THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

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

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S.C. SUPREME COURT

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

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

v.

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

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

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line separating opposing directions of traffic. The white lines on the outside show that there's a paved shoulder, a fairly wide paved shoulder. And you can see the grass shoulders beyond there with the undeveloped areas beyond the shoulders. Pretty wide open stretch of road. It's flat and straight, pretty flat.

Q: Okay. And as we're moving down, let us know when we get close to the hospital site?

A: Okay. Both sides of the road here are peach groves and you can see a sign on the right side of the road, which is the sign for the future Fort Mill Medical Center.

Q: All right. And if you turn to look to the right, what do you see? Where is that in relation to the hospital site?

A: That shows the portion of the hospital site where you see the peach groves.

Q: All right. Now, have you seen the site plans for FMMC, Fort Mill Medical Center?

A: I have. Yes.

Q: And how many entrances off US 21 are there proposed in the site plan for the hospital?

A: The site plan shows three separate driveway entrances from US 21 into the hospital center.

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

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

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

A: Yes.

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

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

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

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

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

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

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

different access points shown.

Q: Okay. Let's keep on going. And I don't think we need to go on out to the interstate. Mr. Walsh, is anything else that you want to comment about this highway? Do we need to go any further at this point?

A: No, I think that is pretty good representation of what's out there.

Q: All right. It looked like, you said you went several different times of day and several times to this site. What you're seeing here representative or typical of what you saw?

A: Fairly representative.

Q: All right. What's the capacity on US 160, I'm sorry, US 21, the one that goes north-south, the two-lane road?

A: Well, from a planning perspective in the very initial stage, when we look at a two-lane roadway, we generally consider the capacity on a daily basis that a two-lane roadway can handle up just over 12,000 vehicles per day.

Q: All right. And do you how many cars or vehicles actually travel on a daily now on US 21?

A: The most recent traffic count on 21 is just

over 6,000.

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

A: Just about 50 percent capacity.

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

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

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

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

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

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

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

A: This is the interchange with Sutton Road here.

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

A: Sutton Road.

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

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

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

THE COURT: Mr. Westbrook?

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

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

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

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

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

MR. WESTBROOK: Thank you, Your Honor.

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

A: Correct.

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

A: Sutton Road runs kind around this way.

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

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

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

A: I have.

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

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

A: I had been to the site one time.

Q: Okay. Was it once or twice?

A: I guess it was twice.

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

A: Yes.

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

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

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

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

Q: And is that relevant to your opinion?

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

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

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

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

MR. GASKINS: Yes, Your Honor.

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

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

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

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

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

THE COURT: All right. Mr. Gaskins?

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

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

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

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

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

MR. GASKINS: Thank you, Your Honor.

MR. WESTBROOK: Thank you, Your Honor.

THE COURT: Go ahead, Mr. Westbrook.

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

A: Yes.

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

A: Yes.

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

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

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

A: Yes, it looks like a date. I'm still having trouble reading it but I think it says 2005. I can see it now. It's come up on my screen. It's June 14, 2005.
Q: All right. Thank you. And what do you see there?
A: You see a street and cul-de-sac and the site area that is now occupied by the truck stop but it's been cleared but it's not developed yet.
Q: All right. Let's go to the next one, Dan. All right. Can you see the date on this?
A: This is dated June 13, 2005.
Q: Okay. Let's see if we can move a little beyond 2005. What's the next one?
A: Okay. This is June of 2006. And you can see the site has been paved. You can see the truck stop as being constructed up to just before you get to the cul-de-sac at the end of the street.
Q: All right. Let's move on, Dan.
A: This is a clear image dated November of 2006.
Q: All right. Let's keep going, Dan. All right. What's the date?
A: Okay. This is dated 2010.
Q: Okay. 2010?
A: That's correct.

Q: What's the next one, Dan?
A: And this is date June of 2011, where you can see at the end of the cul-de-sac where the parking areas for the truck stop before there's a new auxiliary parking lot here that was built between 2010 and 2011.
Q: Okay.
A: It showed the expansion of the site.
Q: All right. Is there another one or is that it? Is there one that's up-to-date?
A: There should be one that's up-to-date. This one's dated 2012.
Q: Okay. Take your circle off, if you don't mind? That's dated what?
A: 2012.
Q: Okay. Good. All right. Now, let's go back out to -- we're looking at the aerial view of Sutton Road there with the truck stop. Show us the principle entrance to the truck stop, Mr. Walsh?
A: It's located right where the hand was. This is the driveway into the truck stop at Sutton Road.
Q: All right. And directly across from that driveway, do you remember the name of that

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

Catawba River, and I don't know the exact boundary of the property up here but it does encompass some of these local streets here and Sutton Road.

Q: All right. And what is your involvement been with the Kanawha site?

A: I was involved -- approximately in 2008 we were enlisted, our services were enlisted to evaluate the traffic generated by the site.

Q: All right. And who enlisted, when you say enlisted your services, what do you mean?

A: We were employed by a firm by the name of Land Design.

Q: Okay. Land Design?

A: Land Design.

Q: Where are they headquartered?

A: They're headquartered in Charlotte.

Q: All right. Who is the person in charge of that project for Land Design?

A: His name is Theron Pickens.

Q: All right. And the Kanawha site development, do you know what the current status of that is?

A: I don't know what the current status of it is.

Q: All right. Your involvement ended in 2008, is that correct?

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

Q: All right. And that goes back to what CHS has identified as its site, is that correct?
A: That's correct. This lighter area that you see extending from the end of the pink line I drew was the site plan's extension of the frontage road, down and across the frontage to the hospital site.
Q: All right. Now, let's take a look at CHS 163. Now, you testified at your deposition you had not looked at the site plan, is that correct?
A: That's correct.
Q: After you were asked that at your deposition, did you look at the site plan?
A: Yes.
Q: All right. Now, the site plan that's there, is that the same roughly the same geometrical figure that we looked at a minute ago?
A: It is.
Q: It's just oriented directionally differently though, isn't it?
A: Correct.
Q: All right. Show us where the interstate is and Sutton Road is?
A: Okay. You can see up here the north arrow pointing towards the bottom left of the screen.

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

Q: Okay. Where's the truck stop?

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

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

A: That's Sutton Ridge Lane.

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

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

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

A: It's labeled medical office building.

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

A: Here is the label for hospital.

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

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

Q: Now, those three driveways, you weren't aware of where those were located until you saw the site plan after the deposition, is that correct?
A: That's correct.
Q: Do those three driveways, entrances into the hospital site, have any bearing on your opinions in this case?
A: No, we did not evaluate those driveways.
Q: All right. Does the location of Sutton Ridge Lane and the frontage road have something to do, any relevance to your opinions?
A: Yes.
Q: All right. Let's go back out, Dan, to Google Earth. And let's go down to the street view of Google Earth, and let's go on the other side of the interstate so we get a kind of head start on things, there at River Crossing Drive, I believe. Is that where River Crossing Drive is, Mr. Walsh?
A: Yes.
Q: Okay. So that's on eastern side of the interstate, is that correct?
A: That's correct.
Q: And let's drive towards the interstate and

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

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

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

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

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

A: That's correct.

Q: Okay. Keep going.

A: Okay.

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

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

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

approaching here?

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

Q: All right.

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

Q: All right.

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

Q: All right.

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

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

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

A: He is.

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

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

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

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

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

A: Probably 30 or 40 years old. I don't really know.
Q: Okay. Do we have any further need for Google Earth?
A: No, I don't think so.
Q: Okay. Let's go, Dan, I think we can go to Demonstrative 41. Is this another chart that you prepared?
A: It is.
Q: All right. And this is not drawn to scale or anything is it?
A: No.
Q: Okay. Now, does this help explain your opinions with respect to the proposed CMC-Fort Mill site?
A: Yes, it does. The distance you can see shown between Sutton Ridge Lane and Interstate 77 southbound ramps is shown as 300 feet.
Q: How do you know it's 300 feet?
A: I measured it.
Q: All right. And that's the distance you said from Sutton Ridge Lane, is that also the distance from the frontage road?
A: Yes.
Q: All right. Now, what's the significance of 300

feet?

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

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

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

Q: So how does that affect safety and operations?

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

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

to this site?

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

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

A: There are not.

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

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

frequent accidents and recurrent congestion generally results.

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

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

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

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

Q: Okay. Now, let's take a look at the bottom half of this page, please? All right. And there's a little chart down there, Mr. Walsh, you see that? What's the reference to 750 feet? How is that relevant to what you're saying?

A: That, again, the description through 750 feet is the distance from the closest interchange ramp to the first full access location.

Q: All right. Is that a recommended distance or a minimum distance or how would you characterize that?

A: I would call that a minimum distance.

Q: All right. And remind us again, what's the distance between the frontage road and the interstate ramp?

A: 300 feet.

Q: All right. Now, does DOT have the authority in your experience to waive that requirement, that 750 foot requirement?

A: Yes, they can.

Q: All right. Have you seen any documentation in this case related to this site from the Department of Transportation waiving or permitting the frontage road as a hospital

entrance here?
A: No.
Q: All right. Let's take a look at Petitioner's Exhibit 115, please? And, again, I believe that's already been admitted without objection. All right. This has DOT letterhead on the front. Who's this letter from specifically at DOT?
A: The letter is from the district engineering administrator, John McCarter, and signed for him by Greg Shaw, who is the district traffic engineer.
Q: All right. Do you know these two gentlemen?
A: I know both of them very well.
Q: All right. And have you worked with them over the years?
A: I've worked with them consistently throughout my career.
Q: All right. Let's go back to the top of the front page, the first page. Who's the letter to?
A: The letter is addressed to Theron Pickens at Land Design.
Q: All right. And I believe you've already mentioned Mr. Pickens, remind us who he is?

A: He works for Land Design and they were the planning firm involved with the Kanawah project and the design of the development of that piece of land.
Q: And is he the person, is that firm that retained you and your firm?
A: That's correct.
Q: All right. What's the date of this letter?
A: February 9, 2011.
Q: Okay. And, again, the subject matter of this letter I forgot to go over a moment ago. Dan, could you pull that out again, please?
A: Yes, the subject matter of this letter is regarding the Kanawha site.
Q: All right. Now, this letter, of course, involves you just said the Kanawha site. In your opinion, though, does it have some relevance to the hospital site, which encompasses, which is part of the larger Kanawha site?
A: It does, because it references the one entrance located across from the Love's Plaza entrance on Sutton Ridge Lane.
Q: All right. I believe you've highlighted two or three relevant bullet points in this letter.

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

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

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

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

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

A: That means traffic signals.

Q: Okay. Red light, green light?

A: That's correct.

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

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

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

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

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

A: That's somewhat tied together because what

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

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

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

from a stop. Traffic is free-flowing.

Q: You're talking a truck?

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

Q: All right.

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

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

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

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

A: Concerns with the things I've already talked

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

Q: And why is that a problem?

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

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

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

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

A: That's correct.

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

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

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

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

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

THE COURT: Mr. Gaskins?

MR. GASKINS: Yes, Your Honor.

MR. WALSH - CROSS EXAMINATION BY MR. GASKINS:

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

A: Correct.

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

A: That is correct.

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

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

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

THE COURT: Let's rephrase that question.

MR. GASKINS: Okay.

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

A: Correct.

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

A: Correct.

Q: That's all I have.

THE COURT: Nothing further, Mr. Gaskins?

MR. GASKINS: Not right now, Your Honor.

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

MR. WESTBROOK: Does DHEC have questions?

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

MS. BIGGERS: No questions.

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

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

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

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

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

A: No, sir.

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

A: No, sir.

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

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

Q: Now, Mr. Gaskins asked you if you had taken any notes when you went to the site observations. Did you need any notes?
A: No, sir.
Q: And you didn't take any photos. Did you need to take any photos, would that have helped you?
A: No, I don't think so.
Q: And you talked about your visual observation but in your direct examination you also referred to -- we looked at some documents, didn't we? We looked at the DOT letter from Theron Pickens, didn't we?
A: That's right.
Q: You relied on that to some extent in your opinions, didn't you?
A: That's right.
Q: We looked at the DOT ARMS, DOT ARMS manual. You relied on that to some extent, didn't you?
A: That's right.
Q: All right. Now, Mr. Gaskins also asked you a good bit about holiday traffic. Let me ask you this, he was asking with respect to the travel time. I want to ask you about holiday traffic with respect to the sites. What's the effect of holiday traffic going to be on the

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

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

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

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

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

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

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

A: That's correct.

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

A: That's correct.

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

A: Not on Memorial Day, itself.

Q: You just did them in May?

A: Correct.

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

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

A: Yes.

Q: And you created this one, right?

A: We did.

Q: All right.

A: My staff and I.

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

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

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

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

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

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

Q: Thank you. No further questions.

THE COURT: Mr. Gaskins?

MR. GASKINS: Nothing further, Your Honor.

MS. BIGGERS: Nothing, Your Honor.

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

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

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

MR. WALSH: Thank you.

THE COURT: You may be excused.

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

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

(Off the Record)

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

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

THE COURT: Excellent.

MR. ANDREWS: David Levitt, please.

THE COURT: Mr. Levitt.

DAVID LEVITT, being duly sworn, testifies as follows:

MR. LEVITT - DIRECT EXAMINATION BY MR. ANDREWS:

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

full name and business address for the record?
A: It's David Samuel Levitt and the business address is two addresses, one is 1778 Emory Ridge Drive, Atlanta 30329 and the other is 9 River Place, Beaufort, South Carolina 29906.
Q: Mr. Levitt, what's your occupation?
A: I'm a healthcare consultant.
Q: All right. And have you been retained to work on this matter that's before the Court today?
A: Yes.
Q: All right. You've provided a copy of your resume to counsel and the other parties?
A: Yes.
Q: All right. Dan, let's pull up Exhibit 69, if we could. And Mr. Levitt will work through that. Let's begin with your education on page three of your resume. Would you review that please, for the Court?
A: Sure. I earned a bachelor's of science from Virginia Tech. I guess the major was industrial psychology and I've got a master's in health services and administration from the George Washington University.
Q: All right. And if we turn to the next page, identify publications and seminars of which you

made presentations. Is that a current list of those?

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

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

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

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

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

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

A: Levitt Healthcare Affiliates.

Q: And what's your position there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: And where do you tend to concentrate over the

last five or ten years of your practice?

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

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

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

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

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

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

Q: Greenville area?

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

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

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

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

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

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

A: Yeah, I assisted them in their original Parkridge application.
Q: All right. And there's been an issue raised concerning services you may have provided to Roper and the development of the Roper-Berkeley facility. Were you retained to provide any assistance in that regard?
A: For the Roper-Berkeley Hospital, I was retained by legal counsel after the applications were submitted, very close to the decision date to review both applications, the Roper-Berkeley and the Roper-Trident CON applications. And I calculated a bed need for Berkeley County and then meet with DHEC to present that calculation.
Q: Were you provided any information in the services you performed, other than what was available to the public?
A: No. They sent me the two CON applications. And I don't believe I even met with anyone from Roper. I just met with legal counsel.
Q: All right. And have you been qualified as an expert in healthcare planning and the Certificate of Need Programs previously, Mr. Levitt?

A: Yes.
Q: Your Honor, I would like to move to qualify Mr. Levitt as an expert in Healthcare Planning and in Certificate of Need Programs.
MR. MULLER: Without objection, Your Honor.
MS. BIGGERS: Without objection.
THE COURT: All right. Without objection, Mr. Levitt is qualified as an expert in the fields of Healthcare Planning and Certificate of Need applications.
MR. ANDREWS: Thank you, sir.
Q: Mr. Levitt, when did you first become involved with Piedmont Medical Center?
A: I believe I started working on projects for them shortly after I started consulting, so the early nineties.
Q: Okay. And were you involved with Piedmont in the consideration of their plans to establish a new hospital in Fort Mill?
A: Yes. As I said, I had done some preliminary work on some of their CON applications in the early mid-nineties. And continued to so some planning assistance throughout that period even until today.
Q: All right. For purposes of background

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

A: Yes.

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

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

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

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

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

A: Yes.

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

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

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

A: Correct.

Q: All right. Dan, let's pull up Demonstrative 135, please. And describe what is it this exhibit, Mr. Levitt?
A: This is an exhibit that shows from 2000 and 2005, the market share or the percentage of total patients. And we talked about how many patients they treated. This is sort of dividing that by the total number of patients in the market at that time. And you can see it was fairly flat. It went down a little bit from 2002 and 2005, 66, 67 percent, down to about 64 percent in 2005.
Q: Now, what would explain the chart that we just looked at, which showed an increase in discharges in a relatively flat market share?
A: It would say that the utilization increased proportionately for them and others.
Q: Okay. Now, and what was the slight decline in market share between 2002 and 2005 represented?
A: That was a shift in the market. Again, it was a very small percentage but that was just a shift in utilization of market share for Piedmont.
Q: Okay. And during that period of time between 1999 and 2000, was Piedmont, based on your

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

A: Yes.

Q: And to what degree?

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

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

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

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

A: Yes.

Q: And what is it?

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

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

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

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

Q: And who are they?

A: Piedmont Medical Center and Presbyterian.

Q: Okay.

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

Q: And did those proposed services include a

hospital?

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

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

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

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

A: Yes.

Q: And were they?

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

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

A: It is the ---

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

A: Basically, it identifies Piedmont as the selected candidate and it asks that Mr. Miller sign the agreement to initiate developing the services.
Q: Okay. And what's the date of this letter?
A: October 1999.
Q: All right. Now, at some point following this letter, apparently there was a decision made to file the CON application by Piedmont, is that right?
A: I'm sorry.
Q: After this letter?
A: Yes.
Q: Piedmont made a decision to file the application that we're here today to talk about?
A: Correct.
Q: And were you involved in the development of that decision?
A: Yes.
Q: Okay. Dan, let's look at Demonstrative 87, please? And are you aware of the decisions, the basis for that decision?
A: Yes.
Q: And what are they?

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

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

application. Have you identified those?
A: Yes, we have.
Q: Let's look at Demonstrative 88 please, Dan. And what are they?
A: The three general goals for the application were to increase services to the residents of York County in York County. Stop the erosion or out-migration of York County residents to the Charlotte area. And to treat those people from York County in York County. And to assure the continued viability of Piedmont Medical Center and the medical staff that supports Piedmont Medical Center by keeping the patients in the county and having those available services.
Q: Okay. Now, you said a moment ago that -- you have some water there?
A: Yes.
Q: Okay. That one of the factors that affected Piedmont's decision to file was the publication of the 2004-2005 State Health Plan. What's your experience, generally, and during that period of time with regard to the review of State Health Plans?
A: The process is statutorily required every two

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

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

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

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

A: Yes.

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

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

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

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

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

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

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

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

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

A: And then applies the 70 percent occupancy rate to that to show a need of 332 beds, 268 existing beds, so you subtract the two and that totals 64 beds.
Q: That is the difference?
A: Correct.
Q: Between the number of the beds identified as being needed based on the mathematical calculation you just identified and the existing beds?
A: Correct. There are 268 existing beds at Piedmont, there is a need for 332, so a difference of 64.
Q: Okay. Now, the two variables that are incorporated into the calculation you identified the population as one, and the differences in the population, is that right?
A: Correct. The factors that drive the calculation would be the population, the growth of the population, and then the utilization of Piedmont Medical Center.
Q: Okay. All right. Now, Dan, turn and kind of look back at the existing bed compliment. Just so we can be clear going forward, 268 beds represents 268 beds of what sort?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Center.

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

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

Q: And what did Mr. Grice advise you?

A: That another location was perfectly okay.

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

A: Yes.

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

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

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

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

Q: And why did you do that?

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

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

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

A: Correct.

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

A: Correct. Piedmont was approved.

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

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

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

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

Q: Have you identified those for us?

A: Yes.

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

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

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

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

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

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

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

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

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

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

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

flat.

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

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

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

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

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

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

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

well as any other hospital in South Carolina.

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

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

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

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

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

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

Mr. Levitt?

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

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

A: Yes, I reviewed that.

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

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

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

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

Q: Okay. Yeah, let's look at the next page that you have highlighted, does it show what the physicians agreed to?
A: Yes.
Q: And what, in fact, does that provide?
A: It talks about the physicians agree to refer all patients to facilities owned, operated or managed directly or indirectly by CMHA and/or to a practitioner who is a member of the medical staff of any such facility, unless, and they're three exceptions to that. And those exceptions are (a) the patient expresses a preference for a different facility or practitioner, (b) the patient insurer determines the facility or practitioner, or (c) the referrals not in the patient's best medical interest according to the physician's judgement.
Q: Okay. Now, have you, in fact, had access to documents produced by Carolinas that showed the extent to which referrals were identified and changed over the same period of time?
A: Yes.
Q: All right. Let's pull up Demonstrative 141, please, Dan? And what do you have here?

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

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

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

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

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

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

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

to.

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

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

MR. ANDREWS: Okay. Fair enough.

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

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

THE COURT: Thank you very much.

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

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

THE COURT: And if that's acceptable to you, Mr. Muller, then that —

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

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

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

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

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

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

Q: And what were those time periods?

A: 2009 through 2011, I believe.

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

A: 2012, I'm sorry.

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

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

Q: And what's in the left-hand column?
A: The name of the practice, the various practices. So this summarizes by practice, it collapses all the zip code information by year from 2009 to 2012 total referrals.
Q: Okay. In general terms -- well, why did you do this in the first place?
A: To look at the trend, as I said, from 2009 to 2012 we experienced a decline in the utilization. Piedmont wanted to see the relationship between the Carolinas physicians, the referral patterns. And what it showed was that the total went from 1200 referrals in 2009 to CHS to over 5,000 by 2012. The biggest jump though, was that Sanger-Rock Hill, went from zero basically, to 2300.
Q: And what is the Sanger group?
A: Sanger is the cardiac group. So we took out Sanger to look at the totals without Sanger. Because, again, the Sanger-Rock Hill went from zero to 2,100, Sanger-Fort Mill from zero to 500. So sort of look at a better trend we took those out and you can see it went from 1200 cases in 2009 to nearly double, 2400 cases by 2012.

Q: Okay. And let's take a look at the second page of this Demonstrative. What's reflected here?
A: This shows the majority of those cases, those four medical practices, the primary care physicians, the Medical Associates of Rock Hill and Fort Mill and the Shiland Family Medicine of Fort Mill and Rock Hill. Those four groups represent over 80 percent of the total. So you can see of the 1200 in 2009, a 1,000 of those were attributable to those groups were 83 percent and that number is pretty consistent. In 2012, it's nearly doubled, went from 1,000, almost 2,000, and went from 1200 total to 2400. But still, about 82 percent of those patients were associated with those four groups.
Q: Now, are there four groups or two groups?
A: Well, it's two groups, four locations.
Q: Okay. And are many of the observations concerning the changes at the various locations?
A: You can see the growth, predominately Fort Mill. The Medical Associates of Fort Mill went from 160 to 542, almost a 240 percent growth compared to a 34 percent growth for Rock Hill. Family Medicine Group, same thing. Fort Mill

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

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

A: Yes.

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

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

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

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

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

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

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

A: I have.

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

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

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

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

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

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

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

Q: All right.

A: And he's a CHS physician.

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

A: This shows those physicians that practiced at

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

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

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

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

A: Correct.

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

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

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

A: Those are the cardiology physicians.

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

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

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

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

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

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

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

Q: And what does this reflect?

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

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

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

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

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

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

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

A: Yes.

Q: All right. Have you analyzed it?

A: I reviewed and analyzed it.

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

A: I have several Demonstratives.

Q: Dan, let's begin with taking a look at Demonstrative 91. And go through this, if you would, Mr. Levitt?

A: Sure. This summarizes what DHEC, in their decision, how they analyzed it, what they accepted and what they rejected. You can see they accepted the need to address out-migration to the Carolinas Medical Center, proposed to treat only their patients that were going to North Carolina for services. They asserted that it would have no impact on any providers, because they were only treating their patients, weren't going to treat anyone else's patients. And their analysis of the financial projections contained a number of flawed basis and we'll talk about those in detail in a minute. From the other column, the rejected column, they did not accept Fort Mill's argument that there was a need to strengthen the existing services in York County. That there would be a tremendous adverse impact on Piedmont if CMC were approved or at the time, Presbyterian were approved. And they misapplied the regulatory standards related to the financial projections.

Q: Okay. Now, what I'm going to ask you to do, Mr. Levitt, is began the process of introducing the framework that's established through the Department's regulations related to the review and approval of competing applications, okay?
A: Yes.
Q: And you're familiar with that?
A: Yes.
Q: All right. Let's begin by pulling up the regulation that addresses that issue. Dan, if you'll pull up Exhibit 29, which is the Agency regulations on page 22? And is that found at regulation 61-15.307.2, Mr. Levitt?
A: No. Yes.
Q: Okay. And what does this section of the regs provide?
A: Instructs DHEC how to analyze competing applications.
Q: Would you read that into the record, please? How should they do that?
A: In the case competing applicants, the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, purposes of a Certificate of Need

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

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

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

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

A: I suppose, yes.

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

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

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

are they?
A: Pull it down and look at the analysis. It's what health planning needs are being addressed by each applicant and what are the likely benefits and risks associated with each project to the residents of York County.
Q: Okay. All right. So we'll return to those at the end of the case. But let's lay those out -- or at the end of your testimony, as well. And let's begin by working through the purposes of the program that you just recently identified. Let's start with the first goal is cost containment, promoting cost containment. In general terms, what's the purpose of that?
A: The purpose of cost containment is to assure that capital expenditure is necessary and there's a need for that before it's approved.
Q: Okay. And have you identified what those principals are related to the application of that purpose for the program?
A: Uh-huh (affirmative response).
Q: Dan, let's pull up Demonstrative 97. And explain what they are if you will?
A: Well, again, to sort of put a little more flesh on that, capital expenditures should not be

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

comparable to previous projects.

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

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

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

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

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

A: Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

some people that need to take a comfort break.

MR. ANDREWS: Absolutely, Your Honor.

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

MR. ANDREWS: Certainly.

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

(Off the Record)

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

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

THE COURT: I thought maybe you were.

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

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

MR. ANDREWS: Okay. Great.

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

promote cost containment.
A: Yes, and this would be that grid and Piedmont best meets the cost containment.
Q: Okay. Let's move to the second purpose then, which is what?
A: To prevent unnecessary duplication.
Q: Okay. And what's the goal of this purpose in the program?
A: Again, to ensure that resources that are approved on your Certificate of Need are necessary and the existing resources are considered when that determination is made.
Q: Okay. And have you prepared Demonstratives as you did with cost containment that weighs out the principals related to this goal?
A: Yes.
Q: All right. Dan, let's pull up Demonstrative 99, please? And would you review those principals for us, Mr. Levitt?
A: Sure. Again, certainly, the two principals are, does the proposed project cause unnecessary duplication, either directly or indirectly, on existing providers in the service area. And the second is, if it does, is there a superior alternative that avoids

that adverse impact to the existing provider.

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

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

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

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

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

A: Correct.

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

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

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

affect of Carolinas application?

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

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

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

Q: Tell us how it works?

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

average daily census of almost 289 patients.

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

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

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

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

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

A: Correct. Regardless, of where they received that, North Carolina or South Carolina. And Georgia, I believe, is in there too, because South Carolina data includes Georgia data as well.

Q: So York County residents who receive services at Piedmont would be a subset of those patient day totals, would that be right?

A: Correct. Some of the patients were treated at Piedmont, some were treated in North Carolina, some were treated in Columbia, some were treated in Charleston. So this is the total of all patients, regardless of where they were treated.

Q: Okay. And the average daily census would reflect what?

A: Again, that's the patient days divided by 365 and that reflects the average number of patients in a bed on an average day. So we had 289 patients by 2011 and we used that population in 2011, divide the two, multiply by the 2018 population to get an estimated 116,000 patient days, divide that by 365 to get 319 average daily census, assuming 65 percent occupancy rate results in a need for 491 beds.

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

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

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

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

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

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

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

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

A: It is.

Q: And what is it?

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

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

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

A: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

A: Correct.

Q: Is there one?

A: Yes.

Q: What is it?

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

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

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

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

A: This is a broad goal that allows DHEC to consider other factors that aren't specifically outlined in the project review criteria.
Q: All right. And have you analyzed the applications to determine which of the applicants best meets this objective?
A: Yes.
Q: All right. And have you identified the issues that you have addressed related to it?
A: Yes. We've identified three issues.
Q: Okay. Let's take a look at Demonstrative 174, Dan? And what are they, Mr. Levitt?
A: Those three issues of the contract with York County, the taxes paid and the issues identified at the site.
Q: Sorry.
A: Sites, plural.
Q: Okay. All right. Let's begin with the first one. There's already been some testimony about the contract between Piedmont Medical Center and York County. Have you reviewed the contracts?
A: Yes. I've reviewed the contracts and the addendum and all the addendums, so I'm familiar with them.

Q: You're familiar with them?
A: Yes.
Q: All right. And have you prepared a Demonstrative that addresses your opinions concerning that?
A: Yes.
Q: All right. Let's pull up Demonstrative 100, please, Dan? What does this show, Mr. Levitt?
A: This shows the benefits that are afforded from the York County contract with Piedmont Medical Center. Their transparency, you heard Mr. Masterton talk about the quarterly and annual reports provided to the county was public information available. And then the obligations in the contract, things that the hospital's required to provide, the reasonable pricing provision, the ambulance services that are operated at a substantial loss to the hospital. Then annual investments in capital and then the charitable contributions and educational scholarships and things like that are required in the contract.
Q: All the hospitals you've represented, and there have been many based on your testimony, have any had any comparable contractual

responsibilities to the counties in which there are located?

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

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

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

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

A: There was.

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

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

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

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

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

A: Yes.

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

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

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

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

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

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

A: Correct.

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

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

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

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

Q: Which site?

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

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

Q: And what are we looking at here?

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

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

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

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

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

A: The Fort Mill Medical Center.

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

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

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

services in York County?

A: It would have a negative impact. As we talked about to the degree that volume is reduced at Piedmont Medical Center, the ability to offer speciality services available there. The volume of those services would all be negatively impacted. And it could have a negative impact on quality.

Q: That's on Carolinas development of the ---

A: Approval of the Carolinas Medical Center at Fort Mill, yes.

Q: Have you developed a Demonstrative that identifies the quality concerns that you have?

A: Yes.

Q: All right. Dan, pull up 167, please? I'm sorry, it's actually 101 or is it 167? All right. And what do you have here, Mr. Levitt?

A: These are the areas that we talked about, reduce the quality of open heart and cardiovascular services by reducing volume, physician availability, and access to resources, other complex services, including neurosurgery, women's services, neonatal and speciality care, the level II-E that they provide at the hospital would all be impacted

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: Did that happen in this case?

A: Yes.

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

A: This is the complete letter for CON application.

Q: What does a complete letter mean?

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

Q: Okay. And are they set forth there in the center of the letter?
A: They are.
Q: Okay. And have you applied those to a separate Exhibit?
A: Yes, we developed a grid based on that.
Q: Okay. Now, before we move to that grid, the first criterion and identified in this letter is what?
A: Complies with the State Health Plan.
Q: And is that unusual?
A: That's always the first criterion of every CON application I've ever seen in South Carolina.
Q: All right. And then there are different categories of criteria that were identified in this case by the CON staffer who sent the letter to you, Ms. Fechtel, is that right?
A: Correct.
Q: Okay. And let's look at Demonstrative 102. And what are we looking at here?
A: This shows those, other than the first one that complied with the Health Plan, shows those other criteria in order of groupings of those three rankings. The second category, the third category, and the fourth category.

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

either applicant if approved on the existing health services. And finally, from a financial perspective what are the material differences in the financial information we compared to similar facilities.

Q: Okay. All right. Let's begin by beginning at the top and working through these different project review criteria. And let's start with section 2, that is the community need documentation. Let's begin by actually turning to the regulations themselves, Mr. Levitt and read for the record the paragraph 802.2(a) it's on page 25 on Exhibit 29?

A: Community documentation 2(a) target population should be clearly identified as the size, location, distribution and socially economic status if applicable.

Q: Okay. Now, the Department found that in terms of target population, that all the applicants equally met this. What's your opinion?

A: Yes. They both identify in the same target area, which is York County.

Q: Okay. And let's move onto the second criterion, which is paragraph (b). What does this address?

A: 2(b) says: Projections of anticipated population changes should be reasonable and based on accepted demographic statistical methodologies with assumptions and methodologies clearly presented in the application. The applicant must use the population statistics consisted with those generated by the state demographer, State Budget and Control Board.

Q: And again, the Department here identified or concluded that both applicants met this provision. What's your opinion?

A: I agree, both applicants met that.

Q: Okay. Let's go ahead and begin a grid. And let's focus it, Dan, let's look at Demonstrative 168.2, which identifies the subpoints of section 2. Is that what this shows, Mr. Levitt?

A: Yes, 2(a) through (e).

Q: Okay. And then what are the findings under 2(a) and 2(b)?

A: They both equally meet.

Q: And so each get a check?

A: Correct.

Q: That would be under (a) and (b)?

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

section?
A: Yes.
Q: All right. Dan, pull up Exhibit 202, please? And what are they, Mr. Levitt?
A: The population of York County obviously is the target population as we said. And the two areas to look at are, do the applicants address out-migration and the services for York County residents.
Q: Okay. All right. Let's go back, with regard to the first issue of addressing the out-migration. What's your basis for identifying what the need is for out-migration? You've earlier testified about Exhibit 99. Dan, let's pull that up? What is this?
A: This is the utilization of all York County residents. So those patients not treated in York County are those out-migrating. So if all York County residents were treated in York County there would be a need for about 200 more beds than are currently available.
Q: Okay. All right. Let's take a look at the second part of the two-part test that you presented related to strengthening the county healthcare system. Now, previously you had an

overview the product line changes. Do you remember that?

A: Yes.

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

A: Oh, yes.

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

A: Yes, it was a lot of data.

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

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

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

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

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

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

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

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

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

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

trend, decrease from Piedmont from 67 to 54 percent with a doubling of the CMC-Charlotte market share from 16 to 30 percent.

Q: All right. Let's move to a different service, looking at changes in the OB market on 180-04. What do you have here?

A: Again, similar trend, not as dramatic, but a decrease in OB market shares, 63 percent to 55 percent for Piedmont with an increase at CMC-Charlotte from 25 to 32 percent.

Q: Okay. Let's take a look at some product line changes related to surgery. Particularly, the next slide at 180-05, what does this show?

A: This shows the plastic surgery market share. This shows basically a flip, so we were at 55 percent, Piedmont was at 55 percent in 2005, went down to 25 percent by 2011. CMC-Charlotte was at 26 percent in 2005, they went to 58 percent by 2011. So a complete reversal of market for that service line.

Q: All right. Let's look at the next one in vascular surgery at 180-06. What's showing here?

A: Again, consistent with cardiac 70 percent market share in 2005 at Piedmont, down to 46

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

Q: And the next one related to orthopaedic surgery?

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

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

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

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

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

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

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

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

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

A: Yes.

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

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

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

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

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

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

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

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

A: These are the sicker, higher acuity cardiac

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

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

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

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

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

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

A: Yes.

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

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

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

Q: In the bottom right-hand?

A: Yes.

Q: Instead of 2010, it should be 2011?

A: I believe so.

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

A: Correct.

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

A: Yes.

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

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

neurosurgery, oncology, spinal fusion, and ENT.

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

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

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

A: These are all York County residents, correct.

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

A: Yes.

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

A: Yes.

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

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

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

A: 56 percent.

Q: Okay.

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

Piedmont.

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

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

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

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

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

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

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

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

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

A: No.

Q: Why?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A: Yes.

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

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

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

A: Correct.

Q: Okay. And what does it show?

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

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

experience, is that right?

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

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

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

whether that was a historical CMC patient or not.

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

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

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

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

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

A: Yes.

Q: And what positions did they take?

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

Q: All right. And would those patients, where

would they have historically received services?

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

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

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

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

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

Piedmont Medical Center.

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

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

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

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

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

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

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

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

A: Piedmont Fort Mill Medical Center application.

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

A: Correct.

Q: Okay. Let's move to the next section of the regulations, which is 2(d), 802.2(d). Dan, if you'll pull this up in the regs in Exhibit 29. I believe it's on page 25. What does this section address, Mr. Levitt?

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

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

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

A: I disagree with that.

Q: Why?

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

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

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

needs for more services and would present them to be better utilized in the future than where they are at Piedmont.

Q: Okay. Have you identified those beds ---

A: Yes.

Q: --- at Piedmont? Dan, let's pull up Demonstrative 178, please. And what does this Exhibit show, Mr. Levitt?

A: This shows the inventory beds, the 288 licensed beds. The 2011 average daily census, 182, I believe that was taken, if not sourced by, I believe that was taken from the Joint Annual Report. That shows the 288 beds minus the 182 daily average daily census shows 106 available beds. Again, we were going to relocate 36 of those to the Fort Mill Medical Center. That still leaves 70 available beds at Piedmont Medical Center.

Q: Okay. Now, the available beds, the 106 available beds, are all of those currently staffed and available for patients?

A: No.

Q: And how many are not?

A: I believe 19 beds are not set up and staffed.

Q: Okay. And those would be among the 106 that

are available and unused in Piedmont on a given day?

A: Correct.

Q: All right. And then among the balance of the beds that would be relocated what's the purpose of the deployment to move them from Rock Hill to Fort Mill?

A: To position them for better utilization. That by having a presence in Fort Mill, as we said in both the 2005 and the 2010 CON application, we will be able to reverse out-migration, increase utilization at both locations, at the Fort Mill Medical Center and at Piedmont Medical Center. So by moving them it's going to put them in a position that will be better utilized and also help Piedmont.

Q: All right. If the beds weren't moved and Carolinas was permitted to build the facility in Fort Mill, how would those 106 unused beds be used?

A: Well, that number, I think, would grow. Those 106 beds would increase because the average daily census at Piedmont would decline and there would be more unused beds at Piedmont Medical Center.

Q: Okay. All right. Then given that analysis, do you believe that Piedmont met the test that's required of applicants to demonstrate justification for locating beds?

A: Yes.

Q: All right. Now, Dan, let's take a look at 168.2 and pull that up? Would there be any reason to apply that provision to Carolinas application?

A: No, they're not relocating any beds.

Q: Okay.

A: Or services.

Q: So there would be a check for PMC?

A: And a dash for CHS.

Q: Okay. All right. Let's move on to the next section. Dan, if you'll pull that up in the regs which is 802.2 paragraph (e)? And read what that addresses, if you would, Mr. Levitt?

A: Current and/or projected utilization should be sufficient the expansion or implementation of the proposed project.

Q: Okay. And how have you analyzed this particular provision?

A: We looked at the historical occupancy of providers, as well as, the projected

utilization of the two Fort Mill hospitals.

Q: Okay. And Dan, let's pull up Exhibit 1(b), page 36, figures 24 and 25? In the application and the updated material, Mr. Levitt, did you project the utilization at Fort Mill Medical Center and Piedmont Medical Center?

A: I did. I did this at both the original application and the updated application and we projected, based on our assumed market share and calculations, about 58 percent occupancy by year three at the Fort Mill Medical Center and resulting occupancy at Piedmont of 66 percent by the third year on the reduced beds at Piedmont.

Q: Why are you connecting the utilization at both Piedmont and Fort Mill?

A: Well, for a number of reasons. The first reason was to show the impact of moving the beds, relocating the 36 beds. I wanted to show what the resulting occupancy and utilization would be at Piedmont on those 232 remaining beds. But then, as well as to give effect to the Fort Mill -- they were going to be operating as a hospital. So Mr. Masterton talked about he would be the CEO of both

facilities. They're going to be operated collectively, so those two facilities will impact one another. And the increase in utilization would occur at both facilities and we wanted to show that even with an increase utilization, both facilities have sufficient beds.

Q: Okay. Your Honor, I'm about to move into a section that will take time. Would this be an appropriate time?

THE COURT: I was just about to say, I think having gone through that. I was going to ask you if you felt this might be a good time to stop. It looks like it would be the best time.

MR. ANDREWS: It would be a good time. Thank you.

THE COURT: We will recess until tomorrow morning. Thank you.

(There being nothing further, Day Two recessed at 5:46 p.m.)

DAY THREE - WEDNESDAY, APRIL 10, 2013

THE COURT: Please be seated. All right. We're back on the record. Good morning, everyone. Day three. Here we go. And Mr. Andrews, are you ready to go?

MR. ANDREWS: I am, sir. Thank you.

THE COURT: All right.

Q: Good morning, Mr. Levitt.

A: Good morning.

Q: Mr. Levitt you were present and in the courtroom during the cross examination of Mr. Masterton, were you not?

A: Yes

Q: And let's call up Carolinas Exhibit 15, which is an excerpt from the Piedmont's Emergency Department application. Did you have any involvement with that application?

A: Yes, I developed that CON application.

Q: All right. And let's pull out figure one if we could, which is entitled Emergency Department Utilization. Do you see that?

A: I do.

Q: And what's reflected here?

A: This shows the historical utilization from 2007 to 2011 for the Piedmont Medical Center

emergency department. It shows the emergency visits, the admissions, the total ED volume and the total hospital admissions from that same time period and then the last row calculates the percentage of the ED admissions as a percent of the total admissions to the hospital.

Q: All right. And are these ED admissions, do they count the York County residents who received services through the Piedmont Emergency Department or do they include York County and others?

A: This is both. The York County residents as well as residents from all counties.

Q: Okay. And that's the total utilization, for example, in calendar year 2011 would be 15,693?

A: Correct. That's the total number of admissions at the hospital regardless of what county they lived in, not just York County but from all counties.

Q: And let's, Dan, pull up if you would Demonstrative 199. Are you familiar with this Demonstrative, Mr. Levitt?

A: Yes.

Q: And if you'll track the -- and this is intended

to show what from admissions point of view?

A: This shows that while the population of the yellow line is increasing, it shows the population increasing through a time period of 2005 to 2011, while the admissions were decreasing. The purple line showing from 2005 about 12,500 admissions going down to less than 12,000 admissions by 2011.

Q: Okay. Now how would you reconcile the over 14,500 admissions showing in 2011 and the document we just reviewed from your application to expand the emergency department with the admissions reflected in Demonstrative 199?

A: Well, 199 is just for York County. The population is the York County population. The admissions are the York County resident admissions. The figure we just saw was the total for all patients regardless of what county they lived in.

Q: Are there any inconsistencies between those two data sets?

A: No, they're not inconsistent. They're different.

Q: Okay. All right. Thank you very much. Now, Mr. Levitt, let me take you back to where we

concluded the line of examination yesterday. You'll recall, and let's pull it up again, Dan, looking at figures 24 and 25 of Exhibit 1, Bates page 36. You were looking at two different figures showing the utilization of Piedmont Medical Center and Fort Mill Medical Center. Do you remember that?

A: Yes.

Q: And why did you present to the Department the relationship between the two?

A: Well, as I said yesterday, the projections for Fort Mill assume out-migration is reversed, more patients are treated in York County both at Fort Mill and at Piedmont, and this demonstrates that the bed compliment at both locations are adequate and sufficient and consistent with experience of other providers. The 58 percent at Fort Mill by year three and 66 percent on the 232 remaining beds at Piedmont justify the project.

Q: Okay. Now, in your qualifications you identified a number of new hospital applications that you had worked on and you had mentioned there were a number of satellite hospital applications. Describe for the judge,

if you would, in general terms what the purpose of satellite hospitals are and how they relate in experience to the main hospital to which they are a satellite.

A: Well, there are a number of goals pertaining to the market and the situation. But generally, the satellite hospital is developed to collaborate, serve as a collaborative hospital, a collaborative location for the main hospital to address some issues in the market, maybe the population is perhaps growing in that area. Changes in utilization, shifts in utilization, out-migration, loss of market share. To remedy some situations in the market to keep the main hospital competitive.

Q: Okay. And are you familiar with the development of satellite hospitals in South Carolina?

A: Yes.

Q: Okay. And have you developed a Demonstrative that shows the common characteristics related to the development of new satellite hospitals?

A: Yes.

Q: All right. Dan, let's pull up Demonstrative 105, please. And review these if you would.

What are we looking at here?

A: Generally from the projects in South Carolina, these are the four common themes or characteristics of the satellite hospitals. They're in generally high growth areas, either in a suburban area or a separate county in the service area. Generally there is excess capacity of the main hospital or strong utilization at the main hospital to address a need for a satellite hospital. And there's a desire to either recover or for growth in the market share through the satellite hospital. Sort of having the physical presence as we outlined in the Fort Mill application, having a physical presence in the area where there is a lower utilization than in other areas. To remedy that and they involve either transfer of existing beds, either alone or in combination with need identified in the Plan.

Q: Okay. Now, based on your familiarity with hospitals in South Carolina that developed satellites, have you developed any Exhibits concerning any of what you believe are particular analogous?

A: Yes.

Q: And what have you developed in that regard?
A: Well, looking at the various satellite hospitals that were developed in the last several years, the market situation most analogous to the Fort Mill Medical Center would be the Waccamaw satellite hospital for the Georgetown Hospital System.
Q: And have you developed a set of Exhibits to demonstrate why you think that's the case?
A: Yes.
Q: And why did you do that?
A: To illustrate from an actual experience what happens when a satellite hospital is developed, what the implications are and what the impact are on both the proposed hospital, the satellite hospital and the main hospital.
Q: Okay. And I understand, Your Honor, there are objections pending related to this and you reserved your ruling for Exhibit 64 related to the admissibility of that. If we can pull it up and I can have Mr. Levitt go through it in whatever detail to lay a foundation for the admission, I'd be happy to do that.
THE COURT: Okay.
Q: All right. Dan, if you will pull up Exhibit

64, please? And let's move to page three of this Exhibit. And just begin, Mr. Levitt, before you talk about what your findings are and your opinions related to them because at this point we're just laying the foundation to move for the admission, what the source of this data is.

A: Well, I do a substantial amount of work for the Georgetown Hospital System which includes Waccamaw Community Hospital and Georgetown Memorial Hospital. In order to get publically available information rather than using information that I have from my work with them, I looked at the Medicare cost reports. Those are publicly available. You can order them or buy them from a variety of sources to get the Medicare cost reports and we looked at the 2002 through 2007 information from those cost reports.

Q: Okay. And have you developed Exhibits showing the relationship among these different data points?

A: Yes, what I pulled from those six cost reports, the 2002, 2003, 4, 5, 6, and 7 cost reports were the net income, net operating income from

those two facilities, the Waccamaw Community Hospital and the Georgetown Community Hospital and that's what shown in this Exhibit.

Q: And how were these Exhibits, how do these Exhibits relate to the testimony and to your opinions concerning the Fort Mill Medical Center application?

A: Well, from a financial feasibility stand point and from the reasonability of the projections contained in the CON applications, this show the actual experience of a system that developed a hospital, shows the financial performance of the new satellite hospital and it shows the resulting utilization and the financial performance of the main hospital.

Q: Were there issues concerning out-migration related to this application?

A: Yes. That was the impetus similar to Fort Mill Medical Center for placing the Waccamaw hospital in the northernmost portion of Georgetown County was to address out-migration and market share shift.

Q: Your Honor, with that, we'd like to move admission of Exhibit 64.

THE COURT: Mr. Muller?

MR. MULLER: Your Honor, I think our original objection to this was simply a recycled Exhibit from the last trial to which we objected. As you can see, the source says Medicare cost reports, no 2008 data is not available. It has not been updated. They have not done anything with it in terms of present day numbers. As you can see, it ends in 2007. But we can ask on cross exam why he has not done that and fill us in on what he intends to do with it. He even testified about it in his deposition. The fact that he said the Court has the ability to judge it for what it is, so I'm happy to waive our objection if he would like to answer questions about it.

THE COURT: Mr. Andrews?

MR. ANDREWS: Well, if Mr. Muller is prepared to withdraw the objection, I'd like to move forward, but I can respond to the points he made particularly concerning the update, Your Honor, I was going to elicit testimony and I probably should have prior to moving, related to the dating of it. I mean I'll ask Mr. Levitt rather than tell you what the issues are related to that. I'll be happy to elicit

testimony concerning that if that's of interest to you. But the short of if is there was no need related to the intent of the updated dated. It was intended to look at the early period following the establishment of the facility.

MR. MULLER: And that's fine, Your Honor. I withdraw the objection and can ask questions of him.

THE COURT: Mr. Muller, if you withdraw the objection, please go ahead.

MR. ANDREWS: Thank you, sir.

Q: All right. Mr. Levitt, let's begin with the point Mr. Muller has raised which concerns the applicable period of time that you've chosen to examine here in this Exhibit. What did you chose the years from 2002 to 2007?

A: We chose 2002 because that was the year prior to Waccamaw opening and then we chose 3 through 7 to show the first five years of operation of the Waccamaw hospital.

Q: Why didn't you continue that out through 2013?

A: Well, this was to really illustrate the experience of the initial opening of the satellite hospital. How it performed compared

to the main hospital and all probable impacts.
Q: Okay. All right. Well, given that, identify what you've found as a result of the comparisons to the operating income and financial performance of Waccamaw and Georgetown during this period of time?
A: Well, prior to opening Georgetown Memorial Hospital, which was the sole hospital in the Georgetown Hospital System, it was operating at a loss. It was ---
Q: Which hospital was operating at a loss?
A: Georgetown Memorial Hospital.
Q: Okay.
A: Was operating at a loss prior to opening the Waccamaw hospital.
Q: Now, was Georgetown a new hospital?
A: No, Georgetown was a long-standing, very old county hospital in Georgetown.
Q: Okay. And where is it located?
A: It's located in the south central part of the county.
Q: In the town of Georgetown?
A: In the town of Georgetown.
Q: All right.
A: And the operation and utilization and payor mix

at Georgetown were such that it was operating at a loss. They identified the growth area, the more desirable payor mix area to the north in the Waccamaw area, just in the northernmost area of Georgetown County, adjacent to Horry County, which is where Myrtle Beach is, where the population was growing and where a tremendous threat was being presented by the Horry County Hospital just over the border in Horry County, they were staging health services and facilities to capture greater market share which included northern Georgetown County.

Q: Was there anything located in southern Horry County near the Georgetown border comparable to the facility like Steele Creek?

A: Yes, there was an outpatient center that offered outpatient services, urgent care, emergency services, physician offices, things like that. So, in response to that Georgetown filed the Waccamaw application and built the Waccamaw Community Hospital and initiated operations in 2003.

Q: All right. And what was the effect over time after Waccamaw became operational on Georgetown?

A: It was positive. Overall, on the system, on Georgetown Hospital System it had tremendous positive impact. The Waccamaw Hospital experienced substantial loses the first year of operation. Almost a $6 million loss. By the second year they were making money, they were well-utilized, making money and you can see by the forth year they had operating income of over $4 million. It went down slightly in 2007. And I believe that was due to capital costs associated with expanding. So, in the period of time they opened, they expanded, they were well-utilized and they showed positive financial impact on the Georgetown System.

Q: Now, you're familiar with Georgetown's operations?

A: Very familiar, yes.

Q: All right. Now, how would Waccamaw have affected the financial performance of Georgetown?

A: Similar to the Fort Mill and the Piedmont Hospital proposal, Waccamaw offered basic hospital services. Georgetown offered some services that weren't available at Waccamaw, so overall the system experienced increased

utilization, positive impact on payor mix and it had an overall positive impact on the system.

Q: Now, when Waccamaw was established, was it anticipated that Waccamaw would take or there would be a shift in some of Georgetown's patients to Waccamaw?

A: Yes. Initially, the initial application was actually a transfer of beds, all the beds, the 40 beds at Waccamaw were from Georgetown Memorial Hospital. At the time, I believe right after that application was approved ---

Q: Now, how many, excuse me for interrupting, but how many beds was it approved for?

A: Forty.

Q: Forty?

A: Yes. They amended the application because there was room in the Plan for additional beds. So, rather transfer all 40 beds, a portion of those, I believe 11 beds were transferred from Georgetown to Waccamaw with the remaining coming out of the need in the Plan.

Q: And did the total change?

A: No. That bed complement of both facilities was still the same, just instead of transferring

from Georgetown, some were transferred and some came out of the need.

Q: Okay. So there was a transfer and a need that was recognized in the Plan, that was what established the basis for the creation of Waccamaw?

A: Correct.

Q: And how does that compare to Piedmont?

A: Very analogous. There's a need in the Plan for the 64 beds; Piedmont's applying for those. Transferring 36 of the beds from Piedmont Medical Center is similar to the transfer of beds from Georgetown to Waccamaw.

Q: Okay. Now, explain why Georgetown's financial performance improved over the years as Waccamaw became established.

A: Well, again, the utilization at Georgetown increased. The types of patients transferred to Georgetown changed. And overall, the system was positively impacted.

Q: Now, when you say the system was positively impacted, what are you referring to?

A: Georgetown Hospital System is the two hospitals combined. They operate together. They consolidate their resources and financial

information and from that perspective, even today, Waccamaw has a positive impact on the system.

Q: By having patients Georgetown shift to Waccamaw, was there any adverse impact on Georgetown that was experienced?

A: No, it was a positive impact.

Q: Okay. And why -- and how does the comparison of resources and assets of Georgetown and Waccamaw compare with what's being proposed between Piedmont and Fort Mill?

A: Again, very similar. The Waccamaw area is a more affluent area, faster growing area. The northern portion is closer to a much larger, also growing area. And so it is very analogous.

Q: And where, in fact, is Waccamaw Community Hospital located?

A: It is in Murrel's Inlet which is literally on the border of Georgetown and Horry County.

Q: All right. Let's take a look at the next page of your exhibit.

THE COURT: And let me just stop for a minute for an administrative, housekeeping measure. Subject to the withdraw of Respondent Carolinas'

objection to Petitioner's Exhibit 64, Petitioner's Exhibit 64 is now being admitted into the record.

MR. ANDREWS: Thank you, sir.

Q: What is this page of the Exhibit? This is page four of Exhibit 64 reflect Mr. Levitt?

A: This just graphically shows that information. The -- what's supposed to be kind of red is the Georgetown hospital and the blue is the Waccamaw Community Hospital graphed together. So, 2003, this line here would be zero basically.

Q: Right here?

A: Yes. So you can see in 2002 that the operating income was negative, below the line for Georgetown the only operational hospital that year. 2003, when they're both operational, they've both lost money so you can see the nearly $12 million combined loss for the two hospitals. And then things started going positive. So while Georgetown in 2004 still showed a loss, Waccamaw showed a positive. In 2005, again, sort of trending up and you can see combined 2006, which was sort of the peak year, where combined they were nearly a $6

million operating income. Again, then they added, actually they added beds during that time. And they added beds again in 2007.

Q: Who is they?

A: The Georgetown Hospital System, so they added beds at the Waccamaw Community Hospital. They have not added beds at Georgetown since I don't know when, but since 2002, they reduced beds by 11 and they've maintained that same bed complement until today.

Q: All right. Let's take a look at the next Exhibit. And what does Exhibit 64-5 look like?

A: 64-5 shows the Georgetown Memorial Hospital historical utilization for that same time period. You can see, 2004, the beds went from 142 in 2002 and 2003 down to 131 in 2004. That was the transfer of the 11 beds.

Q: We're looking at Georgetown's beds, right?

A: Correct. Georgetown transferred 11 beds to create the 40-bed Waccamaw Hospital. You can see the admissions slightly decline from 2002 to 2003 and they continued to drop off a little bit during that time period they went from 9,000 to about 7500 and then down to about 6,000 by 2008. Patient days declined as well

and the average daily census is down, but still well-utilized with about 55 percent occupancy in 2008.

Q: All right. And the ADC at Georgetown during that period from 115 to 73?

A: Correct.

Q: Is that a problem?

A: No, because again, you'll see the next slide what happened at Waccamaw.

Q: All right. Let's move to that slide please, Dan, 64-6, and what does this slide show in general terms? It shows the utilization at Waccamaw, is that right?

A: That's right. This is the Waccamaw Hospital in 2003 when it opened with 40 beds. The very next year on the anniversary, they submitted an application to expand to 54 beds. They added 14 beds. Then from 2004 to 2005, they added additional beds. From 2005 to 2007 they were operating 82 beds and then in 2008 they brought online an additional 42 beds for a total complement of 124 acute-care beds.

Q: Tripling their bed compliment in this time of five years, correct?

A: Correct. Yes.

Q: Okay.
A: And during that same time period, their average daily census, as you can see, went from 30 which was a 76 percent occupancy up to 71 and even with the additional beds, 124 additional acute beds, their occupancy was still nearly 60 percent.
Q: 57.6?
A: 57.6 percent. I'm sorry, I may have said -- I meant 60 percent. 57.6 percent occupancy on 124 beds.
Q: And how does 57.6 percent occupancy in year five operation of Waccamaw compare to what you've projected for year three in Piedmont?
A: It's consistent. We, I believe 58 percent is what we've projected for Fort Mill Medical Center.
Q: Okay. Let's take a look at the next slide. And what does this slide show, Mr. Levitt?
A: Again, this shows the average daily census of the two facilities and while it's not labeled, the third line is the Georgetown Hospital System, so adding the two together. So in 2002, the system with only one hospital had an average daily census of about 115. Then you

can see the steady increase, peaking in 2005 with a slight decline by 2008, but still higher than it was in 2002, 144 patients versus 115 patients.

Q: And how does this relate to your opinion in this case?

A: That by having that northern satellite hospital in a growing area and preventing out-migration from Georgetown County to Horry County, Georgetown Hospital System was able to treat more Georgetown residents, to treat more residents in total and to be in a stronger position.

Q: Okay. And let's look at the last Exhibit in this series and what does this reflect?

A: This is again, just graphically that same information showing the Georgetown Hospital System combined, the red being Georgetown, the blue being Waccamaw and showing the graphically the trend of the average daily census increasing over time and remaining fairly flat from 2005 to 2008.

Q: Now, Mr. Levitt, summarize that and based on your review of the effect on the operating income and utilization of Georgetown and that

it's satellite Waccamaw had, how you believe this relates to your opinions concerning Piedmont and Fort Mill?

A: Well again, as I said, they're very analogous that Georgetown recognized a threat, just as Piedmont did in 2005 by not having a presence in the northern area of their county. There was a threat to the north that had a hospital even not in Georgetown, if a hospital had been built, I think it's called South Strand, at the South Strand site, would have been devastating to Georgetown Hospital System. They were already in a position where they were having negative financial performance, that the threat of the northern provider taking patients out of Georgetown County was negative. They addressed that by building the Waccamaw hospital just as Fort Mill, just as Piedmont is proposing to build Fort Mill hospital and overall strengthened the system and they're in a very positive position today.

Q: If, and is there a tertiary hospital that provides open heart and other complex services in Horry County north of Georgetown County?

A: Yes, that would be Grand Strand Memorial

Hospital which owns the South Strand outpatient location.

Q: And if Grand Strand had established a satellite hospital in Murrels Inlet instead of Georgetown, what effect would it have had on the operation of Georgetown Memorial Hospital?

A: Well, as I said, if they had, either in Murrels Inlet or at the South Strand location just over the line in Horry County -- and that may actually be considered Murrels Inlet as well. It would have been tremendously negative. They would have taken patients out of Georgetown County, they would have left Georgetown and the town of Georgetown to serve what was leftover which would be the lower income, lower payor mix, less desirable payor mix and they would not have been able to consolidate positive financial performance.

Q: Now, prior to the establishment of the Waccamaw hospital, were there residents of the greater Murrels Inlet, northern Georgetown County area who were leaving the county?

A: Yes, they were traveling north. Again, Georgetown while an older town, doesn't have the economic resources of Horry County, of

Myrtle Beach or the restaurants, shopping, things like that. So people tend to travel north, just as they do in Fort Mill.

Q: Okay. All right. Now, let's return your focus to Piedmont and what it proposes to do and what it hopes to establish through the construction of the Fort Mill Medical Center.

Q: How does Piedmont propose to establish a base of patients at Fort Mill Medical Center? Have you developed a Demonstrative to walk us through those steps?

A: Yes.

Q: All right. Dan, let's pull up Demonstrative 181, please. And what does this show Mr. Levitt?

A: Well, as we outlined in the CON application, both the 2005 and the 2010 applications, that the goal of Fort Mill Medical Center is to provide services to northern York County to address the out-migration. Those people leaving York County for services could stay in York County. Improve access to patients treated at Piedmont to ensure that those future patients aren't being transferred to North Carolina or out of state for other services.

And ultimately to meet the needs of the growing population of that area of the county as well.

Q: Okay. Now, in developing this application did you have a specific goal with regard to the market share that Piedmont hoped to capture?

A: Yes.

Q: And what was that?

A: We hoped that by having a presence in northern York County that the market shares for combined Piedmont and Fort Mill would get back close to what we had had, what we had experienced historically just at Piedmont Medical Center. Obviously with an increase in that area. That was one of the areas of the county where while the overall market share of the county was still strong, the Fort Mill, Tega Cay was not. So, by having a presence in that market, those would go up and then we would be back close to where we were historically.

Q: Have you developed a Demonstrative that analyzes the market share throughout the county that you hope to achieve?

A: Yes, we looked at it by zip code historically and what we have projected in the Fort Mill Medical Center application.

Q: All right. Dan, let's pull up Demonstrative 106. And what does it show Mr. Levitt?

A: This shows the market share for Piedmont Medical Center in York County, the various zip codes in York County including the 29707. You can see in 2003, 29707 through 2006, 2003 to 2006, which is not applicable. That's a new zip code. I think someone talked about that. That's a new zip code that was created in 2007 part of 29715, I think, split off, that's the Lancaster County portion of that zip code. So it's a new zip code but it was in with the data.

Q: Let's just take this slowly. Since it's a lot of data. And begin with the identification in the left-hand column. You've got the zip codes and are they the zip codes for all of York County in addition to 707?

A: Yes, those are the zip codes comprised of York County. Some of those extend beyond York County, but those are the York County zip codes and then 707 to address the splitting out of that information. So, we looked at each zip code by year.

Q: Over what period of time?

A: From 2003 through 2011 and when you compare that, excuse me, to the 2017, the third year of operation at the Fort Mill Medical Center, that 2017 combined shows the combined market share of York County in each of those zip codes for both Piedmont Medical Center and Fort Mill Medical Center.

Q: All right. Let's start by identifying what the goal was and what your projections are with regard to the market share that you're projecting that would be obtained by 2017.

A: So by 2017 overall, in total we projected for those zip codes an average of 71.2 percent market share.

Q: And that would be again, for Fort Mill alone?

A: No, that's for all zip codes in York County plus the Lancaster County zip code.

Q: Excuse me, I wasn't clear with my question, Fort Mill Medical Center or for Piedmont and Fort Mill?

A: No, that's for Piedmont and Fort Mill.

Q: This would be the system market share?

A: Correct.

Q: Okay.

A: And that compares to in 2004 for all the zip

codes combined, we have a 68 percent market share. So you can see, it's just a few percentage points higher than where we were historically at the peak in 2004.

Q: All right. Let's go to the next Exhibit and we can kind of track the different points in which there's been a historic market share that's been comparable to what you're projecting. That's 106-2. All right. Let's call that out. It might help to track the data points a little more effectively. Mr. Levitt, what do we have here? Would you walk through this for us?

A: Yeah. This shows that in, by zip code to get to those totals, you know, basically the totals sum up those, but for the first zip code, 29704, in 2004, we had a peak of 82.4 percent market share. By 2017, we're projecting 72.3 or 72.6, I'm sorry, 72.6 percent market share. And that represents 9.7 percentage points less than what we had out our peak.

Q: All right. And so as you work through those, and I want you to do that, what the highlight shows is the historical high from since 2003 compared with what you're projecting in 2017, is that right?

A: That's correct.
Q: And the last column shows the difference between the two?
A: Correct.
Q: Okay. All right. Well, work through each of the York County zip codes and identify what you're projecting.
A: So for each of the zip codes, as we said, we gave the example of 29704 projecting a 72.6 percent market share compared to an 82.4 market share at Piedmont alone. A high from 2004, 29707, about a 65 percent market share. Now, 29707, 29708 and 29715, those are the three that show a dramatic jump from where we were historically.
Q: Why is that?
A: Those are the three northernmost zip codes in York County where historically, Piedmont did not have a large market share. So, you can see in the first one, 29707, we only have five years of data, but in 2008, we had a ten percent market share. That's going to be adjacent to where Fort Mill Medical Center is located. We assume, just as we had historically and even as late as 2011 in Rock

Hill, 29730 and 29732, we had 70 percent market share and 64 percent market share because that's where Piedmont Medical Center is located. So, the zip codes adjacent to the hospital generally have a higher market share, so the zip codes adjacent to the Fort Mill Medical Center would have market share consistent with those, 64, 69 and 72 percent market share.

Q: Good. Just to be clear, the period from 2003 to 2011 is the market share at Piedmont alone, correct?

A: Correct. Just one location at that time Piedmont Medical Center in Rock Hill.

Q: And the projected market share in 2017 reflects the combined market share of both Piedmont and the new Fort Mill Medical Center, is that right?

A: That's correct. So, that was the assumption. That having a presence in northern York at Fort Mill Medical Center we would experience a larger market share for those three zips than we had historically. The rest of them were showing lower than our historical peak at one location, at two locations. So, I think these

are reasonable market share assumptions and achievable.

Q: All right. And then, what would be the total difference from the Piedmont only high point of market share in 2004, with the projected market share when both hospitals would be operating?

A: Our peak in 2004 at Piedmont was 68.1 compared to 71.2 at both Piedmont and Fort Mill combined for a difference of 4.1 percentage points.

Q: Okay. All right. And how did this Demonstrative affect your judgement in this case and how does it demonstrate it?

A: Well, I think it shows it's reasonable that we will get back to where we had been in historical by having a new hospital, new physical presence in northen York County. And it would reverse out-migration and allow patients in York County to be treated in York County.

Q: All right. Now, were you assisted in this analysis by reviewing any maps that Mr. Walsh has previously testified about?

A: I'm sorry, could you repeat that?

Q: Sure. Were you assisted in this analysis or did you consider any of the maps that Mr. Walsh

testified about reflecting the drive time studies that he had done?

A: Yeah, obviously I didn't have those maps at the time developing the information, but I looked at those and considered those and it supports this information.

Q: All right. Let's draw your attention to Demonstrative 38, please. Now, as you've just testified, you did not have access to this map or any drive time study maps from Mr. Walsh at the time you developed your projections, is that right?

A: Correct.

Q: What assumptions did you make about the accessibility of Fort Mill Medical Center to individuals not only in the northeast of York County, but on the eastern side of the county?

A: Well, we assumed that portions of the residents in portions of 29732 and 29730, and even, I guess, to some degree 29704 would access the Fort Mill Medical Center due to proximity. You can see from Mr. Walsh's map, all of those residents of 29730 that live east of 77 are much more -- have easier access to the Fort Mill Medical Center and a portion of those

living to the west have easier access. The brown area shows five to ten minutes, I think, is what Mr. Walsh said. A difference going to Piedmont and Fort Mill, so the same for 29732, perhaps not to the same degree, but portions of that zip code would be accessible to Fort Mill Medical Center versus Rock Hill so we assume that residents of those areas would access Fort Mill that had historically gone to Piedmont.

Q: All right. Based on your experience working with hospitals, Mr. Levitt, including market share analysis, does a drive time difference of five or ten minutes have a material effect on the judgement of patients as to which hospital they would want to use?

A: No, not materially, no.

Q: All right. Now, let's take a look at Carolinas' trial Exhibit, actually, Number 5. Do you recognize this, Mr. Levitt?

A: Yes, from my deposition; I believe Mr. Muller showed that to me.

Q: Okay. What is it?

A: It is the service area map for the 64-bed CON application by Amisub.

Q: So, it's a map or Exhibit that you prepared for

the CON application that was initially filed on behalf of Piedmont?

A: Yeah, I believe this was in the CON application, yes.

Q: Okay. And what does it show?

A: This shows the three zip codes, 29708, 29715 and 29710, the third zip code as the primary service area for the proposed 64-bed hospital.

Q: All right. And why were these zip code areas identified as the service area under the original 64-bed application?

A: The assumption was that having a presence in northern York would allow patients in that area better access to a hospital. Those were the three zip codes identified as the three northernmost zip codes and that's why they were identified as the primary service area.

Q: Okay. Now, did this remain the service area of the proposed Fort Mill Medical Center?

A: No. When we submitted the 100-bed application, we had looked at this, looked at travel times and consistent with what Mr. Walsh testified to yesterday, access for 29710 would require -- there aren't any bridges across the lake. Going around to the north at the time we

submitted the application we thought that made sense, but looking at travel times, residents of that zip code would not have as much access to the Fort Mill area as we had previously understood, so we modified the service area to show 29708, 29715 and then, as we talked about, portions of 29730 and 32.

Q: Let's take a look at that next Exhibit, next page in Carolinas' Exhibit 5. And what does this reflect?

A: This reflects the revised service area. This is actually the remanded CON that adds the 29707 zip code which was just a portion of 29715 at the time, but the original 2005 100-bed application shows the same as this, but there was no 29707 zip code, shifting 29710 to the secondary service area while still in the service area and, in fact, identifying the secondary service area. In the 64-bed application we didn't identify in the map the rest of York County as a secondary service area. I believe we described it, but we didn't show it on the map. This illustrates that and shows the entire York County, all the zip codes in York County either primary or secondary

service area for the 100-bed application.

Q: All right. You mentioned as part of the process looking at some drive times. Did you undertake or retain any drive time analysis such as Mr. Walsh performed?

A: No.

Q: All right. Then what did you look at in considering the question of access of residents on the southern and eastern side of York County?

A: We looked at internet resources, Google Maps, and things like that as well as software, mapping software we have. And then also discussions with Mr. Miller who has very detailed knowledge of the York County market, travel times and travel patterns.

Q: Okay. All right. With that Mr. Levitt, let me ask you to, let me ask your opinion concerning who best meets paragraph 2(e). Let me take you back to that so you have a chance to read that again since we first did that yesterday. If you'd draw up Exhibit 29, please, Dan? Page 25, paragraph 2(e). What does this paragraph mean to you, Mr. Levitt?

A: 2(e) says: The current annual projected

utilization should be sufficient to justify the expansion and implementation of the service.

Q: And which of the applicants best meets that provision?

A: Based on everything we've talked about, Piedmont's application for Fort Mill Medical Center best meets that. CHS does not.

Q: Okay. Dan, let's go ahead and provide the appropriate check. All right. Let's take that, Dan, if you would to the overview, the overview grid at 168.1. Now, with regard to the full community need analysis under section 2, Mr. Levitt, summarize your opinion concerning which applicant best meets that.

A: Yes, taking in total (a) through (e), Piedmont Medical Center best meets the review criteria.

Q: All right. Well, let's move then to section 3. And let's begin with section (a) and let's pull that out with the regs and define what that addresses, please.

A: 3(a) is the distribution accessibility criteria that talks about duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

So, it's looking at the duplication, modernization and basically determining whether or not that has been justified in the CON application.

Q: All right. And how do you apply this section of the regs to Carolinas' application?

A: Again, as we talked about under the purposes of the Act, both direct and indirect duplication of services should be analyzed.

Q: And apply that -- is there any direct unnecessary duplication that Carolinas' Fort Mill Medical Center would present?

A: No, that the 64 beds are needed in the market, additional beds are definitely needed in the market. So, from the direct perspective, no. But from an indirect perspective for all the reasons we've talked about that their duplication of specialized services and higher level services that would be treated in North Carolina, they would transfer those patients to North Carolina versus transferring them to the resources that are available at Piedmont, that's duplication.

Q: All right. Now, should this section be applied to both Carolinas' and Piedmont's applications?

A: Yes.
Q: Now, did the Department do that?
A: No.
Q: All right. Would you then apply it to Piedmont's application? Did they meet this provision?
A: Yes. Again, as we said when we talked about duplication in the context, the purpose of the Act, the need for the additional beds has been demonstrated, both in the Plan and in the CON application. And then rather than duplicate the other services that are available at Piedmont, we are strengthening healthcare services.
Q: And is the transfer of the 36 beds from Piedmont to Fort Mill an unnecessary duplication of existing services?
A: No. In order to increase utilization of both facilities, the transferred beds to Fort Mill is positive and results in positive impact.
Q: And which applicant best meets the tests under 3(a)?
A: Piedmont's application for Fort Mill Medical Center.
Q: Okay. Let's look at the grid that focuses on

3 specifically. And pull that up if you would, Dan, 168.3 and do those checks comport with your opinion?

A: Yes.

Q: All right. And let's move on to paragraph (b) and (c). We'll take these in one fell swoop, Mr. Levitt. Do you agree with the Department's position that both applicants equally meet provisions of (b) and (c) of Paragraph 3?

A: Yes.

Q: Okay. All right. Then let me draw your attention to Paragraph (d). Dan, if you would pull (d) up so Mr. Levitt can publish that.

A: 3(d) says: The proposed facility should not restrict admissions. If any restrictions are applied, their nature should be fully explained.

Q: All right. Now, what's the purpose of this provision?

A: To assure that the services are available to all residents in the area and that they're not identifying certain patient populations that are more desirable than others to treat.

Q: All right. Now, first of all, let's begin with DHEC's position on this. There has been

testimony, and you stated as well, there's a representation from Carolinas that they would shift their patients to the Carolinas Medical Center, is that right?

A: Yes.

Q: All right. And what position did DHEC take with regard to that assumption?

A: DHEC accepted and agreed with that position.

Q: Okay. And have you identified two places in the record that reflect that?

A: Yes.

Q: All right. Let's pull them up. Dan, let's begin with Joint Exhibit 1(B), page 1025. All right. And would you highlight the section of this page that reflects that position? All right. And what does this show, Mr. Levitt?

A: This is from the analysis attached to the decision to approve Carolinas Medical Center and what it says is the projections for Carolinas Medical Center-Fort Mill are based on a high level of current market share and is the only applicant that projects no increase in market share as a result of the proposed project. Carolinas proposes to serve only its existing patient base of patients.

Q: And what's your view of that position?
A: It doesn't make sound health planning sense. They're not going to serve only their patients.
Q: All right. Let's look at the prior page. For the any other such representations and reflecting the Department's position on this issue. What does this portion of the sentence state?
A: The analysis goes on to say Carolinas proposes to serve only its existing base of patients at CMC-Fort Mill, Carolinas captured 56.8 percent market share from northen York County in 2010 as compared to 44.3 percent in 2005.
Q: Did Carolinas, based on your review of the material they submitted to the Department, express positions consistent with the Department's findings?
A: Yes, they also indicated they would only treat their patients.
Q: All right. Let's look at Joint Exhibit 18, Dan, page 502. Pull out that paragraph 10. And read that into the record, if you would, Mr. Levitt where a statement is made by Carolinas. The last sentence.
A: This is from their assumptions for their

inpatient methodology and the last sentence states: Carolinas does not project any additional market share shift from Piedmont Medical Center or from Presbyterian-Mecklenburg facilities. Meaning their only going to be treating their patients.

Q: And let's look at the first sentence of that paragraph. What does that reflect?

A: It says: Assumed patient discharges at CMC-Fort Mill hospital would be derived from York County patients currently seeking care at Carolinas hospital in North Carolina. (Now given a choice to receive care at Carolinas facility closer to home). Again, these two taken together indicate they're only going to be treating their patients.

Q: All right. Now, if indeed this were to occur, what are the implications concerning the use of physicians on the medical staff of Carolinas Medical Center?

A: Well, I think their implied assumption is that only their physicians will be admitting patients and will only be admitting patients they had historically sent to North Carolina. So only CPN physicians would be using CMC-Fort

Mill and for all intents and purposes, it would be a closed medical center.

Q: Now, could it be a closed medical center so that only Carolinas physicians could practice in it?

A: I suppose they could do that but it would be inconsistent with the standards in the Health Plan.

Q: So it would violate the standards in the Health Plan for them to close the medical center?

MR. MULLER: Your Honor, I want to object. He's asking for a legal interpretation from this witness.

MR. ANDREWS: Fair enough. I'll withdraw the question.

THE COURT: I sustain the objection. Well, you've withdrawn it, so that's —

MR. ANDREWS: Sure.

Q: As a health planner who studies the State Health Plan, would it be consistent with the Plan for Carolinas to close the medical center?

A: No. And as we said, the number one criteria, number one importance in the project review criteria was compliance with the State Health Plan. So, if the application had a closed

medical staff, that would be inconsistent with the State Health Plan and the regulations say that an applicant that's not consistent with the State Health Plan can't be approved.

Q: All right. Is there, you've read Carolinas' application and its submission to the Department?

A: Yes.

Q: Have they stated the medical staff would be closed?

A: No.

Q: Okay. Now, have you, in your work on this case, Mr. Levitt, analyzed the extent to which the Carolinas employed physicians who are affiliated with the Carolinas Physician Network, accept patients on governmental programs like Medicaid or uninsured and indigent?

A: Yes.

Q: Have you developed a Demonstrative to identify those various sources of information you've reviewed?

A: Yes, we've done a number of different analyses and I've summarized those in an Exhibit.

Q: Dan, let's look at Demonstrative 203, please.

What's reflected here, Mr. Levitt?

A: This shows the four areas that we looked at to look at what we call payor mix research for the CPN physicians. The first one was included in submission to DHEC and I believe was submitted in July of 2011, so prior to submission we conducted a telephone survey.

Q: Let's pull -- I'm sorry, go ahead.

A: Kim Clayton is an employee at Piedmont Medical Center, works in medical staff services for Piedmont Medical Center and we asked her to conduct some surveys. I had called one facility at the time, one provider, one of the physician practices at the time and in the interest of time, I asked her to duplicate what we had done and call the CPN physicians in York County to determine whether or not they were accepting Medicaid and indigent patients.

Q: All right. Let's take a look at what's in the record concerning that survey. I'm sorry, it's Joint Exhibit 1(B), page 782. And what's reflected here, Mr. Levitt.

A: Again, this is the summary. We had done the same thing for the Presbyterian physicians, but this shows the CHS physicians, the Shiland

Family Medical Practices both Fort Mill and Rock Hill, and then the Medical Associates of Fort Mill and Rock Hill, the two primary care physician practices at the four locations, we looked at some data yesterday about the order of magnitude that those physicians represent for York County referrals and they were 80 percent of the referrals, so the vast majority of those practices in York County that refer to CHS facilities. What it showed for Shiland Family Practice was that no new uninsured patients were being accepted and no new Medicare or Medicaid patients were being accepted. Medical Associates of Fort Mill and Rock Hill both indicated that no uninsured patients would be accepted unless they paid in advance and they were to pay 70 percent of a new patient charge which averaged $290 to $800 prior to being able to schedule an appointment to see a physician.

Q: Okay. Let's then go back to Demonstrative 203, please, Dan? In addition to that survey in 2011, did you learn anything else that supported your opinions?

A: Yes, the second on the list, the interview and

meetings that Mr. Sullivan and I had with the medical staff prior to my deposition in July of 2013, very recently, we talked to the physicians about trends in the market, what they were experiencing, what they were hearing from their patients and what they were experiencing in the market as far as referring patients and what practices were taking what types of patients.

Q: And what did you learn in that regard?

A: It confirmed what we had found out in 2011, that nothing had changed as far as accepting of Medicaid patients at the primary care physicians in Rock Hill.

MR. MULLER: You know, we are now getting into the area we raised earlier in the objection. Mr. Andrews has not pointed it out, but he's asking him a hearsay question from the exact document we're objecting to. And that is a document that is replete with written notes that Mr. Levitt took of multiple doctors who are on the Piedmont Medical Center staff, on the governing board of the applicant. We would not have had an opportunity to depose all of them. So that document is hearsay and his repeating of in his

testimony is hearsay and that's the basis of our objection.

MR. ANDREWS: Your Honor, we don't need Exhibit 65, so I wasn't going to use that, Mr. Levitt's particular notes contain a lot of different issues. Don't object to them and I understand there's an objection so I was going to move through that. Of course, experts can, where it's consistent with what they do in this field, rely on hearsay, information otherwise inadmissable. That's the nature of what he's learned from a broad group and it's not a matter, in our opinion, of whether it's admissible concerning quite a number of members of the board, but we're don't believe that's factually true. But in any event, we believe it is admissible.

THE COURT: All right.

MR. MULLER: Your Honor, Mr. Andrews has pointed out that an expert can in some instances rely on hearsay. It has to be reliable. And our contention and we thoroughly briefed this in the motion in limine, is that information is not reliable, it's anecdotal. It's coming from various sources that can't be repeated. It is

the worst type of hearsay imaginable that he is now relying. Doctors telling him what they've heard from other CPN physicians or what they heard from unidentified patients. We have absolutely no way to refute that, of course, other than calling witnesses, which we will do, but it is the worst kind of rank hearsay you could possibly imagine and that's what he's getting ready to testify -- he's getting ready to repeat unreliable hearsay.

MR. ANDREWS: Frankly, Your Honor, he's finished. It would be a matter of striking it. I don't intend to go in any further depth. It's confirmative of a variety of sources and actually confirmed by Carolinas own documents that we're going to in just a minute, in fact, next. So -

THE COURT: Well, in light of the fact that that is the extent of what you're going to ask, I'm going to overrule your objection. I'm going to not strike what's been entered into the record. But don't -- you're not going to pursue this any further?

MR. ANDREWS: No, I'm not.

THE COURT: And so -- of course, you'll have the

opportunity to bring forth your position of this, the basis of this hearsay evidence upon which Mr. Levitt relied upon for opinion in this matter, the degree of reliability that and the verifiability of that.

MR. MULLER: Thank you, Your Honor.

THE COURT: Thank you.

Q: Mr. Levitt, let's go to your third point on your research related to CPN's acceptability of these patients.

A: Yes, again, prior to my deposition, Ms. Clayton and I did a similar analysis that we did in 2011. We called the physician practices, asked if they accepted Medicaid and self-pay patients and we had similar responses. They didn't.

Q: Okay. And subsequent to the calls before your deposition, have you made any further calls to Carolinas Physician Network offices?

A: I did.

Q: What are those?

A: Yesterday morning I called.

Q: And what did you learn?

MR. MULLER: Your Honor, let me just -- he is repeating information he did not provide during his deposition. Apparently he's done further

research that I didn't have the opportunity to depose him on and how he's expected to testify about it. So, I really, our position is that we're severely prejudiced by all this last minute information. You can see what's on your screen, this update was done apparently in February of 2013.

MR. ANDREWS: Your Honor, let me be clear for the record because apparently it's not. The February 13th calls were made before the deposition.

COURT REPORTER: One at a time, please.

THE COURT: Let's let Mr. Muller complete his objection.

MR. ANDREWS: I'm sorry.

THE COURT: And Mr. Andrews I'll let you fully explain. Thank you, sir.

MR. MULLER: The deposition date is February 11, 2013. He never mentioned any kind of updated survey and I asked him specifically about the survey that he had taken. So, this is the concern we had earlier is that some of these witness, their work has been much more expanded after the deposition is taken and this is a perfect example of that. I mean it is

prejudicing us because we didn't have an opportunity to depose him on these subjects.

THE COURT: All right. Now, Mr. Andrews?

MR. ANDREWS: I apologize, Your Honor. Your Honor, several points. First, the calls had been made. Mr. Levitt, to the best of my recollections, was not asked if it was updated. He doesn't have any obligation to volunteer that information and it certainly was related to the same subject. He was just updating the survey that had been conducted two years before. And frankly, Your Honor, he did the same thing yesterday. Just to gather the information. There is nothing, as I understand the rules of discovery and the rules of evidence, that would exclude information that's directly related to opinions that have been previously identified and the subject matter on which there's been opportunity to explore fully that would prevent any witness from continuing to gather information as long as it is consistent as long as it doesn't change opinions. All of which would be true related to his calls that Mr. Levitt made just to confirm the practice. And that's the issue, is

what's occurring as is a screen at the initial attempt for a patient to establish services. And then —

THE COURT: And I think Mr. Muller's position on this matter, Carolinas' position on this matter is that -- and I realize what you're basically offering is this subsequent to deposition testimony updates by your expert that bolster, in essence, the opinion that is given during the deposition. Not changing that opinion, but rather bolstering it. But at the same time there is an issue, in essence, of the inability of Carolinas in this situation to verify that or research that because it didn't come up in the deposition. And so, there is a certain degree of fairness here and the inability of Carolinas to be able to research what this basis was that bolsters the opinion after the deposition. I wasn't -- I did brief research on this last night. I wasn't able -- I agree with you. I can't find anything that prohibits this. On the other hand, I am concerned about the degree of fairness to Carolinas and their ability to prove this. Mr. Muller, can you determine from the deposition whether Mr.

Levitt was asked the question?

MR. MULLER: I asked him on two separate occasions to relay to me what it is that he did. And he never told me that there was a second updated survey that he had done. He said -- and a lot of this, and lot of these deposition excerpts, I believe, are in our memorandum with the motion of limine.

THE COURT: With the motion.

MR. MULLER: And I asked him, actually asked him once and he had some difficulty identifying who he had spoken to and then I asked him again and went into this, well basically I called and acted like I was a new patient and asked them if they accept Medicare or Medicaid. They said no, no. Not identified who he was speaking to. If the Court will give me a minute, I can probably identify the exact pages of the deposition where I asked him those questions, if it will help the Court to decide the issue.

MR. ANDREWS: May I respond just to something more generally related to the prejudice question?

THE COURT: Yes, sir.

MR. ANDREWS: Which is, Piedmont has no access other than through the standard depositions to issues

of practice of Carolinas Physician Network. And the practices vary. We could have done 30(b)(6) of someone at Carolinas, but we didn't do that. Carolinas has the ability to call anyone from those practices and refute this. We have -- we would not be in a position to object to exceeding the witnesses if it relates to their need to respond to this. And that's the way to manage the prejudice is whether in fact it's done. I would think the Court would have an interest in whether or not this was a practice in 2011, which they denied before the Department in project review, and whether it continues to be. We believe there are multiple sources of evidence that suggest this indeed is a practice and we believe it's reliable. I mean it can certainly be subject to cross examination, but not to exclusion what Mr. Levitt has learned and how we intend to use it.

MR. MULLER: Your Honor, that's the crux of the matter. He identified in very vague terms in his deposition what he had done and it was so vague and so unscientific that we objected to it our motion of limine. The Court reserved that objection to wait to hear how that was

going to be offered. Then in open court he said in addition to that, we've done this updated information. We've not made a test of the deposition of the veracity and reliability of this method that's he's used. We're hearing it for the first time on the stand so we are prejudiced in terms of how he's approaching this. And, you know, the reason we take depositions is because very often the story changes. We would have like to have known how he did it then if he had indeed done it prior to the deposition as he testified. He did not reveal that, so that's the worst kind of prejudice. You know, it's the basic tenet of cross examination, you generally don't want to ask a question you're not sure you know the answer to. I have no idea what he's going to say. And nor will Mr. Andrews solicit that from him because it is unfavorable to his case. So that's the prejudice part of this particular testimony and I understand Mr. Andrews has already pointed out he has a letter on the record that has addressed this issue. I believe if I ask questions about what he did it will be objected to, we do not believe it's

relevant. We don't believe the kind of information he got was reliable in the way he approached it by pretending he's a patient. He didn't identify who he spoke to at CHS. This is compounding that issue with a new updated survey he never disclosed to us.

MR. ANDREWS: Your Honor, just finally, again, this is fundamentally a question of fact. The ability to refute it is solely in Carolinas' hands. They cannot be unfairly prejudiced if they have the ability to call as witnesses those individuals who would be in a position to know what receptionist, back clerk, staff at their practices -- and it has too been identified. Saying to potential patients when they call and say do you take Medicaid, what does it cost if I don't have insurance? In fact, I'll elicit everything that -- despite what Mr. Muller says, what Mr. Levitt knows and said and who he talked with. He got a name this last time. That was an objection before. So they can verify that if they want at the practice. So, we're happy to put all that information on the record and go from there.

MR. MULLER: And Mr. Andrews has just outlined that

this information is factual. It is not the need of expert testimony to provide factual information. He took a 30(b)(6) deposition of our witness on these very issues. He's not sought to introduce that evidence. So that is part of my objection. He's simply trying to get through the backdoor of this expert witness some factual information that apparently he cannot obtain through a 30(b)(6) deposition of our witness.

MR. ANDREWS: And the reason for that, Your Honor, is that the 30(b)(6) witness didn't know, couldn't provide that level of detail. It was a senior official in Carolinas Network Physician System. Didn't have the knowledge.

MR. MULLER: And he denied that would have occurred. So, Your Honor, I maintain my objection as to the scope of this testimony, especially considering that what is now being offered as very likely post-deposition until the time of trial.

MR. ANDREWS: Your Honor, let me say in closing, if I could, that we identified this issue in 2011. It could have been checked out. Could have been specifically responded to saying, no, we

have checked with all of our York County practices and they don't do this. And verify that. That never occurred. And so we felt the issue was still live and still was the subject of research and that's why I asked Mr. Levitt to do it.

THE COURT: Mr. Andrews, let me see if can get clarification here and Mr. Muller, if you would be kind enough to help me here, in essence what we're talking about here is this initial calling interview study that was done by Mr. Levitt in order to attempt to verify or determine whether these certain physician groups were accepting uninsured patients.

MR. ANDREWS: And Medicaid.

THE COURT: And Medicaid patients. And there was an initial study done and that had formed the basis of Mr. Levitt's opinion. Subsequent to his deposition, this matter, he updated that survey and made some additional phone calls to some numbers. He made them to the same physicians.

MR. ANDREWS: Same practices, that's correct.

THE COURT: Same practices and received in essence, I guess, the same information.

MR. ANDREWS: That's right.

THE COURT: And Mr. Muller, your position is that because you weren't aware of the basis for this testimony that this all occurred after the deposition that this is prejudicing you and your ability to refute what he's testifying to?

MR. MULLER: Well ---

THE COURT: In addition to the reliability issue.

MR. MULLER: As Mr. Andrews said, we knew what he contended in the letter he submitted to DHEC. We asked him questions about that and he responded to those questions and that was the basis of our objection. It was a very un-thorough way to survey and it was deceptive in the way he did it and there's no way for us to even determine who he spoke to. You know, and Mr. Levitt has a tendency of doing this, when you point out deficiencies during his deposition, he then tries to bolster before trial and that is exactly what he has done. He has tried to go back and do a more thorough approach to that but I suspect he's not going to tell us who he spoke to by name. I don't know any of the details of what he's saying because he didn't reveal them during his

deposition and it's a game of hide and seek, frankly. And this is a pattern of Mr. Levitt during these depositions.

MR. ANDREWS: Objection to the second time for that, Your Honor. The characterization of Mr. Levitt's practice and his testimony is really out of bounds.

MR. MULLER: Well, I think I can bring some of that out on cross.

THE COURT: All right. And let's not disparage anybody's character here. Let's just get this done. I'm going to tell you what. It's 11:30. We haven't had a break. What I -- how much longer do you anticipate you're going to be with Mr. Levitt? Assuming we get through this.

MR. ANDREWS: Other than this 30 minute delay, I think it's likely to go beyond lunch, but not a lot beyond lunch.

THE COURT: All right. And then you'll have, of course, some, I'm sure, a substantial amount of questioning to do. What I'm thinking is, it might be a perfect time to take an early lunch break. It's 11:30. We'll reconvene at one and that will give me an opportunity to review this and your objection, we'll come back on the

record, I will rule on this and then move forward. Gentlemen, thank you. Ladies and gentlemen, thank you. We're in recess.

(Off the Record)

THE COURT: Please be seated. Okay. We're back on the record. And I do apologize to the parties. That took a little longer than I anticipated. I hope y'all had an enjoyable lunch and relaxed a little bit. Mr. Andrews, I have a question for Mr. Levitt.

MR. ANDREWS: Yes, sir.

THE COURT: Mr. Levitt, sir, is this -- and when I refer to this thing, I'm talking about the surveys ---

A: Yes.

THE COURT: --- in question here, that you took, the telephonic surveys. Are these surveys, this type of thing, is that something you've reasonably relied upon or that is reasonably relied upon by experts in your field of healthcare planning in a Certificate of Need application in formulating your opinions or inferences?

A: Yes.

THE COURT: All right. Ladies and gentleman, based

on this answer, I conclude that the telephone surveys conducted by Mr. Levitt in February of 2013 and the prior survey were of the type of data that is reasonably relied upon by experts in this field of healthcare planning and Certificate of Need application and is proper as a basis for the formulation of his opinion on the subject. Which in this case, is the out-migration of payor, insured patients from Petitioner Piedmont's hospital is in part due to the practice of Respondent's affiliated physicians not taking uninsured, Medicare or Medicaid patients. The Court will consider the testimony elicited from Mr. Levitt regarding the February 13th survey and the prior survey conducted before that, that he and the unnamed Piedmont employee conducted, and which were known to Respondent Carolinas at the time of Mr. Levitt's deposition. However, because of the limited size of the survey group, the fact that Mr. Levitt did not conduct all the surveys, the very limited nature of the survey questions asked and the lack of identity of parties answering Mr. Levitt and the other employee's questions at the various practices,

the Court finds that this evidence is of limited probative value and that any evidence of the subsequent survey that was conducted this week by Mr. Levitt is outweighed by the prejudice to the Respondent Carolinas and therefore the Court will not consider any evidence regarding the most recent survey on permitting the questioning of Mr. Levitt on that survey other than cross examination questions -- well, at all on that matter, but of course cross examination questions as to the crux.

MR. ANDREWS: All right, sir. Thank you, Your Honor. All right. With that, shall I proceed?

THE COURT: Yes, sir. Please.

Q: Mr. Levitt, then if you would, please explain to the Court the nature of your calls, what you did to place the calls in February of 2013. Why you conducted them.

A: Simply -- and perhaps the calling it a survey is a bit much. I just simply called the physician practices, called the primary care physicians practices in York County owned by CHS. When an individual answered the phone -- I believe, I believe it was automated, press

two for an appointment. I pressed two. An individual answered the phone. I said you know, I have a family member that would like to make an appointment -- or one I asked, I said that to the other, that I would like to make an appointment. Asked if they were accepting new Medicaid patients and they said no. On -- I believe on the first call before I said if they were accepting new Medicaid patients, they asked what my insurer was. They said what insurance do they have. I said if they have Medicaid can I make an appointment and they said no. They weren't taking any Medicaid patients. One of them I asked if they were taking Medicare, they said no new Medicare patients either. And self pay? If they paid in advance, they could come. So, it wasn't a scientific survey. It was to confirm what the physicians had told me prior to that in those interviews I conducted.

Q: Let's don't get into any more detail on that.

A: Okay. To confirm what I had heard, that the CPN physicians weren't accepting Medicaid and Medicare patients and self pay, so I called to confirm that and that's what I found out.

Q: Okay. And let's be specific about which practices you called. Do you remember?
A: I called the two Shiland - no, then I called the -- not the Shiland practices, the ---
Q: Dan, if you would, put up Demonstrative 27 which includes a list of all the practices so you'll have them in front of you and you can identify which ones. I'm sorry. I said Demonstrative, I mean Carolinas Exhibit 26.
A: I called Medical Associates, the two Medical Associates locations, Fort Mill and Rock Hill.
Q: Okay. And why did you elect to call those two offices?
A: They were the primary care practices in York County owned by CPN.
Q: Okay. And why didn't you say this is David Levitt the healthcare planner working for Piedmont Medical Center? Why didn't you introduce yourself that way?
A: Well, frankly it didn't occur to me. I wanted to find out if they were accepting new patients. Not if they were accepting new patients if they were asked by me for Piedmont Medical Center.
Q: Okay. Now, the individual that participated in

the calls that were recorded in your July 11, 2011, letter to DHEC for Piedmont, what was her name?

A: Her name was Kim Clayton.

Q: Okay.

A: I couldn't remember that at time of the deposition.

Q: And based on the report that's in the record, what offices did she call? We can pull those up if it would be helpful.

A: Yes, I believe she called those as well as the Shiland Family Practice, both locations.

Q: Okay. And how did the information she obtained in those calls compare to what you learned in yours?

A: They were consistent. They weren't accepting new Medicaid patients. Shiland wasn't accepting Medicare patients and Medical Associates required an advance payment for self pay.

Q: Okay. All right. Now, let's move on and let's go back, Dan, to Carolinas Exhibit 27. In addition to the telephone calls that were made, Mr. Levitt, have you considered any other information that affects your opinion about

whether the Carolinas Physicians restrict the services they provide to their patients?

A: Yes.

Q: And what did you learn through this document?

A: This document shows the payor mix by practice that they provided. And it, we talked about yesterday, I think it was, where we showed that Shiland Family Medicine and Medical Associates, those four locations, represent about 80 percent of the total and you can see the payor mix of those four locations, the percentage Medicaid for Medical Associates of Fort Mill is a fraction of a percent, .3 percent. Medical Associates of Rock Hill is 0.1 percent.

Q: Excuse me a minute. Dan, could you draw those out so we could see them a little better, please? I think that's pretty clear. And what are, I'm sorry, Dan, can you draw out the practice name and then the Medicaid participation for each of those offices? We'll begin with Medical Associates of Fort Mill. And what's the source of this document, Mr. Levitt?

A: This was provided by Carolinas Medical Center in discovery.

Q: All right. And for 2012, what was the Medicaid participation reported by Carolinas of the Medical Associates of Fort Mill?
A: It is 0.3 percent of the patients are Medicaid patients.
Q: All right. And for the Medical Associates of Rock Hill office?
A: 0.1 percent.
Q: Okay. And Shiland Family Medicine?
A: That's the location in Rock Hill and it's 1.0 percent Medicaid.
Q: And what's the Medicaid participation for Shiland Family Medicine Fort Mill?
A: 0.6 percent.
Q: Okay. And do you remember from your review of the referral data yesterday the total percentage in general terms, referrals that these four offices made of all the York County CPN offices?
A: They represent with the exception of, taking out the cardiac --
Q: The Sanger Clinic?
A: The Sanger Clinic, they represented about 80 percent.
Q: Okay. And in the -- Dan, let's go back to the

document, if you would. And you can drop those highlights. Thank you. And actually, I'd like for you to pull out the Sanger Heart and Vascular Institute at Fort Mill and the Sanger Heart and Vascular Institute of Rock Hill. And pull out their Medicaid participation as well for 2012.

A: Above that.

Q: All right. And what is the Medicaid participation of these two clinics that provide cardiac services to York County residents?

A: Fort Mill is about, is 1.5 percent and Rock Hill is 1.6 percent.

Q: And do you remember the general order of magnitude of the number of referrals that came out of the two Sanger Clinics in 2012 based on the data you looked at?

A: 2012 was a very large number, a very large percent.

Q: Around 3,000 between the two offices?

A: Between the two combined, yes.

Q: All right. Okay. Let's take a look -- thank you, Dan -- at the bottom practices, Sanger Heart and Vascular Institute and Rock Hill Pediatrics just to be clear about what that is.

There's a footnote. Dan, if you'll just highlight the left hand corner of that document so we can just call -- well, first of all, sorry. Let's call out the whole corner so we pick up the Sanger and pediatric office down through the Medicaid and the footnote. There you go. All right. Now, there's a Sanger Heart and Vascular Institute line item that says and has a slash Rock Hill Pediatrics. Dan, would you take that all the way through Medicare? I'm sorry. One more. All right. There we go. So we pick up the footnote. And Mr. Levitt, we see that there's a third Sanger office, it has a name and shares it with Rock Hill Pediatric Center and do you see the fourth column that has zero?

A: Yes.

Q: That's in the Medicare column and then read the footnote, if you would.

A: It indicates that pediatric practice does not see Medicare patients.

Q: So, what inference would you draw concerning that line item as to what kind of office is reflected there?

A: That it's a pediatric office.

Q: All right. So then if you look at the internal medicine practice operated by Carolinas York County, the family medicine practice and the cardiac, cardiology practice, what is your conclusion concerning their participation of those six offices in the Medicaid program?

A: That they have a very limited degree of Medicaid participation. A fraction of a percent to a high of 1.6 percent.

Q: Based on your knowledge of demand for services in this county and your experience in this field, what's your opinion concerning the likelihood that these offices providing those services would have that percentage of Medicaid practice if they were not restricting their Medicaid new patients?

A: Well, it wouldn't make any sense. If they're accepting all patients regardless of payor, they would have a normal distribution of payor patients and that's not what's shown.

Q: What is a normal distribution in York County and particularly in Rock Hill and Fort Mill of Medicaid patients?

A: It's in the teens for hospital patients. In the teens, so I mean less than one percent is

substantially lower than the county average.
Q: Than the county average?
A: Yes.
Q: That's for hospitals and based on the testimony you've heard from Dr. Taylor and Dr. Adlakha and otherwise looking at the data that Carolinas provided in Exhibit 27, do you have an opinion about what the general range for physician practices would be of Medicaid?
A: Yeah, some of them -- I heard Dr. Taylor say 50 percent of his OB practice, so substantially higher than less than one percent and single digits.
Q: All right. And let's look at the top line for this document for Carolinas Cancer Specialist. What is the Medicaid participation of that practice?
A: 14.3 percent.
Q: And who are the owners of the cancer center and where is the Carolina Cancer Specialist practice?
A: That's the joint venture between Piedmont and Carolinas Health System.
Q: Okay. All right. Now, based on your review of the data that you've testified about and the

telephone calls, the review of your meetings with physicians, your review of the data in Exhibit 27, Mr. Levitt, what is your opinion concerning which party, whether either party imposes restrictions or would impose restrictions either directly or indirectly on their admissions at their respective hospitals?

A: Well, based on what we've talked about, that the Piedmont Medical Center proposal does not and with the CHS proposal does.

Q: Okay. And what –

THE COURT: I'm sorry, I didn't hear that Mr. Levitt, could you repeat that?

A: I'm sorry, that the Piedmont proposal for Fort Mill does not propose any restrictions and the CHS proposal does.

THE COURT: All right. Thank you.

Q: And let me again ask you to explain how the limitations on the practices of the Carolinas medical practices in York County would impose a restriction on the admissions of CMC-Fort Mill?

A: Well, if the primary care practices aren't accepting Medicaid patients and don't have a history of having any Medicaid or very limited

Medicaid patients, they would then not be -- those patients would not have access to primary care physicians that would refer them to specialist to take them to the hospital. So they sort of act as a gatekeeper to prevent those admissions from occurring.

Q: What if you assumed that some Medicaid patients would come in through the ER. What effect would that have on the restrictions that you've identified?

A: Well, obviously they can't control who shows up at the ER and what their payor sources are, but those would not be CPN patients if they had Medicaid because they wouldn't be in the pool. If they have Medicaid, they're not seeing the CPN patient, the CPN physician, so they would be patients that had historically been treated at Piedmont.

Q: And which patients was it that Carolinas in their application have represented that they would shift?

A: The CHS patients that are treated by CPN physicians.

Q: And what Medicaid participation is reflected in those? In that patient population?

A: In the CPN physicians?
Q: Yes.
A: It is very little. That's what we've been talking about.
Q: Okay. All right. And based on that, what's your opinion about which applicant best meets these terms of 3(d)?
A: The Piedmont application.
Q: Okay. And Dan, let's cut to the grid at 168.2 looking at the components of Section 3. And so, I think previously you testified that both parties equally met Paragraphs 3(b) and 3(c). Do I remember that correctly?
A: Correct. And 3(d) we just said Piedmont meets and CHS does not.
Q: Okay. All right. Let's move to the next section of the regulations. Which is at 3(e) and documenting the needs of access. Do you agree with the Department's position that both parties equally meet that?
A: Yes.
Q: Okay. And then let's move to paragraphs (f) and (g). Would you, Dan, if you'd pull up Exhibit 29, page 26. And Dan, if you'd highlight both of those and Mr. Levitt, if

you'll read each of those into the record, please.

A: (f) states: That the applicant should address the extent to which all residents of the area and in particular low income persons, racial and ethnic minorities, women, the elderly, handicapped persons and other medically underserved groups are likely to have access to those services being proposed and (g) states: The facility providing the proposed services should establish provisions to ensure that individuals who need a treatment as determined by a physician have access to the appropriate services regardless of the ability to pay.

Q: All right. And what's the relationship between (f) and (g)?

A: They're interrelated that they both address individual access to the facility based off of certain criteria including ability to pay as well as other minority identifications.

Q: Okay. All right. Let's begin by looking at the projected levels of indigent care that each of the parties offered. Have you identified those?

A: Yes.

Q: Dan, let's pull up Demonstrative 182, please. And what does this information contain, Mr. Levitt?

A: This is a summary from the two CON applications, or the four CON applications, actually, the 2002 applications for both applicants and the 2010 information submitted shows the Piedmont proposal, both 2005 and 2010 propose three percent of gross revenue to be indigent care. Carolinas, in the original 2005 application projected 3.5 percent. They raised that to 6.3 percent in the most recent application.

Q: Do you believe that increase in their projected indigent care volume was justified?

A: No.

Q: Why not?

A: Based on their patients that they're sending to North Carolina from York County, the experience in their North Carolina facilities, and then from -- most recently, the mix of their physician practices, it's unreasonable.

Q: All right. Did you look at any internal information in the Carolinas application to determine whether the projection of 6.3 percent

was consistent with their application?
A: Yes.
Q: All right. Dan, let's look at Demonstrative 183. And did you prepare this Mr. Levitt?
A: Yes.
Q: And what's the purpose of it?
A: This is to show, we raised this issue in the July 11 submission to DHEC that their payor mix, there aren't enough patients in the payor mix to justify the 6.3 indigent care. So in their initial application, the other category was eight and a half percent of total. So, eight and a half percent total patients in the 2005 application would be other than commercial managed care patients, Medicare and Medicaid patients. So that's the source of the indigent care. Those people that don't have insurance.
Q: But is indigent care showing on that?
A: No. Well, indigent care is a separate line item at the bottom, three and a half percent. And that three and a half percent would come out of the eight and a half percent.
Q: In their initial application?
A: In their initial application. In their revised application, they projected that their other

category would be reduced to three and a half percent. So their managed care went up substantially from 36 percent to 50 percent. Again, the totals have to add up to 100. So it came out of other. And a little bit of Medicaid, so their other went down to three and a half percent, but their indigent care went up to 6.3 percent. So, they're saying that for three and a half percent of their patients, they're going to provide 6.3 percent charity care. So the math just doesn't work. There's not enough uninsured patients to get to that level of charity care.

Q: All right. So, let's break down the components of the payor mix chart that you prepared. You testified earlier about what managed care and commercial are. That's Medicare and Medicaid. Now, what in the presentation of financial information of the hospitals would be included in the other or miscellaneous category?

A: That would be -- given these four categories, that would be self pay, uninsured individuals. It could also include workers' compensation, auto insurance, sometimes that's in commercial but generally that would be in the other

category. VA, CHAMPUS. Sort of the other small, other identified payors.

Q: Now, are all self-pay patients always indigent?

A: No.

Q: And explain how that's the case.

A: No. Self pay just means they don't have either insurance or Medicare or Medicaid. So, an individual could have a job, chose not to buy health insurance, goes to the hospital and that would be in that category.

Q: Because that individual did not meet the hospital's eligibility, charity care eligibility guidelines, would that be true?

A: That could be a category, yes, that they would have sufficient funds to pay their bill and they don't have health insurance and they pay for it.

Q: Okay. And so that other, that miscellaneous category in the initial application was 8.5 and would there have been any justification for reducing that miscellaneous category by over two times, down to 3.5?

A: They didn't identify any, no. And that's inconsistent with doubling of their indigent care.

Q: Okay. All right. Now, the percentage presented are percentages of what did you say?
A: I believe these are percentages of revenue.
Q: Okay. Now, could it be the 6.3 percent are percentages of patients instead of revenue? Would that be a reasonable or plausible interpretation of this data?
A: No, because generally they would have lower. The self pay would have lower charges than average, so then that would be worse.
Q: Okay. Why is it generally true in your experience that self pay would have lower charges?
A: Because they're paying for it. So, if ---
Q: Because -- sorry, go ahead.
A: Because they're aware of what they have to pay for and it becomes very expensive and that's sort of one of the issues that's been identified with healthcare, if you don't have to pay for it then you get lots of things provided to you, so the, the charge is generally lower.
Q: All right. Now, okay. Did you look at any other data beyond the application concerning the reasonableness that led you to an opinion

concerning the reasonableness of the Carolinas projection?

A: Yes.

Q: All right. Let's take a look at Demonstrative 200. And what does this reflect, Mr. Levitt?

A: We looked from the Medicare cost reports for the most recent year available, 2010 or 2011 depending on the facility. The amount of charity care they reported on the charity care schedule compared to their total gross revenue to calculate the percentage of charity care for the CMC facilities in Charlotte and then compared that to Piedmont.

Q: All right. And you pulled this from the Exhibits 75 through 78 and then 81 for Piedmont, is that right?

A: Correct. And those Exhibits were the Medicare cost reports.

Q: All right. Now was this data you had to calculate or was it identified in the cost reports?

A: Well, the two numbers were identified in the cost reports. For instance, for CMC, $188,131,392 was a line item in the cost report. Gross revenues of $3,739 -- 739,648

was in the cost report and then I did the math. I divided the two to get the five percent.

Q: Okay.

A: And I did that for all the facilities. And you can see the range for the CMC North Carolina facilities, five percent for CMC, 2.6 percent for Mercy-Pineville, 4.8 percent for CMC-University. And those are the four facilities they identified as the source of patients for the CMC-Fort Mill hospital. So, looking at the average of those, four and a half percent is their charity care experience in 2011. Again, they projected 6.3 percent at the Fort Mill hospital. CMC-Union, another facility just over the border in North Carolina from South Carolina, they had a three and a half percent charity care percentage, so an average of all five of those hospitals, 4.4 percent. And that compares to the 3.8 percent at Piedmont and Piedmont projected three percent. So, it shows that Piedmont was consistent and the CMC-Fort Mill was inconsistent with their experience.

Q: All right. Did you look at any of the York County data, the extent to which charity care was provided to York County residents from

Piedmont and Carolinas?
A: Yes.
Q: All right. Let's take a look at that. Demonstrative 186, Dan. And what did you find here?
A: Well, we couldn't isolate ---
Q: First of all, I'm sorry, identify if you would just for the record, the source of the information too.
A: This is from -- it's identified as Piedmont Exhibit 14 and I believe that is the database, the North Carolina South Carolina data with the IRS and the Thompson-Reuters information.
Q: You say you believe because you're not certain where the data comes from or you're not certain which Exhibit it was?
A: I'm not certain what Exhibit 14 is.
Q: That's the pivot table of the database and is that where this information came from?
A: Correct.
Q: Okay. And the CHS includes what?
A: CHS, again, that's the four facilities they identified as the source of CMC-Fort Mill patients. The CMC-Main, CMC-Mercy/Pineville and CMC-University hospitals combined, so all

York County residents that were treated in North Carolina in 2011, this is the payor mix for those patients treated at the CHS hospitals.

Q: Okay.

A: Also shown is the York County Piedmont payor mix that shows their mix of patients for York County by payor. Now, we couldn't identify charity alone because it's not a category in the two databases. There is the self pay/charity category. So that includes both those patients that pay out-of-pocket as well as those patients that don't pay out-of-pocket would be the charity. And you can see CHS had about a six percent of their patients were self pay/charity and Piedmont had 10.7 percent of patients as self pay/charity.

Q: Okay. Now, while we're on this document, let's look at the Medicaid line item since we've given so much attention to that previously. What have you found here and what are the implications of the finding?

A: The Medicaid mix for CHS, the four facilities is 11 percent. Piedmont is 18 percent. In their CON application, I believe they projected

15 percent Medicaid so they projected higher Medicaid than they actual experience. Same with the self pay/charity. They had six percent self pay/charity, so that included people that did pay their bill as well as people that didn't pay the bill and they projected higher than that for charity care at the CMC-Fort Mill location which is a much more affluent part of York County.

Q: All right. Let's -- before you leave that, look at the difference between the managed care experience of the two systems. What do you observe there?

A: That the CHS facilities transfer or treat more managed care patients in North Carolina than Piedmont gets out of York County at their facility in Rock Hill.

Q: Okay. All right. Did you look at any documents of particular CHS hospitals concerning their indigent care experience?

A: To the best that I could find, yes, I did.

Q: All right. Dan, let's pull up Demonstrative -- well, before we move to the Demonstrative, I think it's the Bates document is SCHS-1205. And highlight the header on this if you would,

Dan. What is this document, Mr. Levitt?

A: This is the generalized health system, Carolinas Healthcare System departmental performance report for period 12/31/2009, if you scroll back out and go over to the left at the top, I believe it is for business unit Carolinas Medical Center-Pineville.

Q: And why did you look at this?

A: To look at the experience of Pineville. This is the only data I could find that isolated out Pineville from Mercy.

Q: Why is it important to look at Pineville and/or the Pineville Mercy system?

A: Well, based off of their need methodology where they said they're redirecting their patients that went to North Carolina, the majority of those patients went to Pineville.

Q: Let's actually, Dan, cut that back, if you would, to Demonstrative —

MR. MULLER: May I ask the source of that document they just showed?

Q: Sure, it's your document, SCHS-1205. I'm coming back to it.

MR. MULLER: I guess my question is, is it an Exhibit that's been admitted into evidence?

MR. ANDREWS: It's a demonstrative.

MR. MULLER: It's a demonstrative?

MR. ANDREWS: Yes.

MR. MULLER: Because we did have -- this is an incomplete document and we did label confidential in discovery. There's a protocol for using that. I just want to make sure they're following that. I really had no idea they were going to use this document. We had a consent protective order in place ---

THE COURT: Yeah.

MR. MULLER: --- that was designed so that Mr. Andrews was supposed to alert me if he was going to use a document like this. When I looked at it initially, I just thought it was an Exhibit. He's now using a demonstrative without notice.

THE COURT: Mr. Andrews?

MR. ANDREWS: We're not intending to introduce the document into evidence, Your Honor. I thought it would be, or if I intended to do that and put it into the record would be the need to notify counsel and protect it, which I appreciate, but I didn't think it was necessary when we were eliciting limited testimony.

THE COURT: I realize you're just using it as a demonstrative, but it is a confidential document that's sitting up here on the screen and that's your concern.

MR. MULLER: Frankly, if he is using this we would object to it because it is an incomplete document. Now, in all honesty I think we can address it through our witnesses if it not offered as an Exhibit. It is a confidential document. I feel like I need to preserve that. That aspect of the protective order that we mutually agreed to and entered into.

THE COURT: But you're not objecting to Mr. Levitt's testimony from the information, but you're saying you don't want that -- you're objecting to this document being flashed up here?

MR. MULLER: I think that, and I can recall during his -- I just want to be completely honest with the Court.

THE COURT: Yes.

MR. MULLER: I'm nor surprised by this document because Mr. Levitt referenced it in his deposition, I think the only thing that surprised me is, relates to my objection yesterday, Mr. Andrews keeps trying to get

information in the record that might not be admissible through these Demonstrative Exhibits. That is not a document that Mr. Levitt created, it's a document they pulled out of discovery materials that we labeled confidential and now are trying to introduce through this testimony. That's the basis of my objection.

MR. ANDREWS: And in fact, Your Honor, Mr. Westbrook just corrected me, I had forgotten that we had indeed identified this as a potential Exhibit. There was no objection to it. Exhibit 60, chart 83.

MR. MULLER: I stand corrected, but, Your Honor, I just –

THE COURT: That's okay. I was just going to suggest if it was a confidential document you could still have the witness talk about it.

MR. ANDREWS: And I'm frankly, without getting into this, that fact passed me by. I'll be willing to withdraw it as an Exhibit and just use it for limited demonstrative purposes.

MR. MULLER: And I frankly did not realize it was an Exhibit. That's why I asked when it was put up because he indicated it was a Demonstrative, I

simply did not mark it –

THE COURT: Yes, sir. I understand.

MR. MULLER: We did not object to it, I believe.

THE COURT: Right.

MR. MULLER: Is that right?

MS. ROBERTSON: We did not object to that.

THE COURT: So therefore it is an Exhibit –

MR. MULLER: It is. I apologize to the Court, when he said it was a demonstrative –

THE COURT: I'm glad you clarified that. Thank you Mr. Muller and Mr. Andrews, you may proceed.

Q: All right. Mr. Levitt, actually, I was -- before we -- I elicit further testimony about this document, I want to take you back to Demonstrative 200. To specifically look at based on the cost reports, the indigent care experience reported by the Mercy Pineville system. What percent did you find there based on what you identified in the cost reports?

A: It was about 2.6 percent and a little less than $31 million in total charity care.

Q: And to what degree, based on your view of Carolinas' applications would the patient base that Carolinas intends to serve with CMC-Fort Mill be derived from their services at Mercy

and Pineville?

A: The majority of the patients. Those two facilities represent, particularly Pineville, the single largest source for patients for the CMC-Fort Mill facility.

Q: And then what inferences did you make about their historical experience at those two facilities at 2.6 percent and how that compares to the 6.3?

A: That's the source of patients but yet they're projecting nearly three times higher percentage of charity care at their Fort Mill location.

Q: Okay. And with that, let's go back to what I'll refer to as Demonstrative 187.

MR. MULLER: Your Honor, we don't have any objection to withdrawing our Exhibit 83 and just going with a Demonstrative. I'm sorry, never mind. Let me, I stand corrected.

THE COURT: It had been admitted without objection.

Q: It was already admitted, all right. Okay. Let's go back to this document then, Mr. Levitt and let's look at Demonstrative 187, Dan, if you could pull that out. And what does this show?

A: This shows for that for line item provision for

charity care, that they -- their actual experience for the year was $510,847 out of $385,034,797 in gross revenue. And as a percentage that represents a fraction of a percent, 0.13 percent.

Q: Okay. Now, just so the record is clear, you said they. Who are you talking about here?

A: This is the Pineville location. So the Pineville hospital, this was their -- according to this document, this was the amount of charity care they provided in 2010, I think it was.

Q: Okay. And there's an actual line item and there's a budget line item. And are you referring to the actual or the budget as the charity care that was identified in this document?

A: That was the actual amount. I think Ms. Carter, in her deposition said that they reclassify a lot of that charity care and I wouldn't understand why you would reclassify it, and that could be, but I don't understand why you would reclassify it in your budget though. And that was their budget amount was $355,000 out of $375 million or less than one

percent. Or less than .1 percent. So that's what they budgeted and that's what their actual experience was.

Q: Now, what was their actual experience? Have you calculated that?

A: Yeah, that was the .13 percent, I believe.

Q: And their budgeted allocation of charity care was what?

A: .09 percent.

Q: Okay. Thank you. Now, let's actually -- did you do any further review of the Mercy Pineville indigent care experience?

A: I did. The cost report, again, is combined for the two locations. This identified -- we had also identified the Mercy location separately in another document.

Q: Okay. Let's pull that document up. Dan, Demonstrative 20. And what does this document reflect?

A: So, the first column is the Mercy information pulled out and that we got from a North Carolina CON application where they presented their Mercy-only information. It showed $551 million in gross revenue, $199 million in net revenue. The charity identified was

$28,108,000. That represented 5.1 percent of their gross revenue and 14.1 percent of their net revenue.

Q: And what do you have as in the Pineville?

A: Now, in Pineville, there's a difference. We had a Medicare cost report at about $31 million in charity care. And the gross revenue was in there as well. Subtracting those out gives you $661 million in gross revenue at Pineville, $215 million of net revenue at Pineville and the difference between the total charity care at both facilities and the Mercy facility of $2.2 million at Pineville for a 0.3 percent of gross revenue of their indigent care which is consistent, higher, but consistent with their information in the budget and their actual experience.

Q: All right. Now, Mr. Levitt, did you attempt to determine whether or not Carolinas' projection of 6.3 percent was consistent with the indigent care that was projected in CON applications in South Carolina for new hospitals?

A: Yes.

Q: And did you prepare a Demonstrative reflecting that?

A: Yes.
Q: All right. Dan, let's pull up Demonstrative 118, please. What does this show?
A: This shows the information pulled from various CON applications for satellite hospitals since 2005 ---
Q: The Exhibit is identified in the footnote?
A: Correct. There was all the Exhibits we've been provided as Exhibits. I pulled the information from those. What it shows is by the third year of operation for these facilities from highest to lowest, the CMC-Fort Mill at 6.3 percent is by far the highest projected indigent care amount. Going down, Greer-Greenville was the next at 4.13. Two percentage points lower. At the bottom the Trident-Berkeley and the Roper-Mt. Pleasant facilities at less than two percent, 1.9 and 1.8 percent of gross revenue was their charity care percentage. The Fort Mill Medical Center at three percent fell in the middle of the pack.
Q: All right. Now, does Carolinas own and or manage of the hospitals reflected on this list?
A: Yeah, the two Roper hospitals.
Q: And what was the indigent care that those

hospitals projected?

A: Roper-Berkeley in 2008 projected 2.2 percent and Mt. Pleasant, Roper-Mt. Pleasant in 2005 projected 1.9 percent. So, substantially lower than the 6.3 percent projected at CMC-Fort Mill.

Q: And how does the information you extracted from these applications affect your opinion concerning the reasonableness of the 6.3 percent?

A: I find it to be unreasonable. It's just too high. It's not based off their experience. It's not consistent with other projections. It's not consistent with their cost report experience in any of their facilities. I find it unreasonable.

Q: To what degree do the demographics of an area that a hospital serves affect the indigent care of those facilities?

A: Well, I think very directly. To the extent that an area that is obviously more affluent than the number of individuals that would fall below the guidelines for their charity care would be less.

Q: All right. And looking at the counties and the

service areas reflected in the applications on your Demonstrative 118, which of the areas are the most in -- well, how does the Fort Mill area compare in terms of affluence and average incomes to those other areas served by the other hospitals?

A: Well, York County has one of the highest median household incomes in the state. I think it sort of battles back and forth year by year with Beaufort. Beaufort and York are the two most affluent counties in South Carolina. And Fort Mill is the most affluent area within York County based on median household income.

Q: And how would that affect the comparative data compared to the demand or need for indigent care?

A: Generally, if it's in the most affluent area of one of the most affluent counties, it would have a lower percentage of charity care not the highest.

Q: Did you in fact prepare a demonstrative that shows the median household income that you have researched?

A: Yes.

Q: Dan, let's turn to Demonstrative 188, please.

And what is this and where did you get it Mr. Levitt?

A: This is the median household income by zip code for 2012 and 2017. And there's an error on here.

Q: What's that?

A: The source is not ORS.

Q: What is it?

A: It's Claritas.

Q: Okay. And what's Claritas?

A: Claritas is a data source that I don't typically use, but CHS used it so we used it. Planners use it for the most part to get population demographic information. The office of research and statistics generally doesn't project population by zip code, so it's commonly accepted to use that as a source for zip code level information. And what it shows is the 2012 and the projected 2017 median household income by zip code -- and you can see with the highest median household income in 2017, $71,000 is 29708, which is the Fort Mill zip code. The next highest is $61,577, which is the other Fort Mill zip code, 715, and then the portion of Lancaster County is higher than

average, but still 46, 47,000. So, the two highest zip codes in the market are the Fort Mill area. Which is where the proposed hospital is going.

Q: Okay. Now, what effect does the location, and again, the income data have on the reasonableness of the 6.3 percent projection?

A: Well, it's an affluent area with high median household income. There isn't a sufficient pool of indigent patients in that area to justify a 6.3 percent projection by CMC-Fort Mill.

Q: Okay. Are there any other considerations that you took into account in forming an opinion concerning the indigent care projections?

A: Yes.

Q: What's that?

A: Generally, as I said, the experience of the applicant, the demographics of the area, the socioeconomics of the area and the experience of the physicians in the area led to the conclusion that the 6.3 percent is not reasonable.

Q: Okay. Mr. Levitt, are you familiar with the Affordable Care Act?

A: Yes.
Q: What's the, in general terms, with regard to availability of insurance, what would be in your judgment the effect of the full implementation of the Affordable Care Act?
A: Well, the goal of the Affordable Care Act is to assure that individuals have insurance coverage. So, to the extent there are less individuals without insurance, then there would be less of a need for indigent care assumptions and the percentage would be lower.
Q: Okay. All right. Based on all of the research and the testimony you just provided, which applicant would best meet the purposes of 803.3(f) and (g) to serve the medically underserved?
A: The Piedmont application for Fort Mill Medical Center.
Q: All right. Dan, if you'd pull that up. We want to complete that portion of the grid. That would be (e), let's double check, is that right Mr. Levitt?
A: Yeah, (e) was already double checked. (F) would be a check for PMC and an X for CHS.
Q: And (g)?

A: A check for PMC and an X for CHS.
Q: Now, there is one more section that's showing, a subsection of Paragraph 3. What is that?
A: That's 3(h) and that's the impact on existing resources.
Q: Now, Dan, let's turn to the regs and Mr. Levitt if you would read that section, please. Paragraph (h).
A: Paragraph (h) says: Potential negative impact of the proposed project on the availability and or resources of existing providers to serve medically underserved groups must be considered.
Q: Did the Department consider this?
A: No.
Q: All right. Do you believe they should have?
A: Yes.
Q: Do you believe it should be considered now that you're testifying?
A: Yes.
Q: Why?
A: Because it involves an implementation of the service that could potentially have a negative, potentially have an impact on the resources of an existing Piedmont Medical Center provider.

They neglected to consider that.

Q: All right. And have you examined the payor mix in York County and how it's changed?

A: Yes.

Q: On existing providers? All right. Let's take a look at Demonstrative 189, please, Dan. And what is this and what is the source of it, Mr. Levitt?

A: This is from Piedmont Exhibit 14, which I think we just talked about being the North Carolina/South Carolina database and it shows the 2005, 2011 payor mix for York County residents at Piedmont Medical Center. You can see from 2005 to 2011 the percent declined in managed care. Went from 38 to 31 percent or a 16 percent decrease. Medicare went down as well, ten percent. Medicaid went up from 14.8 to 18 percent, a 22 percent increase. The other, again that's over the CHAMPUS, VA, other categories, it went down a little bit, 4.4 percent and you can see self pay/charity went from 3.6 to 10.7 percent. Almost a 200 percent increase.

Q: All right. And this relates to all York County patients served anywhere or just served at

Piedmont?

A: These are the York County residents served at Piedmont Medical Center.

Q: Okay. Now, just to discuss the effects of this and whether it be negative, to what degree does managed care and commercial coverage relate to the cost of the services that a hospital provides?

A: Well, as I believe it was Dr. Taylor talked about, that's the cost shifting or maybe Mr. Masterton talked about that. That the ability to cover those patients that are under other payors that provide less reimbursement, managed care and commercial patients that provide better paying resources use that money, providers use that money to offset the loss on the other patients. So, it's pretty critical that the facility have a strong pool of those patients to offset the Medicaid and self-pay patients.

Q: Okay. And let's -- and so managed care is down 16.6 percent and Medicare is down 9.6 and Medicaid is up 22.5. Charity is up nearly twice. What's the cumulative or aggregate effect on these changes in the payor mix over

that six year period?

A: Their negative. For Piedmont Medical Center there's less, as I said, the pool of managed care patients to offset those other patients.

Q: Now, in Paragraph 3(h), if the question is how would Carolinas' proposed new hospital in Fort Mill affect the ability of existing providers, that is Piedmont to serve medically underserved patients, how would you apply this data to that question?

A: Well, this data combined with the data that we've talked about, that if the CHS-Fort Mill facility were to be approved and those patients, if the patients are treated at that facility are those that have historically gone to North Carolina, what would be left would be treated at Piedmont would be much more Medicaid patients or much more Medicare patients and much less managed care patients.

Q: Okay. All right. And now, Mr. Levitt, have you developed a Demonstrative that shows the effect of the change in payor mix of the hospital?

A: Yes.

Q: All right. Let's take a look at it. Dan, if

you would pull up Demonstrative 67 please. And what is this, Mr. Levitt?

A: This shows, on the left side it shows baseline calculation, can you zoom in on that left side?

Q: Discuss generally what you've prepared. Is this an actual experience that you're proposing in the first two columns or is this a hypothetical?

A: This is a hypothetical that shows the experience of a facility based on a series of assumptions. If there are 34,000 patient days with a payor mix provided here, the different mix of Medicare, Medicaid, managed care and self pay, their contractual adjustments.

Q: And what are contractual adjustments?

A: Contractual adjustments are the difference from what the facility charges and what they get paid. It shows that the net revenue, while they charged $552 million, they would get $200 million. They have $173 million in expenses for a net income of $26 million.

Q: And is that unreasonable distribution of the payor mix and net income for a hospital?

A: No. Actually, this was taken from the Mercy CON application, so this is from what they

projected in the Mercy application.
Q: The one you were referring to earlier in 2010?
A: Correct.
Q: All right. What have you done as a comparison based on?
A: If you can zoom in on the next column, I held the patient base the same, so I said the same utilization, I assumed that the gross revenue would be the same by payor. I adjusted the mix, assumed that the percentage of payment by payor would be the same, so the $551 million in gross revenue, assumed that the percentage for change, so that they would have a lower net revenue, $171 million in net revenue because of the change in payor mix and they had historically made $22 million, I believe it was. They would make $23 million. So, Dan, if you could zoom back out and highlight the top, yeah, all the way across, down to the, yeah, gross revenue. You can see, and zoom it in, you can see the mix of before they had 42 percent Medicare ---
Q: Could you highlight those please, Dan?
A: So 42 percent Medicare, I took up to 55 percent Medicare. The ten percent Medicaid I doubled

to 20 percent Medicaid, so they had more medicaid and Medicare left over, just as Piedmont would have at the main hospital. Managed care went from 40 percent to 15 percent so they would have less managed care and self pay I held pretty constant. I rounded it up to ten percent. So, you can see gross revenue is the same at $551 million. The change happens with what they get paid for that. So then on the next section, the adjustments, that's where the issue happens is they have more adjustments, they get less of the net revenue. They would, you know, the Medicare contractual went from $170 million to $225 million and then you take those away and go down to the net income or net revenue, net revenue and you can see a decline in $28 million from $199 million to $171 million. Again, this is just from a shift in payor. All other assumptions remain the same. So, just by shifting the payor mix, they would be paid $28 million less than they would have been otherwise.

Q: Okay. Has the volume changed?

A: No, volume remains the same. Just -- and charges are the same. The percentage

adjustments are the same by payor, it's just the pie is split differently. Those payors that pay more is smaller, those payors that pay less is the bigger and the net result is negative impact.

Q: So, is it possible for a hospital not to lose any patients but to lose money as a result in the change of the insurance coverage available for those patients?

A: Yes. Simply a shift in payor mix can have a dramatic impact on the bottom line.

Q: And how does this hypothetical that you've prepared relate to your opinion concerning the exposure that Piedmont may have if the Carolinas-Fort Mill hospital is approved?

A: Well, again, as I said to the extent that payor mix of those patients remained in York County treated at Piedmont which is substantially different, which it would be because we showed the CPN physicians have a small Medicare and Medicaid percentage of patients. Then the resulting payor mix at Piedmont would shift similar to this. More Medicare, more Medicaid and you would have negative impact.

Q: All right. And so let's then reach the bottom

line question on Section 3(h). Which applicant best meets this provision?

A: Piedmont Medical Center.

Q: All right. Then let's, Dan, if you can take it to the overview grid for all the review criterion and look at section 3. In section 3 relating to duplication and medically underserved groups, Mr. Levitt, does Piedmont or Carolinas best meet the requirements of these subsections within section 3?

A: Taken in a total, while CHS met a few of those, Piedmont best meets those criteria.

Q: All right. Now, let's move on to the next set of criteria and, Mr. Levitt, let me ask you, let's just move to issues concerning adverse impacts and adverse effects and the regulations and the statutory language related to those. Have you developed an Exhibit that provides an overview of those authorities?

A: Yes.

Q: All right. Dan, let's pull up Demonstrative 190 please. And what's on this chart, Mr. Levitt?

A: This shows the framework for looking at adverse impact, how to consider it, which of those

standards that were left, fit sort of into adverse impact category. The first being 802.22 and distribution of existing healthcare services, 802.3(h) dealing with existing providers to serve indigent groups, 802.16(c) costs and charges of existing providers, 23(a) utilization and staffing of existing facilities and then in the statute, the balancing of improving accessibility against the adverse implications.

Q: Okay. Well, let's work through each one of those. And then we'll identify, actually, the language with respect to each when we get to it. Let's being though, with an overview of your opinions concerning adverse impact. Have you developed a Demonstrative to show that?

A: Yes, I have.

Q: Dan, if you'll pull up Demonstrative 181, please. And how does this reflect your opinions, Mr. Levitt?

A: Well, this is the basis that we determined the adverse impact, that the Piedmont patients would be treated at CMC-Fort Mill, so in the CON application for CMC-Fort Mill, they talked about redirecting patients that went to North

Carolina and not changing the market share and not taking any patients from Piedmont. Well, obviously that's not going to be the case. Those patients will be redirected. They're not going to limit their patients to those going to North Carolina. And the reason they're going to do that -- for a number of reasons, we talked about the inability to control that, but more importantly, their investment in the CMC-Fort Mill facility and the North Carolina facilities, they want to maintain occupancy levels at those facilities, utilization at those facilities. They will continue to attract as many patients as they can and those patients will come from Piedmont Medical Center. And Piedmont will be negatively impacted by that loss in patients, in volume and in revenue and the adverse impact will cause a negative impact on their ability to offer services, both basic and complex as well as it's going to have a negative impact on personnel.

Q: And have you attempted to quantify that impact?

A: Yes.

Q: All right. Have you developed a methodology to

do that?

A: Yes.

Q: All right. Let's explain that to the Court, if you will. Let's start by looking at Demonstrative 192. What is this?

A: This describes the way we addressed the adverse impact. We provided this in the remanded CON application in 2010. We addressed it during project review meeting and this sort of outlines the methodology. It assumes that, you know, just as in the CMC application and in the Fort Mill Medical Center application, patients from all areas of York County would use the facility. The CMC facility in particular, they identified the entire York County as the service area, obviously those further away would use it to a lesser degree than those immediately in the vicinity. We looked at all zip codes in York County. Calculated the historical utilization for Piedmont and North Carolina hospitals. We projected CMC-Fort Mill's market share by zip code. We assumed that the patients would come from both Piedmont and North Carolina based on proximity and market experience. We talked about -- Mr.

Miller and I talked about that and the assumptions at the end of the day resulted in about 67 percent of the patients that would be treated at CMC would come from Piedmont. In order to quantify that from a financial perspective, we looked at the contribution margin, applied that to the lost cases to get the financial impact.

Q: Okay. All right. Let's begin by looking at an overview of the results of your analysis. Dan, let's pick it up at Demonstrative 18.3. All right. And is this a document that reflects your work and methodology, Mr. Levitt?

A: Yes.

Q: And walk us through it if you will.

A: Again, this is the summary of the detailed model that we did that shows the market share in 2011 of 55 percent in total.

Q: I'm sorry, but let's just kind of lay out the basics here. What is PSA and SSA?

A: PSA is primary service area. SSA is secondary service area.

Q: And remind us again what zip codes are in the primary service area?

A: Primary service area would be the three

northern zip codes, 707, 29707, 29708 and 29715 and portions of -- and also the Rock Hill zip codes 29730 and 732. The secondary service area is the rest of York County.

Q: And the one in the lower southeast corner of the county, 704?

A: I believe that was in the secondary service area.

Q: Okay.

A: And you can see, historically in 2011 Piedmont had about a 55 percent market share overall, 55 and 53 percent between the two service areas. Projected cases, using the 2011 use rate, applying it to the 2017 projected population, about 11,536 cases in the market. Projected cases for the North Carolina Fort Mill hospital would be lower in total. About 8,461 or a difference of about 3,000 cases. Applying the contribution margin to that shows a $12 million loss.

Q: Okay. And explain again what the contribution margin is?

MR. MULLER: Your Honor, I just object. I'm a little hesitant to object because this slide is actually favorable to us, but I am looking at

Petitioner's Trial Exhibit and it does not have these numbers in it.

THE COURT: All right.

MR. ANDREWS: It seems like, well first of all, it's my fault again, I'm sorry this slipped through without a source identified in this Exhibit. We have several Exhibits that -- I'm not sure which one Mr. Muller is referring to. If I can elicit some information from the witness. He can identify the source of it.

THE COURT: Let's do that. Let's do that first, Mr. Muller and we'll go back to the objection you might have. Go ahead.

Q: All right. Your Honor. Mr. Levitt, what's the source of this information?

A: This was an Exhibit we provided. We did several different scenarios and this was one of the scenarios.

Q: Okay. And let's just go through them since I don't want to guess and identify which ones they are. Let's start with Exhibit 104.

MR. MULLER: Just for clarity, I've got 103 as the first adverse impact analysis. There may be others after it?

MR. ANDREWS: Well, actually, there are several.

But Your Honor, so that I can get oriented there are actually about four or five Exhibits related to this data. Can we take a break now and I can figure that out.

THE COURT: Recessed for ten minutes.

(Off the Record)

THE COURT: Please be seated.

MR. ANDREWS: Thank you for the break, Your Honor, so I could determine the source of this Demonstrative is Exhibit 104. And we are going to go over that in some detail in a moment.

THE COURT: All right. Mr. Muller, do you have any objection to that?

MR. MULLER: No, I don't Your Honor, I was just looking at Exhibit 103 which was the first one and it didn't match up.

THE COURT: Makes sense, so it's 104. Thank you.

Q: All right. Mr. Levitt, please again describe what Demonstrative 183 does and how it supports your opinions.

A: It summarizes the calculated adverse impact on Piedmont Medical Center with the CMC-Fort Mill hospital. Again, it summarized the impact on market share would be in total from a 55 percent market share in 2011 to about 40

percent market share in 2017 or a loss of about a little over 3,000 patients. Multiplying that out by the contribution margin of about $4,000 per patient results in a negative net impact of about $12 million.

Q: Okay. And I think at the break I had asked you to explain what contribution margin is.

A: Contribution margin is a measure to determine the impact of lost patients. Generally, it's the -- if you don't treat a patient there's lost revenue associated with that patient; you don't get paid for that patient. But there's also an assumption that there's some expenses that you wouldn't incur if you weren't treating that patient either. So, the contribution margin is the difference between the lost revenue and the foregone costs incurred to treat that patient. Piedmont Medical Center in total is about a $4,000 per patient.

Q: Okay. All right. Now, let's, let's go to the Exhibit on which this Demonstrative is based. Which is Exhibit 104. It looks a little intimidating, but I'm sure you can explain it in a way that makes it all understandable with all of this being on one page. Help us work

through this please.

A: I did just explain it, but we'll go through the details.

Q: Details please.

A: What it shows is, again, we looked at every zip code.

Q: I'm sorry, why don't we start with the header and explain what that caption on the document is as a starting point.

A: Yeah, this is slightly different than what we had submitted in the July 11th, I think it was, CON application. And what it is, is it assumes that the CMC-Fort Mill facility will be at 80 percent occupancy. That 67 percent of the impact would come from Piedmont, 33 percent of the impact would come from North Carolina patients being redirected and we limited it to the pool of patients with a case mix index less than 2.0. So this is the non-complex patients that would be treated at the CMC-Fort Mill facility.

Q: And why did you establish an assumption that there would be an 80 percent occupancy at CMC-Fort Mill?

A: Because we think that's what it would be by the

third year of operation. They projected a lower occupancy. But again, they were assuming they would only treat their patients. Did they didn't give any effect to redirected patients, so it would be additional -- in this case, a majority of patients would be redirected patients.

Q: Okay. All right. Now, and you said that you prepared other methodologies. We'll get into those in a little bit. But how was this different than what you submitted to the Department in 2011?

A: All right. This, we eliminated the case mix less than two. We didn't do that in the original submission. And we had a higher occupancy at the proposed Fort Mill Hospital. We lowered it a little bit. And then there was a math error in the model and we corrected that math error.

Q: Okay. All right. And then work through this analysis to show how your methodology works.

A: And also, I believe you asked the difference between this one and what we provided to the Department?

Q: Yes.

A: And also this updates it for 2011 information compared to what was submitted, I think in 2009 at the time of the remand application.
Q: Okay.
A: Okay. So, zooming in on the first column. You can see 2011 and the methodology works the same across. So we'll just look at the first one. The 2011 in 29074, that zip code, Piedmont had 199 patients. Which represented 61 percent of the total. You can see the total of 325, no, I'm sorry, 326. So if you divide 199 by 326 you get 61 percent. So, 61 percent of total patients in that zip code were treated at Piedmont, 30.4 percent or 99 of those patients, were treated at North Carolina hospitals. So the subtotal of those two, the 99 and the 199, 298 patients were those treated at either Piedmont or the North Carolina hospital, so the difference between those, you know, the eight percent of the patients not identified there were treated elsewhere. Likely South Carolina.
Q: In Columbia or other facilities in South Carolina outside of York County?
A: Correct. MUSC, Columbia, exactly. So this showed the baseline of 2011. Going down to

2017, the next section, that same zip code, 29074, we projected at the bottom 367 cases, so the number of cases would go up because the population is expected to grow, so the 2011 cases divided by the 2011 population and apply that to the 2017 population gives us 367 cases. We assume the same market share, that 61 percent, so you multiply the 367 times 61 percent gives you the 224 cases at Piedmont Medical Center. We held the North Carolina at the same, 30.6, 30.4 percent for 112 patients at the North Carolina hospitals. So, that shows the 2017 projected Piedmont utilization if there's no North Carolina hospital in Fort Mill. Zoom back out and go across ---

Q: Before you leave that, Mr. Levitt, just to be clear, what's the basis for your projected increase of hospitalizations in 2011 to 2017?

A: That's the population growth. The population is going to grow and generate more discharges in this instance, in this zip code.

Q: More hospitalizations?

A: Correct.

Q: All right. Okay.

A: So if you highlight, yes, cross, yes, the

total, you do that for each of the zip codes. We add that up. In 2017 there's a projected total at Piedmont of 11,536 for a weighted average market share of 54 percent.

Q: That's for 2017?

A: For 2017. So that basically assumes the market share is held constant. Okay. If you go down to the next section, what we assumed was -- what we started was the proposed North Carolina provider Fort Mill hospital would have 25 percent market share of that zip code.

Q: And what is the basis for that assumption?

A: That was based off the geographic proximity, where that was located relative to the hospital and based on the experience of other providers. So we assumed the 25 percent market share for the new hospital, multiply that again by the same number of projected cases, we have 367 cases. That gives them 92 patients. And the question was, where are those 92 patients going to come from. Well, we made the assumption again based off of geographic proximity for that zip code, half the patients would come from Piedmont, half the patients would come from the North Carolina providers. So,

assuming half of the 25 percent is 12 and a half percent, remember the Piedmont market share was 61 percent in that zip code, so 61 percent minus 12 and a half percent equals 48 and a half percent. So 48 and a half percent times the 367 equals 178 cases. So, if we did that for each of the zip codes, subtotaled or totaled across to the right and adding all of those up resulted in 8,461 cases by 2017 with 4,671 cases at the CMC-Fort Mill facility.

Q: And that's 8,461 would be the remaining cases at Piedmont?

A: Correct. Piedmont's market share would have gone down from 54 percent, I think it was, down to 40 percent, 39.6 percent. And the difference between the 11,000 patients in 2017 without a Fort Mill provider and the 2017 with a Fort Mill provider is 3,076. And that was from the summary table multiply that by the contribution margin gives us the slightly over $12 million negative financial impact.

Q: All right. Why don't we, let's go back and take a look at the assumptions you made that support the result you just identified. What are the drivers in this methodology and key

assumptions you've made?

A: Well, the first assumption is where they would be in 2017, they being Piedmont, would be in 2017 without a provider in Fort Mill. And we held the market share constant. Market share had been fairly constant. When we submitted the first application, it had declined a bit, pretty substantially, actually, from 2005 to 2009; 2010 data looked like it was leveling off. 2011 showed that so in an abundance of caution, we held constant. And the next -- so that tells us where we would be in the future without a provider.

Q: And you held a constant through what period of time?

A: 2017.

Q: 2011 to 2017?

A: 2011 to 2017, which is the third year of operation by both applicants.

Q: Okay. Now, does that assumption take into consideration the effect of the establishment of CMC-Fort Mill?

A: No, that assumes that the market share would stay the same because there is not a CMC-Fort Mill hospital located there. So then to

determine the impact of putting a hospital there, we assumed a market share for that facility. And as I said, in that first zip code, 29704, I assumed 25 percent market share. Going across, you can see those numbers ---

Q: Dan, why don't you pull out half of that and we'll look at the other half.

A: Well, in those zip codes you can see the range is -- no, not there.

Q: Pull out above that. Down below that actually.

A: Down below that.

Q: Down below that.

A: The proposed North Carolina proposed -- yes. That area there.

Q: Sorry, Dan, start on the left. There you go. Take it all the way through. That's good. Okay. Now, there is your assumption you've testified about. Dan, if you could highlight that and make it a little more legible. The first assumption for the 25 percent in 704 is what you've testified about, correct?

A: Correct.

Q: And that's the market share of the CMC-Fort Mill?

A: Correct. In that zip code.

Q: Now, before you go further, the document says proposed North Carolina provider for Fort Mill hospital. Did you make this same assumption when the Department was reviewing the applications for either Carolinas or Presbyterian should be awarded?

A: Yes.

Q: Why?

A: Because both facilities would take a market share in that market. In order to be successful and operational, a hospital located in that area would have a market share of each of the various zip codes. They -- both providers would take from Piedmont and the out-migration to North Carolina.

Q: Now, how does, how did it at this time, Presbyterian's market share and how does it today compare to Carolinas in York County?

A: Very small.

Q: All right. And why then did you treat them and why do you believe they should be treated the same in terms of the assumption you're making?

A: Because they both will take patients. CMC will take patients from Piedmont and itself. Presbyterian will take patients from Piedmont

itself and CMC. And I guess CMC would take from Presbyterian as well.

Q: All right. Now, and as an overview, in general terms what is the assumption that you've made in Exhibit 104 concerning the market share of North Carolina or what percentage of CMC-Fort Mill's cases would be taken from North Carolina hospitals?

A: We would have to look at that.

Q: No, I mean total. Is it not the 6,733 assumption?

A: Yes, in total 33 percent of the patients from North Carolina, 33 percent of the patients at the CMC-Fort Mill hospital would come from North Carolina.

Q: Okay. And you're reflecting this by this analysis?

A: To start with.

Q: Okay. All right.

A: And let me clarify.

Q: Sure.

A: When I say coming from North Carolina, it would be York County residents that historically have been treated in North Carolina. They're from South Carolina but they have historically have

been in North Carolina.

Q: And so the market share of CMC-Fort Mill in 704 would be 25 percent. And go through these zip codes and identify the categories of market share you've assumed for the others.

A: Obviously, for the ---

Q: Stay on that same line, Dan.

A: Yeah.

Q: Thank you.

A: For 29707 and 29708, those zip codes in Fort Mill, a 40 percent market share. For 29701, which is western York, I guess that's the northern, western York, north central York, further away from Fort Mill, they'd only have five percent market share of that zip code.

Q: Now, before we move on, why have you assumed a 40 percent market share, a higher market share for 707 and 707 and 715 and a lower market share for 701?

A: Again, because of the geographic proximity. You know, the 707, 708 and 715, you can see on this view, all three are at 40 percent. That's the -- those are the three zip codes immediately adjacent to where the hospital is going to located, so that's where they would

have the highest market share. Just as Piedmont has the highest market share of the two zip codes it's immediately adjacent to.

Q: Okay.

A: And further out, the further away you go, the less market share you have, so 29717, 29726 a much lower market share of three percent. They will get a few patients, four patients from those areas, but not a lot. And then moving over, 30 and 32, 29730 and 29732, 20 percent and 25 percent. Those are the Rock Hill zip codes. Again, Piedmont has a very strong market share of those zip codes. Some of those would go to the new facility, so a smaller percentage or in between the home zip codes and the distant zip codes of 20 and 25 percent and then, again, the last three on the list, last two on the list, 742, 743 are the western York, three percent, a few patients and seven percent, a little more at 745, which is closer.

Q: All right. And then what was the total market share of York County patients that you assumed CMC-Fort Mill would have?

A: So sort of the weighted average of all the results in 21.9 market share of York County for

the CMC-Fort Mill facility or 4,671 patients which comes out to be about a 80 percent occupancy on their 64 beds.

Q: All right. Now, Mr. Levitt, did you conduct -- at the time when you first undertook the study and developed methodology, did you do anything else to confirm the reliability of your assumptions?

A: Yes.

Q: What did you do?

A: Well, I looked at a number of other facilities in the market share, but in order to determine the range of impact if these numbers were too high or too low, I did a sensitivity. So, I said if it were lower, instead of 67 percent of the patients coming from Piedmont, if it were 50 percent of the patients. And I also went to the other side and said well, if more come from Piedmont, if 80 percent of the patients come from Piedmont, so I looked at the range of those and calculated that out to see what the impact would be, sort of on a high side and a low side, what I call a sensitivity analysis.

Q: Okay. And did you provide that to the Department during it's review?

A: I did.
Q: Okay. And let's look at then. Dan, Joint Exhibit One Bates 43. Exhibit -- figure E, I believe it is. All right. Mr. Levitt, what have you done here?
A: This summarizes what we have done in the past. Again, this is a little different than what we've just looked at. The numbers are comparable and consistent, but what it shows is the sensitivity. This is based off of 2009 instead of 2011. This has the math error in it we talked about. And this, it shows a higher utilization at the CMC or the North Carolina Fort Mill hospital, but what it shows is assuming that 50 percent of the cases instead of 67 percent of the cases. Fifty percent of the cases come from Piedmont, it would have about a $10 million negative impact, 10.4 million, lower obviously because less would come from Piedmont more would come from North Carolina. And then sensitivity two is a higher assumption. That if 80 percent of the patients came from Piedmont instead of 67 percent, obviously it has a higher impact or $16.5 million negative impact. More patients, more

dollars.

Q: Okay. Now, what's the market share data that's presented here?

A: This shows the -- the historical input is the 2009 projected with 2017 based off the 2009 experience, so it shows Piedmont coming from a 50 -- in the first scenario, 53 percent market share to 41.5 percent market share. And the second scenario shows a more dramatic drop from 53.4 down to 33.7 percent market share.

Q: Now, these sensitivity analyses were conducted to support the methodology and analysis that you prepared for the Department, is that correct?

A: Correct. This was submitted to the Department.

Q: All right. And let's actually take a look at Exhibit 103. Now, what you submitted to the Department is in the record. Pull up Exhibit 103 please, Dan. Not Demonstrative, but Exhibit and what is this document, Mr. Levitt?

A: This is that original analysis, corrected for that math error.

Q: Okay. And you identified the math error before and otherwise is there any differences in the assumptions?

A: No, it was -- the math error, it was reading off the wrong cell. It was reading off of the subtotal instead of the total.
Q: Okay. And you corrected that ---
A: That's what this reflects, yes.
Q: --- in Exhibit 103, okay. Did you conduct additional sensitivity analyses?
A: Yes.
Q: Okay. And did you do that the same way you did it originally or did you undertake a different way to analyze the liability of the project?
A: I did it a little differently. Instead of looking at the 50 percent, 67 percent, 80 percent assumption, I looked at it a little differently.
Q: Okay. And have you prepared a Demonstrative to show that?
A: Yes.
Q: All right. Dan, let's look at 18.5, please. Now, this summarizes Exhibit 105, is that correct, Mr. Levitt?
A: Yes.
Q: And let's turn, just quickly before you go ahead and detail this at Exhibit 105 and tell us what you have there.

A: Again, that's the same model and analysis that we did. You can zoom in on the title there.
Q: You mean that you just reviewed in Exhibit 104?
A: Correct. And we changed the assumptions. So, this assumes that the CMC-Fort Mill facility is 80 percent occupancy, same assumption, but instead of 67 percent of the patients coming from Piedmont, we took a proportional impact of the patients.
Q: Why did you do that?
A: To look at what would be the impact if the market share shifted proportionally based off of the historical market shares of the existing providers, Piedmont and the North Carolina providers.
Q: Okay. And then let's move back to Demonstrative 18.5 rather than go through the detail of this document. Does the methodology work the same way as the one you just testified about?
A: It does. With the exception of where the patients would come from. So, as I said, rather than assuming for instance in 29704 we said 50 percent would come from Piedmont, 50 percent would come from North Carolina, we used

the actual percentage. The percentage of market share Piedmont had at that zip code compared to the actual market share of North Carolina providers had. So you will remember Piedmont had a 61 percent market share of 29704 so we assumed 61 percent of the patients from that zip code would come from Piedmont. We did that across the board to come up with a lower impact, about $8.8 million dollars or 2,250 patients less at Piedmont with a CMC-Fort Mill provider if the patients were redirected proportionally to the historical market share. And then this is pretty consistent with the lower scenario of 50 percent. If 50 percent of the patients came from Piedmont, it was very consistent with that.

Q: And you mean one of the two sensitivity analyses you performed?

A: Correct. The lower sensitivity.

Q: Okay. All right. And did you also prepare any other analyses of the adverse impact?

A: Yes.

Q: And what did you do in general terms?

A: I did a third sensitivity that looked at the effect of using the CHS methodology presented

in their remanded application.
Q: And what was that? What was the methodology?
A: Where they assumed a percentage of the historical patients would be treated at CMC-Fort Mill. I believe it was 80 percent of the northern York area patients that had historically gone to North Carolina for care would go to CMC-Fort Mill, 75 percent of the Rock Hill, greater Rock Hill we called it, would go, and 50 percent of the rest of York County would go to the CMC-Fort Mill facility.
Q: All right. Let's take a look at that. Let's look at the Exhibit 106 please, Dan. Is this the document that reflects the market share methodology?
A: No.
Q: I thought I might have gotten it wrong. Then let's look at 107. Now, before we go there, what is this? What does 106 do? I'm sorry.
A: This assumes the market share methodology -- so that uses their methodology to project the utilization at the CMC-Fort Mill, so before I said I assumed 80 percent occupancy or 80 percent utilization, this uses their methodology to get the patient days at CMC-Fort

Mill and it assumes a 67 percent impact at Piedmont and a 33 percent impact to North Carolina.

Q: And what's the effect of that?

A: Well, the effect is, if you look at the utilization proposed facility, if you do their math across the board based off 2011, what they submitted in the CON application is 2009, I think, information. If you update that to 2011, assume the exact same assumption that they had, the number of patient days at the CMC-Fort Mill facility in 2017 would be 4,650 which is very consistent with the 80 percent occupancy that I assumed.

Q: All right. And then let's look at Exhibit 107. And what have you done here?

A: This uses their assumption, again, this is the proportional impact. So, I used their assumptions to get their occupancy at their CMC-Fort Mill facility and I assumed the impact would be proportional to the historical market share. The example there again in 29704, 61 percent of that market share was Piedmont's. So 61 percent of that impact would come from Piedmont and I tallied that across to get this

impact.

Q: And what results did you determine?

A: You can see at the bottom it's consistent with the lower scenario or about $8 million negative impact.

Q: Okay. All right. Under any of these analyses that you've performed, Mr. Levitt, what is your bottom line opinion concerning the effect of the proposed Carolinas facility in Fort Mill on Piedmont's operation?

A: That it would have negative impact. From a contribution margin perspective, from a occupancy/utilization perspective patients are going to be redirected. Those redirected patients have a value both from a utilization standpoint and from a financial stand point and its in the millions of dollars. The low scenario of $8 million is substantial, $12 million, even worse. So and then the high scenario, even higher. These are very large numbers. These are just the inpatient numbers and it's tremendous.

Q: All right. Now, have you analyzed the effect on utilization as well?

A: I did.

Q: The -- before we go there, with regard to this analysis, is this a one year, one-time hit? The $8 to 12 million dollar inpatient, not including outpatient loss of revenue?

A: It's a one year, but not a one time. It's every year. So they would lose that volume with perpetuity. So every year that would be the lost revenue that they would experience.

Q: Okay.

A: Inpatient.

Q: All right. Let's look at your analysis about the impact on specific utilization considerations in addition to the financial. Have you prepared a Demonstrative that reflects that?

A: Yes.

Q: Dan, let's look at 18.4. And what is this slide, Mr. Levitt?

A: This shows the impact on utilization. That in 2011 Piedmont was 63 percent utilized. In 2017 with the 2011 market share, Piedmont would be about 70 percent utilized, but with the CMC-Fort Mill facility in 2017 Piedmont would be only 51 percent utilized or 23 percent less, or 27 percent less than they would be without CMC

facility.

Q: Okay. And what effect would that have on Piedmont?

A: Well, it would have a negative utilization, we'd have excess capacity and we'd go down from 63 percent to 51 percent in occupancy.

Q: How many beds would be in Piedmont would be unused?

A: Over 140.

Q: All right. Let's move to consideration of how DHEC and Carolinas analyzed this issue. Mr. Levitt, let's first turn to Joint Exhibit 1(B), 1018. And let's actually identify where we are. Dan, if you would, pull out of that and put the prior page so we can identify what this document is. And what is this Mr. Levitt?

A: This is the remanded decision letter from Beverly Brandt on the Fort Mill Medical Center application.

Q: Okay. And then let's go to the second page. Look at paragraph three. Concerning adverse impact, what finding did Ms. Brandt make?

A: That the facility would not adversely impact. She made no finding there would be adverse impact.

Q: And specifically concerning Carolinas, what did she find? Dan, if you would highlight the last two lines, please.

A: The end of the -- the sentence states: That proposed CMC-Fort Mill proposes to shift current market share to a facility in South Carolina resulting in less adverse impact to existing facilities.

Q: Less adverse impact to whom?

A: The other applicants. Fort Mill Medical Center and at the time, Presbyterian.

Q: Now, let's also look at Joint Exhibit 1A. Page 474 paragraph 10, Dan. Now, let's Mr. Levitt, do you recall this document or do you want us to pull it out?

A: Yes. No.

Q: All right. What is it?

A: This is the analysis attached to the decision.

Q: All right. And what statement -- is that Ms. Brandt's analysis?

A: This is Ms. Brandt's analysis.

Q: All right. And what does she say there?

A: It is assumed inpatient discharges as CMC-Fort Mill hospital will be derived from York County patients currently seeking care at Carolina's

hospital in North Carolina. (Now given the choice to receive care at Carolina's facility closer to home.) The end of it goes on to say: Carolinas does not project any additional market share shift from Piedmont Medical Center or from Presbyterian-Mecklenburg facilities.

Q: Okay. And what's your opinion of Ms. Brandt's conclusions?

A: They're incorrect. That they said that, CMC said that, but that's not what's going to happen.

Q: Now, the -- at any point did you in representing Piedmont, Piedmont take the position that the adverse impact would put Piedmont Medical Center out of business?

A: I don't think we ever presented that we would be out of business, no.

Q: All right. What effect, then, do you believe that the adverse impact has on Piedmont's operations, its utilization and its long term revenue?

A: Well, it would all be negative. That the utilization would be negatively impacted, the resulting financial impact would be negative. We talked about the ability to offer specialty

services with lower volumes, their inability to do that and, overall, it would just be negative impact to the hospital.

Q: And have you done any independent research in addition to what you've presented related to what the views of practitioners at Piedmont were about the potential for adverse impact?

A: Yes.

Q: Okay. Now, did you review the letters that were presented to the Department from physicians on medical staff at Piedmont?

A: Yes.

Q: Let's Dan, actually pull up Exhibit 31. Did you make a presentation from summaries of those letters to the Department during the project review presentation?

A: We did and then subsequent to that we put some of that in the July submission to DHEC as well.

Q: Okay. Let's go through this document in the record and show for the Court a summary of what the positions were that you've identified from physicians who submitted letters to the Department in support of Piedmont's application. Let's take a look at the first one, Dan. First of all, the overview of these

letters, have you reviewed and analyzed these letters?

A: Yes. Uh-huh (affirmative response). We did. And we presented this at project review as well. We looked at the independent physicians in York County that supported the various projects and as you can see, over 75 percent of the independent physicians supported the Piedmont project, 45 letters in support for Piedmont, one for CHS and 11 for Presbyterian.

Q: Is that 13?

A: I'm sorry, 13. Yes.

Q: All right. And then there were employed docs who submitted letters?

A: There were. 22 Piedmont-employed physicians, 55 CHS-employed physicians and 20 Presbyterian-employed physicians.

Q: Okay. And let's move on to the next slide. Before we leave that, why have you highlighted independent physicians there?

A: Well, obviously, if you're employed then you're going to be writing a letter in support of your facility. So, those independent physicians are the ones that we were focusing on to look at their positions and which applicant they chose

to support.

Q: Okay. And let's take a look at some of those statements in the record. And what does this particular excerpt -- these are all in the record? These letters are in the record?

A: They are. This comes from the project review presentation as well.

Q: Okay.

A: This is Dr. Pennington, a gastroenterologist, states: There will be a drop in patients who use the Rock Hill facility and thus a subsequent drop in the funds available to continue technological advances people in the community have come to enjoy.

Q: All right. Let's move on to the next. And what do you have here?

A: This is from Dr. Fletcher, an orthopaedic surgeon and he states: These past few years have shown that not only Presbyterian but also Carolinas Medical, by their actions, have proven they do not support York County. They routinely continue to encourage their York County practitioners to refer patients to physicians who practice in the Charlotte network facilities.

Q: Okay. Next page.
A: This is a letter from Dr. Powell. Neal Powell, Jr., he states: To allow the migration of Charlotte-based hospitals to York County would contribute to the erosion of overall healthcare delivery in York County.
Q: All right.
A: This is from Dr. Robert Wilson. He states: My main worry is that if another entity builds a hospital in Fort Mill, Rock Hill would become a less attractive place to practice medicine. End result is that fewer top level physicians will want to come to and practice in Rock Hill. This means less good care for Rock Hill patients.
Q: Okay. Is that it? All right. Now, based on your review of these letters or conversations that you've had with physicians on the medical staff, Mr. Levitt, have you identified the themes that have been communicated by the members of the Piedmont medical staff concerning the proposed Fort Mill project?
A: Yes.
Q: All right. Have you prepared a Demonstrative that reflects those?

A: I have.
Q: All right. Let's turn to that. Demonstrative 194, please, Dan. All right. And what do you have here, Mr. Levitt?
A: These are the general themes, the five themes. The concerns, I guess, of what would happen if the CMC-Fort Mill facility were to be approved. The ability to maintain competent quality would be compromised. That the CMC facility would send, continue to send patients to Charlotte, not Piedmont as we talked about for some of those higher level specialty services that are available at Piedmont and then have been historically used by CMC physicians at Piedmont. Physicians, CHS Physicians would refer from within their system so the independent physicians wouldn't get the referrals from those physicians. They would refer to other CHS physicians and to other physicians that would perform at other CMC facilities. It would have an impact on Piedmont's medical staff and the payor mix. And overall the impact would be to weaken the delivery system in York County, both the hospital as well as the medical staff with

physicians in the area.

Q: Okay. Now, let's then, go back to the original analytical framework for adverse impact that you pulled together as Demonstrative 168.4. And let's identify and apply the various criteria to your analysis unless you otherwise identify it. So let's actually, what I'd like to do, if you have a set of the regs with you, so we don't need to leave this screen, if you could read from them. Read, if you would the section 802.22 relating to distribution of existing health services.

A: Twenty-two states: The existing distribution of health services should be identified in the effect of the proposed project on the distribution shall be carefully considered to functionally balance the distribution of the target population.

Q: And how have you analyzed that?

A: Well, as we talked about looking at the distribution of health facilities, the impact on the existing resources and what the proposed effects would be, the proposed CMC facility would have negative impact on Piedmont's resources.

Q: And the 3(h), and then, Dan, go ahead and -- who best meets 22?
A: Piedmont.
Q: And 3(h) you've already analyzed and offered your opinion on so Dan, let's check that as well, 16(c), read that into the record, Mr. Levitt.
A: So 16(c) is cost containment. The impact of the project upon the applicant's cost to provide services and the applicant's patient charges should be reasonable. The impact of the project on the cost of the charges of other providers of similar services should be considered if the data are available.
Q: All right. And what is your opinion concerning the impact of the establishment of CMC-Fort Mill on the cost of charges at Piedmont Medical Center?
A: Well, to the extent that the volume goes down at Piedmont, which it would, the cost per unit of service would fo up. We have fixed costs that are difficult to control. And the cost of per unit service would go up at Piedmont as a result of the lower utilization.
Q: All right. And then who best meets that?

A: Piedmont.
Q: Okay. And 802.23 (a) and (b). Let's read that into the record.
A: Twenty-three is adverse effects on other facilities, 23(a) states: The impact on the current projected occupancy rates or use rates of existing facilities and services should be weighed against the increased accessibility offered by the services and (b) states staffing of proposed services should be provided by unnecessarily depleting the staff of existing facilities or services or causing an excessive rise in the staffing costs due to increased competition.
Q: Okay. And what's your analysis concerning (a), effects on utilization?
A: Well, we talked about the negative impact, the reduction in Piedmont's utilization. So, it would be negative. But the impact would be negative on Piedmont on utilization.
Q: All right. And let's go to the second part of that, before eliciting your opinion related to compliance with section. And what's your opinion concerning staffing?
A: That the approval of CMC-Fort Mill facility

will have a negative impact on staffing as well.

Q: Now, let's pull up Dan, Demonstrative 15. Mr. Masterton testified concerning nurses and his concerns related to the potential approval of CMC-Fort Mill, Mr. Levitt. I'm going to ask your opinion concerning this data.

A: That as Mr. Masterton identified, 23 percent of the nursing staff live in Fort Mill, Tega Cay or Mecklenburg County and those would be the direct nurses at risk for leaving Piedmont if CMC-Fort Mill were approved since it would be closer to where they lived. So the potential negative impact would be to taking staff away from Piedmont Medical Center.

Q: And is that something that's considered in the regulations?

A: Yes. That's what 23(b) talks about. The impact of the proposed project on staffing at the existing facilities.

Q: Why would that be an important consideration for the Department in evaluating adverse impact?

A: Because that's the largest part of, largest expense of a hospital is staffing. The ability

to provide the services is dependant on the particular clinical staff to the extent that the staff are taken away or encouraged to leave or leave on their own volition. It's negative to the hospital.

Q: Okay. Now, Dan, let's go back to 168.4 and look at the fifth factor, and sorry, let me ask you as we are on 23 (a) and (b), Mr. Levitt, which applicant best meets these terms?

A: Piedmont.

Q: Okay. And finally, what is 44-7-180(B)(4) relate to?

A: That's the regulation ---

Q: Statute?

A: I'm sorry, statute that requires the determination of the creating of -- improving accessibility relative to the adverse impact.

Q: Okay. And what's your opinion concerning that balancing test?

A: That the improved accessibility of CMC-Fort Mill Hospital to residents of northern York County is not outweighed by the negative impact it would have on -- the negative impact outweighs that increased accessibility.

Q: Does Piedmont offering a hospital placement in

Fort Mill address the issue of accessibility?
A: It does. The Fort Mill Medical Center would provide access to residents in that area.
Q: All right. Do they, would the Fort Mill Medical Center produce an adverse effect on the operation at Piedmont Medical Center?
A: No, no. A positive impact on the operation at Piedmont Medical Center.
Q: All right. And given your opinions concerning those matters, what determination have you made about which applicant most improves accessibility and avoids adverse effects?
A: Piedmont Medical Center.
Q: All right. Now, let's move at this point, if you would, Dan, if we could convert those checks and Xs to the grid, 168.1. The overview of the project review criteria related to distribution and accessibility should be the next one. And then related to cost adverse impact, bottom, related to cost containment, the two considerations there. So, we'll hold that open until you address 6(a), okay?
A: Okay.
Q: And (h) has already been addressed under section 3. All right. So, I think that takes

us to the third issue you've identified, Mr. Levitt, as you began your testimony concerning project review criteria, you've identified three buckets in which the criteria fell. One was need. You've addressed that. The second was adverse impact. We've concluded that. And the third was financial considerations, is that right?

A: Correct.

Q: All right. So, have you prepared a Demonstrative that identifies the various financial considerations and provides an overview for them?

A: Yes.

Q: All right. Let's take a look at that, Demonstrative 195. And what do you have here?

A: This shows the criteria that are the financial considerations. 802.6(a), gross charges; 802.6(b), projected utilization; 802.7 projected expenses. 802.9.15, net income and financial feasability, 802.16(a) cost containment related to funding; 16(c) charges and 803.17, efficiency.

Q: Okay. Now, let's go ahead and begin, dive into these. The first one is an easy start. The

Department found that all parties equally met the criterion related to projected charges. Do you agree with that?

A: Yes.

Q: Okay. And then let's move to the second part of section 6. Which relates to projected utilization. Would you read from that section of the regs, please? And Dan, let's go ahead and cut to the regs on that.

A: The projected levels of utilization should be reasonably consistent with those experienced by similar facilities in the service area and or state. In addition the projected levels of utilization be consistent with the need level of the target population.

Q: All right. Now, in general terms, why is a utilization being addressed in this financial section of the regs?

A: Because the utilization will drive the financial pro-forma. So, one is directed related to the financials.

Q: And the revenue?

A: And the revenue.

Q: Okay. All right. And what does the regulation require?

A: That the levels are consistent with similar facilities in the service area and the state.

Q: And have you analyzed the utilization of similar facilities in the service area and or state?

A: Yes.

Q: Okay. And let's actually, Dan, go to Exhibit 12, page 37 of this. But let's do the cover page first. So we can identify what the source is, Mr. Levitt.

A: This is the current State Health Plan.

Q: All right. And let's then look page to 37 on this. And why are you using the current State Health Plan to look at this criterion, Mr. Levitt?

A: Because it shows the most recent occupancy experience of the hospitals.

Q: Okay. And which is the region that, there are four regions in the state, is that right?

A: Yes, there are four regions in the state.

Q: Okay. And which is the one that Piedmont and York County is located in?

A: Region 2. Bottom left corner.

Q: Dan, pull that up, please. Okay. And the focus of the regulation as you testified to,

Mr. Levitt, is consistent with similar facilities. So, what have you highlighted here?

A: Well, the first thing highlighted is the total regional average of Region 2 is 55 percent in the most recent year. Last three years was 57, 55, I'm sorry, 57.4, 55.7, 55.0 for the ---

Q: Again, these are statements of the occupancy rates?

A: Occupancy rates of those hospitals in Region 2.

Q: Okay.

A: Well, we also highlighted what were comparable facilities, community hospitals and the only hospital located the service area of York County, Piedmont Medical Center. You can see Piedmont at 57, 58, 62 percent occupancy. Providence Northeast in 2011, I think was their third year, 53 percent. Lexington, 58 percent. Springs, 44 percent and Kershaw at 57 percent.

Q: And we could look at the top of the page, but do you happen to know what years these three columns reflect?

A: I believe it is '09, '10 and '11; 2009, 2010 and 2011.

Q: And what is the proposed occupancy rate, that

is, the percentage of beds that would be occupied at Fort Mill Medical Center?

A: Fifty-eight.

Q: Okay. And then what's your opinion concerning, related to the consistency of Piedmont's proposed occupancy with similar facilities in the region?

A: That it's consistent.

Q: Okay. And how would you evaluate that against Carolinas' projected occupancy?

A: Their occupancy was higher. There were 67 percent, I think.

Q: Year three?

A: Year three, 67 percent, so, much higher, much more well-utilized, again because they had the smaller facility.

Q: All right. Is that consistent with these facilities?

A: It's higher, but consistent.

Q: Okay. Now, there are two parts of the test under 6(b), aren't there?

A: Yes.

Q: And the second one, do you want to look at it again? Relates to, again, I think you've read it, related to the need level of the target

population?
A: Yes.
Q: All right. Now, you -- I'll take the time to do this, do you recall Exhibit 99, your projection of 203 patients leaving the county?
A: Yes.
Q: All right. And how, do the proposed projects relate to that need level of the target population?
A: Again, the 64 additional beds at CMC is a lower percentage of that but still helps to address the needs of the market.
Q: And how does Piedmont's?
A: Again, they are adding 64 new beds and transferring 36 other beds to be better utilized, so it also addresses the needs, perhaps even in a better manner.
Q: Okay. So, then, Dan, let's go back to the grid at 168. Mr. Levitt, which, how would you evaluate the extent to which the applicants meet the projected revenue criterion in 6(a) and (b)?
A: Well, I think, because of 6(b) Piedmont might better meet it, but they both meet it.
Q: Okay. All right. Let's move to the next

section, which is section 7, 802.7 that looks at projected expenses of the applicants. Actually, look, Dan, pull up the reg again. And, Mr. Levitt, please read that into the record.

A: On seven, projected expenses. Projections of construction costs, start up costs, operating costs, debt service, depreciation, manpower costs, et cetera, should be considered with those experienced by similar facilities offering a similar level and scope of service (with proper consideration given to such factors such as inflation, cost of capital, et cetera).

Q: All right. Now, what's the purpose of this provision?

A: To determine if the expenses are reasonable.

Q: All right. Now, in competing applications for the Department to make that determination look at the projected expenses and compare them head to head, is that what the regulation provides for?

A: No. They can, but they need to compare those to other facilities offering similar services.

Q: What does the regulation state?

A: That they -- the projection should be consistent with those experienced by similar facilities offering a similar level of service and scope.
Q: Okay. Did Ms. Brandt do that in her analysis?
A: No.
Q: All right. Now, have you done that?
A: Yes.
Q: All right. So, first category of expenses identified are construction costs. Did you compare the construction costs proposed by Carolinas and by Piedmont against those of similar facilities?
A: Yes.
Q: How did you do that?
A: I looked at the CON applications for comparable facilities and compared that to the projections in the CON application.
Q: Okay. Before we look at that, let's pull out Demonstrative 153. Now, at any point during the review of the costs, the review of these applications, Mr. Levitt, did you communicate with the Department concerning the comparisons that they were undertaking or appeared to be undertaking with regard to the capital costs

for -- that each of the applicants would incur?
A: Yes.
Q: All right. And why did you do that?
A: To make them aware that the capital costs couldn't just be compared across the board looking at what was in the applications. They contained different elements just as the regulation says, proper consideration should be given to -- as an example it gives cost of capital. So, if one applicant includes cost of capital and capitalized interest, then they need to be able to compare that. If one did include it and one didn't include it, it's not a fair comparison to look at the total. So, for that reason, and several others, if there were inflation, again the reg talks about adjusting for inflation. So, you want to make sure the inflations were comparable. The assumptions were comparable, so we adjusted our numbers to make them, as you called it, apples to apples comparison.
Q: Did Carolinas include in their projected capital costs capitalized interest?
A: They did not.
Q: In the application you prepared originally did

you present that?
A: We did.
Q: Okay. And so these were one of the three reasons for adjustments that you present to the Department in your capital costs, is that right?
A: Correct.
Q: All right. Let's look at the second one. What does that relate to?
A: The information submitted by the applicants, we submitted a complete, revised and updated application in 2010; CHS didn't. They ultimately updated their information, but they inflated their construction costs to a different time period than we did. So, in order to compare the numbers, we identified it as deflation, but we adjusted the inflation to be consistent for consistent time periods. So, we adjusted our inflation to the time period that they identified and I think it was 2010 inflated construction costs.
Q: All right. And what is the third issue related to?
A: We included our medical equipment at sort of list price. What the, quote, the list price

would be. Piedmont, as a group purchased, as a member of a group purchase organization we received a 22 percent discount on medical equipment, so we knew that that wasn't what the equipment would cost. It would be 22 percent less, so we adjusted that to reflect the out-of-pocket cost.

Q: All right. And let's look at the next demonstrative, 153.2, Dan, as to how those adjustments were applied. Would you review this please?

A: Sure. You can see the land costs wouldn't be adjusted because none of those factors impact land costs. So, 4.6 million would remain constant. Construction costs were, as we called it deflated from 75 million to 68 million to be comparable to the time period for the CHS application. The equipment costs that reflects the 22 percent discount. A and E costs or the architect and engineering fees, those are a factor, a percentage of the construction costs, so as those go down, as the construction costs go down, the A and E fees will go down and we eliminated the capitalized interest expense. So, taking all those

adjustments into account, the miscellaneous, other expenses remained constant but the overall impact $146 million went down to $118.8 million.

Q: Okay. Now, applying the $118.8 million capital costs figure and Carolinas' proposed capital costs, did you analyze those in accordance with the regulation against other total project costs for other satellite hospitals?

A: Yes.

Q: All right. And let's take a look at that. At Demonstrative 151, please. And what does this one show?

A: This shows for the CON applications filed and approved since 2005 --

Q: Now, are these the CON applications that have been made Exhibits of Piedmont?

A: Yes, these are, as it shows at the bottom, Joint Exhibit 1A, 1B and Piedmont Exhibits 56 through 63.

Q: Okay.

A: This shows the number of beds and the CON application, the total cost, TPC, total project costs. And the total project costs per bed. You can see that the blue numbers boxed are the

CMC-Fort Mill and the Fort Mill Medical Center CON applications, $77 million for CMC and $118 million we just showed for Fort Mill, divided by the number of beds and they're comparable, 1.2 million versus 1.2 million, basically. And you can see there in the middle of the pack, Trident-Berkeley, Roper-Berkeley were the highest, 2.3 million dollars per bed and the lowest was Greer in Pelham in 2005, $700,000 per bed and a little over a million dollars a bed.

Q: Now, are any of the hospitals identified this Exhibit, and they're not all satellite hospitals by the way, are they?

A: No, some of them are replacement hospitals. Some are satellite hospitals.

Q: Okay. Now, among these, are there any facilities other than CMC-Fort Mill associated with Carolinas?

A: Yes.

Q: And which are they?

A: The Roper-Berkeley and Roper-Mt. Pleasant which are the, two of the three highest total cost per bed at 2.2 and 2.5, or 1.5 million dollars per bed.

Q: Okay. And the years are identified there. Is there any significance related to these cost projections and the years that they were offered?

A: Yes. With the exception of Roper-Mt. Pleasant in 2005, obviously the older the facility, the lower the cost. So, the 2005 facilities at the bottom, Greer, East Cooper, The Village, Pelham, are the lower cost per bed because that was before inflation was applied to them. So, if you were to inflate those all to the same year, then they would be comparable.

Q: And they would be comparable, the ones from '05?

A: Perhaps. You know, if you were to increase it depending on the assumption, but even without increasing in the proposed projects fall into the middle of the pack.

Q: Okay. And what does that cause you to conclude related to the extent to which these two proposed projects would meet the standard under the projected capital expenses under section 7?

A: That they would both meet it.

Q: All right. Now, did you evaluate anything else under section 7 other than capital costs?

A: Yes, operating costs.
Q: All right. Dan, let's look at Demonstrative 196. And what's the source of this, Mr. Levitt?
A: These are the Medicare costs reports and CON applications. Oh, I'm sorry. These are the CON applications for the various hospitals. Fort Mill Medical Center, CMC-Fort Mill, Roper-Berkeley, Palmetto-Parkridge and Roper-Mt. Pleasant.
Q: From the CON applications?
A: From the CON applications.
Q: Okay. And what have you done there?
A: Looking at the operating expenses, the total expenses per adjusted discharge, the Fort Mill Medical Center, the $9500, 9558 with CMC lower at 7500 comparing that to the other applicants, Roper-Berkeley at 14,000, Palmetto-Parkridge at 9500 consistent with Fort Mill and Roper-Mt. Pleasant in 2005 at 7100 would be, I guess, comparable to the CMC-Fort Mill in 2010. The same with personnel expenses per adjusted discharge. Again that 3300 for Fort Mill, 3,000 for CMC, 5600 for Berkeley, Roper Berkeley, 4,000 for Parkridge and 3100 for Mt.

Pleasant.

Q: Okay. Let's go through them as you're going through them, evaluate the comparability of Fort Mill and Carolinas to the three applications you've identified.

A: Sure. That they -- because as I said the total expenses per adjusted discharge and the personnel expenses per adjusted discharge, they are comparable to the various facilities. Roper-Berkeley is the highest in 2008. And then the CMC-Fort Mill and Fort Mill Medical Center are comparable to the other two facilities.

Q: Now, the Roper-Berkeley, that's a Carolinas-managed project, is that right?

A: Yes.

Q: And it's nearly twice the total expenses per adjusted discharge?

A: Correct.

Q: Okay.

A: The salaries, I'm sorry, supplies and other expenses, again, the CMC-Fort Mill at 1500 per adjusted discharge is a little more than the Roper-Mt. Pleasant in 2005. The Fort Mill Medical Center 2300 is slightly higher than

that and comparable to the Parkridge and then Berkeley again, higher at 3300. Total FTEs per adjusted bed, this was raised during project review. Fort Mill is at 4.2 CMC-Fort Mill was at 3.1, which in my mind was low and that's what the data showed. Roper-Berkeley was at 5.6, almost double CMC-Fort Mill, Palmetto-Parkridge 4.0, consistent with Piedmont's 4.2. Roper-Mt. Pleasant didn't provide enough information to calculate the FTEs per adjusted occupied bed. And then the indigent care percentage assumptions that CMC-Fort Mill, again, we talked detailed about the 6.3 percent assumption that compares to the three percent at Fort Mill, 2.2 percent at Berkeley, Roper-Berkeley, 4 percent at Parkridge and 1.9 at Roper-Mt. Pleasant.

Q: Let me take you back to the total FTEs for adjusted occupied bed. First of all, what is that attempting to measure?

A: That measures staffing. So, it determines -- the higher the number, the more staff you have basically. And it gives you an idea of how well the facility is staffed.

Q: Is it a good thing or a bad thing to have a low

number relative to others? Do you want more staff in a hospital or less? Or does the regulation make that clear?

A: It depends on who you are and what your position is in the facility, but you would want to ensure that you have adequate staff to provide care for the services. If you're a nurse, then you would want more staff and if you're someone who is more concerned about operating expenses, you would want less staff but you can't have too few staff because you still have to provide for the care of the patients.

Q: Okay. And what inferences do you make of the fact that CMC-Fort Mill proposed to have 3.1 staffing ratio and or level and Roper-Berkeley, a Carolinas partly owned and Carolinas managed hospital as nearly twice that?

A: The 3.1 struck me as low. Four would be the rule of thumb I would use. Four at Parkridge, 4.2 at Fort Mill seemed consistent and the expected 5.6 is a little high.

Q: All right. And what did Palmetto propose in the hospital they were developing?

A: Palmetto Parkridge was 4.0.

Q: All right. And what's your experience with all your years with working with hospitals, the most common range of FTEs per adjusted occupied bed in hospital facilities?

A: Again, that's a common number I've seen. Four is a good target for a project.

Q: Okay. All right. Now, considering the information you reviewed and your testimony here related to both capital and operating expenses, how would you apply section 7?

A: Well, as I said there were some issues with the CMC-Fort Mill, I think they would both comply with that criteria.

Q: All right. Dan, let's flip to 168. The overview grid and so you provide checks under each facility, is that right, Mr. Levitt?

A: Yes.

Q: Okay. Let's move on to the next one. Which is net income and financial feasability. Why have you coupled these two provisions, Mr. Levitt?

A: I think inherently you understand that they are -- that the net income would determine the financial feasibility.

Q: Okay. Dan, let's pull those up and, Mr. Levitt, if you'd read both section 9 and 15.

Since they are on different pages, one at a time.

A: Okay. Nine is net income. The project should show improvement in its net revenue position over time. Especially the first three years until a steady, positive net income trend is attained. Any projected deviations from this pattern should be explained.

Q: All right. And let's go to 15.

A: Fifteen is financial feasability. The applicant must have projected both the immediate and long term financial feasibility of the proposal. Such projections should be reasonable and based on accepted accounting procedures.

Q: Okay. Now, generally, what's the Department attempting to evaluate based on these regulations?

A: To determine if the project is financially feasible, if it shows positive net income and if it, if the facility can afford to do it.

Q: Okay. Now, have you -- again, now if the regulations require, as you've just reviewed, the determination as to the reasonableness of revenue and expenses both based on the

performance of similar facilities, how would that relate to the analysis of net income? Financial feasibility?

A: Again, you would look at the projected experience of similar facilities.

Q: Okay. Now, have you done that?

A: Yes.

Q: All right. Dan, pull up Demonstrative 197. And what do you have here, Mr. Levitt?

A: This shows the projected CMC-Fort Mill, Fort Mill Medical Center, year one, two and three of net income projections. And then the Trident-Berkeley and the Trident-Roper projected net incomes for the same first three years of operation. And what it shows is that CMC-Fort Mill showed a profit in year one of $600,000 increasing to $1.6 million by year two and up to $2.7 million by year three. Contrast that with Fort Mill, it showed a loss the first year of operation by a half million dollars. Almost three million dollar loss in year two and then an increase to about $300,000 by year three.

Q: And why do you have the two Berkeley County projects identified below those?

A: Those were the -- at the time we submitted this

on July 11th, these were the two applications that had been approved most recently and they showed the most comparable analysis and it shows -- similar to Fort Mill Medical Center showed a loss the first two years of operation with a modest positive net income by the third year. So they all had the projected requirement in the regs that a steady increase every year in the bottom line.

Q: Now, did the Department approve both of these applications?

A: Both the Trident-Berkeley and Roper-Berkeley, yes.

Q: And the Roper-Berkeley again, was a project that was sponsored by Roper which is owned and managed by Carolinas?

A: Correct.

Q: It shows nearly a $15 million loss over the first three years of operations and the Department found that financially feasible?

A: Yes.

Q: And was it projected by Roper as financially feasible?

A: Yes.

Q: Okay. And in your opinion was it financially

feasible and consistent with regulations?
A: Yes.
Q: Why?
A: Because it showed a positive trend and that's what the regs call for.
Q: Okay. Based on that, Mr. Levitt, have you made a judgement about whether the applicants meet the criteria for financial feasibility and net income performance?
A: Yes.
Q: And what is that?
A: They both meet that.
Q: Okay. All right. Let's move on to the next one. You've already discussed 16(c), let's take a look at 16(a). Read 16(a) into the record, please.
A: The applicant should have identified all alternative sources and or methods of funding and demonstrated that the method chosen is the most feasible option.
Q: And what does that mean?
A: That means that from the project, the applicant needs to identify that source of funding.
Q: Okay. And do you agree with the Department that Carolinas best met this criterion and Fort

Mill did not?
A: No.
Q: Let's take a look at the record please, Dan, if you'll pull up Joint Exhibit 1(B), page 223. And what is this, Mr. Levitt?
A: This is the evidence of findings letter that was submitted with the CON application to Ms. Brandt from the regional office, I believe it was from John Holland. He's the senior vice president of operations for Tenet Healthcare Corporation. That identified Tenet Healthcare Corporation would fund the project.
Q: And what do they say concerning their plans to fund the project?
A: Well, it states that Tenet Healthcare Corporation, the parent of Amisub is committed to providing the necessary funding. So, in my mind, that's the definitive financing. That corporate is going to pay for it. And it goes on to say though, which I guess caused concerns with Ms. Brandt, the second paragraph, they intend to finance the project with the most appropriate and cost effective capital structure at the time utilizing existing cash reserves, existing lines of credit or the

issuance of debt and or equity. It goes on though to say that as of June 30, 2010, which I believe was about the time the letter was submitted, that Tenet Healthcare Corporation had $711 million in cash and cash equivalents. So again, the project was $120 million. They said they had $711 million in cash, so they could pay for it out of cash. They said depending on what happens to the markets and the economy and finances we'll fund it however we see best, but the first paragraph says we'll fund it.

Q: Now, how did Ms. Brandt evaluate this?

A: She indicated that because it wasn't what she felt as not definitive, she viewed that as a negative.

Q: How did Carolinas represent that it intended to fund its project?

A: They said they were going to pay cash for it, out of reserves.

Q: All right. And the -- how did Ms. Brandt evaluate the issue of one statement being definitively cash, the other statement being we may use cash, we may use credit or some combination thereof?

A: Again, she viewed the leaving the options open as Tenet had, as negative.

Q: What's the best, based on your experience, business course for an applicant?

A: Well, from a business perspective, I think Tenet is appropriate in identifying what the best option is. If interest rates are low, if there cash position is such that they want to pay cash, that's fine. Or if they want to issue debt, that's fine, too, if it's cheap debt. So I think it's best to leave it open. I think though, I think what Ms. Brandt missed is that the first sentence says Tenet is going to pay for it. That's the definitive funding. Amisub will get the money from Tenet. That's -- can't be more definitive than that.

Q: Is there any question in your mind whether Tenet can afford to pay cash to build this hospital?

A: No.

Q: Okay. And all right, let's go back then to the grid at 168. We've got two subpart, 16(a), which we just reviewed and 16(c), which you'll remember was the criterion related to the effects of the proposed project on existing

providers, costs and charges. Do you remember that?

A: Yes.

Q: All right. Now, which applicant best meets both provisions of 16?

A: Well, both provisions would be Piedmont. You know, I think Carolinas identified the source of their funds and I have no reason to believe they can't afford the project either, but the 16(c) part, we identified as being Piedmont, so Piedmont best meets them taken in total.

Q: All right. Let's move to the next provision which is section 17 concerning efficiency. Dan, if you'll pull that up in the regs. And read this into the record, please, Mr. Levitt.

A: Efficiency. The proposed project should improve efficiency by avoiding duplication of services, promoting shared services and fostering economies of scale.

Q: Okay. Now, how did you apply this provision to the two applications?

A: Well, obviously, as we talked about the duplication, the indirect duplication of services by the CMC application present on services at Piedmont, that would be negative.

Shared services that I think they would obviously both applicants would share services and, you know, have benefits of that and then the economies of scale, looking at the 100 beds versus the 64 beds as we talked about, 100 beds would offer an economy of scale savings.

Q: All right. Have you prepared a Demonstrative to show that?

A: Yes.

Q: And let's pull up Demonstrative 168, please, Dan. Now, you testified previously, Mr. Levitt, concerning the cost of Piedmont's proposed facility that made adjustments to them. Are these the costs that are reflected in the Demonstrative before or after those adjustments?

A: This is before adjustments.

Q: Okay. And review what we have here, please.

A: This shows that the 64-bed applications submitted in 2005, the total cost per bed of $1.6 million and construction and equipment costs per bed of $1.3 million. As we said early on, the time line we withdrew that application and submitted a 100-bed application at the time of 2005 and those costs per bed

were $1.2 million or 25 percent less than the cost per bed of the 64-bed facility and the construction and equipment costs per bed were just over a million dollars or about 25 percent less than the 64-bed facility. So, you can see that by the time frame of submitting the two applications, by adding the additional beds to the infrastructure that was proposed, it was 25 percent cost savings for a 100-bed facility versus 64 beds.

Q: Okay. All right. And based on that consideration as well as the one you referenced that avoids duplication, which of the applicants best meets section 17?

A: Piedmont.

Q: Dan, if you would apply that to the grid, please. All right. Mr. Levitt, with regard to the record of the applicant, there are three subsections identified (a), (b) and (d), would you agree with the Department for purposes of (a) and (b) that it is the record of the applicants and also the record and history concerning compliance that both parties equally meet those standards?

A: Yes.

Q: Okay. And then the other consideration relates to obtaining financing in 13(b). What findings have you made with regard to that?
A: That both applicants can fund the project, they can obtain money.
Q: Is that Ms. -- do you agree with Ms. Brandt in applying 3(b) in a way that she did that was consistent with 16(a) that Carolinas best met the that because they had the more definitive capitalization plan?
A: No. For the same reason we talked about.
Q: Okay. All right. So, what would be your determination concerning the compliance of both applicants with the record of the applicant?
A: They both comply.
Q: Okay. All right. Let's take a look then at the last criterion concerning acceptance in section 4(a) and (b). Pull those up please, Dan. And read those please, Mr. Levitt.
A: Acceptability, 4 (a): For the proposal an applicant should have the support of affected persons including local providers and target population. Lack of opposition should not be considered support for the proposed for purposes of these criteria, (b) states: Where

documents of opposition exist for a proposal, such opposition shall be considered along with the application.

Q: All right. Now, and how have you evaluated this section, Mr. Levitt? Let me just ask, cut to the chase if you agree with Ms. Brandt's finding that the applicants equally met this provision?

A: Yes.

Q: Okay. All right. Dan, let's pull up her finding related to this at Joint Exhibit 1(B), page 1030. And read that sentence into the record if you would.

A: All applicants meet the criteria for acceptability. All applicants submitted substantial letters of support primarily from the community. Current reported totals are 10,004 letters for Presbyterian, 5,753 for Carolinas and more than 5,400 for Piedmont.

Q: All right. And have you ever been involved with a case with the volume of letters anywhere near approaching this number?

A: No. No, that's a lot of letters.

Q: What's the purpose of this criterion, Mr. Levitt?

A: To ensure that there's support for the project and that utilization will occur, that for physicians to support the project to refer patients to the proposed project and that the members of the community support the project as well.

Q: Okay. And did they support, did members of the community support all the projects?

A: Yes.

Q: Now, let's take a look a moment at 4(b) and what you said about opposition being considered. Was there opposition expressed to the applicants, to any of the applicants in this case?

A: Yes.

Q: And what was it?

A: There -- well, here Ms. Brandt identified 34 letters of opposition from the community for Piedmont. And then -- so that's what she identified in this.

Q: Did Ms. Brandt identify the letters of opposition to Carolinas and Presbyterian submitted by members of the Piedmont Medical staff?

A: No.

Q: Okay. What weight should be given to those letters, based on your experience?
A: The letters of opposition?
Q: Yes.
A: Not a lot. You know, they were -- it was interesting to me that there were 34 letters of opposition that they were sent to -- the ones I saw that I looked at most recently were sent to Carolinas directly. Ms. Brandt also received some copies but what was interesting to me was that Piedmont submitted a number of applications over time, over the time I worked for them, I never saw a letter of opposition except for this project. Even shortly after we submitted the CON application, there were no letters of opposition.
Q: So what did you ---
A: Imaging Center CON, no opposition. ED CON, no opposition. But with this application there is series letters of opposition.
Q: What inference did you make because of that?
A: That those letters were encouraged to be sent.
Q: Over the period of ten years this case has been active, how many patient encounters would you estimate have occurred at Piedmont Medical

Center?

A: A lot. I mean if you look at ED, they have about 50,000 ED visits so over a ten year period, that would be half a million. In addition to outpatient visits, other admissions, you know, it could be a million.

Q: Okay. Based on consideration of these factors, how would you score the applicants under the acceptability criteria?

A: They all had letters of support. They all demonstrated acceptability. This is what Ms. Brandt found. They both get a check.

Q: Okay. All right. Okay. Mr. Levitt, let me take you back just briefly before we wrap up, you remember the two issues you identified at the outset of your testimony of Exhibit -- I'm sorry, Demonstrative 94. Those key questions, do you recall them?

A: Yes.

Q: Review them again?

A: What Health Plan needs are being addressed by each applicant and what are the likely benefits and risks associated with each of the projects to the residents of York County.

Q: All right. And have you formed opinions

concerning each of these questions?
A: Yes.
Q: All right. Have you developed a Demonstrative related to that?
A: Yes.
Q: Let's take a look at it. What your opinions are related to the needs being addressed by the applicants in Demonstrative 198.1. All right. What do you have here?
A: This shows the first question or framework we talked about. What Health Plan needs are being addressed by each applicant. Carolinas is proposing 64 beds. Piedmont's proposing 100 beds at Fort Mill Medical Center and they're both proposing to strengthen the healthcare system, both the Piedmont Healthcare System as well as the system in York County for physicians.
Q: All right. And as a result of that, which of the applicants best meets in your view the plan needs that relate to the healthcare objectives for York County?
A: I think Piedmont, the Piedmont application better meets the Plan needs.
Q: All right. Now, let's move through to the

second issue again on the next page of this Demonstrative.

Q: Review this, what your opinion is please, Mr. Levitt, concerning the likely benefits and risks associated with approval of either of these applicants.

A: Well, we talked about the benefits of Carolinas' proposal of 64 additional beds in the market and that's positive. Piedmont would have 64 beds, it's not identified, 64 additional beds in the market from the Fort Mill Medical Center. The increased utilization at Piedmont by having the Fort Mill Medical Center, reversing out-migration. Having a positive impact on payor mix and strengthening the specialization by increasing the volume of services. The risks, those associated with Carolinas would be to increase the out-migration rather than reverse it. Would have negative payor mix impact on Piedmont. Weaken the medical staff at Piedmont and overall have a negative impact on Piedmont. And the risk of a 100-bed facility at Fort Mill, for Piedmont would be that it is not as well-utilized as we projected.

Q: All right. What's the likelihood that the risk of the underutilization at Piedmont Medical Center would occur?

A: I think that risk is low.

Q: How do you calculate or how do you evaluate the risks that you've identified for Carolinas?

A: I think that's what we've done for the last several days. We've outlined that, I think, in pretty good detail. That the Carolinas facility will have a negative impact on Piedmont.

Q: Okay. Thank you, no further questions, Mr. Levitt.

MR. MULLER: Your Honor, can I propose cross exam in the morning? I know you were trying to go to six every day, but there is such a mass of information.

THE COURT: There is.

MR. MULLER: That I would appreciate if we could just start in the morning.

THE COURT: Unless there is any objection to that?

MR. ANDREWS: No, and I apologize, Your Honor, that I miscalculated time.

THE COURT: No, and I retained us a little later into the lunch hour, so we have another witness

because in essence you weren't going to ask any questions about that and of course, my intent was the Court doesn't want to hear anything about that.

MR. ANDREWS: I understand.

THE COURT: So, but it is my understanding that you're not going to go there, so I just wanted to be sure that was clear for the record.

MR. ANDREWS: And that's our position.

THE COURT: Yes, sir. Thank you very much.

MR. ANDREWS: Thank you, sir. At this time we would like to call Dr. Sushil Singhi to the stand.

SUSHIL SINGHI, M.D., having been duly sworn, testified as follows:

DR. SINGHI - DIRECT EXAMINATION BY MR. ANDREWS:

Q: All right. Have a seat Dr. Singhi, good morning.

A: Good morning.

Q: That's right and if you might lean forward and make sure you can speak loudly enough so the court reporter can understand everything you have to say. All right. Dr. Singhi, please state your full name and business address for the record.

A: My name is Sushil Singhi. I'm a cardiologist

in Rock Hill. My address, office address is 196 Cardiology Drive, Rock Hill, South Carolina. My zip code is 29732.

Q: All right. Thank you, Dr. Singhi. Are you currently on the medical staff of Piedmont Medical Center?

A: Yes, I am.

Q: And you say that you're a cardiologist, is that correct?

A: Yes.

Q: All right. Dr. Singhi, have you provided a copy of your current curriculum vitae to the parties?

A: Yes, I have.

Q: All right. And let's pull that up as Exhibit 74, please, sir. And does this appear to be your current CV?

A: Yes.

Q: And is it accurate?

A: Yes.

Q: All right. Now, Dr. Singhi, let's just provide a little background concerning your education and experience to the Court before we move to the substance of your testimony. Where did you get your medical degree?

A: I got my medical degree from MGM Medical college, Indore, India.
Q: All right. And when was that?
A: That was in 1982.
Q: All right. And have you received a residency as part of your training as a cardiologist?
A: Yes.
Q: And where did you receive that training?
A: I finished my internal residency in West Virginia with WVU, in Mercy Hospital.
Q: All right. Have you received a fellowship?
A: Yes.
Q: And where did you pursue your fellowship?
A: I was trained at Saint Francis Medical Center in Pittsburgh, Pennsylvania.
Q: All right. And are you board certified?
A: Yes, I am.
Q: In what fields?
A: I'm board certified in cardiology and interventional cardiology.
Q: All right. And have you been licensed to practice medicine?
A: Yes.
Q: Where?
A: I've been licensed to practice in the state of

South Carolina, North Carolina, Pennsylvania and Ohio.

Q: All right. And have you practiced in locales, apparently you have based on where you've been licensed, before establishing your practice in Rock Hill?

A: Yes.

Q: And where was that? Would you review that please?

A: After finishing my fellowship in cardiology, I started practicing at University Hospital in Pittsburgh, Pennsylvania.

Q: And following that, what did you do?

A: Then I moved down south, South Carolina.

Q: Okay. All right. Now, when did you move to South Carolina?

A: Moved in January of 1994.

Q: And was that in the Rock Hill area?

A: Yes.

Q: All right. And who -- what practice did you join at that time?

A: I joined Carolina Cardiology Associates.

Q: All right. And have you since moving to South Carolina become affiliated with hospitals in South Carolina and North Carolina?

A: Yes.
Q: And which facilities are those?
A: Piedmont Medical Center in Rock Hill and a couple other hospitals including well, it was Mercy Hospital which is now being bought out by the CHS is CMC-Mercy in Charlotte. I'm also staff at CMC-Pineville Hospital in Charlotte and least but not is Spring Memorial Hospital in Lancaster, South Carolina.
Q: And you've been a member of the staff at Presbyterian Hospital?
A: Yes.
Q: In Charlotte as well?
A: That's right.
Q: All right. And let's look at the achievements identified on the first page of your CV. Have you held any leadership positions at the hospitals or medical organizations?
A: Yes, currently I'm the president of Carolina Cardiology Associates. I was chief of staff a couple years ago, it was back in 2009.
Q: Of what facility?
A: At Piedmont Medical Center.
Q: Okay.
A: I was also president of the York County Medical

Society in 2010.

Q: All right. And if you look on page seven of your resume, we'll see, or actually, let's begin on page 4. A number of presentations, 25 listed here. In what areas do you intend to provide presentations to other professionals?

A: All most all of the presentations were in the field of cardiovascular medicine.

Q: All right. And have you been responsible for undertaking clinical studies as well?

A: Absolutely.

Q: And what have they involved?

A: They involved in state of the art medicine and future medicine to stay ahead of the curve in the field of cardiovascular medicine. And part of the national and international research trials across the country and across the world.

Q: And if we look at page nine of your CV and what's listed here are a series of publications. Have you continued to stay published in your field?

A: Yes.

Q: All right. Now, let's move to your experience in the Carolinas, and particularly the practice which you joined in 1994. You said it was

Carolina Cardiology?
A: That's correct.
Q: Was it an existing practice when you joined it?
A: Yes.
Q: And could you provide a little bit of its history?
A: Yeah, Carolina Cardiology was founded by my senior partner, Dr. Jay Shah, approximately 30 years ago in Rock Hill, South Carolina. And we've been in the practice for almost 30 years providing the comprehensive cardiovascular car in the Tri-County area including York County, Lancaster and Chester counties.
Q: All right. And when you joined the practice, how many physicians were there, were members of it?
A: When I joined the practice back in 1994, there were four physicians.
Q: Okay. And what number are you today?
A: We have a total seven physicians in my practice.
Q: Okay. And you're -- you said previously you're the president of the practice, is that right?
A: That's correct.
Q: How long have you been in that position?

A: Almost two years.
Q: Okay. And were you an officer of the practice prior to that?
A: Yes.
Q: What were you?
A: I was given executive activity for the last 15 years with my practice including secretary, treasurer, vice president. Ex-officio.
Q: Okay. What's the range of services that you and your partners provide to the patients of Carolina Cardiology?
A: We provide comprehensive cardiovascular care including consultation, admitting patients with cardio problems, providing diagnostic testing in-house, in the office as well as inpatient, in the hospital. We also provide therapeutic procedures including angioplasty, stents. We also include EP services, diagnostic and therapeutic services for cardiovascular services.
Q: What are EP services?
A: Electrophysiology services, which is the electrical problem with the electrical condition of the heart.
Q: Okay. All right. Now, and where do you and

your partners practice medicine? At what hospitals?

A: We commonly practice at Piedmont Medical Center in Rock Hill, South Carolina.

Q: All right. Do you have privileges at other facilities?

A: We do have privileges at other hospitals including Spring Memorial Hospital in Lancaster. CMC-Pineville in Charlotte, North Carolina and Presbyterian Hospital, Charlotte, North Carolina.

Q: Okay. As a percentage of your total hospital-based business, what percentage would you estimate your practice has performed at Piedmont?

A: Approximately close to 100 percent.

Q: So nearly all of it?

A: Nearly all of it.

Q: All right. Now, let me take you back a few years, Dr. Singhi, to 2009. How would you describe the business of your practice at that time?

A: I joined the group back in 1994. And that was one of the most thriving cardiology group I came across and that was the main reason I

moved down south to Rock Hill to join the group. It was a very progressive group. A lot of new procedures were coming on, the hospital in Rock Hill was very supportive to accommodate in my experience -- from University of Pittsburgh to open up new services and the research activities. It was a robust group at the time I joined the practice back in 1994. And it remained like that for a number of years.

Q: Okay. And since the period of time since 2009 have you been in the position to be aware of the operational indicators of the group?

A: Yes, as I'm president of the group, I've been meeting with my administrative folks at least on a weekly basis for at least the last several years. Now that is more often being president of the group and we are tracking all the numbers, the dynamics and the changes as they happen.

Q: Okay. Well, let me take you back. And looking at that period in 2009, how would you describe the business of the group? How were y'all doing?

A: It's not the same as what it used to be. Now

we have ---

Q: What was it like then?

A: In 2009, we used to see a lot of new patients, new consults, referrals from primary care physicians in York County. The are significant changes, not only the hospital setting, but the hospital setting where we get visits or consults or from the ER, the emergency room or from the primary care physicians. There's a steady decline in new referrals, new consults and procedures than what we were used to do before.

Q: Okay. And let me ask you a few more things about what it was like before you began experiencing that decline. And with regard to your office, you said you have seven physicians currently, right?

A: Yes.

Q: And in 2009 was that the same number you had?

A: 2009 we had six physicians, six cardiologists. Now, we just added a new cardiologist who's an EP specialist, so that makes six plus one.

Q: All right. And why did you add an EP specialist?

A: To provide the care for the patient in York

County who have electrical problems with the heart. And we've been working -- pursuing this opportunity for at least five or six years and finally, we got an EP lab in the hospital.

Q: Okay. Now, how many -- what was the total number of the employees in Carolinas Cardiology in 2009?

A: We had 15 employees in my practice.

Q: Okay. And do you know what the payor mix was?

A: At the time, payor mix, yes, Medicare was 50 percent. Medicaid was about four percent. Blue Cross Blue Shield of South Carolina, which is the largest private insurance company was approximately 21 percent.

Q: Okay. And did you have commercial business beyond that?

A: Yes, we did have commercial, it was about 20 percent. And the rest was charity or self-pay patients.

Q: Okay. And so total Blue Cross and commercial business was approximately what together?

A: Forty percent.

Q: Okay. All right. Now, let's talk about then how the status of your group's business in 2009 compares to what it is today. Let's first

begin by talking about the volume and how that's changed. In terms of your total new patients over time, do you have any sense of how today's patient base compares with what you had four years ago?

A: Yes. Significant drop in new referrals. And it's in the range of about 15 to 20 percent per year reduction in the new referrals from primary care physicians.

Q: And over the period of four years, what's the aggregate reduction?

A: Well, about 40 percent reduction in new referrals in our practice.

Q: And are consults a subset of your total new referrals?

A: Yes.

Q: And what are consults? Describe what that would be.

A: For example, we used to have about 2500 new consults. New referrals, per year. Now it has dropped to 1800 new consults per year.

Q: Okay.

A: The last five years or so.

Q: All right. To 800 or 1800?

A: No, 1800.

Q: All right.
A: The new consults. But we also get some new patients, so if we combine the new patients and consults, it was about 40 percent drop in the new patients to the practice.
Q: Okay. And how have your hospital procedures changed?
A: It's also declining because we are being a part of the hospital as a cardiologist. And most of our patients do require some diagnostic procedure and therapeutic done in a hospital setting. Where studies see a significant decline in obviously the consults and new referrals and new patient in the diagnostic as well as the EP procedures.
Q: Okay. And do you know the extent to which your work you've done at the hospital has been reduced over the last four years?
A: Steadily about 10 to 15 percent decline in diagnostic procedure and approximately 30 to 40 percent decline in therapeutics.
Q: And what's the difference between diagnostic and therapeutic procedures?
A: Diagnostic procedures are where you make the diagnosis either by imaging or the procedure

and the therapeutic procedures are where after making the diagnosis, you go in and treat that condition. That's a therapeutic procedure.

Q: Okay. Now, in terms of the state of cardiology as it relates to therapeutic procedures, has there been a general decline in the field as a result of changes in practice?

A: Yes.

Q: Okay. And has that contributed to the overall reduction in the percentage of therapeutic –

MR. GASKINS: I'm going to object, Your Honor. He's leading the witness.

MR. ANDREWS: I am, Your Honor. I'm trying to work through this quickly and there's no dispute about these facts as far as I knew. I'll rephrase.

THE COURT: If you can rephrase it.

MR. ANDREWS: Sure.

THE COURT: Thank you.

Q: Have there been any changes in the industry that's affected the decline in therapeutic procedures?

A: Yes, let me just lay out the background. Overall, across the country there is a decline in therapeutic procedures to treat the patient

with the heart conditions. Especially the coronary artery disease. Across the country, there is a reduction in the number of procedures done. However, the Piedmont and my group has been impacted more than the national averages as far as the decline of those procedures.

Q: Okay. Now, have there been any changes in your staffing?

A: Yes.

Q: Of your own practice?

A: Yes.

Q: And what have they consisted of?

A: Since 2009 there was a significant drop in our new referrals, new patients, new diagnostic procedures in my office. Therefore, we have restructured our office staff base and we have a total of about 15 percent reduction in the staff in my practice.

Q: Now, what have been the effects, Dr. Singhi on this general decline that you testified about of new referrals and reduction in office-based and hospital-based procedures over the last four years?

A: Frankly, if you can get new referrals, new

consults from primary care physicians. There are now seven practices, primary care practices being managed by a big system, mostly from the Charlotte area. Although all three big systems, including CHS, Presbyterian or Novant, and Piedmont or Tenet, they all have primary care practices in York County. However the CHS and Presbyterian had more market share having more primary care physicians over there. We are being impacted by CHS from practices in York County where we used to get at least 25 percent of our new referrals used to come from those primary care physicians. Including Shiland Family Practice, which is over 15 providers and Medical Practice, internal medicine group which is about six internists in that group. And there is a significant reduction in the new referrals in the range of over 70 to 75 percent of the total referrals have gone somewhere else.

Q: And how do you know that?

A: Because as I said, I used to track all the numbers from different practices and different physicians on a monthly basis.

Q: So your office maintains ---

A: Absolutely, yes.
Q: Okay. And what have been the effects of these reductions in referrals on Carolinas Cardiology? What difference has it made to the operation of your practice?
A: I think it is a very significant negative impact in my practice as far as the operation goes. We are not growing. We are not able to buy new equipments or update our equipments in our practice. We had to curtail our staff. The number of staff in our practice. There is a significant financial impact on our practice going forward.
Q: All right. Now, what was your relationship with the Carolinas and I'll refer to it as CHS since your practice is Carolinas too. So the record will be clear, what was the relationship that your group had with the CHS physicians in York County prior to the reduction in referrals?
A: I was making collegial relationship with the primary care physician base and all of this provided newer technologies and discussions, we shared some of our data and enjoyed each of those professional relationships the last

several years since I have joined them.

Q: Prior to the loss of the referrals that you had been receiving, was there any dispute they had with any of the Carolinas physicians of any nature that might have provoked the change in referrals?

A: No, we had not changed our pattern, our way of providing the care so far. Including the best care to their patients, keeping them abreast of what's going on with their patients, so I don't see that we have changed our pattern of how to deal with primary care physicians.

Q: Did you receive any communications -- without testifying about any communications -- did you receive any communications formally from Carolinas notifying you of the change in its referral pattern?

A: As a philosophy or a group practice, we meet with primary care physicians on a regular basis. And we still meet with primary care physicians on a regular basis and something has changed to refer us the patients.

Q: Okay. Now, let's focus on the hospital itself where you and your partners perform procedures. Describe the scope of services that you and

other members of Carolinas Cardiology perform for your patients at Piedmont Medical Center. What do they involve?

A: Well, we perform both diagnostic and therapeutic procedures. Primarily at Piedmont Medical Center. Patients, as I said earlier, I've been to different hospitals as a clinician, as a cardiologist. I've been practicing cardiology for over 22 years. I've been on the faculty at University of Pittsburgh Medical Center in Pittsburgh, Pennsylvania. I've been to a couple of other hospitals in the Pittsburgh area and when I moved down south I've been to all the hospitals you can name, we just named earlier Carolina Medical Center, Spring, Piedmont, so I've been having that kind of blend in my experience of 22 years, so I can compare from a patient service point of view, satisfaction point of view how this business works. And even though we are providing the same care, what I would provide any other place in the country or perhaps in the world and we are seeing the significant impact, of course, the financial impact, I should not be concerned as a physician why there is a financial impact,

but as a physician to provide the patient care that is the time to be providing the good care for my patients. If they need my help and there is no significant resources available by the institution where I am doing 90 percent of my business, then going forward, I think that would be compromising my patient care.

Q: And how would you be compromising your patient care?

A: We as a cardiologist, especially interventional cardiologist who does the therapeutic procedures, are on call 24/7. We have one doctor on call seven days a week. And what I can see when a patient comes in with a heart attack, I'm just giving an example, the time is of the essence. Time is critical. That patient needs to be treated in a very timely fashion. As a cardiologist, as an interventional cardiologist, the most gratifying satisfaction that I get from a patient point of view, when a patient comes in and they need my help with a heart attack and I open up their artery to their heart in a timely fashion, it's one of the most rewarding experiences for a cardiologist and for a

patient. Improving the patient care -- not their well-being but you are improving their life. And that all depends on how timely fashion you provide the care.

Q: All right.

A: Yes, sir.

Q: How does, based on your experience, the various facilities where you practice, how does the quality of care at Piedmont for cardiac patients compare to what you've experienced at other facilities?

A: From my experience being active staff at the various hospitals across the country, I don't see any difference in providing the cardiac care that Piedmont Medical Center -- as a matter of fact, when we talked about the time when the patient comes into the emergency room with a heart attack, and opening of the artery, the Piedmont Medical Center data was from the top, the best data in the country. The time when the patient comes into the emergency room, the time the patient gets the balloon therapy or the standard therapy procedure. We were the top in the country.

Q: What's the term that's used for that, the

measurement of that time?
A: The term they use in our field is door-to-balloon time. Door of the ER to the balloon time, the patient gets the care.
Q: The balloon refers to the angioplasty? The therapeutic procedure?
A: Yes.
Q: All right. And what year was Piedmont recognized for providing exceptionally high quality door-to-balloon time?
A: 2006 to 2007, I think.
Q: Okay. Are you aware of the 2012 award that Piedmont received as the DHEC -- as best hospital in the state?
A: Yes, by the American Heart Association and American Stroke Association have awarded Piedmont as the best hospital for 2012.
Q: Have you yourself received services at Piedmont?
A: Yes.
Q: And why did you do that?
A: My son, my third son was born at Piedmont Medical Center and is doing fine. So I know that the last four years things have went well. Myself had a heart catheterization at Piedmont.

Even though I was staff at different hospitals.
Q: And you chose ---
A: It's the competence, the quality that we provide, my partners, my colleagues provide at Piedmont Medical Center.
Q: Dr. Singhi, can the quality of a cardiac program be effected by the volume of the procedures that a hospital performs?
A: I have no doubts about that. The reason being, there is a national guidelines by the American College of Cardiology that any interventionist who performs a procedure, therapeutic procedure, needs to maintain a certain numbers of those procedures in order to provide the good care to patients. And those number for balloon angioplasty, 50 angioplasties per year per physician. Also the hospital -- the cath lab, who provides this therapeutic procedure, they have to have 300 procedures per year. Same with the open heart surgery program. They have to perform 200 procedures per year in order to maintain the credentialing skills for your patients.
Q: What's the purpose of these thresholds?
A: The purpose has been well-studied by the large

organizations including ACC, American College of Cardiology and American Heart Association, in order to minimize the complications on this life-threatening condition when a patient comes in, you have to maintain your skill by having certain numbers of successful procedures.

Q: All right. Now, with regard to your group, the cardiologists at Carolinas Cardiology, do you know in 2010 or '09 what the average number of therapeutic procedures per cardiologist who were doing that work was?

A: Yes, we have six interventional cardiologists, each of us performing over 80 therapeutic procedures per year.

Q: How many were you doing this past year? Per cardiologist?

A: Two of my partners did not make over 50 last year. Per year, year 2012.

Q: And the average?

A: The average 55 procedures a year.

Q: Okay.

A: Per physician.

Q: Let's move to the issue of your expressing your support for Piedmont Medical Center in this application process. During the Department's

review in 2010, did you provide a letter of support for Piedmont?

A: Yes.

Q: Why did you do that?

A: Piedmont is where I have the most experience with my patients. I live in York County, I practice in York County. My office is in York County. And I see the quality of care that I provide through the Piedmont Medical Center as impeccable out of any other hospital that I have been on staff across the country.

Q: All right. Did you always support Piedmont through this process? Did you write a letter supporting anyone else?

A: Yes, I did support Presbyterian's system initially. I believe it was back in 2005.

Q: All right. Why did you do that?

A: Because the administration from the one hospital I visit more frequently than the Piedmont Medical Center. And me, as a physician, did not want anybody to take us for granted. We just wanted to make sure we are making the right decision for our patients in York County.

Q: Okay. You've obviously changed your mind if

you're here today. Why did you do that?
A: After meeting with the administration from the one and from Piedmont Medical Center, we felt that our patients would be served better by staying here in York County, especially we have all the help available from local hospital. Our concern at the time was the western of York County. Where, where a patient did not have 24/7 service and Novant System came out and they said we'll offer proactive resources to the western part of York County.
Q: Now, what sort of services do you mean?
A: Urgent Care services.
Q: Okay. Physician medical services?
A: Physician medical services.
Q: Has there been anything from 2005 through 2010 concerning the -- what you observed as a dynamic in the medical field within York County that affected your decision to switch your support to Piedmont?
A: Piedmont committed more support to the York County patients. Especially in the western part of York County. They provided more primary care physicians where there was an under supply of primary care physicians. The

commitment to update some parts of the hospital and buy and update some of the equipment that is used to care for some of the patients with cardiac conditions. They promised to provide more resources for the patient.

Q: Okay. What have been your observations over the last seven years concerning the physician base networks operating in York County?

A: Overall, it's not a good thing for my group because there we're still maintaining our independent group and the system gets bought up by the big organizations, the polarization happens. Some patients are asked to leave the county and get healthcare services somewhere else, outside of York County and that's what's been happening the last six years.

Q: Okay. Now, let's actually, let me pull up an Exhibit and ask you to talk about your experience related to it. Dan, if you'll pull up Exhibit 108, please. I know the document there is a little hard to see, Dr. Singhi, but do you recognize this?

A: Yes.

Q: What do you recall it being?

A: It needs to be focused a little bit more. Even

for a practicing cardiologist.
Q: All right. Let's highlight the left hand.
A: Okay. That's better now. Okay. That's better, thank you.
Q: Okay.
A: That's good. Now, we have the data here, the product line for various departments from 2005 to 2011. Yes.
Q: And have you reviewed this document concerning the changes in the volume of shared services performed at Piedmont and by Carolinas concerning the various fields of cardiac medicine in which you're involved?
A: Let me speak for my department, cardiovascular medicine and cath/EP procedures and compared to CHS-Charlotte and at Piedmont Medical Center you can see that in the year 2005 ---
Q: Let me interrupt you by making this a little easier for you. Let's pull up Demonstrative 180-03, Dan. And you can -- we have the data presented here about what you are referring to.
A: Thank you.
Q: Does this make it a little easier?
A: Yes. If you look at this graph from 2005 to 2011, cardiovascular medicine journal, the

market share between CMC and Piedmont Medical Center, as you can see on the right hand, PMC had 67 percent of market share in county vascular medicine and now in year 2012, it's dropped significantly. Down to 43 percent. And CMC, from 15 percent to 29 percent, or double in size of market share.

Q: Now, in the -- what are the cardiovascular medicine services consist of?

A: That includes the patient with cardiovascular symptoms, admissions, consults, referrals to the hospital.

Q: Okay. And let's look at, take a look at the next line or the next graph. I'm sorry, 180-02. The prior one. Let's take a look at what this service, open heart surgery involves. And let me begin, Dr. Singhi, by asking you about -- you don't perform open heart surgery, do you?

A: I don't.

Q: All right. Do you have any relationship in the volume of the open heart surgery services performed at Piedmont?

A: Yes. As like any place else, the cardiologists are the ones who get the referrals or provide

the referrals to heart surgeons. And at Piedmont, we as a cardiologist provide the patient for the cardiovascular surgeon to perform surgeries.

Q: Okay. And from beginning in 2009, what is reflected on this Demonstrative?

A: Yeah, I think what I see is a steady decline in the open heart surgery market share for PMC and the steady increase especially from 2009 is a steady increase in market share for CMC.

Q: And what relationship does this reduction in open heart surgery services have to the -- your reduction in your practice of new referrals and new patients?

A: I think it reflects that when we get less referrals, then there will be less procedures and reflect less open heart surgery referrals for the surgeon or for the institution and the changes in the economics in York County from primary care patient base and I believe, therefore there's a significant decline in open heart surgery in York County at Piedmont Medical Center.

Q: Okay. All right. Let's look at the next chart, related to the changes concerning

complex cath and EP procedures. Sorry, Dan, that's 179.02. Let's go to complex. All right. And explain what this diagram shows, Dr. Singhi.

A: That is complex procedure or complex patients who have multiple co-morbid condition. They have a acuity for illness. The 2005, as you can see on this graph, the Piedmont was over 75 percent procedures were done on this complex patient. There is a steady decline from 2005 to 2011 from 75 percent down to 42 percent. Significant drop in the market share for Piedmont. On the contrary, CMC has a steady rise in their market share for complex procedures.

Q: All right. Now, when there is such a change as reflected here, the loss of nearly half of the services performed in the cath lab between 2005 and 2011, what effect has it had on the delivery of those services and on the personnel who deliver those services in Piedmont?

A: In my opinion, there's a significant ??? part on the finances and on patient care. I know it's very hard to appreciate it, but being a practitioner for over 20 years, I can just walk

you through how the different financial impact can lead to the quality of the patient care.

Q: Well, what's the relationship –

MR. GASKINS: Your Honor, I'm going to object. Dr. Singhi has not testified and no foundation has been laid that he has any knowledge about the financials of the Piedmont Medical Center. He's here to testify about his practice.

THE COURT: Okay. Mr. Andrews?

MR. ANDREWS: Fair enough. I think where he was going not so much the financial analysis of Piedmont, but I'll provide a little more direction to the question.

THE COURT: Thank you.

Q: Dr. Singhi and, I'm sorry, my question may have implied my interest in your observations about Piedmont's financials. But instead, what I'd like you to comment on is what you've observed in the operations of the heart center at Piedmont and the operations of the staff and the technicians concerning the services reflected here. Can you do that?

A: Well, you have highly skilled physicians but in order to have a completely successful team to perform procedures, especially the therapeutic

procedures in the cath lab, we need highly skilled, experienced and trained personnel, especially technicians. A technician can make life pleasurable or miserable.

Q: I experience that everyday with Mr. Bupp.

A: We also have to make sure we continue to retain those highly skilled technicians in my cath lab for the better patient care, not better physician outcome. And what I see the last five years, I hate to say that by the way, in this economy one of the most thriving business was the healthcare industry up until now. But there's a significant impact in our cath lab when there is less procedures in the cath lab. The skilled trained employees, they ask to leave earlier than they're supposed to leave. They're not getting eight hours a day of their work or 40 hours a week and what's happening to -- direct impact on us, on physicians and patient care, those experienced techs are leaving the county and looking for jobs somewhere else. And that's where the biggest change that we have because we deal with the very complex patient. It's a question of life and death and if I don't get skilled technician

on a regular basis, I think in the future or now it will compromise the patient care, which has not happened, but I'm afraid that it may lead to compromising the patient care. With very sick patients coming to the emergency room.

Q: Let's take a look at Demonstrative 177. That looks instead of the market share being extracted from Exhibit 108, the change in volumes and look at the second line if you would, and then the last line. Do you see that reduction in inpatient volume?

A: Yes, what I've been experiencing, there's a significant loss in inpatient volume, especially for cath and EP services, over 50 percent loss over the period of six years. And last but not least, overall the cardiovascular medicine is over 25 percent loss in inpatient.

Q: Okay. And let's talk about your days in the cath lab. What time would you begin providing services?

A: The shift starts at seven o'clock in the morning.

Q: And how about the techs? When do they start?

A: Supposed to be 6:30 in the morning.

Q: Okay. And with the -- how has the reduction in volume effected the length of the time in which you and the techs and the nurses are busy in those cath labs?

A: Let me just take you back. Before 2005, we used to have a tech doing overtime, working in the cath lab sometimes more than 40 hours a week. Now, in 2010, '11 and '12, our employees would be lucky to get 40 hours a week in the cath lab. And I can see their frustrations, by the way. I can see their disparity in how this hospital has gone down as far as the procedures volume and new patients.

Q: What effect does that have on the morale you've observed with the staff?

A: Let me take a pause and think about that. Absolutely, they're demoralized. They're demoralized. They're not getting enough hours and some of them are single parents. Some of their spouses used to work in the Charlotte area for financial institutions in downtown. With this financial market although Charlotte was number two in the country after New York for the financial capital, business. Some spouses lost a job. They were dependent on --

the guy was working in the cath lab and now he or she does not get 40 hours a week. It is pretty detrimental for the family.

Q: Okay. All right. Now, let's move to talk about what would happen if a Fort Mill hospital was built and by whom. If Piedmont were approved to establish a satellite hospital in Fort Mill, would you have privileges there and admit your patients there?

A: I probably get privileges there.

Q: Why would you do that?

A: Because my patient base is in York County. We have a significant number of patients being served from surrounding areas and perhaps building a new facility, there will be a reduction in out-migration of the patients across the state lines.

Q: Why do you believe that would be true?

A: Newer hospital, perhaps more resources, better outlook, new system and I'm sure the patients would try to go there.

Q: Now, if Carolinas were approved to build it's hospital in Fort Mill, would you expect to get privileges there?

A: Probably I would get privileges.

Q: Why would you do that?
A: The reason for me to get privileges at newer hospital, CHS, would be to maintain the continuity of my patient care. Because some of my patients would be admitted over there by primary care physicians or by ER physicians. To maintain the continuity of patient care, I would like to be on staff at the new hospital.
Q: What do you mean by the continuity of patient care?
A: It's a physician/patient relationship. We provide service on not a vertical but a horizontal basis where -- a logical basis where we see the patient, they have problems. We provide not only the preventative care from a cardiology aspect, but we also provide prevention to intervention. And we follow those patients pretty regularly.
Q: Okay. During the last seven years, has continuity of your care to your patients and your partner's patients been maintained to meet your standings?
A: Before, when I came here we used to get a lot of referrals from primary care physicians 25 percent of my referrals of new patients used to

come from CHS, now they are owned by CHS physicians with a significant reduction in the newer patients, referrals to our practice and in the last five or six years. We have also observed that some of our existing patients also are being out-migrated to across the state line out of York County to get care where they could get it at York County at Piedmont Medical Center. Not only we have loss of new referrals but we also have loss of mutual patients or existing patients.

Q: And what effect does that have on the continuity of care?

A: I think that has a significant discontinuity. It can be patient and physician care because now this is all going to be provided to the patient is being duplicated at some of the facilities. It is also dissatisfaction from patients and patient's family side where we find out after we receive some records from some other hospitals.

MR. GASKINS: Your Honor, I'm going to object. He said he wasn't going to get into what he's heard from patient's family.

MR. ANDREWS: Right. I'm sorry, Your Honor. Didn't

know that was coming.

Q: Dr. Singhi, please just talk about your own experience based on review of your own records and observations, not what's communicated by others.

A: Okay. We do get records on patients that were admitted to another facility and we know that they were admitted and treated and some of them do come back for the follow-up with us because of the proximity. If they live in York County and they live in the south part of York County or west or east, some of them in the north, we have been providing the care for a number of years that will come back to us to see us. There is a significant drop in the continuity of the patient care. And I personally don't mind the services which are not available at Piedmont Medical Center, they can go anywhere else. We have referred patients to go across the country. We have referred them to a system in Charlotte, the services we do not have here. We refer patients to MUSC. We refer patients to Wake Forest, Mayo Clinic, Duke, different places. What's the best for the patient, that's what I'm here for.

Q: Okay. All right. Now, if CHS were able to build its facility in Fort Mill, do you have any concerns about whether patients would be shifted from Piedmont to that facility or to North Carolina-affiliated facilities?

A: So far what we have experienced with objective evidence is that when the patient goes to a different system run by outside of York County, outside the state of South Carolina, most of the patients are being asked or end up getting the services different places although the services are available in our area, in York County. We have to respect patients. They're not doctors. One doctor tells them that you need the services. It's hard for our patient to understand what is the significance of their services. Whether it is available at Piedmont or not available at Piedmont. So within the patient/physician relationship, they've been asked, they will ask them to go, most of them.

Q: Okay. Now, if the Carolinas-Fort Mill facility was built what concerns do you have, if any, about the effect it would have on the Piedmont Medical Center Cardiology staff?

A: I think it will have a significant impact on

our group going forward. Since we have been seeing significant decline in new referrals and patients, fewer follow-ups in our practice, once that the other system or CHS opens up, I guess permission to open up new hospital in Fort Mill, that will lead to a significant out-migration of our patients in York County and that will lead to significant impact in patient care. From what I see, we have a highly trained cardiologists in our practice. We have seven cardiologists, six interventional cardiologist and one EP specialist. All of us are board certified in at least anywhere from two to five different specialties. They've been trained at different places in the country. Well trained. Once there is a significant impact because of the other system opening up a new hospital in Fort Mill, and there is a significant reduction in new referrals, procedures in my practice as well as in the hospital, I may not be able to keep my partners or colleagues or associates in the practice. Now I will see out-migration of my patients, my practice is going somewhere else because they are not maintaining their skill.

It's like gas tank is in the reserved mode. And when a new system comes in, by knowing the history, the patient will be getting their care outside York County, we will be absolutely out of gas.

Q: Now, will Carolina Medical Center's 64-bed hospital at Fort Mill provide cardiac catheterization services or other complex cardiac services?

A: No, as far as I know, no. That's not the plan for the new hospital to provide cardiac cath or any EP-related procedures.

Q: Where would the Carolinas related procedures, cardiac procedures be performed? What facility would perform?

A: Most likely CMC-Pineville or CMC-Charlotte, the main hospital. And that's what they do, by the way.

Q: Now, if CMC-Fort Mill were approved what effect would it have on your practice's consideration as to whether to maintain its independent status?

A: It would be very hard for us going forward if the hospital is approved to any other system but Piedmont Medical Center. The reason being

that we would not be able to maintain our independent status.

Q: Why do you believe that might be true?

A: Financially it would be very difficult to maintain and provide the resources for my physicians and staff at Carolina Cardiac Associates.

Q: Now, have you ever had any conversations previously with Carolinas or Presbyterian or maybe CHS or Presbyterian or maybe Piedmont about being employed by those systems?

A: Being an independent group, yes, we have had from time to time conversations with the CHS, Novant and Tenet. All three systems.

Q: And you're still independent today?

A: We are still maintaining our independent status.

Q: And if Carolinas were approved to build the Fort Mill hospital, would you and your group consider being employed by them?

A: That's always a possibility.

Q: If you were to become employed by them based on what you know, what you've observed, would you continue to provide services at Piedmont?

A: Yes, I will continue to provide services at

Piedmont, but I don't know, I cannot guess how much our involvement would be because once we lose our autonomy, flexibility, then it gets out of our hands.

Q: Now, your major competitor in York County for a cardiology group is who?

A: We have -- just to give you background, we have four cardiology groups in York County. Carolina Cardiology Associates, Sanger Heart and Vascular Institute, Carolina Heart Speciality and Palmetto Cardiology.

Q: And your practice is seven. What's the size of Singer

A: Sanger in York County, they have five physicians.

Q: And are the other practices, what sizes are they?

A: CHS has currently one cardiologist and Palmetto has two cardiologists.

Q: So, Sanger and you are the largest practices by far in York County, is that right?

A: Yes.

Q: All right. And did Sanger used to practice at Piedmont?

A: Yes.

Q: Did they used to perform services at Piedmont?
A: Yes.
Q: Are they today on the medical staff at Piedmont?
A: No.
Q: Have they resigned their privileges to your knowledge?
A: Yes.
Q: When did they do that?
A: 2011.
Q: Do they perform any services at Piedmont to your knowledge?
A: No.
Q: What percentage of the remaining services at Piedmont, Dr. Singhi, does your practice provide for the cardiac patients?
A: We have provided comprehensive services at Piedmont Medical Center which includes consults, referrals, ER consults, heart attacks, diagnostic procedures and with the cath lab, EP services. Except for heart transplant, we provide all the services, cardiology services, at Piedmont Medical Center.
Q: And what percentage of the volume of those

services would you estimate that Carolinas Cardiology provides?

A: Let me just understand the question.

Q: Sure.

A: What currently it provides?

Q: What percentage of the total non-open heart surgery, cardiac care services at Piedmont would you estimate that your practice provides?

A: Currently we provide 80 percent of services.

Q: And if you became employed by Piedmont and follow the path of Sanger and resigned your privileges and did not perform any procedures there, what effect do you believe that would have on the operation of Piedmont's cardiology program?

A: Let me understand that. If I join another group?

Q: If you joined another group, you become employed by Carolinas ---

A: Right.

Q: CHS, what effect do you believe that, and if you were -- if your practice partners resigned their privileges at Piedmont and shifted your business ---

A: In the least –

MR. GASKINS: Your Honor, I'm going to object. This is all speculative. There's three or four variables in the hypothetical situation and it's completely speculative.

MR. ANDREWS: Your Honor, it's not speculative, it's actually following the practice of the major competitor in the area and he's certainly able to cross him on it.

THE COURT: I 'm going to overrule your objection and let him answer that question.

A: The question comes in that even though my least interest is to join any system outside the York County, because I think that will be significant impact on the continuity of my patient care or be and/or the inconvenience for my patient to go somewhere else when someplace is already available in their backyard or at Piedmont Medical Center. But there's a real world. If you join another systems, they expect from you to work in the group to do something for them. And that's what the history in the medical field and the health industry is. So, I'll be -- in my opinion, I'll be limited to do things, what I would like to do in the York County for my patients.

Q: And if you were, what effect would that have on Piedmont's cardiology department as you know it today?

A: Well, we provide 80 to 90 percent of volume. Not only for the heart catheterization but also for providing for open heart surgery patients. And that will lead to significant reduction because it is already declining, over 50 percent in some areas, it will be down 70 to 80 percent since we are taking 80 to 90 percent of the cardiology volume at Piedmont Medical Center. And then I can see there is significant reduction in the services and perhaps compromising the quality of patient care, especially patients who comes into the emergency room with heart attacks the time, the door-to-balloon would not be very good.

Q: Thank you Dr. Singhi. Answer any questions please that Mr. Gaskins is going to ask you.

DR. SINGHI - CROSS EXAMINATION BY MR. GASKINS:

Q: Good morning, Dr. Singhi.

A: Good morning.

Q: I believe you testified earlier that you've previously served as the president of the York County Medical Society, is that correct?

A: Yes.
Q: And you're currently in negotiations with them to become part of their system, right?
A: No.
Q: You're not? you're not currently ---
A: We have not signed any letter of intent. We have not signed any contract or confidentiality agreement at this point.
Q: I didn't ask you if you had signed a contract. I said are you currently in negotiations?
A: We're talking. Like any other system across the area.
Q: So, you're currently talking with Piedmont?
A: Yes, we have. Yes.
Q: And if you supported Carolinas today, it probably wouldn't help those negotiations, would it?
A: I think it would be better.
Q: You think it would help?
A: If you have more than one buyers, I would be in a better position right now.
Q: Well, that's not realistic is it, Dr. Singhi?
A: Not from my patient volume, but we have to just mention our infrastructure level.
Q: Now, you talked earlier about the other

A: Okay. Can you rephrase it?
Q: Isn't that position consistent with the one you also held in 2006?
A: Yes.
MR. GASKINS: That's all I have right now, Your Honor.
THE COURT: All right. Does the Department have any questions?
MS. BIGGERS: No, Your Honor.
THE COURT: All right. And re-direct?
DR. SINGHI - RE-DIRECT EXAMINATION BY MR. ANDREWS:
Q: Dr. Singhi, when you were meeting with Presbyterian officials in 2005 and they were soliciting your support, did they make any promises to you?
A: No.
Q: Did they make promises about what they would do in York County?
A: Yes. For the patient, yes they did.
Q: Okay. And did you consider that important?
A: Absolutely.
Q: Is that a reason for your support?
A: Yes.
Q: Did they make those promises to others, to your knowledge?

A: Yes.
Q: Now, the letters in the Demonstrative that Mr. Gaskins just showed to you, they were signed by Dr. Shah and Dr. Fleischer and Dr. Robinson was on Presbyterian letterhead. Do you know why that was the case?
A: No. That was the first time I saw this letter.
Q: And do you know personally those three physicians? Dr. Shah, of course is your partner?
A: Yes. I also knew Dr. Fleischer. He's ---
Q: He's passed away?
A: He's passed away and Dr. Robinson isn't.
Q: Dr. Robinson related to Dr. Taylor?
A: They're the same practice, yes.
Q: Okay. Practice. Dan, do you have, have you been able to identify those letters? Now, do you know whether Dr. Shah, whether all of these physicians had a change of opinion between 2006 and 2010 concerning which applicants they would support?
A: Yes. All three groups are presently practicing independently. And providing admission at local hospitals Piedmont Medical Center almost 100 percent.

Q: All right.

MR. MULLER: Your Honor, if you will give me just a moment please.

Q: And Dan, if you will pull up the Exhibit, is Piedmont Exhibit 66. And let's look at page 65 and 66 of that Exhibit. Do you -- what does this document consist of Dr. Singhi?

A: I believe this is regarding Certificate of Need and addressed to DHEC.

Q: And Dan, if you'll go to the third little paragraph there: As you're probably aware. And this document is in the -- been pre-admitted and in the record as well, Dr. Singhi, will you read this paragraph into the record please?

A: Again, it is addressed to the DHEC Chief. As you are probably already aware, a number of practices in the area are owned by Charlotte-based hospitals and as such these practices have been strongly influenced to refer their patients to Charlotte hospitals as part of their Charlotte network. In fact, this has created a concern for the employees as well as the physicians and their families who reside in York County in that they have to travel into

the Mecklenburg County for surgery as well as diagnostic testing.

Q: All right. And let me -- Dan, turn to the second page of this letter, please. And if you'll look -- if you'll call out the next to the last paragraph. And Dr. Singhi, I'd like you to read this sentence, this paragraph into the record and tell me how it relates to your opinion and those to which of your knowledge your partners.

A: The residents of York County have historically had a choice of healthcare providers given the proximity of Charlotte. Before I started my practice here in York County, many of my patients were going to Charlotte for cardiovascular care. To allow the continued migration of Charlotte-based hospital into York County will have an adverse effect on the existing hospital and to their employees and the ability of Piedmont Medical Center to maintain the higher level of investment in the facility and technology. We would like to treat York County residents in York County or at least offer the option.

Q: All right. And what occurred between 2005 and

2010 that produced this change of position to you that Dr. Shah relates?

A: I concur with this statement where my partner has made in this letter to DHEC that we want to provide care in York County on a consistent basis if the options are available and the patient is able to have -- be taken care of locally.

Q: Okay. Now, let me, Dr. Fleischer was also one of the signatories of that 2006 letter and let's turn to page 21 in Exhibit 66 and look at his letter from January 29, 2010, to Ms. Brandt. Do you see that this is a letter in support of Piedmont's application?

A: Yes.

Q: All right. And Dan, call out the second paragraph, please. And take that down through the, highlight if you would, down through the end of the sentence ending at the fifth line. Without member benefits. All right. Dr. Singhi, please read that sentence or those series of sentences into the record.

A: These past few years have shown that not only Presbyterian but also Carolina Medical Center by their actions have proven they do not

support York County. They continually encourage the York County practitioner to refer patients to physicians who practice in their Charlotte-Mecklenburg facilities. The employees as well as physicians and their families work and live in the county must be routed to the Mecklenburg County for surgery and most diagnostic testing or face high deductibles and out-of-network benefits.

Q: All right. And how does your experience compare to the experience that Dr. Fleischer represented to DHEC?

A: We have also experienced a similar kind of outlook for our patients.

Q: And what field of practice did Dr. Fleischer participate in?

A: Orthopaedic surgeon.

Q: Okay.

THE COURT: I'm sorry, I didn't understand that.

A: Orthopaedic surgeon.

THE COURT: Thank you.

Q: And finally, Dr. Robinson was the third individual to sign that letter. Let's take a letter at the 68, Dan, Exhibit 66. And see that letter? Do you have that in front of you,

Dr. Singhi?
A: Yes.
Q: All right. Pull out the first paragraph if you would, Dan. All right. And just read first four lines please, of that paragraph.
A: I'm writing on behalf of Piedmont Medical Center and the CON application in York County. I have served on Piedmont Medical Center medical staff for 29 years including chairman of the board of trustees and the chief of medical staff. I think this qualifies me as a fair judge of the medical hospital climate in York County.
Q: And then Dan, drop down to the last paragraph. I'm sorry, the second paragraph and pull out the last four lines beginning with the sentence for years we have tried.
A: For years we have tried to bring up the level of care and keep the patients in York County. There is already healthy competition for patients in this area. We do not need more of this as I feel an outside hospital will bring Piedmont Medical Center down to an indigent care center only.
Q: Thank you, Dr. Singhi, no further questions.

added an EP lab, correct?

A: I don't know about the market condition has changed for Piedmont or Tenet, but certainly we were referring a patient for EP services to a different institution and now, since we have the EP specialist they opened up an EP lab at Piedmont.

Q: After you and your practice had discussions about going to CMC-Pineville to conduct those procedures?

A: Yes.

Q: That's all I have.

MS. BIGGERS: No questions.

MR. ANDREWS: Your Honor, one quick response.

DR. SINGHI - RE-DIRECT EXAMINATION BY MR. ANDREWS:

Q: Dr. Singhi, do you believe that the services provided at CMC-Pineville and the cardiac services provided in downtown Charlotte affect the competitive environment in York County?

A: Yes, that is a significant impact.

Q: And currently is there competition in York County?

A: Yes.

Q: Thank you, no further questions.

THE COURT: Anything Mr. Gaskins?

Q: And so the centerpiece of your long-term plan is presence in the northern part of York County is important to you, correct?
A: Yes.
Q: To prevent out-migration to North Carolina, correct?
A: Correct.
Q: To strengthen the services to York County residents, I assume you mean to all York County residents?
A: Yes.
Q: To expand the scope of Fort Mill area services we need to expand services in the Fort Mill area and that part of York County?
A: Yes.
Q: And then publication of need in the 2004-2005 in the State Health Plan?
A: Correct.
Q: Okay. Dan, if you'll pull up Demonstrative 90. And this is the chronology of how things went. In November of 2004, and we were trying to remember, were you involved in filing the initial November 2004 64-bed plan?
A: Yes.
Q: Okay. And that was -- the applicant in that

case was sort of a sole purpose LLC in South Carolina?

A: Correct.

Q: And was the decision made to withdraw that and re-file it under the name of Amisub?

A: Yes.

Q: And that is what resulted in the January 2005 application?

A: Correct.

Q: All right. And so before filing the January 2005 application what I understand from your testimony is you met with Joel Grice?

A: Yes.

Q: And you met with him specifically for the purpose of determining how to best file the application for those 64 beds, is that correct?

A: I wouldn't say how to best, it was to get feedback from what we thought was the best way to file the application.

Q: And his feedback, I assume, was positive?

A: He thought the approach we were taking as a positive one, yes.

Q: Okay. And then, you have here April 2005 the other applicants filed a competing application. It was actually March of 2005, wasn't it?

A: It may have been.
Q: Okay. And so the other applicants filed applications and then did you meet again with Mr. Grice before filing the 100-bed application?
A: I don't recall. I may have. I'm certain I talked to him on the phone, I'm sure, at least.
Q: Well, the reason I remember it is because I believe there was an affidavit in the prior case where Mr. Andrews mentioned that, I thought was you and he met with Mr. Grice to make sure that if you withdrew the 64 bed and filed the 100 bed you wouldn't lose your place in line, so to speak.
A: I don't recall that, but that wouldn't surprise me.
Q: Okay. So you think you probably met with him before filing the 100-bed application?
A: Yes.
Q: All right. Let's take a look at the -- and I'm going to skip -- I assume the November 2004 and January 2005 applications were substantially identical?
A: I believe the only difference was the new legal applicant.

of that page for me. Okay. Fort Mill Medical Center will primarily serve the residents of four zip codes within northeast York County, 29708, which is Tega Cay; 29705 which is Fort Mill; 29730, which is not northeast York County as far as I can tell and 29732 which is greater Rock Hill.

A: 30 and 32 are Rock Hill and they're in the northeast side of the county.

Q: Well, 29730 goes all the way down to the southern county line, does it not?

A: It does. But it also goes all the way to the easternmost edge of the county.

Q: And what happened to Clover?

A: Clover was moved to the secondary service area.

Q: And the secondary service area at this point became all of western York County?

A: The remainder of York County and there's one zip code at the bottom portion.

Q: Okay. Now, in terms of this 100-bed plan versus this 64 bed plan, did Mr. Grice ever tell you that 100 beds was better than 64 beds?

A: Yeah, we talked about the benefits of 100 bed facility, yes.

Q: And did you feel that 100 beds was better than

64 beds?

A: He felt it was better to build them early. That the economies of scale we talked about were positive and the need in the area was substantial.

Q: Was there any other applicant other than Piedmont Medical Center that could transfer beds in order to build a 100-bed facility?

A: That applied?

Q: Yes, that applied.

A: None of them applied. There were those that could have done it, but they didn't apply.

Q: Well, I'm just curious, who would those providers have been that could have transferred beds in York County?

A: Well, Springs could have applied to move beds to York County.

Q: Well, Springs is not in York County, it's in Lancaster County.

A: Correct. But they can move to York County.

Q: How about the three applicants that applied? Presbyterian, Carolinas, HPA? Could any of them transfer beds and make a 100-bed application here?

A: I don't know. I suppose if they had a

relationship with a hospital in South Carolina to transfer the beds, they could.

Q: But none of them could transfer beds within the county because they don't have any beds within the county.

A: Within the county, no. But from another county is clearly outlined in the Plan, a very discreet method on how to do that.

Q: But they have to be transferred beds from a South Carolina county, correct?

A: That would be the assumption, yes.

Q: Have you ever seen, when you say assumption, have you ever seen a part of the South Carolina State Health Plan that allows them to transfer beds from out of state?

A: No.

Q: So you had that, Piedmont had that advantage. They could apply for a transfer of 36 beds to make their application for a larger hospital, is that a fair statement?

A: Of the applicants, sure. But as I said anyone could get it done. Any existing hospital.

Q: And that's why you did it? You did it because Mr. Grice told you that was a good idea.

A: No.

Q: All right. And these other zip codes which we've been talking about getting so populous, and 29074 is one we mentioned, all of western York County, they only have 199 discharges?
A: Correct.
Q: Instead of 1,000?
A: That would be correct.
Q: So the application has changed again a third time?
A: Sure. The market changed. We updated. The same approach, the same methodology with updated information. The population information, updated use rate information, updated projections.
Q: And I take it your market in western York County is now so deteriorated that you've went from 1,000 discharges to less than 200?
A: No. The projections went down. Again, because we refined the projections.
Q: You dropped 800 people from that entire portion of western York County in 29704, which you were tell us was a populous area.
A: We didn't drop those people, we refined the analysis again. Taking Fort Mill in isolation is a little misleading because it is Fort Mill

and Piedmont, so we looked at the redirection from Piedmont, redirected market share, we looked at the redirection from North Carolina and that's how we got to the numbers in the revised figure 17.

Q: And it looks like you enjoyed some pretty big market shares in western York County. Now you're shifting those patients back to Piedmont?

A: Correct. You pointed out the travel issues and assuming that some patients from that area would be treated at Fort Mill but not to the extent we originally thought.

Q: We pointed that out in the last contested case and you changed your application to modify those numbers?

A: Not necessarily in correlation with that, but the numbers were updated as instructed by the judge for the remand and we provided them.

Q: And so now -- and you say strengthen services to York County residents, which is what this Fort Mill application is supposed to do, there's a pretty big portion of western York County that you're not servicing here at all at Fort Mill.

A: Correct, but it strengthens the services to York County because it strengthens Piedmont Medical Center.
Q: So the people of Clover that were one of the three zip codes in the first application are now left out?
A: They're not left out.
Q: They're just redirected to Piedmont?
A: Not redirected, just not redirected from Piedmont.
Q: Lynn, would you pull up CHS Exhibit 27? All right. This is the payor mix document that you were looking at yesterday with Mr. Andrews.
A: Correct.
Q: And this is a physician payor mix, correct?
A: Yes.
Q: It's not what a hospital payor mix would look like, is it?
A: No, but that would the -- based on your application that would be the source of the patients.
Q: Well, according to you, 67.6 of your ED patients get admitted. So, a lot of the patients come in through the emergency room, they don't come in through the door.

the hospital for no apparent reason. For allowing CMC to build a hospital there.

Q: Well, just so we're clear, does that mean that the hospital can't operate with a profit at 51.2 percent?

A: No, that's not the test of adverse impact.

Q: Well, I don't understand -- I guess what you're saying is at 51.2 percent it's got to cut all these services we talked about in order to make a profit?

A: No, I'm saying that's a reduced average daily census. That's the occupancy with the lower averages and that has the impact of taking away that volume. And what I'm saying is, as I said yesterday is if you look at the statute and it says weigh the adverse impact against accessibility. So, while the CMC facility may increase some accessibility, it has a tremendous impact on Piedmont and that outweighs it.

Q: Well, does it have an adverse impact if 51.2 occupancy that you have to cut all the services that we talked about?

A: It could.

Q: It could but you don't know whether it will?

A: I'm not the one that cuts the services.
Q: Let's talk about -- sort of to close out, your Waccamaw-Georgetown model.
A: Yes.
Q: That's what you presented to the Court as an example that happens, how you improve the hospital that is there by building a satellite hospital?
A: Yes.
Q: All right. If we could go -- let's start with Piedmont Exhibit 64 and go to page two. All right. What you did here was you looked at the Georgetown Memorial Hospital would be the equivalent of Piedmont Medical Center in this scenario, correct?
A: Similar, yeah.
Q: So, in 2002 it was losing money and Waccamaw Community Hospital was built when?
A: It opened in 2003.
Q: Okay. So it's still losing money and then by the time we get to 2007, is -- 2006 it made some money, 2007 it's losing about $620,000 a year.
A: Correct. Down from almost $5 million in 2002, $5 million in 2002, lost $5 million in 2003 and

Muller. Does the Department have any questions?

MS. BIGGERS: No, I don't have any questions.

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

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

Q: Dan, let's begin by pulling up Demonstrative 192. Mr. Levitt, Mr. Muller asked you about the placement of section 23(b) related to the utilization, staffing and let's title adverse impact provision. Do you see it there on number four?

A: Yes.

Q: Now, what are these other elements of your analytical framework for evaluating adverse impact?

A: Well, 802.22, the distribution across facilities is also under the adverse impact element of reviewing it.

Q: And which rank is that?

A: Well, it is the second, I believe.

Q: Rank two?

A: Category two.

Q: And the first one was what?

A: Compliance with the Plan.

Q: Okay. And since -- because of Judge Matthews ruling, the first category ranking was which rank, rank two?
A: Yes.
Q: All right. And section 22 is part of that, okay. And how does section 22 related to adverse impact?
A: Well, it goes on, it talks about the distribution and the effect of that distribution on the existing resources.
Q: And the healthcare system, doesn't it?
A: Yes.
Q: Okay.
A: To balance the distribution to the target population.
Q: And what does 3(h) address?
A: That's the ability to serve medically underserved groups.
Q: And how does that relate to adverse impact?
A: Well, to the extent that a provider makes it difficult for an existing provider to serve those groups, it's adverse.
Q: And number three, where is that?
A: 16(c), costs and charges.
Q: And how does that relate to adverse impact?

A: That the impact of the proposed project has to be reasonable and what's the impact on the existing providers with similar services.

Q: And then you just testified about number four and then let's look at number five. What relationship does that have to the adverse impact analysis?

A: Again, the statute states that when determining a CON application that balance of the benefit of improved accessibility needs to be weighed against the effects of duplication.

Q: Okay. So, overall, how would you describe the application of the CON Act and the project review criteria to your adverse impact analysis?

A: They're all elements of it. That it's not just that one standard identified in the letter that says adverse impacts. All these areas address adverse impact and are considered by DHEC and were, and should have been considered by DHEC when determining their opinion.

Q: All right. Now, Mr. Muller also asked you about the average daily census and your review of that. And in particular asked you about Mr. Masterton's testimony concerning the average

daily census and I think it was in February of 2013. Does the State Health Plan in evaluating bed need, look at seasonal fluctuations or does it look at the average daily census over the year?

A: It takes a full year utilization.

Q: And why would it not look at any peak period?

A: Because that wouldn't be representative of the utilization for the year.

Q: And are there allowances made for taking into consideration those times where there is a seasonal peak that's hit?

A: Yes.

Q: How is that done?

A: They're allowed to justify additional bed need in the bed needs section if you can demonstrate seasonality and fluctuations associated with that seasonality.

Q: At what point does an addition does the bed need analysis assume that a hospital would be at the basis of adding beds? What percentage of ---

A: Adding beds, 65 percent is the -- for smaller hospitals.

Q: Okay. And what's the purpose of establishing

the threshold at that level?
A: That's where the state had determined there's a need for additional beds.
Q: And the beds exceeding that level, would they be available to address seasonal fluctuations?
A: Yes.
Q: Okay. And let's look at Demonstrative 178, please Dan. I think your testimony here was apply the average daily census in 2011 and what did you determine?
A: The 182 is the average daily census including psych patients subtracted from the 288, those beds include psych patients, 106 available beds.
Q: And if there were any seasonal fluctuations in a flu season in January or February, how would those patients be served?
A: In those 106 available beds.
Q: Okay. And if 36 beds were relocated would there be sufficient beds available?
A: There would still be 70 available beds.
Q: Okay. Now, if the 36 beds were transferred, would you have an opinion about the effect or that on the average daily census if the beds were transferred to the new Fort Mill Medical

Center?

A: Yes. In addition to the beds being relocated, some of the patients are going to be relocated. Those patients that have historically gone to Piedmont would then go to Fort Mill. So, the census would be lower at Piedmont.

Q: Okay. Now, Mr. Muller also drew out some of the Piedmont Exhibits and identified a change in net income, I think after taxes, at Piedmont of $16 million and $9 million in those two years. Is that right?

A: I know 16, 10, I think.

Q: Sixteen and ten, okay. And have you looked at the comparable net income for that same period of time for the Carolinas facilities?

A: I have.

Q: Okay. And in general terms, how do they compare?

A: A lot higher. Carolinas made substantially more in this time period, so $20, $30 million.

Q: Okay. And let's actually take a look, Dan, at Demonstrative 212. And this data is included in Exhibits that have already been admitted into evidence as Piedmont Exhibit 75A and B, 76, 77, 78 all of which included A and B, A

being 2010 cost reports and B being the 2011. Have you reviewed these Exhibits, Mr. Levitt?

A: Yes. Uh-huh (affirmative response). I created these.

Q: And they are what, cost reports?

A: Medicaid cost reports.

Q: And what does it reflect?

A: Well, it shows CMC-Main made $240 million in 2010, $96 million in 2011. CMC-Union, $17 million and $15 million, 2010 and 2011. CMC-University for 2010 and 2011, $40 million and $38 million and CMC-Mercy for 2010 and 2011, $120 million and $98 million. So, substantially more than the $10 million and $16 million at Piedmont.

Q: Now, are these net income figures for a non-profit system, a public system or a for-profit system? What relationship do they have to the ability of these hospitals to be successful?

A: Well, they all, I mean basically the net income is what drives operations.

Q: What's the relationship between operations going forward and the net income in a given period of time?

A: It feeds it. You have to have positive net

income to –

MR. MULLER: Your Honor, we object to this line of testimony because this expert has not been offered as a healthcare finance expert which apparently he has now gone into that realm. He's now apparently giving us accounting terms and financial terms. He's not been qualified to do that. Obviously, I did not object to him talking about net income because I asked him the same question. He's now gone a step beyond that.

MR. ANDREWS: Your Honor, first of all, I'd be happy to lay a little bit of foundation for this. I don't think it's necessary when we qualified Mr. Levitt, you might recall that one of the areas that he specifically testified about in his resume in the second major category describing his experience is the extent to which he has provided financial forecasting and financial advice to literally scores of hospitals throughout the Southeast and it is an inherent component of healthcare planning.

MR. MULLER: And my objection, Your Honor, is he wasn't qualified that way to start and it is inappropriate to try to do it now on re-direct.

If you feel inclined to qualify him in that way, I should be allowed to challenge his qualifications in terms of healthcare finance.

MR. ANDREWS: Your Honor, let me be a little more precise about the nature of this. It's perfectly consistent, frankly, with testimony that's been offered by several witnesses which is how revenue affects operations of a hospital. I mean nothing could be more fundamental to healthcare planning than that. This is all about, as much about services and quality and utilization as it is the finances related to that. There's been testimony about financial feasibility, testimony about payor mix, there's been testimony about how the generation of income affects ability to invest in future facilities and that's what we're focusing on. We think that's clearly within the scope of what he's been qualified to testify about.

MR. MULLER: And I would simply say, Your Honor, that Mr. Andrews objected to my introduction of the evidence of the financial health of Tenet Healthcare. So if this witness is allowed to testify on these issues, I think that Exhibit

should be admitted and I think I should be allowed to question him about the financial health of Tenet Healthcare which is a billion dollar corporation.

MR. ANDREWS: Your Honor, finally, Mr. Muller raised this issue directly asking Mr. Levitt about whether $16 million and $9 million would be sufficient to operate the hospital. He introduced this issue. I'm simply responding to it by saying well, in that regard how does this income compare to his client.

MR. MULLER: And my objection is, Your Honor, he's already done that with Demonstrative 212. And so he doesn't need to go beyond that unless he wants to open the door to Tenet Healthcare and that Exhibit and everything else that goes with it. If he wants to ask this witness questions about profitability of Carolinas Healthcare System, then I should be entitled to go into questions and get Exhibits admitted about the profitability of Tenet Healthcare System which is a counterpart in this CON proceeding.

MR. ANDREWS: Your Honor, the question and I won't be able at this point to recall precisely -- I know that Alex can read it back to us, but I

think back to it, but it had nothing to do with Carolinas specifically. It had to do with how profitability affects the future operations and how it might limit it. And that was the question again, that's a healthcare planning concept and that's what we're –

MR. MULLER: And, Your Honor, if that's the only question that's going to be asked, to move things on I will withdraw my objection to that question. My objection was related to an extended line of questioning which is where Mr. Andrews looked like he was headed and the aspect of –

THE COURT: I see what you're saying Mr. Muller, and to that, if that's the purpose, Mr. Andrews, this sort of general nature, let's limit it to that and not go into the specific hospital -- I mean other than with the numbers.

MR. ANDREWS: I'm through with that Demonstrative, Your Honor.

THE COURT: All right.

MR. ANDREWS: Thank you.

THE COURT: Thank you.

Q: Mr. Levitt, let me see if I can recall that. The question is in comparison with the

Demonstrative evidence you've just reviewed and what you testified to previously concerning Piedmont's profitability, how does the profitability of a hospital affect its future operations?

A: Well, for a hospital to be able to fund additional capital expenditures, expand services, continue operations, they have to have a positive net income. And the larger that net income is, the more cash they have available to fund those operations and activities and expand services and provide salaries to staff and things like that. So, it's pretty critical.

Q: Thank you. I have nothing further.

THE COURT: Nothing further of the witness. All right. Thank you, Mr. Andrews. Anything?

MR. MULLER: Nothing further, Your Honor.

THE COURT: Anything from DHEC?

MS. BIGGERS: Nothing further from DHEC.

THE COURT: All right. So we are finally concluded with Mr. Levitt.

MR. ANDREWS: We are ready to release Mr. Levitt, Your Honor.

THE COURT: Mr. Levitt, thank you very much. You

Q: Good morning, Mr. Miller. Please state your full name and business address for the record.
A: Yes, Charles Miller. My business address is 747 Mendon Hall Court, Fort Mill, South Carolina 29715.
Q: Mr. Miller, you are currently affiliated with Piedmont Medical Center?
A: Indirectly. I have a management consulting firm currently and I am under contract with Piedmont Medical Center relative to a contractual matter with York County.
Q: Are you the former chief executive officer of Piedmont?
A: That is correct.
Q: And when did you hold that position?
A: I held that position from March of 1999 through March of 2013.
Q: Okay. Have you provided your resume to counsel and has that been made a part of this record?
A: Yes, sir.
Q: All right. Now, Your Honor, we have just recently received an update to Mr. Miller's resume and I was under the impression it had been provided to counsel and I was incorrect about that assumption. I just made it

available and if there's no objection, we'd like to substitute it for the one that's in the record.

THE COURT: Mr. Muller any objection?

MR. MULLER: No objection.

THE COURT: All right. Then without objection –

MR. ANDREWS: Thank you, and I'll hand two up.

THE COURT: --- okay. The resume will be substituted. This is Petitioner's Trial Exhibit 71.

MR. ANDREWS: That's correct.

THE COURT: This is the updated version?

MR. ANDREWS: That is.

THE COURT: Thank you very much.

Q: All right. Mr. Miller, let's work through your resume and begin by starting with your education on page three, if you would please review that for the Court.

A: Yes, I did my undergraduate work in accounting at Virginia Commonwealth University, graduated there in the year of 1973. Subsequently, I did a master's of business administration at Tulane University in New Orleans; I Completed that in May of 1990.

Q: And have you been a certified public accountant

as well, Mr. Miller?
A: Yes. I practiced public accounting, was a CPA in Virginia for about four years.
Q: And are you currently licensed as a CPA?
A: I am not.
Q: All right. And after your stint as a CPA and your education, when did you begin you career working at hospitals?
A: In 1976 to asked to assume a chief financial officer's role at Fauquier Hospital in Warrington, Virginia.
Q: Okay. And did you continue to work with hospitals in the Virginia area?
A: I did. In 1979 I left that position and joined St. Mary's Hospital in Richmond, Virginia, it is owned by Bon Secours Health System, as their controller.
Q: Okay. And let's turn to the second page of your resume and identify the different positions you've had, in general terms, with hospitals before moving to Rock Hill to be CEO of Piedmont.
A: Sure. I functioned -- went to New Orleans in 1987 and was basically the corporate treasurer, chief financial officer of a hospital that

ultimately merged with a second hospital that ultimately was sold to Tenet in August of 1995 and in August 1995 I transitioned from financing operations with Tenet Healthcare and was chief executive officer in one of its facilities in Slidell, Louisiana and then in 1998, I transferred up to Rock Hill.

Q: And when you first arrived at Piedmont in Rock Hill, what was your position?

A: My position was chief operating officer as part of the succession plan for the then CEO who was making plans to transition into another role with the company.

Q: Okay. And then you became the CEO in 1999?

A: That's correct. March of 1999.

Q: All right. And what were the circumstances that led to your departure from Piedmont?

A: After 14 years in March, actually in the spring because these conversations took on for awhile, I wanted to look for other opportunities within Tenet, Piedmont is one of the larger facilities within their network. There was an opening in the regional staff in Dallas, Texas, and so in March I relocated to Dallas to be a part of the Southern States Region.

Q: Okay. And what was your position and what were your responsibilities generally with the Southern States Region?

A: The regional office, sections within Tenet are made up by senior operating officers and chief financial officer, HR person and business development. I was a senior operational staff member who reported to the senior vice president for that region. My responsibilities involved with working with all 13 hospitals within that region. We had hospitals in Georgia, North and South Carolina, Alabama and two in Philadelphia.

Q: Okay. And why have you left that position?

A: That position along with a number of others in the home office were eliminated in September of this year; we got a new chief operating officer at the corporate level who was kind of beginning to put in place his own organizational structure.

Q: Okay. And after leaving -- and how many positions were eliminated when yours was?

A: About 70 total.

Q: And you testified at the outset you currently have a relationship with Piedmont Medical

Center, what's the nature of that?

A: As part of my departure, I set up a consulting firm and while I kind of evaluated other options. There was a matter between the hospital and York County that has been pending for awhile, so I contracted with the hospital to continue to negotiate and represent them before York County Council on that matter.

Q: Okay. And do you have any plans concerning your future employment?

A: Yes. Actually, next Wednesday, April 16th, I will assume the position of chief executive officer of Dallas Regional Medical Center in Mesquite, Texas.

Q: Okay. And what hospital system is that facility owned by?

A: That's owned by Hospital Management Associates.

Q: Okay. All right. With that as your background, Mr. Miller, let's move to the point of discussing your entre into Rock Hill and Piedmont and before we do that, describe for the Court, if you would, the background of Piedmont Medical Center.

A: Piedmont Medical Center was acquired by American Medical International in 1980 from

York County. York County owned the local hospital at the time, York General. Part of that transaction involved a commitment by AMI to basically build a replacement hospital which is the Piedmont Medical Center that exists today. And part of that transaction involved not only cash consideration, but a contractual commitment to build a replacement hospital and provide some other services on behalf of the county.

Q: And during the period of time following the execution of that contract in 1980, what continuing relationship existed between AMI, as the owner now and operator of the new facility and York County?

A: The 1980 agreement basically provided that the hospital would provide ambulance services on behalf of the county. Take care of indigent patients without any cost or remuneration or support from the county. It had some provisions in there about maintaining pricing structures and different things like that. The agreement was subsequently amended five times through that period of time primarily to address some milestone dates relative to the

construction of the hospital and bringing it online. The first significant operational change in that agreement occurred in 1995 with the sixth amendment.

Q: Okay. Now, with the sixth amendment, were there new services that were required of Piedmont?

A: Yes.

Q: And have you developed a Demonstrative that identifies those?

A: I believe we have.

Q: Dan, let's turn to Demonstrative 209, please. And what's presented here related to the sixth addendum of the York County contract?

A: The sixth addendum provided that Piedmont Medical Center would develop a heart center which would include the development of an open heart surgery program and expansion of its cardiac catheterization program to maintain at least two rooms. It created a 20-bed dedicated heart unit, an eight-bed critical-care unit for cardiac patients and post-surgical patients as well as a cardiac rehab program. It contained a commitment on the part of the hospital to develop a neurosurgery program. It, for the

first time expanded the EMS services to establish benchmarks for response times and the placement of EMS units, how the EMS system would grow with the population of the community, provided for some updating of the radiology technology systems like CT in this case as well as the development and operation of Piedmont West Urgent Care Center to be located on the western side of York County.

Q: Okay. Now, when you arrived in 1998, were these services just beginning to come online?

A: That's correct. With the exception of the neurosurgery program, that one was still under development in 1998 when I arrived.

Q: Okay. And since the time that you arrived, over that 14 year period have their been additional new services that Piedmont's established?

A: There are and I've developed a Demonstrative of that.

Q: All right. And Dan, let's look at Demonstrative 210 and what's showing here, Mr. Miller?

A: These are additional services unrelated to the contract itself. We constructed a Women's

Tower that contained an eight-bed dedicated pediatric unit, dedicated OB/GYN operating rooms, a special –

THE COURT: Mr. Andrews? Did he say related or unrelated to the contract?

MR. ANDREWS: Unrelated.

THE COURT: Unrelated. Thank you.

A: These are not contractual obligations.

THE COURT: Yes, sir. I understand. I just wasn't sure on the un part or not.

Q: Thank you. All right. So work through with me, if you would, and what you've done over the period of time to establish new services at Piedmont.

A: Sure. The Piedmont special care nursery which included neonatology coverage 24/7. Eight additional critical-care beds. We began a bariatric surgery program.

Q: What's bariatric surgery?

A: That's a weight loss surgical procedure.

Q: And before we're working through this, eight additional critical-care beds were in addition to what?

A: They were in addition to the 16 general critical-care beds that were a part of the

original structure and in addition to the eight critical-care beds that were dedicated to the heart center bringing our total critical-care bed complement to 32 beds.

Q: Okay. And were these located in any one unit throughout the hospital or were they dispersed?

A: This particular addition was intended to focus on post-surgical patients and was located in the Core Tower.

Q: Okay.

A: The 64-slice CT scan was in addition to the 16 and was actually brought on board to complement the heart program because you can do some cardiac scoring and different procedures with that as well. We began an infusion therapy center, a lung care center, we added the development of EP services with our cardiologists, pain management center, intensivists in our critical-care units, a full-time pulmonologists who are attending to critical-care patients.

Q: Now, are those full-time pulmonologists, were they employees or contractors with the hospital?

A: They are employees.

Q: Okay.
A: As well as we had hospitalists covering both our general acute-care patients and our pediatric service and, again, as employees. We also developed York Family Practice located ---
Q: I'm sorry, let me interrupt here. Excuse me, but up to this point everything you've identified has been on the campus of Piedmont, is that correct?
A: That is correct.
Q: And the remainder of these things you're identifying, are they on Piedmont's campus?
A: They are not.
Q: Okay.
A: And, actually, let me correct myself. The wound care center and the pain management center are across the street.
Q: All right. Go ahead. Pick up at York Family Practice.
A: Okay. York Family Practice which was established in the western part of York County, Piedmont East Urgent Care, which was established on the I-77 corridor in the southern part of the county. Baxter Urgent Care and Baxter Imaging are a part of the

Baxter Community Campus located in Fort Mill, South Carolina. And Tega Cay Family Practice is in that northern, northeastern segment of the county over towards the city of Tega Cay.

Q: Okay. Now, in addition to the services you've brought on during your tenure, discuss in general terms, if you would, the developments in the medical staff of the hospital.

Q: The medical staff had grown significantly through the years. We had a very aggressive program of providing economic support and relocation support for physicians who wanted to come to the community and be a part of our community as well as recruitment initiatives and focused primarily at that point in the early years, anyway, with specialists. The cardiovascular surgery, neurosurgery, provide assistance to orthopaedists, general surgery and those kinds of things.

Q: All right. And how did the services you were bringing on, the heart center, the Women's Tower, the neurosurgery and others relate to your recruitment efforts?

A: They were actually intended to help support and attract high quality individuals. The women's

center provided an impetus for us to start a third OB/GYN group in the community. We recruited two individuals for the bariatric surgery program who assisted us in some very well qualified general surgeons with expertise and skills. The wound care center which supported our vascular surgery program, of course.

Q: Okay. Now, let's move to the utilization of Piedmont during this period of time leading up to the period of 2004, prior to the filing of the application. How was the hospital doing that first six years that you were on campus?

A: Doing very well. We continued to show growth both from admissions and outpatient activity and procedural activity within the operations.

Q: Okay. Dan, pull up Demonstrative 137. This has been a Demonstrative that's been the focus of prior testimony. Mr. Miller, do you recognize it?

A: I do.

Q: And what does it reflect?

A: This reflects inpatient discharges for the period of time 1997 through 2010 both for Piedmont Medical Center as well as some of the

regional hospitals.

Q: And generally, how does it reflect the development and the changes in patients admitted to Fort Mill?

A: It shows, you know, very consistent and steady growth in response to some of the development activities and strategic planning that we were doing up until 2005.

Q: Okay. Now, with regard to the strengths that were reflected by the growth and the recruitment and the expansion of the medical staff, by the way, I don't think I asked you specifically, during this period of time of your onset through 2005, what was the growth in the medical staff?

A: Our growth in the medical staff was probably significant, a little bit of a guess, but we probably added at least 100, 150 physicians to the medical staff.

Q: Okay. And have you developed a Demonstrative to show the strengths of the healthcare system including particularly the hospital and its medical staff at that time?

A: I have.

Q: All right. Dan, let's pull that up, it's

Demonstrative 205, please. And what does this reflect, Mr. Miller?

A: Basically, it reflects that we developed a very diverse, very well-trained medical staff. These physicians that are boarded and come from the finest medical institutions in the country. We had a well-balanced payor mix to support the growth and investments that we were making. That allowed us to maintain state of the art technology and keep pace with development of technology. We were able to maintain the facility that was originally constructed in 1980 and keep it well-kept and expanded and renovated as appropriate and we had access to capital to help us support these activities.

Q: With regard to the developments of the facility, what were the main features concerning the renovation and expansion of Piedmont Medical Center immediately prior to and during your early years?

A: Well, we added the heart center in 1996. We also renovated and expanded the emergency department at that time. We built operating rooms that were dedicated to the heart surgery program as well as the critical-care unit that

we spoke of. In 2004 we added a 95,000 square foot women's center dedicated to women's health issues. We renovated the Core Tower during that 14 year period on two separate occasions to keep it fresh and modern-looking as well.

Q: Okay. Now, thinking back to the Demonstrative that showed a decline in volume that began in 2004, what were the challenges that that loss of patients represented? Have you developed a Demonstrative to show that?

A: I have.

Q: Dan, let's look at 206. And what does this show, Mr. Miller?

A: Well, basically we began to see a period of time, a disruption of the historical referral patterns up to that point we had a very collegial medical community. The boundaries of who owned which practice were not significant. We observed pressure from the Carolinas Health System practices, what I refer to as cherry-picking patients based on their payor mix and we saw the practices beginning to place limitations on the number of Medicare, Medicaid and self-pay patients that they were allowing into their practices.

Q: Now, before we expand on that, I want to ask you to testify in a little more detail concerning the hospital's contractual relationship with York County, okay?
A: Sure.
Q: And you mentioned it in your earlier testimony that the sixth addendum of that contract was a significant development. Let me ask you if you developed a Demonstrative that in addition to the services identifies other responsibilities that the hospital has?
A: We have.
Q: All right. Dan, let's pull up Demonstrative 211. What were those responsibilities that were the principal ones in your mind?
A: Well, they're numbered, the key points. It required us to maintain reasonable pricing, I think as I mentioned earlier, it expanded and got into significant detail of some benchmark accountability relative to the EMS ambulance service. It obligated the hospital through the term of that contract, which was out to 2045, to ensure that there would be adequate capital reinvestment in York County relative to healthcare services and it also obligated the

hospital to provide a very comprehensive annual report relative to the operation of the hospital and its performance on commitments in the contract.

Q: All right. Let's take these issues one at a time and have you go through them in a bit more detail. Let's begin with the pricing issue. Let's turn, if you would, to Exhibit 16, Dan. Let's look at the provisions in the sixth addendum related to pricing. Let's begin on page nine. And highlight the section of that that addresses pricing considerations. What is it, and read that into the record, please, Mr. Miller, and then talk about it.

A: AMI agrees to exert every effort to so conduct its operations and finances to maintain prices for services at the hospital at a reasonable, competitive levels vis-a-vis other hospitals in the quote, unquote peer group as defined in section 3.13(a)(xii) thereof for which MEDPAR pricing information is provided pursuant to subsection 3.13(a)(xii).

Q: Okay. And what did you understand this provision to mean?

A: This provision obligated the hospital to

maintain reasonable and competitive pricing at levels in relationship to what was identified as the peer group of hospitals.

Q: Okay. Let's look at Demonstrative 213 to identify those hospitals that are in that peer group. Would you identify them for the record please?

A: Sure. The first group represents hospitals operating within South Carolina. It's Mary Black in Spartanburg, Palmetto Health Richland here in Columbia as well as Palmetto Health Baptist, Piedmont Medical Center, of course, Providence Hospital here, and Spartanburg Regional Medical Center. And then in North Carolina, Carolinas Medical Center, Carolinas Medical Center-Mercy, Gaston Memorial Hospital and Presbyterian Hospital.

Q: Okay. Now, has the hospital, that is Piedmont, throughout your tenure always been in compliance with its term to set your pricing at competitive, reasonable levels?

A: Actually, we ran into some challenges and based on 2002's MEDPAR report ---

Q: What's a MEDPAR report?

A: That is a compilation of data applied from

Medicare relative to the average charges for Medicare patients in hospitals that's made publically available and released when Congress does its budget every year. It's time-lag, so for instance for 2013, you will get 2012 data. So, it's not always contemporary at all. In 2004 we got 2002, or in 2003 we got 2002 data and identified the fact that we were in first of this list which under the terms of the sixth addendum triggered the need to engage in an action plan on the part of the hospital ---

Q: Let me stop you there before you develop that plan. In 2002, which was the date you testified, the focus of the charges, did you know what the charges were for the other facilities in the peer group?

A: Not until late 2003 when we got the MEDPAR data.

Q: And what did you learn at that time?

A: That we were the highest.

Q: All right. And then, the contract, you said, had a provision for what you do when you learn you're the highest?

A: That's correct.

Q: Did you report that fact to the county?

A: We did. We called, had actually a special council meeting held at the hospital in April of 2004 and self-disclosed that situation to the county at that time.

Q: Did the county, in response to that issue a notice to the hospital?

A: It did. It basically issued a formal notice of their position that we had breached the contract and to sanction the hospital at that time.

Q: All right. And what evolved after the notice of the breach?

A: Well, the hospital was engaged in corrective action of freezing prices and rolling its prices back in a number of areas, we negotiated the eighth addendum to the contract to basically improve the language of this section so it would be a more timely response and accountability on a going forward basis as well as the fact the eighth addendum established for the first time monetary damage privileges should we ever become number one again.

Q: And what are those, what are the damages?

A: I don't recall. I believe it is like $100,000 a month until we correct the action.

Q: And now you said just a moment ago that you froze, rolled back charges. Be more specific, if you would, about after the notice what action the hospital took with regard to its pricing.

A: Well, the hospital as part of the promise in the sixth amendment had developed an action plan that initially we froze our prices and as we moved through the action plan in a number of different areas we actually reduced them to basically bring ourselves down to the level of what they were in 2002.

Q: And the period of time after those -- your charges were frozen and reduced through the time you continued to be CEO among the -- were there 11 hospitals in the peer group?

A: I believe that's correct, yes.

Q: Where did Piedmont fall?

A: I think we are, you know, at this point about the fourth, fifth lowest in the group.

Q: Okay. All right. Now, let's talk about -- Dan, let's go back to Demonstrative 211, please. And let's move to the next item that you've identified on your contractual obligations, ambulance services.

A: The sixth addendum basically expanded the EMS ambulance obligation. In the original 1980 contract made very brief reference to the fact that we would provide that service and over some period amount of time evaluate what would be the appropriate system for the county. The sixth addendum in 1995 actually established response times for geographic areas identified in the contract ranging from eight to 20 minutes depending on where the residents lived. It also identified some requirements to maintain two ambulances on the western side of the county and several ambulances on the east including one in Fort Mill. And a process by which as the county population expanded, how ambulances or first response units would be added to the system.

Q: Under the contract is there any exclusivity provision?

A: No, there's no exclusivity provision. We are not the only EMS provider in York County. There are a couple of rescue squads operating in there. There's also clear language in there that we're to transport patients not only to Piedmont Medical Center but to any hospital in

the counties contiguous to York County as well as appropriate.

Q: Now, what's your experience in that regard?

A: My experience in regard to that is that there are a significant number of out-of-county transports occur every day within the system and have for years.

Q: What are the instructions that the EMS operators have been provided with regard to patient choice and concerning the use of ambulance services?

A: First and foremost would to be compliant with the state and federal law in this regard. Secondly, they are to be respectful of patient choice unless they basically believe the patient has been, that their choice would place them at harm. Again, time being critical depending on the situation. There also some instances in which by regulation and we need to take the patients to a certified stroke center, that kind of thing.

Q: Okay. What are the economic impacts of operation of this service on Piedmont over the years?

A: We lose about four, four and a half million

dollars a year providing that service on behalf of the county.

Q: Now, let's look at the third category. Capital reinvestment. What are the requirements there?

A: The sixth addendum provides that the hospital has to reinvest roughly 108 percent of its average depreciation over the last three years on an ongoing basis and it is a minimum requirement and, again, this contract goes out to 2045.

Q: Okay. And the fourth issue relates to annual reports. What reports are expected of the hospital?

A: And I think we've developed a Demonstrative on this, but this is an annual report that has to be submitted to the county and of course is available for public inspection. It covers financial operations of the hospital.

Q: We'll pull that up just to help you with the contents. We made this, Your Honor, Exhibit 17 the last four annual reports. Mr. Miller, since the last report, what year was the last report that came under while you were CEO?

A: It would be the contract year ending May 31, 2011.

Q: Okay. Let's pull up 17(C) then, Dan, the 2011 report. Let's turn to the table of contents in that Exhibit and just in general terms without reading the entire list of the contents, what does the report incorporate?

A: Identification of our governing structure and participants there, annual financial statements, disclosure relative to our property tax, depreciation report, that whole section there relative to depreciation, capital investment, equipment to show compliance with that section. There's a piece of it there it reports on our support for the medically indigent in our community and our charity and bad debt. We're obligated to provide medical services to the county detention center, report on operations of our emergency department, physician recruitment, a section on EMS operations, pricing, the MEDPAR data report, our support for scholarships and education and donations in the community. Those are the key elements.

Q: Okay. Let's look at a few of those just as a few examples of what these report to the county. Let's begin with the scholarships and

education section. And what's being reported there, Mr. Miller?

A: The sixth addendum requires us to provide some scholarships for both York Tech and Winthrop University. That's the two numbers there, $31,347 each. The CAP scholarship is a self-initiated program that we started at the hospital in support of employees and employee's children who want to go into nursing school. The B section, their educational support, these are not contractual obligations, but this is support that we provide to USC as well as York Tech's nursing program and additional education programs for our employees we provide at the hospital. Again, not a part of the contractual obligation. Section C gets into our work and ensuring that we are not only about just a hospital but about impacting the health status of our community. The Healthy Hometown Project is a major initiative that we engage in both in Rock Hill and Fort Mill as well as York and help bring health educational material to provide throughout the community.

Q: Okay. Let's move to another section of the report relating to indigent care. Dan, if

you'd take us there. And review this for us, please, Mr. Miller.

A: This is our accounting to the county for services that we provide to indigents of York County. You'll see there in B, 939 inpatient situations amounted to just a little short of $31 million. A little over 1300 outpatient encounters at about 3.5 million and then some additional charity reserves that we did. In our facility, charity means individuals that have never been billed for services. They have been screened initially for their ability or inability, as the case may be, to finance their own healthcare. They have not met the requirements for any of the other programs that may be available in the state, Medicaid, et cetera.

Q: Now, let me stop you there and ask for the 939 inpatient accounts, what does that $20.8 million line item refer to?

A: That refers to the charges for the services that are rendered to those 939 encounters.

Q: And what eligibility requirements in general terms apply to those?

A: I think we're at 200 percent of the federal

poverty guidelines.

Q: Okay. And so total charity care under 2011 was approximately what?

A: Twenty-seven, almost $28 million.

Q: Okay.

A: Other uncompensated care, these are bad debts. Those individuals who are unwilling to pay for their healthcare services amounted to almost 25 million.

Q: Unwilling, you mean do not pay and do not qualify for charity?

A: Do not pay and do not qualify.

Q: Okay.

A: And then D what is our compact with the uninsured. Tenet Healthcare Corporation was one of the first organizations in the country to develop a program whereby individuals who have assumed responsibility for their own healthcare, more commonly referred to as self-pay patients, are traditionally penalized for that decision because they have to pay full rates. What Tenet developed is what we refer to as our compact with the uninsured in which we write down their bills to basically the same level that we would be expect to get paid by

managed care companies, Blue Cross, United, Aetna and those groups so that these individuals are benefitting from negotiated rates of large groups and large groups employers and those discounts amounted to a little over $12 million in this period.

Q: All right. And indigent care taxes paid. What's the reference there?

A: Well, all hospitals operating in South Carolina pay an indigent care tax to the state, that's the 6.5 almost 6.7 billion. In the sixth addendum, the hospital is obligated to pay on behalf of York County and York County residents the indigent care tax owed by the county and that's roughly $450,000.

Q: And in the absence of your contract, the county would pick up the county share of the indigent care tax, would that be correct?

A: Correct. In the absence of this contract, the county would be responsible for not only this $450,000 and about $4.5 million cost to provide emergency medical services.

Q: Okay. All right. Let's look next and finally at the financial statement provided in this report. Review this if you would, please.

A: Okay. For this 12 month period, basically the hospital had total billable charges of 592 almost $593 million dollars. It had additional revenue unrelated to patient activity, cafeteria and those kinds of activities of about 2 million. It wrote off contractual allowances over $300 million from government and third-party payors, Medicaid. We had bad debt as I referred to it a minute ago but we refer to here as our unwilling to pay.

Q: Let me stop you there on the bad debt question. What is, during the time you were at Piedmont, what has been Piedmont's practice concerning the pursuit of bad debt against patients who don't pay?

A: We operate an internal, we being Tenet Healthcare Corporation, operates an internal collection agency. Every effort is made to encourage payment, work with individuals with payment plans and we turn individuals over to a credit reporting agency, but to the best of my knowledge is we do not litigate for recovery.

Q: By litigate for recovery, do you mean file

lawsuits against debtors to the hospital?
A: Yes.
Q: Do you impose liens against patients for failure to pay?
A: Not to my knowledge.
Q: Okay. All right. Carry on.
A: And then we have those that are unable to pay. Again, those are those we've pro-actively identified as not having resources to them nor do they qualify for any existing governmental assistance program and then compact for the uninsured is the discounts that we provide to those people who have assumed responsibility for their healthcare.
Q: All right. And let's scroll down to the bottom and look at the -- let's just take it on down to the -- let's actually look at the taxation, your pretax income and the taxation then that Piedmont is subject to.
A: Sure. We're obligated to pay both -- we have a pretax income of $24 million after all of our expenses. We are obligated to pay both federal and state income taxes, state franchise tax, we pay property taxes in York County. Business licences and the indigent care tax looking at

a total of almost 15.6 million for after tax income of $9,160,000 in this period.

Q: The property tax that's identified for Piedmont of 2.1 million, are you familiar with the taxes that are projected for the Fort Mill Medical Center?

A: Yes.

Q: And do you remember generally the amount of those, the property taxes? Does $4 million sound about right?

A: Yes. I was going to say about four, four and a half million.

Q: All right. And what would be, based on information you've had available to you, the general explanation for the difference between Piedmont's property taxes and those that are projected for Fort Mill Medical Center?

A: It would be a combination of the taxes levied by the school board as well as the age of the facility and the value of the property as assessed by the county.

Q: Okay. All right. And the after tax income for 2011 for Piedmont was what?

A: $9,160,000.

Q: And what's the last line on that financial

statement?

A: That represents all the aggregate capital reinvestment that we made in that same 12 month period, 11,487,000.

Q: Now, and that would have a net effect of cash in 2011 of what?

A: That would be negative cash flow in 2011.

Q: Now, there are years where Piedmont has had positive cash flow?

A: Yes.

Q: All right. Let's move on to, actually, the ninth addendum. What did that, without looking at the document or let me call that up, Mr. Miller, what was the ninth addendum intending to address?

A: The ninth addendum was intended to address two points. Number one, we wanted to basically ensure that our communication commitment relative to the comport of the hospital and Tenet, that it be covered under the contractual relationship between Piedmont and the County would exist as well as we had been in discussions with the county relative to Piedmont West Urgent Care, the urgent care situated on the western side of the county in

an interest by some have it expanded as a 24 hour, 7 days a week. There was no data available to basically support an analysis of whether or not that made sense or how it would be utilized, so the hospital agreed to operate the center 24/7 for a period of five years, we believed that would give it an adequate time to test the market and see how it would be utilized by the community at the end of that five years that the hospital could modify those hours but under no circumstances reduce the participation lower than it was prior to the ninth addendum.

Q: And what were the hours of the urgent care center in York prior to the ninth addendum?

A: Eight to eight. Typical with all the other urgent care centers operating in the region.

Q: Okay. And what did you learn as a result of that five year experience?

A: We learned that there was really no demand for a 24/7 on the western side of the county. We have averaged, at best, on a busy night maybe a three patients from nine o'clock at night until seven in the morning, so we lost about $800,000 a year in that test market.

Q: All right.
THE COURT: $800,000 a year, sir?
A: Yes, sir. Is what we lost.
Q: And how did you lose that amount?
A: We had a contract for core physician coverage and staff coverage for those additional hours.
Q: Okay. So that $800,000 a year for how many years?
A: Five years.
Q: So four million?
A: $4 million experiment.
Q: Okay. And after the conclusion of that time what hours were restored?
A: We went back to the original eight to eight hours of the center.
Q: Now, have you contracted that service or subcontracted that with any parties?
A: We did. We actually -- the physicians that operated the center and came to us a number of years ago and asked if they could acquire the center for their own business purposes. We agreed with the consent of the county to transfer that. There is a provision in that sale document, though, that they have to fulfill our obligations relative to the

requirements of the sixth amendment. And is it may subsequently be amended and should they decide they want to sell that business, then basically Piedmont has a first right of refusal in taking over because it has an obligation to make sure of the operation of that clinic out to 2045.

Q: Without regard to who operates it?

A: Correct.

Q: Okay. All right. Were there any issues related to Fort Mill Medical Center that were addressed in the ninth addendum?

A: Yes. We took the opportunity to confirm our position that it was our intent that both the Fort Mill hospital and Piedmont Medical Center would fall under the terms and conditions of the contract and all its amendments with the county.

Q: Okay. Now, have there been any additional addenda to the contract executed since 1990?

A: There's not any that have been executed, as I mentioned earlier, I've been retained by the hospital relative to the negotiations of a tenth addendum. The sixth addendum had a provision in it that provided that the parties

every five years would review the terms and conditions of the sixth addendum. Healthcare being a very dynamic industry and times changing, making sure that we kept the agreement consistent with the intent of the parties. The tenth addendum was initiated to facilitate that review and was presented to the county for initial review in the fall of 2011.

Q: Okay. Has there been any action on that?

A: Yes, there's been quite a lot of activity. The original tenth addendum made some suggestions relative to –

MR. MULLER: Your Honor, can I interrupt the witness for just one second? This tenth addendum we had asked for in discovery. When I asked questions of Mr. Miller in the course of the deposition, he was very vague about it. In the course of his deposition, I asked Mr. Andrews for a copy of it. He indicated that I would have to make a formal request. I then went back to my office, I looked at our prior discovery and I made an email request to Mr. Andrews. He responded by refusing to give it to me on the grounds it was not a final document and he said that if it was ever signed

it he would give it to me. He is now eliciting testimony about that draft after refusing to provide me with a copy of the draft. If you would like, I can show you the email of where Mr. Andrews -- where I asked, made a formal request and Mr. Andrews responded in that manner. I have a copy of it right here.

MR. ANDREWS: There's no need for that. It's not disputed. That's the position we took, Your Honor, because as we explained in that email that it was a confidential negotiation process and I'm happy to end the examination on this. I actually wasn't intending to elicit anything more than what Mr. Miller testified about in his deposition. He elaborated a little further just for the Court's edification. But it's still not final and that remains our position, but I'm happy to move on. We don't need to explore this any further.

THE COURT: Well, in light of that, Mr. Muller, let's have no further discussion that it was sustained since CHS hasn't had an opportunity to review that and it is still in negotiation, let's not have any further —

MR. ANDREWS: That's fine. Happy to move on.

Q: All right. Now, let's shift your attention, Mr. Miller, to Piedmont's interest in establishing healthcare services in Fort Mill. When did that begin in your tenure with Piedmont?

A: Actually in 1999.

Q: And what were the -- discuss the plans relating to the development of a Fort Mill area hospital at that point.

A: We had been alerted by a local development, developer, Clear Springs Development Company that was formed to represent the Close family who owned large blocks of land in the Fort Mill area back then and they were interested formally interested in developing them into some pretty structured community concepts. They had hired some individuals who worked with Disney down in Florida and a similar construction-kind of concepts and part of what they've done in Florida was incorporate some healthcare facilities in those projects and they were interested in soliciting the level of support and interest from healthcare providers to do something similar.

Q: Okay. Before we move into much detail about

that process, let me ask you for a little further background and context to explain why Piedmont had an interest in the development of healthcare services in Fort Mill?

A: Well, clearly Fort Mill, you know, at the time York County was one of the fastest growing areas in the state and within York County, the whole northeast quadrant and north of the Catawba River was growing significantly. It was developing into a bedroom community and it was significantly important for us. We were seeing a lot of out-migration from that area that obviously concerned us as well as the development of the population.

Q: Now, describe, if you would, what Piedmont hoped to accomplish during those early years by establishing a hospital in the Fort Mill area.

A: Well, we were hoping to not only meet the needs of the community that we felt was a medically underserved area in terms of the presence of physicians as well as the easily accessible medical facilities themselves, but also to slow and curb the out-migration.

Q: Now, what was the out-migration?

A: To Charlotte, to North Carolina. Patients were

leaving York County for their healthcare.

Q: Okay. All right. Now, let me take you back to what you began to discuss related to the interest of a developer in establishing a healthcare complex and its system within Fort Mill. Did you receive during this period of time requests for proposals?

A: We did. We received a formal request for proposal from that group.

Q: And let's take a look at that. Exhibit 18, please draw that up, Dan. And let's move to the first page of that document. Okay. What is Exhibit 18, Mr. Miller?

A: It is a request for proposal for Baxter Healthcare Campus.

Q: And what were the expectations -- first of all, who issued the RFP?

A: It was issued by Clear Springs Development.

Q: And what was Clear Springs Development?

A: It's a company that was spawned by the Close family, the owners of all this property for the purposes of helping them develop and structure these communities.

Q: And in general terms, what was the Clear Springs Company developing in the Fort Mill

area?

A: Actually, the family owned a significant amount of acreage all over the Fort Mill area and they had identified potentially six community sites. They weren't necessarily going to develop them all at one time. They were starting with the Baxter, what is known now as the Baxter area which in 1999 was peach trees.

Q: Okay. And what were they hoping, well, what area was identified that would incorporate the healthcare complex?

A: Well, the concept that they were modeling this after was a self-sufficient community that would have a housing, business, town center as well as appropriate healthcare facilities to support the residents of that community. I think we projected at the time there would be close to 1200 homes in this particular project. And so they were soliciting relatively open-ended proposals from the various individuals they had asked or invited to submit a proposal.

Q: All right. Dan, let's pull up Demonstrative 86, please. Mr. Miller, there's been prior testimony concerning this Demonstrative. What does it reflect?

A: This reflects the time line of the development of those services. The conversations began in April of 1999 with the RFP. Those conversations and the submittal of the proposal and evaluation of that ended in October of 1999 with the selection of Piedmont Medical Center to be their healthcare partner and then through August of 2000 basically worked through the agreement and various details. The lawyering of the relationship.

Q: Okay. Now, and who was selected?

A: Piedmont Medical Center.

Q: All right. And as a result of that selection, were you offered an agreement that provided for the development of services in the Fort Mill area?

A: We were.

Q: Sorry?

A: We were.

Q: All right. And did you establish physician practice areas as a result of the agreement?

A: We did. Our RFP response basically laid out a plan of over a ten year period that we would develop and bring services into that area. That included physician practices, the

development of an urgent care center, imaging center and ultimately a hospital.

Q: And did you have the authority to enter into this agreement on your own?

A: I appropriately solicited and appropriately secured the authority to do that, yes.

Q: Let's take a look at that Exhibit 23, please, Dan, where you requested that authority. If you could call out the first section of the memo, Dan, about half the page. And Mr. Miller, identify what this is, please.

A: This is a memo to Reynold Jennings who's a senior vice president of operations for the region at the time that was sent to him from me on October 5th of 2000.

Q: And what were you requesting of Mr. Jennings?

A: Authorization to execute the healthcare alliance agreement.

Q: All right. Dan, let's call out the first paragraph of that so we can see, Mr. Miller, how you presented this request to Mr. Jennings. All right. Mr. Miller, if you can read those sentences if you can see them.

A: Sure. A major portion of Piedmont Healthcare Systems strategic plan for the last decade has

been centered on initiatives to reduce out-migration from York County to Charlotte-based facilities. These initiative have primally been service-related to eliminate the political reasons for patients leaving York County.

Q: All right. Dan, let's go down to the bottom half of that first page and let's call out a couple of excerpts related to background and strategic plan. Dan, if you could just take it up. And read into the record what you said about the background and why you undertook this request, Mr. Miller.

A: Sure. Fort Mill is located in the northeast section of York County. This area is located approximately halfway between Rock Hill and Charlotte, North Carolina. The area has been the highest level of growth in York County and highly favorable demographics population with income. Unfortunately many of the residents of this area particularly the newcomers are oriented to Charlotte for work, shopping, entertainment and also a healthcare standpoint. This combined with a lack of presence of PHS, Piedmont Healthcare System, and its affiliate physicians in this area is resulting in a high

level of out-migration to Charlotte physicians and hospitals.

Q: And why did you make that statement to Mr. Jennings? What significance did it have to you?

A: I think it was important for him to appreciate the quirks of this area, the growth that's occurring as well as the basic forces that are in play that are influencing decisions made by the people who live in that area.

Q: All right. And then let's take a look a what you said concerning the strategic overview.

A: To redirect the out-migration from the Fort Mill market, PHS must first create a relationship between those residents and PHS-associated physicians and outpatient services such as diagnostic testing and outpatient surgery. This strategy is designed to overcome the natural tendency of residents in this area to look to Charlotte for healthcare. Once a patient is tied to PHS-affiliated physicians, they will be more likely to chose PHS facilities in Rock Hill for more advanced diagnostic testing and patient care that would not be available in Fort Mill.

Q: All right. Dan, let's go back to Demonstrative 86. Now, you've just provided the strategic overview and when did you do that to Mr. Jennings?

A: October of 2000.

Q: Four years before you filed the CON application?

A: That's correct.

Q: All right. And the development of the hospital was the last among the contractual expectations that you've identified. What did you -- were you on schedule on the development of these services?

A: Yes. Actually, the physician practices and urgent care center were the first phase we put in place. We followed that with the imaging center. The hospital was originally in our RFP response and the agreement proposed for basically ten years out. So, when the Health Plan basically made a provision for additional beds, we made a consideration going through what would have been a normal CON process and then design, development and construction on the hospital, we would have it opened pretty much on schedule.

Q: Now, how did the contract address the issue of it being a requirement that DHEC first provide its approval before a facility could be constructed?

A: Well, there was a recognition by the folks at Clear Spring Development that this was a CON state and obviously we couldn't be bound to do something without a CON and the law would not allow us to do.

Q: All right. And how did the contract address the rights of third parties, other healthcare providers to develop and provide healthcare services within the Baxter Village development?

A: Actually the agreement provided, had a provision in it that it was an exclusive relationship with Piedmont Medical Center and to the extent that there was an interest by another healthcare provider to locate within these projects, it would require our consent.

Q: Was the selection and process undertaken by Clear Springs open to participation by Presbyterian and Carolinas?

A: It's my understanding that they were invited to submit a proposal as well, yes.

Q: Okay. Now, with regard to the development of

the hospital, did the agreement contemplate a particular site location for the facility?

A: The general site identified was a plot of land within the Baxter community. The agreement also called for us to basically take down a certain amount of acreage on a annual basis, which we did, ultimately leading to site large enough to place a hospital on the site.

Q: Was the site that was identified under the contract the one that was proposed to the Department where Piedmont would develop it's Fort Mill Medical Center?

A: No.

Q: And how would the change occur?

A: The change occurred as we began to develop the CON application and, I guess, we started to play close attention to the site that had originally been identified. You know, we were -- had had some conversations with some folks at Clear Springs about wanting to rearrange some of that acreage in order to better facilitate what we thought would be an improvement to the building to locate the facility on what we originally contemplated as that site for the hospital. Out of the blue,

and I mean we weren't expecting this, they basically contacted me and offered us the site that we ultimately placed in our plan as on option if we were interested in it because they were getting ready to develop their plans for what's referred to as the Kingsley North project.

Q: And what other developments are being considered concerning the development of the Kingsley North project in addition to the site where the hospital would be built?

A: It's a very comprehensive project. It will have, somewhat similar to Baxter, it will have approximately 1200 residential homes in it. It will have a million square footage of commercial office space. There are plans for a 300-room hotel on this site. It's a very comprehensive plan for that area.

Q: Okay. All right. Let's turn to the filing of the plan itself. When did you decide to do that?

A: I guess we started working on it probably in 2004.

Q: All right. And why at that time?

A: Basically, the demographic data that we were