PUBLIC

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

ORIGINAL

In the Matter of	)	
	)	**PUBLIC**
Otto Bock HealthCare North America, Inc.	)	**Docket No.: 9378**
	)	
Respondent	)	
	)	

NON-PARTY ABILITY PROSTHETICS & ORTHOTICS' MOTION FOR INDEFINITE *IN CAMERA* TREATMENT

To the Honorable D. Michael Chappell
Chief Administrative Law Judge

Counsel for non-party Ability Prosthetics & Orthotics ("Ability"), pursuant to Rule 3.45(b) of the Federal Trade Commission's Rules of Practice, 16 C.F.R. §3.45(b), respectfully moves this Court for indefinite *in camera* treatment of commercially-sensitive and confidential portions of the transcript of the April 4, 2018 deposition of Ability's Chief Executive Officer Jeffrey M. Brandt, and for indefinite *in camera* treatment of the entirety of one competitively-sensitive, confidential business document designated as an exhibit to Mr. Brandt's deposition.

Respectfully submitted,

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Email: creagand@whiteandwilliams.com

Counsel for Non-Party Ability Prosthetics & Orthotics

DATED: June 8, 2018

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of	)	
	)	**PUBLIC**
Otto Bock HealthCare North America, Inc.	)	
	)	**Docket No.: 9378**
	)	
Respondent	)	
	)	

NON-PARTY ABILITY PROSTHETICS & ORTHOTICS' MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR INDEFINITE *IN CAMERA* TREATMENT

Pursuant to Rule 3.45(b) of the Federal Trade Commission's Rules of Practice, 16 C.F.R. §3.45(b), Counsel for non-party Ability Prosthetics & Orthotics ("Ability") submits this Memorandum of Law in support of Ability's Motion, filed this date, for indefinite *in camera* treatment of commercially-sensitive and confidential portions of the transcript of the April 4, 2018 deposition of Ability's Chief Executive Officer Jeffrey M. Brandt (the "Confidential Testimony"), and for indefinite *in camera* treatment of the entirety of one competitively-sensitive, confidential business document (the "Confidential Document") designated as an exhibit to Mr. Brandt's deposition (collectively, the "Confidential Information").

Counsel for FTC and counsel for Respondent Otto Bock HealthCare North America, Inc. have stated that they do not oppose Ability's Motion. A corresponding Statement Regarding Meet and Confer is appended to this Memorandum.

Mr. Brandt's deposition testimony was given in response to Subpoenas ad Testificandum in this matter. *See* Exh. A to this Memorandum (Dep. Exh. Brandt 2). Ability produced the Confidential Document at issue in response to Subpoenas Duces Tecum from the Parties. *See* Exh. B to this Memorandum (Dep. Exh, Brandt 3). In fact, the Confidential Document is a

spreadsheet that Ability created *de novo* from its internal corporate data expressly to respond to certain requests for information in the subpoenas that Complaint Counsel and Counsel for Otto Bock served on Ability.

This Court signed a Protective Order Governing Confidential Material in this matter on December 20, 2017 (the Order was entered on December 28, 2017). That Order governs only the handling of Discovery Material, however, and if a Party or non-party wishes to prevent public disclosure of Confidential Material at the hearing, it must seek an order for *in camera* treatment of any document or transcript that a Party plans to introduce into evidence at the administrative trial of this matter. Protective Order ¶ 10.

Complaint Counsel have notified Ability that they intend to offer the Confidential Testimony (Trial Exh. No. PX05149, Bates No. PX05149-001 -- 106) and the Confidential Document (Trial Exh. No. PX03282, Bates No. APO000017) into evidence in the administrative trial of this matter, currently scheduled to begin on July 10, 2018. *See* Exh. C to this Memorandum (Letter from Amy S. Posner, Esq. to Jeffrey Brandt c/o David Creagan, Esq. dated May 23, 2018 & Attachment A). A copy of the Confidential Testimony is Exhibit D to this Memorandum, and a copy of the Confidential Document is Exhibit E.

The Confidential Testimony and the Confidential Document warrant indefinite *in camera* treatment because they contain sensitive and confidential information about Ability's internal business structure, finances, practices, strategies, and contracts that, were it made public or divulged to Ability's suppliers or competitors, would injure Ability's capacity to compete in the market for prosthetic services. In addition, the Confidential Document also contains personal

identifying information and consumer information that require indefinite *in camera* treatment.[1] Therefore, Ability requests indefinite *in camera* treatment of portions of the Confidential Testimony and indefinite *in camera* treatment of the Confidential Document in its entirety.

In support of its Motion, Ability relies on the Declaration of Jeffrey M. Brandt ("Brandt Declaration"), attached as Exhibit F to this Memorandum. The Brandt Declaration provides additional details about the Confidential Testimony (Exh. D) and the Confidential Document (Exh. E) for which Ability seeks *in camera* treatment.

I. Public disclosure of the Confidential Information would seriously injure Ability's competitiveness in the market for prosthetic services by revealing proprietary, commercially sensitive, and confidential information about Ability's business to its suppliers, competitors, and payors.

In camera treatment of information is appropriate when its "public disclosure will likely result in a clearly defined, serious injury to the person, partnership, or corporation requesting" such treatment. 16 C.F.R. §3.45(b). Here, serious competitive injury would result from public disclosure because the Confidential Information is proprietary and material to Ability's business. *See In re General Foods Corp.*, 95 F.T.C. 352, 355 (1980); *In re Dura Lube Corp.*, 1999 F.T.C. LEXIS 255, *5 (1999). Where that is the case, courts generally attempt "to protect confidential business information from unnecessary airing." *H.P. Hood & Sons, Inc.*, 58 F.T.C. 1184, 1188 (1961). Indeed, it is unquestionable that "the confidential records of businesses involved in Commission proceedings should be protected insofar as possible." *Id.* at 1186.

Moreover, Ability is a non-party to this proceeding and is thus entitled to "special solicitude" in the consideration of its request for *in camera* treatment of its Confidential Information. *See In re Kaiser Aluminum & Chem. Corp.*, 103 F.T.C. 500, 500 (1984). Among

[1] The personal identifying and personally sensitive information in the spreadsheet was redacted prior to production of the document to FTC and Otto Bock, but Trial Exhibit PX03282 still contains competitively-sensitive, confidential business information of Ability that should be granted indefinite *in camera* treatment.

the reasons for the "special solicitude" shown non-parties is the realization that "[a]s a policy matter, extensions of confidential or *in camera* treatment in appropriate cases involving third party bystanders encourages cooperation with future adjudicative discovery requests." *Id.* That has certainly been the case here where Ability – a customer of the Parties, not just a "bystander" -- has cooperated with FTC Complaint Counsel and counsel for the Respondent and voluntarily produced documents and provided deposition testimony in this proceeding. All of these factors should further tip the scales toward granting indefinite *in camera* treatment to Ability's Confidential Information.

The Confidential Information for which Ability seeks indefinite *in camera* treatment is non-public and material to Ability's competitiveness in the market for prosthetic services. As required, the Brandt Declaration (Exh. F) demonstrates the non-public nature of the Confidential Information and its materiality to Ability's capacity to compete. *See In re North Texas Specialty Physicians*, 2004 FTC LEXIS 109, at *2-3 (Apr. 23, 2004). According to the Brandt Declaration, disclosure of the Confidential Information to the public, which would include Ability's competitors and suppliers and the payors that reimburse Ability for the prosthetic services provided to patients, would cause serious competitive injury to Ability. *See* Exh. F, Brandt Decl. ¶ 5.

The Confidential Document, by itself, shows the cost of goods ("COG") to Ability (i.e., how much Ability pays various manufacturers and suppliers for prostheses, which includes any negotiated discounts), the allowable claim (i.e., how much Medicare or private health insurers will pay Ability for the prosthetic services provided to patients), the cost to Ability of various microprocessor knees ("MPKs") including any negotiated discounts, and Ability's gross margin ("GM") on each patient. Ability keeps all of that commercially-sensitive information

confidential because it is material to the core of Ability's business and capacity to compete in the marketplace. Ability's competitors, suppliers, and payors would derive competitive advantages from knowing Ability's Confidential Information that would injure Ability's capacity to negotiate costs and prices, shrink its revenue and profit margins, and weaken Ability's overall competitiveness. *See* Exh. F, Brandt Decl. ¶ 6. The Court should thus grant indefinite *in camera* treatment to the Confidential Document in its entirety.

In addition, in his deposition, in answer to questions from counsel for FTC and Otto Bock, Mr. Brandt testified about the data and information in the Confidential Document. All of that testimony should likewise be granted indefinite *in camera* treatment. *See* Exh. F, Brandt Decl. ¶ 9.

Mr. Brandt's deposition transcript also contains his testimony about Ability's internal business affairs, past, present and future, and reveals confidential information about Ability's management, its Board of Directors, its corporate debt and finances, Mr. Brandt's personal thought processes in deciding whether to seek licensure or to open offices in Pennsylvania or other states, and similar non-public matters that have no relevance to the dispute before this Court but that if publicly disclosed would cause injury to Ability's business or reputation and weaken its competitiveness. *See* Exh. F, Brandt Decl. ¶ 10. For these reasons, those portions of the Confidential Testimony should also be granted indefinite *in camera* treatment.

Mr. Brandt also testified at his deposition about Ability's relationships with the various payors (principally, Medicare and private health insurers) that reimburse Ability for the care provided to patients. Those payors are often identified by name and compared with one another as to the approaches they take or might take to different scenarios and treatment options. Public disclosure of those comparisons could damage Ability's relationships with the payors and

consequently injure its ability to compete with other prosthetic service providers. *See* Exh. F, Brandt Decl. ¶ 11. Those portions of the Confidential Testimony should, therefore, be granted indefinite *in camera* treatment.

II. The Confidential Information will remain competitively-sensitive in the future; therefore, indefinite *in camera* treatment is justified.

Because the Confidential Information at issue "is likely to remain sensitive or become more sensitive with the passage of time," *In re Dura Lube Corp.*, 1999 FTC LEXIS *7-8, such that the need for confidentiality is not likely to decrease over time, Ability requests that it be given *in camera* treatment indefinitely. The Brandt Declaration (Exh. F) states why the competitive significance of the Confidential Information is unlikely to decrease over time.

The information in the Confidential Document was drawn from Ability's records for the period January 1, 2016 to December 31, 2017. Ability compiled the information in a spreadsheet that it created expressly in response to the subpoenas Ability received from FTC and Otto Bock. Although the data in the spreadsheet are from the two most recent calendar years, the relationships, ratios, and percentages expressed by the data are unlikely to change for the foreseeable future. *See* Exh. F, Brandt Decl. ¶ 7. Hence, the Court should grant indefinite *in camera* treatment to the Confidential Document and the designated portions of the Confidential Testimony.[2]

III. Conclusion.

For all of the reasons stated in this Memorandum and in the Brandt Declaration, disclosure of the Confidential Information to the public -- and consequently to Ability's competitors, suppliers, and payors -- would cause serious competitive injury to Ability.

[2] Should the Court decide against granting indefinite *in camera* treatment, Ability respectfully asks that the period of *in camera* treatment granted be no less than 10 years from the date of the Court's Order.

Therefore, Ability respectfully requests this Court to grant indefinite *in camera* treatment for the Confidential Information.

Respectfully submitted,

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Email: creagand@whiteandwilliams.com

Counsel for Non-Party Ability Prosthetics & Orthotics

DATED: June 8, 2018

STATEMENT REGARDING MEET AND CONFER

The undersigned certifies that counsel for Non-Party Ability Prosthetics & Orthotics notified counsel for Complainant the Federal Trade Commission and counsel for Respondent Otto Bock HealthCare North America, Inc. by email on June 6, 2018 that it would be seeking *in camera* treatment of the Confidential Information. Both counsel for FTC and counsel for Otto Bock stated by reply email that they would not object to Ability's Motion.

Respectfully submitted,

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Counsel for Non-Party Ability Prosthetics & Orthotics

DATED: June 8, 2018

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of	)	
	)	**PUBLIC**
Otto Bock HealthCare North America, Inc.	)	
	)	**Docket No.: 9378**
	)	
Respondent	)	
	)	

[PROPOSED] ORDER GRANTING INDEFINITE *IN CAMERA* TREATMENT

Upon consideration of non-party Ability Prosthetics & Orthotics' Motion for *In Camera* Treatment, it is HEREBY ORDERED that the following document in its entirety and the designated pages and lines of the transcript of the April 4, 2018 deposition of Jeffrey M. Brandt are granted indefinite *in camera* treatment from the date of this Order:

Trial Exhibit No.	Document Title/ Description	Date	Beginning Bates No.	Ending Bates No.
PX03282	Exh. E to Memo. of Law, Ability Prosthetics & Orthotics Spreadsheet (Dep. Exh. Brandt 1)	00/00/0000	APO 000017	APO 000017

Trial Exhibit No.	Document Title/Description	Date	Redacted Page(s)	Redacted Line(s)
PX05149	Exh. D to Memo. of Law, Deposition Transcript of Jeffrey Brandt (Ability Prosthetics & Orthotics)	04/04/2018	30	12
			47	12-13, 17
			59	19-20
			60	10-11
			61	13, 23-25
			62	1-3
			68	3, 7
			69	3-7, 23-25
			70	1-3, 12

			71	7
			74	12-17
			93	25
			94	2, 20-21
			95	23-24
			96	4, 23-25
			97	1-25
			98	1-3
			100	1-7
			102	1-8, 19, 22, 25
			103	4, 10-15
			109	2, 7-24
			110	22-25
			111	1-5, 12-15, 20-25
			112	1-6, 11-25
			113	1-2
			114	2-3
			115	14-25
			116	1-25
			117	1-17, 22-25
			118	3-10, 18-25
			119	1-25
			120	1-20
			156	8-10, 24-25
			158	6-16
			159	1, 4-7
			161	19-25
			162	1-13, 22-24
			163	20
			164	18-24
			168	19-23
			169	1-9
			170	5-7
			182	22-23
			189	14-17
			192	1-7
			201	9-10, 21
			202	1
			205	13, 25
			207	10, 25
			208	2, 10, 18

			211	16, 21
			212	6
			230	13 17
			233	6-8
			247	11-14, 16
			248	5, 17, 25
			249	3, 9, 16
			250	9, 15, 20
			251	4
			252	19
			253	17-18, 21
			254	5, 21
			255	7
			256	4-5
			258	22-23
			264	11, 17, 22-23
			265	1-11, 15, 18, 20, 23
			266	7-8, 11-12
			267	1-3, 5, 7, 15-17
			269	15, 18

ORDERED:

D. Michael Chappell
Chief Administrative Law Judge

Date: _____

CERTIFICATE OF SERVICE

I, David J. Creagan, declare under penalty of perjury under the laws of the State of Pennsylvania that the following is true and correct. On June 8, 2018, I caused to be served the following documents on the parties listed below by the manner indicated:

- Non-Party Ability Prosthetics & Orthotics' Motion for *In Camera* Treatment, with accompanying Memorandum of Law and all Exhibits, and Statement Regarding Meet and Confer
- [Proposed] Order Granting Indefinite *In Camera* Treatment

The Office of the Secretary: (via FTC E-Filing System)
Donald S. Clark
Office of the Secretary
Federal Trade Commission
600 Pennsylvania Avenue, N.W., Room H-172
Washington, DC 20580

The Office of the Administrative Law Judge (via FTC E-Filing System)
D. Michael Chappell
Chief Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Avenue, N.W., Room H-106
Washington, DC 20580

Complaint Counsel for Federal Trade Commission (via FTC E-Filing System)
Amy S. Posner, Esquire
Federal Trade Commission
400 7th Street, SW
Washington, DC 20024

Counsel for Otto Bock (via FTC E-Filing System)
Christopher Casey, Esquire
Duane Morris LLP
30 South 17th Street
Philadelphia, PA 19103-4196

David J. Creagan

Notice of Electronic Service

I hereby certify that on June 08, 2018, I filed an electronic copy of the foregoing Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment and Memorandum of Law, Exhibits to Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment, with:

D. Michael Chappell
Chief Administrative Law Judge
600 Pennsylvania Ave., NW
Suite 110
Washington, DC, 20580

Donald Clark
600 Pennsylvania Ave., NW
Suite 172
Washington, DC, 20580

I hereby certify that on June 08, 2018, I served via E-Service an electronic copy of the foregoing Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment and Memorandum of Law, Exhibits to Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment, upon:

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Attorney

EXHIBIT A

SUBPOENA AD TESTIFICANDUM PUBLIC DEPOSITION

Provided by the Secretary of the Federal Trade Commission, and Issued Pursuant to Rule 3.34(a), 16 C.F.R. § 3.34(a) (2010)

1. TO	2. FROM
Ability Prosthetics & Orthotics, Inc. c/o David Creagan, White and Williams LLP 1650 Market Street One Liberty Place, Suite 1800 Philadelphia, PA 19103-7395	**UNITED STATES OF AMERICA** **FEDERAL TRADE COMMISSION**

This subpoena requires you to appear and give testimony at the taking of a deposition, at the date and time specified in Item 5, and at the request of Counsel listed in Item 8, in the proceeding described in Item 6.

3. PLACE OF DEPOSITION	4. YOUR APPEARANCE WILL BE BEFORE
White and Williams LLP 1650 Market Street One Liberty Place, Suite 1800 Philadelphia, PA 19103-7395	Erica Fruiterman
	5. DATE AND TIME OF DEPOSITION April 4, 2018 at 9:00 a.m.

6. SUBJECT OF PROCEEDING

In the Matter of Otto Bock Healthcare North America, Inc., Docket No. 9378

7. ADMINISTRATIVE LAW JUDGE	8. COUNSEL AND PARTY ISSUING SUBPOENA
The Honorable D. Michael Chappell Federal Trade Commission Washington, D.C. 20580	Otto Bock Healthcare North America, Inc. Duane Morris LLP 30 S. 17th St. Philadelphia, PA 19103 (215) 979-1000

DATE SIGNED	SIGNATURE OF COUNSEL ISSUING SUBPOENA
3/12/2018	Fruiterman

GENERAL INSTRUCTIONS

APPEARANCE

The delivery of this subpoena to you by any method prescribed by the Commission's Rules of Practice is legal service and may subject you to a penalty imposed by law for failure to comply.

MOTION TO LIMIT OR QUASH

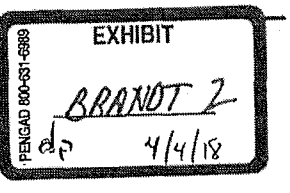
The Commission's Rules of Practice require that any motion to limit or quash this subpoena must comply with Commission Rule 3.34(c), 16 C.F.R. § 3.34(c), and in particular must be filed within the earlier of 10 days after service or the time for compliance. The original and ten copies of the petition must be filed before the Administrative Law Judge and with the Secretary of the Commission, accompanied by an affidavit of service of the document upon counsel listed in Item 8, and upon all other parties prescribed by the Rules of Practice.

TRAVEL EXPENSES

The Commission's Rules of Practice require that fees and mileage be paid by the party that requested your appearance. You should present your claim to Counsel listed in Item 8 for payment. If you are permanently or temporarily living somewhere other than the address on this subpoena and it would require excessive travel for you to appear, you must get prior approval from Counsel listed in Item 8.

A copy of the Commission's Rules of Practice is available online at http://bit.ly/FTCRulesofPractice. Paper copies are available upon request.

This subpoena does not require approval by OMB under the Paperwork Reduction Act of 1980.



UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of **Otto Bock HealthCare North America, Inc., a corporation,**	**Docket No. 9378**

RESPONDENT COUNSEL'S SUBPOENA *AD TESTIFICANDUM* ATTACHMENT TO ABILITY PROSTHETICS & ORTHOTICS

Pursuant to the Federal Trade Commission's Rules of Practice 16 C.F.R. §§ 3.33(a) and 3.33(c)(1), and the Definitions set forth below, Respondent Counsel will take the deposition of the Company or its designee(s), who shall testify on behalf of the Company about matters known or reasonably available to the Company.

DEPOSITION TOPICS

The Company is advised that it must designate one or more officer, director, managing agent, or other person who consents to testify on its behalf, and may set forth, for each person designated, the matters on which he or she will testify. The persons so designated shall testify as to matters known or reasonably available to the Company relating to the following deposition topics:

1. The current orthotic and prosthetic industry and market, including, but not limited to, the market and any submarkets or market segments of prosthetic knee joints.

2. The various microprocessor prosthetic knees and mechanical knees the Company currently purchases, sells or distributes in the United States and/or has purchased, sold or distributed in the past five years.

3. Facts and circumstances related to the Company's decision to purchase, sell or distribute each manufacturer's models of microprocessor prosthetic knees.

4. The orthotic and prosthetic industry and market over the past five years, including, but not limited to, the market and submarkets of prosthetic knee joints.

5. Freedom's position in the prosthetic industry and market in the United States over the past five years.

6. Any communications between the Company and Freedom regarding potential acquisition of any of Freedom's assets or business(es) by the Company.

7. Available microprocessor prosthetic knee and mechanical knee choices by K-Level patients.

8. Strengths and weaknesses of each manufacturer's (i) microprocessor prosthetic knees and (ii) mechanical knees.

9. The competition in the manufacture, sale and distribution of (i) microprocessor prosthetic knees and (ii) mechanical knees in the United States.

10. The impact that Otto Bock's acquisition of Freedom had on the microprocessor prosthetic knee market, including, but not limited to, cost savings, quality improvements, expanded consumer choice, and innovation.

11. The microprocessor prosthetic knees that the Company currently fits on patients in the United States or has fitted in the past five years, including, but not limited to, number of units fitted and revenue received by source and gross margin by manufacturer and model.

12. The competition and/or differences between microprocessor prosthetic knees and mechanical knees.

13. The impact that a price change of one manufacturer's microprocessor prosthetic knee has on the willingness of (i) patients or (ii) clinicians to substitute to another manufacturer's microprocessor prosthetic knee.

14. The functional interchangeability and differences among microprocessor prosthetic knees of different manufacturers.

15. The functional interchangeability and differences between microprocessor prosthetic knees and mechanical knees.

16. Information surrounding the (i) Company's, (ii) patients', or (iii) clinicians' views of microprocessor prosthetic knees of different manufacturers.

17. Patients' reasons for (i) initially choosing or (ii) subsequently switching at the time of replacing the prosthesis, between microprocessor prosthetic knees sold by different manufacturers

18. The factors affecting prosthetists' decisions concerning which type of prosthetic knee to fit on a particular patient.

19. The Company's decision-making process in fitting patients with prosthetic knee joints, including, but not limited to the revenue received per patient and the acquisition cost per prosthetic knee.

20. The limitations and/or ceiling on prices for microprocessor prosthetic knees imposed by Medicare and/or any other payor.

21. The sales, gross margin, and profits for microprocessor prosthetic knees fitted and sold by the Company.

22. Recovery Audit Contractor (RAC) audits, their impact on clinics and any impact on clinical assessments regarding prosthetic devices containing microprocessor controlled knees or mechanical knees.

DEFINITIONS

The following definitions and instructions apply without regard to whether the defined terms used herein are capitalized or lowercase and without regard to whether they are used in the plural or singular form:

1. The term "Company" means Ability Orthotics & Prosthetics, Inc., including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which Company manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on the Company's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.

2. The term "Otto Bock" means Otto Bock HealthCare North America, Inc., including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which Otto Bock HealthCare North America, Inc. manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on Otto Bock's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between Otto Bock and any other person.

3. The term "Freedom" means FIH Group Holdings, LLC, including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which FIH Group Holdings, LLC manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on Freedom's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between Freedom and any other person.

4. The terms "And" and "Or" are interchangeable. "And" is understood to include and encompass "or," and vice versa.

5. The terms "Communication" or "Communications" means, without limitation, oral or written communication of any kind, all electronic communications, emails, facsimiles, telephone communications, correspondence, exchange of written or recorded information, face-to-face meetings, or one-way communication.

6. "Relating to," "related to," "concerning," "regarding," and "surrounding" mean, without limitation, the following concepts: concerning, discussing, describing, reflecting, dealing with, pertaining to, analyzing, evaluating, estimating, constituting, or otherwise involving, in whole or in part.

CERTIFICATE OF SERVICE

I hereby certify that I delivered via electronic mail a copy of the foregoing document to:

Ability Prosthetics & Orthotics, Inc.
c/o David Creagan
White and Williams LLP
1650 Market Street
One Liberty Place, Suite 1800
Philadelphia, PA 19103-7395
creagand@whiteandwilliams.com

Counsel for Ability Prosthetics & Orthotics, Inc.

William Cooke
Federal Trade Commission
Bureau of Competition
400 7th Street SW
Washington, DC 20024
wcooke@ftc.gov

Counsel Supporting the Complaint

March 12, 2018

By: /s/ Erica Fruiterman
Erica Fruiterman
Duane Morris LLP
30 S. 17th Street
Philadelphia, PA 19103
efruiterman@duanemorris.com

Counsel for Respondent Otto Bock HealthCare North America, Inc.

EXHIBIT B

SUBPOENA DUCES TECUM

Provided by the Secretary of the Federal Trade Commission, and Issued Pursuant to Commission Rule 3.34(b), 16 C.F.R. § 3.34(b)(2010)

1. TO

Ability Prosthetics & Orthotics, Inc.
c/o David Creagan, White and Williams LLP
1650 Market Street
One Liberty Place, Suite 1800
Philadelphia, PA 19103

2. FROM

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

This subpoena requires you to produce and permit inspection and copying designated books, documents (as defined in Rule 3.34(b)), or tangible things, at the date and time specified in Item 5, and at the request of Counsel listed in Item 9, in the proceeding described in Item 6.

3. PLACE OF PRODUCTION

Duane Morris LLP
30 S. 17th St.
Philadelphia, PA 19103
(215) 979-1000

4. MATERIAL WILL BE PRODUCED TO

Erica Fruiterman

5. DATE AND TIME OF PRODUCTION

March 12, 2018 at 9:00 a.m.

6. SUBJECT OF PROCEEDING

In the Matter of Otto Bock Healthcare North America, Docket No. 9378

7. MATERIAL TO BE PRODUCED

Documents & materials responsive to the attached Subpoena Duces Tecum Requests for Production

8. ADMINISTRATIVE LAW JUDGE

The Honorable D. Michael Chappell
Federal Trade Commission
Washington, D.C. 20580

9. COUNSEL AND PARTY ISSUING SUBPOENA

Otto Bock Healthcare North America, Inc.
Duane Morris LLP
30 S. 17th St.
Philadelphia, PA 19103
(215) 979-1000

DATE SIGNED

2/27/2018

SIGNATURE OF COUNSEL ISSUING SUBPOENA

Fruiterman

GENERAL INSTRUCTIONS

APPEARANCE

The delivery of this subpoena to you by any method prescribed by the Commission's Rules of Practice is legal service and may subject you to a penalty imposed by law for failure to comply.

MOTION TO LIMIT OR QUASH

The Commission's Rules of Practice require that any motion to limit or quash this subpoena must comply with Commission Rule 3.34(c), 16 C.F.R. § 3.34(c), and in particular must be filed within the earlier of 10 days after service or the time for compliance. The original and ten copies of the petition must be filed before the Administrative Law Judge and with the Secretary of the Commission, accompanied by an affidavit of service of the document upon counsel listed in Item 9, and upon all other parties prescribed by the Rules of Practice.

TRAVEL EXPENSES

The Commission's Rules of Practice require that fees and mileage be paid by the party that requested your appearance. You should present your claim to counsel listed in Item 9 for payment. If you are permanently or temporarily living somewhere other than the address on this subpoena and it would require excessive travel for you to appear, you must get prior approval from counsel listed in Item 9.

A copy of the Commission's Rules of Practice is available online at http://bit.ly/FTCRulesofPractice. Paper copies are available upon request.

This subpoena does not require approval by OMB under the Paperwork Reduction Act of 1980.

EXHIBIT
BRANDT 3
4/4/18

PENGAD 800-631-6989

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of	
Otto Bock HealthCare North America, Inc., a corporation,	**Docket No. 9378**

RESPONDENT COUNSEL'S SUBPOENA *DUCES TECUM* ATTACHMENT TO ABILITY PROSTHETICS & ORTHOTICS

Pursuant to the Federal Trade Commission's Rules of Practice, 16 C.F.R. § 3.34, and the Definitions and Instructions set forth below, Respondent Counsel hereby requests that the Company produce all Documents, electronically stored information, and other things in its possession, custody, or control responsive to the following requests:

1. Any and all documents regarding the qualifications for use of a microprocessor controlled knee or reimbursement policy or terms of any public or private payor, including contracts with payors covering microprocessor controlled knees.

2. Any and all documents regarding the terms offered or applied for the Company's purchase of microprocessor controlled knees by any manufacturer, supplier, distributor or seller, including any proposed or agreed terms.

3. Any and all documents evidencing the number of the Company's clinic locations in the United States and each U.S. State, District, or Territory and the number of clinicians at any of the Company's clinic locations who fitted patients with any type of prosthetic knee.

4. Any and all documents sufficient to show the microprocessor knees the Company currently fits on patients in the United States and each U.S. State, District, or Territory or has fitted for the past five years, indicating for each: (a) manufacturer and model of each microprocessor knee; (b) the number of units fitted and the revenue received by source (e.g., third party payor, patient, etc.) and by K Level for microprocessor knees with HCPCS Codes L5856 or L5858; (c) cost to acquire microprocessor knees with HCPCS Codes L5856 or L5858 by manufacturer and model in units and dollars by channel of purchase (e.g., distributor, direct sale from manufacturers); (d) the cost to service, repair or maintain microprocessor knees over the duration of the Company's warranty to the patient; and (e) the gross margin for each microprocessor knee by manufacturer and model

5. Any and all documents, including, but not limited to, market studies, forecasts, surveys marketing plans, business plans, presentations to the Board of Directors, discussing: (a) any available (i) microprocessor knee and (ii) non-microprocessor (i.e., "mechanical") knee choices by K level; (b) strengths and weaknesses of each manufacturer's (i) microprocessor knees and (ii) mechanical knees; (c) competition in the manufacture, sale and distribution of (i) microprocessor knees and (ii) mechanical knees in the United States and each U.S. State, District, or Territory.

6. Any and all documents that discuss the Company's or patients' views of microprocessor knees of different manufacturers, particularly, but without exclusion, those discussing: (a) functional interchangeability among microprocessor knees of different manufacturers as well as between microprocessor knees and mechanical knees; (b) information on (i) the general willingness of patients to substitute and (ii) actual incidence of patients substituting, among microprocessor knees of different manufacturers; (c) information evidencing patients' reasons for (i) initially choosing or (ii) subsequently switching at the time of replacing the prosthesis, between microprocessor knees sold by different manufacturers; (d) views of (i) the company, (ii) patients, or (iii) clinicians' views of microprocessor knees of different manufacturers; and (e) factors affecting or which may affect prosthetists' decisions concerning which type of prosthetic knee to fit to a particular patient.

7. Any and all documents discussing (a) any impact of small but significant increases in price (e.g., 5% - 10%) of one manufacturer's microprocessor knee (with no accompanying change in quality or product features) on the willingness of (i) patients or (ii) clinicians to substitute to another manufacturer's microprocessor knee; (b) specifically, any impact of a small but significant increases in price (e.g., 5% - 10%) of Otto Bock's or Freedom Innovation's microprocessor knees (with no accompanying change in quality or product features) on the willingness of (i) patients or (ii) clinicians to substitute to another manufacturer's microprocessor knee; (c) the impact of a manufacturer's small, incremental quality improvement or small, incremental design change in its microprocessor knees on patients' willingness to choose that microprocessor knee over that of another manufacturer, including specifically Otto Bock and Freedom Innovation as the other manufacturer (where "incremental" specifically excludes major product changes); and (d) any recommendations of alternative microprocessor knees the Company's clinicians make to patients who wished to switch among manufacturers' microprocessor knees.

8. Any and all documents that discuss the Company's margin between revenue received per patient and acquisition cost per prosthetic knee, specifically with respect to: (a) the minimum acceptable margin in dollars and as a percent of revenue; and (b) any effect of differences in margins among prosthetic knees on clinicians' choices of (i) microprocessor knees or (ii) mechanical knees.

9. Any and all documents pertaining to the current orthotic and prosthetic industry and market, including, but not limited to, the market and any submarkets or market segments of prosthetic knee joints.

10. Any and all documents discussing, describing, or analyzing Freedom Innovations or Otto Bock's position in prosthetic industry and market in the United States over the past five years.

11. Any and all documents evidencing the limitations imposed or ceiling on the prices of microprocessor prosthetic knees imposed by Medicare and private insurers.

12. Any and all documents regarding Recovery Audit Contractor (RAC) audits with respect to: (i) their impact on the Company or other clinics; (ii) their impact on the clinical analysis of prosthetic devices containing microprocessor controlled knees or mechanical knees; and (iii) their impact on prosthetists' recommendations of microprocessor controlled knees or mechanical knees.

DEFINITIONS

The following definitions and instructions apply without regard to whether the defined terms used herein are capitalized or lowercase and without regard to whether they are used in the plural or singular form:

1. The term "Company" or "You" means Ability Prosthetics & Orthotics, Inc., including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which Company manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on the Company's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.

2. The term "Otto Bock" means Otto Bock HealthCare North America, Inc., including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which Otto Bock HealthCare North America, Inc. manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on Otto Bock's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between Otto Bock and any other person.

3. The term "Freedom" means FIH Group Holdings, LLC, including without limitation, any of its predecessors, successors, subsidiaries, departments, divisions and/or affiliates, or any organization or entity which FIH Group Holdings, LLC manages or controls, together with all present and former directors, officers, employees, agents, representatives, independent contractors, or any person acting or purporting to act on Freedom's behalf. The terms "subsidiaries," and "affiliates" refer to any person in which there is partial (25 percent or more) or total ownership or control between Freedom and any other person.

4. The terms "And" and "Or" are interchangeable. "And" is understood to include and encompass "or," and vice versa.

5. The terms "Communication" or "Communications" means, without limitation, oral or written communication of any kind, all electronic communications, emails, facsimiles, telephone communications, correspondence, exchange of written or recorded information, face-to-face meetings, or one-way communication.

6. The term "Merger" means the Agreement and Plan of Merger, dated as of September 22, 2017, by and among Otto Bock HealthCare North America, Inc., OB Roosevelt Acquisition, LLC, FIH Group Holdings, LLC and Health Evolution Partners Fund I (AIV I), LP.

7. The term "Documents" means all written, recorded, and graphic materials of every kind in the possession, custody, or control of the Company. The term "Documents" includes, without limitation: electronic correspondence and drafts of Documents; electronic mail messages; metadata; copies of Documents that are not identical duplicates of the originals in that Person's files; and copies of the Documents the originals of which are not in the possession, custody, or control of the Company.

8. The terms "each," "any," and "all" mean "each and every."

9. "Relating to," "related to," "concerning," "regarding," and "surrounding" mean, without limitation, the following concepts: concerning, discussing, describing, reflecting, dealing with, pertaining to, analyzing, evaluating, estimating, constituting, or otherwise involving, in whole or in part.

INSTRUCTIONS

1. Unless the request specifically, or in context, indicates otherwise, the timeframe applicable to these requests shall be January 1, 2016, through the present.

2. This request for documents shall be deemed continuing in nature so as to require production of all documents responsive to any specification included in this request produced or obtained by the Company up to fifteen (15) calendar days prior to the date of the Company's full compliance with this request.

3. If You claim any form of privilege, whether based on statute or otherwise, as a ground for not answering any Request, state the nature of the privilege claimed (*e.g.*, attorney-client, work product, or other) and set forth all facts upon which the claim of privilege is based.

4. Except for privileged material, You shall produce each responsive document in its entirety by including all attachments and all pages, regardless of whether they directly relate to the specified subject matter. You should submit any appendix, table, or other attachment by either attaching it to the responsive document or clearly marking it to indicate the responsive document to which it corresponds. Except for privileged material, You will not redact, mask, cut, expunge, edit, or delete any responsive document or portion thereof in any manner.

5. Wherever a Request calls for documents and/or communications which are not available to You in the form requested, but is available in another form or can be obtained at least in part from other sources in Your possession, You should so state and either supply the information requested in the form in which it is available or supply the sources from which the information can be obtained.

6. To the extent that You possess any requested documents or information in electronic form, the electronic data, and all underlying metadata, should be produced in a matter that does not modify the metadata.

7. The following instructions apply to electronically stored information:

a. Provide single-page black and white Group IV TIFF images with metadata contained in a separate file.

b. All electronic documents attached to an e-mail are to be produced contemporaneously and sequentially immediately after the parent e-mail.

c. Each production must include a standard Concordance delimited ASCII data (.dat) file as well as an Ipro (.lfp) image load file.

d. Microsoft Excel files should be produced in native file format with a TIFF placeholder stating "This Document Produced in Native File Format Only."

e. Microsoft Project Plans and Microsoft PowerPoint should be produced in both native file format and as TIFF images.

f. All available metadata, including but not limited to the following fields, should be produced:

BegDoc
EndDoc
BegAttach
EndAttach
NumAttach
Custodian
SourceApp
SourceFile
From
To
CC
BCC
Author
Title
Subject
EMailSubject
ConversationIndex
InReplyToID
DateCreated (Combined Date & Time Field)
DateLastMod (Combined Date & Time Field)
DateLastPrnt (Combined Date & Time Field)
DateRcvd (Combined Date & Time Field)
DateSent (Combined Date & Time Field)
PgCount
RecordType
DocExt
FileDescription
Filename
Filesize
Headers
EntryID
IntMsgID
MD5Hash
Sha1Hash
NativeFile
OCRPath

If You are unable to produce responsive documents in this format, You or, if You are represented by counsel, Your counsel, shall discuss the format in which documents are to be produced with counsel issuing this subpoena and agree upon a format before the date for response.

8. This subpoena does not request patient health records or HIPAA protected-information, and no request should be construed to request them. If contained in a responsive document, such information should be redacted in a manner to confirm with HIPAA and expectations of patient privacy.

9. If any Documents are withheld from production based on a claim of privilege, You shall provide, pursuant to 16 C.F.R. § 3.38A, a schedule which describes the nature of Documents, communications, or tangible things not produced or disclosed, in a manner that will enable Respondent Counsel to assess the claim of privilege.

10. You must provide Respondent Counsel with a statement identifying the procedures used to collect and search for electronically stored Documents and Documents stored in paper format. The Company must also provide a statement identifying any electronic production tools or software packages utilized by the Company in responding to this subpoena for: keyword searching, Technology Assisted Review, email threading, de-duplication, global de-duplication or near-de-duplication.

CERTIFICATION

Pursuant to 28 U.S.C. § 1746, I hereby certify under penalty of perjury that this response to the Subpoena *Duces Tecum* is complete and correct to the best of my knowledge and belief.

(Signature of Official)	(Title/Company)
(Typed Name of Above Official)	(Office Telephone)

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was personally delivered to:

Ability Prosthetics & Orthotics, Inc.
c/o David Creagan
White and Williams LLP
1650 Market Street
One Liberty Place, Suite 1800
Philadelphia, PA 19103

Counsel for Ability Prosthetics & Orthotics, Inc.

I hereby certify that I delivered via electronic mail a copy of the foregoing document to:

William Cooke
Federal Trade Commission
Bureau of Competition
400 7th Street, SW
Washington, DC 20024
wcooke@ftc.gov

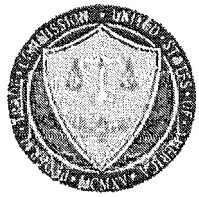
Counsel Supporting the Complaint

February 27, 2018

By: /s/ Erica Fruiterman
Erica Fruiterman
Duane Morris LLP
30 S. 17th Street
Philadelphia, PA 19103
efruiterman@duanemorris.com

Counsel for Respondent Otto Bock HealthCare North America, Inc.

EXHIBIT C



UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Bureau of Competition
Mergers I Division

May 23, 2018

VIA EMAIL

Jeffrey Brandt c/o
David Creagan, Esq.
1650 Market St.
One Liberty Pl. Suite 1800
Philadelphia, PA 19103

RE: *In the Matter of Otto Bock HealthCare North America, Inc.*, Federal Trade Commission Dkt. No. 9378

Dear Mr. Brandt,

By this letter we are providing formal notice, pursuant to Rule 3.45(b) of the Commission's Rules of Practice, 16 C.F.R. § 3.45(b), that Complaint Counsel intend to offer the documents and testimony referenced in the enclosed Attachment A into evidence in the administrative trial in the above-captioned matter. The administrative trial is scheduled to begin on July 10, 2018. All exhibits admitted into evidence become part of the public record unless *in camera* status is granted by Administrative Law Judge D. Michael Chappell.

For documents or testimony which include sensitive or confidential information that you do not want on the public record, you must file a motion seeking *in camera* status or other confidentiality protections pursuant to 16 C.F.R §§ 3.45, 4.10(g). Judge Chappell may order that materials, whether admitted or rejected as evidence, be placed *in camera* only after finding that their public disclosure will likely result in a clearly defined, serious injury to the person, partnership, or corporation requesting *in camera* treatment.

Motions for *in camera* treatment for evidence to be introduced at trial must meet the strict standards set forth in 16 C.F.R. § 3.45 and explained in *In re 1-800 Contacts, Inc.*, 2017 FTC LEXIS 55 (April 4, 2017); *In re Jerk, LLC*, 2015 FTC LEXIS 39 (Feb. 23, 2015); and *In re Basic Research, Inc.*, 2006 FTC LEXIS 14 (Jan. 25, 2006). Motions also must be supported by a declaration or affidavit by a person qualified to explain the confidential nature of the documents. *In re 1-800 Contacts, Inc.*, 2017 FTC LEXIS 55 (April 4, 2017); *In re North Texas Specialty Physicians*, 2004 FTC LEXIS 66 (April 23, 2004). You must also provide one copy of the documents for which *in camera* treatment is sought to the Administrative Law Judge.

Please be aware that under the current Scheduling Order dated April 26, 2018, the deadline for filing motions seeking *in camera* status is June 11, 2018.

If you have any questions, please feel free to contact me at (202) 326-2614.

Sincerely,

Amy S. Posner
Counsel Supporting the Complaint

Attachment A

PUBLIC

Exhibit No.	Description	Date	BegBates	EndEates
PX03282	Ability Prosthetics & Orthotics Spreadsheet: Unnamed	00/00/0000	APO 000017	APO 000017
PX05149	Deposition Transcript of Jeffrey Brandt (Ability Prosthetics & Orthotics)	4/4/2018	PX05149-001	PX05149-106

EXHIBIT D

In the Matter of:

OttoBock Healthcare

April 4, 2018
Jeffrey M. Brandt

Condensed Transcript with Word Index

For The Record, Inc.
(301) 870-8025 - www.ftrinc.net - (800) 921-5555

CONFIDENTIAL
FEDERAL TRADE COMMISSION

In the Matter of)
OTTO BOCK HEALTHCARE)
NORTH AMERICA, INC.,) Docket No. 9378
a corporation,)
Respondent.)
---)

Oral deposition of JEFFREY M. BRANDT, held in the law offices of White and Williams LLP, 1650 Market Street, One Liberty Place, Suite 1800, Philadelphia, Pennsylvania, on Wednesday, April 4, 2018, commencing at 9:06 a.m., before Dianna R. Pugliese, a Registered Merit Reporter, Certified Realtime Reporter, Certified Court Reporter-NJ, and Notary Public.

APPEARANCES:
ON BEHALF OF THE FEDERAL TRADE COMMISSION:
AMY POSNER, ESQUIRE
Federal Trade Commission
400 Seventh Street, SW
Washington, DC 20024
202-326-3563
aposner@ftc.gov

ON BEHALF OF FREEDOM INNOVATIONS:
CHRISTOPHER H. CASEY, ESQUIRE
Duane Morris LLP
30 South 17th Street
Philadelphia, Pennsylvania 19103
215-979-1947
chcasey@duanemorris.com

ON BEHALF OF THE WITNESS AND ABILITY PROSTHETICS & ORTHOTICS:
DAVID J. CREAGAN, ESQUIRE
White and Williams LLP
1800 One Liberty Place
1650 Market Street
Philadelphia, Pennsylvania 19103
215-864-7000
creagand@whiteandwilliams.com

EXAMINATION INDEX

EXHIBIT INDEX

COURT REPORTER: Are there any stipulations?
MR. CREAGAN: Any stipulations?
MS. POSNER: Just so you all know, we each get three and a half hours of on-the-record time.
MR. CREAGAN: Okay.
MS. POSNER: I'm going to save half an hour for after Mr. Casey goes.
MR. CREAGAN: Okay.
MR. CASEY: I'll do the same.
And the witness will read and sign, I assume?
MR. CREAGAN: Yes. Yes.
MR. CASEY: But to the confidentiality of the transcript?
MS. POSNER: Right. Yes. You might want to --
MR. CREAGAN: Yes. Let's mark it confidential, and, you know, if it becomes an issue at any point, we can deal with it. But just to make it easy, just mark it confidential.
MS. POSNER: Okay.
JEFFREY M. BRANDT, having been duly sworn, was examined and testified as follows:

EXAMINATION

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BY MS. POSNER:
Q. Good morning, Mr. Brandt. My name is Amy Posner, and I'm an attorney representing the Federal Trade Commission.
Please state your full name for the record.
A. Sure. Jeffrey M. Brandt.
Q. Where do you work?
A. Ability Prosthetics & Orthotics.
MS. POSNER: Let's have everybody in the room introduce themselves and who they represent.
MR. CREAGAN: I'm David Creagan, White and Williams LLP, and I represent the witness and Ability Prosthetics & Orthotics.
MR. CASEY: Christopher Casey, Duane Morris LLP. I represent Ottobock, the respondent in this matter.
BY MS. POSNER:
Q. Mr. Brandt, what is your current position at Ability Prosthetics & Orthotics?
A. CEO.
Q. Can we agree to call it Ability and we'll both know that that means Ability Prosthetics & Orthotics?
A. Yes. Absolutely, yes.

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Q. Are you employed by anybody else at this time?
A. I am not.
Q. Do you understand that you will be testifying under oath today?
A. Yes.
Q. Is there any reason why you would not be able to testify fully and accurately today?
A. No.
Q. Unless I state otherwise, I will refer to Ottobock Healthcare North America, Inc. and Ottobock HealthCare GmbH as Ottobock.
Is that okay?
A. Yes.
Q. I will refer to FIH Group Holdings, LLC as Freedom Innovations, and I will refer to Ability Prosthetics & Orthotics as Ability.
Is that okay?
A. Yes.
Q. And if I refer to the transaction or the acquisition, I mean Ottobock's acquisition of Freedom Innovations.
Is that okay?
A. Yes.
Q. Have you ever been deposed before?

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A. No.
Q. Okay. So I'd like to briefly explain how today's deposition will be conducted.
The court reporter is recording everything we say. To make her job easier, we don't want to have two people talking at the same time. Okay?
A. Okay.
Q. So please wait until I've finished asking my question before you answer.
A. Okay.
Q. Is that okay?
A. Yes.
Q. And please answer all of your questions orally instead of using gestures so she can take those oral answers down.
A. Okay.
Q. From time to time your counsel may object to one of my questions. These objections will be noted by the court reporter. After an objection is made, you will be expected to answer the question unless your attorney instructs you not to answer.
Do you understand?
A. Yes.
Q. If I ask a question that you do not

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understand, please let me know and I will do my best to rephrase it.
If you respond to a question, I'm going to assume that you understood it.
Is that okay?
A. Yes.
Q. We'll take periodic breaks throughout the day. If you need a break, please let me know and I'll do my best to accommodate you. I may, however, want to finish my current line of questioning before we take a break.
Is that okay?
A. Yes.
Q. Because you're under oath, please answer truthfully, completely, and to the best of your knowledge. If at any point you realize that you have answered a question incorrectly or you remember something else that would make your earlier answer more complete, please let me know and you can add to an earlier answer.
Do you understand?
A. Yes.
Q. Did you do anything to prepare for this deposition besides talk to your counsel?
A. No.

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Q. Did you talk to anyone -- did you communicate with anybody at Freedom about this deposition?
A. No.
Q. Did you communicate with anybody at Ottobock about this deposition?
A. No.
Q. Did you communicate with anybody at Ability about this deposition?
A. Yes.
Q. Who did you speak to?
A. My management team, executive team. More as a matter of collecting the documents that were requested.
Q. Did you review any documents to prepare for today's deposition besides what your lawyer showed you?
A. No.
Q. Can you briefly describe your educational background, starting with college?
A. Sure.
So I have a prosthetics -- it's a prosthetics tech degree. Basically it's a one-year learn-how-to-fabricate prosthetics, which I received from Spokane Falls Community College, SFCC, in

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Spokane, Washington.
I'm sorry. Forgive me. I obtained my bachelor's from Penn State University, graduated in 1995 with a B.S. in psychology. Then went on to Spokane Falls for one year to receive a one-year technical training in fabrication of prosthetics.
And then in 1999 attended Northwestern University's prosthetic and orthotic program. And then at the completion of that program completed two one-year residencies, one in prosthetics, one in orthotics.
Q. What year did you receive the prosthetics technical degree from Spokane Falls?
A. 1996.
Q. And what did that degree allow you to do?
A. It -- so it formally trained me to be a prosthetic technician, which essentially means that I could work at a prosthetic and orthotic practice in their lab and fabricate prostheses.
Q. Did you work in any labs during that time?
A. I did. So in 1996 I worked at the Orthotic Prosthetic Center in Fairfax, Virginia, until -- forgive me but maybe September of 1997.

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I left and moved to Philadelphia and worked for Cocco Brothers in South Philadelphia, as the same job title, as a prosthetic technician.
Q. What type of prosthetics did you fabricate when you worked at Orthotic and Prosthetic Center?
A. I didn't. I was hired as a technician to fabricate prosthetics, and then the second day they asked me to fabricate a brace. They liked what I did, and then I never fabricated a limb while I worked there. I fabricated only orthotics the whole time.
Q. What's the difference between orthotics and prosthetics?
A. So the difference between orthotics and prosthetics is typically defined as orthotics are outside of the body or typically referred to as a brace.
And then prosthetics is also outside the body, but it's typically referred to as an artificial limb and replaces the loss of a limb.
So if you lost your limb below the knee, the prosthesis would replace the part that you lost. Whereas, a brace actually goes around the part that you still have that just isn't functioning properly.
Q. Okay. When you worked at Cocco

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Brothers, what was your position there?
A. Prosthetic technician.
Q. Did you work with prosthetics in that job?
A. Yes.
Q. What did you do?
A. Fabricated prosthetic sockets and then assembled prostheses.
So essentially you would prepare the cast that the prosthetist took of the patient's limb, you would prepare that for fabrication, go through the fabrication process, produce what is an acrylic socket or the acrylic socket interfaces with the patient's limb, and then you assemble a pylon, a foot, a knee, whatever the components required for that particular patient.
Q. How long were you at Cocco Brothers?
A. I was at Cocco Brothers until maybe May of '98.
Q. Is that when you went to Northwestern?
A. No, I actually went to Northwestern in January of '99.
So in May of '98 I left Cocco Brothers and went back to Orthotic Prosthetic Center in Fairfax, and worked, I wouldn't say part time, but

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three-quarter time through the summer and fall of '98 because I had been accepted to Northwestern, so I was kind of splitting time between Fairfax and here, and my fiance was in grad school in Philadelphia, so...

And then in '99 went -- left for Chicago.

Q. When you were at Orthotics and Prosthetics the second time, what was your position then?

A. Just fabrication, back to fabricating braces. Pretty much what it was the first time. There was no real change there.

Q. That was orthotics work and not prosthetics work?

A. For the most part, yes.

Q. Can you tell me about the degree you received at Northwestern?

A. Right. So the degree at Northwestern at that time, 1999, was a six-month certificate course in orthotics and a six-month certificate course in prosthetics. So you actually leave the medical school with not a master's degree, but, rather, a certificate in each discipline, and then you're eligible to do your residencies and take the board exams.

Now there's a master's -- there's

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actually an MSPO. There's actually a master's degree when you go to school now. So -- so that's the certificate. It's technically not a degree, I guess.

Q. Where did you do your two one-year residencies?

A. Right. So orthotics I stayed -- I say stayed -- I stayed in Chicago, but I actually did it at the Rehab Institute of Chicago, or RIC, which at the time housed the Northwestern's program. So when I say I stayed there, it literally means on the same floor, the clinical services for RIC was on the same floor as the academic program for Northwestern. So that was my year there.

And then my second year was prosthetics, which I did at Lawall Prosthetics & Orthotics, which is located in Wilmington, Delaware, and I split time between their freestanding office in Wilmington and their A.I. duPont Children's Hospital office.

They have an office -- this private company actually has an office in duPont Children's, which is about a mile or two from their freestanding office.

Q. When your education at Northwestern and the residencies were complete, what did that -- what did those certificates allow you to do?

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A. Right. So now you're allowed to take the American Board for Certification, or ABC, board exams. And there are three exams in each discipline that you take.

You pass them, then you're certified. You receive a certification from ABC.

Q. Are you certified from ABC?

A. Yes.

Q. When did you become certified from ABC?

A. So I would have finished my orthotic residency in maybe, like, April of 2001.

Probably certified in orthotics in the fall of '01 -- I'd have to get the exact dates -- and then the prosthetics came the next year, basically a year later, fall of '02.

Q. Once you received -- once you take the exams and you pass and you become a member of ABC, what does that allow you to do?

A. So you can seek gainful employment as a certified prosthetist, orthotist.

Q. What can a certified prosthetist, orthotist do?

A. Right. So you can evaluate patients by prescription only. You can evaluate design, fit, and follow up these patients with whatever device they

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received. Patient care.

Q. Without being supervised by anybody else?

A. Correct.

And I'll point out, too, and if your state has licensure, you have to gain licensure in that state as well, so...

Q. There are different state requirements for each -- to become a certified orthotist, prosthetist?

A. So certain -- well, certain states require licensure. So even though you have your ABC certification, you -- if you practice in a licensure state, you have to get a license.

Q. Do you need a license in Pennsylvania?

A. You do.

Q. Do you have one?

A. I do not.

Q. Did you ever have one?

A. No. I've never practiced in Pennsylvania since licensure came in three years ago, so I never -- I never applied for it.

Q. Can you tell me about your employment after you became a certified orthotist, prosthetist?

A. Sure.

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So I believe I -- I'm just trying to think if I was ever fully certified while I was still at Lawall. I think I was. It's L-a-w-a-l-l is the name of the company.

But in October of 2002, I took a job in Pittsburgh for a company named National Rehab Equipment, NRE. And that was I believe October of 2002, I think it was. And that was essentially my first job as a certified prosthetist, orthotist. I may have been certified a little bit before I left Lawall, but I don't recall.

Q. What were your responsibilities at that time?

A. Right. So it was to -- they were a telemedicine wound care company, and they were beginning to start a prosthetic and orthotic division, and so they brought me on to essentially help to grow and develop that line of business for them.

Q. Did you fit prosthetic knees when you were in that role?

A. Yes.

Q. How long were you at National Rehab Equipment?

A. I was there until February of 2004.

Q. Where did you go after that?

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A. I founded Ability in March of 2004, which is the company I currently work for.

Q. What was your first role at Ability?

A. Chief everything. I mean, I was prosthetist, orthotist. I was pretty much a one -- my own person for the first nine months that the company existed.

Q. How long did you see patients at Ability?

A. Probably until about 2012.

Q. How long did you fit knees on patients when you were at Ability?

A. Until that same date, also 2012.

Q. Can you describe your current role and responsibilities at Ability?

A. Sure.

As CEO, my current roles are business development -- they're political in nature. I sit on the -- recently was elected to the board of directors for AOPA, one of our national associations. So I'm trying to spend a little more time, you know, giving back, looking outside of the organization a little bit, after 14 years.

Basically spending time in engaging with the offices. We have ten offices, so I spend time --

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a lot of my time is spent traveling to the offices, and not so much managing them as just culture mining and, again, just time spent engaging.

And then obviously -- I mean, it's still a relatively small corporation in that I'm intimate with my management team, developing strategies and, you know, budgets for the next year, those types of things, strategic initiatives, business development.

Q. Are you involved at all in the acquisition of prosthetics?

A. I'm not sure I understand what you mean by "acquisition of prosthetics."

Q. Do you work with the manufacturers of prosthetics to -- and negotiate pricing for products, for instance?

A. So, yes, to some degree. So that's been a little -- somewhat of a changing role over the past three years for me.

So three, four years ago it might have been me directly, but now it's more like if I get an email from a manufacturer who wants to come in and meet with me for -- to talk about pricing, it's kind of like, okay, you could do that, but I might not be at that meeting. It may be my chief manufacturing officer or my COO who kind of just takes that meeting,

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so...

Q. Who directly reports to you at Ability?

A. Who directly reports to me?

Mark Brady, B-r-a-d-y.

(There followed a brief interruption of the deposition.)

MR. CASEY: Thank you.

THE WITNESS: Kathleen DeLawrence, that's D-e-L -- Lawrence, DeLawrence. And that's all.

BY MS. POSNER:

Q. What is Mark Brady's position?

A. I'm sorry. CFO, chief financial officer.

Q. And what is Kathleen DeLawrence's position?

A. She's the COO.

Q. Do you see any patients currently at Ability?

A. I do not.

Q. When was the last time you saw patients at Ability?

A. I -- 2012.

Q. Can you tell us about Ability generally?

A. Sure.

So we are a patient care company that

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provides orthotic and prosthetic devices. We evaluate, design, fit, and follow up with patients on these devices. We are ten offices spread out across three states. We have five facilities in Pennsylvania, we have three in Maryland, and we have two in North Carolina.

And some of the, you know -- I mean, I founded Ability with the idea that, you know, we could provide a more patient centric experience for these types of devices.

My experiences where I had worked and sort of come up in the profession had been that of sort of could never understand why the facilities weren't a little nicer, why patients didn't receive more awareness and education, even if they couldn't come to you. So -- and outcomes were starting to take hold.

So for me it was kind of like I just -- I just didn't understand why the care wasn't a little higher or a lot higher. So...

Q. So is that the goal of your --

A. That's the founding -- right. That's pretty much the mission.

Q. How many employees work at Ability?

A. Currently we have 41.

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Q. How many of those are certified orthotists, prosthetists?

A. I'm going to say 18 or 19, and forgive me for that because the number can change.

Q. Do you have an idea approximately how many patients you see at Ability? Not you, personally, but Ability sees?

A. Right. I -- forgive me, but I'd have to get the number. It's an obtainable number, but, I'm sorry, I don't have it.

Q. That's okay.

Do you have an approximate idea of how many knees are fit at Ability offices in a year?

A. I believe -- I'm sorry, but if I reference one of the -- one of the exhibits or attachments that we provided, I think it was a hundred knees -- roughly a hundred knees in two years, so roughly 50 a year.

Q. I wish I could pull out that exhibit. It was so small that when I printed it, we couldn't read it, so --

A. Okay.

Q. But I know what you're talking about. So is that over the last two years?

A. I'm sorry, let me clarify that

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statement.

Microprocessor, MPK knees, per the L-Code that was listed in the subpoena.

Q. Okay. So that was Ability has fit approximately a hundred MPKs over the last two years; is that right?

A. I believe, yes.

Q. Who is Brian Kaluf?

A. Brian Kaluf is the certified prosthetist. He's also our director of clinical research and outcomes.

Q. What does he do in that role?

A. So Brian spends a small amount of time seeing patients. And when I say "seeing patients," not necessarily being lead on those cases, but almost practicing as a consultant within the company or an assistant or -- I don't know what the word would be, but just, he's there for some cases. But then primarily leading Ability's efforts to generate research, clinical research.

Q. Why is it important for Ability to generate clinical research?

A. Yes. So as I alluded to earlier, part of founding Ability and wanting to develop more of an evidence-based way of practicing, we needed somebody

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to start to generate -- you know, to challenge the status quo to some degree to say, you know, Why are you doing this? Why are you doing that?

Well, because we've profiled a hundred patients and this is what they all had in common, so we can start to have a reason for doing something and not just because we've always done it that way or just simply we were taught in school, so let's keep doing it that way without questioning anything.

So we also feel like the payor structure is changing. It's the -- we feel like that healthcare changing and being more of a fee for value, I've always felt that orthotics and prosthetics has an incredible value, but how are you going to tell that story if you don't have research and documentation that actually can point to those economic values and those benefits?

So for years I stood by and watched people say, Wow, she's a great walker in that leg. And I would, as a student, sort of get -- you know, and I'd say, What does "great" mean? And people would say, Oh, you know, we don't pay you to ask those questions.

Okay. Well, then I'm going to go create a company that can ask those questions.

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So that was -- that's why I think clinical research is important within Ability.

And, again, it's -- for us as a for-profit entity to have that I think is special. We do invest real dollars to have that, and -- so we're trying to do our part, if you will, for -- you know, to generate research in outcomes. That's kind of our specialty.

Q. How long has Brian Kaluf worked at Ability?

A. I think mid-2011, but I'd have to -- I'd have to clarify that.

Q. He's not a new employee?

A. No, he's not.

Q. Are you aware of any work he's done with Freedom?

A. Yes.

Q. Are you aware of any work he's done with Freedom involving prosthetic knees?

A. No.

Q. Are you aware of any work he has done with Freedom involving a paper that explained the differences between microprocessor knees and mechanical knees?

A. No.

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Q. Would that -- does that sound like something he would do?

A. Yes.

Q. And that's part of his position?

A. Right. Yes.

Q. Who is Jeff Quelet?

A. Jeff Quelet is the -- again, I think it's chief manufacturing officer.

Jeff, primarily, he's a trained certified prosthetist, orthotist, first of all, and he is still to some degree in patient care, but also somewhat on the management team.

And he also handles, you know, interactions with fabricators, manufacturers.

So one thing that's unique about Ability is that we outsource all of our production, so we don't have in-house labs that produce the prosthetics or the braces.

So when you work with 30, 40, 50 manufacturers, Jeff handles a lot of the managing that learning curve, if you will. As our ten offices interact with those manufacturers, if problems arise or quality issues, things like that, Jeff handles those.

Q. Is Jeff an amputee?

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A. He is.

Q. Is he an above-the-knee amputee?

A. He is.

Q. Does he test out knee and leg products for Ability?

A. When you say test them out for Ability, like -- I'm not sure I understand.

Q. Does Jeff Quelet work with manufacturers on development projects?

A. Yes, he --

MR. CASEY: Objection to form.

BY MS. POSNER:

Q. You can answer.

A. Yes.

Q. Do you know the way in which Jeff Quelet works with manufacturers on development projects?

A. I -- yes, I suppose I do.

Q. How does he work with manufacturers on development projects?

A. So sometimes -- so they'll just -- they'll skim through his network or relationships, Hey, will you -- would you be willing to test this, or, What do you think about this, that type of interaction.

Q. Has he -- has Jeff Quelet worked with

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Ability on any of their knee products?

A. So --

Q. I'm sorry. Has Jeff Quelet worked with Freedom on any of their knee products?

A. Yes.

Q. Can you tell me about that?

A. I can. So -- to the degree that I know.

So Jeff is -- I believe Jeff has tried a Freedom knee or Freedom -- Freedom knees, I should say, over the years.

Jeff had -- and, again, I -- I'm not going to speak for him, but Jeff -- when we -- when I first started Ability, Jeff was some type of an educational presenter for Freedom, like on the side, like, just, like, consulting-type thing.

So that only went for, like, a year or two, and then Jeff didn't do that anymore. But then -- at any rate, through the years Jeff has tried knees, Freedom knees, and I honestly don't know if those trials were, quote/unquote, formal or informal or how they were conducted, necessarily.

And I may not even be privy to, especially in the last three years, if he's tried a knee because it wouldn't necessarily be something I would know, just given that I don't have 21 direct

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reports anymore.
Q. You mentioned the last three years. What changed in the last three years?
A. Oh, just -- so as we've added to our management team, I'm trying to develop more of a -- a little more vertical in our organizational structure so that I could just kind of get some work life balance back on a personal note.
So -- right. So, for instance, you know, somebody -- you know, somebody may ask something of Kathleen or Jeff or Mark to look at something and they may -- they may decide, the two of them, to go do that, and then I would just hear about it at a -- you know, a weekly call or, you know, a weekly update type of thing.
Q. Did Jeff Quelet used to report directly to you?
A. It's a -- it's a good question. I think I would say yes, although prior to the last couple years it was a pretty flat relationship in terms of -- what would be the word -- sort of co- -- co-managing or co- -- you know, because Jeff's an owner, because Clay, the CIO, is an owner, I'm an owner. We're essentially not the three originals, I'm the original owner. The two of them came on very recently after I

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started the company.
But prior to bringing on the CFO, the COO, building out our board four years ago, I wouldn't say that any of us reported to any of -- you know, the three of us just kind of ran the company.
Q. Jeff Quelet was one of the people running the company?
A. Correct.
Q. And you said he's a co-owner of Ability?
A. He's a shareholder.
Q. What percentage of Ability does he own?
[redacted]
Q. Do you rely on Jeff's opinions about -- regarding prosthetics?
A. Yes.
Q. Do you rely on Jeff Quelet's opinions regarding knee products?
A. Yes. But not solely, to clarify that. His opinion is part -- his opinion matters, but it's not the sole -- it's not what-Jeff-says-we-do type of an atmosphere.
Q. What is his role as clinical management officer?
A. Right. So he -- he right now is the regional director for Maryland, so he oversees the

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three offices in Maryland. And then on a corporate level, he interfaces with the executive team to discuss the usage of manufacturers and products and put out fires.
I mean, on a daily basis there's a lot of manufacturing questions that come up that Jeff sort of liaises for the practitioners.
Q. Has Jeff discussed with you in any way trying on a Freedom knee in the last two years?
MR. CASEY: Objection to the form.
BY MS. POSNER:
Q. You can answer.
A. Okay. Yes, I believe he has.
Q. When was the last time you and Jeff communicated about his trial of a Freedom knee?
A. Within the last year.
Q. What did he tell you?
A. I believe that -- and, again, I would have -- I would -- I'd -- I believe that he tried a new Freedom knee in the past year.
And I would just want to clarify that because he does -- he does try different knees, and -- so I think he has tried a Freedom knee within the past year.
Q. What did he tell you he thought of the

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Freedom knee that he tried on in the last year?
A. He liked --
MR. CASEY: Objection.
THE WITNESS: He liked it.
BY MS. POSNER:
Q. Did he tell you why he liked it?
A. No. I mean -- so, yes, he probably did, but my qualifying statement around this answer is that when Jeff states that he likes something, sometimes it's unclear as to why he likes it.
So he'll say, like, Wow, it's just really great. And you're like, Well, what do you mean by "great"? He's like, Well, it's really smooth or it's really fast or it's -- okay.
It's typically not met with an answer that is superquantitative or qualitative I guess is the best way to put it.
So it's -- usually, for me, having known him for 25 years, it's -- I put my filter on and I have to go get more information. I kind of put the filter in, and say, I'm glad you're enthusiastic about that product and you're not -- you're not unenthused, so that's good, but now I need to go learn more.
Q. Did Jeff Quelet express enthusiasm about the knee he tried on that was Freedom's last year?

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A. Yes.
Q. Did he tell you that it was smooth?
A. I don't recall the words that he would have -- that he used. I -- that's -- I was using that as an example. So words like that, I'm -- if I try to recall, I'm sure that he used words that were positive and enthusiastic, right, in that line of -- or that theme.
Q. Did you learn more about that knee?
A. I didn't, really. I knew very little other than the name.
Q. What is it called?
A. Quattro. Quattro.
I -- and for me, it was kind of like -- again, there may be other people that know more about that knee than I, but for me, all I really knew was what the name was and that, as it's documented in the Complaint and the Response -- in the respondent's comments back, just that -- sort of this ongoing back-and-forth in the development of the knee features, right.
So to hear that, wow, there's this new knee coming out that's supposed to be great, for me, again, it's like, well, I don't know what great means and -- okay. So they're going to come out with a knee

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that's impressive, and then the respondent, Ottobock, will come out with another knee that's better than that one.
So that was pretty much where I had -- where I had slotted it as, great, I look forward to seeing it, you know, learning more about it.
Q. Is that what you've experienced as a -- in your role at Ability, that Freedom comes out with a knee and then Ottobock comes out with a better knee and then Freedom comes out with a better knee?
MR. CASEY: Objection to form.
THE WITNESS: In the past few years, sure.
BY MS. POSNER:
Q. Can you elaborate on that in any way?
A. I mean, just -- other than, you know, obviously as a -- as a business owner, I'm aware of the -- I'm aware of Freedom having come out with a knee in 2008, and then you're aware of there's, hey, there's another product on the market. Does it have a place in the practice? That type of thing.
But the last, you know, what, four years or so, the -- yeah, they're just -- they're competing.
Q. Who are "they"?
A. Ottobock and Freedom.

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Q. How are they competing?
A. Just with the features or benefits of the -- you know, advancing the technology.
Q. Are there any features that you've seen improve in their products over the last four or five years?
MR. CASEY: Objection to form.
THE WITNESS: So for me not -- for me not enjoying the last four years or more as a clinician, it's very -- that's a -- that's challenging for me to answer that because I don't have direct experience with those features, you know, I mean, hands on myself, you know, looking at patients wearing the latest and greatest knee, and saying, Wow, I'm so glad they addressed that, like I don't have that type of firsthand knowledge.
But to be aware of the features like, you know, for Ottobock -- or -- sorry. Excuse me -- for Freedom to come out with a knee that was water resistant, that was nice because patients who wanted to wash their car on the weekend didn't have to worry about the spray from the car damaging the knee kind of a thing, so -- or potentially damaging the knee.
So, again, you can -- from where I sit, it's like, great. This is -- you know, one of them

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comes out with this, the next -- you know, then the next one makes -- takes their technology and makes it a little better and -- so it's been good.
BY MS. POSNER:
Q. Are there any other attributes that you've noticed improving in the -- in Freedom's and Ottobock's microprocessor knees in the last few years besides water resistance?
A. So again, contextually, this is harder for me, but, like, you know, I know that the processor in the Plié is, I think, faster than in the C-Leg.
But then again, it's like, well, somebody who's in clinical care may say, Jeff, yeah, that was the case a year and a half ago, but now the next iteration of C-Leg's processor is faster than the Plié's. Okay. We'll -- so...
But at one point, yes, the processor was faster, but, you know, then again, the Ottobock C-Leg has, like, a stance flexion feature where if the knee is bent slightly, you know, the knee is very safe.
You know, the Plié has some manual resistance settings that if the user -- you know, it makes it very easy for the user to just reach down and make some adjustments.
The Ottobock has programmable modes,

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right. Freedom doesn't have programmable modes. Although someone may tell me that, Wait a minute. Yes, they do. The Plié 4 or whatever has program -- okay. So...

Yeah, so differences, but, again, depending on user preference, right, or needs of the patient.

Q. Who makes the Plié, just for clarity?

A. Freedom.

Q. And who makes the C-Leg?

A. Ottobock.

Q. What version of the Plié, what number, are you familiar with?

A. To me, it would -- I assume the Plié 1, but I -- or the original Plié, really, for me would have been -- I don't think I was much a part of it beyond that in terms of fitting.

I forget when they came out with the second one, but...

Q. You have 18 or 19 orthotists who work for you and they fit a hundred microprocessor knees over the last two years.

Do you have -- based on that, do you have any familiarity with more recent versions of the Plié?

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MR. CASEY: Objection to form.

THE WITNESS: I don't, personally. I mean, again, I don't -- you know, the feedback is -- the feedback that I get is just from the clinicians and during practitioner meetings where folks will say, Hey, we like this for this.

But, again, these are not -- it's different when practitioners are telling you they have -- they like this knee for this style patient. Hearing that is great. I'm glad that -- I'm glad that you feel that way and I'm glad that you're treating the patient first, then providing them whichever knee is best for them, right.

But am I necessarily processing that as a clinician? Because when you're -- when you're a practitioner or a physician or a PT, to me, I process that a lot differently if I had to be in the room tomorrow with a patient.

My expertise about which one is better and why and who exactly it's for, well, you can believe I would have that down to, you know, an exact science for me, right.

But, again, so I'm not -- I can tell you the company prefers those two knees for the reasons that they -- that they like them.

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BY MS. POSNER:

Q. When you say "the company," you mean Ability?

A. Ability. Sorry.

Q. Which two knees does Ability prefer?

A. The C-Leg and the Plié.

Q. Why?

A. Because they are the two microprocessor knees that we feel like have the greatest quality, durability, service, time in the marketplace.

And by "service," I mean maintenance, you know, like -- so, yeah.

And performance. I mean, they both do what they claim they do.

Q. Which is what?

A. First and foremost, provide stability to an above-knee amputee. Because microprocessor-controlled knee joints are pretty darn sweet for an above-knee amputee.

Q. What do you mean by that?

A. I mean with the way processing power has advanced since the mid-'90s, to have essentially an onboard computer regulating when the knee bends and when it doesn't, and understanding your walking environment, and it's working every second of every

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day to make you safe, that's revolutionary for an amputee who previously didn't have that.

Q. What did those amputees previously use?

A. So they used nonmicroprocessor knees, which were -- they could have been pneumatic or fluid, like a Mauch unit, for instance, M-a-u-c-h. Ossur I believe owns the Mauch unit.

But, anyway, Ottobock has nonmicroprocessor knees. Ossur has nonmicroprocessor knees. These are just knees that really rely on what we call -- they're positionally stable.

So the best way to describe it is if the amputee moves his or her weight in a certain direction unexpectedly, the knee can become very unstable, so they rely on weight line.

So if I were to lean, you know, really far forward over a knee, it might be hyperstable. But if I was walking away from the clerk downstairs, buying coffee, and they said, Oh, you forgot your change and I quickly moved back to -- and leaned my weight backwards, my knee could buckle, you know, bend and go -- and I could fall.

A microprocessor-type knee senses those movements and can quickly make the knee tight so that instead of falling, I might stumble back to the clerk.

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So prior to MPKs in 1999 -- '98, '99, patients received nonmicroprocessor knees and -- with a lot of instruction and a lot of cross your fingers, and they enjoyed a lot of falls.

Q. Do some patients still receive nonmicroprocessor knees today?

A. Some do.

Q. Which patients are most benefited by a nonmicroprocessor knee today?

A. So in my mind there's two -- there's, like, two scenarios sometimes that nonmicroprocessors -- one is a lot of times as people are new amputees, if they have just had an amputation and they are able to exhibit certain -- and perform well on certain outcome tests, potential tests, right, to demonstrate, like, their ambulatory capacity, they may be started in a temporary leg with a mechanical knee.

And the goal behind that is to -- it's a temporary prosthesis. It might only be used for three to six months.

And during that time period, goals can be set, habits can be formed, the patient can work with a therapist. They can spend the time working with the prosthetist on the socket fit, make sure that

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the interface is absolutely perfect. And all the while they're on a mechanical knee.

But they're strong enough, they have enough range of motion, things -- different characteristics that would be evaluated to say, okay, this patient's going to learn how to walk on a non-MPK, right, but they're going to progress -- the idea is that they're going to progress into an MPK --

Q. And you said there's another category?

A. -- on the permanent limb, right.

And then the second category would be, you know, there are still patients, you know, and this is a whole other topic, but there's still patients that have payors, third-party payors, that won't pay for a microprocessor knee.

So sometimes you have patients that can't get the MPK technology, and they have to go in a nonmicroprocessor knee.

Q. Is it your belief, then, that all patients should ultimately be getting a microprocessor knee?

MR. CASEY: Objection to the form.

THE WITNESS: All is tough to say, but most.

You know, there's research that's

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ongoing in our profession that, you know, perhaps is going to show even that lower-level amputees can benefit from microprocessor technology.

So in the future we may -- we may learn more about the patient demographic at lower functioning. Because you have to remember, whenever technology comes out in the O&P profession, it's immediately thought that this is for, like, you know, these high-level, you know, amputees.

And really, in my opinion, as technology gets better, it affords the lower-level patients the ability to at least stay at that lower level and not become further deconditioned, needing a wheelchair or not walking at all and so things like that.

So my personal opinion is not necessarily that all folks need microprocessor, but I do think that people need to be ruled out of microprocessor technology, not ruled in.

So as an evaluative process to say let's start with MPK, and if the outcome measures start to map and lay out that, yes, in fact, you're going to do well with an MPK, great.

But if you're not -- you know, if you start at MPK and you start to do a few measures and you say to the patient, Hold on. Time out. You're

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just -- this type of componentry of technology is not going to be the best fit for you, so we're going to put you in this type of a knee. That's all you need.

BY MS. POSNER:

Q. Is that the current practice at Ability?

A. Yes.

Q. Which types of activities are the clinicians at Ability using as a goal for the patients who they are giving MPKs to?

MR. CASEY: Objection to the form.

THE WITNESS: Right. So it's somewhat activity specific to the patient. But we have outcomes measures or baseline measures that we're administering to the patients to try to get -- to make that determination, yes.

BY MS. POSNER:

Q. So can you explain how a clinician at Ability decides whether an MPK or a non-MPK is best for a transfemoral amputee?

A. Right. So there -- again, there's an AMPPRO, an AMPnoPRO -- these are acronyms -- but they're -- these are outcome measures that -- so they're physical tests that the clinicians are performing in the room with the amputee.

Sometimes these tests are performed by

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the physical therapist, even, that might be working with the patient. It's thought that sometimes they can be more objective if they're given by the PT, which that's another conversation, really, because PTs aren't as familiar with administering the tests.

Ability does a lot of interoperability. Like, Brian will go around and make sure that the practitioners are administering the tests properly and consistently.

So there's the AMPPRO, the AMPnoPRO. We do a PEQ -- I believe it's called a PEQMS. But that's a socket comfort score.

And then I think they're doing -- they're doing some other measures, but I'm not sure if they're just specific to prosthetics or if they overlap into orthotics because we do -- we also do some orthotic outcome measures, too.

So, again, they perform those and see where the patients score and, you know, try to start to formulate their design from that, you know, how they're going to move forward. And taking into account patient -- you know, what the patient wants to do, right. So --

Q. What do you mean, "what the patient wants to do"?

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A. Yeah, so you always -- you always take into account the level of function the patient was before they had the amputation.

So if you're -- if you're climbing ten flights of stairs to your office every day and then you're hit by a bus and you need an artificial limb, you're probably going to sit in the appointment and say, Hey, I want to walk the ten flights to my office when I go back to work.

So getting back to the level of function one was at before an amputation is really important.

Yet we always -- you know, our ears are open for patients who say, you know, Yeah, I think I'm going to take up hiking. And we're like, Well, did you hike before?

No, but I need to get more fit.

Well, let's walk first, you know.

So we try to manage those types of -- match the functional level.

Q. You're matching the functional level with the knee that Ability will ultimately fit the patient with?

A. Correct.

Q. Is the decision of whether a mechanical or a microprocessor knee best for the patient a clinical decision?

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A. Yes.

Q. Who makes that decision?

A. The prosthetist, along with the patient.

Q. Do you know what -- the pricing terms for the different microprocessor knees that Ability is paying for now?

A. Yes, generally.

Q. Can you walk me through those?

A. So I believe for the -- excuse me -- for the Plié, for the Freedom Plié, we are currently

[redacted]

Q. Does Ability purchase any other microprocessor knees?

A. I think on that sheet there was a Rheo

[redacted]

Q. Does Ability purchase any other microprocessor knees besides the Plié, C-Leg, and Rheo?

A. I think there was an Endolite Neon on the list of -- I think it's an Orion, Orion, and I'm not sure what the cost was, but it's -- it is on that sheet. It's on that spreadsheet.

Q. How many Orions were on that --

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A. I purchased --

Q. -- how many -- wait. Let me rephrase. How many Orions did Ability fit in the last two years?

A. I believe one.

Q. Approximately how many Pliés did Ability fit in the last year?

MR. CASEY: Did you say the last year?

MS. POSNER: No, I'm sorry, in the last two years.

THE WITNESS: Two years.

I'd have to look on the sheet. I'm sorry. It was roughly, I don't know --

MS. POSNER: Can we go off the record for a second.

(Discussion off the record.)

(A recess was taken from 10:08 a.m. to 10:32 a.m.)

BY MS. POSNER:

Q. Mr. Brandt, we've just passed around APO000017.

Do you have that document?

A. Yes.

Q. Okay. It is a Excel sheet that has been printed out in four pages. It has been blown up for

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our benefit.

We're going to mark it as Brandt-1.

(Exhibit Brandt-1 was marked for identification.)

BY MS. POSNER:

Q. Do you know what this document is?

A. Yes.

Q. What is it?

A. This is a document that Ability produced that shows -- again, just column headers, it shows the branch, the office, you know, the location of the office, the treating practitioner, an estimated total cogs, it show allowable for the claim, cost of goods, it shows the type of microprocessor knee. Specifically it shows the cost of that knee that was used on that case.

And then some of these other columns are just, you know, almost like a WIP, work-in-progress-type comments that were snapshots along the way of these cases being, you know, performed or produced. Total cogs, gross margin.

Q. We can go through the columns individually --

A. Okay. Sure.

Q. But, generally, is this a list of the

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microprocessor knees that Ability has fit in all of its locations over a particular time period?

A. Correct, it is, over the last --

Q. What is the time period?

A. I'm sorry. Over the last two years.

Q. So is that March 2016 to March 2018?

A. My understanding was that it was January through December of '16 and then January through December of '17.

Q. Okay. So it's January -- this --

A. All of '16, all of '17.

Q. Okay. For clarity, Brandt-1 lists all microprocessor prosthetic knees that were fit at its ten clinics between January 2016 and December 2017; is that right?

A. Correct.

Q. Where was this information pulled from?

A. This information was pulled from our software, Ability's software system that we use, called OPIE, O-P-I-E. It's our practice management and software billing platform that we use to run the company.

Q. Have you been using that software since at least January 2016?

A. Yes.

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Q. Is this list accurate?

A. Yes.

Q. How do you know that?

A. I know that because Ability has had audited financials for the past four years. We employ a CFO and we monitor and have processes in place to make sure that these are accurate.

Q. Is it your usual business practice to keep this information?

A. Yes.

Q. Is it your usual business practice to keep this information in this manner?

A. Yes. With the exception of the MPK Cost column that we added for the convenience of this -- for this report.

Q. And patient ID has been redacted; is that right?

A. That's correct.

Q. Okay. Let's go through the columns. The first column says "Branch." What does that mean?

A. Branch is -- defines the location of the practice where that patient was seen.

Q. What does "Treating Practitioner" refer to?

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A. So that's the practitioner that provided care for that patient.

Q. What does "Patient ID" refer to?

A. That's the ID that's given to the patient within the OPIE practice system.

Q. The next column says "Estimated Total Cogs." What does that mean?

A. So during we call them WIP calls, work-in-progress calls, but during calls that the regional managers would have with the offices, they would ask them for jobs in progress, sometimes to give estimated total cogs on the case. And so those numbers reflect what they would have told them on that day.

Q. Why are there only some of those numbers filled out?

A. I don't know.

Q. The next column says "Allowable (Claim)" and there's something cut off. Do you know what it says after Claim?

A. I don't.

Q. Do you know what this column that's "Allowable" refers to?

A. Right, it refers to the -- to the estimate that we think we're going to get paid for the

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entire case, meaning all of the L-Codes, not just the knee codes, to clarify.

Q. And when you say we would get paid, you mean Ability --

A. Ability.

Q. -- would get paid by --

A. Reimbursed by a third-party payor.

Q. Can you wait --

A. Yes.

Q. -- for clarity and to make her life easier?

When you say we would get paid, do you mean the amount that Ability would get reimbursed by the third-party payor?

A. That is correct.

Q. Would that include Medicaid?

A. Not so much Medicaid, but Medicare, yes.

Q. You mentioned L-Codes.

What's an L-Code?

A. Right. So an L-Code is a -- an L-Code is a system that Medicare CMS or H- -- yeah, CMS at this point, came up with 30 years ago to basically assign descriptors to L-Codes. So you might have L-56, 58 in this example.

The L-Code system is a group of codes

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that have descriptors that define aspects of the components or features of the components in prosthetics and orthotics that then as practices, we assigned L-Codes to complete legs and braces to -- in which to bill them by. So it's the billing submission method.

Q. Do you know which L-Code is used for microprocessor prosthetic knees?

A. Well, it's the 56 -- I'm sorry -- 5658, I believe is the base code.

Q. Is it L-5856?

A. 5856, correct.

Q. Do you know if you can submit a mechanical knee for a reimbursement under L-Code 5856?

A. You cannot.

Q. Why not?

A. Because the features that a 5856 describes are not evident or they're not there on a mechanical knee.

Q. Do all microprocessor knees, regardless of manufacturer, qualify for reimbursement under the same L-Codes?

A. I would say under that code, yes. But then beyond that code, different manufacturers may recommend variances in coding, depending on the

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features or technology that they're claiming on their knee.

And there may not -- and I'll add, there may not be a code. They may actually recommend a miscellaneous code. That means that there's not a code defined yet by CMS in which to capture reimbursement for that aspect of the knee by the technology.

Q. You mentioned before that Ability, well, between January 2016 and December 2017 had purchased knees from Endolite, Ossur, Ottobock, and Plié and Freedom; is that right?

A. Correct.

Q. Do all the microprocessor knees that Ability fit during that period from those manufacturers, are they all -- did you submit them under L-Code 5856 for reimbursement?

A. I can't say without a doubt all of them because I don't know about the Genium, per se. The Genium is another Ottobock product that I'm not sure exactly how that's coded.

Again, my familiarity with some of the codes is -- has changed over the last few years. But it -- as a whole, yes. I mean, the C-Leg, the Plié and the Rheo, in my mind, are used with that base

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code. I think the Kenevo is and I think the Genium is, but they may have other codes attached to them as well.

Q. How does the Genium compare to the Plié, C-Leg, and Rheo?

MR. CASEY: Objection to the form.

THE WITNESS: I -- I only -- I don't know anything -- I know that it's more -- it's considered, like, more robust, more, you know, like I think waterproof or water resistant, at least. But I don't have -- very little experience with the Genium.

BY MS. POSNER:

Q. Let's go back to Brandt Exhibit 1.

A. Okay.

Q. The next column says "Cost of Goods." What does that refer to?

A. Right. So that's the cost of goods for all of the products or all of the fabrication tied to that limb.

Q. The next column says "MPK." What does that mean?

A. Right. That's the -- that means microprocessor knee, and that's the -- this -- that's the brand of knee that was used.

Q. The next column says "MPK Cost." What

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does that refer to?
A. Correct. That's microprocessor knee cost for that particular knee.
Q. So the microprocessor knee cost should be lower than the cost of goods in the two columns before; is that right?
A. Yes.
Q. The next column says "Ordered Item." What does that mean?
A. Again, I think it's part of the WIP process. So I think it's probably just, you know, if you've ordered anything to date to start that case, what have you -- you know, what's been that spend tied to that case thus far.
Q. Okay. When it says "Futures Cog" in the next column, what does that mean?
A. So, again, if it's -- the project's in midstream, it's what do I think I'm going to still incur to finish.
Q. Okay. The column that says "Total Cogs" next to it, what does that refer to?
A. Again, this is back -- this would be I think very similar to the -- to the -- one of the previous columns that was titled Cost of Goods. We can't see what's beyond the divider there, but total

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cogs would certainly be -- if not the same as that, it would -- it would grab in any, perhaps, future cog number.
So it's just -- it's just a number of what we expected to pay for the whole case.
Q. So if we're trying to figure out the final cost of goods number for a particular knee, is it the total cogs column more appropriate or the cost of goods column more appropriate?
A. If you're trying to find the cost of the actual knee, it would be the MPK cost column, just for the knee.
Q. So if we're trying to find the total cogs for the limb, we should use --
A. Right, that's the total cogs column, correct.
Q. What does "GM Percentage" mean?
A. Gross margin percentage.
Q. What is that?
A. So that is the -- essentially the allowable, the claim minus the total cogs. And then whatever that number is converted to a percentage as -- right, so it's just your margin on the case.
Q. Some of those fields -- some of those entries under GM Percentage are blacked out. Do you

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know why?
A. Yeah, they're blacked out on this version, but I think they're just -- they're readable in the --
MR. CREAGAN: Yes, so if I could just interject, I -- this is, again, a color issue. I think the things that appear blacked out here may actually be in like a dark red on the live spreadsheet.
So if we were looking at this on our laptops, I think you would see that in the live spreadsheet.
So -- and I don't know myself why the different colors.
THE WITNESS: The different colors just -- okay. The different colors just denote different ranges of margin.
So I don't know the colors again without [redacted] below.
So it's just to help us understand when we're looking at all of the variables that go into designing and fitting a limb for someone, so that we have some business awareness of where our margins are

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for particular payors and designs of limbs, so...
BY MS. POSNER:
Q. What does Ability do with the margin it makes on a transfemoral limb?
A. So pretty much we put it back into the company. So as I said before, I mean, we have a pretty robust management team. We have research and -- clinical research going on. We -- I think we run a fairly premier practice, so our rents tend to [redacted] higher than industry numbers report. So -- continuing education.
So a lot of that is just pumped back into the company.
Q. Do you have any expenses related to patients that are paid out of that gross margin number?
A. Say that again.
Q. Do you have any -- does Ability offer anything for its patients -- education, follow-up care, anything else -- that has to be paid out of the gross margin number?
MR. CASEY: Objection to form.
THE WITNESS: Right. So some of the

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things that I just -- that I stated I think are maybe less definable, but certainly the way the company is run and the way the offices are laid out and they all sort of factor into, arguably, an outcome, right. But -- our patient satisfaction.

But specifically, you know, we offer continuing education courses. We put on -- we like to put on in-services that talk about different pathologies or products or treatment protocols, things like that.

Patients are -- by way of the current payor system, if we provide a leg for, you know, [redacted] that, there's a profit.

And then the usual life of that limb is usually three to five years, depending. And so during that three to five years, the patient does come back for follow-up visits in which we do not bill payors. We have no mechanism by which to bill a payor for those visits. So it's a bundled payment, if you will, for the life of the limb.

So there are additional -- we talk [redacted]

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[redacted]

And you say, Well, wait a minute. Did we ever -- have we pulled the patient data to say that patient comes back nine times over the next four years and ascribe a dollar amount to those visits and then subtract that from that number to really understand what our true economic value or cost is to treating a patient through the full life of the limb?

BY MS. POSNER:

Q. The next column says "Comments." Who writes comments in that column?

A. I don't know. You know, I can guess. I don't know --

Q. Who do you guess?

A. I mean, I guess that it's -- that it's one of the regional directors that's doing the calls, or that it's, you know, Mark Brady, the CFO, or our CIO, Clay Barrow, who might be on the call to -- that manages the spreadsheet. So...

Q. Moving across the page, the next column says "Device Type." What does that refer to?

A. That just simply describes the type of prosthesis. So transfemoral definitive means above the knee. Trans, across the femur, and then definitive just means that it's a permanent limb. It's not the starter limb.

Q. What does transfemoral definitive bilateral mean?

A. It means that the patient received a leg for each side of the body. So they were missing both legs.

Q. And what is transfemoral replacement socket?

A. That simply just means that the socket of the prosthesis was replaced, and the patient kept their existing knee, shin, and foot.

Q. The next column is labeled "Primary Insurance." Is that the --

A. Correct.

Q. -- insurer that is related to that particular patient?

A. Correct. That's the primary payor, which means that that's the insurance that's in the first position, which is going to basically receive the claim and adjudicate it and then pay per the benefit level.

Q. Is DOS in the next column date of service?

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A. It is.

Q. Is that the first time a patient comes to Ability?

A. No.

Q. What is it?

A. It is the date of the delivery of the prosthesis or the product.

Q. When you say "the delivery of the prosthesis," do you mean to the patient or to Ability?

A. No, to the patient. It's the day that the patient takes possession of the limb.

It's also the date of service is used for billing purposes. It's what you submit on your claim.

Q. The next column is "Date Billed." What does that refer to?

A. I believe that's the date that we actually billed it.

Q. To the insurance company?

A. To the insurance company, correct.

Q. "Claim Number," what does that mean?

A. I don't know. It may be -- it may be a claim that's assigned when the bill...

Excuse me. We use ZirMed, Z-i-r-m-e-d, is a clearinghouse. So when our claims leave OPIE,

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they get put into ZirMed. ZirMed is a clearinghouse that -- from what I understand, it's like a data scrub, right. So if you had the Aetna address wrong or something with POP saying, Don't submit this claim yet.

So I think this claim number may be assigned by ZirMed or the actual insurance company.

Q. The next column says "Estimated GM." What does that refer to?

A. Just -- that's probably the practitioner estimating the gross margin based on how they're proposing to proceed.

Q. The next column says "Year-Month." What does that mean?

A. Year-Month. I think that's just the date it was billed, or the DOS. That might be how they queried it. I'm not sure.

Q. "Year" refers to what?

A. It's the same thing, just the year. It refers to the year of the -- that case.

Q. And "Device Group" refers to what?

A. I don't know, but I surmise it's just -- it's a transfemoral group that captures socket replacements, bilaterals, unilaterals. These are unilaterals if they don't say. So...

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Q. Okay. After looking at Brandt Exhibit 1, how many C-Legs did Ability fit in 2016 and 2017?

A. It looks like 26.

Q. How many Pliés did Ability fit in 2016 and 2017?

A. 16.

Q. How many Rheos did Ability fit in 2016 and 2017?

A. 11.

Q. How many Orions did Ability fit in 2016 and 2017?

A. One.

Q. Were there any other microprocessor knees that Ability fit in 2016 and 2017?

A. Yes. There was a Kenevo, K-e-n-e-v-o, which is an Ottobock knee, and we fit one of those.

Q. Any others?

A. And then we also fit two Geniums.

Q. Who makes the Genium?

A. Ottobock makes the Genium.

So with that, I should correct my previous comment probably about roughly a hundred microprocessor knees in the last two years --

Q. How many --

A. -- for the record.

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Q. For the record, how many -- for the record, how many microprocessor prosthetic knees has Ability fit in 2016 and 2017?

A. 57. And I think only one of these was -- you know what? I'm sorry. It's going to be closer. It's over 60 because there are some down here that are bilateral. I apologize.

Well, it says bilateral, but then the MPK cost is more representative of buying one knee.

Q. Yes, and if you look across to the bilateral on the primary insurance and the date of service --

A. Yes.

Q. -- they're the same dates.

A. Yes.

Q. So is it possible that even though it says bilateral, it's only referring to each individual knee?

A. And it might have been that we only made one side. That they may be a bilateral amputee but we might have only made a leg for one side. Because the cost data was only representative of having purchased one knee.

Q. So if you look down the column that says "MPK Cost," what's the range of price that Ability is

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paying for microprocessor knees in this time frame?

A. Right. So I believe there's a Plié on [redacted] I'm scanning them correctly.

And I think the highest would have been the Genium -- one of the Genium X3s, which is [redacted]

Q. Do you know why the cost of the Genium is so much more expensive than the Plié 3?

A. Because it's a -- again, a more robust, more high -- more high -- higher-performing-type knee.

Q. So --

A. I can't speak to the definitives and the features of the Genium. I'm sorry.

Q. That's okay.

Let's say the cost of all of these microprocessor knees were to increase 5 percent. Would you be moving -- would you move your patients to mechanical knees?

A. No.

Q. Why not?

A. Because clinically we make decisions at Ability about the patient, and so a 5 percent increase would not have me moving my patients to a non-MPK when they, in fact, needed the safety of an MPK.

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Q. The price that Ability is paying for these MPKs, is that the list price of these items?

[redacted]

So as far as I know, these are the net, the net-net numbers.

Q. How does Ability receive a negotiated discount on a microprocessor prosthetic knee?

A. Really just -- I mean, we have relationships with all the companies, and if -- usually they approach you at some point in the beginning of the year or near the end of the previous year and just say, Hey -- okay, they review -- kind of you do, like, an account overview, which I think is pretty standard for all the companies, and usually have some conversation around, you know, Were you up, down? Why? What do you think? Did you see fewer -- you know, just -- all this sort of fact type of conversation.

[redacted]

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[redacted]

It's kind of --

Q. Who from Ability is involved in those conversations?

A. I have been; Kathleen DeLawrence, the COO; the CFO, Mark Brady; Jeff Quelet. That's pretty much at this point the four of us would be involved in that.

Q. You mentioned earlier that Ability is

[redacted]

A. Correct.

Q. Do you know how you came to that price with Freedom?

A. Just continuing to ask them year after year after year that, you know, did we think the price, given the reimbursement levels and given the -- given everything that we've learned about our business and the business of providing patient care in P&O, we feel like the price needs to keep coming down.

Q. Does competition play any role in receiving that price?

A. I'm sure.

MR. CASEY: Objection to form.

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BY MS. POSNER:

Q. In what way does competition result in that price?

A. Well -- so, I mean, for example, I mean, probably five, six years ago -- probably longer than that -- six or seven years ago we were probably paying

[redacted]

price has come down significantly. And, you know, I think that it's probably pretty well documented that it's competition with Freedom's Plié that has contributed to that, at least some.

Also the fact that the technology has been around for a while, too. So I can't imagine that it can't come down just -- just for that alone, right, R&D has -- I mean, I don't know Ottobock's business there, so I don't know, like, if R&D costs have been captured or any of that kind of stuff. So it's like -- but I surmise the knee could and should come down in price, and it has the last few years.

Q. You said it's been pretty well documented that that price decrease is a result of competition. Did I get that right?

A. Well, yeah, I mean, documented in terms of -- maybe it should be more common knowledge just among providers and manufacturers that it's obvious

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from where I sit that they are -- that they are, you know, very traditionally one-upping each other and trying to do -- pack more into a knee for the same price or less.

Q. And "they" is Freedom and Ottobock?

A. Freedom and Ottobock.

Q. And that's in their Plié and C-Leg products?

A. Correct.

Q. How does the Rheo compare to the Plié and the C-Leg?

A. So --

MR. CASEY: Objection to form.

THE WITNESS: -- again, I'm not -- I have very little experience with Rheo. You know, the Rheos that I utilized way back when weren't -- they weren't great. They were kind of in the shop, so to speak, all the time, being sent back for repairs.

So they use, like, an electromagnetic technology, so it's a little different than what the others are using. But I don't have a ton of experience. The Rheo XC is newer, and I admittedly don't know a ton about it.

The big thing with Ossur for a long time was that the knee was too heavy. I do remember that.

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BY MS. POSNER:

Q. Ability acquired one Orion in this two-year period. Why aren't you using more Endolite products for microprocessor knees?

A. Yeah, I mean, again, it's patient preference, practitioner preference of C-Leg and Plié, really.

And some of it's relationship. I mean, we have a relationship with Ottobock and Freedom in terms of just there's a familiarity there with the product and how the companies operate.

Endolite, we don't -- we don't really have a -- you know, it's kind of one of those things where you just, like, Yeah, you know what? We're not, like, actively trying not to use Endolite products, we just don't -- you know, it's kind of like a tube clamp on a prosthesis, right. If you can buy that tube clamp, it's like, you think of that as, like, an Ottobock component, right, like it's the best of the best. Put the Ottobock tube clamp on the patient. You don't think about, like, Oh, let me go to Blatchford Endolite.

And, again, it's not because it's, like, substantiated that their products are inferior, we just don't -- you haven't developed any kind of a

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learning curve or gotten through any kind of a learning curve with their products, so that's really it.

Q. Do sales representatives from the microprocessor knee manufacturers visit your offices?

A. Yes.

Q. Is that what you meant when you said we had familiarity with the companies?

A. That's part of it.

Q. What else is part of it?

A. Certainly Brian being -- Brian being

[redacted]

So we have that relationship, so that -- that obviously put Brian and some of our staff in contact with Freedom and some of the folks at Freedom that were handling that research.

You know, again, so sales reps may be, you know, at a show or a conference meeting up with Ottobock folks to say hi and reconnect and talk about the industry.

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I mean, so again, the relationships are -- you know, Andreas Kannenberg -- Dr. Kannenberg has been to Exton before to chat with Brian and myself and Kathleen about, you know, developing an outcomes registry and things like this.

So there's a lot of -- really with both companies.

Q. How often do sales reps from Freedom visit an Ability clinic?

A. I would say they're all probably once a month.

And when I say "all," I mean both companies, both Ottobock and Freedom.

Q. Do they come to each of your clinics once a month?

A. For the most part, yes.

And that -- again, that's a hard question to answer, too. Because sometimes they're there to troubleshoot a problem with a practitioner about a product. Sometimes they're there because it's a new Ability office, so it's newer, so they're trying to help develop the area with -- along with the practitioner or, you know, suggest, Oh, hey, this -- there's a doctor down the road who loves, you know, prosthetics or, you know, refers...

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So it varies. But on a whole, we see from the reps -- we see our reps a lot. And we encourage practitioners to have relationships with reps, but we also encourage dissemination of information to come down from our management team.

So if -- so what we don't want, our reps walking into offices sort of -- I call this the old school O&P -- we don't want reps walking into offices and saying, Oh, hey, you know, if you buy two legs tomorrow, I'll sell them to you for this.

We tell our practitioners, like, just tell them, Time out. No. If you have a promotional, you send it to practitioners@abilitypo.com and we'll all take advantage of that knowledge at the same time. We're not going to do these one-off, you know, I high-fived you. How come you didn't buy five products from me? We're not going to get into that.

So we're pretty, you know, staunch about that. So...

Q. How did the sales reps from Freedom and Ottobock help a clinic, an Ability clinic, develop an area, as you mentioned?

MR. CASEY: Objection to form.

THE WITNESS: It's more just general information about demographics, or, like, if they know

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there's a prosthetics clinic that happens or an orthotic clinic or something, they may say, Hey, are you guys aware there's a clinic at, you know, XYZ Rehab Hospital?

And we might say, Yes, we knew about that, or, No, we had no idea.

Okay. Well, maybe you guys ought to check into that.

Okay. Thanks. And they're out the door.

Whenever Ability opens an office, we usually do a grand opening and we always invite reps from all companies. That's just us. We've -- you know, again, and people will say, within the industry, I can't believe you're inviting so and so.

And I always say, Look, it's objective, and everybody has to be able to come and celebrate in us opening an office. It's about the patients, it's not about a sale. So...

So just -- that's what I mean by that.

BY MS. POSNER:

Q. And does Freedom send you a specific sales rep to sell microprocessor knees?

A. Again, I'm not too familiar with how they kind of move -- carve up their regions and who --

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like, who goes to which offices.

But I know that there's -- I know they have reps that are covering our offices. If not one, we -- we many times -- because we're spread out and some companies don't include Pennsylvania in the MidAtlantic and some do and all that.

So, again, back to the consistency of the dissemination of the knowledge, we -- we've really pushed to really have one rep for the whole company, if possible.

That generally doesn't work out because some companies use, like, shipping ZIP Code, some companies use states. You know, they have different ways they carve things up. So...

But we try our best to -- you know, if there's a Freedom or an Ottobock rep walking into the Charlotte office, we want Rockville and Exton to have the exact same opportunity.

Q. Do you know if that's worked with Freedom and Ottobock?

A. It has, for the most part.

Q. Who --

A. And Ossur. I mean, that's the other one.

Q. Who is Ability's Freedom rep?

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A. I -- well, see, again, I kind of know from history, I think it's Jeff Dawson, but, again, I can't remember where he covers. So...

Q. Who is Freedom's Ottobock rep?

A. Wait. Wait. Say that again. I'm sorry.

Q. I'm sorry. Who is Ability's Ottobock rep, sales rep?

A. Here -- "here" meaning Pennsylvania -- I think it's Matt Finnegan.

And I think in the South -- I call the two offices in North Carolina the South, but I -- and I think it's Scott Wagner.

And I don't -- but, see, what I don't know is if Matt Finnegan goes into the three offices in Maryland. There might be someone different in Maryland, so, yeah.

Q. Do you know if Jeff Dawson, Matt Finnegan, or Scott Wagner sell the whole suite of their company's products or only microprocessor knees?

A. No, they sell the whole suite, everything.

Q. Does Ability have -- see any other benefits from working with sales representatives for microprocessor prosthetic knees?

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A. Not really. Not really.

Q. Do the sales representatives play any role in the fitting of a prosthetic, of a microprocessor knee prosthetic?

A. Overall, no. I mean, they may be there on occasion during the fitting to offer, you know -- what's the question -- what's the -- like, frequently asked questions, you know, FAQs. Like, if a practitioner has only fit a handful of knees of that specific knee, the rep might be present to help them through the software or, you know, to troubleshoot something that might occur during the fitting.

But on a whole, they're not present.

Q. You mentioned promotions a little bit ago. Are you aware of any promotions that Freedom or Ottobock have offered involving microprocessor knees?

A. Yes, but not specifically. I mean, I'm aware from them hitting my inbox that they do, from time to time, offer promotional-type -- yeah.

Q. Are you aware of any particular promotions that either Freedom or Ottobock have offered involving microprocessor prosthetic knees?

A. No. No. I mean, just, again, generally speaking, it's more of just, you know, one time only or for the next week or -- you know.

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It's not -- it's not like -- yeah, I can't think of anything like you get the red stocking if you order a C Leg or -- I can't think of anything like that.

Q. Are there any promotions that you've heard of that -- where Freedom offers a free knee if you purchase a microprocessor -- a free foot if you purchase a microprocessor knee from them?

A. So I think that both companies -- and I -- and I think I would even throw Ossur into this category -- I think that all of those companies have offered free feet at one time or another with the purchase of a knee.

Q. Do you find those to be effective promotions?

A. I think that when you have the right patient where you actually want that company's foot, it's great.

Q. Why is it good? Why is it great?

A. Well, yeah, because it -- because it lowers your overall cost for the project, increasing your gross margin.

But, again, if you can't use -- if you can't take advantage of the promotion, it's kind of like, okay, well, that's great, but my patient is

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getting -- is, you know, not going to get an Ottobock foot for this case or not going to get a Freedom foot or, you know, one of those things. So, anyway...

Q. Are you familiar with Ohio WillowWood?

A. A little bit, yes.

Q. Are you familiar with their foot products?

A. Not really.

Q. Do your clinicians fit Ohio WillowWood foot products on your patients?

A. I'm sure they do occasionally.

Q. Which company's feet does Ability most often fit?

A. Right. So probably number one is Ossur or Freedom, maybe. And then Ottobock behind that. And then College Park.

I'm trying to think if I'm -- that's probably right. I mean, I still think that Ossur, Freedom, and Ottobock are -- or at least Ossur and Freedom, for sure, are going to be your top two -- when you're thinking about feet, it's pretty much Ossur and Freedom -- excuse me -- I think I said.

And then depending, it might be Ottobock.

Q. When you say "top two," are you just referring to market share or something else?

A. No, just Ability's volume of those -- of the use of those companies' feet.

Q. Why does Ability use Ossur and Freedom as their top two for foot manufacturers?

A. Again, reputation, durability. I mean, Ossur bought the original Flex-Foot, which is the original carbon foot from, you know, 1991. So there's -- I think there's long-standing technology there that they're familiar with.

Freedom also, I believe, in its lineage or its pedigree has Ossur background. So it's probably not surprising -- I think I have that right -- that Freedom's feet would be, you know -- that they would have entered in the market in '08 with a couple of decent feet at that point.

But, again, it's durability, it's breakage, you know, looking at patient feedback, you know, are they comfortable in those products.

The other foot I should note, too, is the RUSH Foot from Ability Dynamics, not to be confused with Ability P&O.

Ability Dynamics is a foot-only company who also has gotten some of our foot sales and selections. It's a Fiberglass foot. It's kind of a

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different take on feet.

Over the last four years we've also ordered from Ability Dynamics as well.

Q. How do College Park's feet compare to Ossur's and Freedom's?

MR. CASEY: Objection to form.

THE WITNESS: Again, I don't -- I'm not going to have a ton of experience there with their feet. But my sort of unrefined is sort of there's -- I feel like there's a fair amount of science behind College Park products, which I like, I'm attracted to.

But I'm -- again, it's like you have to balance the science between the ebbs and flows and the pace of patient care, right. And so I think sometimes smaller companies can't -- I mean, like, I don't -- I don't know that the pricing is necessarily as competitive from College Park. So...

But I also think that sometimes these products are overengineered, and so the science is wonderful and it's -- like, I get it, right, it's a great foot, but if I put a College Park foot on my patient and they say it's too stiff or it doesn't roll over the toe nicely or something like that, okay, then I have to go back to College Park and say, It's a great foot, it's not going to break, but my patients

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don't prefer that. They prefer a Freedom foot or an Ottobock foot or an Ossur foot.

You know, so -- so I have sort of a -- I have a great relationship with College Park, but I don't -- I think it's like -- it's like, okay, you built this for, like, the engineering passion, and that's important, but I don't -- again, how widespread they are.

But you have different regions of the country that people are doing different activities, and -- so we also find sometimes there's parts in the country that people like different brands better because it's the patient profile of that region. So...

BY MS. POSNER:

Q. How does -- how do the Ohio WillowWood feet compare to Ossur and Freedom feet?

A. I'm not --

MR. CASEY: Objection to form.

THE WITNESS: -- really aware of Ohio WillowWood feet. I'm sorry, maybe I'm dating myself leaving patient care, but I'm not really aware of Ohio WillowWood feet. I'm sorry.

BY MS. POSNER:

Q. Is customer service important to Ability?

A. Yes.

Q. Is customer service important to Ability specifically related to microprocessor prosthetic knees?

A. Yes.

Q. Can you explain how?

A. So, yes, microprocessor knees, along with every other product, it's really important because many of the products at Ability, everything is outsourced, so everything is made somewhere else. So it's especially important.

But even in more traditional O&P practices where some part of the prosthesis might be made in-house, you're still putting components on that were manufactured somewhere else.

So things go wrong, they do go wrong, things don't fit, you get the wrong part, there's always -- there can always be something going on.

So, yes, so the interaction with whoever supplied that part is critical because you may have a patient sitting there that's live and has one hour to be seen, right, and so you -- yes.

Q. What has your experience been with Freedom's customer service?

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MR. CASEY: Objection to the form.

THE WITNESS: Freedom's customer service I think has been exceptional. We've had no -- I mean, it's -- I think it's what we would expect. Ability is a pretty dynamic practice, a very dynamic practice that has a very high expectation, and I think we -- I think they do a nice job responding to our dynamism, you know, like wanting things yesterday, wanting resolution, wanting -- you know, need an answer.

BY MS. POSNER:

Q. Does that mean that when you call Freedom, somebody responds?

A. It does. Right. Correct.

Q. Does it mean anything else in addition?

A. Oh, sure. It could mean product -- providing us with product samples so that we can show patients actual devices and have that to show them in the room.

It could mean arranging for a trial on a product so the patient can trial something before we move ahead with it.

It might mean, you know, being -- I mentioned earlier creating awareness and providing educational events. It might mean being a part of an educational event.

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And -- you know, so, I mean, there's a lot of, you know, clinical research study, you know, interacting with a company like that.

So, yeah, it means a lot of things.

Q. What has your experience been with Ottobock's customer service?

MR. CASEY: Objection to the form.

THE WITNESS: So it hasn't been as good, I would say.

I would also say that -- qualify that to say it hasn't been bad. But certainly our relationship and experiences with Ottobock is we've -- we kind of pushed through some of the stuff that, you know, we just -- I think sometimes it's a challenge to work with them, not because they're trying to be that way, but it almost feels like -- you know, like -- it's not as easy, I guess.

You know, when you think of the Staples button, the Easy button, it's -- that's the analogy I would use. But it's not as --

Like, if I called Ottobock and I had the wrong part sitting on the desk, the experience to get that part packaged up and returned to Ottobock would be, in my -- in my memory, would be different than returning it to a different -- another company, right.

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It would just be -- it would be more challenging. So...

Yeah, so the experiences have been not as great, but I also -- "I" meaning Jeff and Ability -- I have always just said, You know what? That's fine. And I don't know if it's culturally or what is the root of that or the why, but that's okay. I have to keep the patient in mind here. And if the best product for the patient is an Ottobock product, put your head down and get them an Ottobock product.

But Ottobock's been fantastic with service and durability. Like there's -- you know what I mean? So it's not -- there's not like there's this history of product breakages and then they don't back it up or send you a new one or anything like that.

I think -- I think the best way to summarize it is Ability is a really progressive, data-driven, patient-care-focused company that wants to do a lot of unique and different things, and I think when we attempt to interact with Ottobock, it's like -- you know, just like clashing sometimes because, you know, the majority of the market is -- practices like myself are -- there are not as many practices like Ability out there, so it's -- I think if Ottobock tells another practice, Hey, we can't have

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that for one week, that practice is more likely to say, Okay, that seems fair.

We're more likely -- Ability is more likely to say, A week, are you kidding me? I need it in 48 hours.

And then that company says -- or then they say, Okay, you're drive -- or Bock says, Okay, you're driving me crazy. They don't literally say that, but -- you can hear it, but it's like, Oh, my gosh, we've got a square peg over here. You know, why can't you just take a week and be fine with that?

Well, no, because my patient's demanding that it be two days and I'm trying to manage their expectations, but at the same time, Bock, could you just work with me?

Sure, we'll figure it out. And -- you know, and then we figure it out.

But resistance is just kind of the -- so it's not -- it's not -- I don't want to paint a picture of it being bad. It's just -- it's just -- I -- I'm sorry, I always -- I'm a big culture -- you know, within my own company, and I just feel like the culture is more like it always has to be, like, hard or difficult or just, like, frustrating kind of a thing.

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But you get what you want. But, you know, in the end you get it for your patient. So...

BY MS. POSNER:

Q. But it takes more time?

A. It could take more time, it could be more headache, it could be -- you know, it's just -- again, it's like -- it's like having a meeting and stating all the things Ability does and how we do them, and it's just kind of like -- it's like we don't -- like we don't fit.

Q. With Ottobock?

A. Yeah. It's like we just don't -- we fit because there's products that we like, but to do beyond that, it's -- it has to be -- it's like both sides have to just, like, put their heads down and just get it done if we're going to interact beyond that, beyond just transactionally.

Q. Can you compare the relationship that Freedom has with -- that Ability has with Freedom to the relationship that Ability has with Ottobock in terms of this culture that you're referring to?

A. Yeah, I think it's more -- it's probably more entrepreneurial or more progressive for -- it's similar to the relationship that we have with Ossur, which is -- it's just easier to -- it's easier to

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operate and execute kind of the mission of Ability with those two companies versus Bock.

But, again, it's not that Bock -- it's not that Bock looks at me and goes, You're crazy, man. Where you -- you know, You don't fabricate, or, You're doing outcomes? Why are you doing outcomes?

So I guess, for the record, it's not a -- Bock and Ability don't go out of their way to, like, butt heads. It's more that we just -- if you're kind of given the choice, it's like, well, you know, if Ottobock were in town and they called me to go to dinner, I'd go to dinner. That's what I mean. Like, it's not -- so it's not like you go out of your way to not have a relationship. But, yeah.

And we're a lot closer in the last five years because there was a sales rep, who's still there, who called me five, six years ago and was basically like, Look, we don't do a ton of business with Ability and we'd love to do more business. Let's sit down and tell me every single thing that -- you know, that you -- that you would like to see change or different or whatever, and let's go from there.

And from that point, we had an Ottobock relationship. So... But it's -- but it's not the same as, you know, some of the others.

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Q. Including Ability's relationship with Freedom.
A. Correct.
Q. Do you have any concerns that Ottobock's purchase of Freedom might change the culture at Freedom?
A. It's -- that's hard to answer. I mean, very little, actually. Because to some degree, I think that there's North American operational cultural things that Ottobock can learn from Freedom's successes in the U.S. Not that Ottobock hasn't been successful in the U.S., because they have.
But I think that -- I think that there could be learning going on from transfer of knowledge, not like necessarily technical knowledge, but just the social part of doing business with P&O practices that, you know, Freedom has shown that their interaction and I think their relationships are all really good.
So, yes, the thought process in my mind, is this going to become an Ottobock company, or is it going to become sort of a help to Ottobock to be less of some of the things that their customers might be critical of them about?
Q. Before you told us that Ability is
[redacted]

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A. Correct. Yes.
[redacted]
A. Right.
Q. Do you have any concerns that the price of the Plié or the C-Leg or both will increase once Ottobock purchases Freedom?
A. Yes.
Q. What are those concerns?
A. That the prices would start going back up.
Q. Why do you think that it's possible that the prices would go back up for the microprocessor knees?
A. Well, I mean, if they chose to raise the -- excuse me. If they chose to just start raising the prices, you know, I would be -- I would be susceptible to that, which would, in turn, lower my margins.
And, you know, we -- we've seen these
[redacted]
of progress to get, you know, what I think is a more appropriate margin for those products, having been out almost 20 years.
You know, I think that these pricing

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levels are reaching where they should be for that technology in my knowledge of how field works and, you know, having a front row seat to these types of reports and budgeting and things. Yeah, I would absolutely be concerned that they would go up.
Q. You mentioned before that you've seen innovation as a result of Ottobock and Freedom working on their microprocessor knees; is that right?
A. Uh-huh. Yes.
That's pretty good to get that far.
Q. You made it to 11:35.
Do you have any concerns that Ottobock's purchase of Freedom might slow the rate of innovation of microprocessor prosthetic knees?
A. Again, has the thought crossed my mind? Yes. But it's -- I mean, it's speculative. But I -- but without knowing -- you know, again, without knowing what the -- what Bock's combined Freedom mission is to do with this technology, it -- it may be perfectly great and it may speed it up. I don't know.
But, yeah, it's crossed my mind, like, wow, is it just going to be -- are we just kind of
[redacted]
Like, if we could fast-forward three

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years from now, will it just be whatever the last iteration of the Freedom/Ottobock iterations were, does that just become the knee, and three years from
[redacted]
be -- not be a good thing, necessarily.
But I think there's other factors, too. I mean, we just -- we don't know where -- we don't know where fee for value is going. We don't -- I mean, in some ways it's hard to sort of extrapolate that in a vacuum and say.
Q. Do you have any other concerns regarding Ottobock's purchase of Freedom?
A. I don't think so.
MS. POSNER: I'm going to reserve the rest of my 30 minutes, and we can go off the record.
(A recess was taken from 11:37 a.m. to 11:52 a.m.)
EXAMINATION
BY MR. CASEY:
Q. Mr. Brandt, I wanted to follow up on some of the questions you were asked this morning.
First, on the -- I believe you testified
[redacted]

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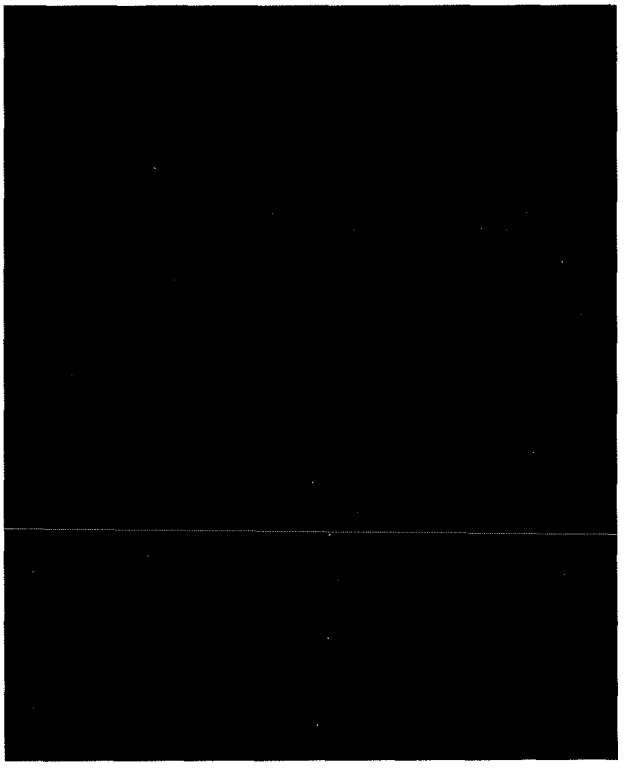

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Q. And what is ABC again?
A. Oh, yeah, it's American Board for Certification. American Board for Certification.
Q. And what does that board do? Do they certify prosthetists?
A. Correct.
Q. Nationwide?
A. Yes.
Q. And what does your ABC certification allow you to do?
A. It allows me to treat patients and provide artificial limbs and braces in those states that don't require licensure.
And in the states that do require licensure -- and I don't know the idiosyncrasies of all those bills -- but in many of those you have to have an ABC certification or what's called a BOC certification, which is, I believe, Board of Certification, which was kind of like a competing entity at one point to provide certifications or governance over this field. You have to have ABC or BOC to apply for your licensure.

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Q. And do you have a BOC certification?
A. I don't.
Q. And Ability operates clinics in Pennsylvania, Maryland, and North Carolina; correct?
A. That's correct.
Q. Do North Carolina and Maryland require certified prosthetist licensure?
A. They do not.
Q. And so what would you need to do to practice prosthetics in Maryland or North Carolina?
A. Just maintain my ABC certification, and then actually be based or -- I don't know if the word is based, but be tied to an office practicing in that state.
So, in other words, with the payors at Medicare, you would have to update your standing with them that they knew that you're in this office. Right. So that's all you would have to do.
Q. And do you have any plans to seek licensure in North Carolina or Maryland?
A. Well, there's no licensure in those two states, so, no, I don't have --
Q. I'm sorry.
A. Yeah.
Q. Okay.

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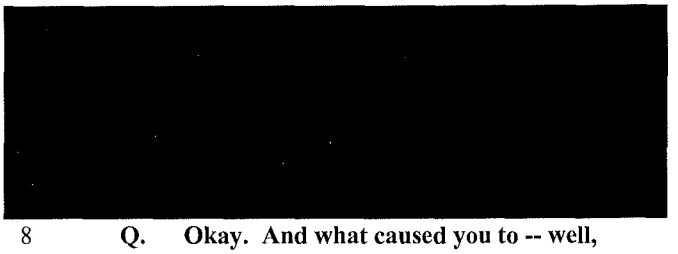

Q. Okay. And what caused you to -- well, strike that.
Do you remember the month and the year that you made this change from seeing patients to not seeing patients?
A. No. 2012, I -- yeah, I mean, I don't -- I'd have to go back and look at exactly when that -- yeah.
Q. I thought you said it was roughly three years ago, which would be 2015.
Do you think it was further back than that?
A. No, no. I think I said earlier that it was, like, 2012 or '13. But three years ago was when I approximated the licensure came in.
Q. Oh, I see.
A. Yeah. So -- yeah, so it's been about six that I've been out of patient care to get -- you

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know, I'd have to go research to get the exact sort of -- it's one of those things that in a growing practice, it's probably more of an evolution over a few months than it would have been just like, boom, tomorrow I'm not seeing patients anymore.

Q. Right.

So around 2012 is when you stopped seeing patients.

A. Correct.

Q. And what was the reason for you in 2012 to stop seeing patients?

A. Just the business was growing and, you know, I wasn't going to, you know, allocate time to patient care when there were other aspects of the business that I was choosing to, you know, head up and be a part of, yeah.

Q. And what were those aspects of the business that you wanted to focus on?

A. Hiring practitioners, opening new offices, understanding the financials more in-depth, putting some visibility to our budgeting and planning.

Q. So is it fair to say that you took on more of a business role in the company?

A. Yes.

Q. Okay. And, by the way, what percentage

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[redacted]

Q. Okay. And the other owners of the company are who?

A. Well, I can name a couple that work on the executive team, but I'd have to get you a cap table because there are shareholders that I don't -- I'm not familiar with. So...

Q. And who are the ones on the executive team that are part owner?

A. Right. So Jeffrey Quelet, Q-u-e-l-e-t.

Q. Do you know his percentage of ownership?

[redacted]

Q. Okay.

A. Clay Barrow, B-a-r-r-o-w. He's around [redacted] information officer.

Kathleen DeLawrence, she's our COO. I [redacted]

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We have me.

Stephanie Greene, who's our chief compliance officer. I'm not sure if it's vested or [redacted]

And then the rest is a lot of other shareholders that were the result of a merger that was done in January of 2011, and that company that we merged with had shareholders or investors, so they came along.

[redacted]

But, again, those are all nonemployee shareholders.

Q. Right.

And what was the company that you merged with in 2011?

A. It was called BridgePoint Medical.

Q. What business was BridgePoint Medical in before the merger?

A. Prosthetics and orthotics.

Q. Did they own clinics?

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A. Yes.

Q. And Mr. Quelet is the CFO?

A. Quelet.

Q. Quelet.

A. No, Mr. Brady is the CFO.

Q. Mr. Brady.

And what is Mr. Quelet's position?

A. He's chief manufacturing officer. I'm not -- I think that's what it is. I'm sorry. Or chief clinical officer.

Q. Okay. And these names you've given me -- Mr. Brady, Mr. Quelet, Mr. Barrow, Ms. DeLawrence, and Ms. Greene and yourself -- is that the entire executive team?

A. Yes.

Q. Okay. And are all of these members of the executive team based in Exton?

A. No, they're not.

Q. Can you tell me who's where?

A. Myself, Mark, and Kathleen are all based in Exton.

And Clay is based in Westminster, Maryland, comes to Exton as needed, a couple times a month.

And then Jeff Quelet is based in

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Hagerstown, spends a lot of his time in the state of Maryland overseeing those three offices. Also comes to Exton as needed.

And then Stephanie Greene resides in Ohio, actually Malvern, Ohio, which the only reason I know that is because of Malvern, PA. So Malvern, Ohio, she's remote. The same thing, comes to Exton as needed.

Q. And does the executive team meet regularly?

A. Yes.

Q. How often do you meet?

A. So we meet by phone every Tuesday for about two hours, and then other than that, me, Kathleen, and Mark are together at least three out of the five days a week we're in Exton.

Q. And what does Mark's job as CFO entail?

A. He's responsible for the financials, the accounting. He has a controller that works under him, and then a couple of accounting types. Forgive me for not -- but, yeah, there's a couple people. Payables, receivables --

Q. Right.

A. -- things like that. Very typical CFO functions.

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Q. Okay. And do you have meetings with Mr. Brady one-on-one?

A. Not especially, no.

Q. You see him around the office since you're there?

A. Yeah, I mean, we're -- it's like a constant state of exchange that way. I mean, we may -- you know, we may go at most five days without speaking. That would be extreme. But, yeah.

Q. But is it fair to say he's an important part of your executive leadership team?

A. Absolutely, yes.

Q. You said you're a for-profit entity. I guess that's obvious because you have profit figures on the spreadsheet here.

To what extent does the gross margin play a factor or play a role in deciding what products you sell or what products you put on patients?

A. Right. It definitely plays a factor, but it's not the primary factor. So we teach and encourage and recommend that you make the decision for the clinical reasons. And the clinical reasons, if that results in a lower margin on a case, that that's completely fine, that that's an accepted part of being in this profession, this industry.

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And just be aware, right. Just -- I mean, the knowledge is three -- you know, half the -- half of the -- you know, half of it is just understanding where you are with that and being aware of it. And if it's lower, it's lower. Okay.

Q. By "where you are with that," you mean where you are with the gross margin?

A. With the margin, right.

Q. And you look at gross margin on a -- I think you called it a case? Is that the way you refer to it? You look at each --

A. Correct.

Q. So each of the line items in the rows of the Exhibit 1, you would consider that -- each of those a case.

A. Correct.

Q. Okay. And -- so it's not just the microprocessor knee that is reflected in those totals, it's the entire prosthesis; is that correct?

A. Correct. That's correct, yes.

To clarify that, this gross -- excuse me -- this Gross Margin column, that is the GM of the entire case, not just the gross margin of the knee reimbursement. Right.

Q. I understand.

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A. Okay.

Q. And so each of those horizontal rows represents one patient?

A. Right.

Q. The outcome for one -- the prosthesis for one patient?

A. Right. That's correct.

Q. When you decided in 2012 to step back from seeing patients and to focus more on the business of running the company, were there any other factors other than the fact that the company was growing that caused you to do that?

A. No. I mean, just plans to grow and -- yeah, I mean, we had merged -- so we had merged in January of 2011. I had the guy that -- the guy that owned the company that we merged with -- yeah, the guy that owned the company that we merged with -- I appointed him CEO. And I was the COO.

And then in March of 2013, so just into 2013, so you -- yeah. Merging with another company and having a CEO, me being the COO was really the big impetus of not being in patient care, right. We just doubled in size and, okay, I'm not seeing patients anymore.

So that gentleman and myself ran the

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company until March of 2013. In March of twenty --

[redacted]

CEO at that point.

Q. And what was that CEO's name?

A. Clint McKinley, M-c -- just like the president, M-c-K-i-n-l-e-y.

[redacted]

So that was that.

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Q. And who made that decision?

A. I did, with the support of the board.

Q. Okay. So there was a board of directors at that point?

A. Uh-huh.

Q. You have to say yes or no.

A. I'm sorry, yes. I apologize.

Q. And how many members of the board of directors were there at that point in March of 2013?

A. So in March of 2013 there were three directors: myself, Clay Barrow, and Clint McKinley.

Q. So they were all inside directors?

A. Correct.

Q. Do you currently have a board of directors?

A. We do not. We -- go ahead.

Q. Well, you go ahead.

A. We do not. Let me rephrase that.

We have a board of directors. It's an inside board, back to being an executive level board at this point.

[redacted]

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[redacted]

Jeff welcomed to having a full-on board, and this person -- we'll introduce you to this person. We'll introduce you to this person. We'll bring this person in, that -- whatever, and all of a sudden we have a board with outside members, so that was March of '13.

[redacted]

So with that we didn't disband the board. We weren't required to have an outside member board, but we kept it because we wanted to keep the cadence of having that and the discipline of that.

[redacted]

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[redacted]

So now it's myself, Clay, and Kathleen are the board, and, you know, the next -- the next iteration will be folks that we think can help us through this next phase of growth.

[redacted]

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[redacted]

Okay. Great.

Q. Just going back to the merger --

A. Yeah.

Q. -- in January of 2011, how big was BridgePoint Medical at that point? How many clinics did they have?

A. So they had three offices and a satellite. One in Charlotte, one in Asheville, both in North Carolina; one in Lexington, Kentucky; and a satellite in Morehead, Kentucky. And the size was probably maybe 3 million, 2.5 million in top line revenue.

Q. And do you know how many certified prosthetists they had at that point?

A. I don't recall, but maybe three.

Q. Do you remember how many certified prosthetists Ability had at that point?

A. I don't.

Q. Do you remember --

A. I mean -- four or five.

Q. Do you remember what your revenues were in January of 2011?

A. I don't specifically, but I do remember

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that the merger was essentially equal in size, so also

[redacted]

Q. Okay.

A. I think we were a little bit bigger than them at the time.

Q. And just so I'm clear, when you did the merger in January of 2011, did you immediately become the COO at that point?

A. Yes.

Q. Okay. So from January of 2011 forward, were you seeing any patients?

A. I think occasionally I was. I'd step in a room and offer, you know, insider guidance or -- you know, but I don't -- I don't remember specifically being lead, necessarily, like, Hey, I'm your prosthetist. Hi. You'll be working with me.

Q. But you were doing the COO functions as well; correct?

A. Correct.

Q. And -- so you testified that around 2012 you completely stopped seeing patients; right?

A. Right.

Q. So do you remember how long it was that you were occasionally seeing patients until you

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completely stopped?

A. Yeah, probably since -- probably from the merger -- from the merger and probably even before, or of course before, but -- the merger was in January of 2011. Probably by -- certainly by March of '13 when I went into full-on CEO mode.

So, again, occasionally during the time of Clint and I being together, I definitely saw some patients, but beyond that, no.

Q. And --

A. Beyond March of '13 -- sorry -- just to clarify.

Q. Right. I understood.

[redacted]

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[redacted]

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[redacted]

Q. So just going back to Exhibit 1, Brandt-1, if you look at the Gross Margin column -- and that's the shaded column --

A. Right.

[redacted]

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correct?

A. Yes.

[redacted]

for a knee?

A. 2008, maybe. Going back ten years.

Q. So it's before the merger?

A. Yes.

Q. So since the merger, has the gross margin been the same as shown here or is it -- has it increased over those years?

[redacted]

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[redacted]

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[redacted]

Q. And you went from a combined about eight total prosthetists back in 2011 to --

A. 18 or 19.

Q. 18?

A. Yes, that's about right.

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Q. And, again, about double?
A. Uh-huh.
Q. You have to say yes or no.
A. Yes. I'm sorry.
Q. And do you remember what the gross margin figures were when you were COO?
A. I don't.
Q. Do you have a ballpark?
A. I know they were lower than this.
Q. I'm talking about on the microprocessor knees.
A. Oh, okay. They were lower.
Q. Do you know how much lower? Do you recall?
A. I don't recall.
Q. Okay. This morning you testified that you went from having -- I thought you testified you went from having 21 direct reports to having fewer than that.
Do you remember that testimony?
A. Yes.
Q. So when did that change take place?
A. It's been occurring over the past three years. So when we brought on -- we brought on Kathleen DeLawrence, the COO -- I can't remember if

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it's three years or four years now -- but in the last three years, with Stephanie Greene having come on a year ago, roughly, Mark was -- the CFO, was involved with the company since the mezzanine group inserted him back in March of '13. He was -- he was part time with the company, but a year ago we brought him on full time.
And so, yeah, I would say over the last three years the direct report numbers have shifted and changed.
Q. And how many direct reports do you have now?
A. Just two, Kathleen and Mark.
Q. Who prepares the figures in Brandt Exhibit 1?
A. Who prepared this actual -- this actual report or these -- or -- I mean, this has come out of OPIE, the software system, but the assemblance of it in this fashion was done by either Clay Barrow or Mark Brady.
Q. Are there regular reports like this that you get?
A. Not regular in the sense that every Tuesday I see something like this. It's more of when the monthly financials are prepared and quarterly

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board reports that we still produce.
And then anything in the interim that would have some of this data would be -- possibly if we were having a meeting and reviewing the Exton office, we may see a more I'll call it granular, but I may see a more granular report on Exton, so we would talk about trends or spot, things like that.
Q. Do you have regional managers in the other offices other than Exton?
A. So we have what we call regional directors. So Eric Shoemaker is the regional director for Pennsylvania for the five in PA; Jeff Quelet is the regional director for Maryland, and he's also -- currently he's also managing the two North Carolina offices. I say managing, but director.
And then within the offices, the certified prosthetist, orthotist, in most of the offices there are two. We sometimes refer to them as managing practitioners, mostly because, you know, we encourage them to understand their office clinically but also as a business, even.
So, you know, it's -- I think that answers that.
Q. Yes, that does.
Are they separate profit centers, the

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regional offices?
MS. POSNER: Objection. Vague.
BY MR. CASEY:
Q. Do you understand what I mean by that?
A. No. If you could clarify.
Q. Let me ask it this way: Do you track the profitability of those offices?
A. Yes.
Q. And how do you do that?
A. Well, through a combination of OPIE and QuickBooks, because there's no financial component to OPIE, so we bridge it with -- there's a lot of dual entry, but we use QuickBooks and OPIE, and then track by office. Or class. Office, class, yes.
Q. When you say "there's no financial component to OPIE," what do you mean?
A. Well, not -- accounting, I should say.
Q. Okay.
A. There's no accounting component to OPIE. So it's not like within the software -- so to produce some of the things that we've produced over the years, we've had to extract information from OPIE and build it ourselves in QuickBooks, or we wouldn't be able to produce the data that we have.
Q. And was this Brandt Exhibit 1 generated

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in OPIE and produced for purposes of responding to the subpoena?
A. I'd have to clarify it, but I think, yes, that this is -- this information has come out of OPIE and QuickBooks, right.
Q. So you could do a query at any point and say, Give me all this data for a longer period of time than the last two years.
A. Correct.
Q. You testified earlier this morning that -- you testified about competition between Ottobock and Freedom Innovations.
Do you recall that testimony?
A. Yes.
Q. And when you were testifying about that competition, were you testifying based on your current knowledge or was that based on your knowledge when you were actually seeing patients back in 2012 and before?
A. Mostly current.
Q. And how did you acquire the knowledge about the competition between Ottobock and Freedom?
A. Just having been a part of the company for well beyond the -- I mean, I think almost for the entire life of Freedom, I think -- I don't know if they were formed in '05 or '03, but -- so we've

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essentially been around as long as they have.
So -- right. So just from my position in the company to -- and my interactions with both companies.
Q. But in terms of the period between 2012 when you stopped seeing patients and today --
A. Right. Right.
Q. -- can you just tell us, like, what --
A. Oh, I see.
Q. -- what information do you get about the competition between Freedom and Ottobock?
A. Right. So, you know, a lot of times -- for example, so we have practitioner meetings two or three times a year where we bring all the clinicians from Ability together in one place for a day or two.
And so throughout that three-years-or-so period, we certainly had Ottobock or Freedom or Ossur or -- you know. And not even just on the prosthetic side, sometimes orthotically, too, but we had presenters at those meetings that talk about, you know, or do a slide deck on that product or something.
So that's generally how I have maintained some level of aware- -- knowledge and awareness about the product.
But then just I think more informally to

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just a regional director, Eric or Jeff or somebody reporting up, to say, Oh, yeah, have you seen this?
And it's like, Oh, no, I haven't seen that. Tell me more about that.
I would also say my own reading. You know, I read the O&P Edge, I read the O&P Almanac, O&P Business News, but they just got acquired, so, you know, I try to read and keep up. Journal of Prosthetics and Orthotics. Whatever I can get my hands on to just...
Q. So I also thought you testified that you were not familiar with any versions of the Plié other than the Plié 1; is that correct?
A. Right. Well, clinically for me, Ability didn't have a lot of microprocessor candidates early on, so from like 2004, the start of the company, up until, I don't know, I think that Plié came out in '8, right, there weren't a lot of patients for me specifically to work with on the Plié from the period of when that would have come out to when I really sort of started to wane in seeing patients.
So we didn't have a -- we certainly weren't fitting this type of a volume. So -- so for me --
Q. When you say "this," you're referring to

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Exhibit 1?
A. Correct, referring to Exhibit 1.
If you were going to say in the 60 -- 60 MPK knees in two years, that number was a pipe dream certainly at that point in the life of the company.
So for me, really in the period of '08 to '11 or '12-ish, if and when I saw a microprocessor candidate, it was pretty much C-Leg for me because that's what I knew. You know, so I -- yeah.
Q. And when you were saying that --
A. So -- so more recent information that I would have -- would have garnered about these newer iterations is certainly more of a -- an observer status of saying, Oh, okay, well, Freedom has come out with this. Okay, well, Bock is coming out with this or -- okay. Okay.
What do people think about water resistance?
We love it. Patients love it.
Okay. What do you think about Bock's, you know, feature?
They love it.
Okay. Great.
Q. But you don't actually ask the people that work for you to get you a sample of it or to look

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at it or feel it or touch it or anything like that?
A. Not as much recently, again, because it's more Eric or Jeff doing that. It's not a -- it's not -- it's not a deliberate decision to say I don't want to see that.
Q. Right.
A. It's more of just because of the -- my position that I'm in, I just -- I don't spend a lot of time necessarily evaluating the products.
Q. So you rely on them to make those judgments?
A. Yes.
Q. So in '08 to '12 when you were seeing patients, roughly how many Pliés did you fit on patients?
A. Oh, I'm going to guess one or two. Again, it's limited.
Q. And you never fit a patient with a Plié 2?
A. Not that I can recall.
Q. You never fit a patient with a Plié 3?
A. No.
Q. "No" meaning you didn't?
A. No, I didn't, correct.
Q. Okay. Have you ever seen the Plié 3?

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A. Yes.
Q. When did you see the Plié 3?
A. I could see it tomorrow -- I mean, I could see it yesterday if I was in the Exton office and someone walked in and had one on.
I mean, so I don't -- I don't know how to answer that.
Q. You've seen it.
A. Yes.
Q. Okay. And you've seen the Ottobock products, the microprocessor knees; correct?
A. You asked me if I've seen them?
Q. Have you seen those?
A. Yes.
Q. Actually seen the --
A. Yes.
Q. -- products? Yes?
A. Yes.
Q. How about the Ossur product?
A. Yes, I have seen -- yes, I have seen the product.
Q. The Rheo?
A. Yes.
Q. And you've seen the Endolite product, the Orion?

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A. Yes.
Q. There was one part of your testimony I confess I didn't quite understand. You said that when you get feedback from clinicians about the products in the marketplace, you said you don't process that feedback as a clinician. I thought that's what you said.
Do you recall that --
A. Right.
Q. -- testimony?
Can you explain what you mean by that?
A. Sure.
So having to rely on other folks who are clinically in the trenches, quote/unquote, in the trenches every day, if they rattle off to me scenarios clinically that make -- that they think make one product better or a different product, you know, I process that as an executive, that that's a good thing that they're doing that and that that patient is getting the outcome and the result.
I'm not processing that as, like, a clinician where if you told me I had to see a patient tomorrow and that clinician was reporting to me all about the Plié or the C-Leg, I would be hearing that and, like, taking notes and, like, Oh, my gosh, I've

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got to put my clinician hat on tomorrow, which wouldn't happen now, but I'm just saying in a vacuum if you said to me You've got to see a patient at 4 o'clock today and then my -- and then Eric walked in and started telling me about the Plié, you better believe I'd be like, Okay, and then you turn this and you program this and you've got a phone app.
I think from an executive's perspective, I've tried to learn to process that as, like, he's giving me a really great report, ask the few questions that I have, and if we still have patients at the root of that, we're good.
And so that's what I meant by that is I have a different filter in now when I hear that. I'm not necessarily committing all of the idiosyncrasies that he or she told me about what's so great about that knee. That's what I -- that's -- to clarify, that's what I said or meant.
Q. So is it -- I'm sorry?
A. That's what I meant.
Q. Yes.
Is it fair to say that the information you get on the microprocessor knees in the market comes from clinicians anecdotally?
MS. POSNER: Objection.

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THE WITNESS: I think that there's some information that's anecdotal that's of value. I mean, I think people saying that -- you know, if someone tries a Plié and the patient just doesn't like how it feels, well, every other variable might say Plié, but they didn't like how it felt. Okay. No Plié; right? I mean, so that's anecdotal.

But with Brian Kaluf, who we spoke -- I spoke of earlier, you know, that's a lot of what Brian has done -- been able to do is, okay, there's feedback, right, but we need to quantify and qualify it so that we can educate people through those.

Like, you know, a patient may say, I don't like the C-Leg, or, I don't like the Plié. And then for us to be able to say, Well, are you feeling X? And they say, Yeah. And we say, Oh, yes, let's address that. We've heard that from 30 other profiles that wear that knee. And around the fifth week they say that that's subsided.

Great.

So that's kind of what I mean about, like, more evidence-based approach and being able to educate folks. Because people don't always, you know -- patients come in and say, Oh, my neighbor has a C-Leg, or, My neighbor has a Plié.

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It's like, Well, okay.

Impossible to bring your neighbor to the appointment, but --

BY MR. CASEY:

Q. Right.

A. -- there's those factors.

So, anyway, to have Brian to be able to put a little more -- what I have always said is if we're going to grow the practice and come up with, you know, more standardized ways to practice and evaluate folks in this industry, we have to remove ourselves to some degree as practitioners about what's -- what we like to use, right.

Because it's -- while it might be great if we have familiarity with a product, just because we don't have familiarity doesn't mean it's not a good product for the patient.

So that's what Brian has helped, I think, move that along a little more to be more just, Here's the data. Let's pick a knee now.

Q. Right.

But because you're not seeing patients and the clinicians are, you rely upon them to --

A. Correct.

Q. -- determine what the patient really wants and you try to accommodate that; correct?

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A. That is correct.

Q. And in terms of clinical education, you give that to Brian Kaluf.

A. Brian, it could be anybody else in the company who maybe they did a case study or something.

And so we have brown bag calls every other Wednesday, where we get all the clinicians on a conference call every other Wednesday. And sometimes during those calls, you know, somebody's presenting something around a product.

So I just -- I don't want to say it's just Brian. You know, there are people that spoke at AOPA and the academy -- association and academy meetings the last few years that have done papers, that are Ability employees, on different products or different protocols type things.

So we're learning from each other for sure. But I'm just saying Brian in terms of having a handle on everything that's going on in education at Ability.

Q. And do you present at conferences about the qualities of various MPKs in the market?

A. No.

Q. Have you ever?

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A. I don't believe.

Q. And just along that same line, you testified this morning that there were two MPKs -- what I have in my notes -- and you can correct me if this is not accurate -- there are two MPKs that have the best quality, durability, service, time in the marketplace, performance. And by service you meant maintenance.

And I'm combining a few of your answers in there, but is that a fair characterization of your testimony?

A. That's fair. Except what I would add to that that I think I added later after reviewing this again was that, yes, there -- there's also Rheo is in that, to be more exact.

Q. So you would say -- amend your testimony to say there are actually three MPKs that have those qualities?

A. I'm not as familiar with the Rheo XC. I know that it's fairly new, and so I think some of those, the company's reputation is okay, but I don't know yet about durability or -- you know, I -- maybe some of that I don't know yet about Rheo, so I don't know that I could throw that in there. But...

Q. Okay. But in the last two years you

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purchased 11 Rheos; correct?
A. Correct.
Q. Which was just five less than the Pliés that you purchased; right?
A. That's correct.
Q. And when you gave that answer, and as -- as amended or as you added to it just now, are you basing that knowledge on what you learned as a clinician back 2012 and prior to that, or are you basing it on your current knowledge of the marketplace?
A. I'm basing it on my current knowledge of the marketplace, that if we've done 11 Rheo XCs in the last two years, that were probably -- there's probably something about the Rheo that I can trust in that process of the clinical evaluation that folks are saying, Hey, this knee has a place.
Q. Okay. And I think you also testified that -- again talking about the two, the Plié and the C-Leg, that both do what they say they do?
Do you remember that testimony?
A. Yes.
Q. Would you include the Rheo also in that category as a product that does what Ossur says it does?

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A. With the exception of my direct -- my -- again, I'm learning about the Rheo XC from the system, so to speak --
Q. Right.
A. -- not from my personal experience. So, again, and I have the most experience with a C-Leg, next the Plié, I have one or two, and then --
Q. Right.
A. It's a beautiful picture; right?
Q. And in terms of your familiarity with the C-Leg as a clinician, what version of the C-Leg were you fitting on patients back in 2012 and prior?
A. I don't even know. I don't know. I guess it would have been the 1 or the 2. I'm not even sure --
Q. Okay.
A. -- when they came out with the 2, but I feel like the 1 went -- maybe eight or nine years for the 1. I'm not sure.
But I know I fit, like -- you know, I fit my first C-Leg ever in 2001 at Lawall in Wilmington, Delaware, for the company, for the Lawall company. It was the first C-Leg.
I flew to Minneapolis, took the course, bought the laptop, all that, you know, so...

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Yeah, so that was my -- pretty much my experience was probably C-Leg 1, but if you told me, Oh, C-Leg 2 came out in '03, then I'd say, Yeah, I probably -- I probably fit a few C-Leg 2s, but I just -- I don't -- yeah.
Q. You don't --
A. In the heat of growing a company and --
Q. Right.
A. -- I just -- it's like I don't remember where the cutoffs were. In the moment I remembered -- probably remembered those cutoffs or, like, anticipating the C-Leg 2 kind of thing, but I don't -- yeah.
Q. Do you know what the current version of the C-Leg that's currently being sold by Ottobock is?
A. I believe it's the 4.
Q. Okay. But you never fit a patient with the C-Leg 4; correct?
A. That is correct.
Q. Is it fair to say you never fit a patient with a C-Leg 3?
A. I don't think I did. I don't think so. I think that's fair.
Q. And you think you may have fitted a patient with a C-Leg 2; you're not sure.

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A. I just would have to know when it switched over.
MR. CASEY: It's about 12:50. Do we want to break for lunch now?
(Discussion off the record.)
(A luncheon recess was taken from 12:50 p.m. to 1:36 p.m.)
MR. CASEY: We're back on the record.
BY MR. CASEY:
Q. Mr. Brandt, I'm going to show you a document that I'm going to mark as Exhibit Brandt-2.
(Exhibit Brandt-2 was marked for identification.)
BY MR. CASEY:
Q. If you could just take a look at what's been marked as Brandt Exhibit 2, and when you have a minute to -- or as much time as you need to familiarize yourself with this, let me know if you know what it is.
A. (Witness reviews document.) Yes, I do.
Q. So do you recognize Brandt-2?
A. Yes.
Q. And what is it?
A. It's a subpoena for deposition with a list of, I believe, 22 questions followed by some

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definitions. Yes.
Q. You've seen this before?
A. Yes.
Q. On the second page of the exhibit where you see the case caption In The Matter of Ottobock Healthcare North America, Inc., A corporation, do you see that?
A. Yes.
Q. It says in the first full paragraph, "Respondent Counsel will take the deposition of the company or its designee or designees who shall testify on behalf of the Company about matters known or reasonably available to the company."
Do you see that?
A. Yes.
Q. So is it your understanding that you are the corporate designee of Ability for purposes of today's deposition?
A. Yes.
Q. So you are testifying on behalf of the company Ability; correct?
A. Yes.
Q. And the topics listed there on pages -- the first page of the page I was just referencing and then numbered pages 2 and 3 list 22 topics.

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Do you see those?
A. Yes.
Q. And did you review those topics before today?
A. Yes.
Q. Did you discuss those topics with anybody at Ability?
A. Only in the -- only related to the documentations that we produced. Only as it relates to pulling this information.
Q. And by "this information," you mean the information --
A. I'm sorry.
Q. -- that was called for by the document subpoena?
A. Correct.
Q. Okay. So apart from the pulling the documents together and discussing those matters internally at Ability, you didn't have any discussions with anybody about these topics; correct?
A. Correct. Only with counsel.
Q. Okay. I don't want to know about those.
A. Okay.
Q. I'm going to show you another exhibit that looks like that exhibit. And this I will mark as

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Exhibit Brandt-3.
(Exhibit Brandt-3 was marked for identification.)
THE WITNESS: Thank you.
BY MR. CASEY:
Q. And when you've had a chance to review the exhibit we've marked as Brandt-3, please let me know if you recognize it.
A. (Witness reviews document.) Yes, I recognize it.
Q. And what is the document marked Brandt-3?
A. It is a subpoena. Also -- or I shouldn't say also. It's a subpoena. It's listing, I think, 12 deposition topics, also followed by definitions, and instructions, yes.
Q. And you've seen Exhibit Brandt-3 before.
A. Yes.
Q. Apart from any discussions you had with your counsel, can you tell me who within Ability you spoke to about responding to Exhibit 3, the subpoena?
A. Yes. To produce these documents, meaning the -- in the document request, Clay Barrow, Mark Brady, Kathleen DeLawrence, Stephanie Greene.
Q. Anybody else?

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A. No.
Q. And who actually searched for the documents?
A. I believe Clay Barrow.
Q. And what was the role of the other three in -- that you mentioned in producing the documents?
A. Well, Stephanie, certainly just understanding the nature of the request and the scope of the document.
And then Clay to actually do the little part of querying the data.
And Mark's involvement in one way or another is in terms of just, like, under -- you know, almost like a participant with Clay in doing that to just, like, vouch that, okay, that is what it is, or we're seeing what we're seeing here, it's accurate, it's right, that kind of a thing.
And, Kathleen, nothing more than just being informed -- nothing beyond being informed of the subpoena and the contents within them. She wasn't involved in any document retrieval or data retrieval.
Q. And did you review the documents that Clay Barrow produced in searching, after he searched?
A. Yes, with counsel.
Q. Mr. Brandt, you testified that you are

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on the AOPA board; is that correct?
A. Correct.
Q. What is AOPA?
A. The American Orthotic Prosthetic Association.
Q. And how long have you been a member of that board?
A. Since December 1, 2017.
Q. Okay. Prior to being a board member, were you a member of AOPA?
A. Yes.
Q. And how long were you a member of AOPA before that?
A. Well, your facilities -- excuse me -- your facilities are -- it's a -- it's a company -- I'm trying to say company -- it's a company membership. So for a long time. Years.
Q. Back to 2004?
A. Correct, or shortly thereafter.
Q. And what's the purpose of AOPA?
A. It's an industry association. So they -- in large part, they take part in legislative governmental issues, interactions with payors, VA, L-Code -- coding issues, by and large.
Q. And are all the O&P clinics in the U.S.

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members of AOPA?
A. No, they are not.
Q. Do you know which ones are?
A. No. I'd have to get a list.
Q. Okay. There's more than -- more than a few? There's --
A. Oh, yes.
Q. Okay. Are there also other industry participants in AOPA, manufacturers or --
A. Yes.
Q. Okay. So manufacturers of prosthetic knees would be members of AOPA as well?
A. That is correct.
Q. So who's on the AOPA board other than yourself?
A. So I can attempt to list names, but I'm probably not going to get everybody --
Q. Well, how many --
A. -- because I just joined.
Q. -- how many are there?
A. Oh, I think, like, 15 board members.
Q. Okay. Well, you don't have to list them all, but you can tell me, are they O&P clinics or are they manufacturers, or what part of the industry do they represent?

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A. Oh, the makeup.
So some of them are CEOs of manufacturers or -- and/or presidents, leaders of those companies. Some are involved in patient care like myself. Excuse me. And -- I'm trying to think -- some are in research.
I think that's it.
Q. And how many --
A. Largely -- mostly manufacturers.
Q. Okay. Are all the major MPK manufacturers on the board -- on the board?
A. So Ottobock has representation, two people. Ossur has one member, one director. And I'd have to -- I'd have to double-check if the former CEO of Hanger -- Hanger -- of Freedom is on there or not. I can't recall.
Q. Okay.
A. I feel like he was and might not be now, or I -- yeah.
Q. Okay. Anyone from Endolite on the board?
A. I don't think so.
Q. Any other --
A. I'm not -- again, I'm not sure.
I'm sorry. What was the --

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Q. Did you have more follow-up?
A. No.
Q. Any other MPK manufacturers represented on the board that you can think of?
A. I don't -- I don't think so, unless -- I don't know if there's someone from Fillauer on the board, but I don't know if they're -- I don't -- I don't know if Fillauer has any or not, microprocessor knee.
Q. What about -- I'm sorry. Were you finished?
A. I'm just -- for me, I'm just trying to recall -- I'm just -- it's more of a wanting to be able to recall the members of the board for you.
Q. That's fine.
A. Okay.
Q. This isn't a memory test.
A. I know. Thank you.
Q. And in terms of the prosthetic clinics, who other than Ability is represented on the board?
A. I'm sorry. Say that again.
Q. I'm sorry. Who other than Ability is represented on the board in terms of -- in the prosthetic clinic space?
A. Right. So Scheck & Siress, which is a

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Chicago-based patient care company, is represented on the board.

There is a company from I believe it's Minnesota. Her name is Teri Kuffel or Kleffel (phonetic) -- Kuffel, Teri Kuffel. She and her husband own a company that is patient care, and she's on the board.

I'm just -- I'm trying to think. I feel like there's another patient care company, but I can't recall right now.

Q. That's fine.

Is anybody from Hanger on the board?

A. Yes.

Q. How many people from Hanger are on the board?

A. I believe just one.

Q. And what is Hanger?

A. What is Hanger?

Hanger is a very large patient care company that provides patient care, just -- I mean, in many respects they do the same thing as other patient care providers. They're just much larger. They're a national firm or practice.

Q. Are there any distributors of prosthetic products represented on the board?

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A. Yes.

Q. Do you remember which ones they are?

A. Cascade is on the board, or the company name is Cascade.

And I don't know if -- again, if Fillauer is -- they're not a distributor.

Tuttle is not on the board.

I don't know if SPS -- SPS is Hanger's distributorship, but I don't think they have representation on the board.

And I think that's it, yes.

Q. And how were you selected for the board?

A. For me, you have to be elected -- put on the ballot for -- to be nominated. And as far as I know, that process was Mike Oros and Jim Weber. Jim Weber is the current president. Mike Oros is the immediate post past is how I think it's said.

And those guys called me in a year or so ago and said, Would you consider, you know, serving a three-year term? And I said, Okay, I'll consider that.

So that's how.

Q. Yes.

And so you -- then it was, you were actually elected?

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A. Right.

Q. By -- who votes?

A. I believe it's AOPA membership. It's a ballot.

Q. And so what are your duties as a board member?

A. So there's, I believe, three board meetings a year, and there's also -- not Steering Committees, but different committees within AOPA that they ask you to participate on or take part in being, you know, constructive to those committees.

And so I'm on -- I'm on a Compensation Survey Committee, a Business Survey Committee that AOPA puts out, so I'm on that committee.

And then I'm also on the Business Content Committee for the national assembly that's held every fall, which helps -- that committee helps to determine the presentations that are going to make the conference, you know, who the presenters are that we're going to select to come and talk.

Q. Have you had any meetings so far?

A. We've had one in January, and there's another one in June.

Q. Did you attend the one in January?

A. Yes, I did.

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Q. Did you make any presentations at the meeting in January?

A. I did not.

Q. What does the Compensation Committee do?

A. Well, it's actually a -- it's a Business Survey Committee. And AOPA every year sends out a survey to members. And the practices fill out and answer the questions in the survey.

And then there's an outside firm that AOPA uses to help, you know, assimilate, aggregate all the feedback. And then they produce a -- they produce a report that shows you as a company where you fit in against different metrics across the respondents that participated in it.

So my role on that committee is budding at this point. It's like, okay, well, I have to do an introductory call in a couple weeks and, you know, kind of assemble the rest of the committee and say, Okay, here's the survey. Do we want to change any of the questions this year? It's just kind of a --

And then -- and then really just, you know, lead the committee on, you know, how do we get more people to respond to it?

It's a very time-consuming survey. Not a lot of companies have the staffing resources to

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complete the survey accurately and things like that, or just complete it, period.

So -- yeah, so things of that nature.

Q. Have you answered surveys like that in the past?

A. Yes.

Q. And what type of information do they ask on the survey?

A. They ask, you know, like how many offices, how many CPOs do you employ? Do you employ any technicians, fitters? Do you -- what kind of benefits do you offer? Do you pay for health insurance for the employee or for the employee's family?

It's just kind of a wide range of just operational-type questions.

Q. There are no financial metrics that are asked about?

A. There are. I mean, like, top-line revenue. I don't know if they ask you about gross margin or expenses or how they -- I feel like they ask about that stuff, but it's not -- it's not teased out in as much detail as a company would have on its P&L ledger. It's more clumped in a group where you just say, What are you spending on benefits? Here's a

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number, right, versus your entire G&A line or whatever.

Q. And then what happens after the survey responses come back?

A. Well, so I'm just learning this, so I don't really know yet, but there's a -- there's a guy on the call -- that was on the call that his firm then just assimilates the data and produces the report, so, yeah.

Q. Have you seen such reports in the past?

A. Just one. Ability participated last year, so I've seen one report.

Q. When was that?

A. Our own.

Q. Pardon?

A. Our own.

Q. Okay.

A. We filled it out last year --

Q. Right.

A. As an AOPA member, we participated in it.

Q. Right.

A. And then maybe October or November or September, I'm not sure, but last fall we then received the report that put Ability against other

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companies similar in size so that you can almost, like, you know, where do you kind of rank or -- yeah.

Q. Was it useful?

A. It's useful, yes. It's useful. I think it needs work.

That's one thing that I'm excited about is being able to tap some new folks and bring some new people onto the committee so that we're not just, you know, Oh, yeah, it's survey time. Send out the survey.

I think there -- I think there's things on there that maybe aren't as relevant to practice today that might have been important to people 20 years ago, 25 years ago.

So, sure, I'd love to, you know, work towards changing it a little bit and make sure we're capturing what AOPA members want.

Q. And what's that? What do AOPA members want?

A. Well, I, in being on a committee, feel like we should be collecting some sort of outcomes data.

So is your company using outcomes? for one, right. Yes or no.

If you are, what outcome measures are

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you using? things like that.

Q. By "outcomes," you mean patient outcomes?

A. Correct.

Q. Did you find any of the financial information that was produced in the survey useful?

A. Yes. I mean, the -- like, for instance,

[redacted]

So that -- that -- yes, that's useful to know that we thought we were high and we are high, and that's okay.

Or, you know, like, that at least now we don't just think we're high, we know we're high and we can either -- whatever we do with that information, we do with it; right?

So -- but, yes, so to understand a benchmark is very helpful.

Q. What about, like, revenue benchmarks of your peer companies; is that something that you find useful?

A. I mean, to know out of the respondents

[redacted]

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So at least we're in that pool for comparisons of other line items. So that's useful.

But revenue number is not like tracking us against our neighbor, like, Oh, you beat him last year, you beat her, she beat him. There's none of that. So it's de-identified.

Q. Do you remember how Ability stacked up in terms of revenue vis-a-vis your peers based on last year's survey report?

A. Well -- so when you say -- they're not really rating us against, like, how well we did against -- it would be more like revenue per practitioner or revenue per employee.

So, again, like if it was -- you know, if we have -- if our revenue per practitioner is $750,000, right, and the other six companies, or five or four, whatever, in our group were 450 per practitioner, well, then, yes, I can see that.

And -- so the things that I -- the things that we could compare, we stacked up, I think, very favorably in terms of just being efficient.

Q. What metrics are you referring to there?

A. The -- like, the revenue per practitioner and the revenue per employee.

Q. And there's no --

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A. Specifically.

Q. There's no profitability data on there?

A. There is profitability data. Thank you.

Q. And so how did Ability compare with the peer firms in profitability?

[redacted]

Q. And as CEO, is there anything you do in response to learning that relative position on profitability with your peers?

A. Any -- rephrase that, if you could.

Q. As the CEO, is there anything that you do after you get the information on where Ability falls vis-a-vis your peers on profitability?

A. Right. So nothing in that particular report to understand what -- to make sure that what

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[redacted]

and that we're aware of it.

And as long as that ties out, we say,

[redacted]

Q. So just getting back to the -- our discussion earlier about when you were seeing patients, is it fair to say that since January 2011, you have not been seeing patients on a daily basis?

A. Correct.

Q. You mentioned the term a couple of times "fee for value."

A. Uh-huh.

Q. Do you remember that testimony?

A. Yes.

Q. What do you mean by "fee for value"?

A. So what I mean by fee for value is it's a -- becoming a more accepted approach by third-party payors in the United States to start to look at an episode of care, if you will, which is -- so, in other words, if I go to a vascular surgeon and they amputate a leg, the insurance company pays the vascular surgeon for the surgery and they pay the hospital, okay, it's

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done.

But if the vas- -- but if the amputation -- what happens when the patient goes to a prosthetist and they never become a walker, they never become a user of the prosthesis? Is it something the surgeon did? Is it something the prosthetist didn't do? Is it something maybe the physical therapist didn't do well or right or correct or something?

So the concept of fee for value is -- the way I'm viewing it is how can we get more of the healthcare system that's involved in the episode of that patient's diagnosis involved in a better outcome?

So if down the road maybe the surgeon, the PT, and the prosthetist are all sharing in the success of a well-fit prosthesis and a well-trained patient by the therapist and a well-done amputation, leveled the bone and all that by the surgeon, and then maybe we all receive 5 percent more because we got a great outcome and it was recordable, measurable.

Conversely, maybe we don't all do a good job or maybe it was out of our control and the fee for value payment in that episode is a minus 5 percent.

So that's for me, essentially, what fee for value is getting at is not just being, like, how many services can I bill for? Whereas the physician

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might go, you know, MRI, x-ray, pills, you know. So how many things can you get down the hallway of the doctors versus when you just step back and say, Well, wait a minute. Let's treat the patient as a team.

And if we're implementing best practices and we're using evidence-based thought processes, we ought to be able to provide care that is really high level and only occasionally doesn't work for that patient.

Q. I want to go back to Brandt Exhibit 1, and I have some questions about some of the things you testified about.

So if we look at Brandt-1, and if you look at the second row down, it says Branch Exton.

Do you see that?

A. Yes.

Q. If you follow that all the way out to the middle of the exhibit where the Comments column

[redacted]

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[redacted]

A. For any case. For anything. I mean -- yeah, so to -- again, like I was saying earlier, it's like, well, are we targeting, you know, 90 percent gross margins?

I would love to have a 90 percent GM, but I don't think it's realistic. So for us to have something in the 60s is a good GM.

Q. And that "for a MPK," does that mean that the company typically gets less than 62 percent for an MPK --

MS. POSNER: Objection. Foundation.

BY MR. CASEY:

Q. -- gross margin?

A. Can you repeat it for me? I'm sorry.

MR. CASEY: Can you read the question back.

(The court reporter read back the following:

[redacted]

THE WITNESS: I would say, generally

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speaking, yes. This MPK is a -- is different, a little bit. The Genium is a little bit different because the cost of goods are higher, and I also think that the recommended billing for that knee is different than what I would call a typical microprocessor knee. I believe there's additional codes that get billed on that, if not miscellaneous codes.

So that, while that still is a fair gross margin on that product, I do want to point that out, that it's a little bit different than, I think, the Plié or the C-Leg, Rheo-type context.

BY MR. CASEY:

Q. And so if you go back seven or eight cells --

A. Okay.

Q. -- and you see Allowable.

Do you see that column?

A. Yes.

[redacted]

Do you see that?

A. Yes.

Q. So what does that represent?

A. So that represents what Ability expects to be paid from the insurance company.

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Q. Okay.

A. On the entire -- on the entire prosthesis.

Q. Right.

When you say "expects to be paid," that's not money that's actually been reimbursed; is that --

A. Yes, it has. At this point -- I'm sorry. For clarification, if this is a date of service of 7/25/16, yes, then we have been paid on that.

Q. Okay. So for the -- the Genium is a higher priced MPK; correct?

A. Yes.

Q. And so the cost of -- do you see the Total Cogs column?

A. Yes.

[redacted]

Q. I see that. Right.

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And so what are the costs -- and I'll ask this for all of the columns -- or for all of the entries, rather -- what costs other than the price of the MPK is included in the Total Cogs number?

A. It could -- it can be a lot of things in there. In this particular situation, I don't -- I mean, I don't know the clinical cases, so the difference of roughly $3,000, I don't know.

But, you know, there could be liners for the limb, there could be a foot, there could be socket charges.

So, again, I'm -- I don't have an answer for you, sitting here today, why that's only a $3,000 difference.

Q. Okay.

A. It's possible that it was just -- that the patient just got the knee and already had the socket. It just could be any one of those scenarios.

Q. But it's additional products that you purchased?

A. Correct.

Q. It doesn't include overhead or other costs?

A. That's correct.

Q. So this is just the cost of the product

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for the entire prosthesis.

A. Yes.

Q. Okay.

A. Or for the entire cost of what that patient got. It may not have been an entire prosthesis.

Q. I see.

A. For clarification.

Like, in this case --

Q. They may not get every component that you --

A. Right.

Q. -- put on the patient.

A. This looks to me like this was simply replacing a Genium, possibly, and there were $3,000 of soft goods or, you know, liners or socks or things that went along with that. Because it would be really hard to provide a socket and a foot for only $3,000 difference there.

Q. Right.

So just getting back to the Allowable column --

A. Yes.

Q. -- what does that represent?

A. That represents what Ability expects to

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be reimbursed for the total job, the total prosthesis.

And in this -- in this report, I don't -- I mean, I honestly don't know if this Allowable here is the allowable as it went to the insurance company or if this is a payment posted type number, meaning because all these cases are closed out.

So is this actually what we ended up getting paid? I would have to clarify that in this report.

It's certainly what we expected to be reimbursed.

Q. Okay. And so if I can understand this, you -- Ability purchases the components for the prosthesis; correct?

A. Correct.

Q. And after that purchase, you fit the patient with those components; correct?

A. Correct.

Q. And it's after that that you submit a claim to the insurance company?

A. Correct.

Q. And is that claim higher than the allowable amount, typically?

A. No. Typically we try to submit the

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claim at what we expect to be paid.

Q. So in the Allowable column, that would represent the amount of the claim?

A. Correct.

Yeah, we -- we've gone through this with our accounting and Mark Brady's -- you know, we haven't -- some companies bill this usual and customary number, which you may be familiar with, which is some inflated number.

We don't do that. We buy -- you know, by way of accounting principles, we're like, Look, we're on accrual method of accounting. This is -- we're booking our revenue to what we expect to get paid.

Q. And are there times when the insurance company reimburses less than the amount of the claim?

A. Generally speaking, in the end, which could be nine months later, no.

[redacted]

But they many times will authorize certain codes. You'll submit the claim. In this case

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[redacted]

Q. Is that common?
A. It's common.
Q. And in what percentage of cases would you say, and just talking about the prosthetic knee market.
A. If you're just talking about MPK knees, it's -- at this point it's much better. So it's not because the codes have been established for a long time and the efficacy of the product is out there and proven.
So most of the basic needs -- or MPKs that are built with established codes do get paid, as long as there was an authorization process or, you know, as a provider, we follow the steps that the payor said, Hey, you need to do this, this, and this. And if they require, like, you know, physicians'

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clinicals or notes from a PT.
So provided we gather everything that we need to submit the claim and provide that product, we're generally okay.
[redacted]
but...
Q. Are you familiar with RAC audits?
A. Yes.
Q. That's R-A-C audits; correct?
A. Correct.
Q. What does R-A-C stand for?
A. Recovery audit contractor.
Q. And what is a RAC audit?
A. So RAC audits came in, again, maybe 2012, '13. RAC audits were -- are basically where Medicare comes in, they hire a contractor to come in and look back on claims.
And basically if Medicare announces a RAC audit on a case, they will ask you for the documentation around the case.
And then from that, they'll just -- they'll determine whether the claim was paid satisfactorily or adjudicated properly, or whether you

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don't have the paperwork to substantiate what you gave the patient, then they'll request -- they'll call it an overpayment, I think, and then request payment back.
Q. Has Ability been subject to RAC audits?
A. We have.
Q. In the recent past?
A. Not really. I mean, in the last two years, not really. But some of that's due -- some of that is due to the RACs not having a contractor, the CMS not having a RAC.
I think the award termed a few years ago and they haven't -- they just recently awarded it.
So we expect RACs to start back up and not just be MPK knees but also be orthotic braces and different things, so...
Q. And so who was the contractor for Medicare for the RAC audits?
A. I can't remember. I know I knew this. I knew this at one point, but, I'm sorry, I can't recall.
Q. That's fine.
So that contract ran out?
A. It did. It -- I think maybe two years ago, two and a half years ago now.

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Q. And since then, you haven't seen a RAC audit? Ability has not had a RAC audit?
A. I don't -- no, I don't believe we have.
Q. What do you base your statement that you believe RAC audits will -- you'll be seeing RAC audits in the future?
A. Oh, just because the new contractors are gearing up to essentially get back out there.
Some of that also comes from AOPA. You know, they do -- AOPA -- AOPA will do periodic updates on the status of the contractors and what are they doing now kind of a thing.
So it's not any private information or anything that they're -- that they're going to be back out there. So...
Q. And how long do the RAC audits take?
A. How long?
Q. Yes.
A. So you're saying if you receive one in the mail today, how long would it take you to gather the information or --
Q. How long would it take to be resolved, one way or the other?
A. Oh. Well, a few years back, more quickly. Like, you know, you send the information in

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and we would have a resolution, you know.
But, I mean, are you talking about RAC or are you talking about Administrative Law Judge hearings for cases? Because there's a back -- there's a, really, thousand-day backlog for ALJ cases. So -- but my knowledge of RACs has been that they're resolved pretty quickly, and --
Q. And how long, roughly?
A. 30 days. 60 days.
Because a RAC, you're just -- I'm just making sure I'm -- RAC you're just responding to a request for the case. And then I've got to think you have appeal rights to RACs. I don't remember. I think you do.
So even if you send it in and they say, Oh, you didn't have the right paperwork, we're going to recoup the money, I think you still have an opportunity to appeal them taking the money. But then -- but then now you're going to be into an Administrative Law Judge sort of bucket, which is going to be three years.
Q. Has Ability ever appealed a RAC audit decision?
A. Oh, yes.
Q. *How many times?*

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A. Well, I know when we put the document request together, we had, I think, five or six that were specifically tied to MPKs that were all favorable for us.
But, again, it's hard for me to answer because I know overall Ability has had great success appealing claims because we have pretty good documentation.
So at all different levels of appeals they start to blur a little bit, but I know that overall we have not had a -- an audit problem, so to speak, or, you know, we've been -- we respond to them. We don't just -- I mean, some companies will say, Oh, yeah, we looked at our notes and they were horrible, so we didn't respond.
I'm like, You've got to respond. You can't just...
So even -- yeah, so we just -- we respond to them and -- but, you know -- but you even have Medicare claims that you submit sometimes that are denied in 14 days. They come back denied. And you appeal them to the first level of review, and they don't get paid at the first level, and you're off -- now you're off to an intermediary and then waiting for the ALJ. So, yeah, there's all of this.

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But RACs, we never had a lot of RACs requested of us anyway, which is a good thing. And then the ones that we had were favorable. So...
Q. And how long did the ones that were favorable take to get resolved?
A. Yeah, I mean, I'd have to look. I feel like they were relatively quick.
Q. And while the RAC audit is being done --
A. Yes.
Q. -- do you keep the money that was reimbursed?
A. I don't believe you do. I think when they announce the RAC, you have to refund the money before you really get into any proceedings of -- I think so.
Q. So the clinic is out the money, having paid for all of the components.
A. Oh, yes. Oh, yes.
Q. So it can affect your profitability.
A. It could, yes.
Q. Has it --
A. Well, if you get enough of them.
Q. Has it affected Ability's profitability?
A. I would submit to you, no, it hasn't because we haven't had -- again, we haven't had a lot

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of them.
And, you know, a lot of companies -- well, I keep saying two or three but it's, like, longer now. But when RACs first started coming out, you know, there's -- well, people were -- people were submitting documents, and then the RAC was saying, No, this is not good enough. We're keeping the money. Right.
And so there were companies that changed their clinical habits because of that, because they didn't want to get a RAC audit. So...
Q. What do you mean by that, "changed their clinical habits"?
A. I think that people would say, Well, if you're -- if the RACs announce -- if the RAC auditors announce that they're going to audit ankle/foot orthosis -- AFO braces, let's say, and they're only going to -- they're going to look at the ones that are hinged at the ankle, that articulate, that bend, you would have -- you have practices that will say, Oh, well, then, we're going to try to -- it's like -- they're, like, code herding or something, right. They say, Well, we're going to -- you know, as long as we can clinically still put someone in a solid brace that's not hinged, we're going to -- we're going to

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move to something that will still work but will help us avoid a RAC audit.

So that's -- that's what I mean by that, people have -- yeah.

Q. Has Ability done that kind of clinical response in response to RAC audits?

A. No.

Q. Have you ever seen that type of a response done in the MPK market?

A. Not directly, but I feel like -- I feel like that -- I mean, again, I don't know if it's considered a source or not, but just in general -- in general conference conversations, you hear people saying, Well, as long as the RACs are looking at MPK knees, I'm not doing them.

And then I kind of look at them like, Seriously? Like, What about your patient?

Well, they're -- you know, what about my patient?

Okay. Well, clearly...

So I -- so I believe that there are people out there that just said, You know what? If you're going to audit every MPK instead of embracing it and just saying, Well, get your documentation in order, justify the knee selection. It's not that

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hard.

And just -- clinically you've got to raise your bar a little bit and have a process by which to choose these knees. And when Medicare calls and says Show us what you've done, show them.

Anyway, so that's just an approach we took.

Q. Okay. And those instances you heard about, did the clinics switch to a mechanical knee as opposed to a microprocessor knee?

A. I assume that they did, or offered it to the patient private pay, which wouldn't -- I don't know how they could do that, really, because it's a covered benefit.

So you can't -- you can't just say, Well, the facility -- the facility's not confident in our documentation processes, so this is going to be private pay for you.

You can't do that. So I surmise mechanical then, yes.

Q. And for smaller clinics, smaller than Ability, that might not have the financial wherewithal to withstand these kinds of audits, would it not be an economic decision that they would make to switch to a mechanical knee so as not to be denied payment?

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MS. POSNER: Objection. Speculation and foundation.

THE WITNESS: I mean, I think some of those companies could do that. I mean, there's companies that probably just stop seeing those types of patients, or said, I can't help you. You need to go down the street to a company that would give them an MPK.

You know, there were 200 -- I think somewhere around 200 companies at one point that had gone out of business over a two-year span during the RAC audits. So...

I don't have the exact number, I apologize, but there definitely was -- there definitely were people that said -- didn't have the resources and -- you know. I mean, that was kind of the headline in a lot of the news bursts about our industry and things, just people couldn't -- they didn't have the wherewithal to survive five or six RAC audits.

BY MR. CASEY:

Q. And do insurance companies typically reimburse for mechanical knees?

A. Yes.

Q. In all cases or -- that you're aware?

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A. Yes.

Q. So there's no problem getting mechanical knees paid for.

A. No.

Q. "No" meaning there is no problem?

A. Correct.

Q. So, in other words, if you choose a mechanical knee for a particular patient, you have no concerns about getting reimbursed a hundred percent?

A. No. Again, as long as everything's in order and you went through the proper authorization channels and -- right.

Q. And would that --

A. You still have to demonstrate a treatment plan that's -- that makes sense.

Q. But referring to your earlier testimony about these smaller clinics, would that have been the concern they would have? In other words, mechanical knee is a sure thing, right, you're going to get paid for it?

A. That's what -- yes, that's how I think probably a lot of them thought.

Q. If you can go back to the exhibit, Brandt-1, and go to the column Primary Insurance.

A. Yes.

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Q. And that represents the insurance companies that were reimbursing for the mechanical -- or the microprocessor knees that are in this chart; correct?
A. Correct.
Q. So we have -- Medicare is on there; correct?
A. Yes.
Q. Medicaid is on there; correct?
A. Yes.
Q. Then you have private payors; correct?
A. Correct.
Q. Then you have VA.
That stands for Veterans Administration; correct?
A. That is correct.
Q. Any other payors that I'm missing? By category, I mean.
A. Oh, by category?
Workers' comp, possibly.
Q. Okay.
A. The second one down, MetLife Home and Auto.
Q. Is that a workers' comp?
A. I'm thinking that it is, or an auto.

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I'm not sure.
Q. And Medicare is a fee schedule; correct?
A. Yes.
Q. So the clinic, your clinic, submits a claim which consists of, in the case of MPKs, maybe several codes?
A. Right.
Q. So there would be 5856 on there; right?
A. Right. Correct.
Q. Maybe one or two other codes; right?
A. Correct.
Q. And Medicare has a -- an amount that they reimburse for those particular codes; correct?
A. Yes.
Q. Do the private payors generally follow the Medicare fee schedule?
A. They follow the Medicare fee schedule in that they usually generate a contract relationship with the provider, like my -- like Ability, where they would use the Medicare fee schedule as a basis for negotiation.
[redacted]
Q. And are there any contracts that Ability has with private payors that have a fee schedule

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that's above the Medicare fee schedule?
A. I don't think so.
Q. So is it fair to say that typically the private payors are either at the Medicare fee schedule or below?
A. Correct.
Q. So that Medicare fee schedule acts as basically a ceiling?
A. Correct.
Q. And is there -- does the patient have to make up some of the cost of the prosthesis?
A. So it just depends on the scenario.
One scenario might be that the patient has Medicare as their primary payor, primary insurance. And if they have a supplemental behind that, what happens is Medicare -- so Medicare pays 80 percent of their fee schedule that you referenced.
So if a device is $100 on the Medicare fee schedule, Medicare is going to pay $80 to Ability.
And then the secondary payment gets -- or the secondary payor gets a copy of the Explanation of Benefits from Medicare, and it says, We paid this claim per the benefit level for a Medicare beneficiary. Now you need to do what you do with the remaining 20.

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And then that secondary insurance will pay the 20 percent, in most cases. So that's one scenario then.
Then -- so --
Q. Before you go on to the next scenario --
A. Yes.
Q. -- how many of your patients have secondary insurance, as a percentage?
A. Who are on Medicare and have secondaries. I would say probably 80 percent of our Medicare beneficiaries have a secondary.
Q. And what is the -- what is a typical -- well, strike that.
What percent of secondary insurers pay that entire 20 percent once Medicare has paid?
A. Oh, it's high 90s.
Q. So most times the secondary insurance covers it?
A. Yes.
Q. And what about for private payors? Let's just take an example. A private payor is paying 70 percent --
A. Of Medicare.
Q. -- of -- well, they're at 70 percent. Medicare is at 80. Okay.

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So there's a 30 percent gap, and the patient has secondary insurance. Can the secondary insurance make up that 30 percent gap?

A. No.

MS. POSNER: Objection. Incomplete hypothetical.

BY MR. CASEY:

Q. What would happen in that instance?

A. So if you have a patient and their primary payor is -- I think as you're saying is 10 percent below what Medicare would pay, you're contractually bound with that insurance company to pay per the -- they reimburse you at the contracted rate.

So if the patient's benefit, though, is, let's say, an 80/20, meaning that Blue or Aetna or somebody will pay 80 percent of their contracted fee with you, now there is a situation where you can balance bill that patient for that 20 percent, but only up to the contracted rate that you have with that commercial payor.

So if you're -- if you're at, you know, we would say 70 -- we would say 70 percent of Medicare, not 10 below Medicare, we would just say 70 percent.

So if I'm 30 percent off of the Medicare

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and the patient's benefit level only pays 80/20, there is going to be some number to balance bill them. Or they may have even another insurance.

Sometimes patients that have a primary insurance that's a commercial, sometimes those patients will carry some sort of a -- another policy or something that from time to time will pick up some of that.

Q. Is that common where a patient would have commercial insurance and a secondary insurance?

A. Not as common, no.

Q. So --

A. And usually it's just whatever the benefit level is for that commercial payor. Because, generally speaking, these are people that are less than 65, so they're usually not of Medicare age. Not all, but most are on a commercial policy if they're younger than 65.

Q. Is the Medicare fee schedule set by state?

A. No.

Q. Do you know how it -- is it set by region?

A. It's -- there are -- so -- yeah, this is going to -- I believe there was a time -- so there are

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still state -- there are still state spreadsheets that are produced that show slight variances in the allowables.

But my understanding is that those used to be generated, maybe the early '80s where -- late '70s, early '80s when the HICVA -- when the L-Code system came in is that those numbers were arrived at based on data they received from the states, from providers like me billing those claims.

I don't -- I don't have any, like, current knowledge of really how they vary from state to state or that my last recollection of that is really that they varied a little bit, but not enough to necessarily change a business strategy or be concerned about it.

I think sometimes in more rural areas CMS might pay more.

But other than that, I'm not -- I'm not familiar.

Q. So in the case of your patients, typically the codes are -- there's one Medicare number for each code throughout the -- throughout your region?

A. Right. So I think we're in two regions. I think our Maryland and PA are in DMERC A, and North

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Carolina is in B, if I'm not mistaken.

So that that DMERC pays a set fee. So that's why I say there's a little disconnect for me even about why states still produce this fee schedule when -- and it might have something to do with Medicaid.

But since the DMACs were before DMERCs, there -- I think there were five or six in the country, and I think when CMS went to a regional system, they started assigning allowables by region, not by state.

But I -- now that I say it, I think it might have to do with tying into Medicaid. When Medicaid is the secondary, it probably helps them on how to pay.

Q. Let's take a scenario where there's no secondary insurance and there's a 20 percent gap. Who pays that?

A. So if the patient has primary and there's no secondary in place, then we -- before we start the job, like, essentially we say to the patient, Here's your insurance picture verification. You do have Medicare, it is active, all that stuff, but you don't have a secondary and the estimated claim here, Medicare is going to pay 80 percent. It's going

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to leave 20 percent which is going to equal $3,500 for you, right.

And then from that point we have to decide on can -- you know, can they afford it? Do they have to apply for a hardship waiver? Are they going to pull out a credit card and pay it, and just say, Okay, no problem.

Yeah, so I guess there's a whole host of ways that we could go after that, right.

Q. And do you?

A. Yes.

Q. Do you provide financing in those instances?

[redacted]

But we've spent a lot of time on that in the last six months to get really more rigorous processes around that.

So if you present a patient's FR, their financial responsibility, and it's $4,000, and they say, Oh, wow, like I don't -- I don't have any money. I can't do it.

We say, Okay, well, then, you need to --

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we're going to get you connected with Stephanie, the compliance officer, and Stephanie is going to run you through a battery of questions so that we can understand what type of a payment plan or whatever to engage in.

And in some cases you can write it off, but you have to make sure that you've done your diligence on the patient's ability to pay before you do so.

Q. And so when you say you're going to change that, what are you going to change?

A. Oh, just to make sure that we -- on every patient where we've either written it off or accepted a payment plan, that we do have our documentation of having gone through that vetting process, right, so that, you know, if the payor ever says, Hey, you know, it looks like you're writing off all your MPK balances. Guess we're paying too much for MPKs, you know.

Whoa, no, you're not. Trust us, we're feeling it. Here's our process.

But, like, you know, even Medicare, CMS has a -- you know, if patients can produce W-2s that show -- W-2s or W-4s, I can't -- W-2s.

If a patient can produce, like, a W-2

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that shows they're below the poverty line on their income, you can write that off, effectively.

So, anyway, just making sure that that process is set in stone and then -- that's what we're doing.

Q. Has there ever been a situation where because the patient couldn't make up the balance of the payment, that you made a clinical decision and switched that patient from one particular knee to another type of knee?

A. Uh-huh. Yes.

Q. And can you give us an example of that?

A. I mean, so there's the clinical, which is -- we're very patient centric, but if a patient -- if we present a patient with a plan to pursue an MPK and it's not part of their benefit coverage or it's not going to be paid, we inform them of that.

And then if they want to privately pay for that knee, they can do that, which that does not happen very often.

Or you can explain to them the trade-offs of going to a mechanical knee and, you know, make sure that they're aware.

That happens infrequently at Ability because more likely what happens is we look at the

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[redacted]

So it's rare that we would do that, but if we did -- and I'm sure we've done it. I mean, I'm not going to sit here and say we haven't done it -- but those folks understand full well what the trade-off is, that they're not going to have, you know, a computer reacting to make their knee stable. So...

And so that's how it goes.

Q. And how -- can you estimate how frequently -- like as a percentage of your overall MPK sales, what percentage are situations where you've switched the patient to a mechanical knee?

A. So it would be like we didn't realize the sale because we went to a non- -- a non-MPK? I'm not -- I'm sorry.

Q. Maybe I didn't phrase the question correctly.

You testified about situations where

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because the patient couldn't make up the difference, that you would counsel the patient about the --
A. Oh, right.
Q. -- trade-offs; right?
A. Right.
Q. And I think you said that in some instances the patient would end up with a mechanical knee as opposed to a microprocessor knee; correct?
A. Right, that could happen, yes.
Q. That has happened; right?
A. Yes.
Q. What I'm trying to get at is how many times that has happened as a percentage of your overall sales.
A. It's very small, tiny. Because what ends up happening most of the time is you figure out a way to work with the patient, and -- yeah, you figure it out.
Q. You don't have a percentage, an estimate?
A. I mean, out of this roughly 60, I mean -- well, he's got MPKs, but 1 percent, 2 percent. It's just a small number because we'll -- mostly what would happen is we would end up working with that patient to try to come up with a solution --

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Q. And --
A. -- for the balance.
Q. Okay. And apart from the payment issues we talked about which might cause the patient to get a mechanical knee as opposed to a microprocessor knee, are there other instances where a patient who could benefit from a microprocessor knee ends up with a mechanical knee?
A. Yes.
Q. Can you tell us -- and, again, putting aside the financial --
A. Right.
Q. -- questions, just a case where -- an example where that would happen?
A. Well, I think that there are patients that are newly amputated that if you -- if you're evaluating the functional level and you say, Wow, this patient -- this patient, if they really put their nose down and buckled down, they could be an MPK candidate in three or four months. But right now, their functional capacity matches better for mechanical knee.
They don't -- in other words, they're doing such limited walking that they don't -- they don't need -- they would never use the features of an

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MPK, potentially, so why are we going to give them that?
We're going to give them the mechanical knee. Get them up, get them walking. And then it's -- you know, it's a very dynamic process because we're 70 percent water. So things are constantly changing when you're attaching a mechanical device to a limb.
So there can be cases where you say, This will be a great MPK candidate, but not yet. And they need to do this, this, and this over the next six weeks in clinic -- not our clinic, but in PT or the rehab unit or whatever.
And if they show that they can make some progress, wow, now if we go to make this person more of a community ambulator, they're going to be better suited for MPK.
So on their temporary limb they might get a mechanical, but the permanent or the definitive prosthesis, they get the MPK. Yes.
Q. Are there instances where that doesn't work and the patient stays on the mechanical knee?
A. Yes.
Q. How often does that happen?
A. If you have documented in your

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evaluation notes that you as a prosthetist think that this patient -- I mean, if there's feedback coming from the tests that we give them that would have you documenting this patient could very well be a good MPK candidate in the near future, then of those, it's probably very small, the numbers that don't graduate into an MPK, if that makes sense, if you follow that.
So there's probably many more that it's just the patient is going to get a mechanical knee on their temporary prosthesis, and then the note -- somewhere in the note it basically is a little more open, like, Probably not an MPK user in the future. We'll see.
I mean, I'm just using very non-clinical, but there may not be quantitative feedback during that initial interaction with the patient that would lead the prosthetist to believe, Hey, this is an MPK candidate. He or she just needs to kind of do their time, get a little stronger, and we'll have them in an MPK.
There is patients that start in a mechanical and either keep that exact mechanical or get another mechanical and then get a permanent limb, and the -- right.
Q. And do some patients prefer mechanical

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knees as opposed to microprocessor knees?
A. Right. So if they're -- yes. If they're more highly functioning, the MPK may actually serve -- I should say highly functioning and also activity specific. If they're in that category, they may find the MPK nice, but they might just prefer to control the mechanical knee on their own because it more suits their activities.
So, I mean, for me personally, if I lost my leg above the knee, an MPK would be wonderful for probably like an hour out of the day. But the other 20 or 16 hours, I'd probably want to be in a mechanical knee because I'm going to just -- I'm going to probably break the -- you know, I'm active, so -- I'm highly active, so I would probably break the MPK.
Q. So explain that to me. How would the MPK break?
A. Oh, maybe just like extreme torques or extreme compression or -- you know. I mean, like if I was driving an oversized dump truck on a job site or something and I was jumping in and out of that cab every day, ten times a day or something, I don't know if I want an MPK.
Q. You've got to --
A. So I don't know exactly how it would

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break, I guess.
Q. It's a computer?
A. It's a computer, right, yeah.
Q. And there's -- depending on the particular MPK, it may not be able to get wet; correct?
A. Right.
Q. Which whereas a mechanical knee can get wet; correct?
A. Correct.
And there may -- you know, there might be some saltwater restrictions on mechanical knees, even, that I don't know that it would be great to get -- you know, you probably have to keep it around freshwater because saltwater would probably bind up a mechanical, a non-MPK.
Q. You mentioned the guy who wants to wash his car; right?
A. Right.
Q. I mean, for most microprocessor knees, he's not able to do that?
A. No, he is.
Q. For a microprocessor knee?
A. Right. Yes.
Q. So most of them can -- you can get them

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wet.
A. At this point now, with the Plié and I'm not sure about the latest C-Leg, I think it can get wet, as long as -- I don't think either of them can be submerged. But I think the Genium can actually be submerged. But -- and I don't know about the Rheo.
Q. And with mechanical knees, there's no restrictions on submerging it?
A. Well, again, it would depend on the mechanical knee, and it would also probably depend on freshwater, saltwater.
And even in freshwater there might be precautions around submerging it, like you've got to dry it immediately or -- you know, so -- yeah.
Q. There's no mechanical knees on Exhibit 1. If you went into your system, could you create a spreadsheet like this for mechanical knees?
A. Yes.
Q. Do you know roughly how many mechanical knees you sold in 2016 and 2017?
A. I do not.
Q. I'm sorry, I didn't mean sold. I mean fitted on patients.
A. I don't know.
Q. Do you know if it's more than the number

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of microprocessor knees you've fitted on patients?
A. I would venture a guess that it's more.
Q. Would you guess that it's much more or a little? I mean, do you have any estimate?
A. Over a hundred.
Q. You're saying in the two years, 2016 and 2017, you believe you probably fit about a hundred mechanical knees total?
A. Yeah.
Because some of these -- some of these roughly 60 knees were -- some of these people probably had mechanical knees on a first prosthesis, right. So I'm just thinking out loud here that the number's probably at least 30.
And then there's probably -- I don't know, maybe a hundred is too high. But I can get the number. I mean, I can get it. So...
Q. Okay. But it's fair to say that you fit probably almost double the number of mechanical knees as opposed to microprocessor knees?
A. I mean, that's a hundred -- that's, like, 120, but -- no --
Q. A little less.
A. -- not double. Less than double.
Q. Okay. Do you know what the gross -- the

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typical gross margin is on the mechanical knee for Ability?
A. I don't.
Q. Do you --
A. I know that it's -- I know that it's higher, I'll offer that. I mean, it's higher than an MPK.
Q. So if the MPK gross margin range starts [redacted]
Q. Maybe.
What would the -- what would the range of the mechanical knee gross margin be?
A. Again, depending on other components on the leg which could change that, I would anticipate in that report seeing a higher GM on mechanical knees.
Q. Do you know, like --
A. Or on the overall prosthesis that had a mechanical knee, yes.
Q. Right. Right. [redacted]
range?
MS. POSNER: Objection. Calls for speculation.
THE WITNESS: I don't think so. I think

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[redacted]
BY MR. CASEY:
Q. So overall, all other things being equal, you make more money on a prosthesis that includes a mechanical knee as a percentage margin than a prosthesis that includes a microprocessor knee?
A. Yes.
Q. Correct?
A. That is correct.
As a percentage, yes.
Q. So putting aside clinical factors, in terms of the business decision you have to make in fitting a patient with a knee, it's better for your margins if you put a mechanical knee on a patient as opposed to a microprocessor knee; correct?
A. If it were financially driven, yes.
Q. Your decisions are not entirely clinically based; correct?
A. Correct.
Q. You are, as you said, a profit-making business, so you have to consider the financial implications of the decisions you make; correct?
A. Right. Yes.
Q. So you wouldn't deny that the fact that you make more money on a -- your margin's higher on a

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prosthesis that includes a mechanical knee, that that has no bearing on the decision, you wouldn't say that, would you?
A. I wouldn't say that.
MS. POSNER: Objection. Assumes facts not in evidence.
BY MR. CASEY:
Q. So the margin you make is a factor in the decision as to what knee to prescribe?
A. It is --
Q. I'm sorry. Strike that.
The margin that you make is a factor in the decision as to what knee you fit on a patient?
A. It is -- again, I don't know how you're using the word "factor."
It's clinically driven. If the margin that ends up appearing is lower than we want it to be, it's information for us to understand that, and maybe that helps us to be aware of some inefficient practice that we're doing somewhere else in the course of treating that patient that we can say, Wow, our margin here was 52. We need to be aware of that. What did we do around that case? Maybe there's something administratively that we wasted time on that could have, you know, made the margin better.

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So, again, I -- in a patient centric mind-set, I look at this gross margin as a result of the clinical decision. And if we're not happy with that result of, we need to look at other places in the business to say, Okay, how do we prove that?
Because I can't start fitting knees based on -- so it -- I wouldn't say it's a factor in the decision. It's more of an outcome that we are aware of and try to understand the impact that could have on the business.
Q. But if a mechanical knee is appropriate for a patient and your margin is going to be higher if you put a mechanical knee on that patient, the smart business decision would be to use a mechanical knee, wouldn't it?
MS. POSNER: Objection. Assumes facts not in evidence.
THE WITNESS: If I was just trying to create high margins, that's what I would do, yes.
MR. CASEY: Do you want to take a quick break?
MR. CREAGAN: Yes, sure.
(A recess was taken from 3:01 p.m. to 3:09 p.m.)
MR. CASEY: We're back on.

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BY MR. CASEY:
Q. So, Mr. Brandt, this morning you were asked a question about what you would do in response to a 5 percent price increase in MPKs.
Do you remember that?
A. Yes.
Q. You remember that testimony?
A. Yes.
Q. So I'm going to ask the question a little bit differently.
If after the merger the combined Ottobock/Freedom increased the price of the C-Leg by a [redacted] roughly -- would you change your purchasing of the C-Leg and purchase something else?
A. I'm going to say probably not.
Q. And why not?
A. Because it probably wouldn't be a significant -- and, again, it wouldn't be a significant enough change in the cost to -- you know, or conversely -- not conversely, but associated -- affected the GM to potentially look for other clinical solutions for people.
Q. What if the price of a C-Leg was [redacted]

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A. Right.
I mean, probably not. I mean, I -- can I -- I mean, can I ask what --
MR. CREAGAN: Sure. If you need the question clarified or --
BY MR. CASEY:
Q. Do you need clarity on that? Do you understand the question?
It's a hypothetical question.
A. Yeah, I guess I -- I all the way up, you know, as we go up every -- I don't know if your line of questioning is every 1,500 -- like, are you looking for a point where I say, Oh, that's too expensive?
Q. For now I'm asking just about the $1,500.
A. Okay. So I --
Q. Let me ask the question again because I left part of it out.
So if every other metric stays the same, your costs are the same, the price of the other products in the market are the same, the only thing that changes is that the C-Leg goes up by $1,500, what would you do?
A. We would still be purchasing it.
Q. And if everything else stayed the same

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but the price of the C-Leg went up by $2,000, would you -- what would you do?
A. We would probably still purchase it.
Q. Now I'm going to ask you the question that you referenced earlier.
Is there a point at which you would switch from the C-Leg, based on a price increase, to some other product in the market?
A. Probably not, but as the C-Leg would [redacted] a decade ago, I would be feverishly talking to Ottobock to try to figure out how can -- how can I stop that or how can I -- how can I preserve this at a reasonable cost so I can keep offering it. Right.
I mean, otherwise I have to start potentially cutting things from the business, other aspects of our operations and our patient care model to continue to buy that product.
So I would -- I would say probably as a return to pre-Freedom competition levels, I would be at that point saying, Can we -- can we look for ways to expand the pie here, and, like, what other value does Ability have that we could work together or collaborate as companies to keep this price where it [redacted]

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So that, again, I could come up with a [redacted] then what -- where that leaves me.
I'm not going to not offer that to the patient. I want to still be able to offer that to the patient if they're -- if it's indicative of a -- of that knee.
So I would just -- that's just me. I mean, I'm like -- I'm like an optimist that way, so I [redacted]
Q. Are you saying you --
A. And let -- and maybe there's some other thing of value in Ability that from fitting those that I could share with Ottobock or collaborate to give Ottobock something to stop the price increases.
Q. Are you saying you wouldn't switch any of your purchases? Like, you wouldn't switch one [redacted]
A. No, I'm -- no. I think along that way, I think certainly we would be smart as a company to look at other knees' clinical benefits, and say, you know, Are there other knees that we need to dive deeper into, and see if there is a clinical equivalent at a lower cost.
Q. And at what point would you reach that

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determination? Or would you strike that process? Is it 10 percent or more than that?

A. Again, I don't know how to answer that. I mean, I discuss these things with our -- with my team, and -- I just don't -- I don't know how to answer -- I don't know to answer that, and I don't -- I feel like -- I feel like I'm committing to that or something or I'm --

Q. It's a hypothetical.

A. I guess north of 10 percent, probably. I mean, it sounds like a -- I mean, I can tell you that if they announced a 3 or 4 or 5 percent price hike, I probably would be aware of that, but it wouldn't cause that -- any kind of migration, or even just going off and doing more research on the other knees.

But 10 or more, yeah, that would probably be, What's going on? What's the end game here? Right. That would have me concerned probably at 10.

Q. And at 10 percent, do you think you would switch any purchases to other knees from the C-Leg?

A. Probably some, but I don't think it would be a mass -- I don't think there would be some

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big shift.

Q. Can you estimate a percentage?

A. Maybe a third.

Q. So if the price of the C-Leg went up 10 percent --

A. Yes.

Q. -- you would switch a third of your C-Leg purchases to other knees.

A. Possibly.

Q. And what other knees would you look to to purchase?

A. Look at the current knees on the market, or we would look to see if there's -- if there are companies that are in development of a knee, possibly, that might -- you know, we could look to the future and say, you know, Maybe we can triage it currently in the market, but maybe there's a way to participate with a company right now so that two years from now there's a knee that's of equal clinical but less expensive.

Q. The same questions for the Plié. If the Plié went up by 10 percent, would you look to other -- would you reduce your purchases of the Plié?

A. No, I don't think so.

Q. If the Plié went up by 15 percent, would

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you reduce your purchases of the Plié?

And, again, all else being equal.

A. I mean, it's starting lower than the C-Leg to begin with, so there's probably a little more room for the Plié to go up before you would change that.

But, yes, there would be also a point with the Plié that we would say, Hey, we need to look around and make sure that we're -- you know, that we're not just so focused on two knees here that -- what happens if they both go up? You know. So...

Q. So if the price of the Plié went up by some amount higher than 10 percent, you would reduce your purchases of the Plié by a certain amount?

A. I think it would have to be -- at the [redacted] go up 20 percent before we would -- before there would be a switch.

But, again, these are hype- -- these are really hard hypotheticals because clinically, you [redacted] a C-Leg and if a patient needed a C-Leg, they got a C-Leg.

I mean -- so we've been there on margins. It's come down. So if it -- if the prices

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go up, we have no -- I mean, we kind of have to go with it. I don't have any recourse other than, like I suggested, to develop deeper relationships to try to create value there somehow.

But we're committed to these MPK knees, [redacted] don't -- I don't know -- I don't know how the market would react to that. That would be like -- yeah. So...

Q. So let me ask you this: If all of the MPKs in the marketplace went up by 5 to 10 percent --

A. Right.

Q. -- and everything else is constant, mechanical knees are the same price, would you switch some patients to a mechanical knee that would otherwise get a microprocessor knee?

A. No.

Q. If all the MPKs in the market went up by 20 percent, everything else stays the same, would you switch some of your purchases of microprocessor knees to mechanical knees?

A. I -- there might be some, but not without -- not without learning that there is -- so maybe we would have to go back and do even deeper research on some of the best mechanical knees, and

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say, like, Okay, here's the comparison, right. Let's dig deeper into the science of some of these and see if there's anything there.

But, again, once MPKs are out like they are, it's -- again, it's -- if you're -- if you're patient centric and your patient needs an MPK, you can't sit there and make an argument -- or, like, a case to the patient to say, My margin is really bad on this, so I'm not going to give it to you. You can't do that.

So there is a point where your margin will go to whatever it goes to if the prices go up. That I think that we would absorb, as speaking for Ability? I think we would even absorb one heck of a price increase before we would change someone to what we knowingly know their insurance covers and that they can benefit from to put them into a mechanical just to pull back margin.

So I don't -- is that -- am I answering that?

Q. Sure. That answers it.

So what about for patients that might benefit from a mechanical knee but might also be appropriate for -- I'm sorry -- might benefit from a microprocessor knee but might also be appropriate for

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a mechanical knee; would there be -- in the face of a 20 percent price increase of MPKs marketwide --

A. Right.

Q. -- mechanical knees stay the same, your costs stay the same, would you begin to look at possibly switching some people that clinically would be appropriate --

A. Right.

Q. -- for a mechanical knee to a mechanical knee?

A. I mean, I don't think so. I think, again, it's a -- it's a -- the margin's not heading in the right direction, but it would be very hard to try to interest someone -- interest a patient in the features and benefits of a mechanical knee knowing full well that MPKs have taken falls to almost nothing, to almost no falls.

Like, it's -- that's an ethical -- you know, to send someone out of your office on a mechanical knee knowing full well if they fall once, they can fracture a femur and be in the hospital.

Like -- so, again, the price increase, thus the gross margin decrease, would reach a point, I surmise, with the market that there would be absolute, like, chaos and revolt, like.

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Like, I don't -- I don't know that providers would just be like, Oh, yeah, Bock's raising prices. We're just going to mechanical knees. That's that.

I mean, I think it would be like a -- I don't know how they would get past a certain point without reaching some tipping point in business decision or relationship with their customers point that would just say, Whoa, you've got to stop raising the price.

Q. Well, I guess that ultimately is the question. Like, if you can't prevail on the companies to -- the MPK companies to not raise their price, you know, what is the -- what is the alternative? You would see the alternative as paying it and reducing your gross margins?

A. Right.

MS. POSNER: Objection. Vague.

Which percentage are we talking about now?

THE WITNESS: Right. I -- again, speaking for Ability, I don't know what other providers would do because I -- again, I -- you know, I think we do a really good job to put clinically what makes sense for the patient. And I think that we

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would absorb a ton of that before we would say we have to look at other options.

But, again, I don't -- I don't know how legally you would do that. As a provider, I would have to go seek counsel and say, How do I do this? Blue Cross is telling me I'm under contract. They cover microprocessor codes. This patient's functional outcome levels scores are off the chart. And then I'm sitting in the room saying to them, Well, my gross margin is 17 percent on an MPK, so I really want you to try this mechanical knee.

I can't -- we're never going to have that -- like, I don't know how to get -- I couldn't get there.

BY MR. CASEY:

Q. My question was, a couple of questions ago --

A. Okay. I'm sorry.

Q. -- it was about a patient where a mechanical knee would be appropriate.

A. Right.

Q. Maybe it's not the best knee for that patient. Maybe the MPK is a better knee --

A. Right.

Q. -- for that patient, but it would be

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appropriate. Clinically appropriate.
In that -- in the face of that kind of a price increase, would you not look to see among your patients whether there are patients that could be fitted with a mechanical knee as opposed to a microprocessor knee?
MS. POSNER: Objection. Vague. Speculation.
THE WITNESS: Again, we might look, but I think the -- to me the inference there is that they -- that you're sitting there in the room with this potential bias towards fitting the mechanical knowing full well they're going to benefit from -- I mean, if you say they benefit from both, okay.
But then if they benefit from both, if -- even if -- even if there's an additional feature or two that they're not going to -- you just -- it's like they're locked in with the mechanical, right. Once you have it, you have it. And if anything changes a little bit, it's not as dynamic as an MPK.
They're kind of two different -- it's like they're two different animals in some ways. So it would -- it would be very hard to -- again, to know that someone could do well in both, but then be sort of like, Yeah, I think you should try a mechanical.

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Like --
So, again, that margin, I would be talking to the manufacturers long before I was talking to the patients about the potential equality between the two products. Because while they're both knees, they're -- they are different. I mean, they can -- they perform differently. So...
That's a -- that's a good one. I mean, it's...
BY MR. CASEY:
Q. So you were asked questions this morning about the merger between Ottobock and Freedom Innovations.
And I think you testified that you would be concerned about a possible price increase; correct?
A. Uh-huh. Yes.
Q. I think your -- what I wrote down is you said that you would be susceptible to that kind of a price increase.
Is that fair?
A. That I would -- that I could be susceptible or --
Q. Well, I thought you said I would be susceptible to such a price increase.
A. Well, what -- I think it crossed my mind

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that, yes, when the merger was announced, that I could be susceptible to a price increase. I wouldn't have -- you know. It would be kind of one-sided or unilateral.
Q. Just to be clear, this thought crossed your mind, but you aren't aware of any plans for Ottobock to raise prices now --
A. Correct.
Q. -- correct?
A. That's correct.
Q. So you've had no indication at all as to whether --
A. No.
Q. -- prices will go up or down?
You don't know?
A. No.
Q. "No" meaning you don't know?
A. "No" meaning I've had no indication, no inferences, no -- if anything, the opposite from both corporations have been Everything's the way it is. Nothing is going to change.
That's been any messaging that I've heard has just been status quo. Operate at status quo.
Q. And you were also asked, I think,

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whether you had concerns that the acquisition would slow innovation.
Do you recall that question?
A. Yes.
Q. And I think you said it was speculative, that you didn't know what the combined companies' mission would be; is that correct?
A. Correct.
Q. But that it crossed your mind that it might be a possibility; right?
A. Yes.
Q. And, again, just to be clear, you don't have any knowledge sitting here today as to whether, in fact, the merger of Ottobock and Freedom Innovations will have any effect on innovation; correct?
A. Correct, I have none.
Q. Have there been times in the industry -- you've been in the industry a long time -- when mergers have actually led to an increase in innovation?
A. Not -- none that I -- I'm sure that there's probably some. I don't -- I'm not a walking -- I don't have, like, a working -- yeah, I wouldn't -- I could think about that.

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Q. Okay.
A. I mean, it's -- I think it's a good question. I don't -- I think sometimes when these mergers happen they happen, they -- you get to a spot that it -- that, you know, the new norm or whatever it is, and you keep going.
And so if there wasn't anything extreme about it, you sort of -- so I'd have to go back and sort of think about that from a -- from the -- with that context, right.
Like, you know, Ossur acquiring Evolution Industries in Orlando. That was, like, an amazing thing because Ossur took that standardization of socket fabrication and kind of, like, scaled it more. Right. So I guess -- I mean, I don't know if it's a true apples to apples, but -- yeah.
Q. Do you think that -- I think you ranked Ottobock's feet somewhat below the Freedom feet in terms of quality; is that right?
A. Correct.
Q. Do you think Ottobock would benefit from owning Freedom's foot products?
A. It depends on the position Ottobock -- it depends on how receptive Ottobock is to change.
And, again, I alluded to that earlier

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about cultural and sort of our engineers, their engineers. You know, I think if -- sure. I mean, I think --
I don't -- I don't know in general -- in general that Ottobock feet are -- you know, they sort of have this stiff -- like, a stiff quality to them that I don't know that that goes over well for patients. Not all Ottobock feet.
But I think that in that example, if Ottobock's receptive, there's probably things that they can take from Freedom and tweak their foot offering, combined foot offering. It's just how --
Again, I don't know how those meetings go a year later when Freedom engineers sit down with Ottobock engineers and say, Wait a minute, we're supposed to merge all this and come up with these great new products.
And Ottobock's engineers say, Yeah, well, we don't -- we don't agree with how you came up with that, and so we're not going to use it.
You know, so I don't -- again, I don't -- if Ottobock's receptive, I think it would be great. So...
Q. But you think Freedom has been an innovative company?

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A. Yes.
Q. And you think that if Ottobock takes that innovation and uses it and improves it, that could be a positive outcome from the merger?
A. Yes.
Q. Okay. Do you pair in a prosthesis different manufacturers' feet with -- strike that. Let me try that again.
When you put a prosthesis together, do you have to have the same manufacturer's knee paired with the foot? In other words, do the feet and the knee have to come from the same company?
A. Right.
No, but I would qualify that, too, with I believe Ottobock in recent years -- and, again, I'd have to -- I'd have to check this -- but I believe Ottobock in recent years has backed off of their recommendation of using their feet with their knees.
I know there was a point where they highly recommended that, kind of like tied to warranty and all that. So I think they've backed off of that and have been more, you know, flexible or, you know, like, We're okay with that. It's not going to void anything. But I'd have to just verify that.
Other than that, I don't know of Ossur

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or Freedom ever saying, like, You have to use an Ossur foot or a Freedom foot as staunchly as Bock -- as the position Bock took.
And I can understand that, you know, to a degree. It was -- you know, it was always, Okay, well, they have their reasons for doing that, and it's almost like you chalk it up to this, like, higher engineering. This is great. They know something about these products that work in tandem that we don't, and I respect that. Let's abide by that.
But, yes, but I think they've gotten more flexible with that.
Q. From a clinical standpoint, are you aware of any advantage to using the same company's -- the same company for the feet and the knee?
A. Clinically, no. Not unless -- not unless that company produced information that said clinically this combination works together to produce this result, then, I mean -- I think we're on the front end of seeing some of that with more development, like with ankles talking to knees and things like this, right.
So we may see a day where knee and ankle absolutely need to be one or two closely mirrored products by the same manufacturer so that we can get

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that step length from a patient or we can get that increased stability.

So maybe that will go back the other way where we have to have the same ankle or -- when I say "ankle," I mean feet -- but the same ankle/foot system paired with the knee system to get an outcome.

But right now, I think if you -- as a prosthetist, if you think you can get a clinical outcome using, you know, a Plié knee with an Ottobock foot, go for it. I mean, do that, then.

Q. What about a Plié knee with a Ohio WillowWood foot; any reason that would not be a good choice for a prosthetist?

A. I -- not that I'm aware. I mean, there could be a -- there could be something out there that I'm not aware of with OWW feet. I'm not very familiar with OWW feet.

Q. Okay. I think you testified earlier about the sales reps, and I think you said that Freedom has one sales rep for your company; is that right?

A. I know of one in Pennsylvania. I don't know if they have a Maryland or a North Carolina rep. I feel like they do, but I just don't -- I don't know them or -- yeah.

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Q. And I think you -- I thought I heard you say that you prefer to have one rep for each manufacturer?

A. We would love for that -- for that to be the case. It isn't always achievable.

Q. And why would you love for that to be the case?

A. Just because we've put a lot of effort into standardizing Ability and the way we operate across the ten offices. So we want to be treated by the manufacturer in that standard way.

And so when you have multiple reps, sometimes you're not treated in a standard fashion, and so it makes it harder to sort through the -- you know, if a rep wants to come in and high-five that practitioner, it's like, Okay, time out. It's fun, high-five, but then now let's get back to the -- make sure the other nine are hearing this, too.

So that's all. That's just to try to keep it normalized and -- so...

Q. So you don't need any more than one sales rep from any particular company; is that right?

A. No, we don't. I mean, other people may answer that differently if they have a need for that rep to come in and help them from time to time, that may cause a need for more than one rep for a company.

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But overall, it's -- we would just like the director of sales to contact our executive team and let's talk about selling to Ability.

Q. You said -- I think you testified that the -- you thought the processor in the Plié is faster than the C-Leg's processor; is that right?

A. Correct.

Q. Were you talking about the Plié 3 or an earlier version of the Plié?

A. I think I was talking about the Plié 3. Again, not knowing exactly which upgrade was done in which iteration. But I thought at one point the processor was faster in the Plié than the -- than that current version of the C-Leg. 4 may be a different -- 4 may be different at this point.

Q. Just to be clear, you don't know whether the current version of the Plié's processor is faster than the current version of the C-Leg?

A. That is correct.

Q. So when you fit a mechanical knee on a patient, is there a follow-up -- strike that.

You testified that there are -- there is a period of follow-up after the fitting; is that correct?

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A. Correct.

Q. And -- so with the microprocessor being out, how many times would that patient have to come back? Is it weekly?

A. So it varies widely. So you might fit a leg on a Wednesday and you may see the patient again Friday. You may not see him for one week. You may see him tomorrow and Friday. It just depends on potential issues that they might have.

Leaving sort of a vacuum of your office where everything is level, parallel bars, to going out now when they're first introducing the prosthesis to their world, sometimes it's like, Whoa, we didn't talk about this.

So -- excuse me -- so sometimes the follow-up can be a couple times in the first week. It may not be for two weeks. The patient might do really well for two weeks.

But, generally speaking, there's follow-up. So at most usually two weeks from the time someone gets a leg. And then depending from that point forward, what -- you know, whatever dictates is necessary.

Q. So I think you said that the follow-up can last for the life of the knee; correct?

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A. Correct.
Q. So if a patient comes back every month for ten years --
A. Right.
Q. -- your prosthetists are going to see them, talk to them, take care of them?
A. That's correct. Yes.
Q. So that's a cost to Ability that is not included in your reimbursement from the payor; correct?
A. Great point. The payor will say that that cost is included in there, that that reimbursement is included.
Q. For ten years?
A. For the life of the prosthesis.
So that is where some of the current discussions around fee for value and some of the research that we're looking into is to really define that ongoing care.
Because this -- these margins -- these margins are not these margins. We know that. These margins don't account for what's probably going to be 12 follow-up visits over the next three, four years.
And even if they're quick visits, still, you know, it could be -- that could be $3,000 cost to

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the practitioner time over three years.
But it's -- we're aware it's an unaccounted for -- you know, so these GMs we know are lower than this, actually. We just don't have the exact yet.
Q. Are there typically more follow-up visits with the microprocessor knee than there are with the mechanical knee?
A. Great question. We have hypothesized that there could be more visits with an MPK and fewer visits with a mechanical. We haven't proven that out yet.
[redacted]
So we are hypothesizing that some of our more advanced devices -- legs and braces, everything included -- could actually take more follow-up visits than our products that are -- that we might call analogous to non-MPK knees.
Q. And what has your experience been in terms of the relative follow-up costs with a mechanical knee versus the follow-up costs with the

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microprocessor knee?
A. I think that there's probably -- I think that will probably be proven out that there are more visits to follow up with an MPK than a non-MPK.
Q. And so in the same way that you said these costs -- or these GM numbers in Exhibit 1 are not the actual gross margin because you're not accounting for those costs --
A. We don't have that final piece yet, right.
Q. -- if the cost of servicing a microprocessor knee is higher than the cost of servicing a mechanical knee, wouldn't that make the delta between the -- between the gross margin on the mechanical knee and the microprocessor knee greater?
A. Yes.
That's why when I finish my research, I want to go to CMS and get an allowable raise for the MPKs, because I don't think they pay enough.
Q. By the way, what about the battery in the MPK; do some patients complain about the battery?
A. I feel like I'm just not in touch recently with that -- with that topic. Because there was a period where I feel like the battery was sort of -- you know, the battery in one of the Pliés was

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removable. I assume it still is.
But people like the fact that they can take the battery out and charge it. Whereas, the battery in the C-Leg was just the C-Leg, you had to plug it into the wall.
So, again, I'm not sure of the current state of that, kind of where the amputee feels about the convenience of that or the length of the battery. Brian Kaluf could -- I'm sure would know more about that for sure --
Q. Have you known of cases --
A. -- or could know more.
Q. I'm sorry.
A. Or could know more about that, yeah.
Q. Have you known of cases where a patient wanted a mechanical knee because they don't want to deal with the battery in the MPK?
A. I think -- yes, I think there are cases like that. Patients don't want to deal with -- depending on lifestyle or activities, that they just would rather -- they walk in the knee and they say, Man, this is great, but, sorry, not plugging it in every night or every couple nights.
Q. Do you remember you were asked about the competition between the C-Leg and the Plié was

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responsible for bringing the price of the C-Leg down? Do you remember that testimony?

A. Yes.

Q. What were you basing that conclusion on?

A. Well, just the data that ten years ago I [redacted] what I was basing it on.

Q. Did you base it on any studies that you've done?

A. No.

Study, can you clarify that?

Q. Well, is there any research you're relying on to come to that conclusion?

A. No. Not -- none other than being part and parcel to the conversations over the last ten years of annual meetings with Ottobock and asking for a price decrease, you know, discounts and what -- you know, how can we lower the price of this product? We love it.

To, you know, having the same conversation with Freedom Innovations who says, Okay, well, our product is whatever it was when it hit the market, 15-something, maybe. I don't know, but I

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think it was around in that range. It has come down a little.

So we've experienced the Plié coming down a little and the C-Leg coming down a lot to be, I think, within a grand -- like right around a thousand dollars' difference. So...

That's the only -- that's my only is just kind of being witness to that, just the ride, the journey.

Q. Is it possible that some of that reduction came from competition from Ossur?

A. It's possible. I personally don't feel like -- you know, I feel like Ossur has been a little absent on the microprocessor knee stage.

Now, whether the Rheo XC is, you know, bringing a new -- a whole other game to the town here -- game to town. But their Rheo came out a long time ago and I feel like it was marginally adopted and just sort of -- I didn't really hear about it after that for a long time.

Q. Although the last two years you bought 11 of them.

A. Absolutely, yes.

Q. So somebody in the building likes the Rheo; right?

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A. Yes.

Q. And you said -- I think you testified that way back when, the Rheo was constantly in the shop.

Do you remember that testimony?

A. We had issues with the Rheo, yes.

Q. And when was way back?

A. Oh, I mean, probably before 2008. And I forget the exact age or time lines of the Rheo, but I think around 2008 it would have been.

Q. So you don't know today whether the Rheo is a product that has issues in terms of things sent to the shop?

A. Correct.

Q. Okay.

A. Yes.

Q. I think you said that it was considered a heavy product -- a heavy knee?

A. This version apparently is not as heavy as their -- the one that they kind of built the Rheo name on. But, yes, it was like wearing a brick.

Q. Okay.

A. I mean, it was bad.

Q. And when you say "this version," you mean the current version --

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A. The current XC --

Q. The XC.

A. -- is apparently lighter than the original Rheo. That just kind of hasn't been around for a while.

I mean, people bought it. I mean, but it's -- it didn't have its way into the top two.

Q. Okay. So just to be clear, when I asked you about buying the feet and the knee together --

A. Yes.

Q. And you were also asked about the promotions this morning.

Do you remember that testimony?

A. Yes.

Q. To be clear, the only benefit to Ability from knee/feet promotions is the financial benefit, that it saves you money; correct?

A. Correct.

Q. Okay.

A. If you were already going to do that foot -- if you were already going to do that manufacturer's foot with that manufacturer's knee, it's like, Okay, if that works, it's great.

Q. But the fact that a company like Freedom might offer a free foot with the knee with the Plié,

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that's a benefit to -- if you did that, you bought that combination, that's a benefit to Ability; correct?

A. Correct.

Q. The benefit is that you save money; correct?

A. Correct.

Q. It improves your margin; correct?

A. Correct.

Q. From a functional standpoint, there's no basis to buy that package as opposed to some other products?

A. Right. To the -- to the -- yeah. Yes. And, also -- and I don't think you mean this -- you're including this in functional, but, also -- I was thinking earlier when you asked about this -- is a by-product of that having the same knee, same foot manufacturer, too, is obviously if something goes wrong, you're calling one company. So...

But, again, that's -- whether that's a benefit to Ability or whether that's a benefit to the patient sort of as a pass-through from Ability because obviously if they break something and they come in your office, you're dialing 1-800-Ottobock and saying, Hey, I've got issues, and it's not managing two

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companies. So...

Q. They have an 800 number?

A. Well, I --

Q. I wasn't aware of that.

A. I -- no, do not dial that. I don't know -- I don't know where it goes.

Q. I promise you I won't.

Do you remember being asked about customer service this morning, specifically about the difference between Ottobock and Freedom customer service?

A. Yes.

Q. I think you testified that your experience with Ottobock customer service has been that it's not as good as Freedom Innovations' but not bad.

Is that fair?

A. That's correct. Yes.

Q. And then I think you testified that In my memory, it was not as great.

Were you basing your comparison of the customer service of Ottobock and Freedom on pre-2012 when you were actually seeing patients, or is it based on current knowledge?

A. It's not based on yesterday, but it's

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more current than 2008. So --

Q. I asked about 2012.

A. Or 2012, rather. Right.

So there could be customer service issues that I personally had or other practitioners around that time frame of '10, '11, '12, that you'd be like, Wow, I can't believe that was so hard, right, that could have been resolved at this point. Because I'm not in an office seeing patients, I don't have the -- I don't have that effect or that feedback from Ottobock to say, Oh, my gosh, they really improved that.

I know that Ottobock -- I feel like Ottobock has changed some of those things. Some of those things have been at the urging of Ability to say just like -- you know, particularly returning a product, right, just -- you know, Ottobock, for example, used to ask you -- maybe they still do. I don't know -- but they would ask you four or five things about returning the product. It was like, Gosh, can we just return the product? Can't you just give me the RA number? I've got a patient in the room. I want to go -- you know.

So -- Well, I need this ZIP Code. I need -- you know, it was always sort of -- it was

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almost like I'm the customer, yet I'm doing all the work here to return the product. Jeez, like --

So it -- so to your point, no. Have I called Ottobock in the last five years to return a product? The answer is no. And so it may be smooth as silk at this point.

So for clarity, yes.

Q. Have you ever complained about customer service to Ottobock in the last five years?

A. Complained in the sense of just like annual meetings with them when they come to the office to visit, and, you know, the couple of people that they've brought through the years, whoever that is in that group, just to say -- you know, when they say, What can we do better, you know, we say, Hey -- in a very respectful way -- like, Well, we would love to have trial units in the offices, or, We would love to have, you know, quicker -- you know, not have to go through three people to get a question answered or -- you know.

So, again, that's just been verbal feedback to say -- that's kind of where the relationship has gotten to that kind of a nice point where you're like, Okay, we're kind of communicating some of this stuff and -- you know.

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So, yes.
Q. So you think Ottobock has improved their customer service in the last couple of years?
A. Yes. I feel like there's been a -- more of an overt effort to be more user friendly to the -- to their customers.
MR. CASEY: I think I've reserved a little bit of time, but I think that's all the questions I have. Thank you.
THE WITNESS: Thank you.
MS. POSNER: I have some more questions. Do you all want to take a break before, or no?
MR. CASEY: I'd like to use the restroom.
THE WITNESS: A quick one.
(A recess was taken from 4:00 p.m. to 4:07 p.m.)
EXAMINATION
BY MS. POSNER:
Q. Mr. Brandt, are you familiar with a company called Nabtesco?
A. Vaguely.
Q. What do you know about them?
A. Not a whole lot. I've heard the name

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before.
Q. Are you familiar with an MPK knee that they may sell?
A. I think I've seen it in ads or, like -- I've never seen it in person, but I don't really have any, like, experience with it or really even know anything about it.
Q. Who are the people at Ability that are most familiar with current MPK offerings?
A. Right. So Brian Kaluf, Eric Shoemaker, Jeff Quelet. Those would be three people that is where I get a lot of my information as far as usage and pros, cons, that type of thing.
Q. Do they inform you about the developments in the microprocessor knee space?
A. Yes.
Q. How do they do that?
A. So it can be informally or casual, just like, you know, you're together for an afternoon at a conference and they say something to you or tell you.
Or it's, again, something like a presentation or, you know, like we're having a practitioner meeting next week and somebody there may do a presentation on knees, and so I'm sitting in the audience at my own meeting and I learn about it then

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as well.
Q. Do you rely on those three individuals regarding the microprocessor knee choices that Ability makes?
A. Yes.
Q. Have any of them told you about Nabtesco's microprocessor knee?
A. No.
Q. Are you familiar with the company named DAW, D-A-W?
A. Yes.
Q. Are you familiar with a microprocessor knee that DAW may make?
A. No, not really.
Q. Have you heard anything about a microprocessor knee that DAW either manufactures or distributes?
A. Again, it would have been fleeting, the same -- the same level of the other company that you mentioned, just -- I may have seen an ad or had a conversation or saw something on it, but that didn't go any further than that.
Q. Have the experts at Ability -- have the individuals at Ability who are most versed in the current MPK offerings mentioned to you anything about

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the DAW microprocessor knee?
A. No.
And, again, some -- again, some of these knees, for one reason or another, those people that I named may have looked at that and said, Well, that's great, but we're not -- we're not necessarily -- they don't view it as an attractive enough offering to even bring it in and trial it or -- they just kind of -- almost they read about it and just dismiss it as, Okay, that's great, you have an MPK, you know, but it's not on the level of an Ottobock or a Freedom or Ossur type of, Endolite type of caliber, so that's -- yeah.
Q. If any knee by Nabtesco or DAW were on the caliber of the C-Leg, the Plié, or the Rheo, do you expect that those individuals at Ability would have brought it to your attention?
A. I do.
Q. Why?
A. Because that's what they -- that's what they do -- that's what they're supposed to do is just make sure that they're aware of clinical options out there for the patients.
And then if there's something that we're not trying, that we at least evaluate it and, you

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know, try to understand more about --
I feel like some of those don't get to that point, just merely because you are -- there's a -- there's a -- what's the word -- not impression but a -- there's a -- there's a decision being made already that either manufacturing is not robust enough or it hasn't been proven.
I mean, there have been times in the last 20 years where you get really excited about a product. Then you use five or six of them, and you go, Holy cow, that was a disaster. Not doing that again.
So when you start to think about Ossur, Freedom, Ottobock, there's a certain amount of history and robustness there that just -- again, durability, that it's being done properly and can hold up to the rigors of a patient, that you just are -- you're a little more dismissive, sometimes, of those types of products.
Q. At what point would you be made aware of a new knee that's on the market? Is it before those gentlemen trialed it and brought it in or is it after?
A. At what point would I be made aware?
I mean, generally anybody coming out with anything is running ads in the magazines that we

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read. So usually it's -- it's usually me finding out about it on my own, and then either saying to one of them, like, Hey, what do you think about this?
And if their response is, Oh, yeah, I looked at that two months ago. It's -- we're not -- it's terrible or --
So that's -- that would be how I --
Q. And I think you said that you had seen ads for microprocessor knees from Nabtesco and DAW; is that right?
A. I think I have, yes.
Q. Did you ask Brian and Jeff and -- is it Sean?
A. Brian, Jeff, and Eric.
Q. Eric, about those knees?
A. I don't -- I don't recall specifically, but, again, there's enough constant communication about patient care and product advancements that there's -- I don't know that it would have been a call, per se, to say, Hey, what do you think about this knee I just saw on the O&P Edge?
It would be more of a roundabout way or, you know, like, Brian calling me and saying, Hey, DAW just called me. They have a new MPK. They want to come to the practitioner meeting and present it.

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And I would be like, Oh, okay. Wow. All right. Let's have them in.
Q. Just to be clear, has DAW called Brian and asked to come in?
A. No, not that I'm aware.
Q. Okay. You were asked a bunch of questions by Mr. Casey about changes you would make if the price of certain products would increase.
Do you remember that?
A. Yes.
[redacted]
If after the merger Ottobock decided to [redacted] what would you do with your Plié purchases?
A. Still continue to purchase them.
Q. Would you shift any of your Plié purchases to any other alternatives?
A. No.
Q. Do you have any other lower cost alternatives that are appropriate for those patients?
A. I don't believe we do. In the MPK category, I don't believe so.

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Q. I believe you also said at one point that if the price of a C-Leg went up 10 percent, you would switch a third of your purchases to alternatives, but you also said something about you [redacted]
The current -- can you clarify those two statements?
A. Sure.
I think that given that the C-Leg is about a thousand dollars above the Plié right now, that if the -- if the C-Leg went up 10 percent, that's a greater -- that's a greater change than the Plié going up.
So -- but my -- so my point was, yes, if the C-Leg went up 10 percent, my approximation of a third, we would look to possibly other knees. [redacted] thousand is -- my point is that clinically if they're indicated for an MPK, we're going to just keep absorbing that price increase.
But during -- while we're absorbing that, we're going to be also working as hard as we can with Ottobock and other companies to try to find good clinical solutions that are hopefully less than [redacted]

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Q. An increase of 10 percent of your current C-Leg price, that looks like it would make a [redacted] Does that make sense?
A. Yes.
Q. Do you have any other alternative -- who would you start switching the C-Leg customers to? Which other products if the price increased to [redacted]
A. Well, I mean, probably keep trying the Rheo XC and Pliés.
But, again, the Ottobock C-Leg is -- it's a great knee, so you don't -- while I'm hypothesizing that maybe a third of them would go into different knees, even with that price hike, it -- that [redacted] because the C-Leg has proven it's a great knee. So...
Q. Are there any knees besides the Plié and the Rheo that you're aware of that you might switch C-Leg users to if the price increased 10 percent?
A. Right. So I think to -- and I think I alluded to this -- but I would -- I think I would probably also launch a little more of a -- more -- even more in-depth to say, you know, Let's look at the Endolite. Is there something we're missing there on

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the -- Orion, sorry. It's Endolite, the manufacturer. But maybe the Orion made by Endolite is something worth looking at.
Q. If you look at --
A. Right, it was 19.
Q. -- Brandt-1 --
A. Right.
Q. What? [redacted]
Q. If you look at Brandt-1, there is one Orion 2 on that list.
A. Correct.
Q. It looks like potentially -- what does it look like the MPK cost is to Ability? [redacted]
Q. That's the full cost of goods. What about just the MPK cost?
A. Oh, I'm sorry. I apologize. I'm looking at the wrong -- [redacted]
Q. Okay. So would that be the most expensive microprocessor knee that you are currently paying for?
MR. CASEY: Objection to form.
THE WITNESS: Thereabouts, yes.

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BY MS. POSNER:
Q. That's over the price of the Rheo that you said that -- let me ask this: You said before [redacted] that right?
A. Yes.
Q. Okay. So the Orion 2 price is over the Rheo; is that right?
A. Correct.
Q. And the Orion 2 price is an increase over the current price Ability is paying for the Plie and the C-Leg; is that right?
A. Correct.
And for -- just for added clarification, that price is at one Orion as well.
So my -- so for me, the -- there's no volume in that, either. So, again, I'm trying to -- I'm also -- I just look ahead like that, so I would like to think, again, like I -- if I were doing more Orions, would that be the price? I would hope not, but it might be.
Q. There was also a bunch of discussion earlier today about gross margin as a percentage. Do you remember that?
A. Yes. Yes.

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Q. How does the absolute margin compare between a microprocessor knee and a mechanical knee?
MR. CASEY: Objection to form.
THE WITNESS: "The absolute margin" meaning just the knee or just the codes that are --
BY MS. POSNER:
Q. Not the percentage, but the actual amount of money that Ability makes on fitting a mechanical knee versus a microprocessor knee.
A. Right. So from a revenue standpoint, it's -- a microprocessor MPK knee generates more revenue than a non-MPK knee.
Is that what you're asking?
Q. That's what I'm asking.
A. Yes.
Q. Do you know how much more revenue a microprocessor knee generates than a mechanical knee?
A. I mean, generally speaking, I mean, if [redacted] total cost of goods of -- I mean -- you know, you're probably talking --
Q. So if you look all the way on the second set of pages, there's an Estimated GM column.
A. Correct.
Q. Is that helpful to you?

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A. Right.
Q. Is that how much actual revenue --
A. Yeah.
Q. -- Ability is getting from each of these knees?
A. Correct. From the entire limb.
Q. For the entire limb?
A. Correct.
Q. That's right.
A. That's right.
Q. Do you know how that compares to the estimated gross margin in dollar numbers on a limb with a mechanical knee?
A. My estimation would be -- well, and there's different kinds of mechanical knees.
So there's some mechanical knees I [redacted] just depends.
But maybe a range of -- again, on just [redacted] thousand, maybe, would be the equivalent number over here.
Because, again, socket and socket and feet and feet, we're going to say they're equal.

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So --
Q. And here taking the Genium X3 out of the picture because those are very high pricings, what's -- it looks like Ability's estimated gross [redacted] per --
A. Correct.
Q. -- knee; is that right?
A. That is correct.
MR. CASEY: Where -- I'm sorry. Could you tell me where you are?
MS. POSNER: What?
The Estimated Gross Margin column.
MR. CASEY: Could I ask for that question and answer to be read back. Sorry.
(The court reporter read back the following:
"Q. And here taking the Genium X3 out of the picture because those are very high pricings, what's -- it looks like Ability's estimated gross [redacted] knee; is that right?
"A. That is correct.")
BY MS. POSNER:
Q. Okay. And let me clarify that.

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That's actually per limb; is that right?
A. I'm sorry?
Q. I said per knee, but it's really per limb; isn't that right?
A. It is per limb, and that's really important because the third or fourth one down that's [redacted] is as high as it is is because the -- if you look over in the Comments, it says LIM, L-I-M, that is a highly specialized socket that was done with that leg. And that LIM socket reimburses for a lot more than a traditional socket.
So, again, it's really important that we look at this Estimated GM as per limb -- not L-I-M but L-I-M-B -- per prosthesis. Because other components in the prostheses can change this number over here (indicating).
Q. Okay. So then leaving this aside --
A. Yes.
Q. -- this Brandt Number 1 aside, based on your experience, does Ability make more money when it fits a microprocessor knee than when it fits a mechanical knee, all other things being equal?
A. Yes.
Q. Do you know how much?

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A. So if I just used the Medicare allowable, which I think is around 33,000 for the codes that are in question, and we were to pay in the [redacted] profit on just the knees.
And I would --
Q. For a microprocessor?
A. For an MPK, right.
And I would guess -- or I would say that it's -- for mechanicals, that it's somewhere in the range of 8 to 14 thousand on a mechanical.
Maybe not as high as 14, but I -- I feel comfortable with the 8. 8 to 10 probably is a better...
Q. Okay. We also discussed RAC audits, or you discussed RAC audits earlier today.
Do you remember that?
A. Yes.
Q. Will Ability clinicians be fitting fewer microprocessor knees as a result -- let me ask -- setting the table question first.
A. Okay.
Q. You mentioned that you were expecting an uptick in the number of RAC audits in the future.

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A. Yes.
Q. Will Ability clinicians be fitting fewer microprocessor knees as a result of that uptick in RAC audits?
A. No.
Q. Why not?
A. Because our documentation process around rationale and justification for an MPK is sound, clinically sound. And so we're not recommending those knees unless we can go all the way to an Administrative Law Judge and win that case.
Q. Will Ability clinicians be fitting fewer Pliés as a result of the expected uptick in RAC audits?
A. No.
Q. Why not?
A. Because it's an MPK knee that will -- we will have justification and rationale well documented and be able to substantiate clinically why we chose it.
Q. Do you think that other clinicians at other facilities will be doing the same as Ability for the RAC audits?
A. Not necessarily.
I think that -- I think that the

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profession has come a long way in the last five, six years with regards to documentation and quantifying with outcome measures, and being able to substantiate why they chose something.
So I -- I'm hopeful that if the RAC audit -- RAC audits tick back up, that -- again, that the result of that is companies sending in sound, clinical files that Medicare goes, Wow, these are amazing. Great. Keep the money.
Q. With regards to competition between Ottobock and Freedom in pricing, do you ever -- have you ever told Ottobock that you would move more microprocessor volume to them if they offered a lower price to Ability?
A. Yes, in the sense that if the price were more competitive, that we would certainly try to look at it differently and make it -- I mean, it's already a great knee, so there's already a lot of instances where regardless of price, we're going to fit it.
But it's -- the dialogue was always, Look, you have the -- you've got to lower the price
[redacted]
you work with us on price?
Q. Have you ever in those conversations

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guaranteed any volumes or suggested that you could sell a certain number of knees for a lower price?
A. We have suggested to both Ottobock and Freedom over the years that targets as far as like, Oh, how many microprocessors do you think you're going to fit?
Oh, 30 this year.
Well, how many of them do you think can be C-Legs or Pliés?
And it's always sort of we're a little wishy-washy with the target concept anyway because it doesn't really fit us. It's kind of like, Look, if I have 57 people that I'm going to fit with knees in two years, we will certainly do our best to keep staff trained and educated and up-to-date.
But at the end of the day, if I fall woefully short of the target or this conceptual sort of you're going to do 20 or 25, I don't know. Like, are we going to change the -- like, do I owe you money? Do I owe you back money because I didn't hit the target?
I can't enter into anything like that. So, yes, I think in those meetings you'll always talk about where you think you can get to just as, like, a stretch goal or a stretch, like, this would be great.

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But at the end of the day, we always make them very aware that in the end, it's -- we don't know where it's going to shake out.
Q. In those discussions is there any discussion about moving patients between a C-Leg and a Plié?
A. Like an existing --
Q. A new patient.
A. Oh, a new patient.
No -- what do you mean, like, you get a new patient a week after the conversation and then you give them -- give them the knee of who you had the -- just had the conversation with?
Q. Or, Ottobock, I'll try to shift more volume to you if you lower the price. And that shift would come from Freedom knees.
A. I mean, not -- again, for us, it's -- I can't guarantee the volume. So it's always been a can you please lower the price.
I've gone to a lot of companies over the 20 years and just said, Please lower the price.
And they say, Well, you do no volume with me.
And I say, That's right, and we probably won't if you don't -- it's just -- it has -- not

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Ottobock, like, other companies.
Q. Fair enough.
A. And they'll say, Well, you know, if you can get it up to 20, we can do this or you'll be the gold level.
It's like, I don't want to be the gold level. I just want what the product's worth right now, even if I did one or 50. So...
Q. You also discussed Ottobock's customer service and said that in the last five years, you've seen the level of customer service increase; is that right?
A. Correct.
Q. Is the level of Ottobock's customer service today at the same level of Freedom's customer service today?
A. I would say not quite. But, again, I mean, like, we've asked Ottobock to do some things and they've done it, so that's a good thing.
But I think, like, you know, it's still -- and maybe it's just going to be history, right, maybe it's just going to be the past is the past, I mean, and it's -- because you carry that with you, right. There's, like, an additional --
You know, if someone walked into the

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prosthetic market today, gets out of school, graduates, and experiences Ottobock today, their impression of the company is probably going to be different from mine because -- just because of legacy, I guess is what I'm trying to say.
So as objective as I'm trying to be about the changes, I'll probably always have a little bit of like, Gosh, it used to be really -- it was really tough, but now it's pretty good working with them.
But somebody new to the industry may say, What do you mean, it's pretty good working with Bock? They're great.
And I'll be like, All right. I'm glad.
Q. Is it as good to work with Ottobock today as it is to work with Freedom?
A. It is not.
Q. What's the difference today?
A. The difference is just -- it's just easier to interact. It's -- I don't -- again, these are like psychosocial -- these are like psychosocial -- you know, this is more like how we as clinicians interact with our patients in the room. We want to act with our suppliers that -- in that same manner.

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And I think it's -- I feel like the only way I can articulate it is just to say that it's just difficult to work with Ottobock. It's like they're not user friendly, but they're more user friendly than they've ever been. And what I mean by that is just interactions are just easy.
You walk up to people from Freedom and it's just -- it's just easy.
And I feel like when we have meetings with Ottobock, it's not -- it's almost like -- it's like we're asking for something. They're selling something. If it matches, great. If it doesn't, see you next year.
It's just not -- and I always say, We've got to figure out how to work with Ottobock better. We've got to figure it out.
And people will say, No, we don't.
And I say, Yes, we do. We've got to figure out how to have a relationship with Ottobock. So...
MS. POSNER: Okay. I have no further questions.
THE WITNESS: Okay.
MR. CASEY: So I have 13 minutes?
MS. POSNER: Something like that.

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EXAMINATION
BY MR. CASEY:
Q. Okay. So you recall your testimony just a few minutes ago when you were asked about the absolute margin of the Plié as opposed to the C-Leg? Do you remember that?
A. Yes.
Q. And I think you testified that you estimated that -- well, I think your testimony was about MPKs generally, that the pure profit was around [redacted]
A. Correct.
Q. When you make that estimate, you're talking about overall the entire number of MPKs that you buy, the average profit to Ability once you do those prostheses, the average profit that is [redacted]
A. Correct. That would be on the higher side. Just for the knee.
Q. "On the higher side," what do you mean?
A. Right. So if the Medicare allowable is [redacted] would represent a high if you received the secondary payment to Medicare.

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[redacted]

Q. Right. I understand that.

So it could be less, depending on the reimbursement --

[redacted]

you described that scenario.

Q. But I think the scenario you just

[redacted]

A. It could, yes.

[redacted]

A. Yes.

Q. We're talking -- and I understand these

[redacted]

A. That's fair.

Q. Okay. I mean, it's your testimony. I'm

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not --

A. Yes.

Q. -- I'm not putting words in your mouth, but I just want to make sure I understand.

So you're saying --

A. Considering all fee schedules, I think

[redacted]

don't. But --

Q. Okay.

[redacted]

Q. Right. Okay.

And the mechanical knees are quite a bit cheaper; right? So they're, I think you said, between 500 to $2,000; correct?

A. Correct.

Q. And what's the typical or an average -- strike that.

What is the average reimbursement on a mechanical knee?

A. Again, I'm not -- I'm not as familiar with that or as prepared for that. So I would probably like to get that.

But I think it's around -- it would have

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[redacted]

Q. Okay. Because you started out, you said

[redacted]

A. I meant on the -- okay. So I think I

[redacted]

Q. Right.

A. I'm sorry. Right. This back-and-forth between --

Q. Yes.

A. -- entire prosthesis and knee. Right.

So, generally, a transfemoral or above-knee prosthesis with a mechanical knee, that

[redacted]

numbers. Right.

And so just the knee -- again, I'm not as familiar with the profit levels of just the mechanical knees. So, again, but if you bought a $500 mechanical knee and put the L-Codes on it that are supposed to be billed with that knee, you're probably only going to see maybe 1,500, 2,000 reimbursement minus the cost of the knee.

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So maybe as little as 1,500 or 2,000 profit on the least costly might -- or non-MPK.

And then if you buy a mechanical, that's 1,500 or closer to two grand, and there may be some over 2,000. I'm sorry if there are, we'll have to check it, but those knees would inherently probably carry codes -- billable codes that would also increase the reimbursement.

So you may spend 2,000 for a mechanical knee and the reimbursement is -- on that knee is, like, 6,000 or 5,500, which would mean your profit's around 4. So...

But that's not to say there's not a mechanical knee that profits more than $4,000. There might be.

Q. Are you not as familiar with the prices of the mechanical knees as you are with the MPKs?

A. I'm not.

Q. And why is that?

A. I'm just not. I haven't -- I haven't followed it as closely.

Q. And the same question for the reimbursement levels for the mechanical knees, are you not as familiar with those as you were the reimbursement levels for the microprocessor knees?

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A. Yeah, I just -- yeah, I mean, I just -- I know that in -- as we discussed earlier in the mechanical knees, they're generally not a pricing concern. They seem to be slotted with what would be commensurate with the reimbursement.

Whereas the MPKs have always seemed to be priced a little bit on the higher side to put pressure on that reimbursement, at least how Medicare has established that allowable.

So I think it's just by default it's caused you to have more of a following of, like, where do the MPK margins stand versus where does that nonmechanical knee margin stand?

If the mechanical knee margin is [redacted] speculated, if that moves a tick or two, it's not as big of a deal if -- than if we get a microprocessor [redacted] what's -- you know, what's happening there?

Q. I think you testified when I asked you about reimbursement that the reimbursement on a mechanical knee is a sure thing; right?

A. It -- I think they're both sure things at this point. But it just -- it depends on the patient's policy.

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Q. But, I mean, it's -- would you say it's harder -- generally speaking, harder to get reimbursed for a microprocessor knee than for a mechanical knee?

A. I think so, yes.

Q. So there may be instances where with the mechanical knee you actually lose money because you don't get reimbursed at all? Does that happen?

A. Say that again. I'm sorry.

Q. Are there instances where on a particular prosthesis you actually lose money because you don't get reimbursed for the microprocessor knee?

A. No, because we are tireless in our pursuit of an authorization.

And if we can't get an auth, we -- if the patient's policy doesn't require an auth, then we keep going until we get a medical director for someone to vouch and say, If we provide this and fit this, you're going to pay it.

If they don't pay it, we go through the normal appeals. We get compliance involved at the payor or we go get outside counsel.

So I -- back -- a long way back in the history of the company, it's possible that we didn't get reimbursed on a knee or two here and there but not in recent memory.

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Q. But other companies that are not as good at the reimbursement system as you are could face that problem, right, in not getting any reimbursement on that microprocessor --

MS. POSNER: Objection. Calls for speculation.

BY MR. CASEY:

Q. Correct?

A. I would -- I would probably agree that if they can't -- if they don't have the resources to fight it or somehow feel like they provided the knee and they shouldn't have, then they probably -- they -- yeah, they probably lose out.

MR. CASEY: Okay. I don't have anything else. Thank you.

THE WITNESS: You're welcome. Thank you.

MS. POSNER: Off the record.

(Witness excused.)

(The deposition concluded at 4:48 p.m.)

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WITNESS CERTIFICATION

I hereby certify that I have read the foregoing transcript of my deposition testimony, and that my answers to the questions propounded, with the attached corrections or changes, if any, are true and correct.

_____ _____

DATE JEFFREY M. BRANDT

_____

PRINTED NAME

CERTIFICATION

I, DIANNA R. PUGLIESE, Registered Merit Reporter, Certified Realtime Reporter, Certified Shorthand Reporter, certify that the foregoing is a true and accurate transcript of the foregoing deposition, that the witness was first sworn by me at the time, place and on the date herein before set forth.

I further certify that I am neither attorney nor counsel for, not related to nor employed by any of the parties to the action in which this deposition was taken; further, that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in this action.

s/Dianna R. Pugliese
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EXHIBIT E

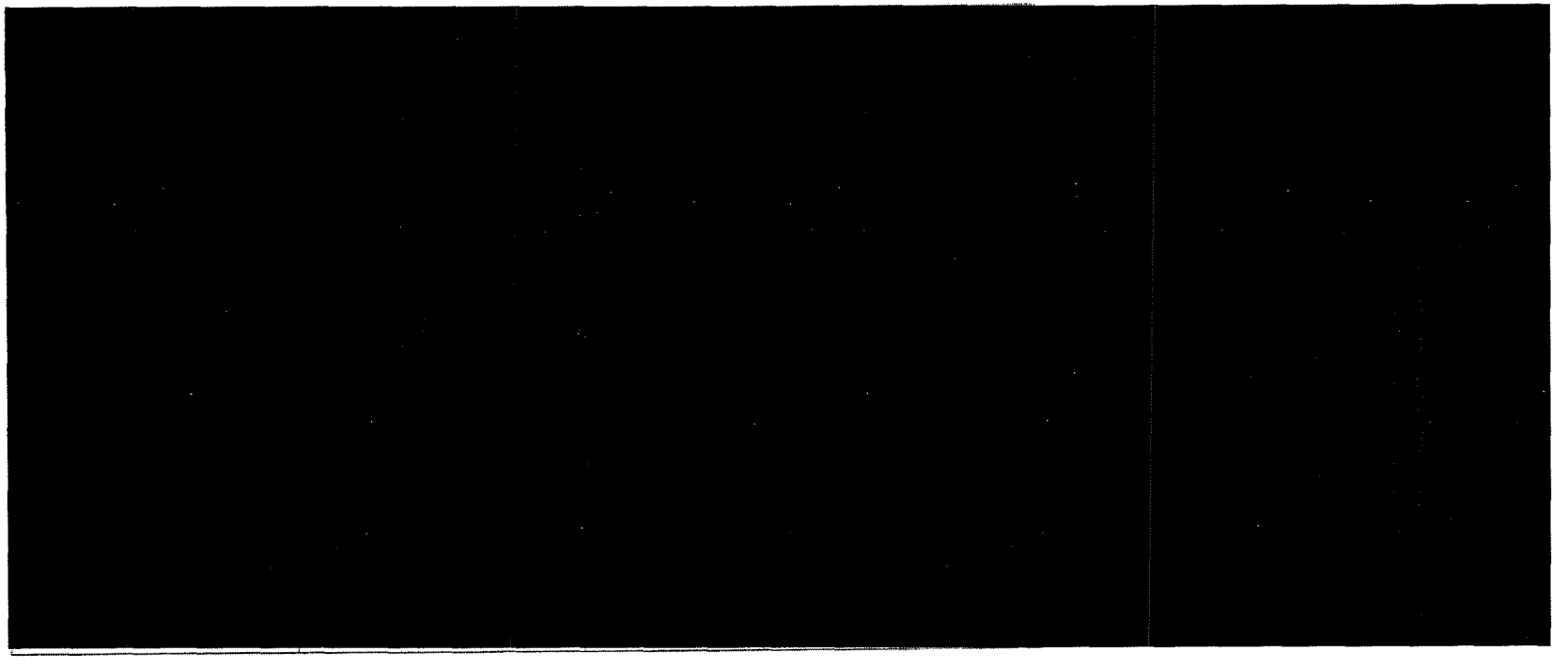
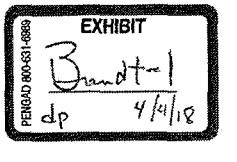


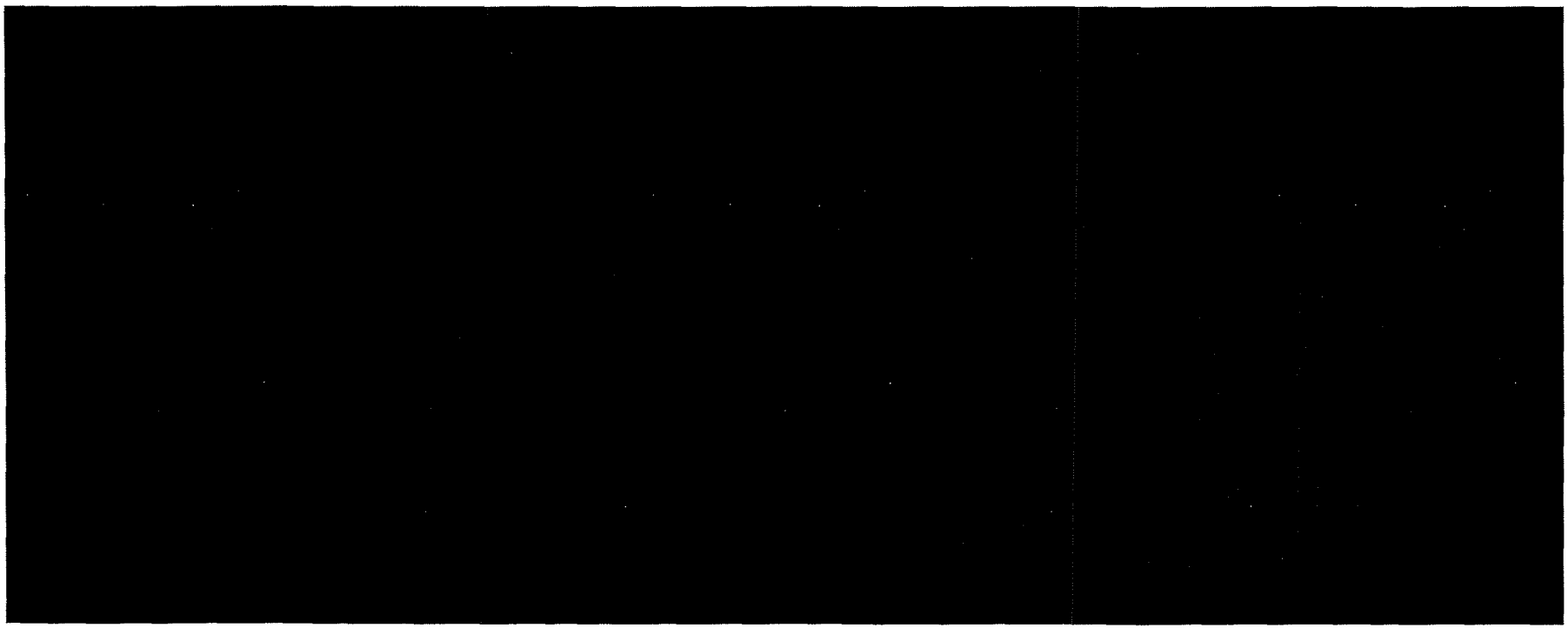
EXHIBIT
BRANDT 1



Device Type	Primary Insurance	DOS	Date Billed	Claim Number	Estimated GM	Year-Month	Year	Device Group
[redacted]								

PUBLIC

Branch	Treating Practitioner	Patient ID	Estimated Total COGs	Allowable (Claim S	Cost of Goods	MPK	MPK Cost	Ordered Item	Future COG	Total COGs	GM%	Comments
[redacted]												



CONFIDENTIAL – FTC Docket No. 9378

APO 000017

EXHIBIT F

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of	)	
	)	**PUBLIC**
Otto Bock HealthCare North America, Inc.	)	**Docket No.: 9378**
	)	
Respondent	)	
	)	

DECLARATION OF JEFFREY M. BRANDT IN SUPPORT OF NON-PARTY ABILITY PROSTHETICS & ORTHOTICS' MOTION FOR INDEFINITE *IN CAMERA* TREATMENT

I, Jeffrey M. Brandt, CPO, hereby declare as follows:

1. I am Chief Executive Officer of Ability Prosthetics & Orthotics ("Ability"). I make this declaration in support of Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite *In Camera* Treatment (the "Motion"). I have personal knowledge of the matters stated herein and, if called upon to do so, could competently testify about them.

2. I have reviewed and am familiar with the documents Ability produced in the above-captioned matter in response to subpoenas from the Federal Trade Commission and Respondent Otto Bock HealthCare North America, Inc.

3. I testified under oath at a deposition held on April 4, 2018, at which counsel for FTC and counsel for Otto Bock questioned me, among other things, about the Confidential Document (Trial Exh. PX03282; Exh. Brandt 1; Bates No. APO000017) that is a subject of Ability's Motion.

4. At my deposition, I also testified about other topics and matters that are also subjects of Ability's Motion.

5. Given my position as CEO of Ability, I am familiar with the type of information contained in the Confidential Document and in my deposition transcript (the "Confidential Testimony" (Trial Exh. PX05149), together with the Confidential Document, the "Confidential Information"). I am also aware of the competitive significance of the Confidential Information for Ability. Based on my review of the Confidential Information, my knowledge of Ability's business, and my familiarity with the confidentiality afforded this type of information by Ability, I submit that disclosure of the Confidential Information to the public, to Ability's competitors and suppliers, or to the entities that reimburse Ability for the prosthetic services provided to patients, would cause serious competitive injury to Ability.

6. The Confidential Document shows the cost of goods to Ability (i.e., how much Ability pays various manufacturers and suppliers for prostheses, which includes any negotiated discounts), the allowable claim (i.e., how much Medicare or private health insurers will pay Ability for the service provided to patients), the cost to Ability of various microprocessor knees ("MPKs") including any negotiated discounts, and Ability's gross margin on each patient. Ability keeps all of that information confidential and it is material to the core of Ability's business. Competitors, suppliers, and payors could derive advantages from that information that would injure Ability's capacity to negotiate costs and prices, shrink its revenue and profit margins, and hamper Ability's competitiveness.

7. The information in the Confidential Document is drawn from Ability's records for the period January 1, 2016 to December 31, 2017, and was compiled in a spreadsheet expressly in response to the subpoenas Ability received from FTC and Otto Bock. The raw data are from the two most recent calendar years, and the relationships, ratios, and percentages expressed by the data are unlikely to change for the foreseeable future.

8. For all of these reasons, I believe that the Confidential Document should be granted indefinite *in camera* treatment in its entirety.

9. In my deposition, I testified about the data in the Confidential Document. All of that testimony should likewise be granted indefinite *in camera* treatment. Those portions of the Confidential Testimony are: page 47, lines 12-13, 17; page 59, lines 19-20; page 60, lines 10-11; page 61, line 13; page 68, lines 3, 7; page 70, line 12; page 71, line 7; page 93, line 25; page 94 lines 2, 20-21; page 95, lines 23-24; page 96, line 4; page 117, lines 22-25; page 118, lines 3-10, 18-25; page 119, lines 1-25; page 120, lines 1-20; page 161, lines 19-25; page 162, lines 1-13, 22-24; page 163, line 20; page 164, lines 18-24; page 168, lines 19-23; page 169, lines 1-9; page 170, lines 5-7; page 182, lines 22-23; page 189, lines 14-17; page 192, lines 1-7; page 201, lines 9-10, 21; page 202, line 1; page 205, lines 13, 25; page 207, lines 10, 25; page 208, lines 2, 10, 18; page 211, lines 16, 21; page 212, line 6; page 230, lines 13-17; page 233, lines 6-8; page 247, lines 11-14, 16; page 248, lines 5, 17, 25; page 249, lines 3, 9, 16; page 250, lines 9, 15, 20; page 251, line 4; page 252, line 19; page 253, lines 17-18, 21; page 254, lines 5, 21; page 255, line 7; page 256, lines 4-5, 12-14; page 264, lines 11, 17, 22-23; page 269, lines 15, 18.

10. I also testified about Ability's internal business affairs, past and present, disclosing confidential information about management, the Board of Directors, corporate debt and finances, my personal thought processes in deciding whether to seek licensure in Pennsylvania or other states, and similar non-public matters that have no relevance to the dispute before this Court but that if publicly disclosed would cause injury to Ability's business or reputation and thereby damage its competitiveness. For these reasons, I request indefinite *in camera* treatment of the following portions of my deposition transcript: page 16, lines 18, 20-22; page 30, line 12; page 61, lines 23-25; Page 62, lines 1-3; page 74, lines 12-17 (subject to an

NDA); page 96, lines 23-25; Page 97, lines 1-25; page 98, lines 1-3; page 100, lines 1-7; page 102, lines 1-8, 19, 22, 25; page 103, lines 4, 10-15; page 109, lines 2, 7-24; page 110, line 22-25; page 111, lines1-5, 12-15, 20-25; page 112, lines 1-6, 11-25; page 113, lines 1-2; page 114, lines 2-3; page 115, lines 14-25; page 116, lines 1-25; page 117, lines 1-17; page 156, lines 8-10, 24-25; page 158, lines 6-16; page 159, lines 1, 4-7.

11. Similarly, at certain points in my deposition, I testified about Ability's relationships with the various payors (principally, Medicare and private health insurers) that reimburse Ability for the care provided to patients. Those payors are often identified by name and compared with one another as to the approaches they take to different scenarios and treatment options. Public disclosure of those comparisons could damage Ability's relationships with the payors and consequently injure its ability to compete with other providers. The following portions of the Confidential Testimony should therefore be granted indefinite *in camera* treatment: page 69, lines 3-7, 23-25; page 70, lines 1-3; page 258, lines 22-23; page 265, lines 1-11, 15, 18, 20, 23; page 266, lines 7-8, 11-12, 16; page 267, lines 1-3, 5, 7, 15-17.

I declare under penalty of perjury that the foregoing is true and correct. Executed June 8, 2018 at Exton, Pennsylvania.

Jeffrey M. Brandt, CPO
Chief Executive Officer
Ability Prosthetics & Orthotics

Notice of Electronic Service

I hereby certify that on June 08, 2018, I filed an electronic copy of the foregoing Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment and Memorandum of Law, Exhibits to Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment, with:

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Chief Administrative Law Judge
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Washington, DC, 20580

Donald Clark
600 Pennsylvania Ave., NW
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Washington, DC, 20580

I hereby certify that on June 08, 2018, I served via E-Service an electronic copy of the foregoing Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment and Memorandum of Law, Exhibits to Non-Party Ability Prosthetics & Orthotics' Motion for Indefinite In Camera Treatment, upon:

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