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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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

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S.C. SUPREME COURT

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

v.

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

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

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there are things that are included and there are things that are not. So what CMS used that needs to be included is different than what GAAP assumes that needs to be included. And that's why it's not a great source for data.

Q: Okay. Now -- and one of the things that is not included on cost reports are taxes, right?

A: That's one of the things, yes.

Q: Okay. And first of all, before we get to your point about cost reports, let me just make sure that I understand. So when you add those taxes to the after tax income, it definitely -- that number ties to the cost report number; does it not?

A: It ties to the cost report number.

Q: All right. And there is no inconsistency, right?

A: The bottom line ties. I haven't gone through and tied through all the numbers that --

Q: Well, your testimony was just about that. So I mean, and you are certainly welcome to go through and look at it some more if you'd like to. But I just wanted to make sure that we understand that there is no inconsistency between those two reports.

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

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

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

Q: Okay.

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

Q: Okay.

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

Q: Oh, really. Okay. And have you -- let me ask you this. Is it part of your job, do you complete and submit cost reports?
A: I do not.
Q: Have you ever done that?
A: No.
Q: So you've never submitted a cost report yourself?
A: No.
Q: All right. Are you aware that whoever does submit the cost report has to attest that all the financial information on that cost report is accurate and that attestation goes to the government as a certification?
A: And once again, I've never testified that the data was inaccurate. But what I've testified to is the day that CMS requires you to submit is different than what is required to be submitted as part of your audited financials.
Q: And I understand that, and I appreciate that distinction. But my question was, are you aware that whoever submits the cost report has to certify that's it accurate to the government? Are you aware of that?
A: Yeah, I'm very aware of that.

Q: Okay. What are DISH payments?
A: Disproportionate share.
Q: Yeah. What does that mean?
A: It represents the -- it's a reimbursement that you get to offset the cost of providing indigent care coverage.
Q: All right. And that's an important source of income for some hospitals; is it not?
A: I don't know if I'd call it a source of income or offset for -- it's a source of revenue. It offsets, you know, the cost of providing uncompensated care.
Q: Right. So for some hospitals, that would be an important source of revenue; wouldn't you agree?
A: It's a source of revenue, yeah.
Q: Yeah. I'm sorry. I couldn't hear your answer.
A: It is a source of revenue, correct.
Q: It's a source of revenue. My question was is it an important source of revenue for some hospitals?
A: I mean, all revenue is important to the hospital.
Q: As it is, I guess, to most companies, right?
A: Yes.

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

see.

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

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

A: Correct.

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

A: Yes.

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

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

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

A: That's correct.

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

A: That's correct.

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

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

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

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

labeled on the PeopleSoft Report.

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

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

Q: What term would you use?

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

Q: What represents your total uncompensated care?

A: That 39,166,113.

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

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

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

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

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

Q: All right.

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

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

A: Uh-huh (affirmative response).

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

A: That would, I believe, be correct.

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

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

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

A: The majority of the charity care comes from a combination of the bad debt expenses and self-pay discount.
Q: Okay. The -- so I take it, then, that a relatively high percentage of that 35.8 million bad debt expense would go into the charity care?
A: I mean, half of bad debt is -- half of 35 million is 17.5 or 17.9. So, I mean that's 50 percent. I mean, it's not much above 50 percent.
Q: Okay. And then how much of bad debt recovery goes into charity care?
A: None of that would feed into charity care. That's actually an offset lowering the number.
Q: All right. How much is -- well, then you have a total line, bad debt total. And I think you said self-pay discount was another significant part of the amount that was a charity care total, is that right?
A: Yes. Self-pay discount of that 4.7 million in self-pay discount, $2.9 -- 2,898,000 remains as sort of an uninsured discount. And then the other $1.9 million of that number is then -- there is a determination when they look at that

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

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

A: Like a name?

Q: Well, is it you?

A: It's not me.

Q: Is it somebody working under your supervision?

A: It's not someone under my supervision.

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

A: It depends.

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

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

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

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

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

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

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

Q: Okay.

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

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

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

A: Okay.

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

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

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

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

A: It's a vendor.

Q: It's a vendor.

A: Yes.

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

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

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

A: It depends on the patient.

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

A: It would depend on the individual patient.

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

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

A: Uh-huh (affirmative response).

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

A: Yes.

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

A: Yes.

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

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

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

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

A: In 2005, I did.

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

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

Q: All right.

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

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

A: It was not.

Q: Okay.

A: Let me rephrase.

Q: Okay.
A: I'm not positive what it was based on. That was something that Mr. Murphy pulled together and provided to me.
Q: Okay. But it sounds like what your initial response is, as far as you know, it was not based on those two hospitals. Would that be an accurate way of saying it?
A: The only thing I would say that that might change it a little bit is that a lot of the patients that are currently seen at Pineville originated at that Fort Mill market.
Q: Let me ask just a few more questions. Let's move onto another topic.
A: Sure.
MR. WESTBROOK: All right. Dan, how about pulling up Bates Page CHS-6879, please.
Q: And Mr. Stewart, this is a -- I'm going to represent to you this is a document CHS produced to us during discovery, is that right?
A: Okay.
Q: And I think this is just --
MR. WESTBROOK: Can you pull that out where we can see it, Dan?
Q: I think is just an email, I believe. It's'

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

A: Uh-huh (affirmative response).

Q: And who is Debra Godfrey?

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

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

A: That's what appears to be.

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

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

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

Q: And why was that?

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

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

A: That's correct.

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

A: That sounds correct.

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

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

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

A: Yep.

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

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

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

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

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

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

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

A: Yep.

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

A: Apparently that was at that point in time.

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

A: Uh-huh (affirmative response).

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

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

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

A: Yeah.

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

A: Uh-huh (affirmative response).

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

A: Probably.

Q: Okay. And I think you talked about Intercompany expense on your direct. So that would be -- as I understand it, Intercompany expense would be employees or contractors or whoever that provides centralized services to a number of CHS' hospitals, right?

A: That's correct.

Q: And they are located off site of where any of those hospitals are --

A: Right.

Q: -- is that correct? And they are accounted for -- the expense of those are accounted for in the Intercompany expense line that you talked about on your direct, right?

A: That's correct.

Q: Okay. And -- but they are not -- if they are Intercompany expense, those FTEs would not be counted as FTEs on the staffing plan, is that right?

A: We accounted for the expense through Intercompany, not through the staffing line item in our projection.

Q: Okay. And then it says, "other thoughts". And you have a number of other thoughts there. Let's bring that down.

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

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

A: Yes.

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

A: That's what she says, correct.

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

A: The expense is captured in the Intercompany line.

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

correct?

A: That's correct.

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

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

A: Cheryl Atkinson is Debra Godfrey's peer.

Q: I'm sorry -- her what?

A: Her peer.

Q: Her peer?

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

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

A: That is September 24th.

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

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

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

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

A: That's correct.

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

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

A: It is.

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

A: It does.

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

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

Q: It would have been you?

A: It would have been me.

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

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

Q: Sure.

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

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

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

A: Yes.

Q: And the date on that is September 24th. So that is early on; isn't it?
A: It's early on. And like I said, I would have to see how that 250 -- I don't -- as I recall, I think our FTEs in year one are like 300 and change. So this has to be -- I mean, this is just something that was early on developing a projection based on, you know, the volume projection at that time.
Q: But it looked from the earlier emails that you were in -- you had -- you were working on a tight deadline to get this out; wouldn't that be correct?
A: A tight -- no, it was a tight time line to get it finished.
Q: Oh, okay. Tight time line to get it finished; you're right. And in fact, you didn't present your pro forma budget projections or your FTEs until December 2010; isn't that correct?
A: I think there were two submissions. And one was in the December time frame and one was in the March time frame.
Q: Okay.
A: But I think the March ones are our final submittals that are in the application.

Q: I grant that. I understand. Thank you.
MR. WESTBROOK: Let's go back to Demonstrative 2.11, please.
MS. ROBERTSON: 211.
MR. WESTBROOK: 211, I'm sorry. Yeah, that's okay.
MR. ROBERTSON: I didn't know if it was yours our ours?
MR. WESTBROOK: I wasn't sure myself. I think it's yours. Thank you very much.
Q: Let's go back to this demonstrative, Mr. Stewart, for just a minute. Now, the category of self-pay discount there. I believe you said that that was one of the -- well, I think you said that it ended up that the two major contributors to the charity care total down at the bottom half were self-pay discount and bad debt expense, is that right?
A: That's correct.
Q: Okay. Let's just look at some of the self-pay discounts for a minute. Now, the process of developing -- I believe you mentioned that the process of developing a patient payment plan for some self-paid patients; isn't that correct?
A: Yes. Well, I don't know if I talked about a

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

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

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

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

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

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

A: That's correct.

Q: On a periodic basis, correct?

A: For a payment plan?
Q: Yes.
A: Yes.
Q: All right. And the hospital, if it's a discounted bill, the hospital would discount the charge before those payments were started, is that right?
A: Correct.
Q: All right. And then the balance after the patient finishes making all his or her payments based on that agreement, based on that discounted rate, there is going to be a balance, right, because it's discounted, correct?
A: Well, you would have already written the balance off in your discount.
Q: Oh, okay. So you write -- that was going to be my question. You go ahead and write that balance off at the beginning?
A: You write that balance off. I think there are sort of two pieces to it. There is the amount that is written off when the agreement is made. But the accounts, you know, the payment plans may or may not be adhered to.
Q: Right. And if the payment plan is adhered to,

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

A: It may fall into the bad debt category.

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

A: Uh-huh (affirmative response).

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

A: Correct.

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

A: That's correct, yes.

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

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

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

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

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

THE COURT: Sure.

MS. ROBERTSON: Thank you.

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

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

(Off the Record)

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

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

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

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

THE COURT: Mr. Westbrook?

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

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

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

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

Q: Yeah.

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

MR. WESTBROOK: Yes.

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

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

MS. ROBERTSON: Clarify that if you could.

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

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

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

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

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

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

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

A: Correct.

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

does that conform with that definition of indigent care?

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

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

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

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

A: And then the uncompensated care includes both

bad debt and charity care.
Q: Okay. Just a moment, Mr. Stewart.
A: Sure.
Q: Do you ever write off co-payments for private insurance?
A: Write off co-payments in terms of like -- so if you are talking about for managed care?
Q: Yeah, or for any private insurer?
A: I'm sure we do.
Q: Okay. And if they are written off, are they ever classified as charity care, those writeoffs?
A: I don't believe that would be classified as charity care.
Q: Okay. Do you know or are you just assuming?
A: I don't know for sure, but I'm pretty sure that that's right.
Q: What about -- Medicare has co-pays, as well, don't they?
A: They do.
Q: Are those --
A: And they can depending on what type of co-insurance you may or may not have.
Q: Are Medicare co-pays ever written off?
A: I'm sure they are.

Q: And Medicaid co-pays are written off, I'm sure as well, is that correct?
A: I'm sure they are.
Q: Are those -- if they are written off, those co-pays for Medicare and Medicaid, does CHS ever classify those as charity care?
A: I don't believe so.
Q: What about contractual adjustments -- are those -- well, I think we've already talked about contractual adjustments. What about deductibles? Are deductibles ever written off?
A: I guess -- I'm a little -- not sure what you mean. I think we talked about co-pays and deductibles.
Q: Well, there is a distinction between co-pays and deductibles; is it not? Or is it --
A: I mean, I would sort of use those -- I mean, either way that's what the portion of the payment that the patient is responsible for.
Q: Okay. So your answers to my questions about co-payments, you were thinking of them as including documents.
A: If it had included documents.
Q: I don't have any other questions. Thank you.
THE COURT: Ms. Robertson?

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

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

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

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

A: No.

Q: And is that determined on a practice basis?

A: It is.

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

A: No.

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

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

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

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

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

A: Thank you.

DR. ALEXANDER - CROSS EXAMINATION BY MR. ANDREWS:

Q: Good morning, Dr. Alexander.

A: Good morning, Stuart.

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

A: That's true.

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

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

A: Thank you. Same here.

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

Physician Network; aren't you?

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

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

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

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

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

A: Two days a week.

Q: Two days a week, is that right?

A: That's correct.

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

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

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

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

A: I was at times, yes.

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

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

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

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

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

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

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

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

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

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

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

Q: Including those who were insured?

A: Sure.

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

A: That is correct.

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

A: I do not know anything about that.

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

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

A: It is actually average.

Q: It's average.

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

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

A: Five.

Q: Five to ten percent?

A: Five practices receive less than ten percent Medicaid.

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

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

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

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

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

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

A: Correct.

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

A: It is.

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

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

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

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

A: I do.

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

A: That's correct.

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

A: That's correct.

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

A: It is.

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

decision; isn't it?
A: That's correct.
Q: And there's no policy, no directive from Carolinas to encourage physicians to take more or less Medicaid or indigent care; isn't that true?
A: That's correct.
Q: And isn't it true that there are some compensation models that could create a disincentive for some physicians in the CPN network to accept Medicaid or particularly indigent patients?
A: All compensation models, if that's what you base your decision on, would make you not take Medicaid.
Q: Now, if we look at -- let's --
MR. ANDREWS: Dan, hit the Medicaid participation column among the CPN practices.
Q: Other than the pediatric practices, there are only two that are in double digits and the rest are all single digits and many are less than a percent or two; isn't that right?
A: Yes.
Q: And would it be your inference based on your experience as a manager of physician practices

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

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

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

A: I do not.

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

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

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

A: That's correct.

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

joined Carolinas; is that about right?

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

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

A: That's correct.

Q: Okay. All right.

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

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

see that?
A: Sure.
Q: It's been highlighted right there. And if you look at that, if you can see it. With my old eyes it's hard to see it.
MR. ANDREWS: And maybe, Dan, can you call it out?
Q: But you will see the pediatric's line and the percentage of inpatient discharges among these services; and particularly pediatrics. And if you will see there, it is 12.47 percent at CMC. Is that consistent with what you would expect it to be?
A: I have no knowledge of what it's supposed to be.
Q: Okay. Now, if you look further down the other hospitals in the Carolinas System in the Charlotte area, you will see after CMC Union a percentage of 1.8 percent for Cleveland, .2 percent for Mercy, .2 percent for Pineville, .4 percent for University and .4 percent for Kings Mountain; do you see that?
A: I do see that.
Q: And Pineville is the closest Carolinas facility to York County and particularly your Fort Mill and Rock Hill offices; isn't it?

A: It is.
Q: But you don't admit pediatric patients there; do you?
A: They do not have a pediatrics floor or a place to admit pediatric patients.
Q: And that's what you prefer and your patients prefer so that you get that degree of specialized care; isn't that right?
A: I do send them to Levine's because of that, yes.
Q: All right. Now, let's go to -- actually let's talk about and take a look at the contract terms that you mentioned.
MR. ANDREWS: Dan, if you pull up Exhibit -- it would be Piedmont's Exhibit 25, the first page of that.
Q: Dr. Alexander, do you recognize this as the term that you discussed with Mr. Gaskins that would be in your employment agreement?
A: I agree, yes.
Q: Okay. And according to this that for consideration provided, that the physician agrees to refer all patients in need of hospitalization, diagnoses or treatments either on an inpatient or outpatient basis to

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

A: That's what it says.

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

A: Within the constraints that are within that statement.

Q: It provides you some flexibility?

A: Yes, it does.

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

A: That's correct.

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

A: It is.

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

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

Q: Sure. You'd have to have confidence in their medical capabilities.
A: Right. You do.
Q: And you'd never make a referral in the absence of that; would you?
A: No, I don't.
Q: All right. And specifically, though, the general requirement in the absence of an exception is for you to refer to Carolinas' own facilities, correct?
A: Yes.
Q: All right. And secondly to Carolinas' employed physicians, that is those physicians who are within the Carolina Physician Network, correct?
A: That's correct.
Q: And in the alternative, if you want to refer to a specialist, for example, a pediatric specialist who may not be within the CPN network, you can chose to do that. And typically the condition, is it not, is that they be CHS friendly?
A: You are encouraged to use CHS friendly, but that's no requirement.
Q: All right. And CHS friendly means that those physicians who receive the referrals agree to

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

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

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

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

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

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

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

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

A: No.

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

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

A: It is.

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

A: I do.

Q: Were you not aware of that?

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

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

A: Yes.
Q: And let's take a look at the Palmetto Pediatric's increase in referrals. From 2009 to 2012, that's increased from 55 to 122. So that's more than doubled, as well; hasn't it?
A: Yes.
Q: Okay. Now, let me change subjects for you, Dr. Alexander. I believe you testified in response to a question that I asked you during your deposition about the process of letters of support being provided for Carolinas. And you, yourself, submitted a letter of support for Carolinas', didn't you, during the DHEC review?
A: Our practice did.
Q: And you were one of several physicians who signed that letter?
A: I was.
Q: Okay. Now, you're not aware that Carolinas representatives were present in any reception area or waiting room of any practices to get a letter from patients or patient's families?
A: I was not aware or am not aware of that.
Q: And if they were doing that, you don't think it would be right; do you?
A: I would not want them doing that in my office.

Q: And in fact, you believed and testified in your deposition that would be unethical; didn't you?
A: I didn't think -- yes, I agree with that.
Q: Okay. Now Dr. Alexander, you said a moment ago you didn't admit patients into Pineville because they don't have the dedicated pediatrics unit, is that right? Did I understand you correctly?
A: That's one of the reasons.
Q: Okay. Is that the biggest reason?
A: It's the biggest reason, yes.
Q: Biggest reason, okay. And you had the benefit of Levine, which is a hospital full of staff trained in and dedicated to caring for children; isn't that right?
A: That's correct.
Q: And I suspect that's a factor, too?
A: It is.
Q: Now, if Carolinas proposed facility in Fort Mill is built, you're not aware that they will have a unit dedicated to children; are you?
A: I'm not aware of that.
Q: And with a 64-bed hospital, that wouldn't be realistic in your experience; would it?
A: I don't know what their decision making would

be on that.
Q: But if they didn't have a unit dedicated to children, your practice generally would be continuing to admit children, your patients into Levine; wouldn't it?
A: That's correct.
Q: Now, if CMC Fort Mill is built, don't you believe that patients of Piedmont would be shifted from Piedmont to Carolinas Fort Mill and to the Charlotte area hospitals, as well?
A: That would totally depend on the patient. I really can't say that for sure.
Q: Okay. Let me actually take you to your deposition and read our discussion related to that.
MR. ANDREWS: Your Honor, may I approach.
THE COURT: Yes.
Q: Dr. Alexander, if you would open that up for me, please.
A: Sure.
Q: And turn to Page 9.
MR. ANDREWS: Dan, if you would pull up Page 9 for us; end of Page 9 going on to Page 10.
Q: Dr. Alexander, starting on Page 9, Line 24, at the end of that page carrying over to Page 10,

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

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

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

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

A: I do believe they would.

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

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

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

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

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

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

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

A: I did.

Q: Okay. All right. Thank you.

MR. ANDREWS: No further questions.

THE COURT: Nothing further?

MR. ANDREWS: Nothing further, Your Honor.

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

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

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

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

A: I am.

Q: Okay. And what does it mean?

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

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

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

Q: Does Piedmont GYN accept Medicaid patients?

A: We do.

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

receive excellent care.

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

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

MR. ANDREWS: Thank you, Your Honor.

MR. REVELL - CROSS EXAMINATION BY MR. ANDREWS:

Q: Good afternoon, Dr. Revell.

A: Good afternoon.

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

A: I do.

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

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

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

consulted your peers in the development of that service?
A: I'm not.
Q: But you were aware that such an effort was being undertaken; weren't you?
A: I was.
Q: Okay. Good. Now, when the Women's Tower opened up, actually many of your patients began using it; didn't they?
A: They did.
Q: Okay. And then actually you felt it increased Piedmont's market share in OB-GYN services?
A: What year was that?
Q: 2004.
A: 2004, yes.
Q: Is that consistent with your memory?
A: (Indicates yes)
Q: Okay. And it was your impression, wasn't it, that a new facility drew a lot of attention back then, and that facility in particular, right?
A: Sure. New facilities always draw a lot of attention.
Q: And you testified to that degree just as you said now that a new facility, patients want to

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

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

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

A: Right.

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

A: I do.

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

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

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

network; wouldn't it?
A: It would be to refer to physicians that I have a relationship with.
Q: And those would be principally physicians in the network, correct?
A: Correct.
Q: Let me actually -- are you aware that Carolinas Physician Networks tracks your referrals and the referrals in your practice?
A: I am.
Q: All right.
MR. ANDREWS: Dan, let's pull up Demonstrative 141.
Q: Are you aware of the extent to which those referrals have increased over the last several years?
A: I am.
Q: It's over doubled the number; haven't they? It's the line right there.
A: Still a very small number.
Q: It is a small number. And it's actually among the smaller among the York County referrals from the CPN practices, correct?
A: It is.
Q: And largely the OB-GYN practice is relatively self-sufficient in terms of the needs for

referrals; would that be fair to say?
A: It would be.
Q: Now, when we talk about the Piedmont GYN-OB Practice, when you said at the onset you were employed by the practice and you're affiliated with Carolina Physician Network, let's make sure the record is clear on this. Who owns your medical office building?
A: A real estate development company.
Q: And who pays the rent to that real estate development company?
A: The practice.
Q: Who actually cuts the check?
A: Well, which office are you referring to? The one in Rock Hill?
Q: The Rock Hill Office, your Rock Hill.
A: In Rock Hill there is a partnership that actually -- a physician partnership that writes the check to the real estate company.
Q: Are you an owner of that physician practice -- that partnership?
A: I am.
Q: Okay. All right. And who employs your 60-plus staff members?
A: Piedmont GYN-OB works for Carolina Physician

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

Q: Who writes your paycheck?

A: Mike Tallwater signs it.

Q: And who is Mike Tallwater?

A: He is the CEO of Carolinas Healthcare System.

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

A: Correct, right.

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

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

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

A: I have.

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

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

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

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

A: It is.

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

A: It is, yes.

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

A: I don't know what that means.

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

A: Give me an example.

Q: A lab.

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

Q: Okay. All right.

A: Wait -- can I clarify?

Q: Sure, please.

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

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

A: I do.

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

A: There is a local imaging company.

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

A: It is not.

Q: And who owns it?

A: Charlotte Radiology.

Q: Okay.

A: At this time they're independent.

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

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

mean before we guess or answer questions about them.

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

THE COURT: Go ahead, sir.

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

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

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

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

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

A: I can't answer that, either.

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

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

medical director.

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

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

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

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

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

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

Q: And a --

A: -- that we have.

Q: What's the name of that practice?

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

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

A: They do.
Q: And are they located in Rock Hill or in Pineville?
A: They are located in Pineville.
Q: Okay. And so your patients served in Rock Hill go to Pineville and are treated at that facility by those physicians?
A: If they don't have a surgeon at Rock Hill.
Q: Right, as you testified about earlier, okay.
A: Right.
Q: All right. Now, are you familiar with the term CHS friendly physicians?
A: I am.
Q: And what does that mean to you?
A: Physicians that are not in a contractual relationship with Carolinas Healthcare System but who use Carolinas Healthcare System's hospitals or services.
Q: And they perform their procedures there. For example, in the case of surgeons?
A: Right.
Q: And there is a preference, is there not, for members who are employed by Carolinas in the absence of an expressed preference in patients to refer your work to physicians who are CHS

friendly and who would perform their services at Carolinas facilities.

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

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

A: Right.

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

A: I do.

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

A: Right.

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

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

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

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

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

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

A: That is correct.

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

A: True.

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

A: Correct.

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

A: Correct.

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

A: Correct.

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

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

Q: Okay. You would take issue with your Carolinas

Healthcare Systems data?
A: Well, we back up a clinic known as Palmetto Volunteers, which is an indigent clinic in Rock Hill. And part of establishing that clinic with Primary Care Physicians to establish that clinic, they came to a sub-specialist and said will you see these patients if we refer them to you? I said, sure, I'll see them. So when they come into our office, I see them. And then it is written off. I just write on there indigent care. So I don't know where that's captured, but I do see them.
Q: And occasionally they are referred to you?
A: Correct.
Q: There's no policy that your practice has adopted related to indigent care. That is sort of an ad hoc arrangement that you've worked out?
A: We do not have a policy except my word that we will see them.
Q: All right. Let me ask you, during the last decade, the women -- the maternity center at CMC-Pineville has become highly regarded and well known in Mecklenburg County; hasn't it?
A: It has.
Q: And it also has established a great reputation

in York County; isn't that true?

A: It has.

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

A: Correct.

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

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

A: I have not.

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

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

Union. You see about 17 percent?
A: Right.
Q: About 16 percent at Cleveland. Small percent, there must be a little OB-GYN Women's Health Service at Mercy, is that right?
A: They do not do obstetrics at Mercy.
Q: And Pineville is nearly doubled that of the other institutions at 33.2 percent; do you see that?
A: I do.
Q: And then University has a large women's health service too apparently; is that right, at 34.4 percent of its discharges?
A: I didn't know that, but they do have a large --
Q: But it's clear from this data, is it not, that women's health services line of business at Pineville is their leading service, is that right?
A: When Mercy built the hospital, I think in 1990, the maternity center was opened. And it was a vital part of that hospital and has always been an emphasis of CMC-Pineville with an expansion of that maternity center with the labor, delivery, recovery and postpartum all in one, which to my knowledge is the only in

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

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

A: Correct.

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

A: I'm not.

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

A: I'm not aware of that risk. What do you mean by risk?
Q: It's a wide open question; fair enough. What I mean by that is there's a possibility that if the hospital is busy that it may run out of delivery rooms. That these are special rooms that are provided for up to three days for a woman who is delivering a child; isn't that right?
A: That is correct. But it is no different than having a limited number of labor rooms and run out of labor rooms.
Q: Well, the labor rooms turn over a lot more quickly than the LDRP rooms do; don't they?
A: They do turn over, but that's why there are more LDRPs than there are labor rooms.
Q: And so it hasn't been a problem at Pineville?
A: It has not.
Q: And how many LDRP rooms do you have at Pineville?
A: 20 -- maybe 36.
Q: 25 to 30?
A: Maybe it's 36 now.
Q: A large number.
A: A large number.

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

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

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

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

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

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

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

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

A: They did.

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

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

A: Yes. Depending on traffic on 485.

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

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

Q: Let me ask you to open your deposition.

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

THE COURT: Yes, sir.

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

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

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

A: Sure.

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

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

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

A: "No."

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

A: "They would."

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

A: "I am not sure."

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

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

MS. BIGGERS: No questions, Your Honor.

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

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

A: Fine.

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

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

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

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

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

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

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

A: Yes, I did.
Q: Okay. If you will describe that, please, for us.
A: So at the time of our July 2011 submission, we looked at Claritas data, which is a generally well accepted population source by zip code, and we looked at the distribution of the population in York County within those three geographic regions. And you can see the little insert of the map of the regions, and this bar graph compares the distribution of the population within those three areas. And this is at the time of the filing, and the data that was available at that time, there was about 22 percent of the population in northern York County, a little over 27 percent of the population was in western York County, and over 50 percent, the bulk of the population, was in the greater Rock Hill area. And I'll just note that this data does include zip code 29707, which between the 2005/'06 review and the 2010/'11 review was split out from another zip code within the county. So the zip code definitions are a little bit different in this review than they were in the last review.

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

A: Yes, that's my understanding.

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

A: Yes, I have.

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

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

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

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

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

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

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

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

Q: And did you do that?

A: Yes, I did.

Q: Could you please tell us about that?

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

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

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

A: Yes.

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

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

the county than in the northern York County area.

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

A: Yes.

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

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

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

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

A: Yes, I did.

Q: And what were your results to this?

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

justification to have the beds in Rock Hill.

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

A: Yes, I did.

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

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

Q: And that's for the 100 beds?

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

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

A: Yes.

Q: Okay.

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

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

MS. ROBERTSON: Yes.

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

MS. ROBERTSON: We've got them.

MR. ANDREWS: Good.

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

MR. ANDREWS: Great.

MS. ROBERTSON: This is where we ---

MR. ANDREWS: Good. Thanks very much.

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

MR. ANDREWS: Okay.

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

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

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

A: Yes.

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

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

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

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

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

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

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

A: I do.

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

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

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

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

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

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

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

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

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

A: Yes, it was.

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

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

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

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

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

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

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

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

projections between various parts of their filings.

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

A: Yes, I did.

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

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

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

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

A: Yes.

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

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

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

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

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

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

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

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

A: Yes.

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

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

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

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

A: Yes.

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

for us.

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

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

A: Yes.

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

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

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

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

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

MS. PLATT - CROSS EXAMINATION BY MR. ANDREWS:

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

A: Good afternoon.

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

A: No.

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

A: No.

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

A: Not that I recall.

Q: Okay. You relied on communications from your office and for Carolinas through Tori Tibshrany, didn't you?

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

was through Tori.

Q: All right. Before she joined you, Ms. Tibshrany was one of the more senior staff members of the CON division, wasn't she?

A: I don't know comparatively how senior she was, but she did work there for a number of years.

Q: Okay. And she, in fact, was employed by the CON division during DHEC's first review of these applications, wasn't she?

A: I think if I'm recalling the timing correctly, yes.

Q: Okay. Now Ms. Tori -- Ms. Tibshrany's responsibilities with the office then principally were to review exemption requests and non-applicability determinations, wasn't that what her principal role was?

A: That's my recollection, yes.

Q: Okay. Now, and as far as you know, she didn't have any formal role in the review of the Fort Mill applications?

A: As far as I know, yes.

Q: You would have asked her about that before working on -- having her work on this case, wouldn't you?

A: I'm sure we would have discussed it if she had

been involved, yes.
Q: Okay. Now, during that period of time the CON office was a relatively small office; it just had five or six professional reviewers, isn't that right?
A: I don't remember the exact number, but it wasn't a large group.
Q: Sounds consistent with what you would have expected to have been there at the time?
A: Reasonably consistent, yes.
Q: Okay. All right. Now, during project review, it's your experience -- you've worked on many different CON applications in South Carolina, right?
A: Yes.
Q: And during project review, the entire CON division comes -- as a general rule, comes to the CON project review meetings, don't they?
A: Yes, from what I recall.
Q: Okay. And do you happen to remember whether, or know since you weren't present at the time, whether Ms. Tibshrany was involved in the project review of these first series of Fort Mill application?
A: I don't know whether she attended that meeting

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

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

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

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

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

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

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

Q: Other than the immediate reviewer and the reviewer's supervisor?
A: I guess if there's, you know, maybe a question related to the State Health Plan they might, you know, talk to Les Shelton, but you know, I don't -- I don't really know one way or another who else they might involve in a larger project.
Q: Okay. And it could have well been possible that Ms. Tibshrany would have been exposed to internal conversations about the review of that first round of applications; wouldn't that be fair to say?
A: It's possible. It did not sound to me in any of our discussions as though she had, you know, any significant role of any kind.
Q: How far before you were retained to work on this case had Ms. Tibshrany come to work for you?
A: Let's see if I can recall. I think Ms. Tibshrany started working with us in 2009, and then this remand project, you know, that we started working on was probably midway through 2010.
Q: And no doubt you had, you or others had

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

A: Could you ask that question again?

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

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

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

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

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

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

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

A: I know that Ms. Tibshrany worked with all of them, yes.

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

A: Yes.

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

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

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

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

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

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

Q: Okay.

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

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

A: Yes.

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

A: Yes.

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

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

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

you see that?
A: Yes.
Q: And the preface to those items states that issues presented in Piedmont's presentation that should be addressed in the cover letter, right?
A: Yes, that's what it says.
Q: And she's not making recommendations about these, but she's stating as a matter of fact what should be addressed in the follow up, correct?
A: I don't know that it's a fact. I think it's her opinion that these items she identified are things that she believes Carolinas should address in their cover letter in their next submission.
Q: Okay. And if you'll look down below, she states the same thing with regard to Novant's presentation, there's one item that she identifies that should be addressed in Carolinas' cover letter as well, correct? You see that?
A: It looks like it, yes.
Q: Okay. And then finally she concludes with directing -- stating that DHEC's follow-up question to CMC that should be further addressed

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

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

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

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

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

A: I believe these were her opinions.

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

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

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

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

A: Correct, I did not prepare those.

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

A: Yes.

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

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

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

A: Yes.
Q: Okay. Now, the need methodology presented here on pages 471 through 485 of this document was developed entirely by Mr. Murphy's planning unit, isn't that true?
A: Yes. I may have sort of proofread it and looked at it, but it was drafted by Mr. Murphy and his team.
Q: And they developed the assumptions on which these projections are based, correct?
A: Yes.
Q: Okay. Now let's take a look at the service area. Now, the primary service areas you've testified consist of the three zip codes in northern York and the three in Rock Hill, and someone else made the decision to identify that as a primary service area; you didn't do that, did you?
A: I did not.
Q: And then there was a determination concerning the percent of patients that would assume to be coming from the primary and the secondary service area, and again, you didn't make those assumptions or develop the rationale for the basis for allocating the distribution of

patients this way, did you?
A: I did not.
Q: All right. Now if you'll look at the bottom of the page, there was an assumption related to ten percent of the -- of the projected utilization from the service area would consist of patients in-migrating from outside of York County, correct?
A: Yes.
Q: Isn't that true? And again, Mr. Murphy's office developed those assumptions as well, true?
A: Yes.
Q: Okay. All right. Now, and they submitted those and you really weren't consulted on them one way or the other, that was just you were handed a conclusion and that was -- and you just accepted it and then applied it through your analysis that you've testified about, correct?
A: Again, I probably reviewed a draft, but they came up with those assumptions and then I reviewed those assumptions and their projections the same way I reviewed Piedmont's information that was submitted in their updates.

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

A: Yes.

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

A: Yes.

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

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

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

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

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

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

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

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

A: Yes.

Q: And there's no discussion within this document of the methodology for projecting outpatient services associated with CMC-Fort Mill, is there?
A: From what I recall, there's discussion of outpatient volumes other places in their submissions, not looking at this. This is the discussion of inpatient utilization.
Q: And so can you identify anywhere in the application specifically that identifies the methodology for the assumption about the outpatient projections?
A: Not without looking at the entire record, I can't recall.
Q: Okay. Well, that's a pretty important element since it's in 62 percent of the revenues that are proposed to be generated in year three would be based on outpatient services at CMC-Fort Mill, isn't it?
A: I don't remember the percentage.
Q: You would accept that it's over 60?
A: I'd have to look at it.
Q: You don't recall that?
A: A good portion of the revenue is certainly based on outpatient services. I don't know the

percentage.

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

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

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

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

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

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

A: Yes.

Q: Okay.

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

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

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

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

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

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

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

DHEC record, true?
A: For the most part. I mean ---
Q: Except to the degree you've updated it based on information you've testified about; would that be right?
A: I guess that would be generally correct. I mean, I've looked at some of Mr. Levitt's exhibits, demonstrative exhibits; I've looked at some of Mr. Sullivan's demonstrative exhibits to the extent they relate to what I presented and testified about on direct.
Q: Okay. All right.
MR. ANDREWS: Let's move to the next page, Dan, please.
Q: Look at paragraph eight and the inpatient projection methodology. Now, the key variables in this element of the assumption are the proposed shift of percentage of patients that have consis- -- been a part of Carolinas' market share in 2009, correct?
A: Well, this is the -- their assumptions with regard to shift by area, yes.
Q: All right. And they were proposing it to summarize it and review it quickly, 75 percent of the patients they've been serving

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

A: Yes.

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

A: Yes.

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

A: Correct. I did not choose these assumptions.

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

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

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

A: I don't know.

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

assumptions really drove the project utilization for CMC-Fort Mill, didn't they?

A: I mean, they were an important component, yes, because they ---

Q: They weren't the only -- excuse me for interrupting. Go ahead.

A: They weren't the only component, but they were a significant component in developing the projections.

Q: Okay. And if these market share assumptions would have been greater, the occupancy for CMC-Fort Mill would have been greater, correct?

A: That's true. I think it would be unrealistic for them to be much higher than that, but I guess that would mathematically be the case.

Q: And if same -- if the flip side's true, if they were less then the occupancy were less -- would be less, and again, unless patients were shifted from another provider such as Piedmont, true?

A: If they were less, the utilization would be less.

Q: Unless they were -- the balance was made up for by other existing providers, that'd be a common way to project utilization in new hospitals, some from the parent and some from existing

providers, true?

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

Q: Okay.

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

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

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

Q: And, Ms. Platt, isn't this the methodology, the element of the methodology in which Carolinas

calculated what the occupancy would be after applying the shift in the market share that you've just testified about?

A: Yes, they would have applied the shift to the projected market discharges and applied the other in-migration factor from outside the service area and calculated the percent occupancy.

Q: Okay. And you don't know the basis for their assumption that CMC-Fort Mill would be occupied at 67.5 percent by year three, do you?

A: I don't know that that percent occupancy was an assumption. I think it was the assumptions that set up the methodology that resulted in that occupancy rate.

Q: Really? So you believe that they chose out of the blue a shift of 75, 80, and 50 percent, and it just happened to land as an occupancy rate of 67.5?

A: I mean, the way the model calculates through is that those shifts are applied to the discharges in the area and it flows through the model and calculates 67.5 percent.

Q: And 65 percent is the percent that's in the State Health Plan that's identified as a trigger

for justifying the approval of additional beds, isn't it, for a hospital this size?

A: It's a factor that goes into the bed need methodology for calculating new beds.

Q: Well, without exceeding that level, the State Health Plan methodology won't recognize a need for new beds for that particular facility, will it?

A: That is a factor in the bed need methodology in the State Health Plan, yes.

Q: And again, unless the -- considering all the factors that affect it, unless the bed need exceeds 67.5 percent there -- a bed need would not be recognized in the State Health Plan, isn't that true?

A: That's generally the way the methodology works.

Q: Okay. All right. Now, if the occupancy assumption -- well, let me ask you to assume that -- well, let me just ask in your experience, have you not participated in the development of utilization projections where there's an assumption about the degree to which a new facility or any service would be occupied and then back into the assumptions for market share that would support that occupancy rate?

A: That's -- that -- generally the way that I develop models, I mean, usually I look at the market share and what's a reasonable level of market share to achieve or to shift and then see how that flows through to the resultant market -- or the resultant utilization.

Q: Okay. And if you ---

A: It's sort of backwards to pick the occupancy target and go backwards to market share.

Q: If you were then, though -- and you don't know whether Carolinas did this based on your testimony, assuming different market shares and they produced an occupancy rate that was too low or one that you didn't -- you believe was too high, then you might want to make changes to the assumptions about market share, wouldn't you?

A: I mean, I wasn't involved in developing that model.

Q: I know, I'm just asking you generally.

A: I mean, if you picked market share assumptions and they ran through and your occupancy rate was higher than you think you could support, then you could reduce the market share and it would be a more conservative model, but I don't

know what they did model-wise.

Q: Okay. Well, you said you reviewed and offered opinions on the '05 applications. Do you know why Carolinas changed its methodology and its market share assumptions from its '05 to its '10 application?

A: I don't know why they changed their methodology, I did not discuss that with them. They developed their methodology. I know that one of the things that changed between 2005 and 2010 was that Carolinas had a greater market share of the service area. So I'm sure that was factored into their projections.

Q: Okay. And in that regard, the inconsistencies that you pointed out between Piedmont's application from '05 to '10 also could have reflected changes in their market share. Did you account for that?

A: Yes. And I think that is quite likely the reason for the decline, but my point was that with a lower level of utilization, their projections didn't support 100 beds.

Q: All right. Well, we'll get to that in a little bit, but let's go back to the question of the occupancy rates. Now, assume for me if you

would that Carolinas' proposed occupancy rate of CMC-Fort Mill was not 67.5 percent but 80 percent.

A: Okay.

Q: That would require different assumptions, would it not, to support that degree of occupancy of the market share it would have throughout York County. True?

A: Yes, it would have to have higher market share if it were 80 percent occupied.

Q: All right. And an 80 percent occupancy reflects a pretty high demand for beds, doesn't it?

A: Yes.

Q: And, in fact, do you recall that the OB service at CMC-Fort Mill is proposed to be 82 percent?

A: I don't remember off the top of my head the varying occupancy levels by unit. I'd have to look at the record to remember exactly.

Q: You couldn't disagree with that though? You wouldn't?

A: I don't recall the precise percentage. I believe the occupancy of the OB unit was a little bit higher than the acute care beds in total, but I don't recall.

Q: Okay. Well, let's take a look at that. Let's see.

MR. ANDREWS: Turn to page 485 of this same document, please, Dan.

Q: Let's go down to the lower right-hand column. See percent occupancy for the OB beds at CMC-Fort Mill?

A: Yes.

Q: And what does that show in year three?

A: 81.9 percent.

Q: Okay. And, in fact, it's year one, right out of the box, 79.5 percent. Do you see that?

A: Yes.

Q: There's a high demand for those beds and -- isn't that true?

A: Those beds would be well utilized.

Q: In fact, they justify more beds, couldn't they?

A: Well, the occupancy standard is not broken down for OB beds and specific, it's for total acute care beds, but it's a pretty high level of utilization.

Q: All right. Now you also participated in the development of the application for the satellite hospital of Georgetown Memorial Hospital, which is Waccamaw Community Hospital, didn't you?

A: Yes.
Q: And, in fact, that hospital was operating at such a high level of utilization that it had to increase from 40 beds to over 124 in the first five years of its operation, isn't that true?
A: I don't remember the exact number of beds, but I do recall that there were multiple expansion projects. Some of those were for rehabilitation beds, not general acute care beds.
Q: And you also participated in the development of the application to create satellite facility for Seacoast Hospital, didn't you?
A: Yes, the -- you mean, Loris' satellite, Seacoast, yes.
Q: Right. And, in fact, the proposed utilization for that facility was over 80 percent, wasn't it? Do you remember that?
A: I don't recall off the top of my head. It was a relatively small facility.
Q: How many beds was it?
A: Again, I don't -- I don't recall. There's too many projects for me to remember every project that ---
Q: Fifty-bed hospital, sound about right?
A: Sounds about right.

Q: And the ...
MR. ANDREWS: Your Honor, if I may approach?
THE COURT: Yes.
Q: Ms. Platt, if you'd take a look at this and identify what it is on page 44.
A: It appears to be a ---
MR. ANDREWS: Excuse me just a minute, Ms. Platt.
THE COURT: Thank you.
Q: Now, identify what this is, please, Ms. Platt.
A: It appears to be sort of the summary table at the end of the presentation of utilization projections for Seacoast Medical Center.
Q: Okay. And this is a document you prepared? It's an excerpt from the 800-page, so forgive me, but I thought we all wouldn't want to carry that around. But this is an excerpt from the CON application you prepared to establish the 50-bed satellite hospital on behalf of Loris Healthcare System, is that right?
A: I did prepare this application. I did not prepare the financial projections. They were derived from a market feasibility study done by Dixon Hughes.
MR. ANDREWS: Okay. And, Your Honor, I'd like to move to introduce this as Piedmont's next

exhibit, which is 118. 118, Your Honor.

THE COURT: Ms. Robertson?

MS. ROBERTSON: Your Honor, I'm not sure we've ever seen this identified as an exhibit, nor do I believe we've ever had them produce this to us.

MR. ANDREWS: Both are true. It's a -- Your Honor, we're operating under the assumption, based on long history of doing this, that exhibits entered through cross-examination of another party do not have to be identified in advance; only those entered in our case in chief. I mean, it defeats the whole purpose of introducing a document which would be the basis for cross-examination to give advance notice of it. We haven't expected that to be applied with regard to our witnesses either. So that would be the basis for why it hasn't been previously identified. And we've laid a foundation for it. It's no surprise to the witness, it's her document.

MS. ROBERTSON: Your Honor, I guess the assumption we had was that the rules that require you to exchange exhibit lists and witness lists were, in fact, to exchange those that you expected to use in this case. We didn't get any notice of

this and, you know, he says it's no prejudice to the witness, but the party certainly has not had an opportunity to look at this or contemplate any questioning with respect to this witness.

MR. ANDREWS: Well, I also offer another grounds for it, Your Honor, without having to have to make a decision about that, it would be offered for impeachment purposes. In direct a few minutes ago, Ms. Platt stated that when I asked her about the assumptions related to 67.5 percent that much greater than that would be unrealistic, and this is a CON application she prepared where the proposal was in excess of 80 percent. That's the basis for the introduction of it. So I think at the very least it would qualify to go in as an exhibit for impeachment purposes.

MR. ROBERTSON: I'm not sure that was her testimony, Your Honor, so I'm not sure that this is appropriate impeachment. But obviously, we've not had a chance to look at it. I mean, if that is the purpose for which he's going to use it on impeachment, I'm just not sure that, in fact, her testimony was the way he just

characterized it.

THE COURT: Well, I'm going to allow it on the basis of an impeachment document. And I think you can establish whether that was her testimony or whether this, in fact -- you can rehabilitate the witness if that was not exactly what she said. I'm going to allow it for those purposes, for impeachment purposes.

(Petitioner's Exhibit Number 118 was admitted into evidence.)

Q: So, Ms. Platt, based on your experience both with the OB and in Waccamaw and here with Seacoast, it's not uncommon for units or entire satellite facilities that are small to operate at high levels of occupancies such as proposed here for 80 percent at Seacoast, isn't that right?

A: Certainly small hospitals can operate at a higher level and so can OB units. I just want to clarify, however, and I've been trying to recall more precisely the situation with Loris and why this application doesn't look like one that I prepared, this -- and it's coming back to me now, I did not prepare this application. It was prepared -- I'm not sure who prepared

it. I know that the utilization projections were prepared by Dixon Hughes and Associates, and my role in working with Loris was after the application was filed in preparation for project review and submission of additional information and then assisting them at hearing. So I did not prepare this document. And I also believe what I said earlier is that I thought the percent shift, projecting a much higher percentage of shift in market share than what was projected by Carolinas was not necessarily reasonable. I don't know that I said that a certain level of occupancy was too high or unrealistic.

Q: Okay. So you believe that for a small hospital an 80 percent occupancy level would be realistic; would you agree to that?

A: It could be achieved. I mean, it could also be less. It's not that -- I don't choose an end result of occupancy. I would pick what I thought were reasonable occupancy or market share percentages and see how that drives the utilization and the ultimate occupancy.

Q: Okay. Well, let me then ask you to assume that the occupancy at CMC-Fort Mill would be 80

percent in year three rather than 67 and a half percent. Do you recall that the average daily census for CMC-Fort Mill at 67 and a half percent was somewhere in the range of 83 patients a day?

A: And say that again.

Q: Let's look at page 41. You got a calculator?

A: I do.

Q: Well, it's calculated for you on page 481.

MR. ANDREWS: Dan, if we could go back to that.

Q: And the question was whether the ADC for a -- for CMC-Fort Mill as projected by year three to be 43 patients a day?

A: Well, I thought you just said 83 patients a day. Sorry.

Q: If I did I misspoke and thank you for correcting me. But 43 is what I meant to say. Is it 43?

MR. ANDREWS: Dan, actually we're going up two lines for average daily census above percent occupancy on page 481. Take it across. Thank you. There you go.

A: Right. The ADC is 43 a day, and that results in an occupancy rate of 67.5 percent.

Q: Okay. And I see you had the calculator there

for me. Run it if the 80 percent, the occupancy were 80 percent, what the average daily census would be?

A: 51.2.

Q: So about a difference of about eight patients per day?

A: Yes.

Q: All right. Now, if we assume the higher occupancy rate of 80 percent then there would need to be an increase in the assumptions about market share in order to achieve that rate of occupancy, right?

A: Yes.

Q: And as we talked about earlier, there basically are two options available to you to calculate that. You could increase the shift from Carolinas; that would be one way, right?

A: Yes.

Q: Another would you could have a given shift from Carolinas and then you could move patients, that is, shift them from existing providers; that would be the alternative, right?

A: Yes.

Q: Now, let's look at the model, Carolinas, to see what they did with respect to that question.

MR. ANDREWS: Dan, look at 478, if you would, and look at the left-hand column called market share and take that all the way down to the bottom. Highlight that, please, if you would. And the next to the last line in particular, call that out, where there -- actually, look at the last three lines and highlight those last three lines, please. Yes, that's it, that left-hand corner. And take that all the way across if you would please, Dan.

Q: And while he's doing that, Ms. Platt, there are really three issues identified there. First, is the shift in share to CMC-Fort Mill from Carolinas, correct?

A: Yes.

Q: Isn't that what that ---

A: The first piece is shift from, I guess that's 75 percent from the Fort Mill area to CMC-Fort Mill.

Q: Yeah. All right. And that 75 percent, as you testified earlier, of the Carolinas patient base, correct?

A: Yes.

Q: And if you take that across, then that is -- that 75 percent of 52.9 is 39.7, right?

A: Yes.
Q: And that's how the math works. And the assumption in Carolinas' model is that's the basis of their projection of who they'd serve; the patients they've served historically and they'll assume for the northern York County regions 75 percent of those?
A: Yes.
Q: Now, the next line in their model, it says gain and share by CMC-Fort Mill. Now, one has a line for shift in share from Carolinas. The next is gain in share, and if we look all the way across, that's zeroed out, right?
A: Yes.
Q: Now, the gain in share as opposed to the shift in share, the gain in share would mean, in this model, gain from other existing providers, wouldn't it?
A: Correct, gain from either Piedmont or the Novant System or other providers who are serving the market.
Q: Right, and that's zeroed out here. And then, now, are you aware that in developing this model that Carolinas had a value, a figure, a number that reflected the percent of which they

would gain from Piedmont or Novant to -- excuse me, Piedmont, the principal provider in York County? Do you know whether that number had been filled, that line had been filled in with something other than zero in prior runs of this model?

A: I don't know one way or the other. I was not involved in the development of the model.

Q: And in 2005, that -- there was that that blank -- you're familiar because you reviewed the application, right? It was filled in reflecting the extent of the market share that would be taken from Piedmont, true?

A: I don't recall what the figure is, but there was some assumption of shift. But at that point in time, as I stated earlier, that Carolinas had a different market share of the area, and they had a significant growth in the market share that occurred between 2005 and 2010.

Q: Now, in your experience, it's more unusual than not, isn't it, that there would be when a new hospital's built gain from, expected from existing providers?

A: That can occur, you know, when -- it depends on

the market situation. But in this instance, Carolinas has a high market share already of the area and they certainly can fill and meet their utilization productions without having to take any market share from other providers.

Q: Yeah, but this isn't a theoretical exercise; it's a real world exercise and -- isn't that true?

A: Well, it's a real world exercise, but all of us are having to present our theory of how we think this would all play out, so we can only do the best that we can do.

Q: Right. And about how not -- how it could play out but how it would play out, and you would agree with me, wouldn't you, that how it will play out or how it's projected to be likely to play out is the important question for the Court to consider?

A: Yes, but again, none of us know that. We're all presenting what we think is the most reasonable way for it to play out.

Q: Well, and in your experience, Ms. Platt, it would be highly unusual for a hospital to invest $80 million in the development of a new project and not expect any incremental growth in

market share, not to be getting any new business from that investment; wouldn't that be unusual?

A: Well, there will be new business because the market overall is growing, so there's going to more discharges for everyone that's serving that market. So to me, that helps to justify the expenditure. It also -- the other Carolinas facilities are full, and they need to be able to meet their sort of systemwide overall demand. So there's many reasons why this project makes sense as a system.

Q: Okay. And that growth would be to the extent they already have market share and are shifting it, that would be growth that would continue to affect their market share? They would continue to gain in Pineville, in CMC-Main, and other Charlotte area hospitals just as they've gained in the past, correct?

A: I didn't say that. What I said is that they would gain volume just by simple population growth even with a constant market share.

Q: And what my question was, there's no reason to believe they wouldn't continue to gain market share without a hospital in Fort Mill since

they've continued to in the past, isn't that true?

A: My understanding is the most recent numbers show that market share has sort of leveled off in terms of Piedmont's loss and Carolinas' gain.

Q: But we're moving back and forth between market share and growth, and even if the market share were flat, they would continue to grow and experience growth, which I thought was your point?

A: Everyone who's serving the market would continue to have growth based on population growth.

Q: Okay. All right. Let's go back to the steps in the utilization methodology.

MR. ANDREWS: And look at number nine, Dan, back on page four.

Q: Now the -- in developing the assumption about the ten percent in-migration, do you know whether Carolinas assumed that that ten percent would all be Carolinas patients or whether they would be patients who had been served by Piedmont in the past from Chester and Lancaster counties?

A: At least from what's presented here in the application, I don't know that they broke that

ten percent down. But I was not involved in developing that ten percent assumption.

Q: And you don't know then whether or not -- and you do recognize that Piedmont historically has served a substantial number of patients from Chester and Lancaster counties? You're aware of that, aren't you?

A: I don't know if I would use the term "substantial" because it implies a comparison. I'm not sure where you're comparing to, but yes, certainly patients do travel from those areas to Carolinas.

Q: All right. And the methodology isn't clear as to whether or not Carolinas is recognizing that they would take from that in-migration market share from Piedmont? That's not clear, is it?

A: I don't know that in this line item it's stated one way or another, but certainly, as you said, they are serving patients from those areas. So it would be closer for those, that same base of patients that is already choosing Carolinas to use a hospital developed by Carolinas in Fort Mill.

Q: All right. Now, let me draw your attention to the next paragraph. The one in paragraph on

page 474, paragraph ten. Now, this states, does it not, that Carolinas is assuming that inpatient discharges at CMC-Fort Mill will come from York County patients currently seeking care at Carolinas hospitals in North Carolina, right?

A: Yes.

Q: All right. Now, there's no reference to market share being constant. There's a specific reference to relying on patients who are currently then in 2010 when this information was presented to DHEC, currently seeking care at Carolinas hospitals, right?

A: Well, it implies they're a part of Carolinas' existing market share.

Q: Well, that would be the necessary implication, wouldn't it?

A: They're currently serving, yeah, they're currently choosing Carolinas.

Q: All right. And you didn't develop that assumption either, right?

A: No.

Q: Now, did you understand that to mean that there would be, let's -- first of all, let's take a look at the last sentence in paragraph ten. If you'll look at that. Carolinas does not

project any additional market share shift from Piedmont or from Presbyterian facilities; you see that?

A: Yes.

Q: Now, do you understand that to mean a position that Carolinas is expressing that they will not -- that CMC-Fort Mill will not cause a shift in patients from Piedmont, or that there would be no shift from Piedmont to any Carolinas facility?

A: Based on the information that's in the application, it's my understanding that there would be no shift from Piedmont to any Carolinas facility for those zip codes. The presentation is clear that the total Carolinas market share would be the same in the zip code service area.

Q: All right. Now, where I'm going to ask you to go is it's clear that's proposed with regard to the utilization of CMC-Fort Mill. Do you know whether in this inpatient projection that there was consideration given to the possibility or the likelihood that CMC-Fort Mill could generate a shift to patients from Piedmont to North Carolina based Carolinas facilities, that is, to

Pineville or to Main? Is there any recognition given to that potential?

A: I don't recall that in the methodology.

Q: What is your position concerning whether or not CMC-Fort Mill will cause further erosion of Piedmont's market share to Carolinas?

A: I don't believe it will. I think -- I think Carolinas will focus on shifting their own market share base to the closest facility, which would be Fort Mill Medical Center. And as I mentioned before, they have incentive to do that given that their other hospitals are well utilized.

Q: Yeah. Well, with regard to tertiary and complex services, CMC-Fort Mill is not going to provide that care, is it?

A: No.

Q: And there's every incentive in the world, isn't there, from a service delivery point of view for Carolinas to want to capture as much tertiary business and complex service business as they can for Piedmont in the North Carolina? There's no disincentive to do that from an occupancy or a workload point of view, is there?

A: Well, as I recall, CMC-Downtown, the main tertiary academic medical center, is very highly utilized. I don't -- I don't know that they could accommodate additional tertiary and high level patients.

Q: They've moved beds to Pineville and added two open heart surgery suites and cath labs there expressly for the purpose of expanding Carolinas' open heart surgery program, have they not?

A: Are you talking about CMC?

Q: Yeah.

A: You'd have to ask another witness. I'm not involved with all the decisions that are made for CMC-Main campus.

Q: I didn't ask about CMC-Main campus. Are you not aware that CMC-Pineville has had an expansion of 86 beds, over $175 million investment to establish and expand a heart program at CMC-Pineville?

A: The way you said it I thought you said CMC-Main, and I asked you CMC-Main and you agreed, so I'm sorry if I misunderstood.

Q: Well, I apologize if I've been confusing you.

A: I do understand that there's a bed expansion at

Pineville. I don't know the status of the open heart program. I've not been involved in writing CON applications for CMC-Pineville in recent years.

Q: And you would not -- so you would not have any reason to believe that Carolinas would not want to capture all the market share they could out of York County at either CMC-Pineville or Main for its open heart program?

A: Again, I reviewed the application based on what was presented to DHEC. It was not within the scope of what I was asked to do to go behind all the numbers and look at all the assumptions and how that played out within their system.

Q: Did you -- you certainly read the letters provided by the physicians who were concerned about the loss of tertiary services to North Carolina, didn't you?

A: I've read some of the letters. There were a huge number of letters submitted by all parties, and I did not review all of them.

Q: Did you review the letters from physicians expressing their concerns about the loss of tertiary and other complex services to Carolinas in North Carolina?

A: I'm aware that there were a few letters to that regard.
Q: A few? Did you ---
A: I don't know the number.
Q: Have you read them?
A: I think I just said that I have read a few letters, but given the thousands of letters that were submitted by all parties, I did not review all of the letters.
Q: I thought my question was clear that I was talking about physician letters, and if it wasn't, let me be clear. Did you read the physician letters in which there were concerns expressed about the loss of tertiary and complex services to Carolinas facilities in North Carolina?
A: I have read some letters to that effect. I don't know how many I've looked at, and I'm sure that I've not looked at the full scope of letters for all of that given how many there were.
Q: Did you give any weight to that possibility in your analysis of the application?
A: My focus was on analyzing the information that was put in the record in terms of the

reasonableness of the projections submitted by the applicants, the assumptions that went into their models. The support letters, my focus was on whether the applicants met the review criteria related to community support or community opposition.

Q: We'll deal more with that more in adverse impact, so I'll come back to that. But let me know move on, Ms. Platt, to your opinions related to financial projections in the application, the criteria to them. Again, you weren't involved in the development of the assumptions or projections for the financial components of the application, correct?

A: Correct.

Q: And the opinions you've offered related to the various components of the slides that you showed in your demonstratives, let me ask you about. Let's actually begin with the ones related to your project review -- your opinions related to expenses. Let's start with section seven of the regulations.

MR. ANDREWS: Dan, if you'll pull up in the regs Section Seven?

Q: You got that? Do you have a copy of the regs

with you, Ms. Platt?

A: I don't, but I have a reference to them within my demonstrative exhibits.

Q: Okay. Good. Now, read the reg, if you would. I just want to make sure we're on the same page.

A: It's criterion 7, projected expenses. Projections of construction costs, start up costs, operating cost, debt service, depreciation, manpower costs, etcetera, should be consistent with those experienced by similar facilities offering a similar level and scope of services with proper consideration given to such factors as inflation and cost of capital, etcetera.

Q: Now, this provides guidance to the Department and to the Court about how to evaluate the reasonableness of projected expenses, doesn't it?

A: Yes.

Q: And you didn't do what's stated here in the regulation, did you?

A: I believe I did.

Q: Well, let me ask you specifically. Did you develop an opinion that was based on whether or

not the projected costs in these various components was consistent with those costs experienced by similar facilities offering a similar level and scope of services? You didn't do that, did you?

A: I compared the two applications that we're here to discuss on the basis of construction costs, startup costs, operating costs, debt service, and a variety of these factors, and that was my understanding of the approach that DHEC takes when they are analyzing applications for new acute care hospitals.

Q: Well, you weren't here for Ms. Brandt's testimony, were you?

A: I was not.

Q: And Ms. Brandt recognized in her testimony that what this meant was a comparison with, as the language says, those costs experienced by similar facilities. Now, experienced by similar facilities would mean existing facilities, wouldn't it?

A: Yes, it would.

Q: And those costs that have been approved by the agency, correct? That the -- that is the basis for determining the level of reasonableness of

the projections, correct?

A: Well, I guess two things along those lines. That is not, in my experience, how DHEC has looked at the expenses. I have not seen them go and pull a variety of different acute care hospitals and necessarily compare those expenses. I think they look to the assumptions that were provided in the applications and the fact that, at least from Carolinas' standpoint, their assumptions were based on other community hospitals of a similar size.

Q: Well, let's take a look at what Mr. Levitt did and testified about it in his demonstrative.

MR. ANDREWS: Dan, if you'll pull up Demonstrative 151.

Q: Now, have you seen this demonstrative? Have these been among those that you've been looking at since the case was pending?

A: I have not focused on this exhibit.

Q: Well, you say you didn't focus on it. You've looked at it, but haven't studied it or gone back behind it; is that what you meant?

A: I haven't even studied it.

Q: Okay. Well, then let's go through it, and may ask you to accept that the applications approved

by the Department for satellite hospitals for new construction are reflected in this demonstrative. Do you see that?

A: I mean, that appears to be what's reflected, but I have not checked on any of these numbers or gone behind them, so, I can only state that that's what's on the page and that's what's represented.

Q: And based on what's on the page and what's represented here, you would agree with me, wouldn't you, that the construction costs for Carolinas Fort Mill and for the Fort Mill Medical Center are consistent with the construction costs that had been recognized and approved in four other CON applications since 2005; wouldn't that be true?

A: They're within the range of what's been presented here on this exhibit. Again, I haven't analyzed this information or gone behind the numbers. I'm also not sure how inflation was considered because, obviously, these projects were proposed at different periods of time.

Q: Exactly. And if you incorporate the inflationary value and the cost over time, then

Carolinas' and Fort Mill's would be even lower than many, if not all, of the satellite hospitals on a per bed basis that had been approved by the Department. Wouldn't that be true?

A: I don't know because I don't know if inflation was taken into consideration or not in these numbers. There's nothing that says anything about an inflation assumption, and I have not evaluated these numbers.

Q: Well, the sources identify the exhibits. The exhibits identify the applications that were submitted to the Department and approved by the Department and the numbers, let me represent to you, will tie directly to those without any inflationary investments, okay?

A: Okay.

Q: So given that, if you wanted to adjust them for inflation, as you raised the point, then it would mean that the 2005 application, those 2005 costs would all be higher, correct?

A: The older the year, the more inflation, yes.

Q: And so again, my question is based on if you wanted to adjust them for inflation to have current figures, then would you agree with me

that Carolinas and Fort Mill facilities would be among the lowest, if not the lowest, on a per bed basis of all the applications approved by the Department for satellite hospitals or community hospitals since 2005?

A: They would certainly be within the range.

Q: Okay.

A: I mean, this is also a different figure than I used for Fort Mill Medical Center for their total project costs. And I guess my point was we're making the assumption that both projects were within this range, then who is the better applicant to meet the criterion.

Q: Well, assuming there's a head to head value, but there again, there are variables in the design and variables in patient services that can affect the cost and do affect the cost of every proposed hospital, aren't there?

A: Yes.

Q: And many of those things improve the experience and improve the quality of services provided by the patients that may cost more, isn't that true?

A: They may or may not and they may be as simple as the land is more costly. It's in a more

expensive area to build.

Q: That's right. There are unlimited numbers of variables that could affect costs and there's nothing in the Department's regulations related to construction costs that suggest for a minute that the lower cost or the better cost and should -- and that applicant proposing lower costs should be considered the better applicant. These regulations in section seven don't say that at all, do they?

A: In my experience, it has been DHEC's practice when they are reviewing comparative applications to analyze the projects side by side and evaluate the more cost effective project.

Q: My question was what the regs require, not what your experience is with DHEC. You would agree with me that the regs say nothing about doing anything to determine reasonableness except looking at similar projects that have been approved and what their experience had been; isn't that true?

A: If you're analyzing one project alone, then you would certainly looked at that one project alone in relation to projected expenses, project costs, startup costs, operating costs. If

you're having to decide between two projects, then you need to go the additional step and compare them with respect to the criteria.

Q: Well, that's your opinion, but the regs don't say that, do they?

A: The regs tell you what to evaluate, but if you're in a situation and DHEC is supposed to decide between two projects, they have to come up with a way to comparatively decide between the two projects. So they look again to the language of the criteria and comparatively evaluate under the criteria.

Q: The project -- well, you would agree with me that the regs don't provide that guidance to the Department and, in fact, with regard to the construction costs and operating costs, the only guidance they provide is compare those costs to existing facilities whether there's a single applicant or competing applicants; you'd have to agree with that, wouldn't you?

A: The plain language of the criteria considers comparison to other existing projects, but again, if DHEC is in a position of having to decide between two, they need to have some direction as to how to compare them to

determine which is the better applicant. At the end of the day, they have to choose one better applicant and approve one applicant, and so they look again to the language of the criteria to shape that comparison. And that's been my experience in terms how they evaluate comparative projects.

Q: Absolutely. And they must do that for criteria in which there is significant meaningful difference, not ones in which they -- such as construction costs where there's three percent difference that there's an opinion that one favors the public, one application would favor the public more even when there is less costs supporting services to patients; isn't that true?

A: I'm not sure I understand your question.

Q: Well, then I'll move on for a minute. Okay. Now, you would agree with me that construction costs that are proposed can change, and for that reason, there should be limited weight that the Department puts on it, isn't that right?

A: I think the weight that they put on project costs falls within the ranking of the criteria. And so the financial section including project

expenses, number seven, I believe was ranked third, if I'm recalling correctly back at the beginning of my slides. And so that's where they evaluate and rank it.

Q: All right. Let's take a look at a document that you produced in discovery, Ms. Platt, 376 and 377.

A: Okay.

Q: Okay. Now, now this particular document ---

MR. ANDREWS: Dan, let's turn to page 181. I think we can do a better comparison here.

Q: You'd want to make sure as you're doing this refined analysis of the costs that you're dealing with apples to apples in the same way that you wanted to make adjustments to the depreciation schedule, correct?

A: Yes.

Q: And what we're looking at --

MR. ANDREWS: Dan, if you would, let's begin by looking at capital costs, it's about halfway down on the left-hand column and just the first line looking at construction. That's right. Let's just start with 2005 and then we'll move over and take a look at the comparisons that are offered with 2010.

MS. ROBERTSON: Mr. Andrews, could I just ask a question? You stated page, 181, is that a Bates 181 or ---

MR. ANDREWS: I'm sorry. No, excuse me. It's CHS Platt 181.

MS. ROBERTSON: Okay. Thank you.

Q: Okay. Now, Ms. Platt, if you can track with me here, if you would, for -- and this is a document, did you prepare this, or is this document from provided to you from Carolinas?

A: It was provided to me by Carolinas. They had entered the various cost parameters into a spreadsheet and shared that with me.

Q: Okay. All right. Let's look at the cost in 2005 for the 100-bed facility for what's identified as Tenet or Piedmont's application. Do you see that, 55,687,051?

A: Yes.

Q: And do you see the Carolinas cost that's identified?

A: Yes, 40,920.

Q: 40,920,000?

A: I'm sorry, 40,920,000.

Q: Okay. Now, what I want you to do is track to identify what those construction costs are for

under the 2010 update?
A: Well, I can't see --
Q: I know, we're going to pull them over for you.
A: I need to be able to see the headings.
Q: And I can ---
MS. ROBERTSON: I'm not sure, Mr. Andrews, this bottom line that y'all pulling up, I'm not sure that matches up under the columns. The second part is Tenet, but yet we're putting it under the Novant and Carolinas columns. It's a little misleading the way I think it's being pulled out and matched up.
MR. ANDREWS: Okay.
MR. ROBERTSON: Not intentionally I don't mean, but it seems to not fall ---
MR. ANDREWS: Mr. Bupp wouldn't do anything intentional like that to mislead anyone except me occasionally.
MS. ROBERTSON: No, but I don't think those columns match up.
MR. ANDREWS: All right. Fair enough.
Q: Okay. So we've got two figures, and if we can go forward. There we go, that's works, and look at the 2010 updates and see how they've changed. And I'll represent to you that there

are three different columns for Tenet that are proposed.

MR. ANDREWS: Let's start there, Dan, if we could in the first three columns or the next three columns under 2010.

Q: So there's Tenet October 3, and then Tenet December 3 and then Tenet December 3 with capped interest. Do you see that, Ms. Platt?

A: I do.

Q: Now, the first 75,631,867 figure, do you recall that that was Tenet's proposed cost at 2014 rates that were inflated?

A: Generally, yes.

Q: And then the next two columns show a reduction in that to 68,160,435. Do you see that?

A: Yes.

Q: Now, I'm going to ask you to assume that there were no material changes in Tenet's construction design or plans, that would simply -- the changes from 55 million to 68 million represented the cost of, increased cost of money and inflation over that time, okay?

A: Well ---

Q: And labor assumptions about that as well.

A: I believe there -- I mean, I can't say that

every single teeny aspect of the project was exactly the same. And I know that at some point in time I believe there was a cath lab included in the project. So I don't know that I could say it is purely just passage of time and inflation.

Q: Okay.

A: I don't know if there was a change ---

Q: I'm talking about increase.

A: What's that?

Q: You're right. All the parties pulled out a cath lab that was proposed, correct?

A: Right.

Q: So everyone had a cath lab and everyone proposed taking out the cath lab?

A: Right. The assumption you were asking me to make is that there were no design changes whatsoever and --

Q: I think I said material changes, but ...

A: To me that's a material change, but it's ...

Q: Okay. Differentiated from the other part. They all had a cath lab and they all proposed --

A: But you're asking me to compare the cost.

Q: Here's what I'm asking you. Let me just go

ahead and make it clear what I'm asking you. I wanted you to compare the increase in the costs from 55 million to 68 million, do the math on that. What's the percent increase?

A: From 55 to 75 or to 68?

Q: No, 55 to 68 after it was taken down.

A: I come up with a 22.4 percent increase.

Q: And that works out to about what per year if -- to the extent that it's driven by inflation?

A: I guess we're going from 2005 to 2010?

Q: Correct.

A: A little over four percent.

Q: All right. Now, do the same calculation with Carolinas, if you would. Look at their $40.2 million 2005 cost and compare that to their 2010 cost. What's their -- just for the record, what's their 2010 cost?

A: It looks like it's 43,447,925.

Q: Okay.

A: Well, I don't have the beginning number now.

Q: I'm sorry, it's 40,920,000.

A: 6.1 percent, 6.2 percent.

Q: Over five years. And what does that work out to be in annual inflation rate?

A: Roughly around one percent.

Q: All right. Now, you're not aware of any material changes other than the dropping of the cath lab in Carolinas proposed project from 2005 to 2010, are you?

A: I believe they may have changed the number of OB beds and perhaps the observation ER a little bit. I don't recall precisely, but there were a few little changes.

Q: Would it be consistent with your memory that they added two OB beds and they reduced their ICU by two beds? There was a net no change?

A: I know there was no change in total beds. That sounds -- I know that there was an increase in the OB beds.

Q: All right. Now, during the staff review you looked at Presbyterian's costs too, didn't you?

A: I did.

Q: And you were concerned, weren't you, that their construction costs dropped from 2005, 45 million to 2010 some 40 million? That concerned you, didn't it?

A: Yes. I believe that that was one of the things in my report, that their construction costs had dropped over the time period.

Q: And one of the reasons you believe that their

costs were understated is because the inflation during this period of time was significant, wasn't it, from 2005 to 2010, and you didn't believe they had reflected that, isn't that true?

A: There was inflation during that time and their cost actually went down.

Q: And you thought that inflation during that period from 2005 to 2010 was significant, didn't you?

A: I mean, it's significant in that it's something that needs to be considered. I's not ---

Q: I mean, that it was a lot of inflation during that period. Post Katrina period was a time where the cost of labor and the cost of supplies increased dramatically, isn't that true?

A: From what I recall, there was a pretty significant increase around the 2008 time period, but I don't know that that didn't settle back down after that by the time these projections were being made in 2010.

Q: But even if it settled back down, you agreed with me in your deposition that the range might be a little less than four to five percent

annually of inflation; isn't that right?

A: I don't recall what I said during my deposition, but certainly there would be some inflation over that time period.

Q: And it would be at a range of three or four percent; you think that would be reasonable?

A: You know, I guess it depends on the methods of the construction and the proposed materials, but there certainly would be some inflation. I don't -- at the time, I believe I looked at a means index for inflation rates when I was looking at the Presbyterian project, and that's in my report.

Q: Yeah, but it would be true that the inflation for that period of time from 2005 to 2010 would be substantially more, two to three times or greater than the one percent inflation rate that's reflected by Carolinas' proposed change from 2005 to 2010 for its construction cost, wouldn't it?

A: I believe the inflation rate would be higher than that one percent, to some degree, maybe a little higher. But I guess the other thing that is taken into consideration is any, you know, design changes, and we've talked about

several small design changes. So it's not just an inflationary factor; there's other factors as well.

Q: All right. Now ---

A: And that's why, I mean, I looked at it on a cost per square footage basis as well, not just a simple total cost figure.

Q: Okay. One of the important considerations related to how much weight DHEC gives and you gave in your opinion to the proposed construction cost and total project cost, is that they can change so much during the many years that it takes from initially filing an application to finally closing out a project, isn't that right?

A: Could you say that again.

Q: Sure. Isn't one of the reasons that the Department should be careful in assigning too much weight to a proposed total project cost, capital cost, is that those costs can change substantially from the time that an application's first filed to many years later when a project's closed out?

A: Well, they can change, but they can't change too much or else it becomes a problem with the

proposed -- you know, with the approved dollar amount of the project. I don't know that that's specifically the reason why that's ranked lower. Again, I mean, if they're approving a dollar amount it has a meaning; it's sort of a bright line that, you know, the Department expects you to come in with your costs close to that figure.

Q: Well, in fact, they give a complete blank check to applicants to increase their cost by ten percent, do they not, before any fine or any additional review is applied, right?

A: There is a ten percent threshold, that's true. But again, it's -- you know, they approve a dollar amount. Yes, I mean, I guess you could say that that dollar amount always has that ten percent cushion in it. But if it had no meaning and no one was expected to hold to it, then I don't know that it would be something that you wouldn't even have to put in the project. There's a dollar amount that's approved. Yes, it has a ten percent cushion, but I don't think that's why it's necessarily ranked where it's ranked.

Q: And even beyond the ten percent, there is just

a small fee that DHEC extracts, assuming that the costs beyond ten percent are not within the applicant's control, true?

A: There is a mechanism to that approval beyond that ten percent with a fine, yes.

Q: Okay. To avoid the fine even if the costs are demonstrated not to be within the applicant's control, true?

A: You can ask for yes, for a cost overrun if it's not within your control.

Q: Okay. Now, and cost overruns are not uncommon, are they?

A: I mean, they happen. I don't -- I couldn't tell you what percentage of the time it happens.

Q: Well, let's look at some of the cost overruns that Carolinas has experienced with its projects.

MR. ANDREWS: Dan, let me ask you to pull up S-CHS-518. All right. And if you'll call out line 24 on the first page of 518 for us. While you're at it, Dan, you might as -- well, no, let's just do one line at a time. That'll be a little easier.

Q: Ms. Platt, can you see that well enough?

That's it's a ---

A: I can see it, but I can't -- I guess I can't read it all the way across. I don't know what the columns are above it.

Q: Okay. Well, I'll represent to you that the first column after the numbering is the year in reviewed, the second is the ID number for the North Carolina CON, the next is the applicant's name, third is description -- or the fourth is a description of a project. The next to the last is the type of service involved, and the final one is the total cost. Okay?

A: Okay.

Q: And line 24 is CMC project, the addition of four floors to a surgical tower to include ICU beds, progressive care beds, and medical telemetry beds. You see that?

A: Yes.

Q: And $70 million cost, you see that?

A: Yes.

MR. ANDREWS: Dan, let's take that to the next page, if yo would, and pull out line 42.

Q: And if you -- the tie on this, Ms. Platt, if you'll look at the description. It says -- you with me ---

A: Yes.
Q: --- cost overrun on F, 673903?
A: Yes.
Q: And do you remember that being the number ---
A: I believe so, yes.
Q: --- for line 24? Okay. All right. And the cost overrun is how much?
A: It looks like it's 13.8 million.
Q: If you do the math on a $70 million project, what percent increase is that for the project?
A: 19.7.
Q: Okay. So a 19.7 percent increase on this particular project for Carolinas Medical Center, right?
A: Correct. I mean, but we don't know anything else about the reasons for that or anything else. I mean, I'm simply doing the math for you.
Q: Thank you. That's what you did in this project modifications, given data, did the math, right?
A: In many cases that's what I did, because that is the way DHEC would approach it and that was what I was asked to do, to compare side by side the information that was put in the DHEC record.

Q: Okay. Well, let's take a look at ---

MS. ROBERTSON: Your Honor, if I might object to comparisons with the North Carolina projects. I don't think Mr. Andrews has laid any foundation for this being a comparison that is, in fact, an equivalent comparison. I think North Carolina has different standards with respect to cost overruns versus South Carolina. We have a ten percent standard here, and I don't believe there's any limit in North Carolina. So to the extent he's asking her to compare cost overruns that operate under two different systems, I think he needs to lay a foundation with respect to that comparison with this witness.

MR. ANDREWS: Your Honor, the purpose of this line of testimony is simply to identify that cost overruns for capital projects are not uncommon and to demonstrate, in particular, Carolinas Medical Center's history in that regard.

THE COURT: Ms. Robertson, I think I -- and I've got that, Mr. Stuart. I mean, I understand your line of questioning with this witness was to talk about the fact that cost overruns are a factor and that there are -- and that at least

with Carolinas they've had that experience. Do we need to go further than that? Because I think the question that Ms. Robertson is getting into is that is the actual degree and the percentage and whether the numbers that are used in the North Carolina CON process, whether they factor in the same things that would be factored in in this state. I think your point is that there are ---

MR. ANDREWS: To demonstrate that.

THE COURT: --- and they -- beyond that ...

MS. ROBERTSON: Well, he's just looking at a history and giving a comparison of different standards, so I think it mischaracterizes kind of the comparison trying to be made. I mean, he's making his point just saying that there's a cost overrun, and I guess to the extent he's trying to compare a historical basis to reflect distinctions between cost overruns in South Carolina with his ten percent that we talked about versus North Carolina then some foundation needs to be laid to show how that comparison is working out.

MR. ANDREWS: I'm not going to explore this much further, Your Honor. If I may ask a question

related to it? Or I'll move on if you want me to.

THE COURT: Well, I don't -- I understand your objection, and I'm not getting from this particularly that there -- the degree of the percentage of the overrun, but just that there are periodically overruns. Is that the are you going to ask this Court to focus on the actual percent of the overrun and how much they overrun or just the fact that there are kind of overruns?

MR. ANDREWS: Well the fact they're overruns, they may be considerable, they're far greater than the three percent difference in the total project cost per bed that's proposed here.

THE COURT: And I think to the extent that we get into the actual percent then I think there would have to be some foundation laid as to how they measure overruns in North Carolina versus if there's -- and if it's different than the way overruns are measured in South Carolina. To the extent that we're going to actually focus on the degree of the overruns, I think you do need to lay more of a foundation. But if you're just going to ask the witness

questions about the fact is she aware that there are overruns in projects, I don't think you have to lay any foundation for that. I would overrule the objection to that extent, but to the extent that we're going to get into the actual degree of the overrun, the percentage of the overrun, then I think there would have to be some foundation laid if in fact there is a difference between the way they measure overruns in the state of North Carolina and the way measure it in South Carolina.

MR. ANDREWS: I would like the record to be clearer than it is presently on that, so I'll ask some questions related to that, if I may?

THE COURT: Thank you, Mr. Stuart.

Q: All right. Ms. Platt, you've got experience in North Carolina and South Carolina with CON applications, don't you?

A: Yes.

Q: In both states, the applications require the total project cost to be identified by the applicant, true?

A: Yes.

Q: And in both states, the Department, if it approves an application, approves the

application and identifies the total project cost that had been proposed by the applicant, true?

A: Yes.

Q: And in both states, there is a report expected at the conclusion of the project as to what the total project costs are, right?

A: Yes.

Q: And the math that's applied to the overrun would be identical in either state, true?

A: You mean in terms of how you would calculate a percent of an overrun?

Q: That's right.

A: You'd calculate a percent the same way.

Q: North Carolina and South Carolina math works the same way, right?

A: Yes.

Q: Now, the issue about the ten percent practice in South Carolina, does it -- is there anything comparable to that in North Carolina that you know of?

A: I'm actually not recalling off the top of my head exactly how the standard works in North Carolina. I haven't had a client in North Carolina that I have written a cost overrun

application for in quite some time.
Q: Now, DHEC's practice with regard to the ten percent waiver, that's not a regulation or standard that you know of, is it? Not a written standard?
A: The ten percent?
Q: Yes.
A: I think it's more of a practice.
Q: It's more of a practice.
A: Yes.
Q: And if a cost for an application, a cost for an actual project exceeds, let's say, 20 percent, there would be a -- that application, that CON would not be withdrawn, would not be revoked by the Department, would it? Have you ever seen that?
A: CON's have been revoked. I don't know, I mean, if you could ask for a cost overrun and explain why the costs have changed.
Q: You've never seen a revocation of a CON because of a cost overrun, have you?
A: Not that I can recall.
Q: And so, at worst, there would be a fine for the overage over ten percent, correct?
A: There is a mechanism for a fine over ten

percent.

Q: If the reason for the overrun is not explained to the satisfaction of the Department, true?

A: Correct.

Q: And you're not aware of whether there's anything comparable to North Carolina to address that factor at all, is that right?

A: I don't know that there's a fine process the same way, and again, I have not looked at those regs for North Carolina for a while because I have not had a client that's run into a cost overrun situation that required review in quite some time.

Q: Okay. Now, generally -- let's move on beyond that. Well, there's one other thing actually on that document that I wanted to draw to your attention and to the Court's.

MR. ANDREWS: Dan, let's look at the second page of that Exhibit 519. And call out line 38, if you would.

Q: Can you read that line, Ms. Platt, from Mercy Hospital?

A: Yes. It looks like there's an application for Mercy Hospital to relocate 11 acute care beds from CMC-Mercy to Pineville.

Q: And for a cost of about $43 million, right?
A: Yes.
Q: About $11 million a -- sorry, about four million dollars a bed?
A: Roughly.
Q: And let's look at line 52. And that was the 2005 application, and 2007 is the Mercy project to move more beds to Pineville, correct?
A: It says Mercy Hospital Inc., Renovation and Expansion Bed Tower 85 acute care beds relocated from CMC-Mercy to CMC, it looks like University, two ORs, two existing heart lung bypass machines and two cardiac cath labs.
Q: For a total project cost of 174 million?
A: Yes.
Q: Roughly two million dollars a bed?
A: Yes.
Q: Now, one of the reasons for your opinion, as I understand it, is that Carolinas demonstrates greater commitment to cost containment than Piedmont; has that been the basis for your testimony?
A: I think -- I'm not sure that's exactly the way that I put it, and when you're looking at the cost factors, Carolinas' project is less costly,

more cost effective when you measure it per bed and look at the expenses in a variety of ways.

Q: Let's take a look at how Carolinas presented to the Department its commitment to containing costs on page ---

MR. ANDREWS: Dan, let's pull up, if you would, S-CHS-456. It's in the record, Your Honor. I'm sorry I don't have the exact Bates record cite that I'm sure Mr. Bupp will provide to us. What's the Bates number on this, Dan? It's Joint A-CHS, there is it, 1.483. Dan, if you'd go back to the body. And let's take it down to the next, just below that, there you go, right there, the bullet points.

Q: You'll see in its submission to the Department, Ms. Platt, that Carolinas is identifying that from the period of time from 1996 through 2010 that it had 74 CON projects and expended $1.3 billion for those projects, $100 million a year on its capital costs. And if the Department's principal focus was to -- was the a desire to contain costs, this hardly can be offered as an example of Carolinas' commitment of doing that, spending over a billion dollars during this period of time. Would you agree with that?

A: No, I wouldn't agree with that. First of all, can you zoom it back out so I can look at it in context?
Q: Sure.
A: What this is being provided for is an example of how Carolinas is invested in the communities that they've served. And your, I guess your proposition that you would like me to agree to assumes that these projects weren't needed to meet the demands of the patients that they're serving in multiple facilities. It doesn't speak to cost containment at all. It speaks to investment in the communities that they're serving and meeting the needs of the patients that they're serving.
Q: Exactly. And every construction project is intended to be evaluated by DHEC primarily for the purpose of determining whether that project is meeting the needs of the residents who are the -- who are identified in those applications, correct?
A: That is one of the evaluations, yes.
Q: And that's one of the purposes of the program, isn't it?
A: Yes.

MR. ANDREWS: Your Honor, if we could take a short break?

THE COURT: Any objection?

MR. ROBERTSTON: None, Your Honor.

THE COURT: All right. Let's take 15 minutes.

(Break from 2:40 p.m. until 3:01 p.m.)

THE COURT: Back on the record.

MR. ANDREWS: Ready, Your Honor.

Q: All right. Ms. Platt, let me draw your attention now to issues related to operating costs.

A: Okay.

MR. ANDREWS: Again, let's -- Dan, pull up section seven of the regs. Seven.

Q: Ms. Platt, criterion 7 identifies operating costs, does it not? That is, startup costs, operating costs, manpower or staffing costs, all costs related to operations are identified in project criterion number 7 as being subject to the same direction that's provided that we just discussed in construction costs, correct?

A: Yes.

MR. ANDREWS: Now, let's take a look at, Dan, Demonstrative 152.

Q: Now, again, this is looking at the experience

of similar facilities at the community hospitals that have been identified by and approved by the Department as a -- as consistent with the language in project criterion 7, isn't it?

A: I guess these parameters are consistent, yes, with the language of criterion 7.

Q: All right. Because they relate to operating costs and staffing costs and other costs, but particularly focusing on those.

A: The indigent care line at the bottom probably is not related to this criterion.

Q: Thank you. All right. Now, with regard to the expenses, which would be lines three, four, and five that you addressed in your testimony, you would agree with me, wouldn't you, that the most important thing for the Department is understanding the assumptions on which these proposed costs are based in order for them to make determinations about their reasonableness, correct?

A: I believe they do need to look at the assumptions. I don't know that that's the most important thing. I think looking at the assumptions is important, understanding the presentation, understanding how it relates to

utilization, and then in this instance where you have more than one application, how the expense parameters compare I believe are all important things to look at.

Q: You want to look how the expense parameters compare and you also want to ensure that the proposed expenses are reasonable, do you not?

A: Yes.

Q: You wouldn't want to have an application that has a labor shortage, would you?

A: Correct.

Q: And you wouldn't want to have an application that doesn't -- that doesn't identify sufficient expenses that would be necessary to support patient care, true?

A: Correct.

Q: Now, here if we look at in this same period of time, Roper Berkeley was an application submitted by a company in which Carolinas has an ownership interest in and, in fact, manages, true?

A: They do have a relationship with Roper Berkeley.

Q: They manage it; do you know that?

A: Yes.

Q: All right. Now, the -- you'll see here that

their proposed total expenses in the Roper Berkeley application, which was for 50 beds, was nearly twice that of the proposed total expenses for CMC-Fort Mill?

A: The total expenses, yes. Yes.

Q: And that would be if you look at the difference in the total FTEs per adjusted occupied bed, you can see that Roper Berkeley project is substantially more, if not almost twice as great, you see that?

A: Yes, it is -- it is higher, but the -- you have to take into consideration all types of things in terms of, you know, what other services that are proposing to be offered within the 50 beds. In a smaller hospital like Roper Berkeley, you're going to have probably more support personnel that are spread over fewer base of patients. So there's all kinds of things that you need to take into consideration.

Q: The difference in those two and the Roper Berkeley satellite hospital and the -- was 50 beds and CMC-Fort Mill was 64, correct?

A: Yes.

Q: And if you compare the Palmetto Parkridge, that is -- that's the Palmetto Baptist Irmo area

proposal for a satellite hospital in 2006, you see how those total expenses per adjusted discharge compare?

A: Yes.

Q: And that's even without the value of inflation, they would be greater than those proposed by Piedmont, wouldn't they?

A: They are higher. Again, you'd have to take into consideration the mix of services that were being offered, you'd have to look at how those align bed category services.

Q: Now, a 76-bed facility was what Palmetto proposed. Smaller than that which Piedmont proposed. And so the analysis that you just applied to Roper Berkeley and Carolinas Fort Mill wouldn't explain the difference, would it?

A: It's -- as far as the FTEs? I mean, that's what I was looking at, the FTEs in terms of the size and the support personnel.

Q: Okay. Well, I was actually talking about the same line I'd asked you a question about earlier, so my apologies for not being clear. Total expenses per adjusted discharge appear to be comparable without considering of the value of inflation between 2006 and 2010; do you see

that?

A: Yes. They're similar, but again, you'd have to take into consideration the mix of service offerings.

Q: Well, for -- it's a community hospital, generally providing services as would be proposed to provide by both Fort Mill Medical Center and CMC-Fort Mill. Community services, non-tertiary services, no specialty services. You don't have any reason to believe the range of services in these proposed satellite hospitals are different, do you?

A: I mean, I haven't studied it side by side. You know, there could be a greater level of outpatient services. They could have a cath lab, for example. I mean, without knowing the background, I can't tell you that it's completely apples to apples.

Q: Well, let me ask you ---

A: It's similar. Yes, they're both community hospitals.

Q: And there's no -- assume there's no cath lab. And the whole purpose of applying the adjusted discharge is to eliminate any differences between outpatient and inpatient assumptions,

correct?
A: That does take it into consideration.
Q: Does it eliminate the difference?
A: It would sort of eliminate the percentage of inpatient/outpatient. It might not take into consideration all the mix of services. Again, I don't know what the mix of services in detail that were proposed by Palmetto Parkridge are, and I don't know how that exactly compares with Fort Mill Medical Center.
Q: But you would accept that for general purposes they're both proposed to be community satellite hospitals and the general range of services being the same?
A: I understand they are both to be community hospitals.
Q: And the FTEs per adjusted occupied bed are almost identical between Fort Mill and Palmetto, correct?
A: They are similar, yes.
Q: And the real outliers in this selection would be CMC-Fort Mill and Roper Berkeley, one being very low in comparison, 75 percent of those offered by Fort Mill and by Palmetto, and then Berkeley being a good bit higher, correct, than

that Roper facility?

A: Are you talking about just the expense lines?

Q: No, I'm sorry. I thought we were just talking about the FTEs per adjusted occupied bed?

A: Oh, okay. I thought you were just asking me about the expenses. In terms of FTEs per adjusted occupied bed, CMC-Fort Mill is the lowest. What I think you need to look at there then is to sort of go beneath that superficial level and look the level of clinical FTEs, which I did do for Fort Mill and CMC-Fort Mill to ensure that there's sufficient clinical staffing. And I think the area that brings CMC-Fort Mill down lower is that there's less overall sort of administrative and support personnel because a lot of sort of administrative level functions are handled at the system level for Carolinas.

Q: Well, and you don't know exactly to what degree Piedmont is making -- providing support personnel from its hospital in Rock Hill or either support personnel from its regional offices in Atlanta or in Dallas, do you?

A: Correct, I don't. But again, when you look at the breakdown of the clinical FTEs, the clinical

FTEs proposed by CMC-Fort Mill are actually, I believe, even slightly higher, at least comparable. So in terms of having sufficient staff for clinical services, I think that CMC-Fort Mill has that staff and where the efficiencies are being achieved are on the non-clinical side.

Q: But when comparing the Carolinas and the Fort Mill applications, you don't know when you're looking head to head at those what assumptions that either the Carolina planning staff made or that Piedmont made concerning their basis for projections about personnel costs, do you?

A: I know what is contained in the application, the staffing plan and the FTEs by position that's presented in the application, so I'm able to break out the clinical FTEs from the support FTEs and look at it that way. As far as exactly how every sort of support function is staffed, I don't have that level of detail for either project.

Q: And so while they're -- to the degree there are differences in assumptions about, for example, relying on contract personnel then instead of employees, you don't know which applicant may

have assumed what with regard to that distinction, do you?

A: Only to the extent that it's stated in the application, and again, to the extent that there's variation of use of contract personnel, I think that would show up in other areas of expenses. So, for example, if Carolinas had a lower level of FTEs because they were relying on more contract staffing, you should see that reflected in other areas of expenses. But what we're seeing is that Carolinas' expenses are lower overall when you look at all the categories. So I didn't find that to be a meaningful exercise.

Q: Well, the point is when you're relating to expenses, what you want to make sure is you're comparing some projections that are reasonable. Section 7 provides a methodology for doing that by looking at the experience of applicants the Department has already approved, correct?

A: Criterion 7 does indicate comparison to applications that are actually existing. I don't believe it says approved. So this exercise in comparing to other approvals is not exactly what is stated in criterion 7.

Q: Well, you didn't do that comparison for applications in hospitals that have been approved or for those that have been operating, did you?

A: I did not compare it to those that have been approved or those that have been operating. I evaluated the assumptions stated by both applicants. Carolinas in their assumptions made it clear that they were looking at other facilities that they operated as a basis for their expenses, and then I compare across the two projects, because at the end of the day DHEC has to pick one of the two projects, which is the reason for the comparison.

Q: Sure. And that doesn't mean though on each and every criterion that there is a meaningful difference; you would agree with that, wouldn't you?

A: There is varying degrees. I mean, some have a bigger difference and some have a smaller difference. If there were sort of negligible differences then I actually considered those to be equally met.

Q: All right. With regard to the assumptions about the extent to which the applicants are

relying on contract services or onsite services, again, you took the -- you didn't test out, you didn't look behind those numbers, isn't that true, to determine whether the assumptions were reasonable with regards to FTEs, for example?

A: As I said before, the approach that I took in my evaluation was to look at the information that was put in the record by each of the two parties so that I could compare them in the way that DHEC would compare them based on the information that DHEC has available to it. So if there's assumptions available, then I reviewed those assumptions for reasonability, but I did not have material to go behind there to evaluate sort of the information behind those assumptions.

Q: Okay. Well, let's create an opportunity that this Court has to do that in a way that DHEC did not.

MR. ANDREWS: Dan, let's pull up, if you would, a document. So let's begin with S-CHS-6874.

Q: Now, Ms. Platt, this is ---

MR. ANDREWS: Dan, highlight the first paragraph if you would.

Q: This is a document that's been the subject in

Mr. Stewart's testimony and has been produced in discovery. This is an email from Mr. Craig Stewart to Ms. Debra Godfrey. Now, and read the first paragraph into the record if you would.

A: "We pulled the staffing sheet together into a summary page; however, our staffing level seems high assuming 26 patients on an FTE per AOB bases. Right now, we're running 4.7 based on the staffing plan provided."

Q: Now, DHEC wouldn't have had any way to know that in September, we'll look at another email in a minute that is dated in September, that before the filing of Carolinas' application that they were looking at a staffing model that instead of putting it at 3.1 FTEs per adjusted occupied bed, they were looking at a 4.7? They wouldn't have had any way to know that, would they?

A: They would not have had any way to know that.

Q: And the record doesn't reflect this, does it?

A: No, it doesn't reflect this, but ---

Q: Did you know it?

A: No. Again, I mean, I looked at it the way DHEC did. DHEC does not have the ability to go back

behind either what Carolinas did and look at the various assumptions they tested, various assumptions that Piedmont may have tested. They look at the record as it's presented to them and evaluate based on the assumptions and the information in the record. And that's what I was asked to do, and that's what I did.

Q: Let's take a look at the closing paragraph.

MR. ANDREWS: Well, first of all, the last two bullet points, please, Dean. You see the bullet point related to six maintenance FTEs? I'm sorry, Dan, the last two bullet, the last two dark bullet points. Yes, there you go.

Q: Read the -- well, I'll read it for you, Ms. Platt. There are six maintenance FTEs, I thought this was done centrally and charged out through intercompany. You understand that to be a reference as to whether or not the cost related to those FTEs would be reflected within CMC-Fort Mill's staffing model or instead be part of the percentage that was paid for the intercompany expense?

A: It looks like it's a discussion of how to handle those FTEs.

Q: And as you've testified earlier, there would be

assumptions that can be made for both applicants about the extent of their reliance on their central office to provide support services for them, right?

A: Yes. Each of them had to make their assumptions in preparing their financial projections.

Q: And again, you don't know how they may have made them differently, do you?

A: I don't know how they made them differently. I'm sure Mr. Stewart spoke to his assumptions on his staffing plan. Again, I evaluated the information that was submitted to the record by both of the applicants and evaluated them based on what was in the record the same way DHEC would evaluate them.

MR. ANDREWS: Let's take a look at the, down in that last three bullet points, Dan.

Q: The first sub-point into other thoughts says imagining, are there any opportunities for cross-utilization of staff (ultrasound, diagnostic and CT). Each have someone 24/7 and there is an additional tech 24/7. Do you understand the gist of these are there any opportunities to cross-utilization, meaning is

there any way that we can get our staff per adjusted occupied bed assumption down lower than it is because we want to get a lower -- we want to submit a lower proposed staffing level to DHEC. Does that appear to be Mr. Stewart's goal, based on your review of this?

A: I think that's reading intent into it. It's obviously a discussion of how to plan an efficient staffing model, a realistic staffing model, and Mr. Stewart was obviously asking questions about that. I don't know about intent one way or another.

Q: Let's take a look the last bullet point of that series and see if this helps clarify it in your mind. Registration 20.4 FTEs, no idea on this one (just looking everywhere possible for opportunities). That would be opportunities to keep -- to lower the staffing proposal, wouldn't it, Ms. Platt?

A: To plan the most efficient staffing possible, yes.

Q: To get their proposal as low as they can for approval by the Department, right?

A: I mean, you'll have to ask Mr. Stewart what his intention was. I mean, maybe it's to ensure

that the project's feasible. It says what it says. I was not privy to this at the time I was doing my evaluation, and I was not asked to review this information.

Q: If you had known that the Department was turning over every leaf looking for every opportunity to drive down its proposed staffing model and its labor needs, would that have made a difference to you in your analysis?

A: You mean Carolinas? You said the Department.

Q: Yes, I'm sorry. Carolinas, thank you.

A: Not necessarily because, for all I know, Piedmont was going through the very same exercise on their end trying to ensure that they had the most reasonable staffing projected in their application. And they had really even more reason to do so because their project has a far narrower net income at the end of the day. They have a loss for the first two years of operation and a small profit in the third year. so they had even more incentive to evaluate their staffing, and they very well may have gone through the same exercise.

Q: If their intent was to produce a competitive -- the most competitive application instead of the

most realistic one; wouldn't that be fair?

A: Not necessarily. I mean, I'm sure both parties spent time trying the prepare the best application that they could.

Q: And by best, don't you believe that the goal should be to present the most realistic application that they could?

A: Yes.

Q: And in that regard, again, it would be useful for any reviewer then to determine the reasonableness of the proposals. And so let's take a look at the assumption about that Carolinas made that it would have 3.1 FTEs per adjusted occupied bed and Piedmont's assumption of 4.0. Have you looked at any -- we've taken a look at two other satellite hospital proposals that had enough detail so that that number could be extracted and they both were either comparable to Piedmont's or much greater, correct, that is, Palmetto Parkridge and Roper Berkeley, true?

A: There were multiple applications in that comparison, the two -- you're pulling two out of there, yes.

Q: Have you looked at any other to determine what

their adjusted occupied beds FTE rate is?

A: I did not. I compared the two applications before DHEC in this matter.

Q: And have you looked at any databases to determine what is the norm for FTEs per adjusted occupied bed?

A: I have not looked at any other sources. I evaluated the information that was presented to DHEC.

Q: Well, let me ask you to do that. Are you familiar with Healthcare Management Partners?

A: Generally.

Q: Okay.

MR. ANDREWS: Dan, let's pull up Demonstrative 286.1.

Q: And look at the cover page if you would, Ms. Platt. This is a report dated October 2010, and let's turn to page three in this exhibit?

MS. ROBERTSON: Your Honor, I would object. I know Mr. Andrews has stated this is a demonstrative, but this is another document or exhibit that I don't believe we've ever been provided or that was provided in discovery. On that basis, I'd object.

MR. ANDREWS: It's offered for impeachment purposes,

your Honor. Ms. Platt has testified concerning the reasonableness of Carolinas' projection of 3.1 FTEs per adjusted occupied bed. This is a report reflecting national experience among varying different hospital groups on that same issue, and I want to offer it for purposes of impeachment.

MS. ROBERTSON: Your Honor, I would just like to point out Rule 27 in the Administrative Law Court rules. It speaks very clear to the exchange of lists of exhibits and witnesses, and it clearly states that you exchange a final list of all exhibits expected to be offered at the hearing. It goes on to say that any exhibit not exchanged prior to the hearing may be excluded from the admission into evidence. I think again we're looking at a back end way to put up demonstratives that are not in the record. This witness has been a witness in this case for some time. They've deposed her. They've known her opinions relative to this comparative analysis, and I'm not sure these exhibits that we are now seeing are really for impeachment purposes.

THE COURT: Mr. Stuart, you don't intend to offer

this into evidence?

MR. ANDREWS: No, sir.

THE COURT: You're just going to ask her if she's aware of this and what it says?

MR. ANDREWS: That's right.

THE COURT: I'm going to allow you to -- I'm going to allow Mr. Stuart to do that. Objection -- for purposes of -- limited purposes of impeachment, it's not going to be admitted into evidence, you can ask her if she's aware of this and what it says and if she is she is and if she's not, she can certainly testify to that.

Q: All right. Ms. Platt, just so we can make sure that what I ask you about, we have an understanding that's consistent with your understanding.

MR. ANDREWS: Dan, turn to page 286.5. This is an executive summary of the hospital performance metrics, and the fourth row, Dan, if you -- that's it. Highlight that.

Q: This is definition of FTEs per adjusted occupied bed. Do you see that, Ms. Platt?

A: Yes.

Q: And it states that it measures the number of

FTEs employees used for each occupied bed similar to the previous ratio a higher percentage compared to its peers indicates that a hospital uses more labor to treat its patients. Is that consistent with your understanding of the definition of FTE per adjusted occupied bed?

A: Yes.

MR. ANDREWS: And Dan, let me ask you to turn to page 13 in this exhibit.

Q: And you'll see here, Ms. Platt, that there are six years of data provided from 2004 to 2009 that reflect FTEs per adjusted occupied bed looking at full group of hospitals or then by hospital category. That includes investor owned such as CMC-Fort Mill and includes state or local government owned such as Carolinas. Do you see that?

A: Yes.

Q: And look -- the averages describe what you see in all overall for all the hospitals? What's the range of average FTEs per adjusted occupied bed?

A: For what year?

Q: For all across the spectrum, from -- what's the

range for this six year period?
A: For all it ranges from it looks like a high of 4.86 to a low of 4.77.
Q: And for investor owned facilities, what's the range?
A: 4.4 looks like it's the highest and 4.28 the lowest.
Q: And for state and local government-owned facilities?
A: Looks like 4.2 is the lowest, or sorry, 4.92 is the lowest and 4.99 is the highest.
Q: Now, and are these as averages for these facilities and for all hospitals generally consistent with your experience in all the years you've worked in identifying FTEs per adjusted occupied bed?
A: I wouldn't say they look unusual but remember these are averages, so you're certainly going to have facilities that are at the high end of the range and facilities that are at the low end of the range, and it doesn't mean they can't operate within those parameters and the whole point is to measure efficiency. This is an average.
Q: Let's take a look then at ---

MS. ROBERTSON: Your Honor, if I could, I'm sorry to interrupt again, but because Mr. Andrews is reading from this, if we're going to do it under the learned treatise exception to hearsay, the witness can be asked about it, I assume that's what he's doing it for, if it's a reliable authority and established as a reliable authority. And I don't think he's established that and maybe it is, but if he can lay that foundation with this witness, I'd appreciate it.

THE COURT: Mr. Andrews.

MR. ANDREWS: Well, Your Honor, if that were coming under the hearsay exception that would be the way I'd do it, but I'm using it for impeachment, it's not necessary. I don't mind making that effort but that doesn't limit the utilization for purposes of impeachment.

MS. ROBERTSON: Well, the rule does speak to the extent which it's called to the attention of an expert witness upon cross-examination, not just upon direct. So otherwise, it is hearsay, but I think still the foundation and whether this is a reliable source that we're even referring to needs to be laid for foundation to ask her questions about this document.

THE COURT: And Mr. Stuart, we do seem to be once again reading this document into the record, which is a concern. With some previous demonstrative exhibits it sort of just gets -- or we basically read en toto into the record. My understanding of your intention here was for you to go to certain sections of this particular exhibit and ask her if she was familiar with this, which is apparently some kind of a report, and ask her if this is consistent with her experience, I think was the question you went with regard to the FTE issue and whether she was familiar with that and if that was consistent with her experience. But it seems like you're reading the document that is not admitted as an exhibit; we're reading that document into evidence and making it an exhibit. Is there any way you can focus your questions without reading the entire document into the record of the entire section?

MR. ANDREWS: I will make a better attempt, Your Honor.

THE COURT: Yes, sir. Thank you.

MS. ROBERTSON: I'll try not to interrupt again, but can we please get a copy of this demonstrative.

I don't believe we've been provided a copy previously. Thank you.

MR. ANDREWS: We certainly will. Your Honor, I'm sorry. If you'll just give us a moment.

THE COURT: No, that's fine. That's fine.

MS. ROBERTSON: Thank you.

Q: All right. Ms. Platt, let me draw your attention to 286.6.

MR. ANDREWS: Dan, if you'll --

Q: I'll give you a hard copy of that, as well. Might be a little easier to review.

MR. ANDREWS: Your Honor, if I may approach?

THE COURT: Yes.

Q: I'm sorry, I wanted to take you to a different page. Yeah, it's page nine of the exhibit. Now, Ms. Platt, you've just said that what you were identifying earlier was the ranges that were averages. This is the page that identifies the peer quartiles.

A: Yes.

Q: Do you see any quartile that's as low as the 3.1 FTEs per adjusted occupied bed on page nine?

A: The lowest quartile that I see is 3.21 in the investor-owned category, which is an average of

the facilities in that first quartile. So it's, again, an average of a smaller portion of the facilities, but it's an average. But I guess the other thing is that this breaks down these facilities into various types in terms of all investor owned not for profit, you know, so ownership, and it's got a couple of categories that might distinguish some types of hospitals with children's and teaching hospitals. It doesn't have anything to do with bed size. It doesn't have anything to do with whether the facilities are, you know, part of a larger local system that may support the facility. So, I mean, these are averages, and that's all they are. So I don't know that they're really relevant to the comparison that I made, which is of the two applicants that are before the court today.

Q: So your point is that there are always many variables that affect the FTE per adjusted occupied bed analysis, aren't there?

A: There are variables, and again, the purpose of my analysis was to compare the information and the assumptions that were provided by each of the applicants, which is the information that

was before DHEC and to compare them for the purposes of determining which was the better applicant.

Q: And you didn't do anything to determine whether 3.1 as an assumption for CMC was reasonable, did you?

A: I did. I looked at the assumptions. I also broke it down into FTEs clinical versus not clinical, which I felt was an important consideration. And when I did that, there were plenty of clinical FTEs in the Carolinas application, and I believe there were more clinical FTEs per adjusted occupied bed than the Piedmont facility. I mean, again, I compared what I was asked to compare and came up with the results that I came up with.

Q: Okay. Based on what's in the record, not based on what the internal assumptions were that were not conveyed to the Department, such as the memos from Mr. Stewart that we just reviewed, correct?

A: Correct. The information that was in the record, that was what I was asked to review.

Q: And that's what your testimony is limited to here today?

A: Yes. I was asked to testify about the information in my report that was a reflection of the comparative projects that were before DHEC.

Q: Okay. Let's move on to the area of charges under 6.a. You've offered an assumption here that again, Piedmont, excuse me, Carolinas better meets this criterion than Piedmont's application. With regard to charges, you would agree me that they have little or no impact on net revenue, correct?

A: They have a little bit of impact to the extent that a commercial payor may negotiate a discount from charges, but most payors are not necessarily affected by charges.

Q: And you've never seen a CON decision based on charges alone, have you?

A: No.

Q: And 6.A like seven and like 6.B, also charges the Department with the review to determine consistency with other existing providers, doesn't it?

A: Yes.

Q: And you didn't do that, did you?

A: I did not. Again, I compared the two projects.

I reviewed the assumptions as the basis for the development of the charges and of the net revenue. And then again, at the end of the day, DHEC has to decide between the two applicants and decide which best meets the comparable charges criterion, and that's what I did. That's what I evaluated.

MR. ANDREWS: Let's take a look for determining consistency with others at Demonstrative 15 please, Dan. 1-5, not -- well, that's 1-5. Your Honor, I'm off in what I need here, so I'll just move on to the next step. Dan, actually how about pull up S-CHS-4082.

Q: Now, in terms of your head-to-head comparison, the -- you analyzed and made a determination that Carolinas' proposed charges were lower than Piedmont's, didn't you?

A: Yes, based on adjusted occupied bed.

Q: And that was affected also by -- I mean, affected fundamentally by their proposed charges, right, for each party? I mean, that's what drives that analysis, correct?

A: The charges create the gross revenue and it then it, right, flows through to the calculation of gross revenue per adjusted occupied bed.

Q: Okay. And one of the important variables in the projections for both parties were their annual -- their assumptions about annual inflation adjustments, true?
A: Inflation would have a function in terms of charges.
Q: And do you remember what those inflationary adjustments were for each party?
A: I don't remember off the top of my head.
Q: Would three percent for Carolinas and four percent Piedmont be consistent with your memory?
A: Those sound like they're within the range of what I recall. They don't sound out of line.
Q: And if you made adjustments so they were based on the same assumptions, such as you made for the depreciation schedule, so you can do an apples to apples comparison, it would affect the analysis, wouldn't it?
A: It would change the math, but I mean, I can't adjust every assumption that both parties make, otherwise it's not a meaningful comparison. The depreciation is a completely different adjustment, because if you -- if you look at the depreciation expense, you have Piedmont with a much more expensive project, millions and

millions of dollars more. But because of their depreciation assumption, their -- the term of the depreciation they assumed, the depreciation expense that flows through into the financial model is roughly the same as Carolinas Medical Center. So they've chosen a very different method of applying depreciation. So I simply used the same term to look at both projects, which to me is a more accurate reflection of the two projects and reflects the fact that Piedmont's project is much more capital intensive. It's a much more costly project. So when the depreciation translates into a depreciation expense, it needs to be reflective of the project costs.

Q: And it's a much more expensive project because it has 36 beds that it intends to provide and has the capability of future growth to meet the needs of York County residents that the Carolinas facility does not have, that's the reason that it's so much more expensive, isn't it?

A: The reason it's more expensive is because it's a larger facility.

Q: Right. Okay. All right. Now, with regard to

the assumptions, you would want to satisfy yourself that the three percent assumption concerning increase charges over time for Carolinas was reasonable, wouldn't you?

A: I didn't look at Carolinas' data, but three percent is very consistent with what I've been using in my financial models over the last several years. I found it very reasonable.

Q: Let's take a look at this document and determine what their actual experience is in the years prior to this application.

MR. ANDREWS: Dan, if you'll look at the last row of that category. It's CMI adjusted charges percent change of them.

Q: And if you'll look at Pineville and University. And look at that period from particularly from 2006 to 2010, last four years.

A: Okay.

Q: Now, during this period of time, if you look at each year, Ms. Platt, that there was -- in 2006 there was a 6.2 percent growth, do you see that, in charges for Pineville and a 10.5 percent for University?

A: Yes.

Q: And taking it to the next year, there was an

eight percent reduction for Pineville, an eight percent growth for University, right?

A: Yes.

Q: '08 increases of 6.2 for Pineville and 7.9 percent for University, correct?

A: I mean, the calculations are there on the page. I didn't do the analysis.

Q: Fair enough.

A: I agree that the numbers are those numbers on the page.

Q: All right. And it carries on out for increases for '09 and '10 for Pineville of over eight percent and for University of 7.3 and then four percent. Do you see that?

A: Yes.

Q: All right. And if you look at ---

MR. ANDREWS: Dan, let's take it up to look at the compounded annual growth rate of those two facilities for the period of time reflected on this document, from 2000 through 2010. We're going the row up, Dan, looking at Pineville and University and the CMI adjusted charges per discharge. That's right.

Q: And if you look at that, the compounded annual growth rate for those two facilities for that

decade, it's six percent a year for Pineville and 9.2 for University; you see that?

A: Yes.

Q: All of those are two to three times, those are two to three times greater than the assumptions that Carolinas presented for Fort Mill concerning annual increase in charges, aren't they?

A: They are higher. I don't -- I don't know that that's necessarily relevant because this is a forward-looking projection and that doesn't necessarily mean that going forward charges are going to increase at the rate that they have in the past. In fact, recently I've been doing projections for people where they've held their charges completely constant because they're anticipating declines in reimbursement, so why increase your charges. So, I mean, they are what they are in the past. The numbers are on the page, but that doesn't necessarily mean that that's the level that should be used going forward.

Q: There was nothing produced in the application or in the record, was there, explaining the reasonableness for Carolinas' projections other

than -- well, at all, was there? It was just this is our assumption, true?

A: I believe that was the statement that was made, and I think a similar statement was made in the Piedmont application. They both stated what their assumptions were. I don't know that either of them provided information as to why that was their assumption. I found both the three percent and the four percent to be reasonable based on my experience developing models for similar healthcare facilities.

Q: But the difference in the three and four percent assumption rates, if you held them constant, treated them the same, the differential then charges between CMC-Fort Mill and Fort Mill Medical Center would be eliminated, wouldn't it?

A: I have not done that math to know if it would be eliminated. It would certainly come closer together.

Q: All right. Now, you also testified that you believe that Carolinas best met project review criterion 4(a) related to letters of support?

A: Yes.

Q: And I believe you said that you believe that

Carolinas had, in fact, more letters as substantially greater volume and that was one of the reasons, in addition to the opposition, that you gave that criterion to Carolinas, right?

A: I believe at the time it was my understanding that they had more letters. Now, my report was prepared in June and submitted in early July, so I don't know that my report took into consideration letters that may have come in after that. But at that time, it was my understanding that Carolinas had more letters.

Q: Well, you testified today that they should be recognized as better meeting that criterion, didn't you?

A: Well, a combination of letters, positive letters and also the negative letters.

Q: All right. Well, let's ---

A: The negative letters were the most critical factor in my mind for both 13(a) and (b).

Q: All right. Well, let's take a look at the volume since you testified about Carolinas having more volume. Let's determine whether, based on Ms. Brandt's letter, you regard that difference as material.

MR. ANDREWS: Dan, pull up if you would, Ms.

Brandt's letter, Joint Exhibit A-1306 and let's go to page nine of ten in her CON analysis, please. All right. Now, and Dan, if you'll look to paragraph 4(a) and highlight the first three lines.

Q: Now, the Department determined that the total letters for Presbyterian were over 10,000 and that for Carolinas, 5,753, and Piedmont more than 5,400, correct?

A: That's what the agency determined or DHEC determined.

Q: And she found that all applicants equally met this criterion for acceptability, didn't she?

A: She did.

Q: Now, quite a number of times, Ms. Platt, you've testified today that you believe the Department interpreted a regulation or applied a regulation in a particular way and used that as a basis for the action you took, didn't you? Do you remember testifying to that effect?

A: Yes, and my understanding of how they've looked at criterion in the past.

Q: And in this regard, the Department did not find any material differences in the letters of support offered for any parties, including

Presbyterian, who had almost two to one for what was submitted for the other applicants, correct?

A: They did not find, I guess, a significant variance in that they found all parties met this criterion. What I'm not sure that the agency took into consideration is that some of the letters that were counted as support letters and where Carolinas' letters actually contained opposition statements or negative statements about -- about Piedmont. And I don't know that she took that into consideration. I don't know how many of the letters she was able to look at, and I don't know if she evaluated Carolinas' letters for the purposes of opposition to Piedmont.

Q: Well, first of all, let's -- 4(a) doesn't say anything about opposition; 4(a) talks about letters of support, correct?

A: Correct, but they sort of go hand in hand ---

Q: Well, I'm sorry for interrupting, but (b) addresses opposition, doesn't it?

A: Correct, but there's also different kinds of opposition. There's opposition where a party formally enters into a review process as an

opponent, and then there's letters that are in opposition, and these letters came in the form of letters of support for Carolinas but really also against Piedmont. They were in the volume of letters of support that came into the agency. It was not a formal party submitting their name as an opponent to the project.

Q: I think you've said, have you not, Ms. Platt, that anyone can develop a marketing campaign and influence people to submit letters?

A: I may have said that.

Q: Would that sound like something you'd want -- a statement you'd want to own?

A: Certainly. I mean, people can do that.

Q: And all applicants did that here, didn't they?

A: All applicants sought community support from the York County area.

Q: And let's take a look at the extent to which Carolinas did that.

MR. ANDREWS: Dan, pull up if you would S-CHS-4106. All right. And what we have here is kind of an email string that, let's begin at page 4107, please, Dan. And just call out the first quarter of the letter down through one, two, three. And I'm sorry, but I didn't -- pull

back out of that.
Q: I want to make sure, you don't have a copy of this in front you, Ms. Platt, that you can confirm that this is an email from Mr. Murphy.
A: It looks likes down at the bottom it says it's from Mr. Murphy.
Q: Okay. Can you see it?
A: Yes.
Q: All right. Good.
A: I can't tell on that page who it's to, but.
Q: Well, and it's just an attachment that says team.
A: Okay.
Q: We'll scroll forward and you can see who's listed there on the "to" line.
A: Okay.
Q: And this is a statement that's saying from Mr. Murphy to the team, I have attached our initial target contact list of employers and civic community organizations for CMC-Fort Mill's support, including sample letters and instructions. You've been included on this email distribution for at least one of the following reasons. And you see there that there are a number of individuals who are

identified as having responsibilities to lead the support initiative?

A: Yes.

Q: Okay. And it identifies that they were involved in helping to get letters in the past. And let's take a look at the next page.

MR. ANDREWS: Dan, let's move on back through that 4109.

Q: And do you see here a list of employers and the number of employees for each employer that are listed?

A: Yes.

Q: On this page that are -- that's being distributed?

A: Yes.

MR. ANDREWS: Dan, go to quickly 410.

Q: You'll see some more of these employers. Do you see that, Ms. Platt?

A: Yes.

Q: Now let's take a look at the next page, 4111. It has a target list of Fort Mill area community organizations?

A: Yes.

Q: All right.

MR. ANDREWS: Now, let's go back if you would to the

front page, 4106, Dan.

Q: And do you see at the bottom of the page, it says from Mr. Murphy and the recipients that were identified, see that?

A: Yes.

Q: Then if you'll scroll up, Mr. Murphy receives an email from Mr. Lordo, and then Mr. Murphy responds, or let's say to summarize, would you agree with that Mr. Lordo says essentially is information Piedmont Tenet's placed a full ad in today's "Rock Hill Herald" and has distributed yard signs showing support for Piedmont facility to many businesses and civic leaders throughout the Fort Mill Township; you see that?

A: Yes.

Q: And what's Mr. Murphy's response in the email just above that?

A: It says, Rod, all I can think to say this Sunday evening is that desperate times calls for desperate measures, talk to you tomorrow, Del.

Q: Okay. Now, let's take a look at some of what those measures were from the public support plan.

MR. ANDREWS: Dan, turn to 3989 in that same CHS series.

MS. ROBERTSON: Your Honor, I object to Mr. Andrews' characterization of what he just said. He's reflecting what he thinks the intent of the email is. It's not at all the intent of the email. He doesn't have the witness on the stand who in fact wrote the email, but yet he's suggesting intent and reading it in and asking this witness about it.

MR. ANDREWS: I'd say that's what redirect if for, Your Honor.

MS. ROBERTSON: In regards to the email.

THE COURT: Mr. Andrews, let's try to not ---

MR. ANDREWS: I'm sorry. I withdraw that internalizing.

THE COURT: --- suggest the intent of the message. I'll figure out what I think the intent of the message is.

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

THE COURT: Thank you, sir.

MR. ANDREWS: All right. On page, Dan do we have this, if you'll call this up, 3989, and Dan, if you'll -- what I'd like for you to do is call out the physician practice plan under the first segment. There you go.

Q: And do you see that this particular document has a series of directed actions concerning its public support plan, Ms. Platt?
A: I'm reading it. It looks like a list of ways in which they have to obtain support.
Q: And the first of which relates to physician practices, correct?
A: Yes.
Q: And among those is they're providing a new script to registration staff; they're asking staff to visit web sites; they're asking physicians to send letters to patients to request support letters. Do you see that?
A: Yes.
Q: They're asking physicians to ask their spouses to visit the web site and provide support too; they're asking practice managers to solicit support as well. Do you see that?
A: Yes.
MR. ANDREWS: Now, let's actually turn to the next page, Dan. It's actually the prior page to this exhibit, 3988.
Q: And, Ms. Platt, do you see that this is said script for CMC-Fort Mill support only for patients who live in York County; you see that?

A: Yes.
Q: And who is it intended, who is it identified to be used by?
A: Registration personnel and physician practices in York County and the emergency department of CMC-Pineville and CMC-Steele Creek.
Q: Were you aware that registration personnel and physician offices and emergency departments were asked to have patients prepare and submit letters of support?
A: I was not aware of the specifics of Carolinas' plans in terms of how they generated support, but I was sure that it included a variety of ways.
Q: Were you aware that they asked, Carolinas asked its Carolinas physician network physicians to write letters to their patients asking for letters of support?
A: I wasn't aware, but I'm not necessarily surprised.
Q: Do you think it's ethical and appropriate for patients who come to see a physician for medical purposes to be asked while they're there to provide letters of support?
A: I've heard of it done in many, many CON

instances. I don't have a problem with it. The patient can say they don't want to, or they can say, you know, let me take it home and think about it. It's not anything that I see as tremendously unusual. I mean, the volume for this project, for all the projects was unusual, but I have seen that done before in other projects.

Q: What would you think of a physician who comment that characterized that practice as unethical?

A: They may not be familiar with what happens in a CON context, but again, I've seen this happen in other CON projects before.

MS. ROBERTSON: And Your Honor, I would object to the characterization. I think that misstates witness testimony in this case, Mr. Andrews' question.

MR. ANDREWS: I don't think it does, Your Honor, but I'm moving on.

THE COURT: Well, all right, let's move on.

MR. ANDREWS: All right.

THE COURT: Thank you.

Q: Now, with regard to --

MR. ANDREWS: Dan, pull up -- pull up S-CHS-4114.

Q: Now, do you see that this is -- has handwritten

in the upper right-hand corner "independent physicians"?

A: Yes.

Q: And what does this appear to be to you, Ms. Platt?

A: Instructions on how to go about writing a letter of support for the CHS hospital in Fort Mill and how you should address it and not to mail it because I'm sure they wanted to have them come in as a group.

Q: And who would that be intended, who was that stated to be for?

A: It looks like based on the handwritten note that at least this one particular page was for an independent physician.

MR. ANDREWS: All right. Dan, let's turn to the next page at 4115. Your Honor, if you'll give us just a moment.

THE COURT: Certainly.

MR. ANDREWS: We're having technical difficulties. There you go.

Q: All right. Ms. Platt, what does this document appear to be?

A: A sample support letter from a physician regarding Carolinas' plans for a 64-bed hospital

in York County.

Q: And the second paragraph states that as a physician practicing in York County, and I'm very familiar with the growth of the community and the need for expanded healthcare services. Currently, there is only one hospital in the county and many residents seek inpatient care in other areas. The addition of a new alternative in York County will give my patients a choice to receive care closer to home. I am supportive of CHS' proposal and I intend to refer patients to the new hospital. That's what it says, isn't it?

A: Yes.

Q: Do you know how many letters of support that Carolinas received from physicians that it did not employ who practice in York County?

A: I'm not familiar with the breakdown of independent versus employed physicians.

Q: Well, let's take a look at that.

MR. ANDREWS: Dan, turn to Exhibit 31, please, Bates 654.

Q: Now, what does this reflect in terms of independent, that is, non-employed physician support for Carolinas' project?

A: Well, it says here that Carolinas received -- just had one independent physician, but I didn't prepare this so I don't who prepared it.
Q: You haven't reviewed the letters of support from physicians to determine the extent to which Carolinas received support from them?
A: I did not go through the 5,000 letters, the 5,700 letters and try to determine whether they were independent or employed physicians.
Q: There weren't 5,000 letters from physicians now were there, Ms. Platt?
A: No, there were not.
Q: It looks like there was something in the order of 150.
A: And I didn't go through all of those to determine whether they were employed or independent.
Q: Well, it looks like Carolinas made a request for physicians who are independent in York County to support their application and only one did that, if this is an accurate representation, right?
A: If this an accurate representation, then that would be the case. But it's also my understanding that Carolinas has more employed

physicians, whereas Piedmont has more independent physicians on their medical staff, so perhaps distribution is in relation to the status of their medical staff.

Q: Meaning members of the medical staff of Carolinas -- I mean ...

MS. ROBERTSON: Your Honor, we've been going now for a number of questions with matters and documents and letters for which this witness was not involved in, does not have any personal knowledge, and I'm going to object to continuing that line of questioning based on Rule 602 in the Rules of Evidence, where a witness who does not have personal knowledge really cannot comment on matters for which they don't. Unless there's some basis or he establishes that she does have personal knowledge, then really these matters should not be gone into with this witness.

MR. ANDREWS: Your Honor, this is a document in the record.

MS. ROBERTSON: Well, it's ---

MR. ANDREWS: And so are all the letters, so it's hardly -- and Ms. Platt is here to testify about her opinions related to the record.

MS. ROBERTSON: That is not accurate to a number of things she has been shown. A number of these documents were discovery documents. They are not part of the Department's record for which Ms. Platt has said that's what she reviewed. We've had thousands of pages of discovery material exchanged between these parties. Those are not materials necessarily that this witness has seen or reviewed. It's not part of the Department's record. And we've gone through now a number of those. And to the extent we continue down this line, I think it's time to object based on her lack of personal knowledge of any of this information and him just seeking to elicit a comment for which she has not had any personal involvement in.

THE COURT: At this point what you're asking the witness about is the letters that were received by physicians, and specifically, we're talking about physicians that are not affiliated with one of the networks. They're independent practicing physicians and the number of letter that were received by the Department?

MR. ANDREWS: That's right.

THE COURT: And this is demonstrative exhibit of

those letters?

MR. ANDREWS: This is a copy of a slide that was presented to the Department.

MS. ROBERTSON: And is it a demonstrative or is it?

MR. ANDREWS: No, it's an exhibit in this case. It's Exhibit 31, and which is, contains the project review slides presented in July of 2011 to the Department.

MR. ROBERTSON: If he's now on matters within the record, then my objection may not relate. It relates to those that we've been going through, and I thought we were continuing to go through that. So if he is asking her about matters within the Department's record, then I won't object on the basis of 602.

THE COURT: Thank you, Ms. Robertson. Mr. Andrews, and perhaps the whole confusion here was just simply that, and I didn't catch it either, whether this was an exhibit in the record, and maybe if you could just make sure that that's clear when you move on to the next item, and that way then if Ms. Robertson has any objection she can lodge that. Otherwise, if it's a document in the record, then ---

MR. ANDREWS: Absolutely.

THE COURT: --- we can proceed. Thank you.

MR. ANDREWS: I'll try to do a better job of that, Your Honor. Thank you. All right. In fact, I've concluded with that line of examination. Your Honor, we've been at it about an hour plus, an hour and a half. I probably have something a little less than an hour to go, but if we could take a short break now before I assume this would be the conclusion.

THE COURT: How about ten minutes? Could we do ten minutes.

(Break from 4:09 p.m. until 4:25 p.m.)

THE COURT: We're back on the record, Mr. Andrews.

MR. ANDREWS: Thank you, Your Honor.

Q: Ms. Platt, let's talk a little bit about indigent care and your opinions related to that.

A: Okay.

MR. ANDREWS: If we could, Trudy, Ms. Robertson, if I could ask your staff to pull up what was Joint A, or actually it's part of -- it's one of your exhibits, so we should be able to get it. Dan, if you would, pull up page 25 of Carolinas Exhibit 12, which reflects apparently a table that's already in the record. Let's just go directly to 1193 of Joint Exhibit A and

the table at the top of the page. I think that will do it for us. Now, you testified in your direct about this exhibit, didn't you, Ms. Platt?

A: Yes. I mean, it was a similar version to this exhibit. Yes, without Presbyterian.

Q: Okay. Yeah, and you've essentially modified this for purposes of the trial exhibit, correct?

A: Yes.

Q: Okay. And this supports your testimony that you believe that CMC-Fort Mill would be more financially accessible than Fort Mill Medical Center, correct?

A: Yes.

Q: Now, first of all with regard to the percentage of charity care as a -- that's reflected percentages of gross revenues, and you're aware that Carolinas nearly doubled their projections of charity care from 3.5 in their 2005 application to 6.3 in the 2010 update, correct?

A: I know that it was increased. I don't -- I don't know the exact percentage, but yes, I know it did increase.

Q: Now, you don't know the eligibility criteria that Carolinas applies to its patients, do you,

for financial charity care?

A: I have looked at their policies related to charity care for the purpose of including it in the CON applications, but I have not spent a significant amount of time evaluating those policies and the guidelines.

Q: And you don't know, do you, about how Carolinas classifies charity care, do you? How they make that judgment as to who should be considered in the charity care category and who falls outside it?

A: I don't know the details on a day-to-day basis of that process. I've looked at their policies and procedures in the context of putting them into applications, but I've not spent time on a day-to-day basis looking at how they evaluate that.

Q: And would it be fair to say you didn't look behind these projections to determine the accuracy or reasonableness of Carolinas' 6.3 percent projection, did you?

A: Only in that it's my understanding that they derived the 6.3 percent from their experience with other similar community hospitals that they operate.

Q: And that's what you read or is what they told you? You didn't determine how they categorized charity care at any of those community hospitals, did you?
A: I did not.
Q: Now let's take a look at the next row, charity and bad debt as a percentage of charges. You would agree with me, wouldn't you, that the Department's definition of charity expressly excludes bad debt?
A: Yes, and that's why we looked at charity alone.
Q: And bad debt wouldn't have any bearing on financial accessibility, would it?
A: It may or it may not. I really don't know that that's the most important evaluation in this table.
Q: Well, in fact, the record here has established that Carolinas files lawsuits and places liens on folks' homes who have bad debt if they're not eligible for charity care. So that wouldn't relate to financial accessibility at all, would it?
A: I was not here for that testimony, so I can't speak to it one way or another.
Q: All right. So let's just -- well, would you

agree with me then that that row on your analysis doesn't really relate to the Department's definition of financial access?

A: DHEC does not include bad debt in their evaluation of charity care.

Q: All right. Now, with regards to the projected Medicaid mix. In terms of medically underserved groups, the Department's definition of that term looks at Medicaid, Medicare and uninsured or underinsured groups, does it not?

A: Yes.

Q: And, in fact, did you compare the projected Medicare mix of CMC-Fort Mill and Fort Mill Medical Center?

A: I'm sure that I did. I don't recall what the percentages were. To me, the Medicaid and the charity were the most relevant because, at this point in time, Medicare is typically looked as a good payer and most hospitals want Medicare patients. So, I don't that in my opinion as an underserved population. My focus was on Medicaid and charity that I think are more truly the underserved populations.

Q: Well, if you're trying to do this as DHEC does it, DHEC looks at Medicare and Medicaid as well

as indigent care, don't they?

A: They do also look at Medicare.

Q: The Medicare, let me ask if this is familiar to you, that Carolinas' proposal was for 30.7 percent and Piedmont's was 42 percent Medicare mix. So 12 percentage points greater. Is that consistent with your memory?

A: I don't recall. I didn't focus on that. Again, in my mind, Medicare is a good payer, most hospitals want to serve Medicare patients, and the real focus in terms of being concerned about underserved populations is charity care and Medicaid.

Q: The charity care adjustment adjusted discharges is driven solely by the application and your assumption that Fort Mill, in fact, would serve 6.3 percent of its patients, or at least 6.3 percent of its gross revenue would be applied to indigent patients, isn't that right?

A: The calculation of charity adjusted discharges of 646 for Carolinas or for CMC-Fort Mill is based on the assumption that 6.3 percent of charges would be charity care.

Q: Right. And so you simply look at the difference between the charity care proposals of

each party and that's what's going to drive that bottom row, isn't it?

A: Yes, but I think the reason I broke that out is it was interesting to me that the variation in charity care percentage between Carolinas and Piedmont or Amisub was significant enough even though Amisub is a larger facility with higher utilization, CMC-Fort Mill or Carolinas actually projects to serve more overall charity adjusted discharges.

Q: And that would be driven by the 60 percent of outpatient services that Carolinas proposed to offer in contrast to a much smaller percentage for Fort Mill, wouldn't it?

A: Well, the adjusted discharges sort of takes that into consideration, so it makes it an apples to apples when you're comparing. It's a function of the 6.3 percent charity care.

Q: Again, you're just doing the math here, aren't you?

A: I am doing the math to calculate what I think is relevant for comparative purposes.

Q: All right. Now, you would agree with me that after full implementation of the Affordable Care Act, the federal act that is intended to and

plans to provide insurance to those who are uninsured, that there will be fewer uninsured individuals that these hospitals would serve. Isn't that true?

A: There should be a smaller percentage of charity care, and those patients ideally would be in another payer category. At the time that this was filed and reviewed by the Department, it wasn't clear whether the Affordable Care Act was going to go through or not. Again, I evaluated what was presented by each applicant.

Q: At the time of the -- at the staff review of the applications?

A: Yes.

Q: All right. Now, let's move on to your testimony concerning your opinions related to the need for 100 beds ---

A: Okay.

Q: --- in Fort Mill. First of all, your opinion was driven largely by, no matter which methodology you applied, your creation or application of these regions, the three regions within York County, correct?

A: I used the three regions as a basis for determining where it made the most sense to put

more beds, whether it made more sense to put more beds in northern York County, relocating the 36 beds as proposed by Piedmont, or to leave those beds in the greater Rock Hill area. And they did align with Carolinas' service area breakdown, but in my opinion, they also made sense in terms of the geographic areas that were most proximate to the proposed beds so that patients would have the most convenient access in terms of travel within their community to the beds at each hospital.

Q: All right.

MR. ANDREWS: Actually, Ms. Robertson, I am going to need your help on this one, if y'all could be so kind to pull up demonstrative, your Demonstrative 3.12?

MS. ROBERTSON: Sure.

Q: Okay. Now, Ms. Platt, in your updated analysis you have -- there's some things that caught my eye that I wanted to ask you about. First of all, the number of beds that are showing for -- in northern York County, this is would be applying the 100 beds in Fort Mill in your analysis of the bed discharge ratio, right?

A: Correct.

Q: And you've got 100 beds in northern York County that would reflect Fort Mill Medical Center's presence there. Now, the beds available to greater Rock Hill and to western York would represent the balance of the beds available after the 64 beds is applied to the 288 beds currently, right?

A: You mean, in other words, after the 36 is relocated?

Q: Yeah. Yeah.

A: Well, and I also took our psychiatric beds because psychiatric beds were really not relevant to this project, and also psychiatric patients, from what I understand, were not included in the community hospital discharges that were evaluated in Exhibit 104, 107 that Piedmont's witness prepared, at least that's my understanding.

Q: And what's your understanding of the number of beds at Piedmont including the psych beds?

A: I think the number is 288.

Q: That's consistent with my understanding, so we agree on that. And how many psych beds are there?

A: I believe there are 20 beds.

Q: Right. And then that would leave a balance of 268, right?
A: And then 36.
Q: Thirty-six, and what's the balance? 232 isn't it?
A: I guess. I'm not sure whether the 32 were -- or I'm sorry, whether the 20 were taken out prior to the 28 -- or the 288 or not.
Q: Well, it looks like the 20 may have been taken out twice because 20 from 232 would be 212, right?
A: That's correct.
Q: And I mean, should I go forward, or are you willing to accept that apparent based on your review of this?
A: Let me look back.
MR. ANDREWS: If we could do a quick override, Dan, we can just cut to the chase on this a little more quickly if you're unclear. Dan, if you'd pull up demonstrative, our Demonstrative 149.1.
Q: What I can do here, Ms. Platt, is show you a copy of your original analysis and you can look at that line and see what you have there under beds for the greater Rock Hill area.
A: That's 232. I, at that time, I thought that

that did still include the psychiatric beds. It may not have.

Q: And if you look down below in that total of the beds, there's 232. I mean, 332, do you see that?

A: Yes, yes.

Q: And if you would add into that 332 the 20 psych beds, you get 342, correct?

A: If you add 20 to 332?

Q: I'm sorry, excuse me, no never mind, never mind. So take 64 beds from the 332, and what do you have?

A: 268.

Q: Okay. So you just weren't sure whether or not the original 332 already had the psych beds excluded?

A: I believe that I thought the original 332 included the psych beds.

Q: Well, the total excluding the psych beds should be how many beds?

A: You mean the total for the county?

Q: That's right.

A: With or without the 100 beds?

Q: With the 100 beds. It's the same number, isn't it? You add 64 to the 268 of acute beds.

A: Okay. Right.
Q: Right?
A: Right. So you're adding either 64 -- okay. That makes sense.
Q: And what's that number?
A: Without the psych beds?
Q: Yes.
A: 332.
Q: Okay. So it would appear to be originally your 332 did not include the psych beds, right?
A: It looks like it did not. I thought it had.
MR. ANDREWS: Okay. So let's go back, Trudy, if we could, to 3.12.
Q: And if we look down at that number of total beds which is 312, then would you agree that that total should be 332?
A: If you include -- yes.
Q: Without psych?
A: Without psych.
Q: 332 without psych. And that the number above the second red box that reflects 13 should then be what?
A: 232.
Q: Okay. And if you do the math, that would cause a change in the beds per 1,000 discharges for

greater Rock Hill, wouldn't it?
A: Yes, it would.
Q: And well for the whole region, I mean, Rock Hill and western York. You want to do the calculation?
A: Sure. I'll just check it again. 7.2, or I'm sorry 7.02. I'm not sure if that's right. Are you doing Rock Hill or which area do you want me to do?
Q: Well, you're doing beds per 1000 discharge ---
A: In which area?
Q: --- instead of 13-0.
A: You're asking me to do the total for Rock Hill and western York combined.
Q: Yes. Well, what you've done. The calculation you've done that represents 13 beds per 1,000 discharges, you see that?
A: Uh-huh (affirmative response).
Q: That's the number that would change, wouldn't it, if you had 232 beds?
A: 7.0
Q: I had 14.2. How are you calculating that?
A: Are you asking, which year are you asking me to do?
Q: Well, I was focused on '17. You'd need to do

it for both years, though, wouldn't you?
A: Okay. Yeah, I mean, yes.
Q: Okay. Neither would be seven, though, would they? Beds per 1,000 discharges, it would be a larger number?
A: Yes, it would be. It would be 14.
Q: For 2017, would that be 14.2?
A: Yes.
Q: Is that what you got?
A: Yes.
Q: And for 2011? You're just dividing the number of beds into the number of discharges, aren't you?
A: Correct.
Q: What do you get for 2011?
A: 12.4.
Q: And that's more beds?
A: I'm doing the discharges per bed.
Q: Okay.
A: Let's see.
Q: Well, the ---
A: Right, right.
Q: --- your column says beds per 1,000 discharges?
A: It is. You're right. Sixteen.
Q: Okay. And again, I don't want to be tedious

about this, but -- so let's just focus on 2017, because we're focused going forward, but the calculation would need to be corrected as well down below for the total York County beds, would it not?

A: Yes.

Q: And why don't you do that math for us?

A: Okay. 15.5.

Q: Okay. That's what I have as well. And just so that the record won't include an incorrect computation, I'm sure you'd want to correct the 16.86, too. So do that match quickly and let's get that right.

A: 17.9.

Q: Okay. Good.

MR. ANDREWS: Now on the next page, which is -- Trudy, if you could pull that up for us please, 313.

Q: Was your application of bed discharge ratio for the Carolinas 64-bed facility?

A: Yes.

Q: And if you look at the beds for the Rock Hill and western York area, you'll see 248?

A: Right.

Q: Now, as we discussed, that should be 264,

should it not?
A: It should be -- well, if you're adding 20 back in, it would be 268.
Q: Excuse me. I'm falling into the trap. 268, you're right.
A: Correct.
Q: Okay. And let's just focus on the correction for 2017. What would the corrected number be?
A: 16.44.
Q: That's what I have. And the totals would be consistent with what they were on the prior page, wouldn't they?
A: Correct.
Q: So they don't need to be changed. And just for, can't help myself, for purposes of completion, then let's go ahead because we've corrected all the others. What would be the 2011 calculation?
A: 18.5.
Q: Okay. All right. Now, your testimony is, as I understand it, that the -- in Mr. Sullivan's exhibit, he relied on some census data that had been updated as it is every year, is that correct?
A: Correct.

Q: And you just got the most recent update in March?
A: April.
Q: Or it was published in March or April? Okay. And but your conclusion was the same, and you moved to a discharge bed to ratio -- bed to discharge ratio analysis to get there. I want to ask you, though, about -- and just looking at what you have up on the screen, in doing that, that's really driven by the assumption that the populations within these different regions of the county, particularly in the lower part of the county have greater access to Piedmont and its beds than they would to either of the hospitals that are proposed in Fort Mill, right? Otherwise, this analysis just doesn't work at all?
A: It's based on my assumption that the people in western York County and the zip codes that comprise greater Rock Hill have more access, greater access to the beds if they're in Rock Hill than in northern York County. They would have to, most of those patients, a good number of those patients would have to drive past Piedmont Medical Center to get services in

northern York County, which would not make sense.

Q: And you advocated that position to the Department and Ms. Brand in her letter repeated it more than once. So, let's take a look at your map.

MR. ANDREWS: Ms. Robertson, if you wouldn't mind, help me one more time on Demonstrative 3.5.

MS. ROBERTSON: Sure.

Q: And looking at the regions, and you've identified of course the green as the northern York County region, correct?

A: Yes.

Q: And the blue is the greater Rock Hill region, right?

A: Yes.

Q: And the blue incorporates three zip codes, 932, I'm sorry, 732, my eyes are failing me, 730 and 704, right?

A: Yes, correct.

Q: Now, and your position is that this analysis makes sense that the population that you've identified in 732, 730, and 704 have greater access to Piedmont than they do -- Piedmont Medical Center than they would to Fort Mill

Medical Center or to Carolinas Medical Center in the Fort Mill area?

A: That the majority of the population in those areas would have greater access to Piedmont Rock Hill.

Q: Yeah, but we're not --

MR. ANDREWS: Let's take a look at, Dan -- thank you, Ms. Robertson. Let's pull our document up, Demonstrative 38, please, Dan.

Q: Now, Ms. Platt, I don't know if you've seen this in your review of the trial materials, but this is demonstrative that is prepared by Mr. Rob Walsh, who is a traffic study engineer, who testified at the trial and his testimony is that in the white -- in the pink zone that those individuals who are residents of these same three greater Rock Hill zip codes, 732, 730 and 704, where they're in the pink zone, they would have greater access, that is, shorter drive times to Fort Mill Medical Center than they would to Piedmont. Now, you've had an opportunity to look at these, have you -- have you?

A: I have. You showed this to me at my deposition.

Q: Okay. Good. Have you attempted to calculate the population that resides in the pink zone?

A: I've not actually calculated the population. I've looked at it in terms of density, and the population density in this area is far greater towards the Piedmont hospital side of I-77. The population is pretty sparse when you look at the pink area zip code 29704. It's pretty rural, very few people live there, and again, the population is denser as you move to the west side of I-77.

Q: Well, we're not talking about the majority of the population, but we're, in fact, talking about your very precise mathematical calculation that is affected by certainly by a few thousands and certainly by potentially tens of thousands of residents who live in the pink zone, wasn't that true?

A: Again, my understanding is that the population is more dense to the west moving into the areas that are not more necessarily more accessible to Fort Medical Center or to -- and this study was done just for Fort Mill Medical Center, not for the location of CMC-Fort Mill. But the pink areas are less dense in terms of their

population, and therefore, their demand for services.

Q: Well, I wouldn't disagree with you that, but would you accept the proposition that if your intent was to evaluate the extent to which beds are accessible to residents of different regions of the county, that what's important is where the residents live and where there's greater geographic proximity to the hospitals rather than what zip codes they may happen to live in?

A: I agree with the premise that they attempted to analyze where patients are closer and have more access. I chose to do it at a zip code level, that was the data that was readily and easily available to do it. To attempt to do it in these sort of travel contours would be much more difficult, and they don't even align necessarily with census track, so it would be difficult to do. So using the zip code level data, which is -- I mean, occasionally you go below that level in health planning, but it's pretty commonly accepted planning measure. The zip code definition that I used I felt were a reasonable surrogate for proximity to the hospital in terms of access.

Q: And you didn't use census track population data that would allowed you to make some more precise determinations about the number of residents in the 730 and certainly in 704 for whom it would be a shorter drive time to either proposed Fort Mill location, did you?

A: I did not use census track because I don't even that census tracks would get you down to a level where you could break up the population into these colored drive time contours. So, you know, I looked at the density of the population. You know, it doesn't necessarily change my opinion. It would be very difficult, I believe, to come up with a calculation of exactly how many people resided in each of those colored areas. It doesn't align with census tracks exactly, so you'd have to go even below that level.

Q: And so you believe that would be more reliable to lump everyone, whether or not they have a shorter drive to the Fort Mill hospital in these larger zip code categories you've created? That was what you did, wasn't it?

A: I evaluated it in terms of zip codes. I found that to be a reasonable planning measure for

analysis of geographic accessibility.

Q: Okay. Now let's take a look at actually the analysis that you haven't spoken much about in your direct, but that you presented to the Department concerning -- to support your maldistribution theory that beds were not equitably distributed if Carolinas -- if Fort Mill -- if Piedmont placed 100 beds in the Fort Mill area. Let me start by doing that.

MR. ANDREWS: And I'm sorry, Ms. Robertson, one more time, if you could help me with Demonstrative 3.7.

Q: Ms. Platt, you'll recognize this as the exhibit that reflected your testimony that showed, I think you testified, that 96,752, the red line and the top figure was what the -- that was reflected in Mr. Sullivan's demonstrative, and you determined that, according to the current census data, the population instead for northern York County was 84,144, right?

A: Yes.

Q: Now, you've described these as post, the blue as post 2010 census and the red as pre 2010 census. In fact, both could be post 2010 census and just be reflecting the updates that's

provided, isn't that true?

A: Well, Claritas does update its data each year, and but the reason I believe that Mr. Sullivan's data is pre 2010 census incorporation into the data is when you look at that, the data source he used, it actually doesn't identify a 2010 census number for each zip code. It identifies a 2000 census number, and then I believe a 2012 number and a 2017 number; whereas, the data that I pulled shows a 2000 census number, a 2010 census number 2013 projection and a 2018 projection. So that would be my basis for the assertion that his data did not yet encompass the 2010 census data.

Q: But you don't know that for a fact, do you?

A: I think it's pretty clear in the way that it's presented. It would seem unusual to me that Claritas would publish a number and not have actual 2010 census data shown on the very same report if it was available and incorporated into, fully incorporated into the projections.

Q: All right. Let me take you back to a demonstrative that, in fact, you reviewed that Mr. Sullivan did present.

MR. ANDREWS: Dan, please pull up Demonstrative 149.1.

Q: Now, Ms. Platt, you'll see on the left your original analysis before you incorporated zip code 707 into the -- this represents your original analysis that you presented to the Department, correct?

A: Yes.

Q: All right. And it shows the differential of over two beds per 1,000 for northern York and just a little over one bed per 1,000 for the balance of the county, right?

A: Yes.

Q: So almost a two to one ratio, which caused you to take the position you did to the Department, correct?

A: Yes.

Q: All right. And then Mr. Sullivan produced the document to the right on more recent data that's identified as Claritas 2013 and shows with the growth of the population in northern York County over time that those ratios become almost identical, and in fact, there are fewer beds per person for northern York than for the rest of the county, correct?

A: Well ---
Q: Isn't that what it shows?
A: Fractionally smaller, but ---
Q: Okay. Fractionally smaller, but very similar?
A: Very similar, I would agree.
Q: All right. And if it indeed were very similar then it would reflect an equitable population base distribution of beds, wouldn't it?
A: It would. Other than -- well, first of all, I don't -- I don't agree with Mr. Sullivan's population projections. I don't dispute that they are incorrect at the time he pulled them, but newer data shows a much lower rate of growth, particularly in northern York County, a very different rate of growth. But the other thing, to balance that, if it was truly sort of an equal distribution is the fact that beds will continue to be needed in greater Rock Hill at Piedmont Hospital to serve tertiary and special needs services that are not going to be offered by a community hospital in northern York County. So if it was truly a balanced comparison like this and if, you know, except that Mr. Sullivan's math was correct, then I would still give the nod to spending less money

and keeping the 36 beds in greater Rock Hill to ensure access to patients who are going to need those tertiary and specialized services.

Q: Well, in fact, let's just -- in looking at the more recent data, you didn't stop with the review of what was reflected for northern York County, did you?

A: I'm not sure I know what you mean.

Q: Well, you had just presented the data in your -- the prior slide we'd looked at that showed that based on the most recent Claritas report that the population for northern York County didn't grow at the rate expected?

A: Correct.

Q: And I said, you didn't stop there in analyzing the beds per person in the county, the distribution of those, did you?

A: No, I just did the population comparison, and I found across all of the areas of population that the growth rate had slowed for all areas of York County.

Q: And did you apply that slowed growth rate according to your model in the same way you had originally to determine how it affected the distribution of the beds?

A: I did.
Q: All right. Well, actually we can just take a look at that. We did that as well since your direct.
MR. ANDREWS: Dan, would you pull that up, please.
Q: All right. Now, what we're pulling up here, Ms. Platt, incorporates the population data. And what I want to do is just make sure we're tying to what you've just testified to, which is that the population in northern York was not 96,752 as reflected earlier, but more recent Claritas data show that it was projected to be in 2020, 84,151. And that ties within seven to the number reflected on your demonstrative that we just looked at, right?
A: Yes.
Q: Okay. And if you then complete that process and look at the beds per 1,000 population, it falls to 1.19, doesn't it?
A: Yes, it does.
Q: And the population in -- for the rest of the county that's reflected there is 195,398. Is that consistent with what you'd found as you undertook this analysis?
A: That looks about right.

Q: All right. And the beds per population for 1,000 population are 1.19, right?
A: Yes.
Q: And that's identical to the bed to population ratio for the northern York County area, isn't it?
A: Yes.
Q: And the -- and that would make it true that the total beds for the total service area, the entire York County would be the same, correct?
A: Yes.
Q: Now let's take a look at -- what effect will this have on if there were only 64 beds in Fort Mill under your bed population ratio? Let's go ahead and show that based on -- we've analyzed this as well, Ms. Platt. Did you analyze it?
A: I did.
Q: And you changed your mind about the value of the model after analyzing it?
A: No, I did not. I was responding to Mr. Sullivan's criticism in terms of whether the bed population ratio was a meaningful tool. I think it is. I moved to also look at the distribution of the discharges, which is what I presented based on Mr. Levitt's calculation. And

what I determined was that the population of northern York County appears to be, I guess in some regards, a younger and healthier population that has a lower demand in terms of discharges. So I felt that was relevant to the presentation.

Q: The beds per 1,000 population if there were only 64 beds under the Carolinas model in northern York County would be .76 per bed, correct?

A: Yes.

Q: I mean, I'm sorry, it would be .76 beds per 1,000?

A: Yes.

Q: And in the balance of the county there would be, according to the characterization you gave it, an inequitable distribution based on population alone of 1.37 beds per same population group, right?

A: If you go out to 2020 that's the math, yes.

Q: In 2020, if you assume a couple years for appeal of this case, it's probably going to be year three of this operation of this hospital for either one, wouldn't you agree?

A: I still think the 2017 projection is reasonable.

I don't know that it's necessary to go to 2020.

Q: If you assume two years for an appeal and two years before the opening of a hospital, the first year of operation is likely to be 2017, isn't it?

A: If you assume that this appeal is going to go on for two more years, yes.

Q: All right. But I promise you the cross-examination won't. All right. Okay, let's move on. Now, let me take you to your testimony about the assumption that there would be -- one of the reasons that Carolinas would want to build CMC-Fort Mill was to shift patients from Mecklenburg County to the Fort Mill area. Did I understand your testimony correct that that was what you understood to be one of their incentives for proposing this hospital?

A: Yes, to decompress the very highly utilized facility at CMC-Downtown.

MR. ANDREWS: Dan, let me pull up Demonstrative 243, please.

Q: Now, Ms. Platt, given what your testimony is about Carolinas' interest in decompressing the utilization of its facilities in North Carolina,

let me ask you to review this data concerning the occupancy rates in 2009 and 2011.

A: Okay.

Q: You see those?

A: Yes.

Q: All right. And as I understood your testimony is that not only Main but all of the Carolinas facilities were full, and that was the incentive that Carolinas had to shift patients to York County. Did I understand you correctly?

A: I don't know that I said they were all full. I think my focus was on CMC and the need to decompress beds at that facility.

MS. ROBERTSON: Your Honor, if I may, sorry to interrupt, but I'm looking at this demonstrative and I believe it's based on a source that was not admitted into the record on the 2013 North Carolina Medical Facilities Plan. I may be wrong, but I don't believe that was ever admitted as an exhibit and this demonstrative seems to based upon that.

MR. ANDREWS: It's true, it wasn't admitted or -- yet, Your Honor. I mean it's one of the things you said you'd wait until -- take it up as we presented it. So and it's still not being

admitted.

MS. ROBERTSON: Actually I thought you had ruled on that, that this was not -- this was not an admissible exhibit.

THE COURT: Which exhibit was this?

MR. ANDREWS: Thirteen I believe, but I'm not sure. Thirteen, Your Honor. And our notes reflect that you didn't rule on it. That was my recollection.

MS. ROBERTSON: Actually, my notes reflect something otherwise. Imagine that. It says that you, in fact, had granted our objection on that and you excluded it.

THE COURT: On grounds of relevance.

MS. ROBERTSON: Your ruling, and then you -- yes, sir, I thought you had, in fact, excluded it and granted that. And if you said you -- something about revisiting, but I thought you, in fact, had ruled on it at the outset.

THE COURT: I believe -- yeah, that's what -- my note says that I granted the motion and said that if you wanted to revisit it at a later time, we would do that, but that 9, 10, 12, and 13 I granted that motion on the grounds of relevance, I think was your objection.

MR. ANDREWS: Well, Your Honor, I'm not moving to introduce it, although I'm happy to do that. I think this demonstrates the relevance issue in part that it, first of all, was an -- simply provides an opportunity in this regard to update the data that's already in the record, that data that Carolinas provided. And it clearly relates to this witness' testimony concerning the effects of the occupancy of the North Carolina facilities on their interest in the Fort Mill hospital.

MS. ROBERTSON: Your Honor, to the extent we're still sourcing a North Carolina Medical Facilities Plan, I think we stand by our objection that that's not relevant. And it does underlie this exhibit, so I think we still question the relevance of that document in this case.

MR. ANDREWS: Your Honor, frankly, it's not an important issue. I'm happy to go with 2009, my guess is they'd want to update it. But if not, then we can just focus on 2009, which was still available.

MS. ROBERTSON: Yes, the footnote from the source for one is in fact the 2013 North Carolina

Medical Facilities Plan, so he's got it sourcing that 2009 line. And Your Honor, if we could get a copy of this demonstrative as well, I don't think we've seen this one prior to.

MR. ANDREWS: Your Honor, with regard to this demonstrative and this data, again, I'm satisfied that it's just -- that the 2011 information provided for consistency. If it allows things to go forward, we don't need it. The 2009 information we do need. I'm not proposing to withdraw that. That's already in the record frankly. It's a document about which there's already been evidence elicted. We believe that -- we'd like to revisit the issue with you concerning other matters concerning the relevance and the need for the admissibility of North Carolina Medical Facilities Plan, but we don't need it for this. I mean, the experience is relatively consistent.

MS. ROBERTSON: And, Your Honor, I guess my question remains that the source for the footnote one he's referring to 2009 ---

THE COURT: Right, and I was going to ask ---

MR. ANDREWS: I was going -- I'm sorry. I should have offered that. The footnotes are reversed.

That's mistake. 2009 is sourced to Carolinas document 555. And it's the '11 data that ties to the 2013 North Carolina Medical Facilities Plan.

MS. ROBERTSON: And, Your Honor, we haven't seen this demonstrative, so we've not had a chance to check that. I guess if Mr. Andrew says that's the case, that's the case. On here, it certainly reflects otherwise.

THE COURT: And I see that. Do you want to take a minute to do that?

MS. ROBERTSON: Yes, sir.

THE COURT: I'm inclined to at least let him proceed along the 2009 lines. Do you want to take five minutes and do that?

MS. ROBERTSON: Yes, sir. And if the 2009 is sourced as he has reflected and we can confirm that, then the 2009 may be okay.

THE COURT: All right. Let's take a five minute recess. All right.

MR. ANDREWS: We can pull that document up if you'd rather avoid a recess. If you want to take a recess, that's fine.

THE COURT: Let's take a five minute recess. I appreciate it, Mr. Andrews.

(Break from 5:15 p.m. until 5:22 p.m.)

MS. ROBERTSON: Your Honor, we're going to withdraw our objection to the reference to the North Carolina Medical Facilities Plan.

THE COURT: Completely -- I mean, completely?

MS. ROBERTSON: Yes.

MR. MULLER: It might be helpful to fill you in a little bit, Your Honor. We discovered that in fact the North Carolina Medical Facilities Plan was sourced in a footnote to one of Ms Carter's exhibits and is now already in evidence.

MS. ROBERTSON: So that being in evidence, we will withdraw our objection.

THE COURT: Well, I was just thinking about all of this, but that just resolves everything, doesn't it? So that was Exhibit 12, right?

MR. ANDREWS: Thirteen, I believe.

THE COURT: Thirteen. I beg -- I keep -- all right, Exhibit 13. All right. Therefore, -- well, I'll let you if you want to offer it at the appropriate time into evidence, you may. Do you want to do that or do you want to ---

MR. ANDREWS: Yes, I'll do that at this point, Your Honor.

THE COURT: All right. Thank you. And without

objection then?

MS. ROBERTSON: That's correct.

THE COURT: And any objection from the Department?

MS. BIGGERS: No, Your Honor.

THE COURT: All right. Without objection, Exhibit 13 which was previously -- which I previously ruled was not admissible is admitted. And Mr. Andrews --

MR. ANDREWS: Thank you, Your Honor.

Q: All right. Ms Platt ---

MR. ANDREWS: Dan, if you'd pull up back Demonstrative 243, please. Let's go back to this document. And again, Your Honor, for the record, I'm sorry that we had crossed our footnotes here and 2009 should be referenced to the South Carolina 555. Did Mr. Bupp already correct it? Thank you, Dan. All right. So, as always, you're way ahead of me. And so we've made an adjustment to the footnotes for 2009 and 2011 sourcing.

Q: All right. Now, with that, Ms. Platt, I'm going to take you back to the subject that this -- I intend this to relate to, which is Carolinas desire to move patients to York County to address the high occupancy of its Mecklenburg

County or North Carolina facility. Now, this is a demonstrative based on -- let's look at 2009 -- the utilization of the Carolinas facilities. This is taken, as I said, from one of Carolinas' own documents, and if you look at the total column, you'll see that 65.3 percent of the beds are occupied, and if you'll look at the total ADC, you compare that to the total beds, you'll see that there are nearly 600 beds available in 2009 in the Carolinas system, right?

A: Six hundred beds comparing those -- I mean, that's assuming that there are not swings in capacity levels. I mean, if you're looking at the bed need driven by the average daily census, you know, I think you'd probably end up with a similar number of beds needed.

Q: All right. Well the -- looking at the average daily census, and over time that takes into account the swings in beds, doesn't it? The increases and the troughs in utilization?

A: It does, but I don't think I could say that there are hundreds of beds not needed because of the swings in census from day to day.

Q: All right. And in fact ---

MR. ANDREWS: Dan, let's take a look at the next demonstrative that looks at this.

Q: If we're -- if Carolinas were interested in relieving the demand on CMC-Main, which as you recall was a showing an occupancy over 83 percent, and they want -- they were able to and wanted to shift patients, these are the facilities into which those patients could be moved for non-tertiary and quaternary services, aren't they?

A: Well, it doesn't work exactly like that. The patients have to be able to go somewhere else proximate to their home. So you're assuming that they're -- that the sort of full beds at downtown CMC are filled by patients that live closer to Kings Mountain or Cleveland Regional or Union Regional. And that may or may not be the situation. What we do know is that there are a lot of patients from York County that go into Charlotte Main, and those patients could be served more proximately with a facility in Fort Mill.

Q: CMC-Main provides services to individuals in the communities represented by every one of these hospitals, does it not, for non tertiary and

quaternary services?

A: Yes, but to varying degrees by area, and you have break out -- certainly for tertiary services, they serve all these areas. But what you're trying to sort of shift back and to relieve the capacity constraints are the-non tertiary patients.

Q: That's what I asked you about. And do you know for a fact that Carolinas today and in 2011, when it showed an 88 percent occupancy, provided non-tertiary, non- quaternary services to many patients who reside in the very communities where these hospitals in the Carolinas system are located, didn't they?

A: I don't know if I could say many. I think it's varying degrees by area. So, you know, it doesn't mean that necessarily there are as many people coming from Union County to use those beds that are non-tertiary as there are from York County. So they're not all sort of equivalent opportunities to offload patients and move them out of CMC.

Q: Now, there may not be equivalent opportunities, those same limitations about the difficulty that Carolinas has apparently had in moving patients

for community services to its community hospitals would be a factor affecting their ability to move patients out of -- out of CMC-Main back to Fort Mill, wouldn't it? Same factors in play?

A: No, I don't think so. I didn't say it was difficult. I said there are varying degrees to which non-tertiary patients are coming from these communities.

Q: And you don't -- but you don't know what they are?

A: I haven't analyzed that in detail, but they're not all the same, it doesn't represent all exactly the same situations as York County. And these patients, or these beds, even if they're available, they don't help alleviate the number of patients coming from York County to CMC because they're not in a -- in an approximate area to meet that demand.

Q: Well, in fact, this data doesn't represent the 86 beds added to Pineville, does it? They would be on top of the 294 of 2011, wouldn't it?

A: They would be in addition to ---

Q: In addition to?

A: --- the Pineville beds. Not your -- the 294 is Mercy and Pineville combined.
Q: Yeah, I understand ---
A: They were added at Pineville not at Mercy.
Q: Right. But they would be added to the 294 looking at the combined number of beds available for those facilities in that system, right?
A: Yes.
Q: And, in fact, Mercy added 230 -- I mean, excuse me, 38 beds as well, didn't they, to help cover the beds that they transferred to Pineville; isn't that true?
A: I'm not the witness to go back through all the bed derivations for Carolinas. I believe there's other witnesses that would know that in more detail than me.
Q: So you don't know whether Pineville, in addition to the 86 beds at Pineville, Mercy added 38?
A: I don't know all the beds that have been added at Mercy or all the other Carolinas facilities. That's not something that I've studied.
Q: All right. Okay. Now, the record that was presented to the Department that was the basis for the opinions you've offered as well, since that's what you said you tried to focus on, did

not include an analysis by Carolinas of the adverse impact they would have on Piedmont, did it?

A: I think it had a discussion of the adverse impact that they would have on Piedmont and the fact that they expected their utilization to be based on their current market share, and as a result, they would not have an adverse impact on Piedmont.

Q: So right, they had a discussion. They didn't attempt to quantify the analysis, did they, other than say zero?

A: Their isn't any analysis to be done if the market share all comes from a shift of existing market share. There's no math to be done.

Q: Isn't common in your experience, Ms. Platt, that there is an assumption that when a new provider moves into a new market that there would be an adverse impact on the existing providers proportionally based on their then existing market share?

A: That is one way to look at adverse impact. And that distribution sort of based on historical market share assumes that there's not going to be a shift from existing providers. So I don't

know that when you're -- when you're building a satellite facility and you have existing market share in an area and you expect patients to be served closer to home, I don't know that you necessarily make the same exact assumption with regard to impact being distributed based on market share.

Q: All right. Now, the most common way to -- for health care planners to undertake that adverse impact analysis is to measure how an existing facility would perform with a proposed facility and compare that to how it would perform in the absence of that facility, right?

A: Typically, I would look at the way that a facility would perform with, you know, a new provider in the market compared to how they are performing today.

Q: That's not the most common way you do that in your years of experience, is it?

A: It's been done a variety of ways, but yes, quite often it's looked at how they're doing today. Because if the facility is feasible today and you look at the impact on the way it operates today, you can determine whether it would still be feasible in the future. No

hospitable or facility is guaranteed growth out into the future necessarily. So to me, if they're feasible today and you add the impact, then you can determine whether they would still be feasible with the introduction of a new facility in the market.

Q: That's not what I asked you, Ms. Platt. I asked you, in your experience, if the most common adverse impact analysis that you've applied is comparing what the facility would be like with the -- what existing providers would be like with the proposed facility and without it, not the look back. We'll talk about that, but the question is simple. Is that the analysis that you most commonly apply as you've done your work over the last 20 years or not?

A: And I would say I don't think that's the most common way. I have done it that way. But I've also looked at comparing the facility today to how they would operate with the facility in the future.

Q: All right. Let's talk about each of those. Let's start with the one that compares the performance with the proposed facility and without it. Now that, and I'll refer to that

as the with and without analysis. You understand what I mean by that, don't you?

A: Yes.

Q: All right. Now, that analysis takes into account growth and inflation, right?

A: Growth in population?

Q: Yes.

A: Yes.

Q: And the -- well, let's just say and that -- the effect of that is the existing facility gets the benefit of that expected growth, doesn't it?

A: In a status quo scenario, they would have the benefit of that -- that growth.

Q: And the -- what you discussed as looking to the current performance, that would be a measure that I'm going to refer to as looking back about how an existing facility, let's say Piedmont, as performing at some point in the past compared with how we would perform in the presence of the proposed facility in the future. Is that ---

A: I don't know if I'd necessarily say past. I mean, I think the point is to look at it as current as possible. I mean, you have to use whatever data is available, so it might be

slightly in the past, but sort of an attempt to look at the current status compared to what would happen in the future with a proposed facility.

Q: And that look back method does not take into account growth, does it?

A: Actually it does because it assumes that that incremental growth in many instances is served by the new provider. And that growth is sort of what justifies the need for the project.

Q: Well, and that growth though is -- is something which you're measuring against the past -- the place of operation in the past to the provider, right, of the existing provider?

A: You're looking at the incremental growth overall of the market, which is the reason that there's a need. But again, I don't know that any provider is necessarily entitled to retain that growth.

Q: Okay. Now, in this analysis, let's actually -- you don't have in the application, do you, a -- either the look back or the analysis of the with and without? It's not in the record, is it, that the Carolinas performed?

A: You mean in Carolinas ---

Q: Yes.
A: --- record? No, they did not perform that analysis because their assumption is that the utilization for the proposed facility will come from existing market share. And under that assumption, there is no impact.
Q: All right.
A: nd Piedmont would benefit from the growth in population, as would Carolinas with respect to their current levels of market share.
Q: Now, in that -- Carolinas' analysis that's in the record, they rely strictly on an analysis based on discharges, don't they?
A: I'm not sure I understand. Strictly discharges as compared to what?
Q: Yeah. Well, there are other factors that any adverse impact analysis you take into consideration other than just utilization, isn't that right?
A: Staffing is one and that's, you know, one of the criterion, the project review criteria. But I mean typically measures of utilization are the fundamental basis for calculating adverse impact.
Q: Okay. Well, you'd also take into consideration

a change in and a shift in medical staff alignment; wouldn't that be a relevant consideration?

A: I mean usually that would be a function of market share. If you were to shift medical staff then you would shift market share. And the assumption that Carolinas presented was that they would not -- they would not shift market share to meet their projections.

Q: And I understand that was their assumption. What I'm talking about is in a normal review of adverse impact, you'd take into consideration the reasonableness of that assumption and whether it would be reasonable for physician alignment to change, and that would -- have you looked at that factor here?

A: I looked at it in terms of market share, which I think is the ultimate reflection of whether a physician alignment would change.

Q: And that was Carolinas' assumption that no market share would change. That's wasn't yours, was it?

A: That was their assumption. As I stated earlier, I was asked to look at what Carolinas put in the record and what Piedmont looked in

the record -- put in the record and analyze them for what they were in the record the way DHEC would look at them.

Q: Now, when Piedmont put in the record letters from physicians saying that there would be a change in physician alignment, you didn't even read those letters, did you?

A: I looked at some of the letters. I did not look at every record in the file.

Q: No. But you haven't taken into consideration the extent that there may be a shift in physician and physician practice that could affect whether there would be an adverse impact on Piedmont; you have not incorporated that into your analysis as you're sitting here, have you?

A: I have not because shift in physician alignment would result in a shift in market share, and my analysis is based on no shift in market share, which was the assumption for Carolinas. Just like I accepted and reviewed Piedmont's market share assumptions and evaluated those, I evaluated the record for what it was, the way DHEC would look at the record.

Q: All right. In addition to the potential for physician shift, there could be change in payer

mix as a result of the introduction of CMC-Fort Mill into York County, couldn't there?

A: There could be.

Q: And that could produce an adverse effect in and of itself without regard to changes in market share, couldn't it?

A: Well, again, if you're assuming that market share is remaining constant for Carolinas and the same base of patients that they're serving today are the ones that they're going to serve in Fort Mill, then it wouldn't have any impact on payer source.

Q: Again, if that assumption proves to be true?

A: If that assumption assumes to be true, which was what was in the record and what I reviewed.

Q: All right. Now, another consideration related to the adverse impact that could result for existing providers is the health of that provider, that is, how well they're doing of their -- isn't that a relevant consideration?

A: You mean sort of the financial health?

Q: No, the general operational health, and financial would be an element of it, but it wouldn't be limited to that, would it?

A: Of the provider that's coming into the market

or the existing provider?

Q: Of the existing provider? Talking about adverse effect on the existing provider, an important consideration is how the existing provider is doing?

A: That's not really something that, you know, the new proposed provider can control, nor is that really something that DHEC can control.

Q: All right. Not talking, but it's a -- the control is not the question. The question is the potential adverse impact and how that should be evaluated. You've testified before that the health or size of an existing provider is a relevant consideration in evaluating adverse impact, haven't you?

A: I don't know if I've used the word health. I mean I think financial, the financial status of the existing provider, if you've got one, I think that's -- I mean, the financial health would be relevant. I don't know what other measures ---

Q: Okay.

A: --- you would look at.

MR. ANDREWS: Your Honor, if I may approach, I want to show Ms. Platt a copy of her deposition in

another case.

THE COURT: Yes, sir,

MR. ANDREWS: All right. I apologize for the size of this, Your Honor, and Ms. Platt but it's -- I knew if I just provided a page there would be issues about that. So here's the entire document.

THE COURT: I understand. It's quite a deposition.

Q: All right. Ms. Platt, open the first page, the cover page, please.

A: Okay.

Q: And tell me if you recognize this document?

A: Yes.

Q: What is it?

A: It appears to be a transcript of my deposition in a Wake County acute care hospital case.

Q: And you provided the deposition, and did you testify in this case?

A: It sort of settled, or there was some parts of summary judgment before it went to hearing, so I did not testify in court, just deposition.

Q: All right. Let me turn your attention to page 77.

A: Okay.

Q: And ---

A: Okay.
Q: All right. I'm going to -- the question I'll read and you can just read the answer. "Is there a particular level that -- that you think is a market share impact that you think is of a particular concern in general?" And your answer? Go ahead and read it.
A: "There really isn't a set level. It's partially a measure measured against the health or the size of the existing provider. For example, if you have a smaller provider with thin margins, then you know a smaller percentage impact could be devastating financially, whereas as if you have a very large hospital or health system, you know, a few percentage -- percentages of impact is, you know, barely going to be a dent." Do you want me to keep going, or?
Q: No that's enough.
A: Okay.
Q: All right. Are you aware of the extent to which Piedmont has lost market share since filing its application in 2005?
A: I'm aware that it has lost market share. And I would just like to clarify that in this

instance here, I was referring to financial health. And that's specifically the example that I gave in terms of financial health. What you just asked me about was other types of health in terms of operations.

Q: Uh-huh, that's right. And do you believe that operational performance is a relevant consideration?

A: Ultimately, its impact is usually measured in terms of financial impact. And what I was speaking to here was financial health of an organization.

Q: And to the extent that you're dealing with a tertiary facility whose -- whose volumes are recognized as a matter of law or as a matter of the State Health Plan to be related to quality, then the effect on market share would be an important consideration, wouldn't it?

A: If it's market share of those tertiary services. What we're talking about here is community services, and we're talking about no shift in market share because Carolinas has sufficient market share to meet their utilization projections without impacting any other provider.

Q: All right. Well, you believe in reality that some patients would, in fact, shift and the representation that Carolinas made is not what would reasonably be expected, don't you?

A: Well, there's -- no one has a crystal ball, and certainly we can't prevent patients who previously have gone to Piedmont from going to Carolinas. But, in my opinion, the fact that Carolinas already has a significant market share in northern York County to me shows that they have the ability to fill the hospital without taking any market share. They've had market share increases in the past, but it -- my understanding is that those have stabilized.

Q: Ms. Platt, my question was whether you would agree that, in fact, some Piedmont patients would shift to Carolinas if that facility was built in Fort Mill, and your answer is yes or no?

A: There may be some patients that shift.

Q: All right. Now, Carolinas' first goal would be to, before shifting patients, would be to ensure that its North Carolina facilities are fully utilized, wouldn't it? Wouldn't that be its primary goal?

A: I think you'd have to ask a Carolinas witness that question.
Q: All right.
MR. ANDREWS: Let's actually, if I could have your exhibit, please, Ms. Sackett. I'm sorry, not exhibit, deposition transcript. Oh, did you already give it to me? Pardon me. Your Honor, if I may approach?
THE COURT: Yes.
Q: If you would open that for me, Ms. Platt.
A: Don't know if I can. Okay.
Q: All right. And turn to page 77, please. All right. Let's take that down through line 18. My question is, "Isn't in their best interest, first of all, to ensure the hospitals in which they've made an investment are fully utilized?" Your answer?
A: "Well, I mean, I certainly think that would be a goal."
Q: "And that would be Pineville, would it not?"
A: "That would be Pineville and yes, they -- they invest in all their facilities."
Q: Okay. Now, you testified that even though there was not an adverse impact analysis, assuming that there would be a loss of market

share proportionate to the market share that the existing providers had, that you didn't see that in the application, but isn't true that you prepared one yourself?

A: I did do one prior to my deposition.

Q: Okay. And let's take a look at that, please.

MR. ANDREWS: Dan, if you'd pull up Ms. Platt's Exhibit 10 to her deposition.

Q: And it should be if you want to look at a hard copy attached as an exhibit, Ms. Platt. And what we have here in your demonstrative is an example of what the with and without analysis that you've seen used in many, many cases, isn't that right?

A: Yes.

Q: All right. And, in effect, what you've done here is you've applied some of Mr. Levitt's assumptions and analysis, correct?

A: I used Mr. Levitt's sort of format and his projection of overall market demand, and then applied actual market shares as the basis for the potential loss and for shift in market share. And the way I believe I characterized this in my deposition was that this would sort of be a worst case scenario, that if providers

all lost in relation to their existing market share, which I don't expect to be the case because Carolinas has a very significant market share in northern York County and in York County, and I believe they will have the ability to shift their patient base to the new facility. So I did this exercise as what I call a worst case scenario.

Q: All right. But, in fact, it's typically not done as a worst case scenario, but the way planners begin their analysis and then make adjustments from it as to their assumption about adverse impact, isn't that right?

A: Not ---

Q: As a general rule?

A: Not necessarily because, I mean, this is, to me, the best starting point if your -- you have a new entrant coming into the market that doesn't necessarily have a market presence, then your assumption would have to be based on shifts within existing market share. But when you have an existing provider that has a large market share and has the ability to ensure that their patients are served closer to home, then you don't necessarily start with this.

Q: All right. Let's turn to the second page of this analysis to determine what your -- how your application of this model, what it resulted in. And the bottom line on this page ---

MR. ANDREWS: Dan, if you'd highlight it, please.

Q: -- is that applying the proportionality adverse impact test to the effect on Piedmont is that in 2017 Piedmont would be projected to lose 1,628 cases, isn't that right?

A: It is. But if you look at the net growth that's offsetting it and you look at the -- where Piedmont would be looking at them today versus 2017, there's almost no impact whatsoever. Piedmont would lose 67 cases, which is on the prior page.

Q: All right. Let's go back to that page and so we can just follow how you have -- how your math works on that.

MR. ANDREWS: Dan, if you'll highlight the last three rows and the headings for them on that page.

Q: Now, you'll see here that Ms. Levitt -- excuse me, Ms. Platt -- let the crowd enjoy that for a moment -- that Mr. Levitt applied -- did a

computation that you've then adjusted and applied the 1,628 cases to. But explain to the Court, if you would, how you've derived the 10,048 cases -- 10,418 cases.

A: Okay. The starting point was the 2009 actual discharges for PMC, CMC, other North Carolina providers and then total. So that's sort of the first block. And then Mr. Levitt grew those cases out to, or those discharges out to 2017 with constant market share to see sort of the status quo in 2017. And so applying constant market share, Piedmont grows from 10,485 cases in the first block to 12,046 in the second block, which would be a net increase of 1,561 cases. The total incremental growth in the market, and again, my understanding of Mr. Levitt's information here is that these are community hospital discharges, so this doesn't take into consideration growth and demand for tertiary and specialty services, but that there would be a net increase of 3,000 cases between 2009 and 2017 that would be available for the various hospitals to serve.

Q: And the distribution of those would work out in a way that Piedmont would have taken a little

over half of those 1,561 correct?
A: Right, based on their market share across the whole county. Yes.
Q: All right. And then the 10,418 would be where they would find themselves with CMC-Fort Mill rather than the 12,046, correct?
A: Correct. So they would be at 10,418, which is just 67 cases lower than they are -- they were in 2009.
Q: All right.
A: So if you're comparing ---
Q: Excuse me.
A: -- their financial feasability or looking at their operations in 2009, and we know that they were feasible in 2009 and they're feasible today, then, you know, the net impact of 67 cases to me is not going to change the feasability of their hospital.
Q: Well, again, there are two different forms of this adverse impact analysis. The first would look at performance that's projected with and without in 2017, correct? And that's the loss of 1,628 cases?
A: Correct.
Q: A different analysis is that you then look back

to how that performance of 10,418 would have compared to Piedmont's performance at a prior point in time, and you're looking as to what their performance was in 2009 and they were only 67 more than 10,418, right?

A: Right.

Q: All right.

A: And I believe that's the relevant analysis because I believe that it's been bound in looking at adverse impact in South Carolina CON cases that the measure of impact is whether an existing facility can take the hit. And so looking at it this way measure whether Piedmont can, based on their current level of feasability, take a hit in terms of a loss of 67 cases.

Q: Well, you're referring ---

A: And this does not ---

Q: Excuse me. I'm sorry, go ahead.

A: This doesn't even take into consideration that there's continued growth and demand for tertiary and other specialized services that are not going to be served by a Fort Mill hospital that Piedmont can continue to serve. And again this is -- I'm considering the worst case scenario

because this assumes that Carolinas' patients are not going to return to be served in York County when there's a Carolinas facility available. And I don't agree with that. I think it makes sense for those patients, that market share base to shift to the new hospital when Carolinas has a facility in York County.

Q: The analysis you performed, you're rejecting the with and the without, you believe that the look back analysis is more accurate and more relevant to your opinion, is that right?

A: Yes.

Q: All right. And let's take a look at your exhibit, which you didn't testify about on your direct, but I'm going to ask you questions about it anyway. Exhibit 33, Page 11.

A: Okay.

Q: Now, this is your workup, again, with some slight differences in the numbers, which I'm sure you can reconcile, that reflects what you just reviewed from your two different forms of adverse impact analysis. Doesn't it? And then applies a contribution margin too?

A: It looks at the impact, yes, taking the difference between 2009 and 2017, applying the

contribution margin per case that Mr. Levitt had previously used and looking at what would the lost contribution margin and the impacts of pre-tax income.

Q: All right. And so what you're doing on the first large category across the large first row, is your look back analysis?

A: Yes.

Q: You're comparing performance that's projected in 2017 to 2011 and applying the -- and then comparing where Piedmont would be in 2017 to where it was in 2009, and find that it's just 62 cases rather now 67 short of where it was, right?

A: Right.

Q: And then you apply the contribution margin to that and show a net loss of $252,359?

A: Yes.

Q: All right. Now, the second part of your table shows the with and without analysis as is stated there, right?

A: Correct.

Q: And here you're applying the loss over the three year, I mean, sorry, over the three regions of 1,623 cases rather than 28. Is that

a function of rounding or why is the number different ---

A: It's a function of rounding.

Q: Okay. And then applying the contribution margin to that, you show a loss to Piedmont that would suffer a six point -- $6,565,043, correct?

A: Right, but that's a loss sort of opportunity. You wouldn't compare that to their current level of operations because that would be, you'd have to essentially grow their financial performance out to 2017 and then subtract that.

Q: All right. Now, the calculation of the loss of 1,623 patients ---

MR. ANDREWS: Let's go back, Dan, if you would to Exhibit 10 to Ms. Platt's deposition that we just visited.

Q: And if you show the loss of the 1,623 cases against the projected 12,046 cases, do the math for me, Ms. Platt, and tell me what that is?

A: What are you -- tell me what you want me to do again? The 1,628 ---

Q: 1,623 losS from the projection of 12,046.

A: Okay.

Q: What percentage of cases is that would be lost?

A: From what starting point?

Q: Well, this is the with and without analysis.
A: Right.
Q: So?
A: So you have to take that variance and you're really dividing it by the with, the 12,046.
Q: Right.
A: 13.4 percent.
Q: Okay. Now, that loss that would be projected is a function of also the -- your analysis assumes, does it not, the occupancy of CMC-Fort Mill would be at 67.5 percent?
A: Yes.
Q: And if, in fact, that CMC-Fort Mill were occupied instead at 80 percent, busy hospital with 53 average daily census instead of -- or 51 instead of 43, then that the adverse effect applying the same proportionality methodology on Piedmont would be considerably greater, wouldn't it?
A: I don't agree because, first of all, again, I believe this is a worst case scenario. I don't believe this is how the market shares are going to play out. Carolinas has a significant level of market share. I believe they have the ability to shift market share because Carolinas'

patients will want to be served closer to home in northern York County. But if you're going to go the next step and assume that they're going to be occupied higher than what they put in their application, then I would assume that that increase in utilization would come as a result of shifting of patients, and I don't know that it would have any impact whatsoever on Piedmont or change these numbers.

Q: Well, in fact ---

A: You would have to assume that all of that incremental growth -- you're asking me to assume that all of that incremental growth would come at the expense of Piedmont, and I don't think that's reasonable.

Q: No, I'm asking you to assume that it would be split evenly, or it would be split to some degree between both Piedmont and Carolinas. That's -- and asking you even to apply your assumption that it would be applied proportionate to their existing market share, that's the common way to perform the adverse impact analysis, true?

A: I disagree. I think that is one way to look at adverse impact. I did it for the exercise of

showing a worst case scenario. I don't believe that's what's going to happen. I believe that Carolinas has significant market share and they have the ability to redirect those patients and that people who are choosing the Carolinas system are going to choose to be served closer to home in northern York County.

Q: Well, in fact, you commented in your review of the various applications on the adverse impact that you projected Presbyterian would have on several different existing providers, didn't you?

A: Yes.

MR. ANDREWS: Dan, let's take a look at that. Let's go to the record and look at S-CHS-981 and 82.

Q: And this is part of your July 2011 submission to the Department, isn't it, Ms. Platt?

A: It appears to be, yes.

Q: Okay. And if ---

MR. ANDREWS: Let's pull out, Dan, the paragraph under Use of Erroneous and Incongruent Data under the analysis related to Presbyterian.

Q: And, Ms. Platt, if -- or what you've done here is you've applied your critique of Presbyterian's own adverse impact analysis,

haven't you?

A: I looked at their adverse impact analysis and yes, I evaluated it.

Q: All right. And what you say here is that Presbyterian's starting point for its impact, that is, its adverse impact study is 2008, however utilization data from calendar year 2009 should have been used as the impact analysis was performed near the end of 2010, this information was available at the time. By using the 2008 data, Presbyterian fails to account for a growth in utilization of least two percent between '08 and '09 experienced by most of the hospitals in the study, isn't that right? That's what you say here?

A: Yes, that's what it says.

Q: And it says that, Further, that Presbyterian's flawed analysis does not consider this growth and underestimates the impact as a result. Now, you'll just remember ---

MR. ANDREWS: Dan, would you pull up real quickly, cut back to Ms. Platt's Exhibit 10 to her deposition.

Q: And this shows that 2009 data was used as a starting point rather than 2010 data because you

prepared this in July of 2011, and that's the same criticism that you had just applied to Mr. Lutz's analysis to Presbyterian, isn't it?

A: No, it's not because in this instance I'm looking at Mr. Levitt's analysis and it's his data. I don't have the ability necessarily to update his data and put it into the categories that he used for community hospital discharges. So I'm using his data for the purposes of adverse impact. What I was criticizing Presbyterian for is that their own consultants did not use the most updated data in presenting their adverse impact analysis. Certainly, Mr. Levitt's analysis could be updated, but this is his analysis and his data source, not mine.

Q: But, in fact, what's critical about your analysis and your conclusion that there would be the growth would cover in the look back analysis the change over time, you were looking back at 2009 saying there were 67 cases short of where they were, and therefore, there's little to no impact at all, and in fact, the measurement wouldn't be against 2009, it would be, at this point in time, against 2011 or 2012, wouldn't it?

A: But then you'd have to update every other factor. So you certainly could do that, but for the purposes of this analysis, the data that I had available to me was 2009 data and Mr. Levitt's 2017 projections.

Q: Right.

A: So I certainly could update it, but again, this was the data that was available to me.

Q: But to show the true impact of the proposed project on the existing providers, you would need to use the more current data so that it would give Piedmont the benefit of the growth that it's actually experienced, isn't that right?

A: You certainly could give them that growth. I mean, this project could go on and on and on and we can keep updating every year and certainly if the data's available, that could be done.

Q: All right.

MR. ANDREWS: Now, let me go on and ask you to look further at your analysis of Presbyterian's impact by turning Dan, to page 986.

Q: Now, and you identify here what you describe as the correct -- the updated and corrected impact,

haven't you?
A: Yes, they had some flaws in their actual mechanical calculations when they were aligning their census tracks with their zip codes and performing their analysis.
Q: Now, what you were critical of Presbyterian previously doing was applying -- the way they applied the look back analysis, they were looking back too far and that was your criticism and the flaw in their methodology, isn't that right?
A: Because they were going further back than current data was available.
Q: Okay. And here you're identifying what you believe should be the correct way to analyze the impact. And what you say here on ---
MR. ANDREWS: Dan, let's pull out the bottom part of the page.
Q: Your finding is that Presbyterian would significantly impact both Piedmont and CMC, didn't you?
A: Yes, because Presbyterian had the lowest market share of all the providers in this review and they would have to take tremendous market share from all existing providers in order to meet

their projections.

MR. ANDREWS: Well, let's look at the next page, Dan, on 987 to see the extent to which Presbyterian proposed to impact existing providers.

Q: Presbyterian didn't describe that impact as significant did they? That was your characterization of it, right?

A: I'm sure they did not.

Q: Okay. And you did, correct?

A: I did.

Q: All right. Let's look at what they proposed the impact be. You'll see in your Figure 33 that there would be a loss of Piedmont of 2,165 cases and that would represent a loss of 15.5 percent, correct?

A: Correct.

Q: And the significant loss on up to CMC would be a total of 8.8 percent for 1,230 cases?

A: Yes.

Q: And split roughly evenly between CMC-Pineville and other CMC facilities, right?

A: Yes.

MR. ANDREWS: Now, let's take a look, Dan, if you'll call out the first paragraph under that table

and highlight the last three lines.

Q: What you say here, Ms. Platt, is that, All of Presbyterian Hospital York's primary service area overlaps with that of CMC-Pineville. As a result, the proposed facility will definitely have an impact on CMC-Pineville's acute care discharges. Now, isn't true here that CMC-Pineville's, as well as CMC-Fort Mill's, proposed service areas completely overlap with Piedmont's proposed service area?

A: Yes. The difference is that Prebyterian had to gain a tremendous amount of market share in order to meet their projections. They had the lowest market share of all the providers in the review, as opposed to Carolinas that has the highest market share in terms of Fort Mill and has the ability to fill their hospital and meet their utilization projections within their current market share base. So, I mean, the overlap is the same, but the assessment of adverse impact is not the same at all. Carolinas and Presbyterian were in completely different situations in going into this review based on their current market share.

Q: All right. Well, let's look at how you

characterized the effect of that impact.

MR. ANDREWS: Dan, let's pull out the last paragraph, if you would, and the last -- the first three lines.

Q: In particular doesn't -- don't you find here, Ms. Platt, that Presbyterian will have what you characterize as a serious adverse effect on these two facilities, meaning CMC-Pineville and CMC-Mercy?

A: Yes. And again, the market share issue here is Presbyterian is taking tremendous market share from other providers. The other issue is that Presbyterian -- this was an impact based on current utilization, whereas the impact that you're trying to analogize to, the one from my deposition that you've quantified or I quantified 1,600 cases, that was a difference with and with out going out into the future. The impact that Presbyterian would have would be an impact that would knock the providers well below their current utilization. Again, they had to capture tremendous market share to meet their projected utilization.

MR. ANDREWS: Your Honor, I can see we're past six o'clock. I'm sorry for having gone long. I was

hoping to finish but since the lateness of the hour, I'm happy to pick it up and wrap up tomorrow morning.

THE COURT: Well, how much later do you think you're going to be?

MR. ANDREWS: Not much.

THE COURT: My preference would be if you think you can finish, we could go ahead and at least finish your cross-examination.

MR. ANDREWS: All right.

THE COURT: I don't mind staying if everybody else -- does anybody have any place they absolute need to be? All right.

Q: All right. Now, Ms. Platt, let's take a look at the next page, actually two pages forward, 989. Now, this is your full page analysis of the with and without adverse impact methodology, isn't it?

A: Yes.

Q: All right. You didn't do a full analysis of the look back adverse impact method, did you?

A: I believe I did look at it both ways.

Q: Okay. But on page 989 this is where you presented your with and without scenario, correct?

A: Yes.
Q: And if we ---
MR. ANDREWS: Dan, you'll highlight the last row of that first table.
Q: This reflects the total number of cases lost at CMC-Pineville and the patient days associated with those, correct?
A: Yes.
Q: And that's 614 cases and 2,398 days, right?
A: Yes.
Q: And then the table below in Exhibit 36, you have identified the effect of that. It would be the loss of 6.8 percent discharges and the same percent for lost days?
A: Yes.
Q: And that's at Pineville. And you've described that impact as being serious, haven't you?
A: Yes.
Q: And on the next page, let's take a look at how you've analyzed the impact on Piedmont.
A: Okay.
Q: Here you identify a 19.5 percent hit on Piedmont in the third year of operation, is that correct?
A: Yes.

MR. ANDREWS: And, Dan, pull out that top paragraph if you would.

Q: And the last sentence here, Ms. Platt, says -- why don't you read it into the record.

A: Sure. As shown -- "As time progresses, the more residents utilize the proposed hospital services the impact will only grow more adverse."

Q: As time progresses, more residents will utilize the proposed hospital services, meaning Presbyterian's proposed hospital, the impact to Piedmont will only grow more adverse, right?

A: Right. And I think you're comparing apples to oranges here because this is -- Presbyterian's utilization assumptions and their need to capture significant market share in order to meet their projections. And you're comparing that to a hypothetical that I did of Carolinas' impact on Piedmont that I don't believe is going to be the case. I put it out as a hypothetical worst case scenario. I don't believe that that's going to be the case because Carolinas has significantly more existing market share, and I believe they have the ability to redirect those patients. Those

patients who have historically chosen to have their services from Carolinas are going to want to be served in northern York County at a more convenient facility. So you're comparing Piedmont's actual assumptions and their need to increase market share with a hypothetical that I don't believe to be the case for Carolinas.

Q: And you don't have any doubt do you, Ms. Platt, that residents of Fort Mill and Tega Cay would -- whether they've used Piedmont or used Carolinas would want to use the new hospital in Fort Mill, do you?

A: They may or they may not. But what's very clear is that the patients who have chosen Carolinas are going to be able to be served closer to home. And there's no reason to think that patients who've historically chosen Piedmont, especially if they're up in Tega Cay, they are so close to Charlotte, if they've chosen Piedmont in the past, I have no reason to think that they would not continue to use Piedmont.

Q: Well, and the physicians at Piedmont may want to get privileges there, or they may go to the emergency department at Carolinas medical

facility. There are unlimited number of way for residents of Fort Mill and Tega Cay and eastern York County to use the CMC-Fort Mill facility, aren't there? And all of that would result in a potential adverse effect on Piedmont?

A: There's nothing that would preclude a patient from using CMC, but in my opinion, the fact that Carolinas has a very significant market share of northern York County, that market share would form the basis for the utilization of the proposed hospital.

Q: Now, Ms. Platt, looking at your Exhibit 37, 19.5 percent hit that Presbyterian's identified that you described as significant is, in fact, you know, if you apply your loss of 1,623 cases in this with and without scenario that's here, I don't know if you've run the numbers, but it's about a 10.3 percent reduction in Piedmont's utilization that would be experienced with Fort Mill that otherwise would have without it. Does that sound about ---

A: Yes.

Q: --- like the math that would work for you?

A: Yes, that --

Q: You have run it?
A: Yes.
Q: Okay.
MR. ANDREWS: All right. Now let's take a look at the next page, Dan, please, 991.
Q: Now, you've performed, in the bottom half of this page, you have concluded that Presbyterian would have a significant impact on Pineville as well as on Piedmont, and if you look down at the bottom of the page, you conclude that that significant impact would be created just with the loss of 6.3 percent of its patients and patient days; isn't that what's reflected by your exhibit?
A: That's the calculation I projected, a 6.3 percent impact resulting from loss of market share because Presbyterian does not currently have the market share it needs in the area to meet its projections.
Q: Ms. Platt, I didn't ask you, did I, about why they were losing. I'm just asking about your characterization of that extent of the loss. And you called it significant, didn't you?
A: I did. But again, you're comparing a hypothetical to Presbyterian's actual projected

shift in market share.

Q: Let's take a look at the next page and see how you characterize the loss that Springs would suffer at page 992. Top of the page, Springs Memorial Hospital will also be severely impacted by Presbyterian. And what percentage ---

MR. ANDREWS: Dan, if you'll call out that table.

Q: --- of cases did Presbyterian project that Springs would lose? Is it 9.9 percent?

A: Yes, it is.

Q: Okay. And now your conclusion, Ms. Platt, and down lower on that page, is that Presbyterian would have a serious impact because it would take some 20 percent of market share, and that it would -- what you say here is Presbyterian will steal over 20 percent market share from existing providers that will result in adverse impact?

A: That's their own assumption. In order to meet their own projections, they make an assumption that they have to take 20 percent market share from other existing providers. Carolinas does not have to do that. And I don't believe that they will. They have sufficient market share to meet their projected utilization from within

their current base of patients.

Q: And the fact they have significant market share does not in any way prevent physicians who are at Piedmont from getting medical staff privileges there or from patients who've historically have been served by Piedmont choosing to go there because it's the new hospital in town, does it?

A: There are no patients that are precluded from going to any hospital.

Q: Thank you. No further questions.

THE COURT: Thank you, Mr. Andrews. Ms. Robertson, if you want to try to get redirect in, I'm willing to sit here and wait. I mean, I don't what Ms. Platt's schedule is like, whether she's planning on being here tomorrow, or.

MS. ROBERTSON: Your Honor, given the hour of the day and how long we have been going, all afternoon, I may not have that much for her, but I really would suggest we just do it in the morning. I think we can probably do it quickly and then move right on in to our next witness.

THE COURT: All right. Any objections to that?

MR. HARRIS: No objections, Your Honor.

THE COURT: All right. Then let's do that. We'll

in my opinion, does not meet or best meet all of the criteria.

Q: Okay. And let's start with your opinion number one, that Piedmont failed to demonstrate a need for 100 beds at Fort Mill Medical Center. And let's start with your subpart A, Piedmont's projections for Fort Mill Medical Center aren't reasonable. Do these opinions reflecting on these topics relate to specific criteria?

A: Yes, they do.

Q: Could you please tell us which ones?

A: Specifically, it relates to 2(c) 2(e), and in my opinion, 4(b). And I would just highlight that 2(c) indicates that the project has to provide services that meet an identified need of the target population, and that's where, I believe, the Fort Mill Medical Center fails to do that. And also I believe 4(b), which is related to opposition and the opposition in this case that Piedmont Medical Center has a direct impact on their ability to -- the ability of the -- to demonstrate need for the 100 beds by that target population.

Q: And under this opinion one, part A, you've indicated the Fort Mill Medical Centers volumes

or their volume projections are unreasonable. Do you have a demonstrative to illustrate this opinion?

A: Yes, I do.

Q: Let's look at Demonstrative 4.16.

A: First of all, as the map at the bottom shows, this demonstrative focuses on those four Zip codes in northern York County. And what the chart indicates is by zip code, it shows the number of patients that Piedmont served per day in 2009 from those three zip codes, and that totals 13. I can't get an arrow as hard as I try. That totals 13. And then the next section illustrates Piedmont's projections for both the Fort Mill Medical Center and Piedmont in Rock Hill, and then the total number of patients that it projects in 2017 for the two hospitals combined. And what that shows in total is that they're projecting to serve more than 40 -- well, 41 patients a day in 2017 compared to the 13 patients per day that they served at Piedmont in 2009. And overall, that's over a 200 percent increase in patient volume.

Q: Is this based on the 2009 data?

A: It is. This was based on the 2009 data that was part of Piedmont's submission to DHEC, but I would also note that their need methodology in their submission to DHEC as noted on the bottom of this includes only med/surg and obstetric patients, so it's not -- it's not total patients, but only med/surg and obstetric patients.

Q: Okay. And do you recall that Mr. Levitt provided an updated data for 2011 as part of this trial?

A: Yes, he did.

Q: And did you -- have you examined that data?

A: I have. And what this next slide shows is that the same chart with the updated data from 2011. And I would note a couple things. First of all, this includes all discharges except normal newborns. And the number of patients that Piedmont served in 2011 were a couple less, down to 11. And again, it just shows an even greater increase that they would have to achieve to reach their projections of 41 patients in 2017.

Q: And what does this data mean in terms of market share?

A: Well, I think that's an important thing to look at, particularly given the small number of patients we're talking about here. And what Piedmont and Fort Mill Medical Center combined, their projections rely on a 40 to 60 shift. A 40 to 60 points of share from other providers within the first three years that Fort Mill Medical Center opens. And that in some zip codes, particularly the 29707, is a point gain of about 20 points a year. And what this chart shows is in the first section, Piedmont's share by zip code in 2011 and the North Carolina provider share in 2011, which was largely CHS, but there was some Presbyterian share in there too. The second section shows Piedmont and Fort Mill Medical Center's combined share in 2017. So, for example, in 29707, they had 7.9 percent share in 2011. They project to have 68.3 percent share in 2017. And then you can see in the far right column, that means a net gain of 60.4 points of share, again, within the first three years that Fort Mill Medical Center opens. And I would note another piece of this is that if we pull out Fort Mill Medical's share alone and separate that from the combined

share with Piedmont, in 29707, Fort Mill Medical Center projects that it will have 47.3 percent share. So the remainder of that 68.3 percent share would be going to Piedmont. And so Piedmont already exists today to serve zip code 29707. But as a result of Fort Mill Medical Center, Piedmont is projecting that it is going to gain points of share not only at Fort Mill Medical Center but at Piedmont.

Q: Have you compared this shift with other market share shifts?

A: I have. In particular, the first analysis I did is compared it with what the North Carolina providers, the share that they have gained over the last six years. And we've heard a lot of testimony about physician alignment and physicians driving share to North Carolina and what the impact that has been on Piedmont. What this chart examines is the share in 2005. And as you may recall, 29707 was not a separate zip code in 2005, which is why we have these brackets for those years. But in 2005, you can see the share that Piedmont had, the share that the North Carolina providers had, and then how that's changed in 2011. And what the last

column shows is that the North Carolina providers gained about 20 points of share over the course of six years. And that was with the physician alignment and with the physician direction of patients that Piedmont claims has occurred in this case.

Q: And are those factors likely to change even if Piedmont builds?

A: In my opinion, no, they will not.

Q: Let's look at Piedmont's Demonstrative 106.1.

A: This is the second analysis that I did relative to the reasonableness of Piedmont's market share changes. And this was, I believe, a demonstrative that Mr. Levitt testified about which shows the change year to -- or excuse me, it shows the actual market share that Piedmont held by zip code each year from 2003 to 2011. And I took this data and looked at the change from year to year. And for purposes of my analysis, I looked at the absolute value. So regardless of plus or minus, I was just trying to determine the magnitude of change in each year. And so that's what I have done on this exhibit and then rank ordered based on that average annual change in market share in the

far column to the right. And as you can see, in most every zip code the market share change has been -- the market share change per year has been five percent or less. There have been three exceptions, and there are two reasons, in my opinion, for those exceptions. The first is that the top two zip codes, 743 and 726, are two of the least populated and smallest zip codes in western York County. And they only had, I think, as I recall, about 150 hospitalized patients in any given year. And so the change in just a few patients could make the percentage be higher. And I think that's the phenomenon that's occurring there. Relative to 29710, which is a larger western York zip, I looked back at that data, and I think there's a problem with the reporting or the data in that zip code specifically because what it showed is that in certain years, particularly those years with the big changes, in one year Piedmont's volume would drop significantly, but you didn't see other providers volume going up by that amount. The total market also dropped. And so if it had been a pure share change, then you would have expected Piedmont's volume to go

down, and another providers volume to go up, but the total market volume to stay the same. And based on my review of that data, that's not what happened. It was a reflection of some anomaly in Piedmont's data. So when I looked at this data in looking at the more populated zips and in looking at that year by year, what I concluded is that overall, the average annual change over these years in market share has been only about two percent. And again, I think that's another factor that demonstrates the unreasonableness of Piedmont assuming that it would have a 60 percent, a 40 to 60 percent share point change in three years.

Q: And that's how much times the historical percentage?

A: Well, in the case of -- I mean, two percent a year versus their 20 percent a year would be ten times.

Q: And again, is the fact that Fort Mill Medical Center, they get to build a hospital in northern York County, do you believe that that will make these share gains possible?

A: No, I don't.

Q: And will they gain some patients?

it just mentioned here, the only Fort Mill Medical Center.

Q: Okay. Now, did you hear Mr. Sullivan testify that he thought there would be a need for 100 beds at Fort Mill Medical Center?

A: Yes.

Q: And do you agree with this?

A: No, I don't.

Q: Would you please describe that?

A: Well, first of all, as I said, I don't believe that Piedmont demonstrated that their projections were reasonable. And I also think that Mr. Sullivan's testimony is not consistent with testimony that he gave in a case that he and I both were involved in in North Carolina.

Q: And which case is that?

A: That would be a case for -- that involved new beds in Wake County, which is the seat of the capital Raleigh.

Q: And could you briefly describe for us the circumstances of that Wake County case?

A: Yes.

Q: I think we have a Demonstrative 4.27. Give us just a second.

A: Yes. This is just a map to very briefly talk

about how the two cases are somewhat analogous. As I said, this is Wake County, home of the capital of Raleigh. This was a review for beds that had been determined as needed in the State Health Plan, just like in this Fort Mill review. One difference in the Wake County review, there were applicants both for new hospitals as well as existing hospitals that proposed to add beds to their existing campuses. But in -- particularly relevant to my opinion about this is the -- there were two applicants, including the one Mr. Sullivan was questioned about by Novant to build a new hospital in that purple shaded area of the county. And similar to northern York, this is an area of Wake County that is growing, and as you can see, there are two proposed hospitals down there, but doesn't currently have a hospital in that region. And Mr. Sullivan was representing the WakeMed Hospital system. They were an applicant that -- they have two existing hospitals in the county, and had projected to add beds to their existing hospital, and so were opposed to the new hospitals in the southern part of the county. And Mr. Sullivan gave two opinions in

that case that I believe are somewhat inconsistent with his opinions here. And the first is that he acknowledged that in the Wake County situation, Novant coming in as a new provider would have a difficult time gaining patients as a result of the physician allegiances and that already existed in Wake County. I will note that in the Wake County situation, Novant does not have a hospital in Wake County, and it doesn't have a hospital in a nearby county. They do have physician practices in that -- in the general Triangle region. But unlike CHS having a hospital in Mecklenburg County, they would be a new hospital provider in that county and in that area. However, I would also point out that as we talked about a moment ago, relative to northern York, Carolinas is -- excuse me -- Piedmont has a fairly small market share, in some Zip codes less than ten percent. Their highest market share is 30 percent. So even though they're not a new provider, they would be -- they're not the dominant provider in northern York County, and I think that's somewhat similar to this Wake County situation.

Q: Okay. And how do you believe Mr. Sullivan's testimony Is inconsistent with this case?

A: Well, as I recall on direct, his direct testimony, he said that Fort Mill Medical Center was really a critical part of the strategy and the only way that Piedmont could reverse out-migration going to North Carolina, and that also 100 beds was wise health planning because of the population growth, and they needed to build the beds. I also recall on cross-examination that he acknowledged that Piedmont would have to do more than just build the hospital, that if there were -- if there were patients who didn't like Piedmont for various reasons, they would have to overcome that and that they would be operating in a competitive environment.

Q: And if we could, let's look at Mr. Sullivan's specific testimony in the Wake County case. And if you could point us to those portions of his testimony that is relevant to your opinions in this Fort Mill case.

A: Well, first of all, this is from a deposition that was taken on Monday, March the 5th, 2012. And from page 190, and and I'll pull out the relevant section. Starting on line 8, and he

was again talking about what a reasonable market share assumption for Novant would have been. And he says that, "You're going to be fighting an uphill battle. You will get some benefit from the improved geographic proximity. But even if Novant wanted to recruit doctors into the area, patients still have --" it says exiting, I think it meant existing "-- loyalties with physicians in Wake County, and they aren't necessarily going to change their allegiances overnight to use a new physician. So those physician practices will grow over time, and it's just a general recognition of the -- of the, you know, difficult competitive environment in which you would be operating."

Q: How do you believe this testimony of Mr. Sullivan in the Wake County case is relevant to the Fort Mill case we're here about today?

A: Again, I think it is -- it's more consistent with his testimony under cross-examination that Piedmont's -- it's not just the Fort Mill Medical Center that they need, but I also think it supports my opinion that the reasonableness of Piedmont being able to achieve 40 to 60 percent points of share in the first three

years the hospital was open is unrealistic in part because of the varied physician relationships we've been hearing about in this case, and that patients are associated with the Carolinas physicians and as -- and those relationships are likely to continue in the future, which will affect their choice of hospitals.

Q: Thank you. And let's now move, if we can, to your second part of your opinion under number one.

MS. ROBERTSON: And Your Honor, we've still got probably 30 or so minutes on this line of questioning under opinion one. I don't know if you want to pause for a lunch, or do you want us to try to wrap up the second part of one?

THE COURT: I'm fine going either way. Do you want a -- is this the appropriate time to take a lunch break, or do you want to go forward, and we can finish it up?

MR. WESTBROOK: You know ---

THE COURT: What would be better?

MR. WESTBROOK: --- I would prefer that they go forward and finish.

MS. ROBERTSON: That's good.

MR. WESTBROOK: So I can ---

MS. ROBERTSON: That's fine.

MR. WESTBROOK: --- frankly, so I can work on their cross during lunch. But ---

THE COURT: Well, let's do it.

MR. WESTBROOK: --- that's a selfish reason. But that's ---

THE COURT: That's a perfectly good reason.

MS. ROBERTSON: That's perfectly fine, Your Honor. I didn't want to go on if others wanted to stop.

THE COURT: Thank you very much. Let's just go ahead an proceed through this.

MS. ROBERTSON: Certainly, certainly.

THE COURT: Thank you.

Q: Let's move, Ms. Carter, to the second part of your opinion under number one, that is that Piedmont's own projections for Fort Mill Medical Center do not demonstrate a need for 100 beds. And can you please explain this portion of your opinion?

A: Yes. Despite everything I just said about why I think their projections are not reasonable, if you look at their own projections, in my mind, even accepting their numbers for the sake of

argument, they do not demonstrate a need for 100 beds. And specifically what I've looked at on this map are the number of patients that Piedmont projects to serve at the new Fort Mill Medical Center in year three that it operates, in 2017. And as you can see, the patients that they project to serve from northern York County, they project an average of 28 patients a day from those three zip codes. And in my opinion, those three zip codes are the ones that Piedmont could argue need greater geographic access to a Piedmont facility. And so those are the patients that if a Fort Mill Medical Center is built would have greater access than they do coming to Piedmont and Rock Hill. And those 28 patients a day, again, these are their own projections, those 28 patients a day at 65 percent occupancy, which is the target in the State Health Plan, those 28 patients would need 43 beds.

Q: And do you recall testimony from Piedmont's traffic engineer that parts of zip code 29730 were closer to the Fort Mill Medical Center site than Piedmont Center Hospital?

A: Yes, I do. And I looked at that study and that

exhibit as it relates to this map. And what I did to account for that is if you consider the geographic area of zip code 29730, I believe that less than half of it is east of I-77, which is roughly the pink shaded area on that traffic map. But to be conservative, I -- and also, I think the western portions appear on Google Maps to be more densly congested in the western portions of that zip code. But I took half of the patients per day that they project to serve at the Fort Mill Medical Center from that zip code, and then I also took the one down here, 29704, which I believe their traffic engineer said was closer, and when you add those to the 28, that brings you to an average daily census of 34 patients that would arguably be closer to a Fort Mill Medical Center, and those 47 patients at 65 percent occupancy would only need 52 beds.

Q: Do you agree that northern York County is growing?

A: Yes.

Q: Do you believe there is a need to go ahead and build 100 beds now?

A: No.

Q: And could you please elaborate?
A: Well, I think they're -- I have three reasons for that. First of all, to my recollection, I don't think anywhere in the seven years of this case, in my opinion, has Piedmont ever said, this is when we're going to need these 100 beds. They have -- I would characterize their argument as the population is growing, just trust us. We need to -- we'll need these 100 beds at some point, and it's better to build them now. But they've never demonstrated, in my mind, a need for -- a need for the 100 beds.
Q: And what is it that Fort Mill Medical Center has projected? Let's look at Demonstrative 4.32.
A: Well, what this demonstrative shows is that in the 2005 submission to DHEC, Fort Mill Medical Center was projected to be operational in 2009, 2010, and 2011 as it's first three years. And in 2010, the projections had year one, two, and three as 2015, '16, and '17. And what you can see here is that in the 2010 submission, Fort Mill Medical Center projects fewer patients per day than they did in 2005, and that was even on top of this population growth, and six more

years of the population growth that they argue is leading toward a need for 100 beds.

Q: And I think you started saying that the three reasons or three issues that you had. Let's look at the second. What's your second reason?

A: Well, the second reason is based on the language in the State Health Plan. And I've alluded a couple times to the variable occupancy rates that the State Plan uses in its planning methodology for more beds. And I would note that the South Carolina State Health Plan doesn't have a requirement for hospitals to meet or be at these occupancy levels like other states do. But as indicated in the highlighted area here, the State Plan does say, "Use of these planning factors is not intended to stem initiative or to suggest that facilities cannot operate at more efficient levels than used in the calculations without additional beds." And what that means to me is that these are targets that the State Plan uses to determine when additional beds may be needed, but it certainly suggests that hospitals can operate at above those occupancy rates, which the Fort Mill Medical Center is not projected to do even by

year three of its operation.

Q: And have you examined the occupancy rates projected by the other satellite hospital applications, I believe as they were cited by Mr. Grice in his testimony?

A: Yes, I have.

Q: All right. And could you please discuss that, and is this your third reason?

A: Yes. What I've done is taken from Mr. Grice's diagnostic -- Demonstrative Exhibit 150, and took the satellite hospitals that he had listed and then added CMC-Fort Mill and Fort Mill Medical Center to those. And what you see in the far left column is the hospital in the year that the applications were submitted, the number of beds that each projected and then the number of patients per day they were projected to have in years one, two, and three, and then I went out to year five for Fort Mill Medical Center. And on the far right I've listed the State Health Plan occupancy planning factor, which for all these sized hospitals is 65 percent. And then the last column shows the difference between the hospitals last projected year and the State Health Plan occupancy factor. So in

the case of Roper Berkeley, the first one, they projected to be at 70 percent occupancy in year three. The State Plan occupancy target for them for that size hospital is 65 percent. So they were projected to be operating five percent above the State Plan target. And as you can see, going all the way down this list on the far right side, that all of the hospitals, all the satellite hospitals that Mr. Grice discussed and CMC-Fort Mill project to operate above that target occupancy rate by the third year, whereas Fort Mill Medical Center even by year five is only projected to be at 62 percent occupancy versus the 65 percent occup- -- excuse me, the 65 percent planning factor for it's size facility. So in my mind, if we are looking at those other satellite hospital applications, they documented that they would need their beds based on their projected utilization. Fort Mill Medical Center has, in my opinion, has not projected that it needs all the beds that it's proposing to build.

Q: And if a hospital does project to operate above the occupancy factor in the State Health Plan, does that trigger the need for bed need?

A: Yes. It would trigger a bed need. Just as it did in the 2004/2005 plan when Piedmont triggered a bed need that is at issue in this case today. At the same time, Piedmont has said they had 19 unused beds then. And then just as in the 2012/2013 State Health Plan, which has also shown a need for beds at Piedmont, and Piedmont currently claims that they have 100 unused beds. So just because -- so the bottom line is that, yes, if you reach these target -- if you reach these occupancy rates, a bed need will be generated in the plan that you have the option to apply for.

Q: And is it your understanding that Mr. Grice approved the applications in this demonstrative?

A: It's my understanding that Mr. Grice approved Roper Mt. Pleasant, Parkridge, Greer, and the Village at Pelham. He did not approve the two Berkeley applications.

Q: Okay. Those were approved by someone else within the Department?

A: I understand those were approved by Ms. Brandt.

Q: And did you hear the Piedmont testimony that compared to other hospitals in the region Piedmont's projected occupancy means that both

Piedmont and Fort Mill Medical Center will be well utilized? Did you hear testimony with respect to that in this case?

A: Yes, I did. But I think what, in my opinion, what that testimony failed to consider is the second part of criterion 6(b), and that indicates that projected levels of utilization have to be consistent with the need of the target population. And so what I heard the Piedmont witnesses indicate is that because there were other hospitals operating in the region at 55 percent occupancy, that they met this criterion because that was the experience of other providers. But you could have a situation where other providers in the region were operating at 20 percent occupancy and that wouldn't mean that you needed to build 100 beds for -- to serve 20 patients a day. So you have to look at not only what other facilities have experienced, but also what is the projected need of the target population. And I would also add to that is just because those other hospitals are operating at 55 percent currently doesn't mean that in years past they weren't operating at higher occupancy rates or that they simply

have overbuilt facilities. But there's no indication that 55 percent is a target level that's supported by the need of the target population.

Q: And I think you indicated a moment ago that Piedmont had generated a bed need, but it also had unused beds and lower occupancy levels than what they said they needed beds. Do you have a demonstrative that illustrates this?

A: Yes, I do. And I think this is, to me, demonstrates that their testimony has been somewhat inconsistent. On the far right, the far right two bars show the projected occupancy rate based on Piedmont's projections for Piedmont and Rock Hill in 2017, 66.2 percent, and for Fort Mill Medical Center at 58.2 percent. Again, these are their projections for the third year that Fort Mill Medical Center is opened. And they have said that at 66 percent occupancy at Piedmont and 58 percent at Fort Mill, they are well utilized. Yet they've also said that when Piedmont was operating at 73.6 percent occupancy in 2005, it had 19 unused and available beds, and that was why they could move 36 beds to the Fort Mill Medical Center.

Similarly, based on an occupancy rate of 62 percent in 2011, they're saying they have over 100 unused beds, and that's the reason that they can move that -- those 36 beds to Fort Mill. So in my opinion, it's not consistent to say at similar or lower occupancy rates, we're well utilized, but at similar or in the case of 2005 higher occupancy rates, we have unused and available beds.

Q: Do you believe that the population growth in northern York County will lead to a need for 100 beds in the future?

A: I don't believe that Piedmont has demonstrated anywhere that I've seen that at what point in time the population will need 100 beds. And as I said a moment ago, yes, the population is growing, but there are also factors at play relative to inpatient hospitalization that are going against that population growth. Some of the industry trends I've talked about and the fact that we had, you know, Medicare is already not paying for readmissions, and that's affecting how many patients are readmitted to the hospital. SG2, which is a well-known health care intelligence company has estimated

that 25 to 30 percent of hospital admissions to a community hospital are not going to be admissions in the future. We have some of these other pilot projects that I mentioned, like Geisinger and others that are showing evidence of reducing hospital admissions by anywhere from 10 to 20 percent. So I think those factors are at play in conjunction with the population growth. And, to me, the bottom line is Piedmont has not demonstrated that they need these 100 beds in Fort Mill.

Q: Do you agree with Piedmont's experts, and I think it was Mr. Sullivan who commented on this, that it's wiser health planning to build 100 bed capacity now.

A: I don't agree if you haven't demonstrated a need for those beds within some reasonable time frame that you should build beds that you haven't demonstrated are needed. And again, I think that is not consistent with the testimony that Mr. Sullivan gave in the Wake County case we referenced a moment ago.

Q: And how is that?

A: Well, in that case, the purple area that I showed on the map, Holly Springs has a pop- --

or was projected to have a population of about 133,000 in 2017. And Mr. Sullivan had opined that that was not sufficient for a 50 -- to support a 50-bed hospital. And if you look at the population of northern York, those three zip codes are about 86,000 in 2017. And yet, he says that population, that makes wise health planning to build 100 beds in that scenario.

Q: And let's look at Demonstrative 4.37. If you could comment on this demonstrative.

A: Yes. This is -- shows the population of Holly Springs, as I was just talking about, that the 133,000 that was part of that service area, which Mr. Sullivan said was insufficient to support a 50-bed hospital, compared to the northern York 2017 population of 86,000 where, again, in my opinion, the hospital in Fort Mill is needed geographically to serve northern York patients, not -- it isn't needed for improved geographic access for the rest of York County, and so that 86,000, Mr. Sullivan thought was wise health planning to build 100 beds. I would also note that in his testimony, if he didn't mean the entire Holly Springs service area but just meant the town of Holly Springs,

that was projected to still be at about 60,000 residents in 2017. And again, he said the 60,000 was insufficient for 50 beds, but yet 86,000 is sufficient for 100 beds.

Q: Okay. And let's look at this testimony that you were referencing in the Wake County case. Can you show us the specific portions of Mr. Sullivan's testimony that you're relying on?

A: Sure. And again, this would come from page 48, and I'll -- I'm sorry. And I think a couple things here. He was talking about what I had alluded to a moment ago, and that is the overall factors affecting inpatient utilization. And he says starting on line 4 -- well, the question is, "None of us as we sit here today can know if what -- what future utilization patterns may bring." And he answers starting on line 4, "Right. And -- and, you know, I think that, you know, health planning decisions need to be based on the most recent and accurate information that you can use. And, you know, if this were, you know, if we were in an economic situation where we're still having, you know, substantial economic growth, and there was a one year blip in utilization, I think you

could write it off as, you know, as -- as an anomaly. But when you see nationwide -- you see declines in hospital utilization, and then you see a Wake County, albeit a little bit later in time than some other parts of the country, I think you have to be concerned that maybe there is a little bit of a change in the demand curve and how that's going to play out in the future. And I could be wrong, I mean, in 2012, the numbers could -- could be up higher. But, you know, what we're seeing in other parts of the country is the numbers have -- have stayed relatively flat over a period of time." And just by way of background here, I say to explain that in the course of the Wake County litigation, Mr. Sullivan and his client had decided that there wasn't a bed need after all and the beds that they had applied for shouldn't have been approved. And so that was why he was arguing the -- about the -- about the utilization here.

Q: Okay. We can look on the next page, our Demonstrative 4.39. I think you have another reference to Mr. Sullivan's testimony in the Wake County case.

A: Yes. And this is from page 208, and I'll pull out the relevant portion. And this was referencing the population base issue that I was just discussing, and he was being asked how high does the population base have to be to support that 50-bed hospital. And he begins to answer on line 9 and talks about the four beds per 1,000, which I think he testified to here. But the relevant portion starts on line 13. He says, "So if you can capture 100 percent market share, in theory, you could probably support a 50-bed hospital with a population of only 25,000 or 30,000 people. But in the real world, a small hospital competing against larger community and tertiary hospitals, you probably need a relative large population base in order to support it. You know, in this case, I think the population would have to be substantially larger than Holly Springs in order to be able to achieve a sufficient volume to support the hospital."

Q: Okay. Does Fort Mill Medical Center here propose to serve patients from outside of northern York County?

A: Yes, they do.

Q: Do you have any opinions relative to whether they need a new hospital or not to do that?

A: Yes. Again, the proposed to serve patients throughout York County, although a very small portion from western York zip codes, but as I've -- as I said, I think that in my opinion, the accessibility issue that is Piedmont's reason for needing to serve -- needing to build a Fort Mill Medical Center is based largely on the three zip codes in northern York County and possibly on that portion of zip code 27230 and then the very southern York zip code that we talked about at most. Otherwise, everybody else that they're proposing to serve has sufficient access to a Piedmont hospital bed at Piedmont Medical Center in Rock Hill.

Q: Okay. Well, turn to Demonstrative 4.40. Ms. Carter, I think that brings us up to your second opinion. And before we go there, can you just give us a conclusion, if you can, on your first opinion that we've just been discussing this morning.

A: It is that, essentially, Piedmont did not demonstrate a need for its project. It didn't demonstrate that it needed to build 100 beds at

Fort Mill Medical Center. Their projections for that facility are unreasonable and, I think, highly unlikely to be achieved, and there's no reasonable assumption to believe that they would be achieved, and their own projections, if you accept their own projections, do not demonstrate that their facility is needed in Fort Mill.

Q: Okay. And we can move now to your second opinion. It is that Fort Mill Medical Center is 100 beds or an unnecessary duplication and maldistribution.

A: Yes, that's correct.

Q: So do your opinions on this subject relate to specific review criteria?

A: Yes, they do.

Q: And which ones are those?

A: Criteria 2(d), 3(a), 3(b), and 22. And I would highlight in particular 2(d), which says that in the case of relocation, which is what Piedmont is proposing to do with the 36 beds, the applicant should address the need that the population presently has for the service the extent to which that need will be met by the proposed relocation. So to me, that says that if you're proposing to relocate, in this case

beds, you have to address the population that is currently utilizing those beds and the degree to which the need of that population will be met by the relocation.

Q: And what are the reasons that you believe Piedmont Medical Center does not comply with these criteria that you just listed?

A: Well, first of all, I don't believe that Piedmont demonstrated that the 36 beds that it's proposing to move to Fort Mill Medical Center would not be needed by the population that they're presently serving. And specifically, as I said a moment ago, the 2012/2013 State Health Plan shows that Piedmont, it actually indicates that Piedmont will have a bed need for 16 patients in 2018. And I would point out that this is based on the 2011 patients and patient days that were served by Piedmont. So those patients that Piedmont served in 2011, if we apply a population growth factor to those patients, those are the patients that are going to need the 16 additional beds in 2018, according to the State Health Plan.

Q: And where do these patients that PMC or Piedmont Medical Center now serves, where do

they reside?

A: The York County patients that they serve reside largely in Rock Hill and western York. Of their York County patients, 90 percent reside in the Rock Hill zip codes or the western York zip codes. Again, in 2011, only 11 patients a day resided from -- resided in the three northern York zip codes. And so it's this predominantly Rock Hill and western York population and that utilization that is driving the bed need for 16 additional beds at Piedmont in 2018.

Q: Well, let's look if we can at Piedmont's Demonstrative 178 that we've seen in this case. I think we've got it on a slide up on the screen. Have Piedmont witnesses testified that they currently have an excess of 100 beds per day?

A: Yes, they have.

Q: Would you comment on this?

A: Well, I think they failed to consider three things when they looked at this demonstrative. And, first of all, that demonstrative includes psychiatric beds and patients, and you certainly couldn't put general acute care patients in psychiatric beds. They also did not factor in

an occupancy rate as the State Plan methodology does as you do when you're planning for beds. And that occupancy rate factors in not only the seasonal fluctuation and volume that you have, but the volume you have based on days of the week, and even specific hours of the day are more heavily utilized. So you need to factor in that occupancy rate in order to ensure that there are beds at Piedmont. And secondly -- or excuse me, thirdly, they considered only their 2011 volume and didn't look to the future 2018 volume to determine the bed need at Piedmont.

Q: Have you calculated the impact of those changes?

A: I have.

Q: Would you please walk us through that.

A: First of all, I adjusted for the first two. I deleted the psychiatric beds and counted only the licensed acute beds and also the acute average daily census from the State Plan, and then adjusted for the occupancy factor that's applied to a hospital the size of Piedmont. And that's 70 percent, according to the State Health Plan. And if you do that math, that means that based on the 2011 data, there would be 31 available beds in 2011. If they relocate

36 beds to Fort Mill Medical Center, then there would be a five bed deficit at Piedmont.

Q: And have you applied the same formula to 2018?

A: I did.

Q: If you could please describe that for us.

A: Again, I looked at the acute average daily census from the State Health Plan, adjusted that for the 70 percent occupancy, and that showed, as it does in the State Plan, a 16 be deficit at Piedmont. If we then relocate, if they relocate 36 beds to Fort Mill Medical Center, that would create an even bigger bed deficit at Piedmont of 52 beds in 2018.

Q: Okay. And does this conclude your opinion number two?

A: No. Actually, I have one more factor here. Because in addition to relocating beds, Fort Mill Medical Center also indicated that they were going to shift patients that are currently served at Piedmont to Fort Mill Medical Center, so I made a final adjustment and took the 230 -- or excuse me, the 36 beds that they're going to relocate to Fort Mill, which left -- leaves them with 232 beds at Piedmont, and I also subtracted the patients that they're going to

shift to Fort Mill from Piedmont, and they still would then result in 2018 with an eight bed deficit at Piedmont. But I think the other important thing to point out about this, in addition to the bed deficit at Piedmont, is the fact that they are shifting 36 beds to Fort Mill and 31 patients per day from Piedmont to Fort Mill, in my opinion, is the very definition to unnecessary duplication. Because except for those 11 patients that are in northern York County, arguably the rest of those patients have access to those beds, and in fact, they're utilizing those beds now at Piedmont, and in my opinion, is unnecessary duplication for them to then move those beds, spend the capital to move beds that they already have to Fort Mill and move the patients along with them.

Q: Thank you. And does that bring us now to your third opinion?

A: Yes, it does.

MS. ROBERTSON: Your Honor, I think this is probably a reasonable spot to stop. If you want to stop for a lunch break because the third one is a little lengthy.

the contribution margin impact would be 12 million.

Q: Okay. Let's look at that slide. I think it's Demonstrative 4.75. Is that reflected in this demonstrative?

A: Yes. Again, I made the same adjustment to pre-tax income for that $12 million reduction in contribution margin and the -- that would adjust their net income in 2011 to a margin of 2.1 percent, and based on 2012 performance, a margin of 4.6 percent.

Q: Okay. Let's now move to your next subpart under your opinion three. Let's look at subpart C. If you can tell us what this opinion is.

A: In my opinion, and based on the analysis I've done, I believe actually Fort Mill Medical Center will have a greater impact on Piedmont than a CMC-Fort Mill Hospital.

Q: And did you hear Mr. Grice testify, I believe it was Mr. Grice, that in his opinion, Fort Mill Medical Center could repair the volume declines at Piedmont Medical Center?

A: Yes, I did hear him say that.

Q: And could you please comment on that?

A: Well, first of all, in order to do that they would have to achieve their projections, and I've already talked about my opinions about the difficulty I thought that they would have in doing that. And in addition to that, their inability to do that, I think it would not put them in a better financial position.

Q: What supports your opinion here?

A: Well, I examined the information submitted to DHEC in this review, the projected financial statements for both Fort Mill Medical Center itself, as well as Piedmont Medical Center with the development of Fort Mill Medical Center, and if you look at the year five, I took this all the way out to year five, they project in 2019 that Fort Mill Medical Center itself will have a net income of about 2.9 million, and then at the same time, they project that Piedmont Medical Center will have a net income of about 7.3 million. Those two combined is a total combined net income of 10.3 million, which based on their revenue at those two facilities results in -- their projected revenue results in a 2.5 percent margin.

Q: And did you compare that against their 2012

actual margins?
A: Yes, I did.
Q: Okay. Let's look at a demonstrative on that and have you comment, 4.78.
A: If you take their, again, projected combined net income in 2019 of 10.3 million and a 2.5 percent margin and compare that to what they reported to York County for 2012, that was a $16.4 million after tax net income and that represented a seven percent margin. Again, based on a difference from their current position today, what they're projecting with Fort Mill Medical Center would be a reduction from their current position.
Q: Now, have you created a chart that summarizes your discussion here?
A: Yes.
Q: Okay. Let's look at that on Demonstrative 4.79.
A: I tried to bring this together because I know there have been a lot of numbers and a lot of margin numbers that I've been discussing, but looking at this in three segments, first of all, this summarizes Piedmont's actual margins from 2005 to 2012 during this time that they

were losing share to Carolinas and feeling the impact of that as they have testified to. And as you can see here, as I stated earlier, other than the one year where they had a margin of 1.2 percent, every other year their margins have been three percent or considerably higher than three percent. Then the analyses that we just -- the various analyses that I walked through, my analysis of the impact at 677 patients or two million in contribution margin, Mr. Levitt's analysis of the 2044 patients or eight million dollar contribution margin, or his other analysis at over 3,000 patients and a $12 million contribution margin, if you look at all of those, again, the only one that has a margin well below three percent is Mr. Levitt's $12 million contribution margin impact, and that results in a 2.1 percent overall margin for Piedmont. And I would point out a couple of things, again, for that -- for that to occur, to going back to the very first demonstrative I had with the arrows and the map, you have to believe their assumptions about what patients are going to do and that the vast majority of patients now going to North Carolina for care

are going to continue to go to North Carolina for care. If that doesn't happen, then there's no way that adverse impact comes about. And then lastly, I looked at this compared to Piedmont's own projections that we just talked about with Piedmont and Fort Mill combined, and that's a -- and they project a combined margin of 2.5 percent, which aside from these two I have highlighted here, that's actually the lowest margin of any of the either actual or the various scenarios that I've discussed.

Q: Let's go back to your summary of opinions. I think we're up to the subparagraph D under your third opinion, and that opinion is the CMC-Fort Mill will not jeopardize Piedmont's services to York County. We've been talking a lot about the financial components of Piedmont's adverse impact. Do you also recall testimony in this case about services that would diminish at Piedmont as a result of CMC-Fort Mill?

A: Yes, I do.

Q: And I think those were services like open heart, emergency, neonatal and intensive care; do you recall that?

A: I believe those were some of the services that

Thursday.

MR. WESTBROOK: Yes, that would be good.

MR. MULLER: This was one of the exhibits that was missing pages and we just -- we needed to go back and check it. And so Mr. Westbrook and I will try to resolve that by Thursday.

THE COURT: If you could, yes. Great. All right. Was there anything else we needed to take up now?

MS. ROBERTSON: No, Your Honor.

THE COURT: All right. If not, then we're at recess until Thursday.

(There being nothing further, Day Twelve recessed at 4:05 p.m.)

DAY THIRTEEN - THURSDAY, MAY 2, 2013

THE COURT: Okay. We're back on the record. And I believe we are ready to start the cross-examination of Ms. Carter, is that right?

MR. WESTBROOK: Yes, Your Honor.

THE COURT: All right. Ready to go, Mr. Westbrook?

MR. WESTBROOK: I am. Thank you.

MS. CARTER - CROSS EXAMINATION BY MR. WESTBROOK:

Q: I am. Good morning, Ms. Carter.

A: Good morning.

Q: Ms. Carter, I would like to start today with

your Demonstrative 4.2.

MR. WESTBROOK: And if I could ask Dan to put that up on the screen, please.

Q: This is the one that's on the screen now. It's entitled, No adverse impact on PMC from CMC-Fort Mill. And I want to ask you about that second paragraph under the arrows over there. It says, "But if CMC-FM is approved, PMC's adverse impact assumes that 60 to 80 percent of northern York patients now going to North Carolina hospitals will continue to travel to North Carolina hospitals and a much smaller percentage will stay in their home community." Is that right?

A: Yes.

Q: Okay. I just want to clarify that I understand the basis for the 60 to 80 percent. I think I understand.

MR. WESTBROOK: But I want to ask Dan to put -- well, the source there is Piedmont Exhibit 104 at CHS's Exhibit 32. Let me ask Dan, put up Piedmont's Exhibit 104 on the screen, please. And that's hard to read. We will isolate it.

Q: I just want to focus on those northern York County zip codes, and those I believe are

29707, 708 and 715, right?

A: Yes.

Q: All right. Let's start, let's just focus on 707 to start off with since it's the first one. And just by way of explanation, the first -- this of course, is Mr. Levitt's adverse impact analysis up here, but that first part, what I'm going to say, see where's labeled at the top 2011, I think of this sort of in thirds. That first big block from 2011 down to the next heading, 2017, that first block is Mr. Levitt's, what he says are the 2011 numbers and market shares, number of discharges and market shares for Piedmont and all North Carolina hospitals, is that right?

A: Yes.

Q: Okay. And then the second block, that middle block where it says 2017, those are Mr. Levitt's projections for 2017 if there is no hospital at all in Fort Mill, is that right?

A: That's my understanding, yes.

Q: Okay. And the bottom block, which also is labeled 2017, that's -- those are his projections if there is, it says a proposed North Carolina provider in Fort Mill, but since

right now the only possibility for that would be CMC-Fort Mill, right? So those are essentially his projections if CMC-Fort Mill is approved, is that right?

A: That's correct.

Q: Okay. Let's just look at -- as I said, let's start out on the top with the 2011 data with 29707.

MR. WESTBROOK: And I want you -- Dan, if you would highlight about four lines down to 84.7 percent.

Q: Ms. Carter, is it your understanding that that is the current market share for that zip code for all of North Carolina hospitals?

A: That's correct. That is what that number represents.

Q: Right. That was what I thought. And the -- let's go down, work our way down 29707 to the middle part, and we see 84.7 percent again, fourth line down. And is it your understanding that is what Mr. Levitt would project the market share would be for North Carolina providers if there's no hospital in Fort Mill in 2017?

A: Yes. My understanding is for 2017, without a hospital in Fort Mill, Mr. Levitt assumed that

market share would stay the same and the only change would be the growth and discharges resulting from population.

Q: Okay. Thank you. And let's go down to the bottom third, the bottom part of this chart. And again, looking at 29707, let's go down to about four lines down, it says 51.5 percent, see that?

A: Yes.

Q: And is it your understanding that that is Mr. Levitt's projection for North Carolina providers, that is, providers obviously in North Carolina, if CMC-Fort Mill is approved? Is that your understanding?

A: That is the market share that would remain in North Carolina if CMC-Fort Mill is approved.

Q: Okay. And, Ms. Carter, you may not need it for this question, but you're going to need it sooner or later. Do you have your calculator with you by chance?

A: There is a calculator up here.

Q: Okay. If you would, that 51.5 percent that we see there, his projected market share for North Carolina providers if CMC-Fort Mill is approved, would you divide that by that 84.7 that is in

the middle block, which is what the market share for North Carolina providers would be if there is no Fort Mill hospital. Just divide 51.5 by 84.7.

A: That's 61 percent.

Q: Okay. And going back -- we you don't have to --

MR. WESTBROOK: Dan, you can stay where you are.

Q: But going back to your Demonstrative 4.2, I think you said in that middle paragraph that I read out it was 60 to 80 percent, is that right?

A: That's correct.

Q: Is that the -- where you got the 60 percent from?

A: Yes.

Q: Is that how you got the 60 percent?

A: Yes.

Q: Okay. That's what I thought. I just wanted to make sure I understood that. And I don't want to take too long to do this, but let's just go over --

MR. WESTBROOK: You don't need to go to the top of the page, Dan. Let's just go over 29708.

Q: And if you'll see for 29708, it's 78 percent,

excuse me, 78.6 percent is his projected market share if there's no Fort Mill hospital, and if you go down, 56.6 percent if CMC-Fort Mill is built, right?

A: Yes.

Q: And so if you divide 56.6 by 78.6, it would fall somewhere between 60 and 80, wouldn't it?

A: It's 72 percent.

Q: Seventy-two percent. And finally, go over and let's do the same thing quickly for 29715. It would be 64.7 percent and the corresponding number for 2017 would be that 50.7 percent and you make that division and it still falls in that range?

A: Yes.

Q: How much is that?

A: That's -- I believe that's 78 percent.

Q: Seventy-eight percent. So that's where you got your range of 60 to 80, I just wanted to confirm that and make sure I understood that, would be dividing those projections for the North Carolina providers in 2017 if CMC-Fort Mill is approved, divide those percentages by the percentage if there's no Fort Mill hospital in 2017, is that right?

A: Yes.
Q: Did I say that right?
A: Well, let me make sure. It is the percentage of share that would remain going to North Carolina providers divided by the current percent of share going to North Carolina providers.
Q: All right. So again, it would be those numbers that we have highlighted there on the screen and that range I believe is like 61 to 78 percent. Is that what you came up with?
A: I believe so, yes.
Q: All right. Thank you for clarifying that. Now let's just look at the bottom part.
MR. WESTBROOK: Let's go back to 29707, Dan, and why don't we just call out the bottom part I think now and make it a little bit larger. And, yeah, let's just look at 29707.
Q: Now, in 29707, what he projects, if you see down there, there's a line item that says "total." He projects there is going to be 1,332 -- 1,332 patients from that zip code in 2017, right?
A: Yes, going to some provider somewhere.
Q: Going to some provider somewhere. And he

divies those up, does he not, by saying we've already established he believes that 51.5 percent are going to go to North Carolina providers, right?

A: Well, as I recall his testimony and how it worked, that wasn't the first one. He first established that he thought that 40 percent would go to the North Carolina Fort Mill hospital and then he determined of that, the -- which one, he determined where it shows in that zip code the percent from Piedmont and from North Carolina providers, the 17 percent and 83 percent, he then determined what that was going to be and then the math worked out between Piedmont and North Carolina providers.

Q: All right. But where he ended up was projecting that 51.5 percent of that 1,332 would go to North Carolina providers. That's where he ended up on this chart, right?

A: Yes.

Q: And that 51.5 percent of 1,332 is presumably, or at least by Mr. Levitt's calculation, you can check him if you want to, but it's 686 is what he's got up there, right? So 686 patients out of those 1,332 would go to North Carolina

providers. Is that his projection?
A: Yes.
Q: And he's projecting, where he ended up with was that Fort Mill Medical Center would get 40 percent of that 1,332, correct?
A: Yes.
Q: And that's 533?
A: Yes.
Q: And that Piedmont would get 2.4 percent of that 1,332, which is 33 patients, is that right?
A: Yes.
Q: All right. And we can do that for 29708 and 297 -- yeah, 29715, but it's the same, it's the same formula, right, that he ended up doing for each one of those zips, is that right?
A: Yes.
Q: Now, so again, just focusing on 29707, one of those three zips, Mr. Levitt's projection, if I understand it, is that of the 1,332 total patients from that zip code in 2017, 51.5 percent would go to North Carolina hospitals and 40 percent would go to CMC-Fort Mill and a little over two percent would go to Piedmont; is that his projection?
A: Yes.

Q: Okay. Thank you. Now, let's go to the Rock Hill zip codes. The two Rock Hill zip codes are 29730 and 29732, right?

A: Yes.

MR. WESTBROOK: And actually, Dan, if you don't mind, let's take us back to Ms. Carter's Demonstrative 4.2, I believe it is.

Q: And 4.2, let's look at that last paragraph at the bottom that says, And 80 to 90 percent of patients from Rock Hill will drive past a CMC-Fort Mill hospital to continue to go to North Carolina for care, right?

A: Yes.

Q: And again, I just want to clarify that 80 to 90 percent, and I think I understand where you get that, but I want to make sure I understand it right.

MR. WESTBROOK: Let's go back to Exhibit 104 Dan. Let's take a look at 29730 I guess is the first one. And 29730 for that -- let's go to that, well, where's 29730, would you highlight that for us, Dan. Okay. It's those two at the end.

Q: Again, about -- for 2-9 -- about four lines down, there's there 22.4 percent, and again, that is the current, according to Mr. Levitt,

that's the current market share that North Carolina hospitals have for that zip code, is that correct?

A: Yes.

Q: And if we go down to the middle part, I've decided to challenge Mr. Bupp this morning. If we could go down to the middle part of this chart. Again, let's look at 29730 and about four lines down, there is that 22.4 percent, which he's projecting essentially wouldn't change, right, if there's no Fort Mill hospital?

A: That's correct.

Q: Okay. And then if we go down to the bottom part -- well, I'm sorry -- yeah, let's go down to the bottom part, the bottom part of the chart, 29730, and we've got there what he's projecting for that zip code for 2017. If there's a Fort Mill hospital there, he is projecting 19.4 percent for North Carolina hospitals, right?

A: That's correct.

Q: And if you divide the 19.4 by the 22.4 earlier, you are going to get something between 80 and 90 percent, is that correct?

A: It's 87 percent.

Q: Eighty-seven percent. Okay. Thank you. And again, just quickly the same thing with 29732, you've got -- for 29732, you've got his 2017 -- we don't even need to go to the top. Let's look at the 2017 projection for North Carolina hospitals without a Fort Mill hospital is 29.1. His projection if there is a Fort Mill hospital for North Carolina providers is, is it 23.3? No. Yeah, that's the middle, it's 29.1 if there is none, no Fort Mill hospital, but if there is a Fort Mill hospital, you go down to the bottom part and for 29732, it's 23.3, right?

A: Yes.

Q: Okay. And you divide 23.3 divided by that 29.1 and you get?

A: Eighty percent.

Q: Eighty percent. So that's where you get your 80 to 90 percent, one is 80 and one is 87, is that right?

A: That's correct.

Q: And that is where you got that 80 to 90 percent, correct?

A: Yer.

Q: I'm right on that?

A: Yes.
Q: All right. And again, just to clarify his projections.
MR. WESTBROOK: Let's stay on the bottom part, Dan, for those two zip codes. He -- well let's just look at the first zip code, 29730.
Q: For 29730, he's got a total number of patients from that zip code that he projects in 2017 of 5,429, 5,429, is that right?
A: Yes.
Q: And he's projecting that 19.4 of those are going to go to a North Carolina hospital, I think we've already looked at that number, and he's projecting that 20 percent -- when I say 19.4, I should have said 19.4 percent of those, and 19.4 percent of 5,429 is 1,053, is that correct?
A: I assume so.
Q: Unless he's calculated wrong.
A: Yes. 1,053.
Q: Okay. And then 20 percent, he's projecting 20 percent of that 5,429 would go to CMC-Fort Mill, and he says, he calculates that as 1,086, is that correct?
A: Yes.

Q: And he's projecting that 56 percent of that zip code would go to Piedmont, and that's 3,041, is that right?
A: Yes.
Q: So Mr. Levitt's projection for 2017 is at least for that zip code of the 5,429 patients, 20 percent would go to CMC-Fort Mill, 19.4 percent would go to North Carolina and 56 percent would go to Piedmont, right?
A: Yes.
Q: And you could do -- we won't take the time to go through 2973 whatever the other one is too, but it would be the same calculation, wouldn't it?
A: Yes.
Q: Set of calculations? Okay. Thanks. Thank you, Ms. Carter. Okay, let's go ---
MR. WESTBROOK: I think we can take that off the board now or off the screen now, Dan. Thank you.
Q: Now, it's clear, it's been made clear I think throughout this hearing and before this hearing that CHS's position is in this case and that your opinion is that CMC-Fort Mill is not going to shift any market share from PMC if it's

approved, is that right?

A: No additional market share, that's right.

Q: No additional market share, right. Okay. Thank you. And just to be clear on that, CHS projects that CMC-Fort Mill is going to shift zero discharges from Piedmont after CMC-Fort Mill is built, is that correct?

A: Well, I think the way I explained it in my direct testimony is that the assumption that there is no shift from any hospital other than the CHS hospitals is based on a pattern of utilization. And so, you know, there are a variety of circumstances that patients would make up that pattern of utilization, but that pattern of utilization would remain the same as represented by the CHS market share, current market share.

Q: But the result of that pattern of utilization would be, in your opinion and CHS's position, that zero discharges would shift from Piedmont to CMC-Fort Mill?

A: The equivalent effect of that is that if you look at market share and you translate that to discharges, it wouldn't be any additional discharges shifting from Piedmont.

Q: None, right?
A: That's correct.
Q: All right. And another way of saying that is that CMC-Fort Mill will not take any more patients from Piedmont than they've already taken, is that right?
A: Again, I think to, as I said on Tuesday, if you're thinking about this in terms of a pattern of utilization, there are going to be patients of the CMC-Fort Mill hospital who have previously been inpatients at a CHS facility. That pattern of utilization, there' going to be a component of that pattern of utilization that consists of patients who have been patients at CHS hospitals before and now go to the CMC-Fort Mill hospital. Within that, there is going to be a set of patients who've never been an inpatient before, but again, are representative of that pattern of patients that historically go to CHS hospitals and that pattern is still going -- is going to shift to CMC-Fort Mill. So to try to isolate it down to patients number one through number 5,000, that set of patients is different every year. But it is what, it is the set of patients in the aggregate represented

by the market share that is representative of what I'm discussing in my testimony.

Q: Okay. I think I understand what you're saying but just to help, again, help me clarify your position on that.

MR. WESTBROOK: Dan, would you put up Ms. Carter's deposition, please.

Q: And let me get a copy of it, Ms. Carter for you to take a look at. Ms. Carter, you've got multiple depositions here. Let's see if I can help guide you so you don't have to turn to -- where I'm going to be looking, Ms. Carter, is where I'm asking Dan to put on the screen and ask you to look at is the deposition dated February 14th, 2013.

A: Okay. I have that.

Q: All right. Good. Let's turn to page 104, please.

A: 1-0?

Q: 104.

A: Four.

MR. WESTBROOK: And I'm going to ask Dan to highlight lines one through six, please.

Q: And let's just publish it. I'll read the question and you read the answer, and then feel

free to explain. The question starts mid sentence on line 1, "Is it your understanding," I'm going to read from here. "Is it your understanding, is it CHS's position and your opinion that CHS by shifting that volume to CMC-Fort Mill, that CMC-Fort Mill is not going to take any more patients from Piedmont?" And what's your answer?

A: "Yes, that is the basis of the projection in the application."

Q: Okay. Now, is that the same thing that you were just saying? It may have been. I just wasn't sure.

A: As I said on Tuesday, and I believe I specifically said on Tuesday that both in the course of the deposition and in my testimony on Tuesday, I was, as a planner, I tend to think of share and patients and use those terms interchangeably. And so, again, in the sense that patients is represented by the pattern of utilization and by the current market share that CHS has, then that is correct, that there would be no more share shifted, there would be no more pattern, there would be no more pattern changes shifted from Piedmont.

Q: All right. Ms. Carter, the emergency department is a source -- let me see if I can phrase this better. For CHS hospitals, and I assume all hospitals, you can tell me if you disagree, a high percentage of inpatient admissions come through the emergency department, isn't that correct?

A: Generally, usually a majority of inpatient admissions come through the emergency department.

Q: All right. Good. And CHS, there's been a good bit of testimony in this case about CHS's acquisition of physician practices in York County in the last several years, and you've been here for most or all of the testimony, haven't you?

A: Yes.

Q: And CHS, in your opinion, is not going to stop acquiring physician practices in York County if CMC-Fort Mill is built?

A: Well, as I believe I have said in this same deposition, I think that -- I think that what's happened in York County, in my opinion, is similar to other markets, there has been a lot of activity that tends to get concentrated in a

few years, and that seems based on the data, and I think even reflected by Mr. Levitt's, I know at least in his deposition, he said that he thought Piedmont's market share had gone up and their volume had gone up in 2012, that would seem to bear out that some of the activity over the last several years has settled down. That doesn't mean that CHS won't acquire physician practices in the future; it doesn't mean that Piedmont won't acquire physician practices in the future or Novant continue to acquire physician practices in the future.

Q: All right. So I think what you said there, again, just responsive to my question was you would expect CHS to continue to acquire physician practices in York County in the future if CMC-Fort Mill is built, right?

A: I would expect based on where I believe the healthcare industry is going that all of the providers, CHS, Novant, and Piedmont included would continue to acquire physician practices in York County.

Q: All right. And you mentioned the last year or two, I'm not sure exactly sure how you put it a moment ago, but utilization of Piedmont did you

say had leveled off or gone -- been a slight increase or something of that nature?

A: I believe I recall Mr. Levitt, again he may have testified to it in his trial, but I specifically recall in his deposition he indicated in 2011 and 2012, he thought the Piedmont utilization had gone up and their market share had gone up.

Q: Right. But the increase in Piedmont's utilization in the last few years has been from uninsured patients, hasn't it?

A: I haven't -- I know I've heard testimony that, as I said on Tuesday, my experience with clients in about every market I serve, their commercial patients have gone down, their charity care uninsured patients have gone up, their Medicaid patients have gone up, and I recall testimony that Piedmont's mix of patients have shifted, like the industry has shifted to more uninsured, more Medicaid, fewer commercial payments. In terms of actually looking at the patients that are driving the increase, I haven't analyzed those specific patients in terms of what their payer mix is. But Piedmont's payer mix has changed, as I just

said, such that commercial has gone down, Medicaid and uninsured have gone up as with just about every other client I work with.

Q: All right.

MR. WESTBROOK: Dan, let's look at Piedmont's Demonstrative 159, please.

Q: Do you recall seeing this demonstrative earlier during the testimony I think of Mr. Masterton?

A: Yes, I do believe I recall seeing this.

Q: All right. Now, I recall at the time Mr. Muller has some objections to this because the scales on either side, there are different scales, aren't there, the one from managed commercial and the one for self-pay charity, right?

A: Yes.

Q: But it says there, sort of the I guess the point there, according to this chart, it says it's sourced in the ORS, and that's the South Carolina Office of Research and Statistics, is that right?

A: Yes.

Q: Is that self-pay charity admissions at Piedmont during this period of time have increased 175 percent and managed commercials down negative

23, is that right? Is that what it says?

A: That's correct.

Q: Now, again to overcome, so I don't want to mislead and Mr. Muller felt this was misleading demonstrative. Let's go to another demonstrative that takes those two sort of bottom line figures.

MR. WESTBROOK: And Dan, this would be Demonstrative, I believe, it is 282. Yeah.

Q: Now, that shows, again, doesn't that show what the previous chart showed that during this period of time a 23 percent decrease at Piedmont in managed care commercial admissions and a 175 percent increase?

A: It shows those two percentages, and I would make two comments. Again, this is -- this is -- this trend is very consistent within the industry, consistent with the clients that -- consistent with the experience of my clients. And the other thing I would note relative to the testimony I gave a moment ago, what I have not analyzed is to determine whether the historical share that Piedmont has had, whether the payer mix within that population has changed or the increase, or what is the payer mix of

the increase that specifically Piedmont has gained.

Q: So, I'm sorry, I wasn't sure I quite followed what you just said. You said you had not looked at the payer mix in York County to see if it's changed for the last few years?

A: No, I did not say that.

Q: And have you seen anything that would suggest that CHS as a whole or any CHS facility, as far as that goes, has experienced a 175 percent increase in self-pay charity admissions in the last six or seven years?

A: I have not looked at, to the best of my recollection, I haven't looked at the percentage increase.

Q: Have you looked at anything that would indicate that CHS or any CHS facilities experienced a 23 percent drop in managed care commercial in the last six to seven years?

A: I have not calculated the percentage increase for CHS in terms of payer mix from 2005 to 2011.

Q: Okay. Now, if CMC-Fort Mill is approved, CHS physicians in York County are going to continue to refer their patients to CHS facilities.

Wouldn't you expect that to be true?
A: That would be my expectation.
Q: That would be consistent with the industry trends, the testimony you gave the other day, wouldn't it?
A: Yes.
Q: All right. And the most important factor in determining where a patient goes for specialty physician services is referral by their primary care physician, isn't that right?
A: That's my opinion, yes.
Q: All right.
MR. WESTBROOK: Let's look, Dan let's look at, pull up CHS 9692.
Q: This is the New England Journal of Medicine article that you read into the record, parts of it yesterday, correct?
A: Yes.
Q: And just to give the title, it says, Hospitals race to employ physicians, the logic behind a money losing proposition by Dr., how do you pronounce that fellow's name, do you know?
A: I do not know.
Q: K-O-C-H-E-R and Dr. Sahni, S-A-H-N-I, is that right?

A: Yes, although I think Mr. Sahni is just a mister, not a doctor.

Q: You're right, BS. All right. I'm going to ask you to read part of this into the record, please.

MR. WESTBROOK: Let's go down and, Dan, would you highlight the portion that I gave to you earlier and why don't -- well, let's just read that and then we'll go, because it spills over to the next page. Dan, why don't we -- okay, Dan, I'm sorry, you know what you're doing a lot better than I do. You go ahead and highlight it and then we'll get Ms. Carter to read it.

Q: Okay. Why don't you just read that into the record, Ms. Carter, starting just the highlighted portions and then I'll ask you a question or two about that.

A: "For hospitals to break even, newly hired PCPs must generate at least 30 percent more visits and --" ---

Q: Let me stop you right there and ask you, PCPs stands for what?

A: Primary care physicians.

Q: Okay. Thanks. Go ahead. I'm sorry.

A: --- "at least 30 percent more visits and new specialists 25 percent more referrals than they do at the outset. After three years, hospitals expect to begin making money on employed physicians when they account for the value of all care, tests, and referrals. Skeptics note that often they already capture this value from physicians without employing them through stable referral networks and hospital practice choices. Outpatient office practices of employed physicians seldom turn a profit for hospitals. Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities."

Q: Okay. Do you agree with those statements?

A: Yes.

Q: All right.

MR. WESTBROOK: And let's go down to the next highlighted portion, Dan.

A: And let me just say that I don't, I haven't done any of my own research relative to the percentages that they specifically quote in this article. I have no reason to disagree with them, but I think in my experience, many

hospitals do lose money on primary care physicians, and they -- from a financial perspective they make it up on the volume of patients referred to specialists and/or things that are performed in their hospitals.

Q: All right. And would you read that sentence into the record, please?

A: Yes, I believe this was what I read yesterday.

Q: Oh, really? Okay.

A: Yes.

Q: Read it again, please.

A: "Hospital employed PCPs generally direct patients to their own hospitals and specialists affiliated with them."

Q: All right. Good. And since you read it into the record yesterday, I assume you agree with that as well, right?

A: Yes.

Q: All right. Now, Ms. Carter, you gave a good bit of testimony about your background, introduced your resume into evidence and so forth. You've done a good bit of CON work over the years and that's clear. The majority of that work, in fact, the vast majority of your CON work has been in North Carolina, is

that right?
A: Yes, it has.
Q: And in North Carolina, you were explaining this to me, there's a legal standard that involves where the party would be substantially prejudiced by a CON, a new CON or CON applied, is that right?
A: Yes.
Q: And that's sort of -- and that substantial prejudice analysis is not a, as I understand it, it's not a CON criteria but it's a legal standard, I believe is the way you described it, that is somewhat similar to an adverse impact analysis, is that right?
A: Let's see if I can explain this. It is not a CON standard. It is not applied in certificate of need reviews in any way. Where it has come into play in CON, it's come into play in the CON appeal process and that's whereby I mean it's a legal standard, as I understand it, as to whether or not a party to an appeal can prove legally, whether or not they even had an application in, that they would be substantially prejudiced by the outcome of the CON case.
Q: All right. And I think that you could

specifically recall testifying about substantial prejudice on one occasion. There was a deposition involving a freestanding ER case, is that right?

A: Yes.

Q: All right. And other than this case right here, and when I say this case, I mean this trial and the updated applications and the one back in 2009, the Fort Mill Medical Center case, other than this case, you can't recall another case you've worked on where adverse impact was a major issue, is that correct?

A: To the best of my recollection, no.

Q: And you yourself have never done, you yourself personally have never done an adverse impact analysis for a client who is concerned about the adverse impact, is that correct?

A: As I recall, I think I couldn't recall any at my deposition. I don't want to say that I've never done one, but I can't recall one.

Q: Okay. Let's go to the demonstrative, I'd like to go, Ms. Carter, to your Demonstrative 4.69, please, Dan. And this is a demonstrative you testified about yesterday, right?

A: Yes.

Q: And this says, the heading is "PMC's projected impact not adverse," right?
A: Yes.
Q: And you've got -- just to, just to, I know you went over this yesterday, but just to refresh our memories, I think what you've got there is a column that says Actual 2009 PMC Experience, right?
A: Yes.
Q: And is the source for that -- you've got your sources at the bottom. Would the source for those numbers be Piedmont Supp. CON.487?
A: I believe that's correct.
Q: And then the second column is Mr. Levitt's projected 2020 PMC experience with CMC-Fort Mill, is that right?
MS. ROBERTSON: Your Honor, if I could just clarify for the record. Mr. Westbrook, you referred to yesterday, Tuesday.
MR. WESTBROOK: Tuesday, you're right.
THE COURT: That's right.
MR. WESTBROOK: Seems like only yesterday.
MS. ROBERTSON: It does.
THE COURT: Any references referring to yesterday, we're actually referring to the last time we

were in this hearing, which was Tuesday.

MR. WESTBROOK: Thank you very much.

THE COURT: Thank you, Mr. Westbrook.

Q: So that second column, the one that's projected 2020 PMC experience, those are Mr. Levitt's 2020 projections if CMC-Fort Mill is built, is that right?

A: Yes, but just to clarify, at the time he made those projections, they were if either of the North Carolina providers was approved, but at this point yes, CMC-Fort Mill.

Q: Right. Thank you. And the source for that would be, again, looking down at the bottom it would be Piedmont Supp. CON 545?

A: I believe those -- yes, those two pages correspond.

Q: Okay. And then your final column has the difference, percentage difference between those numbers line item by line item, right?

A: Yes.

Q: And now in the margins of either side, in the big font are two numbers, and the one on my right is hard to read, but I believe is that 23 million and something?

A: Yes. I believe it's 23.5 million.

Q: And that's bad debt ---
A: Yes.
Q: --- did I understand you to say? And the one on my left is clearer to read and that's 24,914,730, right?
A: Yes.
Q: And that's bad debt too?
A: Yes.
Q: Now, the 24,914,730 number, that would represent the bad debt that is did I understand you to say would be included in those actual 2009 PMC experience; is that what that is?
A: That was my recollection, yes.
Q: All right. I would like to go, just remember that number -- well, it's 24.9 million, so let's everybody just keep that in our heads for a minute because I couldn't find that number, and I wanted to see if I'm missing something here. Let's go to Piedmont Supp. CON.487. Now this is the, one of the annual reports from Piedmont to York County, is that right?
A: Yes.
Q: This is one of the reports that they make on a -- yeah, it says annual, yeah, and this is the one for fiscal year 2009 ending May 31st, 2009,

right?
A: Yes.
Q: All right. Now, I don't see a $24 million number on that page. Am I -- was that through a calculation, or am I just missing something?
A: Well, there is a $26.2 million number for those unwilling to pay, and I'm not sure whether I just -- or I may have pulled -- there was a subsequent, there were subsequent pages I believe to the York County report that gave more detail about bad debt, and it may be that that's where I pulled that number because I ...
Q: Let's look at one of the subsequent pages. Now, first of all, this says for those unwilling to pay, I know that doesn't specifically say bad debt. Does that sort of sound like it might be bad debt to you?
A: Generally, I would assume that that was bad debt.
Q: Okay. Let's go over to Bates page 492, which is just a few pages, and this is 487, this is part, so 492 I'm going to represent to you is part of the same report. Look at 492, and it's sort of in the middle of the page there. You see other uncompensated care right there?

A: Yes.
Q: And it says in paren, bad debt division, right?
A: Yes.
Q: And that's that 26.2 number, isn't it?
A: Yes.
Q: Okay. So that, would that confirm to you that that number on that first page that we looked at is the actual bad debt number for the 26.2?
A: Yes.
Q: Okay.
MR. WESTBROOK: Let's go back, Dan, to that, to 487, please.
Q: So the 24.9 number is just a clerical error, would that be the best way to describe it, or --
A: It would appear that way, yes.
Q: Okay. So the actual number that should be for bad debt is 26.2? Okay, good. All right. Bear with me for just a second, Ms. Carter.
MR. WESTBROOK: I am going to go low tech for a minute, and I apologize to everybody, especially you because I only have one -- I don't know of a better way to do this, I'm afraid, and Ms. Robertson, I'm going to put this over here and I'm going to block Ms. Biggers' view, but let's

see here. Can I lean it right here, Your Honor?

THE COURT: That would be fine. That might be the easiest way.

MR. WESTBROOK: Okay. Good. We'll see how this works. All right.

THE COURT: Don't sneeze.

MR. WESTBROOK: I know I won't.

Q: I think we're going to be juxtaposing two things, and so I think it might be easier to write something down. Now, from this 487, again, I mean Bates page 487. This is the 2009 York County report and I want to focus on those expenses, and expenses would be under that category "Funds Applied"; would they not?

A: That's how they've -- the format of this report to York County is a little different from most financial statements in terms of the words that they use, but yes, that would essentially be their expenses.

Q: And if you'll see the total expenses, it says 207, and that's supposed to be 207 million, right?

A: That's correct.

Q: Two hundred seven million 286. And that's the

number on your demonstrative. We can go back if you need to refresh your memory. Isn't that the total number on your demonstrative?

A: Yes.

Q: And it's got, the first line items says, To pay full and part-time employees 68,310,000 and the next line item to provide employee benefits 15,278,000. Would you mind using your calculator and adding those two numbers, please? What is that number?

A: Eighty-three five eighty-eight.

Q: Eighty-three five eighty-eight. All right. And then let's go -- I want to skip that line. I'll come back to the purchase supplies in a minute, but let's go down to something a little simpler. Depreciation and amortization, what is that?

A: Ten million three sixteen.

Q: Okay. I'm just going to write down here the abbreviation for depreciation, and I'm sorry, 10 million what?

A: Three sixteen.

Q: Okay. And then the one under that is interest, right?

A: Yes.

Q: How much is interest?
A: 16,287
Q: 16,287. And then the one we skipped over is to purchase supplies, utilities, insurance and other expenses, is that right?
A: Yes.
Q: And that is what?
A: 97,094.
Q: And I'm going to call that "supplies and other." Okay. Is that good enough since I'm afraid this thing is going to fall over any minute so I'm going to write as little as possible. All right. And what's the total again, please?
A: 207,286.
Q: 207,286.
MR. WESTBROOK: Okay. Let's go back to the demonstrative please Dan.
Q: All right. And this is again, Demonstrative 469, and let's look at your column about the 2009 experience.
MR. WESTBROOK: And just kind of go down to the expense detail Dan, please.
Q: Salaries and benefits 83,588, that checks off, doesn't it?

A: Yes.
Q: All right. And the 10,316 for depreciation checks off?
A: Yes.
Q: 16,287 for interest checks off?
A: Yes.
Q: 97,094 checks off?
A: Yes.
Q: And the 207,286 checks off, right?
A: Rounding, considering rounding, yes.
Q: Considering rounding, right. Thank you. And so that $26 million of bad debt is not included there, is it?
A: In the report to York County, the 26 million in bad debt would have been included or taken into account in the net revenue calculation.
Q: Uh-huh (affirmative response).
A: But at the end of the day, in my -- it doesn't change my opinion about the difference in the bottom line.
Q: Okay. But the $26 million is not part of that 207, right?
A: It is not, that is correct.
Q: Okay. And if we added that 26, what was that number again, do you recall or do we need to go

back, it was 26 something, 26 ---

MR. WESTBROOK: Dan, how about just run it back quickly to 487 just so we can get it right.

Q: And that, what they call "those unwilling to pay" which I think we established as bad debt is 26,292, is that right?

A: Yes.

Q: Why don't you add 26,292 and the 207,286 and what do you come up with?

A: 233,578.

Q: 233,578. Okay. All right. Good. Let's go back to the demonstrative for a second, I keep forgetting the number of it, but I think it's 4.69. Yeah. And let's focus on the 2020 column, and again, I would you look down at the expense, the bottom half where it says expense details and we've got those same categories. Let's see if I can flip this over without doing any damage. And on 2020, what are salaries and benefits?

A: 88,184.

Q: I tell you what, you know what I think it's going to work easier is if we go the other way. Let's go to the source of this 545, kind of like we did the way, and I'm going to write

down what that has and then we'll check it off again.

MR. WESTBROOK: So let's go, Dan, to Piedmont Bates page 545, please.

Q: And here are Mr. Levitt's projections, right?

A: Yes.

Q: Okay. Let's go to the last column 2020 is what we're focused on here, and if we'll go down to I think operating expenses. You see where that is, Dan, and Ms. Carter?

A: Yes.

Q: And the first line item is Salaries, Wages and Benefits, right?

A: Yes.

Q: So would you read that off for me, please?

A: 88,184.

Q: 88,184. Let's find depreciation on here. Where is depreciation?

A: It's below the line, I believe.

Q: All right. Yes. For some reason, it's -- I'm sure it's a good reason, but for some reason it's down there. Depreciation and amortization, last -- go over to 2020, what is it?

A: 12,328.

Q: Depreciation 12,328?

A: Yes.
Q: Okay. What about interest?
A: 15,195.
Q: 151, oops, 195. All right. And is bad debt singled out on there?
A: It is. It's listed in Mr. Levitt's projection here as an expense, whereas in the York County that we were just looking at, it was a deduction from revenue.
Q: Gotcha. And how much is that bad debt?
A: 23,508.
Q: 23,508. And I believe that's the same number, is it not, that was hard to read in the margin of your demonstrative over on the right side, right?
A: Yes.
Q: That was that same number. That's where you got that from, right? Okay. And now what are -- we also have up there supplies, other controllable expenses and non-controllable expenses/corporate overhead, right?
A: Yes.
Q: Can you add those three numbers for me?
A: 121,001.
Q: 121,001?

A: Yes.
Q: All right. And what does this all add up to?
A: 260,216.
Q: 260,216. And that's the total that you had on your demonstrative, right?
A: With some rounding, yes.
Q: With some rounding, yes. Let's go back to the Demonstrative 4.69 and just kind of confirm. You had salaries and benefits of how much?
A: 88,184.
Q: So we got that checked off. Depreciation, what was your depreciation?
A: 12,328.
Q: What was your interest?
A: 15,195.
Q: What was your bad debt? Well, you didn't have bad debt singled out, right? But you had it in the margin it was 23.
A: Yes, it was included with the ---
Q: It was included with the other.
A: --- the other.
Q: So if you add these two together, does it come up to that number 144,511 that you have?
A: Yes.
Q: So that, you just added the bad debt into the

other. I mean, that's included in the other, right?

A: That's correct.

Q: Okay. So it appears, isn't this true, that on the 2020 column, you included bad debt of about 20, a little over $23 million, and on the 2009, that did not include bad debt of about $26 million, is that right?

A: To be clear, bad debt was -- in the 2009 experience, bad debt was not included in the York County report as an expense detail, but that column includes bad debt. It just treats it as a deduction from revenue, and so it's factored into the net revenue line item.

Q: All right.

MR. WESTBROOK: Let's look at demonstrative 289, Dan.

Q: All right. Now, Demonstrative 289 has these two sets of numbers, and if you'll see, it's got -- on both of them it's got bad debt broken out as a separate line item, right?

A: Yes.

Q: And then we totaled both of them, and the 2009 is 233,577,000 and the 2020 remains the same at 260,218,000, is that right?

A: Yes.
Q: Now, wouldn't you agree that this is a more complete and really a fairer way of comparing the 2009 expenses and the projected 2020 expenses?
A: Well, to fully do this with my analysis, you have to then adjust the net revenue impact of switching how you're looking at bad debt, because the focal point of my Demonstrative 4.69 was the difference in the bottom line and what was driving that difference. And so the fact that bad debt is treated differently as whether it's an adjustment to revenue or an expense, it falls out the same on the bottom line, and so in order to -- if you're going to treat it the same in both, then you also need to make the adjustment on the revenue side.
Q: All right. But I do remember your testifying ...
MR. WESTBROOK: Dan, I'm going to rely on your quick hands here. Let's go back to 4.69 for a minute.
Q: I do remember your testifying, isn't this correct, and that your testimony focused on the total, just on the expenses at the bottom.

MR. WESTBROOK: Just focus on that bottom part, Dan.

Q: That the difference, the percentage difference in the total expense between 2009 and 2020 was 25.5 percent. Didn't you testify about that?

A: I believe I did, and the point was I was trying to determine in my analysis what was driving the difference between Piedmont's actual 2009 experience resulting in an after tax income of 10.8 million and a five percent margin and virtually the same volume resulting in a net loss in year 2020. And so I looked at the expense items in more detail. You are correct that the expense items, the expense detail on the 2009 side does not include bad debt because, as we've been talking about, that was taken into account with revenue on that report.

Q: All right. And the way that 25.5 percent was derived, was it not, was by dividing $207 million, and I'm just going to round up to $207 million by $260 million. Wasn't that way you got the 25.5 percent increase?

A: Well it's ---

Q: Well, it's not quite that simple, I'm sorry. You would do a couple more steps to that, but that's -- those are the two factors?

A: It represents the difference between those two factors.

Q: Right.

MR. WESTBROOK: Let's go back to our demonstrative, Dan, 289.

Q: And if you include the bad debt, what would the -- and so 25.5 percent, what would the increased interest be between 233 million and 260 million? And why don't you just walk us through the steps for the record. I think you would start off, would you not, by subtracting the 233 from the 260, is that correct?

A: Yes, and that difference is 26.641.

Q: And then you would divide that by what?

A: The 233,577, and that difference is 11.4 percent.

Q: 11.4 percent. Now, this is a period of time from 2009 to 2020, so that is -- is that 11 time periods? In other words, 2009 to 2010 would be one; 2010 to 2011 would be two ---

A: Yes, it's 11 years.

Q: --- something like that. Isn't that 11? Are you able with your calculator to calculate what the compound annual growth rate would be over that 11 period from 233 million to 260 million?

A: No. I can't calculate like that on this calculator.
Q: But just looking at it, it's -- we're talking about 11 years, and I believe you said the total was 11.4 percent change, is that right?
A: Yes.
Q: So wouldn't that be about one percent or maybe a little over one percent a year?
A: Somewhere in that ballpark, yes.
Q: Okay.
MR. WESTBROOK: Let's go to CHS Exhibit 32, page 15, Dan.
Q: Now, this is something you've prepared, is that right?
A: Yes.
Q: And, in fact, that was a demonstrative that you testified about yesterday that was based on, it may have even been identical to this but, I'm not sure, Demonstrative I believe it's 4.81, is that right?
A: Yes.
Q: Okay. And again, the print's a little hard to read but I think we can -- I'm not going to go into a whole lot of detail on this so. I think what you did here, you correct me if I'm wrong,

is you compared -- you selected some South Carolina counties and compared them, their situation in terms of healthcare and so forth and hospital services and so forth to York County and you also grouped some counties and made comparisons, is that right?

A: I took the counties that were closest in size to York County plus or -- well, all the counties plus or minus 50,000 population in South Carolina, and those are the individual counties. And then I grouped the urban regions around those counties, and I think specifically Berkeley, those three Berkeley counties are actually grouped that way in the State Health Plan.

Q: Those three Berkeley -- oh, I see, Berkeley, Charleston ---

A: The Berkeley Charleston, and Dorchester. Yeah.

Q: --- and Dorchester. All right. I want to ask you about some of these. One of the counties, and I'm not going in any particular order but just, well, let's see -- because one of the counties that you compared York to was Anderson County, right?

A: Yes.

Q: And in Anderson county, I think you have listed that there are two hospitals in Anderson, but actually both those hospitals are owned by the same company, right?

A: That's why I have only one hospital system listed.

Q: Right. And that one hospital system, that's -- I'm not exactly sure of the full name for it, but it's something that's commonly called AnMed, is that right?

A: Yes.

Q: And AnMed actually is managed by CHS, right?

A: Yes, they are.

Q: Coincidentally, right? I guess coincidentally. So AnMed, so there are two hospitals in Anderson county. They're both AnMed hospitals, and one of them is a specialty hospital, right? It's not a general acute care hospital; it's a women's and children's hospital, right?

A: Well, I think -- I mean, it is a women's and children's hospital, but women's and children's services are provided. I mean, the women's and children's services are traditionally included in general acute care.

Q: All right. But these two hospitals, one is a

women's and children's hospital and one is a more general hospital, both owned by AnMed, both owned by CHS. They're not competing with each other, are they?

A: Both managed by CHS.

Q: Did I say -- did I say something different?

A: You said owned by CHS.

Q: I'm sorry. Both managed by CHS. They're not competing with each other, are they?

A: No.

MR. WESTBROOK: And let's go to Piedmont's Exhibit 15 for a minute, please. And Dan, I'm not sure what page this is but there's a page on the Anderson County here.

Q: Anderson County's out-migration, you see that over on the left under ---

MR. WESTBROOK: Dan, would you highlight 23.9 percent. That out-migration rate for Anderson County is a good bit lower than the out-migration rate for York County, isn't that true?

A: Yes.

Q: I mean York County's out-migration is the 40s, isn't it? Forty-six, does that sound right?

A: Somewhere in that neighborhood, yes.

Q: Somewhere in that neighborhood. And this is

about 24 percent. And the out-migration, actually this is an interesting chart because it shows where the out-migration is going.

MR. WESTBROOK: And if you will scroll down, Dan, I think there is a percentage that shows that 17 percent of the out-migration is going to Greenville County, which is of course I guess not too surprising being right next door to Anderson County, right?

A: That's correct.

Q: And there are a number of hospitals in Greenville County, but none of those hospitals in Greenville County have an extensive physician network in Anderson County, isn't that correct?

A: I do not know the extent of the physician networks by the Greenville hospital systems in Anderson County.

Q: All right. So you don't know whether the Greenville Hospital System or any other Greenville hospital has a physician network in Anderson County that's comparable to the presence that CHS has in York County?

A: I don't know the comparability of that.

Q: And it is true that neither Greenville Hospital System or any other Greenville hospital is

attempting or has attempted to build a hospital in Anderson County, is that correct?

A: To the best of my knowledge, nobody has submitted a certificate of need to build a hospital in Anderson County.

Q: All right. Now, Lexington County is another county that you actually seemed to kind of focus on, and I know you found some real analogies between Lexington County and York County, right, in your testimony, I was about to say yesterday again, but day before yesterday?

A: Yes.

Q: All right.

MR. WESTBROOK: And let's go back, Dan, to -- well, that's okay, I don't think we need to go back. That's fine.

Q: But again, and I think this is one of the analogies, just like in York County, there's only hospital in Lexington County, Lexington Medical Center, right?

A: That's correct.

Q: And there are two hospital systems, I believe, in Richland; there's Palmetto Health and there's Providence, correct?

A: That's correct.
Q: And again, wouldn't you agree that neither Palmetto Health nor Providence have extensive physician networks with employed physicians in Lexington County anywhere near comparable to what CHS has in York County?
A: Again, I don't know the comparability of those.
Q: All right. And Parkridge, which of course is under construction right now, and that's not open, right?
A: That's correct.
Q: And it's out there by Columbiana Mall, correct?
A: Yes.
Q: And it's close to the Lexington County line, but it's in Richland County, right?
A: Yes.
Q: Lexington, I mean excuse me, neither Palmetto Health nor Providence is attempting to build a hospital or has attempted to build a hospital or get a CON to build a hospital in Lexington County, is that correct?
A: That's correct. As I said on Tuesday, that was one of the differences, though I thought slight, because Parkridge virtually does sit on the county -- on the county line. The other thing

going back to the point that I would just add relative to the physicians in Lexington County, I do not know, as I said a moment ago, I don't know the comparability of the employed physicians. I do know that there are physicians, particularly specialists, who are on the medical staff of both Lexington and the Palmetto Hospitals.

Q: All right. But I believe Mr. Murphy testified, I may be getting these numbers slightly wrong, but I think he testified that currently CHS had somewhere between 70 and 90, and you correct me if I'm getting my numbers wrong but that's my memory of employed physicians currently in York County. Neither Palmetto nor Providence had anywhere near that number of employed physicians with offices in Lexington County; isn't that true, or do you know?

A: I don't know the comparability.

Q: All right. And another county that you compared on your chart was Spartanburg County, right?

A: Yes.

Q: Now, there are two hospital systems in Spartanburg County, there's Spartanburg Regional

and there's Mary Black, right?
A: That's correct.
Q: And both of them have been there for a long time, haven't they?
A: That's correct.
MR. WESTBROOK: And let's go, Dan, to the State Health Plan, the current State Health Plan 2012-2013. What exhibit number is that?
Q: Exhibit 12. Piedmont's Exhibit 12, I believe. And going to page III-18.
MR. WESTBROOK: And Dan, can you find Mary Black on there? It's in Region I, I believe. And let's highlight Mary Black.
Q: Now, this shows the occupancy rates for the last three years for data that they had from 2009 through 2011, right, Ms. Carter?
A: Yes.
Q: And Mary Black's occupancy rate for those three years, for each of those three years if you round them is 42 percent, is that correct?
A: Yes.
Q: Now, 42 percent occupancy rate, would you consider that underutilized?
A: I would consider that less than-- less than well utilized.

Q: Less than well utilized. Is that the same thing as saying underutilized? Or is there a difference?

A: From, as I believe I testified in my deposition, that there are times when hospitals who have a current lower occupancy rate and lower than ideal occupancy rate may be -- may have historically operated at higher occupancy rates, which is why they needed the beds at some point in time. But what I would say is they are at 42 percent occupancy, again, assuming that is over some sustained period of time. They wouldn't need all the beds that they have currently.

Q: And so they're not really -- would you agree then that Mary Black is really not thriving right now in competition with Spartanburg Regional; would you agree with that?

A: Not necessarily. I don't think you can -- you can determine that just purely based on inpatient occupancy rates.

Q: And are you aware of any hospital system, hospital or hospital system headquartered outside of Spartanburg County that has an extension -- extensive physician network in

Spartanburg County the way that CHS has in York County?

A: Again, I have not looked at the comparability of the physician networks with Spartanburg County.

Q: Are you aware of any hospital system outside Spartanburg County that has announced its intention to try to build a hospital in Spartanburg County?

A: I'm not aware of anybody having submitted a CON application to build a hospital in Spartanburg County.

Q: Now, one county you didn't check out, you didn't look at was Aiken County, and I'm going to ask Dan to go back to Piedmont Exhibit 15 and ask you a couple of questions about Aiken County. Now, you're originally from Greenville, I believe, is that right?

A: That's correct.

Q: So, I mean, you're generally familiar I guess with Aiken County; you've been there before, haven't you?

A: Yes.

Q: Okay. Now, Aiken County is on a state border just like York County is, right? York County

borders North Carolina; Aiken County borders Georgia, correct?

A: That's correct.

Q: Augusta is right across the -- right across the state line, right?

A: Yes.

Q: And there's only one hospital in Aiken County, and that's Aiken Regional Medical Center, right?

A: I believe that's correct.

Q: And let's go back to that page on the State Health Plan exhibit, Exhibit 12, Piedmont's Exhibit 12, Bates, or not Bates page but page III-18 and let's look at Aiken County occupancy rate. It's going to be I think a little bit better than Mary Black's. It's in the low 60s, right?

A: Yes.

Q: All right. So, and I think there's been testimony that Piedmont's current occupancy rate is around 62, is that right? Do you recall that?

A: I believe that's correct, yes.

Q: So they have similar occupancy rates, right?

A: Yes.

Q: Now, let's go to Piedmont Exhibit 15, please.

Let's find Aiken County in this chart. Aiken County, let's go down to the out-migration rate for Georgia. That's a 64 percent out-migration to Georgia. So that's even higher out-migration to Georgia than York County out-migration to North Carolina, isn't it?

A: Yes.

Q: And there are a number of hospitals in Augusta, right?

A: Yes.

Q: But none of those hospitals have extensive physician networks in Aiken County comparable to the extensive physician network that CHS has in York County, isn't that true?

A: I don't know the comparability of the physician networks.

Q: And no Georgia hospital, to your knowledge, has attempted to build a hospital in Aiken County, isn't that correct?

A: Not to my knowledge.

Q: And wouldn't you agree that if an Augusta hospital were to try to build a hospital in Aiken County, that's it's likely that Aiken Regional would oppose that vigorously?

A: I don't know what Aiken General would do.

Q: Let's go back to CHS exhibit.

MS. ROBERTSON: Your Honor, if I might just interpose an objection to the questioning with respect to the comparability of the physician network systems that Mr. Westbrook -- he's stating it in the record. Ms. Carter has not done any comparisons, but yet he was questioning, he is suggesting that comparability, and there's nothing in the record to lay a foundation for the comparability of those other physician networks.

THE COURT: Mr. Westbrook?

MR. WESTBROOK: I think I've asked the last question I'm going to ask on this topic. I would simply say in response to that I asked her if she knew, and she said she didn't know. I think there has been plenty of evidence over the extensiveness of the physician -- of CHS's physician network in York County. She may, and I will simply say this, she opened the door by saying these counties were comparable. She said these counties that she selected, Anderson and the others, Lexington and Spartanburg and the others were comparable to York county, and she gave some ways in which they were comparable

and analogous ---

THE COURT: Yes, sir.

MR. WESTBROOK: --- and I'm trying to suggest that maybe there are some ways they're not all that comparable.

THE COURT: Right. And I think that what Ms. Robertson suggesting is that your questions are not -- Ms. Carter is testifying that she is not aware of the physician networks and what's going on in these counties that she did make the comparison with. And Ms. Robertson, I do understand that there's been no evidence introduced into the record at this time about the physician networks in these counties outside of York County. Certainly there are plenty of evidence of -- and not aware of that and I understand that Mr. Westbrook's questions were asking about that, but there has been no evidence introduced into the record.

MS. ROBERTSON: Right. His questions are suggestive that there had been but there has not been so I wanted the record to be clear that that's not in the record.

THE COURT: Thank you, Ms. Robertson. I'm aware of that and you are about ready to move on, is

that true, Mr. Westbrook?

MR. WESTBROOK: I am.

THE COURT: Thank you.

MR. WESTBROOK: Thank you Your Honor.

Q: Let's go back to CHS Exhibit 32, page 15. And there's a column there that has systems per 100,000, right?

A: Yes.

Q: That's I guess pretty obvious what that means, is how many hospital systems per 100,000's populations in each of these counties and county groupings, correct?

A: That's correct.

Q: And York, there's a line item about halfway down that says York as approved, so that means would be York with assuming that CMC-Fort Mill -- well, right now CMC-Fort Mill has the nod from DHEC, so that would include the 64 beds --

A: Yes.

Q: --- for CMC-Fort Mill? And the systems per 100,000 ---

MR. WESTBROOK: Dan, if you'd just isolate that column for a moment. What's that number for York county as approved, .87?

A: Yes.
Q: .87 per 100,000, right?
A: Yes.
Q: That's the highest number in that column, right?
A: As I testified on Tuesday, it is the highest number there similar to Spartanburg, and it's actually, I did not calculate the Berkeley number because when I originated this, I think the, and I'm not sure if the Berkeley situation had been resolved, but nevertheless, the Berkeley number will be one point something with the approval of those two hospitals in Berkeley County.
Q: All right. Let's go to demonstrative, your Demonstrative 4.77, please. And this a demonstrative you testified about yesterday, correct?
A: On Tuesday, yes.
Q: Sorry, Tuesday, yeah. And it's titled FFMC Greater Impact, and you've got a number from 2019 over there at the bottom, 7,374,043, and then a number from year five of 2019 there that says 2,961,062, right?
A: I'm sorry, I thought you were ---
Q: No, I'm sorry. Well, I was kind of mumbling

through that. So the thing I want to focus on is that number, that 2,961,000 number, you see that?

A: Yes.

Q: Now, what you end up doing on some later pages is comparing those numbers, Is that correct?

A: I compared the combined net income that you can see on the bottom of this chart ---

Q: Right.

A: --- and that margin of 2.5, combined margin of 2.5 percent to other calculations I made.

Q: Okay. You've got your sources listed down there at the bottom. The source for the 2-9, for the stuff on my left hand, that set of projections on the left-hand side of the screen would be Petitioner's Exhibit 1 page 519?

A: Yes.

Q: All right. Again, I just can't find that $2.9 million number. It may be on there, but I wanted to see if I'm just missing something.

MR. WESTBROOK: Can we go, Dan, to Bates page 519?

Q: And this is for -- this is for 2019, so we can just focus on the 2019 column, right, Ms. Carter?

A: Yes.

Q: And once again, I -- unless is that -- I see the $2.8 million, which is a pretty high number and it's not that far off from the $2.9 million, but I was just wondering where you got the $2.9 million from.
A: Unless there's a wrong page reference, because I mean I highlighted directly from the document, but what you've pulled up is not the same number.
Q: Right.
A: It's a lower number.
Q: This is Mr. Levitt's projections for 2019, right?
A: Yes.
Q: And it's the -- the Bates number is the same that you've listed as the source on your demonstrative, right?
A: It's the same Bates number, yes.
Q: And that $2.8 million, what line item is that? It's the net income, right?
A: Yes, the after tax income.
Q: Okay. And that's what you were going after, right?
A: Yes.
Q: So is this just a clerical error, is that what

this is, or do you ...

A: I'm not sure it's that either.

Q: So that $2.9 million number is not rounded off or anything; it's a very precise number? It carries all the way out, doesn't it? So I mean it looks like it came from somewhere, right?

A: Well, and the reason I say I'm not sure it's a clerical error is because you can, if you understand how I put together Demonstrative 4.77, just as you all are doing here, I mean, I directly pulled from this same source and pulled that number. So, and it's overlaid so I can't see if it was in fact the number below it.

Q: Well, let's go back out. Dan, take it out ---

A: So, in other words, just to be clear. I didn't type in the 2,961,062. I extracted it from.

Q: You extracted it from somewhere?

A: From this document or ...

Q: Just take a minute or a couple of minutes. I mean, it's not that big an issue really, but I just wanted to understand where that number came from.

A: It's looks like what I'm looking -- I'm looking at the other numbers on the page, and it may be just an incorrect page reference because when I

look at the document in my Demonstrative 4.77, the other line items are slightly off as well.

Q: Okay. Are there -- all right. Okay. Well, so at this point, it sounds like you're just not sure about that number, right, where that came from, at least where it derived?

A: Well, I think it came from this document that I have on the left side of Demonstrative 4.77. What it -- if you have on the screen page 519, then perhaps it was a different, it was a different page number.

Q: Okay. All right. But obviously, you're not sure what that page number is right now, right?

A: That's correct, not without going back and looking through that material.

Q: All right. Okay. Let's move on then. Now, let me ask you a hypothetical. If Presbyterian had stayed in the case and ended up winning the CON and Presbyterian ended up building its hospital in Fort Mill, and I believe it's your opinion that Presbyterian's hospital in Fort Mill would have definitely taken patients away and adversely impacted Piedmont, right?

A: In order for -- in my opinion, in order for Presbyterian to meet its projections, that's the

only way it could have met its projections because Presbyterian has so little market share in York County now. It would have to have taken the volume from somebody else if it were going to meet its projections.

Q: Okay. And if Presbyterian had built, again hypothetically speaking, if Presbyterian had ended up getting the CON and building that hospital in Fort Mill, and if, just hypothetically speaking, if it had taken patients away from CMC-Pineville or other CHS facilities, but Pineville being the closest one, if it had taken patients away from Pineville, that -- in a significant fashion that would have hurt Pineville? It would have been an adverse impact on Pineville, right?

A: I haven't looked at any adverse impact on North Carolina facilities as a result of whatever might happen in York County.

Q: Well, I understand that, and I know you haven't done that analysis, but I'm just asking you to sort of again hypothetically and as a matter of principle, if Presbyterian or we could pick some other or any hospital had built a hospital in Fort Mill and taken a significant number of

patients away from CMC-Pineville, that would have been an adverse impact on Pineville? It would have hurt Pineville, right, if you take volume away from them?

A: If volume was to be taken away from CMC-Pineville in your hypothetical, it would have an impact on Pineville. Whether that would be adverse or not, I don't know. It would not necessarily be adverse.

Q: Let's look at your trial testimony from 2009.

MR. WESTBROOK: Dan, I'm going to ask you to put page 1931 up on the screen, please.

Q: And Ms. Carter, if you need a hard copy, let me know, but I think it's only a line or two I want you to look at. I was hoping it would be clearer on the screen.

MR. WESTBROOK: From the 2009 trial, page 1931, Dan, if you could zoom that in.

Q: And what I want you to look at is -- bear with me for a second, page 1931, right? 1931 ---

MS. ROBERTSON: Do you have a copy to give her, or something just a page ---

MR. WESTBROOK: Sure.

MS. ROBERTSON: --- she might need to look at it in context.

MR. WESTBROOK: Sure. I do.

Q: I can give you the whole thing, but since it's kind of bulky, I'll just start with this and if you want more, let me know.

A: Okay.

MR. WESTBROOK: I'm sorry. Is it okay if I approach the witness, Your Honor?

THE COURT: Yes, you may approach the witness.

Q: All right. And what I want you to do, Ms. Carter, is let's start on ---

MR. WESTBROOK: And Dan, how about just highlighting starting with page 8 -- it's not page 8, line 8, line 8, and we're going to go down through line 21, okay?

Q: And I'll read the question and you read the answer, okay? Question starting on line 8, "Right, but if in fact Presbyterian, for example, were to build that hospital in Fort Mill and if Presbyterian, and you may think that this is not going to happen, but if they were able to redirect out-migrating patients who are currently going to Pineville or CMC or Mercy and redirect those patients to Presbyterian's facility in Fort Mill, that would hurt Carolina's Healthcare System, would it

not?" And what was your answer?

A: "As you said, assuming they were able to accomplish that."

Q: Question, "Yeah."

A: "And that would certainly take volume away from Carolinas."

Q: It would certainly take volume away from Carolinas. And did I understand you to say that wouldn't necessarily -- that taking volume away would not necessarily be an adverse impact?

A: What I said was anytime a -- anytime you take volume away from a provider, that's an impact. Whether it is adverse in terms of the -- that it adversely affects the provider, just because you take volume away doesn't necessarily mean that there's an adverse impact on the provider. The provider may be able to continue to move forward.

Q: All right. Now, if CMC-Fort Mill is built and if it takes patients away from CMC-Pineville, your opinion is that would definitely not be an adverse impact on CMC-Pineville, correct?

A: What I think I demonstrated on Tuesday is that Pineville was, in its 2007 application, it was projected to be above its targeted occupancy

rate by the third year that that expansion project was developed and is growing faster than projected in that application, and the subsequent projections that were presented to DHEC that showed the shift of patients from Pineville to CMC-Fort Mill showed that there would be fewer patients going to Pineville than originally projected, but again, that -- yes, there's less volume, but that impact is not adverse to Pineville.

Q: All right. And, in fact, I mean the idea of shifting volume from Pineville to CMC-Fort Mill is basically part of the strategy, part of the plan that CHS has in this case, isn't that correct?

A: Yes.

Q: All right. So you wouldn't consider it adverse impact if it's part of the strategy, would you? Part of the plan?

A: Particularly if as projected for Pineville, they're going to continue to be utilized at the level that they were projected to be in the materials submitted to DHEC.

Q: Now, Fort Mill Medical Center projects a third year occupancy of 58 patients, right?

A: Yes.
Q: And that projects for 100 beds, that's a 58 percent occupancy rate that it's projecting, correct?
A: That's correct.
Q: Now, obviously, if it was a smaller hospital, if it was say a 64-bed hospital, 58 patients in a 64-bed hospital would be a lot higher occupancy rate? It would be 90 something, right?
A: Yes. It would be 91 percent.
Q: But it's not a 64-bed hospital. It's 100-bed hospital, or at least that's what's proposed. And so the occupancy rate projected is 58 percent, and I believe you've testified that that is too low to justify the need for a 100-bed hospital?
A: What I have testified to is that I'm not aware, in my opinion, of Piedmont ever demonstrating a need to have all 100 beds, and that is assuming that you believe Piedmont's projections, which I don't believe are reasonable.
Q: Well, I understand that and I appreciate that clarification. But didn't you also testify, and if you didn't that's great, it will cut out --

it'll make cross-exam a lot shorter. Didn't you also testify that 58 percent occupancy rate is, in your opinion, too low to justify a 100-bed hospital?

A: What I said was that you -- my recollection of Piedmont's testimony is that the 58 percent was reasonable because they compared it to other existing facilities in the region which were operating at similar levels. And my testimony was that you have to -- you can't look just at existing facilities because either they could have overbuilt the facilities or they could have operated at higher occupancy rates at some time in the past when there was greater inpatient utilization. But since their occupancy would have been reduced, you also have to compare it with the target need of the population, and that is what in my opinion they failed to do. And so the bottom line is if they're going -- in my opinion, if they're going to be occupied at 58 percent, they don't need all 100 beds they have.

Q: All right. Okay. Thank you.

MR. WESTBROOK: Let's look at, Dan, how about pulling up again Exhibit 12, please, the current

State Health Plan 2012-2013 State Health Plan, and go to I think that same page we've looked at before, page III-18.

Q: Let's just take it region by region. Region I for this three year period, it gives the occupancy rates for all the hospitals in Region I, right?

A: That's correct, yes.

Q: And the average in 2009 was 53.5 percent occupancy rate, is that right?

A: 53.5 in 2009.

Q: I'm sorry 53.5 percent, I'm sorry, yes. And in 2010, 52.1 and in 2011 52.6 percent, is that correct?

A: Yes.

MR. WESTBROOK: Now, let's go to Region II, Dan.

Q: And the average for those three years in Region II is all 57, 55 to 57, right?

A: Yes.

Q: And for Region III? All the hospitals in South Carolina Region III, 54 through 57, is that right?

A: Yes.

Q: And for Region IV, all the hospitals in Region IV for that three year period is 54.9, 56.7, Is

that correct?
A: Yes.
Q: And there are only four regions in South Carolina, is that correct?
A: I believe that's correct.
Q: So the four regions that we just looked at would contain all the hospitals in South Carolina?
A: Yes.
Q: Let's look at Joint Exhibit 1A, please, page 593. Now, I think we've -- somebody's looked at this before and it's -- one of the problems with this one is that the headings are hard to read, but I think we can try to manage that. The headings at the top, it says at the top "Summary of Services Carolinas Hospitals in Four County Region," correct?
A: Yes.
Q: And those four counties are Cleveland, Gaston, Mecklenburg, and Union, right?
A: That's correct.
Q: All right.
MR. WESTBROOK: Let's go to -- Dan, see if you can find, we'll just take several of these. See if you can find Cleveland.

Q: And I know you talked about Cleveland yesterday. That's not -- obviously it's not in Mecklenburg County, is it?
A: No, it's in Cleveland County.
Q: It's in Cleveland County. And the total licensed beds for Cleveland are 241, is that correct?
A: That's what this chart represents. I haven't verified that that's the current correct number.
Q: All right. This chart, by the way, I'm just going to represent to you is produced by CHS to us in discovery, and in fact, it's got a Bates number on there of CHS 555 in addition to the exhibit number I just called out. And the average daily census acute is 91, is that correct?
A: That's what this chart says.
Q: And this CHS chart says average daily census specialty is zero, right?
A: That's what it says, yes.
Q: So to get the occupancy rate, would you divide the 91 by 241?
A: Yes.
Q: And what is that?
A: Thirty-eight percent.

Q: All right. Let's go to Mercy Hospital.
MR. WESTBROOK: Is that the next one, Dan?
Q: Again, hard to read but can you tell that's CMC-Mercy?
A: Yes, I can see that.
Q: All right. Again, let's -- at the time, and I guess, you know what we should do, I believe somewhere on this chart it says that this is 2009 data.
MR. WESTBROOK: Dan, can you find that and see if I'm right about that?
Q: So just to be clear, we're looking at 2009 data.
A: Okay.
Q: There's more recent data, of course. But in 2009, at least, Mercy had -- how many beds did it have listed there? 196?
A: 185 if you take out the -- I don't -- I'm not sure the 11 are acute care beds. I can't see what ---
MR. WESTBROOK: Let's take a look. Dan, what does that 11 represent?
A: Those are psych, psych beds.
Q: Psych chemical dependency? Okay. so take those out and it's got what?

A: 185.
Q: 185. All right. And what's the average daily census for Mercy?
A: It was 86.
Q: Eighty-six. And then that nine would be the specialty. Would that -- if we took out the psych beds, those 11 psych, would be it be fair to take out those nine, too?
A: Yes, I would think so.
Q: Okay. Let's divide 86 into 185 and what's that?
A: It's 46 percent.
Q: Forty-six percent. And then the next one is Pineville, is that right?
A: Yes.
Q: All right. And we've got, at this point in time in 2009, 110 beds at Pineville?
A: Yes.
Q: An 81 average daily census. What's that occupancy rate?
A: Seventy-four percent.
Q: Seventy-four percent. Now, Pineville, there's been a good bit of testimony about the expansion at Pineville. I've actually heard a couple of different things, and maybe you can

clarify this for me. Maybe I misheard or maybe this is just somebody was mistaken of the testimony, but were there 86 or 96 beds added in the most recent expansion of Pineville?

A: There were 86 beds that were moved from CMC-Mercy and CMC-University to Pineville. And so that, a couple of points I would make on those calculations you've had me make. Since 2009, CMC-Mercy has, as I just said, they have shifted beds to Pineville. They have also since shifted programs, specialty surgery programs from CMC to CMC-Mercy, which has affected CMC-Mercy's utilization in a positive way. And then the last thing I would say relative to Cleveland is, to me, Cleveland is one of the examples of they have, you know, a number of licensed beds from their history and -- but that would not, I would not look at Cleveland and say today, based on the current volume that they have, that if they were contemplating building 241 beds that they needed to build 241 beds.

Q: All right. Thank you. And this, of course, is just a snapshot in time, right? We're looking at 2009 and some things have changed since

2009, right?
A: That's correct.
Q: But since 2009, CMC-Pineville has added in the way you just explained, 86 beds, not 96, right?
A: That's -- well, there were a couple of different projects and this -- this bed count intervenes with various phases of shifting that. The bottom line is when the -- maybe the most accurate way to say it is when the Pineville expansion project is complete, it will have 206 beds.
Q: Two hundred and six beds. And I believe you've told me that that 206 beds become operational sometime in 2013, was it, or have they already become ---
A: They were projected to become operational in July of 2013, and I don't know the current update. At some point in time, I believe Mr. Hummer indicated that they might be available, might be fully available sometime this spring.
Q: This spring. And Mr. Hummer is the CE -- not CEO, but essentially --
A: The president.
Q: --- the CEO, the president or administrator or whatever the title is.

A: Of Pineville.
Q: Of Pineville. Thanks. All right. So that 110 beds that Pineville had in 2009, that's going to move up to 206 sometime in 2013, if it hasn't already. Let's go -- what's the next column over there? Is that University?
A: Yes. And I would just say along with the increase of 206 beds to Pineville, again, there were tertiary programs that were being shifted to Pineville, so the average daily census would be expected to go up along with those beds as the patients are shifted to Pineville as well.
Q: All right. And University in 2009 had a 130 beds, is that right?
A: That's correct.
Q: And 61 average daily census? What's that occupancy rate?
A: That is 47 percent, and again, that would be prior to the shift of beds from CMC-Mercy to Pineville.
Q: All right. And the last column there, is that King's Mountain?
A: Yes.
Q: Actually, it's not the last column I see; it's the next to the last column. King's Mountain

had what, 92 beds of which -- what's that 20 represent, though?

A: I think those are psychiatric beds.

Q: Okay. Well, let's just look at the 72 beds, and then the average daily census of 20 acute care patients. Is that the way you read that?

A: Yes.

Q: And what would that occupancy rate be?

A: Twenty-eight.

Q: All right. Let's go to -- well, let me just ask you this. Again, realizing this is in 2009; there have been changes made since then. You were here for Mr. Murphy's testimony, right?

A: Yes.

Q: And I believe Mr. Murphy said that -- I asked him did he have any hospitals in the -- in that 11 county region, I believe it was an 11 county region or a 13 county region, whatever it was that he works in, that were unsuccessful and he asked me to define it, and I said, well, however you define it. And I think he said that he felt they were all successful. Would you agree with that?

A: Yes.

Q: Okay. Let's look at Exhibit 38B, please. This

is Piedmont's Exhibit 38B. This is a 2012 hospital license renewal application, Ms. Carter.

A: And can I -- can I just ---

Q: Certainly.

A: --- let me clarify something about what I just said?. Yes, I would agree that, to the best of my knowledge, those are successful hospitals, and I can't recall if Mr. Murphy said this or not, but it is in part based on not only their inpatient volume but their outpatient volume. And again, my point relative to the 100 beds is that Piedmont is proposing for Fort Mill Medical Center is all other things being equal and assuming they could make their projections, it's not that they couldn't be a successful hospital there, it is the fact that they don't need to spend the capital to build the beds that they don't need. So, could they be, if they could achieve their projections, which I don't believe they could, but if they achieve their projections, could they be successful at an occupancy rate of 58 percent. I'm not saying that they couldn't be. I'm saying that the very criteria required under the CON regulations

is that you do not unnecessarily duplicate facilities that exist, and that would be exactly what they were doing if they built all 100 beds and didn't need all of those beds.

Q: All right. Thank you. Let's look at 38B. This is the 2012 hospital license renewal application. I don't think we have quite this -- something quite like this in South Carolina, but this is a form that every hospital in North Carolina has to fill out on an annual basis, is that correct?

A: Yes. And it's the equivalent, in my mind anyway, of the JARs reports in South Carolina.

Q: And the JARs reports of South Carolina, that's the acronym for Joint Annual Reports?

A: That's correct.

Q: And so the -- what we have here is the 2012 application for CMC-University, is that correct?

A: Yes.

MR. WESTBROOK: And let's go to page 9. Dan, if you could go there. I think page 9 is where I want to go.

Q: And it's got -- this has actually been filled in. You see it in handwriting, average daily census. They've put it in as 57.94. Is that

right?
A: Yes.
Q: And beds for this --
MR. WESTBROOK: Dan, let's go to that page with beds. Which page is that? Page 8.
Q: At 8 it says, again at the time of this report was filled out, 130 beds, is that right?
A: Yes. Again, and I'm not positive, but I believe that's prior to beds shifting to CMC-Pineville.
Q: Okay. So this may have been prior to the shift to Pineville, right?
A: It may have been. I'm not positive, but it may have been.
Q: I gotcha. Now, at this point in time though, when this application was filled out, it was 130 beds, an average daily census of 57.94. Can you calculate what that occupancy rate was at that point in time, please?
A: It would be 45 percent.
Q: Okay. Let's go to Exhibit, Piedmont Exhibit 36B, please. Again, this is the 2012 renewal application, license renewal application for Mercy/Pineville. And, Ms. Carter, I think there's been some testimony to this before, but

for some purposes, Mercy and Pineville compile and submit their information jointly, is that right?

A: They -- as you can see here, they share the same license, but actually this report separates their utilization.

Q: It does.

A: To get them separate.

Q: It does. So even though it's one report, I think you can look at separate, information separated as you just said, right?

A: Yes.

Q: Okay. Let's look at, go over to page 9 on this one. And what's the average daily census listed there? 102.75, is that right?

A: And this is for I think the top said CMC-Mercy.

Q: Yeah, good point. CMC-Mercy, right?

A: Yes.

Q: Okay. So for Mercy in this application, it was average daily census of 102.75. And how many beds at this point in time did Mercy have? 179?

A: Yes.

Q: And what's that occupancy rate?

A: Fifty-seven percent.

Q: Fifty-seven percent, okay. And if we'll go over to page 10, I believe we'll see this same kind of information broken out for CMC-Pineville, correct?
A: Yes.
Q: And again, Pineville 90.94 average daily census, is that right?
A: Yes.
Q: And at this point in time, 126 beds, so the occupancy rate would be what?
A: Seventy-two percent.
Q: Seventy-two percent, okay. And okay, all right. Now, CMC-Fort Mill projects a third year occupancy rate of 68 percent, is that right?
A: I believe that's correct.
Q: Okay.
MR. WESTBROOK: Let's just, just to be sure, Dan would you pull up ---
Q: I know it's 60 something percent, but I don't want to misquote and it didn't sound like you were positive about that so let's just check. CHS 481, what's that third year occupancy rate, does it say it on there?
A: 67.5 percent.
Q: 67.5 percent. So, all right. And now, I

believe you've said you haven't done an analysis of when in the future CMC-Fort Mill may or may not need to expand beyond 64 beds, have you?

A: I have not, and I think I may have been asked if at some point in time if I knew what the plans were, and I don't have any knowledge of any plans ---

Q: Okay. You don't have. I'm sorry.

A: --- regard to an expansion.

Q: I didn't mean to cut you off. But you haven't done that analysis and you're not aware of any plans, right?

A: That's correct.

Q: Okay. Now, under the South Carolina State Health Plan, there's a 65 percent target occupancy rate that's been talked about. I think you talked it and other witnesses have as well. My understanding is that at a 65 percent occupancy rate, that's the trigger for possible expansion or possible bed need expansion by a hospital in South Carolina, is that correct?

A: Well, the way the State Plan works is, and specifically relative to a future CMC-Fort Mill hospital is it will take its utilization, it will be benchmarked against a 65 percent

occupancy rate because that's the rate for a 64-bed facility, and if future utilization based on population growth is expected -- is expected to need more beds based on that occupancy factor than a bed need would be shown in the State Plan that someone could apply for.

Q: All right. And you were here for Mr. Sullivan's testimony, right?

A: Yes.

Q: And do you remember Mr. Sullivan testifying that at 68 percent or 67.5 percent rounded up to 68 percent, that would be an occupancy rate at which a hospital would be -- would be ready to start thinking about an expansion. Do you recall him saying something to that nature?

A: He very well may have, yes.

Q: Would you agree with him on that?

A: I think as I mentioned to you in my deposition, I think that it is -- it's certainly conceivable that a hospital at that rate would begin thinking about that, and as I said a -- at that level the State Health Plan is likely to trigger a need for more beds. Depending on how a hospital configures its beds, because not every patient can go in every kind of bed, but

depending on how they configure their bed, their beds, some can operate at higher levels, as again, contemplated by the State Health Plan that hospitals can operate at higher levels than those targeted occupancy rates and -- but yes, they may be thinking about this. But I think the second point that I would make relative to this is that, in my opinion, the need for CMC, a CMC-Fort Mill hospital to add beds in the future is a very different scenario than the need for Fort Mill Medical Center to build 100 beds because, as I've opined about already, there's more to it than just whoever -- than just a building being there with a certain number of beds, and therefore, patients are going to come. So it's based on the physicians associated with that facility, the patients associated with those physicians and the patient's choice about which organization or which system they want to be a patient of. And so in the future if there's a need for CMC-Fort Mill to add beds, that does not necessarily equate to a Fort Mill Medical Center needing those same or a similar number of beds.

Q: All right.

THE COURT: Mr. Westbrook, perhaps this is a good time to take a -- we've been going at it for a little while.

MR. WESTBROOK: That's great. Your Honor, I am actually like three or four questions away from being done with this topic if you would give me about five more minutes, I think I'll be through.

THE COURT: All right. Well, then when we reach that point, if you could let us know and we will take a quick break.

MR. WESTBROOK: I sure will.

THE COURT: Thank you, sir.

Q: Ms. Carter, what is -- the term "shell space" or "shelled-in space" in a hospital, what does that mean?

A: To me, generally that means that the outside walls are already constructed, but there's nothing other than outside walls.

Q: All right. So there's outside walls constructed, but it's empty inside to be used for something in the future, is that right?

A: Yeah, to be -- the build-out to be finished at some point in the future.

Q: Okay. Good. Thank you. And there is no shell

space in the CMC-Fort Mill design, is there?
A: To the best of my recollection and knowledge, I don't believe so.
Q: Now, if you were to add additional beds at any hospital, if you're adding additional beds at any hospital, but including CMC-Fort Mill, that would require new construction, would it not?
A: Generally it does unless you have some space. I mean, some hospitals can add beds either by converting observation bed space or other things like that. But many times, it requires new construction.
Q: Many times. And in particular if there is no shell space, right?
A: Or if there -- if there's no shell space or if there is no other space that can be converted, it would require new construction.
Q: All right. And also, if you add beds in the future, it's -- you would have to get a CON in South Carolina, would you not, to add additional beds?
A: Yes.
Q: And a CON can -- a CON process can be time consuming, can't it?
A: It can take a while.

Q: It can take a while, can't it? It can be expensive for the clients, can't it?
A: I assume so.
Q: Now, CMC-Fort Mill, for medical surgical beds --
A: And let me just add to that last point. Yes, it can take a while as evidenced by this case, but I would say that in my experience that this is case is unusual, and I think it's fairly unusual in South Carolina too.
Q: All right. Conceded. But in any event, in any case, CON, CON cases, particularly contested CON cases, even if this is an outlier case, can be time consuming and are often time consuming and expensive, wouldn't you agree?
A: And it certainly adds to the process, which is part of the reason why the -- that along with construction and everything else is part of the reason why the occupancy factors are what they are, is to allow -- allow for that time lapse between when something might be needed and when it can be developed.
Q: Ms. Carter, have you read -- you know who Bo Sellers is?
A: Yes.

Q: Mr. Sellers is a CHS employed architect, is that correct?
A: That's correct.
Q: And have you read his deposition?
A: I may have. I don't recall specifically. I may have.
Q: All right. Do you know, and if you don't know this is fine, but do you know that or would you agree rather that CMC-Fort Mill's design, except for OB beds and ICU beds only has room for another 18 to 20 med/surg beds that they can add at that current design; is that your understanding?
A: I don't know.
MR. WESTBROOK: Your Honor, I think this is a good time to break.
THE COURT: All right. Let's take a 15-minute recess.
(Lunch break from 12:07 p.m. until 1:20 p.m.)
THE COURT: Okay. We're back on the record. Mr. Westbrook.
MR. WESTBROOK: Thank you, Your Honor.
Q: Ms. Carter, an important factor affecting the level of Medicaid care the hospital provides is the degree to which its employed physicians

accept Medicaid patients; would you agree with that?

A: I would say that that can be a factor. There are certainly other factors that are -- well, there are a couple of things that influence that. First of all, it depends on -- by and large in any market, typically a physician practice payer mix is different from a hospital payer mix. If you think about it just in terms of a physician practice is going to see patients when they are well, and so they have more visits associated with patients who are well, which frequently are, you know, commercially insured patients. On the Medicaid side it might be, you know, some well children visits, but then hospitals see people at least on the inpatient side only generally when they are sick. And so it doesn't have a payer mix typically for the more well patients, and so that affects the payer mix. In addition to that, admissions to a hospital may not be, may not come exclusively from physicians who are employed by the hospital, and so the payer mix of whoever the physicians are that admit to the hospital, again, well, physician practice and

hospital payer mix are not parallel. You would have those patients as well, as well as patients who may not even have a physician in the community and may come directly to the emergency room.

Q: All right. And thank you for that answer, but going back to my question. I think my question was, isn't it true that an important factor, one important factor in determining the level of Medicaid care the hospital provides would be the receptivity of the degree to which its employed physicians accept Medicaid patients?

A: I recall that you said a very important factor. I would say it is a factor among others that influences ultimately what a hospital's payer mix is going to be.

Q: Is it an important factor?

A: It's a -- I mean it's a factor. It depends on -- again, for a given hospital it's going to depend on, number one, how many employee physicians they have, the mix of patients that they get from employed versus non-employed physicians as to its degree of influences on that number.

Q: What about with CHS Hospitals, or CHS -- for

example, CHS or CMC-Pineville or CMC-Main where there are a lot of employed physicians? Wouldn't you think that would be an important factor with CHS hospitals? Don't you think it would be an important factor with CMC-Fort Mill?

A: Okay. Are you asking me about all three hospitals, or?

Q: Well, let's take it -- let's start with CMC-Fort Mill.

A: Again, it is, it will -- it's going to depend on those factors that I mentioned as to whether or not -- which factor ends up influencing one way or another. It depends on how many employed physicians practice there versus how many non-employed physicians admit their patients there.

Q: All right. Is it an important factor with respect to why CHS facilities in Charlotte providing more medicaid than Presbyterian facilities in Charlotte?

A: Again, I don't know. There are several very large independent physician groups in Charlotte who also admit patients to CHS Hospitals in Charlotte. I don't know to what degree the amount of Medicaid that CHS facilities serve in

Charlotte, which is significant on a statewide comparative basis. I don't know to what degree that is influenced by their employed physicians versus the independent physicians who admit there.

Q: All right. Let me ask you to look, or ask Dan to pull up your trial testimony from 2009, and I'll hand you the page again I'm going to ask you to read from, please. This is page 1867 from the 2009 trial testimony, Ms. Carter. I'm going to get set up with 1867, and we're going to go into 1868 as well. I want to ask you to start, let's look at my question starts around line 18, and I'll just read it. I'm going to read the question if you will read your answer please. Question: "Your experience in Charlotte or your understanding of Carolina's experience in Charlotte is that they provide, Carolinas provides a great deal more Medicaid than Presbyterian in that area, isn't that correct?" Answer?

A: "Of the analyses that I've seen, yes, that's my understanding."

Q: Question: "And the reason for that would be related," and we'll go over to the next page,

"to employee physicians and their receptivity to Medicaid patients; is that one of the reasons?" Answer?

A: "That is certainly part of it. In my experience even beyond Charlotte is whether or not physicians are going to accept Medicaid."

Q: Okay. Thank you. And so, as you say, it's a factor and as you say, that's certainly part of it in your trial testimony but that's the factor that you testified about in that trial. You said, "In my experience even beyond Charlotte is whether or not physicians are going to accept Medicaid." That sounds a little more definite ---

A: Well ---

Q: --- what you testified a moment ago.

A: --- I would disagree with that.

Q: Okay. You would disagree with my characterization of what you said?

A: Yes.

Q: Okay.

A: Because you, in the prior trial testimony you specifically asked the question if the reason for that would be related to employed physicians, and I said, as I've said here,

that's part of it, and then my answer went on to say it's whether or not physicians are going to accept Medicaid. And again, it is -- it's not just whether or not employed physicians or non-employed physicians are going to accept Medicaid. Physicians, as I believe one of the Piedmont physicians testified in this hearing that they had had to limit their Medicaid, it's difficult for physicians to -- well, let me put it this way, many of them manage the amount of Medicaid that they accept in their practices. And so that's why I say it is a factor of any physician, whether employed or not, whether or not they accept Medicaid. And also as this goes on to indicate, part of the reason some of the free clinics that CHS provides in Charlotte, which is where many of the Medicaid patients receive their physician-related services, and Medicaid patients accessing care sometimes it is primary care that they're accessing in the emergency department rather than in a physician's office.

Q: By the way, are you aware of any free clinics that CHS runs in northern York County?

A: I don't know one way or the other.

Q: So the answer is you're not aware of any, is that correct?
A: I don't know whether they do or I don't know whether they don't.
Q: So you are not aware of them, right?
A: If they exist, I'm not aware of them.
Q: Now, under the Affordable Care Act even in states that choose not to expand Medicaid, the state insurance exchanges should at least theoretically lower the number of uninsured patients; is that your understanding?
A: I believe as I testified in my deposition in this case, theoretically it should. A lot will depend on where the uninsured in any given state are in terms of on the poverty scale how that relates to the state health insurance exchanges and subsidies and whether or not they can afford the state -- whether or not they can -- excuse me, afford insurance through the state health exchange.
Q: Back in 2005, in the 2005 application CHS projected, was it 3.5 percent charity care? It was three point something, right?
A: It was three point something. I can't recall the exact number.

Q: And Presbyterian projected three point something, right?
A: I believe that was correct.
Q: And Piedmont projected 3.0, I believe, is that right?
A: I believe that's correct.
Q: Now, Mr. Murphy was in charge of CHS's application back in 2005 and he's in charge in the updated applications of 2010, right?
A: That's my understanding.
Q: And at one point in time on the updated applications, you and your firm were charged with the primary responsibilities for preparing the updated application, isn't that correct?
A: As I testified in my deposition, there were -- there was a period of time where things went back and forth in terms of whether or not our firm was going to prepare the updated information and what parts of it versus at what point in time the CHS management company was going to do that.
Q: And that point in time when it looked like you and your firm were going to be preparing the updated application, or parts of the updated application, was back when the submission date

from DHEC was in February of 2010. It was later extended, right?

A: That's -- I believe that's correct.

Q: And then when that deadline was changed, that's when the decision to submit what you were working on was also changed, is that right?

A: That was one of the decisions. In other words, it became more of a fluid process after February in terms of what we worked on versus what CHS management company worked on versus what CHS management company worked on and what was -- maybe the easiest way to say it is, to the best of my knowledge, the bulk of what was submitted to DHEC originated with the CHS management company. There were a couple of analyses that we did that they folded in, and I believe that there were some utilization projections that we discussed between the two organizations as they were finalized.

Q: But after February of 2010, the CHS management company, that's Mr. Murphy's division, right?

A: Yes.

Q: The CHS management company under Mr. Murphy made a decision to submit different information than some of the information you were working on,

isn't that right?
A: No.
Q: Let's look at your deposition page 35, please. And this would be -- yeah, so this would be the earliest of your depositions. Ms. Carter, I'm going to ask you to look at page 35. This is line 16, and this is part of a long answer you're giving to a question of mine. You're certainly welcome to read anything you want to for context, but I want to read line 16 through 18. If you can just read that sentence out loud, please.
A: "And then that did not, the decision to submit that change and there was a decision to submit different information."
Q: And the decision to submit different information was a decision made by CHS management company, Mr. Murphy; wouldn't that be correct?
A: It was, but what I would say is that my prior answer on that page talks about updating the models so that they could feed into the utilization model specifically. I guess I want to make sure this is characterized correctly, is it is not as though we were preparing information that the CHS management company

completely disregarded and substituted completely different information.

Q: Uh-huh (affirmative response).

A: My -- the characterization is that we were preparing information including updating models that would potentially feed into a utilization model, and once it was determined that that wasn't going to be filed in February, the actual documents themselves were different in terms of what CHS submitted to DHEC. It doesn't necessarily mean that the base information was different.

Q: Okay. Well, I understand that and I'm not suggesting that what you did was disregarded, but it doesn't say on that sentence, it doesn't say "documents"; it says different information, doesn't it; isn't that what it says? Isn't that what you said?

A: Those are the words I said, and what I'm trying to explain is in the context -- if you read the context of my entire answer ...

Q: Well, let's do that. Let's do that. Let's start, I think at the bottom of page 34 is where this line of questions start. I have a question that starts on line 25 at page 34, and

I'll read the questions and you've got a long answer and you can read the entire answer into the record. Line 25 my question is, "Okay. In your role you said very, but the role that you and your firm had, tell me how that varied over time. And again just from, you know, the updated start after the trial, in other words." Answer?

A: "Right. As I believe Ms. Platt mentioned yesterday, there was a little bit of uncertainty as to what the timing was going to be on updated information. And so at one point in time earlier on when we thought the submissions were going to be in February, we were charged with updating models so that they could feed into utilization model. And then, of course, that stopped because we learned that we weren't filing updated information in February, and I may not be remembering the timing correctly, but at one point in time, we were charged with the primary responsibility for preparing an updated application in the application format, and we did work on that. And then that did not -- the decision to submit that change and there was a decision to submit different information. And

then I would say that maybe to characterize it as our role relative to what was submitted to DHEC in both October and December was providing some supporting information and then in reviewing some of the documents. We did not review everything before it was submitted, but reviewed some of the documents."

Q: Okay. Thank you. So your role after February changed to a role of being over reviewing some documents and providing some feedback?

A: Yes and no. Ultimately, that was our role with what was submitted to DHEC. As I explained here, there was some -- there was going, and it may not be in this place of my deposition, but somewhere in my deposition there was between -- my recollection between the February filing and at some point later on in the year, it fluctuated back and forth depending on when we thought the submission date was and my interpretation of what the capacity was at the management company as to what we were charged with doing versus what the management company was charged with doing. But ultimately, what was submitted to the management company, there were parts of it that we reviewed, there were

pieces of it that we had direct input on. I think that's the best way to characterize what occurred.

Q: All right. And the materials actually submitted in October 2010 and December of 2010, that would have been primarily from Mr. Murphy's group, is that right?

A: Yes, they compiled that information.

Q: And in October 2010, Presbyterian submitted a new charity care projection of about six percent or maybe it was six something percent of charity care, is that right?

A: I don't recall that one way or the other.

Q: All right. And CHS did not submit a revised charity care projection until December of 2010, do you recall that?

A: I recall, as I believe Mr. Murphy testified and I understood at the time, that in fact, we had discussions about what was appropriate to submit in October given the wording of Judge Matthews' Order, and Mr. Murphy made the decision to follow how he read the Order, and it made sense to me, to rely on the application that had been submitted in 2005. And then DHEC came back and said we do want updated information, and that