

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM
THE ADMINISTRATIVE LAW COURT

H.W. Funderburk, Jr., Administrative Law Judge

Case No. 18-ALJ-07-0100-CC
Appellate Case No. 2019-001159

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SC Court of Appeals

Trident Medical Center, LLC d/b/a Trident Medical
Center,..... Respondent,

v.

South Carolina Department of Health and Environmental
Control and Medical University Hospital Authority d/b/a
MUSC Radiation Therapy Center – Berkeley County, ... Respondents,

Of Which, Medical University Hospital Authority d/b/a
MUSC Radiation Therapy Center – Berkeley County is
the..... Appellant.

RECORD ON APPEAL
VOLUME I

Daniel J. Westbrook
Travis Dayhuff
A. Mattison Bogan
William C. Wood, Jr.
Nelson Mullins Riley & Scarborough LLP
Post Office Box 11070
Columbia, SC 29211
(803) 799-2000

David B. Summer, Jr.
William R. Thomas
Parker Poe Adams & Bernstein LLP
121 Main Street, Suite 1100
Columbia, SC 29201
(803) 255-8000

*Attorneys for Appellant Medical University
Hospital Authority d/b/a MUSC
Radiation Therapy Center – Berkeley
County*

*Attorneys for Respondent
Trident Medical Center, LLC d/b/a
Trident Medical Center*

[Additional counsel listed on inside cover.]

Ashley C. Biggers
Vito M. Wicevic
South Carolina Department of Health
& Environmental Control
2600 Bull Street
Columbia, SC 29201
(803) 898-3350

*Attorneys for Respondent South Carolina Department of
Health and Environmental Control*

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**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Trident Medical Center, LLC, d/b/a)
Trident Medical Center,)
)
Petitioner,)
)
v.)
)
South Carolina Department of Health and)
Environmental Control and)
Medical University Hospital Authority)
d/b/a MUSC Radiation Therapy Center -)
Berkeley County,)
)
Respondents.)
_____)

Docket No. 18-ALJ-07-0100-CC

**ORDER GRANTING
PETITIONER'S MOTION FOR
JUDGMENT AS A MATTER OF LAW
AND
DENYING CERTIFICATE OF NEED
ON OTHER GROUNDS**

This matter comes before the South Carolina Administrative Law Court (ALC or Court) on the Motion of Trident Medical Center, LLC, d/b/a Trident Medical Center (Petitioner or Trident) for Judgment as a Matter of Law.¹ The Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center - Berkeley County (Respondent or MUSC)² opposes the Motion.

As a matter of procedural background, on January 24, 2019, Trident made the Motion before the Court after the conclusion of several days of testimony in a hearing contesting the approval of an application for a Certificate of Need (CON) issued to Respondent by the South Carolina Department of Health and Environmental Control (DHEC or Department).³

FILED

MAY 14 2019

SC ADMIN. LAW COURT

¹ During the hearing, attorneys for Trident referred to the Motion as a request for "Judgment as a Matter of Law." (Trial Tr. 1209:3-4; 1220:1-5). Filings with the Court caption the Motion as one for "Directed Verdict." Since the Court cannot grant a Motion for Directed Verdict, the Motion will be treated as one for Judgment as a Matter of Law.

² The Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center - Berkeley County was referred to during trial as "MUSC." This naming convention continues in this Order, except when use of "Medical University Hospital Authority" or "MUHA" is necessary for clarity.

³ The hearing was scheduled, and conducted, to resolve several other matters raised by Petitioner with respect to the approval of the CON Application. However, because the assertion set forth in the Motion could be dispositive in either reversing DHEC and denying the CON or resolving the issue in favor of MUSC, which would then leave the Court to decide the remaining matters set forth during the hearing, the Court and the parties agreed post-hearing to initially address and brief only the issue set forth in the Motion in the interest of judicial economy.

In its Motion, Trident contends that MUSC Cancer Care Network, LLC, (the entity identified in the application as the manager/operator of the proposed project) is an unlawful joint venture and, therefore, the CON Application as presented to DHEC does not comply with the CON standards and criteria and must be denied. Trident asserts that the management company is unlawful because the state constitution prohibits political subdivisions from being joint owners or stockholders of companies and because the enabling statutes of MUSC and MUHA do not permit either to form or own for-profit entities. Therefore, Trident asks the Court to overturn DHEC's decision to approve the Certificate of Need in its request for relief.

On May 22, 2017, MUSC filed a CON Application (Application) seeking DHEC's approval to establish a radiation therapy center in Berkeley County, South Carolina. As a state entity, MUSC provides comprehensive cancer care with multidisciplinary treatments that include surgery, radiation oncology, medical oncology, and other patient care needs at its main campus located on the peninsula in downtown Charleston. To better serve its cancer patients in and around the growing areas of Berkeley and Dorchester counties (North Area), the proposed radiation therapy center in Berkeley County will benefit the roughly 30% of MUSC cancer patients who live in the North Area and currently travel to the main MUSC campus in downtown Charleston for treatment. The planned center is slated to include a linear accelerator, a CT scanner, examination rooms, offices, and other space for planning, storage, and clerical and administrative support.

DHEC deemed the Application complete for purposes of review on July 10, 2017. A project review meeting in which all parties participated was held on September 20, 2017. On October 4, 2017, Petitioner filed a written reply to address Respondent's arguments. DHEC approved the CON Application by letter dated November 22, 2017. Petitioner timely filed a Request for Board Review on December 15, 2017; that request was denied, thereby making the decision granting the CON final. On March 1, 2018, Petitioner sought administrative review as an affected person with standing to challenge DHEC's decision. After conducting discovery, a contested case hearing was held before the ALC over the course of five days in January 2019.

During the hearing, the Court heard testimony from several witnesses, including Margaret Murdock, the Director of the CON Program at DHEC who reviewed and approved the Application, and Dr. Patrick Cawley who, as well as being a practicing physician, holds numerous executive positions within MUSC and its affiliated organizations.

The Court also heard testimony from Daniel Sullivan on behalf of Trident and David Levitt on behalf of MUSC. Both of these witnesses were qualified to testify as experts in healthcare planning and healthcare finance pursuant to Rule 702, SCRE.

Having observed the aforementioned witnesses, as well as others before the Court, and considering the evidence presented at the hearing along with the post-trial memorandums and exhibits submitted by both parties, the Court makes the following Findings of Fact by a preponderance of the evidence:⁴

FINDINGS OF FACT

A. CON Review

Under the State Certificate of Need and Health Facility Licensure Act (CON Act), S.C. Code Ann. § 44-7-110, *et seq.* (2018 & Supp. 2017), DHEC is the agency charged with implementing the South Carolina CON Program through the granting of CONs and the licensing of healthcare facilities. To effectuate this obligation, DHEC is required to publish a biennial South Carolina Health Plan (State Health Plan) to establish the need for medical facilities and services. The State Health Plan includes an inventory of existing services, the projections of need for additional services and facilities, and the standards for distributing the facilities and services across designated multi-county regions referred to as “service areas”. S.C. Code Ann. § 44-7-180(B).

In determining whether to grant or deny a CON, the Department evaluates a proposed project under the review criteria found in the CON Regulations, S.C. Code Ann. Regs. 61-15 (Supp. 2017), and under the policies and standards set forth in the applicable State Health Plan. Pursuant to the CON Act, the Department may not issue a CON to an applicant “unless the application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations.” S.C. Code Ann. § 44-7-210(B) (2018); *see also MRI at Belfair, LLC v. S.C. Dep’t of Health and Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the Project Review Criteria are independent requirements for approval of a CON). Even if an application complies with the State Health Plan, the Department can refuse to issue a CON based

⁴ To the extent that any Findings of Fact set forth herein shall be considered not to be Findings of Fact but Conclusions of Law, they may be deemed as such.

on the Project Review Criteria and other regulations it identifies. S.C. Code Ann. § 44-7-210(B). However, no project can be approved unless it is consistent with the State Health Plan. S.C. Code Ann. Regs. 61-15 § 307(1).

In regard to the Application at issue, the State Health Plan that applies to the proposed project is the 2015 Health Plan, enacted August 13, 2015. Chapter IX of the State Health Plan sets forth the CON standards for the addition of a linear accelerator (LINAC), the device that administers radiation treatment, in the service area. The Department reviewed the Application for consistency with Standard 7 because it was considered an expansion of the services MUSC already offered in the service area at its main campus, rather than an application to establish new services to be reviewed under Standard 6. The service area consists of Berkeley, Charleston, Colleton, and Dorchester counties (Service Area). The Department identified the following Project Review Criteria (PRC) as relevant to the proposed project and used them to review the CON Application:

- a. Compliance with Need outlined in the State Health Plan (Chapter IX)
- b. Community Need Documentation
- c. Distribution (Accessibility)
- d. Medically Underserved Groups; and
- e. Financial Feasibility

(DHEC Ex. 1, p. 370). These PRCs were ranked according to their relative importance, with the most important listed first. All other relevant criteria were considered to be of equal import.

B. The Entities Involved

The Motion before the Court requires a determination of the constitutionality of the entity identified in the Application as the operator and manager of the proposed facility. As such, it is first necessary to analyze the organizational structure of the Medical University of South Carolina and its relevant affiliated entities.

MUSC: In 1913, the General Assembly accepted a transfer of private property and established the Medical University of South Carolina as a state agency, now governed by S.C. Code Ann. § 59-123-10, *et seq.* MUSC is run by a board with specified authorities and powers established through its enabling legislation in S.C. Code Ann. § 59-123-60(A). While the majority of functions take place in Charleston, MUSC is increasingly forming strategic alliances with other hospitals and hospital systems across South Carolina, extending its reach into other areas of the state.

MUSC has received numerous designations and awards for providing high levels of healthcare in many areas of disease, including cancer care. In fact, as stated in the Application, the MUSC Hollings Cancer Center (Hollings Cancer Center) is one of the leading cancer treatment centers in the Southeast and one of fewer than 70 cancer centers in the nation – and the only one in South Carolina – to receive a designation from the National Cancer Institute (NCI). (DHEC Ex. 1, p. 7).

MUHA: MUSC consists of three main bodies: the medical school, the hospital, and the physician practice group.⁵ In 2000, the General Assembly established the Medical University Hospital Authority (MUHA) as a separate state agency to be run by a board comprised of the same members that serve on the MUSC board. (Trial Tr. 678:14-18). Through powers enumerated in its enabling legislation, MUHA is granted the authority to manage, regulate, and operate the healthcare functions of MUSC. MUHA is also specifically authorized to establish not-for-profit corporations or entities as the board finds necessary to facilitate the healthcare operations of MUSC. S.C. Code Ann. § 59-123-60(E)(13).

UMA: University Medical Associates (UMA) is MUSC's physician practice plan that also operates as a 501(c)(3) entity. (Trident Ex. 56, p. 2). According to MUSC's 2018 Comprehensive Annual Financial Report that contains the organizational chart of MUSC and its affiliates, UMA is a "non-profit corporation established to promote and support the educational, medical, scientific, and research purposes of the University." *Id.*

MUSC SV: The same organizational chart also states that MUSC Strategic Ventures (MUSC SV)⁶ was "formed in September 2015 to allow affiliation with tax exempt entities to support the missions and programs of The Medical University of South Carolina, UMA and MUHA." *Id.* As described in the Application, MUSC SV was "established at the direction, and for the support and benefit, of [MUSC], an agency and political subdivision, and public university, of the State of South Carolina that works in close collaboration with [MUHA], also an agency and political subdivision of the State of South Carolina." (DHEC Ex. 1, p. 9). Governed by an eight-member

⁵ "MUSC and its affiliates, Medical University Hospital Authority and University Medical Associates, collectively known as MUSC, is both a teaching hospital and referral center and is South Carolina's only academic medical center...[achieving] international recognition and national acclaim as a premier biomedical research, educational, and clinical institution." (DHEC Ex. 1, p.7) (CON Application).

⁶ According to the Certificate of Incorporation and Articles of Amendment, MUSC SV was first formed under the name "MUSC Health" in September 2015 and became MUSC Strategic Ventures in December 2015. (MUSC Memo., Ex. 2 and 3) (Trial Tr. 680:17-22 (Dr. Cawley)).

Board of Directors, "MUSC SV functions for charitable, scientific and educational purposes in support of MUSC (including MUHA) and [UMA], and to lessen their burdens, by conducting activities that otherwise would be conducted by one or more of such entities." *Id.* at 10. MUSC SV's "main function is to joint venture with other companies or entities to help fulfill [MUSC's] mission. (Trial Tr. 680:9-12 (Dr. Cawley)).

MUSC Cancer Care Network, LLC: The MUSC Cancer Care Network, LLC (The Network) is a for-profit Delaware limited liability company that was formed in January of 2016 and is authorized to do business in South Carolina. (DHEC Ex. 1, p. 10). The Network is owned 51% by Alliance Oncology, LLC (Alliance), a for-profit Delaware company headquartered in California, and 49% by MUSC SV, the 501(c)(3) entity previously described. (Trident Ex. 14, Schedule I).

The company's Management Agreement states that The Network was "organized to form a strategic relationship between Alliance and [MUSC SV] for the development, operation and management of the oncology service line for certain hospitals in South Carolina, in order to extend [MUSC's] reputation for academic excellence to various communities and Alliance's operations and marketing expertise with respect to oncology services[.]" (Trident Ex. 13, p. 1).

According to the Management Agreement, The Network is to form individual limited liability companies (Contractors) as joint ventures between The Network and hospitals. *Id.* Each Contractor and hospital will form its own Service Agreement for each site. *Id.* The Network Management Agreement outlines what both Alliance and MUSC SV are obligated to do with respect to the services to be provided by the Contractors to the hospitals pursuant to the Service Agreements. *Id.* All of the services to be performed by The Network for the sites will be in exchange for fair market value charges that are expected to be based upon a percentage of collections from oncology services provided to each site. The Network Management Agreement also provides that each site shall pay a management fee to The Network in the amount of 5% of net revenues. *Id.*

Under the company's Management Agreement, Alliance agrees to: (a) assist The Network in procuring and obtaining financing for all equipment and office space associated with a particular facility site; (b) employ all administrative and technical personnel for each site; (c) provide marketing services related to each site; (d) provide billing and collections services to each site, subject to the parties' choice that the hospital entity at that site may choose to perform such services

itself; and (e) provide, in its discretion, working capital advances (capped at \$500,000 for each advance) to The Network to be repaid with interest. (Trident Ex. 13, p. 2-3).

MUSC SV agrees to: (a) provide The Network with clinical standards developed by the Hollings Cancer Center and with the quality metrics to be met for each facility; and (b) provide telemedicine services to the sites.⁷ Alliance and MUSC SV agree jointly to: (a) share personnel and costs related to information technology at the sites, with Alliance being responsible for managing the services themselves; and (b) establish a research database, with a central Institutional Review Board and a tumor board, in order to support clinical trial participation at all sites. (Trident Ex. 13, p. 3-4).

While the Operating Agreement states that Alliance will control all billing, it also states that it is the intention of the parties to operate The Network in such a manner as to preserve the tax-exempt status of MUSC SV so long as MUSC SV or one of its affiliates remains a member, by "promoting health for a broad cross-section of the community, especially those persons who are poor." (Trident Ex. 14, p. 7). In setting out that The Network will provide services to all patients, including individuals covered by Medicare or Medicaid, without expectation of payment in order to further MUSC SV's tax-exempt purposes, the Operating Agreement provides the following:

All Members are aware of the limitations on the actions of [The Network] due to the tax-exempt status and charitable purpose of [MUSC SV], and each Member agrees that any decision of [The Network] (i) to forego an action which would be inconsistent with the tax-exempt status of [MUSC SV] or (ii) to take an action which furthers the charitable purposes over any profit-making motives of [The Network], shall not be a breach of the duty of loyalty or a breach of any fiduciary duty to [The Network], notwithstanding that any such decision is not in the best interests of [The Network].

Id. at 7-8.

⁷ MUSC received millions of dollars in grants from the General Assembly in 2018 to develop its telemedicine program. (Trial Tr. 1081:23-1082:7 (Dr. Jenrette)). "MUSC has gotten heavily into telemedicine in the last five to six years. I think we have over 80 different types of programs right now. When it comes to cancer care, we do tele-cancer consultations remotely. We also do what we call virtual tumor boards. And there's dietary follow up, things like that...Just about everything we're doing anymore heavily involves telemedicine." (Trial Tr. 711:21-712:7 (Dr. Cawley)).

Additionally, under the terms of the Operating Agreement, MUSC SV also agrees to allow each center to use the name "Hollings Cancer Center" as part of a separate licensing agreement to be negotiated with each facility. (Trident Ex. 14, p. 16).⁸

MUSC Health: Dr. Cawley informed the Court that MUSC Health is not a legal entity but "really a brand construct in which we encompass all things clinical across all of MUSC and all of its related entities[.]" (Trial Tr. 681:11-14). Dr. Cawley described his role as CEO of MUSC Health as "a way to portray and talk about how I have the authority to go across any of those related entities when it becomes a clinical issue." *Id.* at 681:18-21.

Dr. Cawley serves as the Vice President of Health Affairs for MUSC and is the Executive Director of MUHA.⁹ (Trial Tr. 677:5; 678:4-5). Dr. Cawley also sits on the Executive Committee of the board of UMA and is the Chief Executive Officer of MUSC Health. (Trial Tr. 678:25; 680:14-16). He is the Chief Executive Officer of MUSC SV and is one of the two MUSC members appointed to the board that governs The Network. (Trial Tr. 681:7; DHEC Ex. 1, p. 16).

According to the testimony of Dr. Cawley, the MUSC radiation program functions under MUHA. (Trial Tr. 682:5-8). The Hollings Cancer Center is the brand name for the MUSC cancer system. *Id.* at 700:17-18. Radiation oncology is a sub-entity of the Hollings Cancer Center. *Id.* at 687:8-9. Given his positions at MUHA, MUSC Health, and MUSC SV, Dr. Cawley testified that his role in terms of the radiation oncology program is to simply move forward in a strategic direction. *Id.* at 682:14-17.

Dr. Cawley also testified that the joint venture with Alliance provides MUSC with access to capital because Alliance is responsible for buying the relatively expensive equipment for the proposed facility. (Trial Tr. 764:9-18; 705:14-20). In addition, the set-up of The Network is also advantageous to MUSC from a financial perspective because the joint venture means that neither the assets nor liabilities of The Network will appear on MUSC's balance sheets. (Trial Tr. 764:19 - 765:11).

⁸ Additional Findings of Fact relating to the business structure of The Network will be discussed *infra*. (See Conclusions of Law, Section C, pp. 26-30).

⁹ While these entities are technically run by two different boards, the same people sit on both boards and both boards include Dr. Cawley. (Trial Tr. 677:14-18).

C. The CON Application

Dr. Cawley signed the CON Application on behalf of MUHA under the titles of CEO of MUSC Health and Vice President of Health Affairs at MUSC. (DHEC Ex. 1, p. 1, 6; Trial Tr. 761:20-23).

The CON Application identifies MUHA as the organization responsible for the Application and as the licensee. (DHEC Ex. 1, p. 1, 3) Under the "Management" section of the Application, Greg Spurlock, who is the President of Alliance Oncology, is listed as the Administrator of the facility in his capacity as the Managing Member of The Network. *Id.* at 3.

In a subsection captioned "Ownership or Control of the Facility," the applicant is instructed to "[a]ttach a list of names and addresses of the owners of the facility, indicating percent of ownership of each owner" and to "[c]ircle the appropriate information regarding ownership." *Id.* at 4. The box designating the owner as a "Government – State" entity is circled under this section.¹⁰ *Id.* The provided attachment goes into further detail stating: "[MUHA] is the licensee. MUSC Cancer Care Network, LLC [The Network] is the management company and is a Delaware limited liability company licensed to do business in South Carolina. Alliance Oncology, LLC is the majority owner of [The Network] with a 51% membership interest. MUSC Strategic Ventures is the minority owner of [The Network] with a 49% interest." *Id.* at 5-6. The attachment section goes on to provide the mailing addresses for Alliance and MUSC SV as well as the address for Equity, LLC who is identified as the sole owner of the building where the facility will be located under the terms of a lease. *Id.* at 6.

In another section of the Application and per Reg. 61-15 § 202, the applicant is instructed to "provide the following ownership information." Specifically, item (b) reads:

Name and address of licensee or prospective licensee. (Note: The licensee is defined as the legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility or service; **the owner of the business. The licensee must be the entity to whom the Certificate of Need is issued.**)

Id. at 13; Reg. 61-15 § 202(2)(b)(8)(b). (emphasis added).

¹⁰ The designations that could have been circled in this section include: Individual, Partnership, Corporation, Proprietary, Non-Profit, Government – State, and Other (Specify). (DHEC Ex. 1, p. 4).

The licensee is again identified as MUHA under this section and the title of the licensee's governing body is listed as Medical University Hospital Authority Board of Trustees with Donald R. Johnson, II, MD as the presiding officer of the governing body. *Id.* at 14. A list of the entire MUHA Board is provided to identify all Officers of the Licensee in Attachment D of the Application. *Id.* at 103. A diagram of the officers of MUSC Health is provided as the requested Organizational Chart of the licensee.¹¹ *Id.* at 105-6. MUHA and the building owner are also identified as the only "persons and/or legal entities claiming liabilities of the licensee or of the facility or service for which the Certificate of Need is requested[.]" *Id.* at 14-15; Reg. 61-15 § 202(2)(b)(8)(f).

As required, two documents were also submitted with the Application in order to verify approval of the project by the licensee's governing body. The first showed that the MUHA Hospital Operations, Finance and Quality Committee approved a measure by Dr. Cawley to move forward on a CON application to establish a radiation therapy center in North Charleston on December 11, 2014.¹² (DHEC Ex. 1, p. 220-1). The other document attached to the Application establishing governing body approval was submitted in the form of a record of The Network's Board Meeting Minutes from March 7, 2017, representing that Dr. Cawley made a motion to move forward with the CON application for the Berkeley County LINAC project. *Id.* at 222-3. This motion was seconded by Greg Spurlock, the President of Alliance and the Managing Member of The Network, and unanimously approved by the other members of The Network's board. *Id.* The Application was submitted to DHEC shortly after on May 22, 2017. It is curious that the board of the supposed management company, contracted only to operate a healthcare facility, would need to vote to move forward on the submission of a CON application to establish the facility in the first place.

The Application also contains documentation, such as quotes from vendors for medical and office equipment, addressed to The Network or Alliance and not to MUHA. (DHEC Ex. 1, p. 53, 85). To prove the project's Financial Feasibility as a requirement of the Application, MUHA submitted a letter from Greg Spurlock, President of Alliance and the Managing Member of The Network, stating, "I am responsible for the organization's financial operations and to secure funding for large capital projects. The total capital costs of the project for CON purposes is \$9.8M." *Id.* at 160.

¹¹ Dr. Cawley testified that MUSC Health was not actually a legal entity but more of a brand construct.

¹² MUSC SV, the MUSC affiliate that jointly owns The Network with Alliance, was not established until September 2015.

The letter further assures that the project will be financed by an affiliate of The Network or by an outside third party, depending on the interest rates available. *Id.* at 60.

Despite the fact that The Network or Alliance is clearly funding the project and voting to move forward to establish the facility, the Application identifies The Network as only the management company engaged by the licensee to manage or operate the facility. *Id.* at 15. The details provided for the Network include: an address in California; a Board of Managers as the title of the governing body; Greg Spurlock, Managing Member of The Network as the Presiding Officer of the governing body; the respective Alliance and MUSC SV ownership interests in The Network; and five informally named Board Members (3 from Alliance and 2 from MUSC Health). *Id.* at 15-16.

Because MUHA was the applicant and identified as the licensee, Maggie Murdock of DHEC reviewed the Application for consistency with Standard 7, as an expansion of the services MUSC already offered in the Service Area, as opposed to an application to establish new services that would have been reviewed under Standard 6. Standard 7 only requires that the applicant provide internal data for the previous two years as evidence that the licensee's already existing facility has met the minimum utilization threshold in order to establish the need for expansion to comply with the State Health Plan. (Trial Tr. 565:16-566:4). Standard 6 requires a much more stringent review of the utilization data for the entire Service Area. *Id.* at 566:19-567:15.

Murdock also relied on MUSC/MUHA's historical records and reputation in other areas of the Application. (DHEC Ex. 1, p. 376-7). In fact, Regulation 61-15 directs that certain criteria can be met through a provider's service history. Certainly, as referenced in the Application, MUSC has a reputation and pattern for serving patients in South Carolina and a history of following both South Carolina and federal laws. Other answers in the Application directed Murdock to refer to information already on file at DHEC with regards to MUHA's policies on patient access, patient's rights, patient quality and safety policies, billing practices, and history, or lack thereof, of citations from DHEC for deficiencies, complaints, failure to follow procedure, and the like. (DHEC Ex. 1, p. 17; 36-37; 40; 38-39).

As to the PRC of Service to Medically Underserved Groups, Murdock relied solely on MUHA's history of service to indigent patients. Specifically, the Application provides MUHA's historical figures of indigent care treatment from 2011-2016 and projections of that treatment from 2017-2020. As to MUHA's policies on indigent care, the Application provides:

The level of indigent care provided by MUHA reflects a tradition of commitment to helping the entire population of South Carolina and the Lowcountry. MUHA will continue its historical tradition of working with all governmental levels to address the issues of indigent care and secure adequate funding for the future.

....

MUHA is an operating and approved disproportionate share medical facility. Due to this funding, Medicaid contractual adjustments and indigent care costs are offset, allowing for the continued support of health care for all South Carolina citizens.

(DHEC Ex. 1, p. 40-41). Additionally, as an attachment entitled "Indigent Care Commitment Letters," Dr. Cawley included a letter to DHEC in his capacity as the CEO of MUSC Health and as the VP of Health Affairs at MUSC stating, "MUHA, the applicant ... commits that the facility will accept Medicare and Medicaid patients and the services that are not likely to be reimbursed for indigent and charity patients will be provided at a percentage that is comparable to all other existing outpatient services, if any in the services area." *Id.* at 167-8. A copy of the "Assurances" page contained earlier in the Application is also included in the attachment. *Id.* at 169. There are no mentions of Alliance's policies or historic treatment with respect to medically underserved groups. However, The Network Operating Agreement makes clear that Alliance will be in charge of all billing for the proposed project.

In all, the Application provides various answers to multiple questions regarding ownership and/or control of the facility. While those answers provide a somewhat murky picture of the overall organizational structure of the proposed project, it is clear from Murdock's testimony that she believed that MUHA was the licensee and that the facility was going to be run according to the standards that DHEC has come to expect from other MUSC/MUHA facilities. In fact, with respect to the proposed project, when asked what she knew about the entity of Alliance, if anything, Murdock responded, "I don't recall specifically sitting here today." (Trial Tr. 650:11-13).

Perhaps that was the intended effect of this particular Application. However, having reviewed the information provided by MUSC in the CON Application and in considering all testimony along with the evidence presented in the Operating and Management agreements of The Network, the

Court finds that MUHA is not the actual licensee of the proposed project as represented in the Application.¹³

Issues

In the Motion, Trident claims that the proposed project, as planned and submitted to DHEC for approval, constitutes a joint venture that violates S.C. Const. art. X, § 11 as well as MUSC and MUHA's enabling legislation. If the answer to that claim is affirmative, then Trident contends, as a matter of law, that the Department's decision to approve the CON Application must be reversed.

The Court finds the issue presented in Trident's Motion requires a two-step analysis:

1. Is The Network a joint venture created and operating in violation of the constitutional prohibition on political subdivisions being joint owners or stockholders of companies, and is The Network illegal or *ultra vires* because the enabling statutes of MUSC and MUHA do not permit ownership of for-profit entities?
2. If The Network is unconstitutional or *ultra vires*, does that render the Application, as presented to DHEC, not in compliance with the CON standards and criteria so as to require the Court to overturn DHEC's approval and issuance of the CON?

Additionally, the Court finds that as the trier of fact in the *de novo* hearing, a third issue concerning the validity of the CON should also be addressed at this juncture:

3. Is the Certificate of Need correctly issued to the actual licensee?

Standard of Review

The ALC has jurisdiction over this matter pursuant to S.C. Const. art. I, § 22; S.C. Code Ann. §§ 1-23-320, -600(B), 44-1-60(F), and 44-7-210(E); S.C. Code Ann. Regs. 61-15; and Rule 11 of the SCALC Rules. Trident timely filed its request for a contested case hearing regarding DHEC's decision. *See* S.C. Code Ann. Regs. 61-15 § 401. Because Trident is an existing provider of radiation therapy services in the service area, it is an "affected person" for the purposes of

¹³ *See* discussion *infra* pp. 29-33.

participating in a contested case related to DHEC's decision. See S.C. Code Ann. § 44-7-130(1) (2018); S.C. Code Ann. Regs. 61-15 § 103(1).

A contested case hearing conducted before this Court in a CON matter is a trial *de novo*, in which "the whole case is tried as if no trial whatsoever had been had in the first instance," and the administrative law judge conducting the hearing is the sole finder of fact, who "must make sufficiently detailed findings supporting the denial or grant of a permit application." *Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004) (quoting *Blizzard v. Miller*, 306 S.C. 373, 412 S.E.2d 406 (1991) and *Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control*, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002)). The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. *S.C. Cable Television Ass'n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). The trier of fact may also give an expert's testimony the weight he or she determines it deserves, *Florence Cty. Dep't of Soc. Servs. v. Ward*, 310 S.C. 69, 425 S.E.2d 61 (Ct. App. 1992), and may accept the testimony of one expert over that of another. *S.C. Cable Television Ass'n, supra*.

Jurisdiction

The Administrative Procedures Act (APA) authorizes the ALC to conduct contested case hearings regarding agency decisions and to hear the appeals of agency decisions. S.C. Code Ann. §§ 1-23-380, 505(3), and 600. In contested cases involving agency licenses, permits, and other approvals, the ALC's jurisdiction is limited to claims arising from the application of the requirements, standards, and criteria in the relevant agency statutes and regulations.

In its Motion, Trident claims that the proposed project, as planned and submitted to DHEC for approval, constitutes a joint venture that violates S.C. Const. art. X, § 11 as well as MUSC and MUHA's enabling legislation; therefore, the Application does not comply with CON standards and criteria.

MUSC argues that the Motion should be denied because the Court does not have proper jurisdiction over Trident's claims that The Network is an illegal entity as (a) these claims are not based upon the application of the standards and criteria in the relevant DHEC statutes and

regulations; (b) these claims are not “as-applied” constitutional challenges to the application of the standards and criteria in the relevant DHEC statutes and regulations; and (c) Trident failed to raise these claims during the DHEC review process.

A. Subject Matter Jurisdiction

MUSC contends that the ALC does not have subject matter jurisdiction to address Trident’s claim that The Network is illegal because that claim does not arise from the application of the relevant DHEC statutes or regulations. More specifically, MUSC contends that claims of The Network’s illegality are based upon the Court’s application of the state constitution and the enabling statutes for MUSC and MUHA and not from DHEC or the ALC’s application of the CON standards in the State Health Plan and the PRCs.

MUSC also argues that even if Trident’s claims are valid, they “have no meaningful nexus to MUSC’s CON application or the proposed facility at all.” (MUSC Memo., p. 7). MUSC posits that should The Network have to be dissolved, “such a result would have no material effect on MUSC’s CON application or the proposed facility.” *Id.* MUSC suggests that as the licensee of the facility, MUHA would just contract with Alliance to manage the facility or would manage the facility itself. *Id.* “That Trident’s claims of illegality – even if meritorious – would have no material effect upon MUSC’s CON application or the proposed facility further demonstrates that these claims are not properly part of a CON contested case.” *Id.* The Court disagrees. Should a determination be made that The Network is illegal or *ultra vires*, then the necessary dissolution of that entity would affect many aspects of the proposed project, the CON Application, and the Department’s review thereof.

By regulation, a CON application specifically requires certain information regarding the ownership and management of a proposed project. S.C. Code Ann. Reg. 61-15 § 202(2)(b)(8). The information provided is of necessary import when DHEC reviews an application to determine a project’s compliance with the State Health Plan and the relevant PRC and regulations.

For example, in this instance MUHA is identified as the applicant and licensee. At the very outset, that one identification shaped the scope of all DHEC (and ALC) review because the Application was reviewed under Standard 7, as an expansion of existing services already provided by MUSC, as opposed to an application to establish new services that would have been reviewed under Standard 6. (Trial Tr. 565:15-566:4 (Murdock)). Had the Application identified The Network or Alliance as the applicant and licensee, as the Court finds should have been the case, the direction

and scope of DHEC review and the application of the CON standards in the State Health Plan and the PRCs would have been significantly altered.

Similarly, Reg. 61-15 § 802 sets forth a list of thirty-three criteria that are to be addressed by the applicant in the CON application and considered by DHEC during its review, including: (13) Record of the Applicant (Owner and/or Administrator); (14) Ability to Complete the Project; (15) Financial Feasibility; and (31) Medically Underserved Groups.¹⁴ If the proposed manager/operator of the project - The Network - is an unconstitutional and, as such, illegal entity, then the project's ability to comply with any of these CON criteria and standards, as submitted to DHEC, can certainly be called into question.

In the aforementioned instances, and in others to be discussed herein, the determination of the legality of the project as presented to DHEC does arise from the application of the agency standards and regulations because such a determination would necessarily result in multiple changes to the Application. It could be reviewed under another standard altogether or, at the very least, review of the project using the relevant PRCs would be substantially redirected. Stated differently, MUSC submitted the Application for review with a constitutionally suspect joint venture company as the management entity and MUHA as the licensee. In doing so, the Application heavily, and inextricably, relies on the beneficial aspects of each entity as strategically presented to DHEC to render a more favorable application of the CON standards and criteria. For this reason, and in this case, a very meaningful nexus does, in fact, exist between the determination of The Network's constitutionality and the agency's application of the CON standards in the State Health Plan and the PRC.

Because the claim arises from the information provided by MUSC to facilitate the Department's application of the CON standards in the State Health Plan and the PRCs in Regulation 61-15, the ALC does have subject matter jurisdiction. Further, the remedy requested by Trident, to overturn DHEC's approval of the Application and deny the CON, is a remedy authorized to be granted by the ALC as relief.

¹⁴ As previously discussed, the Application as submitted is set up so that MUHA is the point of reference for DHEC review of the Record of the Applicant and service to Medically Underserved Groups while The Network, through the assurances of the CEO of Alliance, is provided as the reference point to determine Financial Feasibility.

B. "As-Applied" Constitutional Claim

MUSC argues that the question of the constitutionality of The Network is not an "as applied" constitutional claim so the Court again lacks subject matter jurisdiction to consider the issue. The constitutional challenge raised by Trident is to the joint venture arrangement proposed by MUSC as set forth in the Application and considered by DHEC in its application of the CON standards and PRC. The Motion does not require the Court to determine the constitutionality of any statute or law, which would not be within the jurisdiction of the ALC.¹⁵ Nor does the claim include allegations that DHEC applied a CON standard or criterion in a manner that violates the state or federal constitution.

Rather, Trident's Motion involves the statutory authority granted to MUSC through its enabling legislation and the applicability of the joint ownership prohibition set forth in S.C. Const. art. X, § 11 to the proposed project *as submitted to and reviewed by DHEC*. The Court agrees with MUSC that this matter does not involve an "as applied" constitutional claim. Because the issue to be determined does not require the ALC to invalidate a law or regulation passed by the General Assembly, the Court has the authority to consider the facts and determine whether particular conduct or arrangements before it violate constitutional and statutory restrictions. If a party were to challenge as unconstitutional the enabling statute's prohibition against MUHA's forming a business partnership with a for-profit entity, that challenge might well exceed the jurisdictional limits imposed on this Court by the South Carolina Supreme Court. However, the issue is whether the facts show that MUSC has crossed a constitutional and/or statutory line, not whether the line as drawn or applied is constitutional.

C. Procedural Jurisdiction

MUSC further contends that even if the ALC has subject matter jurisdiction over Trident's claim that The Network is unconstitutional, illegal, or *ultra vires*, the ALC still cannot adjudicate the claim because Trident did not raise the issue during DHEC review of the Application. As support for this argument, MUSC points to S.C. Code Ann. § 44-7-210(E) which provides that "[a] contested case hearing of the final agency decision must be requested in accordance with Section

¹⁵ "Allowing ALJs to rule on the constitutionality of a statute would violate the separation of powers doctrine." *Ward v. State*, 343 S.C. 14, 18, 538 S.E.2d 245, 247 (2000).

44-1-60(G). The issues considered at the contested case hearing considering a Certificate of Need are limited to those presented or considered during staff review.”

MUSC’s argument misapprehends the limitations set forth in § 44-7-210(E) and interpreted by the Court of Appeals in *Marlboro Park Hosp. v. S.C. Dep’t of Health & Envtl. Control*, 358 S.C. 573, 595 S.E.2d 851 (Ct. App. 2004) (holding that the law limits a contested case hearing to the issues presented or considered by DHEC staff but does not limit evidence concerning those issues).

As previously discussed, Regulation 61-15 required MUSC to address in its CON Application certain specifics involving the licensee, the ownership of the proposed manager/operator of the facility, the record of the applicant (including both the licensee and the manager/operator), the ability to complete the project, the financial feasibility of the proposed project, and the applicant’s history of and projections for service to medically underserved groups. Also, under Regulation 61-15 § 202(d), MUSC was required to, and did, assure DHEC that the facility would be operated in accordance with the law through the attestation of Dr. Cawley. (DHEC Ex. 1, p. 43). Thus, the ownership of the manager/operator of the proposed project and its effect on the project’s ability to comply with the CON standards and criteria was presented to DHEC staff as an issue for consideration. Further, because DHEC is required by law to determine whether a proposed project complies with the State Health Plan, PRCs, and other regulations before it can recommend approval (S.C. Code Ann. § 44-7-201(C)), DHEC also considered the ownership, management, and other issues discussed above. Under § 44-7-210(E), the Court has the authority to consider the issues raised in Trident’s Motion.

Furthermore, as discussed in its Motion, Trident did not have a complete picture of The Network’s structure and its integral role in the operation and financing of the proposed project until the completion of discovery and the testimony presented by MUSC during the hearing.¹⁶ In discovery, MUSC presented for the first time organizational and operational documents that more fully described The Network’s ownership and its interests and responsibilities with regard to the proposed project. In discovery, Trident took the deposition of Dr. Cawley as to The Network’s ownership and role in the proposed project. Further evidence on the ownership issue was revealed and elaborated on during the testimony of Dr. Cawley and David Levitt in the hearing. It is clear

¹⁶ Ms. Murdock’s testimony shows that DHEC did not have a complete picture of this set-up, either. *See supra*, pp. 12.

that Trident heavily relied on such evidence and testimony in moving the Court to determine that the proposed project, as presented to and reviewed by DHEC, cannot meet the standards and criteria of the CON law when those specific requirements are proposed to be met by an entity that is unconstitutional, illegal, or *ultra vires*.

Under the *Marlboro Park* doctrine, the Court has the authority to consider evidence on the issues even when the evidence is first revealed after the completion of the DHEC staff review. After all, the majority of the hearing was premised on a mistake pertaining to the minimum utilization threshold that MUSC submitted in the CON Application to satisfy Standard 7. That mistake was not discovered until after the review and approval of the Application and, therefore, was not and could not have been specifically raised as an "issue" by Trident during DHEC's review of the Application. MUSC did not contest the Court's procedural jurisdiction or authority to hear that issue. Trident has asked the Court to consider the evidence of The Network's unconstitutional ownership in connection with its review and consideration of whether MUSC's CON Application meets the requirements of the applicable CON law. Consideration of the evidence and issues raised in the Motion is consistent with the law as interpreted by the court in *Marlboro Park*.

Finally, the Court is cognizant that Trident must raise the issue before the ALC in order to preserve it for appeal. As the venue best suited to make the factual determinations specific to this case in relation to this Application, and as a matter of judicial economy, particularly as the term relates to contested CON cases before the ALC,¹⁷ the issue is properly before the Court. To raise the issue before DHEC, assuming it was discoverable during DHEC review, would have been futile. To raise the issue for the first time on appeal to the Court of Appeals would be misguided. Procedure and judicial economy dictate that the issue be decided here rather than forcing the parties to litigate the matter further.

Conclusions of Law

To clarify, MUSC SV was established by, and is an affiliate of, MUSC and UMA, the physician practice plan affiliate of MUSC. MUSC SV is a non-member, nonprofit entity established to further the missions and programs of MUSC and UMA "including their collaboration with MUHA,

¹⁷ The General Assembly has set specific time parameters on the ALC in contested cases and other matters involving CONs. (See S.C. Code Ann. § 44-7-210 (G)).

a subdivision of the State of South Carolina.” (DHEC Ex. 1, p. 9; MUSC Memo., Ex. 4 (MUSC SV Articles of Incorporation at 1-2)). MUSC SV was not established by, and is not an affiliate, of MUHA.

The Network was incorporated as a for-profit Delaware LLC and is a joint venture between MUSC SV and Alliance Oncology, also a for-profit company. (DHEC Ex. 1, p.10) MUSC SV owns 49% of The Network while Alliance owns 51%. *Id.* at 5-6. The Network is identified in the CON Application as the operator/management company of the proposed project. *Id.* at 5, 10. MUHA is identified as the applicant and licensee of the project. *Id.* at 1, 3.

A. Is The Network illegal or *ultra vires* because the enabling statutes of MUSC and MUHA do not permit ownership of for-profit entities? Is The Network an unlawful joint venture formed in violation of the constitutional prohibition on political subdivisions being joint owners or stockholders of companies?

MUSC disputes the merits of Trident’s position that the use of MUSC SV to create and jointly own an interest in a private, for-profit entity (The Network) is contrary to MUSC and MUHA’s enabling statutes and violates the prohibition against joint ownership set forth in S.C. Const. art. X, § 11.

1. Enabling Statutes

In 1913, the South Carolina General Assembly accepted the transfer of property from the private Medical College of South Carolina and established the renamed “Medical University of South Carolina” as a state agency. In its current form, MUSC is governed by S.C. Code Ann. § 59-123-10, *et seq.* In its enabling legislation, MUSC’s governing board is given the authority to elect officers and to appoint professors and fix their compensation. The statute further provides that the MUSC board has the following powers:

- (1) to make bylaws and regulations considered expedient for the management of its affairs and its own operations not inconsistent with the constitution and laws of this State or of the United States;
- (2) to confer the appropriate degrees in medicine, dental medicine, pharmacy, nursing, health-related professions, and graduate studies in related health fields upon students and other persons as in the opinion of the board of trustees may be qualified to receive them; and
- (3) to make contracts and to have, to hold, to purchase, and to lease real estate property for corporate purposes; and to sell and dispose of personal property and any buildings that are considered by it as surplus

property or no longer needed and any buildings that it may need to do away with for the purpose of making room for other construction. These powers must be exercised in a manner consistent with Chapter 35 of Title 11 [the South Carolina Procurement Code].

S.C. Code Ann. § 59-123-60(A).

Finally, S.C. Code Ann. § 59-123-30 confirms MUSC's original 1832 charter and recognizes all of the rights and privileges granted therein. The original charter provides no authority for MUSC to create subsidiary or affiliated corporate entities. (Trident Motion, Ex. C (Original Charter)). The law specifically requires all revenue earned by MUSC to be expended for a public purpose and makes MUSC subject to the Freedom of Information Act and to state ethics laws. S.C. Code Ann. § 59-123-60(B)(C)(D).

In addition to creating MUSC and its board, in a 2000 amendment to the same legislation, the General Assembly established MUHA as a separate state agency to be governed by a board composed of the same persons that sit on the MUSC board. As conceived by the General Assembly, "[w]henever the board functions in its capacity as the governing body of the hospital,¹⁸ the board of trustees is constituted and designated as the Medical University Hospital Authority, an agency of the State of South Carolina[.]" S.C. Code Ann. § 59-123-60(E). MUHA is granted the sole authority to manage, regulate, and operate the healthcare, as opposed to the educational, functions of MUSC, including the power to:

establish such not-for-profit corporations as the board considers necessary to assist the authority in carrying out its functions; provided, that any entity created pursuant to this subsection is considered to be an entity of the authority and subject to all laws and regulations applicable to the authority under this section. The formation of for-profit corporations by the authority is strictly prohibited.

S.C. Code Ann. § 59-123-60(E)(13).

The language of these enabling statutes makes two things clear: (a) MUSC has no statutory authority to create a subsidiary or affiliated corporation of any kind to perform the educational functions it is charged with performing; and, (b) MUHA is granted only the authority to establish not-for-profit entities to carry out its functions with regard to the healthcare operations of MUSC,

¹⁸ "Hospital" is defined in the enabling legislation to mean "the Medical University hospitals, clinics, and other health care and related facilities." S.C. Code Ann. § 59-123-60(E). Under § 59-123-60(L), all real and personal property, tangible and intangible, relating to the hospital is deemed to be the property of MUHA.

with the limitation that any such nonprofit entities are subject to all laws and regulations applicable to MUHA. Neither MUSC nor MUHA is given any authority to form for-profit corporations. *See Medical Soc. of S.C. v. Medical Univ. of S.C.*, 334 S.C. 270, 513 S.E.2d 352 (1999) (“An agency created by statute has only the authority granted it by the legislature.”).

Trident asserts that because MUSC’s enabling statutes do not explicitly vest any authority in MUSC to create subsidiary or affiliated entities, MUSC SV and The Network are illegal or *ultra vires*. MUSC argues that since it is a public university, MUSC has the implied powers to undertake actions “necessary and proper for the achievement of the ends for which the university was founded.” *Moe v. Bd. of Trustees of Univ. of S.C.*, 255 S.C. 46, 54, 177 S.E.2d 137, 140 (1970). Because MUSC SV was established by MUSC and UMA to further their missions and programs, and because the MUSC board has the implied power to undertake actions necessary to further its mission, MUSC argues that it can establish MUSC SV and that Trident’s claims that MUSC SV and The Network are illegal or *ultra vires* are without merit.

The Court does not find MUSC’s argument of implied power to be persuasive. While it is true that MUSC’s enabling statutes do not explicitly vest any authority in MUSC to create subsidiary or affiliate entities, MUHA, which is established and addressed in the exact same legislation as MUSC, is granted the explicit authority to create non-profit subsidiaries. MUHA’s grant of this authority is limited by the requirement that any nonprofit subsidiary or affiliated entity it creates is subject to all of the laws applicable to MUHA; MUHA is specifically prohibited from creating for-profit entities.

Under the doctrine of statutory construction “*expression unius est exclusio alterius*,” the grant of authority to MUHA to create nonprofit subsidiaries and affiliates compels the conclusion that the absence of such grant of authority to MUSC in the same statute means that the General Assembly did not intend for MUSC to have such authority. Therefore, no such authority can be implied. (*See, e.g., Nelson v. Ozmint*, 390 S.C. 432, 702 S.E.2d 369 (2010) (holding that inclusion of an early release provision for second offenders but not including such provision for third offenders in the same statute compelled the conclusion that the General Assembly intended that no early release would apply for third offenses). Accordingly, because MUSC’s enabling statutes do not explicitly vest any authority in MUSC to create subsidiary or affiliated entities, the Court finds that MUSC SV and The Network are illegal or *ultra vires*.

Moreover, it should be noted that the Court cannot find that a state agency has the implied authority to engage in conduct that violates the South Carolina Constitution.

2. S.C. Const. art. X, § 11

Trident further asserts that the use of MUSC SV to create and jointly own an interest in a private, for-profit entity (The Network) violates the constitutional prohibition against joint ownership. The S.C. Const. art. X, § 11 provides, in relevant part, that “neither the State nor any of its political subdivisions shall become a joint owner of or stockholder in any company, association, or corporation.”

In *Nichols v. South Carolina Research Authority*, 290 S.C. 415, 421, 351 S.E.2d 155, 158 (1986), the South Carolina Supreme Court (Supreme Court) considered whether the South Carolina Research Authority (the Authority), which it determined was an agency of the State, could engage in joint ventures “by receiving some degree of ownership in high technology firms” as part of its mission to promote research and development and to enhance the research capacities of the state’s public and private universities. In invalidating the joint venture transactions entered into by the Authority, the Supreme Court found that “[t]he Constitution clearly prohibits public agencies, such as the Authority, from engaging in joint ownership with private parties.” *Id.* The Supreme Court held that the Authority was prohibited from entering any joint venture with a private business based on (a) the absence of any express enabling legislation and (b) the plain language of Article X, § 11.

Nichols involved the direct participation by a state agency in joint ventures in which the agency itself would have an ownership interest in a private company. In this case, MUSC is not the direct owner of The Network, the entity that will lease the facility space, employ all of the administrative and technical clinical staff, own all of the equipment, and manage and operate the proposed radiation therapy center. Instead, MUSC has chosen to establish and utilize MUSC SV, an MUSC-controlled non-profit affiliate, to jointly own the private, for-profit company. (Trident Ex. 56; MUSC Ex. 63). As specifically acknowledged by Dr. Cawley, MUSC SV’s purpose is to “predominately joint venture[] with for-profit companies that we otherwise couldn’t work with as part of MUHA or MUSC.” (Trident Motion, Ex. A (Cawley Dep. 37:11-18)). In other words, with respect to the proposed project, MUSC SV is being used by MUSC to joint venture with a private, for-profit company (Alliance) and to hold an ownership interest in another private, for-profit

company (The Network) because MUHA and MUSC, as state agencies, are prohibited under the law and the South Carolina Constitution from holding these interests directly.¹⁹

This attempt by MUSC to circumvent the restrictions placed on it as a governmental entity and to do indirectly what it cannot do directly is exactly the type of conduct condemned by the Supreme Court in *O'Brien v. S.C. ORBIT*, 380 S.C. 38, 668 S.E.2d 396 (2008). In the *ORBIT* case, the Supreme Court examined whether the City of Charleston's investment of retirement benefits in a newly created trust that included equity securities violated the Article X, § 11 prohibition against joint ownership in any company, association, or corporation. Although recognizing that the City's actions were "laudable and well-intended," the Supreme Court held:

It is troubling that the City attempted to avoid the constitutional prohibition on investing in equity securities, thereby using government funds to jointly own a company with other investors, by merely setting up a trust. Although ORBIT is set up as a trust, it functions as an investment manager for the City and, as such, is no different than any other investment house (Merrill Lynch, Oppenheimer, etc.). The veneer of a trust does not change that. More importantly, the status of ORBIT as a trust is irrelevant. Article X, § 11 concerns the *investing* of government funds. The investment takes place when the City transfers money to the trust to be used for the express purchase of equity securities. It is abundantly clear from the record that the City's investment in ORBIT is for the expressed purpose of circumventing the constitution. The City's investments violated the constitutional prohibition.

Id. at 43, 668 S.E.2d at 398-399.

In this case, MUSC is using MUSC SV to joint venture with a private, for-profit entity to establish a radiation center that MUHA, by its own admission, cannot adequately finance alone. As part of the joint venture, MUSC SV will have a minority ownership interest in a private, for-profit corporation (The Network) that is majority owned and controlled by another private, for-profit company (Alliance). Under Article X, § 11, neither MUSC nor MUHA can hold such an ownership

¹⁹ It should be noted that in this case the structure of the proposed project is fundamentally different from the arrangements approved by the courts in cases such as *Johnson v. Piedmont Mun. Power Agency*, 277 S.C. 345, 287 S.E.2d 476 (1982) and *Gilbert v. Bath*, 267 S.C. 171, 227 S.E.2d 177 (1976), which involved long-term leases of assets and management arrangements between governmental entities and private companies. *See also, Taylor v. Richland Memorial Hosp.*, 329 S.C. 47, 495 S.E.2d 431 (1998) (approving a joint venture between Richland Memorial and Baptist Hospital reasoning, in part, that all parties were governmental and/or non-profit so as to alleviate concerns that any interest in profits would supersede the public mission or even incidentally benefit a private party).

interest. The use of MUSC SV to circumvent the joint ownership prohibition mirrors the conduct condemned and invalidated by the Supreme Court in *ORBIT* using the “veneer of a trust.”²⁰

In response, MUSC relies on *Brashier v. S.C. Dep't of Transp.*, 327 S.C. 179, 490 S.E.2d 8 (1997), *overruled on other grounds by I'On, LLC v. Town of Mt. Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000), to support its contention that MUSC's affiliation with MUSC SV does not violate the joint ownership prohibition and, therefore, MUSC SV's ownership in a private, for-profit company does not violate the constitution.

In *Brashier*, the Supreme Court considered the claim that the Department of Transportation's (SCDOT) plan to finance, develop, and operate the Southern Connector, a toll road in the Upstate, violated, *inter alia*, the Article X, § 11 prohibition on political subdivisions jointly owning companies. *Id.* at 187-88, 490 S.E.2d at 13. SCDOT's plan included establishing a nonprofit, public benefit corporation without members, the Southern Connector 2000 Association, Inc. (Association). The Association would then pay a developer to construct the Southern Connector (through the Association's issuance of tax-exempt bonds), would manage and operate the toll road, and would eventually dissolve and distribute any assets directly to SCDOT upon the repayment of the bonds. *Id.* at 183, 490 S.E.2d at 10.

In reaching the conclusion that SCDOT's establishment and involvement with the Association did not violate the constitutional prohibition against joint ownership, the Supreme Court noted that SCDOT had a certain amount of control over the Association and its directors. Further, upon dissolution of the Association, its assets would be distributed to SCDOT. *Id.* at 187-188, 490 S.E.2d at 13-14. The Supreme Court determined:

SCDOT is not a stockholder in Association. The agreements make it clear the Southern Connector will be owned by SCDOT but operated by Association. “[T]his Court has never held a public entity's naked title to property operated by a private entity resulted in unconstitutional joint ownership.” *Johnson v. Piedmont Mun. Power Agency*, 277 S.C. 345, 355, 287 S.E.2d 476, 481 (1982) (also noting public entity had acquired neither stock nor any other form of ownership in private company). At no time will SCDOT and Association jointly own anything. *Nichols v. South Carolina*

²⁰ MUSC argues that the *ORBIT* holding is inapposite to this case because it is based on “very specific provisions” limiting investment in the stock market. The Court does not agree with that limited interpretation. The Article X, § 11 provision that prevents investment in the stock market is also the very same provision that prevents joint ownership in a private entity, stating that “neither the State nor any of its political subdivisions shall become a joint owner of or stockholder in any company, association, or corporation.”

Research Auth., 290 S.C. 415, 351 S.E.2d 155 (1986), cited by Appellant, is clearly distinguishable. In *Nichols*, a state agency admitted that in carrying out joint ventures, it planned to procure ownership interests in private entities. *Id.* at 421, 351 S.E.2d at 158.

327 S.C. at 188, 490 S.E.2d at 13.

The Court finds that SCDOT's involvement with the Association in *Brashier* is quite different from MUSC's "once-removed" ownership of The Network in this case. MUSC SV, the nonprofit affiliate created by MUSC, will absolutely have an ownership interest in a private, for-profit entity. It will share this ownership interest in The Network with another private, for-profit entity, Alliance. Per the Operating Agreement, the Managing Member, who is the CEO of Alliance, along with the Alliance-majority board, maintain greater control over The Network in almost every aspect. (Trident Ex. 14; see discussion *infra* pp. 31-32). Moreover, upon dissolution of The Network, assets will be distributed to both Alliance and MUSC SV, and any other subsequent members, in accordance with their respective capital account balances. (Trident Ex. 14, p. 22). MUSC argues that once MUSC SV is dissolved, its assets will be distributed to MUSC, the political subdivision that established it. (MUSC Memo., p. 14). While that may be the case, MUSC neglects to take that analysis one level deeper to recognize that it is the dissolution (or, perhaps more importantly, the profit distribution) of The Network, not MUSC SV, that is of crucial import. The profits from The Network flow through to both MUSC SV and Alliance. In *Brashier*, only one entity stood to profit – the public entity of SCDOT.

Further, in this case, Trident is not asserting MUSC's affiliation with MUSC SV is the unconstitutional joint ownership at issue. Instead, Trident maintains that MUSC's attempt to use its wholly-owned subsidiary, MUSC SV, to circumvent the joint ownership prohibition fails under *O'Brien v. S.C. ORBIT*, 380 S.C. 38, 668 S.E.2d 396 (2008), a case decided ten years after *Brashier*. As previously discussed, in *ORBIT* the Supreme Court found that a governmental entity could not use an affiliated entity to do indirectly what it was forbidden to do directly - have an ownership interest in a private, for-profit entity.

In this case, MUSC's use of MUSC SV to create and jointly own an interest in a private, for-profit entity (The Network) violates the constitutional prohibition against joint ownership in S.C. Const. art. X, § 11 as espoused in *Nichols*, *ORBIT*, and *Brashier*. The Court finds that The Network is an entity formed in violation of the state constitution and, as previously discussed, outside of the

authority enumerated in MUSC and MUHA's enabling legislation. As such, The Network is an unconstitutional and, therefore, illegal or *ultra vires* entity.

B. If The Network is unconstitutional or *ultra vires*, does that render the Application, as presented to DHEC, not in compliance with the CON standards and criteria so as to require the Court to overturn DHEC's approval of the Application and deny the CON?

Because of the specifics laid out in the Application by MUSC, the ultimate dissolution of The Network requires a second inquiry as to whether the CON standards in the State Health Plan along with the relevant DHEC criteria and PRC can still be satisfied in order to approve the CON. The Court finds that the necessary dissolution of The Network substantially alters the Application and materially affects the proposed project, as presented to and approved by DHEC, in several ways.

MUSC argues that a determination of The Network to be unconstitutional or *ultra vires* has "no meaningful nexus" to the Application or the CON and posits that should The Network need to be dissolved, "such a result would have no material effect on MUSC's CON application or the proposed facility." (MUSC Memo., p. 7). Rather, MUSC suggests that as the licensee of the facility, MUHA would just contract with Alliance to manage the facility or would manage the facility itself. *Id.*

While changes in management companies have not always been considered "substantial" so as to warrant DHEC review under Reg. 61-15 §. 605,²¹ in this case, because of the nature of the Application as submitted by MUSC, a change in the management company is not just an administrative adjustment.

For instance, in the Application submitted to DHEC, the ability to obtain financing for the project is established through the assurances of the CEO of Alliance, not MUSC, MUHA or any of the related MUSC affiliates. (DHEC Ex. 1, p. 160). Further, The Network Management Agreement provides that Alliance agrees to assist The Network in procuring and obtaining financing for all equipment and office space and provide, in its discretion, working capital advances (capped at \$500,000 for each advance) to be repaid with interest. (Trident Ex. 13, p. 2-3).

²¹ See also *Carolina Regional Cancer Center, LLC v. S.C. Dep't of Health and Envtl. Control* (2015 WL 2159474).

In reference to Alliance's duty to procure and obtain financing, MUSC representatives testified that, as an international provider of cancer care, Alliance is able to secure advantageous prices on LINACs and other costly equipment to be used in the operation of the proposed project because they buy in high volume, as opposed to a single-purchase buyer like MUSC. (*See* Trial Tr. 905:16-22; 705:14-20; 764:9-18). If Alliance, as 51% majority owner (retaining 51% of the profits) of The Network is unable to participate in the joint venture as planned, then financing for the project *as presented to and reviewed by DHEC* would likely be completely different. When the opportunity to share in the profits of a project carrying the name of an NCI-designated cancer treatment center is foreclosed, the feasibility of funding that project is likely also foreclosed.²²

Considering that Financial Feasibility of the project is one of the five PRC deemed by the Department to be important in this matter, such an alteration fundamentally and substantially changes the Department's application and review of the relevant PRC. In *MRI at Belfair, LLC v. S.C. Dep't of Health and Envtl. Control*, the South Carolina Court of Appeals determined it was proper for the ALC to consider the important PRCs in its substantial change analysis during a contested case. 394 S.C. 567, 716 S.E.2d 111 (2011). The Court of Appeals found the ALC conducted a permissible comparison of the original project's compliance with the PRCs to the amended project's compliance with the same criteria. *Id.* at 574; 716 S.E.2d at 114. "[I]f satisfaction of the project review criteria is a statutory prerequisite to obtaining a CON, we find any change that would impact the applicant's ability to comply with the same criteria as relevant evidence on whether the change is substantial enough to create a new project." *Id.* at 574-5; 716 S.E.2d at 114-5.

Following that reasoning, this Court finds that upon the necessary dissolution of The Network, the project's ability to satisfy the PRC of Financial Feasibility, as submitted to, reviewed, and approved by DHEC through the attestations in the CON Application, is no longer present. In this case, Alliance is more than just a manager/operator of the proposed project. Alliance is the key to the financial feasibility of the project, as submitted to DHEC, and of The Network, as provided in

²² "They [Alliance] know how to operate these centers, they do it well, they make money." (Trial Tr. 905:2-4 (Levitt)).

the Management and Operating Agreements. Without Alliance, the change in Financial Feasibility is substantial. It is enough to create a new project.²³

C. Is the CON correctly issued to the actual licensee?

In considering the evidence and testimony presented in this case, the Court has previously found that MUHA is not the actual licensee of the proposed project as represented in the Application. As discussed, the Application provides various answers to multiple questions regarding ownership and/or control of the facility.²⁴

Specifically, in one section of the Application and per Reg. 61-15 § 202, the applicant is instructed to “provide the following ownership information.” Item (b) reads:

Name and address of licensee or prospective licensee. (Note: The licensee is defined as the legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility or service; **the owner of the business. The licensee must be the entity to whom the Certificate of Need is issued.**)

Id. at 13; Reg. 61-15 § 202(2)(b)(8)(b). (emphasis added).

The licensee is again identified as MUHA under this section and the title of the licensee’s governing body is listed as Medical University Hospital Authority Board of Trustees with Donald R. Johnson, II, MD as the presiding officer of the governing body. *Id.* at 14. A list of the entire MUHA Board is provided to identify all Officers of the Licensee in Attachment D of the Application. *Id.* at 103. MUHA and the building owner are also identified as the only “persons and/or legal entities claiming liabilities of the licensee or of the facility or service for which the Certificate of Need is requested[.]” *Id.* at 14-15; Reg. 61-15 § 202(2)(b)(8)(f).

Additionally, item (k) in the ownership section of the Application reads:

²³ While there was testimony as to MUSC’s negative financial statement and supposed inability to adequately fund the project without Alliance, the Court does not find that a detailed analysis of MUSC’s current financial situation is necessary. Although applicants are required to provide a current annual budget under Regulation 61-15 and in Question (B)(16) of the application, for reasons unknown, MUSC failed to include MUHA’s current annual budget to show financial feasibility in the Application. (Trial Tr. 643:4-25). While DHEC may have assumed that MUHA was financially able to support the project without the necessary documentation to justify that assumption, the Court does not. If MUSC now wishes to divulge what it previously chose to conceal through the assurances of Alliance, it is free to do so upon re-application.

²⁴ See *supra* Findings of Fact, The Application, pp. 8-12.

Is there any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested and/or provided in (b) through (g) above. YES NO. If yes, provide information similar to that required in (b) through (g) above.

Id. at 16.

While "NO" is circled and the Application continues to represent that MUHA, as the licensee, is "the legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility or service," it is clear from the underlying formation agreements of The Network that it is, in fact, The Network that intends to own and control almost every aspect of this radiation therapy center and others it plans to develop in South Carolina. The Network is run by a Managing Member, Greg Spurlock who is the President of Alliance, and the 3-Alliance/2-MUSC-member Board of Directors.²⁵ While the Management Agreement of The Network is replete with references of "with input from MUSC"²⁶ it is also clear from the details of the Operating Agreement that, in almost every respect, Alliance is in control of this operation, carries the rights of first refusals, owns 51% of the company, and will carry away at least 51% of the profits from this joint venture.

The Network Management Agreement provides that Alliance agrees to: (a) assist The Network in procuring and obtaining financing for all equipment and office space associated with a particular facility site; (b) employ all administrative and technical personnel for each site; (c) provide marketing services related to each site; (d) provide billing and collections services to each site, subject to the parties' choice that the hospital entity at that site may choose to perform such services itself; and (e) provide, in its discretion, working capital advances (capped at \$500,000 for each advance) to The Network to be repaid with interest. (Trident Ex. 13, p. 2-3). All personnel, to include physicists, dosimetrists, anyone operating equipment, and any necessary administrative staff, will all be employees of Alliance and all are to be selected by Alliance. *Id.* at 2. They are only to report to MUSC with respect to quality assurance. *Id.* These undertakings by Alliance as

²⁵ A third community member appointed by MUSC will also be added to the board to purportedly even things out but, upon reading the Operating Agreement, that member does not have any actual voting rights and is more of an observer.

²⁶ Alliance has control but "subject to MUSC's input" in the following areas: Capital Expenditures, Marketing Strategy, and Information Technology (as it relates to connectivity between site and medical records interfacing). MUSC is to control Quality Assurance and provide Telemedicine from its doctors to the sites. Alliance has sole control over every other aspect of the business.

the majority owner of The Network constitute more than just managerial or operational logistics within the proposed facility.

Furthermore, the Operating Agreement of The Network fully spells out the company's intentions to **own – not just manage – this and other radiation therapy centers** all under the MUSC SV-licensed name "Hollings Cancer Center:"

Whereas, the Members desire for [The Network], either directly or indirectly through separate facility-specific entities in which it owns an interest; to provide oncology equipment, space, staffing (including a regional director for administrative services and physicists and dosimetrists), physician recruitment, integrated clinical services, marketing services, billing protocols, clinical standards, research support, related information technology solutions and all other technology used in cancer treatment for the facilities in the network.

....

Whereas, the Members intend for [The Network] to identify opportunities to develop, acquire or hold ownership interests in, and hold ownership interests in facility-specific entities which own and operate cancer programs, including oncology centers, as determined and agreed to pursuant to the terms of this Agreement[.]

(Trident Ex. 14, p. 2).

4.1 General Business Purpose. The business to be conducted by [The Network] shall be to hold, directly or through one or more of the Operating Companies, ownership interests in Centers, to provide services for the entire oncology service line for the Centers and to carry on any and all activities necessary, proper, convenient, or advisable in connection therewith.

Id. at 7.

Finally, as MUSC's expert, Dan Levitt, testified when describing the management of The Network: "they recognize from a business perspective [Alliance] ha[s] a majority on the Board, but from a clinical perspective, MUSC has majority on the clinical standard." (Trial Tr., p. 800:20-21). In describing the governing powers granted to Alliance and MUSC SV through The Network agreement, Levitt pointed out, "this says that four members of the board have to agree to this – of these different elements of operating the facility or the organization. So, this would prevent Alliance's three board members from outvoting MUSC on matters specifically identified [under certain provisions]..." (Trial Tr., p.799:5-8) In going on to describe the circumstances and nuances of a supermajority vote as provided for in the Agreement, Levitt stated:

...relocating the center, there would have to be a supermajority vote. So, at least one of the MUSC board members would have to agree that moving it makes sense. And then on the next page, any material change to the business, purpose or mission of the corporation that would adversely impact [MUSC's] tax-exempt status. So, the mission of MUSC or MUHA would have to – you know, if we're changing something that would impact the mission, it has to be done under a supermajority vote.

(Trial Tr. 799:12-23). If MUHA were the actual licensee/owner of the proposed project as stated in the Application, then it would be the MUHA board voting on the regular business and clinical matters of the facility. MUHA would decide on a relocation or a material change to the business, not a supermajority of The Network. In essence, Levitt implied that a supermajority of The Network's board could change the purpose or mission of the proposed project from the MUSC/MUHA mission to something else entirely. Thus, it is completely conceivable that even the basic mission of a cancer treatment center located in South Carolina, operating through a Certificate of Need issued to a public hospital in South Carolina under the name "Hollings Cancer Center," a name recognized and touted as part of that public hospital, could be changed by the supermajority vote of the California-based board of a company registered in Delaware.

In fact, one of the documents in the CON Application used to verify approval of the project by the licensee's governing body was submitted in the form of the record of The Network's Board Meeting Minutes from March 7, 2017, roughly 2.5 months before the Application was submitted. It simply does not follow logically that the management company hired only to run or operate a facility would be the entity to vote to move forward in the application process to establish the facility in the first place. Even more confounding, the only board verification pertaining to MUHA or MUSC's approval of the project was a 2014 vote by the MUHA Hospital Operations, Finance and Quality Committee to move forward on a radiation center in North Charleston.²⁷

While the CON Application is replete with listings of MUSC's accolades, achievements, and good intentions to bring cancer treatment closer to the people of the Service Area, very little is divulged about the actual intent of The Network: to establish the first in a statewide franchise of private radiation therapy centers operating under the name associated with a public hospital while remaining majority owned and controlled by a for-profit company. The intent to better serve the

²⁷ MUHA submitted a CON application for a radiation therapy center in the Service Area in 2015 but it was denied. (Trial Tr. 594:18-25).

citizens of South Carolina is admirable. The business plan by which to accomplish that objective is not. Factually, it is evident that The Network is not simply the management company contracted by MUHA to run the proposed project.²⁸ Under Regulation 61-15 §202, the “ultimate responsibility and authority for the conduct of the facility or service” as “the owner of the business” lies in the hands of The Network, not MUHA. And, the ultimate control of The Network lies with its 51% owner Alliance, not MUSC SV.

Furthermore, the Court finds the language found in S.C. Code Ann. § 44-7-230(A)&(E) concerning the limitations and non-transferability of Certificates of Need to be particularly instructive on the issue of ownership and the actual licensee:

(A) The Certificate of Need, if issued, is valid only for the project described in the application[.]

(E) A Certificate of Need is nontransferable. A Certificate of Need or rights thereunder may not be sold, assigned, leased, transferred, mortgaged, pledged, or hypothecated, and any actual transfer or attempt to make a transfer of this sort results in the immediate voidance of the Certificate of Need. **The sale or transfer of controlling interest or majority ownership in a corporation, partnership, or other entity holding, either directly or indirectly, a Certificate of Need, results in the transfer and voidance of a Certificate of Need.**

Id. (emphasis added).

If a statute’s language is plain and unambiguous and conveys a clear and definite meaning, there is no occasion for employing rules of statutory interpretation and the court has no right to look for or impose another meaning. *Paschal v. State Election Comm’n*, 317 S.C. 434, 436, 454 S.E.2d 890, 892 (1995). “Under the plain meaning rule, it is not the court’s place to change the meaning of a clear and unambiguous statute.” *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature. *Id.*

Regulation 61-15 § 202 states that “[t]he licensee must be the entity to whom the Certificate of Need is issued.” The language of S.C. Code Ann. § 44-7-230(E) is unambiguous and evidences

²⁸ In the pro forma for the facility that was submitted with the Application, there is no management fee line item to be paid to anyone for operating the proposed project. (DHEC Ex. 1, p. 165).

the General Assembly's intent to make a CON void should the controlling interest or majority ownership of the licensee change. Inversely, it only makes sense that the General Assembly also intended that the Certificate of Need be issued in the first place to the entity that maintains the controlling interest or majority ownership in the project that is the subject of the CON Application. In this case, with a 51% ownership and controlling interest in The Network, it is evident that Alliance Oncology, LLC, should have been identified as the true licensee, not MUHA.

In *Carolina Regional Cancer Center, LLC v. S.C. Dep't of Health and Envtl. Control* (2015 WL 2159474), one entity increased its minority ownership in the LLC that owned the healthcare facility holding the CON. In that case, the ALJ agreed with the conclusions of two experts who opined that the change in ownership was not substantial for CON purposes because it did not change the original licensee's position as the majority owner with a controlling interest in the facility. The assurances attested to under Reg. 61-15 §202(2)(d)(9) in the CON application remained true -- the controlling interest in the healthcare facility was not sold or leased or otherwise disposed of.

In this case, the same assurance was given in MUSC's CON Application by Dr. Cawley. (DHEC Ex. 1, p. 43). Unfortunately, the facts and circumstances in this case indicate that the attestation that MUHA held the controlling interest in the proposed project was false. Under the definition of "licensee," The Network is the "owner of the business." Because Alliance is the majority owner with a controlling interest in the LLC that owns the healthcare facility, it is Alliance who is the actual licensee and it is Alliance who must have been issued the CON in order for the CON to remain valid under S.C. Code Ann. § 44-7-230(A)&(E). As such, the Court finds the Application to be improperly approved and the CON previously issued to be void.²⁹

Order

The proposed project is not an expansion of existing MUSC services as presented in the Application and approved by DHEC. It is the beginning of a for-profit cancer treatment franchise that is majority-owned, financed, and run by Alliance in exchange for the patients and reputation

²⁹ In recognizing that Alliance Oncology, LLC is the actual licensee of the proposed project, the CON Application should have been submitted and reviewed under Standard 6 as an application to establish new services, rather than a Standard 7 application to expand MUSC's existing services. Because Standard 6 has a different method of evaluating minimum utilization thresholds, the rounding issue still before the Court is of no consequence since the CON was invalidly issued and void under S.C. Code Ann. § 44-7-230(A)&(E).

of MUSC. While the idea of broadening the scope of MUSC Hollings Cancer Center's outreach to patients across South Carolina is well-intentioned, it must be executed in accordance with the South Carolina Constitution, the enabling statutes of MUSC and MUHA, and with the transparency that should be fundamental to a public, nonprofit state agency.

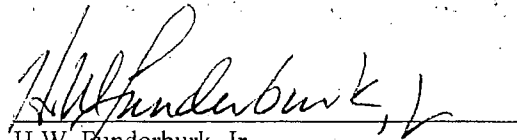
The Court finds that the proposed project, as submitted to and approved by the Department, constitutes an unlawful joint venture in violation of S.C. Const. art. X, §11 and the enabling statutes of MUSC and MUHA, S.C. Code Ann. § 59-123-60(13). As such, the CON Application cannot comply with the State Health Plan or the PRCs and the Application must be denied. The Court **GRANTS** Petitioner's Motion for Judgment as a Matter of Law.

Additionally, the Court finds that the CON was improperly and invalidly issued to MUHA as the licensee of the proposed facility and is thereby void under S.C. Code Ann. § 44-7-230(A)&(E).

IT IS THEREFORE ORDERED that the Certificate of Need for MUSC/MUHA's proposed project for a radiation therapy center in Berkeley County, South Carolina is **DENIED**.

AND IT IS SO ORDERED.

May 14, 2019
Columbia, South Carolina


H.W. Funderburk, Jr.
Administrative Law Judge

FILED

MAY 14 2019

SC ADMIN. LAW COURT

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Trident Medical Center, LLC, d/b/a)
Trident Medical Center,)
)
Petitioner,)
)
v.)
)
South Carolina Department of Health and)
Environmental Control and)
Medical University Hospital Authority)
d/b/a MUSC Radiation Therapy Center -)
Berkeley County,)
)
Respondents.)
)

Docket No. 18-ALJ-07-0100-CC

**ORDER DENYING RESPONDENT'S
MOTION TO RECONSIDER, ALTER
OR AMEND**

FILED

JUN 14 2019

SC ADMIN. LAW COURT

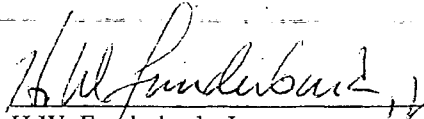
This matter comes before the South Carolina Administrative Law Court (ALC or Court) upon the Motion of Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center - Berkeley County (Respondent or MUSC)¹ for the Court to Reconsider, Alter, or Amend its Order granting Petitioner's Motion for Judgement as a Matter of Law and Denying Certificate of Need on Other Grounds. Trident Medical Center, LLC, d/b/a Trident Medical Center (Petitioner or Trident) opposes the Motion. The South Carolina Department of Health and Environmental Control has not supported or opposed the Motion.

After considering the issues raised by MUSC and Trident's response, the Court respectfully denies the Motion. The Court's Order issued May 14, 2019, is Final.

IT IS THEREFORE ORDERED that MUSC's Motion to Reconsider, Alter, or Amend is **DENIED**.

AND IT IS SO ORDERED.

June 14, 2019
Columbia, South Carolina


H.W. Funderburk, Jr.
Administrative Law Judge

¹ The Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center - Berkeley County was referred to during trial as "MUSC" and will be so referenced in this Order.

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Trident Medical Center, LLC d/b/a
Trident Medical Center,

Petitioner,

vs.

South Carolina Department of Health
and Environmental Control and Medical
University Hospital Authority d/b/a
MUSC Radiation Therapy Center –
Berkeley County,

Respondents.

Docket No.: _____

**PETITION FOR ADMINISTRATIVE
REVIEW AND REQUEST FOR
CONTESTED CASE HEARING**

Pursuant to S.C. Const. art. I, § 22; S.C. Code Ann. § 1-23-320, § 1-23-600(B), § 44-1-60(G), and §§ 44-7-110 *et seq.*; S.C. Code Ann. Regs. 61-15; and Rule 11 of the RPALC, Petitioner Trident Medical Center, LLC d/b/a Trident Medical Center (“Trident”), by and through its undersigned counsel, petitions the Court for administrative review and requests a contested case hearing on (1) the South Carolina Department of Health and Environmental Control’s (“Department”) November 22, 2017 decision to grant a Certificate of Need (“CON”) to Respondent Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center – Berkeley County (“MUSC”) for the expansion of radiation therapy services through the addition of a sixth linear accelerator at a total project cost of \$9,804,548 (“Proposed Project”) (“Staff Decision”) (**Exhibit A**); and (2) the Department Board’s January 31, 2018 decision not to conduct a final review conference on the matter, thereby rendering the Staff Decision the final agency decision. (**Exhibit B**). In support of this Petition, Trident respectfully submits the following:

PROCEDURAL BACKGROUND

1. On May 22, 2017, MUSC submitted its CON application for its Proposed Project.
2. On June 7, 2017, Trident provided notice to the Department of its status as an affected person and its opposition to the Proposed Project. (Exhibit C)
3. The application was deemed complete by letter from the Department, dated July 10, 2017, and publication in the South Carolina State Register, dated June 23, 2017. (Exhibit D)
4. On July 6, 2017, Roper St. Francis Hospital – Berkeley, Inc. (“Roper”) submitted a CON application for the establishment of radiation therapy services with the addition of a Varian True Beam LINAC at a total project cost of \$11,608,014 (“Roper’s Proposed Project”).
5. Roper’s Proposed Project was deemed complete on August 23, 2017 and notice was published in the South Carolina State Register, dated August 25, 2017. (Exhibit E)
6. Trident notified the Department of its status as an affected person and its opposition to Roper’s Proposed Project by letter dated September 8, 2017. (Exhibit F)
7. The Department held a project review meeting on both MUSC’s and Roper’s Proposed Projects on September 20, 2017, and all parties participated.
8. On October 4, 2017, Trident’s health care planning consultant, Sullivan Consulting Group, Inc., submitted written comments responding to MUSC’s and Roper’s arguments as presented at the project review meeting. (Exhibit G)
9. On November 22, 2017, the Department issued letters approving MUSC’s Proposed Project (Exhibit A) and Roper’s Proposed Project. (Exhibit H)

10. On December 15, 2017, Trident timely requested that the Department Board conduct a final review conference(s) with regard to MUSC's Proposed Project (Exhibit I) and Roper's Proposed Project (Exhibit J).¹

11. By letters dated January 31, 2018, the Department Board declined to conduct a final review conference on either project, thereby rendering the Department's decisions the final agency decisions. (Exhibit B and Exhibit L)

12. Trident now petitions this Court for administrative review and a contested case hearing with regard to MUSC's Proposed Project. By separate petition, Trident petitions the Court for administrative review and a contested case hearing regarding Roper's Proposed Project.

FACTUAL BACKGROUND

Competing Applications

13. The "CON Regulations" (S.C. Code Ann. Regs. 61-15) define competing applicants as

two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service. An application shall be considered competing if it is received by the Department no later than fifteen (15) calendar days after a Notice of Affected Persons is published in the State Register for one or more applications for similar services and/or facilities in the same service area. . . .

S.C. Code Ann. Regs. 61-15, § 103.6. *See also* S.C. Code Ann. § 44-7-130(5).

14. There is no need for an additional linear accelerator in the service area and certainly no need for two additional linear accelerators. Roper's CON application was filed within the regulatory time frame to be considered a competing application; yet, the Department

¹ Pursuant to the attached email from the Director of the CON Program, Trident did not receive notice of the Department's decision until December 8, 2017. Therefore, Trident timely filed its request for final review with the Department Board within 15 days of the date that the Department mailed notice of the decision to Trident. (Exhibit K)

inexplicably concluded that MUSC's and Roper's CON applications were not competing. (Exhibit B and Exhibit L)

15. Because the applications, in fact, were competing, the Department could approve only the one that most fully complied with the requirements, goals, and purposes of the CON Act; the standards and criteria set forth in the South Carolina Health Plan, enacted August 13, 2015 ("State Health Plan"); and the applicable project review criteria. S.C. Code Ann. § 44-7-210(B). *See also* S.C. Code Ann. Regs. 61-15, § 307.2.

16. Neither MUSC's nor Roper's CON application complies with the State Health Plan, the CON Act, or the CON Regulations; therefore, the decisions to approve MUSC's Proposed Project and Roper's Proposed Project must be overturned.

Community Need

17. There is no community need for additional radiation therapy services in the Berkeley, Charleston, Colleton, and Dorchester Counties service area. Trident has ample capacity to meet the needs of service area residents. Trident currently operates only two of its three linear accelerators due to low utilization volume. Exhibit M, p. 3. In 2016, Trident's utilization was only 63.2%. *Id.* at p. 10. Utilization of radiation therapy treatment for all providers has remained flat between the years of 2013 and 2016. *Id.* at p. 8.

18. While the service area has seen a slight increase in the number of cancer patients being served (approximately 12.5% between 2013 and 2016), there was no corresponding increase in the number radiation therapy treatments. *Id.* at p. 7. Newer treatment protocols, higher intensity treatments per patient, and improved technology for more precise targeting of tumors has reduced the number of radiation therapy treatments required for many cancer patients. *Id.* at p. 8.

19. In fact, MUSC upgraded its equipment in recent years, allowing it to treat patients more efficiently. Exhibit G, p. 1. As a result, MUSC's utilization remained relatively flat between 2013 and 2016 and actually decreased slightly between 2015 and 2016. Exhibit M, p. 13.

20. MUSC failed to demonstrate any institutional need for an additional linear accelerator. MUSC presented no evidence that its patients experienced delays in receiving treatment or that it needed to extend its hours to accommodate patient volume. Exhibit G, p. 1.

21. To the extent that MUSC is experiencing any capacity constraints, Trident has ample capacity to meet those needs. Trident is approximately 15 minutes from the site of MUSC's Proposed Project. MUSC could refer patients to Trident for treatment, allowing patients residing in Berkeley and Dorchester Counties to be treated closer to home. *Id.* at p. 2.

22. Referral to Trident would address any concerns MUSC physicians have with regard to patients traveling long distances, which is one reason large cancer centers often refer patients to local providers after an initial diagnosis and the establishment of a treatment plan. Exhibit M, p. 15.

23. In sum, there is no community need for additional radiation therapy services in the service area, and to the extent that MUSC has an institutional need due to capacity constraints, those issues can be addressed without expending \$9 million dollars² on a project that will substantially adversely impact other area providers, most particularly Trident.

Distribution (Accessibility)

24. Because there is no need for additional radiation therapy services in the service area, the Proposed Project does nothing to increase accessibility to services, including accessibility to services for the medically underserved.

² MUSC's Proposed Project and Roper's Proposed Project combined equate to the expenditure of approximately \$20 million on two unneeded projects.

25. The Proposed Project is, in fact, an unnecessary duplication of services. Residents in the service area have more options for radiation therapy treatment than almost all other service areas in the State. Exhibit M, p. 16.

26. MUSC defined its service area as Berkeley and Dorchester Counties and portions of North Charleston. *Id.* at p. 13. However, southern Berkeley County residents are closer to MUSC's Mount Pleasant location. *Id.* Thus, the location of MUSC's Proposed Project will do nothing to increase accessibility to services for those residents.

27. Locating not one, but two, additional linear accelerators in a service area with no need at a combined project cost of approximately \$20 million dollars does nothing to increase accessibility to services, is an unnecessary duplication of services, does not contain costs, and represents regressive health planning.

Financial Feasibility

28. Because there is no community need for additional radiation therapy services in the service area, MUSC's ability to meet its utilization projections is questionable. Because its utilization projections are suspect, the Proposed Project may not be financially feasible.

Adverse Impact

29. Furthermore, the operation of two new linear accelerators in a service area with no need will substantially adversely impact other area providers, and Trident will be the most heavily impacted.

30. Trident ceased operating one of its three linear accelerators due to low utilization. Trident operated at only 63% of capacity in 2016. There has been no growth in radiation therapy utilization in the service area for several years, and there is no credible evidence that the trend will reverse. In fact, the evidence indicates that radiation therapy volumes are stabilizing, if not declining.

31. At the project review meeting, MUSC addressed the number of patients traveling from Berkeley and Dorchester Counties. However, there is no evidence that MUSC will redirect these patients to its new facility. In all likelihood, these patients are traveling to the Hollings Cancer Center because of its specialized services and will continue to do so. Exhibit G, p. 2.

32. In reality, MUSC will compete with Trident for patients, redirecting market share from Trident and exacerbating Trident's already low utilization rates. *Id.* This adverse impact will be compounded by the addition of another unneeded linear accelerator at Roper.

LEGAL ARGUMENTS

33. In response to (i) the Department's November 22, 2017 decision to grant a CON to MUSC for the Proposed Project; and (ii) the Board's January 31, 2018 decision not to conduct a "Final Review" of the decision, thereby rendering the Department's Staff Decision the final agency Decision (hereinafter, collectively, "Department's Decision"), in accordance with S.C. Code Ann. § 44-1-60(G); reserving its right to raise any and all issues presented to and considered by the Department below, and incorporating each and every allegation set forth in paragraphs 1 through 32 above as if restated verbatim, Trident respectfully requests that the Court reverse the Department's Decision for the following reasons:

a. The Department's Decision is arbitrary, capricious, and affected by other error of law or fact, because the Department incorrectly concluded that MUSC's Proposed Project and Roper's Proposed Project were not competing. The CON applications met the statutory and regulatory definition of competing applications. Because the applications were competing, the Department could approve only the application that complied, or most fully complied, with the State Health Plan, the CON Act, and the project review criteria set forth in the CON Regulations. S.C. Code Ann. § 44-7-210(B). *See also* S.C. Code Ann. Regs. 61-15, § 307.2. MUSC's CON application failed to comply with the State Health Plan, the CON Act and

the project review criteria; therefore, the Department's Decision to approve MUSC's Proposed Project must be overturned.

b. The Department's Decision is arbitrary, capricious, and affected by other error of law or fact, because there is no community need for an additional linear accelerator in the service area. Therefore, MUSC's Proposed Project fails to comply with the project review criteria set forth at SC. Code Ann. Regs. 61-15, § 802.2, and the Department's Decision must be overturned.

c. The Department's Decision is arbitrary, capricious, and affected by other error of law or fact, because MUSC's Proposed Project is an unnecessary duplication of services which does nothing to increase accessibility to services. Therefore, MUSC's Proposed Project fails to comply with the project review criteria set forth at SC. Code Ann. Regs. 61-15, § 802.3 and 802.31, and the Department's Decision must be overturned.

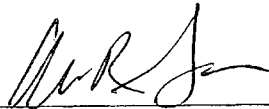
d. The Department's Decision is arbitrary, capricious, and affected by other error of law or fact, because MUSC's Proposed Project is not financially feasible. Therefore, MUSC's Proposed Project fails to comply with the project review criteria set forth at SC. Code Ann. Regs. 61-15, § 802.15, and the Department's Decision must be overturned.

e. The Department's Decision is arbitrary, capricious, and affected by other error of law or fact, because MUSC's Proposed Project will substantially adversely impact other area providers, including Trident. Therefore, MUSC's Proposed Project fails to comply with the project review criteria set forth at SC. Code Ann. Regs. 61-15, § 802.23, and the Department's Decision must be overturned.

WHEREFORE, based on the foregoing, Trident respectfully requests that the Court issue an Order:

- A. Reversing the Department's Decision to grant a CON to MUSC for its Proposed Project;
- B. Finding the Department's Decision to be arbitrary, capricious, and affected by other error of law or fact; and
- C. Denying MUSC's CON application.

Respectfully submitted,



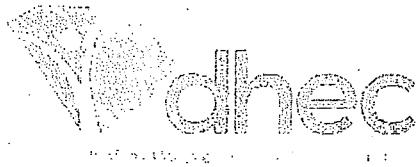
William R. Thomas (SC Bar #16348)
Walter H. Cartin (SC Bar #78405)
PARKER POE ADAMS & BERNSTEIN LLP
1221 Main Street, Suite 1100 (29201)
Post Office Box 1509
Columbia, SC 29202
Telephone: 803-255-8000
Facsimile: 803-255-8017
willthomas@parkerpoe.com
waltcartin@parkerpoe.com

*Attorneys for Petitioner
Trident Medical Center, LLC d/b/a Trident Medical
Center*

Columbia, South Carolina
March 1, 2018

Exhibit A

To Petition for Administrative Review and
Request for Contested Case Hearing



November 22, 2017

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Patrick J. Cawley, MD
Medical University Hospital Authority
169 Ashley Avenue
Charleston, SC 29425

Decision Granting Certificate of Need for:
Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center -
Berkeley County
Expansion of radiation therapy services by adding a sixth linear accelerator.
Total project cost: \$9,804,548.
Matter No.: 2449
Berkeley County

Dear Dr. Cawley:

The South Carolina Department of Health and Environmental Control (Department) has reviewed the application of Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center - Berkeley County (MUSC) to receive a Certificate of Need (CON) for the expansion of radiation therapy services by adding a sixth linear accelerator at a total project cost of \$9,804,548 (Project). After consideration of the entire administrative record in this matter, the Department concludes MUSC has presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina Health Plan*, enacted August 13, 2015 (*Plan*). Accordingly, it is the decision of the Department that a Certificate of Need be issued for this Project. This decision is based on the following findings:

Pursuant to Regulation 61-15, Section 103.6, the following application is potentially competing with the above-referenced matter:

2470 - Roper St. Francis Hospital - Berkeley, Inc. d/b/a Roper St. Francis Hospital - Berkeley (RSFB); Establishment of radiation therapy services with the addition of a Varian True Beam LINAC at a total project cost of \$11,608,014.

SC Department of Health and Environmental Control

The Department concludes that the instant application and RSFB's application do not meet the definition of "[c]ompeting applicants" pursuant to Regulation 61-15, Section 103.6 because approval of both applications will not exceed the need for the service.

Trident Medical Center, LLC d/b/a Trident Medical Center (Trident) and CareAlliance Health Services d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours - St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis - Berkeley Hospital (collectively "Roper") are Affected Persons in this matter, pursuant to Regulation 61-15, Section 103.1, and both Trident and Roper oppose the Project. After considering documents and arguments submitted by the Affected Persons in opposition to the Project, including comments made at a project review meeting conducted by the Department in this matter on September 20, 2017, the Department finds that the opposition has not provided evidence sufficient to require denial of a CON for the Project.

Compliance with the Need outlined in the South Carolina Health Plan

Chapter IX of the *Plan* sets forth the CON Standards for the addition of a linear accelerator (LINAC) to a service area:

Standards 1 through 4 - MUSC stated in its application that the proposed LINAC would have a treatment capacity of 5,000. MUSC further provided sufficient documentation that it will provide IMRT and IGRT treatments in sufficient volume to justify this proposed planning capacity.

Standard 5 - The Project would be located in the service area comprised of Charleston, Dorchester, Berkeley, and Colleton Counties (Service Area).

Standard 6 - Not applicable to the Project.

Standard 7 - According to MUSC's 2015 and 2016 JARs, MUSC's existing LINACs have operated at a combined use rate that exceeded 80% in both years. In its application MUSC reasonably projected a use rate of over 50% capacity on the proposed unit within three years of the Project's implementation.

Standard 8 - MUSC projected utilization and submitted letters of support for the Project from MUSC-affiliated physicians.

Standard 9 - MUSC states in its application that "[a]s an existing provider, the applicant currently complies with the above standards and will continue to do so through the proposed project."

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.1.

Community Need Documentation

MUSC clearly identified its target population and, using population statistics consistent with those generated by the State Demographer, MUSC made reasonable projections of anticipated population changes, with assumptions and methodologies clearly outlined in the application. MUSC has sufficiently demonstrated that the proposed Project will meet an identified need and that the projected utilization of the Project is sufficient to justify its implementation.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.2.

Distribution (Accessibility)

The Department finds that the Project will not result in unnecessary duplication or modernization of services based on MUSC's documentation regarding both need and accessibility. MUSC states that patients have access to the Project by self-referral and by internal and external physician referral; that referrals derive from private physician practices, public clinics and other hospitals; and that access to the facility also comes from physicians affiliated with MUSC Health. MUSC states that patients are admitted to MUSC facilities without regard to race, sex, creed, or national origin. MUSC referenced its Patient Rights and Responsibilities policy, its charity care and financial assistance policies, and its historical and projected amount of indigent care to demonstrate that it has established provisions to insure that individuals in need of treatment as determined by a physician have access to the Project, regardless of ability to pay.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.3.

Medically Underserved Groups

MUSC addressed the contribution of the Project in meeting the health needs of members of medically underserved groups, particularly uninsured, low-income, and indigent patients. The Department considered MUSC's historical and projected indigent care in comparison with the percentage of population in the Project's service area which is medically underserved, and the extent to which the medically underserved populations are expected to use the Project if approved. The Department further considered MUSC's documented performance in meeting its obligation under applicable regulations requiring provision of uncompensated care, its indigent care plan, community service, and access by minorities and handicapped persons to programs receiving federal financial assistance. Finally, the Department considered the extent to which Medicare, Medicaid, and medically indigent patients are served by MUSC.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.31.

Financial Feasibility

MUSC reasonably projected both the immediate and long-term financial feasibility of the Project using projected income statements that are based upon accepted accounting procedures. MUSC provided a letter from John Cooper, an accountant, stating that the information contained in the proforma was prepared by Hospital Finance, and certifying that all of the assumptions, calculations, and information contained in the projections were prepared accurately to the best of his knowledge.

The Department finds that MUSC has sufficiently complied with 3 S.C. Code Reg. 61-15, Section 802.15.

The Department has determined the findings required by 3 S.C. Code Reg. 61-15 § 501 are not applicable to this Project.

The issuance of a Certificate of Need does not constitute approval for any proposed construction, licensing, or certification changes. You should contact the following individuals for information concerning these related issues: Bureau of Radiological Health, Mr. Aaron Gantt, (803) 545-4400; Division of Health Facilities Construction, Mr. William McCallum, (803) 545-4211; Division of Health Licensing, Ms. Gwendolyn Thompson, (803) 545-4370; and Bureau of Certification, Ms. Maryjo Roué, (803) 545-4293.

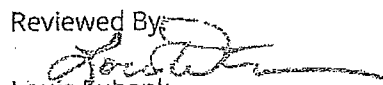
A copy of the Guide to Board Review is enclosed for your convenience.

Written By:



Maggie Parham Murdock
Director
Certificate of Need Program

Reviewed By:



Louis Eubank
Chief, Bureau of Healthcare
Planning and Construction

Enclosure: Guide to Board Review

Cc: William Thomas, Esquire
Matt Hasbrouck (Via Email: Matthew.Hasbrouck@hcahealthcare.com)
Ralph Barbler, Esquire
Kathy Platt (Via Email: kplatt@plattthmc.com)
Sarah Bacik (Via Email: baciks@musc.com)
Daniel Westbrook, Esquire (Via Email: dan.westbrook@nelsonmullins.com)

South Carolina Board of Health and Environmental Control

Guide to Board Review

Pursuant to S.C. Code Ann. § 44-1-60

The decision of the South Carolina Department of Health and Environmental Control (Department) becomes the final agency decision fifteen (15) calendar days after notice of the decision has been mailed to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of \$100 is filed with Department by the applicant, permittee, licensee or affected person.

Applicants, permittees, licensees, and affected parties are encouraged to engage in mediation or settlement discussions during the final review process.

If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within thirty (30) calendar days after notice is mailed that the Board declined to hold a final review conference. In matters pertaining to decisions under the South Carolina Mining Act, appeals should be made to the South Carolina Mining Council.

1. Filing of Request for Final Review

1. A written Request for Final Review (RFR) and the required filing fee of one hundred dollars (\$100) must be received by Clerk of the Board within fifteen (15) calendar days after notice of the staff decision has been mailed to the applicant, permittee, licensee, or affected persons. If the 15th day occurs on a weekend or State holiday, the RFR must be received by the Clerk on the next working day. RFRs will not be accepted after 5:00 p.m.
2. RFRs shall be in writing and should include, at a minimum, the following information:
 - The grounds for amending, modifying, or rescinding the staff decision;
 - a statement of any significant issues or factors the Board should consider in deciding how to handle the matter;
 - the relief requested;
 - a copy of the decision for which review is requested; and
 - mailing address, email address, if applicable, and phone number(s) at which the requestor can be contacted.
3. RFRs should be filed in person or by mail at the following address:
South Carolina Board of Health and Environmental Control
Attention: Clerk of the Board
2600 Bull Street
Columbia, South Carolina 29201
Alternatively, RFR's may be filed with the Clerk by facsimile (803-898-3393) or by electronic mail (boardclerk@dhec.sc.gov);
4. The filing fee may be paid by cash, check or credit card and must be received by the 15th day.
5. If there is any perceived discrepancy in compliance with this RFR filing procedure, the Clerk should consult with the Chairman or, if the Chairman is unavailable, the Vice-Chairman. The Chairman or the Vice-Chairman will determine whether the RFR is timely and properly filed and direct the Clerk to (1) process the RFR for consideration by the Board or (2) return the RFR and filing fee to the requestor with a cover letter explaining why the RFR was not timely or properly filed. Processing an RFR for consideration by the Board shall not be interpreted as a waiver of any claim or defense by the agency in subsequent proceedings concerning the RFR.
6. If the RFR will be processed for Board consideration, the Clerk will send an Acknowledgement of RFR to the Requestor and the applicant, permittee, or licensee, if other than the Requestor. All personal and financial identifying information will be redacted from the RFR and accompanying documentation before the RFR is released to the Board, Department staff or the public.
7. If an RFR pertains to an emergency order, the Clerk will, upon receipt, immediately provide a copy of the RFR to all Board members. The Chairman, or in his or her absence, the Vice-Chairman shall based on the circumstances, decide whether to refer the RFR to the RFR Committee for expedited review or to decline in writing to schedule a Final Review Conference. If the Chairman or Vice-Chairman determines review by the RFR Committee is appropriate, the Clerk will forward a copy of the RFR to Department staff and Office of General Counsel. A Department response and RFR Committee review will be provided on an expedited schedule defined by the Chairman or Vice-Chairman.
8. The Clerk will email the RFR to staff and Office of General Counsel and request a Department Response within eight (8) working days. Upon receipt of the Department Response, the Clerk will forward the RFR and Department Response to all Board members for review, and all Board members will confirm receipt of the RFR to the Clerk by email. If a Board member does not confirm receipt of the RFR within a twenty-four (24) hour period, the Clerk will contact the Board member and confirm receipt. If a Board member believes the RFR should be considered by the RFR Committee, he or she will

respond to the Clerk's email within forty-eight (48) hours and will request further review. If no Board member requests further review of the RFR within the forty-eight (48) hour period, the Clerk will send a letter by certified mail to the Requestor, with copy by regular mail to the applicant, permittee, or licensee, if not the Requestor, stating the Board will not hold a Final Review Conference. Contested case guidance will be included within the letter.

NOTE: If the time periods described above end on a weekend or State holiday, the time is automatically extended to 5:00 p.m. on the next business day.

9. If the RFR is to be considered by the RFR Committee, the Clerk will notify the Presiding Member of the RFR Committee and the Chairman that further review is requested by the Board. RFR Committee meetings are open to the public and will be public noticed at least 24 hours in advance.
10. Following RFR Committee or Board consideration of the RFR, if it is determined no Conference will be held, the Clerk will send a letter by certified mail to the Requestor, with copy by regular mail to the applicant, permittee, or licensee, if not the Requestor, stating the Board will not hold a Conference. Contested case guidance will be included within the letter.

II. Final Review Conference Scheduling

1. If a Conference will be held, the Clerk will send a letter by certified mail to the Requestor, with copy by regular mail to the applicant, permittee, or licensee, if not the Requestor, informing the Requestor of the determination.
2. The Clerk will request Department staff provide the Administrative Record.
3. The Clerk will send Notice of Final Review Conference to the parties at least ten (10) days before the Conference. The Conference will be publically noticed and should:
 - include the place, date and time of the Conference;
 - state the presentation times allowed in the Conference;
 - state evidence may be presented at the Conference;
 - if the conference will be held by committee, include a copy of the Chairman's order appointing the committee; and
 - inform the Requestor of his or her right to request a transcript of the proceedings of the Conference prepared at Requestor's expense.
4. If a party requests a transcript of the proceedings of the Conference and agrees to pay all related costs in writing, including costs for the transcript, the Clerk will schedule a court reporter for the Conference.

III. Final Review Conference and Decision

1. The order of presentation in the Conference will, subject to the presiding officer's discretion, be as follows:
 - Department staff will provide an overview of the staff decision and the applicable law to include [10 minutes]:
 - Type of decision (permit, enforcement, etc.) and description of the program.
 - Parties
 - Description of facility/site
 - Applicable statutes and regulations
 - Decision and materials relied upon in the administrative record to support the staff decision.
 - Requestor(s) will state the reasons for protesting the staff decision and may provide evidence to support amending, modifying, or rescinding the staff decision. [15 minutes] *NOTE: The burden of proof is on the Requestor(s)*
 - Rebuttal by Department staff [15 minutes]
 - Rebuttal by Requestor(s) [10 minutes]

Note: Times noted in brackets are for information only and are superseded by times stated in the Notice of Final Review Conference or by the presiding officer.
2. Parties may present evidence during the conference; however, the rules of evidence do not apply.
3. At any time during the conference, the officers conducting the Conference may request additional information and may question the Requestor, the staff, and anyone else providing information at the Conference.
4. The presiding officer, in his or her sole discretion, may allow additional time for presentations and may impose time limits on the Conference.
5. All Conferences are open to the public.
6. The officers may deliberate in closed session.
7. The officers may announce the decision at the conclusion of the Conference or it may be reserved for consideration.
8. The Clerk will mail the written final agency decision (FAD) to parties within 30 days after the Conference. The written decision must explain the basis for the decision and inform the parties of their right to request a contested case hearing before the Administrative Law Court or in matters pertaining to decisions under the South Carolina Mining Act, to request a hearing before the South Carolina Mining Council. The FAD will be sent by certified mail, return receipt requested.
9. Communications may also be sent by electronic mail, in addition to the forms stated herein, when electronic mail addresses are provided to the Clerk.

The above information is provided as a courtesy; parties are responsible for complying with all applicable legal requirements.

Exhibit B

To Petition for Administrative Review and
Request for Contested Case Hearing



Board:

Allen Amster, *Chairman*
Ann B. Kirol, DDS, *Vice Chair*
L. Clarence Batts, Jr., *Secretary*

R. Kenyon Wells
Charles M. Joye II, P.E.
David W. Gillespie, MD

January 31, 2018

Electronic Mail and U.S. Certified Mail Delivery 9214 8969 0099 9790 1410 7901 44
William R. Thomas (willthomas@parkerpoe.com)
Parker Poe Adams & Bernstein, LLP
Post Office Box 1509
Columbia, SC 29202

Electronic Mail and U.S. Mail Delivery
Daniel J. Westbrook (dan.westbrook@nelsonmullins.com)
Travis Dayhuff (travis.dayhuff@nelsonmullins.com)
Nelson Mullins Riley & Scarborough, LLP
Post Office Box 11070
Columbia, SC 29211

Electronic Mail Delivery
Ashley C. Biggers (biggerca@dhec.sc.gov)
SCDHEC – Office of General Counsel
2600 Bull Street
Columbia, SC 29201

**RE: Docket No. 17-RFR-84, Medical University Hospital Authority d/b/a MUSC
Radiation Therapy Center – approval of Certificate of Need for the expansion
of radiation therapy services by adding a sixth linear accelerator.**

Dear Counsel of Record:

The South Carolina Board of Health and Environmental Control will not conduct a Final Review Conference on the above-referenced matter.

CONTESTED CASE GUIDANCE

S.C. Code Section 44-1-60 provides that if the Board declines in writing to schedule a final review conference, the staff decision becomes the final agency decision, and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court (ALC) within thirty calendar days after notice is mailed to the applicant, permittee, licensee, and affected person that the Board declined to hold a final review conference.

A request for a contested case hearing before the Administrative Law Court must be filed within the time allowed and in accordance with the Rules of the ALC, including payment of the ALC's filing fee, at the following address:

S.C. Department of Health and Environmental Control

2600 Bull Street, Columbia, SC 29201 (703) 792-1111

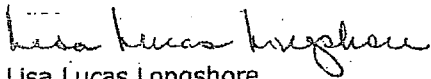
ROA_0054

Clerk's Office
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

The ALC's Notice of Request for Contested Case Hearing form and the Rules of the ALC can be found at the ALC's website: <http://www.scalc.net>. Further information on filing a request for a contested case hearing before the ALC may be obtained by calling the Clerk's Office at the Administrative Law Court (803-734-0550):

If a party files a request for a contested case hearing with the ALC, the party must serve a copy of the request on DHEC and any other parties at the same time the request is filed with the ALC. A copy of the request for a contested case hearing must be delivered or mailed to DHEC at the address at the top of this memorandum.

Sincerely,



Lisa Lucas Longshore
Clerk
S.C. Board of Health and Environmental Control

The above information on filing a request for a contested case hearing before the Administrative Law Court is provided as a courtesy; parties before the ALC are responsible for complying with all applicable requirements of the Court.

Exhibit C

To Petition for Administrative Review and
Request for Contested Case Hearing



William R. Thomas
Partner
Telephone: 803.253.8658
Direct Fax: 803.255.8017
willthomas@parkerpoe.com

Atlanta, GA
Charleston, SC
Charlotte, NC
Columbia, SC
Greenville, SC
Raleigh, NC
Spartanburg, SC

JUN 07 2017

June 7, 2017

VIA HAND DELIVERY AND EMAIL
Louis W. Eubank, MSW, MPH
Director, Certificate of Need Program
Bureau of Health Facilities and Services Development
SC Department of Health and Environmental Control
301 Gervais Street
Columbia, South Carolina 29201

Re: Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center –
Berkeley County
Certificate of Need Application for the expansion of radiation therapy services by
adding a sixth linear accelerator at a total project cost of \$9,804,548
DHEC Matter No. 2449

TRIDENT MEDICAL CENTER'S AFFECTED PERSON STATUS AND OPPOSITION

Dear Mr. Eubank:

Pursuant to S.C. Code Ann. §§44-7-130(1) and 44-7-210(C) and Regulation 61-15 §§103(1) and 305, I am writing on behalf of Trident Medical Center, LLC, d/b/a Trident Medical Center ("Trident"), an existing provider of similar services located in Charleston, South Carolina, which is in the same health service area and geographic area to be served by the applicant, to notify the Department that Trident is an "affected person" with respect to Medical University Hospital Authority's ("MUHA") CON application referenced above, and that it opposes the approval of MUHA's CON application. Trident is also requesting that a project review meeting be held by the Department prior to the Department making a decision on this CON application. More specifically, Trident opposes the above referenced CON application because, among other reasons, the project does not comport with the purposes of the CON Act; the project does not comply with the standards set forth in the 2015 *South Carolina Health Plan*; the project is not needed; the project will have an adverse impact on Trident's radiation therapy program; the project does not increase accessibility to catheterization services; and the project will not contain costs.

Please copy Matt Hasbrouck at Trident and myself on any future correspondence to or from the Department concerning this CON application. Thank you for your consideration of Trident's position, and please let me know if you have any questions or concerns.

Sincerely,

William R. Thomas

WRT/ccq

cc: Matt Hasbrouck, COO (via email Matthew.Hasbrouck@hcahealthcare.com)

Exhibit D

To Petition for Administrative Review and
Request for Contested Case Hearing



July 10, 2017

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Patrick J. Cawley, MD
Medical University Hospital Authority
169 Ashley Avenue
Charleston, SC 29425

Re: Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center
– Berkeley County

Project: Expansion of radiation therapy services by adding a sixth linear
accelerator at a total project cost of \$9,804,548.

Matter No. 2449

Dear Dr. Cawley:

This is to notify you the South Carolina Department of Health and Environmental Control ("Department") has determined the above-referenced project to be complete for purposes of review by the Certificate of Need Program. Enclosed is an invoice for the required application fee. It may be paid by check made payable to the S.C. Department of Health and Environmental Control or by electronic check through the Department's website (www.scdhec.gov) using the "Pay Invoices" hyperlink at the bottom of each webpage. This is a secure website. If payment is not received within fifteen (15) days of your receipt of this invoice, the pending application will be considered withdrawn and this matter closed. Should this deadline fall on a weekend or State holiday, it will be extended to the next calendar day that is neither weekend nor holiday pursuant to S.C. Regulation 61-15, Section 303.

Should the Department receive your application fee within the fifteen (15) day deadline, the Department will render a decision no earlier than thirty (30) days, but no later than one-hundred (120) days from the date notice is provided to affected persons in the State Register, unless a public hearing is held pursuant to Regulation 61-15, Section 305.

The Department has determined the relative importance of the project review criteria, pursuant to Regulation 61-15, Section 304, which will be used to review your application. The

specific criteria to be used are set forth below and are ranked according to their relative importance, with the most important being listed first. All other relevant criteria will be given equal importance.

- a. Compliance with the Need outlined in the South Carolina Health Plan
- b. Community Need Documentation;
- c. Distribution (Accessibility);
- d. Medically Underserved Groups; and
- e. Financial Feasibility.

The above criteria are set forth in Regulation 61-15, Section 802. Should you wish to submit any additional information to the Department in support of your application, you have thirty (30) days from the receipt of this correspondence to do so.

If you have any questions, please contact me at 803.545.4492.

Sincerely,



Maggie Parham Murdock
Director, Certificate of Need Program
South Carolina Department of Health and Environmental Control

Enclosures: Application Fee Invoice

Cc: William R. Thomas, Esquire

Matt Hasbrouck (Via Email: Matthew.Hasbrouck@hcahealthcare.com)

Sarah Bacik (Via Email: baciks@musc.com)

Daniel Westbrook, Esquire (Via Email: dan.westbrook@nelsonmullins.com)

Affecting Pickens County**AnMed Health d/b/a AnMed Health Home Health Agency**

Establishment of a new Home Health Agency in Pickens County at a total project cost of \$0.00.

Affecting Sumter County**Alan Jamieson d/b/a South Carolina Treatment Associates**

Establishment of an Outpatient Narcotic Treatment Program in Sumter County at a total project cost of \$45,500.

In accordance with Section 44-7-210(A), Code of Laws of South Carolina, and S.C. DHEC Regulation 61-15, the public and affected persons are hereby notified that for the following projects, applications have been deemed complete, and the review cycle has begun. A proposed decision will be made as early as 30 days, but no later than 120 days, from June 23, 2017. "Affected persons" have 30 days from the above date to submit requests for a public hearing to Nic Gerrald, Certificate of Need Program, 2600 Bull Street, Columbia, S.C. 29201. If a public hearing is timely requested, the Department's decision will be made after the public hearing, but no later than 150 days from the above date. For further information call (803) 545-3495.

Affecting Allendale County**NHC/OP, L.P. d/b/a NHC HomeCare-Aiken**

Establishment of a new Home Health Agency in Allendale County at a total project cost of \$1,000.

Affecting Berkeley County**Medical University Hospital Authority d/b/a MUSC Health Emergency Services**

Construction of a 15,300 sf Freestanding Emergency Department (FSED) in Berkeley County at a total project cost of \$13,584,161.

Medical University Hospital Authority d/b/a MUSC Radiation Therapy Center- Berkeley County

Expansion of radiation therapy services by adding a sixth linear accelerator at a total project cost of \$9,804,548.

Affecting Charleston County**Medical University Hospital Authority d/b/a MUSC Shawn Jenkins Children's Hospital and Pearl Tourville Women's Pavilion (SJCH)**

Expansion of pediatric open heart services to include a pediatric open heart operating room at a total project cost of \$1,102,991.

Affecting Oconee County**NHC/OP, L.P. d/b/a NHC HomeCare-Laurens**

Establishment of a new Home Health Agency in Oconee County at a total project cost of \$1,000.

Affecting Pickens County**AnMed Health d/b/a AnMed Health Home Health Agency**

Establishment of a new Home Health Agency in Pickens County at a total project cost of \$0.00.

Exhibit G

To Petition for Administrative Review and
Request for Contested Case Hearing

Sullivan Consulting Group, Inc.

2090 Bethany Way · Alpharetta, Georgia 30004 · (770) 753-4222 · Fax: (770) 753-4223

October 4, 2017

Margaret P. Murdock
Director, Certificate of Need Program
Bureau of Health Facilities and Services Development
SC Department of Health and Environmental Control
301 Gervais Street
Columbia, South Carolina 29201

**Re: Medical University Hospital Authority d/b/a MUSC Radiation Therapy
Center - Berkeley
Matter No. 2449**

**Roper St. Francis – Berkeley d/b/a Roper St. Francis Hospital - Berkeley
Matter No. 2470**

Dear Ms. Murdock:

On behalf of Trident Medical Center, LLC d/b/a Trident Medical Center ("Trident"), I am submitting this letter in response to the comments presented by the Medical University Hospital Authority ("MUHA") and Roper St. Francis ("RSF") at the Project Review Meeting held on September 20, 2017. RSF and MUHA seek to add new linear accelerators at facilities to be developed in southern Berkeley County, and Trident is opposed to both projects. Trident is an existing provider of radiation oncology services serving the area both applicants propose to serve, and Trident will be adversely impacted by the approval of either project.

We will first address the information presented by each applicant separately.

MUHA's Project

Trident opposes MUHA's project for several reasons as set forth in our Project Review presentation, which MUHA failed to rebut. These include:

- There is no need for additional linear accelerator capacity at MUHA. MUHA's radiation therapy treatments have not increased in recent years. During this period MUHA has upgraded its facilities and equipment, which allow it to treat patients more efficiently. MUHA failed to present any evidence that patients are experiencing delays in receiving treatment or that its hours of operation have been extended to accommodate the volume of patients. MUHA has no need to add capacity at this time.
- MUHA failed to demonstrate that there is a need for enhanced access to radiation therapy services in southern Berkeley County where it proposes to place its unit. Trident is less than

15 minutes from MUHA's proposed location and has available capacity with its linear accelerators. As discussed at the Project Review Meeting, only two of Trident's three linear accelerators are currently in use because of the lack of sufficient utilization. Trident can readily accommodate any patients MUHA would like to refer for radiation treatment if it desires to have its patients from Berkeley and Dorchester Counties served closer to their homes.

- MUHA's project will clearly have an adverse impact Trident. MUHA discusses the number of patients traveling to other facilities for radiation treatment from Berkeley and Dorchester Counties. The assumption that MUHA will be able to redirect most of these patients to its new radiation therapy facility is not supported by any evidence. The likelihood is that many of these patients are traveling to the Hollings Cancer Center because of its specialized services and many will continue to do so. MUHA will compete for patients with Trident, and to the extent it is successful in capturing new market share, the underutilization of Trident's radiation therapy program will be exacerbated.

For all of these reasons, MUHA's project does not comply with the relevant CON review criteria and should be denied.

RSF's Project

RSF's project suffers from even greater deficiencies than those of MUHA.

RSF has manipulated its radiation therapy capacities in an attempt to demonstrate compliance with the South Carolina Health Plan. As MUHA noted in its presentation, the capacity for the linear accelerators in its system was 22,000 treatments prior to 2017 (3 linear accelerators with a capacity of 7,000 treatments each plus one Cyberknife with a capacity of 1,000 treatments). RSF submitted a letter to DHEC seeking to have its capacity modified by stating that its three linear accelerators provide IMRT/IGRT and should be adjusted to a capacity of 5,000 treatments, reducing the system's capacity to 16,000 treatments.

In its letter, RSF indicated that 20-25% of its treatments utilized IMRT/IGRT, which are low percentages relative to other providers. For example, 66% of Trident's radiation treatments in 2016 utilized IMRT/IGRT and 72% of MUHA's utilized these technologies. If RSF's capacity is 22,000 treatments annually, then its existing units operated at only 74% of capacity in 2016.

The 2017-2018 South Carolina Health Plan sets forth the following criterion:

6. *New Radiotherapy services shall only be approved if the following conditions are met:*
 - a. *All existing units in the service area have performed at a combined use rate of 80 percent of capacity as evidenced in the most recent Joint Annual Reports preceding the filing of the applicant's Certificate of Need application; and*

- b. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold...*

RSF's project fails under both elements of this criterion. Correcting the treatment capacities in the table presented on p. 14 of RSF's Project Review presentation demonstrates that in 2016 the service area's overall utilization rate was only 73.2%, far below the Health Plan's 80% target.

**BCCD Service Area Radiation Therapy Utilization
With Corrected Capacities for RSF**

	2016 Capacity	2016 Treatments	2016 % Utilization
Roper Hospital	8,000	5,915	73.9%
St. Francis Hospital	14,000	10,191	72.8%
Trident	16,500	10,422	63.2%
MUHA	24,000	19,221	80.1%
Total Service Area	62,500	45,749	73.2%

RSF also cannot demonstrate that it will perform a minimum of 50% of capacity annually without reducing the utilization of existing machines in the service area below the 80% threshold. As a starting point, existing machines in the area are already operating below 80%, and as demonstrated in Trident's Project Review presentation, the volume of treatments in the area has not been increasing historically and there is no reason to expect significant growth in the future. Moreover, Trident is the provider that will be most directly impacted by RSF's proposed new unit, and it operated at only 63% utilization in 2016.

RSF also failed to produce any other evidence of the need for new linear accelerator capacity. There is no documentation of patient delays in receiving treatment or that RSF has extended hours of operation. RSF has been implementing a plan to reduce its radiation therapy capacity, which hardly supports expansion into Berkeley County. The project is simply intended to allow RSF to capture new market share by placing a linear accelerator in southern Berkeley County.

Placing the proposed linear accelerator at RSF Hospital – Berkeley does not comport with sound health planning. This new hospital will open simultaneously with the opening of the radiation therapy service. The new hospital will not have the range of specialists or adjunctive therapies that are available at existing radiation therapy providers in the service area.

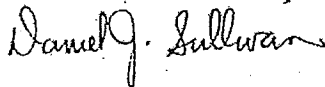
Margaret P. Murdock

October 4, 2017
Page 4

For all of these reasons, RSF's project is not consistent with the relevant CON review criteria and should be denied.

We appreciate the opportunity to submit this response and would be happy to provide any additional information.

Sincerely,

A handwritten signature in cursive script that reads "Daniel J. Sullivan".

Daniel J. Sullivan
President

Exhibit I

To Petition for Administrative Review and
Request for Contested Case Hearing



William R. Thomas
Partner
Telephone: 803.253.8658
Direct Fax: 803.255.8017
willthomas@parkerpoe.com

Atlanta, GA
Charleston, SC
Charlotte, NC
Columbia, SC
Greenville, SC
Raleigh, NC
Spartanburg, SC

December 15, 2017

Via E-mail (LUCASLM@dhec.sc.gov) &
Via Hand Delivery

The Honorable Lisa Lucas Longshore
Clerk of the Board
SC Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

RECEIVED

DEC 15 2017

Re: Request for Final Review

Decision Granting Certificate of Need for:

Medical University Hospital Authority, d/b/a MUSC Radiation Therapy Center –
Berkeley County

Project: Expansion of radiation therapy services by adding a sixth linear
accelerator at a total project cost of \$9,804,548 ("Proposed Project")

Matter No.: 2449

Berkeley County, South Carolina

SC Department of
Health and Environmental
Control

Dear Ms. Longshore:

Pursuant to S.C. Code Ann. § 44-1-60; the State Certification of Need and Health Facility Licensure Act (S.C. Code Ann. §§ 44-7-110 *et seq.*) ("CON Act"); S.C. Code Ann. Regs. 61-15 ("CON Regulations"); the South Carolina Administrative Procedures Act (S.C. Code Ann. §§ 1-23-310 *et seq.*) ("APA"); and Article I, Section 22 of the South Carolina State Constitution; on behalf of our client, Trident Medical Center, LLC, d/b/a Trident Medical Center ("Trident"), I am writing to request that the Department Board conduct a final review conference of the Department staff's November 22, 2017 decision to grant a Certificate of Need ("CON") to the Medical University Hospital Authority, d/b/a MUSC Radiation Therapy Center – Berkeley County ("MUSC") for the above-referenced Proposed Project.¹ **Exhibit A.** Reserving its right to raise any issue considered by or presented to the Department, Trident respectfully requests that the Department Board reverse the Department staff's decision and deny Roper's application for a CON for the reasons set forth herein and within the exhibits attached hereto. Also, enclosed with this Request for Final Review, please find a check in the amount of \$100.00 as payment of the filing fee.

¹ As demonstrated by the email from Ms. Murdock, Director of the CON Program, attached as **Exhibit B**, Trident did not receive notice of the Department's decision until December 8, 2017. Therefore, Trident timely files this request for final review, per the Department's Guide to Board Review, within fifteen days of the date that the Department electronically mailed notice of the staff decision to Trident, which timely identified itself to the Department as an affected person in this matter.

Procedural Background

On May 22, 2017, MUSC filed its CON application for the Proposed Project. Subsequently, on July 6, 2017, Roper St. Francis Hospital – Berkeley, Inc., d/b/a Roper St. Francis Hospital – Berkeley ("Roper") filed a CON application for the addition of a sixth linear accelerator ("Roper's Proposed Project"). MUSC's CON application was deemed complete on July 10, 2017. Roper's CON application was deemed complete on August 23, 2017. Trident filed its notice of opposition and status as an affected person with regard to MUSC's Proposed Project on June 7, 2017 (Exhibit C) and with regard to Roper's Proposed Project on September 8, 2017 (Exhibit D). A project review meeting was held on September 20, 2017 in which all parties participated. The Department issued letters on November 22, 2017 approving both MUSC's Proposed Project (Exhibit A) and Roper's Proposed Project. Exhibit E. The Department electronically mailed Trident the decision letter on December 8, 2017, and Trident now seeks final review and respectfully requests that the Board reverse the Department's decision and deny MUSC's request for a CON for its Proposed Project. By separate letter, Trident also seeks final review and requests that the Department Board reverse the decision to approve Roper's Proposed Project. In support of its position, Trident submits the following:

Arguments

The Department staff's decision to approve MUSC's CON application must be overturned because the CON application fails to comply with the standards set forth in the State Health Plan, the goals and purposes of the CON Act, and the applicable project review criteria set forth in the CON Regulations. S.C. Code Ann. § 44-7-210(B). See also S.C. Code Ann. Regs. 61-15, § 307.1.

Competing Applicants

The CON Act defines competing applicants as

two or more persons or health care facilities . . . who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities.

S.C. Code Ann. § 44-7-130(5). See also S.C. Code Ann. Regs. 61-15, § 103.6. As demonstrated herein, there is no need for an additional linear accelerator in the service area; yet, the Department approved two. Thus, contrary to the Department's determination, MUSC's Proposed Project and Roper's Proposed Project should have been considered competing. Because the applications were competing, the Department, at best, could approve only the one that most fully complied with the requirements, goals, and purposes of the CON Act; the standards and criteria set forth in the State Health Plan; and the applicable project review criteria. S.C. Code Ann. § 44-7-210(B). See also S.C. Code Ann. Regs. 61-15, § 307.2. As demonstrated herein and in Trident's separate request for final review of the Department's decision to approve Roper's Proposed Project, neither of these projects complies with the State Health Plan, the CON Act, or the CON Regulations; therefore, both decisions must be reversed.

Community Need

There is no community need for additional radiation therapy services in the Berkeley, Charleston, Colleton, and Dorchester Counties service area. Trident has ample capacity to meet the needs of service area residents. In fact, Trident currently only operates two of its three linear accelerators due to low utilization volume. Exhibit F, p. 3. In 2016, Trident's utilization was only 63.2%. *Id.* at p. 10. Utilization of radiation therapy treatment for all providers has remained flat between the years of 2013 and 2016. *Id.* at p. 8. While the service area has seen a slight increase in the number of cancer patients being served (approximately 12.5% between 2013 and 2016), that did not translate into an increase in the number radiation therapy treatments. *Id.* at p. 7. Newer treatment protocols, higher intensity treatments per patient, and improved technology for more precise targeting of tumors has reduced the number of radiation therapy treatments required for many cancer patients. *Id.* at p. 8.

In fact, MUSC upgraded its equipment in recent years, allowing it to treat patients more efficiently. Exhibit G, p. 1. As a result, MUSC's utilization remained relatively flat between 2013 and 2016 and actually decreased slightly between 2015 and 2016. Exhibit F, p. 13. MUSC presented no evidence that its patients experienced delays in receiving treatment or that it needed to extend its hours to accommodate patient volume. Exhibit G, p. 1. Thus, MUSC failed to demonstrate any institutional need for an additional linear accelerator either.

To the extent that MUSC is experiencing any capacity constraints, Trident has ample capacity to meet those needs. Trident is approximately 15 minutes from the site of MUSC's Proposed Project. MUSC could refer patients to Trident for treatment, allowing patients residing in Berkeley and Dorchester Counties to be treated closer to home. *Id.* at p. 2. The referral to Trident would address any concerns MUSC physicians have with regard to patients traveling from long distances, and it is not uncommon for large cancer centers to refer patients to local providers after an initial diagnosis and the establishment of a treatment plan. Exhibit F, p. 15. In sum, there is no community need for additional radiation therapy services in the service area, and to the extent that MUSC has an institutional need due to capacity constraints, those issues can be addressed without the need to expend \$9 million dollars² on a project that will substantially adversely impact other area providers, most particularly Trident.

MUSC's CON application fails to comply with the project review criteria set forth at S.C. Code Ann. Regs. 61-15, § 802.2.

Distribution (Accessibility)

Because there is no need for additional radiation therapy services in the service area, the Proposed Project does nothing to increase accessibility to services, including accessibility to services for the medically underserved. The Proposed Project is an unnecessary duplication of services. Residents in the service area have more options for radiation therapy treatment than almost all other service areas in the State. Exhibit F, p. 16. MUSC defined its service area as Berkeley and Dorchester Counties and portions of North Charleston. *Id.* at p. 13. However, southern Berkeley County residents are closer to MUSC's Mount Pleasant location. *Id.* Thus, the location of MUSC's Proposed Project certainly will do nothing to increase accessibility to

² Approximately \$20 million on two unneeded projects.

services for those residents. Locating not one, but two, additional linear accelerators in a service area with no need at a combined project cost of approximately \$20 million dollars does nothing to increase accessibility to services, is an unnecessary duplication of services, and represents regressive health planning. MUSC's CON application fails to meet the project review criteria set forth at S.C. Code Ann. Regs. 61-15, § 802.3 and § 802.31.

Financial Feasibility

There is no community need for MUSC's Proposed Project. Because there is no community need for additional radiation therapy services in the service area, MUSC's ability to meet its utilization projections is questionable. Because its utilization projections are suspect, the Proposed Project may not be financially feasible. Thus, MUSC's CON application fails to meet the project review criteria set forth at S.C. Code Ann. Regs. 61-15, § 802.15.

Adverse Impact

The operation of two new linear accelerators in a service area with no need will substantially adversely impact other area providers, and Trident will be the most heavily impacted. Trident ceased operating one of its three linear accelerators due to low utilization. Trident operated at only 63% of capacity in 2016. There has been no growth in radiation therapy utilization in the service area for several years, and there is no credible evidence that the trend will reverse. In fact, the evidence indicates that radiation therapy volumes are stabilizing, if not declining.

At the project review meeting, MUSC addressed the number of patients traveling from Berkeley and Dorchester Counties. There is no evidence that MUSC will redirect these patients to its new facility. In all likelihood, these patients are traveling to the Hollings Cancer Center because of its specialized services and will continue to do so. Exhibit G, p. 2. In reality, MUSC will compete with Trident for patients, redirecting market share from Trident and exacerbating Trident's already low utilization rates. *Id.* This adverse impact will be compounded by the addition of another unneeded linear accelerator at Roper. MUSC's CON application fails to comply with the project review criteria set forth at S.C. Code Ann. Regs. 61-15, § 802.23.

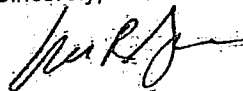
Conclusion:

MUSC's CON application fails to comply with the standards of the State Health Plan, the goals and purposes of the CON Act, and the applicable project review criteria. There is no community need for the Proposed Project. The Proposed Project is an unnecessary duplication of services which will do nothing to increase accessibility to services. The financial feasibility of the Proposed Project is questionable at best, and the facts demonstrate that the Proposed Project will substantially adversely impact other area providers, particularly Trident. For these reasons, the Department's decision to approve the Proposed Project must be reversed and MUSC's request for a CON denied. See S.C. Code Ann. § 44-7-210(B). See also S.C. Code Ann. Regs. 61-15, § 307.1.

The Honorable Lisa Lucas Longshore
December 15, 2017
Page 5

With best regards, I am

Sincerely,



William R. Thomas

WRT
Enclosures

cc: Ashley C. Biggers, Esquire (via hand delivery with enclosures)
Vito Wicevic, Esquire (via hand delivery with enclosures)
Margaret P. Murdock, Esquire (via hand delivery with enclosures)
Ralph Barbier, Esquire (via hand delivery with enclosures)
Daniel J. Westbrook, Esquire (via hand delivery with enclosures)

Exhibit M

To Petition for Administrative Review and
Request for Contested Case Hearing

Trident Medical Center
Opposition to Berkeley County Radiation Therapy
Certificate of Need Applications
Project Review
Ryan Clements
Dan Sullivan
September 20, 2017



TRIDENT
HEALTH

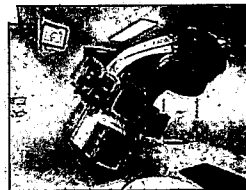
TRIDENT CANCER CENTER

- Ryan Clements, Director of the Cancer Center
- Dan Sullivan, MBA, Health Planning and Finance



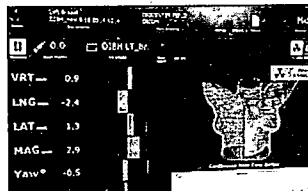
State of the Art Technology

- 3 Linear Accelerators
 - Varian
 - TrueBeam w/OSMS and Perfect Pitch technology
 - 2100EX w/ Rapid Arc
 - Elekta Synergy S
- Brachytherapy
 - HDR/LDR
- EMR/Treatment Planning
 - ARIA
 - Eclipse
 - Variseed/ Oncentra



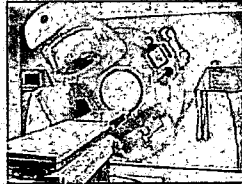
Comprehensive Treatment Options

- Linac Treatments
 - Stereotactic Radiosurgery
 - Stereotactic Body Radiation Therapy
 - Rapid Arc
 - IMRT/VMAT
 - 3D
- Advanced Imaging
 - Optical Surface Monitoring system(OSMS)
 - Respiratory Gating
 - CBCT/IGRT



Capacity/Utilization

- Due to the lack of patient volumes we only operate **two** of our **three** Linacs.
- We have the capacity to treat over 100 patients during our business hours.
- Our typical patient volumes have been between 45 and 50 patients per day.



Radiation Oncologist

- Each Radiation Oncologist has more than 20 years of clinical experience and brings his/her own specialized area of interest and training to this accomplished group.
- Our Radiation Oncologist collaborate weekly at our Multidisciplinary Cancer Conference to discuss newly diagnosed cancer cases.
- Referrals from any institution or practice are welcomed and consulted within 0-2 business days.
- Our Rad. Oncs follow all NCCN guidelines and best practices to ensure each plan is customized to each patients.



Program Accreditations

- Trident was the first in the Lowcountry to receive ACR accreditation in 2013.
- Accredited by the Commission on Cancer.

Projects Under Review: Roper-Berkeley

Roper St. Francis Hospital – Berkeley (Roper-Berkeley)

- ☐ Expand Roper St. Francis' existing radiation therapy services by adding a new linear accelerator ("linac") to Roper-Berkeley when it opens in October 2019.
- ☐ Locate the service in a new medical office building on the hospital campus.
- ☐ Total project cost: \$11,608,014.

Projects Under Review: MUHA

Medical University Hospital Authority

- ☐ Add 6th linac to MUHA's existing radiation therapy service.
- ☐ Locate in a medical office building in the Nexton development in Berkeley County.
- ☐ Total project cost: \$9,804,548.

Trident Health

- Trident already serves cancer patients in need of radiation treatment in the area that will be served by the Roper-Berkeley and MUHA projects.
- Trident has ample capacity on its existing linacs to serve the current and projected needs of the area.

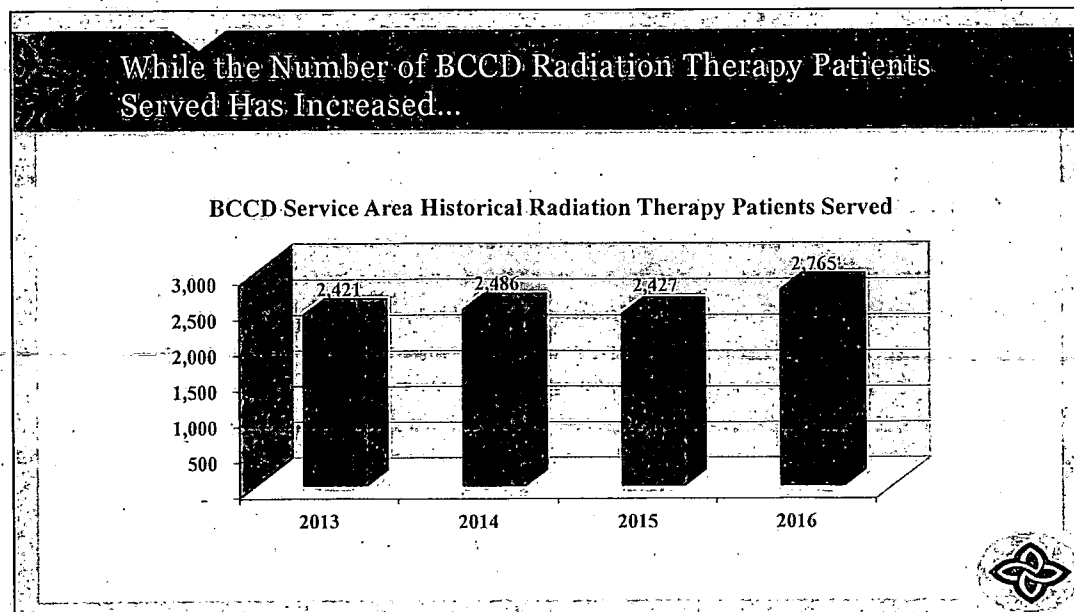
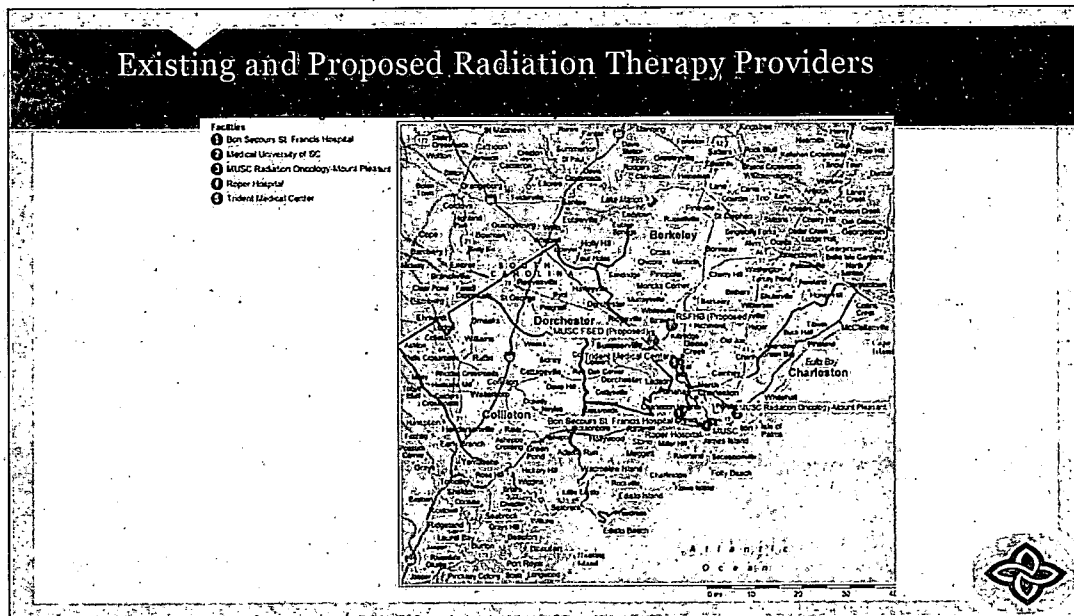
Specific Review Criteria

The Department specified the following criteria for review of these projects.

- a. Compliance with the Need outlined in the South Carolina Health Plan;
- b. Community Need Documentation;
- c. Distribution (Accessibility);
- d. Medically Underserved Groups; and
- e. Financial Feasibility.

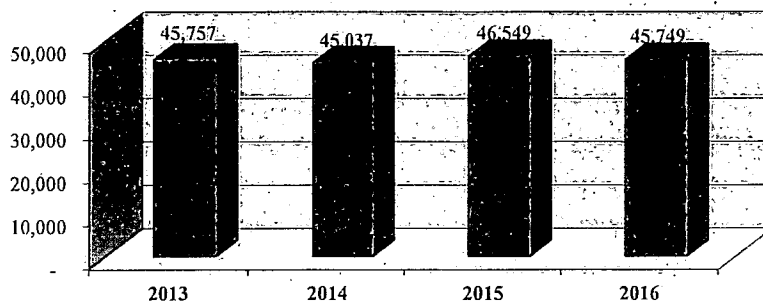
Neither Project Addresses a Community Need

- The SC Health Plan identifies the Berkeley/Charleston/Colleton/Dorchester ("BCCD") service area for evaluating need for radiation therapy services.
- The BCCD area is served by three providers:
 - ❖ Trident
 - ❖ MUHA
 - ❖ Roper
- These providers offer services in 5 locations distributed throughout the area.



...The Number of Radiation Therapy Treatments Has Remained Stable

BCCD Service Area Historical Radiation Therapy Treatments



Radiation Treatments per Patient Are Declining

- New treatment protocols utilize fewer, higher intensity treatments per patient, particularly for prostate and breast cancer patients.
- Improved technology also allows for more precise targeting of tumors.
- Payors are encouraging shorter courses of radiation treatment, including stereotactic radiosurgery ("SRS") and stereotactic body radiation therapy ("SBRT"), which require fewer fractions.
- While both applicants project growth in new cancer patients over the next 5 years, a greater number of patients does not automatically result in more treatments; as seen in recent years.
- There is not a need for more radiation therapy capacity in the area proposed to be served by MUHA and Roper.



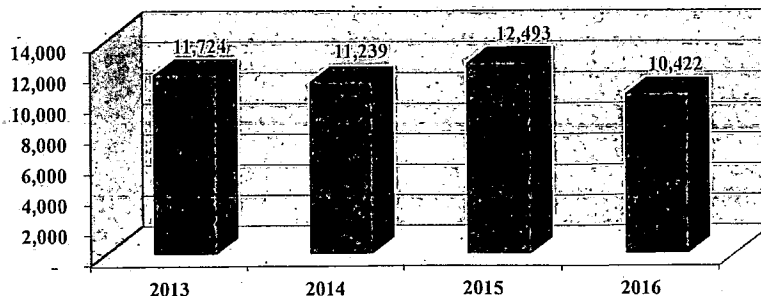
No Need for A Berkeley County Radiation Provider

- Both applicants discuss the need for a provider to serve Berkeley County noting that the County currently has no provider.
- Trident is located in northern Charleston County near the borders of Berkeley and Dorchester Counties.
- Both applicants propose to locate in southern Berkeley County, which is very close to Trident's radiation therapy center.
- There will be minimal improvements in access for residents in central and northern Berkeley County.
- There is certainly not a need for two new linacs in southern Berkeley County.



Trident Has Seen a Decline in Radiation Treatments Primarily Due to a Reduction in Treatments per Patient

Trident Radiation Therapy Treatments



Roper-Berkeley's Project is Not Consistent with the 2017-18 S.C. Health Plan

The South Carolina Health Plan states:

b. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold...



Trident Has Ample Available Capacity

BCCD Service Area
Historical Utilization of Existing Radiotherapy Providers

2016			
Provider	Treatments	Capacity	% Utilization
Trident Medical Center	10,422	16,500	63.2%
MUSC	19,221	24,000	80.1%
Roper Hospital	5,915	6,000	98.6%
Roper St. Francis	10,191	10,000	101.9%
Total	45,749	56,500	81.0%

Source: Joint Annual Reports of Hospitals



Roper-Berkeley's Project is Not Consistent with the 2017-18 S.C. Health Plan

- Trident is currently operating well below 80%.
- Trident operates only 2 of its 3 linacs because of insufficient utilization.
- The approval of Roper-Berkeley's project will impede Trident from reaching 80% utilization for the foreseeable future.
- Given the lack of growth in radiation treatments historically, there is no reason to expect future radiation treatments to increase materially.
- The approval of Roper-Berkeley's project will result in the overall utilization rate falling below 80%.



Roper-Berkeley's Project Will Reduce Service Area Utilization Below 80%

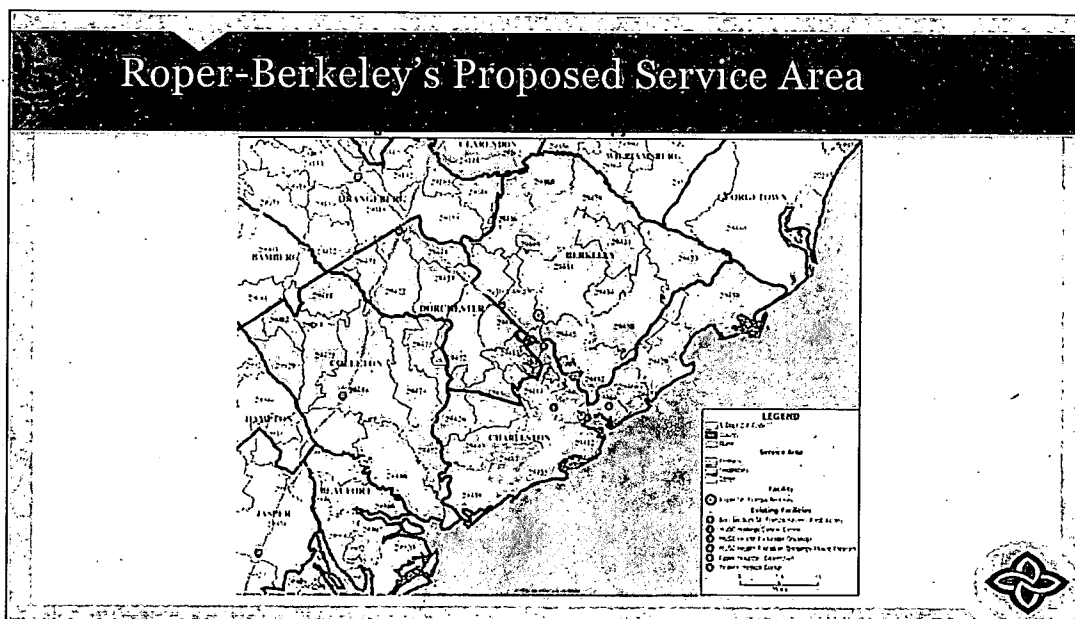
2016 Radiation Treatments in BCCD Service Area	45,749
Available Capacity	56,500
2016 Utilization %	81.0%

Additional Capacity Proposed by Roper-Berkeley	5,000
Future Capacity with Roper-Berkeley	61,500
Future Utilization % based on 2016 Volumes	74.4%

Radiation Treatments with 5% Growth	48,036
Future Utilization % with 5% Growth	78.1%



Roper-Berkeley's Proposed Service Area



Roper-Berkeley's Project Does Not Address A Community Need

- Roper-Berkeley's location is on the periphery of the area it proposes to serve.
- Patients in the southern portion of Dorchester and Berkeley Counties are closer to Trident, MUHA's Mount Pleasant location, and in some cases the downtown providers than they would be to Roper-Berkeley's site.
- It is not appropriate health planning to place a new radiation therapy service in a fledgling hospital that will offer a limited range of cancer treatment services.
- Because of downsizing its number of units, Roper St. Francis' existing linacs operate at relatively high rates of utilization.

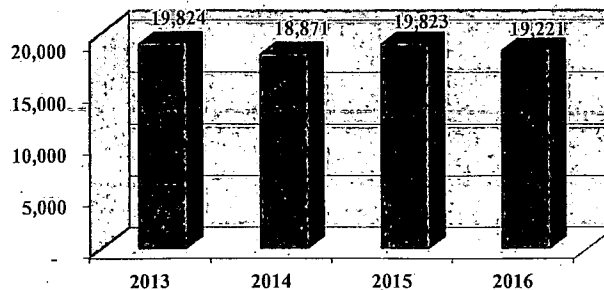
MUHA's Proposed Service Area

- MUHA defines its service area as Berkeley and Dorchester Counties as well as portions of North Charleston.
- Southern Berkeley County residents (e.g., Daniel Island) are closer to MUHA's Mount Pleasant location.
- MUHA has seen no growth in radiation therapy treatments in recent years which undermines its argument that it needs additional capacity.
- In 2016, MUHA's existing linacs operated at 80% of capacity, and the application identified no current capacity constraints.



MUHA' Treatment Volumes are Not Increasing

MUHA Historical Trend in Radiotherapy Treatments

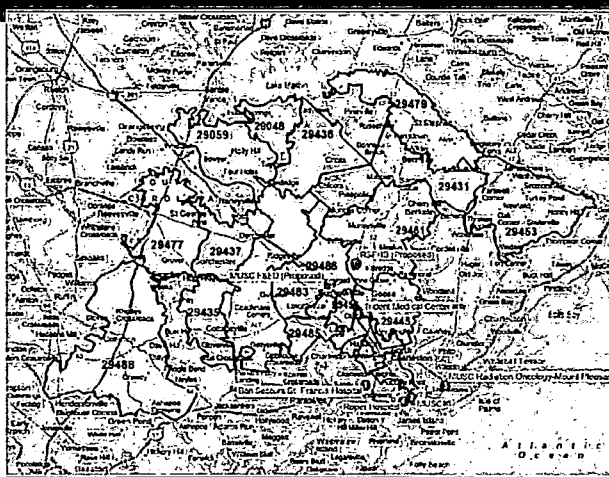


Trident Will be Adversely Impacted by the Approval of Either Project

- Trident draws its radiation patients primarily from the areas MUHA and Roper propose to serve.
- Several of the referral sources for Trident's radiation therapy program also refer patients to MUHA and Roper.
 - The development of either MUHA's or Roper-Berkeley's project will result in the redirection of some of Trident's referrals.
- Trident currently operates only two of its three linacs because of its low utilization levels.
 - Approval of additional linacs in close proximity to Trident's campus will exacerbate the underutilization of its program.



Trident Radiation Therapy Service Area





Neither Project Improves the Distribution of Services

- Radiation therapy services are planned on a regional basis.
- Simply because some patients choose to drive past an existing provider to receive radiation therapy services at MUHA or Roper does not establish a need for another location, particularly one that so clearly duplicates Trident's services.
- If MUHA's or Roper's medical oncologists are concerned with the travel patients will experience in reaching existing locations, they can refer these patients to Trident for radiation treatment.
- Large cancer centers in the United States often refer patients to local providers for treatment after initial diagnosis and treatment plans are completed.
- Trident has state-of-the-art linear accelerators and would welcome such referrals.




Radiation Services are Well-Distributed Today Within the BCCD Area

- MUSC has two radiation therapy locations:
 - ❖ Peninsula (two different buildings)
 - ❖ Mount Pleasant
- Residents of North Charleston, Summerville, and Moncks Corner can access MUSC's East Cooper location via I-526 if they do not choose to drive to the Peninsula.
- Roper also has two locations:
 - ❖ Roper Hospital
 - ❖ Bon Secours St. Francis Hospital
- Similarly, residents of the northern portion of the service area can access St. Francis via I-526.



Radiation Services are Well-Distributed Today Within the BCCD Area

- Residents of the BCCD area already have more options to receive radiation therapy treatment than almost all service areas in South Carolina.
- MUHA and Roper should seek to expand services at one of their existing locations if they perceive a need for additional capacity.
- The proposals to place linacs in southern Berkeley County are designed to redirect patients away from Trident.
- \$20 million in new healthcare expenditures is simply not needed when Trident has ample capacity to treat area patients.



Each Project Will Result in Unnecessary Duplication

- Trident is located in northern Charleston County near Berkeley County and is already accessible to the area proposed to be served by both applicants.
- Trident has underutilized linacs and its utilization will be further reduced by the approval of either project.
- Radiation treatments have remained flat over the last several years and there is no reason to expect a significant increase in treatments over the next few years.



STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 18-ALJ-07-0100-CC

Trident Medical Center, LLC, d/b/a)
Trident Medical Center,)
Petitioner,)
v.)
South Carolina Department of)
Health and Environmental Control)
and Medical University Hospital)
Authority, d/b/a MUSC Radiation)
Therapy Center-Berkeley County,)
Respondents.)

ADMINISTRATIVE HEARING

Monday, January 14, 2019

10:11 a.m. - 3:16 p.m.

Tuesday, January 15, 2019

10:04 a.m. - 5:45 p.m.

Wednesday, January 16, 2019

10:15 a.m. - 7:00 p.m.

Wednesday, January 23, 2019

10:05 a.m. - 5:59 p.m.

Thursday, January 24, 2019

1:33 p.m. - 4:17 p.m.

The Administrative Hearing before the Honorable H.W. Funderburk, Jr. was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 14th day of January, 2019, the 15th day of January, 2019, the 16th day of January, 2019, the 23rd day of January, 2019, and the 24th day of January, 2019 before Nadine A. Garrett, Court Reporter and Notary Public in and for the State of South Carolina.



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(803) 252-3445 / (800) 822-0896

ROA_0090

APPEARANCES

David Beam Summer, Jr., Esquire

William R. Thomas, Esquire

Parker Poe Adams & Bernstein, LLP
1221 Main Street, Suite 1100
Columbia, South Carolina 29201
Attorney for the Petitioner

Ashley Caroline Biggers, Esquire

Vito M. Wicevic, Esquire

S.C. Department of Health and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201
Attorney for the Respondent SC DHEC

Daniel J. Westbrook, Esquire

Travis Dayhuff, Esquire

Nelson Mullins Riley & Scarborough, LLP
1320 Main Street, 17th floor
Columbia, South Carolina 29201
Attorney for the Respondent MUSC

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DAY TWO:**TODD WILLIAMS, M.D.:**

MR. THOMAS.	DIRECT EXAMINATION.	176
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DANIEL J. SULLIVAN:

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DAY THREE:**DANIEL J. SULLIVAN:**

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PATRICK D. CAWLEY, M.D.:

MR. WESTBROOK.. . . .	DIRECT EXAMINATION.	675
MR. SUMMER.	CROSS-EXAMINATION.	745
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DAY FOUR:**DAVID LEVITT:**

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MR. THOMAS.	CROSS-EXAMINATION.	940
MR. DAYHUFF.. . . .	REDIRECT EXAMINATION.	989

DAY FIVE:**JOSEPH M. JENRETTE, III, M.D.:**

MR. WESTBROOK.. . . .	DIRECT EXAMINATION.	993
MR. WESTBROOK.. . . .	MOTION.	1000
MR. THOMAS.	CROSS-EXAMINATION.	1049
MR. WESTBROOK.. . . .	REDIRECT EXAMINATION.	1096

DANIEL J. SULLIVAN:

MR. THOMAS.	DIRECT EXAMINATION.	1104
MR. DAYHUFF.. . . .	CROSS-EXAMINATION.	1173
MR. THOMAS.	REDIRECT EXAMINATION.	1202

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ROA_0092

POST-TRIAL MOTION:

MR. SUMMER. 1208
 Certificate 1224

EXHIBITS

(All Exhibits were marked and admitted prior to the hearing and introduced as follows:)

Joint Exhibit Number 1. 13,16,452
 (Compilation of Radiation Therapy Section from
 2013-2017 Joint Annual Reports for MUSC
 Medical Center, Robert Hospital, and
 Trident Medical Center and from 2014-2017
 for Bon Secours St. Francis
 Xavier Hospital)

Joint Exhibit Number 2. 13,16,846
 (2008-09 SC Health Plan, Radiation Therapy
 Section)

Joint Exhibit Number 3. 13,16,848
 (2010-11 SC Health Plan, Radiation Therapy
 Section)

Joint Exhibit Number 4. 13,16
 (2012-13 SC Health Plan, Radiation Therapy
 Section)

Joint Exhibit Number 5. 13,16,82
 (2015 SC Health Plan, Radiation Therapy
 Section)

Joint Exhibit Number 6. 13,16,432
 (2017-18 SC Health Plan, Radiation Therapy
 Section)

Joint Exhibit Number 7. 13,16
 (2018-19 SC Health Plan, Radiation Therapy
 Section)

Petitioner's Exhibit Number 1. 13,16
 (TMC's Linac Utilization - Native Excel)

Petitioner's Exhibit Number 2. 13,16
 (Todd Gallati, Biography and Curriculum
 Vitae)

Petitioner's Exhibit Number 3. 13,16,118
 (Ryan M. Clements, MHSA, Curriculum Vitae)

Petitioner's Exhibit Number 4. 13,16,221
 (Daniel J. Sullivan Curriculum Vitae)

Petitioner's Exhibit Number 5. 13,16,177
 (Todd Edward Williams, M.D., Curriculum
 Vitae)

Petitioner's Exhibit Number 6. 13,16
 (MUSC's February 2, 2015 CON Application
 for a linac in North Charleston)



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ROA_0093

Petitioner's Exhibit Number 7.	13,16
(Sullivan - Work Papers)	
Petitioner's Exhibit Number 8.	13,16,287
(Sullivan Revised Slides)	
Petitioner's Exhibit Number 9.	13,16,152,296
(Sullivan Revised Slides)	
Petitioner's Exhibit Number 10.	13,16
(Sullivan Revised Slides)	
Petitioner's Exhibit Number 11.	13,16,263
(Sullivan Slides)	
Petitioner's Exhibit Number 12.	13,16,120
(Trident Radiation Therapy Service Area)	
Petitioner's Exhibit Number 13.	13,16
(Alliance Agreement with MUSC)	
Petitioner's Exhibit Number 14.	13,16,762,1155,1209
(Operating Agreement of MUSC Health Cancer Care Network, LLC)	
Petitioner's Exhibit Number 15.	13,16,123
(Trident Health Project Review Slides)	
Petitioner's Exhibit Number 16.	13,16,755
(June 30, 2017 Audited Financial Statements)	
Petitioner's Exhibit Number 17.	13,16,756
(June 30, 2016 Audited Financial Statements)	
Petitioner's Exhibit Number 18.	13,16,756
(June 30, 2015 Audited Financial Statements)	
Petitioner's Exhibit Number 19.	13,16,252
(Radius Map with Drive Times)	
Petitioner's Exhibit Number 20.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 21.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 22.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 23.	13,16,278
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 24.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 25.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 26.	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	



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ROA_0094

Petitioner's Exhibit Number 27	13,16,273
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 28	13,16,277
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 29	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 30	13,16,279
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 31	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 32	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 33	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 34	13,16
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 35	13,16,279
(MUSC Linac Volume Reports - Treatments Native Files)	
Petitioner's Exhibit Number 36	13,16,274
(MUSC Rad Onc Treatment Procedures Native Files)	
Petitioner's Exhibit Number 37	13,16,315
(MUHA Interim Financial Statements - June 30, 2018)	
Petitioner's Exhibit Number 38	13,16
(MUSC Linac Volume Reports - Per Machine Crosstab - Native Files)	
Petitioner's Exhibit Number 39	13,16
(MUSC Linac Volume Reports - Activity Tabular Crosstab - Native Files)	
Petitioner's Exhibit Number 40	13,16
(MUSC Linac Volume Reports - FY 18 Treatment Volumes by Procedure - Native Files)	
Petitioner's Exhibit Number 41	13,16
(MUSC Linac Volume Reports - FY 18 Patients Treated by Posta - Native Files)	
Petitioner's Exhibit Number 42	13,16
(MUSC Linac Volume Reports - Comparison Native Files)	



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ROA_0095

Petitioner's Exhibit Number 43	13,16,279
(MUSC Lin-Ac Volume Reports - FY 18 Treatment Volume by Machine - Native Files)	
Petitioner's Exhibit Number 44	13,16
(MUSC Linac Volume Reports - Mt. Pleasant Pat Ins FY 15- Native Files)	
Petitioner's Exhibit Number 45	13,16
(MUSC Linac Volume Reports - Pat Ins. FY 15 - Native Files)	
Petitioner's Exhibit Number 46	13,16
(MUSC Linac Volume Reports - Mt. Pleasant Pat Ins. FY 16 - Native Files)	
Petitioner's Exhibit Number 47	13,16
(MUSC Linac Volume Reports - Patients with Insurance - Native Files)	
Petitioner's Exhibit Number 48	13,16
(MUSC Linac Volume Reports - Patient List with Insurance - Native Files)	
Petitioner's Exhibit Number 49	13,16
(MUSC Linac Volume Reports - Patient List with Insurance - Native Files)	
Petitioner's Exhibit Number 50	13,16
(MUSC Linac Volume Reports - Patient Data with Payor - Native Files)	
Petitioner's Exhibit Number 51	13,16
(MUSC Capacity - Native Files)	
Petitioner's Exhibit Number 52	13,16
(MUSC Capacity Comparison - Native Files)	
Petitioner's Exhibit Number 53	13,16,261
(MUSC Utilization - Native Files)	
Petitioner's Exhibit Number 54	13,16,626
(Handwritten Notes)	
Petitioner's Exhibit Number 55	13,16,99
(December 22, 2015 DHEC Letter to David Levitt)	
Petitioner's Exhibit Number 56	13,760
(Comprehensive Annual Finance Report for the Year Ended June 30, 2018)	
Respondent DHEC's Exhibit Number 1	13,16,250,729
(Application for Certification of Need for a Health Facility or Service)	
Respondent MUSC's Exhibit Number 1	13,16,682
(CV of Patrick Cawley, M.D.)	
Respondent MUSC's Exhibit Number 2	13,16,994
(CV of Joseph Jenrette)	
Respondent MUSC's Exhibit Number 3	13,16,792
(CV of David Levitt)	



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ROA_0096

Respondent MUSC's Exhibit Number 4.	13,16,709
(Alliance Contract)	
Respondent MUSC's Exhibit Number 5.	13,16,706,797
(Alliance Contract)	
Respondent MUSC's Exhibit Number 6.	13,16
(MUSC Audited Financial Statement 2017)	
Respondent MUSC's Exhibit Number 7.	13,16
(MUSC Audited Financial Statement 2016)	
Respondent MUSC's Exhibit Number 8.	13,16
(MUSC Audited Financial Statement 2015)	
Respondent MUSC's Exhibit Number 9.	13,16,281
(MUSC Project Review Slides)	
Respondent MUSC's Exhibit Number 10.	13,16,371
(TMC Project Review Slides)	
Respondent MUSC's Exhibit Number 11.	13,16,832
(Levitt Utilization Workbook)	
Respondent MUSC's Exhibit Number 12.	13,16
(Compilation of MUSC Linac Volume Reports)	
Respondent MUSC's Exhibit Number 13.	13,16
(Sullivan Work Papers)	
Respondent MUSC's Exhibit Number 14.	13,16
(Excerpts from Roper Berkeley 2017 CON Application)	
Respondent MUSC's Exhibit Number 15.	13,16
(Excerpts from MUSC 2015 CON Application)	
Respondent MUSC's Exhibit Number 16.	13,16,507
(Excerpts from Trident's 2012 CON Application)	
Respondent MUSC's Exhibit Number 17.	13,16
(Excerpts from Tideland's 2017 CON Application)	
Respondent MUSC's Exhibit Number 18.	13,16
(Excerpts from Beaufort Memorial's 2017 CON Application)	
Respondent MUSC's Exhibit Number 19.	13,16,368
(Excerpts from St. Joseph's Candler's 2017 CON Application)	
Respondent MUSC's Exhibit Number 20.	13,16
(Exemption Request by Trident for Linac dated August 17, 2018)	
Respondent MUSC's Exhibit Number 21.	13,16
(Exemption Approval for Trident for Linac Dated September 18, 2018)	
Respondent MUSC's Exhibit Number 22.	13,16,362
(Grand Strand CON Application)	
Respondent MUSC's Exhibit Number 23.	13,16
(GSRMC Response to Project Review)	
Respondent MUSC's Exhibit Number 24.	13,16
(Data from ClinicalTrials.gov showing MUSC Current Trials)	



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ROA_0097

Respondent MUSC's Exhibit Number 29.	13,16
(Radiation Therapy Section from SC Health Plan, 2008-09 DRAFT)	
Respondent MUSC's Exhibit Number 31.	13,16
(Becker's Hospital Review Article: 100 Hospitals and Health Systems with Great Oncology Programs)	
Respondent MUSC's Exhibit Number 32.	13,16
(Pro Forma Worksheet)	
Respondent MUSC's Exhibit Number 33.	13,16
(Linac Pro Forma Nexton in CON 5.4.17)	
Respondent MUSC's Exhibit Number 34.	13,16
(MUSC Utilization data for CY2018)	
Respondent MUSC's Exhibit Number 35.	13,16
(Map Showing MUSC Linac, Palmetto Primary Care MOB, and MUSC Community Hospital at Nexton)	
Respondent MUSC's Exhibit Number 36.	13,16
(Excerpt Showing Linac Capacity Standards from 2015 SC Health Plan)	
Respondent MUSC's Exhibit Number 37.	13,16
(Excerpt Showing Linac Capacity Standards from 2012-13 SC Health Plan)	
Respondent MUSC's Exhibit Number 38.	13,16,270
(List of MUSC Linear Accelerators, Annual Capacity, and Model Year)	
Respondent MUSC's Exhibit Number 39.	13,16,286
(Table Showing MUSC Linac Utilization by FY)	
Respondent MUSC's Exhibit Number 40.	13,16,827
(Table Showing MUSC Linac Utilization by CY)	
Respondent MUSC's Exhibit Number 41.	13,16
(Table and Graph Showing MUSC Linac Utilization by Month for CY17-18)	
Respondent MUSC's Exhibit Number 42.	13,16,881
(Tables Showing V600 Utilization Separate From Other Linacs)	
Respondent MUSC's Exhibit Number 43.	13,16
(Map Showing MUSC Linac Locations)	
Respondent MUSC's Exhibit Number 44.	13,16,376
(Map Showing Linacs in Eastern South Carolina)	
Respondent MUSC's Exhibit Number 45.	13,16,700
(Map Showing MUSC and Joint Venture Linac Locations)	
Respondent MUSC's Exhibit Number 46.	13,16,727
(Map Showing MUSC Proposed Services at Nexton)	
Respondent MUSC's Exhibit Number 47.	13,16,365
(Map Showing Grand Strand and 21st Century Linac Locations)	



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ROA_0098

Respondent MUSC's Exhibit Number 48...	13,16
(Map Showing Trident and MUSC Linacs)	
Respondent MUSC's Exhibit Number 49...	13,16
(Map Showing Charleston Tri-County Area)	
Respondent MUSC's Exhibit Number 50...	13,16,372
(Map Showing the Charleston Tri-County Area, Including City Labels)	
Respondent MUSC's Exhibit Number 51...	13,16,890
(Map Showing Various Medical Services in the Charleston Tri-County Area)	
Respondent MUSC's Exhibit Number 52...	13,16
(Map Showing Points of Interest in the Charleston Area)	
Respondent MUSC's Exhibit Number 53...	13,16
(Map Showing the Nexton Development and Proposed Services, including inset of Nexton Development)	
Respondent MUSC's Exhibit Number 57...	13,16
(Bios. of MUSC Radiation Oncologists)	
Respondent MUSC's Exhibit Number 58...	13,16,1084
(Comparison of Radiation Oncologists at MUSC and Trident)	
Respondent MUSC's Exhibit Number 59...	13,16,358
(Medical Oncologists at Trident)	
Respondent MUSC's Exhibit Number 61...	13,16,930
(Comparison of Clinical Trials at MUSC and Trident)	
Respondent MUSC's Exhibit Number 62...	13,16,676
(Slide Showing MUSC Organizational Chart)	
Respondent MUSC's Exhibit Number 63...	13,16,703
(Slide Showing Organization Chart of Partnership with Alliance)	
Respondent MUSC's Exhibit Number 64...	13,16
(Map Showing MUSC Location in South Carolina)	
Respondent MUSC's Exhibit Number 65...	13,16
(Total Project Costs)	
Respondent MUSC's Exhibit Number 66...	13,16
(Space Plan)	
Respondent MUSC's Exhibit Number 67...	13,16
(Construction Schedule)	
Respondent MUSC's Exhibit Number 68...	13,16,810
(MUSC Radiation Therapy Capacity by Fiscal Year)	
Respondent MUSC's Exhibit Number 69...	13,16,871
(MUSC Linac Patient Origin FY15-FY16)	
Respondent MUSC's Exhibit Number 70...	13,16,871
(Map Showing MUHA Radiation Therapy Service Area)	



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ROA_0099

Respondent MUSC's Exhibit Number 71..	13,16,873
(Service Area Population Projections - All Ages and Age 65+)	
Respondent MUSC's Exhibit Number 72....	13,16
(Drive Time Analysis)	
Respondent MUSC's Exhibit Number 73..	13,16,894
(Median Household Income Analysis by Tri-County Submarket)	
Respondent MUSC's Exhibit Number 74.....	13,16
(MUSC Linac Projected Volumes)	
Respondent MUSC's Exhibit Number 75..	13,16,907
(MUSC Linac Projected Volumes)	
Respondent MUSC's Exhibit Number 76.....	13,16
(Estimated MUSC Capture of New Cancer Patients from Berkeley and Dorchester)	
Respondent MUSC's Exhibit Number 77..	13,16,895
(2013-16 MUHA Indigent Care)	
Respondent MUSC's Exhibit Number 78.....	13,16
(2017-20 MUHA Projected Indigent Care)	
Respondent MUSC's Exhibit Number 79..	13,16,876
(Service Area Trend in Radiation Therapy Patients)	
Respondent MUSC's Exhibit Number 80.....	13,16
(Service Area Trend in Radiation Therapy Treatments)	
Respondent MUSC's Exhibit Number 81.....	13,16
(Service Area Trend in Radiation Therapy Treatments)	
Respondent MUSC's Exhibit Number 82.....	13,16
(Service Area Trend in Radiation Therapy Treatments)	
Respondent MUSC's Exhibit Number 83..	13,16,877
(Service Area Trend in Radiation Therapy Treatments)	
Respondent MUSC's Exhibit Number 84...	13,16,1144
(Service Area Trend in Radiation Therapy Treatments Per Year)	
Respondent MUSC's Exhibit Number 85...	13,16,1145
(Bar Graph Showing MUSC Historical Trend in Radiotherapy Treatments, 2010-2018)	
Respondent MUSC's Exhibit Number 86...	13,16,879
(Bar Graph Showing MUSC Historical Trend in Radiotherapy Treatments, 2007-2018)	
Respondent MUSC's Exhibit Number 87..	13,16,1147
(Trident Medical Center Radiotherapy Treatments, 2013-2018)	
Respondent MUSC's Exhibit Number 88..	13,16,880
(Trident Medical Center Radiotherapy Treatments, 2016-2018)	



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ROA_0100

Respondent MUSC's Exhibit Number 89. . . 13,16,1183
(MUHA's Projected Utilization for New Linac
and Total Service Area)

Respondent MUSC's Exhibit Number 90. 13,16
(Projected Utilization with MUHA Assumptions
Updated and Corrected)

Respondent MUSC's Exhibit Number 91. 13,16
(Linac Utilization Corrected 2017 and 2021)

Respondent MUSC's Exhibit Number 92. . . 13,16,836
(Timeline Showing Points at Which MUSC Linac
Utilization Reached 80 percent for Two
Consecutive Years)

Respondent MUSC's Exhibit Number 93. . . 13,16,921
(Trident's Recent Investment in Linac)

Respondent MUSC's Exhibit Number 94. 13,16
(Bar Graph Showing MUSC Linac Utilization
FY15-FY18)

Respondent MUSC's Exhibit Number 95. 13,16
(Timeline Showing Trident's Pursuit of
Linac Services)

Respondent MUSC's Exhibit Number 96. 13,16
(Timeline Showing Trident's Pursuit of
Linac Services with Trident and Service
Area Volume)

Respondent MUSC's Exhibit Number 97. 13,16
(Comparison of Pro Formas from Various Linac
Applications)

Respondent MUSC's Exhibit Number 98. . . 13,16,886
(Drive Time Comparison for Three Northern
Areas to MUSC Downtown, East Cooper, and
Nexton)

(All Original Exhibits were retained by the Court.)

STIPULATIONS

It is stipulated and agreed that this hearing
is being taken pursuant to the rules of the
Administrative Law Judge Division and the South
Carolina Rules of Civil Procedure.



CREEL COURT REPORTING, INC.

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ROA_0101

1 (All Exhibits were marked prior to the hearing.)

2 **CALL TO ORDER:**

3 **THE COURT:** We are on the record on case number 17-
4 ALJ-07-0100 (sic). It's a contested case
5 requested by Trident Medical Center, LLC, doing
6 business as Trident Medical Center, versus the
7 South Carolina Department of Health and
8 Environmental Control and the Medical
9 University Hospital Authority doing business as
10 the MUSC Radiation Therapy Center, Berkeley
11 County. And the Petitioner is challenging the
12 Certificate of Need issued for this radiation
13 therapy center to be built in Berkeley County.
14 Now, attorneys for Trident, William Thomas and
15 David B. Summer, right? Good morning.

16 **MR. THOMAS:** Good morning.

17 **MR. SUMMER:** Good morning.

18 **THE COURT:** And DHEC is represented by Ashley
19 Biggers.

20 **MS. BIGGERS:** Good morning.

21 **THE COURT:** Anybody else with you today?

22 **MS. BIGGERS:** Just me, Your Honor.

23 **THE COURT:** All right. And MUSC represented by
24 Daniel Westbrook and Travis Dayhuff. Anybody
25 else?



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ROA_0102

1 MR. THOMAS: That's all, sir.

2 THE COURT: That's it? All right. We'll begin this
3 morning with opening statements, proceed then
4 to the presentation of witnesses and exhibit,
5 and we'll finish some day with closing
6 arguments with the -- I think somebody has
7 proposed skipping closing arguments. We'll
8 talk about that when we get there.

9 MR. THOMAS: Perhaps with prop.

10 THE COURT: All right.

11 MR. DAYHUFF: Your Honor, would you like to deal
12 with the admission of exhibits into evidence
13 before or after the opening?

14 THE COURT: We'll deal with those in just a second,
15 if you don't mind. I've got my little spiel
16 that I've got to do, because everybody needs to
17 know what we're going to do. And I'm sure it's
18 going to be a surprise to you. But as you
19 know, there will be witness, and cross
20 examination, and all of that. And following
21 the presentation of witnesses, we'll talk about
22 the closing arguments, which you, I think, have
23 agreed that we'll do by proposed orders
24 instead. That'll be fine.

25 PRELIMINARY MATTERS:



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ROA_0103

1 **THE COURT:** Now, any motions or stipulations before
2 we begin? That would be the exhibits. This
3 would be your time to do the exhibits.

4 **MR. DAYHUFF:** So, we mentioned this to your clerk.
5 The parties have agreed upon a set of exhibits
6 that we'd like to have admitted into evidence
7 in this case and I will go through those for
8 the record now. We have joint exhibits.

9 **THE COURT:** Okay.

10 **MR. DAYHUFF:** Those are exhibits that both Trident
11 and MUSC have agreed upon. Those are Numbers
12 1 through 7. Petitioner Trident has Exhibits
13 Numbers 1 through 55. Respondent DHEC has one
14 exhibit, Number 1. And then Respondent MUSC
15 has the following exhibits: Numbers 1 through
16 24, 29, 31 through 53, 57 through 59, and 61
17 through 98. And, Your Honor, the reason we
18 have those missing numbers, that's a result of
19 our agreeing upon joint exhibits and we also
20 withdrew some exhibits, creating those holes.
21 We have not yet provided our exhibits to you,
22 which we can do at this time. All parties have
23 given their exhibits to the court reporter, so
24 we're ready there. So, at this time we'd ask
25 -- all the parties would ask that The Court



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ROA_0104

1 enter the agreed upon exhibits into evidence.

2 **THE COURT:** Now is it also -- before I do that -- is
3 it also my understanding that, if an exhibit is
4 not used, you may withdraw it?

5 **MR. DAYHUFF:** That's correct. At the conclusion of
6 the case, the parties have agreed to get
7 together. And if there are exhibits we did not
8 need, did not use, and we can agree to withdraw
9 them, we'll engage in that exercise at the
10 conclusion of the case.

11 **THE COURT:** Okay. All right. That's fine then.
12 With that agreement and stipulation the
13 exhibits, as you've described, they are
14 admitted.

15 (Joint Exhibit Numbers 1 through 7 were admitted into
16 evidence.)

17 (Petitioner's Exhibit Numbers 1 through 55 were
18 admitted into evidence.)

19 (Respondent DHEC's Exhibit Number 1 was admitted into
20 evidence.)

21 (Respondent MUSC's Exhibit Numbers 1 through 24, 29,
22 31 through 53, 57 through 59, and 61 through 98 were
23 admitted into evidence.)

24 **MR. DAYHUFF:** May I approach?

25 **THE COURT:** Yes.



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ROA_0105

1 MR. DAYHUFF: Here's our exhibits.

2 THE COURT: All right. Beginning with opening
3 statements.

4 OPENING STATEMENT BY MR. THOMAS:

5 MR. THOMAS: May it please The Court, Your Honor.

6 Before I begin, I did want to make some
7 introductions. You know Mr. Summer. I've got
8 Mr. Ryan Clements with me. He is the director
9 of Trident's Cancer Center. I've got Mr. Todd
10 Gallati with me, who is the CEO of Trident
11 Health. I've got Mr. Sullivan with me, who is
12 Trident's health care planning and finance
13 expert.

14 I'm going to have to get my expert -- I
15 may be doing this manually. Technical
16 difficulties here. All right. Looks like
17 we're there.

18 Your Honor, Trident Medical Center is here
19 today because we are opposed to MUSC's project
20 to locate a 9.8 million dollar radiation
21 therapy center approximately six miles away
22 from Trident's Hospital campus where it already
23 operates three linear accelerators. And we're
24 specifically asking The Court to reverse
25 Trident's (sic) decision because the project



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ROA_0106

1 does many things. So Your Honor, we are going
2 to argue that the project doesn't comply with
3 the State Health Plan, specifically Standard 7,
4 that there's not a community need for a linac
5 in this region and this region of the service
6 area. And the service area, Your Honor, is four
7 counties. It's Berkeley, Charleston,
8 Dorchester, and Colleton County. And the
9 reason that it's not needed in this region,
10 it's going to be four operational linacs in
11 very close proximity to USC's proposed project.
12 We're also going to argue that this project
13 duplicates services. It doesn't contain costs.
14 It doesn't meaningfully improve access for any
15 of the patients in this region of the service
16 area. And it doesn't particularly benefit
17 medically underserved groups. And it's a
18 program that's going to adversely impact
19 Trident, because Trident already operates well
20 below its capacity, its stated capacity and
21 its actual capacity. We're going to talk more
22 about those terms in a little bit.

23 So, what's a radiation therapy center? I
24 figured I'd give a quick primer on this, but
25 you'll hear more from that from our director of

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ROA_0107

1 cancer care and the physicians in this case
2 that will be testifying. But essentially a
3 radiation therapy center uses a linear
4 accelerator and other modalities such as
5 brachytherapy units to deliver the
6 administration of radiation to treat cancer and
7 normally cancerous tumors. So, MUSC is
8 proposing to install this unit called a
9 TrueBeam -- Trident already has one. They're
10 actually getting another one -- just a few
11 miles away from Trident's linacs. And these
12 are very sophisticated pieces of equipment.
13 They cost on the order of two and a half, three
14 and a half million dollars. They are
15 specifically regulated under the State Health
16 Plan and therefore they fall under the CON Act
17 and its regulations. And there are specific
18 standards in the Health Plan for these units.
19 And I just -- you know, here's what one looks
20 like. It's kind of -- this is a TrueBeam,
21 probably very similar to something that MUSC is
22 getting. It's a Varian model. That's kind of
23 the state of the art in the industry.

24 So, what are the purposes? I always like
25 to start here, because that kind of guides us



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ROA_0108

1 through this. But, you know, the purpose of
2 the CON Act to promote cost containment, you
3 know, to prevent the unnecessary duplication of
4 healthcare services, guide the establishment of
5 healthcare facilities and services that will
6 best meet the public needs and insure that high
7 quality services are offered in the state. And
8 what I think you'll find at the end of this is
9 MUSC doesn't really accomplish those goals,
10 given what's already available in the service
11 area.

12 So, the controlling statutes, Your Honor
13 -- you're familiar with these, because we dealt
14 with this in a case this past center. And
15 we're going to be focused heavily on the State
16 Health Plan, that the controlling statutes
17 here, the Department may not issue a
18 Certificate of Need unless an application
19 complies with the South Carolina Health Plan,
20 the project review criteria, and the other
21 regulations. And, you know, nothing in the
22 provision of the Act shall be construed as
23 requiring the Department to approve any
24 project, which is inconsistent with the Health
25 Plan. And the regulations just basically back



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ROA_0109

1 that up. But they kind of get a little bit
2 more specific. They say a project doesn't have
3 to satisfy every criterion, but it cannot be
4 approved, it just cannot, unless it's
5 consistent with the South Carolina Health Plan.
6 And that's a very important concept here,
7 because, while some of the -- I remember from
8 the South Carolina Bar exam, Your Honor. Back
9 when I took it, you could fail one section, you
10 know, but still pass. You failed two, you were
11 done. If you happened to fail a Bar, luckily
12 I didn't, but you never knew which ones you
13 didn't pass and that was always -- you know,
14 you didn't know which ones to go back and
15 study.

16 But at the end of the day, here are --
17 these are the project review criteria that are
18 listed as the most important in the applicable
19 State Health Plan. And as you can see, the
20 number one was compliance with the need
21 outlined in the section of the Plan. Then
22 community need documentation, distribution,
23 revenues, expenses, financial feasibility, and
24 cost containment. Now, for some reason, and
25 I'm still not sure, even after deposing the



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ROA_0110

1 DHEC CON director, she decided she wanted to
2 evaluate the plan based on these five. So,
3 we're going to focus them -- focus on these,
4 but compliance with the need outlined in the
5 Plan, community need, documentation,
6 distribution, medically underserved groups and
7 financial feasibility. So, that's what we're
8 going to be focused on. However, we may
9 discuss concepts of cost containment as well.

10 So, kind of -- let's start with the very
11 first one there, Your Honor. We believe that
12 the evidence is going to show that MUSC's
13 project never complied with the Health Plan and
14 it cannot come into compliance now. That is
15 our -- a very important argument. So, what
16 does Standard 7 say. That's the one we contend
17 that MUSC doesn't meet. It says expansion of
18 an existing service, whether the expansion
19 occurs at the existing site or in an alternate
20 location of the service area, shall only be
21 approved if the service area is operated at a
22 minimum use rate of 80 percent of capacity for
23 each of the past two years. So, how is this 80
24 percent capacity determined? Well, you take
25 the capacity threshold chosen by the applicant,



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ROA_0111

1 here MUSC, and you divide it by the actual
2 number of treatments performed by the applicant
3 in each of the past two years. So, you have to
4 be in compliance in year number one past and
5 year number two past. You can't conglomerate
6 them and then take an average and say, well,
7 overall in the past two years they were above
8 80 percent. It's got to be in each of the past
9 two years.

10 So -- and there's a couple of other
11 standards. So how do you get to the capacity
12 number? Well, this is right out of the Health
13 Plan. A provider that performs primarily
14 conventional radiation therapy treatments on
15 its linac -- and I'm going to use linac. I
16 probably should have said that, Your Honor.
17 Short for linear accelerators. It's a lot less
18 to say. But the provider can assign, if
19 they're just doing these things called
20 conventional radiation therapy, and you'll
21 learn more about what that is, a capacity of
22 7,000 treatments. If you can document
23 sufficient volume of IMRT treatments on a
24 linear accelerator, you can assign yourself
25 5,000 treatments of capacity. And if you can



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ROA_0112

1 document a sufficient volume of something
2 called SBRT treatments, stereotactic body
3 radiotherapy, then you can assign yourself a
4 capacity of 4500 treatments. And, you know,
5 I've provided an example here. You can
6 probably give the gist. But if a provider has
7 two linear accelerators and both of them do a
8 sufficient volume of something called IMRT, or
9 intensity-modulator radiotherapy, then they can
10 assign a capacity of 5,000 to each unit or
11 10,000 overall. And in order to get -- to kind
12 of get past what I call first base here in the
13 State Health Plan, you have to show that you
14 performed a minimum of 80 percent or in this
15 case, in this example, 8,000 treatments or more
16 to be approved. If you can't show this, can't
17 be approved. You can't average two years, just
18 like we said.

19 So let's bring ourselves back to May 22nd,
20 2017. MUSC submitted its CON application.
21 That's the one received by the Department.
22 And they represented that they had achieved
23 this 80 percent threshold in fiscal year 2015.
24 And that becomes very important in this
25 litigation, Your Honor. And that's 2014 --



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ROA_0113

1 that fiscal year 2015 goes from July '14 to
2 June '15. And fiscal year 2016, July '15 to
3 June '16. And they said they were operating at
4 82.6 percent in fiscal year 2015 and 80.1
5 percent in fiscal year 2016. So, MUSC stated
6 that its capacity was 24,000, represented that
7 three of its linacs had a capacity of 5,000
8 treatments per year and two of its linacs had
9 a capacity of 4500 treatments a year.
10 Basically what they were representing is that
11 they had sufficient volumes to show that they
12 did enough IMRT on three machines to justify
13 the 5,000 and they did enough SBRT on two of
14 their linacs to justify the 4500. These become
15 important concepts.

16 So, roughly a month ago, just before I was
17 to depose their health planning expert, who's
18 in the room with us today, MUSC produced
19 documents showing that in fiscal year 2016 was
20 actually operating below the 80 percent
21 capacity number. But it claims that its CON-
22 application still should be approved because it
23 was operating at 79.97, Your Honor, just a hair
24 below 80 percent. And one of the reasons they
25 gave is, well, you round up. That's how you



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ROA_0114

1 get there. And they also claimed that because
2 they achieved the 80 percent threshold -- this
3 is what you're going to hear from them --
4 following the DHEC staff approval in a couple
5 of years, that that also provides you the basis
6 to uphold the DHEC staff decision.

7 Well, Trident did not agree with that, as
8 you might imagine. There is no provision for
9 rounding up in the State Health Plan. In fact,
10 the language is pretty specific. I read it
11 earlier, but what it says is that the linac has
12 to be operating at a minimum use rate of 80
13 percent, so that's the -- that's a floor.
14 That's the minimum it needs to be for the past
15 two years. It's not an approximate use rate.
16 It's not an almost use rate. It's a minimum
17 use rate of 80 percent. 79.97 percent is not
18 80 percent in any realm of mathematics, other
19 than third-grade rounding when you're asked to
20 do your rounding from hundreds to tens, tens to
21 ones, ones to so on and so forth. We ain't
22 going to go through that.

23 So, we're also going to contend that MUSC
24 didn't exactly use each of the past two years
25 in the CON application, Your Honor. They used



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ROA_0115

1 a time period that began 11 months before its
2 CON application submission date so that it
3 could achieve the required 80 percent, even
4 though its data was not correct. They didn't
5 know that at the time. I'm not accusing MUSC
6 of any malfeasance. I'm just saying the data
7 was wrong. They used the wrong data. They
8 found out in December that they used the wrong
9 data. And now they're going to ask, you know,
10 for you to kind of overlook that.

11 Now, if you analyze their capacity percent
12 using a more recent two-year period -- so,
13 let's say calendar year 2016 or a rolling 12
14 months from the time they actually applied,
15 they can't even get to 80 percent by rounding,
16 okay. And then furthermore, their capacity
17 percentage is skewed, because MUSC wrongly
18 assigned lower capacity numbers to two of its
19 linacs when it had no justification to do so.
20 MUSC doesn't perform a sufficient volume of
21 SBRT treatments on either of its linacs that
22 have a 4500 capacity to justify that number.
23 And when these capacity thresholds are
24 corrected, they don't come close to making that
25 required 80 percent. Now, Your Honor, we

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ROA_0116

1 expect to hear from MUSC that you can round up,
2 you can look at more recent time periods in
3 order to see that we have come into compliance,
4 but none of those arguments, Your Honor, the
5 evidence will show that it just doesn't hold
6 water, you know.

7 We've already talked about the minimum
8 threshold of 80 percent. That's specific
9 language in the Health Plan. The plain
10 language says minimum 80 percent, so 79.97
11 percent doesn't get you there.

12 And then that comes, Your Honor, with a
13 whole host of problems if you start saying,
14 well, maybe we ought to let them round up.
15 Because, you know, do you round up 79.52 to 80?
16 What about 79.49? I mean, 79 is pretty darn
17 close to 80. Does that become 79.5, which then
18 becomes 80?

19 So, now, I'm telling you, if you accept
20 their capacity standards, these are very
21 important considerations. If you actually
22 assign the correct capacity standards, you
23 can't even get there by rounding, as I've
24 already said. And in terms of using data from
25 a later time period, for instance like calendar



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ROA_0117

1 year 2017 and calendar year '18, which they
2 have now because it's January 2019, I think
3 what you're going to hear them say is, look,
4 you should be able to do that. You can
5 consider new data, Your Honor. But I will tell
6 you that this would be very unjust for several
7 reasons. So, you know, we know that courts
8 have found that using data that post dates the
9 actual CON review to demonstrate need is
10 appropriate. I'll give them that. I'll
11 concede it. But it's always been to bolster
12 the need for a service in an application that
13 has either been properly approved or improperly
14 denied. So, in this case we have neither of
15 those two scenarios.

16 Moreover, Your Honor, this is the bigger
17 consideration. If DHEC had denied the CON
18 application at the time, MUSC would have had to
19 make a series of pretty hard decisions. Number
20 one, do they appeal DHEC? Do they actually
21 say, you know, we're going to take our rounding
22 argument on up? They didn't have the future
23 utilization, so they would have had to come to
24 this court and say they should have rounded.
25 You know, I can't predict what they would have



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ROA_0118

1 done, but it's a decision they would have had
2 to make. It's a decision point.

3 MUSC would also, if they decided to go
4 forward, MUSC would have the burden of proving
5 beyond a preponderance of evidence in this
6 contested case that DHEC's decision to not
7 allow rounding was arbitrary and capricious.
8 Instead Trident Medical Center, we have the
9 burden of proof. So, that's why you can't just
10 willy nilly say, well, I guess I could consider
11 -- I should consider this later time period,
12 because it really -- it's not fair from the get
13 go. Our posture is totally changed. We're the
14 ones having to come in and bring the lawsuit
15 and have the burden of proof. Perhaps we would
16 have filed a motion for summary judgement back
17 then and it would have been, you know,
18 potentially granted.

19 So, there's too many unknowns just to
20 allow an applicant to say in a case where
21 conceivably the CON application was improperly
22 approved, because DHEC didn't have the benefit
23 of the information of the correct data, that,
24 you know, just let's overlook that, we can use
25 future data.



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ROA_0119

1 Moreover, there was a third applicant in
2 this litigation that settled out. And that was
3 Roper. And who knows, perhaps Roper would have
4 stayed in. Their linac is going to be located
5 three miles away from MUSC's. And perhaps they
6 would have stayed in if MUSC had the burden of
7 proof. And that's something else we couldn't
8 know. So, that's why we can't just use future
9 data, Your Honor.

10 So we're going to ask you to ignore their
11 request that you consider rounding and future
12 date. And I would also remind The Court -- and
13 we kind of had this issue in the last case --
14 the standard states each of the past two years.
15 And we believe that means from the date of the
16 CON application and not some, you know, future
17 period that was premised on a -- because when
18 the decision was premised on a mistake. The
19 good news for you, Your Honor, is we're not
20 going to -- I don't think we're going to
21 discuss the word existing at all in this case.

22 So, Trident contends -- so that's the --
23 that was the State Health Plan compliance
24 project review criteria. Now, community need.
25 We contend there's no community need. Even if



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ROA_0120

1 you can get past -- if MUSC can get past that
2 threshold issue of the State Health Plan,
3 there's no community need because in this
4 service area, this four-county service area,
5 Your Honor, the number of linear accelerator
6 treatments, and there's about 45, 46,000 or so,
7 hasn't changed in nearly a decade. Going back
8 to 2010. Even though the population in this
9 area has changed by 10 percent or more, a
10 little bit more than that, the number of
11 radiation therapy treatments through 2017 has
12 gone down. We don't have a complete view of
13 2018 yet, but we know 2017 it's actually gone
14 down a little less than a half a percent. So,
15 what does that tell you? That tells you -- and
16 you're going to hear this from the physicians
17 -- that the way these treatments are delivered,
18 the technology's gotten better, there are less
19 treatments per patient, there's something
20 called hypofractionation, a lot's changed in a
21 decade. But one thing that hasn't changed is
22 the number of treatments that are being
23 delivered in the area. So, why then did the
24 Department decide that it should approve two
25 linear accelerators at the same time and there

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ROA_0121

1 wasn't a need for either?

2 And that brings me back to Roper Berkeley.
3 Even if you find, okay, maybe there's a need
4 for one more Roper Berkeley's three miles away
5 from MUSC's proposed site, so they would
6 fulfill that need. The other thing is Trident,
7 Your Honor, you're going to see -- the evidence
8 is going to show that Trident has ample
9 capacity to handle all of MUSC's projected
10 volume at Nexton, which is about 3800
11 treatments. It has radiation therapy
12 capabilities that will not be at MUSC's site in
13 Summerville, the Nexton location. It's going
14 to have -- we have stereotactic procedures. We
15 have high-dose radiation. I believe the MUSC
16 CON says they're not going to be doing
17 stereotactic procedures there.

18 Moreover, Trident's radiation therapy
19 program is ACR accredited, meaning it maintains
20 very high standards of patient care, staffing,
21 and quality. And the other kicker is we use --
22 utilize TrueBeam linac equipment that MUSC
23 proposed to locate there. But ours are going
24 to be stereotactic capable.

25 And lastly, and I think this is a very



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ROA_0122

1 important aspect that you're going to hear, is
2 that Trident has three board-certified
3 radiation oncologists who all trained at MUSC.
4 They are MUSC physicians. A couple of them
5 served on their clinical professor staff. Two
6 of them are chief residents at MUSC. So, you
7 know, essentially you've got MUSC already
8 operating at Trident.

9 There are now access issues, Your Honor.
10 This isn't the best map. I'm going to walk
11 over here and just point out. Here you've got
12 Trident Medical Center. That's the H. That's
13 where its three linacs are. This is the four-
14 county service area, Berkeley, Dorchester,
15 Colleton, and Charleston. MUSC is right up the
16 road, I-26. That's the red dot. The green dot
17 here just three miles up -- I think that's Alt
18 17 going towards Moncks Corner -- that there is
19 where Roper's going to have a linear
20 accelerator in just under a few -- just a few
21 months. And then this gives you a better view,
22 Your Honor, kind of a close up. This is a map
23 that's got some radii, I suppose, around
24 Trident and maybe Summerville locations. And
25 it shows that MUSC's proposed site there at



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ROA_0123

1 Nexton just off I-26 and Trident is just off I-
2 26. It's just a few miles away and a very
3 short drive down an interstate. And so, you
4 know, they proposed to locate I think as the
5 crow flies five and a half miles, but as the
6 drive maybe closer to seven. But it's about
7 three miles from Roper's linear accelerator.
8 So, you know, in this small region, going back,
9 you're going to have three here and one here.
10 So, do we really need a fifth here? That's one
11 of the questions. And patients in that area
12 have access to those -- will have access to
13 those linear accelerators, so it's just not a
14 big access issue here.

15 And then what you're going to hear from
16 MUSC is, you know, patients choose MUSC. And
17 those patients that choose MUSC, they shouldn't
18 have to drive all the way downtown. But we're
19 going to -- you know, I think the evidence is
20 going to show that very few cancer patients, or
21 people who show up in a doctor's office, they
22 don't normally know they have cancer. But, you
23 know, when they come into a primary care
24 physician's office, Your Honor, the evidence is
25 going to show that they kind of start going



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ROA_0124

1 where their physicians direct them. So, if
2 they're in the MUSC physician -- I mean,
3 system, the MUSC Health System, they're going
4 to go where they're directed by the doctor to
5 the specialist. And the fact of the matter is,
6 is that those specialists, the medical
7 oncologists, urologists and such, they can
8 refer to Trident. Nothing prevents them from
9 doing that contractually or under the law. And
10 in fact, Trident does treat referrals. The
11 radiation therapy center already treats
12 patients from MUSC and Roper. And the evidence
13 is going to show that at least we're not aware
14 of any complaints there. So, we have the, you
15 know, capacity. We have the MUSC trained
16 physicians. We have the high technology and
17 the staffing and the access in the location,
18 Your Honor.

19 Now, you know, let's talk a little bit
20 about duplicating services. They claim it
21 won't duplicate any service, but I would claim
22 this is black letter duplication, Your Honor.
23 You know, Trident is actually only using two
24 linacs, even though it's licensed for three.
25 That just because the volumes dictate that

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ROA_0125

1 that's what it could do. They are currently
2 upgrading a ten-year-old linac that is
3 incompatible with these other two linacs with
4 the latest and greatest technology, another
5 TrueBeam. This one is, you know, going to be
6 a 2018 model, and so it's state of the art.
7 So, you know, Trident's going to have all the
8 technology MUSC needs to treat their patients
9 if they're worried about that.

10 But the bottom line is, is that MUSC
11 employs a lot of physicians. Trident doesn't.
12 We're a hospital that relies on referrals from
13 physicians in the market who are out there.
14 And so, you know, MUSC -- you hear this concept
15 of their patients. They want to give their
16 patients the convenience. MUSC doesn't have
17 rights. They don't own any patients. But, you
18 know, the fact of the matter is, there are
19 great referral options at Trident for MUSC-
20 trained physicians. And they can refer there
21 if they want. Now, we know and the evidence is
22 going to show that and we understand they're
23 not encouraged to refer, but maybe that's a
24 practice that needs to change, rather than just
25 adding linear accelerators all over the place.



1 We believe the evidence is going to show
2 that patients rarely specifically choose a
3 health system for ancillary services. You
4 know, they're referred for things like surgery
5 and heart catheterization and radiation therapy
6 through a primary care system network,
7 gatekeepers, on up to specialist, then
8 ultimately to a radiation therapist. You know,
9 Trident submits that, if MUSC cared about
10 patient convenience, then it would have -- you
11 know, it would have prodded its physicians to
12 refer to Trident for the last decade.

13 Now let's talk a little bit about
14 medically underserved groups. We'll get more
15 into this. But, you know, what you're going to
16 find out -- the evidence will show that MUSC
17 doesn't really even know the payer mix. And
18 the payer mix is the type of patients -- you
19 know, what kind of reimbursement do they have,
20 Medicare, Medicaid, commercial insurance, Blue
21 Cross Blue Shield, and so on. They have no
22 idea what their payer mix is. They were
23 questioned about this recently. They don't
24 know. They just assume that it was for their
25 entire system of radiation care. But the fact



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ROA_0127

1 is, is that they specifically located in a
2 specific location that has kind of a different
3 income demographic. So, it's a little
4 different. And then also their indigent care
5 numbers are pretty low for a not-for-profit
6 hospital, Your Honor, that doesn't pay taxes.
7 This is a not-for-profit hospital. And I think
8 they're delivering less than two percent
9 indigent care. So, we're not so sure that this
10 application benefits medically underserved
11 groups.

12 And in terms of financial feasibility, you
13 know, by their pro formas, they appear to be
14 financially feasible, but we know that one half
15 of that money, of the quote unquote profits, is
16 going to a group called Alliance Oncology. And
17 so, that's a couple of hundred thousand dollars
18 a year to MUSC. So, Trident's wondering, why
19 are they going to trouble, Your Honor? Why are
20 they going to the trouble of spending ten
21 million dollars for this? Is it really for
22 patient convenience or is it really for
23 something else? Is it to gain market share in
24 this area? And the other thing is, nobody
25 really knows, at least on the Trident side,



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ROA_0128

1 where the money is coming from. Because MUSC
2 has engaged a lot of planning projects right
3 now, including a 150 million dollar hospital
4 purchase throughout the state, they're getting
5 four hospitals; another 320 million dollar
6 hospital they're wanting to build in Berkeley
7 County; a 40 million dollar micro-hospital in
8 Beaufort; you know, trying to finish up a 400
9 million dollar project down on the peninsula.
10 And this is a state -- you know, a state
11 affiliated hospital, MUSC. So, we're a little
12 concerned about that. And we don't think that
13 any of these expenses have been factored into
14 their overall pro forma, which is very
15 important, because, you know, the Department
16 requires an applicant to put the overall system
17 pro forma in a CON application to demonstrate
18 financial feasibility. Now, adverse impact --
19 this is not a specific project review criteria,
20 Your Honor, but it is specifically referenced
21 in the State Health Plan. The benefits of
22 improved accessibility will be equally weighed
23 with the adverse effects of duplication and
24 evaluating the CON. And as I showed you -- I
25 don't think I showed you this one, but this is

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ROA_0129

1 a primary service area exhibit. This is -- the
2 yellow is Trident's primary service area for
3 radiation therapy patients. MUSC is literally
4 locating right there in that red dot kind of in
5 the heart of it. So, to say that they're not
6 going to affect Trident is just an untenable
7 position, Your Honor.

8 And one of the things that I do want to
9 talk about is that, you know, if there's not
10 going to be any improvement of access, and we
11 know there's going to be some adverse impact,
12 then Trident wins on that particular provision.
13 And moreover, one thing we want to talk about
14 is convenience and access aren't the same
15 thing. They're not the same concepts in terms
16 of community health planning and they shouldn't
17 be confused as such. And you'll hear more
18 about that from Trident's expert.

19 Now I'll talk about a couple of untenable
20 positions from MUSC and then I'm going to wrap
21 up. You know, you're going to hear things like
22 the fact that Trident is making state-of-the-
23 art upgrades right now to one of its units is
24 somehow a reason that justifies MUSC's linear
25 accelerator in Nexton. It just doesn't make a



1 lot of sense, Your Honor. They're upgrading a
2 ten-year-old unit with a state-of-the-art --
3 they already have this state-of-the-art unit.
4 They're getting another one. You're going to
5 hear from their director of cancer care why
6 they're doing that.

7 The other thing you're going to hear a lot
8 about, it's going to be kind of like a beauty
9 competition I think, MUSC wants to make it into
10 one. But they're going to talk about how
11 they're an NCI-designated cancer center,
12 National Cancer Institutes, okay; that their
13 cancer program is in the U.S. News & World
14 Report top 20; they do clinical trials and
15 Trident doesn't do that; and that they're
16 medical staff is so much bigger than Trident's,
17 Your Honor. You're going to hear that from
18 them. But I think that's just noise. Those
19 are all red herrings. That's not what this is
20 about. This is about a radiation therapy
21 center at Nexton in the Summerville area where
22 they're not going to be, you know doing, cancer
23 surgery. They're going to be doing radiation
24 therapy of the kind that's being done at
25 Trident right now. In effect, their medical



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ROA_0131

1 staff may be bigger, but that's because they're
2 a 600 and plus bed hospital. Trident's a 300
3 bed. It better be bigger to service those
4 patients.

5 Your Honor, you know, we'd also tell you
6 that we think the evidence will show that most
7 cancer patients, they don't know that MUSC's
8 got a bigger medical staff and that they're
9 ranked in the top 25. They go to MUSC because
10 their MUSC physicians send them there, okay.
11 And these folks could certainly be sent to
12 Trident if they wanted to, if the physicians
13 wanted to.

14 Now, kind of wrapping up. DHEC's decision
15 was arbitrary and capricious. Why? Well,
16 first of all, while they did not know that they
17 were below the 80-percent threshold, because
18 MUSC presented incorrect data in their
19 application for fiscal year 2016, if their
20 position is now they would accept rounding or
21 that they came into compliance, then we believe
22 that would be arbitrary and capricious. Again,
23 I'm not going to get too much into this, but,
24 you know, we think what they're going to say is
25 79.96 percent gets rounded to 80, but 79.94



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ROA_0132

1 does not. I chuckle there because I couldn't
2 believe we were talking about that in the
3 deposition. But, you know, the difference
4 between 79.94 and 79.96 is just a few patients,
5 you know. So, you know, if you consider a
6 20,000-treatment program, you know, we're
7 talking about six verses eight patients, that's
8 what makes it arbitrary. That's why there's a
9 cutoff of 80 percent, Your Honor. Eighty
10 percent is the number. It's not 79.97, .94 or
11 95. It's 80 percent.

12 Now at the time of the decision, DHEC did
13 not ask if MUSC's linac capacity assignments
14 were valid. And the Court -- we believe the
15 evidence is going to show that they are not.
16 In fact, DHEC doesn't even have a system in
17 place right now to check and see if the
18 capacities that are self assigned by radiation
19 therapy providers are accurate. You're going
20 to hear testimony from Ms. Murdock at DHEC that
21 they're working on a way to check that out.
22 And the easiest way to do it would be to have
23 a line item in the state health plan that shows
24 per unit how many stereo -- you know, if you're
25 doing stereotactic, you've got a 4500 capacity,



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ROA_0133

1 how many stereotactics are you doing to get to
2 a sufficient volume? Maggie -- Ms. Murdock,
3 excuse me, doesn't know what sufficient volume
4 means. She doesn't know. She'll admit that on
5 the stand. She doesn't know. But I think we
6 all know that one percent's not sufficient
7 volume. Perhaps even eight or ten percent's
8 not sufficient volume. Heck, MUSC's own expert
9 has suggested that 20 to 25 percent of
10 procedures, specialized procedures, on a linac
11 is not sufficient volume, and we agree with
12 him.

13 So, our request is simple, Your Honor. We
14 ask, because of all the reasons I've talked
15 about, all the evidence you're going to hear,
16 that you overturn MUSC's -- or DHEC's decision
17 to approve MUSC's CON application for a linear
18 accelerator. Thank you, Your Honor.

19 **THE COURT:** Ms. Biggers.

20 **OPENING STATEMENT BY MS. BIGGERS:**

21 **MS. BIGGERS:** Thank you, Your Honor. Ashley Biggers
22 here on behalf of the Department. I am going
23 to have a brief opening statement, run through
24 some of the facts of our decision, and I think
25 -- and address just briefly a couple points Mr.



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ROA_0134

1 Thomas raised in his opening.

2 So, DHEC issued its decision in this case
3 in November of 2017. This was an application
4 that had been submitted to us earlier that
5 year, beginning of 2017. Now, this -- it was
6 May 22nd, 2017. Now, at that time the South
7 Carolina Health Plan that was adopted on August
8 13th, 2015 was the one in effect. So, pursuant
9 to our laws, that's the version of the South
10 Carolina Health Plan that we considered in
11 applying the standards for this decision.

12 The project was for the expansion of
13 MUSC's existing radiation therapy services line
14 through the addition of a new linear
15 accelerator, in addition to the ones they
16 currently own, to be placed in a free-standing
17 medical office building in the Berkeley county
18 area, which by definition in statute of a
19 radiation therapy facility you'll see that
20 makes it a radiation therapy facility, which
21 also by definition in the statute makes it a
22 healthcare facility. And actually an existing
23 radiation -- the standards in the Plan apply to
24 expanding an existing service apply whether
25 you're expanding it at that current site or at



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ROA_0135

1 an additional site, a separate site. That's
2 within the standard specific to radiation
3 therapy services.

4 So, DHEC reviewed the application,
5 reviewed the standards. Now, it's true that at
6 the time that we were reviewing the standards,
7 our reviewer looked at the most recent two
8 years of JARS data. And I believe you'll hear
9 her testify that that is typically her starting
10 point. She starts with, I'm going to pull the
11 most two recent years of JARS data I have,
12 because JARS are documents, joint annual
13 reports, that facilities are required to report
14 and DHEC has access to that, will give an
15 overview of -- for, the reason it would be
16 relevant in this case, for the number of
17 radiation therapy treatments that they have
18 provided in those two years of JARS reporting
19 data. Now, she did say in her deposition
20 that's her starting point. What I think you
21 ~~will hear her expand upon in her testimony that~~
22 wasn't asked about in her deposition is that,
23 well, I would -- but if there were more updated
24 or recent data available or if, for some
25 reason, someone told me there were a mistake on



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ROA_0136

1 their JARs, I would take that into
2 consideration.

3 We did learn in discovery in this case
4 that for one of the years of JARs data that Ms.
5 Murdock, our reviewer, looked at, there was a
6 slight discrepancy, just actually not unusual
7 for hospitals in general or other healthcare
8 facilities when they're compiling these
9 reports, that they end up going back through it
10 a second time and finding that some of their
11 numbers were slightly off, that put it just
12 slightly under 80 percent for one of those
13 years. But what I would ask this Court, which
14 I know you're already aware of, but just a
15 reminder for the benefit of everyone, is that
16 this is a de novo hearing. And the law, I
17 believe is well settled, that when the
18 Administrative Law Court has jurisdiction to
19 conduct a contested case in a de novo capacity,
20 that while new issues that were not either
21 raised to or considered by staff below, can't
22 be raised at a de novo hearing at the ALC.
23 Certainly updated evidence can be. And just
24 like Ms. Murdock, in reviewing the staff data,
25 would have considered any updated data before



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ROA_0137

1 making her decision at the time of her
2 decision, we believe it's also appropriate for
3 this Court, making the final decision at this
4 point in time, when I believe that you're going
5 to see a lot of the exhibits introduced by both
6 Trident and MUSC in this case are going to be
7 involved data that's more recent than what
8 they've -- what either side submitted to DHEC,
9 means that Your Honor can also consider the
10 most recent two years worth of data available
11 to you in making that decision. And I think
12 that when you review that, you will see that
13 Standard 7 is still met at this time, based on
14 the most -- the two most recent years.

15 So, the standard also -- the Standard 7 in
16 particular of the State Health Plan, it's the
17 one applicable when you're expanding an
18 existing service, and it does address capacity
19 thresholds. Capacity is one of the issues that
20 you have to look at in determining whether or
21 not the 80 percent is met, because you're going
22 to be looking at what's the capacity of the
23 machine and then how many treatments have you
24 provided with the machine. And the standard
25 addresses the 80 percent that's already been



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ROA_0138

1 discussed regarding just the existing
2 facility's past expansion -- past use rate for
3 the past two years, not -- so for the purposes
4 of meeting the State Health Plan, it does not
5 matter what Trident's use rate was. If Trident
6 claims it has a low use rate, for some reasons
7 their use rate has fallen, for purposes of
8 meeting the State Health Plan criteria, that
9 does not matter because this is an expansion in
10 the CON standards, and the State Health Plan
11 focus on MUSC's use rate and whether or not
12 they can establish that they've met the 80
13 percent and that they can then establish that
14 going forward within three years they'll be
15 able to achieve at least a 50 percent use rate.

16 Community need documentation -- now and
17 I'm going to move on to our project review
18 criteria that we consider most important. And
19 actually let me just also add here, while the
20 standards in the CON health plan are certainly
21 CON standards that we do believe have to be met
22 in every case, I believe that when you look at
23 the -- where the statute discusses the South
24 Carolina Health Plan content, and it would
25 include, you know, identifying criteria that

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ROA_0139



are generally considered to be most important for a particular service, and then you -- I believe that DHEC does have the ability. And if you look at just about any CON case that's probably ever been in front of this Administrative Law Court, with the exception of a few, I think you will see that in the past it has been standard that DHEC staff may identify one as important to a particular project that wasn't listed in the Plan as most relevant to that standard. Or they may have decided, even though it was listed in the Plan as most relevant to that standard, they decided not to apply it in that particular circumstance, that identification project review criteria deemed most important is something that we do want the input of the Planning Committee in. But in that instance, because project review criteria are listed in the regulation separate from the Plan, I do believe DHEC has discretion to also look at other project review criteria not listed specifically in the Plan. Looking at community need documentation in particular. Here MUSC -- we were focused on MUSC's identification of their targeted

1 community for the community need documentation.
2 And they discussed their patients, who
3 currently seek treatment in downtown
4 Charleston, but live in the other counties that
5 are northern of Charleston county that are part
6 of the service area identified for radiation
7 therapy services in the Plan, who, despite the
8 fact that Trident does exist and does provide
9 radiation therapy treatments, they -- for
10 whatever reason, there are those who drive past
11 and don't stop and have their radiation
12 treatment at Trident. Instead they go to MUSC
13 downtown. And MUSC's application was focused
14 on making more accessible and trying to fulfill
15 the community need that they have identified
16 through their information about who their
17 patients are, where they live, recognizing that
18 a number of them do come from the Berkeley
19 county, Dorchester county area, and are already
20 driving past that area and want to go downtown.
21 And this would -- this satisfies, not only the
22 community need documentation project criteria,
23 it also goes to the distribution accessibility.
24 And with community need I would look, again,
25 just in the law at section -- in our

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ROA_0141

1 regulation, Regulation 61-15, at Section 802.2,
2 the Community Need Documentation, Subsection e,
3 which says current and/or projected utilization
4 should be considered to justify expansion of
5 the proposed service. And this is -- this
6 review was about the need for MUSC's project.
7 And looking at their current utilization and
8 where those people are coming from and their
9 projected utilization and how many they project
10 those people would fulfill the future
11 projections to utilize a Berkeley county linear
12 accelerator, I will demonstrate that's been
13 met.

14 And medically underserved groups and
15 financial feasibility, I believe there will be
16 ample evidence in this trial to address those
17 issues and show that in fact DHEC was correct
18 in deciding that those were met.

19 Adverse impact is something that Mr.
20 Thomas raised in his opening. It was not one
21 of the project review criteria identified by
22 DHEC. It's not one of the project review
23 criteria -- I'm sorry, it's not addressed in
24 one of the CON standards in the State Health
25 Plan when you're looking at expanding an



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ROA_0142

1 existing service. But I do believe -- I would
2 just remind everyone that Trident has the
3 burden of proof in this case. And if they
4 believe that there is specific evidence beyond
5 a general statement that there will be adverse
6 impact, if they can actually provide, which
7 they did not to the Department, some kind of
8 quantifiable financial impact or quantifiable
9 here's how it will affect our utilization to
10 this Court -- you know; I do believe they made
11 a general statement to the Department, but they
12 did not quantify that to the Department. And
13 so, since they have the burden of proof, I
14 would ask The Court to keep this in mind as the
15 case goes on. It is their burden of proof to
16 establish that and I believe it should be
17 established in a quantifiable manner if it is
18 going to otherwise cause The Court to disagree
19 with MUSC's evidence that they meet all of the
20 applicable Plan standards and project review
21 criteria. That's all I have. Thank you, Your
22 Honor.

23 **THE COURT:** Thank you, ma'am.

24 **OPENING STATEMENT BY MR. WESTBROOK:**

25 **MR. WESTBROOK:** May it please The Court. I'm Dan



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ROA_0143

1 Westbrook and I'm here to represent the Medical
2 University Hospital Authority, which I'm just
3 going to refer to as MUSC if that's okay. Also
4 with me here today is our client representative
5 Ms. Sarah Bacick, who is the senior planner for
6 MUSC; my partner, Travis Dayhuff; our paralegal
7 back there, Tammie Pope; our health planning
8 expert, Mr. Levitt, who's going to testify on
9 Thursday, if the trial goes that long, and I
10 think it probably will; and our tech support,
11 Mr. Dan Bupp from Horizon Trial Solutions.

12 So, MUSC. MUSC holds a special place in
13 this state. It's a premier academic medical
14 center. It's the leading research medical
15 center in South Carolina. As my friend, Mr.
16 Thomas, mentioned, it has been designated --
17 I'll add it's the only hospital in South
18 Carolina designated by the National Cancer
19 Institute. U.S. News & World Report has ranked
20 it, as Mr. Thomas alluded to, among the top 25
21 cancer hospitals in the country and has also
22 ranked it as the overall best hospital in South
23 Carolina. No surprise then that MUSC draws its
24 patients from all over the state and, as far as
25 that goes, out of state.



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ROA_0144

1 But in recent years it's not always been
2 that easy to get to MUSC's main hospital
3 downtown Charleston, down on the Charleston
4 peninsula. Traffic issues, parking issues, and
5 in recent years actually occasional flooding
6 have created challenges of access. And this
7 can be particularly difficult for radiation
8 therapy patients, because the typical treatment
9 regime for radiation -- I think I meant to say
10 regimen instead of regime. It's regimen I
11 think -- regimen for radiation therapy is
12 outpatient daily treatments five days a week
13 for a number of weeks; three, four, five, six,
14 seven weeks sometimes, whatever it takes. For
15 several weeks at any rate. And so the patient
16 drives down to the hospital, to the cancer
17 center, gets the treatment. It doesn't take
18 that long to get the treatment. But then has
19 to drive back home, come back the next day,
20 drive home, so forth and so on. What's more,
21 a lot of MUSC's facilities down in downtown
22 Charleston are in older buildings that are
23 difficult to renovate. There's not a lot of
24 space downtown Charleston to expand. So,
25 because of all of these reasons, in the last

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ROA_0145

1 few years MUSC has started taking its services,
2 expanding its services off the Charleston
3 peninsula.

4 On Wednesday afternoon we are going to put
5 a witness on the standard, Dr. Pat Cawley, who
6 is the CEO of MUSC Health. That's the clinical
7 arm of MUSC. And Dr. Cawley is going to
8 testify, among other things, about MUSC's
9 mission. And that mission is not just to
10 provide care for local citizens, but to provide
11 care and resources for the entire state. And
12 to better implement that, MUSC is now providing
13 healthcare services in places like Mount
14 Pleasant, and Beaufort, Murrells Inlet,
15 Orangeburg, lots of places. And, in fact,
16 it's negotiating, I think, right now to acquire
17 -- to try to acquire four rural hospitals in
18 different parts of the state.

19 So, in other words, MUSC is not content to
20 stay down on the peninsula and make people come
21 to it. It's taking its services out to the
22 people. Dan, let's see that blue map, the blue
23 map. Now, as this map indicates, you probably
24 all know this anyway, but in case you don't,
25 Berkeley and Dorchester counties lie directly



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ROA_0146

1 north of Charleston county. I-26, as you see
2 there, really tracks very closely the county
3 line between Berkeley and Dorchester. And as
4 we go forward, I'm just going to use for
5 convenience the term north area. I stole that
6 from Mr. Thomas, who used it in one of the
7 depositions. And when I talk about the north
8 area, I'm really just going to refer very
9 generally to this very northern part here
10 that's of Charleston County that sticks up into
11 here where the town of North Charleston is,
12 where Trident Medical Center is, as a matter of
13 fact, and Berkeley County and Dorchester County
14 particularly along the interstate. But that --
15 all of that I'm just going to refer to as the
16 north area. And no precise boundaries there,
17 though. I'm just using it as a shorthand.

18 Dan, let's take a look at the next map,
19 please. So, here's another map of the same
20 area. The population -- what you'll hear in
21 this trial, Your Honor, is the population in
22 the north area has been growing for the last
23 few years. It's projected to grow, continue
24 growing for the next few years, as a large
25 community of homes and businesses that's being



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ROA_0147

1 developed called Nexton there at the green
2 circle. And in addition to that, industries
3 and employers have started to spring up along
4 or locate along the interstate. There's a
5 Volvo plant, as you see up there near the top,
6 there's a Mercedes plant, an Air Force base, a
7 Boeing plant. A lot of employers are locating
8 along that interstate near that Nexton area.
9 And the north area is attracting not only these
10 kind of businesses, but also healthcare
11 facilities. In particular, specifically, the
12 three hospital systems in Charleston; that is
13 Trident, Roper, and MUSC.

14 Let's take them one at a time, Dan. Let's
15 look at Trident. So, Trident -- as you see
16 there, in the North Charleston area is where
17 Trident Medical Center is located. Across the
18 county line into Dorchester is its sister
19 hospital, Summerville Medical Center. Trident
20 has a CON for a freestanding emergency
21 department near the Nexton area. They'll be
22 building that, I assume, fairly soon. It's
23 also got a freestanding emergency department up
24 near Moncks Corner. And it's been in
25 operation, I think, for a while and has a CON



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ROA_0148

1 to build a hospital up there as well, which I
2 assume will get built at some point.

3 Roper is also in the area. Up in Moncks
4 Corner they've got in operation a freestanding
5 emergency department and an outpatient surgery
6 center. They are building, and will be opening
7 fairly soon, a new hospital, Roper St. Francis
8 Berkeley Hospital near Carnes Crossroads, which
9 is not far from Nexton.

10 And finally there's MUSC. MUSC has three
11 projects that are being -- that have been
12 proposed and for which DHEC has approved CONs.
13 These are all near Nexton. None of them are
14 operational yet because they are all being
15 challenged. There is, at the bottom there,
16 MUSC's freestanding emergency department. That
17 case is going to be tried in March before Judge
18 Robinson. Up at the -- there's a community
19 hospital for which a CON has been approved by
20 DHEC. That case has been assigned to Judge
21 Lenski and will be tried sometime in the future
22 I guess. And then there's the radiation
23 therapy center, which is why we are here this
24 week.

25 The north area -- and, Dan, I think we can



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ROA_0149

1 take that down, that map down now. The north
2 area is particularly important to MUSC's
3 radiation oncology program because over 30
4 percent of MUSC's radiation oncology patients
5 live in that area. They live up there. They
6 are currently driving down, mostly down I-26,
7 down to the Charleston peninsula, in the
8 traffic, finding the parking, dodging the
9 floods, but they are getting there, they are
10 going there, every day, five days a week for
11 several weeks to get those and then driving
12 back home every day, making that round trip,
13 most of them. Now, MUSC wants to build this
14 radiation therapy center I Nexton to make -- to
15 give these patients, patients that are already
16 going to MUSC, better access, closer access, to
17 MUSC's radiation therapy treatment, closer to
18 their homes.

19 On Thursday morning we plan to call a
20 witness named Buddy Jenrette, Dr. Buddy
21 Jenrette. He's the long-time chair of the
22 Radiation Oncology Department for MUSC. And
23 Dr. Jenrette's going to testify about how
24 MUSC's program, radiation oncology program
25 works. He's going to testify that there are



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ROA_0150

1 three oncologists that are typically involved;
2 three specialists -- different kinds of
3 specialists, a medical oncologist, a surgical
4 oncologist, a radiation oncologist that work
5 together; that each of these kinds of
6 specialists has one or more sub-specialties;
7 and that they work in integrated multi-
8 disciplinary teams together. That's the way
9 they provide cancer care at MUSC on the
10 peninsula and that's the way they are going to
11 provide cancer care at MUSC at Nexton.

12 Now, Trident has suggested that, rather
13 than build a radiation therapy center in
14 Nexton, we just refer our patients to Trident,
15 our radiation oncology patients that live in
16 the north area, just refer them to Trident. As
17 you're going to hear from our witnesses, that's
18 not an option that MUSC is going to really
19 consider or agree to. Once again, focus on
20 mission. MUSC's mission is to provide the
21 broadest, deepest, most comprehensive, most
22 highly-specialized care in this -- radiation
23 oncology care in the state. It's not going to
24 hand off that responsibility to other
25 providers.



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ROA_0151

1 Let me address two or three of Mr. Thomas'
2 arguments. Treatments have decreased or stayed
3 flat in the last several years. Not clear if
4 that's going to continue in the future. It has
5 the last few years. However patients, cancer
6 patients, unfortunately, are increasing due to
7 population growth, incidence rates -- cancer
8 incidence rates, the adverse impact, as Ms.
9 Biggers pointed out, is not a priority criteria
10 in this case. And Mr. Levitt, who's here with
11 us today and who's going to testify on
12 Thursday, is going to demonstrate that there
13 will be no adverse impact. Our focus is going
14 to be on, again, the patients -- or close to a
15 third of our patients currently come from this
16 area. That's who we're focused on. We are not
17 trying to steal their patients from them.
18 Patients can choose to go where they want to.
19 If Trident has a good cancer system, they'll
20 continue to go there. If Roper has a good
21 system, they'll go there. MUSC, we know we
22 have a good system and I'm sure we'll get our
23 share of patients as well. We're trying -- our
24 goal is not to take their patients. It's to
25 take our services closer to our patients.

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ROA_0152

1 MUSC's finances. Mr. Thomas is suggesting
2 that, because of -- as I understand his
3 argument, MUSC is on what he considers shaky
4 financial ground, that this project may not be
5 financially feasible. First of all, that
6 argument I don't think was preserved because I
7 don't think it was raised below. But
8 regardless of that, I'll just -- we can address
9 that argument. Dr. Cawley and Mr. Levitt will
10 address that argument. I'll just point out one
11 thing for Your Honor to take back with you
12 today. This particular project -- whether this
13 particular is feasible or not, this project is
14 going to cost MUSC less than five million
15 dollars. MUSC is a 49 percent partner in this.
16 It's going to cost less than five million
17 dollars. MUSC has annual budgets of over two
18 billion dollars. It's not going to be hard for
19 MUSC to fund this project.

20 Standard 7 of the State Health Plan -- Mr.
21 Thomas spent a good bit of time on that, so
22 let's put it up on the screen, Dan. Let's look
23 at it one more time. I asked Dan to highlight
24 just what I think are the key parts of this.
25 And I'll just read it into the record.



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ROA_0153

1 Expansion of an existing service shall only be
2 approved if the service has operated at minimum
3 use rate of 80 percent of capacity for each of
4 the past two years. Now, as Mr. Levitt, our
5 expert, is going to testify on Thursday, there
6 are multiple ways that MUSC meets this
7 standard. I certainly agree with Ms. Biggers'
8 comments, I appreciate them, in her opening
9 statement. I'm just going to show you very
10 quickly two ways.

11 Dan, let's go to the next slide. Fiscal
12 year '15 and fiscal year '16, it is true that
13 in our application we submitted inaccurate
14 numbers inadvertently. We were -- as it turns
15 out when we -- during the discovery process, we
16 looked at our numbers and realized that we had
17 counted something called port films as linear
18 accelerator treatments. They're not linear
19 accelerator treatments, so we disclosed that to
20 the other parties. And instead of what we had
21 said in the application, we only had, for
22 fiscal year '16, 19,192 treatments. Now, at a
23 24,000 capacity, which we believe and DHEC
24 believes is the capacity for our five existing
25 linear accelerators, 80 percent would be



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ROA_0154

1 19,200. We came in at 19,192, eight less than
2 what would be exactly 80 percent. Eight
3 treatments less. Now, Mr. Levitt's going to
4 testify that the average number of treatments
5 that a radiation therapy patient gets is 18, so
6 we're short there less than half a patient.

7 Mr. Thomas said you can't round up because
8 where do you draw the line? Is it 79.5 or is
9 it 79.51 or what is it? I don't know, but I
10 think 79.97 is pretty doggone close. And it
11 seems to me to be kind of strained common sense
12 to say 79.97, less than half a patient, doesn't
13 meet the 80 percent standard.

14 Another way of looking at it though.
15 Let's go to the next slide, Dan. This is after
16 all, as Ms. Biggers pointed out, a de novo
17 trial, a de novo hearing. You can't consider
18 new evidence. And the standard says you look
19 at the past two years. The past two years of
20 2017 -- calendar year 2017 and calendar year
21 2018. You know, we are at 81.9995 percent for
22 calendar year 2017, which I'm going to take the
23 liberty -- I'm just going to be rash about it
24 and round it up to 82 percent. And in calendar
25 year 2018 80.49 percent. I don't care if you



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ROA_0155

1 consider that 80 or 81 percent. It's certainly
2 over. That's in the past two years. That's
3 fine, Dan. You can take that one down I
4 believe now.

5 To wrap up, Your Honor, let me just go
6 back to -- digress for a moment to the FED
7 case. I mentioned Judge Robinson's case that's
8 coming up in March, the freestanding ED case.
9 As I think you know, MUSC made the decision not
10 to oppose Trident's freestanding ED CON in that
11 case, just as it made the decision in this case
12 not to oppose Roper's linear accelerator CON
13 for a new accelerator to put at their Carnes
14 Crossroads Hospital. After MUSC announced that
15 decision, or made that decision, of course
16 Trident and Roper got together and cut a deal
17 to not oppose each other and to, in effect, try
18 and carve up the north area and squeeze out
19 MUSC. Your Honor, I'll harken back to the CON
20 Act -- one of Mr. Thomas' early slides, the
21 purpose of the CON Act. I don't think that's
22 how health planning should work, particularly
23 the -- I mean, the purposes of the CON Act
24 included things like quality of care and best
25 satisfying the public needs. It's not in the



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ROA_0156

1 public needs to keep MUSC -- force MUSC to stay
2 on the peninsula to serve patients who appear
3 to be determined to drive down there regardless
4 of what other cancer centers lie in between
5 them and MUSC. MUSC's own patients, people who
6 live in the north area and who choose to go to
7 MUSC, for whatever reason they've made that
8 choice, deserve better access to the broadest,
9 deepest, most comprehensive and most
10 specialized cancer care in the state. Thank
11 you, Your Honor.

12 **THE COURT:** All right. We are at 11:23. Mr.
13 Thomas, do you want to start with your witness?

14 **MR. SUMMER:** Your Honor, do you mind if we take a
15 quick restroom break?

16 **THE COURT:** That would be fine. I think that would
17 be delightful for several of us. We'll be at
18 ease for ten, 15 minutes. What do you think?

19 **MR. WESTBROOK:** Ten is good.

20 **MR. SUMMER:** I'll go to five, but whatever ---

21 **THE COURT:** Well, we've got a lot of folks to fit
22 in. Let's try ten.

23 (Off the Record)

24 **THE COURT:** We're back on the record on case number
25 17-ALJ-07-0100. And Mr. Thomas I believe or



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ROA_0157

1 Mr. Summer?

2 **MR. THOMAS:** I will let Mr. Summer take this one,
3 Your Honor.

4 **THE COURT:** All right.

5 **MR. SUMMER:** Thank you, Your Honor. Trident would
6 like to call its first witness, Todd Gallati.

7 **THE COURT:** Come over here to be sworn, sir.

8 **TODD GEORGE GALLATI,** having been duly sworn,
9 testifies as follows:

10 **COURT REPORTER:** Please state your full name.

11 **MR. GALLATI:** Todd George Gallati.

12 **COURT REPORTER:** Please spell it.

13 **MR. GALLATI:** T-O-D-D G-E-O-R-G-E, last name's
14 Gallati, G-A-L-L-A-T-I.

15 **MR. GALLATI - DIRECT EXAMINATION BY MR. SUMMER:**

16 Q: Thank you, Mr. Gallati. If you would, please
17 explain to The Court what your employment title
18 is.

19 A: I'm the CEO of Trident Health.

20 Q: Okay. Before we start talking about your
21 facilities, let's explain to The Court a little
22 bit about your background if you would. Let's
23 just start with where you went to college and
24 look at your education a little bit.

25 A: Yeah. I attended Florida State University



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ROA_0158

1 where I received a bachelor's degree. Then
2 went on to the University of Florida where I
3 had gotten an MBA as well as a master's in
4 health administration.

5 Q: Okay. You have an MBA. Would you explain to
6 The Court what the master's in health
7 administration entails and what the difference
8 between that and your MBA is?

9 A: Yeah. My master's in health provided more
10 emphasis obviously on healthcare
11 administration, some of the nuances of
12 healthcare policy, health planning, healthcare
13 financing, and operations. Whereas the
14 master's in business administration was your
15 typical MBA program with finance. So, it's a
16 dual degree. We spent half the time studying
17 and preparing for the MBA and then half the
18 time getting a master's in health
19 administration. That also included a one-year
20 residency out in the field working as an
21 administrative resident.

22 Q: Tell us a little bit about your employment
23 history. What led you to Trident? Where did
24 you start?

25 A: I actually have 30 years of experience with



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ROA_0159

1 healthcare administration. I started with HCA
2 right out of my master's program and worked at
3 North Florida Regional for eight years where I
4 did a variety of jobs, including director of
5 planning, assistant administrator, chief
6 operating officer. And then I went to Lake
7 City Medical Center with HCA as a CEO at that
8 hospital before going to Gulf Coast Medical
9 Center as the CEO there in Panama City. I
10 served about seven years there before coming to
11 Trident in Summerville Medical Center here
12 about ten years ago.

13 Q: Okay. Talk to me a little bit about your role
14 with the System. What does your role entail?

15 A: As the System CEO, responsible for Trident
16 Medical Center, which is a 313 bed hospital
17 located in North Charleston, a 124 bed hospital
18 in Summerville Medical Center, as well as our
19 two freestanding ERs. So, responsible for the
20 operations and finance -- financial operations
21 of that system.

22 Q: Describe to The Court -- Summerville obviously
23 is in Dorchester County. Where are your
24 facilities up in Moncks Corner and Berkeley
25 County?



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ROA_0160

1 A: So, we have two freestanding emergency
2 departments, one in Moncks Corner, which is in
3 the upper portion of Berkeley County. We see
4 about 15,000 patients there annually. We also
5 have another freestanding emergency department
6 in North Charleston, that's Centre Pointe
7 Medical Center.

8 Q: I'd like to talk a little bit about the history
9 of Trident and its evolution in the tri-county
10 area.

11 MR. SUMMER: Can you put that map back up on the
12 board? There we go..

13 Q: And I think Mr. Thomas had already pointed out
14 that your facility with the current linear
15 accelerators is located right there. That's
16 also that northern piece of Charleston County.
17 How was it that Trident decided to build a
18 hospital there? What's the history of that?

19 A: Well, I think it's rather unique. Back in the
20 late '60s, early '70s, the county officials,
21 community officials, actually approached HCA
22 because they were seemingly having some issues
23 with the two hospitals, one in Dorchester
24 County and one in Berkeley County, some issues
25 of viability and need for greater services.



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ROA_0161

1 Q: So, if we go back to the early '70s, that's
2 long before Volvo and long before Mercedes,
3 this is back when you didn't have people with
4 employers and insurance in those two counties,
5 right?

6 A: Correct. I mean, there was some question
7 about, you know, can you support a hospital in
8 the middle of some cow pastures. There were
9 some folks on the peninsula that evidently
10 thought HCA was crazy for looking at
11 development, but there was a need. And the
12 reason for the name Trident was it was central
13 to the tri-county area. That location was
14 picked on purpose to be close to as much of the
15 growing population projected over the next 20
16 years as possible.

17 Q: And so there were two struggling hospitals.
18 Did they eventually close?

19 A: Yeah. At the time that Trident Medical Center
20 opened -- received the CON in the early '70s,
21 opened in mid-'70s, '75, those two hospitals
22 were closed. And there was always a commitment
23 by Trident, as well as HCA, to make sure that
24 Dorchester and Berkeley Counties were well
25 supported from a healthcare perspective. There



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ROA_0162

1 were some -- a lot of discussions, it sounds
2 like, back in those times related to, okay,
3 you're closing two hospitals. Are you
4 abandoning these two communities? Absolutely
5 not. We're committed to providing services
6 there into the future. And we've done that.
7 Trident Medical Center was then expanded to
8 another facility, Summerville Medical Center,
9 about seven miles away from Trident in
10 Dorchester County. And we also opened the
11 freestanding emergency department around that
12 same time in Berkeley County.

13 Q: Okay. Talk to me a little bit about the
14 development of that Summerville Hospital. How
15 has it grown and what is your commitment there?

16 A: Well, it started 20 plus years ago as an
17 outpatient center and has grown into a -- for
18 probably the last ten or 15 years has been
19 about a hundred bed hospital. It's just
20 recently expanded to 124 beds. We actually,
21 for a relatively small hospital, see a
22 significant amount of emergency department
23 patients, nearly 70,000 ER patients, annually
24 at that location.

25 Q: Now, in May of 2016 you also got a Certificate



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ROA_0163

1 of Need to build a hospital where?

2 A: In Moncks Corner.

3 Q: Okay. And was that CON hung up in litigation
4 for a while?

5 A: Yeah. I believe that CON was filed in 2008 and
6 the decision was not finalized through the
7 court system until '16.

8 Q: And what's the status of the development of
9 that hospital?

10 A: That hospital currently is in the planning
11 phase. There were some drainage issues that
12 the Army Core of Engineers is reviewing. We're
13 waiting for a final decision from them to
14 proceed with that development.

15 Q: Okay. Let's talk a little bit about your
16 market. We'll just go ahead and just use this
17 slide if you will. But explain to The Court
18 what you consider to be Trident's market.

19 A: Well, we actually receive 80 percent of our
20 patients from Dorchester and Berkeley Counties.

21 So, the majority of that yellow area, the big
22 -- the larger yellow area makes up Dorchester
23 and Berkeley County. A smaller amount from the
24 Charleston county area as well as Colleton,
25 which makes up that smaller yellow graphic.



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ROA_0164

1 Q: Does HCA also have a hospital in Colleton?

2 A: We do, Walterboro. We have a hospital in
3 Walterboro, Colleton Medical Center.

4 Q: Okay. So, you get tertiary care referrals that
5 come over from there?

6 A: Yes.

7 Q: Okay. Explain to The Court the nature of
8 Trident proper tertiary care, the types of
9 things that are now available there in terms of
10 services.

11 A: Yeah. Trident Medical Center is the larger of
12 our two hospitals and it does service as the
13 tertiary of our health system. We actually
14 have most services that you would expect to see
15 in a larger community hospital, but we also
16 have added recently trauma services. So, we're
17 a Level II trauma center that we added in 2015.
18 We also operate 17 behavioral health beds there
19 as well. But advanced cardiac services makes
20 up the largest service line that we see, as
21 well as other surgical service lines in
22 addition to oncology that we're talking about
23 today.

24 Q: So, you have open heart, neurosurgery, all of
25 the things you would expect in a tertiary care



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ROA_0165

1 facility?

2 A: Correct. Yeah. Short of transplant services,
3 we are able to provide significant care to
4 almost all of our patients.

5 Q: Okay. Let's talk a little bit about radiation
6 oncology, because you indicated that you had
7 that service as part of your tertiary services
8 that are provided. Explain to The Court how
9 your system is set up, what you have in the way
10 of linear accelerators and how they operate.

11 A: Yeah. If I look at our oncology service, one
12 of our primary services is radiation oncology.
13 We have a radiation treatment center, a cancer
14 center, with three linear accelerators. We
15 provided about 11,000 patient treatments in the
16 past year, actually a little bit greater than
17 that. We have an oncology floor where we treat
18 inpatients. And we have a service line
19 meetings where we're able to plan services in
20 the future as well as improve our current level
21 of oncology services. We have a multi-
22 disciplinary approach to many of our different
23 services within oncology. Breast care is one
24 of those that we're particularly proud of in
25 how we care for those patients. Trying to



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ROA_0166

1 bring the physicians to the patient as opposed
2 to having patients have to travel around and
3 have to coordinate multiple appointments.

4 Q: So, is that similar to the multi-disciplinary
5 approach that was explained by MUSC?

6 A: I don't know exactly how they do it, but it
7 sounds very similar. Yes.

8 Q: When you're looking at your overall commitment,
9 obviously there are some service lines that
10 make more money than others, and you've
11 explained how you've gone out both into
12 Summerville and up into Berkeley County with
13 expanded services. Have you also just been
14 approved for a new behavioral health service?

15 A: We have. We have a Certificate of Need to
16 expand our behavioral health service. It will
17 be close to our campus. And we hope to develop
18 a 60-bed freestanding hospital as part of that
19 project.

20 Q: Would you agree with me that that's not exactly
21 high margin work?

22 A: No. No, not at all. It ranks as one of our
23 lower profitability service lines.

24 Q: Why is it important -- when you look at all of
25 the service lines that you have and then



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ROA_0167

1 hundreds of millions of dollars of investment
2 that you've made, why is it important for you
3 to protect your investment, for example, in
4 oncology?

5 A: Well, we feel like we have a responsibility to
6 the service area to provide high quality and
7 complete services. And what I mean by complete
8 services is a large breadth of services, not
9 just try and provide those services that only
10 provide money to the bottom line. It's
11 important for us to be a complete provider of
12 services. That's part of our mission, part of
13 our commitment we made back in the early '70s
14 to this community. And oncology is one of
15 those areas that completes our health system
16 from a service line perspective.

17 Q: If you would please, let's turn our attention
18 to this project, which is, as we've heard, is
19 going to be located at that red dot is near the
20 Nexton development. And that's going to be the
21 project we're here talking about today, right?

22 A: Correct.

23 Q: That's the oncology program. That H is your
24 Trident Medical Center. And then the green is
25 Roper's new hospital; is that correct?



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ROA_0168

1 A: Correct.

2 Q: And Roper has also been approved for a brand
3 new linear accelerator as well, right?

4 A: Yes.

5 Q: Explain to The Court why your system is opposed
6 to this project that MUSC is trying to build.

7 A: Well, we -- the bottom line is we don't think
8 there is a community need. On top of that, the
9 thresholds for individual facility need for
10 radiation oncology we don't believe were met.
11 When I look at the number of treatments in the
12 market, it's really quite amazing, given the
13 growth that we've had in the greater Charleston
14 area where we see significant growth in a lot
15 of different areas, we don't see any growth in
16 radiation cancer treatment procedures. And I
17 think that is somewhat surprising, but given
18 the efficiency by which the technology and the
19 treatment protocols have been improved, you're
20 seeing less treatments per patient. So, very,
21 very stable market, 45, 46,000 total treatments
22 over the past year. And ten years ago it was
23 very, very similar to that with very little
24 growth. In fact, some decline in some of those
25 periods.



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ROA_0169

1 Q: And did you see the various numbers that MUSC's
2 attorneys were putting up in terms of their
3 total number of treatments?

4 A: Yes.

5 Q: Those were pretty static, weren't they?

6 A: Yeah, very stable.

7 MR. WESTBROOK: Objection, leading. I haven't --
8 that's -- all I'm saying is, there's been a
9 number of leading questions I haven't objected
10 to. If I'm granted the same latitude, it's
11 okay. I just don't want to ---

12 MR. SUMMER: I can rephrase the question.

13 THE COURT: All right. I'm going to sustain the
14 objection to the point that ---

15 Q: When you look across the service area, which is
16 the four counties, and you look at other
17 providers, what do you notice in terms of the
18 volumes over the years?

19 A: Well, as I said, you see about 46,000 total
20 treatments with three different providers,
21 primarily making up that 46,000. We have
22 11,000 treatments that we provided and that's
23 remained relatively stable. Roper has actually
24 increased the number of treatments -- their
25 treatments have increased slightly. And we see



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ROA_0170

1 -- some of the data I saw, saw a decline in the
2 Medical University. Keep in mind Medical
3 University is twice the size of our program in
4 terms of overall volume.

5 Q: From your perspective at Trident, do you
6 believe that the project at MUSC complies with
7 the State Health Plan?

8 **MR. WESTBROOK:** Objection. This is not an expert.
9 He's not a health planner. He hasn't been
10 designated as an expert. That calls for an
11 opinion that requires special knowledge and
12 expertise and he doesn't have it.

13 **THE COURT:** I sustain that objection.

14 **MR. SUMMER:** Okay.

15 Q: Do me a favor. Let's look at the State Health
16 Plan. And let's look specifically at -- that's
17 going to be in the joint exhibit book that
18 should be right there. See it? It's going to
19 be Joint Exhibit Number 5.

20 **(Joint Exhibit Number 5 was introduced into the**
21 **record at this time.)**

22 Q: I'm not going to walk you through this
23 document, but what I want to ask you is, is as
24 a hospital administrator, what familiarity do
25 you have with the South Carolina State Health



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ROA_0171

1 Plan?

2 A: A fair amount of familiarity. I certainly have
3 referenced it several times in relation to some
4 of our projects as well as others' projects.

5 Q: Okay. Is it a document you use to make
6 decisions about your hospital?

7 A: Absolutely.

8 Q: Okay. Is it a document that you routinely rely
9 upon?

10 A: Yes.

11 Q: What is your understanding about when you want
12 to go do a project; does it have to be
13 consistent with the Plan?

14 A: It does.

15 Q: All right. Let's talk a little bit about
16 community need. Specifically from your
17 knowledge of -- and you just talked about the
18 volumes in which you do. Do you see a
19 community need for additional linear
20 accelerators?

21 **MR. WESTBROOK:** Objection. Same objection as
22 before. He's trying to sneak in an expert
23 opinion by a guy who's not been designated as
24 an expert. The fact that he's -- listen, I'm
25 familiar with the State Health Plan, but I'm



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ROA_0172

1 sure not an expert on health planning. There's
2 no foundation that he has this level of
3 expertise. He hasn't been offered as an
4 expert. And this requires special knowledge to
5 offer an opinion on need.

6 **MR. SUMMER:** Your Honor, I'd like to respond to that
7 if I could. I think it's important for The
8 Court to understand why we're here today. This
9 is the chief executive officer of the System
10 that's opposing MUSC. And I think it's
11 important for -- at least from his decision-
12 making process, to talk about why his facility
13 is opposed. So, it doesn't go so much as to
14 expertise, but it does go to the very heart of
15 why we're here. And he should be -- you know,
16 under Rule 701, as a lay witness, he ought to
17 be able to talk about things that are within
18 his knowledge in doing his job.

19 **MR. WESTBROOK:** If I could respond. Rule 701, I've
20 got it right here. I'm not going to read the
21 whole thing. But for lay witness you're
22 limited to opinions or inferences which are --
23 there are three criteria. You've got to meet
24 all three. And the last one says do not
25 require special knowledge, skill, experience or



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ROA_0173

1 training. What he's asking requires that kind
2 of specialized knowledge. That's why Mr.
3 Sullivan, his expert, is here. Mr. Sullivan
4 can give all the opinions he wants about
5 whether they meet community need criteria.
6 That's why our health planner, Mr. Levitt, is
7 here. These are the guys that offer opinions.
8 Now, he can say I don't like it, because it's
9 going into my service area or whatever he wants
10 to say. But he can't give an opinion about
11 whether it meets a criteria or what his ideas
12 about community need are under the State Health
13 Plan.

14 **THE COURT:** Anything further, Mr. Summer? Any
15 response to that?

16 **MR. SUMMER:** Your Honor, I think what I'm going to
17 do is back up and just talk to him generally
18 about his opposition to the project, let him
19 enumerate why he ---

20 **THE COURT:** I think he could probably do that for a
21 little bit here too. So, we will sustain that
22 objection.

23 **Q:** So, when you -- based on your knowledge of the
24 State Health Plan and as an administrator, what
25 motivated your system to oppose this project?



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ROA_0174

1 A: Well, right out of the gate it was the initial
2 threshold of 80 percent was concerning. And
3 then looking at the community need and
4 distribution of radiation cancer treatment
5 options, there was concern there as well. So,
6 we looked at that stable market where we were
7 not seeing an increase in total radiation
8 treatment procedures in the tri-county area.
9 We also know that Roper St. Francis will be
10 operating -- opening up and operating a new
11 linear accelerator in the very near future.
12 So, adding a fourth linear accelerator in the
13 north area was a concern of ours. And to think
14 about a fifth one coming up even closer to
15 Trident Medical Center from a distribution of
16 linacs did not make sense.

17 MR. SUMMER: Put that map back up please.

18 Q: You talked about distribution and the proximity
19 of these various things to each other. From
20 your perspective, what adverse impact are you
21 worried about, first at Trident and then on the
22 community at large with adding yet again
23 another linear accelerator?

24 A: Well, as I said earlier, we operate the
25 smallest of the three radiation cancer centers.



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ROA_0175

1 We have three linear
2 accelerators currently performing about 11,000
3 procedures. Medical University's program
4 that's twice our size. And as they potentially
5 are able to add another linear accelerator,
6 they're frankly going to take some of our
7 patients that we're currently treating and
8 really not improving the access in any way,
9 since they're only about ten minutes away.
10 Their proposed location is only about ten
11 minutes away from ours. So, you know, we
12 certainly are concerned about our ability to
13 treat similar numbers of patients in the future
14 and concerned about staff as well as our
15 stability that we've had and our three
16 radiation oncologists, will they also have
17 enough patients to take care of for the future.

18 Q: Let's talk about where they're going to locate
19 this proposed project. You've heard it's going
20 to be a Nexton project. Who is developing the
21 building where this is going to be?

22 A: The healthcare campus is being developed and
23 overseen by Palmetto Primary Care.

24 Q: Can you explain to The Court who Palmetto
25 Primary Care is?



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ROA_0176

1 A: Palmetto Primary Care is a large multi-
2 specialty physician group, independent
3 physician group, in Greater Charleston area.
4 They have approximately 100 providers in their
5 group. And they have been given the exclusive
6 right to develop Nexton from a healthcare
7 perspective.

8 Q: So, will MUSC be leasing from Palmetto Primary
9 Care?

10 A: Correct.

11 Q: Okay. Have you looked at leasing any space up
12 there in the same building?

13 A: We have. Now, as I understand it, Medical
14 University's space for radiation oncology is
15 right next door to Palmetto Primary Care's main
16 medical office building. And both MUSC and
17 Trident have looked at leasing space in that
18 building.

19 Q: Have you had any restrictions placed on you in
20 terms of what kind of physicians you can put up
21 there?

22 A: Well, yes. Absolutely. We've been told by
23 Palmetto Primary Care and the developer that
24 there are certain ---

25 MR. WESTBROOK: Objection. Hearsay.



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ROA_0177

1 THE COURT: Sustained.

2 MR. SUMMER: Well, I could probably get it in with a
3 business record if I have to. I beg The
4 Court's indulgence.

5 Q: What, if any, exclusivity does MUSC have as the
6 types of physicians that can be put in that
7 building?

8 MR. WESTBROOK: I'm going to object to that as far
9 as a foundation. How does he know what --
10 what's the basis for him knowing what MUSC's
11 exclusivity rights are, under what?

12 MR. SUMMER: I'll try and lay the foundation, Your
13 Honor.

14 Q: In attempting to negotiate leases from Palmetto
15 Primary Care, what, if any, restrictions have
16 been placed upon you in what physicians you're
17 going to be allowed to put there?

18 A: There are certain specialties that we've
19 requested to occupy the space that we're going
20 to lease at the medical office building
21 developed by Palmetto Primary Care. And some
22 of those specialties have been allowed, will be
23 allowed, and some of those specialties will not
24 be allowed. As we understand it, the Medical
25 University has an exclusive on those



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ROA_0178

1 specialties that aren't allowed.

2 **MR. WESTBROOK:** Objection. Look, again, what's the
3 basis of his supposedly factual testimony here?
4 Is this coming from a document that we haven't
5 seen that hasn't been produced? I haven't seen
6 anything like this. This is the first I've
7 heard of any of this. What is -- is it based
8 on -- if it's based on what somebody told him,
9 which is what he started to say a minute ago,
10 then it's hearsay. If it's based on a
11 document, then let me see the document.
12 There's been no foundation that he knows what
13 he's talking about. I mean, maybe he does,
14 but, I mean, we haven't heard it.

15 **MR. SUMMER:** Go back and ask a series of questions
16 to try to lay a foundation, if that pleases The
17 Court.

18 **THE COURT:** Okay.

19 **Q:** In your role as CEO of the System, do you
20 oversee the leasing of space and the location
21 of physicians that are employed by ---

22 **A:** Yes. I would have to approve that.

23 **Q:** Okay. And in that role have you been presented
24 with information from Palmetto Primary Care
25 regarding the exclusivity arrangement that it



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ROA_0179

1 has with MUSC?

2 A: Yes.

3 MR. WESTBROOK: Objection. Again, he's been
4 presented information. We don't know -- is this
5 verbal information? That's what he tried to
6 say at the beginning.

7 THE COURT: All right. Let me short circuit this a
8 little bit. Mr. Gallati has testified that --
9 as I understand it, he's testified that they've
10 attempted to negotiate placement of physicians.
11 Some categories of specialty have been allowed.
12 Some categories of specialty have not been
13 allowed. I don't know that he knows why that's
14 happened. He does know that it has happened.

15 MR. WESTBROOK: Correct, Your Honor. And if he was
16 just testifying about what's allowed for
17 Trident, I wouldn't have an objection. But
18 he's testifying on the basis of what knowledge
19 ---

20 THE COURT: That's why I want to short circuit it. I
21 think, Mr. Summer, that he can testify about
22 what he's tried to do, what has been allowed,
23 what has not been allowed. What he doesn't
24 necessarily know is why it hasn't been allowed
25 or what agreements there may be with other



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ROA_0180

1 folks that would cause them not to allow.

2 Q: Let me ask you another question about
3 specifically Trident and what's been allowed.
4 Would Trident be allowed to place oncologists
5 in that building?

6 A: I would have to look at the list of -- the
7 latest list that Palmetto Primary Care
8 presented to us on what would be allowed to
9 answer that question.

10 Q: What is your concern about the alliance, if you
11 will, between Palmetto Primary Care and MUSC
12 with this project?

13 A: Well, the alliance potentially creates a shift
14 in referrals to the Medical University, to
15 other parties. So, we certainly have been
16 interested in the development of that building
17 as well as other parties.

18 Q: When you think of the potential adverse impact
19 that this project may have on your program, why
20 is that affiliation with Palmetto of concern to
21 you?

22 A: Palmetto Primary Care has been one of our major
23 referral sources for many, many years within
24 Trident Health. They are an independent group
25 not affiliated with any facility. But because



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ROA_0181

1 of our location and our relationship with them,
2 they've referred to Trident Health facilities
3 over the years significantly and less to other
4 health systems. So, I'm concerned about the
5 future relationship between the Medical
6 University and Palmetto Primary Care in terms
7 of those referrals.

8 Q: You've heard the argument that's been made that
9 this is just to take care of the MUSC patients
10 in the marketplace. Does this alliance with
11 Palmetto Primary Care cause you to question
12 that?

13 A: Yes. My belief is these patients would be --
14 in a large extent would be new patients to the
15 Medical University, new referral relationships
16 leading to new patients.

17 Q: There has also been reference that, you know,
18 flooding is such a huge problem downtown.

19 **MR. WESTBROOK:** Objection. Mischaracterization. I
20 don't recall saying in my opening remark that
21 it was a huge problem. I said occasionally.
22 I don't think there's been any evidence that
23 it's been a huge problem.

24 Q: Did you hear the opening remarks by MUSC's
25 counsel?



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ROA_0182

1 A: Yes.

2 Q: And did you hear referencing to flooding as
3 being a reason why they need a linear
4 accelerator in the north area?

5 A: I heard that brought up several times.

6 Q: Okay. What's been your experience -- with that
7 argument, let's take NICU for example. When
8 your facility attempted to get NICU beds and
9 talked about the difficulties of getting on the
10 peninsula and flooding, what was the reaction
11 from Medical University?

12 A: Well, one of the arguments we made in trying to
13 expand our NICU services was that there would
14 be better access to care. The patients
15 frequently have to travel from Trident or
16 Summerville Medical Center, the patient's
17 family members, to see the patients that are
18 being cared for at the Medical University.
19 That access was not deemed -- we had heard from
20 patient families that that was not convenient
21 for them and that sometimes there was flooding
22 concerns downtown and other parking concerns
23 and it wasn't convenient. The Medical
24 University argued that that was not the case
25 and it wasn't a problem. In fact they tout



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ROA_0183

1 that over a million patients are served on the
2 peninsula at the medical university and that's
3 touted by their public relations.

4 Q: Talk to me a little bit -- we're going to turn
5 our attention -- well, before we leave adverse
6 impact, there's one sentence I want you to look
7 at in the State Health Plan. If you'll look at
8 that Joint Number 5. And there should be a
9 sentence there dealing with adverse impact and
10 accessibility. And that's on page Roman
11 Numeral IX-6 in the Joint Exhibit Number 5. Do
12 you see that at the end of the importance of
13 review criteria? What's that sentence say?

14 A: The benefits of improved accessibility will be
15 equally weighted with the adverse effects of
16 duplication in evaluating CON applications for
17 this service.

18 Q: Okay. From your perspective, what does that
19 mean?

20 **MR. WESTBROOK:** Objection. He can't testify as to
21 what that means. -- Again, he's not an expert.
22 He can't give -- first of all, he doesn't know
23 what it means. He could give his opinion if he
24 was an expert, but he's not.

25 Q: Do you believe MUSC's project is consistent



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ROA_0184

1 with that statement?

2 A: I do not.

3 Q: Why?

4 A: I think, as I stated earlier, the compliance
5 with need is certainly questionable with
6 meeting the 80 percent threshold as well as the
7 community need documentation that shows a very
8 stable market with little to no increases, in
9 some cases by certain competitors decreases of
10 radiation oncology treatments.

11 Q: So, it's likely there's going to be an adverse
12 effect on other providers, right?

13 **MR. WESTBROOK:** Objection. Leading.

14 **THE COURT:** I think so. Sustain that.

15 Q: Would you expect there to be an adverse effect
16 on other providers with the addition of this
17 new linear accelerator on the market?

18 **MR. WESTBROOK:** Objection. Not an expert. Can't
19 give an opinion on adverse impact on other
20 providers.

21 **MR. SUMMER:** I can rephrase it.

22 Q: Would you expect there to be an adverse effect
23 on your facility because of the addition of a
24 new linac in the market?

25 A: Yes. As I stated earlier, going from three



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ROA_0185

1 linear accelerators to perhaps five in the
2 north area is going to have a detrimental
3 effect on Trident Health's radiation oncology
4 program.

5 Q: Let's put this into context, because there are
6 not one new one that DHEC approved. They
7 actually approved how many?

8 A: Two.

9 Q: And who got the other one?

10 A: Roper St. Francis at their Berkeley Hospital
11 was awarded a CON and will be opening their
12 service later this year.

13 Q: Okay. So, you know you're going to have an
14 additional one. Does that make an addition for
15 MUSC more likely to have a greater adverse
16 effect on Trident?

17 A: Yes. Being the smallest of the three programs,
18 we do have the most concern for that impact,
19 negative impact.

20 Q: Now, let's talk a little bit about that Roper
21 project, because we've also heard that referred
22 to -- and I'm assuming we may very well get
23 questions about that. What precipitated your
24 system's decision to withdraw its opposition to
25 the Roper project in exchange for their



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ROA_0186

1 opposition to your freestanding ED?

2 A: Well, I think the most immediate thing that
3 precipitated us withdrawing our concern had to
4 do with the fact that we were talking to them
5 about our freestanding ER in a similar
6 location. And based out of a business
7 decision, we mutually agreed to drop each
8 others', drop the concern over each others'
9 project. But the fact that they are developing
10 their project with some growing volumes over
11 the last five years, developing their project
12 inside of a hospital and it's further into the
13 service area, in other words it's further away
14 from Trident Medical Center, we believe that,
15 if any of them were going to be approved, that
16 had the least impact on us.

17 Q: Okay. You said that it made sense to do it at
18 the hospital. Why?

19 A: Well, though these are outpatients, there is a
20 safety element. A lot of times these patients
21 are quite ill. Sometimes in certain
22 circumstances patients are inpatients that we
23 treat. For palliative care and other reasons,
24 the convenience of having that service inside
25 a hospital is helpful..



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ROA_0187

1 Q: I'm going to ask you to take a look at
2 Trident's Number 55. Let's see if we can find
3 that. It's going to be easy. It's the very
4 last one in this book. Made it easy for us.

5 **(Petitioner's Exhibit Number 55 was introduced into**
6 **the record at this time.)**

7 Q: Trident's Number 55 is a letter from DHEC dated
8 December 22, 2015 denying MUSC its request to
9 put a linear accelerator in the north area.
10 Are you familiar with this decision?

11 A: I am.

12 Q: Okay. And there's several reasons stated. The
13 exhibit speaks for itself. What I want to do
14 is turn your attention over to the second page
15 of that exhibit. At the bottom it says DHEC
16 00018. You see the section that says Community
17 Need Documentation?

18 A: Yes.

19 Q: Okay. The last sentence of that number two,
20 which is one of the reasons DHEC denied them
21 from doing this, as a result, many of the
22 existing units in the service area are already
23 operating well below capacity. Do you see
24 that?

25 A: Yes.



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ROA_0188

1 Q: Is that your understanding of the way things
2 are today?

3 A: Yes.

4 Q: So, if DHEC denied them the ability to add a
5 linear accelerator in December of 2015, why in
6 the world did the Department two years later
7 approve two new ones?

8 MR. WESTBROOK: Objection. He doesn't have a basis
9 for knowing what ---

10 THE COURT: He knows what they did. He doesn't know
11 why. Sustained.

12 Q: Can you think of any reason why it would make
13 sense to add two after you denied one?

14 MR. WESTBROOK: Objection. Calls for speculation.

15 MR. SUMMER: I think he can answer that.

16 THE COURT: He's asking the witness for his mental
17 state. I think he can ask the question. Let's
18 see what he says. So, overruled.

19 Q: Can you think of any reason?

20 A: No. I see a market area. In our market I see
21 the number of procedures staying very, very
22 stable. I don't see why that decision was
23 made.

24 Q: All right. If you would be so kind as to
25 answer any questions that Mr. Westbrook might



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ROA_0189

1 have. Thank you.

2 **MR. GALLATI - CROSS-EXAMINATION BY MR. WESTBROOK:**

3 Q: Mr. Gallati, how are you doing?

4 A: Good. You're not going to ask any leading
5 questions, are you?

6 Q: Well, I'm on cross, so I guess I can. Sorry
7 about that. Seems unfair, doesn't it? Mr.
8 Gallati, you would agree with me -- I'm going
9 to start off with a leading question, I'm
10 afraid. You would agree with me, would you
11 not, that the radiation therapy center that
12 MUSC is proposing in Nexton would improve
13 access for MUSC patients who live in that area;
14 isn't that true?

15 A: Well, I certainly think that they're going to
16 provide some additional convenience. As I said
17 earlier, the Medical University has treated
18 about a million patients on the peninsula in
19 the past year and is actually investing another
20 350 million dollars on the peninsula to expand
21 services. So, there might be some additional
22 convenience. Maybe the amount of meaningful
23 access is the big question.

24 Q: Well, I appreciate that nuance, but let me just
25 see if I can drill down and ask it a little



1 more precisely then. Would you agree with me
2 that this center for residents of Berkeley and
3 Dorchester County, it would improve access for
4 those patients; isn't that true?

5 A: I don't think meaningful access.

6 **MR. WESTBROOK:** Let me ask Mr. Bupp, friend there,
7 to put up -- and, Tammie, do we have Mr.
8 Gallati's deposition?

9 Q: Mr. Gallati, how about open that up for me
10 please. That's the sealed deposition from --
11 you recall when I took that deposition of you
12 in your conference room over there in
13 Charleston, right?

14 A: Yes.

15 Q: Okay. And let me ask you to turn to page 30.

16 **MR. WESTBROOK:** And, Dan, if you would put that up
17 on the screen for us so we can see it.

18 Q: And what I'm going to do is start at line six
19 with the question, which I believe I'm asking.
20 At some point I may get you to read your
21 response. So, question starting on line six.
22 It says, all right. And you would agree with
23 me that it would improve access for residents
24 of Berkeley and Dorchester County who are
25 currently going to MUSC's main hospital for



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ROA_0191

1 services? Mr. Thomas: Object to the form. You
2 can answer. Answer. Would you read your
3 answer into the record please?

4 A: Yes, that would seem to improve access for
5 those patients.

6 Q: You didn't qualify that with the word
7 meaningful at the time, did you?

8 A: It doesn't appear that I did add that nuance,
9 no.

10 Q: Okay. Thank you. Now, you went through with
11 Mr. Summer the various facilities that you have
12 around that area, the north area, North
13 Charleston, Moncks Corner, so forth and so on.
14 And I went a little bit over that in the
15 opening and I think Mr. Summer took you through
16 that with a little more detail. You've also
17 got a pending CON application to build a
18 freestanding emergency department in James
19 Island?

20 A: Correct.

21 Q: That's pretty far from Trident Medical Center,
22 isn't it?

23 A: It's approximately 20 to 25 miles.

24 **MR. WESTBROOK:** Dan, let's put up demonstrative 26
25 on the screen, please. This is not an exhibit.



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ROA_0192

1 This is just a demonstrative. That's all it
2 is.

3 Q: But is this a map -- I'm not going to focus on
4 the mileage at this point. I just want you to
5 look at -- do you see where it says James
6 Island, Trident James Island FED, the yellow
7 circle there? Do you recognize that as being
8 approximately the location on James Island
9 where your freestanding -- or proposed
10 freestanding ED will be?

11 A: Yes.

12 Q: And do you see Trident Medical Center up there
13 with the blue circle up there?

14 A: Yes.

15 Q: And between your proposed freestanding ED and
16 Trident Medical Center, it looks like there are
17 two Roper Hospitals and MUSC's main hospital;
18 is that right?

19 A: Yes.

20 Q: Wouldn't you agree you're closer -- that
21 proposed freestanding ED is closer to the
22 service areas of -- the primary service areas
23 of Roper and MUSC than Trident?

24 A: Yes.

25 Q: What percentage of your patients come from



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ROA_0193

1 James Island right now?

2 A: I would say less than five percent.

3 Q: You were talking earlier in your testimony --

4 **MR. WESTBROOK:** That's fine, Dan, you can take that
5 down.

6 Q: -- about Palmetto Primary Care. Isn't it true
7 that Palmetto Primary Care went first with HCA
8 to offer them space in their Nexton facility --
9 MOB rather, and HCA, the parent company of
10 Trident, turned that down? Isn't that true?

11 A: I don't know who PPCP went to first, but we
12 never turned them down.

13 Q: Okay. So, HCA -- I'm sorry, go ahead.

14 A: We've always been interested in leasing space
15 in that area, in that office building. And, in
16 fact, we will be leasing space in that office
17 area.

18 Q: All right. Let's go back to radiation therapy.
19 That is a profitable service line, isn't it?

20 A: Correct.

21 Q: And population in the service area, in your
22 service area, is growing; is it not?

23 A: Correct.

24 Q: And that's why -- I believe you said that was
25 one of the reasons way back whenever it was in



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ROA_0194

1 the '70s that you put Trident Medical Center,
2 picked that site, was because -- to take
3 advantage of where the population growth would
4 occur; isn't that right?

5 A: HCA as well as community officials appeared to
6 see a need there, yes.

7 Q: Okay. Now, your three machines, your three
8 linear accelerators, until fairly recently --
9 well, let me back up for a second. So, you
10 have a Varian model EX; is that correct?

11 A: Correct.

12 Q: And a Varian TrueBeam?

13 A: Correct.

14 Q: You're getting a second TrueBeam some time in
15 the coming few months; is that right?

16 A: Correct.

17 Q: And you used to have something -- another
18 model, a brand called Synergy Elekta; is that
19 right?

20 A: Correct.

21 Q: And that has been shut down and in fact removed
22 from the premises; is that correct?

23 A: Yes.

24 Q: Okay. And at some point you decided to replace
25 that Synergy Elekta -- which I'm just going to



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ROA_0195

1 refer to as Elekta, if that's okay, just for
2 brevity. You decided to replace that Elekta
3 with this second Varian TrueBeam that's coming
4 in a few months; is that correct?

5 A: Correct.

6 Q: Okay. All right. And you never considered
7 simply not replacing the Elekta, right? You
8 never considered just shutting it down, putting
9 it off and just going with two machines; isn't
10 that correct?

11 A: We kept an eye on the market volumes as well as
12 the use of our current machines for quite some
13 time before we made the decision to replace the
14 Elekta.

15 Q: Okay. But ---

16 A: We ultimately decided to replace it.

17 Q: Right. But my question is, there was never a
18 point in time when you considered not replacing
19 it, just shutting it down and ---

20 A: There were points in time where we considered
21 that. We did not make a decision on that until
22 most recently where we decided to replace it.

23

24 Q: All right. Well, let me ask you to go back to
25 your deposition.



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ROA_0196

1 MR. WESTBROOK: Dan --

2 Q: Maybe I'm mis-remembering what you said, so
3 let's take a look at page 28. And let's go to
4 line 2, top of page 28 I believe it is. And so
5 I'm going to read my question and let you read
6 your answer. The question is, all right. And
7 so if volume is going to at best stay flat and
8 perhaps continue to decrease, did you consider
9 not going with three linear accelerators and
10 just letting -- instead of replacing the
11 Synergy just de-installing it, if there's such
12 a word as de-installing, and going with two?
13 And what was your answer?

14 A: We did not. Did not consider that, no.

15 Q: Okay. So, did you or did you not consider just
16 de-installing or shutting down the Elekta and
17 going on with two?

18 A: We considered all alternatives throughout, you
19 know, the last five years with declining
20 volumes on the Elekta. We ultimately decided
21 to replace it.

22 Q: I understand. I just don't understand why you
23 said you never considered that at your
24 deposition.

25 A: I think until you make a decision, you're



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ROA_0197

1 considering all alternatives.

2 Q: All right. So, just a misunderstanding then by
3 me, I guess. So, the Elekta was a more
4 specialized unit, I believe, than the Varians.
5 And I think the way you described it in your
6 deposition was less user friendly and less
7 efficient than the Varians for general
8 radiation therapy treatments, correct?

9 A: Correct. It was more of a niche-type machine
10 that was used for limited purposes.

11 Q: And I think another reason you stressed that
12 you wanted to replace or needed to replace the
13 Elekta, because it was not a Varian and so it
14 was -- this is my word, not yours, but you can
15 correct me if I'm wrong. It really wasn't as
16 compatible with the Varians as a Varian would
17 be; is that right?

18 A: Correct.

19 Q: Okay. And so the Elekta was shut down in 2015;
20 is that right? If you don't know the date,
21 that's ---

22 A: I don't know the exact date.

23 Q: But it was shut down at some point, it was
24 taken off the premises, and you're getting a
25 new Varian in a few months?



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ROA_0198

1 A: Correct.

2 Q: All right. And at least for the last five or
3 six years, you've only run two machines,
4 correct?

5 A: For the last few -- I would say for the last
6 few years we've essentially only run two
7 machines. I don't know the exact volume on the
8 Elekta.

9 Q: All right. So, you talked about Roper. Mr.
10 Summer asked you some questions about Roper.
11 And originally you opposed Roper and MUSC, then
12 you decided to -- you and Roper got together
13 and one of you didn't oppose the FED, the other
14 one didn't oppose the linear accelerator, and
15 so you're no longer opposing Roper in this
16 case. You're aware, are you not, that Mr.
17 Sullivan, your expert, sent a letter to DHEC
18 saying -- and has testified or will testify
19 that the Roper application was actually weaker
20 than MUSC's; are you aware of that?

21 A: I've seen Mr. Sullivan's letter. Yes.

22 Q: And in fact, isn't it true that Trident, in a
23 petition filed with this Court to start this
24 appeal, accused Roper's application of being
25 disingenuous and manipulating data; isn't that



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ROA_0199

1 correct?

2 A: I don't recall that.

3 Q: Okay. Well, let's get the petition, which is
4 part of this Court record that was filed in
5 this case. You see that headline -- headline,
6 what am I saying -- the caption -- I'm mixing
7 up my media here -- there? And it says
8 Petition for Administrative Review and Request
9 for Contested Case Hearing. You read that?

10 A: Yes.

11 **MR. WESTBROOK:** Let's go to the end, Dan, and see.

12 Q: This is signed by your attorneys, Parker Poe,
13 correct?

14 A: Yes.

15 Q: Attorneys for Petitioner, Trident Medical
16 Center. Let's turn to paragraph 24. Paragraph
17 24. I'll read the first part if you'll read
18 the second. It says, because it knew that it
19 could not meet the State Health Plan standard,
20 Roper manipulated its data by assuming its
21 capacity reduction was retroactive for the
22 previous two years. And the site. What does
23 the last sentence say, Mr. Gallati?

24 A: That statement states, Id. Roper's data
25 manipulation was disingenuous and should not



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ROA_0200

1 have been accepted by the Department.

2 Q: So, that's what your lawyers filed on behalf of
3 your company with this Court; isn't that
4 correct?

5 A: Yes.

6 Q: Okay. Bear with me just a moment, Mr. Gallati.

7 MR. WESTBROOK: No further questions. Thank you.

8 THE COURT: Any Re-Direct?

9 MR. SUMMER: Just a couple. Thank you, Your Honor.

10 MR. GALLATI - REDIRECT EXAMINATION BY MR. SUMMER:

11 Q: I'm going to work my way back. I want to talk
12 a little bit -- and I know that Mr. Clements
13 will probably talk about this as well. But
14 what is the relevance of treatment planning and
15 not having the same machines?

16 A: Well, treatment planning is a big part of
17 radiation cancer treatments. Having similar
18 machines is very important for the
19 effectiveness and efficiency. Not just speed,
20 but also patient safety, being able to perform
21 similar treatments on those patients on
22 alternate machines should one be full or should
23 one not be operating. Having similar
24 technology allows us to have similar treatment
25 protocols.



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ROA_0201

1 Q: So, let me ask you this. If a patient has had
2 a treatment plan done on a Varian machine, if
3 you're running three Varians, can they be
4 treated on any of the three machines?

5 A: In most cases, yes.

6 Q: Okay. Is that true with the Selektä (sic)?

7 A: The Elekta, no.

8 Q: Okay. And so is that one of the reasons why it
9 was so limited in use?

10 A: Yeah... It became obsolete when we started
11 treatment planning on a machine that also had
12 duplication in the department. We had an
13 alternative machine.

14 Q: Again, we can talk to Mr. Clements more about
15 that. Is the Elekta a more specialized
16 machine?

17 A: As I said before, I think it's just more of a
18 -- yes, more of a niche machine, specialized.

19 Q: Let's look at this notion of the freestanding
20 ED on James Island. Are there any hospitals on
21 James Island?

22 A: No. There's no freestanding ERs or hospitals
23 on James Island.

24 Q: Any hospitals on Johns Island?

25 A: No hospitals on Johns Island.



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ROA_0202

1 Q: Okay.

2 A: That's certainly one of the reasons that we
3 believe emergency access was necessary. The
4 amount of physicians as well as emergency and
5 even hospital resources are very limited on
6 James and Johns Island. The nature of
7 emergency departments in relation to a
8 radiation oncology center are very different
9 reasons and need for speed and access to those
10 centers is very different.

11 Q: Is your decision to go to James Island similar
12 to your decision to serve counties like
13 Berkeley and Dorchester that didn't have a
14 hospital?

15 A: Yes.

16 Q: Okay. To the best of your knowledge, is
17 anybody else planning to build a freestanding
18 ED for those folks on James Island?

19 A: No. We're not aware of any activity to develop
20 any emergency services there besides ours.

21 Q: Let's go back to this notion that Roper's data
22 was manipulated and was disingenuous and should
23 not have been accepted by the Department. Did
24 that factor at all into your decision about
25 settling with Roper?



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ROA_0203

1 A: Can you repeat the question?

2 Q: Okay. You were asked to read language from a
3 pleading, which I think may have been the first
4 time you read it, but you were asked to read
5 language from a pleading. Did that language in
6 any way, shape, or form enter into your
7 decision-making process to settle with Roper to
8 build your freestanding ED and to allow them to
9 build the accelerator?

10 A: No. No.. Our decision to settle with Roper
11 was, as I stated, a business decision to allow
12 them to proceed with their project and allow us
13 to proceed with our freestanding ED, which we
14 felt like was very necessary for the community.

15 Q: In your mind, why was that a superior decision
16 as opposed to MUSC's freestanding center?

17 A: Well, the fact that it was further away from
18 Trident and on a hospital -- inside of a
19 hospital, created some belief by us that that
20 was a superior application.

21 Q: Thank you very much. Nothing further.

22 THE COURT: Mr. Gallati, you can retreat to your
23 seat.

24 MR. GALLATI: Thank you.

25 THE COURT: Anybody want to go to lunch?



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ROA_0204

1 MR. THOMAS: I'd love to. I vote for that.

2 THE COURT: All right. It is a little less than a
3 quarter until 1:00. How about let's be back
4 here about 2:00 o'clock. That'd be -- have
5 enough time to get some sustenance?

6 MR. WESTBROOK: Yes, sir. I think that'll work.

7 MR. THOMAS: Thank you.

8 THE COURT: We'll be adjourning until then.

9 (Off the Record)

10 THE COURT: We are back on the record in 17-ALJ-07-
11 0100. And we are ready for our next witness.

12 MR. THOMAS: Your Honor, Trident Medical Center
13 calls Ryan Clements to the stand.

14 COURT REPORTER: Sir, please state and spell your
15 first and last name for me.

16 MR. CLEMENTS: R-Y-A-N, Ryan Clements, C-L-E-M-E-N-
17 T-S.

18 RYAN CLEMENTS, having been duly sworn, testifies as
19 follows:

20 MR. CLEMENTS - DIRECT EXAMINATION BY MR. THOMAS:

21 Q: I ask you to state your name again for the
22 record.

23 A: Ryan Clements.

24 Q: Okay. Where do you live, Mr. Clements?

25 A: In Charleston, South Carolina.



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ROA_0205

1 Q: Are you married?

2 A: Yes.

3 Q: Do you have any kids?

4 A: I do.

5 Q: How many?

6 A: I have three, three girls.

7 Q: Tell The Court what your occupation and your
8 title is.

9 A: I'm the director of the Cancer Center at
10 Trident.

11 Q: And can you describe generally what your duties
12 are?

13 A: So, I -- the Cancer Center actually includes
14 radiation oncology, also we have an outpatient
15 infusion therapy center. And so I actually
16 operate both of those facilities as well as the
17 program itself.

18 Q: And how long have you been the director of the
19 Trident Cancer Center?

20 A: Six years.

21 Q: Okay. Now, as part of your job, are you
22 involved in procuring equipment for Trident's
23 radiation therapy center?

24 A: Yes, I am.

25 Q: Okay. And kind of generally familiar with the



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ROA_0206

1 capabilities of that equipment?

2 A: Absolutely, yes.

3 Q: All right. Are you involved in staffing the
4 radiation
5 therapy center?

6 A: Yes.

7 Q: Okay. In terms of making sure patients get
8 scheduled on a timely manner, does the buck
9 stop with you?

10 A: Yes, it does.

11 Q: Are you generally familiar with the folks on
12 Trident's medical staff, like the physicians
13 who are involved in the treatment of cancer?

14 A: Yes, I am.

15 Q: All right.

16 **MR. THOMAS:** Let's put up Mr. Clement's CD, which is
17 Trident Petitioner Exhibit 3. If I can
18 approach here, Your Honor.

19 **(Petitioner's Exhibit Number 3 was introduced into**
20 **the record at this time.)**

21 Q: You can look on that, but why don't you turn to
22 tab three in here. It may be easier for you to
23 flip through. And I'm not going to ask you,
24 you know, things by, you know, kind of point by
25 point in your resume, but I thought what I



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ROA_0207

1 would ask you is why don't you just kind of
2 describe for The Court your work history from
3 maybe any training you had, education from high
4 school forward.

5 A: High school forward; okay. So, I'm also a
6 radiographer as well. So, I got my associate's
7 degree from Marshall University as a
8 radiographer. At that point I transferred to
9 Savannah, Georgia where I attended Armstrong
10 Atlantic State University. I got my bachelor's
11 degree there, healthcare administration with an
12 emphasis on radiation therapy. From that point
13 I actually moved up to Fredericksburg, Virginia
14 and worked as a radiation therapist there. I
15 actually also went to school to Strayer
16 University, attended -- it's an online school.
17 I got my master's degree in health service
18 administration.

19 Q: And where -- just give The Court a little bit
20 about your work history.

21 A: So, as a radiographer, of course, you know, I
22 worked as a clinical radiographer as well,
23 taking x-rays and things of that nature. And
24 as far as radiation therapy, heavily involved
25 in just treating patients. So, I actually



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ROA_0208

1 operated those linacs, linear accelerators, and
2 things that we've been discussing today for at
3 least four or five years. And then I kind of
4 moved up from that point into the
5 administration role.

6 Q: Sounds good. Let's move to Exhibit P 12,
7 Petitioner's 12, which I think The Court, most
8 of us have seen.

9 **(Petitioner's Exhibit Number 12 was introduced into**
10 **the record at this time.)**

11 Q: And you can -- if you want to look at it in a
12 notebook there, Mr. Clements, it's going to be
13 tab 12 for you, I believe.

14 A: Yes.

15 Q: Okay. Great. All right. You've got it on the
16 screen. I'm not going to ask you much about
17 this, but I just want to ask you, is this an
18 accurate portrayal of where Trident Medical
19 Center and its linacs are located, where it
20 says Trident Medical Center?

21 A: Yes, it is.

22 Q: Is this where generally Trident's primary
23 service area, where most of its radiation
24 therapy patients come from?

25 A: Yes, it is.



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ROA_0209

1 Q: Okay. And the red dot, what does that
2 represent?

3 A: That is the MUSC's proposed location for their
4 linear accelerator.

5 Q: Okay. And how about the green dot?

6 A: The green dot is the Roper St. Francis approved
7 linac that they'll be placing there this year.

8 Q: Okay. If you could for The Court, why don't
9 you just provide kind of a general overview of
10 Trident's cancer program, kind of what it is
11 that you do, kind of in a general sense for
12 now.

13 A: Sure. So, we do have a comprehensive program
14 and we -- that offers radiation oncology as
15 well as outpatient infusion therapy, and we
16 also have an inpatient oncology floor as well.
17 We work with several physicians from a multi-
18 disciplinary approach to cancer care. And
19 basically on a weekly basis we offer a -- we
20 have a tumor board to actually discuss all
21 sites of cancer amongst surgeons, med-oncs, rad
22 oncs, radiologists, pathologists. And we all
23 discuss those cancer cases and what's the best
24 way to proceed treating in taking care of those
25 patients according to NCCN guidelines, so.



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ROA_0210

1 Q: What are NCCN guidelines, kind of ...

2 A: It's a National Comprehensive Cancer Network.
3 It's -- it is the standards, the national
4 standards to take care of cancer patients.

5 Q: Okay.

6 A: Depending on what they have.

7 Q: And you mentioned tumor boards. Is that just
8 kind of a fancy term for when cancer doctors
9 get together to meet about patients?

10 A: Yeah. It's a cancer conference. Some people
11 call it a cancer conference. But, you know, we
12 discuss all their -- actually the patients --
13 the imaging, their pathology, and their current
14 state, and how do we proceed forward with this
15 particular patient.

16 Q: Does Trident have any specific kind of multi-
17 disciplinary clinics?

18 A: Yes, we do. We launched a multi-disciplinary
19 breast cancer program back in 2017. And what
20 that is, is basically, as I believe Todd
21 Gallati stated, is we're bringing the
22 physicians to the actual patient. When the
23 patient comes to the cancer center where
24 they'll see a radiation oncologist, a surgeon,
25 and med onc same day, same location, within 24



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ROA_0211

1 to 48 hours after their diagnosis.

2 Q: Okay. Now, is that -- the tumor board -- I'm
3 going to ask a quick question about the tumor
4 board. The multi-disciplinary clinic you just
5 described, that's different than a tumor board?

6 A: It's still those same physicians coming
7 together, but it's breast specific.

8 Q: Okay.

9 A: The tumor board is actually talking about all
10 cancer cases. So, this multi-disciplinary
11 breast clinic is actually patients diagnosed
12 and they're actually coming to the center and
13 the patient's going to be meeting with all
14 those physicians instead of having to break up
15 their appointments, which increases the amount
16 of time between diagnosis, the treatment, and
17 things of that nature. So, they can get that
18 -- you know, see all of those physicians all in
19 the same location.

20 Q: Okay, good. Take you to Petitioner's 15.

21 ~~(Petitioner's Exhibit Number 15 was introduced into~~
22 ~~the record at this time.)~~

23 Q: Do you recall attending the project review
24 meeting before DHEC in this case -- or in this
25 matter?



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ROA_0212

1 A: I do, yes.

2 Q: Okay.

3 **MR. THOMAS:** Could you go, VickiLynn, to, I think,
4 slide number three if you would.

5 Q: All right. Can you tell the Judge -- first of
6 all, were you involved in creating this slide,
7 Mr. Clements?

8 A: Yes.

9 Q: Okay. Can you tell the judge what's going on
10 here and if there's been any changes to this
11 particular slide since it was presented to DHEC
12 in 2017?

13 A: Sure. The only changes there is the Elekta
14 Synergy S. What's going on on this slide is
15 basically what we offer from a radiation
16 oncology standpoint. We still, of course, have
17 the Varian TrueBeam and we have the 2100EX.
18 The Elekta Synergy S, we are replacing that and
19 basically upgrading that to another TrueBeam.
20 We still offer the brachytherapy, HDR/LDR, and
21 everything else there is the same.

22 Q: Kind of generally can you tell the Judge just
23 generally how a radiation -- or how a linear
24 accelerator works?

25 A: Okay. So, it's just basically like -- just



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ROA_0213

1 like an x-ray machine. X-rays can take
2 pictures and you can see bones and things like
3 that, because of the energy that its produced.
4 From a radiation therapy standpoint it's a
5 thousand times more powerful. So, it is at a
6 therapeutic range. So, we have to be very
7 precise in where we treat and things of that
8 nature, so -- because we're actually -- our
9 intent is to actually kill cancer cells. Now,
10 healthy cells, they can be damaged, but they
11 can repair themselves. Cancer cells cannot.
12 So, that's the only reason that allows us to
13 treat with radiation therapy.

14 Q: Okay. And what is -- just generally again,
15 brachytherapy? What is that?

16 A: So, if you think about a linear accelerator,
17 it's radiation coming from outside into the
18 body. Brachytherapy gets treated from within.
19 So, it's basically a radioactive seed that's
20 housed in actually a little machine and there's
21 catheters that are placed within -- inside the
22 tumor or next to the tumor and the machine
23 actually pushes that seed through that
24 catheter. The seed sits there and radiates
25 from within -- inside out at the tumor. And



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ROA_0214

1 then over a certain amount of time that's
2 determined by the physician and physicist, and
3 they actually retract that seed back into the
4 machine. That's HDR.

5 Q: What's LDR?

6 A: LDR is actually when they actually implant
7 seeds into the actual tumor or -- like for
8 instance prostate seed implants. So, if
9 there's prostate cancer, they would actually
10 put sometimes hundreds of seeds into the
11 prostate. They're about the size of a grain
12 of rice. And that's where they stay. We never
13 retract those back out. So, they actually stay
14 there and radiate. And over time the
15 radioactive seeds diminish and cut by half-
16 lives and things like that, so.

17 Q: Do those set off the metal detectors with TSA?

18 A: We do have to give them a card. We have to
19 give them a card indicated that, yeah.

20 **MR. THOMAS:** Let's go to the next slide there,
21 VickiLynn, of Petitioner 15, number four.

22 Q: Okay. Again this slide, did you create this
23 slide as well?

24 A: Yes.

25 Q: Can you tell the Judge a little bit about the



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ROA_0215

1 slide and what it's describing?

2 A: Okay. So, our linac treatments that we offer,
3 of course, is stereotactic radiosurgery. That
4 is a form of high-dose radiation treatment that
5 is delivered over a very short amount of time.
6 Normal radiation treatments are delivered over
7 multiple treatments. You can get anywhere from
8 30 to 40 treatments. But this is a very highly
9 concentrated dose in a very small area. For
10 stereotactic radiosurgery is usually done in
11 the brain. Stereotactic body radiation therapy
12 is done outside of the brain, typically in the
13 lung, done some livers, and things of that
14 nature. And those treatments are about five
15 treatments. We deliver those in five
16 treatments and the patient's complete.
17 RapidArc is a form of radiation therapy that --
18 if you think about -- we don't deliver all the
19 radiation into one angle, at one site. We have
20 to break up the dose in percentages at
21 different angles. So, RapidArc is a continuous
22 angle as -- you turn the machine on. The
23 machine starts to rotate and deliver radiation
24 at the same time as well as changing the shape
25 of the beam, all is going on at the same time



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ROA_0216

1 dynamically. And what that does is decreases
2 side effects and maximizes the dose to the
3 cancer.

4 Q: Just for the record, does Trident have RapidArc
5 technology on its radiation therapy units?

6 A: Yes, it does.

7 Q: Okay. On which ones?

8 A: On both.

9 Q: Okay. And would that be the Clinac and the
10 TrueBeam?

11 A: Yes, correct. And we will have it on the third
12 when we replace it as well.

13 Q: Okay. And the third one is going to be what?
14 What kind of unit?

15 A: It is a TrueBeam. It will be a TrueBeam.

16 Q: All right.

17 A: A stereotactic TrueBeam.

18 Q: How about what's IMRT/VMAT?

19 A: So, IMRT is intensity-modulated radiation
20 therapy. And it also is similar to RapidArc,
21 but it actually is more at the station. It
22 doesn't have like a -- it doesn't rotate at the
23 same time. It just kind of treats in one area.
24 It changes -- modulates the beam, the shape of
25 the beam, and then moves to a different angle,



1 modulates the beam, moves to a different angle.
2 So, and that's basically the premise around
3 IMRTs.

4 Q: And VMAT?

5 A: Yeah. It's volumetric. It's kind of like the
6 same thing, but they treat at a -- at different
7 angles and in different shapes as well, so they
8 contour the tumor.

9 Q: What about 3D? What does that mean?

10 A: 3D is more for larger things that we're
11 treating, say for breast cancer. So, we're
12 going to -- in order to encompass the entire
13 breast, we usually treat those with usually two
14 beams, one from this angle -- one from the
15 medial angle and one from the lateral angle.
16 And basically it's all designed to miss the
17 heart, lungs, and things of that nature. Just
18 encompass the entire breast tissue.

19 Q: All right. And I want to -- quickly could you
20 go through kind of what this advanced imaging
21 bullet means?

22 A: Sure. So, optical surface monitoring is -- we
23 feel is important for stereotactic
24 radiosurgery. Basically it's these three
25 cameras that are mounted to the ceiling and



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ROA_0218

1 they actually shine a digital fiducial markers
2 that lay across the patient's -- say if we're
3 treating the brain. They actually lay those
4 digital fiducial markers across the patient's
5 face and it detects any kind of a movement. If
6 there's any kind of a movement, the machine
7 will actually shut off. And it actually
8 watches that movement. And we can see that
9 movement dynamically happening and set limits
10 to say, okay, you know, if it gets outside of
11 this tolerance, the machine will pause until we
12 get -- to make sure that patient gets back on
13 target.

14 Q: What's respiratory gating?

15 A: So, that's treating mainly for lung, mainly.
16 Anything that's moving, but mostly lung. So,
17 again we use that OSMS technology to watch the
18 patient's breathing. So, if you imagine a
19 tumor in the lung, as a person takes a deep
20 breath in, that tumor's going to move in a
21 certain direction. And as they exhale, they'll
22 -- exhale, the tumor will move back into the
23 target. So, the OSMS will allow us to keep
24 that tumor in the target area as they're
25 breathing.



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ROA_0219

1 Q: But essentially as a lay person, that means I
2 don't have to hold my breath while I'm getting
3 treated, is that ...

4 A: Correct.

5 Q: Okay. And just -- go ahead, let's finish this
6 one up. What's CBCT/IGRT?

7 A: So, these linear accelerators are now fitted
8 with a actual CT scanner built onto them. So,
9 we can actually take a CT scan of the patient
10 prior to the treatment. We take that image.
11 We match it up to what was planned from a
12 dosimetry team and we can match it up perfectly
13 to ensure that we're treating that patient in
14 the exact same area every day for every
15 treatment.

16 Q: Okay. Thank you. Let's go to the next slide.
17 All right. Tell us a little bit about this
18 slide, the capacity utilization. Did you
19 create this one as well?

20 A: Yes.

21 Q: Okay. Just quickly run through these bullet
22 points, if you would.

23 A: So, we have three linacs. And our current
24 capacity is only allowed -- really is enough
25 for only two linacs. So, there wasn't enough



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ROA_0220

1 for a third linac. So, we -- well, we had a
2 third linac just in case one breaks down. But
3 we have a capacity to treat, you know, well
4 over a hundred patients during our business
5 hours with all three linacs running easily with
6 the technology that we have.

7 Q: Have you had that volume of referrals in order
8 to fire up the third linac, so to speak?

9 A: Not yet, not yet.

10 Q: We'll move on. What's the Sarah Cannon
11 Research -- let me ask you this. Is the --
12 okay, we got it up here. All right. Tell The
13 Court just quickly about these bullet points if
14 you could, Mr. Clements.

15 A: Sure. At Trident we have three radiation
16 oncologists. Of course, there are 20 years of
17 clinical experience. We have Dr. Margaret
18 MacDowell, Dr. Todd Williams, and Dr. William
19 Collins. And they all actually -- they
20 actually all trained at MUSC. And they all
21 participate in our weekly multi-disciplinary
22 cancer conferences. They participate in multi-
23 disciplinary clinics. They're heavily involved
24 in actually developing these clinics. So, we
25 want to collaborate with them on those kind of



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ROA_0221

1 programs. And they're really in tune to --
2 when referrals come in, that they're getting
3 them in within, you know, 24 to 48 hours. Even
4 some -- most often that same day if they can.
5 And they all certainly support NCCN guidelines.
6 And that's how they practice.

7 Q: Is the NCCN guidelines, is that considered
8 somewhat of a gold standard?

9 A: Yes. Yes, it is.

10 Q: What is the Sarah Cannon -- let me ask you
11 this. What accreditation do you have at
12 Trident's radiation therapy center?

13 A: So, our radiation therapy center was accredited
14 by the American College of Radiology, ACR
15 accredited. One of the first in our area to
16 actually achieve that, so.

17 Q: And what does that mean practically, if you are
18 ACR accredited, what does that mean?

19 A: So, ACR has a set of standards that indicates
20 that you meet a certain quality standard. And
21 so we actually approved to them. They came out
22 and surveyed our site, looked at all our
23 policies, all of our standards, and things that
24 we had in place. That actually met their
25 standards and so they certified us as ACR



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ROA_0222

1 accredited.

2 Q: How many -- let me ask you this. What is -- my
3 understanding is Trident is affiliated with
4 something called the Sarah Cannon Research
5 Institute; is that right?

6 A: That's correct.

7 Q: Can you describe for The Court what that is,
8 the Sarah Cannon Research Institute?

9 A: So, the Sarah Cannon Cancer Institute is HCA's
10 oncology resource. So, there is where all the
11 research and things are done to develop
12 programs. And they're actually extending their
13 resources out into the other HCA markets; you
14 know, allowing us to tap into those resources
15 as well. And they actually bring the play book
16 to help us stand up different programs, multi-
17 disciplinary clinics and things of that nature,
18 and any improvements and policies and
19 protocols, they have all that built within
20 Sarah Cannon Cancer Institute. And so we are
21 happy to have that resource.

22 Q: Do you know if they run clinical trials?

23 A: Yes. Yes, they run many clinical trials and
24 molecular profiling and all kind of research-
25 driven initiatives.



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ROA_0223

1 Q: Okay. Now, how is Trident -- is Trident taking
2 advantage of the Sarah Cannon Research
3 Institute resources at this time?

4 A: Yes.

5 Q: Can you give The Court a little bit of color
6 around that and what we're doing there?

7 A: Sure. So, they're -- as of right now we're
8 actually -- they're actually helping us stand
9 up a lung nodule clinic as we as a multi-
10 disciplinary thoracic clinic. So, they're
11 actually bringing the play book to us to say,
12 okay, guys, this is how we typically set these
13 things up. They're, you know, doing any
14 analysis of saying, okay, let's look at the
15 kind of physicians we need to bring to the
16 market and things of that nature, of what the
17 community needs. So, those are the kind of
18 things that they're bringing to the table.

19 Q: Okay. Now, is Trident an NCI program?

20 A: No. No, we're not. You know, those kind of --
21 there's not many in the country that I'm aware
22 of. And it's one of those things where that's
23 more of an academic setting, institutions that
24 actually have those kinds of things. And
25 they're heavy on research and things of that



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ROA_0224

1 nature. So, we're more of a community-based
2 hospital, so we're not NCI accredited. I
3 wouldn't think anyone would really expect us to
4 be.

5 Q: Okay. Does Trident engage in a lot of cancer
6 research on its campus?

7 A: No, not too much. No, not at all. Again,
8 we're not -- it's more of an academic setting.
9 And so we rely on outside resources to tap into
10 that if we need it.

11 Q: Okay. Do you as the director of the Cancer
12 Center have an expectation of your physicians
13 that they're going to use evidence-based
14 medicine?

15 A: Absolutely. Absolutely. So, that's -- they're
16 always referred to -- even in our multi-
17 disciplinary tumor board, they're always
18 referred to according the NCCN Guidelines.
19 That's like the saying in our multi-
20 disciplinary tumor boards, according to NCCN
21 Guidelines, it says X, Y, and Z. This is how
22 we take care of our patient. So, they heavily
23 support operating in that fashion.

24 Q: Do you know how many physicians there are on
25 Trident's medical staff who engage in the



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ROA_0225

1 treatment of cancer patients?

2 A: We have a lot on our medical staff that care of
3 medical -- take care of oncology patients. I
4 couldn't really guess how many, but there is a
5 lot.

6 Q: Do you have gastroenterologists on staff?

7 A: Yes, we do.

8 Q: What type of cancer might they engage in
9 treating?

10 A: More in the colon, colorectal, you know, colon
11 and things of that nature, and pancreatic,
12 things of that nature. So, we have urologists,
13 we have medical oncologists on staff, we have
14 -- drawing a blank here -- thoracic surgeons,
15 things of that nature, so yeah.

16 Q: What about endometrial cancers? Do you have
17 folks on staff that treat that?

18 A: Yes, we do. We actually have OB/GYN oncology
19 surgeon.

20 Q: Okay. And how about for lung cancer? Are
21 there pulmonologists on staff for that?

22 A: Yes. Pulmonologists as well as thoracic
23 surgeons.

24 Q: In terms of the patients who live in -- the
25 residents who live in Berkeley/Dorchester area



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ROA_0226

1 who get treated on a linac downtown or even
2 West Ashley, can Trident offer anything to
3 those type of patients?

4 A: Absolutely. As I stated before, we -- our
5 radiology oncologists are MUSC trained, so it's
6 nothing but typically a phone call from a
7 physician to a physician. They all have cell
8 phones. They all share each other's cell phone
9 numbers. That's typically how referrals come
10 in. They call the physician and say, I have
11 this patient. What do you think about treating
12 him? And then our physician will take down the
13 name and number. Our front office will just
14 call that patient and make an appointment that
15 day or next.

16 Q: Does Trident now get referrals from, say, MUSC
17 and Roper Hospitals?

18 A: A lot from Roper. Roper is one of our second
19 highest referral source. Not as many from
20 MUSC.

21 Q: How many would you guess in a year that you get
22 from MUSC?

23 A: I'd say ---

24 **MR. WESTBROOK:** Object. Calls for speculation.

25 **MR. THOMAS:** I apologize. You got me.



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ROA_0227

1 MR. WESTBROOK: The word guess.

2 Q: On average, Mr. Clements, do you have an idea
3 of how many cancer referrals to the radiation
4 therapy program you would get from MUSC?

5 A: I'd say ten, maybe ten to 15 I would say.

6 Q: Okay. At least in terms of that, have you
7 heard any complaints from the MUSC physicians
8 that have actually referred patients to the
9 radiation therapy center?

10 A: Not at all.

11 Q: Okay. You mentioned Dr. MacDowell, Williams,
12 and Collins. Are these physicians Board
13 Certified in radiation oncology?

14 A: Yes, they are.

15 Q: Does Dr. Williams specialize in anything in
16 particular in the radiation oncology realm?

17 A: Absolutely. And they all treat all sites.

18 Q: When you say all sites, you mean all cancers?

19 A: All cancers. All cancer sites. Dr. Williams,
20 he specializes more in the head and neck and
21 lung. Dr. Collins, he's more of the colon,
22 colorectal and prostate, and Dr. Margaret
23 MacDowell, she specializes more in the GYN,
24 breasts, things of that nature. But they all
25 take care of all cancer sites.



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ROA_0228

- 1 Q: Okay. And I think you mentioned earlier, where
2 did all three of these physicians do their
3 training?
- 4 A: They all trained at MUSC. They trained with
5 Dr. Jenrette.
- 6 Q: Are you kind of familiar -- what would the most
7 common types of cancer, kind of the incident
8 rates on a national basis.
- 9 A: Uh-huh.
- 10 Q: What are those, just to kind of give The Court
11 some kind of flavor of what the most common
12 cancers are out there?
- 13 A: Sure. So, skin is actually the most common.
14 But the most common treatment for that is
15 surgery. So, then you go into breast, lung,
16 prostate, and colon, and then head and neck.
17 So, those are the most common sites there.
- 18 Q: All right. Those are the most common sites
19 that are actually treated via radiation
20 therapy?
- 21 A: That would be breast, lung, colon, colorectal,
22 head and neck, and prostate.
- 23 Q: And Is there a physician -- it seems like you
24 mentioned earlier the radiation oncologist,
25 they actually -- at least one of them



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ROA_0229

1 specializes in each one of those areas,
2 correct?

3 A: Yes, they do.

4 Q: So, do Trident's radiation oncologists treat
5 pancreatic cancer?

6 A: Yes.

7 Q: Okay. How about liver and kidney cancers?

8 A: Yes, we do.

9 Q: Bladder cancers?

10 A: Absolutely, yes.

11 Q: Endometrial GYN cancers?

12 A: Yes.

13 Q: Okay. Is radiation therapy ever used in the
14 treatment of skin cancer?

15 A: Yes, it is.

16 Q: Does Trident provide that service as well?

17 A: We sure do.

18 Q: Okay. Are you aware of anything, you know, in
19 your position as the director of the Cancer
20 Center here, that anything that would prevent
21 an MUSC physician from actually referring to
22 Trident Medical Center's radiation oncologists?

23 A: I am not aware of anything that would prevent
24 them from sending us a patient, not at all.

25 Q: Okay. Do you know of physicians on Trident's



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ROA_0230

1 medical staff -- first of all, does Trident
2 Medical Center employ a lot of cancer
3 physicians that treat cancer?

4 A: We do not. We do not employ a lot of
5 physicians there, but we have a lot more
6 medical staff.

7 Q: That have privileges at the hospital?

8 A: Privileges, yes.

9 Q: Do you know if there are physicians on
10 Trident's medical staff who treat cancer
11 patients and refer them to MUSC's radiation
12 therapy program?

13 A: I would say that probably goes on. Again, the
14 physicians have -- they talk by via cell phone.
15 So, I wouldn't have those numbers, but they
16 would talk just to indicate -- talk through
17 that patient's case to see where is the best
18 place for them to get treated maybe from a
19 convenience standpoint where, if they live
20 downtown, then, yeah, probably should keep them
21 down at MUSC. But if they live up in this
22 area, we have the same type of treatment.

23 **MR. WESTBROOK:** Objection, Your Honor. He's
24 testifying as to hearsay. He's been doing it
25 for the last few sentences. He's talking about



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ROA_0231

1 what these doctors are saying to each other.
2 He's not even a party to the conversation.

3 **MR. THOMAS:** I think in his position as director of
4 the Cancer Center, he knows kind of how the
5 referral networks work in the greater
6 Charleston area. It's part of his job to know
7 that. So, I mean, I think he's just testifying
8 his actual knowledge in his capacity as an
9 administrator.

10 **MR. WESTBROOK:** Well, he may have some way to
11 testify that. There may be a way to get that
12 information out. He may have that knowledge.
13 But he's talking now about what a physician
14 says to another physician, this and the other
15 ---

16 **THE COURT:** I think he's testifying about how it
17 works. I don't know that he's testifying about
18 any particular number of cases even, just how
19 it might work. I think I will allow that.

20 **Q:** Would it be impossible, Mr. Clements, for a
21 Trident radiation oncologist to participate in
22 a multi-disciplinary setting, let's say, you
23 know, to Roper physicians, cancer physicians?

24 **A:** No, not at all. With today's technology,
25 Webex, and FaceTime, and things of that nature,



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ROA_0232

1 it's very easy to attend a multi-disciplinary
2 discussion about a patient's case, which we
3 offer that with our tumor boards now.

4 Q: How do you offer that with a tumor board?

5 A: In our weekly tumor boards we actually have a
6 Webex session set up. There's patients that
7 are on the list and physicians are part of that
8 patient's care, they can actually join in on
9 the conversation via Webex. We have Webex at
10 the moment, conference call.

11 Q: I may have already asked you this, but is the
12 tumor board certified by anybody?

13 A: Yes, it is. Actually in order for --
14 physicians come there, when they attend, they
15 actually get CME credits. So, MUSC actually
16 certifies our tumor board in order for our
17 physicians to get CME credits.

18 Q: Okay. Let's talk about staffing of the
19 radiation therapy program. Can you kind of
20 take us through the type of kind of major staff
21 positions at Trident and, if you can recall,
22 like how many of that particular staff you
23 might have at the radiation therapy center?

24 A: Well, starting at the top, of course we have
25 three radiation oncologists. Next down from



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ROA_0233

1 that id. we have two radiation medical
2 physicists. We also have three dosimetrist.
3 We have six radiation therapists. We have
4 three oncology nurses. And then we have
5 actually two cancer navigators. And also we
6 have three front office -- three of our front
7 office teams.

8 Q: Without getting, you know, too involved with
9 it, can you just briefly describe to The Court
10 what like a physicist does. I've always been
11 fascinated that you got a physicist on staff.

12 A: I think we're all fascinated with what they do.
13 I still am. But their job is actually to
14 calibrate -- insure that the calibration of the
15 treating machines are meeting the standard.
16 And they also QA and check every treatment plan
17 that is created and developed. And they also
18 take part in developing many of the highly
19 specialized treatment plans, as we spoke of,
20 stereotactic radio surgery, SBR -- and
21 stereotactic body radiation therapy. So,
22 that's their job.

23 Q: And Trident engages in SRS and SBRT type of
24 treatments?

25 A: Yes.



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ROA_0234

1 Q: Okay. How about dosimetrists? What does a
2 dosimetrist do?

3 A: So, a dosimetrist, they receive the plan from
4 -- receive the images from the CT, because
5 every patient receives a regular CT scan.

6 Q: Let's go back to that. Why does a patient
7 receive CT scans?

8 A: So, what we do, every patient -- we call it CT
9 simulation. So, every patient goes into the CT
10 scanner. They actually -- before they get
11 scanned, the radiation therapist actually
12 positions that patient just like they would be
13 in the radiation treatment position. So, it's
14 the name CT simulation. They do the scan in
15 that position. Then those images are pushed to
16 the dosimetrist. At that point the radiation
17 oncologist has wrote his prescription of what
18 he wants to treat, what he doesn't want to
19 treat, how much dose does he want to deliver to
20 the target. The dosimetrist takes all of that
21 information and they start working on that --
22 working through developing that treatment plan
23 with all of those criteria to try to meet the
24 dose limits of different organs. And then they
25 call the physician and say, okay, how do you



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ROA_0235

1 like this plan? He'll make some modifications
2 and things of that nature. And signs off after
3 a physicist has checked it.

4 Q: What is a -- I guess you were one, you would be
5 able to tell us. What does a radiation
6 therapist do?

7 A: So we are the administrators of the beam. We
8 actually administer the radiation therapy.
9 So, we take that planning once it's all
10 complete and it's all sent to the machine. We
11 actually set the patient up in the treatment
12 room, in the proper treatment position, line
13 the patient up to the target, and we would do
14 a CT scan, as I stated before, that's built
15 already on the linear accelerator to ensure
16 everything's lined up properly, and we would
17 actually check and make sure all the parameters
18 are correct and actually ---

19 Q: Press the button?

20 A: --- press the button.

21 Q: Somebody's got to do it.

22 A: Yes.

23 Q: And you mentioned you had three oncology RNs.

24 A: Yes.

25 Q: What do they do?



1 A: So, they're -- we have one that's oncology --
2 is our oncology certified nurse, and others,
3 they're all RNs. And their job is to take care
4 of just radiation oncology specific patients.
5 So, their knowledge is -- their knowledge base
6 is specific to oncology patients.

7 Q: Okay. And what about the nurse navigators?
8 You mentioned that. What does a nurse
9 navigator do?

10 A: So, as soon as patients are diagnosed, we want
11 those nurse navigators to connect with those
12 patients. And they stay with that patient from
13 the time they're diagnosed all the way through
14 what we call survivorship. So, they're there
15 to ensure that they're getting all the
16 resources that they need throughout their
17 entire cancer journey and ensuring that they're
18 getting to their appointment, any financial
19 distress, and things like that. They just --
20 they really provide those resources that
21 patient needs throughout their entire journey.

22 Q: Okay. Let's talk a little bit -- this has been
23 raised earlier, but Trident recently got an
24 exemption, I think, for one of the Elekta
25 Synergy. Am I ---



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ROA_0237

1 A: Correct.

2 Q: --- describing that correctly?

3 A: Uh-huh.

4 Q: You know, why did Trident decide to replace the
5 Elekta Synergy unit?

6 A: So, the Elekta Synergy, it had a lot of
7 limitations, from field size to just really a
8 niche-specialized machine, mainly for just
9 stereotactic treatments. We wanted to bring --
10 we always want to bring the best technology to
11 the community, so we're always looking for the
12 next best thing. And when there was an
13 opportunity to replace that machine, --
14 especially now that we have all Varian
15 machines, all Varian EMR system, electronic
16 medical records -- and now we have an
17 opportunity to replace that machine with
18 another Varian machine to provide us with the
19 synergies that we need within our department in
20 redundancy.

21 Q: What do you mean --- you mentioned the term
22 redundancy. What do you mean by that?

23 A: So, when we have all these -- we have enough
24 volume, of course, for two machines. So, if
25 one of them goes down, it's a long day and the



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ROA_0238

1 patients are very inconvenienced if we don't
2 have another solution for them. So, now with
3 three machines we'll have that redundancy with
4 the Varian linac to where, if a machine goes
5 down, it's just easily they could just transfer
6 from one machine to the other machine without
7 any ...

8 Q: So, if you kept the Elekta Synergy -- when did
9 the Elekta Synergy get taken offline to where
10 it was not usable by Trident anymore?

11 A: It was 2015, Q4 -- Q3 of 2015.

12 Q: Is that when you took it offline permanently?

13 A: No. It always stayed online. We even kept the
14 service contracts up on it just in case if we
15 ever -- should ever needed it, the volumes
16 increased enough to where we needed it, it was
17 there. We could always use it, it was just we
18 never had enough volume for all three, so we
19 just -- when the TrueBeam -- when our new
20 TrueBeam turned on, all of those patients moved
21 over there and that's how we operated.

22 Q: When did you get that -- when did Trident get
23 that new TrueBeam that you're talking about?

24 A: 2015 in the Q3.

25 Q: Okay. Has Trident dismantled the Elekta



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ROA_0239

1 Synergy linac unit?

2 A: Yes. We did that about two, three months ago.

3 Q: Okay. But up until that point was it usable if
4 you needed it?

5 A: Yes, it was.

6 Q: Okay.. If you kept the Elekta online, and I'll
7 give you a scenario. If one of the Varian's
8 needed to be serviced or broke down, what would
9 that mean for patient treatment, radiation
10 therapy treatment in your center?

11 A: If we kept the Elekta ---

12 Q: Yeah.. So, if the Elekta was there and you had
13 -- and one of your two Varians went down. what
14 would that mean for a patient?

15 A: So, since it is a -- there's only two -- really
16 two vendors out there, Varian and there's
17 Elekta. And they don't interface too well
18 between the EMR systems, so we have -- Varian
19 also has an EMR system called Aria. And they
20 also have a separate planning system called
21 Eclipse. And it would mean a complete re-plan
22 if the -- in order to move one patient from a
23 Varian machine to an Elekta machine.

24 Q: What would that entail, the re-plan?

25 A: It's many hours of work, basically starting



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ROA_0240

1 from scratch and basically going back to the CT
2 scan that they did earlier and planning the --
3 it's a complete re-plan. It takes several
4 hours for the dosimetrist and physicist to re-
5 plan for that specific machine.

6 Q: Okay.

7 **MR. THOMAS:** VickiLynn, can you call up Exhibit P --
8 Petitioner 9, page 4?

9 **(Petitioner's Exhibit Number 9 was introduced into**
10 **the record at this time.)**

11 Q: Okay. Let's talk a little bit about Trident's
12 volumes on here. In 2010 how many radiotherapy
13 treatments did Trident do on its linac, Mr.
14 Clements?

15 A: 13,300. A little over 13,300.

16 Q: Okay. And then it looks like there's a decline
17 there from 2010 to 2017. In a service area
18 total, what was kind of done -- all treatments
19 in 2010, if you can tell?

20 A: 46,000, a little over 46 -- 46,264.

21 Q: How about 2017?

22 A: 46,000, just over 46,000.

23 Q: Okay. Now, do you know how many Trident
24 treatments were done in 2018 calendar year?

25 A: Yes. It's 12,000 -- it's a little over 12,000.



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ROA_0241

1 Q: Okay.

2 A: Yes.

3 Q: All right. You mentioned some of the
4 treatments earlier like the 2D, the 3D, or the
5 IMRT, SBRT, and SRS, kind of the alphabet soup.
6 Can you tell The Court just about how long some
7 of these take? Like what would be the average
8 time for one of these 2D or 3D treatments, the
9 external beam treatments on the linac, how long
10 does that generally take on average based on
11 your experience?

12 A: So, they're all scheduled in 15-minute time
13 slots except stereotactic radiosurgery, when we
14 do them for the brain, because that is one
15 shot. You get one shot to get that right. Of
16 course we're going to get it right anyway, but
17 it's just -- we take a lot of extra time on
18 stereotactic radiosurgery. So, that could take
19 about a 30-minute time slot, 20 or 30-minute
20 time slots for those kind of patients. But
21 everything else, due to the technology and
22 improvements and efficiency, it's 15-minutes
23 time slots.

24 Q: Okay. And how many hours a day does your
25 radiation therapy center operate or see



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ROA_0242

1 patients? It may operate longer, but how many
2 hours are patients scheduled for?

3 A: Eight hours.

4 Q: Okay. So, if they're in 15-minute increments,
5 is it possible that you could do four per hour
6 per unit?

7 A: Yes.

8 Q: Okay. Any idea how many SBRT treatments
9 Trident's performing annually? Is that
10 something that kind of ...

11 A: Around 170.

12 Q: Okay. And what's Trident's kind of health plan
13 capacity -- the South Carolina Health Plan,
14 what capacity did Trident assign to those three
15 units, if you know?

16 A: Five thousand for the TrueBeam machines. And
17 for the Elekta Synergy it was more like 4,500.

18 Q: Okay. What about the Clinac?

19 A: I believe it was -- I cannot recall. I believe
20 it's 5,000 I want to say.

21 Q: Okay. Now, is the State Health Plan capacity
22 volume for Trident, is that kind of a realistic
23 capacity number?

24 A: No. I don't believe so, just because I think
25 it's outdated. With the technology that's



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ROA_0243

1 improved over the years, we've -- it's become
2 more efficient, much more efficient delivery
3 methods. And so I believe that number is
4 understated.

5 Q: Okay. Based on the fact can do four a day --
6 I mean, four per hour per unit, is that like 32
7 per unit per day essentially on an eight-hour
8 day?

9 A: Yeah.

10 Q: Okay. So, we could do that math and kind of
11 figure that out, couldn't we?

12 A: Yes. Absolutely.

13 Q: Now, did you have a chance to look at MUSC's
14 CON application and the quote for the TrueBeam
15 they have in there?

16 A: Yes, I did.

17 Q: Was there anything in the quote that indicated
18 that at the Nexton Center that MUSC would be
19 offering a service that's not offered at
20 Trident?

21 A: Not at all. Actually I think they -- it looks
22 like they may be offering something less. I
23 don't see that they're offering stereotactic
24 radiosurgery. So, no, they're not offering
25 anything new or anything that we do not have.



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ROA_0244

1 Q: Okay. And do you know if they're going to be
2 doing HDR at the Nexton site?

3 A: No. They are not offering that.

4 Q: Okay. Last question for you. Does Trident
5 participate in patient surveys through Press
6 Ganey for its cancer program?

7 A: Yes, we do.

8 Q: Okay. And where are your scores in terms of
9 patient satisfaction?

10 A: We stay consistently above the 90th percentile
11 on patient satisfaction. So, patients love us
12 and we love our patients, so it's just
13 something we continue to prove every year, so.

14 MR. THOMAS: All right. I've got no further
15 questions for this witness, Your Honor. I'll
16 turn him over to Mr. Westbrook.

17 **MR. CLEMENTS - CROSS-EXAMINATION BY MR. WESTBROOK:**

18 Q: Mr. Clements, how are you doing?

19 A: I'm fine. How are you?

20 Q: Good. Just to be clear, you're not an MD, are
21 you?

22 A: I am not.

23 Q: And I believe you started at Trident in January
24 of 2013; is that right?

25 A: That's correct.



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ROA_0245

1 Q: And at the risk of getting a little laborious
2 in stuff that I think Mr. Thomas did a good job
3 of covering, I'm just going to try to clarify
4 for my mind the three machines that you've had
5 over time and when they came and when they went
6 and that sort of thing. So, let me just see if
7 I have it right. So, when you came in 2013,
8 January of 2013, you had a Varian model EX,
9 which is different than the TrueBeam, right?

10 A: That's correct.

11 Q: And you had this Synergy Elekta that we talked
12 about a good bit, right?

13 A: That's correct.

14 Q: And then in 2015 you installed a Varian
15 TrueBeam and at that time you shut down the
16 Elekta, but kept it on site, correct?

17 A: We didn't shut it down. We just -- we didn't
18 have any patients on it, because it was not
19 enough patients to put on that machine.

20 Q: All right. Bear with me just a second Mr.
21 Clements. Okay. So, at 2015 the Elekta was
22 just there in reserve; is that the right way to
23 put it?

24 A: That's correct.

25 Q: And it was sort of sitting there waiting in



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ROA_0246

1 case either of the other machines were to go
2 down for some reason?

3 A: It was there, yes. Or whether we had an
4 increase in volume, then we could start using
5 it.

6 Q: All right. But neither of the other machines
7 went down, did they?

8 A: No. There were some down times.

9 Q: I guess my question is, did you operate the
10 Elekta during that period of time?

11 A: We tried to avoid it because of the extensive
12 re-planning that was needed. So, when you're
13 talking about downtime, talking about extensive
14 downtime, the machine was down for like a week.
15 When we're talking about downtime, we're
16 talking about it was down for maybe a half a
17 day.

18 Q: So, you never operated the Elekta then?

19 A: No.

20 Q: So, in fact, since 2013, January 2013 when you
21 arrived, you've never operated more than two
22 machines at one time; isn't that correct?

23 A: That's correct.

24 Q: Okay. So, in 2015 is when you got the new
25 TrueBeam; is that right?



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ROA_0247

1 A: Correct.

2 Q: The first TrueBeam, let me put it that way.

3 A: The first one.

4 Q: The first TrueBeam. And then so from 2015 to
5 the present, you've had those three on site,
6 the EX, the Varian EX, the Synergy Elekta, and
7 the TrueBeam, but you've only operated two at
8 a time.

9 A: That's correct.

10 Q: Okay. And then in September 2018, I believe,
11 is when the Elekta was actually removed from
12 the premises, correct?

13 A: That's correct.

14 Q: And so now you have two on site. But in a few
15 months, maybe -- was it next month, March, you
16 are getting a second TrueBeam, what is that?

17 A: That's going to be end of Q1. We should have
18 it by the end of March.

19 Q: Okay.

20 A: It will probably come online in April.

21 Q: All right. Come online in April you hope.

22 A: Uh-huh.

23 Q: And at that time you'll still only operate two?

24 A: That's correct, if volumes permit.

25 Q: And I'm sure you hope someday the volume will



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ROA_0248

1 justify or permit you to operate three, but
2 that's, at this point, some indefinite time in
3 the future, right?

4 A: Correct.

5 Q: Okay. Thank you, Mr. Clements, for walking me
6 through that. Now, let me go back over some of
7 the staffing questions. So, if I understand
8 it, you have three radiation oncologists who
9 have staff privileges, not employed, right?

10 A: Correct, they're contract.

11 Q: They're contract?

12 A: Yeah. They're contract and they're employed --
13 I mean, not employed, sorry. My apology.

14 Q: That's all right.

15 A: Staff privileges.

16 Q: They have staff privileges. They're private
17 practice though, right?

18 A: Correct.

19 Q: Private physician practice, three radiation
20 oncologists. And those three -- each one of
21 them treats all cancer sites?

22 A: That's correct.

23 Q: And they trained at MUSC, right?

24 A: Correct.

25 Q: Back in -- all three of them trained there, it



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ROA_0249

1 would have been the 1980s, 1990s?

2 A: I couldn't guess when, but it was some time
3 back then, yes.

4 Q: We could ask Dr. Williams tomorrow.

5 A: Yes.

6 Q: Okay. So, as far as medical oncologists, same
7 thing, you don't employ any, but you have some
8 with staff privileges, correct?

9 A: Correct.

10 Q: And your go-to group, as I understand it, is a
11 private group called Charleston Cancer Center?

12 A: They are the closest one that's most -- closely
13 aligned with us.

14 Q: All right. And so you use them more frequently
15 than the other group that you use; isn't that
16 correct?

17 **MR. THOMAS:** Object to the -- just the phrasing of
18 the question as using them. I'm not sure
19 that's ---

20 **MR. WESTBROOK:** Let me rephrase that.

21 Q: You more commonly work with the medical
22 oncologists at Charleston Cancer Center than at
23 any other group; is that correct?

24 A: They refer to us the most.

25 Q: They refer to you ---



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ROA_0250

1 A: Yes.

2 Q: --- more often, okay. And they have four
3 medical oncologists and one physician
4 assistant, correct?

5 A: They may have a second physician assistant now,
6 but yes, that's a close accurate number.

7 Q: All right. And there's a second group called
8 Lowcountry that I believe you talked about that
9 you also make referrals to you, but not as much
10 as Charleston Cancer Center; is that right?

11 A: They are our second highest referral.

12 Q: And they have five or six medical oncologists;
13 is that right?

14 A: Yes. It's around five or six, yes.

15 Q: All right. And you don't employ any surgical
16 oncologists, but you also, I believe at the
17 time of your deposition at least, did not know
18 if you had any with staff privileges; is that
19 right?

20 A: Not a surgical -- not that I know of of a
21 surgical oncologist.

22 Q: All right. I know you testified about a
23 colorectal surgeon who does cancer surgery.
24 But that colorectal surgeon does other kinds of
25 surgery, non-cancer surgery as well, correct?



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ROA_0251

1 A: Yes, correct.

2 Q: All right. Now, you talked to Mr. Thomas about
3 the tumor board. You've got one tumor board.
4 It's a general tumor board. It's not focused
5 on any one subspecialty, is it?

6 A: Correct. We focus on all sites.

7 Q: All sites. All right. And it meets once a
8 week, correct?

9 A: Correct.

10 Q: And how long does the meeting last?

11 A: It can last an hour, hour and a half.

12 Q: All right. And at this point in time you have
13 one multi-disciplinary oncology team for breast
14 cancer, correct?

15 A: Correct.

16 Q: And you are working on developing some other
17 multi-specialty oncology teams, but at this
18 point you've only got the one for breast
19 cancer, correct?

20 A: So, we -- for breast cancer, but then we also
21 -- you know, the tumor board is for all sites.

22 Q: I understand the tumor boards for all sites.
23 But in terms of a multi-disciplinary clinical
24 team, or clinic I believe Mr. Thomas referred
25 to it, at this point you just have the breast



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ROA_0252

1 cancer, correct?

2 A: That's correct.

3 Q: All right. You don't do cancer services by
4 telehealth, do you?

5 A: We do not.

6 Q: And let's talk about NCI for a minute. Mr.
7 Thomas asked you a few questions about that.
8 That is a nationally-recognized designation,
9 correct?

10 A: Yes, it is.

11 Q: And that NCI designation is something that you
12 would like to achieve at Trident in the future;
13 isn't that correct?

14 A: It's not our focus, because it's more -- as I
15 stated before, it's more from an academic
16 university research institute. We're more of
17 a community-based hospital, so it's not our
18 focus. That would have to come down from
19 corporate if that would be something that HCA
20 sites would want to achieve. But I haven't
21 heard that.

22 Q: All right. And I understand that distinction
23 and that's why I'm asking. I heard you on your
24 Direct Exam make a distinction from academic
25 and the kind of hospital that you are. But as



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ROA_0253

1 I understand it, that NCI designation is
2 certainly something that you would like to
3 reach for in the future; isn't that correct?

4 A: We haven't discussed it. Again that would take
5 a lot of academic, you know, research and
6 things of that nature that we don't currently
7 have.

8 Q: It would take a lot of resources, wouldn't it?

9 A: You have to just be an academic research
10 facility, an institute. Those are those kinds
11 of places that typically have that.

12 Q: Well, let's go to your deposition for a minute,
13 Mr. Clements. If you will open that up for me
14 and take a look at it and I'll get a page for
15 you in just a second. Mr. Clements, let's turn
16 to page 56.

17 **MR. WESTBROOK:** And, Dan, if you would find page 56.

18 Q: And, Mr. Clements, take a look at starting at
19 line six. And I'm just going to read the
20 question that I asked you at your deposition.

21 I'm sorry. Let me know when you're ready.

22 A: Sorry.

23 Q: No hurry.

24 A: Okay.

25 Q: All right. So, we're on page 56?



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ROA_0254

1 A: Uh-huh (affirmative response).

2 Q: Let's start at line six. I'm going to ask you
3 the question, read it into the record, and then
4 I'm going to ask you to tell me what your
5 answer was. So, the question from me at the
6 deposition was: All right. Okay. Thank you.
7 And now I get to my question. NCI designation,
8 do you have any plans to try to obtain an NCI
9 designation? And what is your answer?

10 A: Not at this time. Certainly something to reach
11 for in the future, but not at this time.

12 Q: Okay. So, my confusion is, when you say in
13 that deposition certainly something to reach
14 for in the future, but it sounds like you're
15 backing off of that now. Is that something you
16 want to reach for or not?

17 A: That would have to come down from corporate,
18 that kind of a designation. So that would be
19 something we would be discussing with Sarah
20 Cannon Cancer Institute and things of that
21 nature to see if they would even want to go in
22 that direction.

23 Q: But at this point in time you're not actively
24 planning towards applying for an NCI
25 designation, are you?



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ROA_0255

1 A: Not at all.

2 Q: Okay. All right. Now, we were talking a
3 moment ago about multi-disciplinary programs.
4 You have the breast cancer multi-disciplinary
5 program we talked about. Now, you don't do
6 that in collaboration with any other hospital;
7 that's internal to Trident; is that correct?

8 A: So, we -- the physicians that's involved in
9 that group is the medical oncologists,
10 radiation oncologists, and the surgeon, so we
11 do collaborate with them.

12 Q: And they are in private practice. They're not
13 employed, right?

14 A: Correct. Surgeon.

15 Q: The surgeon you're talking about -- I'm sorry.
16 I didn't mean to cut you off. Go ahead.

17 A: I'm sorry. The surgeon, they are employed. We
18 do have an employed surgeon that's ---

19 Q: Is that the colorectal surgeon we were talking
20 about?

21 A: Not for breast, no.

22 Q: Okay.

23 A: No worries.

24 Q: And who is that breast surgeon, by the way,
25 that participates on the tumor board?



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ROA_0256

- 1 A: We have a Dr. Litton, Thomas Litton, and a Dr.
2 David Ford.
- 3 Q: And they're both employed by Trident?
- 4 A: Correct.
- 5 Q: Okay. You're not aware, are you, of any
6 patients being treated by any of the three
7 Trident radiation oncologists and at the same
8 time receiving care from oncology specialists
9 outside Trident, are you?
- 10 A: It's a challenging question, because patients
11 come to us for radiation. They may get their
12 chemo at another facility, so that is a form of
13 oncology care.
- 14 Q: Right. Are you currently -- do you have any
15 such patients right now who are currently
16 getting radiation oncology from -- and if you
17 don't know the answer, that's fine -- but that
18 are currently getting radiation oncology at
19 Trident and getting medical oncology or some
20 other kind of oncology treatment at another
21 facility?
- 22 A: Yes. Yes. I mean, medical oncologists
23 typically deliver their chemotherapy within
24 their offices, so.
- 25 Q: And I'm sorry. I should make a distinction.



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ROA_0257

1 I guess my question, to word it better, are you
2 aware of any that are getting radiation
3 oncology at Trident and receiving medical
4 oncology services at the same time or other
5 kind of oncology services from another
6 healthcare facility or hospital? In other
7 words, not a private physician office.

8 A: So, I don't know if I'm stating this correctly,
9 but if you think about Roper, the Lowcountry
10 Hematology Group, they are Roper employed.

11 Q: I see.

12 A: So, of course when they refer patients to us
13 for radiation, they're doing their chemotherapy
14 and things within their office, so I guess you
15 could say that that care is ---

16 Q: All right. I understand. Thank you. Now,
17 with respect to referrals, annual radiation
18 oncology referrals that you get from Roper and
19 MUSC, I think you just testified on Direct that
20 you get a good deal more from Roper than you do
21 MUSC; is that right?

22 A: Correct.

23 Q: And did you not tell me in your deposition that
24 you gave me an estimate of 20 radiation
25 oncology referrals combined from those two



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ROA_0258

1 facilities per year on average?

2 A: Not combined. I would say from one entity, but
3 not combined.

4 Q: Well, I may well have misunderstood you. But
5 let's take a look at your deposition.

6 A: Okay.

7 Q: That was what I had thought you said. Let's
8 take a look at page -- you've got your
9 deposition. Let's take a look at page 16.

10 **MR. WESTBROOK:** And, Dan, if you could stick 16 up
11 there for us, please.

12 Q: Now, what I'm going to -- and I think this is
13 going to spill over to the next page, so we're
14 going to read on page 16 and then at some point
15 we'll need to turn over to page 17. So, let's
16 start on line -- let's start on line 16 on page
17 16 with my question and then we'll go from
18 there. Because this is kind of a long excerpt,
19 I'm just going to read it into the record. You
20 tell me if I misread anything, okay, Mr.
21 Clements? So, starting on line 16 I say: All
22 right. And that would be true for both MUSC
23 and Roper, or would you get more from one or
24 about the same from each of them, you think?
25 Answer: Look at it more as a whole. I



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ROA_0259

1 wouldn't say, you know, 20 from MUSC, 20 from
2 Roper. I would say more as a -- for both.

3 Question: Okay. So, let me make sure I
4 understand you. Are you saying that it would
5 be, then, combined 20 for both of them or about
6 40 from both of them? And the answer on the
7 next page is, answer: Right, combined, yeah.

8 Question: Okay. So, like ten from one and ten
9 from the other to combine to a sum around 20 or
10 so? Answer: Estimation. So, am I misreading
11 that or misunderstanding that? I thought you
12 were estimating that you got 20 combined from
13 Roper and MUSC combined, 20 per year. Is that
14 not what you intended to say?

15 A: No. That is not what I intended to say. I
16 would say 20 from MUSC, but it's a lot more
17 from Roper.

18 Q: Okay. How many from Roper do you get on
19 average during a year?

20 A: I would have to look back at that number.

21 Q: Okay. You don't -- I don't want you to guess,
22 because I'll get an objection from my friend
23 over there.

24 A: Yeah.

25 Q: But can you make a reasonable estimate at this



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ROA_0260

1 point in time or not? If you can't, that's
2 fine.

3 A: Not at this time.

4 Q: Okay. All right. And I believe you testified
5 on Direct you estimated you get ten or 15 from
6 MUSC per year; is that right?

7 A: Uh-huh (affirmative response).

8 Q: Okay. Now, Trident refers, I believe, you tell
9 me, again this is an estimate, less than ten
10 radiation oncology patients a year to MUSC.
11 Does that sound right to you?

12 A: That's an estimation.

13 Q: Yeah, of course.

14 A: Yes. That's just an estimation. I only know
15 -- I mean, I would have to speak to the
16 physicians, because, again, it's a physician-
17 to-physician conversation. And, you know, that
18 very well may be, so.

19 Q: All right. But, again -- and we can look it up
20 if you need to, but I think -- again,
21 understanding this is an estimation.

22 A: Sure.

23 Q: I'm not trying to hold you to an exact number.

24 A: Sure.

25 Q: But your best estimate at your deposition was



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ROA_0261

1 less than ten per year. Does that sound right?

2 A: Yes.

3 Q: All right. Hold on just a minute, Mr.
4 Clements. If you could bear with me just a
5 second, please.

6 A: Sure.

7 Q: No further questions. Thank you.

8 **MR. CLEMENTS - REDIRECT EXAMINATION BY MR. THOMAS:**

9 Q: I've got a couple of Re-Directs. Mr. Westbrook
10 just asked you about the number of referrals
11 that MUSC sent down. At the time of your
12 deposition, did you have that number, you know,
13 ready to go or report or anything like that?

14 A: I did not.

15 Q: Okay. And in their application MUSC represents
16 that they're going to do about 210 patients at
17 the Nexton Cancer Center of 3800 treatments, I
18 think. Would Trident have the ability to
19 absorb that many referrals from MUSC if they
20 were to do it?

21 A: I would say double that.

22 Q: Okay. And in terms of -- I know Mr. Westbrook
23 asked you at your deposition about this idea of
24 referrals from Trident down to MUSC. But does
25 Trident Medical Center make a referral to MUSC?



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ROA_0262

1 A: That's something that I would -- you know, I
2 would speak to the physicians about. Again,
3 that's a physician-to-physician conversation.
4 They may have, just dependent on where the
5 patient lives. But not because of a quality
6 issue or anything like that.

7 Q: And can Trident, is it even possible for
8 Trident to track what private practitioners on
9 the medical staff are referring down to MUSC?

10 A: That would be very difficult to track just
11 because it's more of a phone call conversation
12 and that's nothing that's entered into the
13 system that you can just pull.

14 Q: Okay.

15 **MR. THOMAS:** That's all the questions I have, Your
16 Honor. At this time I would like to ask The
17 Court to release Mr. Clements as a witness in
18 this case.

19 **THE COURT:** Mr. Westbrook, do you have any
20 objection?

21 **MR. WESTBROOK:** No objection.

22 **THE COURT:** Mr. Clements, thank you, sir, for being
23 with us.

24 **MR. CLEMENTS:** Thank you.

25 **THE COURT:** I can you can -- you are free to leave.



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ROA_0263

1 MR. CLEMENTS: Thank you so much. Thank you, Your
2 Honor.

3 MR. THOMAS: That's all the witnesses I have for
4 today, Your Honor. I think we're starting in
5 the morning with my radiation oncology expert,
6 Dr. Williams.

7 THE COURT: Okay. Now, is there any interest in
8 starting a little bit earlier tomorrow?

9 MR. THOMAS: My problem is, Your Honor, is that he's
10 ---

11 THE COURT: He's coming from ---

12 MR. THOMAS: I don't know that he's coming from
13 Charleston. I think he's coming from Newberry,
14 though. He's staying with his parents. And I
15 need a little bit of time in the morning with
16 him, if possible.

17 THE COURT: Okay. That's fine. I just ...

18 MR. THOMAS: Dr. Cawley I'm glad to start at 9:00.

19 THE COURT: All right. We'll be at -- close for
20 today and we'll reconvene at 10:00 o'clock
21 tomorrow morning.

22 (Monday, January 14, 2019 ended at 3:16 p.m. and
23 reconvened on Tuesday, January 15, 2019 at 10:04
24 a.m.)

25 THE COURT: We're back on the record this morning in



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ROA_0264

1 case number 17-ALJ-017 -- 07 I think it is --
2 17-0100 (sic). And, Mr. Thomas, I believe you
3 are on deck again.

4 **MR. THOMAS:** Yes, sir. Trident Medical Center would
5 call its next witness, Todd Williams, M.D. to
6 the stand. And just, Your Honor, you'll see a
7 new face back here for Trident. That's Ms.
8 Caitlyn Bobo. She is the director of support
9 operations for Trident. She's our client
10 representative today. I think she -- you were
11 here for some of the diagnostic CAT trial we
12 did back in June.

13 **COURT REPORTER:** Sir, please state and spell your
14 first and last name.

15 **DR. WILLIAMS:** Todd Williams, T-O-D-D W-I-L-L-I-A-M-
16 S.

17 **TODD WILLIAMS, M.D.,** having been duly sworn,
18 testifies as follows:

19 **DR. WILLIAMS - DIRECT EXAMINATION BY MR. THOMAS:**

20 Q: Good morning, Dr. Williams, how are you?

21 A: Good.

22 Q: I'm going to ask you to restate your name once
23 again for the record.

24 A: Todd Williams.

25 Q: And what is your occupation, sir?



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ROA_0265

1 A: Radiation oncologist.

2 Q: And are you in private practice?

3 A: Yes.

4 Q: Okay. Now, does your practice have a contract
5 agreement with Trident to provide radiation
6 oncology services?

7 A: Yes, it does.

8 Q: Okay. And where exactly is your office
9 located?

10 A: Our offices are located in the hospital in the
11 Cancer Center.

12 Q: You're not getting paid to testify today, are
13 you?

14 A: I am not.

15 Q: Okay.

16 MR. THOMAS: Let's put Petitioner's Number 5 up on
17 the screen.

18 (Petitioner's Exhibit Number 5 was introduced into
19 the record at this time.)

20 Q: And let me show you, Dr. Williams, if I might.
21 If you turn to tab 5 in this notebook, I think
22 you'll see your CV. I'm going to ask you a few
23 questions about this. Where did you do your
24 medical education?

25 A: At the Medical University in Charleston.



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ROA_0266

- 1 Q: Okay. And what years were you there?
- 2 A: Like '80 -- 1983 through, what is it, '87.
- 3 Q: Okay. And I skipped a step, but where did you
- 4 do your undergrad education?
- 5 A: Here in Columbia at the University of South
- 6 Carolina.
- 7 Q: Okay. And what was your degree in?
- 8 A: Chemical engineering.
- 9 Q: Where did you do your postgraduate training?
- 10 A: After medical school I stayed at the Medical
- 11 University in Charleston in residency. Well,
- 12 I, immediately after medical school, did an
- 13 internship in general surgery at the Medical
- 14 University and then went on to radiation
- 15 oncology residency at the Medical University.
- 16 Q: And how long was that residency?
- 17 A: Three years.
- 18 Q: Okay. And are you Board Certified in radiation
- 19 oncology?
- 20 A: I am.
- 21 Q: What did you do after your residency at MUSC?
- 22 A: I went on staff at the Medical University
- 23 initially as an instructor and eventually an
- 24 assistant professor.
- 25 Q: Okay. And what does that mean to be instructor



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ROA_0267

1 in radiation ---

2 A: It's just the initial starting point as a staff
3 member. It's just an academic rank, the first
4 academic position, and you progress through
5 assistant, associate, and full professor.

6 Q: Did you train residents at MUSC?

7 A: I did.

8 Q: And how long were you at MUSC for?

9 A: Approximately ten years.

10 Q: Okay. So, when would you have left?

11 A: Around 2000 or so. That's when I went up to
12 Myrtle Beach, Carolina Regional Cancer Center.

13 Q: Okay. And what did you do at Carolina Regional
14 Cancer Center?

15 A: I was in private practice at that point. I left
16 the academic center and just a -- I was on
17 staff at the Carolina Regional Cancer Center.

18 Q: And when you were there, how many linear
19 accelerators did they have?

20 A: I think we eventually had three including a
21 tomotherapy unit.

22 Q: Okay. And is it your understanding MUSC has a
23 tomotherapy unit as well?

24 A: They do.

25 Q: Okay. And what types of cancer would you have



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ROA_0268

1 treated then as a radiation oncologist in Horry
2 County, South Carolina?

3 A: Basically every kind. You know, there's
4 actually very few cancers that can't be treated
5 with radiation at least at some point in their
6 treatment, other than possibly leukemias and
7 things like that, fairly unusual except --
8 unless they're getting a bone marrow transplant
9 where you would do a total body irradiation for
10 preparation for a bone marrow transplant.

11 Q: Okay. Now, when you went from MUSC to CRCC,
12 did the type of cancer patient you see change
13 at all or was it the same type of cancer
14 patient?

15 A: No, not really, basically the same types of
16 cancers, basically everything.

17 Q: How about at Trident Medical Center? Any
18 different types of cancers you treated at MUSC
19 that you might not have treated at Trident?

20 A: No. Basically the same types.

21 Q: Okay. Got a little off schedule there, but tell
22 us about -- do you belong to any professional
23 organizations?

24 A: Yes. A member of ASTRO, which is the American
25 Society of Therapeutic Radiology and Oncology.



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ROA_0269

1 Sort of our radiation oncology's main national
2 group.

3 Q: Okay. And when you were at MUSC either as a
4 resident or a clinical assistant professor
5 there, did you engage in research activity?

6 A: Yes. I engaged in clinical research. I
7 actually helped develop clinical trials. We
8 were actively involved with several of the
9 national cooperative group trials, including
10 RTOG, which is the Radiation Therapy Oncology
11 Group, and the CALGB, which is the Cancer and
12 Leukemia Group B. So, several of these NCI-
13 designated cancer associations we were actively
14 helped develop protocols with them and
15 participated, put a lot of patients on
16 protocol.

17 Q: If you turn to page -- it looks like -- you'll
18 see on the bottom of your CV there -- Trident
19 Trial Exhibit 005 and then a dash number at the
20 very bottom of the page. Could you go to 007
21 for me?

22 A: 007?

23 Q: Yes. It should say Bibliography.

24 A: Oh, correct.

25 Q: And is this an accurate representation of your



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ROA_0270

1 published articles either that you were primary
2 or co-author on?

3 A: Yes.

4 Q: Okay. And if you turn the page and then look at
5 dash 009 in the same exhibit, would this be an
6 accurate representation of your Published
7 Abstracts?

8 A: Yes, it is.

9 Q: Okay. And have you published anything since
10 you've been at MUSC?

11 A: No, I really haven't.

12 Q: Now, Dr. Williams, do you stay current with the
13 latest techniques in radiation therapy?

14 A: Yes, I do. I mean, we all keep current, reading
15 the current literature, maintain CME credits,
16 continuing medical education credits, we all go
17 to yearly meetings where we get updates on all
18 the latest techniques and knowledge on cancer
19 treatment.

20 Q: What is the National Comprehensive Cancer
21 Network?

22 A: That is just sort of a compendium of large well-
23 known cancer centers throughout the country that
24 have sort of developed this network in terms of
25 developing standards of care for cancer



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ROA_0271

1 patients. And it's used by pretty much
2 everybody now in terms of guidelines and how
3 patients are treated. And it's kept -- it's
4 always updated continuously with new research
5 and new clinical trial findings.

6 Q: Can you name some of the institutions that are
7 in that network that kind of, you know, I guess,
8 publish these protocols or ---

9 A: Yeah. It's centers, major cancer centers, like
10 Sloan Kettering Cancer Center in New York, MD
11 Anderson Cancer Center in Houston, Mayo Clinic
12 in Rochester and, of course, in -- down in
13 Florida in Jacksonville. You know, big centers
14 like that. I think Vanderbilt is also one. And
15 Duke probably. So, a lot of these big huge
16 cancer centers.

17 Q: And do you personally, and the other radiation
18 oncologists at Trident, utilize the national --
19 I think the NCCN protocols when treating
20 radiation therapy patients?

21 A: Yes, we all do. We discuss the NCCN guidelines
22 and tumor board when we discuss patients every
23 week.

24 Q: Now, do you have any kind of areas that you
25 specialize in in terms of radiation oncology?



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ROA_0272

1 A: When I was at the Medical University I
2 specialized in thoracic and head and neck
3 malignancies, just because at that time at the
4 Medical University each of the attending sort of
5 -- was sort of an expert in a certain field that
6 they would do research in and concentrate in
7 their clinicals, their studies, and whatnot.
8 And I just carried that through to private
9 practice, too. When I was at Myrtle Beach, I
10 treated most of the head and neck cancers there.
11 And at Trident I probably treat 90, 95 percent
12 of the head and neck cancers at that location.

13 Q: Now, do you treat any other cancers utilizing
14 the linear accelerators outside of that field --
15 -

16 A: Yes. I mean, we all treat everything basically.
17 It's just that we have certain interests that
18 we, you know, have. One of my partners does
19 most of the breast cancers. And another of my
20 partners does most of the prostate cancers.
21 Again, just it's out of interest. But all of us
22 can treat basically all of these cancers.

23 Q: Okay. And do your partners also use the NCCN
24 guidelines?

25 A: Yes.



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ROA_0273

1 Q: What types of treatments do you utilize on the
2 linac at Trident when you treat the various
3 cancer patients?

4 A: Basically what everyone else does, sort of
5 routing standard treatments in terms of
6 palliative care. But also for the curative
7 cases we use a lot of IMRT, the intensity
8 modulated radiation therapy. And for certain
9 cases, SBRT, the stereotactic body radiation
10 therapies, for small lung lesions and sometimes
11 solitary bone metastases. And also we utilize
12 SRS technology, the stereotactic radiosurgery,
13 for certain brain tumors and metastases. And
14 that's all done using the linear accelerator.

15 Q: Okay.

16 **MOTION BY MR. THOMAS:**

17 **MR. THOMAS:** Your Honor, at this time I'd like to
18 offer Dr. Williams as an expert in the field
19 radiation oncology.

20 **MR. WESTBROOK:** No objection.

21 **THE COURT:** All right. Without objection, Dr.
22 Williams is so qualified.

23 Q: Dr. Williams, I want to take you back a little
24 bit to your time at Carolina Regional Cancer
25 Center when you were working with Dr. Bass and



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ROA_0274

1 Dr. Goetowski and a few others. When you were
2 at CRCC, did you treat patients who were
3 diagnosed with cancer at MUSC, who would have
4 otherwise received their medical and surgical
5 consults there?

6 A: Yes.

7 Q: Okay. How often did that occur?

8 A: Fairly frequently. You know, a fair number of
9 patients would go down to the Medical University
10 for consultations, second opinions. And,
11 because they lived up in Horry County, quite a
12 trek from Charleston, they would be referred
13 back for the treatment of their disease.

14 Q: Were you able to engage in kind of a multi-
15 disciplinary treatment regimen with those
16 patients, even though they were referred by
17 medical ---

18 A: Yes.

19 Q: --- MUSC oncologists and surgical oncologists?

20 A: Yes. And for a while we were an affiliate of
21 the Medical University and actively participated
22 in weekly tumor boards with the head and neck
23 cancer clinic down in Charleston with Dr. Day
24 and his crew and we would video conference in
25 with them.



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ROA_0275

1 Q: And just as a practical matter, because I don't
2 think I got into this with Mr. Clements
3 yesterday, but where are the linear accelerators
4 kind of physically located within the hospital
5 at Trident?

6 A: They are usually on the first floor of most
7 hospitals just because they're housed in what we
8 call vaults, which are generally concrete
9 enclosures with very thick walls, up to several
10 feet thick of sealed reinforced concrete just
11 for shielding purposes, you know, because the
12 linear accelerators generate megavoltage x-rays,
13 which actually take a lot of concrete to sort of
14 attenuate the beams, so it's safe for, you know,
15 folks to be around.

16 Q: And, again, Mr. Clements got into this a little
17 bit yesterday, but, you know, he's not a
18 physician. But, you know, can you describe for
19 The Court kind of, you know, with a little bit
20 of specificity, not getting too far into the
21 weeds, but how does a linear accelerator
22 actually treat cancer?

23 A: Well, with the use of radiation, various forms
24 of radiation. We use x-rays and we use actually
25 particles, electrons. The general way in which



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ROA_0276

1 radiation actually kills cancer is that it
2 generally damages the DNA in the cancer cells,
3 okay. And we actually fractionate the
4 treatments out. So, the treatments are given on
5 generally a daily basis, but over a period of
6 time. And when the radiation treats -- you
7 know, the cancer cells are exposed to the
8 radiation, the DNA in the cancer cells is
9 damaged. And then the next day more damage is
10 accrued, more damage, more damage. So, the
11 damage sort of accrues over a period of time in
12 the cancer cells. And the cancer cells, not
13 being normal, they don't have the normal repair
14 mechanisms that normal cells have, so, again,
15 this damage sort of accumulates. And over time
16 the cancer cells try to divide and they can't
17 and they die. Where, you know, obviously we
18 treat normal cells along with the cancer cells,
19 but they're being normal, they do have the
20 repair mechanism. So, actually between the
21 treatments each day, the normal cells will do a
22 lot of the repair, so they can actually tolerate
23 the radiation much better than the cancer cells
24 do. So, that's why you get sort of the
25 differential effects of the radiation on cancer

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ROA_0277

1 cells versus the normal cells. You know, it
2 doesn't kill the cancers out right. A few of
3 the cancer cells may die outright from
4 radiation, but generally it's over a period of
5 time as the damage accrues in the cancer cells
6 and they -- when they try to divide down the
7 road, tomorrow, next week, next month, at that
8 point they die and that's how the cancer sort of
9 ...

10 Q: And how about -- you mentioned SBRT and SRS.
11 How are those different than maybe the IMRT and
12 the conventional that maybe take a little bit
13 more time?

14 A: Well, the SBRT and the SRS are where we use much
15 less number of fractions. Basically SRS is a
16 single fraction where a very high dose of
17 radiation is delivered to a very, very small
18 volume in the body, generally in the brain.
19 Okay. And that very high dose in a single
20 treatment is very effective in treating small
21 things, like small cancers in the brain... SBRT,
22 again, as the name sort of defines, it is used
23 elsewhere in the body, mainly in the lungs. We
24 treat a lot of small little lung cancers with
25 the stereotactic body radiation where the



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ROA_0278

1 treatments are -- it's between three and maybe
2 five treatments. But, again, a very high dose
3 of radiation to a very small volume. And,
4 again, these techniques are only available
5 because the technology has really progressed
6 over the last, you know, ten, 15 years where we
7 can safely deliver these very high doses of
8 effective radiation to very small volumes, very
9 tight tolerances. I mean, we treat within
10 millimeters where we want to treat or where we
11 don't want to treat. And with the SRS,
12 techniques like that, it's even less than a
13 millimeter. I mean, it is amazingly precise.

14 Q: What is that meant for kind of the overall
15 number of treatments per patient that cancer
16 patients receive today versus maybe, you know,
17 back ten years ago?

18 A: Well, I mean, obviously these SBRTs, SRSs are
19 becoming more frequent because more and more
20 data is coming up that they are very effective
21 in terms of treating these cancers. So, in
22 terms of those cases, the numbers have declined,
23 because these small little lung cancers that we
24 now treat in a week, you know, 20 years ago we
25 would treat them over a period of seven weeks



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ROA_0279

1 and be just as effective. So, again, it's nice
2 that we can get these small little lesions taken
3 care of very quickly for the convenience of the
4 patient and obviously resources and whatnot.
5 But in general, I mean, the -- in several cancer
6 sites, the number of treatments that are
7 required to take care of the cancers is going
8 down. Like breast cancer, as an example, it's
9 hypofractionation, in other words decreased
10 fractionation, is actually recommended for most
11 breast cancers now. So, in other words, breast
12 cancers now can be treated in a period of three
13 weeks as compared to like five or six weeks as
14 few as, you know, ten years ago.

15 Q: When you say three weeks -- I didn't mean to cut
16 you off -- is that 15 treatments?

17 A: Around 15. It's actually 16, but ...

18 Q: Does breast cancer -- is that one of the more or
19 less common cancers?

20 A: It's very common.

21 Q: Does Trident treat a lot of breast cancer
22 patients?

23 A: We do.

24 Q: In terms of the technology, I won't go through
25 the different types of systems because I think



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ROA_0280

1 Mr. Clements did a good job of that yesterday,
2 but have there ever been any cases that have
3 come to you from a surgical or medical cancer
4 specialty that you haven't been able to treat
5 because Trident lacked the equipment to do so?

6 A: No. Not that I can recall recently, no.

7 Q: Are you aware of any type of cancer that can be
8 treated using radiation therapy in general that
9 can't be treated at Trident's radiation therapy
10 center?

11 A: Well, like I mentioned before, we do not do TBR,
12 total body irradiation, for preparation for the
13 bone marrow transplantation. That's kind of a
14 specialized procedure that we do not do.
15 There's only a few places that do that in the
16 state.

17 Q: Other than that, can you think of anything?

18 A: No. No. Not really.

19 Q: Can you tell me a little bit about your
20 colleagues, just so that The Court understands,
21 you know, who the other physicians are on staff
22 at Trident?

23 A: I've got two partners, Will Collins and Margaret
24 MacDowell, both Board Certified radiation
25 oncologists. We actually kind of all trained



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ROA_0281

1 together too. That's -- we're all MUSC trained
2 radiation oncologists.

3 Q: In terms of the physicists and dosimetrists that
4 you work with, tell The Court a little bit about
5 them.

6 A: We have two physicists that work in the
7 department that sort of maintain, calibrate, and
8 -- the machines and also participate in
9 treatment planning. And we've got multiple
10 radiation therapists that actually run the
11 machines, treat the patients from day to day.
12 And we have two oncologic nurses that work with
13 us and the patients.

14 Q: And is the Center ACR certified?

15 A: Yes, it is..

16 Q: Okay. Tell me about -- is there a tumor board
17 at Trident?

18 A: There is.

19 Q: Can you tell The Court a little bit about it?
20 I mean, Mr. Clements spoke ---

21 A: Trident is a general tumor board. In other
22 words, all cancer patients are eligible to be
23 discussed in the tumor board. It occurs weekly.
24 And, you know, basically it's been going on for
25 years. It's staffed -- not staffed, but



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ROA_0282

1 multiple physicians, including radiologists,
2 pathologists, surgeons, medical oncologists, all
3 of the cancer specialties participate and
4 regularly attend the tumor boards each week.

5 Q: Do you utilize in your practice the concept of
6 evidence-based medicine?

7 A: Yes.

8 Q: Can you explain to The Court what that means?

9 A: Again, evidence-based medicine is just basically
10 what we're trained to use. It's medical
11 evidence that was derived through basic and
12 clinical research, these big cooperative group
13 trials that I talked about before where new
14 treatment techniques, new medications are used
15 in the treatment of cancer patients. As these
16 results come out, they are incorporated in
17 guidelines like the NCCN guidelines and
18 obviously literature. But, again, just using
19 the basic research and clinical research results
20 in the treatment of your patients. And that's
21 obviously used in the evidence from that source.

22 Q: Okay. Now, Trident's -- I think The Court has
23 heard a little about this -- they are not an
24 NCI-designated center, are they?

25 A: No.



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ROA_0283

1 Q: Okay. And there's not an academic component at
2 Trident?

3 A: No, it is not.

4 Q: Okay. Does not being an NCI facility in any way
5 affect the way you treat cancer patients?

6 A: No, no. I mean, the NCI designation is a great
7 thing for the state to have, but it's a research
8 thing in terms of basic and clinical research.
9 In terms of how the patients are treated, be it
10 at the Medical University or at Trident or
11 Roper, wherever, everyone's going to be going by
12 the NCCN guidelines. Those are the national
13 guidelines.

14 Q: Is that kind of what the gold standard of ---

15 A: It is. It is.

16 Q: All right. How did most of the patients that
17 you treat at Trident come to you for treatment?

18 A: You know, with the radiation oncology
19 department, most of our patients have already
20 been diagnosed with cancer. So, in other words,
21 most of our referrals will come from medical --
22 other cancer doctors; medical oncologists,
23 surgical oncologists. But often times from
24 pulmonologists and occasionally family practice
25 physicians will diagnose these issues and refer



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ROA_0284

1 them to us. But most of our referrals are from
2 other cancer doctors.

3 Q: And how about -- do you receive referrals
4 personally from physicians that are either
5 employed by or on staff with other institutions?

6 A: Yes.

7 Q: Do those institutions include MUSC and Roper?

8 A: Yes.

9 Q: Okay. Do you have any difficulty treating those
10 patients on the linear accelerator because they
11 came from another institution's affiliated
12 doctor?

13 A: No.

14 Q: Do you receive more referrals from certain
15 outside institutions?

16 A: We probably get more referrals from Roper-based,
17 Roper Hospital-based physicians than we do the
18 Medical University.

19 Q: Okay. Let's talk a little bit about multi-
20 disciplinary cancer treatment. Is this an
21 approach that is used at Trident?

22 A: Yes.

23 Q: How so?

24 A: Well, just the basic way in which cancer
25 patients are treated is multi-disciplinary. The



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ROA_0285

1 vast majority of cancer patients actually
2 require multiple physicians to treat their
3 cancer. Oftentimes the treatments are multi-
4 disciplinary and the patients are receiving
5 radiation, they're receiving chemotherapy, some
6 type of surgical intervention may be planned.
7 So, again, it's very routine nationwide
8 basically that we all oncologists, as a general,
9 will work in a multi-disciplinary atmosphere.

10 Q: And when you receive referrals from, you know,
11 physicians that may not be on the staff at
12 Trident, are you able to work with them in a
13 multi-disciplinary fashion?

14 A: Sure, sure.

15 Q: You never had any problems doing that?

16 A: Never.

17 Q: Okay. Can you explain a little bit about what
18 palliative care is?

19 A: Palliative care is a treatment that is offered
20 and delivered with the intent of not curing the
21 patient, because at that point in the stage of
22 their disease it's not considered curable, but
23 they may have symptoms like pain or shortness of
24 breath, coughing, that can be relieved by
25 possibly a course of radiation, possibly



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ROA_0286

1 chemotherapy. There's different types of
2 palliative care. That's what that's for.

3 Q: And is that something that you engage in at
4 Trident's Cancer Center?

5 A: Every day.

6 Q: And sometimes are those inpatients that you have
7 to deliver the palliative care to?

8 A: Yes.

9 Q: How often does that occur?

10 A: Most of our patients are outpatient, but
11 probably between five and ten percent of our
12 patients at any one time are inpatient.

13 Q: So, do they have to get any transport for
14 Trident Medical if they're inpatients to ---

15 A: Yeah. They're transported through wheelchair,
16 you know, a gurney, whatever, however, a
17 hospital bed down to our Center, which is on the
18 first floor.

19 Q: Okay. Is your -- I think I forgot to ask Mr.
20 Clements this yesterday. But does Trident
21 Cancer Center have an outside entrance that's
22 different than the hospital?

23 A: Yes.

24 Q: Okay. And separate ---

25 A: Well, we actually -- yeah, there's actually --



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ROA_0287

1 there's actually three doors that they can
2 access the Cancer Center.

3 Q: And one of those is from the parking lot?

4 A: Yes.

5 Q: Okay. And just so I touch on this, does Trident
6 offer HDR and LDR techniques?

7 A: Yes, we do.

8 Q: Okay. I think Mr. Clements did a pretty good
9 job describing that yesterday and so I won't go
10 too much further into that. Doctor, in your
11 opinion, can the vast majority of patients who
12 are diagnosed with cancer from this north area
13 of North Charleston, Dorchester, and Berkeley
14 County be treated at Trident's radiation therapy
15 center if that's the type of treatment they
16 need?

17 A: Yes.

18 MR. WESTBROOK: Objection. Leading.

19 MR. THOMAS: I'm asking if the vast majority -- I
20 don't think it's a leading question.

21 THE COURT: I agree. It's not leading.

22 MR. WESTBROOK: Sorry.

23 Q: You can answer.

24 A: Yes.

25 Q: What's your basis for that opinion?



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ROA_0288

1 A: Well, again, the linear accelerator's the
2 equipment that Trident is equipped with is
3 fairly standard for radiation therapy centers,
4 so we just have the capability of treating
5 basically any cancer patient that comes in the
6 door.

7 Q: Okay. In your opinion, can Trident radiation
8 oncologists participate in multi-disciplinary
9 care for MUSC's patients who were referred to
10 Trident for radiation therapy?

11 A: Yes. Yes.

12 Q: And I think you've already kind of talked about
13 how you do that. In terms of the lower
14 fractionated treatments you were describing
15 earlier, what is the trend for treating cancer
16 patients using lower fractionated treatments?

17 A: Well, I mean, again, it just -- there's more and
18 more data coming out that these
19 hypofractionated, which means just less number
20 of treatments, tend to be as efficacious and as
21 effective as longer series of treatments. I
22 mentioned the breast cancers, it's now
23 considered a standard of care that the patients
24 do just as well with these shorter regimens.
25 I mean, there's still situations where some



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ROA_0289

1 ladies would require longer treatment courses.
2 But another area that is actually quite a large
3 number of patients with prostate cancer, there's
4 more and more data that the shorter treatment
5 regimens are very effective and very safe to
6 deliver. And that can be a huge number of
7 patients. In fact the meeting I went to in
8 December, there's three fairly new trials that
9 have shown non-inferiority. In other words, the
10 shorter treatments have been shown to be no less
11 effective and no less tolerable than longer, you
12 know, courses of treatment. We used to, and
13 oftentimes still do, treat prostate cancers with
14 external beam treatments for eight and nine
15 weeks, where now the data is coming out where
16 these shorter regimens of around four weeks --
17 it's called sort of moderate hypofractionation,
18 it's not SBRT, but still less treatments --
19 these four weeks of treatment are just as
20 effective and as safe in delivering. And,
21 again, I think a lot of that has been because of
22 the advance in the technology and being able to
23 so accurately treat patients now as how we used
24 to do things 20, 25 years ago. But it's just --
25 it's become safer.

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ROA_0290

1 Q: Doctor, that's all the questions I have for you
2 today. Please answer any that Mr. Westbrook
3 would have for you. Thank you.

4 **DR. WILLIAMS - CROSS-EXAMINATION BY MR. WESTBROOK:**

5 Q: Hey, Dr. Williams. How are you doing?

6 A: Good morning.

7 Q: All right. Dr. Williams, let's see. I think
8 what I -- let's just go back over your training
9 for just a second that Mr. Thomas ran through
10 with you. You were at MUSC in the '80s in med
11 school; is that right?

12 A: Correct.

13 Q: You got your internship around, what, '88?

14 A: It was like '87, '88.

15 Q: Okay. And finished your residency -- I think
16 you said you started in '88..

17 A: '89 I think my residency.

18 Q: It was a three year?

19 A: Yes, sir.

20 Q: So, that would have been '92?

21 A: Yes.

22 Q: Okay. And then you taught until around 2000 or
23 2001; is that right?

24 A: Correct.

25 Q: And then went up to what I'm going to call CRCC,



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ROA_0291

1 Dr. Bass' group upon in Myrtle Beach, right?

2 A: Yes, sir.

3 Q: And that's a private practice? Dr. Bass was the
4 primary owner or the sole owner ---

5 A: Yes.

6 Q: --- is that correct? And I'm sorry. I jumped
7 ahead of myself. We'll come back to Dr. Bass in
8 a second, but let me go back to MUSC for a
9 second. Training there was -- any complaints
10 about your training at MUSC?

11 A: No, it was very good.

12 Q: Mentors. I think you said -- told me you had
13 fine mentors; is that ---

14 A: Mentors, including Dr. Jenrette.

15 Q: All right. And when you left MUSC in 2000, 2001
16 to go to CRCC, now, that was the last time you
17 actually practiced medicine at MUSC would have
18 been 2000, 2001?

19 A: Yes. Now, when we became like an affiliate of
20 the Medical University up in Myrtle Beach, we
21 were given sort of clinical professorships,
22 which, you know, doesn't really stand for
23 anything. I think they just do that
24 automatically. But, yeah, that's ---

25 Q: I think you referred in your deposition that is



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ROA_0292

1 to an honorary associate professorship?

2 A: Yeah. Exactly. But, yeah, basically the last
3 time I did academic work was when I, you know,
4 was at the Medical University.

5 Q: And that would have been the last time you
6 actually practiced medicine ---

7 A: In an academics ---

8 Q: --- physically in the MUSC facility?

9 A: Correct. Correct.

10 Q: Okay. And so, the clinics that you did with
11 CRCC and MUSC, that would have been in the early
12 2000s; is that right?

13 A: Correct.

14 Q: And so, the -- correct me if I'm wrong. I think
15 -- so, the last formal affiliation that you had
16 with MUSC would have been through those clinics;
17 is that right?

18 A: Correct.

19 Q: And that would have ended in 2004, 2006?

20 A: Something like that. I don't know the exact
21 timing. But you're right, it's ---

22 Q: The middle of the decade?

23 A: I think was a time when the Medical University
24 was trying to develop these little associated
25 facilities across the state and they were



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ROA_0293

1 pushing -- you know, they were doing it in
2 several locations across the state and we were
3 one of those. But that didn't last forever. I
4 think that whole program got dissolved after a
5 while.

6 Q: And that affiliation, again, I think you
7 described it to be as a peripheral affiliation;
8 is that right?

9 A: Yes, sir.

10 Q: All right. And, again, so that would have been
11 somewhere in the middle of that decade, 2004 to
12 2006 when that ended?

13 A: Something like that, yes, sir.

14 Q: Okay. That was your last affiliation ---

15 A: Yes.

16 Q: --- with MUSC. Do you know when MUSC received
17 its NCI designation?

18 A: I don't remember. I actually don't know when
19 they actually received the full designation.

20 Q: All right. So, you and your two partners --
21 what's the name of your private practice?

22 A: The Radiation Oncology Associates of Charleston.

23 Q: Okay. The three of you are the only three
24 radiation oncologists that practice at Trident;
25 is that right?



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ROA_0294

1 A: Correct. Correct.

2 Q: Okay. And Mr. Thomas asked you about referrals
3 with other facilities or with physicians
4 associated with other facilities. I believe
5 that you estimated, to me at least, that MUSC
6 refers -- yeah, MUSC refers approximately five
7 to ten radiation oncology patients a year to you
8 and your two partners?

9 A: Yes, sir.

10 Q: And you and your partners, I believe you
11 estimated, refer five or less radiation oncology
12 patients a year to MUSC; is that right?

13 A: Yeah. It's only -- quite rare, yes, sir.

14 Q: The number of treatments -- you told us -- you
15 spent some time with Mr. Thomas talking about
16 how the number of treatments had gone down at
17 least with some sites.

18 A: In some cancer sites, yes, sir.

19 Q: Some cancer sites.

20 A: Yes, sir.

21 Q: Over the last few years. You're not aware of
22 any research, are you, showing that the
23 treatments are going to continue to go down,
24 that they will be down -- that they'll be fewer
25 in the next, you know, five years from now than



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ROA_0295

1 they are today? You're not aware of any of that
2 kind of research, are you?

3 A: I don't know of any data to say that. It's just
4 that the trends are in that direction. You
5 know, it takes a while for physicians across the
6 country to sort of adapt or adopt these new
7 regimens. You know, like I said, with the
8 breast, the hypofractionation for the breast has
9 been developing over actually a decade or more.
10 I mean, a lot of that early data came from
11 Canada, but it's been slowly adopted in this
12 country. And, again, all of this kind of takes
13 time. And now the national organizations are
14 sort of accepting that saying, okay, this should
15 be the new standard for breast cancer in this
16 country. But, again, it occurs over time. It's
17 not like it happens immediately. And in terms
18 of prostate cancer, again, a large -- generally
19 a large patient population for any radiation
20 oncology center. I mean, this is fairly new
21 data, okay, and it's not like everyone's going
22 to jump on board and say, okay, I'm going to
23 start doing this and that's all we're going to
24 do. It's going to take time for people to sort
25 of adopt that over a period of time. But that's



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ROA_0296

1 the trend, is that these treatments are becoming
2 less and less numerous.

3 Q: All right. And that has been the trend for a
4 decade or so?

5 A: Yes, sir.

6 Q: And, again, going back to my question, let me
7 ask it a little different way. Am I clear --
8 do I understand correctly though that you're not
9 aware of any data or any research findings that
10 show that that trend is necessarily going to
11 continue for the next decade, are you?

12 A: Well, like I mentioned, the three noninferiority
13 trials that were presented at the recent ASTRO
14 meeting in San Francisco in -- actually the
15 meeting was in September. I went to sort of a
16 summary meeting. Again, this is fairly new data
17 for prostate cancer, but it is data that
18 supports these lower treatments to be as
19 efficacious and safe as more extended
20 treatments. And they're actually working on
21 more trials with SBRT for prostate cancers,
22 which will even further shorten prostate cancer
23 potentially down to a week or two of treatments.
24 So, again, there is research currently ongoing
25 that will either say, no, this isn't what we



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ROA_0297

1. should be doing or, yes, this is as good. But
2. that's sort of the trend is that they're looking
3. at these new techniques.

4. Q: Let me ask you to turn to page -- well, you
5. don't have it, so let me give it to you.

6. A: Sure.

7. Q: Here's your deposition, Dr. Williams, when we
8. last got together. And if you will do me a
9. favor and look at the front page of that
10. deposition and tell me what the date of that --
11. I'll let you get it open.

12. A: Hang on.

13. Q: You need a letter opener along with the ---

14. A: Right. I'm sorry. What do you want me to look
15. at?

16. Q: If you will look at the front page, maybe the
17. cover page, and tell me what the date is on that
18. deposition.

19. A: November 27th, 2018.

20. Q: All right. And if you will take a look over at
21. page 32 please. And I'm going to ask you to
22. look, when you get there ---

23. A: Yes.

24. Q: Take your time -- towards the bottom of the
25. page.



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ROA_0298

1 **MR. WESTBROOK:** And, Dan, if you could put page 32 up
2 on the screen so we can all see it.

3 **Q:** I'm going to ask you to start looking at line 18
4 down at the bottom of the page. I'm going to
5 read that into the record and you tell me if I'm
6 reading it accurately. So, I'm going to start
7 reading at line 18; are you there?

8 **A:** Uh-huh (affirmative response).

9 **Q:** Okay. The research that you've seen and the
10 data that you've reviewed; have you seen
11 anything that shows that treatments, the number
12 of treatments or the number of -- the length of
13 treatments -- by that I mean the number of weeks
14 treatments, is -- will be lower in the next few
15 years than it is right now? And your answer is,
16 that I really can't say.

17 **A:** Well ---

18 **Q:** Tell me about -- explain that to me.

19 **A:** Yeah. That's still true. I mean, like I said,
20 this is still -- a lot of this is still in the
21 research phase.

22 **Q:** All right.

23 **A:** I can't say that the treatments will become less
24 in the next ten years. Nobody can. But the
25 current data -- and, again, this November 27th



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ROA_0299

1 was before I went to my meeting where I actually
2 ---

3 Q: In San Francisco?

4 A: Exactly.

5 Q: Okay.

6 A: It was early December.

7 Q: And I'm sorry to interrupt, but that was 2018;
8 is that right?

9 A: Yes.

10 Q: Okay. Go ahead. I'm sorry.

11 A: Just a month ago.

12 Q: Got you.

13 A: So, again, that was some new data that I wasn't
14 aware of. But, again, I still -- you can't say
15 that it is going to continue to go slower, but
16 that's the trend.

17 Q: All right.

18 A: And they are looking -- the new research is
19 going in that direction. So, again, I can't say
20 for sure, yes, that's going to happen, because
21 I can't predict the outcome of research.

22 Q: Sure.

23 A: But that's what it's showing.

24 Q: Sure. And the seminar -- if that's the wrong
25 word, you correct me. The seminar that you went



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ROA_0300

1 to in San Francisco in December, was that --
2 those findings you're talking about, was that
3 focused on prostate cancer?

4 A: Well, it's on everything. It's actually nice.
5 It's sort of a -- it's called Best of ASTRO. In
6 other words, the meeting -- our ASTRO meeting is
7 a long meeting. It's like a week-long meeting
8 that everything you can imagine is presented.
9 And what this meeting I went to is sort of a
10 summary meeting that lasted only two days, which
11 was nice. And all the leaders of the different
12 groups in ASTRO, the lung group, the GYN group,
13 whatever, the prostate cancer group, summarized
14 the major findings of the major meeting and just
15 presented them at this shorter meeting, which
16 was very nice.

17 Q: All right. And so, where we are today with
18 respect to treatments, the number of treatments
19 on average for radiation therapy I'm sure varies
20 considerably depending on the type of cancer.
21 Correct?

22 A: Yes, sir.

23 Q: But the overall average for -- and you testified
24 you and your two partners do everything, right?

25 A: Yes, sir.



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ROA_0301

1 Q: So, the overall average number of treatments per
2 patient I believe you told me was between 25 and
3 30. Is that right?

4 A: For a definitive patient, in other words a
5 curative patient. The palliative patients where
6 we're just trying to relieve pain or bleeding or
7 coughing, shortness of breath, we try to speed
8 those up. And generally they're between five
9 and fifteen treatments.

10 Q: All right.

11 A: But for curative cases, you're right, it's more
12 in the lines of like 25, sometimes 35
13 treatments.

14 Q: Twenty five, 35?

15 A: Yes, sir.

16 Q: And typically that's over five or six weeks; is
17 that right?

18 A: Yes.

19 Q: Doctor, you talked about the tumor board. You
20 have -- once again, I think you have a
21 generalist -- or general tumor board that meets
22 once a week; is that right?

23 A: Yes, sir.

24 Q: And how long do those meetings typically last?

25 A: Usually an hour to an hour and a half long.



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ROA_0302

1 Q: All right. You don't do any telehealth or
2 telemedicine cancer services at Trident, do you?

3 A: We do not.

4 Q: You don't do research -- don't have a research
5 program at Trident, do you?

6 A: We do not.

7 Q: And you yourself, you mentioned, to answer to a
8 question of Mr. Thomas, that you haven't
9 published anything since you left MUSC; is that
10 right?

11 A: It's been a long time.

12 Q: And you don't do research ---

13 A: I don't do any clinical research at the current
14 time.

15 Q: You don't really run any clinical trials at
16 Trident, do you?

17 A: We do not. But the medical oncology group that
18 we're most associated with does do some clinical
19 trials, but they tend to be more like drug
20 company trials that they participate in. But
21 you're right, at Trident Hospital itself we do
22 not participate in any clinical trials.

23 Q: The Sarah Cannon affiliation began with Trident
24 in 2018; is that right?

25 A: Yes.



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ROA_0303

1 Q: And the Cannon affiliation at least so far has
2 not had any effect on your day-to-day practice,
3 has it?

4 A: Well, it has because a lot of the computer
5 systems that we use, the electronic medical
6 records, is now sort of integrated into the
7 Sarah Cannon system. So, it's more of a
8 seamless thing with the whole Sarah Cannon
9 Cancer Network. And the Sarah Cannon folks, the
10 regional director, is actively participating in
11 developing a thoracic -- multi-disciplinary
12 thoracic clinic at the -- at Trident Hospital.

13 Q: All right. That clinic, that development of
14 that thoracic clinic hasn't been launched yet
15 though, has it?

16 A: It's in the development phase. The clinic
17 itself, you're right, has not been initiated
18 yet.

19 Q: All right. Let me go back and rephrase the
20 question I asked you a moment ago. Maybe I
21 asked it the wrong way. In terms of your day-
22 to-day practice in your life with your patients,
23 does the Cannon Institute effect directly what
24 you do with your patients?

25 A: No.



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ROA_0304

- 1 Q: Is it your understanding or isn't it your
2 understanding that in terms of capabilities, if
3 the MUSC Nexton project is ultimately approved
4 -- I'm sorry, I'm making this squeak for some
5 reason. Maybe I'm the only one that hears it.
6 Maybe it's inside my head. But anyway, let me
7 back up and start that question over again. I'm
8 going to try to launch that question a little
9 better.
- 10 A: Sure.
- 11 Q: So, in terms of capabilities, it's your
12 understanding that the Nexton project for MUSC,
13 if it's approved, will be comparable, very
14 comparable to the downtown project; is that
15 correct?
- 16 A: As far as I understand, yes.
- 17 Q: And if MUSC Nexton is approved, you don't know
18 of any reason, do you, why MUSC's patients from
19 the Berkeley/Dorchester area or the North
20 Charleston area would not choose to go there?
21 You don't know of any reason they wouldn't, do
22 you?
- 23 A: Not that I'm aware of, no.
- 24 Q: Okay. I don't have any other questions. Thank
25 you.

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ROA_0305

1 MR. THOMAS: One or two follow-ups, Your Honor.

2 THE COURT: Okay. Re-Direct.

3 DR. WILLIAMS - REDIRECT EXAMINATION BY MR. THOMAS:

4 Q: Just a couple, Dr. Williams, and we'll get you
5 on your way. Mr. Westbrook asked you a couple
6 of questions about the number of treatments. He
7 talked about the curative versus the palliative.
8 And I think you used a number between 25 and 35
9 for curative and palliative between five and 15.

10 A: Yes.

11 Q: But then how about SBRT, how many treatments do
12 those patients get?

13 A: Between three and five.

14 Q: Okay. And SRS, how many?

15 A: Generally one.

16 Q: Okay.

17 A: But sometimes we we'll fractionate that out as
18 to up to three treatments if we're treating a
19 larger brain lesion, but generally one. I'm
20 sorry.

21 Q: Okay. So, if you had an SRS patient and you
22 have a conventional patient getting 25 and the
23 SRS gets one, then the average there for those
24 two is 12 and a half, right?

25 A: I guess. Yes.



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ROA_0306

1 Q: Okay. Mr. Westbrook asked you about
2 capabilities of Nexton, asked you if you thought
3 the capabilities at the Nexton MUSC site would
4 be similar to downtown. Were you aware that, as
5 of now in the Certificate of Need application
6 that MUSC filed, that Nexton will not be
7 offering stereotactic treatment?

8 A: I didn't know that.

9 Q: Okay. And -- but they do offer that downtown,
10 correct?

11 A: Yeah, I'm sure. Yes, they do.

12 Q: And then Mr. Westbrook asked you a question
13 about do you yourself as a radiation oncologist
14 refer patients down to MUSC. What would be an
15 occasion where you would do that?

16 A: If it was more convenient for the patient to be
17 treated, if they lived down in that area.
18 That's happened on occasion. You know,
19 obviously if it's a patient that requires
20 something specialized like the total body
21 irradiation, things like that. But basically
22 it's fairly, fairly unusual.

23 MR. THOMAS: I have no other questions, Your Honor.
24 I ask at this time that we release this witness.

25 MR. WESTBROOK: No objection.



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ROA_0307

1 THE COURT: All right. Dr. Williams, you may step
2 down and you may also leave if you wish.

3 DR. WILLIAMS: Thank you very much.

4 THE COURT: You could also choose to stay with us.

5 DR. WILLIAMS: Yeah, unfortunately I have to get to
6 work.

7 MR. THOMAS: Permission to walk him out?

8 THE COURT: Sure. We'll be at ease for a minute or
9 two here.

10 (Off the Record)

11 THE COURT: We're back on the record.

12 MR. THOMAS: Trident will call its next witness,
13 Daniel Sullivan.

14 THE COURT: I have a question.

15 MR. THOMAS: Yes, sir.

16 THE COURT: I noticed Mr. Dayhuff and Mr. Westbrook
17 have changed chairs. We're at 11:00 o'clock.
18 How long are we going to be with -- this is your
19 expert, right?

20 MR. THOMAS: Yes, my health planning expert. I would
21 imagine we would go at least an hour and a half
22 on direct with him. I would think we -- you
23 just never know how the flow kind of goes.

24 THE COURT: Now, do you want to -- how do you want --
25 that would lead us to take a lunch break between



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ROA_0308

1 Direct and Cross.

2 MR. DAYHUFF: I think that's fine.

3 THE COURT: That's okay?

4 MR. DAYHUFF: Yeah.

5 MR. THOMAS: I would imagine he would prefer that.

6 THE COURT: All right.

7 MR. DAYHUFF: And not have to work through lunch?

8 MR. THOMAS: Yeah.

9 THE COURT: All right. Go ahead.

10 COURT REPORTER: Please state your full name and
11 spell it.

12 MR. SULLIVAN: Daniel J. Sullivan, D-A-N-I-E-L S-U-L-
13 L-I-V-A-N.

14 DANIEL J. SULLIVAN, having been duly sworn, testifies
15 as follows:

16 MR. SULLIVAN - DIRECT EXAMINATION BY MR. THOMAS:

17 Q: Good morning, Mr. Sullivan.

18 A: Good morning.

19 Q: Could you state your full name for the record,
20 please?

21 A: Daniel Joseph Sullivan.

22 Q: And what's your occupation, Mr. Sullivan?

23 A: I'm a healthcare management consultant.

24 Q: And do you own your own business?

25 A: I do.



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ROA_0309

1 Q: And, tell you what, why don't we go to
2 Petitioner 4 real quick in the notebook that you
3 probably have open right there in front of you.

4 A: I do.

5 (Petitioner's Exhibit Number 4 was introduced into
6 the record at this time.)

7 Q: All right. And can you tell The Court a little
8 bit about your education, work history? I think
9 we're working to get the exhibit up on the
10 screen.

11 A: Sure. I received an undergraduate degree in
12 economics and public policy studies from Duke
13 University and a master in health administration
14 from Duke University.

15 Q: And how about your work history? Why don't you
16 talk a little bit about that?

17 A: Sure. I've been working in healthcare now for
18 45 years.

19 Q: Say it with pride.

20 A: Yeah. I started off working at Duke Medical
21 Center.

22 Q: Let's hold off. We're going to get this.

23 MR. THOMAS: I'm sorry, Your Honor. Do they have a
24 set of notebooks perhaps? It's just our system
25 doesn't like to talk. We may just go to paper



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ROA_0310

1 because I want to move us along. Do y'all have
2 the set of notebooks that we made you?

3 **THE COURT:** We have -- these are yours, right?

4 **MR. THOMAS:** Yes, sir. If you'd turn to tab 4 in
5 there, Your Honor, that'll bring up Mr.
6 Sullivan's CV.

7 **THE COURT:** All right.

8 **MR. THOMAS:** There we go.

9 **THE COURT:** All right.

10 **Q:** All right. So, you were taking us through your
11 work history.

12 **A:** Sure. I started off at Duke University Medical
13 Center right out of undergrad and worked in a
14 variety of administrative roles. And then
15 during the two years I was in grad school, I
16 also worked there. And then immediately after
17 receiving my master in health administration I
18 went to work in the consulting arena for a
19 company called Amherst Associates. Amherst was
20 a national healthcare management consulting
21 firm. And I worked at Amherst for approximately
22 eight years. We merged with the firm of Ernst
23 & Whinney, which became Ernst & Young. I was
24 there for two years and then set up my own
25 company. Throughout all of those various



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ROA_0311

1 employments, my focus has been sort of in two
2 general areas, healthcare planning and
3 healthcare finance. Healthcare planning would
4 involve things like market analysis, demand
5 projections for various kinds of healthcare
6 services, also includes strategic planning for
7 healthcare organizations or planning for a new
8 product line or for a new facility, things of
9 that nature. On the healthcare finance side my
10 initial work with Amherst Associates was
11 developing financial feasibility studies for tax
12 exempt-bond issues that we used in offering
13 statement. Over time began to develop other
14 kinds of financial analyses, looking at
15 hospitals; debt capacity to undertake projects.
16 We looked at the projected performance of
17 individual services, became familiar with things
18 like reimbursement for healthcare services and
19 so forth. And so I've been doing those types of
20 things fairly consistently. Sort of early on in
21 my career, Certificate of Need was just really
22 just getting started. And a lot of the skills
23 that I just mentioned were skills that you could
24 use in developing Certificate of Need
25 applications. There's a demand element, you

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ROA_0312

1 have to project utilization of services.
2 There's a financial element in terms of what the
3 feasibility of the project is. A sort of
4 strategic element in terms of how does this
5 particular product or service impact the
6 healthcare system more broadly. And so I've
7 been doing Certificate of Need work since 1980.
8 My first testimony as an expert witness was in
9 1981. I've been doing that pretty consistently
10 since that time, so.

11 Q: All right. And in terms of health planning,
12 does that involve knowledge about the patient
13 flow in a health system, kind of from a soup to
14 nuts type situation?

15 A: It does. I mean, it's understanding the
16 mechanics of, you know, how patients choose or
17 how -- sometimes they don't choose, but how
18 patients get into a particular healthcare system
19 and then, you know, also looking at things like,
20 you know, what influences where patients go for
21 different types of services.

22 Q: Okay. Are you familiar with the South Carolina
23 Health Plan, Mr. Sullivan?

24 A: I am.

25 Q: How does what you do in South Carolina as health



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ROA_0313

1 planning and a finance consultant involve the
2 South Carolina Health Plan?

3 A: Well, it's a pretty fundamental document for a
4 lot of what I do, particularly in the
5 Certificate of Need arena. In South Carolina
6 that is sort of the starting point for any
7 consideration of filing a CON application. For
8 services that are specifically covered by the
9 Plan, you need to be familiar with the
10 standards. For certain types of services there
11 are need projections in the Plan that tell you
12 whether or not there's a need for more of a
13 particular service or facility. And in sort of
14 understanding the criteria that DHEC uses and
15 how that fits together with what's in the State
16 Health Plan.

17 Q: And how often would you say you work
18 specifically with the South Carolina Health
19 Plan?

20 A: I won't say daily, but weekly at least.

21 Q: Have you ever been involved in any committees
22 related to the South Carolina Health Plan?

23 A: Yeah. I served on a task force a few years ago
24 where they were looking to basically redevelop
25 the structure of the Certificate of Need Program



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ROA_0314

1 in South Carolina. And that committee was
2 making recommendations about ways to change what
3 services are regulated and also how the State
4 Health Plan standards would be developed. But
5 from time to time I've been involved on behalf
6 of particular clients in making suggestions to
7 DHEC about modifications to certain sections of
8 the State Health Plan.

9 Q: Just an estimate, but how many CON-related
10 projects and matters would you say you've work
11 on in the state of South Carolina?

12 A: More than 100. I don't know how many, but ...

13 Q: Okay. And how many linear accelerator projects
14 do you think you've been involved in in your
15 health planning consultant kind of nationwide?

16 A: Something north of 50. I don't know the exact
17 number.

18 Q: Okay. In South Carolina have you been qualified
19 as an expert in a linear accelerator case in
20 health planning and finance?

21 A: I have.

22 Q: Okay. Do you remember that case?

23 A: Yeah. It was a case involving -- the Myrtle
24 Beach situation involving the -- what formerly
25 was the Carolina Regional Cancer Center that we



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ROA_0315

1 heard talk about lately. But I was actually
2 working with Grand Strand Medical Center, who
3 was seeking to add a linear accelerator to the
4 hospital.

5 Q: Okay. And how many times do you think you've
6 been qualified as an expert in healthcare
7 planning and finance in a court of law?

8 A: More than a hundred times. I don't know the
9 exact number.

10 Q: How about in South Carolina?

11 A: More than 20.

12 **MOTION BY MR. THOMAS:**

13 **MR. THOMAS:** Judge, at this time I'd ask The Court to
14 qualify Mr. Sullivan as an expert in the areas
15 of healthcare planning and healthcare finance.

16 **MR. DAYHUFF:** No objection, Your Honor.

17 **THE COURT:** Without objection, Mr. Sullivan, you are
18 an expert.

19 **MR. SULLIVAN:** Thank you, sir.

20 Q: Mr. Sullivan, can you explain to The Court how
21 you became involved in this particular case?

22 A: Sure. I was initially involved in this case I
23 guess when the Medical University filed an
24 application back in 2015 to add a linear
25 accelerator. And then subsequent to that, when



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ROA_0316

1 they re-filed the application in 2017 I was
2 asked to participate in that one as well.

3 Q: And fair to say you've had an opportunity to
4 review the CON application in this ---

5 A: I have in some depth, yes.

6 Q: Okay. And can you give The Court just a general
7 overview -- and I think they know by now -- but
8 what this case is about or what the project, the
9 MUSC project is about?

10 A: Sure. It's roughly a 9.8 million dollar capital
11 expenditure to develop a radiation therapy
12 center in the Nexton development, which is on
13 the edge of Summerville right off of Exit 199
14 off of I-26. It's -- it would include the
15 purchase of a TrueBeam, a Varian TrueBeam linear
16 accelerator and as well as the construction of
17 various physical spaces on a campus that
18 includes other medical facilities.

19 Q: Okay. Did you have an opportunity to -- well,
20 during the CON review process, did you have an
21 opportunity to present Trident's opposition to
22 DHEC?

23 A: I did. Mr. Clements and I, I think, both spoke
24 at the project review meeting last year -- or
25 was that last -- I guess it was two years ago



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ROA_0317

1 almost..

2 Q: Yeah. I think September 20th, 2017 there on the
3 screen. Do you recognize that?

4 A: I do.

5 Q: Okay. And just for The Court -- I'm not sure
6 that this concept has come up -- but what is
7 project review at DHEC?

8 A: Typically -- I won't say in every case, but
9 typically when a project involves a project of
10 some consequence or impact on the healthcare
11 system, particularly one that's being challenged
12 by other parties, DHEC will hold what's called
13 a project review meeting to allow the applicant
14 to sort of present its application, any
15 additional information that the applicant wants
16 to present, and also allows any opposing parties
17 to be present and to present information about
18 why the application perhaps should not be
19 approved. And then subsequent to that meeting
20 all of the parties have the opportunity to file
21 additional information sort of addressing things
22 that were raised by the opponents in a
23 particular matter or simply supplementing the
24 record with additional information.

25 Q: Turn in your notebook there, and we'll try to



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ROA_0318

1 get it on the screen for you, to Petitioner's
2 15.

3 A: Okay.

4 Q: I believe these are the slides we talked a
5 little bit about yesterday with Mr. Clements.
6 And if you could go to specifically page 11 for
7 us.

8 A: Okay.

9 Q: And describe here what's on the screen for The
10 Court if you would, Mr. Sullivan.

11 A: Sure. At the time that DHEC rules on an
12 application is complete and ready to begin the
13 review process, they issue a letter. And in
14 that letter they list the priority criteria that
15 they're going to evaluate in evaluating the
16 project. And these five criteria were the ones
17 identified for, I believe -- there were two
18 projects, actually, involved in this review at
19 this point in time, MUSC and Roper. And these
20 were the criteria that were identified for both
21 of the applicants.

22 Q: Okay. I want to jump over to Joint Exhibit 5
23 real quick. And I believe you've got a notebook
24 here. Go to tab 5 for me if you would.

25 A: Okay.



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ROA_0319

1 Q: All right. And this is the, just for the
2 record, the 2015 State Health Plan. And, Mr.
3 Sullivan, is that the applicable health plan for
4 this particular project?

5 A: It was. That's what DHEC designated.

6 Q: And if you would turn over to page 12 in the
7 Health Plan for me. It is the last page of that
8 particular exhibit.

9 A: Okay.

10 Q: Joint 5. I'm catching up here on the computer.
11 I love it when paper and notebook is faster than
12 the computer. All right. We got it. Mr.
13 Sullivan, can you describe for The Court what's
14 the data on this page?

15 A: Sure. This shows the -- first of all, back up
16 a little bit. The state is divided into
17 planning areas or service areas for determining
18 the need for radiation therapy services. And so
19 you can see the various service areas throughout
20 the state. Obviously the one we're talking
21 about today is the second to the last one on
22 there, the Berkeley, Charleston, Colleton,
23 Dorchester planning area. And this shows the
24 historical utilization of existing providers.
25 In this case this was for 2013 and it shows what



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ROA_0320

1 the capacity of existing units were. And then
2 it calculates a utilization rate based on
3 dividing the historical utilization by the
4 capacity.

5 Q: Okay. And in the 2015 service area is there a
6 need for a linear accelerator listed in the DHEC
7 State Health Plan?

8 A: There is not. In that Berkeley/Charleston
9 service area the average utilization rate was
10 73.5 percent. I think there's been some
11 testimony already about the fact that there --
12 maybe not testimony, but certainly discussion
13 about the fact that there's an 80 percent target
14 utilization rate, which is one of the criteria
15 in the State Health Plan.

16 Q: Okay. And how many linacs is listed there as
17 the number in the particular service area that
18 we're dealing with here today?

19 A: Twelve.

20 Q: Okay. And the Planning Area Capacity is listed
21 there as what?

22 A: 62,500.

23 Q: Okay. All right. And back in 2015 -- prior to
24 getting back into Petitioner's 15, we're going
25 to talk a little bit about those slides. How



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ROA_0321

1 many linear accelerators did DHEC approve in
2 2015 as a result of the Roper and MUSC
3 applications?

4 A: Well, it was in 2017.

5 Q: 2017, I apologize.

6 A: Okay. They approved two.

7 Q: Okay. Now, let's go -- we talked a little bit
8 about the project review slide, which was 11.
9 Yeah, I believe so. And I want to go back to
10 the slides if we could to Exhibit 15 and go to
11 page 12. And so what's on this slide, Your
12 Honor -- I mean, Mr. Sullivan.

13 A: This is beginning the discussion about community
14 need for another radiation therapy unit in the
15 area. And it's describing who the three
16 providers are and sort of where the existing
17 units are located in the community. So, it's
18 sort of setting the stage for assessing whether
19 or not there's a community need for additional
20 radiation therapy capacity.

21 Q: All right. Let's turn to the next page 13 of
22 this Exhibit 5 (sic). And this is -- would this
23 be the map you presented at the project review
24 meeting?

25 A: It is. The purple dots on there, if you will,



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ROA_0322

1 are the existing providers. And the two red
2 dots that are sort of, you know, to the north of
3 those providers are the proposed -- what was at
4 that time the proposed Roper linear accelerator
5 and the proposed MUSC Nexton project.

6 Q: Okay. And then we've got a series of multi-
7 colored graphs after that, if you would go to 14
8 for me.

9 A: Sure.

10 Q: That's self explanatory, but you can briefly
11 touch on it.

12 A: Sure. This just looks at trends and various
13 types of utilization statistics for radiation
14 therapy facilities. And the first one looks at
15 the trend in the historical radiation therapy
16 patients served. And the information that's
17 used on here comes -- each provider files an
18 annual questionnaire with DHEC and they report
19 on their the number of patients and the number
20 of treatments that they serve radiation therapy.
21 So, this was derived from various years what's
22 called joint annual reports.

23 Q: Okay.

24 A: And for some reason on these slides the actual
25 numbers don't appear. But, as you can see, the



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ROA_0323

1 number of patients was increasing over this
2 period of time, which it's certainly one
3 starting point for looking at what the future
4 need is for radiation therapy services.

5 Q: Let's go to the next slide, page 15 of Exhibit
6 15. How about this?

7 A: Well, this is probably the more important
8 statistic. And this is how many radiation
9 therapy treatments were actually being performed
10 in the service area. And we'll have some later
11 slides that actually put numbers to all of this.
12 But, as you can see, that the number of
13 radiation therapy treatments really hadn't
14 grown. The number of patients was growing, but
15 the number of radiation therapy patients was not
16 growing. And, you know, the simple fact is that
17 the number of treatments per patient has been
18 declining in the service area. So, while the
19 number of cancer patients is increasing in the
20 service area, the number of patients who are
21 being referred for radiation therapy is
22 increasing in the service area, the actual
23 utilization of radiation therapy units in the
24 service area was not increasing. In fact at
25 this point in time the trend had been a little



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ROA_0324

1 bit down, the numbers were dropping a little
2 bit. And so, you know, sort of health planning
3 101, when you have declining utilization in an
4 area, an area that historically was able to
5 serve a certain number of radiation treatments,
6 and that number has declined, it wouldn't lead
7 you to believe off the bat, you know, that there
8 would be a need for additional capacity in the
9 area.

10 Q: Let's go to the next page. All right. Why
11 don't you just kind of run down through these
12 bullets. I think you've touched on it a little
13 bit here, but ---

14 A: Yeah. You know, without repeating everything
15 Dr. Williams just talked about, there's the --
16 you know, the newer protocols are resulting in
17 fewer treatments for different types of cancers,
18 some fairly common cancers, like he'd mentioned
19 for breast and prostate. And that's had an
20 impact on -- I'm sorry, we skipped over to the
21 next one.

22 MR. THOMAS: Yeah. Can we go back one? We're going
23 to 16. There we go.

24 Q: Okay.

25 A: And as Dr. Williams talked about, the technology



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ROA_0325

1 has improved from more precise targeting. You
2 know, we're using SRS and SBRT to a greater
3 extent, which have fewer fractions or treatments
4 for a course of treatment. But, you know, as I
5 said, even though both applicants in this case,
6 Roper and MUSC, were projecting that more
7 patients would require radiation treatment in
8 the future, there was certainly no indication
9 that there was going to be a significant
10 increase in the need for radiation therapy
11 capacity in the future.

12 **MR. THOMAS:** Let's go to the next slide if we could,
13 17.

14 **Q:** All right. Would you explain what's going on on
15 this page if you could.

16 **A:** Sure. Both applicants in this case -- going
17 back in time now when Roper was still involved
18 in this -- were arguing that there was no cancer
19 provider in Berkeley -- I mean, no radiation
20 therapy provider in Berkeley County. And that's
21 technically true. But Trident is located about
22 a mile from the Berkeley County line. It's also
23 located very close to the Dorchester County
24 line. And it's located in pretty close
25 proximity to the population centers where the



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ROA_0326

1 concentration of population is in Berkeley
2 County. And so, in my view, approval of either
3 of these projects would have resulted in minimal
4 improvement in geographic access to the
5 radiation therapy services. And the one area
6 that you might be able to argue, is somewhat
7 remote from radiation services, would be
8 northern Berkeley County where Moncks Corner is.
9 But no one was proposing to put a radiation
10 therapy unit in Moncks Corner. Everything was
11 sort of crowding around that southern portion of
12 Berkeley County.

13 Q: Is that population area that you're talking
14 about kind of the density, is that the Goose
15 Creek area?

16 A: Yeah. Goose Creek is kind of the heart of that,
17 you know. And there's a number of other sort of
18 suburban communities just outside of Goose Creek
19 that are developing.

20 **MR. THOMAS:** Let's go to the next slide.

21 Q: And it's another graph.

22 A: Yeah. And, you know, the primary provider of
23 radiation therapy services to that community,
24 that North Charleston, Dorchester, Berkeley
25 County community, is Trident Medical Center.



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ROA_0327

1 Trident is the most proximate facility there.
2 That's where they draw the majority of their
3 patients. And Trident's radiation treatments
4 have been declining. They had a little bit of
5 a growth bump up in 2015. It went down in 2016.
6 So -- and just a little bit of history; Trident
7 added a radiation therapy unit back in 2013,
8 they initiated another unit. And at that time
9 Trident's volume was going up. But very shortly
10 thereafter their volume started declining. And
11 so all of a sudden Trident was sitting there
12 with a lot of excess capacity in its radiation
13 therapy unit. So, there certainly wasn't a
14 capacity constraint in terms of the ability to
15 serve patients in the northern part of the
16 service area, you know, the four county service
17 area. And so another concern we had is that the
18 project was going to further increase the degree
19 to which there was unused capacity of radiation
20 therapy services in the area.

21 **MR. THOMAS:** Okay. Let's go to page 25 next if we
22 could.

23 **Q:** We're going to go to page 25 in Exhibit 15, Mr.
24 Sullivan.

25 **A:** Sure.



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ROA_0328

1 Q: All right. This is a slide that's entitled
2 MUHA's Proposed Service Area. Can you talk a
3 little bit about that?

4 A: Sure.

5 Q: And, again, this is in the context of -- this is
6 what was presented to DHEC at the project review
7 meeting back in 2017.

8 A: That's right. MUHA divided up its market into
9 a number of sub markets. And what it said that
10 it was targeting for this particular radiation
11 therapy center were three sub markets. It was
12 Summerville, Moncks Corner, and North
13 Charleston. Summerville is -- I think what they
14 called Summerville was sort of the Summerville
15 area in Dorchester County and maybe a small
16 portion of Berkeley County. Moncks Corner would
17 be that northern part of Berkeley County. And
18 then -- or the rest of Berkeley County. And
19 then North Charleston would include the area
20 south of their proposed site, going all the way
21 down to the boundary of Charleston, just to the
22 north of -- even onto the peninsula of
23 Charleston. And, you know, I have some concerns
24 about this service area. First of all, within
25 Berkeley County, the southern part of Berkeley



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ROA_0329

1 County is Daniel Island. And, Your Honor, I
2 don't know how much you know about Charleston
3 geography, but Daniel Island is immediately
4 adjacent to Mt. Pleasant. 526, which was the
5 new expressway they built -- I think of it
6 recent, but it was probably 20 years ago -- that
7 kind of goes around the outskirts of Charleston,
8 connects North Charleston, Daniel Island, and
9 Mt. Pleasant. And so for Daniel Island folks,
10 they could easily go to Mt. Pleasant. For folks
11 who are in the southern portion of that North
12 Charleston community that MUSC was targeting, a
13 lot of those are as close or in some cases even
14 closer to MUSC downtown than they would be to
15 the proposed center up in Nexton, you know, up
16 at Exit 199. And, you know, the other concern
17 I had about it is that their service area almost
18 completely overlaps the service area of Trident,
19 you know. So, it wasn't an area that wasn't
20 being served. It was simply an area that they
21 wanted to come in and serve patients in where I
22 didn't see a need for another provider.

23 Q: The last bullet there, the 80 percent capacity,
24 can you describe why that's an important
25 concept?



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ROA_0330

1 A: Sure. In the State Health Plan, the criterion
2 that MUSC was traveling under was criterion
3 seven. And the first test that they had to pass
4 was whether or not for the past two years their
5 existing linear accelerators were operating at
6 a minimum of 80 percent utilization.

7 Q: Okay. And at the time that you reviewed the
8 application and DHEC reviewed the application,
9 what was the representation?

10 A: The representation -- and I think it was based
11 on the two prior fiscal years, fiscal years '15
12 and '16 -- that MUSC had exceeded 80 percent in
13 both of those years. In 2016 I think the
14 percentage was 80.1 percent.

15 Q: Okay. And of course we know -- has that figure
16 changed since then?

17 A: Yeah. We learned a few weeks ago that the
18 numbers were off for fiscal 2016. And, in fact,
19 the number was below 80 percent. Instead of
20 being a little over 80 percent, it was actually
21 below 80 percent. They adjusted that number
22 down.

23 Q: Okay. We'll get into that in a little bit. I
24 want to kind of go to the next slide, just so we
25 can kind of finish out what you showed to DHEC.



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ROA_0331

1 And I don't know if I asked you this, but did
2 you create the slides that we're going over?

3 A: I did, all of them.

4 Q: Okay. I just wanted to make sure. And tell The
5 Court about page 26 here in Exhibit 15.

6 A: Sure. This was just to sort of graphically
7 depict what was going on at MUSC. MUSC really
8 wasn't having any growth in utilization of
9 radiation therapy services. In fact, their
10 number in 2016 was below what their number was
11 in 2013. And so, if they had been operating
12 with the number of radiation therapy units they
13 had effectively in 2013, from a health planning
14 standpoint it didn't strike me that there was
15 all of a sudden a dire need for additional
16 capacity in 2016 based on volumes that were
17 somewhat lower.

18 **MR. THOMAS:** Let's go to number 27 in P 15 if we
19 could. For the record, I don't know if I said
20 this earlier, Your Honor, instead of saying
21 Petitioner's 15, I'm going to try to keep that
22 shortened to P 15 or whatever exhibit I'm
23 referring to.

24 Q: Tell us about this slide of P 15, page 27.

25 A: Sure. This is where we talked about the adverse



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ROA_0332

1 impact of the approval of either the MUSC or
2 Roper projects. You know, as I already
3 mentioned, the area that both of these
4 applications sought to serve was the area that
5 was -- the primary area that Trident drew
6 patients from. The source of referrals that
7 either of these applicants would seek to tap
8 into were the same sources that Trident received
9 its referrals from. And so the expectation was
10 there'd be some material redirection of patients
11 away from Trident to one or the other of these
12 proposed linear accelerators and also that
13 Trident was already an underutilized program and
14 so the approval of either of these projects was
15 likely to exacerbate that underutilization.

16 **MR. THOMAS:** Okay. Let's see the graphic on the next
17 page, on 28.

18 **Q:** What does this graphic show, Mr. Sullivan?

19 **A:** This was a depiction of Trident's primary and
20 secondary service area for radiation therapy
21 patients at that time. This was, I think, based
22 on 2016 data, as I recall. And what it shows is
23 that the MUSC and the Roper projects are pretty
24 much directly in the middle of the primary
25 service area, that's the lighter yellow shading



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ROA_0333

1 of the zip code. And so, obviously Trident had
2 a legitimate concern about the potential impact
3 of this project on their future operations.

4 **MR. THOMAS:** Let's go to the next slide, Ms.
5 Mitchell.

6 Q: We're going to page 29 of P 15, Mr. Sullivan.

7 A: Sure. You know, one of the criteria is
8 distribution of services. And in my estimation,
9 this project would do virtually nothing to
10 improve the distribution of radiation therapy
11 services. Again, we're talking about community
12 need here. And with community need we're not
13 looking at the institutional interest of any
14 particular provider. We're looking at it from
15 the standpoint, is the community as a whole
16 going to benefit from the approval of one or
17 more of these projects. And in this case I
18 didn't see any significant improvement in the
19 distribution of services. The MUSC project was
20 closer to Trident than the Roper project, but
21 neither one was so distant that it really made
22 a tremendous difference in terms of patient's
23 ability to access radiation treatment.

24 Q: Okay. In terms of the third bullet there, can
25 you explain what you meant by that?



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ROA_0334

1 A: Sure. The -- you know, the point that I think's
2 been raised already in this proceeding is that,
3 if the medical university or Roper's medical
4 oncologists or other referring physicians are
5 concerned with patients having to travel
6 downtown or to St. Francis over in West Ashley
7 to get radiation treatment, there's another
8 alternative. And that alternative would be to
9 allow them to get their radiation treatment at
10 Trident, which would be significantly more
11 accessible for those patients who lived in that
12 northern part of the service area.

13 Q: And in your bullet point 4 what's the point
14 you're trying to make there?

15 A: That the referral of patients to other centers
16 to receive radiation treatment is not something
17 that's unusual or rarely done. You know, I
18 worked on a case in Alabama in the last couple
19 of years where the University of Alabama at
20 Birmingham, which was an NCI-designated cancer
21 treatment center, would diagnose patients and
22 then they would consult with radiation treatment
23 centers in the communities and refer those
24 patients back to those local radiation treatment
25 centers to receive their treatment, so they



1 wouldn't have to drive from north Alabama or
2 south Alabama to Birmingham to get treatment.
3 You know, I personally have friends, you know,
4 who've been to MD Anderson and have been able to
5 come back to Charleston and receive radiation
6 treatments in Charleston even though the
7 protocols were developed perhaps in conjunction
8 with, you know, consultation with the MD
9 Anderson folks.

10 Q: Just for the record, where is MD Anderson?

11 A: It's in Houston.

12 **MR. THOMAS:** Okay. Let's go to slide 31, which would
13 be not the next one, but the one after that.

14 Q: And here I think we're still on the distribution
15 project review criterion. Could you kind of
16 round that out for us here?

17 A: Sure. You know, this service area has probably
18 better access to radiation services than almost
19 any other service area in South Carolina. The
20 units are located, you know, into different
21 population pockets within the community. For
22 example, there are five units downtown now with
23 Roper and four at Medical University. There's
24 only one unit over in Mt. Pleasant, but they do
25 have access to a unit there. And there are now



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ROA_0336

1 two units over at West Ashley. And there are
2 three units located at Trident at the north
3 area. So, you've got a good distribution of the
4 existing units. And what would occur, if DHEC
5 were to approve both of the projects, that you
6 would now have five units all clustered in a
7 relatively close proximity to each other in the
8 northern part of the service area, when you
9 would have large sections of service area that
10 would have fewer units. Mt. Pleasant, for
11 example, which I think is now the second --
12 maybe the fourth largest city in South Carolina
13 I believe, is growing very rapidly, has single
14 unit. West Ashley, which is I think also
15 approximate to what MUSC calls the Sea Island,
16 that area would only have two units. And so it
17 didn't seem to be any logic expressed by the
18 applicants, in this case MUSC or Roper, that
19 would support clustering as many units as they
20 were proposing in that north area.

21 Q: Okay. And bullet point 2 and bullet point 3.
22 Can you explain what you meant there?

23 A: It would seem that, if there was a need for
24 additional capacity -- I mean, I didn't see it,
25 but, you know, if there was a need for



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ROA_0337

1 additional capacity, it would be better for the
2 healthcare system if MUSC and Roper would expand
3 one of their existing sites. One thing about
4 healthcare planning I think that all healthcare
5 planners recognize is, when you expand services
6 at an existing location, that has the least
7 impact on the healthcare system. It's when you
8 begin to develop facilities in new locations
9 that you begin to alter referral patterns and
10 you begin to have greater impacts on existing
11 providers. In some cases there's a good reason
12 to do that. In this case I didn't see a good
13 reason to do that. So, by expanding -- you
14 know, if indeed there was a need for new
15 capacity, which I don't think had been
16 demonstrated, expanding at their existing
17 locations -- for example for MUSC expanding in
18 Mt. Pleasant where they only had a single unit
19 that was well utilized -- would have made
20 perfect sense. And for Roper, adding another
21 unit to West Ashley perhaps would have made
22 sense.

23 Q: All right. Let's round it out. Next slide 32.
24 This is concept of unnecessary duplication. Can
25 you explain to The Court what that means and how



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ROA_0338

1 it is applicable in this case.

2 A: Sure. You know, the approval of any new project
3 results in duplication of services, unless it's
4 the only one, you know, in the service area.
5 And that's certainly not the case here. In some
6 cases that duplication is necessary. You know,
7 for example, a particular subgroup in the
8 population is not being well served by the
9 existing providers, so it makes sense to provide
10 additional capacity to meet the needs of those
11 folks. But when you add a new service or
12 additional capacity to an area that's already
13 well served, whether it's excess capacity
14 already existing and where you don't have a
15 material improvement in access to care for
16 patients, then in my view that would represent
17 unnecessary duplication.

18 Q: All right. Let's go to -- we're going to go
19 into the actual application, which is the DHEC
20 record. I believe that's DHEC Exhibit 1.

21 **(Respondent DHEC's Exhibit Number 1 was introduced**
22 **into the record at this time.)**

23 A: Okay.

24 Q: And I think it's right here.

25 A: Thank you.



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ROA_0339

1 Q: I think you've already kind of talked about the
2 description of the project. If you turn over to
3 -- first of all, let's talk about this just to
4 get it on the record. On the first page that
5 Ms. Mitchell's put up here, DHEC 1, what is the
6 date that DHEC actually received the
7 application?

8 A: May 22nd, 2017.

9 Q: Okay. And approximately how far in advance of
10 that is that from MUSC's fiscal year 2016 ending
11 date?

12 A: About 11 months.

13 Q: Okay. And let's go into the CON application to
14 page CON 11 if we could.

15 A: Okay.

16 Q: And I think this is a summary of the project
17 cost. But one of the things I wanted to ask you
18 about -- I've heard it mentioned a couple of
19 times in Cross -- but in reviewing the
20 application, Mr. Sullivan, did you see any cost
21 associated with a telehealth service at the MUSC
22 Nexton site?

23 A: I did not.

24 Q: Okay. Is it your understanding, based on the
25 application, that MUSC's going to provide any



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ROA_0340

1 stereotactic radio surgery at the Nexton site?
2 A: It's my understanding they weren't planning to
3 do that.

4 Q: Let's go to -- we're going to stay in the
5 application now, but you mentioned roughly where
6 this was going to be located. Approximately how
7 far away?

8 **MR. THOMAS:** Do you have Petitioners 19? Do you
9 think you could pull that up real quick?

10 Q: And I might ask you to go into another notebook.
11 Go to P -- let's go to P 19.

12 A: Okay.

13 Q: Just so -- to make sure we get it in the record.
14 There we go.

15 **(Petitioner's Exhibit Number 19 was introduced into**
16 **the record at this time.)**

17 Q: Have you seen this slide before?

18 A: I have.

19 Q: Okay. And this is one that was produced by
20 MUSC, correct?

21 A: Right.

22 Q: And tell The Court what does it show?

23 A: It just shows, as the crow flies, if you will,
24 distances both Summerville Medical Center and
25 Trident Medical Center. And then at the very



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ROA_0341

1 top where those two circles sort of intersect is
2 the Nexton community where MUSC is proposing to
3 put its facility.

4 Q: Okay. And I'm going to use my pen here and kind
5 of point on the screen. But is this
6 intersection here between -- I think it says 176
7 and I think that's Alternate 17, across there,
8 is that known as Carnes Crossroads?

9 A: It is.

10 Q: And right on the northern part of that X between
11 these two roads, is that where Roper Hospital's
12 linear accelerator will be?

13 A: Yes. That's where the new hospital is being
14 developed.

15 Q: Okay. All right. And just -- I know it doesn't
16 say exactly, but will the Roper linac be closer
17 to Nexton than the Trident linac?

18 A: Will the Roper be closer to Nexton?

19 Q: Yes.

20 A: Yes.

21 Q: Yeah. The one at Carnes Crossing.

22 A: It'll be about three miles away.

23 Q: Okay. Now, let me go to Respondent's 35, if I
24 could. We'll talk about this site.

25 (Respondent MUSC's Exhibit Number 35 was introduced



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ROA_0342

1 into the record at this time.)

2 Q: All right. Have you seen this slide produced by
3 MUSC?

4 A: I have.

5 Q: Okay. What does this slide show?

6 A: It's, I guess, sort of a blowup of a portion of
7 this Nexton development. And on the south end
8 it shows where the proposed Berkeley linac is.
9 It also shows where the Palmetto Primary Care
10 Physicians medical office building is. Both of
11 those are in close proximity to each other, that
12 southern portion of Nexton. And then at the
13 northern part of the slide it shows where the
14 proposed MUSC community hospital is in Nexton.

15 Q: A lot of green in that slide, isn't it?

16 A: There is.

17 Q: What's your takeaway from this slide, given what
18 MUSC chose to point out there?

19 A: Well, I guess it's two things. I mean, one,
20 this unit's not going to be located in a
21 hospital. And there are certain advantages, as
22 Dr. Williams, that some patients who are served
23 by linear accelerator are inpatients. And the
24 ability to transport those patients down an
25 elevator is a lot easier than transporting them



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ROA_0343

1 in an ambulance. Secondly, that the proposed
2 site of the linear accelerator is going to be
3 right next to the a large office building that
4 Palmetto Primary Care has developed.

5 Q: And why is that significant?

6 A: Well, Palmetto Primary Care, as Mr. Gallati,
7 testified to yesterday, is a very large primary
8 care group. I think he said over a hundred
9 professional and a significant source of
10 referrals for Trident and for its radiation
11 oncology program. And the proximity of these
12 two things would lead one to believe that there
13 would at least be some effort on MUSC's part to
14 try to market its radiation therapy services to
15 those physicians who historically have referred
16 patients to Trident. And that certainly raises
17 concerns as it relates to the potential impact
18 of the project.

19 Q: Okay. There's a line -- and you can go back to
20 DHEC Exhibit 1 CON. I believe it's on page 10.
21 I probably should have gone there before another
22 one. But there's a line. And I will read it
23 for you and ask you to comment. It says, the
24 Network is committed to providing the highest
25 quality of care for its patients at the most



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ROA_0344

1 affordable cost, creating a value proposition
2 currently not available in Berkeley County. Do
3 you have any opinions on that assertion?

4 A: I do.

5 Q: Can you expound on those?

6 A: Yeah. I'm not quite sure what a value
7 proposition is, but, you know, I think what
8 they're tending to say is that the approval of
9 this project is going to create something that
10 currently is not available to Berkeley County
11 residence. And I simply disagree with that.
12 You know, I mean, Berkeley County residents,
13 particularly those that are located approximate
14 to the proposed MUSC radiation therapy site,
15 have very good access to radiation therapy. And
16 if there was any concern about them having
17 access, the fact that Roper is now going to have
18 a radiation therapy center located about three
19 miles away and more into the interior of
20 Berkeley County, would indicate to me that
21 there's going to be no true value from an access
22 standpoint or from a cost standpoint to the
23 development of the MUSC project.

24 Q: You know, it's -- I don't know if it's a joke or
25 whatever you want to call it, but in Richland



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ROA_0345

1 and Lexington County -- and we always talk about
2 the Congaree River, Saluda as being a
3 geographical barrier. That's why, you know,
4 people from Lexington don't really come into
5 Richland County unless they work and vice versa.
6 But my question to you is, is there any such
7 similar geographic barrier around Berkeley
8 County that somehow prevents its patients from
9 accessing Trident?

10 A: There is not. The access from Berkeley is
11 actually pretty good. I-26, as well as
12 secondary roads in that area, make accessing
13 Trident pretty straight forward. And while
14 traffic has increased in that area, the density
15 of traffic is, at least based on my experience
16 in driving through Charleston, is south of where
17 Trident is where you have the really intense
18 traffic. And so, I think there's excellent road
19 access. It's relatively short travel times.
20 MUSC is going to provide a very marginal
21 improvement and access and only -- I mean, not
22 to the point where it would dictate that you
23 should approve the project.

24 Q: Let's turn over in DHEC Exhibit 1 to page 18.

25 A: Okay.



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ROA_0346

1 Q: Figure four, I think we talked a little bit
2 about this when we were going over your project
3 review slides. So, figure four, you mentioned
4 that the 80.1 percent was an inaccurate figure.
5 How do you know it is inaccurate?

6 A: Well, one, my understanding from Ms. Murdock's
7 deposition is that MUSC told DHEC that it was
8 inaccurate. Two, they produced documents that
9 showed sort of running totals on a monthly basis
10 of utilization of the linear accelerators at
11 MUSC. When you look at the utilization for
12 fiscal year 2016, it's not 19,221, it's 19,192.

13 Q: Okay. I think I'm going to try to get us there
14 and to Petitioner's Exhibit 53. I think that's
15 what you're referring to. And quickly, I don't
16 think we need to put it up on the screen,
17 because I think the Judge has seen it. But if
18 you go to Joint Exhibit 5 for me, which is the
19 State Health Plan, the applicable 2015 State
20 Health Plan.

21 A: Okay.

22 Q: And just -- I want you to read into the record
23 what Standard 7 states.

24 A: Okay. Expansion of an existing service, whether
25 the expansion occurs at the existing site or at



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ROA_0347

1 an alternate location in the service area, shall
2 only be approved if the service has operated at
3 a minimum use rate of 80 percent of capacity for
4 each of the past two years and can project a
5 minimum use rate of 50 percent of capacity per
6 year on the additional equipment within three
7 years of implementation.

8 Q: And keep going.

9 A: If the additional equipment is a specialized
10 radiotherapy unit as described in either
11 Standard 2, 3, or 4 above, then the existing
12 provider may propose an annual capacity for that
13 additional unit, based on the specialized use of
14 the equipment by that applicant. If the
15 applicant can justify this proposed annual
16 capacity, then this capacity will be used in CON
17 application calculations, as well as future
18 capacity calculations, for that applicant.

19 Q: While I've got you in there why don't we just go
20 back one page to -- in Joint Exhibit 5. I think
21 it's IX4 in the actual State Health Plan. Let
22 me know when you're there.

23 A: I'm there.

24 Q: There's a reference to Standards 2, 3, and 4
25 that I want you to read into the record. We're



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ROA_0348

1 going to be talking about those.

2 A: Okay. Sure. Standard 2, linear accelerators
3 providing IMRT or IGRT have a capacity of 5,000
4 treatments per year. A facility must document
5 that it is providing or will provide these
6 specialized treatments in sufficient volume to
7 justify why it should be held to this planning
8 capacity.

9 Q: Okay. And without having to read it into the
10 record, for number 3, is it pretty much the same
11 language for the standard, but it applies to
12 IMRT/IGRT linacs that area also performing
13 stereotactic procedures?

14 A: Correct.

15 Q: Okay. And what is the capacity that is assigned
16 to those units?

17 A: 4500 treatments per year.

18 Q: All right. And then Standard 4, same concept,
19 but these are linear accelerators that are just
20 providing stereotactic radiotherapy, correct?

21 A: Correct.

22 Q: And what is the capacity listed there that the
23 provider can assign?

24 A: 1500.

25 Q: Okay. And I guess the next question I have is,



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ROA_0349

1 that capacity can only be assigned if done in
2 sufficient volume?

3 A: Right. That's what it says.

4 Q: We'll talk a little bit about that later. I'd
5 like to go back to Exhibit P 53 if we could,
6 which is that MUSC spreadsheet that you were
7 referencing.

8 A: Okay.

9 **(Petitioner's Exhibit Number 53 was introduced into**
10 **the record a this time.)**

11 Q: Okay. Well, this will be fun to read. When I'm
12 looking at the MUSC document, Mr. Sullivan, P 53
13 here, is June -- if you go down a little bit --

14 **MR. THOMAS:** Thanks for pulling that out.

15 Q: If you go to it looks like in the middle of the
16 pullout there where it says June '16, do you see
17 that?

18 A: I do.

19 Q: Okay. And there's -- it looks like it's
20 highlighted in yellow. It looks like MUSC has
21 labeled that as 80 percent. Do you see that?

22 A: I do.

23 Q: Okay. Do you agree with that percentage
24 assignment there?

25 A: I don't.



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ROA_0350

1 Q: Why not?

2 A: Because it's been rounded and the actual
3 percentage is 79.97 percent.

4 Q: Okay. And 79.97 is actually a rounding from
5 79.96667 or something along those lines?

6 A: That's correct, repeating.

7 Q: And just on the line item, if you keep going to
8 the right there, there's a red square. And then
9 right after that there's a number, 19221. What
10 does -- do you know what that number represents?

11 A: Yeah. I think the column heading is -- says
12 JAR, J-A-R, which is what was reported on the
13 joint annual report.

14 Q: Okay. And then the percentage there is 80.1
15 percent. What's the number to the right of
16 that?

17 A: That's the corrected number based on the actual
18 data there shown on the first numerical column
19 on the spreadsheet.

20 Q: Okay. And then again there they've listed that
21 as 80 percent, correct?

22 A: That's right.

23 Q: Okay. And, again, I think you've already
24 mentioned, the CON was submitted to the
25 Department how many months after June '16?



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ROA_0351

1 A: Almost 11 months.

2 Q: Okay. In terms of that, that submission date
3 and using the fiscal year number, do you have an
4 opinion about that?

5 A: Well, I mean, the starting point usually is to
6 look at the JARs. And so the two most recent
7 JARs from my understanding would have been 2015
8 and 2016 JARs. But because the standard in the
9 State Health Plan talks about, you know, looking
10 at the two most recent years, I mean, I think a
11 reasonable approach might have been to look at
12 two calendar years, because you had two
13 complete calendar years of '16 and '15 that were
14 available before the application was filed. And
15 that would have given probably the two
16 consistent time periods from the closest period
17 in time to when the application was filed.

18 MR. THOMAS: Can you pull up Petitioner's 11 real
19 quick?

20 (Petitioner's Exhibit Number 11 was introduced into
21 the record at this time.)

22 Q: This is Petitioner's 11. Can you explain what's
23 on this slide, the source of it?

24 A: Sure. This is just taken from this exhibit,
25 Petitioner's 53. I guess the first point it



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ROA_0352

1 makes is that during fiscal year 2016 MUSC fell
2 short of 80 percent. 79.97 is not 80 percent.
3 On a calendar year basis for 2016 they were at
4 79.33 percent. So, I don't think anybody would
5 round that up to 80 percent. And then, even if
6 we looked at the rolling 12 months right after
7 the time where they filed the application -- I'm
8 sorry, this would be the -- yeah, I mean right
9 after the time they filed the application, the
10 actual utilization rate was about 76.89 percent.
11 Again, well below the 80 percent target.

12 Q: Might that have been a reason MUSC didn't want
13 to use calendar year rolling 12?

14 MR. DAYHUFF: Object to the form of the question.
15 Leading.

16 Q: What reason may MUSC have had for not wanting to
17 use calendar year 2016 or the rolling 12, Mr.
18 Sullivan?

19 A: Well, certainly from reviewing this data, as you
20 went closer in time to the period in which the
21 application was filed, the farther below the 80
22 percent target MUSC's utilization fell.

23 Q: Okay. So, in terms of the data that you see
24 here that DHEC didn't have access to at the
25 time, in your opinion did this application at



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ROA_0353

1 the time, had DHEC had the access to the correct
2 data, would it have complied with Standard 7 of
3 the State Health Plan?

4 A: In my view it would not.

5 Q: Okay. Can you provide the basis for your
6 opinion?

7 A: Sure. The State Health Plan says a minimum of
8 80 percent. And so that establishes a floor, if
9 you will, the lowest utilization level that
10 would be consistent with the standard. And
11 79.97 is simply not at that floor. I mean, it's
12 -- I think I used the analogy in my deposition
13 if you're running a hundred yard dash and you go
14 99.9 yards, you don't hit the tape, you know,
15 you don't cross the finish line. And I think
16 the same thing is true here. If it had said in
17 the State Health Plan about 80 percent, close to
18 80 percent, then I think, you know, maybe they
19 would be consistent with it. But it said a
20 minimum of 80 percent. And so, you know, I
21 think that it would be a slippery slope to say,
22 well, it's not quite there, but it's close,
23 because then where do you draw the line, if it's
24 79.7, 79.6, 79.5? You know, there is -- it
25 would be arbitrary to say we'll round up here,



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ROA_0354

1 but we wouldn't round up in other situations.
2 And I think the notion of rounding up is
3 inconsistent with the notion of meeting a
4 minimum level of utilization.

5 Q: Are you aware of any situations where the State
6 of South Carolina rounded up in order to bring
7 an applicant into compliance with the Standard?

8 A: No.

9 Q: Let's talk about the concept I believe we heard
10 in the opening and I believe that was discussed
11 in Ms. Murdock's deposition, this idea of using
12 later time periods. In your opinion can The
13 Court rely on the latest data showing MUSC at 80
14 percent for, say, calendar years 2017 and 2018
15 given the de novo posture of the contested case?

16 A: Well, The Court certainly can consider that, but
17 I don't think it would be sufficient to
18 establish the need for this project. And let me
19 give you my logic for that.

20 Q: Okay.

21 A: This application was filed in May of 2017. The
22 applicant represented to DHEC that it met the
23 requirements of achieving at least 80 percent in
24 the two prior years. DHEC relied on that
25 information in approving the application. And



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ROA_0355

1 if that information was wrong, then DHEC should
2 have denied the application at that point in
3 time. And that changes the whole posture of
4 this project.

5 Q: How so?

6 A: Because if it were denied, then -- and I'm not
7 going to give a legal opinion, but just my
8 health planning understanding is it sort of
9 flips things around in terms of what has to
10 happen going forward. In that case MUSC would
11 have to appeal its denial. It would have to
12 prove that it should have been approved, that
13 DHEC erred in some way in denying its
14 application. And if you -- in addition, it
15 might have changed the decision that Roper made
16 not to participate in the process. I don't know
17 that. I mean, I'm just saying that's one
18 possible outcome.. It certainly would have
19 opened the door subsequent to that to other
20 parties perhaps seeking to get approval for a
21 linear accelerator. There wouldn't be one
22 approved one in the inventory that didn't meet
23 the criteria. And it creates a tremendously un-
24 level playing field. You know, this isn't the
25 first time I've encountered this issue. I've



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ROA_0356

1 encountered it in other states before as well.

2 Q: Like where?

3 A: In Florida. Florida -- and I'm not saying that
4 MUSC did this. But in Florida what would happen
5 is applicants would apply for things knowing
6 that they didn't meet the standards and then
7 they would drag out litigation to the point
8 where the numbers all of a sudden lined up to
9 demonstrate a need for the project. And then
10 they would go forward with litigation and say,
11 okay, we meet the standards now. And so, I
12 think that -- I think with this -- from my
13 perspective, you know, as a health planner, what
14 I'm evaluating is did DHEC make the right
15 decision back in 2017 to approve this
16 application? In my view because they didn't
17 meet the standard, I would say no. And you
18 can't fix that by saying, well, gosh, we meet it
19 in the future, because the determination was at
20 the time we made this decision you had two years
21 of prior data where you were over 80 percent.
22 So, I think you can use later data to bolster an
23 argument. Let's say that you were at 80.1
24 percent as originally reported in the
25 application. And if you came back today and



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ROA_0357

1 said, gosh, in 2017 and 2018 were 82 or 83
2 percent, that even shows even more why we need
3 this additional capacity, I think that's a whole
4 different situation.

5 Q: So, in your estimation what should happen?

6 A: I mean, I think the -- well, I think one of two
7 things. I think that probably the best thing
8 would be for the application to be denied and
9 for MUSC -- or MUSC to withdraw its application
10 and to re-file under more recent data and then
11 try to demonstrate to DHEC that, based on the
12 current data, that it is in compliance with the
13 State Health Plan.

14 Q: Okay. In terms of this rounding up issue or the
15 later -- the consideration of more recent data,
16 do you have any other opinions with respect to
17 those two issues?

18 A: To the rounding up?

19 Q: Well, the rounding up in terms of the other
20 standards in the State Health Plan.

21 A: I'm sorry. I'm just --

22 Q: That's all right. Well, do you have any
23 opinions as to what the capacity MUSC stated?

24 A: Oh, I'm sorry. I wasn't quite following your
25 train of thought. Yeah, I mean, the -- you



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ROA_0358

1 know, we've been focusing right now on the
2 utilization number. But another critical
3 component of the calculation of utilization is
4 with the capacity of the existing units.

5 **MR. THOMAS:** Can we go to Respondent's 38 please.
6 Judge, I'm fine, but I just -- I know we've been
7 going awhile. I'm not sure if anybody wants to
8 take a break or anything like that. I'm good.

9 **MR. DAYHUFF:** We're fine.

10 **MR. THOMAS:** All right. Thank you, Judge. Let's go
11 to 38.

12 **(Respondent MUSC's Exhibit Number 38 was introduced**
13 **into the record at this time.)**

14 **Q:** This is showing you what's been marked as
15 Respondent's 38. And it's an MUSC slide. And
16 it shows the various capacities of MUSC's linac
17 units. Do you see that, Mr. Sullivan?

18 **A:** I do.

19 **Q:** Okay. Do you agree with the assignment of the
20 4500 capacity TrueBeams? And the TrueBeams I'm
21 asking about here are specifically TB140 and
22 TB41.

23 **A:** I don't. I mean, the -- I wasn't fully -- at
24 the time of my deposition I didn't even know
25 what capacities MUSC was assigning to various



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ROA_0359

1 units. I was sort of speculating, you know, on
2 what the capacities were based on my
3 understanding of what they were each doing. But
4 I think that when you look at the TrueBeams, I
5 think they probably do qualify for the -- the
6 140 and the 41 certainly qualify for the 5000
7 standard because of the IMRT percentage. I'm
8 not so sure that they qualify for the adjustment
9 down to 4500..

10 Q: Okay. Let's talk about the actual standards.
11 And if you want to pull up Joint 5 again to look
12 at the verbiage there ---

13 A: Sure.

14 Q: --- the capacities.

15 **MR. THOMAS:** And specifically for the record it'd be
16 Joint Trial Exhibit 5 at page five.

17 A: Okay.

18 Q: And so in order to -- let's start with Standard
19 3 here for radiotherapy. In order to have the
20 capacity of 4500 treatments per year, what must
21 a facility document?

22 A: That it is providing or will provide, and it's
23 talking about stereotactic procedures now, these
24 specialized treatments in sufficient volume to
25 justify why it should be held to this planning



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ROA_0360

1 capacity.

2 Q: Okay. In your opinion what does sufficient
3 volume mean?

4 A: I think the dictionary definition is enough for
5 the particular situation. You know, sufficient,
6 you know, to meet the needs of a particular
7 situation. You know, in my view from a health
8 planning standpoint, it would have to be some
9 material level that would actually impact the
10 capacity of the unit to serve patients. You
11 know, if you're serving only a handful of these
12 types of patients, it has a pretty minimal
13 impact on the overall capacity of the facility.
14 And I think that's what this standard is getting
15 at. If you're doing procedures that take longer
16 than the typical procedure, that may reduce your
17 overall capacity to serve patients. But if
18 you're only doing a handful of these procedures,
19 then that has a very minimal impact and would be
20 insufficient.

21 Q: Okay. Now, what informs your opinion of why you
22 do not believe the 4500 assignment to those two
23 linacs is a reliable proposition?

24 A: I don't believe either one of those LINACs has
25 really done a sufficient number of stereotactic



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ROA_0361

1 procedures to warrant that.

2 Q: Okay. Now, did you have an opportunity to look
3 at the native data files that were produced by
4 MUSC?

5 MR. THOMAS: I mean, just for the record I want to
6 put one up. Ms. Mitchell, if you could put up,
7 say, Petitioner's 27.

8 (Petitioner's Exhibit Number 27 was introduced into
9 the record at this time.)

10 Q: Can you explain to The Court kind of what this
11 document, which I believe in the record is over
12 100 pages of spreadsheet data, what it is?

13 A: Right. This is showing for fiscal year 2016 the
14 individual treatments that were done at MUSC.
15 And in this case I believe this is for the Mt.
16 Pleasant facility.

17 Q: Okay. This has got the location MPT; is that
18 your understanding?

19 A: Yes.

20 Q: Okay.

21 A: And so what it does is it shows the type of
22 treatment -- in that fourth column it shows the
23 type of treatment that was being provided.

24 MR. THOMAS: Okay. And we have a demonstrative that
25 we've already given to the other side, DHEC and



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ROA_0362

1 MUSC. And I think we'll put it up on the
2 screen, but I'll give it to you, Judge. This
3 won't be entered into evidence. It's just a
4 demonstrative based on some of the native files.

5 Q: So, Mr. Sullivan, for the fiscal year 2016 in
6 the Mt. Pleasant, what did you find there in
7 terms of the number of the specialized
8 stereotactic treatments that they did there?

9 A: Well, if you sort all of this data, I counted 12
10 -- they didn't do any what's called SRS,
11 stereotactic surgery. At least they didn't
12 report any. They only reported SBRT, or
13 stereotactic body radiation treatments.

14 Q: How do you know that?

15 A: Because that's what the codes show.

16 Q: Okay.

17 A: There's other documents that say that directly.

18 Q: Okay. And I think you might be referring to
19 Petitioner's 36, which is a rad onc treatment
20 procedure code key.

21 **(Petitioner's Exhibit Number 36 was introduced into**
22 **the record at this time.)**

23 A: Right.

24 Q: So, what was the percentage -- the total volume
25 of SBRTs was what at Mt. Pleasant in fiscal year



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ROA_0363

1 2016?

2 A: Twelve.

3 Q: Okay. And what was the total number of
4 treatments done at Mt. Pleasant?

5 A: 4567.

6 Q: So, the percent of the total there?

7 A: It's .26 percent, so a quarter of a percentage
8 point basically.

9 Q: Okay. And in your opinion, would that be
10 sufficient volume to justify a 4500 treatment
11 capacity for that unit?

12 A: It would not.

13 Q: Okay. And in terms of fiscal year 2017, let's
14 see here, I see you don't have a column for that
15 one.

16 A: Yeah. When I was putting this together, I
17 couldn't put my fingers on that particular ...

18 Q: Okay. But then you did have a column for fiscal
19 year 2018?

20 A: Yes.

21 Q: What did you find there?

22 A: It's .39 percent, so about four tenths of one
23 percent.

24 Q: Okay. And the assignment of the lower capacity
25 number of 4500, do you believe in your opinion



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ROA_0364

1 was that proper here?

2 A: I do not.

3 Q: Okay. And practically, if this unit has an
4 assignment of 4500, what does that allow MUSC to
5 say about its Mt. Pleasant linear accelerator in
6 terms of capacity operation?

7 A: Well, it says that it's operating above 100
8 percent of capacity in 2018.

9 Q: Okay. And in terms of the IMRT treatments, what
10 is your understanding of how long an IMRT
11 treatment will take?

12 A: You know, based on Mr. Clement's testimony,
13 about 15 minutes.

14 Q: Is it your understanding that Dr. Jenrette
15 testified about the same time?

16 A: Yes. I read his deposition.

17 Q: All right. Could you do a calculation -- if you
18 do it in your head, great. If you need a
19 calculator, I can provide that. But if there
20 are 250 days in a year and an IMRT treatment
21 takes 15 minutes in an eight hour day, what
22 would the functional capacity of that IMRT unit
23 be?

24 A: Well, if you assumed that there are eight hours
25 operating in a day, eight times 250 days is 2000



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ROA_0365

1 available hours. If you divide 2000 -- I'm
2 sorry, if you multiply 2000 available hours by
3 4, assuming that you could do 4 per hour, then
4 that would be 8000 would be the functional
5 capacity. You would want to build in a little
6 hedge time for maintenance or whatever. I
7 mean, certainly something between 7000 and 8000
8 treatments.

9 Q: Okay. So, in terms of the Exhibit 28 --

10 **MR. THOMAS:** If we can pull that up again.

11 **(Petitioner's Exhibit Number 28 was introduced into**
12 **the record at this time..)**

13 Q: And this is another native file, this is the IX,
14 the Clinac IX. I believe it's the fiscal year
15 data from 20 -- 7/1/2015 to 6/28/2016. Did this
16 Clinic unit perform any SRS or SBRT? Do you
17 know?

18 A: I believe it had a small number, but very small
19 number.

20 Q: Do you recall -- do you know what the assignment
21 was to this particular linac?

22 A: Yeah. I think MUSC assigned 5000 to this unit.

23 Q: Okay. Let's go on back down to your
24 demonstrative here. And, again, I think it's --
25 we can go to the native file. I do want to get



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ROA_0366

1 it into the record, but it's Petitioner's 23 and
2 that's the native file from 2014 on the TB4
3 unit.

4 **(Petitioner's Exhibit Number 23 was introduced into**
5 **the record at this time.)**

6 Q: I guess it was maybe installed a little bit
7 after the beginning of the fiscal year 2015, but
8 it's from 8/13/2014 to 6/30/2015. And that's
9 the fiscal year '15 data for that unit. And how
10 many SBRTs did you see that were done on that
11 downtown TrueBeam unit?

12 A: 233.

13 Q: Okay. What were the total treatments?

14 A: 5,477.

15 Q: So, your percent of the total there?

16 A: 4.3 percent.

17 Q: Okay. Now, same thing, I'm going to ask you for
18 Petitioner's 30, which is also native data, but
19 it's for that TB4 unit. That's the Mt. Pleasant
20 unit. That's fiscal year -- yeah, 2016. We
21 talked about that. P35 -- let me check
22 something real quick to make sure I'm doing the
23 right thing. Yeah, I'm sorry. Let's go to
24 Petitioner's 30. That's the fiscal year data,
25 fiscal year 2016 for the TrueBeam unit downtown.



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ROA_0367

1 (Petitioner's Exhibit Number 30 was introduced into
2 the record at this time.)

3 Q: And how many SBRT treatments were done in fiscal
4 year 2016, Mr. Sullivan?

5 A: 343.

6 Q: What was the total number of treatments there?

7 A: 5693.

8 Q: Okay. And so, the percent of that total?

9 A: Six percent.

10 Q: Okay. And then for the record, looks like if we
11 turn to Petitioner's 35, another native file,
12 did you do your sort on this?

13 (Petitioner's Exhibit Number 35 was introduced into
14 the record at this time.)

15 A: Yes.

16 Q: Okay. What did you find for -- it looks like we
17 only had six months of data here, but for fiscal
18 year 2017, the six months there?

19 A: 155 for that SBRT.

20 Q: And that was what percent of the total?

21 A: 4.8 percent.

22 Q: Okay. And then let's go for fiscal year 2018,
23 I believe that's Petitioner's 33 -- or excuse
24 me, Petitioner's 43.

25 (Petitioner's Exhibit Number 43 was introduced into



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ROA_0368

1 the record at this time.)

2 Q: And that was more of a compendia document that
3 looks like the data's been sorted for us. But
4 what did you find in terms of what was being
5 done downtown on the TrueBeam unit in fiscal
6 year 2018?

7 A: 389 SBRT treatments.

8 Q: Okay. Out of a total number of how many
9 treatments?

10 A: 4,813.

11 Q: Okay. Percentage?

12 A: 8.1 percent.

13 Q: Why did you want to look at the fiscal year 2017
14 and 2018 even though that wasn't considered by
15 the Department?

16 A: Just to see if there was any justification for
17 those units having that capacity.

18 Q: Okay. And so where does that place MUSC's
19 capacity given this data that we've just gone
20 over with The Court?

21 A: Well, I think that if you just make the
22 adjustments to these two units -- and I think
23 there's other issues we'll address -- but that
24 would add 500 to the Mt. Pleasant unit, that
25 would add 500 to the capacity of the downtown



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ROA_0369

1 TrueBeam. So, instead of having a 4500
2 capacity, they'd each have 5,000. So, that
3 would be an overall increase in capacity of
4 1,000 treatments.

5 Q: And I just want to make for the record clear.
6 Until we saw the actual assignments of the
7 capacities on this slide, is there anywhere
8 where you saw a capacity assignment per unit at
9 MUSC?

10 A: I did not. You know, I -- in my deposition I
11 was just trying to infer from other things what
12 those capacities might be, but I had no clear
13 idea of what they were claiming.

14 Q: Okay. And to your knowledge, did MUSC show DHEC
15 the capacities by unit and what the specialized
16 treatment were per unit at any time during the
17 CON review process?

18 A: I never saw that.

19 Q: Okay. I'd like to go to Respondent's 9 if we
20 could. I'll show the front page there. If you
21 want to look on the screen or if you want to use

22 ---

23 A: I can pull it up. That's fine.

24 **(Respondent MUSC's Exhibit Number 9 was introduced**
25 **into the record at this time.)**



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ROA_0370

1 Q: Okay. All right. So, what is this document,
2 Mr. Sullivan?

3 A: This was the project review presentation that
4 MUSC presented. You know, that same meeting
5 that I discussed earlier where I discussed our
6 opposition.

7 Q: Okay.

8 **MR. THOMAS:** Could you flip over, VickiLynn, to page
9 25 of that particular exhibit?

10 Q: Now, this is a -- I guess a critique of Roper
11 St. Francis' capacity. Can you tell us what
12 MUSC's position was there on the top half of the
13 page?

14 A: Sure. This was discussing what Roper had said
15 in its -- in one of its submissions to DHEC
16 about why it adjusted the capacity of its units.
17 And it noted that over the years, that 20
18 percent was IMRT or IGRT and then also talked
19 about St. Francis having IMRT/IGRT of 25
20 percent. And then the little note under that
21 says these numbers are lower than the national
22 average and do not justify the lower capacity.

23 Q: Okay. So, is -- although we're talking about
24 SBRTs, were the SBRTs anywhere close to 20 or 25
25 percent --



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ROA_0371

1 A: They were not.

2 Q: -- of the unit capacity? Okay. I want to take
3 you back to Exhibit P 43, which is the -- it's
4 the kind of compendium 2018.

5 A: Right.

6 Q: I want you to look at the far side of that --
7 the far right-hand column of that spreadsheet,
8 Mr. Sullivan.

9 A: Okay.

10 Q: And there is -- at the top it says Varian 600CD.
11 Do you see that?

12 A: Right.

13 Q: Okay. How many treatments in fiscal year 2018
14 did MUSC do on that particular unit?

15 A: Seventy three.

16 Q: And what do you understand those treatments to
17 be?

18 A: I think Dr. Jenrette described that in his
19 deposition as being total body irradiation. As
20 was discussed earlier this morning, that's done,
21 as I understand it, to prepare a patient for a
22 bone marrow transplant.

23 Q: Okay. And just as an initial foray in
24 addressing the standards, what is your
25 understanding of what assignment of capacity



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ROA_0372

1 this particular unit was given?

2 A: I believe it was 5,000.

3 Q: Okay. And in terms of the standards in the
4 State Health Plan, is there an exception to
5 assign a capacity standard of 5,000 to a unit
6 that is doing strictly TBIs?

7 A: No.

8 Q: Okay. I believe Dr. Jenrette testified that
9 these can take two or three hours long, correct?

10 A: Right.

11 Q: All right. So, if they're taking two or three
12 hours and there are 73 of them, what does that
13 mean for the other, you know, 1900 hours this
14 machine could be operating?

15 A: Yeah. I mean ---

16 Q: Or maybe it's less than that, 1700 hours or
17 something.

18 A: If you multiply this by let's even say three,
19 you know, so you'd be talking about a little
20 over 210 hours.

21 Q: Okay.

22 A: And you subtract that from the available hours
23 in a year, which are 2,000. That would still
24 leave you with 1790 available hours in the year
25 where the unit wasn't being utilized.



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ROA_0373

1 Q: Okay. And if that unit were capable of doing
2 conventional IMRT treatments at 15 minutes a
3 piece, how many available treatments are we
4 talking about?

5 A: A little more than 7,000.

6 Q: Okay. So, what capacity assignment would you
7 give this particular unit?

8 A: I mean, based on what's in the State Health
9 Plan, it should be assigned a 7,000.

10 Q: Okay. Practically speaking what should it be
11 assigned?

12 A: Yeah. I mean, it has that capacity. You know,
13 this is an older machine. And I'm sure we'll
14 have testimony that it's limited in what it can
15 do. But, I mean, MUSC has chosen to retain this
16 unit when they could have replaced it with a
17 more modern unit. But there's certainly no
18 basis, based on the standards of the State
19 Health Plan, to give it anything other than a
20 7,000 capacity.

21 Q: So, if we use -- and I don't know if you want a
22 calculator for this. I don't know if I have
23 one. That would be bad on my part.

24 A: I've got a phone if I need it.

25 Q: Yeah. You know, in terms of using 27,000



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ROA_0374

1 treatments as MUSC's capacity --

2 **MR. THOMAS:** Can you pull up R 39, Respondent's 39
3 for me? We are going to use one of MUSC's
4 exhibits.

5 **(Respondent MUSC's Exhibit Number 39 was introduced**
6 **into the record at this time.)**

7 Q: So, for fiscal year '15, you see there they have
8 19,819 treatments listed. If their capacity was
9 27,000, what would that utilization percentage
10 be?

11 A: One second.

12 Q: Yep.

13 A: 71.08 or 71.1.

14 Q: Okay. And for fiscal year '16 the 19192 ---

15 A: I'm sorry. I did '16. Do you want me to do
16 '15? I'm sorry. That was '16 I just
17 calculated.

18 Q: Okay. We've got that on the record. What about
19 '15 then?

20 A: Okay.

21 Q: 19,819 divided by 27,000.

22 A: 73.4 percent.

23 Q: Okay. Let's do fiscal year -- let's roll up
24 forward to fiscal year '17 at 19,048. First of
25 all, we know that's below the 80 percent



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ROA_0375

1 threshold using the 24,000 capacity standard,
2 but what would it be using 27,000?

3 A: 70.5 percent.

4 Q: Let's do the same for fiscal year '18, Mr.
5 Sullivan.

6 A: 74.4 percent.

7 Q: Okay. So, in terms of if we use that capacity
8 numbers that should be used in your opinion, is
9 there any time period where MUSC meets the 80
10 percent threshold in the last four years,
11 whether they be fiscal, calendar, rolling 12,
12 otherwise?

13 A: No.

14 **MR. THOMAS:** Can we go to Petitioner's 8, please?

15 **(Petitioner's Exhibit Number 8 was introduced into**
16 **the record at this time.)**

17 Q: And did DHEC have the benefit of any of this
18 data, Mr. Sullivan, the capacity data?

19 A: Did not.

20 Q: Okay. I want to run through some of these other
21 slides that you created real quickly. In terms
22 of Petitioner's 8, it looks like that would be
23 page 1, what is this slide?

24 A: This was taken the data we were just discussing.
25 This was the utilization for fiscal year 2018.



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ROA_0376

1 Q: Okay.

2 A: And, you know, I was just trying to run some
3 calculations just to see what the percentage of
4 IMRT was and what the percentage of SBRT was on
5 each of these individual units in that one year
6 just to -- because it appeared to me that they
7 were -- some of these units had very low
8 utilization of either service. And if we look
9 at SBRT, you know, we've already gone through
10 those numbers, there's only two units that had
11 any volume in 2018. And the percentages we've
12 already talked about before. The TB 140, which
13 is a Mt. Pleasant unit, I rounded it to zero,
14 but it's actually a fractional. It was .26 I
15 think or point -- something like that. So, in
16 terms of IMRT, there was certainly -- there were
17 machines that did relatively high percentages.
18 I think that if you're doing over 40 percent
19 IMRT, that's probably good enough to be
20 sufficient. And so I would assign 5,000 to the
21 first four units. And as you see, there's no
22 IMRT and no SBRT under that Varian 600CD unit,
23 so that's why I set 7,000 for that unit.

24 Q: Okay. It looks like you did give them 4500 kind
25 of benefit of the doubt for the TB 4.



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ROA_0377

1 A: I did for the purposes of the deposition because
2 I really didn't know what assignments they had
3 made. But as I began to look at the numbers
4 more closely, I realized that probably didn't
5 make sense.

6 **MR. THOMAS:** Can we go to Exhibit -- I mean page five
7 in Exhibit 8? Just skipping over a couple of
8 the pro forma spreadsheets.

9 Q: Okay. And just quickly go through this. I
10 think it's fairly self explanatory, but if you
11 can tell The Court what you did.

12 A: Sure. This is -- this is what was report --
13 these are the corrected numbers using the 24,000
14 capacity.

15 Q: All right.

16 A: And what this shows is that in '16 and '17 they
17 did not hit the 80 percent standard and they
18 were not added in -- they were over 80 percent
19 in '15, but '15 and '16 were the two target
20 years that were used in the application. They
21 didn't meet the standard.

22 Q: All right. So, if this data came to light, MUSC
23 wanted to use its JAR data for fiscal year -- if
24 the mistake had come to light at any time in,
25 you know, up until fiscal year 2018, the end of



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ROA_0378

1 that, and it was reported, the two JAR data
2 years that would have been relied upon, as they
3 were relied upon in the original application,
4 would have shown what in terms of meeting the
5 threshold?

6 A: If they used the two most recent JAR?

7 Q: Yeah.

8 A: That would have been '15 and '16, so the result
9 would have been they had not met it.

10 Q: Okay. What if they had used the 2016 and 2017
11 JAR?

12 A: They would not have met it, because both years
13 were under 80 percent.

14 Q: Okay. All right. We're going to jump back into
15 the CON application now.

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

17 **MR. THOMAS:** Yes.

18 **THE COURT:** I hate to do this to you, but I was
19 anticipating that we'd be done around 12:30, so
20 I'm going to have to take a break just for a
21 minute here.

22 **MR. THOMAS:** All right. No problem. And I think
23 it's going to start going a lot faster.

24 **THE COURT:** We'll be at ease for a couple of minutes
25 if anybody else needs to.



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ROA_0379

(Off the Record)

THE COURT: Back on the record. Mr. Thomas, where you were. Exhibit 8, five -- page five?

MR. THOMAS: Yeah. But we're going back to DHEC 1 on page 19.

Q: Mr. Sullivan, I would like to direct your attention to CON 19 in DHEC 1, caption Service Area. And there's a line item in here and it states approximately 16 percent of MUHA's radiation therapy patients, the largest distribution of patients from Tri-County, reside in Moncks Corner, Summerville submarkets. A new location would be more convenient for these patients and it brings -- this project brings radiation therapy to a county which does not currently have radiation therapy available within the county boundaries. And we've already kind of talked about the county boundaries a little bit. But do you have any thoughts on that statement in terms of the submarket that appears here on Figure 5?

A: Yeah. I mean, I think I touched on this a little bit earlier, but, you know, a significant percentage of the patients come from East Cooper. There's only one unit over there. And



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ROA_0380

1 a portion of what I think Moncks Corner
2 includes, which I think is Berkeley County, also
3 would be proximate to there. And certainly
4 people, even from North Charleston, who were
5 close to the 526 freeway, would have relatively
6 easy access over to Mt. Pleasant. So, Mt.
7 Pleasant would be a good place for another unit
8 if they wanted to avoid having patients drive
9 downtown, because the Mt. Pleasant campus is not
10 like the downtown campus. It's not on the
11 peninsula. It's not -- has the same kind of
12 capacity constraints and so forth. West Ashley
13 and the Sea Islands represent 16 percent of the
14 total patients in 2015 and I guess about 13
15 percent in 2016, again, a relatively large chunk
16 of their patients. MUSC has nothing on that
17 part of the service area.

18 Q: Let me stop you there. If MUSC were to put one,
19 a linac in West Ashley for instance, what would
20 that mean for patients in the Beaufort/Colleton
21 area?

22 A: That would certainly be closer for patients
23 coming up from the southern areas, because I
24 think geographically most people would travel up
25 Highway 17 and West Ashley would be closer than



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ROA_0381

1 going to downtown.

2 Q: I'm going to hand you -- one of the largest, I
3 guess, submarkets, as it were, listed is North
4 Charleston, correct, in terms ---

5 A: Right.

6 Q: And what's the percentage there of treated in
7 fiscal year '16?

8 A: '16 was 15 percent.

9 MR. THOMAS: Okay. I'm going to hand you a
10 demonstrative that I've already presented to the
11 opposing parties, Judge. And for the record,
12 there's not a title on here, but it's the 29405
13 North Charleston ZIP code.

14 A: Right.

15 Q: And what can you tell us about this
16 demonstrative exhibit that shows the 29405 ZIP
17 code of North Charleston, which is one of the
18 ones that MUSC says it wants to serve at the
19 Nexton site?

20 A: Yeah. This ZIP code actually goes pretty far
21 south. As you can see, it goes right to what's
22 called the neck of the peninsula in Charleston.
23 And I think you get into that ZIP code when you
24 cross over the bridge on the King Street
25 Extension. And that -- residents on the



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ROA_0382

1 southern part of that ZIP code certainly would
2 be closer to downtown, significantly closer to
3 downtown than to the Nexton site. They would be
4 certainly closer to Trident as well, which is
5 between Nexton and the southern part of that ZIP
6 code. And the majority of that ZIP code is
7 relatively close to Trident. So, I mean,
8 there's really no material advantage in terms of
9 access either to a MUSC facility or to a
10 facility generally given Trident's location.

11 Q: Okay. Now, I want to go now to CON page 20 if
12 we could. Turn the page there. And I like
13 this. It shows the Tri-County area and it shows
14 specifically where Berkeley, Dorchester, and
15 Charleston are. And can you explain to The
16 Court where Trident is on this map relative to
17 Dorchester and Berkeley Counties and where MUSC
18 is proposing its location?

19 A: Yes. Trident is in Charleston County in that
20 little sort of sliver of Charleston County that
21 goes between ---

22 Q: Right here?

23 A: Right there between Berkeley and Dorchester
24 Counties. And so it's very close to -- it's
25 very close to the populations of both of those



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ROA_0383

1 counties. And certainly not materially
2 different from what's being proposed by MUSC.

3 Q: Okay. Turn the page over to Certificate of Need
4 page 21 for me.

5 A: Okay.

6 Q: In DHEC 1. It's just the very next page. And
7 there's a population table there. And you've
8 touched on this a little bit, but we're seeing
9 large material growth and population for the
10 various age cohorts in these particular areas.
11 Do you have an opinion on how population and the
12 kind of cancer care need for additional
13 radiation therapy units plays out?

14 A: Yeah. I mean, as I mentioned earlier, you know,
15 we have been experiencing a lot of population
16 growth in this four-county area. And the number
17 of cancer patients is going up, but the number
18 of cancer treatments is not. And for example in
19 2010 I believe the population was only a little
20 over 700,000. So, we've added almost 85,000
21 people in the four-county area between 2010 and
22 2016 and yet the number of cancer treatments I
23 think are actually slightly down if you look
24 over a long period of time. So, you know, the
25 notion that population growth is going to drive



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ROA_0384

1 a lot more demand for linear accelerator
2 capacity just hasn't born out historically.
3 And, you know, based on the testimony this
4 morning about your continued research in terms
5 of the hypofractionation, fewer treatments per
6 patient, there's certainly not an expectation
7 that treatments per patient are going to go up
8 in the future. If anything, there's going to be
9 downward pressure on treatments per patient in
10 the future as well. So, I don't think
11 population growth is going to drive a lot of
12 additional need for radiation therapy capacity.

13 Q: Let's talk about -- I just put a P 9, page four
14 for you. And tell The Court about this chart.

15 **(Petitioner's Exhibit Number 9 was introduced into**
16 **the record at this time.)**

17 A: Sure. This was just trying to get a little
18 broader look at what's going on with radiation
19 therapy utilization in this area. And if you
20 look at the four providers are on here -- and
21 Bon Secours St. Francis didn't start offering
22 services until '14, so that's why there's no
23 entries in the first couple of years. And what
24 you see is that, where we were in 2010, we're
25 almost exactly there in 2017. It's actually



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ROA_0385

1 down slightly, .4 percent. And so, despite
2 pretty rapid population growth, approaching
3 100,000 people moving into the area, it really
4 hasn't driven the demand for radiation therapy
5 capacity.

6 Q: All right. Within P 9, if we could go and look
7 at page three within Petitioner's 9.

8 MR. THOMAS: That's going to be page -- well, we'll
9 stay there. Maybe we'll talk about this.

10 Q: Mr. Sullivan, did you prepare this slide?

11 A: I did.

12 Q: And what does this slide show?

13 A: This shows, based on data available, I think it
14 comes through the CDC, but it's reported by
15 South Carolina, that the number of new cancer
16 cases has gone up. It's gone up virtually every
17 year. I think the one exception was 2008. But
18 there's been an average of two percent annual
19 growth in the number of new cancer cases. So,
20 that's an indication of the aging of the
21 population and the growth in the population.

22 Q: What's kind of the rule of thumb in terms of how
23 many of those new cancer cases are going to
24 require radiotherapy?

25 A: Typically about 50 percent.



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ROA_0386

1 Q: Let's go to -- let's try to get to page three.
2 If not, we'll go with: -- here we go. What does
3 this slide show that you prepared on P 9 at
4 three?

5 A: This shows what the individual providers of
6 radiation therapy are seeing in terms of patient
7 growth. And we've had an increase of about 25
8 percent in the number of radiation therapy
9 patients, cancer patients receiving radiation
10 therapy. But at the same time, there was no
11 growth in the number of treatments.

12 Q: Okay. Let's go to Petitioner's 9, page five.
13 Round off this exhibit. And what does this
14 exhibit show, P 9, page five?

15 A: It shows the change in the average number of
16 treatments per patient. And what it shows is
17 not surprising that the number of treatments per
18 patient has been declining over this period of
19 time. And MUSC has had about a 25 percent drop
20 in the number of treatments per patient, Trident
21 about a 27 percent drop, Roper about a 28
22 percent drop.

23 Q: And this is in the context of more cancer
24 patients, correct?

25 A: Right, right. And so there's -- you know, it's



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ROA_0387

1 just the model of delivering radiation has
2 changed and it's changed the relationship
3 between number of cancer patients and number of
4 treatments.

5 Q: Go to DHEC -- in the DHEC record Exhibit 1, page
6 22 if you could.

7 A: Okay.

8 Q: And this is a MUSC submarket drive time analysis
9 I suppose. And what are your thoughts about
10 this? I guess the source is Microsoft MapPoint.

11 A: I mean, I've used MapPoint before. I mean, it's
12 a -- gives you a good ballpark estimate of drive
13 times. But first of all this chart just looks
14 at MUSC facilities in relation to these
15 populations. And obviously if you put Trident
16 in here or if you put the approved Roper project
17 in here, these drive times would look
18 dramatically different. They would be must
19 shorter for patients. Secondly, the -- and not
20 only looking at the drive time, they've added
21 in, in this particular chart, parking and way
22 finding somewhere between ten and 20 minutes.
23 I've never done that with my drive time analyses
24 and it certainly doesn't make a whole lot of
25 sense in this case because MUSC downtown offers



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ROA_0388

1 valet parking so the patients can pull right up
2 to the door and then valet park their vehicles.
3 So, there's not a lot of way finding and parking
4 time that would be required. So, I think the
5 chart's misleading in some respects. I mean,
6 one it just looks at drive times from MUSC --
7 the two MUSC facilities and not other
8 facilities. And then, you know, these areas are
9 geographically relatively large. Like North
10 Charleston, for example, we talked about that
11 one ZIP code, 29405. That ZIP code is not going
12 to take you 16 minutes to drive to MUSC. I
13 mean, it's very close to the downtown. It may
14 be 16 minutes from other parts of North
15 Charleston. So, anyway, I just don't think this
16 offers a lot of insight into true access to
17 radiation therapy services.

18 Q: And then you'll see on the next couple of pages
19 here, CON 23, 24, and 25, it's kind of the
20 utilization and projected volume methodology.
21 Did you have any opinions about what MUSC did in
22 this portion of the application?

23 A: I did. You know, MUSC -- if we go over to page
24 26 first, I think that's probably -- the chart
25 up there on Figure 13 at the top. And what that



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ROA_0389

1 -- I guess the figure number is cut off, but --
2 there we go. This shows what the overall
3 projection was for the for all of the MUSC units
4 including the new one out at Berkeley. This
5 assumed relatively modest growth I think of
6 about two percent a year in radiation therapy
7 treatments. Whether that's going to be achieved
8 or not, I'm not sure. MUSC hasn't grown
9 historically. The market hasn't grown
10 historically. And so this may be a somewhat
11 optimistic view of what's going to happen in
12 terms of future growth. But if we turn back now
13 to page 25. And the chart at the Figure 12,
14 which spills over to the top of page 25, shows
15 how the projections were done for the Berkeley
16 facility specifically. I do have a couple of
17 problems with this. One is, the assumption is
18 that there's going to be 110 patients shifted
19 from MUSC and there's a quote capture of new
20 cases at the site. When I first read this, I
21 thought that meant the market share that would
22 be taken away from other providers. I think Mr.
23 Levitt in his deposition was discussing, well,
24 that was really -- I believe what he said is
25 that's coming from growth in the market. But

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ROA_0390

1 that growth in effect is shifting market share
2 away from existing providers. As we've seen,
3 providers have been able to maintain sort of
4 level utilization levels only by increasing the
5 number of cancer patients that they're serving.
6 And so if 100 of those patients are going to be
7 taken away from other providers -- and who's the
8 most likely provider to lose those hundred
9 patients? Trident, since they're the most
10 proximate provider. And they'd get referrals
11 from physicians who were going to be located in
12 close proximity to MUSC -- I think this is an
13 indication that the project is going to
14 adversely impact existing providers and
15 particularly Trident.

16 Q: Okay.

17 A: One other point I wanted to make on this.

18 Q: Yeah.

19 A: This projects utilization for the new facility
20 based on 18 treatments per patient. that has
21 not been MUSC's overall experience. And I think
22 maybe the explanation is they're not planning to
23 do SRS or some of these other exotic treatments
24 out there. But MUSC's treatment numbers have --
25 treatments per patient have been trending



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ROA_0391

1 downward pretty consistently over time. And I
2 think that's probably an optimistic assumption
3 about what the treatments per patient are going
4 to be at that facility.

5 Q: And we don't need to cull it up, but I believe
6 Trident trial Exhibit 9 at page five show that
7 number of treatments per patient in 2017 was
8 13.3.

9 A: Right. And granted that includes types of
10 patients that perhaps won't be treated here, but
11 I think something on the order of 15 would
12 probably be a more realistic assumption for
13 projecting utilization.

14 Q: Okay. If you turn over to CON 26 for me.
15 There's a section here, Impact on Existing
16 Facilities. And one of the statements there is
17 Hollings Cancer Center offers patients access to
18 more clinical trials than other institutions in
19 the state which is why patients choose to
20 receive care at MUSC radiation therapy center.
21 And I've got a couple of questions to you.
22 First of all, this idea of patient choice and
23 the choosing of care, in your experience, 40
24 years of health planning, how do health -- how
25 do patients get into healthcare systems and to



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ROA_0392

1 kind of the more advanced treatment, whether it
2 be for heart cath or radiation therapy, that
3 type of thing?

4 A: I mean, typically it's going to be -- it starts
5 with the primary care physician, you know. And
6 patients may choose a primary care physician for
7 a number of reasons. It might be geographic
8 proximity or it might be because of somebody they
9 knew. It might be because they're at MUSC, you
10 know, and they were at a teaching hospital. I
11 don't know all the reasons. But that primary
12 care physician is going to diagnose an issue and
13 then is going to refer that patient to a
14 surgeon, you know, a urologist, or medical
15 oncologist. And that medical oncologist is
16 going to recommend to that patient where they go
17 to get their radiation treatment. And so, I
18 mean, I don't doubt that there are some patients
19 who get on the internet and research. But,
20 based on my experience in doing surveys of
21 patients and over the years, they oftentimes are
22 somewhat oblivious to a lot of the accolades
23 about healthcare organizations that, you know,
24 they like to tout all the time. So, I would
25 think that the NCI designation probably isn't



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ROA_0393

1 the major driver. It's the fact that MUSC has
2 primary care physicians, you know, to kind of
3 see it through a broad geographic area and most
4 physicians are referring patients to the linear
5 accelerator.

6 Q: Okay. You know, in terms of this idea of the
7 size of a hospital, has it been your experience
8 that patients are aware of the types of
9 physicians and the numbers of physicians on
10 medical staff?

11 A: Not to my knowledge -- I mean, I'm barely aware
12 of it and I'm a professional in this industry.

13 Q: Do you have an opinion -- we saw your slide
14 earlier, but, you know, that was presented more
15 than a year ago I think. But in terms of
16 duplication of services, would MUSC's project
17 qualify as a duplication of service -- as an
18 unnecessary duplication of services?

19 A: In my view, yeah, it's a perfect example of an
20 unnecessary duplication.

21 Q: Why is that?

22 A: Because it's -- one, they haven't demonstrated
23 that they need additional capacity, which is
24 sort of a prerequisite to approving the unit.
25 Secondly, where they propose to put it is not an



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ROA_0394

1 area that has a particular access problem. And
2 I guess the third thing would be, given the
3 approval of the Roper project in Berkeley, even
4 if one could argue that there was an access
5 problem for Berkeley County residents, that
6 access issue has already been addressed by the
7 Roper project. So, to build another unit three
8 miles away from Roper and when the testimony has
9 been that Trident is only operating two of its
10 three units because of low utilization, I think
11 it clearly is an unnecessary duplication.

12 Q: Okay. Let's -- we've talked about that. In
13 terms of page -- turn to CON 27.

14 A: Okay.

15 Q: Sorry. I had to get my bearings straight here.

16 A: Okay.

17 Q: At the top there there's a sentence indicating
18 that the accelerator has the capability to be
19 upgraded to provide stereotactic treatments, but
20 that they will not be -- upgrades will not be
21 purchased initially. What are your thoughts on
22 that?

23 A: Well, I think it -- it sort of mitigates a lot
24 of the rational on the application. The
25 application is where this highly specialized



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ROA_0395

1 cancer treatment organization, you know, would
2 have these various recognitions and awards. But
3 what's being proposed for this particular
4 location in Nexton is really just sort of a
5 community radiation therapy center that's going
6 to be doing sort of standard treatment. I mean,
7 IMRT and IGRT are sort of the standard in the
8 industry now for treating patients. They will
9 be doing that. But they're not doing any exotic
10 radiation, total body irradiation, they're not
11 doing stereotactic treatments, which take
12 somewhat longer and require a little more
13 treatment planning. It seems that those
14 patients they determine are still okay to be
15 able to drive downtown and receive their care.
16 And so, what they're really going after is sort
17 of the bread and butter patients that are
18 exactly what Trident is serving right now.

19 Q: In the second kind of full paragraph there,
20 maybe it's the first full paragraph, which
21 starts In the most recent 12 months, there's a
22 statement that begins MUSC currently has three
23 linear accelerators that provide IMRT or IGRT
24 and have capacity for 5,000 treatments per year
25 and two linear accelerators that perform



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ROA_0396

1 stereotactic procedures and have capacity of
2 4500 treatments per year, and they give the
3 total capacity number there. But is the
4 standard that the linear accelerator perform
5 stereotactic procedure?

6 A: No. The standard is they perform a sufficient
7 number to justify a lower capacity.

8 Q: Okay. And did you see anything in the
9 application that justified the 24,000 capacity?

10 A: I did not.

11 Q: Okay. In terms of community support, which is
12 in the CON application, did you see anything in
13 the application that indicated there was great
14 community support for this project?

15 A: I believe there were 10 letters of support in
16 the application. A couple of them were from
17 administrators from other parts of the state
18 that were affiliated with MUSC and then I think
19 there were eight MUSC physicians. But there
20 were -- when I think of community support, I
21 often -- I mean, what I think of is local
22 citizens who would describe particular problems
23 they're having now in accessing services because
24 of the current distribution of radiation therapy
25 services. But I didn't see any of that in the



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ROA_0397

1 letters of support.

2 Q: Okay. Turn over to Petitioner 6 for me, if you
3 would.

4 A: Okay.

5 Q: What is this?

6 **MR. THOMAS:** And, Judge, just for your edification,
7 it's a hundred-and-something-page document, so
8 it's kind of hard to put the whole thing up on
9 the screen, but I'll go to certain portions of
10 it, I suppose.

11 Q: But what is this document, Mr. Sullivan?

12 A: This is the -- well, I guess it was -- I think
13 it was filed at the very beginning of 2015. It
14 was the application that MUSC filed for a
15 radiation therapy unit back in the end of 2014,
16 beginning of 2015.

17 Q: Okay. And do you know where that particular
18 linac was going to be located back in the 2015
19 application that was submitted?

20 A: Yeah. It was going to be very close to Trident
21 Medical Center. I mean, it was just almost
22 literally across the street from Trident.

23 Q: Okay. And what did the Department do in terms
24 of approving or denying this application?

25 A: It denied the application.



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ROA_0398

1 Q: What was your understanding of the bases for the
2 denial?

3 A: Well, there were several.

4 Q: Well I tell you what, let's go to P 55. I think
5 that's the actual denial letter.

6 A: Okay.

7 Q: We need to get that into evidence. All right.
8 Let me know when you get there.

9 A: I'm there.

10 Q: Okay. So, I've shown you -- I believe this is
11 the December 22nd, 2015 denial letter addressed
12 to Mr. Levitt on behalf of MUHA, we've been
13 calling them MUSC. What is your understanding
14 of the bases for the denial of this particular
15 CON application, this MUSC linac project, back
16 I guess 18 months before MUSC submitted the
17 application for the Nexton project?

18 A: I think the starting point is I think the
19 Department found that the project wasn't in
20 compliance with the South Carolina State Health
21 Plan and there were a couple of reasons for
22 that. MUSC had suggested that the capacity of
23 the proposed unit should be 5,000 rather than
24 7,000. And the Department rejected that saying
25 they hadn't presented enough evidence that they



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ROA_0399

1 would provide sufficient number of procedures to
2 justify the lower capacity. And then it got
3 into the discussion of Standard 7, which we've
4 been talking a lot about today. And it found
5 that they didn't meet the 80 percent capacity
6 requirement. And so they found -- under
7 Community Need Documentation, they said that the
8 need projections that MUSC had put forth were
9 not supported by utilization data from the JARS
10 and that it showed a yearly decline in
11 utilization of all linear accelerators in the
12 area, including MUSC's units. And as a result,
13 existing units in the service area are already
14 operating far below capacity, well below
15 capacity.

16 Q: In terms of -- I assume you're aware of the
17 approval letter in this case.

18 A: I am.

19 Q: Okay. Did you have occasion to compare the
20 approval letter in our case with the denial
21 letter in the 2015 MUSC linac matter?

22 A: I did.

23 Q: What did you find?

24 A: Well, even though in my belief that
25 circumstances really haven't been changed in any



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ROA_0400

1 material way, the Department sort of flipped its
2 position in these key areas. It found that the
3 project was in compliance with the State Health
4 Plan. And, granted, they were relying on what
5 turned out to be inaccurate data in making that
6 determination, they accepted the capacities that
7 MUSC put forward at face value without any
8 documentation as to the realistic nature of
9 those capacities. It looked at community need,
10 but it looked at community need in a much more
11 narrow sense in that it only looked at the need
12 for MUSC to reduce travel times for its
13 patients. It didn't look at the need in the
14 context of the entire community and all the
15 providers that were offering radiation therapy
16 services. And so -- and then it also found that
17 the distribution was appropriate, whereas in the
18 original 2015 decision they found that there
19 wasn't any justification under the distribution
20 criterion. And the only difference between the
21 '15 application and the '17 application in
22 reality is that they moved six miles up the
23 road. And to me, that wasn't a material enough
24 change to warrant a finding that the
25 distribution would be improved -- or an

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ROA_0401

1 accessibility would be improved.

2 Q: Okay. We're in the home stretch here. We're
3 going to go to Petitioner's 9.

4 A: Okay. I'm there.

5 Q: Okay. I'll leave the slide up there. All
6 right. We're back in Petitioner's 9 and we're
7 going to go through these quickly, so can you
8 tell The Court what's going on here just to ...

9 A: Sure. This is sort of a long-term look at
10 MUSC's radiation therapy utilization. And as
11 you can see, their volumes were higher in 2011
12 and 2012 than they were in the subsequent years.
13 I think their 2018 number in their exhibits is
14 slightly over 20,000, but a little below where
15 they were back then. And so it's been sort of
16 a random fluctuation, but basically somewhere
17 between 19 and 20,000 treatments, so there
18 hasn't really been any material growth in the
19 utilization.

20 **MR. THOMAS:** Okay. And the next page, Petitioner's
21 9 on page nine. Or is that the next page?

22 Yeah, you're right.

23 Q: This is Petitioner's 9, page eight. Just
24 quickly go through this.

25 A: Okay, sure. This is Trident's trend in



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ROA_0402

1 utilization. And you can see Trident is
2 operating a fair amount below where it was in
3 2010. And as I recall, 2010 data was the data
4 that we were using when we applied for the third
5 unit at Trident because we had seen a growth
6 trend up until that point in time and then the
7 market began to change fairly quickly after
8 that. And Trident has continued to operate at
9 relatively flat levels, a little spike up in '15
10 and then back down again in '16. So, they're
11 operating in this sort of eleven thousand,
12 eleven thousand five range.

13 Q: Okay. Let's see. And I want to talk a little
14 bit, Mr. Sullivan -- let's talk about medical
15 underserved group real quickly. And if we can
16 go to CON 165. Mr. Sullivan, I'm showing you
17 MUSC's pro forma from their application.

18 A: Right.

19 Q: I don't have too many question here, but in
20 terms of the idea of one of the -- I believe one
21 of the project review criteria is medically
22 underserved groups.

23 A: Right.

24 Q: Do you have an opinion on that with respect to
25 MUSC's application?



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ROA_0403

1 A: Yeah. I mean, I don't see this project as
2 having any real focus on serving medically
3 underserved groups. The indigent care that's
4 projected in this application is right around
5 two percent of total revenues. That's certainly
6 not a high level of indigent care. The
7 application made some mention of the fact that
8 portions of the service area in Berkeley County
9 and Dorchester County had somewhat lower
10 socioeconomic groups in terms of median
11 household incomes, yet there was no adjustment
12 for serving a disproportional number of indigent
13 patients in this particular project.

14 Q: Okay. Let's go to P 37 if we could.

15 **(Petitioner's Exhibit Number 37 was introduced into**
16 **the record at this time.)**

17 Q: And this is MUSC's, I guess, June 30th of fiscal
18 year 2018 interim financial statement. And I
19 believe you heard in the opening arguments you
20 heard Mr. Westbrook talk about the fact that
21 MUSC has billions of dollars of operating
22 revenues. How much operating income did they
23 have in fiscal year 2018? If you look at ---

24 **MR. DAYHUFF:** Your Honor, I'm not sure exactly where
25 this is going. If this is going into an



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ROA_0404

1 argument that I have heard made, not at the DHEC
2 staff level, but subsequent to that in pleadings
3 that have been filed. And that argument was
4 that MUSC has a long list of projects. And
5 because of that long list of projects somehow
6 this project is not feasible. That argument was
7 not raised before DHEC. If it's not raised
8 before DHEC, it can't be raised here.

9 **MR. THOMAS:** First of all, Your Honor, Mr. Dayhuff
10 misstates the law. The law is, if the item was
11 raised or considered by DHEC. And it's an
12 issue, it's not an argument. The issue of
13 financial feasibility was 100 percent considered
14 by the Department. And we know that because it
15 was one of the project review criteria that Ms.
16 Murdock had to consider in order to render a
17 decision. In fact, in the decision letter
18 itself there's a section that says financial
19 feasibility. Now, you can take into
20 consideration things that have happened
21 subsequent to. Here's what's happened since
22 MUSC has applied for the application. First of
23 all, they've had some financial reporting
24 periods, which we're going to start talking
25 about. Secondly, they're now engaged in several



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ROA_0405

1 different massively expensive projects that
2 weren't on the table back in 2017. But as to
3 the actual issue of law -- and I'm happy to
4 brief it. I hope we don't have to go there,
5 that'll take some time. But the actual law is,
6 I can bring up any new evidence related to an
7 issue that was brought up or considered by the
8 Department. And financial feasibility was
9 considered by the Department.

10 **MR. DAYHUFF:** May I response?

11 **THE COURT:** Yeah.

12 **MR. DAYHUFF:** The law is 44-7-210(E), a contested
13 case hearing of the final agency decision must
14 be requested according to 44-1-60. The issues
15 considered at the contested case hearing
16 considering a CON are limited to those presented
17 or considered during the DHEC staff review.
18 Trident did not raise this issue below. The
19 issue is not financial feasibility. Their
20 assertion is that, because MUSC has lots of
21 projects, even more now, MUSC somehow doesn't
22 have funds for a nine million dollar linear
23 accelerator. They never mentioned the long list
24 of projects at DHEC staff review level.

25 **MR. THOMAS:** They didn't have them.



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ROA_0406

1 **MR. DAYHUFF:** Mr. Sullivan ---

2 **THE COURT:** Just a minute.

3 **MR. DAYHUFF:** --- opined in his expert deposition
4 with me that he was not making such a claim in
5 this case. So, they have no expert testimony on
6 this either. This is a new issue that DHEC
7 never considered. This issue doesn't even
8 fairly fit in financial feasibility. The
9 question in financial feasibility is do we have
10 the funds to start a linear accelerator project
11 and continue a linear accelerator project. I
12 don't know what this claim is. It's not
13 financial feasibility. We don't even have to
14 decide really, because this claim was not
15 raised, not even approached in any of the slides
16 we just saw from DHEC review. And we can ask
17 this witness whether he opined before DHEC about
18 this issue and he will say no.

19 **MR. THOMAS:** It's not a -- the issue is financial
20 feasibility, Your Honor. It's 100 percent the
21 issue. And one of the issues I'm raising, as you
22 hear Mr. Sullivan -- excuse me, Mr. Westbrook
23 bring up in the opening, is that they've got
24 plenty of money to do this. They make billions
25 of dollars -- or they have billions of dollars



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ROA_0407

1 in revenue. Well, you know what? Enron had
2 millions of dollars in revenue. They didn't
3 make any profits.

4 **THE COURT:** Well, okay. Mr. Thomas, I don't think
5 we're talking about a nuclear power plant here.

6 **MR. THOMAS:** I think we might be, Your Honor. That's
7 the problem.

8 **THE COURT:** But on the other hand, I'm going to allow
9 you a little leeway with this financial
10 feasibility.

11 **MR. THOMAS:** Okay. I'll relate it back to something.
12 And I can ---

13 **THE COURT:** If you can, that'd be great. But, Mr.
14 Dayhuff, I'm looking at this skeptically, but
15 I'm going to let him go for a little bit.

16 **MR. DAYHUFF:** Thank you.

17 **Q:** Let me back up just a second, Mr. Sullivan. On
18 CON 162 -- well let me ask you this. Is the
19 facility required, the CON applying facility
20 required to present their facility-wide budget?

21 **A:** They are.

22 **Q:** Why -- as a health planner, why would they be
23 required to show a facility-wide budget?

24 **A:** Well, because the overall operation for the
25 facility obviously have an impact about your



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ROA_0408

1 ability to operate a proposed new service
2 effectively. You know, if, for example, you had
3 huge operating losses or massive debts on your
4 balance sheet, it might be an indication that
5 there would be question marks about the long-
6 term viability of a new project that you were
7 proposing.

8 Q: Okay. And if -- let's go to CON 163 for me real
9 quick.

10 A: Okay.

11 Q: Okay. There it is. All right. So, this is the
12 facility budget, correct?

13 A: Right.

14 Q: CON 163. And it shows a fairly healthy net
15 income there, doesn't it?

16 A: It does.

17 Q: Okay. And roughly half of that net income is
18 comprised of total non-operating revenues, isn't
19 it?

20 A: It is.

21 Q: Okay. And those are things like capital grants,
22 investment income, net capital gains and
23 contributions and that sort of thing, correct?

24 A: Yes.

25 **MR. DAYHUFF:** Your Honor, can I add one more bases to



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ROA_0409

1 my objection? I just found the deposition site
2 that I referred to with respect to Mr. Sullivan.
3 So, obviously my first line here is that this
4 wasn't raised below. My second line is, if you
5 don't provide your expert opinions in a
6 deposition that precedes this matter, you can't
7 come in and then opine about an opinion that you
8 haven't offered. Asked Mr. Sullivan about this
9 very issue. And it goes like this, Mr.
10 Sullivan, you know, it's smaller than some of
11 the other very -- you know, the Women's Pavilion
12 and, you know, so forth that are under
13 construction, that's 380 million dollars. And
14 the new hospital is 325 million dollars. He's
15 talking about the Berkeley County Hospital
16 proposed. And I don't know how many, hundreds
17 of millions, the acquisitions of the CHS
18 hospitals would be. That was referenced by Mr.
19 Thomas. And so there's a lot out there.
20 Question by me, so this long list of projects
21 that we have. Answer, right. Question, you're
22 not opining that this project should be denied
23 or that this project fails to satisfy a
24 particular criterion because of said long list
25 of projects, are you? Answer, I'm not. So, I

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ROA_0410

1 add to my objection the basis that this opinion
2 was not offered to us in Mr. Sullivan's
3 deposition.

4 **MR. THOMAS:** Have I asked him to offer an opinion
5 yet, Your Honor?

6 **THE COURT:** I don't think you have.

7 **MR. THOMAS:** Thank you.

8 **THE COURT:** But, now, Mr. Dayhuff, if he does, you've
9 already laid out ---

10 **MR. THOMAS:** It's a sensitive subject, I get. I
11 mean, you know ---

12 **THE COURT:** Let's get back to what we're doing.

13 **Q:** All right. So, Mr. Sullivan, back to these --

14 **MR. THOMAS:** And he's an expert in healthcare
15 finance, so I'm getting this type of data in
16 through him. They still have a long line of
17 witnesses, Your Honor, that they're going to put
18 up and I get to ask all kinds of questions about
19 financial feasibility to prove a point. Simply
20 because he may not have an opinion on it,
21 doesn't mean I can't ask him about that. And
22 that's kind of my response to Mr. Dayhuff.

23 **MR. DAYHUFF:** I have never had an expert witness be
24 on the stand who has said in a deposition, I
25 don't have an opinion on this, and then we have



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ROA_0411

1 to go into his opinion on this.

2 **THE COURT:** Well, I think the argument is, he hasn't
3 yet gone into his opinion. Now, I'm not sure
4 what the purpose of these questions are if
5 they're not to elicit that opinion, but let's --
6 I'll listen to him a little bit.

7 Q: So, Mr. Sullivan, again, before I was
8 interrupted, one half of their income --
9 projected income in 2019, came from operations,
10 the other half came from non-operating revenues?

11 A: Correct.

12 Q: Okay. And did MUSC ever provide any data in the
13 application? I guess they couldn't for fiscal
14 year 2018, right?

15 A: Right.

16 A: Because it hadn't been completed. But in
17 Exhibit 37 there was a -- we have the net income
18 statement for fiscal year 2018, correct?

19 A: Right.

20 Q: All right. And do you recall what MUSC's
21 operating income was in 2018?

22 A: It was a negative 2.9 million dollars.

23 Q: Okay. So -- and that was off total operating
24 revenues of how much?

25 A: Roughly 4.3 billion dollars.



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ROA_0412

1 Q: Okay. And the net income statement, I think
2 that may be a gross number. How about the total
3 operating revenues?

4 A: I'm sorry. I was giving you the patient service
5 numbers. Yeah, the net patient service revenues
6 were 1.4 and change.

7 Q: Okay.

8 A: Billion.

9 Q: Billion. Okay. So, MUSC didn't make anything
10 off operations in that year; is that correct?

11 A: That's correct.

12 Q: Okay. All right. In terms of -- I want to sum
13 up now, Mr. Sullivan.

14 A: Okay.

15 Q: In your opinion, does this project comply with
16 the State Health Plan?

17 A: In my opinion, it does not. And I can explain
18 why.

19 Q: Yeah. Just -- you've done a lot of explanation.
20 Just kind of -- yeah, that's a nice tight
21 summary.

22 A: Okay. It was not consistent with Standard 7
23 under this radiotherapy criteria, particularly
24 because its utilization was below 80 percent.
25 And if we use more realistic capacities for its



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ROA_0413

1 units, it would have been even farther below 80
2 percent. So, I don't believe it's consistent.

3 Q: Okay. In your opinion is there a community need
4 for this project?

5 A: In my opinion there is not. There is adequate
6 capacity in the area that MUSC is proposing to
7 serve. Trident is an available provider with
8 excess capacity and there's a brand new unit
9 being approved -- being developed three miles
10 away from where they're proposing to ...

11 Q: Are there any meaningful barriers to access to
12 linear accelerator services in the north area?

13 A: In my view there are not.

14 Q: Okay. So, does -- in your opinion does this
15 project improve access to radiation therapy
16 services?

17 A: In my opinion it does not. It just represents
18 an unnecessary duplication of existing services.

19 Q: Okay. Should this project have been approved by
20 the DHEC staff?

21 A: In my opinion it should not.

22 Q: Thank you. I have no other questions.

23 **THE COURT:** We are at approximately 1:40. What's
24 your thoughts about the afternoon?

25 **MR. THOMAS:** I'd like to eat, Your Honor.



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ROA_0414

1 **MR. DAYHUFF:** I'd like to eat too. I would think
2 we'd need an hour to eat and then I would like
3 to go as long as The Court is willing to go. I
4 mean, we could ask, I suppose, if we could
5 finish this witness. I don't ...

6 **MR. THOMAS:** We can do this tomorrow instead of -- I
7 think, Travis, we agree it's Ms. Murdock and Dr.
8 Cawley.

9 **MR. DAYHUFF:** That's correct.

10 **MR. THOMAS:** I think tomorrow's a short day. If you
11 needed to go into tomorrow, I wouldn't blame you
12 for that.

13 **MR. DAYHUFF:** I understand. So, that's a
14 possibility, I suppose, at this point.

15 **THE COURT:** All right. Well, let's take the expanded
16 hour. So, we'll be back at 2:40.

17 **(Off the Record)**

18 **THE COURT:** We are back on the record. And, Mr.
19 Sullivan, you are back on the stand. You've
20 kindly put yourself in the position of jeopardy.
21 And you are still under oath, sir.

22 **MR. SULLIVAN:** Thank you.

23 **THE COURT:** Mr. Dayhuff.

24 **MR. DAYHUFF:** May I proceed, Your Honor?

25 **THE COURT:** Please, sir.



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ROA_0415

1 **MR. DAYHUFF:** I had an adrenaline shot to the heart
2 at lunch, so I'm ready to go.

3 **MR. SULLIVAN - CROSS-EXAMINATION BY MR. DAYHUFF:**

4 Q: Mr. Sullivan, good afternoon.

5 A: Good afternoon.

6 Q: So, I got -- correct me if I'm wrong. I got the
7 impression that you do not believe MUSC's CON
8 application should be approved. Is that
9 correct?

10 A: I think that's a good summary.

11 Q: Good. So, we're going to talk about that in a
12 minute. But you've also offered health planning
13 opinions concerning many other MUSC applications
14 over the years.

15 A: I have.

16 Q: All right. So, MUSC submitted a CON application
17 to establish a community hospital that we heard
18 a little about yesterday, I think --

19 A: Yes.

20 Q: -- in southern Beaufort County that DHEC
21 reviewed and approved. And it's your expert
22 health-planning opinion that this application
23 should have been denied by DHEC and should now
24 be denied by the ALC; is that right?

25 **MR. THOMAS:** Object to the form, Your Honor. And the



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ROA_0416

1 reason why is I don't think MUSC is the
2 applicant in that case. It's a joint venture.
3 So, it's -- it is not ---

4 **MR. DAYHUFF:** Did I say Beaufort? Berkeley. I'm
5 sorry. Berkeley. It's an application ---

6 **THE COURT:** Wrong county.

7 **MR. THOMAS:** Okay. Yeah. Right.

8 **THE COURT:** First objection it's the wrong county.
9 Second objection, ask the question again.

10 **MR. DAYHUFF:** Yes, let me try that again.

11 **Q:** It's your expert opinion that the MUSC CON
12 application or CON application in which MUSC is
13 an owner or an interested party for a hospital
14 in southern Berkeley County, it's your expert
15 opinion that that should be denied by the ALC;
16 is that correct?

17 **A:** True.

18 **Q:** All right. The opposition to that application
19 is based in part upon the fact that Trident has
20 a CON to build its own hospital in Moncks
21 Corner; is that right?

22 **A:** That's one part.

23 **Q:** In part, correct. We heard yesterday from Mr.
24 Gallati that Trident has held CON for that
25 hospital since 2016. Do you recall that?



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ROA_0417

1 A: Yes..

2 Q: And do you also recall that this project has not
3 been implemented by Trident yet?

4 A: Right. My understanding is there are wetlands
5 issues that they're still dealing with.

6 Q: That's right. Roper received a CON for its
7 Berkeley County Hospital in 2016 also; isn't
8 that true?

9 A: Yes..

10 Q: And that's going through construction and will
11 open relatively soon; is that right?

12 A: That's my understanding, yes.

13 Q: So, suffice it to say, you don't know when or
14 even if the Trident Hospital project that served
15 as part of the basis for opposing MUSC's
16 Berkeley County Hospital will be built?

17 **MR. THOMAS:** Object to this line of questioning, Your
18 Honor. He's asking about a CON that was filed
19 for the Berkeley County Hospital. He's asking
20 my witness about that case and this is about a
21 linear accelerator case.

22 **MR. DAYHUFF:** Certainly -- well, I understand, Your
23 Honor. This won't be long. But I'm certainly
24 allowed to explore this expert's work as a part
25 of Cross-Examination of his expert opinions.



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ROA_0418

1 **THE COURT:** All right. I think you're right. You
2 can explore his opinions, the basis for them.
3 But let's try to get to this particular CON as
4 quickly as you can.

5 **MR. DAYHUFF:** I will. And then we'll move through
6 these quickly and be there.

7 **Q:** MUSC filed an application to add 14 intensive
8 care bassinets to it's neonative -- neonatal
9 care unit, intensive care unit, that'll be
10 located in the new children's hospital. We
11 heard about that also earlier in this trial; did
12 we not?

13 **A:** We did.

14 **Q:** MUSC is one of five regional perinatal centers
15 in South Carolina, correct?

16 **A:** True.

17 **Q:** It's your expert health planning opinion that
18 DHEC should not have approved and the ALC should
19 not have awarded -- or should not award, these
20 intensive care basinetts to MUSC?

21 **A:** That's not correct.

22 **Q:** Do you opine the MUSC should receive 14
23 intensive care basinetts?

24 **A:** My opinion was that DHEC could have approved
25 both projects. They could have approved MUSC



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ROA_0419

1 and approved Trident.

2 Q: All right. MUSC submitted the CON application
3 to establish an FED in southern Berkeley County
4 that DHEC reviewed and approved, right?

5 A: Correct.

6 Q: You offered health planning opinions in
7 opposition to that application, didn't you?

8 A: I did.

9 Q: MUSC submitted applications to establish a
10 pediatric AFC and a pediatric imaging center in
11 North Charleston. You opposed those
12 applications?

13 A: I did.

14 Q: When those two facilities open, which will be
15 relatively soon, pediatric patients and their
16 parents who reside in Berkeley County,
17 Dorchester County, northern Charleston County,
18 who choose MUSC for their pediatric care, will
19 no longer have to drive all the way down to the
20 peninsula; isn't that right?

21 A: I assume that's true.

22 Q: All right. That improved geographic access to
23 MUSC care that these peds patients and their
24 parents will experience as a result of those new
25 facilities is similar to the improved geographic



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ROA_0420

1 access of patients from Berkeley County,
2 Dorchester County, North Charleston County will
3 experience if we get a linear accelerator in the
4 Nexton area.

5 A: Well, if those patients are choosing to drive to
6 downtown today and they don't want to utilize
7 other facilities, that's true that that would
8 reduce their travel time.

9 Q: A few years back we submitted a CON application
10 for a linac in North Charleston. You opposed
11 that application.

12 A: I did.

13 Q: Tidelands Health submitted a CON application to
14 establish elective PCI program at Georgetown
15 Memorial Hospital.

16 MR. THOMAS: I'm going to object now, Your Honor.
17 Now he's not even on MUSC. He's talking about
18 Tidelands up in Georgetown ---

19 MR. DAYHUFF: MUSC supported that application, Your
20 Honor. This gets at his history of opposing
21 MUSC projects no matter where they are, and
22 particularly when they involve improving
23 geographic access for patients.

24 MR. THOMAS: I'm going to object to that. He was
25 representing an entirely different entity, Grand



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ROA_0421

1 Strand Hospital up there. So, Tideland's was the
2 applicant there. If MUSC has some affiliation,
3 great, but now we're getting real far afield
4 here, Your Honor. So, you know, I object as to
5 relevance, Rule 401 and 403. I think it's
6 prejudicial as well.

7 **THE COURT:** Well, I'm not -- I'm not sure how
8 prejudicial it is, but it's certainly far
9 afield.

10 **MR. DAYHUFF:** I understand, Your Honor. I'll just
11 ask one more question and we'll be done with
12 this.

13 **Q:** In the last 20 years, Mr. Sullivan, can you
14 recall a single MUSC CON application for any
15 healthcare facility, any healthcare service,
16 that MUSC proposed to locate in Berkeley County,
17 Dorchester County, or North Charleston County,
18 that you reviewed and thought, you know what,
19 this application makes good sense and it should
20 be approved?

21 **A:** I don't recall one.

22 **Q:** All right. Let's talk about MUSC's cancer care.
23 How many linear accelerators does MUSC currently
24 operate?

25 **A:** Five.



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ROA_0422

1 Q: And the linear accelerator treatments, radiation
2 treatments, that MUSC provides are part of the
3 MUSC Hollings Cancer Center; isn't that right?

4 A: That's true.

5 Q: And are you generally familiar with the Hollings
6 Cancer Center?

7 A: I am.

8 Q: MUSC obviously treats cancer patients through
9 the Hollings Cancer Center. We also do cancer
10 research.

11 A: True.

12 Q: We train physicians and other providers to
13 provide cancer care.

14 A: That's correct.

15 Q: Dr. Williams, who was here earlier, was trained
16 at MUSC.

17 A: That is correct.

18 Q: MUSC's cancer program has over 60 cancer sub-
19 specialists who concentrate on specific types of
20 cancer and cancer treatments.

21 A: I saw deposition testimony to that effect.

22 Q: Does MUSC treat cancer with a multi-disciplinary
23 team approach?

24 A: That's my understanding.

25 Q: And do you know how many multi-disciplinary



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ROA_0423

1 cancer teams, or I think they may have been
2 referred to as clinics, MUSC has?

3 A: I don't recall the number. There was some
4 testimony about that. I think Dr. Jenrette
5 testified about that in his deposition. I don't
6 recall the number.

7 Q: Do you recall whether it was above or below ten?

8 A: I don't.

9 Q: Okay. Now, multi-disciplinary team approach
10 puts multiple physicians with different cancer
11 specialties together to treat patients' cancer,
12 correct?

13 A: That's true.

14 Q: And does that approach benefit patients?

15 A: I think it's been proven true through research
16 to improves the outcomes for patients.

17 Q: All right. Makes it more convenient for
18 patients?

19 A: Sure.

20 Q: Less trips back and forth. And it results in
21 better communication amongst the cancer
22 providers.

23 A: It can. I mean, it really depends on who the
24 providers are, but it can result in better
25 communication.



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ROA_0424

1 Q: Sure. Generally it would result in better
2 communication when you get folks together.

3 A: Sure.

4 Q: Does MUSC have tumor boards in its cancer care
5 program?

6 A: They do.

7 Q: Are tumor boards beneficial to patients?

8 A: I think they are, yes.

9 Q: Does MUSC have tumor boards for all major
10 anatomical sites?

11 A: I've heard testimony to that effect. I don't
12 have any independent knowledge of that, but I
13 know that there's been testimony about that.

14 Q: Do you have any reason to doubt that MUSC has
15 tumor boards in all anatomical sites?

16 A: I don't.

17 Q: All right. MUSC conducts clinical trials
18 involving radiation oncology?

19 A: That's my understanding.

20 Q: And these trials advance cancer care generally?

21 A: They can.

22 Q: And they also provide patients access sometimes
23 to new cancer treatments they would not
24 otherwise be able to access.

25 A: That's possible.



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ROA_0425

- 1 Q: All right. Dr. Jenrette estimated that 12 to 15
2 percent of his patients were involved in cancer
3 trials. Do you have any reason to doubt that?
- 4 A: I don't.
- 5 Q: MUSC provides specialized orthopaedic oncology
6 care?
- 7 A: Again, I've heard testimony to that effect.
- 8 Q: All right. Adult, pediatric, blood, and bone
9 marrow transplant program?
- 10 A: I know they have that program.
- 11 Q: All right. And MUSC has the only program in
12 South Carolina that offers treatment for
13 advanced melanoma.
- 14 A: You asked me that at my deposition. I didn't
15 know that.
- 16 Q: Don't know. Let's talk a little more
17 specifically about cancer providers at MUSC.
18 And when we're talking about cancer providers,
19 what are the three primary types of cancer
20 providers?
- 21 A: Medical oncologist, radiation oncologist, and
22 surgeons.
- 23 Q: All right. And do you know how many med oncs
24 MUSC has?
- 25 A: I saw a slide I think maybe Mr. Levitt prepared.



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ROA_0426

1 I don't know the number. There were a number of

2 ---

3 Q: Many suffice it to say.

4 A: There were several.

5 Q: Okay. The med oncs at MUSC are subspecialists
6 who focus their practices on treating certain
7 types of cancer with chemo; is that right?

8 A: I'm sure that -- based on the testimony you
9 heard this morning from Dr. Williams, I think
10 people tend to gravitate towards one
11 subspecialty or the other. That's my
12 understanding.

13 Q: Right. Well, and if you don't know, it's okay.
14 Do you know whether the med oncs at MUSC are
15 subspecialists who focus on specific types of
16 cancer?

17 A: I don't -- I mean, I would assume that's the
18 case, but I don't have any specific knowledge.

19 Q: Okay. We have many rad oncs at MUSC?

20 A: I think I saw seven or eight.

21 Q: Okay. And the rad oncs are subspecialists too,
22 right, focusing on particular types of cancer?

23 A: I saw testimony to that effect.

24 Q: Right. And you saw Dr. Jenrette's testimony,
25 right?



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ROA_0427

1 A: I did.

2 Q: What type of cancer does he focus on?

3 A: He does Gamma Knife, so that's primarily brain
4 and head.

5 Q: MUSC has rad oncs that specialize in pediatric
6 cancer?

7 A: I'm aware of that.

8 Q: Gynecological cancer?

9 A: Again, I don't know this for a fact, but, again,
10 I've read testimony about all of this.

11 Q: And breast cancer.

12 A: Yes.

13 Q: How many cancer surgeons do we have at MUSC?

14 A: Don't know.

15 Q: These cancer surgeons are subspecialists too,
16 right?

17 A: Some are.

18 Q: All right. Do you know how many subspecialists
19 we have in cancer versus generalists?

20 A: I don't.

21 Q: All right. Do you know whether we have a
22 subspecialist cancer surgeon that focuses on
23 breast cancer?

24 A: I am aware of that, yes.

25 Q: Cancers of the ear, nose and throat?



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ROA_0428

- 1 A: I read that in Dr. Jenrette's testimony.
- 2 Q: Colorectal cancer?
- 3 A: Yes.
- 4 Q: Brain cancer?
- 5 A: Yes.
- 6 Q: GYN cancer?
- 7 A: Yes.
- 8 Q: Even bone cancers and sarcoma?
- 9 A: Yes.
- 10 Q: Having access to med oncs, rad oncs, and cancer
- 11 surgeons who are cancer subspecialists is
- 12 advantageous for patients from a clinical
- 13 standpoint.
- 14 A: It certainly can be, yes.
- 15 Q: Are there times that it's not advantageous?
- 16 A: In some cases it wouldn't matter. You know, a
- 17 good general surgeon could achieve the same
- 18 outcome as a subspecialist.
- 19 Q: The acronym NCI stands for what?
- 20 A: National Cancer Institute.
- 21 Q: All right. And the NCI is our federal
- 22 government's principal agency for cancer
- 23 research and training.
- 24 A: That's true.
- 25 Q: NCI conducts and funds research and studies for



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ROA_0429

1 cancer prevention.

2 A: Yes.

3 Q: Cancer causation.

4 A: Yes.

5 Q: Cancer treatment. Cancer detection.

6 A: Yes.

7 Q: Sponsor clinical trials for cancer.

8 A: Yes.

9 Q: Last but not least, they designate and provide
10 support to certain cancer programs around the
11 country.

12 A: They do.

13 Q: And MUSC's Hollings Cancer Center is an NCI-
14 designated center.

15 A: They are.

16 Q: The only designated center in South Carolina NCI
17 designated.

18 A: Yes.

19 Q: Approximately one of seven in the nation?

20 A: That's correct.

21 Q: These designations are not easy to get, are
22 they?

23 A: You have to meet a stringent set of standards.

24 Q: NCI designation is an important designation for
25 purposes of cancer training and cancer research.



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ROA_0430

1 A: Sure. I mean ---

2 **MR. THOMAS:** Wait a minute. I want to object there.
3 I didn't hear a question. I heard a statement.
4 And what I'm concerned about here, Your Honor,
5 is that Mr. Dayhuff's doing a lot of testifying.
6 And I'm fine if he wants to get all of this
7 through this witness. It seems more appropriate
8 through Dr. Jenrette, his expert in cancer care.
9 But I'm fine with it coming in this way, but I
10 don't expect it to come in at Dr. Jenrette as
11 well in kind of a redundant, you know, second
12 bite at the apple. And that's what I'm afraid
13 of.

14 **MR. DAYHUFF:** I appreciate the advice about our trial
15 presentation, but I think this is appropriate
16 cross-examination.

17 **MR. THOMAS:** It wasn't a question.

18 **THE COURT:** The last one wasn't a question.

19 Q: Is NCI designation an important designation for
20 purposes of cancer training and cancer research?

21 A: Yes.

22 Q: NCI designation can be really important for
23 folks with rarer cancers, true?

24 A: Could be, yes.

25 Q: Now, as I recall, you don't have an opinion on



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ROA_0431

1 the question of whether an average NCI-
2 designated cancer center provides a higher
3 quality of cancer care than a non-designated
4 cancer center, right?

5 A: Yeah. I don't think it's -- there's a general
6 rule. I think that it depends on the individual
7 provider and their actual practices.

8 Q: Was MUSC ranked as the best hospital in South
9 Carolina in 2018 by U.S. News & World Report?

10 A: Yes.

11 Q: And U.S. News & World Report also ranked MUSC's
12 cancer care as number 24 nationally; is that
13 right?

14 A: True.

15 Q: Have you done any health planning work for Mayo
16 Clinic in Jacksonville?

17 A: Maybe one small project several years ago.

18 Q: And how about -- same question, Duke?

19 A: I have done work for Duke, but not CON work.

20 Q: All right. Does MUSC's radiation oncology
21 program have high Press Ganey scores?

22 A: Again, I heard testimony from Dr. Jenrette to
23 that effect.

24 Q: And, again, what are Press Ganey scores?

25 A: It's basically an organization that collects



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ROA_0432

1 information from patients post treatment to
2 measure their satisfaction with the number of
3 different aspects of the care.

4 Q: Do you agree that MUSC provides high quality
5 cancer care?

6 A: Yeah. I've nothing to indicate they don't.

7 Q: If The Court approves MUSC's CON application,
8 MUSC will provide high quality cancer care at
9 the Nexton location, won't they?

10 A: I don't know if I can say that as a definitive
11 statement. They have the potential to do that,
12 yes.

13 Q: What does your 30 plus years in health planning
14 experience tell you?

15 A: That they have the infrastructure in place where
16 that could happen.

17 Q: And it doesn't -- your health planning expertise
18 doesn't lead you to the conclusion that it is
19 very likely to happen?

20 **MR. THOMAS:** I'm going to object, Your Honor. Now
21 he's asking my witness to speculate as to what
22 kind of cancer care is going to be provided at
23 Nexton.

24 **THE COURT:** Yeah, I agree, Mr. Thomas. And, Mr.
25 Dayhuff, unless you've got something to say that



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ROA_0433

1 would tell me that you're not asking him to
2 predict the future ---

3 **MR. DAYHUFF:** Well, I would say this, Your Honor. I
4 understand. He's a health planner. Health
5 planners take averages. They look at systems.
6 And it was my assumption that, if a facility
7 provides cancer care for a long time, they
8 provide high quality cancer care, and they open
9 a facility somewhere else, a health planner
10 could come to the conclusion they're more likely
11 than not to provide that ---

12 **THE COURT:** And I think that's what he said. I think
13 that certainly he said, as I believe, that MUSC
14 has the capacity to do that. Now, whether they
15 will in any particular case ...

16 **MR. DAYHUFF:** Fair enough.

17 **THE COURT:** For example, my mother-in-law. I would
18 like to have high level of care for her. But
19 you can't tell me for sure that that's what
20 she'll get.

21 **MR. DAYHUFF:** Right.

22 **THE COURT:** And I think -- tailor your questions to
23 what he can actually testify to.

24 **MR. DAYHUFF:** Understood.

25 **Q:** Roper Cancer Care; Roper was a part of the



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ROA_0434

1 contested case process when these applications
2 -- when the MUSC application was reviewed,
3 right?

4 A: True.

5 Q: They filed an application for a linac. MUSC
6 filed in May of 2017 and Roper filed thereafter
7 in July, I believe.

8 A: Sounds right.

9 Q: All right. You have a general familiarity with
10 Roper Cancer Care?

11 A: General.

12 Q: All right. How many linacs do they have?

13 A: They have, I believe, three at the moment.

14 Q: Roper does not do cancer research, right?

15 A: I don't know a lot about Roper's research. I'm
16 not aware that they do research. I don't know
17 the specifics.

18 Q: They don't train physicians to be cancer
19 providers.

20 A: Not to my knowledge.

21 Q: They don't have cancer subspecialists.

22 A: I think they do.

23 Q: How many subspecialists?

24 A: I don't know, but, I mean, I've got family
25 members who have seen doctors at Roper who I



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ROA_0435

1 thought were subspecialists for cancer
2 treatment.

3 Q: Roper doesn't have tumor boards for all
4 anatomical sites?

5 A: Not that I'm aware of.

6 Q: Does Roper conduct clinical trials ---

7 A: I don't know.

8 Q: --- for radiation oncology?

9 A: I don't know.

10 Q: You don't know?

11 A: I don't know.

12 Q: All right. Is Roper NCI designated?

13 A: No.

14 Q: Is Roper ranked in the U.S. News & World Report
15 in cancer?

16 A: No.

17 Q: All right. Trident cancer care, you are
18 generally familiar with Trident cancer care,
19 right?

20 A: I am.

21 Q: They operate -- well, they have three linacs?

22 A: True.

23 Q: No formal cancer research is being done at
24 Trident?

25 A: True.



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ROA_0436

- 1 Q: The -- we heard a little about the Sarah Cannon
2 affiliation. That affiliation is relatively
3 new; is it not?
- 4 A: It is.
- 5 Q: Trident is not NCI designated.
- 6 A: They're not.
- 7 Q: Trident doesn't train med oncs, rad oncs, or
8 cancer surgeons?
- 9 A: Not to my knowledge.
- 10 Q: Does Trident utilize the multi-disciplinary care
11 system?
- 12 A: Yes.
- 13 Q: All right. And they haven't been utilizing that
14 very long, have they?
- 15 A: Well, they haven't had dedicated teams. I think
16 they've been practicing multi-disciplinary care,
17 which is the standard of any radiation therapy
18 provider. You're consulting with the various
19 physicians who are involved in the patient's
20 care. They don't have them all under one roof,
21 but they do practice multi-disciplinary care.
- 22 Q: Did you hear Mr. Clements' testimony about
23 multi-specialty care teams, clinics?
- 24 A: I did.
- 25 Q: And do you recall when you said the first one of



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ROA_0437

1 those was established?

2 A: Right. I think we're talking about one that's
3 totally within the structure of Trident. And,
4 you know, this was an issue that came up in
5 another case I was involved in. And oncologists
6 practice multi-disciplinary care. That's the
7 nature of their practice. They have to talk
8 with the surgeons. The medical oncologist talks
9 with the radiation oncologist, talks with the
10 primary care physician. So, there is a multi-
11 disciplinary approach in virtually every case.
12 Sometimes it's not under one roof, though.

13 Q: Fair to say that it's -- the multi-disciplinary
14 approach has become more formalized at Trident
15 in the very recent past?

16 A: Yeah. In terms of having dedicated teams. Yes.

17 Q: And as of today, they have one multi-specialty
18 cancer clinic team and that's for breast cancer.

19 A: That's right.

20 Q: We talked about -- well, we haven't talked
21 about. We heard about cancer providers at
22 Trident. I believe we heard there were three
23 rad oncs that work at Trident.

24 A: That's my understanding.

25 Q: Now these rad oncs are not subspecialists, are



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ROA_0438

1 they?

2 A: I think he -- I think Dr. Williams this morning
3 testified that they each have an area of
4 specialty.

5 Q: All right. Do they focus their practice on a
6 particular type of cancer?

7 A: I think they do. But, as he said, he says I do
8 90 to 95 percent of the head and neck cancers
9 and then I also do other cancers as well.

10 Q: All right. They take care of all cancer sites?

11 A: Sure. I think that's true of many radiation
12 oncologists.

13 Q: The surgeons that Trident has, that perform
14 surgery on cancer, those are general surgeons;
15 are they not?

16 A: They are.

17 Q: Not subspecialists in cancer?

18 A: Not to my knowledge.

19 Q: Trident's not NCI designated?

20 A: No.

21 Q: Trident's not ranked in the 2018 U.S. News &
22 World Report in cancer or in anything else?

23 A: No.

24 Q: I think it was Mr. Clements that mentioned
25 Trident had the ACR designation.



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ROA_0439

1 A: Correct.

2 Q: They received that relatively recently; is that
3 correct?

4 A: Maybe three or four years ago.

5 Q: Yeah. I was thinking it was on Mr. Clements' CV
6 for 2013 or '14. Does that sound right?

7 A: Yeah. I mean, it was right around the time that
8 they got the third linear accelerator. I don't
9 remember the exact date.

10 Q: Does MUSC have the ACR accreditation too?

11 A: I think they do.

12 Q: Does Trident provide high quality cancer care?

13 A: I believe they do.

14 Q: All right. The high quality cancer care
15 provided at MUSC is both broader and deeper than
16 the cancer care provided by Trident; isn't that
17 right?

18 A: In terms of the breadth of resources, yes.
19 There are more professionals there and they
20 offer a broader range of subspecialties.

21 Q: And the high quality cancer care provided at
22 MUSC is also both broader and deeper than the
23 cancer care provided by Roper?

24 A: That would be my assumption.

25 Q: All right. MUSC, we mentioned, filed its linear



1 accelerator CON application in May. Roper filed
2 in July. They were reviewed together. Trident
3 opposed both CON applications; is that right?

4 A: True.

5 Q: And you presented your health planning opinions
6 in opposition to both of these applications at
7 the September 20th, 2017 DHEC project review
8 meeting?

9 A: I did.

10 Q: All right. I'm going to walk back through a few
11 of those slides that you saw earlier today and
12 ask some questions.

13 A: Sure.

14 **MR. DAYHUFF:** Mr. Bupp.

15 Q: All right. And just for the record, this is
16 your power point pack here?

17 A: Right.

18 Q: Exhibit 10.

19 A: It was a combination between Mr. Clements and
20 myself.

21 Q: I see.

22 A: The majority of it is mine.

23 Q: This slide is a combination of your work product
24 and Mr. Clements?

25 A: Yes.



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ROA_0441

1 Q: But we will find many of your health planning
2 opinions in opposition to the MUSC and Roper
3 applications in this?

4 A: You will.

5 Q: All right. Let's look at Bates page 422,
6 Exhibit 10.

7 A: Okay.

8 Q: All right. First bullet point, due to the lack
9 of patient volumes we operate only two of three
10 linacs. And that's because -- is that true,
11 one?

12 A: This is Mr. Clements' slide, but I think that is
13 true, yes.

14 Q: Fair enough. In that situation where Trident
15 has been operating only two of its three linacs,
16 has that been going on since 2015?

17 A: That's the testimony that I heard.

18 Q: Right. I think I heard Mr. Clement say, when
19 they installed the third linac in 2015, they
20 ceased operating the Elekta Synergy S. Does
21 that sound right?

22 A: Yes.

23 **MR. DAYHUFF:** All right. Let's look at 427, Mr.
24 Bupp.

25 Q: All right. Trident has ample capacity on its



1 existing linacs to serve current and projected
2 needs of the area. That's true of both the
3 needs sought to be served by Roper and MUSC with
4 their CON application?

5 A: Yes.

6 Q: And that's just the math, right, I think you
7 told me in your deposition?

8 A: Sure. I mean, you know, they've got one linac
9 that's not being utilized. They could easily
10 accommodate at least 5,000 more treatments on
11 that machine.

12 Q: All right. And that's enough capacity to cover
13 both the projected treatments that could be done
14 at the new Roper facility and the new MUSC
15 facility?

16 A: I'm not sure that's true. I can't remember what
17 Roper's projection was, but I thought it was
18 something north of 4,000. And MUSC's was a
19 little bit less than 4,000. But what I was
20 talking about is meeting the needs of the
21 residents of the area. And the needs right now
22 have not changed a whole lot over recent years.

23 Q: All right. And it's your opinion that there's
24 not need for either the Roper or MUSC linac in
25 Berkeley County.



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ROA_0443

1 A: True.

2 Q: All right. Let's move from kind of the
3 mathematical, I suppose, to the actual. For
4 Trident to actually absorb or serve the patients
5 that MUSC and Roper propose to treat in their
6 Berkeley County linacs, one or more of the
7 following things would need to occur, right?
8 One, Trident would have to operate three linacs,
9 something it hasn't done since 2015.

10 A: True.

11 Q: And which LINAC would they need to bring back
12 into operation at this point?

13 A: Well, they are in the process of installing
14 another TrueBeam. And my understanding is that
15 all three will be in operation. It's just that
16 the volumes will primarily be performed on two
17 of those machines.

18 Q: All right. The linac -- the third linac, the
19 one that I believe we heard would be held in
20 reserve, wouldn't that be the 2100 EX 2002, the
21 older Varian?

22 A: Yeah. I think that one would be sort of the
23 backup machine, is my understanding.

24 Q: Is that the one that he described as providing
25 redundancy, Trident, Mr. Clements?



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ROA_0444

- 1 A: Sure.
- 2 Q: All right.
- 3 A: I mean, today it's being used on a regular basis
- 4 to treat patients.
- 5 Q: Right. Because the new linac that you
- 6 mentioned, the new Varian that they obtained
- 7 approval from DHEC for in September or so of
- 8 2018 is not installed yet..
- 9 A: Right.
- 10 Q: And it'll be installed in March ---
- 11 A: Right.
- 12 Q: --- or April of 2019.
- 13 A: That's my understanding.
- 14 Q: All right. When they install that new Varian
- 15 TrueBeam, they will operate that unit and the
- 16 unit that was the third unit at Trident that was
- 17 installed in 2015, the Varian, and they will
- 18 have the older Varian as a backup redundancy for
- 19 the first two.
- 20 A: Right. And potentially spillover for whatever
- 21 reason they needed it, you know, on a daily
- 22 basis.
- 23 Q: If utilization goes up enough, they will have
- 24 the third to operate.
- 25 A: Right.



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ROA_0445

1 Q: Now -- so, they would have to do that to be able
2 to absorb the patients MUSC and Roper propose to
3 treat, they'd have to have three that operate.
4 Let's focus on MUSC for a minute. To absorb or
5 treat the patients that MUSC proposes to treat,
6 many of these patients that currently choose
7 MUSC for their care would have to start choosing
8 Trident for their care.

9 A: Or Trident would have -- I mean, MUSC would have
10 to -- their doctors would have to actively refer
11 the patients to Trident.

12 Q: That's the other way I suppose this could
13 happen, that Trident could absorb the MUSC
14 patients as long as cancer physicians at MUSC,
15 who diagnose these patients, develop their
16 treatment plans, would agree to outsource those
17 patients to Trident for radiation treatment.

18 A: Yes.

19 Q: All right. Now, how likely is it, in your
20 health planning opinion, that MUSC patients
21 would change their provider preference from MUSC
22 to Trident, when they've had the option of
23 choosing Trident for years, instead of choosing
24 Trident, they drive past it to go down to the
25 peninsula?



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ROA_0446

1 A: I think it would be likely if, for example, the
2 medical oncologist at MUSC said, you don't have
3 to drive down here every day if you don't want
4 to. You're welcome to do that, but you can go
5 to Trident instead. We have a good working
6 relationship with them. Their doctors are all
7 trained at MUSC. And they will communicate your
8 treatment on an ongoing basis to me, so I can
9 monitor your care.

10 Q: How likely is it, in your expert health planning
11 opinion, that MUSC's cancer physicians, who
12 place great emphasis on their multi-disciplinary
13 approach, with seamless communication between
14 multiple cancer providers in one integrated
15 system, would say, you know what, we should
16 outsource our patients to a different hospital
17 system for cancer care?

18 A: I mean, given the culture of MUSC, I'd say it's
19 fairly unlikely. But, I mean, would that be to
20 the benefit of the patient? Sure.

21 Q: Let's look at MUSC Exhibit 59.

22 **(Respondent MUSC's Exhibit Number 59 was introduced**
23 **into the record at this time.)**

24 Q: So, take a look at this for me, Mr. Sullivan.
25 This is a exhibit that lists Trident's medical



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ROA_0447

1 oncologist.

2 A: Okay.

3 Q: I'm not sure if all these folks are still here.
4 I think you told me maybe there were five or
5 six. Ryan Kalinsky, Mt. Pleasant, South
6 Carolina. And I guess the question here is,
7 have you done any research or analysis to
8 determine whether the med oncs that work with
9 Trident that are getting patients -- let's say
10 Mr. Kalinsky -- Dr. Kalinsky from Mt. Pleasant
11 is diagnosing patients -- or folks at Trident
12 are diagnosing patients with the participation
13 of this rad onc, with the med onc that's working
14 in conjunction with Trident and they're
15 developing a treatment plan and then they're
16 outsourcing the Mt. Pleasant area patients to
17 MUSC for rad onc care?

18 A: I don't know.

19 Q: You don't know. You've done no research at all?

20 A: I have not.

21 Q: With respect to any of these rad oncs?

22 A: I have not.

23 Q: So, we don't know whether Trident is practicing
24 what you preach with respect to MUSC in this
25 case?



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ROA_0448

1 A: I don't know.

2 **MR. THOMAS:** I need to object to the form of that.
3 I think it's a characterization. He keeps
4 saying Trident, Trident, Trident. These are on
5 Trident's medical staff. They have privileges
6 at Trident, Your Honor. They're not employed by
7 Trident. They're private practitioners. So,
8 Mr. Sullivan couldn't know, you know, what they
9 do. And I guess the question about the
10 research, the characterization's got to stop at
11 Trident, Trident, Trident. Those aren't Trident
12 physicians. They're on their medical staff.
13 They could be on medical staffs of other places.
14 They could be on Roper's medical staff. They
15 could be on MUSC's. They could be on
16 Colleton's, East Cooper's. We don't know where
17 they have privileges. They do have privileges
18 at Trident. That gives them the ability to
19 actually walk in the hospital door and not get
20 arrested when they treat a patient. That's what
21 that means. But they're not Trident doctors.
22 In the same way an MUSC physician is employed by
23 MUSC. And I just want to get that straight for
24 the record, because he keeps saying Trident,
25 Trident, Trident.



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ROA_0449

1 **MR. DAYHUFF:** I appreciate Mr. Thomas' testimony. We
2 heard during his case about how they have
3 radiation oncologists and medical oncologists
4 that are associated with them and their program.
5 I was simply asking this expert whether he had
6 done any analysis to see if the folks associated
7 with Trident, whether they're employed, whether
8 they're independent contractors, the ones that
9 are doing cancer care there, are they engaging
10 in this practice of multi-disciplinary care yet
11 they outsource? That was the question. And I
12 think he answered it. He doesn't know.

13 **MR. THOMAS:** As long as -- and, again, just the
14 characterization. For the record, I just don't
15 want it to say Trident outsourced this or
16 Trident did that when it's a physician who's on
17 Trident's medical staff. It's a lot different,
18 Your Honor.

19 **THE COURT:** Okay. I think I understand.

20 **MR. THOMAS:** Okay.

21 **Q:** So, we don't know, I think was the answer to
22 that question, right?

23 **A:** Yes.

24 **Q:** All right. Good. We do know that Trident's
25 sister hospital in Myrtle Beach, Grand Strand,



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ROA_0450

1 is not practicing what you're preaching with
2 respect to MUSC and the outsourcing of patients
3 for rad onc, right?

4 A: They did for many years.

5 Q: All right. Well, let's lay a little foundation,
6 I suppose. Both Trident and Grand Strand are
7 owned by the same parent company; is that right?

8 A: Correct.

9 Q: And what parent company is that?

10 A: HCA.

11 Q: All right. And you do health planning work for
12 Grand Strand, including CON applications?

13 A: I do.

14 Q: All right. Let's look at MUSC Exhibit 22.

15 **(Respondent MUSC's Exhibit Number 22 was introduced**
16 **into the record at this time.)**

17 Q: All right. And let's look -- so, it's -- before
18 we move on. Grand Strand Regional Medical
19 Center Certificate of Need for a Linear
20 Accelerator and CT. Let's go to the next page,
21 please. Go to the next page. All right. Mr.
22 Sullivan, do you see your name there at the
23 bottom?

24 A: I do.

25 Q: Page three. All right. Do you recall working



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ROA_0451

1 on a CON application for Grand Strand to get a
2 linear accelerator about five years or so ago?

3 A: I do. I remember vividly.

4 Q: Good. Really, like it was yesterday?

5 A: Yes.

6 Q: All right. This application was successful,
7 right?

8 A: It was ultimately, yes.

9 Q: All right. Grand Strand was able to get a CON
10 and establish a linac. Was it at the hospital or
11 near the hospital?

12 A: At the hospital.

13 Q: At the hospital in Myrtle Beach. Now, when
14 Grand Strand obtained that CON for a linac,
15 there was a provider called Carolina Regional
16 Cancer Center that had several linacs in Myrtle
17 Beach, right?

18 A: They did.

19 Q: Dr. Williams, we heard, worked there for a long
20 time, earlier today.

21 A: He did.

22 Q: And CRCC's linac services were quality linac
23 services, weren't they?

24 A: There was some question about that.

25 Q: Okay.



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ROA_0452

1 A: Yeah.

2 Q: So, you had some question as to whether CRCC's
3 linac services met the standard of care?

4 A: Not the linacs meeting the standard of care, the
5 -- it's a complicated situation, but the ---

6 Q: Let's focus on the radiation oncology.

7 **MR. THOMAS:** No, no. Your Honor ---

8 A: That is the complicated situation.

9 Q: Okay.

10 A: The urologists in the area were given the
11 opportunity to invest in the radiation therapy
12 center. And in a very short period of time,
13 previously about 30 percent of patients with
14 prostate cancer were getting radiation
15 treatment. The other 70 percent were getting
16 either no treatment or surgical treatment.
17 Within a short -- I can't remember if it was one
18 year or two years after the urologists invested,
19 70 percent of the prostate cancer patients were
20 getting radiation treatment. So, there was some
21 question about whether or not that represented
22 quality care. That was one of the issues that
23 was raised during the course of that particular
24 proceeding.

25 Q: Was there any conclusion about that in that



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ROA_0453

1 particular proceeding?

2 A: I don't recall what the findings were.

3 Q: Did you draw any conclusion about that?

4 A: I couldn't. I'm not a clinician.

5 Q: Right. Okay. Let's look at MUSC Exhibit 47.

6 **(Respondent MUSC's Exhibit Number 47 was introduced**
7 **into the record at this time.)**

8 Q: So, 47's in evidence. We have a light blue dot.

9 Does that approximate where Grand Strand is
10 located?

11 A: It does.

12 Q: All right. And 21st Century Oncology, CRCC, the
13 yellow dot, do you see that?

14 A: Yes.

15 **MR. DAYHUFF:** Let's go to DX15.

16 Q: So we've calculated, using Google Maps, that
17 those two facilities were three and a half miles
18 apart, seven minutes apart. Sound right to you?

19 A: Sounds right.

20 Q: Instead of establishing -- well -- yeah, instead
21 of establishing its own linac at Grand Strand,
22 Grand Strand could have implemented the solution
23 you propose for both MUSC and Roper. That is,
24 diagnose the patients who come to you for cancer
25 care, develop a treatment plan, and outsource



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ROA_0454

1 them to CRCC.

2 A: They could have, but there were distinguishing
3 factors in that case that were much different
4 from the circumstances in Charleston.

5 Q: I see. Grand Strand did not do that. They
6 established their own linac?

7 A: No. We believe very strongly that having no
8 hospital based linear accelerator in the market
9 was a problem, because there were a material
10 number of patients who were inpatients of the
11 hospital who were having to be transported by
12 ambulance to 21st Century. And so that was one
13 of the bases for trying to get another linear
14 accelerator. The second one was, there was a
15 tremendous need for additional capacity in the
16 area. The 21st Century facility was performing
17 linear accelerator treatments at 9:00 and 10:00
18 o'clock at night on patients. And since there
19 was a need for another unit -- I mean, a
20 recognized need in the State Health Plan. And
21 it made more sense, given that there was an
22 identified need, there was no underutilized
23 capacity in Horry County, to put that facility
24 at the hospital where it would serve a broader
25 range of patients.



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ROA_0455

1 Q: Another reason that Grand Strand did not adopt
2 the solution you've prescribed for MUSC, Grand
3 Strand wanted to provide patients that come to
4 Grand Strand for cancer care with multi-
5 disciplinary cancer care within one integrated
6 institution.

7 A: I'm sure that was part of the reason, yes.

8 Q: Grand Strand, like MUSC, did not want to
9 fragment cancer care for their patients between
10 multiple healthcare providers.

11 A: Again, with explanation that's true. That was
12 one of the arguments that was raised. But for
13 many, many years Grand Strand sent all of their
14 patients to -- or virtually all of their
15 patients to the CCRC facility. So, it was only
16 at the point where that facility was so --
17 operating so much at over capacity and that
18 there was an identified need for another unit in
19 the market, that Grand Strand decided that was
20 the appropriate time to bring a linear
21 accelerator in-house.

22 Q: And did CRCC apply to address that need showing
23 in the market?

24 A: They did.

25 Q: And Grand Strand opposed that application,



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ROA_0456

1 right?

2 A: I think -- I'm not sure we opposed their
3 application. I think we supported our
4 application. I think Grand Strand didn't care
5 if two got approved, so.

6 Q: You helped Grand Strand achieve that very
7 legitimate planning goal, adding a linac at
8 Grand Strand, so Grand Strand's cancer care
9 could be what Dr. Jenrette at MUSC called
10 seamless, didn't you?

11 A: That was not the motivating factor. That was a
12 byproduct of doing it. The motivating factor
13 was to address a need that was identified in the
14 area to create another setting that perhaps
15 wasn't colored by the ownership of the surgeons
16 in the facility. And then also to provide a
17 more accessible point of access for inpatients
18 of a hospital who needed radiation treatment.

19 Q: Let's look at another one. MUSC Exhibit 19.

20 **(Respondent MUSC's Exhibit Number 19 was introduced**
21 **into the record at this time.)**

22 Q: It's another CON application. SJC Oncology
23 Services. Do you recall this CON? It's a
24 little more recent. It looks like 2017.

25 A: I do.



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ROA_0457

1 Q: All right. Who was the applicant in this CON
2 application?

3 A: Well, it says right there on the cover. It's
4 SJC Oncology Services.

5 Q: Okay. Good.

6 A: It's basically an affiliate of St.
7 Joseph/Candler health system down in Savannah.

8 Q: All right. St. Joseph's/Candler. Is that a big
9 medical center in the city, right?

10 A: Yeah. I think it's actually two hospitals.

11 Q: Kind of a major city medical center like MUSC?

12 A: Well, I think some would argue that Memorial
13 Health is the one that's more like MUSC. That
14 was the teaching facility and that was the
15 public facility. St. Joe's/Candler would be
16 more like Roper.

17 Q: Okay. Fair enough. Do you recall how big --
18 how many total beds St. Joseph's/Candler ---

19 A: Between the two hospitals, probably something
20 500, 550 range, something like that.

21 Q: MUSC is around 600 or so?

22 A: Yes, 600 plus.

23 Q: But I hear you, Memorial's more of a teaching
24 hospital in Savannah?

25 A: Right.



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ROA_0458

1 Q: Okay. Fair enough. Now, with your assistance
2 -- and by the way, I don't know if -- you worked
3 on this CON application too, right?

4 A: I did.

5 Q: You were the healthcare planner. With your
6 assistance, St. Joseph/Candler established a
7 linear accelerator in Bluffton, South Carolina
8 in 2017, right?

9 A: Right. They had an existing presence in Hilton
10 Head and so they were seeking to -- they were
11 operating at capacity at that unit. I don't
12 think there was any question that they were at
13 capacity. And then they sought to expand. And
14 rather than expand on Hilton Head, they sought
15 to put a unit at Bluffton.

16 Q: All right. They had a linac in Hilton Head.
17 Bluffton is an island, I guess, or an area
18 adjacent to Hilton Head, right?

19 A: Yeah. It's not an island. It's part of the
20 mainland.

21 Q: It is at least adjacent, right?

22 A: It is.

23 Q: Very good. Well, instead of establishing a
24 linac, St. Joseph/Candler could have implemented
25 the solution you proposed for both MUSC and



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ROA_0459

1 Roper. They could have diagnosed patients from
2 Bluffton who came to St. Joseph for care,
3 developed a treatment plan, and then outsourced
4 patients to, say, Beaufort Memorial Hospital to
5 do linac.

6 A: Well, Beaufort was also at capacity and was also
7 seeking another linear accelerator. And I
8 believe that both projects were ultimately
9 approved, because it was determined that there
10 was a need in the area for both units.

11 Q: All right. Did St. Joseph/Candler oppose the
12 Beaufort CON application?

13 A: No.

14 Q: All right. Let's look at a few more DHEC
15 slides.

16 **MR. DAYHUFF:** Dan let's go to -- back to MUSC Exhibit
17 10, Bates 431..

18 **(Respondent MUSC's Exhibit Number 10 was introduced**
19 **into the record at this time.)**

20 Q: And I think I understood your testimony earlier,
21 I think you referred to this slide. The point
22 here is that the number of cancer patients in
23 the service area is increasing, right?

24 A: It is.

25 Q: And that's due to population both growing and



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ROA_0460

1 aging?

2 A: True.

3 Q: And the total population in this service area,
4 it's growing, the over-65 population is growing
5 even faster, isn't it?

6 A: It is.

7 Q: And does the over-65 population cohort consume
8 more healthcare services per capita than the
9 overall population?

10 A: It does.

11 Q: And is that particularly true of cancer
12 services?

13 A: It is. They say if you live long enough, you're
14 going to get cancer.

15 Q: Now, the population growth trends, you know,
16 increase in the general -- significant increase
17 in the over-65, that's projected to continue for
18 the next eight or ten years or so?

19 A: Well, at least in the next five or six years.
20 I don't know that I have data that goes beyond
21 that.

22 Q: All right. Let's look at MUSC Exhibit 50.

23 **(Respondent MUSC's Exhibit Number 50 was introduced**
24 **into the record at this time.)**

25 Q: All right. In that population, projected



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ROA_0461

1 population growth, it's clustered, isn't it, in
2 certain portions of southern Berkeley and
3 southern Dorchester County?

4 A: That's one of the hot spots.

5 Q: Okay.

6 A: There's other areas. I mean, the peninsula, for
7 the first time in a while, is actually growing
8 fairly rapidly because of the development of a
9 lot of new condos and town homes and so forth on
10 the peninsula.

11 Q: But certainly if we think about let's say
12 Berkeley County, you have a lot of the
13 population growth centered around the southern
14 portion near Nexton.

15 A: That has been true historically. Because of the
16 economic development though with the Volvo plant
17 coming in, with the Mercedes plant, with the
18 growth in the Lockheed plant, you're seeing the
19 growth starting to move farther north towards
20 the Moncks Corner area. So, for a long time I
21 would agree with you that the most rapid areas
22 of growth were around Goose Creek, Carnes
23 Crossing, those areas, Summerville and the --
24 and you know, Nexton's kind of on the edge ---

25 Q: Right.



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ROA_0462

1 A: --- of where the growth is. There's not a lot
2 of growth to the north and west, I guess, of
3 Nexton right now. But there's planned growth
4 there, I guess.

5 Q: So, historically a lot of growth in southern
6 Beaufort County, Goose Creek, Carnes Crossing,
7 the places where both Roper and MUSC would like
8 to have -- well, Roper will -- and MUSC would
9 like to have a linear accelerator?

10 A: Yes. That's been a growth area.

11 Q: And we're going to see -- as we have Volvo and
12 other industry, we're going to see population
13 growth maybe up the 26 corridor?

14 A: Yeah. I mean, it's -- if you've driven that way
15 lately, I mean, it's pretty amazing to see that,
16 you know, they're building new bridges pretty
17 far to the west on 26 now around Exit 194, which
18 used to be just a sleepy little Jedburg area,
19 you know, and now they're building a new bridge
20 there over the highway. There's a whole exit
21 dedicated just to the Volvo plant along 26. And
22 so my expectation is that the growth is going to
23 continue out that direction.

24 Q: All right. And then apparently also maybe also
25 in Moncks Corner, which is, I guess, in the mid



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ROA_0463

1 section of Berkeley County.

2 A: Yeah. I mean, it's -- if you take the lake out,
3 I mean, it's pretty much the northern part of
4 where people live today.

5 Q: Let's look at 432 back in MUSC Exhibit 50 (sic).
6 All right. And I think the point of this slide
7 is that the treatments have remained stable.
8 And I believe your analysis on that is, even
9 though we have increasing population, the
10 radiation oncology treatments are not increasing
11 because we're using less treatments per patient.

12 A: Right.

13 Q: Right? And that's changed the way you do your
14 health planning analysis and make your
15 assumptions?

16 A: It has.

17 Q: In your health planning in the past you would
18 use 23, 25 treatments per patient as a go-by?

19 A: Yes.

20 Q: And now you use 15 to 18?

21 A: That's been my current experience.

22 Q: All right. Let's look at 433, please. All
23 right. I want to focus on -- well, maybe the
24 last bullet point. There is not a need for more
25 radiation therapy capacity in the area proposed



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ROA_0464

1 to be serve by MUHA and Roper. That's your
2 health planning opinion, right?

3 A: Yes.

4 Q: Applies to both to the Roper and MUSC Berkeley
5 County linacs, right?

6 A: Yes.

7 Q: Let's look at 434. I think this is your -- one
8 of your access slides. Let's see. Yeah. One,
9 two, three, fourth bullet point. There will be
10 minimal improvements in access for residents in
11 central and northern Berkeley County. From, I
12 suppose, either the Roper or the MUSC linac; is
13 that right?

14 A: True.

15 Q: All right. Let's look at MUSC 444.

16 **(Respondent MUSC's Exhibit Number 44 was introduced**
17 **into the record at this time.)**

18 Q: It's another map, Mr. Sullivan. Now, when we're
19 considering whether something is an improvement,
20 it involves a comparison, right?

21 A: Yes.

22 Q: Right. And what you're comparing in the
23 previous slide is the geographic access that
24 Berkeley and Dorchester County residents and
25 residents in North Charleston have to Trident's



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ROA_0465

1 linacs versus the geographic access they would
2 have to the new proposed linacs for both MUSC
3 and Roper.

4 **MR. THOMAS:** And Travis, I'll have to make an
5 objection to the slide. The Roper St. Francis
6 dot is just flat wrong. It's about 15 to 20
7 miles north of where it should be. In fact, if
8 you put the dot, it would cover a portion
9 perhaps of the red dot, but at least be probably
10 millimeters away. I just wanted to point that
11 out for the record before we get ---

12 **MR. DAYHUFF:** That's fine. The Roper St. Francis --
13 oh, the Roper St. Francis dot, yeah. I see it.

14 **MR. THOMAS:** Yeah.

15 **MR. DAYHUFF:** And you're right.

16 Q: It's farther north than it should be, right?
17 That's not Carnes Crossing?

18 A: No, that's Moncks Corner. That's where Roper
19 has other facilities.

20 Q: Right. That's where their hospital is going.
21 No. That's where they have the FED. You're
22 right. Okay. Well, but suffice it to say, when
23 you're making that comparison, when you reach
24 the conclusion --

25 **MR. DAYHUFF:** Wow, did you see that?



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ROA_0466

1 MR. THOMAS: There we go.

2 MR. DAYHUFF: Mr. Thomas, you're mistaken.

3 Q: The comparison you're making is the difference
4 in access for folks in those counties in the
5 north area between the new proposed linacs and
6 Trident's existing linacs.

7 A: Right.

8 Q: Right.. And MUSC and Roper's linacs are close to
9 Trident, so you find it to be a non-improvement
10 in access or a minimal improvement.

11 A: Right.

12 Q: But you're making the wrong comparison, aren't
13 you? Let's take MUSC for example. You've
14 looked at the patient working data in this case
15 and you know that MUSC gets a sizeable number of
16 patients from Berkeley and Dorchester counties,
17 North Charleston County. It's approximately 30
18 percent of our total patients; isn't that right?

19 A: You do get that percentage.

20 Q: All right. These patients are currently
21 traveling long distances from their homes to get
22 to get to MUSC care on the peninsula or in Mt.
23 Pleasant.

24 A: Not all of them are traveling long distances.
25 Parts of North Charleston are relatively close



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ROA_0467

1 to the peninsula. But ---

2 Q: Many.

3 A: But the patients in Berkeley and in Dorchester
4 County have had somewhat longer drives to get
5 downtown. But I don't think I'm wrong. I think
6 these -- you said I'm looking at this wrong and
7 I disagree with that.

8 Q: The access, though, one other way to look at
9 access if for those that are choosing MUSC and
10 going all the way down to the peninsula, the
11 MUSC proposed location in Nexton would be better
12 for them, easier for them to access from a
13 geographic perspective?

14 A: Sure. I mean, it would cut down their travel
15 time.

16 Q: Sure.

17 A: But that's sort of turning health planning on
18 its head.

19 Q: Bringing resources closer to patients is turning
20 health planning on it's head?

21 A: No. You start with community need. The first
22 question is, is there a community need for the
23 facility. And community need can be established
24 in a number of ways. One would be, is there a
25 need for additional capacity at the individual



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ROA_0468

1 provider that's seeking a CON. I don't think
2 MUSC has demonstrated that. Secondly, looking
3 at it from a community perspective, is there a
4 geographic access hole generally to radiation
5 oncology services in a particular part of the
6 service area. Again, I don't think that's true.
7 But even if it were true prior to these
8 applications being filed, Roper is filling that
9 need now. . . And the third consideration then
10 would be any -- you know, if you kind of pass
11 the test of the first two steps. We need more
12 capacity, there's an access problem, then we
13 look at the institutions specific concerns.
14 Yeah, we've got patients from that area and we
15 could put the unit down here on the peninsula.
16 We could put it in Mt. Pleasant. We decided
17 that we're going to put it up here and that will
18 cut down travel time for some patients.

19 Q: These patients, 30 percent of our patients, who
20 for years have been leaving their homes in
21 Berkeley County and Dorchester County and North
22 Charleston and traveling past Trident to go down
23 to the peninsula to get cancer care, they're
24 part of this community, this service area we're
25 talking about.



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ROA_0469

1 A: They are.

2 Q: And their access would be improved if they're
3 going to choose MUSC cancer care to have a
4 location in Nexton.

5 A: Yeah. I mean, their travel time would be
6 reduced.

7 Q: Right.

8 A: I'm not disputing that.

9 Q: In your three-part process for determining when
10 we take those people's long travel into
11 consideration is the way you would analyze
12 markets in health planning?

13 A: Sure. I mean, if -- I mean, institution
14 specific planning is part of any project, you
15 know, if a particular provider wants to provide
16 services in a certain way to certain population.
17 But it has to be balanced with that community
18 need considerations. That's why the Certificate
19 of Need Program exists.

20 Q: Right. And the balance in your health planning
21 analysis tilts towards Trident, a low utilized
22 provider, and against the folks that are
23 traveling past Trident, who want access to
24 MUSC's cancer care.

25 A: It might. I'm doing this from an objective



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ROA_0470

1 standpoint. And the objective standpoint is
2 where are services located currently? Do
3 patients have to travel long distance to get
4 radiation? In any market I've ever been in,
5 patients drive by existing providers because
6 they choose to go farther away to receive
7 treatment. That's their right. I mean, and I
8 think that's fine. At the point in time in
9 which there's a demonstrable community need and
10 will improve the distribution and accessibility
11 of services, then I think that's the appropriate
12 time for a provider to relocate services in
13 another part of the market. But I don't believe
14 that those predicates have been met in this
15 particular case.

16 Q: In your deposition you testified, you know, it
17 would be a different matter if Trident was at 85
18 percent capacity. Then there might be a health
19 planning argument to have a location for MUSC in
20 the Nexton area.

21 A: Sure. Because there would be an access problem
22 for patients.

23 Q: Let me give you a hypothetical. Let me ask you
24 to assume that Trident had two rather than three
25 linacs today. What would Trident's 2017 or



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ROA_0471

1 current utilization be with two linacs? We
2 heard some testimony today that they're doing
3 about, what, 11,000, 12,000 treatments?

4 A: Yeah. A little over -- between 11 and 12.

5 Q: So, if we were to give them a capacity based on
6 two linacs rather than three, their capacity
7 would be over 85 percent; wouldn't it?

8 A: It would.

9 Q: All right. Well -- so, if Trident hadn't added
10 a third linac in 2015 that it didn't need --
11 because remember they unplugged the second as
12 soon as they installed the third -- you would be
13 in position to agree that there would be a good
14 argument that it's time to provide folks that
15 are using MUSC services with access to services
16 in southern Berkeley County.

17 A: I would not agree with that because Trident
18 didn't add a linac. All they did was replace an
19 existing linac. They have three -- they have
20 the capacity of three units. It would be
21 unreasonable to calculate the capacity based on
22 two units.

23 Q: When they don't utilize unit number three and
24 haven't since 2015, it would be unreasonable to
25 calculate capacity in that way.



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ROA_0472

- 1 A: Sure. Just like in a hospital. If a hospital
2 has 300 beds and you're only utilizing 200 of
3 them, you don't discount the other 100 beds
4 because they don't have enough patients to fill
5 them. They have that capacity, they just don't
6 have the demand for the service.
- 7 Q: That's interesting. Let's talk about hub and
8 spoke model a little bit. We talked about that
9 in your deposition. Hub and spoke is a model
10 that many hospitals utilize and have been
11 utilizing for years, right?
- 12 A: Sure.
- 13 Q: I think you learned about it in graduate school
14 in 1978.
- 15 A: That's true.
- 16 Q: Right. You remember it like it was yesterday.
- 17 A: I remember things from '78 a lot better than
18 last week.
- 19 Q: In this model a large medical center is the hub.
20 And the hospital developed spokes in
21 geographically dispersed areas away from the
22 hub, right?
- 23 A: Yeah.
- 24 Q: And the hub and the spoke are part of the same
25 hospital facility or hospital entity.

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ROA_0473

1 A: System.

2 Q: System, right. And typically the hub is where
3 inpatient services are provided that are more
4 complex, more acute, and the spokes are where
5 you provide outpatient care typically; is that
6 true?

7 A: I think we talked about this. Outpatient care
8 or sometimes community hospitals, you know, that
9 would be smaller, less specialized hospitalized.

10 Q: Got you. Some of the outpatient spokes we
11 commonly see, hospitals established AFCs?

12 A: Yes.

13 Q: Linacs?

14 A: Yes.

15 Q: FEDs?

16 A: Yes.

17 Q: Community hospitals?

18 A: Yes.

19 Q: All right. And the benefit for patients of this
20 model is these outpatient spokes are out in the
21 community, closer to homes, making the spokes
22 easier to access than the hub.

23 A: Sure.

24 Q: St. Joseph/Candler executed on the hub and spoke
25 model in that CON that we looked at a moment



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ROA_0474

1 ago.

2 A: True.

3 Q: Hub in Savannah, linac spoke in Bluffton,
4 apparently another spoke on Hilton Head Island.

5 A: Right. They found a need and they were able to
6 demonstrate consistency with the State Health
7 Plan and they were allowed to do it.

8 Q: Trident uses the hub and spoke model too, right?

9 A: They do.

10 Q: FED spokes in Moncks Corner, James Island?

11 A: Well, haven't gotten the one in James Island
12 outright.

13 Q: On the way. Proposed potential Trident Moncks
14 Corner Hospital, another example of a spoke from
15 the main Trident Hospital?

16 A: Yes.

17 Q: Summerville Hospital is an example of a spoke?

18 A: Yes.

19 Q: MUSC with this linac project is hoping to
20 execute upon the hub and spoke model that many,
21 many other hospitals, including your clients,
22 have executed upon in the past.

23 A: Sure. But the hub and spoke is a strategy.
24 It's not a need. It's a strategy that health
25 systems use. Again, we go back to CON involves



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ROA_0475

1 community health planning. And hub and spoke
2 doesn't always work in concert with the hub and
3 spoke model.

4 Q: I think I understand. You view hub and spoke as
5 something that could be used in a manner that's
6 contrary to CON practice?

7 A: It could be.

8 Q: Right.

9 A: Or it could also be totally consistent with CON
10 practice.

11 Q: Right. And a spoke can sometimes be used by a
12 hub to go into a market where it was no market
13 share?

14 A: Right.

15 Q: That's not the case here though, right? MUSC
16 shares Berkeley County, Dorchester, North
17 Charleston market with Trident and Roper.

18 A: All three of those systems serve that market.

19 Q: So, they wouldn't be putting a spoke in a market
20 where they don't have market share.

21 A: Right. They would be putting a spoke in a
22 market where they hope to gain additional market
23 share.

24 Q: In your opinion.

25 A: In my opinion.



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ROA_0476

1 Q: MUSC's utilization projections don't rely on the
2 market shift to the patients from Trident to
3 MUSC, do they?

4 A: What they wrote down on the application doesn't
5 rely on that. But in my experience, the benefit
6 of a hub and spoke approach is to increase
7 market share.

8 Q: Before we leave geographic access, hub and
9 spoke, during your deposition you provided MUSC
10 with free health planning advice. And you
11 suggested, I think, that Mt. Pleasant would be
12 a better place to put our sixth linac than
13 Nexton. Do you recall that?

14 A: I do.

15 Q: All right. MUSC already has a linac facility in
16 Mt. Pleasant, right?

17 A: They do.

18 Q: So, adding a second linac at our location in Mt.
19 Pleasant does not affect, much less improve,
20 geographic access for folks that are choosing
21 MUSC that live in Berkeley County?

22 A: It does not. It does -- I mean, if MUSC's
23 argument is we need additional capacity, it
24 solves that particular issue.

25 Q: All right. It doesn't do anything for the folks



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ROA_0477

1 who need to access a linear accelerator and want
2 to choose MUSC.

3 A: Right. If you look at his through the lens of
4 only MUSC's wants and desires. But if you look
5 at it from the community need standpoint, you
6 would say there's only one linac located in Mt.
7 Peasant, which is a pretty large population base
8 and could probably support a second linac.

9 Q: Well, you know, and I appreciate that you
10 describe that as looking at it through MUSC's
11 lens and their wants and desires. Don't we also
12 have wants and desires of the population that
13 lives in Berkeley County, Dorchester County,
14 North Charleston?

15 A: I'm sure we do.

16 Q: And they have preferences; do they not?

17 A: I'm sure they do.

18 Q: And their preferences are their own and they're
19 valid and they're free to execute upon those
20 preferences.

21 A: Sure. I mean, patients have free will.

22 Q: Yeah. And our regulation has geographic access
23 as one of the things we need to consider when
24 we're planning healthcare facilities. There are
25 other considerations too.



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ROA_0478

1 A: Sure.

2 Q: That's one of them.

3 A: But we don't tag patients as belonging to any
4 particular system. We look at the need for
5 services based on the overall geographic
6 distribution of services, not from an
7 institution specific perspective.

8 Q: Yeah. We don't tag patients as belonging to
9 anyone but health planners recognize all the
10 time that there are market shares in various
11 service areas.

12 A: Sure.

13 Q: That exist and deserve to be recognized and
14 served by the providers, right?

15 A: Well, I'm not sure I'd go that far, but they
16 certainly recognize and try to demonstrate the
17 need for a service that there was an existing
18 market share in a given area.

19 Q: Fair enough.

20 **MR. DAYHUFF:** MUSC Exhibit 10, please, Dan, Bates
21 page 439. Let's get that up.

22 Q: All right. Roper-Berkeley's Project Will Reduce
23 Service Area Utilization Below 80 Percent.
24 Roper applied under a State Health Plan section
25 that I skipped, Standard 6, that required you to



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ROA_0479

1 look at the market, right, what they would do to
2 the capacity or the utilization percentage of
3 linear accelerators in the service area?

4 A: Right.

5 Q: All right. That consideration does not apply to
6 MUSC's linac, a different standard.

7 A: True..

8 Q: All right. But your conclusion here was that
9 Roper can't satisfy the State Health Plan
10 Standard 6.

11 A: Correct.

12 Q: All right. You described Roper as playing games
13 with capacity ---

14 A: I did.

15 Q: --- in this process, right? To raise their
16 utilization level to justify their Berkeley
17 County linac, right?

18 A: I did say that.

19 Q: Essentially right before they applied, they
20 engaged in a maneuver that shrunk their capacity
21 and thereby raised their utilization percentage.

22 A: Right. And also raised the area wide
23 utilization.

24 Q: And you had even stronger words for Roper's
25 health plan in your post-project review letter,



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ROA_0480

1 right?

2 A: I don't remember exactly what I said, but I'm
3 sure I did.

4 Q: Well, let's look, DHEC Exhibit 1, CON 360 to -
5 61. This is your letter, right?

6 A: It is.

7 **MR. DAYHUFF:** All right, Mr. Bupp, are you there?
8 Looking?

9 Q: RSF has manipulated its radiation therapy
10 capacities, right?

11 A: Yes.

12 Q: Those were your terms. I think we heard
13 yesterday that Trident called this disingenuous
14 manipulation of capacities in a pleading that
15 was filed. Do you recall that?

16 A: I do.

17 Q: Did MUSC change its capacities on the eve of
18 filing to lower its -- to lower its capacity and
19 raise its utilization?

20 A: No.

21 Q: Did we send a letter to DHEC asking for our
22 Varian CD that does a hundred treatments a year
23 to have a different capacity?

24 A: I mean, nothing happened on the eve of filing
25 the application as it related to capacities as



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ROA_0481

1 MUSC.

2 Q: All right. Let's look at MUSC Exhibit 10, Bates
3 442. I think Mr. Sullivan looked at this
4 earlier today. All right. 2016, MUHA -- I'm
5 looking at the last bullet point -- MUHA's
6 existing linacs operated at 80 percent of
7 capacity, the application identified no current
8 capacity constraints. And I want to focus on
9 the capacity constraints. You -- capacity
10 constraints in your opinion are what type of
11 thing?

12 A: What I described earlier about CCRC in Horry
13 County where you're performing linear
14 accelerator treatments late into the evening, on
15 Sunday mornings, patients were having
16 appointments canceled because of inability to
17 accommodate them at the scheduled time. Those
18 would be the types of capacity constraints I'm
19 talking about.

20 Q: All right. And your point, at least here -- you
21 described them for me and I appreciate it. Your
22 point is here that you didn't see them
23 identified in MUSC's application. And without
24 those, it causes you to question whether they
25 need a linac, a new linac.



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ROA_0482

1 A: Right.

2 Q: Right? The capacity constraint indicia for
3 linac that you identify is not set forth in the
4 State Health Plan, is it?

5 A: No. I mean, the State Health Plan sets a
6 minimum utilization at which they consider that
7 you're reasonably using your capacity at 80
8 percent.

9 Q: Right. And this capacity constraint indicia,
10 people are being treated late at night,
11 difficulty to schedule, it's not in the
12 regulations either, the CON regulations.

13 A: Well, there is nothing specific to that, but
14 that certainly goes to the issue of community
15 need.

16 Q: When the capacity constraints you described
17 manifest themselves, that's not a good thing for
18 the provider, the physicians, the patients,
19 right?

20 A: It's not.

21 Q: Consequently, from a health planning
22 perspective, it's better to plan for an obtain
23 more capacity for healthcare service before you
24 start experiencing capacity constraint.

25 A: And I think that's why the State Health Plan



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ROA_0483

1 uses 80 percent, because at 80 percent you're
2 not bursting at the seams.

3 Q: Exactly. So, in our 2015 State Health Plan that
4 applies to MUSC, we have a linac section that
5 says if you have a current service and you're at
6 80 percent or higher, now it's time to do good
7 planning and go get a linac before you
8 experience capacity constraints that could
9 inconvenience patients, be difficult for
10 doctors, be hard on the provider.

11 A: Yeah. I mean, that's the way the State Health
12 Plan works.

13 Q: Right. Now, I mentioned just a moment ago one
14 of our linacs is an older Varian linac we use
15 for total body irradiation, right?

16 A: Right.

17 Q: Now, it has a capacity of what, a State Health
18 Plan capacity?

19 A: I believe it's 5,000.

20 Q: Five thousand. All right. And it does only
21 several hundred treatments a year, not even a
22 hundred. I think we looked ---

23 A: Seventy three.

24 Q: Seventy three last year.

25 A: Yeah.



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ROA_0484

- 1 Q: Now, because this linac is one of our five
2 current linacs, it has the effect of making our
3 actual capacity lower than our State Health Plan
4 capacity, doesn't it?
- 5 A: As a practical matter?
- 6 Q: As a practical matter.
- 7 A: As a practical matter, that's probably true, but
8 that's sort of a self-inflicted wound.
- 9 Q: Well, we'll get there I suppose. Roughly 5,000
10 treatments or 4,000 -- 4500 treatments lower
11 roughly, 4400 treatments.
- 12 A: I didn't quite follow that math.
- 13 Q: Yeah. Because it's not doing 4000, it's doing
14 50.
- 15 A: But that's different from capacity. That's how
16 many you were actually doing. Capacity is how
17 many could you do.
- 18 Q: Well, is it your understanding that that old
19 linac can do all the arsenal of rad onc
20 procedures that the newer one's can do?
- 21 A: Well, I mean, my recollection is, from Dr.
22 Jenrette's testimony, that they can do
23 conventional radiation treatment. I don't think
24 it had the capability of doing IMRT or
25 stereotactic.



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ROA_0485

1 Q: Do you recall Dr. Jenrette talking about its --
2 do you believe he talked about its ability to do
3 standard linac treatments at a high quality at
4 that equipment's age? I could certainly wait to
5 hear what Dr. Jenrette says.

6 A: You can ask Dr. Jenrette. I don't recall.

7 Q: All right. But that low capacity for whatever
8 reason it's caused, that has the effect of
9 increasing utilization on our other linacs,
10 right?

11 A: Again, because MUSC has chosen not to replace
12 that unit.

13 Q: Okay. And our State Health Plan capacity
14 doesn't recognize that, right, because it's not
15 in the State Health Plan.

16 A: Well, it shouldn't recognize it.

17 Q: Well, it doesn't.

18 A: It doesn't and it shouldn't.

19 Q: Would you consider that limited use, that very
20 low volume, a capacity constraint?

21 A: No.

22 Q: All right. Just trying to get your blessing on
23 our first CON application in 20 years. So, you
24 think TBI is a choice for us, right? So, we
25 just choose to do it and that's our problem.



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ROA_0486

- 1 A: As I recall, Dr. Jenrette said that TBI could be
2 done on other linacs as well.
- 3 Q: Yeah. And when he said that, he said it would
4 cause the other linacs to have scheduling
5 difficulties because TBI takes how long to do?
- 6 A: Two and a half to three hours.
- 7 Q: Right. So, we do choose to do it. Does anyone
8 else do TBI in the area?
- 9 A: I don't think anybody has the need to do it,
10 because they're not doing bone marrow
11 transplants.
- 12 Q: Right. Because we have patients that need it.
- 13 A: Right.
- 14 Q: So, we do it. And do you know anything about
15 the vault that houses this old low-volume linac?
- 16 A: That Dr. Jenrette testified it was undersized.
- 17 Q: Undersized, 40 or 50 years old, sitting in a
18 hospital building built in 1954, too small for
19 a modern linac. Does that all sound familiar?
- 20 A: I think he said there was a linac that could fit
21 in there, but not the TrueBeam.
- 22 Q: He was hopeful, wasn't he, that they had
23 developed a new linac that could fit in that
24 tiny space, because that would be great, right?
- 25 A: I thought he said there actually was one he



1 thought would fit in there, but ---

2 Q: We'll ask him about that.

3 A: Okay.

4 Q: I think he believes there could be a solution.

5 A: Yes..

6 Q: Right now there isn't. But we will talk to Dr.
7 Jenrette.

8 A: But you don't have to put the linac in that
9 space.

10 Q: Right. I mean, it would be really easy in that
11 area to renovate a 1954 building, do a new
12 vault. Could you imagine the cost containment
13 issues with that?

14 A: I'm not saying that's the solution. I'm saying
15 the solution would be to apply to relocate that
16 linac to a different site.

17 Q: Berkeley County?

18 A: Mt. Pleasant.

19 Q: Mt. Pleasant, you love that place.

20 A: I do.

21 Q: It is nice. Let's look at MUSC Exhibit 10.
22 And, Dan, do you need a break? We've been going
23 ...

24 A: I'm good if everybody else is.

25 Q: Fair enough. MUSC Exhibit 10, Bates 444. I



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ROA_0488

- 1 think this is your adverse impact slide from
2 project review. In short, Trident is going to
3 be hurt by the approval of either project.
4 That's your opinion, right?
- 5 A: Right.
- 6 Q: In your 30-plus -- was it 45-plus years?
- 7 A: Well, I've only been in healthcare consulting
8 for 38 years.
- 9 Q: Thirty eight. In your 38 years of healthcare
10 consulting, you've done how many adverse impact
11 analyses?
- 12 A: You know, more than 100.
- 13 Q: More than 100. So, generally adverse impact
14 includes a calculation of lost cases for
15 procedures.
- 16 A: I've done it many different ways. That's
17 certainly one way to do it, yes.
- 18 Q: Well, and if it's not generally the way it's
19 done, I guess I would like to know that. But I
20 assumed it was new service is going to cause
21 existing service, a loss of cases or procedures
22 through redirection and that's an element of
23 adverse impact; is that true?
- 24 A: That's one element, yes.
- 25 Q: Okay. And then there's going to be a monetary



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ROA_0489

1 value that is tied to the loss of cases or
2 procedures

3 A: Oftentimes I don't do the monetization of the
4 impact for a variety of different reasons, but
5 ---

6 Q: In your hundreds of adverse impact analyses,
7 roughly what percentage do you monetize, half?

8 A: Maybe. Maybe half.

9 Q: And what percentage of your adverse impact
10 analyses do you calculate the loss of procedures
11 in cases?

12 A: Probably more like 75 percent.

13 Q: Seventy five percent. All right. In order to
14 monetize the loss, you've got to understand the
15 hospital's margin on the case -- type of case,
16 right?

17 A: Sure.

18 Q: All right. Now, I heard earlier today that --
19 and I think you had a slide, which I don't need
20 to look at, where you discussed referrals from
21 Palmetto Primary Care, right?

22 A: Right.

23 Q: Now, you didn't do any analysis with respect to
24 the number of referrals that Trident currently
25 gets from Palmetto Primary Care, did you?



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ROA_0490

1 A: I did not.

2 Q: All right. And you've not done an analysis in
3 this cause that quantifies the amount of
4 potentially lost cases or procedures?

5 A: I've not done a formal analysis, that's correct.

6 Q: All right. And you've not done an analysis that
7 monetizes the loss because of course you'd have
8 to do the volume before you do the monetization.

9 A: That is true.

10 Q: You could have stopped me. You couldn't do --
11 now, at least initially you offered to me that
12 you didn't do adverse impact because you weren't
13 sure you understood MUSC's projections.

14 A: But that was part of it. And part of it is it's
15 very hard in this case because we've got two
16 different applicants and we have, you know, sort
17 of an uncertain projection of -- from my
18 perspective -- of what the true utilization's
19 going to be at that unit in Berkeley County.

20 Q: All right. You didn't do adverse impact in part
21 with respect to Roper because their projections
22 were way out there.

23 A: They were.

24 Q: Now, the factors of being unsure about
25 utilization at MUSC Roper and the factor that



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ROA_0491

1 their projections were way out there, neither of
2 those two things prevented you from doing an
3 adverse impact, a redirection calculation. It
4 just made it harder. You'd have to use ranges.

5 A: Sure. I'd have to use ranges, I'd have to use
6 a lot of assumptions.

7 Q: Now, monetizing the loss from either of those
8 was not possible because you didn't have the
9 information from Trident to do that.

10 A: Yeah. I mean, I guess it was possible. I just
11 -- I never asked for that information.

12 Q: Is it a factor -- your decision not to do, what
13 I'll call a traditional adverse impact analysis,
14 an analysis that considers lost volume and then
15 lost money, is it because in part MUSC plans to
16 serve patients, a market, that it already serves
17 as opposed to redirect patients that Trident
18 serves?

19 A: That didn't have anything to do with it. I
20 mean, I would have taken into account the fact
21 that MUSC had some historical presence in that
22 market.

23 Q: Is it a factor -- or was this a factor in your
24 decision not to do adverse impact? I think we
25 heard Mr. Gallati say Trident's linac service



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ROA_0492

1 line is profitable. Did you hear that?

2 A: I did.

3 Q: And it's profitable doing 63 percent of its
4 State Health Planning capacity, right?

5 A: Yeah. I think it might be slightly higher than
6 that now, but, yeah, it was profitable at 63
7 percent.

8 Q: Is that a reason why there's no adverse impact
9 analysis?

10 A: No. Quite honestly, the reason I do adverse
11 impact analysis is because I thought the other
12 issues in the case were so compelling that I
13 didn't think it was that important to do the
14 adverse impact analysis.

15 Q: Particularly the 80 percent?

16 A: Yes.

17 Q: Okay. Well, back before DHEC, you believed we
18 were at 80.1 percent, right?

19 A: I still had concerns about your capacity
20 numbers; but that was the number that was
21 reported.

22 Q: But you still felt good enough about it to set
23 adverse impact aside?

24 A: Well, I felt that, once we got discovery, we
25 would find that that 80 percent was perhaps



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ROA_0493

1 built on shaky ground.

2 Q: You had a feeling?

3 A: I've been down this road before.

4 Q: I see. All right. If the DHEC State Health
5 Planning Committee is particularly concerned
6 about adverse impact for a particular type of
7 facility or service, what do they do?

8 A: Well, I think they can make a reasonable
9 inference. Someone once used the example that,
10 if you're in a car and another car is coming at
11 you head on and just about to hit you, you may
12 not be able to assess the exact amount of
13 adverse impact, but you're pretty sure there's
14 going to be an adverse impact. And I think that
15 that analogy is, in this case, if you have an
16 approved provider at Roper, who's going to draw
17 patients from the same area that MUSC seeks to
18 serve, I think it's a pretty clear bet that MUSC
19 is going to redirect patients away from Trident.
20 And so I can't give you a specific
21 quantification, but they could say, you know --
22 and also in the State Health Plan it said the
23 benefits of improved access must be equally
24 weighed with the impact on existing providers.
25 Since there's no -- in my view, no improvement



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ROA_0494

1 in accessibility that would result in the
2 approval of MUSC's project, then any adverse
3 impact -- and I think it would be hard to press
4 even for MUSC to say they would have no adverse
5 impact on Trident. I think that weighing that
6 equation would definitely weigh in favor of
7 denial of the project.

8 Q: Gosh, that equation would have inputs on both
9 sides of it if you would have done an adverse
10 impact analysis, right? Because we know what
11 the geographic access improvements were going to
12 be reap for patients that choose MUSC. But we
13 don't know what's on the other side.

14 A: We know that it's going to redirect patients
15 away. I mean, I could give you a range of
16 different assumptions and you would be tearing
17 those apart right now as we sit here on Cross-
18 Examination, but ---

19 Q: Well, you mentioned something that was important
20 ---

21 A: Yes.

22 Q: --- about the State Health Plan. When the State
23 Health Plan, the Health Planning Committee, DHEC
24 will recommend the standard State Health Plan
25 committee adopts. When they're really concerned



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ROA_0495

1 about adverse impact, they can incorporate an
2 adverse impact standard into the Plan. That's
3 one thing they can do.

4 A: Well, they did. They have that language at the
5 end of the chapter on radiation therapy.

6 Q: Oh, yeah. They do. They have the balancing
7 language.

8 A: Yeah.

9 Q: But in Standard 6 that applied to Roper, there's
10 an adverse impact standard embedded in Standard
11 6.

12 A: There is.

13 Q: And that doesn't exist for MUSC in Standard 7,
14 right?

15 A: Not an explicit one, no.

16 Q: Definitely no words like they have in 6 appear
17 in 7. There's no adverse impact standard in 7.

18 A: Right. The overall -- the all-encompassing
19 adverse impact standards at the end of the
20 chapter.

21 Q: The sentence beneath the project review
22 criterion are the most important?

23 A: Yeah. I mean, that's basically saying look at
24 these criterion, but by the way, you have to
25 weigh the impact along with the -- what the



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ROA_0496

1. increase is in access.

2 Q: Right. And that's another way the State Health
3 Planning Committee can make the point that the
4 adverse impact is really important for a
5 particular service. They make adverse impact a
6 priority criterion in the State Health Plan,
7 right?

8 A: They could.

9 Q: Well, that's what they do when they're concerned
10 about adverse impact. They make it one of the
11 most important criteria that DHEC needs to
12 consider.

13 A: They could do that. Sure.

14 Q: Sure. Well, that's kind of the standard way,
15 right? They either embed adverse impact into a
16 standard, like Standard 6, and/or they include
17 it in a list of the most important criterion.
18 So, DHEC is sure to analyze it.

19 A: Or they say, DHEC, you have to read the whole
20 chapter and you have to balance impact with
21 increases in accessibility.

22 Q: Or it's mentioned in that little sentence all
23 the way up under those most important criterion.
24 We'll get to that.

25 A: Well, one might say that that's the most



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ROA_0497

1 important criterion because it's the last one
2 mentioned.

3 Q: Oh, you consider that to be in the list?

4 A: I consider that to be a consideration that
5 they're directing the Department to take in
6 their evaluation of the project.

7 Q: How about this. Is adverse impact in the list
8 of most important criterion in the linac section
9 of the 2015 State Health Plan or the 2016 State
10 Health Plan?

11 A: No. I'm not sure there was a '16 Health Plan,
12 but it wasn't in the '15.

13 Q: I just made that up, 2017.

14 A: It wasn't in the '15 or the '17.

15 Q: Thank you.

16 **MR. DAYHUFF:** Let's look just for a moment at Joint
17 Exhibit 5, Dan, 2015.

18 A: Okay.

19 Q: I meant that Dan, but you too.

20 A: Too many Dans in this proceeding.

21 Q: Bates page 2926. And we should have pulled this
22 up before, but let's just for the record. Is
23 that the 2015 State Health Plan?

24 A: It is.

25 Q: And is that the list of most important criteria?



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ROA_0498

1 A: It is.

2 Q: All right. And adverse impact is not in that
3 list, right?

4 A: It's underneath the list, under the same
5 subject.

6 Q: It's on the list, but it's underneath the list,
7 right?

8 A: Sure.

9 Q: All right. All right. Let's look at DHEC
10 Exhibit 1, Bates page CON 369. Did you have a
11 chance to see that as it's scanning by you?

12 A: I did.

13 Q: July 10th, 2017, what is this for the record,
14 Mr. Sullivan?

15 A: This is the complete letter. That's what I call
16 it, anyway.

17 Q: You mean the deemed complete letter?

18 A: Yes.

19 Q: Okay. Good. And what does the deemed complete
20 letter do?

21 A: It basically says that the application is
22 considered complete and ready to begin the
23 review cycle.

24 **MR. DAYHUFF:** All right. And let's scroll up, Dan
25 Bupp.



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ROA_0499

1 Q: It also provides a list, right?

2 A: It does.

3 Q: Let's see. Where is this list? What is the
4 Department telling us with this list?

5 A: Well, the Department decided not to follow what
6 was in the State Health Plan and chose their own
7 criteria.

8 Q: Okay. And do you believe they're not -- they
9 don't have the discretion to do that?

10 A: I think they do.

11 Q: Okay. And they chose that list for a reason,
12 right? Do you recall why?

13 A: No.

14 Q: Okay. Fair enough. So suffice it to say, this
15 list provided by the Department to the parties,
16 and this is MUSC's complete letter, this would
17 have gone to Trident, right?

18 A: It did.

19 Q: And it goes to the parties who are participating
20 in the DHEC review process to let them know what
21 the most important criteria are going to be for
22 the DHEC staff review, right?

23 A: Correct.

24 Q: And adverse impact was not included in that
25 list?



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ROA_0500