Pleasant.

18 Q: Let me take you back to the total FTEs for
19 adjusted occupied bed. First of all, what is
20 that attempting to measure?

21 A: That measures staffing. So, it determines --
22 the higher the number, the more staff you have
23 basically. And it gives you an idea of how
24 well the facility is staffed.

25 Q: Is it a good thing or a bad thing to have a low

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1 number relative to others? Do you want more
2 staff in a hospital or less? Or does the
3 regulation make that clear?

4 A: It depends on who you are and what your
5 position is in the facility, but you would want
6 to ensure that you have adequate staff to
7 provide care for the services. If you're a
8 nurse, then you would want more staff and if
9 you're someone who is more concerned about
10 operating expenses, you would want less staff
11 but you can't have too few staff because you
12 still have to provide for the care of the
13 patients.

14 Q: Okay. And what inferences do you make of the
15 fact that CMC-Fort Mill proposed to have 3.1
16 staffing ratio and or level and Roper-Berkeley,
17 a Carolinas partly owned and Carolinas managed
18 hospital as nearly twice that?

19 A: The 3.1 struck me as low. Four would be the
20 rule of thumb I would use. Four at Parkridge,
21 4.2 at Fort Mill seemed consistent and the
22 expected 5.6 is a little high.

23 Q: All right. And what did Palmetto propose in
24 the hospital they were developing?

25 A: Palmetto Parkridge was 4.0.

1 Q: All right. And what's your experience with all
2 your years with working with hospitals, the
3 most common range of FTEs per adjusted occupied
4 bed in hospital facilities?

5 A: Again, that's a common number I've seen. Four
6 is a good target for a project.

7 Q: Okay. All right. Now, considering the
8 information you reviewed and your testimony
9 here related to both capital and operating
10 expenses, how would you apply section 7?

11 A: Well, as I said there were some issues with the
12 CMC-Fort Mill, I think they would both comply
13 with that criteria.

14 Q: All right. Dan, let's flip to 168. The
15 overview grid and so you provide checks under
16 each facility, is that right, Mr. Levitt?

17 A: Yes.

18 Q: Okay. Let's move on to the next one. Which is
19 net income and financial feasibility. Why have
20 you coupled these two provisions, Mr. Levitt?

21 A: I think inherently you understand that they are
22 -- that the net income would determine the
23 financial feasibility.

24 Q: Okay. Dan, let's pull those up and, Mr.
25 Levitt, if you'd read both section 9 and 15.

1 Since they are on different pages, one at a
2 time.

3 A: Okay. Nine is net income. The project should
4 show improvement in its net revenue position
5 over time. Especially the first three years
6 until a steady, positive net income trend is
7 attained. Any projected deviations from this
8 pattern should be explained.

9 Q: All right. And let's go to 15.

10 A: Fifteen is financial feasibility. The
11 applicant must have projected both the
12 immediate and long term financial feasibility
13 of the proposal. Such projections should be
14 reasonable and based on accepted accounting
15 procedures.

16 Q: Okay. Now, generally, what's the Department
17 attempting to evaluate based on these
18 regulations?

19 A: To determine if the project is financially
20 feasible, if it shows positive net income and
21 if it, if the facility can afford to do it.

22 Q: Okay. Now, have you -- again, now if the
23 regulations require, as you've just reviewed,
24 the determination as to the reasonableness of
25 revenue and expenses both based on the

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1 performance of similar facilities, how would
2 that relate to the analysis of net income?
3 Financial feasibility?

4 A: Again, you would look at the projected
5 experience of similar facilities.

6 Q: Okay. Now, have you done that?

7 A: Yes.

8 Q: All right. Dan, pull up Demonstrative 197.
9 And what do you have here, Mr. Levitt?

10 A: This shows the projected CMC-Fort Mill, Fort
11 Mill Medical Center, year one, two and three of
12 net income projections. And then the Trident-
13 Berkeley and the Trident-Roper projected net
14 incomes for the same first three years of
15 operation. And what it shows is that CMC-Fort
16 Mill showed a profit in year one of \$600,000
17 increasing to \$1.6 million by year two and up
18 to \$2.7 million by year three. Contrast that
19 with Fort Mill, it showed a loss the first year
20 of operation by a half million dollars. Almost
21 three million dollar loss in year two and then
22 an increase to about \$300,000 by year three.

23 Q: And why do you have the two Berkeley County
24 projects identified below those?

25 A: Those were the -- at the time we submitted this

1 on July 11th, these were the two applications
2 that had been approved most recently and they
3 showed the most comparable analysis and it
4 shows -- similar to Fort Mill Medical Center
5 showed a loss the first two years of operation
6 with a modest positive net income by the third
7 year. So they all had the projected
8 requirement in the regs that a steady increase
9 every year in the bottom line.

10 Q: Now, did the Department approve both of these
11 applications?

12 A: Both the Trident-Berkeley and Roper-Berkeley,
13 yes.

14 Q: And the Roper-Berkeley again, was a project
15 that was sponsored by Roper which is owned and
16 managed by Carolinas?

17 A: Correct.

18 Q: It shows nearly a \$15 million loss over the
19 first three years of operations and the
20 Department found that financially feasible?

21 A: Yes.

22 Q: And was it projected by Roper as financially
23 feasible?

24 A: Yes.

25 Q: Okay. And in your opinion was it financially

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1 feasible and consistent with regulations?

2 A: Yes.

3 Q: Why?

4 A: Because it showed a positive trend and that's
5 what the regs call for.

6 Q: Okay. Based on that, Mr. Levitt, have you made
7 a judgement about whether the applicants meet
8 the criteria for financial feasibility and net
9 income performance?

10 A: Yes.

11 Q: And what is that?

12 A: They both meet that.

13 Q: Okay. All right. Let's move on to the next
14 one. You've already discussed 16(c), let's
15 take a look at 16(a). Read 16(a) into the
16 record, please.

17 A: The applicant should have identified all
18 alternative sources and or methods of funding
19 and demonstrated that the method chosen is the
20 most feasible option.

21 Q: And what does that mean?

22 A: That means that from the project, the applicant
23 needs to identify that source of funding.

24 Q: Okay. And do you agree with the Department
25 that Carolinas best met this criterion and Fort

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RECORD 000833

1 Mill did not?

2 A: No.

3 Q: Let's take a look at the record please, Dan, if
4 you'll pull up Joint Exhibit 1(B), page 223.
5 And what is this, Mr. Levitt?

6 A: This is the evidence of findings letter that
7 was submitted with the CON application to Ms.
8 Brandt from the regional office, I believe it
9 was from John Holland. He's the senior vice
10 president of operations for Tenet Healthcare
11 Corporation. That identified Tenet Healthcare
12 Corporation would fund the project.

13 Q: And what do they say concerning their plans to
14 fund the project?

15 A: Well, it states that Tenet Healthcare
16 Corporation, the parent of Amisub is committed
17 to providing the necessary funding. So, in my
18 mind, that's the definitive financing. That
19 corporate is going to pay for it. And it goes
20 on to say though, which I guess caused concerns
21 with Ms. Brandt, the second paragraph, they
22 intend to finance the project with the most
23 appropriate and cost effective capital
24 structure at the time utilizing existing cash
25 reserves, existing lines of credit or the

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RECORD 000834

1 issuance of debt and or equity. It goes on
2 though to say that as of June 30, 2010, which
3 I believe was about the time the letter was
4 submitted, that Tenet Healthcare Corporation
5 had \$711 million in cash and cash equivalents.
6 So again, the project was \$120 million. They
7 said they had \$711 million in cash, so they
8 could pay for it out of cash. They said
9 depending on what happens to the markets and
10 the economy and finances we'll fund it however
11 we see best, but the first paragraph says we'll
12 fund it.

13 Q: Now, how did Ms. Brandt evaluate this?

14 A: She indicated that because it wasn't what she
15 felt as not definitive, she viewed that as a
16 negative.

17 Q: How did Carolinas represent that it intended to
18 fund its project?

19 A: They said they were going to pay cash for it,
20 out of reserves.

21 Q: All right. And the -- how did Ms. Brandt
22 evaluate the issue of one statement being
23 definitively cash, the other statement being we
24 may use cash, we may use credit or some
25 combination thereof?

1 A: Again, she viewed the leaving the options open
2 as Tenet had, as negative.

3 Q: What's the best, based on your experience,
4 business course for an applicant?

5 A: Well, from a business perspective, I think
6 Tenet is appropriate in identifying what the
7 best option is. If interest rates are low, if
8 there cash position is such that they want to
9 pay cash, that's fine. Or if they want to
10 issue debt, that's fine, too, if it's cheap
11 debt. So I think it's best to leave it open.
12 I think though, I think what Ms. Brandt missed
13 is that the first sentence says Tenet is going
14 to pay for it. That's the definitive funding.
15 Amisub will get the money from Tenet. That's
16 -- can't be more definitive than that.

17 Q: Is there any question in your mind whether
18 Tenet can afford to pay cash to build this
19 hospital?

20 A: No.

21 Q: Okay. And all right, let's go back then to the
22 grid at 168. We've got two subpart, 16(a),
23 which we just reviewed and 16(c), which you'll
24 remember was the criterion related to the
25 effects of the proposed project on existing

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1 providers, costs and charges. Do you remember
2 that?

3 A: Yes.

4 Q: All right. Now, which applicant best meets
5 both provisions of 16?

6 A: Well, both provisions would be Piedmont. You
7 know, I think Carolinas identified the source
8 of their funds and I have no reason to believe
9 they can't afford the project either, but the
10 16(c) part, we identified as being Piedmont, so
11 Piedmont best meets them taken in total.

12 Q: All right. Let's move to the next provision
13 which is section 17 concerning efficiency.
14 Dan, if you'll pull that up in the regs. And
15 read this into the record, please, Mr. Levitt.

16 A: Efficiency. The proposed project should
17 improve efficiency by avoiding duplication of
18 services, promoting shared services and
19 fostering economies of scale.

20 Q: Okay. Now, how did you apply this provision to
21 the two applications?

22 A: Well, obviously, as we talked about the
23 duplication, the indirect duplication of
24 services by the CMC application present on
25 services at Piedmont, that would be negative.

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- 1 Shared services that I think they would
2 obviously both applicants would share services
3 and, you know, have benefits of that and then
4 the economies of scale, looking at the 100 beds
5 versus the 64 beds as we talked about, 100 beds
6 would offer an economy of scale savings.
- 7 Q: All right. Have you prepared a Demonstrative
8 to show that?
- 9 A: Yes.
- 10 Q: And let's pull up Demonstrative 168, please,
11 Dan. Now, you testified previously, Mr.
12 Levitt, concerning the cost of Piedmont's
13 proposed facility that made adjustments to
14 them. Are these the costs that are reflected
15 in the Demonstrative before or after those
16 adjustments?
- 17 A: This is before adjustments.
- 18 Q: Okay. And review what we have here, please.
- 19 A: This shows that the 64-bed applications
20 submitted in 2005, the total cost per bed of
21 \$1.6 million and construction and equipment
22 costs per bed of \$1.3 million. As we said
23 early on, the time line we withdrew that
24 application and submitted a 100-bed application
25 at the time of 2005 and those costs per bed

1 were \$1.2 million or 25 percent less than the
2 cost per bed of the 64-bed facility and the
3 construction and equipment costs per bed were
4 just over a million dollars or about 25 percent
5 less than the 64-bed facility. So, you can see
6 that by the time frame of submitting the two
7 applications, by adding the additional beds to
8 the infrastructure that was proposed, it was 25
9 percent cost savings for a 100-bed facility
10 versus 64 beds.

11 Q: Okay. All right. And based on that
12 consideration as well as the one you referenced
13 that avoids duplication, which of the
14 applicants best meets section 17?

15 A: Piedmont.

16 Q: Dan, if you would apply that to the grid,
17 please. All right. Mr. Levitt, with regard to
18 the record of the applicant, there are three
19 subsections identified (a), (b) and (d), would
20 you agree with the Department for purposes of
21 (a) and (b) that it is the record of the
22 applicants and also the record and history
23 concerning compliance that both parties equally
24 meet those standards?

25 A: Yes.

1 Q: Okay. And then the other consideration relates
2 to obtaining financing in 13(b). What findings
3 have you made with regard to that?

4 A: That both applicants can fund the project, they
5 can obtain money.

6 Q: Is that Ms. -- do you agree with Ms. Brandt in
7 applying 3(b) in a way that she did that was
8 consistent with 16(a) that Carolinas best met
9 the that because they had the more definitive
10 capitalization plan?

11 A: No. For the same reason we talked about.

12 Q: Okay. All right. So, what would be your
13 determination concerning the compliance of both
14 applicants with the record of the applicant?

15 A: They both comply.

16 Q: Okay. All right. Let's take a look then at
17 the last criterion concerning acceptance in
18 section 4(a) and (b). Pull those up please,
19 Dan. And read those please, Mr. Levitt.

20 A: Acceptability, 4 (a): For the proposal an
21 applicant should have the support of affected
22 persons including local providers and target
23 population. Lack of opposition should not be
24 considered support for the proposed for
25 purposes of these criteria, (b) states: Where

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1 documents of opposition exist for a proposal,
2 such opposition shall be considered along with
3 the application.

4 Q: All right. Now, and how have you evaluated
5 this section, Mr. Levitt? Let me just ask, cut
6 to the chase if you agree with Ms. Brandt's
7 finding that the applicants equally met this
8 provision?

9 A: Yes.

10 Q: Okay. All right. Dan, let's pull up her
11 finding related to this at Joint Exhibit 1(B),
12 page 1030. And read that sentence into the
13 record if you would.

14 A: All applicants meet the criteria for
15 acceptability. All applicants submitted
16 substantial letters of support primarily from
17 the community. Current reported totals are
18 10,004 letters for Presbyterian, 5,753 for
19 Carolinas and more than 5,400 for Piedmont.

20 Q: All right. And have you ever been involved
21 with a case with the volume of letters anywhere
22 near approaching this number?

23 A: No. No, that's a lot of letters.

24 Q: What's the purpose of this criterion, Mr.
25 Levitt?

1 A: To ensure that there's support for the project
2 and that utilization will occur, that for
3 physicians to support the project to refer
4 patients to the proposed project and that the
5 members of the community support the project as
6 well.

7 Q: Okay. And did they support, did members of the
8 community support all the projects?

9 A: Yes.

10 Q: Now, let's take a look a moment at 4(b) and
11 what you said about opposition being
12 considered. Was there opposition expressed to
13 the applicants, to any of the applicants in
14 this case?

15 A: Yes.

16 Q: And what was it?

17 A: There -- well, here Ms. Brandt identified 34
18 letters of opposition from the community for
19 Piedmont. And then -- so that's what she
20 identified in this.

21 Q: Did Ms. Brandt identify the letters of
22 opposition to Carolinas and Presbyterian
23 submitted by members of the Piedmont Medical
24 staff?

25 A: No.

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- 1 Q: Okay. What weight should be given to those
2 letters, based on your experience?
- 3 A: The letters of opposition?
- 4 Q: Yes.
- 5 A: Not a lot. You know, they were -- it was
6 interesting to me that there were 34 letters of
7 opposition that they were sent to -- the ones
8 I saw that I looked at most recently were sent
9 to Carolinas directly. Ms. Brandt also
10 received some copies but what was interesting
11 to me was that Piedmont submitted a number of
12 applications over time, over the time I worked
13 for them, I never saw a letter of opposition
14 except for this project. Even shortly after we
15 submitted the CON application, there were no
16 letters of opposition.
- 17 Q: So what did you ---
- 18 A: Imaging Center CON, no opposition. ED CON, no
19 opposition. But with this application there is
20 series letters of opposition.
- 21 Q: What inference did you make because of that?
- 22 A: That those letters were encouraged to be sent.
- 23 Q: Over the period of ten years this case has been
24 active, how many patient encounters would you
25 estimate have occurred at Piedmont Medical

1 Center?

2 A: A lot. I mean if you look at ED, they have
3 about 50,000 ED visits so over a ten year
4 period, that would be half a million. In
5 addition to outpatient visits, other
6 admissions, you know, it could be a million.

7 Q: Okay. Based on consideration of these factors,
8 how would you score the applicants under the
9 acceptability criteria?

10 A: They all had letters of support. They all
11 demonstrated acceptability. This is what Ms.
12 Brandt found. They both get a check.

13 Q: Okay. All right. Okay. Mr. Levitt, let me
14 take you back just briefly before we wrap up,
15 you remember the two issues you identified at
16 the outset of your testimony of Exhibit -- I'm
17 sorry, Demonstrative 94. Those key questions,
18 do you recall them?

19 A: Yes.

20 Q: Review them again?

21 A: What Health Plan needs are being addressed by
22 each applicant and what are the likely benefits
23 and risks associated with each of the projects
24 to the residents of York County.

25 Q: All right. And have you formed opinions

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1 concerning each of these questions?

2 A: Yes.

3 Q: All right. Have you developed a Demonstrative
4 related to that?

5 A: Yes.

6 Q: Let's take a look at it. What your opinions
7 are related to the needs being addressed by the
8 applicants in Demonstrative 198.1. All right.
9 What do you have here?

10 A: This shows the first question or framework we
11 talked about. What Health Plan needs are being
12 addressed by each applicant. Carolinas is
13 proposing 64 beds. Piedmont's proposing 100
14 beds at Fort Mill Medical Center and they're
15 both proposing to strengthen the healthcare
16 system, both the Piedmont Healthcare System as
17 well as the system in York County for
18 physicians.

19 Q: All right. And as a result of that, which of
20 the applicants best meets in your view the plan
21 needs that relate to the healthcare objectives
22 for York County?

23 A: I think Piedmont, the Piedmont application
24 better meets the Plan needs.

25 Q: All right. Now, let's move through to the

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1 second issue again on the next page of this
2 Demonstrative.

3 Q: Review this, what your opinion is please, Mr.
4 Levitt, concerning the likely benefits and
5 risks associated with approval of either of
6 these applicants.

7 A: Well, we talked about the benefits of
8 Carolinas' proposal of 64 additional beds in
9 the market and that's positive. Piedmont would
10 have 64 beds, it's not identified, 64
11 additional beds in the market from the Fort
12 Mill Medical Center. The increased utilization
13 at Piedmont by having the Fort Mill Medical
14 Center, reversing out-migration. Having a
15 positive impact on payor mix and strengthening
16 the specialization by increasing the volume of
17 services. The risks, those associated with
18 Carolinas would be to increase the out-
19 migration rather than reverse it. Would have
20 negative payor mix impact on Piedmont. Weaken
21 the medical staff at Piedmont and overall have
22 a negative impact on Piedmont. And the risk of
23 a 100-bed facility at Fort Mill, for Piedmont
24 would be that it is not as well-utilized as we
25 projected.

1 Q: All right. What's the likelihood that the risk
2 of the underutilization at Piedmont Medical
3 Center would occur?

4 A: I think that risk is low.

5 Q: How do you calculate or how do you evaluate the
6 risks that you've identified for Carolinas?

7 A: I think that's what we've done for the last
8 several days. We've outlined that, I think, in
9 pretty good detail. That the Carolinas
10 facility will have a negative impact on
11 Piedmont.

12 Q: Okay. Thank you, no further questions, Mr.
13 Levitt.

14 MR. MULLER: Your Honor, can I propose cross exam in
15 the morning? I know you were trying to go to
16 six every day, but there is such a mass of
17 information.

18 THE COURT: There is.

19 MR. MULLER: That I would appreciate if we could
20 just start in the morning.

21 THE COURT: Unless there is any objection to that?

22 MR. ANDREWS: No, and I apologize, Your Honor, that
23 I miscalculated time.

24 THE COURT: No, and I retained us a little later
25 into the lunch hour, so we have another witness

1 because in essence you weren't going to ask any
2 questions about that and of course, my intent
3 was the Court doesn't want to hear anything
4 about that.

5 **MR. ANDREWS:** I understand.

6 **THE COURT:** So, but it is my understanding that
7 you're not going to go there, so I just wanted
8 to be sure that was clear for the record.

9 **MR. ANDREWS:** And that's our position.

10 **THE COURT:** Yes, sir. Thank you very much.

11 **MR. ANDREWS:** Thank you, sir. At this time we would
12 like to call Dr. Sushil Singhi to the stand.

13 **SUSHIL SINGHI, M.D.,** having been duly sworn,
14 testified as follows:

15 **DR. SINGHI - DIRECT EXAMINATION BY MR. ANDREWS:**

16 Q: All right. Have a seat Dr. Singhi, good
17 morning.

18 A: Good morning.

19 Q: That's right and if you might lean forward and
20 make sure you can speak loudly enough so the
21 court reporter can understand everything you
22 have to say. All right. Dr. Singhi, please
23 state your full name and business address for
24 the record.

25 A: My name is Sushil Singhi. I'm a cardiologist

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1 in Rock Hill. My address, office address is
2 196 Cardiology Drive, Rock Hill, South
3 Carolina. My zip code is 29732.

4 Q: All right. Thank you, Dr. Singhi. Are you
5 currently on the medical staff of Piedmont
6 Medical Center?

7 A: Yes, I am.

8 Q: And you say that you're a cardiologist, is that
9 correct?

10 A: Yes.

11 Q: All right. Dr. Singhi, have you provided a
12 copy of your current curriculum vitae to the
13 parties?

14 A: Yes, I have.

15 Q: All right. And let's pull that up as Exhibit
16 74, please, sir. And does this appear to be
17 your current CV?

18 A: Yes.

19 Q: And is it accurate?

20 A: Yes.

21 Q: All right. Now, Dr. Singhi, let's just provide
22 a little background concerning your education
23 and experience to the Court before we move to
24 the substance of your testimony. Where did you
25 get your medical degree?

- 1 A: I got my medical degree from MGM Medical
2 college, Indore, India.
- 3 Q: All right. And when was that?
- 4 A: That was in 1982.
- 5 Q: All right. And have you received a residency
6 as part of your training as a cardiologist?
- 7 A: Yes.
- 8 Q: And where did you receive that training?
- 9 A: I finished my internal residency in West
10 Virginia with WVU, in Mercy Hospital.
- 11 Q: All right. Have you received a fellowship?
- 12 A: Yes.
- 13 Q: And where did you pursue your fellowship?
- 14 A: I was trained at Saint Francis Medical Center
15 in Pittsburgh, Pennsylvania.
- 16 Q: All right. And are you board certified?
- 17 A: Yes, I am.
- 18 Q: In what fields?
- 19 A: I'm board certified in cardiology and
20 interventional cardiology.
- 21 Q: All right. And have you been licensed to
22 practice medicine?
- 23 A: Yes.
- 24 Q: Where?
- 25 A: I've been licensed to practice in the state of

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1 South Carolina, North Carolina, Pennsylvania
2 and Ohio.

3 Q: All right. And have you practiced in locales,
4 apparently you have based on where you've been
5 licensed, before establishing your practice in
6 Rock Hill?

7 A: Yes.

8 Q: And where was that? Would you review that
9 please?

10 A: After finishing my fellowship in cardiology, I
11 started practicing at University Hospital in
12 Pittsburgh, Pennsylvania.

13 Q: And following that, what did you do?

14 A: Then I moved down south, South Carolina.

15 Q: Okay. All right. Now, when did you move to
16 South Carolina?

17 A: Moved in January of 1994.

18 Q: And was that in the Rock Hill area?

19 A: Yes.

20 Q: All right. And who -- what practice did you
21 join at that time?

22 A: I joined Carolina Cardiology Associates.

23 Q: All right. And have you since moving to South
24 Carolina become affiliated with hospitals in
25 South Carolina and North Carolina?

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1 A: Yes.

2 Q: And which facilities are those?

3 A: Piedmont Medical Center in Rock Hill and a
4 couple other hospitals including well, it was
5 Mercy Hospital which is now being bought out by
6 the CHS is CMC-Mercy in Charlotte. I'm also
7 staff at CMC-Pineville Hospital in Charlotte
8 and least but not is Spring Memorial Hospital
9 in Lancaster, South Carolina.

10 Q: And you've been a member of the staff at
11 Presbyterian Hospital?

12 A: Yes.

13 Q: In Charlotte as well?

14 A: That's right.

15 Q: All right. And let's look at the achievements
16 identified on the first page of your CV. Have
17 you held any leadership positions at the
18 hospitals or medical organizations?

19 A: Yes, currently I'm the president of Carolina
20 Cardiology Associates. I was chief of staff a
21 couple years ago, it was back in 2009.

22 Q: Of what facility?

23 A: At Piedmont Medical Center.

24 Q: Okay.

25 A: I was also president of the York County Medical

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1 Society in 2010.

2 Q: All right. And if you look on page seven of
3 your resume, we'll see, or actually, let's
4 begin on page 4. A number of presentations, 25
5 listed here. In what areas do you intend to
6 provide presentations to other professionals?

7 A: All most all of the presentations were in the
8 field of cardiovascular medicine.

9 Q: All right. And have you been responsible for
10 undertaking clinical studies as well?

11 A: Absolutely.

12 Q: And what have they involved?

13 A: They involved in state of the art medicine and
14 future medicine to stay ahead of the curve in
15 the field of cardiovascular medicine. And part
16 of the national and international research
17 trials across the country and across the world.

18 Q: And if we look at page nine of your CV and
19 what's listed here are a series of
20 publications. Have you continued to stay
21 published in your field?

22 A: Yes.

23 Q: All right. Now, let's move to your experience
24 in the Carolinas, and particularly the practice
25 which you joined in 1994. You said it was

1 Carolina Cardiology?

2 A: That's correct.

3 Q: Was it an existing practice when you joined it?

4 A: Yes.

5 Q: And could you provide a little bit of its
6 history?

7 A: Yeah, Carolina Cardiology was founded by my
8 senior partner, Dr. Jay Shah, approximately 30
9 years ago in Rock Hill, South Carolina. And
10 we've been in the practice for almost 30 years
11 providing the comprehensive cardiovascular care
12 in the Tri-County area including York County,
13 Lancaster and Chester counties.

14 Q: All right. And when you joined the practice,
15 how many physicians were there, were members of
16 it?

17 A: When I joined the practice back in 1994, there
18 were four physicians.

19 Q: Okay. And what number are you today?

20 A: We have a total seven physicians in my
21 practice.

22 Q: Okay. And you're -- you said previously you're
23 the president of the practice, is that right?

24 A: That's correct.

25 Q: How long have you been in that position?

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1 A: Almost two years.

2 Q: Okay. And were you an officer of the practice
3 prior to that?

4 A: Yes.

5 Q: What were you?

6 A: I was given executive activity for the last 15
7 years with my practice including secretary,
8 treasurer, vice president. Ex-officio.

9 Q: Okay. What's the range of services that you
10 and your partners provide to the patients of
11 Carolina Cardiology?

12 A: We provide comprehensive cardiovascular care
13 including consultation, admitting patients with
14 cardio problems, providing diagnostic testing
15 in-house, in the office as well as inpatient,
16 in the hospital. We also provide therapeutic
17 procedures including angioplasty, stents. We
18 also include EP services, diagnostic and
19 therapeutic services for cardiovascular
20 services.

21 Q: What are EP services?

22 A: Electrophysiology services, which is the
23 electrical problem with the electrical
24 condition of the heart.

25 Q: Okay. All right. Now, and where do you and

1 your partners practice medicine? At what
2 hospitals?

3 A: We commonly practice at Piedmont Medical Center
4 in Rock Hill, South Carolina.

5 Q: All right. Do you have privileges at other
6 facilities?

7 A: We do have privileges at other hospitals
8 including Spring Memorial Hospital in
9 Lancaster. CMC-Pineville in Charlotte, North
10 Carolina and Presbyterian Hospital, Charlotte,
11 North Carolina.

12 Q: Okay. As a percentage of your total hospital-
13 based business, what percentage would you
14 estimate your practice has performed at
15 Piedmont?

16 A: Approximately close to 100 percent.

17 Q: So nearly all of it?

18 A: Nearly all of it.

19 Q: All right. Now, let me take you back a few
20 years, Dr. Singhi, to 2009. How would you
21 describe the business of your practice at that
22 time?

23 A: I joined the group back in 1994. And that was
24 one of the most thriving cardiology group I
25 came across and that was the main reason I

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1 moved down south to Rock Hill to join the
2 group. It was a very progressive group. A lot
3 of new procedures were coming on, the hospital
4 in Rock Hill was very supportive to accommodate
5 in my experience -- from University of
6 Pittsburgh to open up new services and the
7 research activities. It was a robust group at
8 the time I joined the practice back in 1994.
9 And it remained like that for a number of
10 years.

11 Q: Okay. And since the period of time since 2009
12 have you been in the position to be aware of
13 the operational indicators of the group?

14 A: Yes, as I'm president of the group, I've been
15 meeting with my administrative folks at least
16 on a weekly basis for at least the last several
17 years. Now that is more often being president
18 of the group and we are tracking all the
19 numbers, the dynamics and the changes as they
20 happen.

21 Q: Okay. Well, let me take you back. And looking
22 at that period in 2009, how would you describe
23 the business of the group? How were y'all
24 doing?

25 A: It's not the same as what it used to be. Now

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1 we have ---

2 Q: What was it like then?

3 A: In 2009, we used to see a lot of new patients,
4 new consults, referrals from primary care
5 physicians in York County. There are significant
6 changes, not only the hospital setting, but the
7 hospital setting where we get visits or
8 consults or from the ER, the emergency room or
9 from the primary care physicians. There's a
10 steady decline in new referrals, new consults
11 and procedures than what we were used to do
12 before.

13 Q: Okay.. And let me ask you a few more things
14 about what it was like before you began
15 experiencing that decline. And with regard to
16 your office, you said you have seven physicians
17 currently, right?

18 A: Yes.

19 Q: And in 2009 was that the same number you had?

20 A: 2009 we had six physicians, six cardiologists.
21 Now, we just added a new cardiologist who's an
22 EP specialist, so that makes six plus one.

23 Q: All right. And why did you add an EP
24 specialist?

25 A: To provide the care for the patient in York

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1 County who have electrical problems with the
2 heart. And we've been working -- pursuing this
3 opportunity for at least five or six years and
4 finally, we got an EP lab in the hospital.

5 Q: Okay. Now, how many -- what was the total
6 number of the employees in Carolinas Cardiology
7 in 2009?

8 A: We had 15 employees in my practice.

9 Q: Okay. And do you know what the payor mix was?

10 A: At the time, payor mix, yes, Medicare was 50
11 percent. Medicaid was about four percent.
12 Blue Cross Blue Shield of South Carolina,
13 which is the largest private insurance company
14 was approximately 21 percent.

15 Q: Okay. And did you have commercial business
16 beyond that?

17 A: Yes, we did have commercial, it was about 20
18 percent. And the rest was charity or self-pay
19 patients.

20 Q: Okay. And so total Blue Cross and commercial
21 business was approximately what together?

22 A: Forty percent.

23 Q: Okay. All right. Now, let's talk about then
24 how the status of your group's business in 2009
25 compares to what it is today. Let's first

1 begin by talking about the volume and how
2 that's changed. In terms of your total new
3 patients over time, do you have any sense of
4 how today's patient base compares with what you
5 had four years ago?

6 A: Yes. Significant drop in new referrals. And
7 it's in the range of about 15 to 20 percent per
8 year reduction in the new referrals from
9 primary care physicians.

10 Q: And over the period of four years, what's the
11 aggregate reduction?

12 A: Well, about 40 percent reduction in new
13 referrals in our practice.

14 Q: And are consults a subset of your total new
15 referrals?

16 A: Yes.

17 Q: And what are consults? Describe what that
18 would be.

19 A: For example, we used to have about 2500 new
20 consults. New referrals, per year. Now it has
21 dropped to 1800 new consults per year.

22 Q: Okay.

23 A: The last five years or so.

24 Q: All right. To 800 or 1800?

25 A: No, 1800.

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1 Q: All right.

2 A: The new consults. But we also get some new
3 patients, so if we combine the new patients and
4 consults, it was about 40 percent drop in the
5 new patients to the practice.

6 Q: Okay. And how have your hospital procedures
7 changed?

8 A: It's also declining because we are being a part
9 of the hospital as a cardiologist. And most of
10 our patients do require some diagnostic
11 procedure and therapeutic done in a hospital
12 setting. Where studies see a significant
13 decline in obviously the consults and new
14 referrals and new patient in the diagnostic as
15 well as the EP procedures.

16 Q: Okay. And do you know the extent to which your
17 work you've done at the hospital has been
18 reduced over the last four years?

19 A: Steadily about 10 to 15 percent decline in
20 diagnostic procedure and approximately 30 to 40
21 percent decline in therapeutics.

22 Q: And what's the difference between diagnostic
23 and therapeutic procedures?

24 A: Diagnostic procedures are where you make the
25 diagnosis either by imaging or the procedure

1 and the therapeutic procedures are where after
2 making the diagnosis, you go in and treat that
3 condition. That's a therapeutic procedure.

4 Q: Okay. Now, in terms of the state of cardiology
5 as it relates to therapeutic procedures, has
6 there been a general decline in the field as a
7 result of changes in practice?

8 A: Yes.

9 Q: Okay. And has that contributed to the overall
10 reduction in the percentage of therapeutic -

11 **MR. GASKINS:** I'm going to object, Your Honor. He's
12 leading the witness.

13 **MR. ANDREWS:** I am, Your Honor. I'm trying to work
14 through this quickly and there's no dispute
15 about these facts as far as I knew. I'll
16 rephrase.

17 **THE COURT:** If you can rephrase it.

18 **MR. ANDREWS:** Sure.

19 **THE COURT:** Thank you.

20 Q: Have there been any changes in the industry
21 that's affected the decline in therapeutic
22 procedures?

23 A: Yes, let me just lay out the background.
24 Overall, across the country there is a decline
25 in therapeutic procedures to treat the patient

1 with the heart conditions. Especially the
2 coronary artery disease. Across the country,
3 there is a reduction in the number of
4 procedures done. However, the Piedmont and my
5 group has been impacted more than the national
6 averages as far as the decline of those
7 procedures.

8 Q: Okay. Now, have there been any changes in your
9 staffing?

10 A: Yes.

11 Q: Of your own practice?

12 A: Yes.

13 Q: And what have they consisted of?

14 A: Since 2009 there was a significant drop in our
15 new referrals, new patients, new diagnostic
16 procedures in my office. Therefore, we have
17 restructured our office staff base and we have
18 a total of about 15 percent reduction in the
19 staff in my practice.

20 Q: Now, what have been the effects, Dr. Singhi on
21 this general decline that you testified about
22 of new referrals and reduction in office-based
23 and hospital-based procedures over the last
24 four years?

25 A: Frankly, if you can get new referrals, new

1 consults from primary care physicians. There
2 are now seven practices, primary care practices
3 being managed by a big system, mostly from the
4 Charlotte area. Although all three big
5 systems, including CHS, Presbyterian or Novant,
6 and Piedmont or Tenet, they all have primary
7 care practices in York County. However the CHS
8 and Presbyterian had more market share having
9 more primary care physicians over there. We
10 are being impacted by CHS from practices in
11 York County where we used to get at least 25
12 percent of our new referrals used to come from
13 those primary care physicians. Including
14 Shiland Family Practice, which is over 15
15 providers and Medical Practice, internal
16 medicine group which is about six internists in
17 that group. And there is a significant
18 reduction in the new referrals in the range of
19 over 70 to 75 percent of the total referrals
20 have gone somewhere else.

21 Q: And how do you know that?

22 A: Because as I said, I used to track all the
23 numbers from different practices and different
24 physicians on a monthly basis.

25 Q: So your office maintains ---

1 A: Absolutely, yes.

2 Q: Okay. And what have been the effects of these
3 reductions in referrals on Carolinas
4 Cardiology? What difference has it made to the
5 operation of your practice?

6 A: I think it is a very significant negative
7 impact in my practice as far as the operation
8 goes. We are not growing. We are not able to
9 buy new equipments or update our equipments in
10 our practice. We had to curtail our staff.
11 The number of staff in our practice. There is
12 a significant financial impact on our practice
13 going forward.

14 Q: All right. Now, what was your relationship
15 with the Carolinas and I'll refer to it as CHS
16 since your practice is Carolinas too. So the
17 record will be clear, what was the relationship
18 that your group had with the CHS physicians in
19 York County prior to the reduction in
20 referrals?

21 A: I was making collegial relationship with the
22 primary care physician base and all of this
23 provided newer technologies and discussions, we
24 shared some of our data and enjoyed each of
25 those professional relationships the last

1 several years since I have joined them.

2 Q: Prior to the loss of the referrals that you had
3 been receiving, was there any dispute they had
4 with any of the Carolinas physicians of any
5 nature that might have provoked the change in
6 referrals?

7 A: No, we had not changed our pattern, our way of
8 providing the care so far. Including the best
9 care to their patients, keeping them abreast of
10 what's going on with their patients, so I don't
11 see that we have changed our pattern of how to
12 deal with primary care physicians.

13 Q: Did you receive any communications -- without
14 testifying about any communications -- did you
15 receive any communications formally from
16 Carolinas notifying you of the change in its
17 referral pattern?

18 A: As a philosophy or a group practice, we meet
19 with primary care physicians on a regular
20 basis. And we still meet with primary care
21 physicians on a regular basis and something has
22 changed to refer us the patients.

23 Q: Okay. Now, let's focus on the hospital itself
24 where you and your partners perform procedures.
25 Describe the scope of services that you and

1 other members of Carolinas Cardiology perform
2 for your patients at Piedmont Medical Center.
3 What do they involve?
4 A: Well, we perform both diagnostic and
5 therapeutic procedures. Primarily at Piedmont
6 Medical Center. Patients, as I said earlier,
7 I've been to different hospitals as a
8 clinician, as a cardiologist. I've been
9 practicing cardiology for over 22 years. I've
10 been on the faculty at University of Pittsburgh
11 Medical Center in Pittsburgh, Pennsylvania.
12 I've been to a couple of other hospitals in the
13 Pittsburgh area and when I moved down south
14 I've been to all the hospitals you can name, we
15 just named earlier Carolina Medical Center,
16 Spring, Piedmont, so I've been having that kind
17 of blend in my experience of 22 years, so I can
18 compare from a patient service point of view,
19 satisfaction point of view how this business
20 works. And even though we are providing the
21 same care, what I would provide any other place
22 in the country or perhaps in the world and we
23 are seeing the significant impact, of course,
24 the financial impact, I should not be concerned
25 as a physician why there is a financial impact,

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1 but as a physician to provide the patient care
2 that is the time to be providing the good care
3 for my patients. If they need my help and
4 there is no significant resources available by
5 the institution where I am doing 90 percent of
6 my business, then going forward, I think that
7 would be compromising my patient care.

8 Q: And how would you be compromising your patient
9 care?

10 A: We as a cardiologist, especially interventional
11 cardiologist who does the therapeutic
12 procedures, are on call 24/7. We have one
13 doctor on call seven days a week. And what I
14 can see when a patient comes in with a heart
15 attack, I'm just giving an example, the time is
16 of the essence. Time is critical. That
17 patient needs to be treated in a very timely
18 fashion. As a cardiologist, as an
19 interventional cardiologist, the most
20 gratifying satisfaction that I get from a
21 patient point of view, when a patient comes in
22 and they need my help with a heart attack and
23 I open up their artery to their heart in a
24 timely fashion, it's one of the most rewarding
25 experiences for a cardiologist and for a

1 patient. Improving the patient care -- not
2 their well-being but you are improving their
3 life. And that all depends on how timely
4 fashion you provide the care.

5 Q: All right.

6 A: Yes, sir.

7 Q: How does, based on your experience, the various
8 facilities where you practice, how does the
9 quality of care at Piedmont for cardiac
10 patients compare to what you've experienced at
11 other facilities?

12 A: From my experience being active staff at the
13 various hospitals across the country, I don't
14 see any difference in providing the cardiac
15 care that Piedmont Medical Center -- as a
16 matter of fact, when we talked about the time
17 when the patient comes into the emergency room
18 with a heart attack, and opening of the artery,
19 the Piedmont Medical Center data was from the
20 top, the best data in the country. The time
21 when the patient comes into the emergency room,
22 the time the patient gets the balloon therapy
23 or the standard therapy procedure. We were the
24 top in the country.

25 Q: What's the term that's used for that, the

1 measurement of that time?

2 A: The term they use in our field is door-to-
3 balloon time. Door of the ER to the balloon
4 time, the patient gets the care.

5 Q: The balloon refers to the angioplasty? The
6 therapeutic procedure?

7 A: Yes.

8 Q: All right. And what year was Piedmont
9 recognized for providing exceptionally high
10 quality door-to-balloon time?

11 A: 2006 to 2007, I think.

12 Q: Okay. Are you aware of the 2012 award that
13 Piedmont received as the DHEC -- as best
14 hospital in the state?

15 A: Yes, by the American Heart Association and
16 American Stroke Association have awarded
17 Piedmont as the best hospital for 2012.

18 Q: Have you yourself received services at
19 Piedmont?

20 A: Yes.

21 Q: And why did you do that?

22 A: My son, my third son was born at Piedmont
23 Medical Center and is doing fine. So I know
24 that the last four years things have went well.
25 Myself had a heart catheterization at Piedmont.

1 Even though I was staff at different hospitals.

2 Q: And you chose ---

3 A: It's the competence, the quality that we
4 provide, my partners, my colleagues provide at
5 Piedmont Medical Center.

6 Q: Dr. Singhi, can the quality of a cardiac
7 program be effected by the volume of the
8 procedures that a hospital performs?

9 A: I have no doubts about that. The reason being,
10 there is a national guidelines by the American
11 College of Cardiology that any interventionist
12 who performs a procedure, therapeutic
13 procedure, needs to maintain a certain numbers
14 of those procedures in order to provide the
15 good care to patients. And those number for
16 balloon angioplasty, 50 angioplasties per year
17 per physician. Also the hospital -- the cath
18 lab, who provides this therapeutic procedure,
19 they have to have 300 procedures per year.
20 Same with the open heart surgery program. They
21 have to perform 200 procedures per year in
22 order to maintain the credentialing skills for
23 your patients.

24 Q: What's the purpose of these thresholds?

25 A: The purpose has been well-studied by the large

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1 organizations including ACC, American College
2 of Cardiology and American Heart Association,
3 in order to minimize the complications on this
4 life-threatening condition when a patient comes
5 in, you have to maintain your skill by having
6 certain numbers of successful procedures.

7 Q: All right. Now, with regard to your group, the
8 cardiologists at Carolinas Cardiology, do you
9 know in 2010 or '09 what the average number of
10 therapeutic procedures per cardiologist who
11 were doing that work was?

12 A: Yes, we have six interventional cardiologists,
13 each of us performing over 80 therapeutic
14 procedures per year.

15 Q: How many were you doing this past year? Per
16 cardiologist?

17 A: Two of my partners did not make over 50 last
18 year. Per year, year 2012.

19 Q: And the average?

20 A: The average 55 procedures a year.

21 Q: Okay.

22 A: Per physician.

23 Q: Let's move to the issue of your expressing your
24 support for Piedmont Medical Center in this
25 application process. During the Department's

1 review in 2010, did you provide a letter of
2 support for Piedmont?

3 A: Yes.

4 Q: Why did you do that?

5 A: Piedmont is where I have the most experience
6 with my patients. I live in York County, I
7 practice in York County. My office is in York
8 County. And I see the quality of care that I
9 provide through the Piedmont Medical Center as
10 impeccable out of any other hospital that I
11 have been on staff across the country.

12 Q: All right. Did you always support Piedmont
13 through this process? Did you write a letter
14 supporting anyone else?

15 A: Yes, I did support Presbyterian's system
16 initially. I believe it was back in 2005.

17 Q: All right. Why did you do that?

18 A: Because the administration from the one
19 hospital I visit more frequently than the
20 Piedmont Medical Center. And me, as a
21 physician, did not want anybody to take us for
22 granted. We just wanted to make sure we are
23 making the right decision for our patients in
24 York County.

25 Q: Okay. You've obviously changed your mind if

1 you're here today. Why did you do that?

2 A: After meeting with the administration from the
3 one and from Piedmont Medical Center, we felt
4 that our patients would be served better by
5 staying here in York County, especially we have
6 all the help available from local hospital.
7 Our concern at the time was the western of York
8 County. Where, where a patient did not have
9 24/7 service and Novant System came out and
10 they said we'll offer proactive resources to
11 the western part of York County.

12 Q: Now, what sort of services do you mean?

13 A: Urgent Care services.

14 Q: Okay. Physician medical services?

15 A: Physician medical services.

16 Q: Has there been anything from 2005 through 2010
17 concerning the -- what you observed as a
18 dynamic in the medical field within York County
19 that affected your decision to switch your
20 support to Piedmont?

21 A: Piedmont committed more support to the York
22 County patients. Especially in the western
23 part of York County. They provided more
24 primary care physicians where there was an
25 under supply of primary care physicians. The

- 1 commitment to update some parts of the hospital
2 and buy and update some of the equipment that
3 is used to care for some of the patients with
4 cardiac conditions. They promised to provide
5 more resources for the patient.
- 6 Q: Okay. What have been your observations over
7 the last seven years concerning the physician
8 base networks operating in York County?
- 9 A: Overall, it's not a good thing for my group
10 because there we're still maintaining our
11 independent group and the system gets bought up
12 by the big organizations, the polarization
13 happens. Some patients are asked to leave the
14 county and get healthcare services somewhere
15 else, outside of York County and that's what's
16 been happening the last six years.
- 17 Q: Okay. Now, let's actually, let me pull up an
18 Exhibit and ask you to talk about your
19 experience related to it. Dan, if you'll pull
20 up Exhibit 108, please. I know the document
21 there is a little hard to see, Dr. Singhi, but
22 do you recognize this?
- 23 A: Yes.
- 24 Q: What do you recall it being?
- 25 A: It needs to be focused a little bit more. Even

1 for a practicing cardiologist.

2 Q: All right. Let's highlight the left hand.

3 A: Okay. That's better now. Okay. That's
4 better, thank you.

5 Q: Okay.

6 A: That's good. Now, we have the data here, the
7 product line for various departments from 2005
8 to 2011. Yes.

9 Q: And have you reviewed this document concerning
10 the changes in the volume of shared services
11 performed at Piedmont and by Carolinas
12 concerning the various fields of cardiac
13 medicine in which you're involved?

14 A: Let me speak for my department, cardiovascular
15 medicine and cath/EP procedures and compared to
16 CHS-Charlotte and at Piedmont Medical Center
17 you can see that in the year 2005 ---

18 Q: Let me interrupt you by making this a little
19 easier for you. Let's pull up Demonstrative
20 180-03, Dan. And you can -- we have the data
21 presented here about what you are referring to.

22 A: Thank you.

23 Q: Does this make it a little easier?

24 A: Yes. If you look at this graph from 2005 to
25 2011, cardiovascular medicine journal, the

1 market share between CMC and Piedmont Medical
2 Center, as you can see on the right hand, PMC
3 had 67 percent of market share in county
4 vascular medicine and now in year 2012, it's
5 dropped significantly. Down to 43 percent.
6 And CMC, from 15 percent to 29 percent, or
7 double in size of market share.

8 Q: Now, in the -- what are the cardiovascular
9 medicine services consist of?

10 A: That includes the patient with cardiovascular
11 symptoms, admissions, consults, referrals to
12 the hospital.

13 Q: Okay. And let's look at, take a look at the
14 next line or the next graph. I'm sorry, 180-
15 02. The prior one. Let's take a look at what
16 this service, open heart surgery involves. And
17 let me begin, Dr. Singhi, by asking you about
18 -- you don't perform open heart surgery, do
19 you?

20 A: I don't.

21 Q: All right. Do you have any relationship in the
22 volume of the open heart surgery services
23 performed at Piedmont?

24 A: Yes. As like any place else, the cardiologists
25 are the ones who get the referrals or provide

1 the referrals to heart surgeons. And at
2 Piedmont, we as a cardiologist provide the
3 patient for the cardiovascular surgeon to
4 perform surgeries.

5 Q: Okay. And from beginning in 2009, what is
6 reflected on this Demonstrative?

7 A: Yeah, I think what I see is a steady decline in
8 the open heart surgery market share for PMC and
9 the steady increase especially from 2009 is a
10 steady increase in market share for CMC.

11 Q: And what relationship does this reduction in
12 open heart surgery services have to the -- your
13 reduction in your practice of new referrals and
14 new patients?

15 A: I think it reflects that when we get less
16 referrals, then there will be less procedures
17 and reflect less open heart surgery referrals
18 for the surgeon or for the institution and the
19 changes in the economics in York County from
20 primary care patient base and I believe,
21 therefore there's a significant decline in open
22 heart surgery in York County at Piedmont
23 Medical Center.

24 Q: Okay. All right. Let's look at the next
25 chart, related to the changes concerning

1 complex cath and EP procedures. Sorry, Dan,
2 that's 179.02. Let's go to complex. All
3 right. And explain what this diagram shows,
4 Dr. Singhi.

5 A: That is complex procedure or complex patients
6 who have multiple co-morbid condition. They
7 have a acuity for illness. The 2005, as you
8 can see on this graph, the Piedmont was over 75
9 percent procedures were done on this complex
10 patient. There is a steady decline from 2005
11 to 2011 from 75 percent down to 42 percent.
12 Significant drop in the market share for
13 Piedmont. On the contrary, CMC has a steady
14 rise in their market share for complex
15 procedures.

16 Q: All right. Now, when there is such a change as
17 reflected here, the loss of nearly half of the
18 services performed in the cath lab between 2005
19 and 2011, what effect has it had on the
20 delivery of those services and on the personnel
21 who deliver those services in Piedmont?

22 A: In my opinion, there's a significant ??? part
23 on the finances and on patient care. I know
24 it's very hard to appreciate it, but being a
25 practitioner for over 20 years, I can just walk

1 you through how the different financial impact
2 can lead to the quality of the patient care.

3 Q: Well, what's the relationship -

4 **MR. GASKINS:** Your Honor, I'm going to object. Dr.
5 Singhi has not testified and no foundation has
6 been laid that he has any knowledge about the
7 financials of the Piedmont Medical Center.
8 He's here to testify about his practice.

9 **THE COURT:** Okay. Mr. Andrews?

10 **MR. ANDREWS:** Fair enough. I think where he was
11 going not so much the financial analysis of
12 Piedmont, but I'll provide a little more
13 direction to the question.

14 **THE COURT:** Thank you.

15 Q: Dr. Singhi and, I'm sorry, my question may have
16 implied my interest in your observations about
17 Piedmont's financials. But instead, what I'd
18 like you to comment on is what you've observed
19 in the operations of the heart center at
20 Piedmont and the operations of the staff and
21 the technicians concerning the services
22 reflected here. Can you do that?

23 A: Well, you have highly skilled physicians but in
24 order to have a completely successful team to
25 perform procedures, especially the therapeutic

1 procedures in the cath lab, we need highly
2 skilled, experienced and trained personnel,
3 especially technicians. A technician can make
4 life pleasurable or miserable.

5 Q: I experience that everyday with Mr. Bupp.

6 A: We also have to make sure we continue to retain
7 those highly skilled technicians in my cath lab
8 for the better patient care, not better
9 physician outcome. And what I see the last
10 five years, I hate to say that by the way, in
11 this economy one of the most thriving business
12 was the healthcare industry up until now. But
13 there's a significant impact in our cath lab
14 when there is less procedures in the cath lab.
15 The skilled trained employees, they ask to
16 leave earlier than they're supposed to leave.
17 They're not getting eight hours a day of their
18 work or 40 hours a week and what's happening to
19 -- direct impact on us, on physicians and
20 patient care, those experienced techs are
21 leaving the county and looking for jobs
22 somewhere else. And that's where the biggest
23 change that we have because we deal with the
24 very complex patient. It's a question of life
25 and death and if I don't get skilled technician

1 on a regular basis, I think in the future or
2 now it will compromise the patient care, which
3 has not happened, but I'm afraid that it may
4 lead to compromising the patient care. With
5 very sick patients coming to the emergency
6 room.

7 Q: Let's take a look at Demonstrative 177. That
8 looks instead of the market share being
9 extracted from Exhibit 108, the change in
10 volumes and look at the second line if you
11 would, and then the last line. Do you see that
12 reduction in inpatient volume?

13 A: Yes, what I've been experiencing, there's a
14 significant loss in inpatient volume,
15 especially for cath and EP services, over 50
16 percent loss over the period of six years. And
17 last but not least, overall the cardiovascular
18 medicine is over 25 percent loss in inpatient.

19 Q: Okay. And let's talk about your days in the
20 cath lab. What time would you begin providing
21 services?

22 A: The shift starts at seven o'clock in the
23 morning.

24 Q: And how about the techs? When do they start?

25 A: Supposed to be 6:30 in the morning.

1 Q: Okay. And with the -- how has the reduction in
2 volume effected the length of the time in which
3 you and the techs and the nurses are busy in
4 those cath labs?

5 A: Let me just take you back. Before 2005, we
6 used to have a tech doing overtime, working in
7 the cath lab sometimes more than 40 hours a
8 week. Now, in 2010, '11 and '12, our employees
9 would be lucky to get 40 hours a week in the
10 cath lab. And I can see their frustrations, by
11 the way. I can see their disparity in how this
12 hospital has gone down as far as the procedures
13 volume and new patients.

14 Q: What effect does that have on the morale you've
15 observed with the staff?

16 A: Let me take a pause and think about that.
17 Absolutely, they're demoralized. They're
18 demoralized. They're not getting enough hours
19 and some of them are single parents. Some of
20 their spouses used to work in the Charlotte
21 area for financial institutions in downtown.
22 With this financial market although Charlotte
23 was number two in the country after New York
24 for the financial capital, business. Some
25 spouses lost a job. They were dependent on --

1 the guy was working in the cath lab and now he
2 or she does not get 40 hours a week. It is
3 pretty detrimental for the family.

4 Q: Okay. All right. Now, let's move to talk
5 about what would happen if a Fort Mill hospital
6 was built and by whom. If Piedmont were
7 approved to establish a satellite hospital in
8 Fort Mill, would you have privileges there and
9 admit your patients there?

10 A: I probably get privileges there.

11 Q: Why would you do that?

12 A: Because my patient base is in York County. We
13 have a significant number of patients being
14 served from surrounding areas and perhaps
15 building a new facility, there will be a
16 reduction in out-migration of the patients
17 across the state lines.

18 Q: Why do you believe that would be true?

19 A: Newer hospital, perhaps more resources, better
20 outlook, new system and I'm sure the patients
21 would try to go there.

22 Q: Now, if Carolinas were approved to build it's
23 hospital in Fort Mill, would you expect to get
24 privileges there?

25 A: Probably I would get privileges.

1 Q: Why would you do that?

2 A: The reason for me to get privileges at newer
3 hospital, CHS, would be to maintain the
4 continuity of my patient care. Because some of
5 my patients would be admitted over there by
6 primary care physicians or by ER physicians.
7 To maintain the continuity of patient care, I
8 would like to be on staff at the new hospital.

9 Q: What do you mean by the continuity of patient
10 care?

11 A: It's a physician/patient relationship. We
12 provide service on not a vertical but a
13 horizontal basis where -- a logical basis where
14 we see the patient, they have problems. We
15 provide not only the preventative care from a
16 cardiology aspect, but we also provide
17 prevention to intervention. And we follow
18 those patients pretty regularly.

19 Q: Okay. During the last seven years, has
20 continuity of your care to your patients and
21 your partner's patients been maintained to meet
22 your standings?

23 A: Before, when I came here we used to get a lot
24 of referrals from primary care physicians 25
25 percent of my referrals of new patients used to

1 come from CHS, now they are owned by CHS
2 physicians with a significant reduction in the
3 newer patients, referrals to our practice and
4 in the last five or six years. We have also
5 observed that some of our existing patients
6 also are being out-migrated to across the state
7 line out of York County to get care where they
8 could get it at York County at Piedmont Medical
9 Center. Not only we have loss of new referrals
10 but we also have loss of mutual patients or
11 existing patients.

12 Q: And what effect does that have on the
13 continuity of care?

14 A: I think that has a significant discontinuity.
15 It can be patient and physician care because
16 now this is all going to be provided to the
17 patient is being duplicated at some of the
18 facilities. It is also dissatisfaction from
19 patients and patient's family side where we
20 find out after we receive some records from
21 some other hospitals.

22 **MR. GASKINS:** Your Honor, I'm going to object. He
23 said he wasn't going to get into what he's
24 heard from patient's family.

25 **MR. ANDREWS:** Right. I'm sorry, Your Honor. Didn't

1 know that was coming.

2 Q: Dr. Singhi, please just talk about your own
3 experience based on review of your own records
4 and observations, not what's communicated by
5 others.

6 A: Okay. We do get records on patients that were
7 admitted to another facility and we know that
8 they were admitted and treated and some of them
9 do come back for the follow-up with us because
10 of the proximity. If they live in York County
11 and they live in the south part of York County
12 or west or east, some of them in the north, we
13 have been providing the care for a number of
14 years that will come back to us to see us.
15 There is a significant drop in the continuity
16 of the patient care. And I personally don't
17 mind the services which are not available at
18 Piedmont Medical Center, they can go anywhere
19 else. We have referred patients to go across
20 the country. We have referred them to a system
21 in Charlotte, the services we do not have here.
22 We refer patients to MUSC. We refer patients
23 to Wake Forest, Mayo Clinic, Duke, different
24 places. What's the best for the patient,
25 that's what I'm here for.

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1 Q: Okay. All right. Now, if CHS were able to
2 build its facility in Fort Mill, do you have
3 any concerns about whether patients would be
4 shifted from Piedmont to that facility or to
5 North Carolina-affiliated facilities?

6 A: So far what we have experienced with objective
7 evidence is that when the patient goes to a
8 different system run by outside of York County,
9 outside the state of South Carolina, most of
10 the patients are being asked or end up getting
11 the services different places although the
12 services are available in our area, in York
13 County. We have to respect patients. They're
14 not doctors. One doctor tells them that you
15 need the services. It's hard for our patient
16 to understand what is the significance of their
17 services. Whether it is available at Piedmont
18 or not available at Piedmont. So within the
19 patient/physician relationship, they've been
20 asked, they will ask them to go, most of them.

21 Q: Okay. Now, if the Carolinas-Fort Mill facility
22 was built what concerns do you have, if any,
23 about the effect it would have on the Piedmont
24 Medical Center Cardiology staff?

25 A: I think it will have a significant impact on

1 our group going forward. Since we have been
2 seeing significant decline in new referrals and
3 patients, fewer follow-ups in our practice,
4 once that the other system or CHS opens up, I
5 guess permission to open up new hospital in
6 Fort Mill, that will lead to a significant out-
7 migration of our patients in York County and
8 that will lead to significant impact in patient
9 care. From what I see, we have a highly
10 trained cardiologists in our practice. We have
11 seven cardiologists, six interventional
12 cardiologist and one EP specialist. All of us
13 are board certified in at least anywhere from
14 two to five different specialties. They've
15 been trained at different places in the
16 country. Well trained. Once there is a
17 significant impact because of the other system
18 opening up a new hospital in Fort Mill, and
19 there is a significant reduction in new
20 referrals, procedures in my practice as well as
21 in the hospital, I may not be able to keep my
22 partners or colleagues or associates in the
23 practice. Now I will see out-migration of my
24 patients, my practice is going somewhere else
25 because they are not maintaining their skill.

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1 It's like gas tank is in the reserved mode.
2 And when a new system comes in, by knowing the
3 history, the patient will be getting their care
4 outside York County, we will be absolutely out
5 of gas.

6 Q: Now, will Carolina Medical Center's 64-bed
7 hospital at Fort Mill provide cardiac
8 catheterization services or other complex
9 cardiac services?

10 A: No, as far as I know, no. That's not the plan
11 for the new hospital to provide cardiac cath or
12 any EP-related procedures.

13 Q: Where would the Carolinas related procedures,
14 cardiac procedures be performed? What facility
15 would perform?

16 A: Most likely CMC-Pineville or CMC-Charlotte, the
17 main hospital. And that's what they do, by the
18 way.

19 Q: Now, if CMC-Fort Mill were approved what effect
20 would it have on your practice's consideration
21 as to whether to maintain its independent
22 status?

23 A: It would be very hard for us going forward if
24 the hospital is approved to any other system
25 but Piedmont Medical Center. The reason being

1 that we would not be able to maintain our
2 independent status.

3 Q: Why do you believe that might be true?

4 A: Financially it would be very difficult to
5 maintain and provide the resources for my
6 physicians and staff at Carolina Cardiac
7 Associates.

8 Q: Now, have you ever had any conversations
9 previously with Carolinas or Presbyterian or
10 maybe CHS or Presbyterian or maybe Piedmont
11 about being employed by those systems?

12 A: Being an independent group, yes, we have had
13 from time to time conversations with the CHS,
14 Novant and Tenet. All three systems.

15 Q: And you're still independent today?

16 A: We are still maintaining our independent
17 status.

18 Q: And if Carolinas were approved to build the
19 Fort Mill hospital, would you and your group
20 consider being employed by them?

21 A: That's always a possibility.

22 Q: If you were to become employed by them based on
23 what you know, what you've observed, would you
24 continue to provide services at Piedmont?

25 A: Yes, I will continue to provide services at

1 Piedmont, but I don't know, I cannot guess how
2 much our involvement would be because once we
3 lose our autonomy, flexibility, then it gets
4 out of our hands.

5 Q: Now, your major competitor in York County for
6 a cardiology group is who?

7 A: We have -- just to give you background, we have
8 four cardiology groups in York County.
9 Carolina Cardiology Associates, Sanger Heart
10 and Vascular Institute, Carolina Heart
11 Speciality and Palmetto Cardiology.

12 Q: And your practice is seven. What's the size of
13 Singer

14 A: Sanger in York County, they have five
15 physicians.

16 Q: And are the other practices, what sizes are
17 they?

18 A: CHS has currently one cardiologist and Palmetto
19 has two cardiologists.

20 Q: So, Sanger and you are the largest practices by
21 far in York County, is that right?

22 A: Yes.

23 Q: All right. And did Sanger used to practice at
24 Piedmont?

25 A: Yes.

1 Q: Did they used to perform services at Piedmont?

2 A: Yes.

3 Q: Are they today on the medical staff at
4 Piedmont?

5 A: No.

6 Q: Have they resigned their privileges to your
7 knowledge?

8 A: Yes.

9 Q: When did they do that?

10 A: 2011.

11 Q: Do they perform any services at Piedmont to
12 your knowledge?

13 A: No.

14 Q: What percentage of the remaining services at
15 Piedmont, Dr. Singhi, does your practice
16 provide for the cardiac patients?

17 A: We have provided comprehensive services at
18 Piedmont Medical Center which includes
19 consults, referrals, ER consults, heart
20 attacks, diagnostic procedures and with the
21 cath lab, EP services. Except for heart
22 transplant, we provide all the services,
23 cardiology services, at Piedmont Medical
24 Center.

25 Q: And what percentage of the volume of those

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- 1 services would you estimate that Carolinas
2 Cardiology provides?
- 3 A: Let me just understand the question.
- 4 Q: Sure.
- 5 A: What currently it provides?
- 6 Q: What percentage of the total non-open heart
7 surgery, cardiac care services at Piedmont
8 would you estimate that your practice provides?
- 9 A: Currently we provide 80 percent of services.
- 10 Q: And if you became employed by Piedmont and
11 follow the path of Sanger and resigned your
12 privileges and did not perform any procedures
13 there, what effect do you believe that would
14 have on the operation of Piedmont's cardiology
15 program?
- 16 A: Let me understand that. If I join another
17 group?
- 18 Q: If you joined another group, you become
19 employed by Carolinas ---
- 20 A: Right.
- 21 Q: CHS, what effect do you believe that, and if
22 you were -- if your practice partners resigned
23 their privileges at Piedmont and shifted your
24 business ---
- 25 A: In the least -

1 **MR. GASKINS:** Your Honor, I'm going to object. This
2 is all speculative. There's three or four
3 variables in the hypothetical situation and
4 it's completely speculative.

5 **MR. ANDREWS:** Your Honor, it's not speculative, it's
6 actually following the practice of the major
7 competitor in the area and he's certainly able
8 to cross him on it.

9 **THE COURT:** I 'm going to overrule your objection and
10 let him answer that question.

11 A: The question comes in that even though my least
12 interest is to join any system outside the York
13 County, because I think that will be
14 significant impact on the continuity of my
15 patient care or be and/or the inconvenience for
16 my patient to go somewhere else when someplace
17 is already available in their backyard or at
18 Piedmont Medical Center. But there's a real
19 world. If you join another systems, they
20 expect from you to work in the group to do
21 something for them. And that's what the
22 history in the medical field and the health
23 industry is. So, I'll be -- in my opinion,
24 I'll be limited to do things, what I would like
25 to do in the York County for my patients.

1 Q: And if you were, what effect would that have on
2 Piedmont's cardiology department as you know it
3 today?

4 A: Well, we provide 80 to 90 percent of volume.
5 Not only for the heart catheterization but also
6 for providing for open heart surgery patients.
7 And that will lead to significant reduction
8 because it is already declining, over 50
9 percent in some areas, it will be down 70 to 80
10 percent since we are taking 80 to 90 percent of
11 the cardiology volume at Piedmont Medical
12 Center. And then I can see there is
13 significant reduction in the services and
14 perhaps compromising the quality of patient
15 care, especially patients who comes into the
16 emergency room with heart attacks the time, the
17 door-to-balloon would not be very good.

18 Q: Thank you Dr. Singhi. Answer any questions
19 please that Mr. Gaskins is going to ask you.

20 **DR. SINGHI - CROSS EXAMINATION BY MR. GASKINS:**

21 Q: Good morning, Dr. Singhi.

22 A: Good morning.

23 Q: I believe you testified earlier that you've
24 previously served as the president of the York
25 County Medical Society, is that correct?

- 1 A: Yes.
- 2 Q: And you're currently in negotiations with them
- 3 to become part of their system, right?
- 4 A: No.
- 5 Q: You're not? you're not currently ---
- 6 A: We have not signed any letter of intent. We
- 7 have not signed any contract or confidentiality
- 8 agreement at this point.
- 9 Q: I didn't ask you if you had signed a contract,
- 10 I said are you currently in negotiations?
- 11 A: We're talking. Like any other system across
- 12 the area.
- 13 Q: So, you're currently talking with Piedmont?
- 14 A: Yes, we have. Yes.
- 15 Q: And if you supported Carolinas today, it
- 16 probably wouldn't help those negotiations,
- 17 would it?
- 18 A: I think it would be better.
- 19 Q: You think it would help?
- 20 A: If you have more than one buyers, I would be in
- 21 a better position right now.
- 22 Q: Well, that's not realistic is it, Dr. Singhi?
- 23 A: Not from my patient volume, but we have to just
- 24 mention our infrastructure level.
- 25 Q: Now, you talked earlier about the other

1 A: Okay. Can you rephrase it?

2 Q: Isn't that position consistent with the one you
3 also held in 2006?

4 A: Yes.

5 MR. GASKINS: That's all I have right now, Your
6 Honor.

7 THE COURT: All right. Does the Department have any
8 questions?

9 MS. BIGGERS: No, Your Honor.

10 THE COURT: All right. And re-direct?

11 DR. SINGHI - RE-DIRECT EXAMINATION BY MR. ANDREWS:

12 Q: Dr. Singhi, when you were meeting with
13 Presbyterian officials in 2005 and they were
14 soliciting your support, did they make any
15 promises to you?

16 A: No.

17 Q: Did they make promises about what they would do
18 in York County?

19 A: Yes. For the patient, yes they did.

20 Q: Okay. And did you consider that important?

21 A: Absolutely.

22 Q: Is that a reason for your support?

23 A: Yes.

24 Q: Did they make those promises to others, to your
25 knowledge?

- 1 A: Yes.
- 2 Q: Now, the letters in the Demonstrative that Mr.
- 3 Gaskins just showed to you, they were signed by
- 4 Dr. Shah and Dr. Fleischer and Dr. Robinson was
- 5 on Presbyterian letterhead. Do you know why
- 6 that was the case?
- 7 A: No. That was the first time I saw this letter.
- 8 Q: And do you know personally those three
- 9 physicians? Dr. Shah, of course is your
- 10 partner?
- 11 A: Yes. I also knew Dr. Fleischer. He's ---
- 12 Q: He's passed away?
- 13 A: He's passed away and Dr. Robinson isn't.
- 14 Q: Dr. Robinson related to Dr. Taylor?
- 15 A: They're the same practice, yes.
- 16 Q: Okay. Practice. Dan, do you have, have you
- 17 been able to identify those letters? Now, do
- 18 you know whether Dr. Shah, whether all of these
- 19 physicians had a change of opinion between 2006
- 20 and 2010 concerning which applicants they would
- 21 support?
- 22 A: Yes. All three groups are presently practicing
- 23 independently. And providing admission at
- 24 local hospitals Piedmont Medical Center almost
- 25 100 percent.

1 Q: All right.

2 MR. MULLER: Your Honor, if you will give me just a
3 moment please.

4 Q: And Dan, if you will pull up the Exhibit, is
5 Piedmont Exhibit 66. And let's look at page 65
6 and 66 of that Exhibit. Do you -- what does
7 this document consist of Dr. Singhi?

8 A: I believe this is regarding Certificate of Need
9 and addressed to DHEC.

10 Q: And Dan, if you'll go to the third little
11 paragraph there: As you're probably aware.
12 And this document is in the -- been pre-
13 admitted and in the record as well, Dr. Singhi,
14 will you read this paragraph into the record
15 please?

16 A: Again, it is addressed to the DHEC Chief. As
17 you are probably already aware, a number of
18 practices in the area are owned by Charlotte-
19 based hospitals and as such these practices
20 have been strongly influenced to refer their
21 patients to Charlotte hospitals as part of
22 their Charlotte network. In fact, this has
23 created a concern for the employees as well as
24 the physicians and their families who reside in
25 York County in that they have to travel into

1 the Mecklenburg County for surgery as well as
2 diagnostic testing.

3 Q: All right. And let me -- Dan, turn to the
4 second page of this letter, please. And if
5 you'll look -- if you'll call out the next to
6 the last paragraph. And Dr. Singhi, I'd like
7 you to read this sentence, this paragraph into
8 the record and tell me how it relates to your
9 opinion and those to which of your knowledge
10 your partners.

11 A: The residents of York County have historically
12 had a choice of healthcare providers given the
13 proximity of Charlotte. Before I started my
14 practice here in York County, many of my
15 patients were going to Charlotte for
16 cardiovascular care. To allow the continued
17 migration of Charlotte-based hospital into York
18 County will have an adverse effect on the
19 existing hospital and to their employees and
20 the ability of Piedmont Medical Center to
21 maintain the higher level of investment in the
22 facility and technology. We would like to
23 treat York County residents in York County or
24 at least offer the option.

25 Q: All right. And what occurred between 2005 and

1 2010 that produced this change of position to
2 you that Dr. Shah relates?

3 A: I concur with this statement where my partner
4 has made in this letter to DHEC that we want to
5 provide care in York County on a consistent
6 basis if the options are available and the
7 patient is able to have -- be taken care of
8 locally.

9 Q: Okay. Now, let me, Dr. Fleischer was also one
10 of the signatories of that 2006 letter and
11 let's turn to page 21 in Exhibit 66 and look at
12 his letter from January 29, 2010, to Ms.
13 Brandt. Do you see that this is a letter in
14 support of Piedmont's application?

15 A: Yes.

16 Q: All right. And Dan, call out the second
17 paragraph, please. And take that down through
18 the, highlight if you would, down through the
19 end of the sentence ending at the fifth line.
20 Without member benefits. All right. Dr.
21 Singhi, please read that sentence or those
22 series of sentences into the record.

23 A: These past few years have shown that not only
24 Presbyterian but also Carolina Medical Center
25 by their actions have proven they do not

- 1 support York County. They continually
2 encourage the York County practitioner to refer
3 patients to physicians who practice in their
4 Charlotte-Mecklenburg facilities. The
5 employees as well as physicians and their
6 families work and live in the county must be
7 routed to the Mecklenburg County for surgery
8 and most diagnostic testing or face high
9 deductibles and out-of-network benefits.
- 10 Q: All right. And how does your experience
11 compare to the experience that Dr. Fleischer
12 represented to DHEC?
- 13 A: We have also experienced a similar kind of
14 outlook for our patients.
- 15 Q: And what field of practice did Dr. Fleischer
16 participate in?
- 17 A: Orthopaedic surgeon.
- 18 Q: Okay.
- 19 **THE COURT:** I'm sorry, I didn't understand that.
- 20 A: Orthopaedic surgeon.
- 21 **THE COURT:** Thank you.
- 22 Q: And finally, Dr. Robinson was the third
23 individual to sign that letter. Let's take a
24 letter at the 68, Dan, Exhibit 66. And see
25 that letter? Do you have that in front of you,

1 Dr. Singhi?

2 A: Yes.

3 Q: All right. Pull out the first paragraph if you
4 would, Dan. All right. And just read first
5 four lines please, of that paragraph.

6 A: I'm writing on behalf of Piedmont Medical
7 Center and the CON application in York County.
8 I have served on Piedmont Medical Center
9 medical staff for 29 years including chairman
10 of the board of trustees and the chief of
11 medical staff. I think this qualifies me as a
12 fair judge of the medical hospital climate in
13 York County.

14 Q: And then Dan, drop down to the last paragraph.
15 I'm sorry, the second paragraph and pull out
16 the last four lines beginning with the sentence
17 for years we have tried.

18 A: For years we have tried to bring up the level
19 of care and keep the patients in York County.
20 There is already healthy competition for
21 patients in this area. We do not need more of
22 this as I feel an outside hospital will bring
23 Piedmont Medical Center down to an indigent
24 care center only.

25 Q: Thank you, Dr. Singhi, no further questions.

1 added an EP lab, correct?

2 A: I don't know about the market condition has
3 changed for Piedmont or Tenet, but certainly we
4 were referring a patient for EP services to a
5 different institution and now, since we have
6 the EP specialist they opened up an EP lab at
7 Piedmont.

8 Q: After you and your practice had discussions
9 about going to CMC-Pineville to conduct those
10 procedures?

11 A: Yes.

12 Q: That's all I have.

13 MS. BIGGERS: No questions.

14 MR. ANDREWS: Your Honor, one quick response.

15 DR. SINGHI - RE-DIRECT EXAMINATION BY MR. ANDREWS:

16 Q: Dr. Singhi, do you believe that the services
17 provided at CMC-Pineville and the cardiac
18 services provided in downtown Charlotte affect
19 the competitive environment in York County?

20 A: Yes, that is a significant impact.

21 Q: And currently is there competition in York
22 County?

23 A: Yes.

24 Q: Thank you, no further questions.

25 THE COURT: Anything Mr. Gaskins?

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1 Q: And so the centerpiece of your long-term plan
2 is presence in the northern part of York County
3 is important to you, correct?

4 A: Yes.

5 Q: To prevent out-migration to North Carolina,
6 correct?

7 A: Correct.

8 Q: To strengthen the services to York County
9 residents, I assume you mean to all York County
10 residents?

11 A: Yes.

12 Q: To expand the scope of Fort Mill area services
13 we need to expand services in the Fort Mill
14 area and that part of York County?

15 A: Yes.

16 Q: And then publication of need in the 2004-2005
17 in the State Health Plan?

18 A: Correct.

19 Q: Okay. Dan, if you'll pull up Demonstrative 90.
20 And this is the chronology of how things went.
21 In November of 2004, and we were trying to
22 remember, were you involved in filing the
23 initial November 2004 64-bed plan?

24 A: Yes.

25 Q: Okay. And that was -- the applicant in that

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RECORD 000906

1 case was sort of a sole purpose LLC in South
2 Carolina?
3 A: Correct.
4 Q: And was the decision made to withdraw that and
5 re-file it under the name of Amisub?
6 A: Yes.
7 Q: And that is what resulted in the January 2005
8 application?
9 A: Correct.
10 Q: All right. And so before filing the January
11 2005 application what I understand from your
12 testimony is you met with Joel Grice?
13 A: Yes.
14 Q: And you met with him specifically for the
15 purpose of determining how to best file the
16 application for those 64 beds, is that correct?
17 A: I wouldn't say how to best, it was to get
18 feedback from what we thought was the best way
19 to file the application.
20 Q: And his feedback, I assume, was positive?
21 A: He thought the approach we were taking as a
22 positive one, yes.
23 Q: Okay. And then, you have here April 2005 the
24 other applicants filed a competing application.
25 It was actually March of 2005, wasn't it?

- 1 A: It may have been.
- 2 Q: Okay. And so the other applicants filed
3 applications and then did you meet again with
4 Mr. Grice before filing the 100-bed
5 application?
- 6 A: I don't recall. I may have. I'm certain I
7 talked to him on the phone, I'm sure, at least.
- 8 Q: Well, the reason I remember it is because I
9 believe there was an affidavit in the prior
10 case where Mr. Andrews mentioned that, I
11 thought was you and he met with Mr. Grice to
12 make sure that if you withdrew the 64 bed and
13 filed the 100 bed you wouldn't lose your place
14 in line, so to speak.
- 15 A: I don't recall that, but that wouldn't surprise
16 me.
- 17 Q: Okay. So you think you probably met with him
18 before filing the 100-bed application?
- 19 A: Yes.
- 20 Q: All right. Let's take a look at the -- and I'm
21 going to skip -- I assume the November 2004 and
22 January 2005 applications were substantially
23 identical?
- 24 A: I believe the only difference was the new legal
25 applicant.

1 of that page for me. Okay. Fort Mill Medical
2 Center will primarily serve the residents of
3 four zip codes within northeast York County,
4 29708, which is Tega Cay; 29705 which is Fort
5 Mill; 29730, which is not northeast York County
6 as far as I can tell and 29732 which is greater
7 Rock Hill.

8 A: 30 and 32 are Rock Hill and they're in the
9 northeast side of the county.

10 Q: Well, 29730 goes all the way down to the
11 southern county line, does it not?

12 A: It does. But it also goes all the way to the
13 easternmost edge of the county.

14 Q: And what happened to Clover?

15 A: Clover was moved to the secondary service area.

16 Q: And the secondary service area at this point
17 became all of western York County?

18 A: The remainder of York County and there's one
19 zip code at the bottom portion.

20 Q: Okay. Now, in terms of this 100-bed plan
21 versus this 64 bed plan, did Mr. Grice ever
22 tell you that 100 beds was better than 64 beds?

23 A: Yeah, we talked about the benefits of 100 bed
24 facility, yes.

25 Q: And did you feel that 100 beds was better than

1 64 beds?

2 A: He felt it was better to build them early.
3 That the economies of scale we talked about
4 were positive and the need in the area was
5 substantial.

6 Q: Was there any other applicant other than
7 Piedmont Medical Center that could transfer
8 beds in order to build a 100-bed facility?

9 A: That applied?

10 Q: Yes, that applied.

11 A: None of them applied. There were those that
12 could have done it, but they didn't apply.

13 Q: Well, I'm just curious, who would those
14 providers have been that could have transferred
15 beds in York County?

16 A: Well, Springs could have applied to move beds
17 to York County.

18 Q: Well, Springs is not in York County, it's in
19 Lancaster County.

20 A: Correct. But they can move to York County.

21 Q: How about the three applicants that applied?
22 Presbyterian, Carolinas, HPA? Could any of
23 them transfer beds and make a 100-bed
24 application here?

25 A: I don't know. I suppose if they had a

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RECORD 000910

- 1 relationship with a hospital in South Carolina
2 to transfer the beds, they could.
- 3 Q: But none of them could transfer beds within the
4 county because they don't have any beds within
5 the county.
- 6 A: Within the county, no. But from another county
7 is clearly outlined in the Plan, a very
8 discreet method on how to do that.
- 9 Q: But they have to be transferred beds from a
10 South Carolina county, correct?
- 11 A: That would be the assumption, yes.
- 12 Q: Have you ever seen, when you say assumption,
13 have you ever seen a part of the South Carolina
14 State Health Plan that allows them to transfer
15 beds from out of state?
- 16 A: No.
- 17 Q: So you had that, Piedmont had that advantage.
18 They could apply for a transfer of 36 beds to
19 make their application for a larger hospital,
20 is that a fair statement?
- 21 A: Of the applicants, sure. But as I said anyone
22 could get it done. Any existing hospital.
- 23 Q: And that's why you did it? You did it because
24 Mr. Grice told you that was a good idea.
- 25 A: No.

- 1 Q: All right. And these other zip codes which
2 we've been talking about getting so populous,
3 and 29074 is one we mentioned, all of western
4 York County, they only have 199 discharges?
- 5 A: Correct.
- 6 Q: Instead of 1,000?
- 7 A: That would be correct.
- 8 Q: So the application has changed again a third
9 time?
- 10 A: Sure. The market changed. We updated. The
11 same approach, the same methodology with
12 updated information. The population
13 information, updated use rate information,
14 updated projections.
- 15 Q: And I take it your market in western York
16 County is now so deteriorated that you've went
17 from 1,000 discharges to less than 200?
- 18 A: No. The projections went down. Again, because
19 we refined the projections.
- 20 Q: You dropped 800 people from that entire portion
21 of western York County in 29704, which you were
22 tell us was a populous area.
- 23 A: We didn't drop those people, we refined the
24 analysis again. Taking Fort Mill in isolation
25 is a little misleading because it is Fort Mill

1 and Piedmont, so we looked at the redirection
2 from Piedmont, redirected market share, we
3 looked at the redirection from North Carolina
4 and that's how we got to the numbers in the
5 revised figure 17.

6 Q: And it looks like you enjoyed some pretty big
7 market shares in western York County. Now
8 you're shifting those patients back to
9 Piedmont?

10 A: Correct. You pointed out the travel issues and
11 assuming that some patients from that area
12 would be treated at Fort Mill but not to the
13 extent we originally thought.

14 Q: We pointed that out in the last contested case
15 and you changed your application to modify
16 those numbers?

17 A: Not necessarily in correlation with that, but
18 the numbers were updated as instructed by the
19 judge for the remand and we provided them.

20 Q: And so now -- and you say strengthen services
21 to York County residents, which is what this
22 Fort Mill application is supposed to do,
23 there's a pretty big portion of western York
24 County that you're not servicing here at all at
25 Fort Mill.

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1 A: Correct, but it strengthens the services to
2 York County because it strengthens Piedmont
3 Medical Center.

4 Q: So the people of Clover that were one of the
5 three zip codes in the first application are
6 now left out?

7 A: They're not left out.

8 Q: They're just redirected to Piedmont?

9 A: Not redirected, just not redirected from
10 Piedmont..

11 Q: Lynn, would you pull up CHS Exhibit 27? All
12 right. This is the payor mix document that you
13 were looking at yesterday with Mr. Andrews.

14 A: Correct.

15 Q: And this is a physician payor mix, correct?

16 A: Yes.

17 Q: It's not what a hospital payor mix would look
18 like, is it?

19 A: No, but that would be the -- based on your
20 application that would be the source of the
21 patients.

22 Q: Well, according to you, 67.6 of your ED
23 patients get admitted. So, a lot of the
24 patients come in through the emergency room,
25 they don't come in through the door.

1 the hospital for no apparent reason. For
2 allowing CMC to build a hospital there.

3 Q: Well, just so we're clear, does that mean that
4 the hospital can't operate with a profit at
5 51.2 percent?

6 A: No, that's not the test of adverse impact.

7 Q: Well, I don't understand -- I guess what you're
8 saying is at 51.2 percent it's got to cut all
9 these services we talked about in order to make
10 a profit?

11 A: No, I'm saying that's a reduced average daily
12 census. That's the occupancy with the lower
13 averages and that has the impact of taking away
14 that volume. And what I'm saying is, as I said
15 yesterday is if you look at the statute and it
16 says weigh the adverse impact against
17 accessibility. So, while the CMC facility may
18 increase some accessibility, it has a
19 tremendous impact on Piedmont and that
20 outweighs it.

21 Q: Well, does it have an adverse impact if 51.2
22 occupancy that you have to cut all the services
23 that we talked about?

24 A: It could.

25 Q: It could but you don't know whether it will?

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1 A: I'm not the one that cuts the services.

2 Q: Let's talk about -- sort of to close out, your
3 Waccamaw-Georgetown model.

4 A: Yes.

5 Q: That's what you presented to the Court as an
6 example that happens, how you improve the
7 hospital that is there by building a satellite
8 hospital?

9 A: Yes.

10 Q: All right. If we could go -- let's start with
11 Piedmont Exhibit 64 and go to page two. All
12 right. What you did here was you looked at the
13 Georgetown Memorial Hospital would be the
14 equivalent of Piedmont Medical Center in this
15 scenario, correct?

16 A: Similar, yeah.

17 Q: So, in 2002 it was losing money and Waccamaw
18 Community Hospital was built when?

19 A: It opened in 2003.

20 Q: Okay. So it's still losing money and then by
21 the time we get to 2007, is -- 2006 it made
22 some money, 2007 it's losing about \$620,000 a
23 year.

24 A: Correct. Down from almost \$5 million in 2002,
25 \$5 million in 2002, lost \$5 million in 2003 and

1 Muller. Does the Department have any
2 questions?

3 **MS. BIGGERS:** No, I don't have any questions.

4 **THE COURT:** All right. Thank you. Mr. Andrews,
5 sir?

6 **MR. LEVITT - RE-DIRECT EXAMINATION BY MR. ANDREWS:**

7 Q: Dan, let's begin by pulling up Demonstrative
8 192. Mr. Levitt, Mr. Muller asked you about
9 the placement of section 23(b) related to the
10 utilization, staffing and let's title adverse
11 impact provision. Do you see it there on
12 number four?

13 A: Yes.

14 Q: Now, what are these other elements of your
15 analytical framework for evaluating adverse
16 impact?

17 A: Well, 802.22, the distribution across
18 facilities is also under the adverse impact
19 element of reviewing it.

20 Q: And which rank is that?

21 A: Well, it is the second, I believe.

22 Q: Rank two?

23 A: Category two.

24 Q: And the first one was what?

25 A: Compliance with the Plan.

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- 1 Q: Okay. And since -- because of Judge Matthews
2 ruling, the first category ranking was which
3 rank, rank two?
- 4 A: Yes.
- 5 Q: All right. And section 22 is part of that,
6 okay. And how does section 22 related to
7 adverse impact?
- 8 A: Well, it goes on, it talks about the
9 distribution and the effect of that
10 distribution on the existing resources.
- 11 Q: And the healthcare system, doesn't it?
- 12 A: Yes.
- 13 Q: Okay.
- 14 A: To balance the distribution to the target
15 population.
- 16 Q: And what does 3(h) address?
- 17 A: That's the ability to serve medically
18 underserved groups.
- 19 Q: And how does that relate to adverse impact?
- 20 A: Well, to the extent that a provider makes it
21 difficult for an existing provider to serve
22 those groups, it's adverse.
- 23 Q: And number three, where is that?
- 24 A: 16(c), costs and charges.
- 25 Q: And how does that relate to adverse impact?

1 A: That the impact of the proposed project has to
2 be reasonable and what's the impact on the
3 existing providers with similar services.

4 Q: And then you just testified about number four
5 and then let's look at number five. What
6 relationship does that have to the adverse
7 impact analysis?

8 A: Again, the statute states that when determining
9 a CON application that balance of the benefit
10 of improved accessibility needs to be weighed
11 against the effects of duplication.

12 Q: Okay. So, overall, how would you describe the
13 application of the CON Act and the project
14 review criteria to your adverse impact
15 analysis?

16 A: They're all elements of it. That it's not just
17 that one standard identified in the letter that
18 says adverse impacts. All these areas address
19 adverse impact and are considered by DHEC and
20 were, and should have been considered by DHEC
21 when determining their opinion.

22 Q: All right. Now, Mr. Muller also asked you
23 about the average daily census and your review
24 of that. And in particular asked you about Mr.
25 Masterton's testimony concerning the average

1 daily census and I think it was in February of
2 2013. Does the State Health Plan in evaluating
3 bed need, look at seasonal fluctuations or does
4 it look at the average daily census over the
5 year?

6 A: It takes a full year utilization.

7 Q: And why would it not look at any peak period?

8 A: Because that wouldn't be representative of the
9 utilization for the year.

10 Q: And are there allowances made for taking into
11 consideration those times where there is a
12 seasonal peak that's hit?

13 A: Yes.

14 Q: How is that done?

15 A: They're allowed to justify additional bed need
16 in the bed needs section if you can demonstrate
17 seasonality and fluctuations associated with
18 that seasonality.

19 Q: At what point does an addition does the bed
20 need analysis assume that a hospital would be
21 at the basis of adding beds? What percentage
22 of ---

23 A: Adding beds, 65 percent is the --, for smaller
24 hospitals.

25 Q: Okay. And what's the purpose of establishing

1 the threshold at that level?

2 A: That's where the state had determined there's
3 a need for additional beds.

4 Q: And the beds exceeding that level, would they
5 be available to address seasonal fluctuations?

6 A: Yes.

7 Q: Okay. And let's look at Demonstrative 178,
8 please Dan. I think your testimony here was
9 apply the average daily census in 2011 and what
10 did you determine?

11 A: The 182 is the average daily census including
12 psych patients subtracted from the 288, those
13 beds include psych patients, 106 available
14 beds.

15 Q: And if there were any seasonal fluctuations in
16 a flu season in January or February, how would
17 those patients be served?

18 A: In those 106 available beds.

19 Q: Okay. And if 36 beds were relocated would
20 there be sufficient beds available?

21 A: There would still be 70 available beds.

22 Q: Okay. Now, if the 36 beds were transferred,
23 would you have an opinion about the effect or
24 that on the average daily census if the beds
25 were transferred to the new Fort Mill Medical

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1 Center?

2 A: Yes. In addition to the beds being relocated,
3 some of the patients are going to be relocated.
4 Those patients that have historically gone to
5 Piedmont would then go to Fort Mill. So, the
6 census would be lower at Piedmont.

7 Q: Okay. Now, Mr. Muller also drew out some of
8 the Piedmont Exhibits and identified a change
9 in net income, I think after taxes, at Piedmont
10 of \$16 million and \$9 million in those two
11 years. Is that right?

12 A: I know 16, 10, I think.

13 Q: Sixteen and ten, okay. And have you looked at
14 the comparable net income for that same period
15 of time for the Carolinas facilities?

16 A: I have.

17 Q: Okay. And in general terms, how do they
18 compare?

19 A: A lot higher. Carolinas made substantially
20 more in this time period, so \$20, \$30 million.

21 Q: Okay. And let's actually take a look, Dan, at
22 Demonstrative 212. And this data is included
23 in Exhibits that have already been admitted
24 into evidence as Piedmont Exhibit 75A and B,
25 76, 77, 78 all of which included A and B, A

- 1 being 2010 cost reports and B being the 2011.
2 Have you reviewed these Exhibits, Mr. Levitt?
- 3 A: Yes. Uh-huh (affirmative response). I created
4 these.
- 5 Q: And they are what, cost reports?
- 6 A: Medicaid cost reports.
- 7 Q: And what does it reflect?
- 8 A: Well, it shows CMC-Main made \$240 million in
9 2010, \$96 million in 2011. CMC-Union, \$17
10 million and \$15 million, 2010 and 2011. CMC-
11 University for 2010 and 2011, \$40 million and
12 \$38 million and CMC-Mercy for 2010 and 2011,
13 \$120 million and \$98 million. So,
14 substantially more than the \$10 million and \$16
15 million at Piedmont.
- 16 Q: Now, are these net income figures for a non-
17 profit system, a public system or a for-profit
18 system? What relationship do they have to the
19 ability of these hospitals to be successful?
- 20 A: Well, they all, I mean basically the net income
21 is what drives operations.
- 22 Q: What's the relationship between operations
23 going forward and the net income in a given
24 period of time?
- 25 A: It feeds it. You have to have positive net

1 income to -

2 **MR. MULLER:** Your Honor, we object to this line of
3 testimony because this expert has not been
4 offered as a healthcare finance expert which
5 apparently he has now gone into that realm.
6 He's now apparently giving us accounting terms
7 and financial terms. He's not been qualified
8 to do that. Obviously, I did not object to him
9 talking about net income because I asked him
10 the same question. He's now gone a step beyond
11 that.

12 **MR. ANDREWS:** Your Honor, first of all, I'd be happy
13 to lay a little bit of foundation for this. I
14 don't think it's necessary when we qualified
15 Mr. Levitt, you might recall that one of the
16 areas that he specifically testified about in
17 his resume in the second major category
18 describing his experience is the extent to
19 which he has provided financial forecasting and
20 financial advice to literally scores of
21 hospitals throughout the Southeast and it is an
22 inherent component of healthcare planning.

23 **MR. MULLER:** And my objection, Your Honor, is he
24 wasn't qualified that way to start and it is
25 inappropriate to try to do it now on re-direct.

1 If you feel inclined to qualify him in that
2 way, I should be allowed to challenge his
3 qualifications in terms of healthcare finance.

4 **MR. ANDREWS:** Your Honor, let me be a little more
5 precise about the nature of this. It's
6 perfectly consistent, frankly, with testimony
7 that's been offered by several witnesses which
8 is how revenue affects operations of a
9 hospital. I mean nothing could be more
10 fundamental to healthcare planning than that.
11 This is all about, as much about services and
12 quality and utilization as it is the finances
13 related to that. There's been testimony about
14 financial feasibility, testimony about payor
15 mix, there's been testimony about how the
16 generation of income affects ability to invest
17 in future facilities and that's what we're
18 focusing on. We think that's clearly within
19 the scope of what he's been qualified to
20 testify about.

21 **MR. MULLER:** And I would simply say, Your Honor,
22 that Mr. Andrews objected to my introduction of
23 the evidence of the financial health of Tenet
24 Healthcare. So if this witness is allowed to
25 testify on these issues, I think that Exhibit

1 should be admitted and I think I should be
2 allowed to question him about the financial
3 health of Tenet Healthcare which is a billion
4 dollar corporation.

5 **MR. ANDREWS:** Your Honor, finally, Mr. Muller raised
6 this issue directly asking Mr. Levitt about
7 whether \$16 million and \$9 million would be
8 sufficient to operate the hospital. He
9 introduced this issue. I'm simply responding
10 to it by saying well, in that regard how does
11 this income compare to his client.

12 **MR. MULLER:** And my objection is, Your Honor, he's
13 already done that with Demonstrative 212. And
14 so he doesn't need to go beyond that unless he
15 wants to open the door to Tenet Healthcare and
16 that Exhibit and everything else that goes with
17 it. If he wants to ask this witness questions
18 about profitability of Carolinas Healthcare
19 System, then I should be entitled to go into
20 questions and get Exhibits admitted about the
21 profitability of Tenet Healthcare System which
22 is a counterpart in this CON proceeding.

23 **MR. ANDREWS:** Your Honor, the question and I won't
24 be able at this point to recall precisely -- I
25 know that Alex can read it back to us, but I

1 think back to it, but it had nothing to do with
2 Carolinas specifically. It had to do with how
3 profitability affects the future operations and
4 how it might limit it. And that was the
5 question again, that's a healthcare planning
6 concept and that's what we're -

7 **MR. MULLER:** And, Your Honor, if that's the only
8 question that's going to be asked, to move
9 things on I will withdraw my objection to that
10 question. My objection was related to an
11 extended line of questioning which is where Mr.
12 Andrews looked like he was headed and the
13 aspect of -

14 **THE COURT:** I see what you're saying Mr. Muller, and
15 to that, if that's the purpose, Mr. Andrews,
16 this sort of general nature, let's limit it to
17 that and not go into the specific hospital --
18 I mean other than with the numbers.

19 **MR. ANDREWS:** I'm through with that Demonstrative,
20 Your Honor.

21 **THE COURT:** All right.

22 **MR. ANDREWS:** Thank you.

23 **THE COURT:** Thank you.

24 **Q:** Mr. Levitt, let me see if I can recall that.
25 The question is in comparison with the

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1 Demonstrative evidence you've just reviewed and
2 what you testified to previously concerning
3 Piedmont's profitability, how does the
4 profitability of a hospital affect its future
5 operations?

6 A: Well, for a hospital to be able to fund
7 additional capital expenditures, expand
8 services, continue operations, they have to
9 have a positive net income. And the larger
10 that net income is, the more cash they have
11 available to fund those operations and
12 activities and expand services and provide
13 salaries to staff and things like that. So,
14 it's pretty critical.

15 Q: Thank you. I have nothing further.

16 **THE COURT:** Nothing further of the witness. All
17 right. Thank you, Mr. Andrews. Anything?

18 **MR. MULLER:** Nothing further, Your Honor.

19 **THE COURT:** Anything from DHEC?

20 **MS. BIGGERS:** Nothing further from DHEC.

21 **THE COURT:** All right. So we are finally concluded
22 with Mr. Levitt.

23 **MR. ANDREWS:** We are ready to release Mr. Levitt,
24 Your Honor.

25 **THE COURT:** Mr. Levitt, thank you very much. You

- 1 Q: Good morning, Mr. Miller. Please state your
2 full name and business address for the record.
- 3 A: Yes, Charles Miller. My business address is
4 747 Mendon Hall Court, Fort Mill, South
5 Carolina 29715.
- 6 Q: Mr. Miller, you are currently affiliated with
7 Piedmont Medical Center?
- 8 A: Indirectly. I have a management consulting
9 firm currently and I am under contract with
10 Piedmont Medical Center relative to a
11 contractual matter with York County.
- 12 Q: Are you the former chief executive officer of
13 Piedmont?
- 14 A: That is correct.
- 15 Q: And when did you hold that position?
- 16 A: I held that position from March of 1999 through
17 March of 2013.
- 18 Q: Okay. Have you provided your resume to counsel
19 and has that been made a part of this record?
- 20 A: Yes, sir.
- 21 Q: All right. Now, Your Honor, we have just
22 recently received an update to Mr. Miller's
23 resume and I was under the impression it had
24 been provided to counsel and I was incorrect
25 about that assumption. I just made it

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1 available and if there's no objection, we'd
2 like to substitute it for the one that's in the
3 record.

4 **THE COURT:** Mr. Muller any objection?

5 **MR. MULLER:** No objection.

6 **THE COURT:** All right. Then without objection -

7 **MR. ANDREWS:** Thank you, and I'll hand two up.

8 **THE COURT:** --- okay. The resume will be
9 substituted. This is Petitioner's Trial
10 Exhibit 71.

11 **MR. ANDREWS:** That's correct.

12 **THE COURT:** This is the updated version?

13 **MR. ANDREWS:** That is.

14 **THE COURT:** Thank you very much.

15 **Q:** All right. Mr. Miller, let's work through your
16 resume and begin by starting with your
17 education on page three, if you would please
18 review that for the Court.

19 **A:** Yes, I did my undergraduate work in accounting
20 at Virginia Commonwealth University, graduated
21 there in the year of 1973. Subsequently, I did
22 a master's of business administration at Tulane
23 University in New Orleans; I Completed that in
24 May of 1990.

25 **Q:** And have you been a certified public accountant

1 as well, Mr. Miller?

2 A: Yes. I practiced public accounting, was a CPA
3 in Virginia for about four years.

4 Q: And are you currently licensed as a CPA?

5 A: I am not.

6 Q: All right. And after your stint as a CPA and
7 your education, when did you begin your career
8 working at hospitals?

9 A: In 1976 I was asked to assume a chief financial
10 officer's role at Fauquier Hospital in
11 Warrington, Virginia.

12 Q: Okay. And did you continue to work with
13 hospitals in the Virginia area?

14 A: I did. In 1979 I left that position and joined
15 St. Mary's Hospital in Richmond, Virginia, it
16 is owned by Bon Secours Health System, as their
17 controller.

18 Q: Okay. And let's turn to the second page of
19 your resume and identify the different
20 positions you've had, in general terms, with
21 hospitals before moving to Rock Hill to be CEO
22 of Piedmont.

23 A: Sure. I functioned -- went to New Orleans in
24 1987 and was basically the corporate treasurer,
25 chief financial officer of a hospital that

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1 ultimately merged with a second hospital that
2 ultimately was sold to Tenet in August of 1995
3 and in August 1995 I transitioned from
4 financing operations with Tenet Healthcare and
5 was chief executive officer in one of its
6 facilities in Slidell, Louisiana and then in
7 1998, I transferred up to Rock Hill.

8 Q: And when you first arrived at Piedmont in Rock
9 Hill, what was your position?

10 A: My position was chief operating officer as part
11 of the succession plan for the then CEO who was
12 making plans to transition into another role
13 with the company.

14 Q: Okay. And then you became the CEO in 1999?

15 A: That's correct. March of 1999.

16 Q: All right. And what were the circumstances
17 that led to your departure from Piedmont?

18 A: After 14 years in March, actually in the spring
19 because these conversations took on for awhile,
20 I wanted to look for other opportunities within
21 Tenet, Piedmont is one of the larger facilities
22 within their network. There was an opening in
23 the regional staff in Dallas, Texas, and so in
24 March I relocated to Dallas to be a part of the
25 Southern States Region.

1 Q: Okay. And what was your position and what were
2 your responsibilities generally with the
3 Southern States Region?

4 A: The regional office, sections within Tenet are
5 made up by senior operating officers and chief
6 financial officer, HR person and business
7 development. I was a senior operational staff
8 member who reported to the senior vice
9 president for that region. My responsibilities
10 involved with working with all 13 hospitals
11 within that region. We had hospitals in
12 Georgia, North and South Carolina, Alabama and
13 two in Philadelphia.

14 Q: Okay. And why have you left that position?

15 A: That position along with a number of others in
16 the home office were eliminated in September of
17 this year; we got a new chief operating officer
18 at the corporate level who was kind of
19 beginning to put in place his own
20 organizational structure.

21 Q: Okay. And after leaving -- and how many
22 positions were eliminated when yours was?

23 A: About 70 total.

24 Q: And you testified at the outset you currently
25 have a relationship with Piedmont Medical

1 Center, what's the nature of that?

2 A: As part of my departure, I set up a consulting
3 firm and while I kind of evaluated other
4 options. There was a matter between the
5 hospital and York County that has been pending
6 for awhile, so I contracted with the hospital
7 to continue to negotiate and represent them
8 before York County Council on that matter.

9 Q: Okay. And do you have any plans concerning
10 your future employment?

11 A: Yes. Actually, next Wednesday, April 16th, I
12 will assume the position of chief executive
13 officer of Dallas Regional Medical Center in
14 Mesquite, Texas.

15 Q: Okay. And what hospital system is that
16 facility owned by?

17 A: That's owned by Hospital Management Associates.

18 Q: Okay. All right. With that as your
19 background, Mr. Miller, let's move to the point
20 of discussing your entre into Rock Hill and
21 Piedmont and before we do that, describe for
22 the Court, if you would, the background of
23 Piedmont Medical Center.

24 A: Piedmont Medical Center was acquired by
25 American Medical International in 1980 from

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1 York County. York County owned the local
2 hospital at the time, York General. Part of
3 that transaction involved a commitment by AMI
4 to basically build a replacement hospital which
5 is the Piedmont Medical Center that exists
6 today. And part of that transaction involved
7 not only cash consideration, but a contractual
8 commitment to build a replacement hospital and
9 provide some other services on behalf of the
10 county.

11 Q: And during the period of time following the
12 execution of that contract in 1980, what
13 continuing relationship existed between AMI, as
14 the owner now and operator of the new facility
15 and York County?

16 A: The 1980 agreement basically provided that the
17 hospital would provide ambulance services on
18 behalf of the county. Take care of indigent
19 patients without any cost or remuneration or
20 support from the county. It had some
21 provisions in there about maintaining pricing
22 structures and different things like that. The
23 agreement was subsequently amended five times
24 through that period of time primarily to
25 address some milestone dates relative to the

1 construction of the hospital and bringing it
2 online. The first significant operational
3 change in that agreement occurred in 1995 with
4 the sixth amendment.

5 Q: Okay. Now, with the sixth amendment, were
6 there new services that were required of
7 Piedmont?

8 A: Yes.

9 Q: And have you developed a Demonstrative that
10 identifies those?

11 A: I believe we have.

12 Q: Dan, let's turn to Demonstrative 209, please.
13 And what's presented here related to the sixth
14 addendum of the York County contract?

15 A: The sixth addendum provided that Piedmont
16 Medical Center would develop a heart center
17 which would include the development of an open
18 heart surgery program and expansion of its
19 cardiac catheterization program to maintain at
20 least two rooms. It created a 20-bed dedicated
21 heart unit, an eight-bed critical-care unit for
22 cardiac patients and post-surgical patients as
23 well as a cardiac rehab program. It contained
24 a commitment on the part of the hospital to
25 develop a neurosurgery program. It, for the

1 first time expanded the EMS services to
2 establish benchmarks for response times and the
3 placement of EMS units, how the EMS system
4 would grow with the population of the
5 community, provided for some updating of the
6 radiology technology systems like CT in this
7 case as well as the development and operation
8 of Piedmont West Urgent Care Center to be
9 located on the western side of York County.

10 Q: Okay. Now, when you arrived in 1998, were
11 these services just beginning to come online?

12 A: That's correct. With the exception of the
13 neurosurgery program, that one was still under
14 development in 1998 when I arrived.

15 Q: Okay. And since the time that you arrived,
16 over that 14 year period have there been
17 additional new services that Piedmont's
18 established?

19 A: There are and I've developed a Demonstrative of
20 that.

21 Q: All right. And Dan, let's look at
22 Demonstrative 210 and what's showing here, Mr.
23 Miller?

24 A: These are additional services unrelated to the
25 contract itself. We constructed a Women's

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1 Tower that contained an eight-bed dedicated
2 pediatric unit, dedicated OB/GYN operating
3 rooms, a special -

4 **THE COURT:** Mr. Andrews? Did he say related or
5 unrelated to the contract?

6 **MR. ANDREWS:** Unrelated.

7 **THE COURT:** Unrelated. Thank you.

8 A: These are not contractual obligations.

9 **THE COURT:** Yes, sir. I understand. I just wasn't
10 sure on the un part or not.

11 Q: Thank you. All right. So work through with
12 me, if you would, and what you've done over the
13 period of time to establish new services at
14 Piedmont.

15 A: Sure. The Piedmont special care nursery which
16 included neonatology coverage 24/7. Eight
17 additional critical-care beds. We began a
18 bariatric surgery program.

19 Q: What's bariatric surgery?

20 A: That's a weight loss surgical procedure.

21 Q: And before we're working through this, eight
22 additional critical-care beds were in addition
23 to what?

24 A: They were in addition to the 16 general
25 critical-care beds that were a part of the

1 original structure and in addition to the eight
2 critical-care beds that were dedicated to the
3 heart center bringing our total critical-care
4 bed complement to 32 beds.

5 Q: Okay. And were these located in any one unit
6 throughout the hospital or were they dispersed?

7 A: This particular addition was intended to focus
8 on post-surgical patients and was located in
9 the Core Tower.

10 Q: Okay.

11 A: The 64-slice CT scan was in addition to the 16
12 and was actually brought on board to complement
13 the heart program because you can do some
14 cardiac scoring and different procedures with
15 that as well. We began an infusion therapy
16 center, a lung care center, we added the
17 development of EP services with our
18 cardiologists, pain management center,
19 intensivists in our critical-care units, a
20 full-time pulmonologists who are attending to
21 critical-care patients.

22 Q: Now, are those full-time pulmonologists, were
23 they employees or contractors with the
24 hospital?

25 A: They are employees.

1 Q: Okay.

2 A: As well as we had hospitalists covering both
3 our general acute-care patients and our
4 pediatric service and, again, as employees. We
5 also developed York Family Practice located ---

6 Q: I'm sorry, let me interrupt here. Excuse me,
7 but up to this point everything you've
8 identified has been on the campus of Piedmont,
9 is that correct?

10 A: That is correct.

11 Q: And the remainder of these things you're
12 identifying, are they on Piedmont's campus?

13 A: They are not.

14 Q: Okay.

15 A: And, actually, let me correct myself. The
16 wound care center and the pain management
17 center are across the street.

18 Q: All right. Go ahead. Pick up at York Family
19 Practice.

20 A: Okay. York Family Practice which was
21 established in the western part of York County,
22 Piedmont East Urgent Care, which was
23 established on the I-77 corridor in the
24 southern part of the county. Baxter Urgent
25 Care and Baxter Imaging are a part of the

1 Baxter Community Campus located in Fort Mill,
2 South Carolina. And Tega Cay Family Practice
3 is in that northern, northeastern segment of
4 the county over towards the city of Tega Cay.

5 Q: Okay. Now, in addition to the services you've
6 brought on during your tenure, discuss in
7 general terms, if you would, the developments
8 in the medical staff of the hospital.

9 Q: The medical staff had grown significantly
10 through the years. We had a very aggressive
11 program of providing economic support and
12 relocation support for physicians who wanted to
13 come to the community and be a part of our
14 community as well as recruitment initiatives
15 and focused primarily at that point in the
16 early years, anyway, with specialists. The
17 cardiovascular surgery, neurosurgery, provide
18 assistance to orthopaedists, general surgery
19 and those kinds of things.

20 Q: All right. And how did the services you were
21 bringing on, the heart center, the Women's
22 Tower, the neurosurgery and others relate to
23 your recruitment efforts?

24 A: They were actually intended to help support and
25 attract high quality individuals. The women's

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1 center provided an impetus for us to start a
2 third OB/GYN group in the community. We
3 recruited two individuals for the bariatric
4 surgery program who assisted us in some very
5 well qualified general surgeons with expertise
6 and skills. The wound care center which
7 supported our vascular surgery program, of
8 course.

9 Q: Okay. Now, let's move to the utilization of
10 Piedmont during this period of time leading up
11 to the period of 2004, prior to the filing of
12 the application. How was the hospital doing
13 that first six years that you were on campus?

14 A: Doing very well. We continued to show growth
15 both from admissions and outpatient activity
16 and procedural activity within the operations.

17 Q: Okay. Dan, pull up Demonstrative 137. This
18 has been a Demonstrative that's been the focus
19 of prior testimony. Mr. Miller, do you
20 recognize it?

21 A: I do.

22 Q: And what does it reflect?

23 A: This reflects inpatient discharges for the
24 period of time 1997 through 2010 both for
25 Piedmont Medical Center as well as some of the

1 regional hospitals.

2 Q: And generally, how does it reflect the
3 development and the changes in patients
4 admitted to Fort Mill?

5 A: It shows, you know, very consistent and steady
6 growth in response to some of the development
7 activities and strategic planning that we were
8 doing up until 2005.

9 Q: Okay. Now, with regard to the strengths that
10 were reflected by the growth and the
11 recruitment and the expansion of the medical
12 staff, by the way, I don't think I asked you
13 specifically, during this period of time of
14 your onset through 2005, what was the growth in
15 the medical staff?

16 A: Our growth in the medical staff was probably
17 significant, a little bit of a guess, but we
18 probably added at least 100, 150 physicians to
19 the medical staff.

20 Q: Okay. And have you developed a Demonstrative
21 to show the strengths of the healthcare system
22 including particularly the hospital and its
23 medical staff at that time?

24 A: I have.

25 Q: All right. Dan, let's pull that up, it's

1 Demonstrative 205, please. And what does this
2 reflect, Mr. Miller?

3 A: Basically, it reflects that we developed a very
4 diverse, very well-trained medical staff.
5 These physicians that are boarded and come from
6 the finest medical institutions in the country.
7 We had a well-balanced payor mix to support the
8 growth and investments that we were making.
9 That allowed us to maintain state of the art
10 technology and keep pace with development of
11 technology. We were able to maintain the
12 facility that was originally constructed in
13 1980 and keep it well-kept and expanded and
14 renovated as appropriate and we had access to
15 capital to help us support these activities.

16 Q: With regard to the developments of the
17 facility, what were the main features
18 concerning the renovation and expansion of
19 Piedmont Medical Center immediately prior to
20 and during your early years?

21 A: Well, we added the heart center in 1996. We
22 also renovated and expanded the emergency
23 department at that time. We built operating
24 rooms that were dedicated to the heart surgery
25 program as well as the critical-care unit that

1 we spoke of. In 2004 we added a 95,000 square
2 foot women's center dedicated to women's health
3 issues. We renovated the Core Tower during
4 that 14 year period on two separate occasions
5 to keep it fresh and modern-looking as well.

6 Q: Okay. Now, thinking back to the Demonstrative
7 that showed a decline in volume that began in
8 2004, what were the challenges that that loss
9 of patients represented? Have you developed a
10 Demonstrative to show that?

11 A: I have.

12 Q: Dan, let's look at 206. And what does this
13 show, Mr. Miller?

14 A: Well, basically we began to see a period of
15 time, a disruption of the historical referral
16 patterns up to that point we had a very
17 collegial medical community. The boundaries of
18 who owned which practice were not significant.
19 We observed pressure from the Carolinas Health
20 System practices, what I refer to as cherry-
21 picking patients based on their payor mix and
22 we saw the practices beginning to place
23 limitations on the number of Medicare, Medicaid
24 and self-pay patients that they were allowing
25 into their practices.

1 Q: Now, before we expand on that, I want to ask
2 you to testify in a little more detail
3 concerning the hospital's contractual
4 relationship with York County, okay?

5 A: Sure.

6 Q: And you mentioned it in your earlier testimony
7 that the sixth addendum of that contract was a
8 significant development. Let me ask you if you
9 developed a Demonstrative that in addition to
10 the services identifies other responsibilities
11 that the hospital has?

12 A: We have.

13 Q: All right. Dan, let's pull up Demonstrative
14 211. What were those responsibilities that
15 were the principal ones in your mind?

16 A: Well, they're numbered, the key points. It
17 required us to maintain reasonable pricing, I
18 think as I mentioned earlier, it expanded and
19 got into significant detail of some benchmark
20 accountability relative to the EMS ambulance
21 service. It obligated the hospital through the
22 term of that contract, which was out to 2045,
23 to ensure that there would be adequate capital
24 reinvestment in York County relative to
25 healthcare services and it also obligated the

1 hospital to provide a very comprehensive annual
2 report relative to the operation of the
3 hospital and its performance on commitments in
4 the contract.

5 Q: All right. Let's take these issues one at a
6 time and have you go through them in a bit more
7 detail. Let's begin with the pricing issue.
8 Let's turn, if you would, to Exhibit 16, Dan.
9 Let's look at the provisions in the sixth
10 addendum related to pricing. Let's begin on
11 page nine. And highlight the section of that
12 that addresses pricing considerations. What is
13 it, and read that into the record, please, Mr.
14 Miller, and then talk about it.

15 A: AMI agrees to exert every effort to so conduct
16 its operations and finances to maintain prices
17 for services at the hospital at a reasonable,
18 competitive levels vis-a-vis other hospitals in
19 the quote, unquote peer group as defined in
20 section 3.13(a)(xii) thereof for which MEDPAR
21 pricing information is provided pursuant to
22 subsection 3.13(a)(xii).

23 Q: Okay. And what did you understand this
24 provision to mean?

25 A: This provision obligated the hospital to

1 maintain reasonable and competitive pricing at
2 levels in relationship to what was identified
3 as the peer group of hospitals.

4 Q: Okay. Let's look at Demonstrative 213 to
5 identify those hospitals that are in that peer
6 group. Would you identify them for the record
7 please?

8 A: Sure. The first group represents hospitals
9 operating within South Carolina. It's Mary
10 Black in Spartanburg, Palmetto Health Richland
11 here in Columbia as well as Palmetto Health
12 Baptist, Piedmont Medical Center, of course,
13 Providence Hospital here, and Spartanburg
14 Regional Medical Center. And then in North
15 Carolina, Carolinas Medical Center, Carolinas
16 Medical Center-Mercy, Gaston Memorial Hospital
17 and Presbyterian Hospital.

18 Q: Okay. Now, has the hospital, that is Piedmont,
19 throughout your tenure always been in
20 compliance with its term to set your pricing at
21 competitive, reasonable levels?

22 A: Actually, we ran into some challenges and based
23 on 2002's MEDPAR report ---

24 Q: What's a MEDPAR report?

25 A: That is a compilation of data applied from

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1 Medicare relative to the average charges for
2 Medicare patients in hospitals that's made
3 publically available and released when Congress
4 does its budget every year. It's time-lag, so
5 for instance for 2013, you will get 2012 data.
6 So, it's not always contemporary at all. In
7 2004 we got 2002, or in 2003 we got 2002 data
8 and identified the fact that we were in first
9 of this list which under the terms of the sixth
10 addendum triggered the need to engage in an
11 action plan on the part of the hospital ---

12 Q: Let me stop you there before you develop that
13 plan. In 2002, which was the date you
14 testified, the focus of the charges, did you
15 know what the charges were for the other
16 facilities in the peer group?

17 A: Not until late 2003 when we got the MEDPAR
18 data.

19 Q: And what did you learn at that time?

20 A: That we were the highest.

21 Q: All right. And then, the contract, you said,
22 had a provision for what you do when you learn
23 you're the highest?

24 A: That's correct.

25 Q: Did you report that fact to the county?

1 A: We did. We called, had actually a special
2 council meeting held at the hospital in April
3 of 2004 and self-disclosed that situation to
4 the county at that time.

5 Q: Did the county, in response to that issue a
6 notice to the hospital?

7 A: It did. It basically issued a formal notice of
8 their position that we had breached the
9 contract and to sanction the hospital at that
10 time.

11 Q: All right. And what evolved after the notice
12 of the breach?

13 A: Well, the hospital was engaged in corrective
14 action of freezing prices and rolling its
15 prices back in a number of areas, we negotiated
16 the eighth addendum to the contract to
17 basically improve the language of this section
18 so it would be a more timely response and
19 accountability on a going forward basis as well
20 as the fact the eighth addendum established for
21 the first time monetary damage privileges
22 should we ever become number one again.

23 Q: And what are those, what are the damages?

24 A: I don't recall. I believe it is like \$100,000
25 a month until we correct the action.

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1 Q: And now you said just a moment ago that you
2 froze, rolled back charges. Be more specific,
3 if you would, about after the notice what
4 action the hospital took with regard to its
5 pricing.

6 A: Well, the hospital as part of the promise in
7 the sixth amendment had developed an action
8 plan that initially we froze our prices and as
9 we moved through the action plan in a number of
10 different areas we actually reduced them to
11 basically bring ourselves down to the level of
12 what they were in 2002.

13 Q: And the period of time after those -- your
14 charges were frozen and reduced through the
15 time you continued to be CEO among the -- were
16 there 11 hospitals in the peer group?

17 A: I believe that's correct, yes.

18 Q: Where did Piedmont fall?

19 A: I think we are, you know, at this point about
20 the fourth, fifth lowest in the group.

21 Q: Okay. All right. Now, let's talk about --
22 Dan, let's go back to Demonstrative 211,
23 please. And let's move to the next item that
24 you've identified on your contractual
25 obligations, ambulance services.

1 A: The sixth addendum basically expanded the EMS
2 ambulance obligation. In the original 1980
3 contract made very brief reference to the fact
4 that we would provide that service and over
5 some period amount of time evaluate what would
6 be the appropriate system for the county. The
7 sixth addendum in 1995 actually established
8 response times for geographic areas identified
9 in the contract ranging from eight to 20
10 minutes depending on where the residents lived.
11 It also identified some requirements to
12 maintain two ambulances on the western side of
13 the county and several ambulances on the east
14 including one in Fort Mill. And a process by
15 which as the county population expanded, how
16 ambulances or first response units would be
17 added to the system.

18 Q: Under the contract is there any exclusivity
19 provision?

20 A: No, there's no exclusivity provision. We are
21 not the only EMS provider in York County.
22 There are a couple of rescue squads operating
23 in there. There's also clear language in there
24 that we're to transport patients not only to
25 Piedmont Medical Center but to any hospital in

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1 the counties contiguous to York County as well
2 as appropriate.

3 Q: Now, what's your experience in that regard?

4 A: My experience in regard to that is that there
5 are a significant number of out-of-county
6 transports occur every day within the system
7 and have for years.

8 Q: What are the instructions that the EMS
9 operators have been provided with regard to
10 patient choice and concerning the use of
11 ambulance services?

12 A: First and foremost would to be compliant with
13 the state and federal law in this regard.
14 Secondly, they are to be respectful of patient
15 choice unless they basically believe the
16 patient has been, that their choice would place
17 them at harm. Again, time being critical
18 depending on the situation. There also some
19 instances in which by regulation and we need to
20 take the patients to a certified stroke center,
21 that kind of thing.

22 Q: Okay. What are the economic impacts of
23 operation of this service on Piedmont over the
24 years?

25 A: We lose about four, four and a half million

1 dollars a year providing that service on behalf
2 of the county.

3 Q: Now, let's look at the third category. Capital
4 reinvestment. What are the requirements there?

5 A: The sixth addendum provides that the hospital
6 has to reinvest roughly 108 percent of its
7 average depreciation over the last three years
8 on an ongoing basis and it is a minimum
9 requirement and, again, this contract goes out
10 to 2045.

11 Q: Okay. And the fourth issue relates to annual
12 reports. What reports are expected of the
13 hospital?

14 A: And I think we've developed a Demonstrative on
15 this, but this is an annual report that has to
16 be submitted to the county and of course is
17 available for public inspection. It covers
18 financial operations of the hospital.

19 Q: We'll pull that up just to help you with the
20 contents. We made this, Your Honor, Exhibit 17
21 the last four annual reports. Mr. Miller,
22 since the last report, what year was the last
23 report that came under while you were CEO?

24 A: It would be the contract year ending May 31,
25 2011.

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1 Q: Okay. Let's pull up 17(C) then, Dan, the 2011
2 report. Let's turn to the table of contents in
3 that Exhibit and just in general terms without
4 reading the entire list of the contents, what
5 does the report incorporate?

6 A: Identification of our governing structure and
7 participants there, annual financial
8 statements, disclosure relative to our property
9 tax, depreciation report, that whole section
10 there relative to depreciation, capital
11 investment, equipment to show compliance with
12 that section. There's a piece of it there it
13 reports on our support for the medically
14 indigent in our community and our charity and
15 bad debt. We're obligated to provide medical
16 services to the county detention center, report
17 on operations of our emergency department,
18 physician recruitment, a section on EMS
19 operations, pricing, the MEDPAR data report,
20 our support for scholarships and education and
21 donations in the community. Those are the key
22 elements.

23 Q: Okay. Let's look at a few of those just as a
24 few examples of what these report to the
25 county. Let's begin with the scholarships and

1 education section. And what's being reported
2 there, Mr. Miller?

3 A: The sixth addendum requires us to provide some
4 scholarships for both York Tech and Winthrop
5 University. That's the two numbers there,
6 \$31,347 each. The CAP scholarship is a self-
7 initiated program that we started at the
8 hospital in support of employees and employee's
9 children who want to go into nursing school.
10 The B section, their educational support, these
11 are not contractual obligations, but this is
12 support that we provide to USC as well as York
13 Tech's nursing program and additional education
14 programs for our employees we provide at the
15 hospital. Again, not a part of the contractual
16 obligation. Section C gets into our work and
17 ensuring that we are not only about just a
18 hospital but about impacting the health status
19 of our community. The Healthy Hometown Project
20 is a major initiative that we engage in both in
21 Rock Hill and Fort Mill as well as York and
22 help bring health educational material to
23 provide throughout the community.

24 Q: Okay. Let's move to another section of the
25 report relating to indigent care. Dan, if

1 you'd take us there. And review this for us,
2 please, Mr. Miller.

3 A: This is our accounting to the county for
4 services that we provide to indigents of York
5 County. You'll see there in B, 939 inpatient
6 situations amounted to just a little short of
7 \$31 million. A little over 1300 outpatient
8 encounters at about 3.5 million and then some
9 additional charity reserves that we did. In
10 our facility, charity means individuals that
11 have never been billed for services. They have
12 been screened initially for their ability or
13 inability, as the case may be, to finance their
14 own healthcare. They have not met the
15 requirements for any of the other programs that
16 may be available in the state, Medicaid, et
17 cetera.

18 Q: Now, let me stop you there and ask for the 939
19 inpatient accounts, what does that \$20.8
20 million line item refer to?

21 A: That refers to the charges for the services
22 that are rendered to those 939 encounters.

23 Q: And what eligibility requirements in general
24 terms apply to those?

25 A: I think we're at 200 percent of the federal

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1 poverty guidelines.

2 Q: Okay. And so total charity care under 2011 was
3 approximately what?

4 A: Twenty-seven, almost \$28 million.

5 Q: Okay.

6 A: Other uncompensated care, these are bad debts.
7 Those individuals who are unwilling to pay for
8 their healthcare services amounted to almost 25
9 million.

10 Q: Unwilling, you mean do not pay and do not
11 qualify for charity?

12 A: Do not pay and do not qualify.

13 Q: Okay.

14 A: And then D what is our compact with the
15 uninsured. Tenet Healthcare Corporation was
16 one of the first organizations in the country
17 to develop a program whereby individuals who
18 have assumed responsibility for their own
19 healthcare, more commonly referred to as self-
20 pay patients, are traditionally penalized for
21 that decision because they have to pay full
22 rates. What Tenet developed is what we refer
23 to as our compact with the uninsured in which
24 we write down their bills to basically the same
25 level that we would be expect to get paid by

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- 1 managed care companies, Blue Cross, United,
2 Aetna and those groups so that these
3 individuals are benefitting from negotiated
4 rates of large groups and large groups
5 employers and those discounts amounted to a
6 little over \$12 million in this period.
- 7 Q: All right. And indigent care taxes paid.
8 What's the reference there?
- 9 A: Well, all hospitals operating in South Carolina
10 pay an indigent care tax to the state, that's
11 the 6.5 almost 6.7 billion. In the sixth
12 addendum, the hospital is obligated to pay on
13 behalf of York County and York County residents
14 the indigent care tax owed by the county and
15 that's roughly \$450,000.
- 16 Q: And in the absence of your contract, the county
17 would pick up the county share of the indigent
18 care tax, would that be correct?
- 19 A: Correct. In the absence of this contract, the
20 county would be responsible for not only this
21 \$450,000 and about \$4.5 million cost to provide
22 emergency medical services.
- 23 Q: Okay. All right. Let's look next and finally
24 at the financial statement provided in this
25 report. Review this if you would, please.

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1 A: Okay. For this 12 month period, basically the
2 hospital had total billable charges of 592
3 almost \$593 million dollars. It had
4 additional revenue unrelated to patient
5 activity, cafeteria and those kinds of
6 activities of about 2 million. It wrote off
7 contractual allowances over \$300 million from
8 government and third-party payors, Medicaid.
9 We had bad debt as I referred to it a minute
10 ago but we refer to here as our unwilling to
11 pay.

12 Q: Let me stop you there on the bad debt question.
13 What is, during the time you were at Piedmont,
14 what has been Piedmont's practice concerning
15 the pursuit of bad debt against patients who
16 don't pay?

17 A: We operate an internal, we being Tenet
18 Healthcare Corporation, operates an internal
19 collection agency. Every effort is made to
20 encourage payment, work with individuals with
21 payment plans and we turn individuals over to
22 a credit reporting agency, but to the best of
23 my knowledge is we do not litigate for
24 recovery.

25 Q: By litigate for recovery, do you mean file

1 lawsuits against debtors to the hospital?

2 A: Yes.

3 Q: Do you impose liens against patients for
4 failure to pay?

5 A: Not to my knowledge.

6 Q: Okay. All right. Carry on.

7 A: And then we have those that are unable to pay.
8 Again, those are those we've pro-actively
9 identified as not having resources to them nor
10 do they qualify for any existing governmental
11 assistance program and then compact for the
12 uninsured is the discounts that we provide to
13 those people who have assumed responsibility
14 for their healthcare.

15 Q: All right. And let's scroll down to the bottom
16 and look at the -- let's just take it on down
17 to the -- let's actually look at the taxation,
18 your pretax income and the taxation then that
19 Piedmont is subject to.

20 A: Sure. We're obligated to pay both -- we have
21 a pretax income of \$24 million after all of our
22 expenses. We are obligated to pay both federal
23 and state income taxes, state franchise tax, we
24 pay property taxes in York County. Business
25 licences and the indigent care tax looking at

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1 a total of almost 15.6 million for after tax
2 income of \$9,160,000 in this period.

3 Q: The property tax that's identified for Piedmont
4 of 2.1 million, are you familiar with the taxes
5 that are projected for the Fort Mill Medical
6 Center?

7 A: Yes.

8 Q: And do you remember generally the amount of
9 those, the property taxes? Does \$4 million
10 sound about right?

11 A: Yes. I was going to say about four, four and
12 a half million.

13 Q: All right. And what would be, based on
14 information you've had available to you, the
15 general explanation for the difference between
16 Piedmont's property taxes and those that are
17 projected for Fort Mill Medical Center?

18 A: It would be a combination of the taxes levied
19 by the school board as well as the age of the
20 facility and the value of the property as
21 assessed by the county.

22 Q: Okay. All right. And the after tax income for
23 2011 for Piedmont was what?

24 A: \$9,160,000.

25 Q: And what's the last line on that financial

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1 statement?

2 A: That represents all the aggregate capital
3 reinvestment that we made in that same 12 month
4 period, 11,487,000.

5 Q: Now, and that would have a net effect of cash
6 in 2011 of what?

7 A: That would be negative cash flow in 2011.

8 Q: Now, there are years where Piedmont has had
9 positive cash flow?

10 A: Yes.

11 Q: All right. Let's move on to, actually, the
12 ninth addendum. What did that, without looking
13 at the document or let me call that up, Mr.
14 Miller, what was the ninth addendum intending
15 to address?

16 A: The ninth addendum was intended to address two
17 points. Number one, we wanted to basically
18 ensure that our communication commitment
19 relative to the comport of the hospital and
20 Tenet, that it be covered under the contractual
21 relationship between Piedmont and the County
22 would exist as well as we had been in
23 discussions with the county relative to
24 Piedmont West Urgent Care, the urgent care
25 situated on the western side of the county in

1 an interest by some have it expanded as a 24
2 hour, 7 days a week. There was no data
3 available to basically support an analysis of
4 whether or not that made sense or how it would
5 be utilized, so the hospital agreed to operate
6 the center 24/7 for a period of five years, we
7 believed that would give it an adequate time to
8 test the market and see how it would be
9 utilized by the community at the end of that
10 five years that the hospital could modify those
11 hours but under no circumstances reduce the
12 participation lower than it was prior to the
13 ninth addendum.

14 Q: And what were the hours of the urgent care
15 center in York prior to the ninth addendum?

16 A: Eight to eight. Typical with all the other
17 urgent care centers operating in the region.

18 Q: Okay. And what did you learn as a result of
19 that five year experience?

20 A: We learned that there was really no demand for
21 a 24/7 on the western side of the county. We
22 have averaged, at best, on a busy night maybe
23 a three patients from nine o'clock at night
24 until seven in the morning, so we lost about
25 \$800,000 a year in that test market.

1 Q: All right.

2 **THE COURT:** \$800,000 a year, sir?

3 A: Yes, sir. Is what we lost.

4 Q: And how did you lose that amount?

5 A: We had a contract for core physician coverage
6 and staff coverage for those additional hours.

7 Q: Okay. So that \$800,000 a year for how many
8 years?

9 A: Five years.

10 Q: So four million?

11 A: \$4 million experiment.

12 Q: Okay. And after the conclusion of that time
13 what hours were restored?

14 A: We went back to the original eight to eight
15 hours of the center.

16 Q: Now, have you contracted that service or
17 subcontracted that with any parties?

18 A: We did. We actually -- the physicians that
19 operated the center and came to us a number of
20 years ago and asked if they could acquire the
21 center for their own business purposes. We
22 agreed with the consent of the county to
23 transfer that. There is a provision in that
24 sale document, though, that they have to
25 fulfill our obligations relative to the

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1 requirements of the sixth amendment. And is it
2 may subsequently be amended and should they
3 decide they want to sell that business, then
4 basically Piedmont has a first right of refusal
5 in taking over because it has an obligation to
6 make sure of the operation of that clinic out
7 to 2045.

8 Q: Without regard to who operates it?

9 A: Correct.

10 Q: Okay. All right. Were there any issues
11 related to Fort Mill Medical Center that were
12 addressed in the ninth addendum?

13 A: Yes. We took the opportunity to confirm our
14 position that it was our intent that both the
15 Fort Mill hospital and Piedmont Medical Center
16 would fall under the terms and conditions of
17 the contract and all its amendments with the
18 county.

19 Q: Okay. Now, have there been any additional
20 addenda to the contract executed since 1990?

21 A: There's not any that have been executed, as I
22 mentioned earlier, I've been retained by the
23 hospital relative to the negotiations of a
24 tenth addendum. The sixth addendum had a
25 provision in it that provided that the parties

1 every five years would review the terms and
2 conditions of the sixth addendum. Healthcare
3 being a very dynamic industry and times
4 changing, making sure that we kept the
5 agreement consistent with the intent of the
6 parties. The tenth addendum was initiated to
7 facilitate that review and was presented to the
8 county for initial review in the fall of 2011.

9 Q: Okay. Has there been any action on that?

10 A: Yes, there's been quite a lot of activity. The
11 original tenth addendum made some suggestions
12 relative to -

13 **MR. MULLER:** Your Honor, can I interrupt the witness
14 for just one second? This tenth addendum we
15 had asked for in discovery. When I asked
16 questions of Mr. Miller in the course of the
17 deposition, he was very vague about it. In the
18 course of his deposition, I asked Mr. Andrews
19 for a copy of it. He indicated that I would
20 have to make a formal request. I then went
21 back to my office, I looked at our prior
22 discovery and I made an email request to Mr.
23 Andrews. He responded by refusing to give it
24 to me on the grounds it was not a final
25 document and he said that if it was ever signed

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1 it he would give it to me. He is now eliciting
2 testimony about that draft after refusing to
3 provide me with a copy of the draft. If you
4 would like, I can show you the email of where
5 Mr. Andrews -- where I asked, made a formal
6 request and Mr. Andrews responded in that
7 manner. I have a copy of it right here.

8 **MR. ANDREWS:** There's no need for that. It's not
9 disputed. That's the position we took, Your
10 Honor, because as we explained in that email
11 that it was a confidential negotiation process
12 and I'm happy to end the examination on this.
13 I actually wasn't intending to elicit anything
14 more than what Mr. Miller testified about in
15 his deposition. He elaborated a little further
16 just for the Court's edification. But it's
17 still not final and that remains our position,
18 but I'm happy to move on. We don't need to
19 explore this any further.

20 **THE COURT:** Well, in light of that, Mr. Muller,
21 let's have no further discussion that it was
22 sustained since CHS hasn't had an opportunity
23 to review that and it is still in negotiation,
24 let's not have any further -

25 **MR. ANDREWS:** That's fine. Happy to move on.

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1 Q: All right. Now, let's shift your attention,
2 Mr. Miller, to Piedmont's interest in
3 establishing healthcare services in Fort Mill.
4 When did that begin in your tenure with
5 Piedmont?

6 A: Actually in 1999.

7 Q: And what were the -- discuss the plans relating
8 to the development of a Fort Mill area hospital
9 at that point.

10 A: We had been alerted by a local development,
11 developer, Clear Springs Development Company
12 that was formed to represent the Close family
13 who owned large blocks of land in the Fort Mill
14 area back then and they were interested
15 formally interested in developing them into
16 some pretty structured community concepts.
17 They had hired some individuals who worked with
18 Disney down in Florida and a similar
19 construction-kind of concepts and part of what
20 they've done in Florida was incorporate some
21 healthcare facilities in those projects and
22 they were interested in soliciting the level of
23 support and interest from healthcare providers
24 to do something similar.

25 Q: Okay. Before we move into much detail about

1 that process, let me ask you for a little
2 further background and context to explain why
3 Piedmont had an interest in the development of
4 healthcare services in Fort Mill?

5 A: Well, clearly Fort Mill, you know, at the time
6 York County was one of the fastest growing
7 areas in the state and within York County, the
8 whole northeast quadrant and north of the
9 Catawba River was growing significantly. It
10 was developing into a bedroom community and it
11 was significantly important for us. We were
12 seeing a lot of out-migration from that area
13 that obviously concerned us as well as the
14 development of the population.

15 Q: Now, describe, if you would, what Piedmont
16 hoped to accomplish during those early years by
17 establishing a hospital in the Fort Mill area.

18 A: Well, we were hoping to not only meet the needs
19 of the community that we felt was a medically
20 underserved area in terms of the presence of
21 physicians as well as the easily accessible
22 medical facilities themselves, but also to slow
23 and curb the out-migration.

24 Q: Now, what was the out-migration?

25 A: To Charlotte, to North Carolina. Patients were

1 leaving York County for their healthcare.

2 Q: Okay. All right. Now, let me take you back to
3 what you began to discuss related to the
4 interest of a developer in establishing a
5 healthcare complex and its system within Fort
6 Mill. Did you receive during this period of
7 time requests for proposals?

8 A: We did. We received a formal request for
9 proposal from that group.

10 Q: And let's take a look at that. Exhibit 18,
11 please draw that up, Dan. And let's move to
12 the first page of that document. Okay. What
13 is Exhibit 18, Mr. Miller?

14 A: It is a request for proposal for Baxter
15 Healthcare Campus.

16 Q: And what were the expectations -- first of all,
17 who issued the RFP?

18 A: It was issued by Clear Springs Development.

19 Q: And what was Clear Springs Development?

20 A: It's a company that was spawned by the Close
21 family, the owners of all this property for the
22 purposes of helping them develop and structure
23 these communities.

24 Q: And in general terms, what was the Clear
25 Springs Company developing in the Fort Mill

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1 area?

2 A: Actually, the family owned a significant amount
3 of acreage all over the Fort Mill area and they
4 had identified potentially six community sites.
5 They weren't necessarily going to develop them
6 all at one time. They were starting with the
7 Baxter, what is known now as the Baxter area
8 which in 1999 was peach trees.

9 Q: Okay. And what were they hoping, well, what
10 area was identified that would incorporate the
11 healthcare complex?

12 A: Well, the concept that they were modeling this
13 after was a self-sufficient community that
14 would have a housing, business, town center as
15 well as appropriate healthcare facilities to
16 support the residents of that community. I
17 think we projected at the time there would be
18 close to 1200 homes in this particular project.
19 And so they were soliciting relatively open-
20 ended proposals from the various individuals
21 they had asked or invited to submit a proposal.

22 Q: All right. Dan, let's pull up Demonstrative
23 86, please. Mr. Miller, there's been prior
24 testimony concerning this Demonstrative. What
25 does it reflect?

1 A: This reflects the time line of the development
2 of those services. The conversations began in
3 April of 1999 with the RFP. Those
4 conversations and the submittal of the proposal
5 and evaluation of that ended in October of 1999
6 with the selection of Piedmont Medical Center
7 to be their healthcare partner and then
8 through August of 2000 basically worked through
9 the agreement and various details. The
10 lawyering of the relationship.

11 Q: Okay. Now, and who was selected?

12 A: Piedmont Medical Center..

13 Q: All right. And as a result of that selection,
14 were you offered an agreement that provided for
15 the development of services in the Fort Mill
16 area?

17 A: We were.

18 Q: Sorry?

19 A: We were.

20 Q: All right. And did you establish physician
21 practice areas as a result of the agreement?

22 A: We did. Our RFP response basically laid out a
23 plan of over a ten year period that we would
24 develop and bring services into that area.
25 That included physician practices, the

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1 development of an urgent care center, imaging
2 center and ultimately a hospital.

3 Q: And did you have the authority to enter into
4 this agreement on your own?

5 A: I appropriately solicited and appropriately
6 secured the authority to do that, yes.

7 Q: Let's take a look at that Exhibit 23, please,
8 Dan, where you requested that authority. If
9 you could call out the first section of the
10 memo, Dan, about half the page. And Mr.
11 Miller, identify what this is, please.

12 A: This is a memo to Reynold Jennings who's a
13 senior vice president of operations for the
14 region at the time that was sent to him from me
15 on October 5th of 2000.

16 Q: And what were you requesting of Mr. Jennings?

17 A: Authorization to execute the healthcare
18 alliance agreement.

19 Q: All right. Dan, let's call out the first
20 paragraph of that so we can see, Mr. Miller,
21 how you presented this request to Mr. Jennings.
22 All right. Mr. Miller, if you can read those
23 sentences if you can see them.

24 A: Sure. A major portion of Piedmont Healthcare
25 Systems strategic plan for the last decade has

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1 been centered on initiatives to reduce out-
2 migration from York County to Charlotte-based
3 facilities. These initiative have primally
4 been service-related to eliminate the political
5 reasons for patients leaving York County.

6 Q: All right. Dan, let's go down to the bottom
7 half of that first page and let's call out a
8 couple of excerpts related to background and
9 strategic plan. Dan, if you could just take it
10 up. And read into the record what you said
11 about the background and why you undertook this
12 request, Mr. Miller.

13 A: Sure. Fort Mill is located in the northeast
14 section of York County. This area is located
15 approximately halfway between Rock Hill and
16 Charlotte, North Carolina. The area has been
17 the highest level of growth in York County and
18 highly favorable demographics population with
19 income. Unfortunately many of the residents of
20 this area particularly the newcomers are
21 oriented to Charlotte for work, shopping,
22 entertainment and also a healthcare standpoint.
23 This combined with a lack of presence of PHS,
24 Piedmont Healthcare System, and its affiliate
25 physicians in this area is resulting in a high

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1 level of out-migration to Charlotte physicians
2 and hospitals.

3 Q: And why did you make that statement to Mr.
4 Jennings? What significance did it have to
5 you?

6 A: I think it was important for him to appreciate
7 the quirks of this area, the growth that's
8 occurring as well as the basic forces that are
9 in play that are influencing decisions made by
10 the people who live in that area.

11 Q: All right. And then let's take a look at what
12 you said concerning the strategic overview.

13 A: To redirect the out-migration from the Fort
14 Mill market, PHS must first create a
15 relationship between those residents and PHS-
16 associated physicians and outpatient services
17 such as diagnostic testing and outpatient
18 surgery. This strategy is designed to overcome
19 the natural tendency of residents in this area
20 to look to Charlotte for healthcare. Once a
21 patient is tied to PHS-affiliated physicians,
22 they will be more likely to choose PHS
23 facilities in Rock Hill for more advanced
24 diagnostic testing and patient care that would
25 not be available in Fort Mill.

- 1 Q: All right. Dan, let's go back to Demonstrative
2 86. Now, you've just provided the strategic
3 overview and when did you do that to Mr.
4 Jennings?
- 5 A: October of 2000.
- 6 Q: Four years before you filed the CON
7 application?
- 8 A: That's correct.
- 9 Q: All right. And the development of the hospital
10 was the last among the contractual expectations
11 that you've identified. What did you -- were
12 you on schedule on the development of these
13 services?
- 14 A: Yes. Actually, the physician practices and
15 urgent care center were the first phase we put
16 in place. We followed that with the imaging
17 center. The hospital was originally in our RFP
18 response and the agreement proposed for
19 basically ten years out. So, when the Health
20 Plan basically made a provision for additional
21 beds, we made a consideration going through
22 what would have been a normal CON process and
23 then design, development and construction on
24 the hospital, we would have it opened pretty
25 much on schedule.

1 Q: Now, how did the contract address the issue of
2 it being a requirement that DHEC first provide
3 its approval before a facility could be
4 constructed?

5 A: Well, there was a recognition by the folks at
6 Clear Spring Development that this was a CON
7 state and obviously we couldn't be bound to do
8 something without a CON and the law would not
9 allow us to do.

10 Q: All right. And how did the contract address
11 the rights of third parties, other healthcare
12 providers to develop and provide healthcare
13 services within the Baxter Village development?

14 A: Actually the agreement provided, had a
15 provision in it that it was an exclusive
16 relationship with Piedmont Medical Center and
17 to the extent that there was an interest by
18 another healthcare provider to locate within
19 these projects, it would require our consent.

20 Q: Was the selection and process undertaken by
21 Clear Springs open to participation by
22 Presbyterian and Carolinas?

23 A: It's my understanding that they were invited to
24 submit a proposal as well, yes.

25 Q: Okay. Now, with regard to the development of

1 the hospital, did the agreement contemplate a
2 particular site location for the facility?

3 A: The general site identified was a plot of land
4 within the Baxter community. The agreement
5 also called for us to basically take down a
6 certain amount of acreage on a annual basis,
7 which we did, ultimately leading to site large
8 enough to place a hospital on the site.

9 Q: Was the site that was identified under the
10 contract the one that was proposed to the
11 Department where Piedmont would develop it's
12 Fort Mill Medical Center?

13 A: No.

14 Q: And how would the change occur?

15 A: The change occurred as we began to develop the
16 CON application and, I guess, we started to
17 play close attention to the site that had
18 originally been identified. You know, we were
19 -- had had some conversations with some folks
20 at Clear Springs about wanting to rearrange
21 some of that acreage in order to better
22 facilitate what we thought would be an
23 improvement to the building to locate the
24 facility on what we originally contemplated as
25 that site for the hospital. Out of the blue,

1 and I mean we weren't expecting this, they
2 basically contacted me and offered us the site
3 that we ultimately placed in our plan as an
4 option if we were interested in it because they
5 were getting ready to develop their plans for
6 what's referred to as the Kingsley North
7 project.

8 Q: And what other developments are being
9 considered concerning the development of the
10 Kingsley North project in addition to the site
11 where the hospital would be built?

12 A: It's a very comprehensive project. It will
13 have, somewhat similar to Baxter, it will have
14 approximately 1200 residential homes in it. It
15 will have a million square footage of
16 commercial office space. There are plans for
17 a 300-room hotel on this site. It's a very
18 comprehensive plan for that area.

19 Q: Okay. All right. Let's turn to the filing of
20 the plan itself. When did you decide to do
21 that?

22 A: I guess we started working on it probably in
23 2004.

24 Q: All right. And why at that time?

25 A: Basically, the demographic data that we were

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