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| 1 | IN | THE UNITED STATES DISTRICT COURT |
| 2 |  | FOR THE DISTRICT OF MARYLAND |
| 3 |  |  |

4 CC RECOVERY, INC. \*

5 Plaintiff \*

6 vs. \* Case No. 1:12-cv-03786-JKB

7 CECIL COUNTY, MARYLAND \*

8 Defendant \*

9 \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

10 Deposition of LESLIE HENDERICKSON, Ph.D. was

11 taken on Tuesday, May 13, 2013, commencing at 10:24

12 a.m., at the Law Offices of Karpinski, Colaresi & Karp,

13 120 East Baltimore Street, Suite 1850, Baltimore,

14 Maryland, before Abraham Weinapple, Notary Public.

15 \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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20 REPORTED BY:

21 A. WEINAPPLE

1 APPEARANCES:

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1 LESLIE HENDRICKSON, Ph.D.,

2 the Deponent, called for examination by the Defendant,

3 having been duly sworn to tell the truth, the whole

4 truth, and nothing but the trust, testified as

5 follows:

6 (Whereupon, prior to the commencement of the

7 deposition the Second Notice of Deposition Duces Tecum,

8 Report of Dr. Hendrickson, and Clinic Cost Projections

9 were marked Hendrickson Deposition Exhibit No. 1, No. 2

10 and No. 3 for identification).

11 EXAMINATION BY MR. KARPINSKI:

12 Q. Dr. Hendrickson, I assume you've been

13 deposed before?

14 A. Yes, I have been.

15 Q. Let me show you what's marked as Exhibit 1

16 to your deposition. Would you take a moment to look at

17 that?

18 A. The papers are out of order. Page 3 is

19 after page 4.

20 Q. Okay. Well, we'll correct that.

21 A. Thank you. I have reviewed the document.

1 Q. And are you able to identify the document?

2 A. Do you mean the Second Notice?

3 Q. Yes.

4 A. Yes, I have received a copy of that document

5 before.

6 Q. And did you review the documents that were

7 requested in the notice?

8 A. Yes, I did review the documents.

9 Q. And have you provided all those documents

10 with you today?

11 A. Yes, I have.

12 Q. Why don't you briefly tell me a little bit

13 about you educational background?

14 A. I have a Bachelor's and Master's and Ph.D.

15 in Sociology.

16 Q. And where did you obtain those degrees?

17 A. I obtained my Bachelor's degree from San

18 Francisco State College. I obtained my Master's and my

19 Doctorate degrees from the University of Oregon.

20 Q. And why don't you walk me through your work

21 history?

|  |  |  |  |
| --- | --- | --- | --- |
| 1 |  | A. | Upon graduation -- you mean upon graduation |
| 2 | with | my | Ph.D.? |
| 3 |  | Q. | Yes. |

4 A. I spent a year with Booz, Allen & Hamilton

5 in Philadelphia, and then I went to the University of

6 Pennsylvania Law School and I spent three years there

7 on the staff of the law school working up for the

8 Health Law Project, in which I made studies of the

9 Philadelphia area hospitals, neighboring health centers

10 in Philadelphia, as well as participating in a review

11 of health conditions in Pennsylvania State prisons.

12 Q. Okay.

13 A. I then returned to Oregon.

14 Q. Approximately what year was that?

15 A. '74. I took a year off in '73 and I worked

16 in the Ethiopian Famine Relief for three months, so

17 that would be part of my work history. I returned to

18 Oregon and I found a position in Eugene School District

19 as a Program Evaluations Specialist and spent

20 approximately 9 or 10 years evaluating programs. I

21 went into business for myself as a software company

1 operator putting -- I was the 16th person in Oregon to

2 own an IBM PC and I started a computer IBM PC software

3 program called Research. I sold it for two years and I

4 then took a position with the Medicaid program in

5 Salem, Oregon, in the State of Oregon's Medicaid

6 program, and my job title, I was the Senior Budget

7 Analyst in the Medicaid program, and after that

8 position I was promoted upward to be a manager in the

9 division called, which was then called Seniors and

10 Persons With Disability. I then was recruited as a

11 loaned executive to the State of New Jersey and I

12 accepted a position as an Assistant Commissioner in the

13 State of New Jersey.

14 Q. What did you do as the Assistant

15 Commissioner?

16 A. I supervised nursing home reimbursements,

17 Medicaid Home and Community based care programs. I

18 supervised the state's large pharmaceutical assistance

19 program known as the PAAD program. I also supervised

20 eight field offices that did 30,000 preadmission

21 screenings a year for nursing home admissions.

|  |  |  |
| --- | --- | --- |
| 1 | Q. | Okay. |
| 2 | A. | After leaving the State of Oregon I spent |
| 3 | two years | working for a company called Maximus as the |

|  |  |  |  |
| --- | --- | --- | --- |
| 4 | Revenue | Services Director. |  |
| 5 | Q. | Have to catchup. | You | said after leaving |

6 Oregon. You mean after leaving New Jersey?

7 A. I apologize. After leaving New Jersey. I

8 retired from New Jersey and so I then went to -- in my

9 retirement I went back to work and I worked full time

10 for a company known as the Maximus Consulting Company

11 and, as I said, as a Revenue Services Director, and in

12 a 2-year period I visited approximately 12 states

13 analyzing regulatory language and cost reports for the

14 purpose of maximizing Federal reimbursement to the

15 states.

16 Q. Okay.

17 A. I then went into business for myself and

18 founded my own consulting business, and for the last 10

19 years I've been employed by numerous clients ranging

20 from nursing home chains to substance abuse treatment

21 companies.

1 I have two enduring relationships, one with

2 a public consulting group out of Boston, in which I've

3 done over 25 studies with their staff, major statewide

4 programs and reviews and, in fact, I'm currently on two

5 such projects for them in Colorado right now, and,

6 secondly, I've had a -- I have a 3-year contract with

7 the American Association of Retired Persons.

8 Q. The name of your company, is it Hendrickson

9 Development?

10 A. Yes, it is.

11 Q. How many employees are there at Hendrickson

12 Development?

13 A. Only myself.

14 Q. And how long has it been in existence?

15 A. Ten years.

16 Q. Ever since you left Maximus?

17 A. That's right.

18 Q. In terms of your work when you were employed

19 by either Oregon or New Jersey, did any of that work

20 involve the administration or oversight of Methadone

21 clinics?

1 A. No. In my work as a private consultant I've

2 done approximately 25 needs assessments for substance

3 abuse programs, including Methadone treatment centers

4 as well as detoxification programs and outpatient

5 programs.

6 Q. And out of those 25 assessments, how many of

7 them related to a profit or a loss analysis of a

8 Methadone clinic?

9 A. None of them.

10 Q. And I want to make sure I understand what

11 you mean by needs assessment, because I've been reading

12 some of your articles but, quite frankly, there are a

13 number of them. By needs assessment, is that where you

14 look at the geographic area?

15 A. Yes. Unfortunately, my best work is

16 unpublished. It's really proprietary to the company

17 and I don't really tell people that I've done job or

18 where I've looked or who I've done it for. But I use

19 the Maptitude, 2014 Mapping Platform. It's a GIS

20 system run from the Caliper Corporation and it's a very

21 professional mapping program. It also gives

1 demographics for any area that you're interested in,

2 including your regularly shaped objects. You know, if

3 you draw an object on the map, a polygon of some sort.

4 So I then review the sample statistics on the area. I

5 review state statistics. I identify similarly located

6 or close -- similar programs that are located nearby.

7 I do a population analysis of how many people might be

8 estimated to use the program. So this work is

9 primarily on a focus of the caseload or the number of

10 people who might use the program.

11 Q. And that's what you mean by needs

12 assessment; am I correct?

13 A. Yes, that's right.

14 Q. Did you do a needs assessment in connection

15 with CC Recovery versus Cecil County?

16 A. Yes and no. I wasn't asked to do a needs

17 assessment. I was asked to do the forecast of cost of

18 revenue, but I did -- for my own purposes I did kind of

19 a thumbnail kind of a mental exercise just to see if

20 the need for the program was present.

21 Q. Do you have an understanding of how many

1 Methadone clinics there are in Cecil County?

2 A. I collected that information at one time,

3 but I don't recall how many are in Cecil County.

4 Q. Would that be something that you would do in

5 connection with a needs assessment?

6 A. Yes. I collected data from the state and

7 it's part of the documents that I gave you showing the

8 utilization of each program in Maryland, so I did

9 collect that information.

10 Q. Okay.

11 A. I also did a mapping analysis of the drive

12 zone around the proposed location, which gave a good

13 estimate of the -- it's a block level aggregation

14 census estimate of the population that could be

15 potentially served in the area.

16 Q. But am I correct that in connection with

17 that analysis you did not plot out where other

18 Methadone clinics would have been?

19 A. That's correct.

20 Q. What certifications or licensures do you

21 hold? Obviously you're a Ph.D.; correct?

|  |  |  |
| --- | --- | --- |
| 1 | A. At one time I | held an Assistant Living |
| 2 | Administrator's License | but let it lapse because as |
| 3 | I -- I obtained that in | my final year as an Assistant |
| 4 | Commissioner, but I let | it lapse when I was on the road |

5 for Maximus because my office was in Carmel, Indiana

6 and I commuted every week from New Jersey to Indiana,

7 so I just couldn't keep up with the Continuing

8 Education requirements.

9 Q. Sure.

10 A. I hold no other certifications or licensure.

11 Q. And let's just take the 10-year period where

12 you've been out on your own. Out of the work that you

13 do, how much of it is related to providing expert

14 witness services?

15 A. I don't have a percentage calculation of

16 that work. My Web site lists the number of times I've

17 provided expert witness testimony. I think it's now

18 more than a dozen.

19 Q. Do you have an approximation of how much it

20 is?

21 A. I wouldn't wish to attempt an approximation.

|  |  |  |
| --- | --- | --- |
| 1 |  | Q. Okay. |
| 2 |  | A. I would have to go back through my invoices |
| 3 | and | actually calculate total hours and what percent of |
| 4 | all | hours was spent doing this work. |
| 5 |  | Q. And do you have an understanding of how much |

|  |  |  |
| --- | --- | --- |
| 6 | of the work is done for | Plaintiffs as opposed to |
| 7 | Defendants? |  |
| 8 | A. Well, some of | the work is really done for |
| 9 | zoning board hearings. | I don't know if there's a |
| 10 Plaintiff or a Defendant in a zoning board hearing. |
| 11 | There's | an applicant. |  |
| 12 | Q. | Right. |  |
| 13 | A. | Right. So no, I'm | not sure how I could |

14 characterize that question.

15 Q. Why don't we do it this way. Well, let me

16 show you Exhibit 2, and am I correct that Exhibit 2 is

17 your report that you prepared in this case?

18 A. Yes, I believe it is.

19 Q. And I believe if you look at, it's not

20 numbered, but I think if you go to page 22 and the next

21 page, which is not numbered, but then the following

1 page is 24, it gives a listing of cases or matters in

2 which you had been retained as --

3 A. Yes, that's right.

4 Q. -- as an expert; is that correct?

5 A. Yes, that's correct.

6 Q. As you know, Doctor, this isn't a guessing

7 game, so why don't we just go through these and you can

8 tell me what you recall about the issues that were

9 raised with regard to the various cases in which you've

10 been retained as an expert and/or provided testimony.

11 The first on there is 2013, Sunrise Detox versus City

12 of White Plains, and that was a case pending in Federal

13 Court?

14 A. Yes, and I was a witness for Sunrise Detox.

15 Q. Do you recall what the issue was in that

16 particular case?

17 A. It was just a straightforward needs

18 assessment. It was a program needed. I believe it was

19 a detoxification program.

20 Q. And the next is 2012. Again, it was

21 appearing in front of the Georgia Planning Commission

1 involving Sunrise?

2 A. Yes. It was a straightforward

3 detoxification program.

4 Q. And was that a needs assessment you did?

5 A. Yes, it was. It wasn't contested. It was

6 just a fairly routine application. They just wanted a

7 needs assessment for it.

8 Q. And just so that I understand this. When

9 you say "needs assessment", you analyze the area and

10 determine the need for it?

11 A. Yes, that's correct.

12 Q. In 2011 and 2012, there's Darling, et al

13 versus Douglas, et al.

14 A. Yes. I presented testimony on four separate

15 occasions. I was a witness for Darling, et al, and

16 this was a disability rights coalition lawsuit against

17 the State of California in the state's attempt to close

18 the Adult Day Health Care Program, and I presented

19 descriptions of the characteristics of the people that

20 were impacted by the potential closure, as well as

21 quantitative analyses of the impact of the closure and

1 offset from nursing home admissions. So I did a cost

2 tradeoff kind of analysis part of this work.

3 Q. Okay.

4 A. The Lawrence, New Jersey, I testified, I

5 believe, four times in this hearing. It was for a

6 detoxification program in Lawrenceville and it was very

7 hotly contested.

8 Q. And --

9 A. In fact, my work was reviewed in Superior

10 Court of New Jersey and in part because of my work the

11 case law was established that detoxification was an

12 inherently beneficial program, apparent beneficial need

13 under New Jersey law.

14 Q. And when you say "detoxification" what

15 exactly do you mean? When you say detoxification

16 program?

17 A. By detoxification program I mean a substance

18 abuse treatment program that generally lasts from 7 to

19 10 days where folks are treated on an inpatient basis

20 and they're helped to detoxify from the effects of

21 either alcohol or opioid abuse. It's the gateway to

1 treatment. I think of treatment as occurring after

2 that. Detoxification simply helps to remove the poison

3 from their body and gets their physical health

4 stabilized prior to treatment.

5 Q. And what was the gist of your testimony in

6 connection with --

7 A. I analyzed the need for the program. I

8 reviewed how many people, how many programs there were

9 in the state, how many people received services, the

10 population of people who needed services in the area,

11 where people went in that area to get the services, how

12 many left the county, left that area to get the

13 services, where the county sent its people that it

14 referred to for detoxification - Philadelphia, a

15 hundred miles away, southern New Jersey, et cetera.

16 Q. The next one is 2011, Township of -- is it

17 Teaneck?

18 A. Yes. This was a review of -- I did this for

19 a nursing home. It was a nursing home case and I

20 reviewed Medicare statistics on a number of folks who

21 used skilled nursing facility services in the region

1 and why that number changed over time.

2 Q. 2009, Commonwealth of Virginia. It says

3 "Affidavit on culture change and nursing homes".

4 A. Yes, that's right. I don't quite actually

5 remember what I wrote there. There's a lot of detail,

6 but a culture change is the general philosophical

7 movement to make nursing homes less institutional and

8 more homelike, and I believe it was on the -- well,

9 anyway, I don't want to speculate. I don't quire

10 recall in detail what I did there.

11 Q. But it was a matter involving your nursing

12 homes and, --

13 A. Yes.

14 Q. -- as you described, culture changes? 2009,

15 Commonwealth of Virginia, Department of Health,

16 testimony for Administrative Law Judge hearing?

17 A. Yes. This was an analysis for the State of

18 Virginia nursing homes, looking at the relationship

19 between the size of the nursing home and the cost of

20 the nursing home.

21 Q. In terms of analyzing the cost what, per

1 patient as determined by the size of the facility?

2 A. Yes. Looking at per patient costs to see if

3 they varied depending on whether the facility was small

4 or large.

5 Q. And the next is 2008-2009, New Jersey Board

6 of Adjustment.

7 A. Both the Oradell and the Cheshire cases were

8 needs assessments for nursing homes.

9 Q. And who retained you for those, the nursing

10 homes?

11 A. Yes, that's right.

12 Q. And it looks like there's really two

13 Cheshire cases?

14 A. Possibly, yes.

15 Q. You believe there was that needs assessment

16 as well with regard to 745 Highland Avenue?

17 A. I understand. The first reference,

18 Cheshire, is really testimony given to the U.S.

19 District Court, the District of Columbia, and the

20 second reference to Cheshire is really material

21 prepared for the zoning board.

1 Q. And I'm not trying to put words in your

2 mouth, you said District of Columbia. Do you mean the

3 United Stated District Court for the District of

4 Connecticut?

5 A. I do. Thank you for correcting me, sir.

6 Q. That's all right. And what was your

7 testimony in the Federal Court in Connecticut?

8 A. It related to the needs assessment for the

9 nursing home.

10 Q. And was the testimony -- well, let me just

11 ask you. The testimony in 2008 --

12 A. You know, I think -- no. There could have

13 been some assisted living, dementia care programs mixed

14 in here, too. I intend to include both of them

15 together, the dementia care programs and nursing home

16 programs. I would have to go through each one and sort

17 out. I did a few dementia care programs here also.

18 Q. 2008, Township of Hamilton, New Jersey

19 Zoning Board of Adjustment?

20 A. Yes. This was a skilled nursing facility

21 issue. They wanted to expand the skilled nursing

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | facility | beds. |  |
| 2 | Q. | Okay. |
| 3 | A. | The Whippany was a dementia | care program, I |
| 4 | believe. |  |  |
| 5 | Q. | And what was your role with | the Whippany |
| 6 | case? |  |  |
| 7 | A. | To identify how many people | locally might |

8 have dementia care and what the potential utilization

9 was.

10 Q. So that was another needs assessment;

11 correct?

12 A. Yes. These are all needs assessment.

13 Q. Have you been retained as an expert ever to

14 testify regarding the profitability of a particular

15 medical facility?

16 A. No, I haven't.

17 Q. Have you ever been retained by Mr. Polin

18 before?

19 A. No, I haven't.

20 Q. How were you contacted about this case?

21 A. I received a telephone call from Mr. Howard.

1 Q. How do you know Mr. Howard?

2 A. I don't. I'm not -- he called me. I don't.

3 I had no previous contact with him before his call.

4 Q. Called you out of the blue?

5 A. Yes, called me out of the blue.

6 Q. No prior contact. And do you have the parts

7 of your file with you? I see you had some other stuff.

8 Do you have any part of your file when you --

9 A. No.

10 Q. Okay.

11 A. The file has 80 or 90 documents in it.

12 Q. But the entire file was on that thumb drive

13 that my secretary is copying right now?

14 A. Yes.

15 MR. KARPINSKI: Let me go ahead and just see

16 where she is in getting it copied to get some portions

17 of it.

18 THE WITNESS: Okay.

19 RECESS

20 Q. Let's not waste any time. Let's proceed

21 with your report.

|  |  |  |
| --- | --- | --- |
| 1 | A. Well, you know, I would | like to say that on |
| 2 | the one hand I have not presented | any testimony before |
| 3 | regarding the cost of revenues in | a court situation. |
| 4 However, as a Senior Budget Analyst in the Oregon |
| 5 | Medicare Program I | did hundreds of analyses of future |
| 6 | costs, and part of | my work for the public consulting |
| 7 | group I frequently | do cost projections. For example, |

8 in January I worked on a study for the Arkansas

9 Medicaid Program of their Behavioral Health Care rates,

10 and used very similar methodologies on the labor

11 statistics to project forward costs that they would

12 incur. So I want the record to show that I've had

13 substantial cost projection experience. I just haven't

14 testified before about projecting costs for a health

15 care facility.

16 Q. I understood. Why don't we go through, and

17 you have a number of studies that you have been

18 involved in starting on page, I believe, 15. What I'd

19 like to do, Doctor, just to make this simple, would be,

20 I'm interested in any of the studies or publications or

21 articles that have to do with needs assessments or

1 analyzing the profitability of medical facilities. And

2 what I'd like to do is, why don't you go through and

3 then just put an asterisk next to those that you think

4 may fall within that category. I think if we go

5 through all the other studies that you have we could be

6 here until tomorrow and you probably do want to catch a

7 train going back to New Jersey. So let's just focus in

8 on that subject area in terms of and we can then talk

9 about those publications or studies.

10 A. Would you repeat your question?

11 Q. Sure.

12 A. What your task is to me.

13 Q. I'm interested in either the articles or

14 studies that you have done that involved either

15 performing or analyzing a needs assessment and/or

16 performing a profit and loss analysis for a medical

17 facility.

18 A. By needs assessment, several of these

19 involve statewide needs assessments where entire state

20 programs are being reviewed to comment on the need for

21 particular kinds of programs within the state. On

1 these larger studies, they're really state-wide studies

2 done with a national consulting company, and so they're

3 not the kind of address specific or region specific

4 within a state or town or county specific studies that

5 I typically do in my role as an individual consultant

6 with clients.

7 Q. I understand.

8 A. Okay.

9 Q. And with that said why don't you --

10 A. Yes. Well, kind I just start at the top?

11 Q. Well, why don't you put a one next to those

12 that are needs assessments, and then if there are any

13 that are a profit and loss analysis, I understand that

14 you told me that you do that on more of a consultant

15 basis than maybe your actual publication, put a one by

16 a needs assessment and then a two by profit and loss

17 analysis.

18 A. I'm going to put a two for the Utah Medicaid

19 Expansion Assessment because it was a study of the

20 Affordable Health Care Act expansion for the State of

21 Utah, and it really looked at all the puts and takes in

1 the revenues and the costs that is involved in this

2 massive state expansion under the ACA program. So I

3 think that might fit your profitability issue.

4 Q. Sure.

5 A. I'm going to put a one next to the June,

6 2012 study of mental health system in the State of

7 Texas. We did an extensive cost work by procedure code

8 looking at five years worth of data on the number of

9 users and each procedure code, the cost for units of

10 service, the number of units of service, and did some

11 projections of those forward. I'm not sure if that's

12 profitability or if it's just cost analysis.

13 Q. Why don't you put a two by that one as well.

14 A. I'm going to put a maybe two by that.

15 Q. Okay.

16 A. Well, the 2011 December work for Colorado, I

17 would say that smaller portions of these reports dealt

18 with potential revenue that the state might occur

19 because of changes in its programs or Federal

20 initiative that might be involved. So there's a

21 profitability analysis to the state here on its health

1 programs, but that was more -- I'm going to put a two

2 in front of the Technical assistance help to Nevada

3 Medicaid staff. We did extensive analyses of whether

4 the state was saving or losing money on its Medicaid

5 Waiver Program, the tradeoff of the gains and losses

6 from the program.

7 The 2010 Privatization study of the Utah

8 State Hospital, we examined the gains and losses to the

9 State of Utah if it privatized the forensics unit

10 within its state mental health hospitals. I think I

11 would call that a two.

12 In the 2009 Business Process Redesign of the

13 Texas Medicaid Transportation Program, parts of that

14 dealt with how the program could be better redesigned

15 to be more efficient. Some of it dealt with costs. A

16 lot of it costs. A small bit deal with profit

17 projections on how they might be a little bit more

18 profitable, but it was mostly a business redesign, a

19 very long and complicated business redesign process.

20 This is the largest program of its kind in the country,

21 over five million ride. It's one of the largest public

1 transportation providers in the country. So I'd say

2 kind of a 1 and 2.

3 Q. What was your role with regard to that

4 project?

5 A. Oh, I did the cost analysis of all the

6 transportation programs, the taxicab rides, the buses,

7 the planes. I looked at as much historical data as I

8 could get, some 10 years of data. I looked at the

9 number of users, the cost per ride. We did some

10 projections forwards of what the system was going to be

11 incurring in the future.

12 Q. Okay.

13 A. On many of these studies my task is, because

14 of my quantitative background and my budgeting skills,

15 my budgeting background, I get tasked with the analysis

16 of the dollars.

17 Q. Okay.

18 A. The 2009 June Cost Analysis, I would call

19 that two. We reviewed all the contracts that the

20 Division of Blind Services had with the lighthouses and

21 the other major blind providers, and then made

1 suggestions as to how those contracts could be changed.

2 As part of that work I did a capitation rate analysis

3 for the Conklin Center in Daytona Beach. The Conklin

4 Center is only one of two programs in the United States

5 that serves people who are both blind and mentally

6 retarded, and I reviewed their costs and revenue and

7 then made recommendations to the state as to the

8 capitation payment that the center would receive from

9 the state going forward into future years. So that

10 almost all of this stuff is just work on cost reports.

11 I mean, where you're looking at the profit and loss

12 statements of various providers. I have done a lot of

13 looking at cost reports of providers, certainly like

14 the nursing homes' profitability and losses, and I

15 should probably say that, to make it clear, that in the

16 State of New Jersey nursing homes that -- I have read

17 numerous analyses of their cost reports and have done

18 many cost report analyses and that's all profit and

19 loss for a particular medical facility. It's probably

20 the single largest group of medical facilities that I

21 have done profitability analyses on.

1 The May, 2009 work for the Texas Department

2 of Rehabilitative Services, I compared 5,000 rates. I

3 analyzed the rates that were paid by the department on

4 some 5,000 procedure codes and compared them to 10,000

5 procedure codes that Medicare paid for those same

6 services. So I did a lot of Excel spreadsheet work,

7 cross walking groups of costs, durable medical

8 equipment. And where there were significant

9 differences in the rates we did research and understand

10 why the rates would be different. I'm not sure if you

11 would categorize that as profitability of the health

12 care facility or not.

13 Q. Why don't you put it down as a two.

14 A. (Indicating). The 2008 November Assessment

15 was simply a really large needs assessment of all

16 mental health programs in the State of Oregon. We

17 prepared a lot of cost components, you know, big

18 spreadsheets showing where all the dollars went by

19 procedure code, by type of provider, made

20 recommendations on how that money could be moved around

21 or changed in the future.

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Q. | Okay. |  |
| 2 | A. | Much of the work on costs is | really advice |
| 3 or recommendations to the state on how they should be |
| 4 | spending their money | in | the future. The revenue part |
| 5 | of our work comes in | on | these large studies by |
| 6 | examining the impact | on | Federal funds and other funds |
| 7 | reimbursement. |  |  |

8 For example, my work for Maximus when I

9 worked on hospital cost reports for state mental health

10 Hospital, the issues were, if you change the state

11 rules in some way would the state obtain more revenue

12 from the change? In fact, you really could describe my

13 two years with Maximus as a revenue services director

14 just what the job says. I analyzed intermediate care

15 facility programs in Indiana. I analyzed nursing

16 homes, state operated nursing homes and intermediate

17 care facilities in Maryland. I analyzed juvenile

18 rehabilitation programs in Nevada, plus intermediate

19 care facilities in Nevada. And in all of this work it

20 was really involved with the profitability or

21 maximizing revenue to the state generally by examining

1 their cost reports for these institutions and seeing

2 ways in which more other different costs could be

3 claimed, or state rules could be changed to increase

4 the revenue.

5 Q. Okay.

6 A. So in that sense there were many health care

7 facilities for which I did profitability analyses. The

8 2008 October PASSPORT data, PASSPORT study. PASSPORT

9 is the name of their really large home and community

10 base care waiver in Ohio. And, again, it's a situation

11 where I analyzed the utilization of particular procedure

12 codes and we made recommendations to the state on how

13 those procedure codes could be changed or altered or

14 redone. That was my role in that work.

15 The Money Follows the Person work in West

16 Virginia, this is really a redesign of programs, not

17 necessarily focusing on costs. But as part of that

18 work I did publish in the work a cost effectiveness

19 model of analyzing the gains and losses to the state if

20 it expanded its Money Follows the Person program,

21 because the Money Follows the Person is a Medicaid

|  |  |  |
| --- | --- | --- |
| 1 | funded, CMS Medicaid funded | program concept that |
| 2 | encourages the states to go | into institutions, state |
| 3 | mental health hospitals and | nursing homes and take |
| 4 | people out of them and move | them into community. So |

5 there's a savings offset because the state saves money

6 by not paying a higher institutional cost and swapping

7 in a lower home and community base care cost for the

8 person. So I built a model that showed the savings

9 that would result, if you will, the profitability by

10 various levels of the money -- various levels of after

11 the Money Follows the Person program.

12 The Integrated Funding Analysis of 2007 for

13 West Virginia, we examined the costs of the State of

14 West Virginia on its substance abuse and problems. We

15 interviewed folks associated with county jails, state

16 prisons, state police, education staff and attempted to

17 identify all of the costs that the State of West

18 Virginia put into dealing with the impact of substance

19 abuse issues. Billions. I remember it was just

20 horrendously large when you started adding it all up

21 everywhere.

1 The 2006 study in West Virginia was our

2 first West Virginia study. The heart of that study was

3 a review of the financing of the community mental

4 health centers, where they spent their money, where

5 the -- the state budget, where the money went. We made

6 recommendations on how the money could be respent

7 better. I don't know if that's a profitability study,

8 but it's an analysis of where they're spending the

9 money and how it could be redesigned better.

10 Q. Okay.

11 A. The Alaska Long Term Care and Cost Study.

12 That's the actual title of it. We focused a lot on the

13 cost of the programs, we looked at cost effectiveness

14 of programs. Again, it's an effort to say if you spent

15 your money in one place, would you make more or would

16 you have more available to spend? So it's kind of

17 where the revenue -- can you get revenue or some

18 additional funds you didn't have before by respending

19 your money in some program mode rather than other

20 program modes.

21 Q. Let me ask you this, Doctor. Have you had

|  |  |  |
| --- | --- | --- |
| 1 | an occasion where you had a client | contact you to ask |
| 2 | you to determine the profitability | of a particular |
| 3 | location for a business? In other | words, to analyze |
| 4 | their revenues, their expenses and | then model out -- |

|  |  |  |  |
| --- | --- | --- | --- |
| 5 | A. | No. |  |
| 6 | Q. | Model how much money | they'd make? |
| 7 | A. | No, not a particular | location. |

8 Q. Well, we've gone through our more global

9 studies of various programs; is that correct?

10 A. Well, in this list of published works, but I

11 have pointed out in my previous testimony, as an

12 Assistant Commissioner I reviewed the cost reports, the

13 profit and loss statements out of numerous nursing --

14 there are over 320 nursing homes in the State of

15 Oregon, and as the Revenue Services Director I did

16 review numerous cost reports from the major medical

17 facilities, including the CMS, the Medicare 2552 Cost

18 Reports for state mental health hospitals, and the

19 corresponding ICF and rehabilitation cost reports.

20 Q. Okay.

21 A. So those are all address specific reports

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | which you do review profits and losses of | the |  |
| 2 | institutions. |  |
| 3 | Q. We began talking about that you | were |
| 4 | contacted by Mr. Howard? |  |
| 5 | A. Yes. |  |
| 6 | Q. And when were you contacted? |  |
| 7 | MR. POLIN: Is this a good time | to take | a |
| 8 | break? |  |  |

9 MR. KARPINSKI: Let's take a break right

10 now.

11 RECESS

12 A. I have no specific recollection of the date

13 when Mr. Howard called me.

14 Q. Do you have notes from your conversations?

15 A. No, I don't.

16 Q. Do you recall anything that was discussed?

17 A. Yes. Mr. Howard asked if I could -- he said

18 he was interviewing several people, it was a telephone

19 interview, and he asked how much time I thought it

20 would take to -- I think he asked for a needs

21 assessment or to look at a particular program and do a

1 needs assessment and asked how much time it would take,

2 and he later called me back and the conversation

3 developed from there.

4 Q. And what was that conversation when he

5 called you back?

6 A. You know, I don't actually remember the

7 conversations in detail, but they morphed into instead

8 of a needs assessment, per se, like I usually done, the

9 request evolved into I'll look at the projection of

10 costs and revenues going forward, and I remember I gave

11 him a list of my cost analysis experience, and I

12 believe it was based on that observation of my

13 experience that they decided to have me do that. I

14 remember submitting him a list of the cost analysis

15 work that I had done.

16 Q. Is that part of the material that's in your

17 file?

18 A. Probably not, no. I think it was just ad

19 hoc list, although I may have that on my Web site. I

20 may have list on my Web site.

21 Q. If it's not on your Web site do you think

1 you have somewhere in your office?

2 A. I think so. I think it's -- I'm pretty sure

3 I have it somewhere. I remember making up a list like

4 that, and I think it's on my Web site, but it's

5 probably in a file somewhere. I think it might be in

6 my Web site file on my Internet Explorer, or Windows

7 Explorer.

8 Q. And if Mr. Howard no longer has it, would

9 you have a problem giving me a copy of it?

10 A. If I can -- I can't guarantee you it would

11 be the same document I gave Mr. Howard. I mean, I

12 didn't keep a -- folks ask me for stuff, I just send it

13 to them. I don't keep track of them, you know.

14 Q. How many times do you think you've spoken to

15 Mr. Howard?

16 A. Maybe three times.

17 Q. Do you have notes from any of those

18 conversations?

19 A. No.

20 Q. And the first time was just to --

21 A. Right.

1 Q. -- see whether you'd be interested?

2 A. Yes. I believe there were 1 or 2 calls.

3 Then near the end of the process I called him to

4 inquire about his tax report, his tax returns for the

5 facility and he gave me -- rather than have him send me

6 a tax return, he gave me some information off. I

7 needed two numbers. He gave me two numbers off the tax

8 return. I remember he was in his office and I said

9 don't bother sending the thing to me, I just need these

10 numbers and he gave me those numbers. I remember that

11 in a telephone call, and I put them into the

12 spreadsheet, I remember that.

13 Q. Do you actually have the tax returns for Mr.

14 Howard's other businesses?

15 A. I have. I used one of the tax returns in my

16 report. I obtained a copy of a tax return which I used

17 in my report, and then I verbally got the two numbers I

18 needed off the tax return for a second facility and I

19 put that in my report. I do have the original -- I do

20 have the first tax return, a hard copy of that.

21 Q. And it's a tax return from where?

1 A. It's an IRS tax return from a nursing

2 facility, 2012 data in a nursing facility. I'm sorry.

3 A Methadone treatment center. And I do make a

4 reference to it in the document.

5 MR. POLIN: Those are one of the tax

6 returns. I think those are attached to Western

7 Maryland.

8 MR. KARPINSKI: That's what I was about to

9 ask.

10 MR. POLIN: Which we're going to provide

11 you.

12 Q. Do you remember the name of the facility?

13 A. I have it in the spreadsheet. I don't

14 actually. It's in the tax return form. I don't

15 actually remember the name of it.

16 Q. But just so that I understand, you have one

17 tax return and then you have the numbers from a second

18 year of the tax return?

19 A. Yes. I used the numbers -- in my report I

20 used the numbers from one of his returns and I got the

21 numbers from a second return for use in the report. So

1 I used numbers from two of his treatment programs in my

2 report.

3 Q. And do you have an understanding of where

4 that treatment facility is located?

5 A. These were 2012 IRS 1120S forms. Those were

6 the names of the forms that I took the numbers off of.

7 Q. Do you know where the facility is actually

8 located --

9 A. Yes.

10 Q. -- within the State of Maryland?

11 A. I knew at the time I looked at the report,

12 but I don't recall where it is.

13 Q. Do you know how long that facility has been

14 in operation?

15 A. I remember it was operation more than a few

16 years. It had been an established program.

17 Q. Any particular reason why you wouldn't ask

18 for the tax returns for every year that it had been in

19 operation?

20 A. Because I didn't need the tax returns for

21 every year it had been in operation. I was really just

1 trying -- I was using it to calculate the margin

2 percentage and I didn't need the historical margin

3 percentages because I was just using a current margin

4 percentage.

5 Q. So it would not be of interest to you to

6 know what the margin percentage had been over the years

7 he had been in operation?

8 A. Well, it might have been of interest but it

9 wasn't needed. But I was also using the West Virginia

10 Health Care Authority data on nine centers, and I've

11 used those numbers off and on again over the years, the

12 West Virginia data, because they're the only ones that

13 have the revenue and the cost for Methadone treatment

14 programs that I know of, but I didn't really need, I

15 wasn't doing a historical study. I was attempting to

16 look at the margin to establish the best margin

17 percentage that I could.

18 Q. And what was the margin percentage for the

19 two years for the facility that Mr. Howard was running?

20 A. Well, I have it in my spreadsheets, but I

21 didn't put it in the report, and I don't know those

1 margin percentages offhand. I averaged the margin

2 percentages from the nine West Virginia programs with

3 the two margins from Mr. Howard's treatment programs to

4 get the most robust average that I could.

5 Q. The facility that Mr. Howard operates, do

6 you have any information regarding the level of

7 competition there is for that facility? In other

8 words, is there even --

9 A. No.

10 Q. -- another facility in that area?

11 A. No, I don't. I do not.

12 Q. And do you have an idea of how many patients

13 are seen at that facility?

14 A. No, I do not.

15 Q. And do you know how many years it had been

16 in operation beyond that it has been a well-established

17 business?

18 A. No, I do not know the specific number of

19 years Mr. Howard's programs has been in operation.

20 Q. Your report says you had conversations with

21 Mr. David as well?

1 A. Yes.

2 Q. Who

is Mr. David?

3 A. Mr.

David developed the pro forma that I

4 relied on.

5 Q. And do you have an understanding of when you

6 received that pro forma?

7 A. I don't have the date on when I received the

8 pro forma, but I believe the -- I might have put the

9 date in the file name when I got it. I sometimes do.

10 So you can into my records and get the date, probably

11 the exact date I received it.

12 Q. And you had previously said that the

13 information regarding the margin for Mr. Howard's

14 facility are probably on your spreadsheet. Do you have

15 your spreadsheet here?

16 A. Well, it's on the thumb drive that I gave

17 you.

18 Q. It's not in your other papers you brought?

19 A. No. There's probably -- as you know,

20 there's like 80 or 90 documents there and it didn't

21 seem reasonable to ask me to make a hard copy of 80 or

1 90 documents when it could be 7 or 800 pages. I would

2 have to bring -- and spreadsheets are all so difficult

3 to copy as you know, I mean to convert to pages. So I

4 thought it would be best -- you guys can look at the

5 formula, look at what I did, you know, go into the

6 details of the plumbing.

7 Q. What do you recall about your conversations

8 with Mr. David?

9 A. Well, reviewed the pro forma, talked about

10 it.

11 Q. Is Exhibit 3 the pro forma that you were

12 provided?

13 A. He provided me two pro formas actually, one

14 assuming Medicaid and one assuming not Medicaid, and I

15 would have to check this document against my

16 spreadsheet files to see if it was the same pro forma,

17 because I know I had two from him, so I only see one

18 here. So I'm not sure -- this certainly looks like it,

19 but I wouldn't want to answer your question

20 definitively yes or no until I have a chance to compare

21 it against the documents that I have in my possession.

1 Q. How many conversations did you have with

2 Mr. David?

3 A. I don't know. I didn't keep track of them.

4 Q. Did you take any notes of your

5 conversations?

6 A. No.

7 Q. Would it be fair to say that you don't have

8 any notes at all of the conversations you had with

9 Mr. Howard and Mr. David?

10 A. I think so, yes, that would be fair.

11 Q. Do you have notes of conversations you had

12 with anyone in connection with the work that you done

13 on this case?

14 A. No. I would usually make changes directly

15 into the spreadsheet. Like, for example, the

16 information I got from Mr. Howard I just put a note in

17 the spreadsheet, you know, oral from Mr. Howard. I

18 mean, I kind of tagged the data source of my

19 information in the documents that I work on rather than

20 keeping it in a separate side document. Well, I tend

21 to keep our -- if people send me attachments, like

1 e-mails with attachments, so I document the date that I

2 got the attachment, who sent it to me, any conversation

3 about it. So those are the kinds of notes that I keep

4 or, really, folks when they make comments about

5 material that they send me. But the conversation with

6 Mr. Howard, I just got really -- I was interviewed by

7 him, I sent him some cost stuff and he gave me two

8 numbers. So it's not like it's a big note, if I made a

9 note about what I did with Mr. Howard.

10 Q. Do you think you spoke to Mr. David on more

11 than one occasion?

12 A. Oh, yes. Probably 5 or 6 times probably.

13 Not a lot, but some.

14 Q. And you don't believe you took any notes in

15 those conversations?

16 A. No.

17 Q. Do you think you marked up any of the

18 spreadsheets?

19 A. Well, I certainly made changes in the -- I

20 know Mr. David sent me some e-mails which I have copied

21 you on, and those e-mails had information in them, and

1 I kept those e-mails. So in a sense, where it made

2 sense to keep notes, like if I got some paragraphs of

3 information or comments from him I would keep them in

4 an e-mail, I would keep those e-mails. But other

5 than -- you know, I used to keep a lot of notes, but

6 after 40 years of doing this I just got buried with

7 notes and I try to work as efficiently as I can and

8 just capture the information I need, put it into my

9 work and move along.

10 Q. Okay. I want to go through just a couple of

11 these quickly in terms of things you reviewed. The

12 first is Cecil County Drug & Alcohol Council document

13 entitled Plans, Strategies and Priorities For Meetings,

14 the identified needs of the general public and the

15 criminal justice system for alcohol and drug abuse

16 evaluation, prevention and treatment. Do you see that?

17 A. I do.

18 Q. And that's from 2009 to 2011. Is there

19 anything more recent, to your knowledge?

20 A. Well, I don't know. These are -- I'm giving

21 you a list of the documents that were available to me

1 at the time that I did the work and that I received

2 from parties or that I found on my own.

3 Q. Is that a document that you received from a

4 party or is that a document you found on your own?

5 A. I'm not sure. Mr. Polin sent me some 5 or 6

6 documents of Cecil County information, and so the

7 likelihood is that this is a document I received from

8 him.

9 Q. Okay.

10 A. I have an e-mail containing the documents

11 that I received from him as part of the documentation

12 and you could identify which came from him.

13 Q. Sure. And do you have any idea when the pro

14 forma prepared by Mr. David was actually prepared? In

15 other words, is it your understanding that it was

16 prepared in connection with his application process, or

17 was it prepared in connection with this litigation, or

18 do you not know one way or the other?

19 A. I believe it was prepared prior to the

20 litigation because he gave it to me at the beginning of

21 the -- well, let me back up. Let's just let say I do

1 not determinatively know for certain, so I shouldn't

2 speculate on when it was prepared. I don't know the

3 date or month when it was prepared.

4 Q. And do you have an understanding if Mr.

5 David is affiliated with any drug treatment facilities?

6 A. Yes, I believe that he is affiliated with

7 the Cecil County Recovery, and I know that he has a

8 professional background in substance abuse treatment.

9 Q. Do you if know if he's involved with any

10 Methadone treatment facilities in Montgomery County?

11 A. I don't know. I know that he works with --

12 I know he works with Mr. Howard, in that, he's received

13 advice and help from Mr. Howard with an experienced

14 treatment operator, and I don't know to what extent

15 Mr. David has duties of employment at other treatment

16 centers.

17 Q. And so did anyone ever disclose to you that

18 he's actually involved as a principal in another drug

19 treatment facility?

20 A. The question of whether he's involved in

21 other facilities didn't arise.

1 Q. Did you ask Mr. David or Mr. Howard to see

2 what they could do to provide you information regarding

3 the profitability of other drug treatment facilities in

4 the State of Maryland?

5 A. Yes. Well, I obtained information on Mr.

6 Howard's returns.

7 Q. For a 2-year period?

8 A. I used one year. I used one year of data

9 for two centers. That's what's in my spreadsheet.

10 Q. One year for two centers?

11 A. Yes, that's right, because that's the data

12 that -- I had that snapshot in time for the West

13 Virginia centers, so I wanted to get data for all the

14 years for the same center, so that's where my interest

15 was in that year.

16 Q. And the two centers are located where?

17 A. I don't recall offhand. They're in

18 Maryland, but I don't recall offhand where they were.

19 One is called Turning Point, I believe, and the other I

20 think is Western Maryland. That's my recollection, but

21 one of them might be in Elkton. I'm not sure. I mean,

1 I could check my records and establish that, if you

2 want it.

3 Q. Would I be correct in saying that you were

4 not asked to do basically a market analysis to

5 determine --

6 A. Correct.

7 Q. -- how CC Recovery was fair given the

8 various business competitors there are in the local

9 Elkton/Cecil County area?

10 A. No, but I told you I did do a short kind of

11 needs assessment up front just to see if there was a

12 need to know. I just wanted to have grounding for

13 myself, and so what I did was, I did a map of a

14 30-minute drive zone around the proposed address and

15 observed it. See, let me back up a little bit. I

16 think of these programs like this is really regional

17 medical programs serving -- they're located within one

18 county, but typically serve people from other

19 surrounding counties as well. In an outpatient program

20 like this I typically use a 30-minute driving zone, and

21 so I did a map then using the Maptitude 2014 by the

1 Caliper Corporation and drew a map which showed the

2 driving zone, and then the demographics in the driving

3 zone were approximately 525,000 people. Adults,

4 525,000 adults. And I know from my experience looking

5 at various states, that roughly speaking anywhere from

6 1 1/2 to 3 percent of those folks in an adult

7 population, it varies by state, so, roughly speaking,

8 somewhere in that range, those folks may have drug

9 abuse or dependency problems, and of that number, of

10 the total population of adults, maybe 1/2 of 1 percent

11 probably wants services and would seek them if they

12 were available and --

13 Q. Is that based on your experience?

14 A. The 1 1/2 to 3 percent is based on SAMHSA

15 Substate studies which are available at the SAMHSA Web

16 site. SAMHSA stands for the Substance Abuse and Mental

17 Health Services Administration. It's a Federal

18 substance abuse mental health agency. The roughly 1/2

19 of 1 percent comes from household surveys in the State

20 of New Jersey, and that's the percentage that the State

21 of New Jersey methodology uses in their analysis of

1 adult populations, and it's reasonable because it fits

2 with the stats on how many people who abuse drugs get

3 treatment.

4 So if you apply those percentages it did

5 seem that there were sufficient people in the 30-minute

6 drive zone, that regardless of the level of services

7 being provided and other providers, to provide a

8 reasonable caseload of 300 folks for this program, so I

9 did that kind of quick and dirty off the top of my

10 head, you know, to kind of see if the numbers fit

11 right, and they do fit. So I wasn't asked to do more

12 detail, 25-page marketing analysis, and I didn't do

13 that in this case.

14 Q. And as we sit here today, do you even know

15 the number of service providers in the 30-minute area

16 around Elkton?

17 A. No. And again, if you just want to get a

18 perspective, you can calculate, regardless of how many

19 service providers there are, you can calculate an

20 estimate of the number of people who need services and

21 are not getting them in last past year. So you can

1 identify that information independently from knowing,

2 you know, the level of utilization of service

3 providers.

4 So to answer your question, it didn't seem

5 necessary for the work that I was being asked to do. I

6 wasn't asked to do a needs assessment. I was being

7 asked to really look at the cost report the guy's

8 doing, the pro forma, and project it forward.

9 Q. Well, wouldn't it be fair to say that given

10 the number of service providers would affect

11 profitability?

12 A. As a general rule, the supply and demand do

13 affect the profitability of business.

14 Q. You have one McDonald's within a 30-mile

15 radius and then you have 10 McDonald's within a 30-mile

16 radius, I mean, the number of people that actually will

17 go to one that existed before, it's going to be

18 adversely affected by competition; correct?

19 A. I'm not sure how to answer that question

20 because there are already probably 2 or 3,000 people

21 within a 30-minute drive of that address who at the

1 time I did that work weren't getting services and might

2 be persuadable to come to that place to get services

3 because it was in a reasonable driving zone. This is

4 not -- you know, Methadone treatment is not selling

5 McDonald's hamburgers. This is a different business.

6 Q. So sitting here today you don't even know

7 whether the service providers in the Elkton area were

8 at full capacity, do you?

9 A. I'm not sure what you mean. What is

10 capacity in a Methadone treatment program?

11 Q. That they are not able to see anymore

12 patients, that they have reached the number of patients

13 that they are able to service.

14 A. But they're not capped by license, though.

15 It's not like beds. This is a very different situation

16 from beds. I don't really think Methadone treatment

17 programs have a capacity actually.

18 Q. Are you familiar with the COMAR regulations

19 that relate to Methadone clinics in Maryland?

20 A. Well, I understand that -- see, suggesting

21 that there's a certain amount of elasticity, in that,

1 if the demand is there the supply of services can be

2 increased to meet the demand, because it's mostly a

3 labor input operation. It isn't a high tech operation.

4 You're not limited by your supply. You're really

5 limited by your -- you have some limitations on your

6 parking spaces probably and the size of the physical

7 facility, but if you expanded your hours that would

8 probably accommodate some of that. If you have more

9 people come you hire more staff. I mean, I don't know

10 what -- I don't really have a sense of what a -- this

11 is very different from inpatient beds, where the state

12 puts a cap, you got X many beds and that's it, and that

13 is your capacity. But capacity isn't a word that's

14 usually applied to outpatient programs. It's a word

15 that applies to inpatient programs in my experience.

16 Q. So it would not be of any significance to

17 you to know that the other service providers in a

18 3-miles radius around where this facility was going to

19 open are not at full capacity? That would be of no

20 significance to you at all; am I correct?

21 A. Well, I wasn't -- but you have to go back to

1 what I was asked to do.

2 Q. What were you asked to do?

3 A. I was asked to look at the pro forma

4 projections and project them forward, and that's what I

5 did. So you're asking me about other topics or other

6 studies or other analyses that I could do, or there

7 might be of interest -- there are many things that

8 would be of interest to me. I understand that several

9 months afterwards, after the Cecil County Recovery --

10 after to get established was derailed that a facility

11 opened up in the nearby area and brought in 300 people,

12 meaning that if they had been allowed to open in a

13 timely way they might have had those 300 people, and so

14 it's just proving that at the time that they had the

15 concept and attempted to get started the demand was

16 there for the program.

17 Q. But with the program that had opened that

18 now was servicing 300 people, doesn't that affect the

19 profitability of CC Recovery?

20 A. Well, what's affecting the profitability of

21 CC Recovery is the fact that they can't open because

1 the county, you know, derailed them because of what the

2 county did. If the county hadn't derailed them and

3 they had been allowed to open in a timely way they

4 would have those 300 people probably. And are there

5 another 300 people? Well, I'm not sure.

6 Q. Your analysis assumes that there would be

7 another 300 people; correct?

8 A. My analysis assumes that a reasonable

9 caseload to assume in the cost analysis would be the

10 average caseload of a Maryland Methadone program.

11 Q. And, in fact, as I look at your 1-year

12 physical impact, you don't even consider a ramp-up

13 period to get to 300 patients, do you?

14 A. No, I don't. That's true.

15 Q. Why did you not? Any new business does have

16 a ramp-up period.

17 A. Yes, it does have a ramp-up period, I agree

18 with that.

19 Q. In your analysis you use the phrase

20 "Reasonable Margin Percentage". And what exactly is

21 your definition of that?

1 A. Well, reasonable means I have documentation,

2 I've got some substantiation of what facilities, what

3 Methadone treatment facilities have as their margins.

4 Q. And just so that I'm clear on that, that

5 would be the documentation you have for the nine West

6 Virginia facilities and the two facilities?

7 A. That's correct, that's correct.

8 Q. And what costs are included within that

9 reasonable margin percentage?

10 A. Well, I asked that. I had a telephone

11 conversation or e-mail which I include in my documents

12 with the West Virginia folks, and they said they

13 include everything. They don't exclude anything.

14 Q. Did you ask specifically what everything is?

15 A. Well, I recall asking if there was any costs

16 excluded and they said no, they include all of the

17 material on the cost reports that places submit.

18 Q. Are you sufficiently well versed on how

19 Methadone clinics are run in West Virginia as opposed

20 to Maryland to --

21 A. No.

1 Q. -- discuss the differences in operations?

2 A. No, I'm not. I've never studied the -- I

3 never visited a West Virginia Methadone clinic.

4 Q. On page 6 you say that you have researched

5 the mean average of patients in Maryland, which I

6 believe you said is 305; correct?

7 A. Yes. I notice in my report I use 305 and I

8 got 308 in there, too. So I think the 308 might be a

9 typo. It should have been 305 I think possibly.

10 Q. What was the median?

11 A. Two hundred.

12 Q. Two hundred.

13 A. And I say in my report, the median is not --

14 the median is a good descriptive average of the

15 half-way mark, but it doesn't balance against all

16 patients. So if you use a median you end up under

17 projecting the number of patients. I took that

18 information from the N-SSATS file. I downloaded the

19 information on the 13,700 facilities approximately in

20 the SAMHSA's N-SSATS, N-S-S-A-T-S, file, and sorted the

21 file identifying the programs in Maryland and deleted

1 the other states out of the data and the Maryland tab

2 with the Maryland data is contained in the

3 documentation that I provided you so you can see the

4 raw statistics and see my calculation.

5 I sorted the facilities by size and then

6 added up the average of the ones that had patients, and

7 that calculation is documented in the Excel

8 spreadsheet. You can see where the number comes from.

9 Q. Did you do an independent cost approach?

10 A. Could you describe what you mean by an

11 "independent cost approach"?

12 Q. Well, in terms of the costs, did you rely

13 upon the pro forma or did you do your own independent

14 analysis?

15 A. Well, I relied upon the pro forma mainly

16 because it seemed reasonable, but you could see from my

17 analysis of the costs that I went into at some length

18 looking at Bureau of Labor Statistics on these

19 categories and what the costs are and what the cost

20 increases might be. I've done similar work like that.

21 For example, in the Arkansas Behavioral Health Work

1 that I did in January, I did a 6-state peer study of

2 substance abuse, substance abuse staff looking at many

3 of these same labor characteristics.

4 The description of the staffing here, I

5 mean, how many staffs there are and what the duties,

6 they seem reasonable to me. It seemed like about the

7 kind of staffing level you would have in a program like

8 this. I looked at a lot of distributions of staff in

9 both dementia care units, nursing homes and assisted

10 living programs and these are kind of a reasonable

11 array of staff.

12 Q. Of course it's a staffing level for 200

13 clients; correct?

14 A. Yes, that's right.

15 Q. Is there any reason you didn't use the

16 number of clients reflected in the pro forma which also

17 reflects Mr. David's estimation of costs?

18 A. I recall at the time that I thought it would

19 me more conservative, I would actually have a lower

20 estimate. That while it would cut against Mr. David's

21 size of damages that it was a more conservative

1 approach.

2 Q. How could it be a more conservative approach

3 to use 305 as your basis for revenue and yet use

4 expenses based upon 200 patients?

5 A. Well, hold on. Let me think about that.

6 That's a good question. I just need to --

7 Q. Sure. Take your time.

8 A. -- go back and think about my logic there,

9 because I remember addressing that and thinking about

10 it.

11 Q. Sure.

12 A. It's not -- see, the costs on Table 1, the

13 costs actually don't enter into the calculation here.

14 I did the calculations based on revenue and margin. So

15 the costs don't enter into it.

16 Q. You didn't evaluate the costs?

17 A. In Table 1 --

18 Q. Table 1 is what? What are you referring to?

19 A. Table 1 in my report. So look at Table 1.

20 Q. Page 9?

21 A. Right. If you look at that table you'll see

|  |  |  |
| --- | --- | --- |
| 1 | that | it just -- you calculate the revenue and then you |
| 2 | look | at the margin on the revenue and that gives you |
| 3 | your | bottom line numbers. |
| 4 |  | Q. But you're using a revenue source of 305? |
| 5 |  | A. That's right. |
| 6 |  | Q. When Mr. David is telling you he's only |

|  |  |  |  |
| --- | --- | --- | --- |
| 7 | going to | have 200 clients? |  |
| 8 | A. | That's right. |  |  |
| 9 | Q. | Why would you do that? |  |  |
| 10 | A. | Because I think the 300 -- see, I'm | not -- | I |

11 don't critically take the numbers that people shove at

12 me. I try to use what's in my best judgement as to

13 what a reasonable cost projection going forward would

14 be, and in my case no -- a lot of Methadone programs

15 have more than 200. We talked about earlier, what is

16 capacity in a Methadone program? I believe it's a lot

17 of elasticity there, so I think it's more reasonable to

18 me to say to take the average size of the Methadone

19 program in the State of Maryland and use that as the

20 basis, the cost load estimate, rather than take what

21 the person puts in the pro forma. There's

1 speculations. I also note there were other numbers

2 that have been presented to the zoning board which were

3 even lower and which didn't make a lot of sense to me.

4 Q. Well, do you have an understanding of the

5 physical limitations of the particular site we're

6 talking about?

7 A. No, but I believe that you can -- they were

8 talking about a program that was going to be open 3 or

9 4 hours a day. If you open the thing in the afternoon

10 you can handle no more than 200 people. I mean, that's

11 my recollection, that this was almost like a part-time

12 program. But I want to go back to Table 1, and the

13 point here is that the costs, whether they're based on,

14 you know, five counselors or six counselors or seven

15 counselors don't enter into the calculations here.

16 It's the revenue number and the margin number that

17 drives the bottom line.

18 Q. So let me ask you this, then. What, if any,

19 utility is the pro forma that's been marked as Exhibit

20 3? How did you use that in your analysis?

21 A. Well, I used it in several ways. I took the

|  |  |  |
| --- | --- | --- |
| 1 | staff title to estimate inflationary costs going |  |
| 2 | forward. |
| 3 | Q. Right. |
| 4 | A. So that was a significant usage. I also |
| 5 | took the revenue assumptions out of it. |
| 6 | Q. Which would be what? Out of what's been |
| 7 | marked as Exhibit 3, what would be the revenue |
| 8 | assumption? |
| 9 | A. Can I see Exhibit 3, please? Or do I have | a |
| 10 | copy? |  |
| 11 | Q. I think it's right in front of you. There |  |
| 12 | you go. |  |
| 13 | A. You gave me a copy. Okay. |  |
| 14 | Q. Actually, let's do this, make life simple |  |

15 for ourselves. You put a check mark by what you relied

16 upon in the pro forma, because as I just understood

17 your testimony you relied upon the assumed net margin,

18 which I then assume is the margin after expenses. So

19 that's how came up with 305 patients with an assumed

20 net margin of 35.73. Fine.

21 A. I told you where I got the net margin from;

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | right? |  |  |
| 2 | Q. | Yes. |
| 3 | A. | Documented. | I told you where I got the |
| 4 caseload from. Documented. |
| 5 | Q. Yes. And I'm following all that. |  |
| 6 | A. All right. |  |
| 7 | Q. Now, what I'm asking you, though, | is, and I |
| 8 | understand what you're telling me, that you | used the |
| 9 | titles and in your report you go through an | analysis of |
| 10 | how those expenses would change over time. |  |
| 11 | A. This material here where he talks | about the |

12 dosage levels and what you get for selling the product,

13 and that's where the profit calculations come from,

14 it's in the sale of the pharmaceuticals to the clients

15 that use the program.

16 Q. How about all these other costs, like

17 payroll company, alarm system, Lee's advertising, all

18 that?

19 A. Well, yes, I used all that information in

20 rolling forward an estimate of what those costs would

21 be in the future in order to obtain the percentage

1 assumptions that I used going forward.

2 Q. Why would you need to do that if you already

3 have a set assumed net margin rate of 37.73?

4 A. Well, I wanted to go forward in the future

5 to see because I assume on the non-Medicaid patients

6 that the revenue -- that he would attempt to cover,

7 that the owner of the business, the owner of a

8 business, not necessarily -- I didn't ask Mr. David or

9 Mr. Howard what they would do, but that it was

10 reasonable to assume in the analysis that given that

11 the Medicaid revenue is fixed that the owner of the

12 business would attempt to recoup whatever cost changes

13 there were going forward by increasing the charges to

14 the patients in succeeding years. So in order to get a

15 reasonable -- I wanted to cap that as an increase in

16 the costs, a percentage increase in the costs, so

17 that's why I did that.

18 Q. Let me ask you this. The report assumes

19 that half the patients are going to be Medicaid, half

20 are not going to be, they're going to be private pay;

21 correct?

|  |  |  |
| --- | --- | --- |
| 1 | A. | Yes. |
| 2 | Q. | And when you say "private pay" what do you |
| 3 | mean? |  |
| 4 | A. | I mean both -- well, actually, I think of |
| 5 | two main | sources. I think of self-pay or insurance, |

6 private insurance companies, and sometimes I think of

7 things like Tricare there, too. They're kind of

8 government pay but they're sort of private pay and I

9 typically -- I certainly exclude Medicaid and --

10 Q. And how was it determined that half would be

11 Medicaid and half would be private pay?

12 A. I discussed that with Mr. David and I

13 didn't -- I didn't have a good rationale for making

14 other assumptions. I mean, I didn't have a sense of

15 that. See, the problem is is that there's only one

16 state in the country that actually collects data on

17 everybody in the system that uses services, that's New

18 Jersey. Everyone else just collects data on

19 state-funded clients. So you have no way of knowing in

20 states how many private pays there are using substance

21 abuse treatment programs. So it turns out to be really

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | an elusive | assumption to go for, or to try | to get a -- |
| 2 | I surveyed | every state substance abuse  | licensing |
| 3 | agency and | their data and every state east | of the |

4 Mississippi River, and I can only find one state that

5 tracked the data on private patients, and even then it

6 doesn't always give the payers source. It just tells

7 you everybody, but it may not identify payer source

8 very accurately. So it's just a really hard assumption

9 to get at, and so I talked about that with Mr. David

10 and we kind of came to the conclusion in the absence of

11 decent data 50 percent might be a reasonable

12 assumption.

13 Q. Okay.

14 A. And since he was involved in the ownership

15 with the program going forward, it did seem that I

16 should have some reliance upon his judgements.

17 Q. Just so that I understand, have you ever

18 done in connection with doing an analysis something

19 called EBIDTA, E-B-I-D-T-A? Do you know what that is?

20 A. Earnings Before Income Taxes and

21 Depreciation.

|  |  |  |
| --- | --- | --- |
| 1 | Q. | Right. |
| 2 | A. | No, I have not done that analysis. |
| 3 | Q. | Have you ever done a terminal analysis? |
| 4 | A. | Could you describe what you mean by "a |
| 5 | terminal | analysis"? |
| 6 | Q. | What the business would be worth at the end |
| 7 of its life? |
| 8 | A. | No, I have not done a terminal analysis. |
| 9 | Q. | Have you ever done a present value analysis? |
| 10 | A. | As distinct from a net present value |
| 11 | analysis? |  |
| 12 | Q. | Yes. |
| 13 | A. | Well, this gets a lot to be like the current |
| 14 | analysis. | I mean a present analysis. |
| 15 | Q. | And that present value analysis, is that |

16 what you believe you did?

17 A. No, I wouldn't use that to describe what I

18 did. Net present is usually some discounting. You

19 discount future cash flows by inflation. It's

20 typically not done in health care analysis business

21 that I do.

1 Q. How about your analysis? Did it take into

2 consideration net income pretax or is net income post

3 tax?

4 A. I didn't include tax calculations in there.

5 Q. What's your understanding of what the

6 corporate tax rate would be?

7 A. I wouldn't wish to speculate on what a

8 particular corporate tax rate is. There's various

9 things that I didn't include. I didn't include the

10 sunk cost that the person had before. He obviously

11 incurred like construction, electrical bills, he had

12 fees to pay, he had lawyers' fees to pay. So there

13 were various other costs involved in an operation that

14 I didn't include.

15 Q. And is your net income fully allocated,

16 includes depreciation and everything else?

17 A. I'd have to go back to the pro forma to see

18 to what extent it included. Can I take a look at it?

19 Q. It's right in front of you.

20 A. Sure. No, I don't think that this pro

21 forma, while it has allowances for some taxes, I don't

1 think it includes -- I don't think it takes into

2 consideration U.S. Tax Code in the calculation of its

3 numbers. I think it excludes tax-related

4 considerations, such as depreciation.

5 Q. And the 308 patients that you have, or the

6 305 in the report, I'm just interested, do you have an

7 understanding of what the variation was, the high and

8 the low in this particular region?

9 A. It's in the spreadsheet, but I don't --

10 there are 4 or 5 facilities that had zero. There are

11 other that has upwards to 5 and 600 at the bottom of a

12 distribution and it's quite a variation of programs.

13 Q. Okay.

14 A. But the actual array of -- so I have both

15 the in staff data on the utilization, but I also

16 obtained utilization from the Department of Mental

17 Health & Hygiene, and that information by program for a

18 fiscal year is in the spreadsheet. You can see that

19 variation there.

20 Q. And I take it you were not asked to do a

21 market share analysis?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 |  | A. | No, | I wasn't. | for |
| 2 |  | Q. | The | yearly net revenue -- |
| 3 |  | A. | But | you see, I'm not sure a market share |
| 4 analysis is possible in Maryland, though. I mean, |
| 5 | the | reasons I stated | earlier, nobody collects data | on |
| 6 | how | many private pay | use these facilities. If you | get |

7 the data on utilization from the state, all you're

8 getting is state funded folks. So it's literally

9 impossible to do a market share because you're missing

10 a -- you don't know what you're missing in terms of the

11 market.

12 Q. How did you come up with $4,160.00 per

13 Medicaid patient?

14 A. In my documentation in the spreadsheet it

15 shows the pro forma for the Medicaid, the pro forma for

16 the non-Medicaid and that's off the pro forma on the

17 Medicaid. You can see where the number comes from.

18 Q. That's the pro forma provided to you by

19 Mr. David?

20 A. Yes, but it's based on Medicaid

21 reimbursement rates, which I assume, which you'll

1 notice in my analysis, I assume the Medicaid is not

2 going to change the rate. So in some way if Medicaid

3 changes the rates my analysis is conservative, because

4 it's underestimating what the potential damages are.

5 Q. Yes. But your analysis also assumes there's

6 going to be an increase in private pay rate; correct?

7 A. Yes, only to the extent that they reflect

8 actual cost increases that the person is going to

9 encounter in the operation of his program.

10 Q. But isn't it true that there has not

11 actually been an increase in private pay charges?

12 A. I don't know. I don't. I'm not even sure

13 how I would find out that information. Folks are

14 really loathed to tell you what they charge people and

15 it's also very negotiable. That's my experience with

16 substance abuse treatment providers. I don't think it

17 would be possible. I'm not sure how I would go about

18 even obtaining that information on Maryland Methadone

19 treatment programs given the proprietary nature of that

20 information and the squishiness of the rates.

21 Q. Why don't you take a look at Exhibit 3, just

1 to make sure I understand it. It says "Salaries

2 Costs", it says "Calculate", it says "Manual",

3 "Manual", "Auto". Do you have an understanding of what

4 that means? Right at the top here (indicating). And

5 if you don't know, I understand you didn't prepare this

6 spreadsheet.

7 A. My assumption is that these are information

8 that he inputted into the program versus information

9 that the machine calculated. He would identify how

10 many staffs are there and the hours of workweek per

11 staff. So that would be stuff that he would plug in.

12 Q. And then the top part are just the job

13 titles and employee payroll information; correct?

14 A. Yes, that's correct.

15 Q. Did you calculate the percentage of overall

16 expenses that Mr. David attributed to salaries?

17 A. You know, I did at one time. I don't

18 remember what it is, but I did take a look at that

19 stuff. I do remember.

20 Q. In your experience, is there a prevailing

21 percentage of overall expenses that are typically

1 attributable to payroll?

2 A. Do you mean for health care programs?

3 Q. Yes, sir.

4 A. Health care facilities?

5 Q. Yes, sir.

6 A. They tend to be high, 75, 80 percent.

7 There's fluctuation, though, across those types of

8 programs depending on the technology and equipment you

9 have to use. But typically labor costs are your

10 primary input.

11 Q. And just so I'm clear, does your analysis

12 take in to effect any capital expenditures, such as

13 depreciation, loan costs?

14 A. Financing costs?

15 Q. Financing, any of that?

16 A. No, it doesn't. These are really primarily

17 just basic operating costs. But, again, the analysis,

18 the cost of, I'm really using the analysis, the cost to

19 get at a percentage increase and calculate what an

20 owner might increase the non-Medicaid portion of its

21 revenue by and thinking that an owner, rationally

1 operating owner would attempt to capture back some of

2 those costs. And if you look at the percentage

3 increases, they're pretty low, you know, under two

4 percent because labor costs took a dip. I actually

5 noted this in the Arkansas work I did earlier in a

6 6-state study. The recession had a real impact on the

7 salaries of people in these behavorial health programs.

8 So when you have a baseline with the dip in it and

9 you're projecting that forward, your projection is

10 picking up that dip, so you're not getting a huge --

11 you're not getting 3 and 4 percent increases from year

12 to year on this labor stuff. So I came up with what I

13 thought seemed to be very reasonable, based on the

14 analysis, the cost very reasonable percentage increases

15 going forward. But the bottom line, though, is really

16 based on the margin, the calculations and the revenue

17 calculations. It's not based on what costs I included

18 or didn't include, and you can raise depreciation or

19 other issues, but they're not used in the calculation

20 of the lost revenue.

21 Q. They're relevant in the issue of an actual

1 bottom line profitability of a business, are they not?

2 A. Yes, yes.

3 Q. When you look at page 10 and the list of

4 various categories - managers, counselors, it's on your

5 report, Doctor. On your report.

6 A. Are you suggesting that the damages that he

7 should receive are really appropriately based on his

8 tax situation and that that would be the proper way of

9 calculating the damages, the net that he would get back

10 after taxes?

11 Q. I'm not suggesting anything. I'm asking you

12 what you consider in terms of what the profitability

13 would be?

14 A. Okay. So what would you like me to look on

15 this report?

16 Q. Page 10. I just want to make sure. The

17 actual costs for managers, counselors, that comes

18 directly from the pro forma; correct?

19 A. Yes, that's right.

20 Q. Did you do anything to independently verify

21 that those are what is being paid in the marketplace?

1 A. They seemed reasonable amounts. I looked at

2 hourly data on maybe 6 or 7 states and categories and

3 these numbers don't jump out at me as being odd, too

4 high or too low. They tend to vary by states, you

5 know. Like the difference between RNs and LPNs, the

6 hourly gap might vary, you know. Some are close, some

7 are 4 or 5 bucks apart, some are just a buck or two

8 apart. But these numbers all looked pretty reasonable.

9 I mean, nothing jumped out at me as usually low or

10 unusually high. The salary levels are not very high in

11 this field, basically, because you're mainly

12 counselors.

13 Q. Then on page 11 you say "The 'All Other

14 Expenses' pooled all remaining lines in the pro forma.

15 This category contains 23 lines from the pro forma

16 amounting to..." "...20 percent of all anticipated

17 expenses". Do you see that?

18 A. Yes, I do.

19 Q. And is that in keeping with what you have

20 customarily seen?

21 A. Well, I think earlier you asked me and I

1 said 75 to 80 percent. Twenty percent outside of that

2 would be actually quite consistent with the 80 percent

3 estimate. This is about what you find. It's not

4 unusual.

5 Q. Did you do a comparison on the payment, the

6 Medicaid payments in West Virginia as compared to

7 Maryland?

8 A. No, I didn't.

9 MR. KARPINSKI: Why don't we take a couple

10 minute break here.

11 RECESS

12 MR. KARPINSKI: We were talking earlier

13 about a spreadsheet that you had prepared. Mark that

14 as Exhibit 4.

15 (Spreadsheet prepared by Dr. Hendrickson was

16 marked Hendrickson Deposition Exhibit No. 4 for

17 identification).

18 Q. I'll show it to you. Is Exhibit 4 the

19 spreadsheet we've been discussing?

20 A. Yes, one of the spreadsheets.

21 MR. KARPINSKI: I can' find another

1 spreadsheet in here. Why don't we go off the record.

2 RECESS

3 Q. Sir, there's an individual in your documents

4 referenced by Jim Green. Do you know who that is?

5 A. Yes. Mr. Green is an attorney in Florida.

6 Q. What's your understanding of his role in

7 connection with this case?

8 A. I don't have an understanding of his role in

9 connection with this case.

10 Q. It appears that you participated on some

11 conference calls with him?

12 A. I'm not sure what you're referring to. That

13 may be the case. I just simply don't recollect any

14 calls.

15 Q. Sitting here today you don't recall having

16 any discussions with Mr. Green about this case?

17 A. No. All my conversations have really been

18 with Mr. Polin. I am -- I believe that perhaps

19 Mr. Polin could tell you that information. I can't.

20 Q. I had asked you earlier about you qualifying

21 as an expert. Has there ever been a time where you

1 have not qualified as an expert?

2 A. No. I've always qualified.

3 MR. KARPINSKI: Those are all the questions

4 I have for you. Thank you very much for your time

5 today.

6 THE WITNESS: You're welcome.

7 MR. KARPINSKI: Read and sign, not read and

8 sign?

9 MR. POLIN: Let's read and sign.

10 (EXAMINATION CONCLUDED)

11 -----------------------

12 12:35 p.m.

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1 CERTIFICATE OF DEPONENT

2

3 I hereby certify that I have read and examined

4 the foregoing transcript, and the same is a true and

5 accurate record of the testimony given by me.

6

7 Any additions or corrections that I feel are

8 necessary, I will attach on a separate sheet of paper to

9 the original transcript.

10

11

12

13

14 LESLIE HENDRICKSON, Ph.D.

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|  |  |  |  |
| --- | --- | --- | --- |
| 1 | STATE | OF | MARYLAND |
| 2 |  |  | SS: |
| 3 |  |  | I, Abraham Weinapple, a Notary Public of the |
| 4 | State | of | Maryland, do hereby certify that the within |
| 5 named, LESLIE HENDRICKSON, Ph.D., was deposed at the |
| 6 | time | and place herein set out, and after having been |
| 7 | duly | sworn by me, was interrogated by counsel. |
| 8 |  | I further certify that the examination was |

9 recorded stenographically by me, and this transcript is

10 a true record of the proceedings.

11 I further certify that I am not of counsel

12 to any of the parties, nor an employee of counsel, nor

13 related to any of the parties, nor in any way interested

14 in the outcome of this action.

15 As witness my hand and notarial seal this

16 21st day of May, 2014.

17

18 MY COMMISSION EXPIRES

19 MAY 8, 2015 NOTARY PUBLIC

20

21

1 I N D E X

2

3 DEPONENT LESLIE HENDRICKSON, Ph.D.

4 Examination by Mr. Karpinski 3

5

6 E X H I B I T S

7 HENDRICKSON

8 No. 1 Second Notice of Deposition Duces Tecum 3

9 No. 2 Report of Dr. Hendrickson 3

10 No. 3 Clinic Cost Projections 3

11 No. 4 Spreadsheet by Dr. Hendrickson 82

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